



**SUMMARY REPORT**

PHOTO CREDIT: LOGAN ABASSI UN/MINUSTAH

# Better Spending, Better Care

A Look at Haiti's Health Financing



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**A**mid recurrent natural disasters and severe financial hardship Haitians face formidable challenges to their health. Maternal and infant mortality rates are 5 and 3 times higher than the regional average. Access to health care is low compared to low-income countries and particularly among the poorest households. Delivery of preventive health services like immunizations is below minimum standards. Patients often bypass the public health system for lack of trust, and rely on consultations from traditional healers or simply purchase medication directly from unregulated providers for their medical needs. Haiti faces the challenge of meeting the United Nations' Sustainable Development Goals on health and improving outcomes for the poor despite declines in external financing for health and relatively low government contributions compared to other low-income countries to finance the health sector. In light of this, Haiti's healthcare system must operate more efficiently, and access to services must become more equitable and reach vulnerable populations.



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## **HEALTH OUTCOMES HAVE IMPROVED IN HAITI BUT BASIC SERVICES ARE LACKING**

**Since the 1990s, health outcomes for Haitians have improved considerably.** However, measures of equity and coverage of health and water and sanitation services are below many other low-income countries. While Haitians can now expect to live longer, access to basic health services is still lacking. For example, the proportion of mothers who deliver in health facilities assisted by a skilled birth attendant is almost twice as great (70 percent) in low-income countries compared to Haiti (37 percent). As well, mothers are far less likely to deliver in a health facility if they are in the lowest household income quintile (9 percent) than if they are in the highest (76 percent). Only 68 percent of children under 24 months received all three diphtheria, tetanus, and pertussis vaccine doses, compared to 80 percent in similar countries. Despite these difficulties, maternal and child mortality fell by about half between 1990 and 2015. However, these two measures of mortality remain respectively five and four times higher than Latin America and Caribbean countries. Based on current trends, Haiti will not meet the United Nations' Sustainable Development Goals to reduce the maternal mortality ratio to less than 70 maternal deaths per 100,000 live births, and the under 5 mortality rate to 24 or lower deaths per 1,000 live births by 2030.

**Lack of service coverage may be partially explained by the fact that, compared with other countries, Haiti has low physical access to the primary care level.** The country has only 0.3 dispensaries per 10,000 inhabitants, and there are large variations across the different departments. This ratio is well below the target set by Haiti's Ministry of Health and Population (MSPP), and it is also low relative to other countries. Physical access to the second level of primary health care, the health center, is better: Haiti has 1.2 health centers per 30,000 inhabitants, which is comparable to other low-income countries. By contrast, the density of community referral hospitals is very high in Haiti. However, these hospitals are often not adequately equipped for the level of care they are supposed to provide.

**Another constraint is the poor quality of care, which is considerably worse in preventive clinical care services.** Only 62 percent of pregnant women

receive physical examinations that meet minimum standards, and 3 out of 10 health providers fail to ask patients about pregnancy risk factors. Only 20 percent of medical consultations with pregnant women incorporate preventive care, or dispensing essential nutritional interventions, such as folic acid supplementation. Health facilities also score poorly on internal management processes, possibly explaining the low preparedness of health staff to deliver care according to clinical guidelines. Many health facilities operate without any data collection system, which makes monitoring, and evaluation as well as quality supervision problematic.

**Average life expectancy at birth has increased in Haiti but compared to low-income countries, Haiti spends more on health care relative to what the system produces.** This points to inefficiencies in health expenditure. Haitians can now expect to live until the age of 63, eight years longer than in 1990. This is similar to many low-income countries such as Rwanda, Comoros, and Tanzania, except Haiti outlays almost twice as much to achieve this outcome. In other words, even though Haiti has scarce resources, it could do more.

## **RAISING EFFICIENCY OF HEALTH PROVIDERS TO IMPROVE HEALTH OF THE POOR**

**Efficiency has not been the priority given frequent emergencies.** A succession of disasters and political instability have had the effect of focusing national policy and international partners primarily on acute health needs and short-term priorities, diverting attention and financing towards 'firefighting' and away from long-term issues like sustainability. Hurricane Matthew of October 2016 is one of the recent illustrations of this situation, in which the state and development partners have focused their efforts on urgent needs. The hurricane reportedly killed at least 1,000 people, affected 1.4 million Haitians directly, and displaced 175,000 people inside the country. Post-catastrophe response has often taken the form of construction or rehabilitation of hospitals without planning for how running costs will be borne after the initial emergency has passed. More than half of all health expenditure is allocated towards curative, rather than preventive care, even though the top causes of morbidity and disability could be resolved at the primary care level.



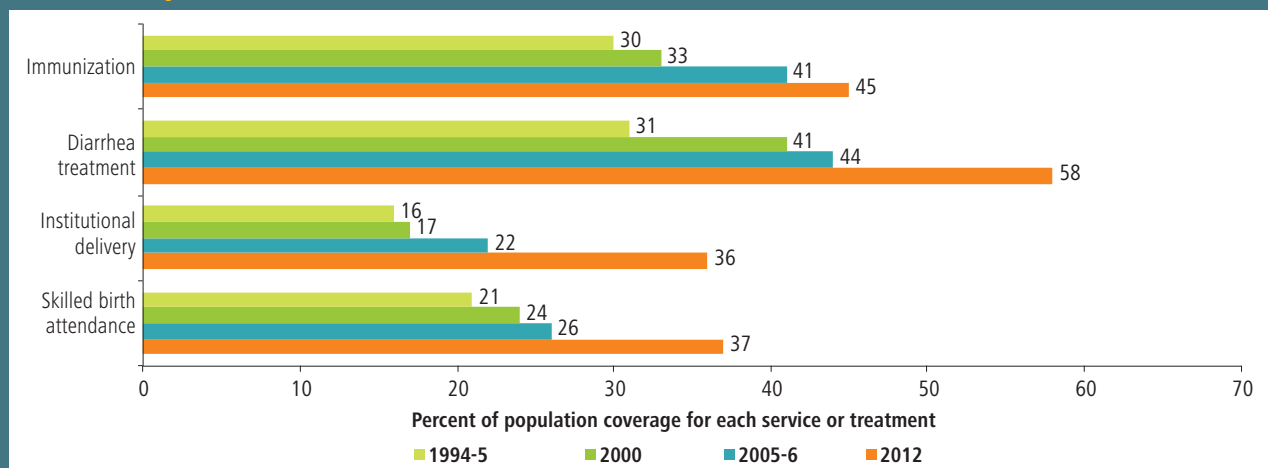
PHOTO CREDIT: VICTORIA HAZOU UNMINUSTAH

## Cholera and the Importance of Basic Services

Relative to other low-income countries and the Latin American and Caribbean region, Haiti performs poorly on water, sanitation and hygiene indicators, which is concerning given the country's cholera epidemic. Cholera deaths are disproportionately higher in the poorest households -- 2.4 percent reported death of at least one household member, while only 0.1 percent of the wealthiest reported the same outcome. Members of the poorest households are 24 times more likely to die from cholera than those in the wealthiest households.

