

FINANCING HEALTHCARE IN AFRICA



Overview

Health outcomes for many African countries have improved over the past 20 years, especially in respect of the common communicable, maternal and childhood diseases. Maternal mortality in Africa has decreased by 27 per cent over the past two decades, and mortality in children under the age of five years is declining by around 2.5 per cent per year. In Africa, malaria has been reduced by 34 per cent since 2000 and the mortality rate by 54 per cent. Despite the progress made, health systems in most African countries are weak and lag behind those in other regions of the world. Africans live an average of 14 years less than the average for the rest of the world. Africa has fewer than half the number of doctors per 1 000 people than does South-East Asia.

Low investment and the unsustainable dependency on aid for many basic primary healthcare interventions are two of the chief contributors to weak healthcare services in Africa. Other contributing factors include dislocation between policies, plans, budgets and spending, and lack of transparency and accountability.

As African governments move towards expanding the coverage and quality of healthcare, coupled with the scaling-up of interventions in the control and treatment of communicable diseases (malaria, TB and HIV/AIDS), securing adequate financing will be one of the many challenges that will need to be overcome. Achieving greater value for money, finding alternative sources of

financing, re-prioritising existing resources, increasing domestic revenues, and more predictable and progressive aid modalities will have to be considered.

This position paper on Financing Healthcare in Africa is based on a recent conference in Dar es Salaam on health financing in Africa, which was co-hosted by the Collaborative Africa Budget Reform Initiative (CABRI), Tanzanian Ministry of Finance, Global Fund, World Health Organisation (WHO) and Organisation for Economic Co-operation and Development (OECD). Finance and health officials from 14 African countries, development partners and industry experts

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participated in two days of deliberations on financing issues related to universal healthcare, communicable diseases, nutrition and the recent outbreak of Ebola in parts of West Africa. Briefing documents for the conference were prepared by Oxford Policy Management, WHO and CABRI staff.

The position paper also draws on two policy dialogues on value for money that CABRI convened with health and finance officials. These dialogues provided an opportunity for officials to examine the many complexities

they face when seeking to ensure that public spending: (i) aligns with policy priorities and budget allocations; (ii) is affordable and within the rules; and (iii) achieves the desired results.

Investing in sustainable and resilient health systems

Research has shown that countries can realise significant rates of return if they invest in the prevention and treatment of communicable diseases, such as malaria, TB and HIV/AIDS. Similar returns can be realised for investments in nutrition programmes. Investments in these disease-specific areas, mainly through a vertical approach¹, have increased considerably over the last decade, and important results have been achieved. However, many African countries face the real trade-off between investing in the strengthening of their health systems or directing the bulk of resources towards controlling or eradicating one or more of the common communicable diseases. In the case of malaria, for instance, the money that is spent on insecticide-treated bednets and indoor residual spraying could have been spent on diagnostic capabilities. Expenditure on antiretroviral drugs could have trained more doctors and nurses. The fiscal space to undertake comprehensive malaria, TB and HIV/AIDS programmes, alongside the strengthening of healthcare services, is limited. High aid dependency, especially

1 Vertical approaches refer to investments targeting a specific disease and delivered through specific mechanisms not integrated in the national health system. Horizontal approaches, on the other hand, are delivered through existing national health systems.

where donors have a particular preference and operate their own parallel systems, adds a complex dimension to the design and implementation of policies aimed at strengthening the health system.

Despite the many challenges, African governments need programmes that respond to malaria, TB and HIV/AIDS and, at the same time, strengthen health systems to deal adequately with chronic illnesses, such as obesity and heart disease, which are seen as constituting the greater threat over the next two decades. This means integrating disease-specific programmes into health system strengthening and tackling the same from a universal healthcare perspective within a basic benefits package. This process is complex and requires an integrated approach to fiscal and financial programming, planning, human resources and capacity-building. Ministries of health should increase their governance capacity, to ensure that different actors work in an integrated way, and build their capacity to contract with civil society organisations, especially in HIV/AIDS programmes, where awareness building is considered a critical intervention that must be conducted at community level. It will also be critical for development partners to integrate disease-specific programmes within national processes rather than creating parallel systems.

Prioritising value for money and analytical capabilities

Obtaining value for money within budget constraints has become more important

than ever in the context of declining aid and tax revenues in Africa. Value for money improves delivery and also provides a strong incentive for the allocation of additional resources from both domestic revenues and

development assistance. Value for money also demonstrates capability and confidence in the effectiveness of local systems. The general consensus on the need for increased value for money, however, is not always

Box 1: A value-for-money framework

Let us imagine that a minister of health wants to improve the value for money achieved by some aspect of government. How might he or she think about an intervention or policy to attain that goal? There is no universally applicable answer. However, a framework with seven dimensions – range, objective, yardstick, guidance, bureaucracy, involvement and verification – is useful in this process.

Range: What is the range, or scope, of the programme? The approach adopted depends on considerations regarding institutional capacity, demand from service users (or potential users), external pressures, the potential for improvement, etc.

Objectives: To improve value for money, a government could seek to improve economy, efficiency or effectiveness. It could also seek to improve value by spending money more fairly (enabling more people to have access to a service) or with greater integrity (being more open and accountable about spending decisions).

Yardstick: If a government wants to improve value for money it must be able to measure the improvement. This is likely to involve performance indicators.

