Date: 04/July/2012

Keynote address by Dr L.G. Sambo, Regional Director of WHO Regional Office for Africa at the Conference of Ministers of Finance and Health, Tunis 4-5 July, 2012

- Honourable Ministers
- Mme Director General of WHO,
- Executive Directors of Cooperation Agencies
- Colleagues, HHA Directors;
- Eminent Experts;
- Distinguished Guests;
- Ladies and Gentlemen,

It is an honour and great pleasure on behalf of HHA agencies to introduce a theme reflecting the noble values of any equitable health system – *Universal Health Coverage*.

But what is UHC?

The Fifty-eighth World Health Assembly (2005) defined universal health coverage as "access of all population to key promotive, preventive, curative and rehabilitative health interventions at an affordable cost, thereby achieving equity in access".[1] It is an aspiration of the majority of countries around the world that requires an effective homegrown sustainable financing strategy. It implies equitable and efficient revenue collection, prepayment, pooling, and purchasing of cost-effective health packages.

Universal health coverage is consistent with the United Nations Universal Declaration of Human Rights, the WHO Constitution[2], the AU Africa Health Strategy and the UNICEF Social Protection Strategy and Framework[3] – all which acknowledge that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.

THE PURPOSES OF UNIVERSAL HEALTH CARE COVERAGE ARE:

- to meet population health needs;
- to remove financial barriers to health care;

[1] WHO: Social health insurance: sustainable health financing, universal coverage and social health insurance. Fifty-eighth World Health Assembly document A58/20. Geneva; 2005.

[2] WHO: Basic documents. Geneva; 1999.

[3] UNICEF: Social protection in Eastern and Southern Africa: A framework and strategy for UNICEF. New York: UNICEF.

- to reduce incidence of catastrophic health expenditures
- this should facilitate the attainment of national and internationally agreed health goals; and
- ultimately contribute to better quality of life, poverty alleviation and human development.

I will touch on some key issues that need to be addressed in our efforts to attain UHC.

IN THE AFRICAN REGION, THE COVERAGE OF ESSENTIAL HEALTH SERVICES IS UNEVEN.

The most recent estimate of *maternal mortality ratio* in Sub Saharan Africa reveals 480 deaths per 100,000 live births. The high maternal mortality is attributed to low coverage of key maternal health services, such as, antenatal care (43%), skilled birth attendance (48%), and contraceptive prevalence (24%). We have important gaps in maternal health services.[4] And these gaps are seriously compromising progress towards MDG5.

Under-five mortality rate is 119 deaths per 1000 live births. Most childhood deaths could have been averted if all children had access to available vaccines. For instance:

- routine immunization coverage is 77%;
- The Immunization coverage with new vaccines is low; and the pace of its introduction has been very slow due to issues related to cost, prices and funding; this is limiting access of children to cost-effective interventions that could avert millions of child deaths.
- Only 50% of countries are implementing Integrated Management of Childhood Illness (IMCI) as expected.

These coverage gaps in ensuring universal coverage with essential child health interventions are compromising progress towards MDG4, in spite of the significant progress in some countries.

The coverage of pregnant women with HIV receiving antiretroviral medicines to prevent MTCT is 50%; antiretroviral therapy (ART) coverage among people with advanced HIV infection is 49%; case detection rate for all forms of tuberculosis is 60%; these indicators clearly show gaps in coverage of disease control interventions; and they obviously affect progress towards MDG6.

Some of the solutions to the health challenges lie outside the boundaries of the health sector. The conditions, in which people are born, grow, live and work strongly influence their health.

[4] WHO: World Health Statistics 2012. Geneva; 2012.

For example, the percentage of the African population using improved drinking-water sources is about 63%; and population using improved sanitation is 34%.

One may ask: why is the coverage of health and health related services so low in the African Region? Of course, this is due to weak capacity of public services in terms of organization and management of human, financial and technological resources. I mean the overall capacity of the infrastructure to ensure access to health services.

LET ME DRAW YOUR ATTENTION TO HEALTH RESOURCES

With regard to Health facilities: According to the WHO Global Health Observatory, 79% of AFR countries have less than 1 district hospital per 100 000 population. The low density of health care facilities means that health care coverage is very limited.

Health workforce: According to the World Health Statistics 2012, the African Region has only 1.4% of the total number of physicians and 2.8% of the total number of nursing and midwifery personnel. Thirty six (36) of the 57 countries with a critical shortage of health workers are in Africa. These statistics illustrate the critical gaps in human resources of health and the urgent need to scale-up training of health professionals.

Essential medicines: The World Health Statistics 2012 indicates that, the median availability of selected generic medicines in public health facilities of AFR countries is less than 40%. The shortage of essential medicines at public health facilities forces patients to purchase them from private pharmacies and street vendors. The pharmaceutical sector in most of countries faces problems of regulation, availability, quality, access and rational use of medicines.

Health financing: According to the World Health Statistics 2012, about 46% of countries in the African Region spent a total of less than US$44 per capita; which is the minimum estimated to ensure everyone have access to a set of essential health interventions [*2009 High Level Taskforce on Innovative Financing for Health Systems*]. At the current level of funding, 54% of countries in the African Region cannot ensure universal access to even a limited set of essential health services.

The World Health Report 2010, highlights a significant correlation between high levels of out-of-pocket payments and the incidence of financial catastrophe and impoverishment. Evidence contained in that report shows that when the ratio of out-of-pocket health expenditure to total health expenditure is below 15-20%, the incidence of financial catastrophe is negligible.

Regrettably, 34 countries out of total 46 in the African Region, are above the 20% threshold. The challenge for them is to see how quickly to move to 20% threshold.

Yesterday, some speakers mentioned that higher levels of health funding might not translate into better health service coverage or improved health outcomes, if the resources are not used *efficiently* and *equitably*.

