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**FINANCIAL RISK PROTECTION TOWARDS UNIVERSAL HEALTH COVERAGE IN  
THE WHO AFRICAN REGION**

**Report of the Secretariat**

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## BACKGROUND

1. Health systems provide services that can produce substantial improvements in the health of individuals. However, accessing these services can claim over 10% of household incomes (catastrophic spending), while some may be pushed into poverty (impoverishment) as a result. Some households may forgo needed health services because of their inability to pay.
2. Ensuring access for all to essential health care services while safeguarding people against the financial hardship associated with paying for these services, is well reflected in national and international policy documents.<sup>1,2</sup> Indeed, ensuring financial risk protection as part of universal health coverage (UHC) is recognized as one of the targets for the health sector in the Sustainable Development Goals (SDGs) and the WHO Thirteenth General Programme of Work, 2019–2023.<sup>3</sup> Achieving financial risk protection requires action in all aspects of health financing. The legal and policy frameworks must include strategies to mitigate financial barriers, financial resources must be mobilized, pooled and allocated in ways that reduce the burden of financing health services on households.
3. Since 2015, WHO and partners have been monitoring country progress on reducing financial hardship. The indicators used include the incidence of “catastrophic health spending” and the proportion of the population “impoverished” due to out-of-pocket health spending.<sup>4</sup>
4. In December 2021, WHO reviewed progress on UHC, specifically how health financing policies can support increases in equitable service coverage and improvements in financial protection. While the service coverage index has been improving globally from an average of 45 in 2000 to 68 in 2019 (the maximum score being 100), the incidence of catastrophic health spending has been increasing, placing a heavy financial burden on individuals seeking health care.<sup>5</sup> The review noted that the world was not on track to achieve the UHC objectives.<sup>6</sup>
5. In the WHO African Region, only six Member States<sup>7</sup> have managed to increase service coverage while simultaneously reducing catastrophic health spending. Ten Member States<sup>8</sup> have a very high level of catastrophic health spending while their service coverage remains very low. This indicates persistent barriers to access, while people who have access incur high out-of-pocket payments. Although 27 Member States<sup>9</sup> in the WHO African Region have recorded relatively low levels of catastrophic health spending, they have low service coverage.

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<sup>1</sup> UN General Assembly resolution on Global health and foreign policy (A/RES/67/81)

<sup>2</sup> General Assembly Resolution "Global health and foreign policy: health employment and economic growth" (A/RES/71/159)

<sup>3</sup> SDG target 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all; Indicator 3.8.2:

Proportion of population with large household expenditures on health as a share of total household expenditure or income

<sup>4</sup> World Health Organization; World Bank. 2014. Monitoring progress towards universal health coverage at country and global levels: framework, measures and targets. World Health Organization and the International Bank for Reconstruction and Development / The World Bank,

<sup>5</sup> World Health Organization; World Bank. 2021. Tracking Universal Health Coverage : 2021 Global Monitoring Report. World Health Organization and the International Bank for Reconstruction and Development / The World Bank,

<sup>6</sup> World Health Organization; World Bank. 2021. Global Monitoring Report on Financial Protection in Health 2021. World Health Organization and World Bank

<sup>7</sup> Algeria, Cabo Verde, Mauritius, Namibia, Seychelles, and South Africa-<https://aho.afro.who.int/country-profiles/af>

<sup>8</sup> Angola, Benin, Cameroon, Côte d'Ivoire, Eswatini, Mauritania, Nigeria, Sierra Leone, Togo, Uganda. WHO AFR (2021) Integrated observatory (<https://aho.afro.who.int/country-profiles/af>, accessed 25 May 2022)

<sup>9</sup> Botswana, Burkina Faso, Burundi, CAR, Chad, Comoros, Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Madagascar, Malawi, Mali, Mozambique, Niger, Rwanda, Senegal, South

6. Given the high financial burden of out-of-pocket health spending within the WHO African Region, the purpose of this technical paper is to highlight the key issues and identified challenges to improving financial risk protection in the Region. This paper also proposes actions that WHO and Member States can take to address the financial burden of out-of-pocket health spending and therein advance the attainment of UHC in Africa.

## ISSUES AND CHALLENGES

7. **Inadequacy of resources for financing the health sector.** The level of financing for the health sector remains inadequate when compared to resource requirements. The current health expenditure across all Member States averages US\$ 54 per capita, with general government health expenditure averaging US\$ 14.8 per capita.<sup>10</sup> This is against an estimated per capita requirement of US\$ 127 to deliver an essential package of health services.<sup>11</sup> Member States with lower per capita allocation of government resources are associated with higher out-of-pocket payments.

8. **High out-of-pocket health spending.** It is noted that 28<sup>12</sup> of the 47 Member States within the WHO African Region fund more than a quarter of their current health spending through out-of-pocket payments. Among them, 12 Member States<sup>13</sup> fund more than a half of their total health spending through out-of-pocket payments. Paying for health care through out-of-pocket spending is not only inefficient but also an inequitable way of paying for health care services.