Haiti reports a comparably high rate of treatment for children with diarrheal disease (58 percent), which is slightly higher than the average for similar countries (50 percent) and just below the Latin American and Caribbean region's average (59 percent). This indicator also increased considerably since the 2005-6 survey, up from 44 percent (Figure 1). However, 18 percent of children under 5 still die from diarrheal diseases in Haiti.

**FIGURE 1. Coverage Rates of Key Preventive and Curative Health Services: Haiti Demographic and Health Survey, 1994–2012**



Sources: Data is drawn from Demographic Health Surveys conducted in the following years: 1994–95, 2000, 2005–06, and 2012.

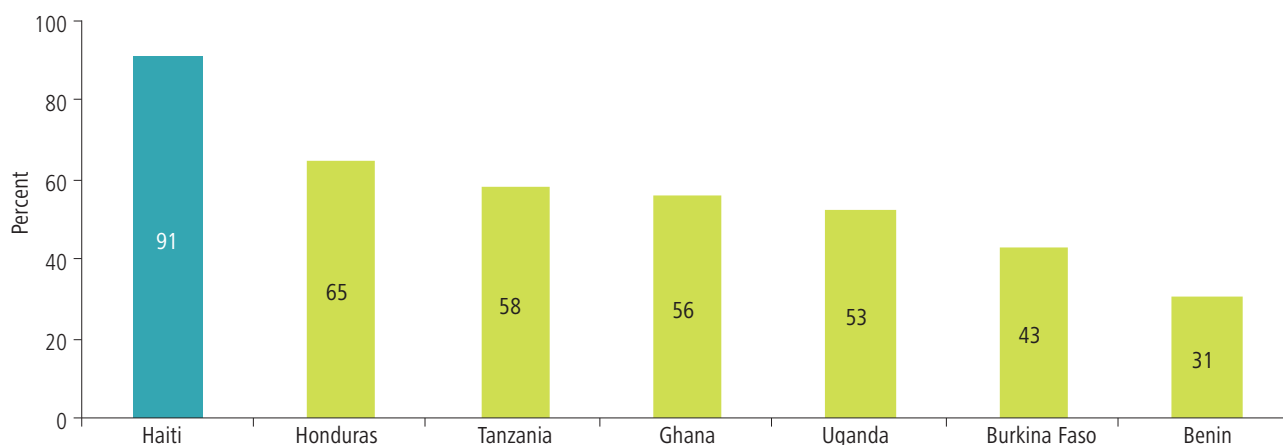
**TABLE 1. Technical Efficiency, Haiti and Other LICs**

Country	Percentage of sample that is not efficient (<1)	Average score <sup>1</sup>	Sample
Haiti	96%, CALs; 99%, CSLs; 99%, dispensaries	0.30, CALs; 0.09, CSLs; 0.04, dispensaries	79 CALs, 265 CSLs, 342 dispensaries
Burkina Faso	—	0.86	25 PHC facilities
Ethiopia	75%	0.57	60 health posts
Ghana	78%	0.88	Random selection of 86 health facilities
Guatemala	71%, but 53% have a score >0.9	0.78	34 health posts

Sources: World Bank staff, 2016; Akzali et al. 2008; Sebastian and Lemma 2010; Marshall and Flessa 2011; Hernandez and Sebastian 2013.

Note: — = not available; CALs = centres de santé avec lit (health centers with bed); CSLs = centres de santé sans lit (health centers without bed), LICs = low-income countries; PHC = primary health care.

**FIGURE 2. Human Resources Salary Payment as Share of Government Operating Budget: Haiti and Selected Countries, Various Years**



Source: Adapted from Better Spending, Better Services: a review of public finances in Haiti (2016).

**The efficiency of health providers is very low, especially at the primary care level.** Technical efficiency measures assess how well health facility inputs, such as supplies and equipment, are converted into actual health services delivered. Haiti’s health facilities score very low on this measure in comparison with other low-income countries. Dispensaries, the main provider of primary health care, are the most inefficient type of health facility in Haiti, with an average technical efficiency score of 0.04 (table 1)<sup>1</sup>. Efficiency is also low in all other mid-sized health facilities and hospitals.

**As much as 38 percent of total health expenditure in Haiti is spent in the hospital sector.** This proportion

is far greater than in other countries at a similar level of economic development. In recent years, Burundi, Tanzania, and Afghanistan have spent, respectively, 23 percent, 26 percent, and 29 percent of total health expenditure on hospitals. Further, the greater proportion of expenditure in Haiti’s hospital sector does not always translate to greater volume in service delivery. In fact, only 23 percent of hospitals in Haiti score satisfactorily on measures of efficiency. Low efficiency can be traced to a number of issues. Although the proportion of hospital expenditures seems to be higher in absolute terms, the funds available for hospitals are very low. Other countries like the Dominican Republic have a higher level of hospital spending than in Haiti.



<sup>1</sup> The technical efficiency score ranges from 0 to 1. A score of 1 means that the health facility is on the efficiency frontier and so is efficient. A score below 1 demonstrates poor performance, especially if the score is close to zero.

Experts, however, find fault with this approach as low investments in primary care and prevention lead to excessive use of emergency services and direct consultations with specialists on health problems that can be addressed at the primary level. The country is undergoing reforms to relieve congestion in major hospitals and help reduce costs at the national level.

**Low staff productivity and low service readiness in health facilities are two key factors that lead to inefficiency.** For example, the volume of patient consultations by health staff is quite low, and individual health personnel only provide an average of six consultations a day, or less than one patient per hour. Productivity is also negatively influenced by moonlighting (when publicly employed health staff provide services to patients in the private sector during off-hours), limited service readiness and high staff absenteeism, which on its own contributes to the waste of estimated \$3 million dollars per year. Service readiness is low overall; only 32 percent of health facilities provide essential medicines and only 31 percent possess basic medical equipment. Additionally, a study of health facilities in three departments shows that health staff in primary health care facilities often only work half-time (4 hours a day) despite receiving a full-time salary.<sup>2</sup> Productivity is also lowered by declines in patient flow into health facilities as a result of financial barriers; these factors greatly reduce access to services for the

