Africa HEALTH

SPECIAL FOCUS

Universal Health Coverage

A cautious optimism for UHC in Africa



Despite the cacophony of voices declaring support for Universal Health Coverage (UHC), the World Health Organisation (WHO) says that come 2030 or there about, the organisation would like to see a situation where everyone in the world is able to get the health services they need, without suffering financial hardship when paying for these services. No doubt, encouraging every nation on the globe to reach its people with all health services is a lofty ideal. However, a key question is: haven't we been here before?

Evoke the World Health Assembly 1977 resolution of 'Health for all by the Year 2000'. As this mantra was chanted: 'The main social target of governments and of WHO was the attainment by all the world's people of a level of health that would permit them to lead a socially and economically productive life by the year 2000'. It was envisaged that this global health goal would be implemented by ensuring access to essential primary health care (PHC) and reduction by finite amounts of the burden of disease, disability and premature death. On D-day, out of the welter of words and the plethora of plans, little of practical value emerged and nothing sufficiently potent to end the old and unpleasant ways of doing things happened. Due to several obstacles, in particular the lack of political will to implement measures to achieve this global objective, the Health for all (HFA) agenda was never achieved. The PHC strategy itself was subjected to palliative measures and compromises made for the sake of taking action – but the basic problems remain. What has changed now? And what are the indications that things might be different this time around?

We are told the main differentiating feature is the inclusion of 'improving financial access'. But this shift in focus is taking a life of its own and now beginning to appear as the real deal. Then and now, policy reforms and tackling management issues are considered to be important determinants of progress. For example, the lingering problems faced by health managers at all levels – insufficient coordination to provide integrated service, inadequate information about finance and costs to improve efficiency, the problem of over- and under-utilisation of health services, and inadequate management of available human resources – remain unresolved. Even at that, efforts at finding the resources to achieve UHC are not very promising, especially in sub-Saharan Africa (SSA).

In April 2001, heads of state of African Union countries met in Abuja, Nigeria and pledged to a set target of allocating 15% of their annual budgets to improve the health sector. At that time, the median level of general government health expenditure from domestic resources from Africa Union Countries was very close to USD 10, with a thousand-fold difference between the minimum (USD 0.38) and the maximum (USD 380). Ten years after (2011), a report produced by WHO observed that while 27 countries increased the proportion of total government expenditures allocated to health, only Rwanda and South Africa achieved the 'Abuja Declaration' target of 'at least 15%'. Meanwhile, seven countries reduced their relative contributions of government expenditures to health during the same period, and there was no obvious trend upwards or downwards in 12 other coun-

Dr Tarry Asoka is a seasoned consultant on health insurance in Nigeria. He thinks UHC can work, but cautions that it is going to require some creativity in the face of weak political will from governments

tries. But crucially, the report emphasised, 'the absolute level of resources available in relation to the health needs is well below what is needed'. And there are no signs whatsoever to suggest that things have changed much in the years following this report.

Other developments aimed at mobilising domestic resources for the health sector in SSA have not faired better either. A recent journal article published by *International Health* claims that 'social health insurance schemes in Africa leave out the poor'. Examining the proportion of women who delivered with assistance of a skilled health professional in relation to their wealth status, the paper demonstrated that in the five selected countries (Ghana, Tanzania, Kenya, Rwanda and Ethiopia) where national or community-based health insurance schemes exist; only Rwanda's poor seem to have almost the same level of access to a doctor/midwife, as the rich. Ghana, which for example has premium exemptions for pregnant women, has huge gaps in access: 'less than 50% of women in the poorest quintile deliver with the assistance of a skilled professional, compared with 97% in the richest quintile', the paper stated.

And in Nigeria, the richest country on the continent, three years after the national health law (National Health Act, No.8 of 2014) mandated the federal government to set aside at least 1% of the Consolidated Revenue Fund (CRF) to finance a Basic Health Care Package for all citizens, no funds have been released as no budgetary provisions have been made. There is news that some international donors in the country have put funds together to pilot what could be possible if 1% of the CRF is available to the health sector in 3 of its 36 states. What a paradox for an 'Africa Beyond Aid' plan that is being promoted by the current Ghanaian President, Nana Akufo-Addo. Yet, there may be opportunities that could propel African countries to make progress towards achieving UHC.

Beyond identifying workable health financing strategies and making them function properly within country-specific contexts, advances in development finance are worth exploring. Top on the list is 'Impact investment'. Structured like private equity funds in matured markets, these investment funds focus both on social impact and financial returns to investors (albeit modest), as well as paying annual fees to fund managers. In the health sector, supporting the set up of health insurance plans, providing access to essential medicines, developing and maintaining provider networks, etc., that target poorer populations in both urban and rural areas are some projects considered agreeable to this concept. A related approach is 'Blended Finance', which aims to programme public (foreign government), philanthropic or development institution capital in such a way as to catalyse private investors to invest their capital in something they otherwise would not do. These could be infrastructural development in whatever form, but it would contribute to increasing access to health services in many ways. There is a sense that these ideas are becoming widespread among mainstream philanthropic foundations and donor agencies, in addition to commercial investors.