Guidance: Essentially, this aspect of the framework is about communication and training. The public managers, auditors, inspectors and so on who are to be involved in the improvement project need to know what is required of them.

Bureaucracy: It is important that suitable systems and processes are in place to manage the improvement work.

Involvement: If public money is to be spent on a programme to improve value for money, the programme itself ought to be credible to stakeholders, which could include politicians, public managers, service users and the general public.

Verification: How will the government assure itself, and the public, that there have been improvements in value for money? Who will carry out the validation of results?

Source: CABRI (2015) *Value for money in public spending*

matched by an understanding of what this means. The definition of value for money as ‘the optimal use of resources to achieve the intended outcomes’ is difficult to measure. Box 1 provides a useful framework that governments can apply to attain the goal of increased value for money.

The framework is useful, especially in cases where governments decide to adopt ‘strategic purchasing’ of medicines and other supplies. Having a ‘yardstick’ that includes comparative unit costs provides a quantifiable measure to determine if economy and efficiency have improved. Having an insight into the capability of the bureaucracy will inform the decision on whether to assign cost-benefit-analysis to staff or to have it out-sourced. Essentially, ministries of health and finance need to develop their analytical and operational research capacities. These should engage in understanding how reforms in strategic financing and defragmentation of funding pools impact on health system efficiency, effectiveness and equity over the longer term.² Particularly, the importance of decreasing pool fragmentation so as to ensure cross-subsidisation between rich and poor members of the community or country, as well as between healthy and sick people, was emphasised strongly at the Dar es Salaam conference.

2 Pooling of financial resources is one of the four health-financing functions, simply defined as ‘the accumulation of prepaid healthcare revenues on behalf of a population’. The more fragmented pools are, the less the opportunity to manage financial resources and health risks across pools, typically leading to a decrease in equity in access and financing across the system.

Increasing fiscal space to enhance health coverage

Moving from current healthcare services to universal health coverage (UHC) may seem like a bridge too far for many African countries. The WHO defines UHC as a health system that gives all people access to the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be

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effective, while also ensuring that the use of these services does not expose the user to financial hardship. Although the cost of putting in place such a system may appear unaffordable, countries across all income levels can take steps to move closer to UHC, as has been shown in the case of Nepal, Thailand and El Salvador, to name a few.

Once countries have decided to move towards UHC, one of the first things they would need to do is to determine the size of the financing gap. This is the gap between the current public and private expenditure on health services as a percentage of GDP (also the *per capita* spend on health) and the estimated cost of implementing UHC. At the conference in Dar es Salaam, it was suggested that a key element of such

financing could be a commitment to the sharing of resources, to spread the financial risks of ill-health across the population. This would require the private providers of health services to partner with the government in bringing their specialisation and facilities into the ambit of the national health service. The system would work like insurance – a large pool of prepaid funds will have to be collected to cover the healthcare costs of those in need, regardless of their ability to pay. In addition, countries are advised to prioritise improved domestic resource mobilisation, and to increase efforts to eliminate inefficiencies.

Investing in preparedness as well as ex-post mitigation for epidemics

With the recent Ebola epidemic, mainly in the West African countries of Liberia, Sierra Leone and Guinea, which resulted in more than 11 300 deaths, the reality of underinvestment and capacity constraints in the health sector assumed greater urgency. The Ebola crisis highlighted the lack of preparedness to tackle health crises, which was exacerbated by the delayed reaction of the international community in translating pledged financial support into services. Countries must consider whether to invest in mitigation strategies, such as the pandemics insurance offered by the African Risk Capacity (ARC), or to invest in their health systems so as to ensure readiness for the next epidemic. Evidence shows that both preparedness and mitigation strategies are important, although financial mitigation

strategies remain in their infancy, and would need to be further developed to enhance their appeal to national governments.

Emergency preparedness is the key to managing future epidemics. This covers areas such as surveillance, early detection and clear protocols and procedures to deal with detected cases, including sensitisation

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to cultural practices that might worsen a pandemic. Some countries develop this function in an integrated way through the health system; others focus on ‘preparedness teams’. Whichever form emergency preparedness takes, clear roles should be specified across the central, regional and local levels of the health system. The ability to waive bureaucratic procedures for the release of emergency funding is crucial, as is the involvement of communities.

Exploring the potential of private sector innovations

Various private sector initiatives were presented and discussed at the Dar es Salaam conference. These included: portable solar systems for health facilities; private clinics set up in containers; and social impact bonds being developed by the Global Fund. The innovations provided by the private sector were recognised as valuable in emergency situations, where

health systems fail. However, private sector goals do not always align with those of UHC; for example, profit-seeking motives versus furthering financial risk protection, improvement in efficiency versus lack of demonstrable cost-effectiveness in private sector service delivery, and the creation of short-term solutions versus the need for long-term investment in health. Involving the private sector was recognised, therefore, as having huge potential, but requiring careful consideration.

CABRI's continued engagement

Because of their shared challenges and opportunities on the way towards UHC, African countries have expressed the desire to continue engaging with and learning from each other in terms of health financing. Future work on health financing will focus on efficiency gains, health assessment tools, training courses for health budget examiners, and an in-country review.



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Collaborative Africa Budget Reform Initiative (CABRI) Secretariat, PostNet Suite 217,
Private Bag X32, Highveld Park, Centurion, 0169, South Africa
Tel: +27 12 492 0022 | www.cabri-sbo.org