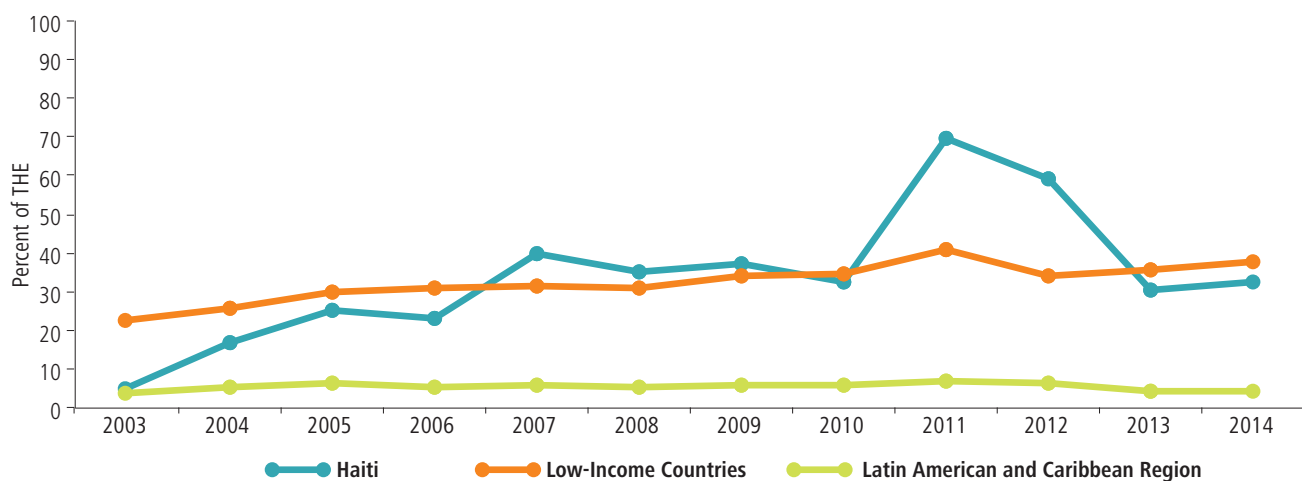
poor. The fact that the Ministère de la Santé Publique et de la Population (MSPP) allocates 90 percent of its operating budget to personnel costs (Figure 2) means that operational budgets are too tight to ensure an adequate supply of all the other inputs required.

## CHANGING THE HEALTH FINANCING MODEL TO SAVE LIVES

**After the 2010 earthquake, a large share of external emergency funding emphasized strengthening infrastructure through the construction and rehabilitation of hospitals, yet the operating costs for many of these facilities are not sustainable.** In the immediate aftermath of the earthquake, several capital investments in infrastructure were funded by development partners in the form of donations to the MSPP. The necessary operational costs that followed these capital investments have proved to be unaffordable, posing further funding challenges for the health sector.

**Haiti is reliant on the substantial flow of humanitarian aid that climbed sharply following the 2010 earthquake.** Over time, external financing has also been very volatile. After surging in the wake of the devastating 2010 earthquake, it sharply declined, with the health sector being among the most affected

**FIGURE 3. External Financing as Share of Total Health Expenditure: Haiti, LICs, and LAC Region, 2003–14**



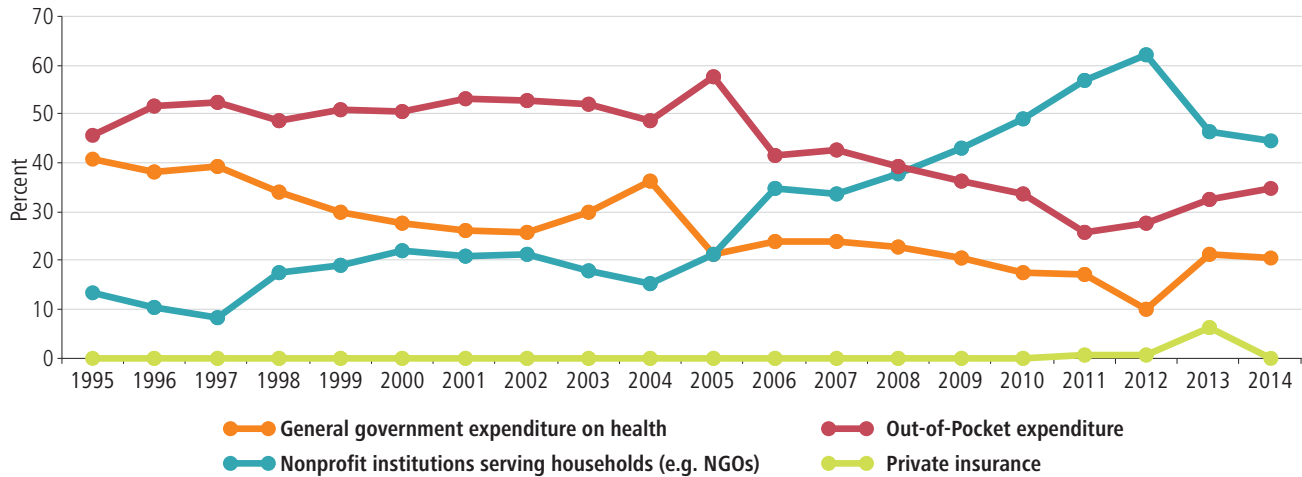
Source: GHED 2016.

Note: LAC = Latin America and the Caribbean; LICs = low-income countries; THE = total health expenditure.



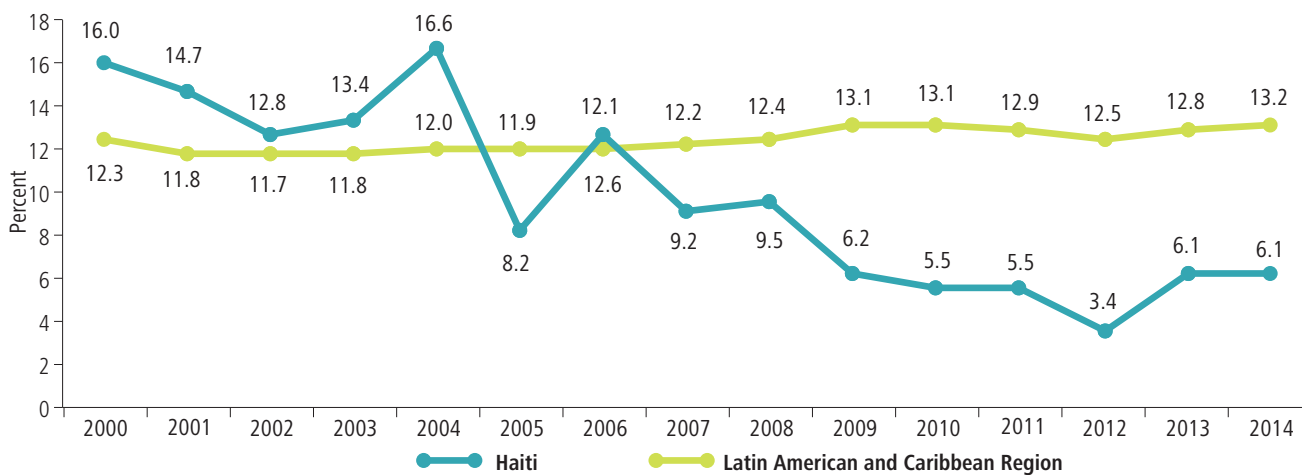
<sup>2</sup> However, it is important to note that the highest paid physicians in public institutions receive a salary of between 30,000 and 40,000 gourdes (approximately between \$500 and \$650 dollars). Assuming the doctor works full time, or 40 hours per week, this comes to about \$3 dollars per hour.

