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ENSURING SUSTAINABLE FINANCING FOR UNIVERSAL HEALTH COVERAGE IN AFRICA IN THE MIDST OF CHANGING GLOBAL AND LOCAL ECONOMIC FACTORS

Report of the Secretariat

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BACKGROUND

1. Universal health coverage (UHC) is about ensuring that all people have access to quality essential health services they need for their health and well-being without incurring financial hardship. Universal health coverage is the translation of efforts to ensure the right to health and well-being for people throughout their life course considering social, economic, political and environmental changes. It is critical for achieving the highest standard of life and for sustainable and inclusive economic development. However, less than half of the people in Africa are accessing the essential health services they need to actualize health as a basic human right.[1]

2. Ensuring sustainable financing is a critical element of attaining universal health coverage, and therefore contributing to the Sustainable Development Goals (SDGs). The importance of sustainable financing for universal health coverage has been endorsed by Member States.[2] Sustainable financing requires both the mobilization of adequate funding to support services, as well as ensuring that those funds are allocated and used in an equitable, efficient and predictable manner over time, to protect households from financial hardship.

3. Several Member States in the Region have implemented innovative reforms towards ensuring sustainable financing for universal health coverage. For instance, in 2007, Gabon enacted a law that created a health insurance scheme, the "*Caisse Nationale d'Assurance maladie et de Garantie Sociale (CNAMGS)*". The scheme is partially funded by contributions from the formal sector and subsidized for the poor by a 10% tax imposed on mobile phone sales and a 1.5% tax on remittances from abroad. Over time, total health expenditure (THE) per capita grew from Int$ 247[3] in 2007 to Int$ 321 in 2014.[4] Furthermore, out-of-pocket payments (OOPs) as a share of total health expenditure reduced from 44% in 2007 to 22% in 2014. Other countries like Rwanda introduced health insurance by: instituting social health insurance for formal sector employees, financed by 15% of salary shared equally between the employee and employer; scaling up community-based health insurance to the national level and funding it by means-tested premiums for higher income groups and government subsidies for the very poor; a 5% mandatory contribution from other insurance schemes; and the Military Medical Scheme for the military.[5] These efforts have mobilized resources to fund an essential package that increased health coverage of services to 74%.[6]

4. Member States of the Region in 2017 adopted a framework of actions for strengthening health systems for universal health coverage and the SDGs in Africa (AFR/RC67/10).[7] It provides a menu of options for countries to consider, as they improve their systems and services to facilitate

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1 Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017. License: CC BY-NC-SA 3.0 IGO.

2 UN General Assembly 67/81: Global health and foreign policy; UN General Assembly, Dec, 2012.

3 Currency unit that would buy in a given country a comparable amount of goods and services as a US dollar in the United States. Source: World Bank, https://datahelpdesk.worldbank.org/knowledgebase/articles/114944-what-is-an-international-dollar (last accessed 02/04/2018).

4 Musango, L., & Aboubacar, I. (2010). *Assurance maladie obligatoire au Gabon : un atout pour le bien-être de la population*. World Health report.

5 Health Insurance law 2016 ; *Official Gazette n° 04 of 25/01/2016; http://www.moh.gov.rw/fileadmin/templates/HLaws/Health_Insurance_law_2016.pdf*

6 Government of Rwanda, 2016. Rwanda Demographic and Health Survey 2014-15. Kigali, Rwanda: National Institute of Statistics, Ministry of Finance and Economic Planning, Ministry of Health, and ICF International.

7 Accessible on the WHO Regional Office for Africa website: http://www.afro.who.int/sites/default/files/2018-01/AFR-RC67-10%20Framework%20for%20health%20systems%20development-Rev%2023.09.17.pdf

achievement of universal health coverage and other SDG targets. The framework of actions recognizes the need for innovative means to finance health services if universal health coverage attainment is going to be feasible in the Region. Such innovations are needed to mobilize required resources, in an equitable and efficient manner.

5. This technical paper reviews the state of spending on health in the African Region and provides guidance to Member States on addressing challenges to ensure attainment of universal health coverage and the SDGs.

ISSUES AND CHALLENGES

6. **Inadequate spending on health:** On average, total health expenditure (THE) per capita in the Region has grown at a rate of 6.83% per annum from Int$ 141.65 in 2000 to Int$ 296.52 in 2015. While the growth rate was comparable to that in other WHO regions, the average total health expenditure in absolute terms was lower than that in all but the South East Asian Region. Moreover, there are also marked inequalities in average total health expenditure in the Region ranging from Int$ 99.49 per capita in low-income countries to Int $ 898.40 per capita in high-income countries such as Seychelles.

