Financing Universal Health Coverage in Africa

Sam Agatre Okuonzi discusses how to finance UHC in Africa

Health financing is the raising and spending of financial resources with the primary intention of improving health. Typically, the sources of health financing are general taxation, donor aid, deficit funding (or borrowing), ear-marked taxation, and social and private health insurance. Expenditures are made in health facilities, on community and out-reach services, pharmacies, drug shops, sanitation, nutrition, training and research.[1] From the origins and evolution of health financing, a lot of difficulties have been faced and many lessons learned.

Evolution of health financing

Health financing has gone through major changes. Family or household in-kind payment for healing and spiritual care has been the main mode of health "funding" for thousands of years. When hospitals were established in Europe, they became an integral part of monasteries and convents. They were owned and run by churches.[2] Later, it was charities that funded hospitals. In 1890, Sweden made hospitals a function and responsibility of local authorities. There was a clear association between the poor and the development of health systems. In Britain the Poor Law and in other European countries the Social Assistance Laws enabled the poor to get free health care provided by salaried government doctors and midwives. This practice spread throughout Europe and beyond. Home nursing developed as a distinct charitable movement to help the poor. Later, nursing homes begun to be subsidised by local authorities.

Another wave of health financing was the voluntary health insurance movement. This involved salaried workers and miners, who made regular contributions for health care from their salary. In 1863, Chancellor Bismarck of Germany introduced a law to make health insurance compulsory, and the practice spread quickly to other countries. But compulsory health insurance excluded many people, notably farmers and fishermen. Therefore, countries endeavoured to extend healthcare coverage by reducing insurance premiums and by subsidising health care costs.

Additional mechanisms were devised to cover the poor, the aged and the disabled. In this way, industrialised countries managed to achieve universal health coverage, starting with Russia in 1938, Britain in 1948, Scandinavia in the 1960s, Canada in 1970, Italy in 1980, and South Korea and Malaysia in the 1990s.[1] The only high-income country that has refused to adopt the universal approach is USA. There are estimated 80 million people who have no access to health care in USA, caused by negative and racist attitudes to the poor and the association of poverty with blacks and immigrants.[3]

Many poor countries have proved that a country should not wait to become rich to attain universal health care. Existing resources in any nation can be used in such a way that a reasonable package of basic health care can be provided to everyone. The illustrious examples of the poor countries are Costa Rica, Sri Lanka, Cuba, Kerala of India, Vietnam, Thailand, Indonesia and Mauritius. Rwanda is close to attaining universal health care. These countries took only 20-30 years to attain universal health care and reduced their mortality to as low as that of the wealthy nations.[4]

But many low-income countries, including in Africa, have failed to achieve universal health care. Health care expenditure has risen exponentially due to increasing demand for health care arising from increased awareness, better knowledge, aging populations, and changing disease patterns. This was exacerbated by the global economic crisis of 1970s and 1980s, when health systems in poor countries began to deteriorate. In 1990s, these countries had reached health care "cost explosion".

The Primary Health Care (PHC) approach had been introduced partly to address health financing. But the introduction and practice of PHC did not stop the downward spiral of health services due to lack of financing. In the 1990s, health reforms were introduced to try and raise health financing, mainly through user fees and insurance schemes. After nearly 20 years with no positive results, people finally became disillusioned with financing reforms. Today, health financing remains the most intractable challenge for the health sector. Some have argued and concluded that UHC in poor countries cannot be funded internally. This is why SDGs (and MDGs before them) have a component on global compact for financing health care.

Difficulties

A national health system is built on the framework and foundation of a sound health financing. The overwhelming difficulty with health financing in a poor country is that the available funding dedicated to health care is far too low for a basic health care universal coverage. The option of user fees to augment health finance is self-defeating, as it discourages service utilisation and reduces overall health benefits.[2] Neither is health insurance particularly viable in poor

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countries. Sachs 2005 compared health insurance performance of different countries. He concluded that a country with a gross domestic product (GDP) below US$500 per capita would not benefit at all from health insurance. He advocated donor funding of UHC of a basic health care package.