**FIGURE 4. Finance Source as Share of Total Health Expenditure: Haiti, 1995–2014**



Source: World Health Organization, Global Health Expenditure Database: <http://apps.who.int/nha/database>.

**FIGURE 5. Government Health Expenditure as Share of General Government Expenditure: Haiti and LAC Region, 2000–2014**



Source: GHED 2016.  
Note: LAC = Latin America and the Caribbean.

(Figure 3). Government spending has not made up for the decrease in development assistance for health, and instead, has actually dropped significantly.

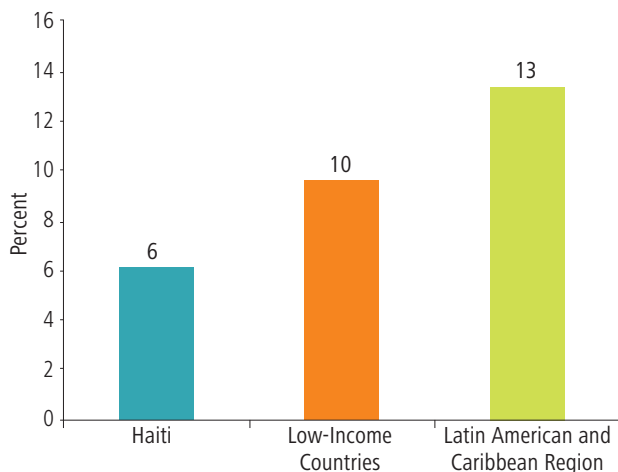
**Even though external aid is a big part of total health expenditure, donor coordination is low.** Since Haiti does not have a strong coordination mechanism in place and 90 percent of external funding is off-budget, it has been difficult to track, monitor and plan how these resources are applied to the health sector. This means funding has not been maximized for long-lasting and positive impacts.

**The high proportion of external aid for health has also crowded-out domestic financing, which has**

**been in a downward trend.** Domestic financing as a share of total health spending has been steadily decreasing since the 1990s -- public funding is the smallest source of financing for the health sector after private insurance. In 2004, it represented 36 percent of total health expenditure and fell to 21 percent in 2015 (Figure 4). Between 2000 and 2005, Haiti's health sector received domestic allocations of 14 percent on average. This was similar to the average for the LAC region (Figure 5). However, in 2014 domestic allocations were only 6 percent, which is only half the average proportion that other low-income countries spend on health. Since then, the percentage of total government expenditure going to health has continued to fall, reaching 4.4 percent in the latest 2016-17

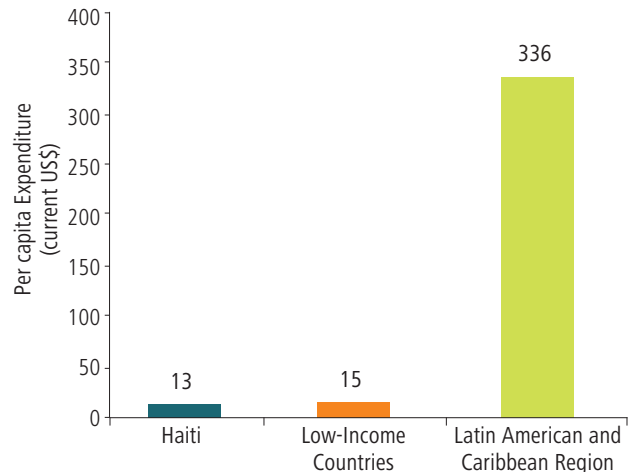


**FIGURE 6. Share of Government Expenditure Towards Health: Haiti, Low-Income Countries and Latin American and Caribbean Region, 2014**



Source: World Health Organization, Global Health Expenditure Database: <http://apps.who.int/nha/database>.

**FIGURE 7. Government Expenditure on Health Per Capita: Haiti, Low-Income Countries, and Latin American and Caribbean Region, 2014**



Source: World Health Organization, Global Health Expenditure Database: <http://apps.who.int/nha/database>.

budget. Government health expenditure as a percentage of GDP has been hovering at 1–2 percent and is currently below that of the average low-income country. The budget also shows that government health expenditure per capita in Haiti is \$13 dollars, which is lower than the low-income country average of \$15 dollars. This indicator is much lower than the average for neighboring countries like the Dominican Republic (\$180 dollars) or Cuba (\$781 dollars) and the Latin American and Caribbean region, which has a public expenditure of \$336 dollars per capita (Figure 7).

## **EQUITABLE ACCESS MEANS PRIORITIZING PRIMARY HEALTH CARE**

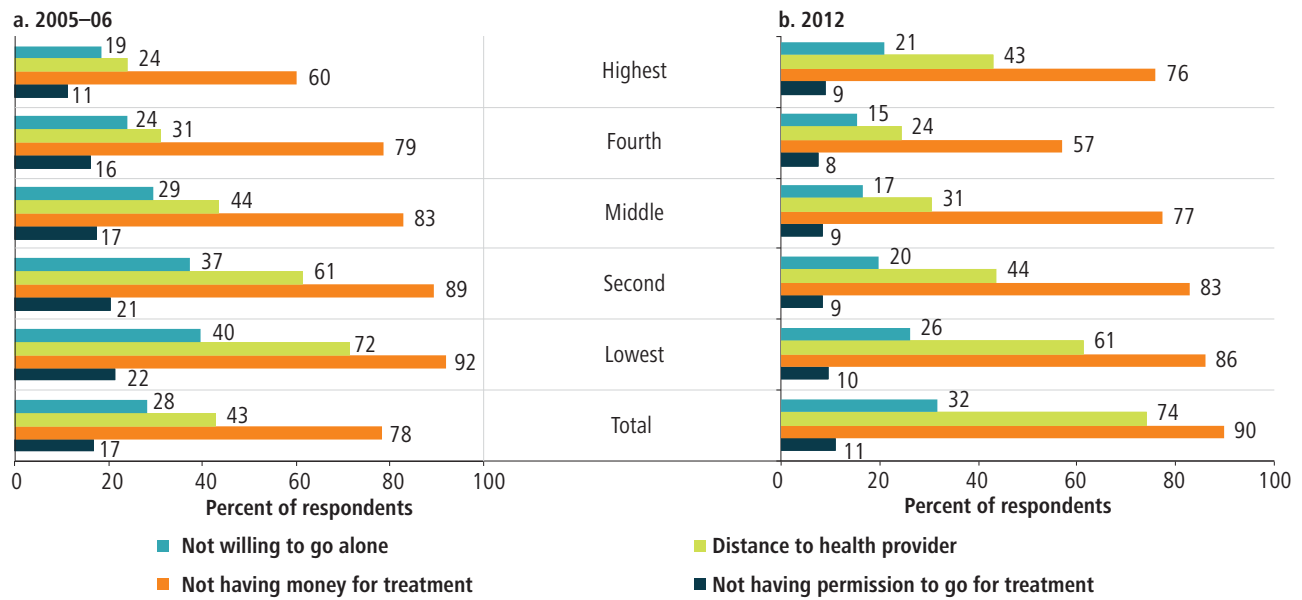
**Financial and geographical access are the key obstacles to healthcare in Haiti.** Almost all health facilities (93 percent) charge user fees, which burdens the poorest populations the greatest. Nearly two-thirds (63 percent) of households in the lowest wealth quintile decide against consulting a health provider because they cannot afford it. In 2012, transportation was the second most common factor, after finance, that prevented women aged 15–49 from accessing health services (Figure 8).