7. **High out-of-pocket (OOP) spending on health:** Health funds are principally from public, donor/external, private or OOP sources. Of these, OOP spending represents the most inequitable source, most likely to lead to catastrophic health expenditure. The statistics show that the average share of OOPs as a proportion of total health expenditure declined from 44.55% to 34.98% between 2000 and 2015. This is a dramatic decline given that OOPs above 15-20% of total health expenditure is highly correlated to a high incidence of catastrophic payments.[8] Recent evidence shows that the African Region accounts for the fastest growing rates of catastrophic health expenditure[9] since 2000, with annual growth rate estimated at 5.9% per annum and has the lowest coverage of essential health services.[1]

8. **High rates of impoverishment due to ill-health:** In the Region, 118 million people, representing 11.4% of the population of Member States, are faced with catastrophic spending on health. Furthermore, the Africa and Asia Regions account for 97% of the 97 million people impoverished due to expenditure on health.[3]

9. **Declining economic performance among Member States:** Statistics from the World Bank show that between 2000 and 2016, sub-Saharan Africa enjoyed stable economic growth. In the last few years, however, this rate of growth has slowed markedly; for instance, current estimates show that economic growth was only 1.24% in 2016 from a peak of 7.08% in 2007.[10] This is likely to constrain the range of effective options for increasing the fiscal space for health.

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8 World Health Organization. (2010). World Health Report, 2010: health systems financing the path to universal coverage. World Health Report, 2010: *health systems financing the path to universal coverage*.

9 Catastrophic health expenditure (CHE) occurs when OOP payments for health services consume such a large portion (based on a pre-determined threshold) of a household's available income, potentially pushing the household into poverty.

10 https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG (Last accessed on 23/11/2017).

10. **Inadequate and inequitable government spending on health:** Member States have committed themselves to spending at least 15% of their budgets on health. However, this has not been consistently translated into improved allocations to the health sector. In fact, health spending as a proportion of government spending has dropped in 21 of the 47 Member States since 2000.[11] Member States spent on average only 9.9% of their budget on health in 2014, lower than other regions in the world.[8] On average, health spending in the Region is 2.01% of GDP,[7] but varies from 0.4% of GDP in Nigeria to 5.62% of GDP in Namibia, implying marked inequalities in spending across countries.[8] Moreover, government health expenditure for countries with similar income levels varies greatly from 10 to 60% of total health expenditure, implying that other factors determine allocation of public spending to health. Recent evidence also shows that in general, public health spending in the Region largely subsidizes the rich.[12] There is therefore need to better target spending for greater equity.

11. **Inadequate coverage by prepayment schemes:** Compulsory prepayment mechanisms are comparatively more equitable and are a sustainable means of improving financial protection.[13] The share of total health expenditure arising from prepayment schemes such as health insurance currently represents a very low proportion of health expenditure in the African Region (3.87%) in 2015, which is a modest increase from 2.47% of total health expenditure in 2000. Currently, only four Member States have achieved greater than 20% population coverage by a health insurance scheme. These include Rwanda (74%),[4] Ghana (55%),[14] Gabon (40%),[15] and Kenya (20%).[16]

12. **Increasing dependence on external financing for health:** External financing as a share of total health expenditure in the Region rose from 9% in 2000 to 24.42% in 2015.[10] This coincided with reductions in the share of government investment in health as a proportion of total health spending, suggesting a displacement effect of public financing by external financing. Increasing dependence on external financing does not bode well for sustainability of financing in Africa as external financing tends to be unpredictable.

13. **Weak information systems and evidence-base for health financing in countries:** Effective planning and monitoring for health financing in the region is hampered by inadequate evidence. This is largely due to inadequate institutionalization of prospective and retrospective resource tracking as well as routine production of household survey data which provides information on utilization and household payments for health. Thus, the availability of timely evidence on expenditure, utilization and distribution of the benefit of public financing in countries and financial protection is poor.

14. **Disconnect between resources and essential services:** Resources are primarily mobilized to provide essential services that populations need for their health and well-being. However, many

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[11] WHO calculations based on the data from Global Health Expenditure Database: http://apps.who.int/nha/database last accessed on 17/02/2018.

[12] Asante A, et al. Equity in health care financing in low-and middle-income countries: a systematic review of evidence from studies using benefit and financing incidence analyses. PloS one. 2016;11(4):e0152866.

[13] Xu, Ke, et al. "Protecting households from catastrophic health spending." Health affairs 26.4 (2007): 972-983.

[14] Ghana Statistical Service (GSS), Ghana Health Service (GHS), International. I. Ghana Demographic and Health Survey 2014. Rockville, Maryland, USA: GSS, GHS, and ICF International; 2015.

[15] Direction Générale de la Statistique - DGS/Gabon, ICF International. Gabon Enquête Démographique et de Santé 2012. Calverton, Maryland, USA: Direction Générale de la Statistique - DGS/Gabon and ICF International; 2013.

[16] Kenya National Bureau of Statistics, Ministry of Health/Kenya, National AIDS Control Council/Kenya, Kenya Medical Research Institute, Population NCf, Development/Kenya. Kenya Demographic and Health Survey 2014. Rockville, MD, USA; 2015.