However, officials of ministries of finance argued that donor aid for health increases local expenditure in form of counter-part funding, thus starving expenditure on industry and investment and disrupting macro-economic stability by increasing inflation.[5] They further contend that donor aid has problems of absorption capacity and with the cohesion of national programs.

Macro-economic stability – the balance between the national budget, the internal debt, the balance of payment, and the debt burden – is the single most important priority of governments. It has three components: fiscal (taxation and expenditure), monetary (money supply and interest rate) and financial (mobilising savings and other resources for investment, employment and social services).

This macro-economic dilemma was addressed by the WHO's Macro-Economics and Health Commission report of 2001. The commission advised that: 1) donor aid be scaled up, 2) domestic health financing be scaled up, 3) countries use a basic package approach, 4) countries establish the cost of the package, and 5) countries use part of health financing for global health goods, including disease surveillance, data dissemination, and on drugs for neglected tropical diseases.

Apart very low per capita health expenditure, the other critical health financing difficulties are low health budget share, low capacity to mobilise resources for health, a large share of out-of-pocket payments for health care, widespread inefficiencies and inequalities in the health system, and the stagnation and even reversal of development assistance. Corruption in the health sector has emerged as a major issue for health financing.

Strategies

Health spending is no longer just consumption.[6] Studies have shown that poor quality health care linked to low level health financing causes more deaths than disease itself.[7] The new approach to health financing is therefore the high-performance health financing (HPHF) approach. HPHF is the adequate, sustainable and resilient health funding system, with pooling of funds that allows financial risk of ill-health to be spread throughout the population, and where spending is efficient and equitable to ensure quality of health care and financial protection for all people.

HPHF benefits the economy in six ways: 1) building human capital; 2) providing skills, jobs, labour mobility and formalisation of labour force; 3) reducing poverty and equity, by avoiding out-of-pocket payments; 4) improving efficiency and financial discipline through pooling and bulk purchasing, and fostering consumption and purchasing power in the economy as people get relief from crippling health care costs; and 6) strengthening health security through disease surveillance, community health workers, public health laboratory networks, and information systems.

Closing the health funding gap in poor countries will require a mixed approach of domestic and international funding. The general roadmap is to (a) scale up what works, (b) focus of the big picture (whole-of-government approach), and (c) strengthen health financing leadership, governance and organisation. Raising tax revenue remains the most reliable determinant of progress towards UHC.[8] It leads to many additional benefits. In practical terms, there is a wide scope for raising tax in low-income countries without raising the already high common taxes. For significant progress to be made to UHC, it is estimated that $41 per capita of health spending be made in addition to what is already being spent.[9] Seventy-five percent of this spending has to go to building the health system. Another study by Mark W. Moses (2016) estimates a minimum of $71 per

capita total health spending in low-income countries to achieve UHC.

There are unacceptable trade-offs that policy makers must desist from on the path to UHC.[10] These unacceptable trade-offs are: (1) expanding coverage of low priority services before everyone has access to the basic priority package; (2) including in the UHC package only those who can pay, excluding those in informal economy and the poor, even if it is easier to do so; (3) giving high priority to very costly services whose coverage will provide substantial financial protection but with very limited overall health benefits; (4) expanding coverage for the well-off before doing so for the worse-off groups when the costs and benefits are not vastly different; and (5) shifting from out-of-pocket payment to some kind of mandatory prepayment (e.g. health insurance) in a way that makes health financing less progressive (i.e. that excludes the poor).

Conclusion

Health financing remains the most intractable challenge for poor countries. And yet as a function of ministries of health it is a relatively neglected function, often overshadowed. It is less focused on. The struggle with health financing is littered with many failures. But there are many good lessons too. The key message is the need to innovate health financing within the local and national context so as to attain and expand UHC, with an eye on equity, efficiency, effectiveness, quality, sustainability and resilience. In particular, it will be critical to build a corruption-free health financing system.

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