**Patients in need of treatment face high costs and often incur significant debt after visiting a private**

**clinic or after hospitalization.** Out-of-pocket payments have been rising; in fact, they have nearly reached pre-earthquake levels, which represented about 35 percent of total health expenditure. The incidence of catastrophic health expenditures has also increased, and vulnerable populations, such as the unemployed, the retired, and households with more than three children under 5 are the most affected. Households visiting a private clinic are almost three times more likely to encounter catastrophic health costs. Those seeking care from a traditional healer are also twice as likely to face catastrophic health expenses as households treated at a public dispensary or health center. This is concerning, because households from the lowest wealth quintile consult traditional healers more often than households from the highest wealth quintile. Yet, traditional healers' performance is neither regulated nor monitored and could pose a health risk for the poor.

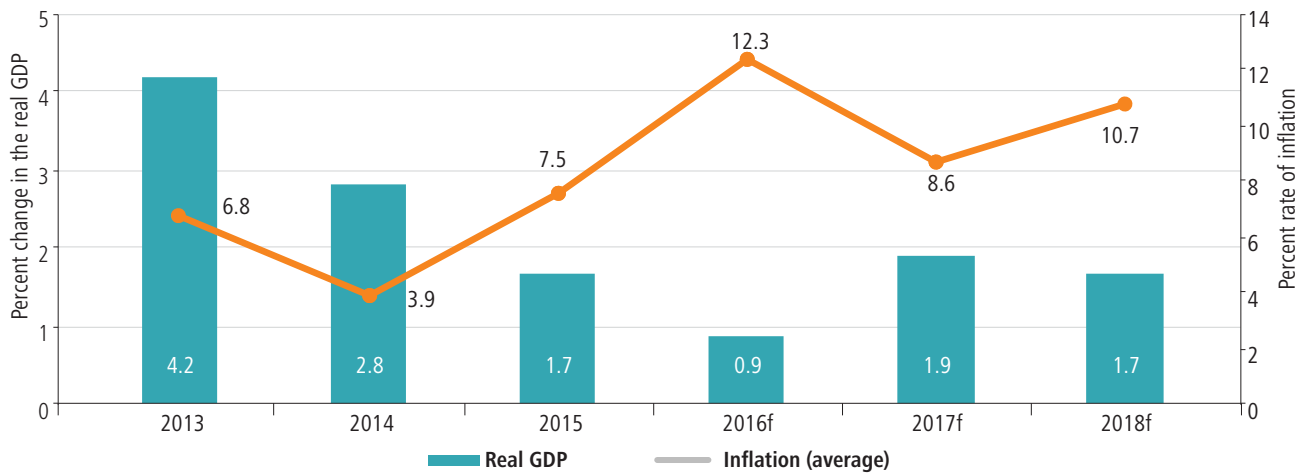
**In countries where basic services are lacking (such as Haiti), universal health coverage can only be achieved by prioritizing primary health care in the long-term. This includes extending access for the most vulnerable and poorest populations to essential health services.** With more than half of the population living on less than \$1.90 dollars per day and more than 30 percent unemployment, Haitians face severe access barriers and vulnerability to catastrophic health expenditure. Without access to high quality health services and universal financial protection,

**FIGURE 8. Reported Obstacles to Access to Health Care Services, by Wealth Quintile: Haiti, 2005–06 and 2012**



Sources: DHS 2005–06, 2012. Percentages shown do not add up to 100%, as respondents may have cited multiple obstacles.

**FIGURE 9. Annual Trends in GDP, 2013–15, and Forecasts: Haiti, 2016–18**



Sources: Ministry of Economy and Finance, Bank of the Republic of Haiti, and World Bank staff calculations.

patients are forced to choose between impoverishment due to out-of-pocket expenses and forgoing access to health services altogether. Still, as 93 percent of workers in Haiti are in the informal sector, it is difficult

to establish national and public health insurance systems. Currently, no government policy exists to protect vulnerable populations from health-related financial losses.

## THE WAY FORWARD FOR HEALTH IN HAITI

Economic projections indicate that economic growth in Haiti will likely remain low. This makes it even more important to use existing resources efficiently, and the seven strategic shifts described below aim to facilitate progress towards this goal. Reduction in GDP growth is affecting domestic revenues and shrinking the government budget across the board - the health budget is no exception. In addition, there is an urgent need to increase donor coordination with a focus on the poorest populations. At the same time, the MSPP should continue to work to increase domestic financing for health and affordability for the poor. That requires prioritizing primary health care through better-targeted spending and staffing. Stronger sector coordination would enhance service delivery and quality across the board. Ultimately, the most vulnerable populations in Haiti are best served by the strategic planning, allocation, and implementation of health financing. This financing must be applied towards a well defined set of essential health services to be delivered through health facilities with a high capacity for translating health service inputs into the delivery of quality, accessible and affordable health services. This will make the health system more equitable and more efficient, with higher patient flows into previously underused facilities, and improved public health outcomes, which will save lives.

The seven strategic shifts that Haiti could prioritize to accelerate its progress towards universal health coverage are:

**1. Prioritize primary health care. Realign resources from hospital to primary and community health care and cost and prioritize the existing Plan Directeur (Health Master Plan).**

To achieve better health outcomes with the resources available, government and development partners should spend more on primary health care by shifting resources away from hospitals. In view of Haiti's double burden of disease -- the coexistence of communicable and non-communicable diseases as the main causes of death -- health prevention and promotion interventions would yield the highest rate of return on investments as they address both types of diseases.

Resources should be realigned based on the Plan Directeur, which needs to be costed and prioritized. Currently, funding allocations made at the departmental level in Haiti are based on historically set values, instead of being tailored to population need. The MSPP should adjust the resource allocation formula so it is driven by the priorities that would be set in the *Plan Directeur*, and by the health and socioeconomic needs of the poor, relevant health system characteristics, updated data on disease burden, and the population covered. To guarantee service delivery to the population, health facilities must possess the necessary resources (staff, inputs, etc.).

**The MSPP should lead this resource re-orientation exercise with the support of development partners.** Strengthening the delivery of primary health care will maximize the potential impact of preventive health services and reduce the leading causes of morbidity in Haiti. Currently, only 19 percent of health expenditure is directed towards preventive care while 54 percent goes to curative care. This shift of resources from hospitals to the primary care level should be data-driven and guided by a long-term strategy (see shift 2).