Member States still lack up-to-date essential health packages to guide investments with mobilized resources. This introduces the potential for poor allocation of mobilized resources due to the absence of an evidence-based process to determine investment priorities.

ACTIONS PROPOSED

Member States should:

15. **Establish mechanisms for increasing domestic public financing for health:** Member States should implement measures to increase domestic resource mobilization for better public funding for health. Evidence-based measures that can be considered include (i) mandatory prepayment schemes (National Health Insurance) with possible public subsidies for persons who cannot contribute; (ii) new tax sources on Value Added Tax (VAT) levies, mobile money transactions, health hazards (sugar, tobacco and alcohol), (iii) cross-subsidies from private insurance schemes, among others. The macroeconomic and social context, the equity and cost-effectiveness of proposed sources should guide the adoption of new sources of funding for health.

16. **Shift out-of-pocket payments to more progressive means:** While these remain a critical source of financing particularly for facility-level activities in some Member States, their regressive nature makes them incompatible with UHC expectations. Member States should explore institutional changes needed to shift out-of-pocket payments into a pre-payment modality but done in a way that maintains the benefits of out-of-pocket payments in supporting facility activities.

17. **Develop and implement sound resource mobilization strategies for transitioning from external financing support:** To support transition to self-reliance in health care spending, Member States should start early planning and implementation of sustainable financing reforms. Furthermore, the cost-effectiveness, affordability, budget impact, sustainability and the need for health interventions, as well as the integration of chosen interventions within overall national systems such as the procurement systems should be considered in the adoption of new technologies.

18. **Improve efficiency in health care spending:** In addition to raising more resources for health, Member States should ensure value for money and reduce wastage of resources that have already been mobilized. For instance, by improving public financial management, minimizing health worker absenteeism, improving procurement practices and promoting local manufacturing of health products, Member States can minimize waste and improve efficiency across programmes and the overall health system.

19. **Engage and create an enabling environment for the private sector:** The private sector accounts for up to 50% of health service delivery in many Member States in the Region. Member States should institute the necessary policy and legal frameworks for engaging the private sector so as to harness the benefits of innovative health financing practices within the private sector including information and claim processing platforms, as well as service providers to extend service coverage .

20. **Establish up-to-date packages of essential health services:** It is critical that the package of essential services that are guaranteed for all, irrespective of capacity to pay, be well defined across all life cohorts. These are important for guiding investments in human resources, infrastructure, and commodities needed for effective provision of essential services. Essential services needed for each

life cohort should be elaborated by level of care and across the public health functions in each Member State.

21. **Institutionalize efforts for generating statistics, information and knowledge for universal health coverage:** Member States should invest in building the institutional capacity needed to ensure that statistics, information and knowledge are generated across all the dimensions of the Health Systems Strengthening for universal health coverage and the SDGs Framework of actions, to allow a better understanding of how resources mobilized are contributing to universal health coverage and other SDG targets that are important for health and well-being for all, at all ages.

WHO and partners should:

22. **Support capacity-building efforts for Member States to ensure implementation and monitoring of health financing reform:** This should be through provision of technical expertise for developing and implementing health financing strategies and plans, providing training to develop and apply tools and methods for health financing, and creating platforms that foster experience sharing and learning on the design and implementation of health financing reform. It should also enable health authorities to engage in a more meaningful and productive way with Ministries of Finance, other relevant line ministries, parliamentarians, civil society and partners to foster sufficient prioritization of health within the overall government budget.

23. **Support countries in developing essential health packages to guide investment decisions:** This should include technical support and strengthening of local capacity to design, and cost-benefit packages that are adapted to the epidemiological, economic and demographic context. WHO should also provide the necessary tools and guidance required for Member States to design essential packages.

24. **Promote efforts for generating evidence for advocacy and policy formulation for sustainable financing for health:** This should include support for priority setting for health financing research. The support to research institutions should promote generation of evidence of health financing practices that work, National Health Accounts and strengthening of National Health Observatories. The evidence should be adapted to different contexts whilst also fostering learning between countries and support efforts to translate health financing research into actions at the national level. WHO should support inclusive and evidence-based dialogue for improved and efficient financing for health.

25. **Support high-level advocacy for health financing**: WHO and partners should leverage partnerships with existing entities and their platforms such as the African Union, regional economic communities and others, so as to engage key stakeholders such as Heads of State, Ministers of Finance and Parliamentarians and advocate for improved domestic spending for health. Further still, WHO should foster policy dialogue between Ministers of Health and Finance to advance implementation of health financing reform and alignment of the reforms therein to public financial management reforms.

26. **Monitor progress in sustainable financing for universal health coverage**: This should include continued support for generating statistics, information and knowledge for universal health coverage across the dimensions of the Health Systems Strengthening for universal health coverage

and the SDGs Framework of actions. This should inform country progress in moving towards universal health coverage. In addition, support should be provided to Member States to develop health expenditure data tools to monitor progress towards improving health expenditure.

27. The Regional Committee reviewed the report and adopted the actions proposed.