Other than looking for resources to finance UHC, what many observers are advising countries to direct their attention if optimising the health of their populations is the ultimate goal of UHC, is to look beyond the health system and begin to also address the social determinants of health. These may entail political programmes that include: better living standards, upgrading housing, improved nutrition, safe water and sanitation etc. Other actions could be related to tackling the rising prevalence of chronic diseases, such as cardiovascular diseases, diabetes and the rest through policies aimed at tobacco control, promoting healthy lifestyles and diets and so on.

Even within the health sector itself, it is suggested that actions intended to attain UHC could employ explicit priority interventions such as malaria control, maternal, newborn and child health care to drive the necessary improvements into the health system. Moreover, strong emphasis on district and community health systems where implementation and service delivery happens is vital, if a strengthened health system is seen as a necessary part of the toolbox to achieve UHC.

Despite these recommendations, the path or mechanisms for the realisation of UHC remains vague for many countries, in particular the nations in SSA. The *Lancet* alerts readers that in order to achieve the new 'health for all' programme through UHC, two misunderstandings must be appreciated. 'UHC is neither a destination to be reached nor a panacea for delivering better health, even in its broadest definition'. As progress is being made but slow, this should be a useful insight that could lessen the pain and frustrations of those clamouring for UHC nationally and globally.



Health insurance is to be encouraged, but it won't bring the comprehensive coverage it promises

What does UHC mean, and is it attainable? And perhaps of particular interest given that this year heralds the 40th anniversary since the Alma Ata declaration, how does it vary from primary health care?

In simple terms, UHC is a healthcare system in which it is envisaged every citizen can receive health services without incurring financial hardship. Objectives include a strong, efficient, and well run health system; a means of financing the services (the critical bit); access to essential medicines and technology; and finally, a sufficient capacity of well-trained, motivated health workers.

Is it new? No it isn't. Norway is credited with being first with an UHC system back in 1913. Britain's NHS was launched in 1948 and is listed as being the sixth such system. So quite why it has suddenly come to the fore within the World Health Organisation agenda, isn't immediately clear.

But for sure there is some clear thinking behind it and hence its active promotion and adoption by groups such as the Africa Union Health Ministers. The premise is that investment in Africa's health systems is key to inclusive and sustainable growth.



Strong economic growth in recent years has helped reduce poverty to 43% of the population. Yet, as Africa's population expands – it is estimated to reach 2.5 billion by 2050 – the region faces a critical challenge of creating the foundations for long-term inclusive growth. Many countries still contend with high levels of child and maternal mortality, malnutrition is far too common, and most health systems are not able to deal effectively with epidemics and the growing burden of chronic diseases, such as diabetes. These challenges call for renewed commitments and (as WHO urges) the solution lies in accelerated progress towards UHC – the principle that everyone receives needed health services without financial hardship.

It is convenient to have a solution to point to. But can it work when finance remains the principal constraint in Africa? But the UHC proponents prefer not to dwell on such aspects at this stage. Much better to make the argument of why it is worth going the extra mile to try to make it work because there is a demonstrable benefit if it can be made to work: in other words, the investment will pay off.

The primary reason for investing in UHC is a moral one, they say: it is not acceptable that some members of society should face death, disability, ill health or impoverishment for reasons that could be addressed at limited cost. Who can argue with that? And strong health and disease surveillance systems also halt epidemics that take lives and disrupt economies. In 2015, the economic cost to the three Ebola-affected countries is said to be in excess of $1billion. Who can decry avoiding such waste?

But while health expenditure in Africa has increased significantly, domestically financed government spending has stalled. Only four countries met the Abuja Declaration target of 15% of government spending in 2016, and spending in almost 30 countries actually decreased.

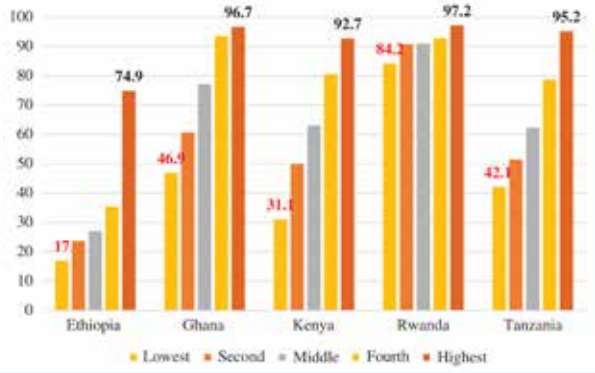
Middle-income country health spending is growing, but largely due to the growing middle classes fuelling a welcome growth in private healthcare. Whilst positive, these groups still represent only a fraction of the population and the services they are accessing are not affordable to the majority of the populations. The middle-income countries are also facing an additional challenge: they are losing the significant funding they have been receiving from groups such as the Global Fund and the immunisation specialists at GAVI. It is a tapered process, but it is truly challenging the gains made against many diseases as governments cannot easily suddenly replace the generous but necessary funding support that had been received previously.