**2. Increase equitable access to quality care. Update and implement a facility mapping tool by reclassifying health facilities to enhance service readiness and facilitate the development of a functioning referral network.**

The MSPP should develop a facility mapping tool to i) identify existing public and private facilities; ii) establish their service readiness (mostly in terms of staff and inputs); and iii) map population coverage of each facility. The first step is to build on the "carte sanitaire" already completed under the Service Provision Assessment survey, which was a census of all health facilities in Haiti. This information can be used to map the services that are actually being delivered in each facility. The findings of such a mapping tool will identify service gaps or redundancies and trigger a re-categorization of certain facilities. However, it does not necessarily mean building new dispensaries. Taking into consideration the investment priorities that would be defined in the *Plan Directeur* (see shift 1), certain inefficient community referral hospitals could

## Service Readiness in Haiti

Haiti has far less infrastructure and equipment than other low-income countries, significantly weakening service readiness and quality. Only 32 percent have essential medicines, and 31 percent have basic medical equipment. The availability of electricity, water, and bathrooms is far lower in Haiti (31 percent) than in Kenya (86 percent) and Uganda (64 percent). Similarly, availability of basic medical equipment in Haiti (49 percent) is about half of that observed in Kenya and Uganda. There is almost no budget to pay for drugs and running costs at the health facility level, given that the MSPP assigns 90 percent of its operating budget to staffing costs. To address these challenges, the MSPP needs to map existing facilities (*carte sanitaire*) then systematically confirm they meet minimum criteria for service readiness. If the criteria are not fulfilled, a licensing agency managed either by the MSPP or outsourced to a third party should downgrade or close the facilities.

be transformed into health centers. As health centers, these facilities will have increased operational expenditures and will provide primary health care and health promotive services. In other cases, facilities might be converted into primary health care units, upgraded to hospitals, or given special attention to ensure service readiness. Merged facilities would be better equipped with drugs and medical equipment.

The re-categorization of facilities should be aligned with the definition of a coherent and effective referral system. Strategies to cope with the potential decrease to access resulting from the re-categorization of institutions should be considered, such as developing systems to provide subsidized transportation options to hospitals for patients. In this process, it is critical to agree on a minimum package of services that will be financed and provided at the primary level.

**3. Spend more wisely on hospitals. Place a moratorium on the construction of new hospitals until existing hospitals can be mapped and a new hospital licensing program guided by the Essential Service Package is established. Development partners should also finance technical assistance to support the financial sustainability of hospitals.**

Pending the development of a facility mapping exercise and a hospital licensing program

that aligns with the Essential Services Package, MSPP should consider putting a temporary moratorium on new hospital construction. The still ongoing externally-financed wave of hospital construction was not accompanied by plans to sustain operational costs and maintain service delivery. Consequently, hospitals are currently lacking funds, while the MSPP has not provided enough financing to meet rising operational costs, affecting the capacity to ensure staff recruitment, training and provision of medical equipment and commodities. In the short term, no new hospital should be built unless it responds to urgent functional or geographical needs that will remain beyond the emergency period.

Addressing the issue of sustainability requires an urgent effort from the MSPP and partners to:

1. Suspend further hospital construction;
2. Consolidate existing hospital infrastructure (based on the prioritization and costing of the *Plan Directeur*, and the findings of the mapping exercise; see shift 1 and 2 above);
3. Set up a licensing policy (i.e. define parameters with which hospitals can be built or expanded);
4. Improve hospital performance and sustainability.

Donors need to be involved in the process of spending more wisely on hospitals. The MSPP should encourage development partners to fund technical assistance for developing business plans and improving hospital management to strengthen the financial sustainability of hospital acquisitions or programs by the government.

To achieve better use of external funding, the government can take a bigger role in guiding donors on what they need to invest in, and ensuring coordination of financing and interventions. One means of ensuring this function is to assess and strengthen existing cooperation mechanisms. This could include strengthening the Study and Programming Unit (l'Unité d'Etude et de Programmation, UEP), and in particular, its external cooperation service in charge of coordinating donors.

**4. Improve technical efficiency at PHC level.** *Value-for-money in service delivery should be increased, especially at the first level of care.*

**As facilities are re-categorized and distribution of basic equipment and medicines improves (see shifts 1 and 2), it is vital to improve technical efficiency.** As shown before, primary care level facilities in Haiti are less efficient than in other low-income countries. Low productivity is found in health facilities across all categories. Dispensaries, and health centers with and without beds are already known to be especially inefficient. Dispensaries are essential for the provision of primary care in Haiti, representing 4 in 10 health facilities, yet they score very poorly on several key service readiness indicators: minimum personnel, basic infrastructure, basic equipment, and drugs. Dispensaries are less likely than other facility types to be fully equipped with the necessary medicines (13 percent), equipment (54 percent), and infrastructure (7 percent), and patient volumes are extremely low.

**Increasing value-for-money will require increasing patient flow and human resources reform.** Less than one percent of dispensaries are efficient in terms of the number of patient visits for a given number of staff. In fact, only one of every 342 dispensaries operates efficiently, in terms of capacity for providing the number of visits expected considering its available staff resources. Absenteeism, moonlighting and slow demand by the poor contribute to low productivity, and in turn further depress patient numbers. Facilities are not properly classified and referral networks are not in place (see shift 2), which impedes improvements to efficiency. It is however crucial to ensure financial and geographical access to services to encourage service utilization (and thus higher productivity).

**One way to strengthen accountability and increase productivity is to link the funding of health personnel and institutions to results.** The MSPP just began implementing results-based financing in 10 percent of primary care facilities and will start to pay providers based on the coverage and quality of care. The results-based financing model was implemented in March 2016 in 80 primary level health facilities, of which 50 are sponsored by the World Bank and 30 by the United States Agency for International Development (USAID). The 80 facilities include dispensaries, health centers, and community referral hospitals. Decentralization of key human resource decisions and improvements to

**The Role of Technical Assistance in Improving Hospital Efficiency**

Compared with other low-income countries, Haiti fares poorly in hospital efficiency, despite 38 percent of its total health expenditure being spent at this level. Development of a hospital licensing policy and further work to improve hospital performance are needed. Only 23 percent of hospitals in Haiti are efficient in terms of bed occupancy rate, average length of stay and unit cost per bed day -- three measures for efficiency of hospital care. Dealing with this issue will require an urgent effort to set up a licensing policy, impede further hospital construction, consolidate existing hospital infrastructure, map out needed hospitals, and ensure that hospital services are provided in selected institutions where the required quantity of care can be obtained while improving quality. It is also crucial to explore how hospital management can be improved. A line of technical assistance will be needed to implement these important reforms.

human resource management practices are also important ingredients of the results-based financing model. Poor working conditions lead to low satisfaction and productivity by medical staff. Increasing non-salary operational budgets would improve service readiness and overall performance of health workers. A survey of medical staff and health managers in three departments finds that inadequate supply of medicines and equipment, and limited opportunities for job growth are key factors in poor motivation and performance. One way to free up resources for medicines, equipment and medical supplies is to address the large number of administrative staff on payroll. For example, 87 percent of the operational budget at the University Hospital of the State of Haiti is allocated towards staff payroll, which is high based on international benchmarks. In public facilities, administrative staff represent nearly half of the workforce, which is also high in comparison to other low-income countries. Decentralization of human resources would make health facilities more accountable, limit absenteeism and raise productivity.

