MLI
Ministerial Leadership Initiative
ASPEN GLOBAL HEALTH AND DEVELOPMENT

EXECUTIVE SUMMARY

Situational Analysis of Resource Allocation Reform in Senegal's Health Sector

M.S.P.

RESULTS FOR DEVELOPMENT INSTITUTE

SUMMARY

In this unfavorable international environment, Senegal is confronted with considerable budgetary constraints that exacerbate the exclusion of the weakest individuals. This situation also increases competition among the various ministerial departments. More than ever, good governance is imperative. By reforming its allocation criteria, Senegal's Ministry of Health and Prevention (MSP) will be in a position to defend its budget when competing with other sectors by optimizing its resources and creating the best conditions to attract technical and financial partners.

The MSP aims to improve the efficiency and effectiveness of government spending and optimize every dollar invested. This is the rationale for this study, which was carried out by Digit Medic Afrique (DMA) for the MSP and supported by the Ministerial Leadership Initiative for Global Health (MLI).[1] Accordingly, the first step for an efficient and equitable reform that is acceptable to all stakeholders would be to adapt fund release methods to the reality in the field and to the specific goals that have been reevaluated.

For too long, the methods for allocating and distributing resources have been based on a "**historic vision**" of the health system, which perpetuates an often unjust and static economic model. The main result of this recurring centralized procedure is the creation and widening of a gap between budgetary resource allocation and the actual objective needs of health structures. If this situation persists, it could completely fracture Senegal's health system, to the detriment of the most disadvantaged populations.

The limitations and lack of efficiency of the MSP's budget allocation methods are due to two parameters that have been in place for numerous years:

1. A budget allocation method that follows a systematic process based purely on historical criteria (money appropriated plus new measures);
2. The lack of a management style that fosters a "**results-based culture**" that is quantitative or qualitative, with warning systems and performance indicators.

The current method of resource distribution does not sufficiently take into account certain fundamental and objective parameters and ignores the natural evolutions of Senegal's demographic and social structure:

- the imbalance of health mapping due to concentrating resources in certain areas, such as Dakar and the regional capitals;
- poor health infrastructure in the remotest regions: Matam, Tamba, Kolda;
- the concentration of resources on tertiary (type 3) hospital structures;
- the growing separation of certain populations from the health system due to migration;
- the increase of the daily expenses for households: travel, lodging, etc.;
- the loss of confidence in the health system;
- the loss of motivation and frustration of health workers due to the "injustice" they experience; and
- numerous parameters with direct and profound influence on public health needs of populations

An analysis, even superficial, of the current allocation system reveals many inconsistencies that result directly in the imbalance of the health pyramid. These inconsistencies make the health system inefficient and increase social injustice in regards to the constitutional right to access to equitable health coverage for all.

[1] MLI is a 4-year program that works to strengthen the leadership capacity of ministries of health in Ethiopia, Mali, Nepal, Senegal, and Sierra Leone in order to advance policy in three interrelated areas: health financing for equity, donor harmonization in health, and reproductive health. MLI is a program of Aspen Global Health and Development, a legacy program of Realizing Rights: The Ethical Globalization Initiative, in partnership with Results for Development Institute and the Council of Women World Leaders. MLI is funded by the Bill & Melinda Gates Foundation and the David and Lucile Packard Foundation.

For instance:

- The resource concentration on urban hospital structures (> 37%), which receive the largest share of available public resources. This practice seriously penalizes the intermediate and decentralized structures of the national health system. (CNS 2005 Report);
- Health posts "at the bottom of the ladder," which represent the first point of contact for populations that are the most at risk and vulnerable, receive a minuscule and marginal portion (< 3%) of the distributed resources.

These inconsistencies in the resource allocation system translate into the following reality;

- an increasing gap between the health pyramid and the real needs of populations;
- significant disparities due to geographic location even within the same level of the system;
- penalizing households by increasing their contribution to the financing of the health system, which is exacerbated in certain geographical location; and
- the installation of a *de facto* two-tier public health system pitting urban populations against rural populations, and socially integrated populations against populations at risk.