But is UHC passing the buck? If governments committed the 15% of GDP as agreed in the Abuja Declaration, then there would not be the need for a largely insurance-based UHC system. Is it not surprising that the AU ministers voted for it, as it passes the onus for funding healthcare to the private sector or to national health insurance schemes? Primary Health Care was substantially similar in what it aimed to achieve (being the core base of the health pyramid) but it relied on public sector expenditure to make it work.

Doctor and nurse unemployment in Africa remains significant. Thousands of vacancies exist across all tiers of the health service, but funds are not available to finance them. Meanwhile there are influential groups like

Bryan Pearson, editor of Africa Health, feels that too many will be left behind because by its very nature, health insurance is for the have's not the have not's. Better we should return to campaigning for the 15% of GDP promises of the Abuja declaration.

Proportion of women aged 15-49 who delivered with the assistance of a skilled health professional in five countries with national health insurance systems



Source: DHS data for Ghana (2014), Kenya (2014), Rwanda (2014), Ethiopia (2011) and Tanzania (2015). From: Int Health. 2018;10(1):1-3. doi:10.1093/inthealth/ihx046

AMREF mounting campaigns for proper recognition of community health workers, including that they should be paid. Again, only the most mean-spirited ministry official would disagree with the principle, but unless there is more money to spend in the MoH coffers, they are helpless to intervene.

Meanwhile many of the best doctors and nurses simply head overseas. Their training costs having largely been borne by their home country, but the benefits accrue to someone else.

This health workforce issue in fact goes much deeper. The shortages of appointed skilled health workers is a huge hindrance to the achievement of health targets. The estimated shortage of doctors, nurses, and midwives in WHO AFRO countries below the SDG Index threshold (4.45 physicians, nurses and midwives per 1000 population) was about 2.7 million in 2013. When all categories of health workers are included, the shortfall is estimated at 4.2 million. This total shortfall is expected to increase to 6.1 million in 2030. Shortages of health workers at the country level are exacerbated by severe imbalances in the density of skilled health workers: it is estimated that over 90% of pharmacists and dentists practice in urban areas, other cadres have similar distributions (World Health Organization 2016). Furthermore, accurate, updated, and nationally consistent information on health workforce is not always available, highlighting the need for strengthening essential countrywide information systems.

And yet this health workforce issue is also one of the most salient causes of the failure of PHC as envisaged in 1978. The workforce did not form the desired pyramid: with PHC at the base, District care at the centre, and Tertiary care at the top. PHC was introduced as a silo on its own. Doctors and nurses in the curative world, never properly bought in or became integrated with those working at the primary and preventive level. It is the same today in most places. Hence community health workers are expected to work voluntarily or for just very small amounts of cash, and it is rare to find them fully integrated into the larger health system. And yet it is human nature that you need leadership, mentoring, recognition and support to work efficiently and effectively. PHC fractured from its lack of senior professional leadership.

Access to safe, affordable, and quality essential medicines and technologies remains a challenge. Despite progress in some areas, access to medicines in Africa remains low. The availability of selected medicines has been found to be as low as 21% in some instances, and weak pharmaceutical regulation, inadequate procurement and supply systems, limited access to information, all contribute to unnecessarily high prices and contribute to the dislocation of health delivery. Services become 'cash and carry' often with key medicines or consumables having to be bought from a local market. These conditions also contribute to the region having a significant circulation of counterfeit or falsified drugs. This all contributes to the gaps in access to essential HIV/AIDS, TB, and malaria services allowing them to remain as important barriers to achieving UHC in many countries.

Which brings us to the new nexus at the core of UHC: health insurance. Financial protection is generally low in Africa, requiring most patients to pay for health services from their own household income, so-called out-of-pocket (OOP) payments. Patients in low-income and lower-middle-income countries are less protected against high OOP than those in higher-middle-income countries. Out-of-pocket payments have increased in nearly all countries, and the regional average has increased from US$15 per capita in 1995, to US$38 in 2014. As a result, 11 million Africans are falling into poverty every year due to high out-of-pocket payments. Protecting people against the impoverishing effect of health payments is intended to become a cornerstone of UHC and a key driver to prevent poverty in Africa.

But is UHC too reliant on health insurance as the financial panacea? That is where I came in to this debate, and it is where I leave it? The history of health insurance in Africa is distinctly chequered, and distinctly mired in controversy. The public are highly suspicious (with good cause) of government agencies holding 'their' money; and owners of clinics and hospitals are equally nervous about having to wait inordinate amounts of time for reimbursement. That is not to say that some systems work well nor is it say that as time goes on it is going to become ever more important and relevant as a means of protecting the health of the individual or the family.

But the fundamental problem is that it doesn't tick the box of 'leaving no one behind', which is a key emotive call from those proposing UHC and its justification for being the new core policy. With a significant percentage of the workforce either in the informal sector or unemployed it almost by definition can't reach the poor. It thus isn't addressing the inequality it sets out to resolve. To me it is a bit like adopting the USA health system prior to Obamacare: if you can afford you can have, but if you can't you are on your own. Social health insurance is just not the right fiscal solution for Africa if your intention is to 'leave no one behind'. But maybe after years of fighting unsuccessfully for the Abuja declaration option, it is the best fallback option? But let us not dress it up as being the comprehensive solution it isn't.