**The availability of medicines could also be improved by revamping supply chain management.** Considerable savings could result from enhancing the coordination of the distribution network and focusing on last-mile distribution, potentially by outsourcing to local transport companies, which has been successfully piloted in Haiti. Lack of proper storage management and information systems affects the availability of medicines at the facility level. Sometimes, subsidized products are siphoned off at the regional depots and



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### Health Financing in Haiti Over Time

Total health expenditure has increased over the past 20 years driven mainly by external financing to NGOs while the government has played an increasingly marginal role in financing the sector. The increase in external financing has changed the structural composition of health spending. In 1995, households were the main financiers of the health system through out-of-pocket payments (46 percent), followed by the government (41 percent) and then NGOs (13 percent). Since then, the proportion contributed by the government has decreased substantially down to 21 percent in 2014. In the same year, out-of-pocket payments contributed 35 percent of total health expenditure while NGOs and other private institutions serving households represented 44 percent (Figure 4).

In the past, Haiti's health sector received domestic allocations of between 9 and 14 percent of the national budget. Between 2000 and 2005 government health expenditure as a percentage of the general government budget was 14 percent on average. During the years between 2006 and 2010 the same indicator was 9 percent. Due primarily to donor funding displacement in the post-earthquake period, the national budget allocations to health in 2012 were dramatically reduced to 3.4 percent (Figure 5). In Haiti, government expenditure on health represented just 6.1 percent of total government expenditure in 2014, well below the Abuja declaration recommended allocation of 15 percent.

The drop in external financing raises issues of sustainability of investment programs. From the highest levels in 2012–13 to 2014–15, the off-budget external financing has declined by 25 times and the on-budget external financing by five times, representing a massive loss for the health system. Public treasury funds have also decreased but at a slower pace, while the operating budget has increased slightly but not enough to compensate for the sharp drop in external funding. A large portion of external resources is currently used to finance operating costs such as vaccines, the health workforce, and medical products. With the withdrawal of external funding, the Haitian government needs to start paying recurrent expenses to ensure the maintenance of capital investment and the functioning of the health system. Large financing gaps for recurrent costs are emerging, and they are likely to continue. Faced with lack of a system for tracking donor resources and how they are used and with limited public financing, the government may not be able to plan and take over the costs of maintenance and operation.

sold to private sector pharmacies that then resell the products. Subsidized products end up in the hands of private providers, instead of being distributed at a subsidized price or free of charge by a public facility. As a result of stock-outs, public health facilities purchase medicines from the private sector that are normally subsidized but are sold at market prices.

**Departments with the poorer technical efficiency data should immediately be prioritized for technical and financial support by the MSPP and its partners.** Hospitals managed by non-government organizations (NGOs) are more efficient than public hospitals. Private for-profit hospitals are the lowest-performing entities and they also spend more than facilities managed by the MSPP and NGOs. Further studies should be conducted to better understand why NGO managed hospitals perform better and what can be learned from them. The MSPP needs to engage with these private entities and include them in the proposed facility/hospital licensing program (see shift 3).

**5. Better use of external funding. Haiti should have an adequately staffed and well-functioning donor coordination unit that conducts donor tracking and transition planning.**

The MSPP should establish an adequately staffed and well-functioning donor coordination unit to ensure adherence to the MSPP's costed and prioritized Plan Directeur (shift 1). The role of the unit would be to align all partners under a single plan to reduce inefficiencies related to the fragmentation of external financing and increase complementarity and continuity of interventions. Almost half of total health expenditure is externally financed, typically off-budget, and channeled through hundreds of implementers. Still, there is no established and regular mechanism for donors and the MSPP to discuss and coordinate technical and financial contributions, which both undermines the MSPP's stewardship role and generates inefficiencies. To maximize the full potential of combined financial contributions to health in Haiti, this issue must be addressed. One option is to strengthen the external cooperation service of the Study and Programming Unit (l'Unité d'Etude et de Programmation, UEP), which is responsible for coordinating donors.

As many donors are reducing financing or withdrawing, a properly functioning donor coordination unit

would make transition plans to match health system needs with available resources. Development partners should be required to register with the unit. This will allow the building and management of a national database of cooperation projects, making planning processes easier for the government. Although the coordination unit is only part of the solution, it will contribute to tackling the current situation where external financing has, on one hand, fueled unsustainable hospital construction and, on the other hand, is "emergency aid" which is volatile in nature and not necessarily what Haiti needs given its burden of diseases and existing health infrastructure.

**Haiti should build on existing examples of donor harmonization under specific programs and expand their scope to harmonize the most important external sources of finance in the health sector.** For example, the MSPP has led the development of a national manual for results-based financing which aligns key donors such as the World Bank, USAID, and the Global Fund (starting in 2016) around an outcomes-driven purchasing mechanism for primary care. Although the project is a good example of donor alignment, a weakness is that it is still 100 percent donor-financed.

**Key donors should agree with the MSPP on a program to strengthen public financial management practices.** In the medium term, targeting the departmental and local level would greatly increase the efficiency of public spending by improving budget planning and reporting, fostering a better allocation of resources and predictability. Also, it would have an impact on reducing potential intergovernmental leakages. In the short term, harmonized procedures and agreements among partners on levels of per-diems and salaries could cut transaction costs. To this end, the Ministry of Health and development partners should draft and sign a memorandum of understanding to identify minimum standards for emergency financing - including requirements that capital investments, such as construction of hospitals, are supported by plans long-term financial sustainability.

**6. Increase resources for health. Leverage greater health financing overall by increasing public health expenditure through better tax collection and more sustainable external financing.**

Haiti should leverage greater overall health financing, especially through domestic sources.

Despite pressing health care needs, Haiti has seen a sharp drop in government expenditure on the sector over the last two decades with a consequent increase in donor-dependency. However, donor financing is itself decreasing and thus, the government urgently needs to plan for increasing domestic funding for health to avoid a spike in out-of-pocket expenditures. Increasing public spending on health may require a broad increase in domestic resource mobilization or specifically for the health sector. One way of achieving the latter is by introducing earmarked taxes for health. Together with expanded domestic resources for health, Haiti should also work towards more sustainable external financing in line with the *Plan Directeur*.

**Haiti raises little tax revenue given its economic status and there is scope to raise more.** Sin taxes on alcohol and tobacco present an interesting option for sourcing funds for the health sector while discouraging consumption. Haiti has no tax on tobacco and the tax rate is 4 percent for locally produced spirits and 16 percent for imported alcohol. On average, taxes account for 31 percent of the retail price of cigarettes in low-income countries and 47 percent in the Latin American and the Caribbean region so there is scope for imposing taxes on these products in Haiti. An estimated minimum of \$8.2 million dollars per year could be generated by applying a 25 percent alcohol tax and earmarking the additional tax revenue to health. The proceeds from such a tax would represent an increase of almost 11 percent in government health spending, or \$0.76 dollars per capita. Since the health sector incurs a disproportionate cost compared to other sector, for the consumption of these goods, earmarking of tax revenues to the health sector can be justified. Developing dedicated taxes for health raises technical and political issues that warrant a thorough assessment.