9. The proportion of the population incurring **catastrophic health payments and impoverishment due to out-of-pocket** payments in the WHO African Region remains high. In Africa, on average, 13% of the population incur impoverishing health expenditures because they spend more than 10% of their household budget on health.<sup>14</sup> This is explained by the increase in out-of-pocket spending per person,<sup>15</sup> with **medicines, age and outpatient care identified as the main drivers**. It is important to note that while the rate of impoverishment is reducing in Africa and globally, it is reducing at a lower rate in Africa when compared to the rest of the world. This is likely to compromise efforts within African countries to reduce poverty in line with SDG 1.

10. Health spending in low-income countries and fragile States relies heavily on **external aid**. According to the 2021 Global Health Expenditure Report, external aid for health has risen considerably since 2005.<sup>16</sup> Looking at trends, external aid as a percentage of current health expenditure has averaged

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Sudan, Zambia, Zimbabwe. WHO AFR (2021) Integrated observatory (<https://aho.afro.who.int/country-profiles/af>, accessed 25 May 2022)

<sup>10</sup> WHO Global Health Financing database ; <https://apps.who.int/nha/database> Accessed March 2022

<sup>11</sup> 2017b. World Health Statistics 2017: Monitoring Health for the SDGs. Sustainable Development Goals. Geneva: World Health Organization. ([http://www.who.int/gho/publications/world\\_health\\_statistics/2017/en/](http://www.who.int/gho/publications/world_health_statistics/2017/en/), accessed 25 May 2022)

<sup>12</sup> Algeria, Angola, Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Ghana, Guinea, Guinea-Bissau, Liberia, Madagascar, Mali, Mauritania, Mauritius, Niger, Nigeria, Senegal, Sierra Leone, Togo, Uganda. WHO Global Health Financing database; <https://apps.who.int/nha/database>. Accessed March 2022

<sup>13</sup> Cameroon, Central African Republic, Chad, Comoros, Equatorial Guinea, Guinea, Guinea-Bissau, Liberia, Nigeria, Senegal, Sierra Leone, and Togo. WHO Global Health Financing database; <https://apps.who.int/nha/database> Accessed March 2022

<sup>14</sup> WHO, World Bank; Global monitoring report on financial protection in health 2021

<sup>15</sup> World Health Organization; World Bank. 2021. Tracking Universal Health Coverage : 2021 Global Monitoring Report. World Health Organization and the International Bank for Reconstruction and Development/The World Bank.

<sup>16</sup> The top five recipients of external health aid in 2019 were Nigeria, Ethiopia, the United Republic of Tanzania, Kenya and Mozambique, three of which are middle-income countries. On a per capita basis, the top five low- or middle-income country recipients of health aid were Botswana, Eswatini, Lesotho, Zambia and , Zimbabwe.

slightly over 30% for the last 10 years – although it is over 50% in South Sudan and Mozambique. External aid has been important in addressing critical resource shortfalls and supporting countries to sustain coverage with priority interventions. However, continued reliance on external resources is a threat to the sustainability of these interventions. If the transition to domestic resources is not well planned and implemented, the burden of financing shifts more to households paying out of pocket.

**11. Equity in access remains a challenge.** There are differentials in access to health care as the population in higher-income groups are more likely to access health care than those in lower-income categories.<sup>17</sup> This puts the latter group at high risk of financial hardship as health insurance coverage remains very low and mainly among the rich.<sup>18</sup> Insurance coverage is low in sub-Saharan Africa, at an average of only 8%. Only four countries in sub-Saharan Africa have so far attained an insurance coverage of more than 20% of their populations.<sup>19</sup> These equity differentials exist across other dimensions of vulnerability, including but not limited to location and gender.<sup>20</sup>

**12. Limited options of financing health care for the elderly.** The number of older people is growing fastest in the African Region.<sup>21</sup> This number is projected to triple from 54 million in 2020 to 163 million by 2050 with important health, social and environment implications.<sup>22</sup> Ageing has been noted as a predisposing risk factor for financial hardship especially among the poorest parts of the population. Further, the prevalence of catastrophic spending and impoverishment is reported to be higher in households with noncommunicable diseases.<sup>23</sup> Within the African Region, the median proportion of the population spending more than 10% of the household budget out of pocket on health (incurring catastrophic health spending) is highest among households with older members – including at least one older person aged 60 years and above – (12.9%) compared to younger households (4.5%).

**13. Data and information gaps on financial risk protection monitoring in Africa.** The data sets available for monitoring financial risk protection across the WHO African Region were on average from 2015, with some countries' datasets going as far back as 2010. The most recent survey data available were from 2018.<sup>24</sup> Undertaking population based surveys is costly, an investment many countries are unable to meet. Across these countries, analyses of financial risk protection indicators are not routinely conducted even when data are available.

**14. Gaps in technical expertise in the design, implementation, and monitoring of health financing reforms** across countries in the WHO African Region. While capacity is progressively increasing within the African Region, this is not available across all the countries.

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<sup>17</sup> World Health Organization; World Bank. 2021. Tracking Universal Health Coverage: 2021 Global Monitoring Report. World Health Organization and the International Bank for Reconstruction and Development/The World Bank.

