Title: Cross-country comparison of the costs of healthcare services, and the cost drivers, at cross-border locations in Kenya, Rwanda, Uganda and Tanzania

Primary Field: Health care financing and expenditures

Sub-field: Payment mechanisms

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Abstract:

Background:

Private sources of expenditure constitute 20 to 49 percent of total health expenditure among East African Community (EAC) partner states (Burundi, Kenya, Rwanda, Tanzania and Uganda). Out-of-pocket expenditures make up between 68-95 percent of private spending, exposing households to catastrophic expenditures and impoverishment. With varying levels of insurance coverage (from 2% in Uganda to 95% in Rwanda), EAC Health Ministers recognized the need to enhance Social Health Protection Systems that reduce financial barriers to healthcare. The aim of this study was to gather objective, cross-country, comparable healthcare cost data to inform the development of sustainable healthcare financing systems for the EAC region.

Methods:

The USAID-funded Cross-Border Health Integrated Partnerships Project collected financial and activity data from July 2014-June 2015 at 45 public and private clinics, health centres and hospitals within five kilometers of five cross-border locations in Kenya, Rwanda, Uganda and Tanzania. The excel-based Management Accounting System for Hospitals (MASH) was used to analyze the data from a provider perspective and generate average costs per outpatient visit and per inpatient bed day at 42 health facilities. MASH uses a top-down approach to allocate all facility costs to outpatient and inpatient departments. Outpatient visit and inpatient bed day unit costs are then derived by dividing the total department cost by the number of services provided in the time period.

Results:

Results are presented by country, ownership and level (clinic, health centre, hospital) for the cost per outpatient visit and inpatient bed day. Unit costs varied widely between countries. Outpatient visit unit costs were US$1.54-14.19 (Kenya), US$3.09-4.11 (Rwanda), US$ 0.69-11.05 (Uganda), and US$3.38-13.56 (Tanzania). Inpatient bed day unit costs were US$20.37-49.00 (Kenya), US$14.64-17.24 (Rwanda), US$4.97-20.38 (Uganda). Costs were higher at private facilities compared to public facilities, and at hospitals compared to smaller clinics and health centres. Labor was the major cost driver in Kenya and Tanzania while drugs and supplies contributed the most to unit costs in Rwanda and Uganda. The contribution of drugs and supplies to overall costs was greater at hospitals compared to health centres and clinics, reflecting the increased complexity of services offered at higher level facilities. In all countries, workload was 3-5 times higher at public facilities compared to private facilities, with clinician ratios as high as 1:15,000 outpatient visits in public facilities compared to 1:4,000 in private facilities.

Conclusions:

Implementing social protection systems in the EAC will require domestic resource mobilization from both public and private sources and well-structured systems to support the healthcare financing functions of collection, pooling, and purchasing. The results of this study can support purchasing decisions by giving insight into the cost of providing healthcare services, and the cost drivers across countries and different levels of facilities. In addition, the findings can inform the design of provider payment systems that account for differences in costs across countries, ownership and levels and ensure sustainable provider reimbursement. Finally, the results can augment discussions on workload, staffing norms, and technical efficiency of facilities across the EAC region.