Given this context, it is difficult for Senegal to reach defined international or national goals despite the significant and persistent financing efforts made by the authorities, as they have become the victims of "**budgetary evaporation**" due to a lack of cohesion and monitoring of the system.

Although it has come a long way and achieved quantifiable progress, the MSP still faces numerous challenges with efficiently managing the health system. These challenges result from easily identifiable issues "**that are easy to correct.**" There is a discrepancy between the historical system of resource allocation and actual operational health care needs. These issues revolve around a core issue that requires rapid deployment of budget reallocation reform within the public health system.

In conclusion, while the MSP is clearly in command of the political criteria and macroeconomic data of its health system, its central position at the top of the health pyramid results in a real distancing, if not isolation, from its operational base. Following financing and decentralization policy efforts, it seems that the system has reached limits in terms of efficiency. This credibility problem in our health system is due to a lack of understanding of the real situation in the field, which is constantly evolving to the rhythm of our nation's socio-demographic evolution.

In order to reach this crucial step in its history, the MSP must adapt and adopt "**a new political and philosophical vision of its mission as a public service.**" Its authority to co-determine and apply health policies at the highest level must be balanced by a better collaboration with various levels of the health pyramid that have practical knowledge of "the field."

To implement the proposed composite allocation criteria, the MSP must move from a hierarchical and centralized method to an approach based on more dialogue and participation. These criteria are called composite because they take into account all the issues of resource allocation in a crosscutting manner. For example:

- demographic weight;
- poverty index; and
- technical platform.

Method for Calculating New Resource Allocation Criteria Scores:

The score given to each region equals the sum of points linked to the demographic weight, to the poor population and to the technical platform (number of health centers), each representing a section. On the understanding that the distribution of the 1,000 points is based on the following percentages:

- Demographic weight: 50% is equivalent to 500 points
- Contribution to poverty: 30%, is equivalent to 300 points
- Technical platform: 20%, is equivalent to 200 points

*Ss = (Tr * Points) / Ts*
Ss: Score per section
Tr: Total demographic weight, population contributing to poverty or existing technical platforms for the selected region
Points: Number of points attributed to the section in question, 500, 300 or 200
Ts: Total of demographic weight, population contributing to poverty or existing technical platforms for Senegal

Score for the region = Sum (population score + poverty score + technical platform score)

Score = sum of section total /1,000

Scenario of these criteria applied to a budget of 1 billion CFA francs

REGIONS	POP	SCORE 1	POOR POP	SCORE 2	CS	SCORE 3	TOTAL	*TEST / 1,000 MF*
DAKAR	**2,622,408**	113	482, 523	105	19	48	**266**	***268,964,654***
DIOURBEL	**1 ,319,308**	57	167,552	37	4	15	**105**	***104,986,203***
FATICK	**627,804**	27	37,040	8	6	15	**51**	***51,313,887***
KAOLACK	**1,250,428**	54	165,056	36	7	18	**109**	***108,736,413***
LOUGA	**777,085**	33	39,631	9	5	15	**56**	***55,601 706***
SAINT LOUIS	**1,370,968**	59	117,903	26	8	20	**107**	***106,985,941***
TAMBACOUNDA	**729,471**	31	49,604	11	9	23	**66**	***65,991,328***
THIES	**1,471,754**	63	186,913	41	9	23	**128**	***128,434,190***
ZIGUINCHOR	**474 374**	20	30,834	7	5	13	**41**	***40,994,613***
KOLDA	**971,986**	42	98,171	21	2	10	**68**	***67,991,065***
TOTAL	**11,615,586**	500	1,375,228	300	74	200	**1,000**	***1,000,000,000***

It is by getting as close as possible to the populations and their needs, by means of a policy of proximity that inverses the way information is gathered and channeled within the health pyramid (from the pragmatic to the political, from the empirical to the theoretical) that the MSP will best insure the efficiency and effectiveness of tomorrow's health system and make better informed, hence more equitable, allocation decisions. It is also with this plan of action, by improving its performance and obtaining results through dialogue, that the MSP will best avoid conflicts of influence and social movements, thus creating the best conditions for national allocation decisions.

For a copy of the full report, please visit: *http://www.ministerial-leadership.org/*.