<sup>18</sup> Barasa E, Kazungu J, Nguhiu P, et al. Examining the level and inequality in health insurance coverage in 36 sub-Saharan African countries. *BMJ Global Health* 2021;6:e004712.

<sup>19</sup> Barasa E, Kazungu J, Nguhiu P, et al. Examining the level and inequality in health insurance coverage in 36 sub-Saharan African countries. *BMJ Global Health* 2021;6:e004712

<sup>20</sup> Kwesiga, B, Aliti, T, Nabukhonzo, P et al. What has been the progress in addressing financial risk in Uganda? Analysis of catastrophe and impoverishment due to health payments. *BMC Health Serv Res* 20, 741 (2020).

<sup>21</sup> World Health Organization; World Bank. 2021. Global monitoring report on financial protection in health 2021. Geneva: World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2021.

<sup>22</sup> <https://www.afro.who.int/fr/node/15161>

<sup>23</sup> Murphy, A, Palafox, B, Walli-Attaei, M, Powell-Jackson, T, Rangarajan, S, Alhabib, K.F et al, 2020. The household economic burden of non-communicable diseases in 18 countries. *BMJ global health*, 5(2), p.e002040.

<sup>24</sup> Sierra Leone, United Republic of Tanzania and Togo.

## ACTIONS PROPOSED

15. To achieve financial risk protection and UHC in the WHO African Region, the following actions are recommended.

16. **Actions by Member States:**

- (a) **Increase public financing through tax reforms and prioritize allocation to health, and explore innovative financing mechanisms (including ring-fencing tobacco and alcohol “sin taxes” for health) for the health sector** with a special focus on ensuring progressive coverage with quality and affordable health services. Equitable and targeted resource allocation is critical to reducing the extent of out-of-pocket spending and is consistent with the aspirations of African countries to transition towards sustainable financing in accordance with the Addis Ababa Agenda for Action 2015. Stronger political commitment including legislative support from parliaments is key to achieving this goal.
- (b) Build the analytical capacity of countries to undertake robust economic analysis to inform budget negotiations, resource allocation decisions and make a business case for investing in health and social protection to ministers of finance. **Prioritize action on the key drivers of out-of-pocket spending especially among the poor and vulnerable.** Equity should be central to health financing reforms. Key actions include reducing **the gaps in the coverage of outpatient medicines, the elderly and treatment of NCDs,**<sup>25</sup> which are notable key drivers, so as to reduce the extent of out-of-pocket health spending as it remains a major cause of household financial hardship.
- (c) **Promote and implement policy, legislative and regulatory frameworks** to enable adequate, predictable, and timely flow of resources to the front-line/service delivery level where they are most needed. This requires ensuring alignment of health financing and public finance management reforms at country level.
- (d) Where appropriate, **limit duplication across resource pools**<sup>26</sup> so as to **maximize efficiency and ensure equitable allocation of health spending** to deliver cost-effective, essential, affordable, timely and quality health services.
- (e) Take **intersectoral action to promote increased social protection** in the Member States with health insurance coverage implemented as part of the broader country social protection frameworks, with inherent mechanisms to promote equity and serve the poor, the vulnerable, including rural dwellers. Mandatory health insurance schemes are preferred as they can raise adequate pools and ensure risk sharing. This should be jointly done with interventions aimed at addressing social determinants of health that address vulnerability, promote healthy ageing and improve the quality of life of older persons.
- (f) **Improve the targeting of benefit packages to meet the health needs of elderly and multigenerational households.** This will be critical in reducing financial hardship, especially for the poorest and most vulnerable segments of elderly populations.
- (g) Take steps to **increase investment in ensuring the availability of data and strengthen analytical capacity for monitoring financial risk protection.** Once the data are available, the indicators should be generated as part of routine monitoring.

<sup>25</sup> Kankeu, HT, Saksena, P, Xu, K and Evans, DB, 2013. The financial burden from non-communicable diseases in low-and middle-income countries: a literature review. Health research policy and systems, 11(1), pp.1-12.

<sup>26</sup> Both in the context of prepaid health insurance schemes but also for different funding pools across the health sector.

- (h) Strengthen **institutional capacity of national government authorities** to design, implement and monitor health financing reforms for UHC consistent with national sustainable development strategies.
- (i) Institutionalize whole-of-government accountability and transparency in resource allocation and utilization.
- (j)

17. **Actions by the WHO Secretariat:**

- (a) Continue to support Member States in **implementing health financing reforms to reduce financial hardship** due to out-of-pocket health care payments.
  - (b) Support countries to monitor progress of these reforms using country-specific analytics and intelligence. This will focus on ensuring the needs of the poorest and most vulnerable segments of elderly populations are met, following the principle of leaving no one behind.
  - (c) Work with partners to support Member States, using **the delivery for impact approach** for intensified health financing support to countries. This approach emphasizes better planning for implementation, capacity building and sharing of best practices and lessons learnt for effective problem-solving, and drives action with a focus on tracking results to show evidence of impact.
18. The Regional Committee noted the technical document and adopted the actions proposed.