**In addition to increasing domestic financing for health, Haiti should also ensure optimal allocation and use of resources to target key health priorities and make full use of donor funding for essential health inputs, such as vaccines.** Vaccines in Haiti have been fully funded by donors for some time. Haiti differs in this respect from most other low-income countries, which generally contribute to financing the purchase of vaccines from their domestic resources. However, full funding from donors for vaccines without any government co-financing is

less and less frequent. It is therefore urgent that the government begin to allocate some of its own funds to the vaccines to avoid any drop or interruption in vaccine supply. Similar arguments apply to other inputs and health services considered essential by the government.

**7. Increase the affordability of health services for the poorest people. The feasibility of removing user fees for selected services or target populations – children under 5 and pregnant women, especially in rural areas – should be assessed.**

**The feasibility of removing user fees for selected services including maternal and child health should be assessed, especially in rural areas.** User fees negatively affects not only equity in access but also efficiency of health facilities and ultimately health outcomes. Almost all health facilities charge user fees to bridge the gap in funding and consequently, catastrophic health and out-of-pocket expenditures are both increasing. In 2013, almost one quarter of households reported not consulting a provider when sick, and among those, 49 percent could not afford care. Because of the high poverty rate in Haiti, any amount of user fees, even very low ones can deter the poor from seeking care. A larger proportion of publicly managed facilities charge user fees compared to those run by NGOs. Although dispensaries are thought to be pro-poor because they are in rural areas – where the majority of the population is poor – they receive a higher proportion of wealthy beneficiaries (22 percent belong to the highest quintile) than poorer ones (18 percent belongs to the lowest quintile). Following the removal of user fees for maternal and child health services in several facilities in Grand’Anse, patient attendance levels were 200 percent greater than with the existing cost-sharing schemes. However, since currently user fees are an important part of health facilities operating budget, their removal needs to be carefully assessed, so that it will not affect the availability or worsen further the quality of services provided.

**Mechanisms to increase affordability to health services for the poorest should be pursued.** These include a transportation voucher program or the revival of the equity fund at the facility level to protect the poorest from direct and indirect costs of health care.



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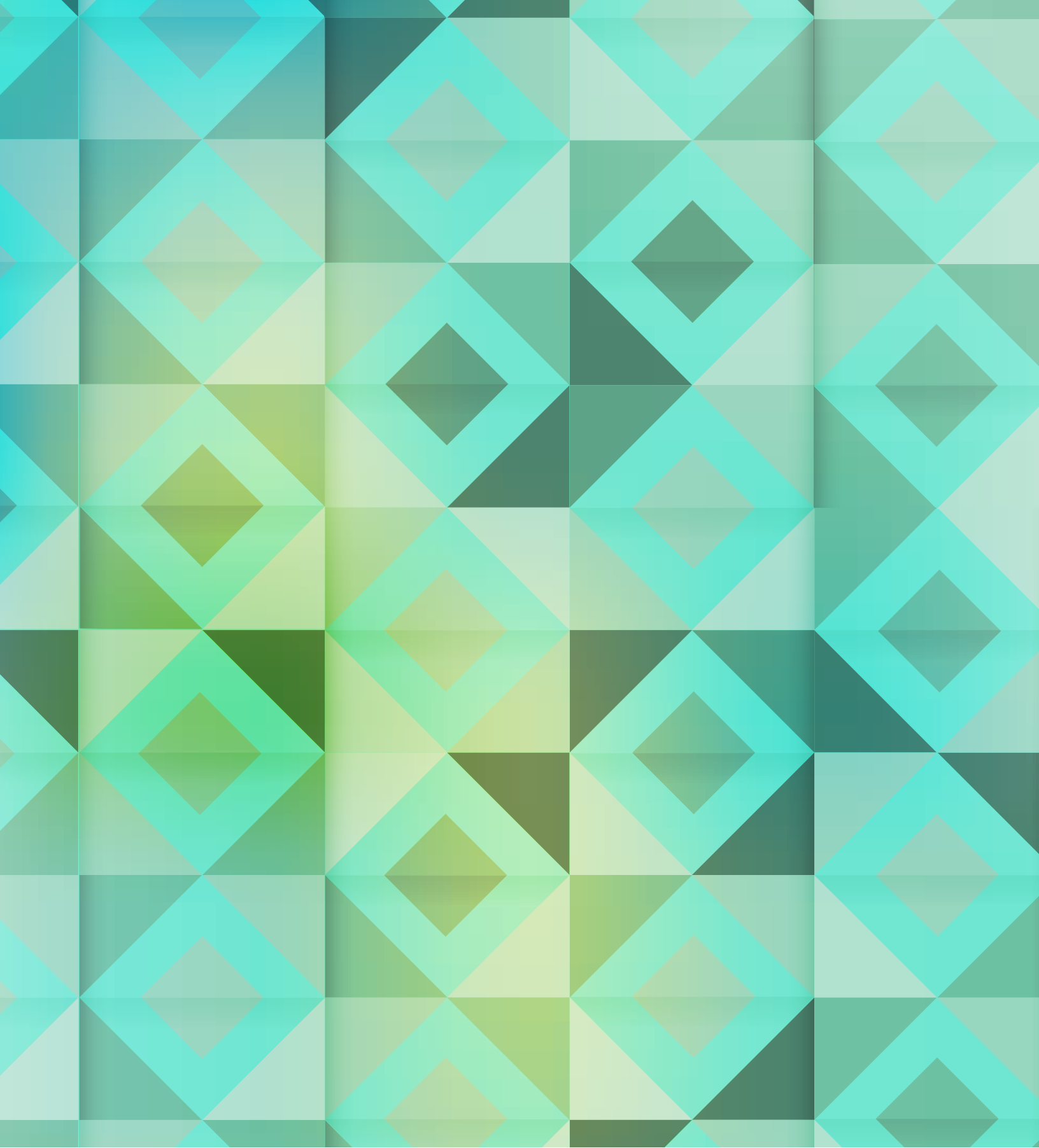
Mobile clinics and services provided by community health workers are mostly used by the poor and should be strengthened. As discussed in shift 1, more resources should be allocated to expand and strengthen community care.

**New revenue streams for hospitals should be explored.** Alternative sources of revenue for the health system from high wealth individuals, the Haitian

diaspora and religious organizations should also be examined. Pooling of these resources could allow the purchase of medical equipment and basic health products. In addition, other cost savings could come from nationally-pooled procurement of medical equipment and commodities. Ultimately, all the resources and cost savings should help finance more affordable services for the poorest population to increase the health of all Haitians.







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