WE WISH TO PROPOSE FOUR MAJOR THRUSTS FOR ATTAINING UNIVERSAL HEALTH COVERAGE:

1. First, *strengthening the capacities of public health infrastructure* to provide effective, safe, and quality health services. Infrastructure includes "*staffing, buildings, technologies; utilities such as power and water supply; waste management; transport and communication; and FINANCING investments, maintenance and recurring costs*". Health infrastructure entails public investments and Governments will have to explore innovative ways of harnessing the resources of the private sector, NGOs and communities.
2. Second, *raising sufficient resources for health* - from domestic and external sources. It is possible to *increase domestic resources* through improved efficiency of tax revenue collection; revisiting of government budgets to meet the 15% Abuja commitment; innovative financing, such as taxes on tobacco, alcohol, air tickets, foreign exchange transactions, mobile phones; and leveraging of private sector inputs. Predictable, harmonized and *increased development assistance* for health is critically necessary especially for low-income countries.
3. The third thrust is on *removing financial risks and barriers* - to access through compulsory prepayment, i.e. payment before need for health care arises. As mentioned earlier, in 34 countries of the African Region out-of-pocket payments account for more than 20% of total health spending (WHO 2012). This exposes households to risk of financial catastrophy and impoverishment. Prepayment and risk pooling are essential to addressing this challenge. Prepayment can be organized through:
    - *general taxation,*
    - *compulsory contributions to health insurance, or*
    - *both*.

    I wish to emphasize that prepayment and pooling of available financial resources to spread financial risk across the population will help to ensure that people can use health services without fear of financial ruin.
4. The fourth thrust is about *promoting efficiency of national health services to optimize resources and maximize results.* The World Health Report 2010 on health systems financing estimated that *about 20-40% of resources spent on health are wasted through inefficiency*. Such resources could be redirected towards the pursuit of universal health care coverage.

Since the adoption of the World Health Assembly resolution on '*Sustainable health financing, universal coverage and social health insurance*' in 2005, 20 countries (Benin, Burundi, Botswana, Congo, Cote D'Ivoire, Ghana, Gabon, Kenya, Malawi, Mali, Mauritius, Namibia, Rwanda, Senegal, Sierra Leone, South Africa, Seychelles, Togo and Uganda) have declared intentions to implement policies towards Universal Health Coverage. Others have undertaken financial feasibility analysis towards the same endeavour.

It is critically important to draw lessons from countries around the world that have almost attained universal coverage through taxation, compulsory health insurance or a mix of the two.

SOME OF THE FACTORS THAT HAVE CONTRIBUTED TOWARDS UNIVERSAL HEALTH COVERAGE ARE:

- *high per capita income* that increased capacity of businesses and citizens to prepay;
- *a large formal sector* that facilitated the ability to contribute and increased collection of contributions;
- *Urbanization and communication* that facilitated the delivery of services;
- *Skilled labour force,* including HR, to manage health financing schemes;
- Existence of *solidarity within society* that facilitates cross-subsidization from rich to poor, and from healthy to sick;
- *Government's stewardship capacity* to launch, guide and sustain a process of compulsory prepayment; and
- *Availability of public and private health services* of "acceptable" quality.

In contrast to the abovementioned enabling factors, majority of African countries are characterized by relatively:

- *Low per capita gross domestic product (GDP),*
- *Large informal agricultural sectors that are difficult to tax,*
- *Limited volumes of taxable imports,*
- *Insufficient skilled labour force, including HRH crisis,*
- *Fragile health infrastructure, and*
- *Institutional weaknesses that may compromise the efficiency of compulsory prepayment mechanisms.*

In spite of these challenges, some countries are implementing health insurance schemes on a national scale. So far, the two well-documented success stories are Ghana and Rwanda that are implementing a mixed health financing system. While *Ghana is fundamentally tax-based (earmarked tax and mandatory premiums)*, *Rwanda is essentially community-based health insurance (with contributions from households, government, employers and donors)*.

IN THE PURSUIT OF UHC, THE MINISTRIES OF FINANCE IN COLLABORATION WITH INTERNATIONAL FINANCING INSTITUTIONS HAVE A MAJOR ROLE TO PLAY, for example, in the following aspects:

- Development of strategic health financing plans and incorporating them into national development frameworks.

- Assessment of financial feasibility and financial sustainability of prepaid health financing systems;
- Strengthening the national health financing system, including financing structures, processes and management systems as well as building or strengthening national prepayment systems;
- Strengthening of health sector financial management skills, including competencies in accounting, auditing, actuarial science, health economics, budgeting, planning, financial monitoring and reporting;
- ensuring timely disbursement of allocated health budgets;
- Supporting institutionalization of efficiency and equity monitoring and national health accounts within national information management systems;

National parliaments have a very important role to play in the adoption of UHC policy and legislation, and allocation of adequate resources for its successful implementation.

UHC is a noble vision for Africa and we should take concrete steps to invest in the health of the human capital, which is very essential for economic growth and sustainable development.

Thank you.

Table 1: Selected countries total health expenditure per capita, life expectancy, under-five mortality rate and maternal mortality rate

Country	Total health expenditure per capita, 2009 (US$)	Life expectancy	Under-five mortality rate (per 1000 live births)	Maternal mortality ratio (per 100,000 live births)
Equatorial Guinea	804	53	121	240
Botswana	581	61	48	160
South Africa	521	55	57	300
Mauritius	382	73	15	60
Seychelles	301	73	14	…
Namibia	297	57	40	200
Gabon	266	62	74	230
Angola	201	52	161	450
Algeria	181	72	36	97
Swaziland	169	49	78	320
Cape Verde	150	71	36	79

Source: WHO: World Health Statistics 2012. Geneva; 2012.