AfHEA

African Health Economics and Policy Association
Association Africaine d'Economie et Politique de la Santé

Toward universal health coverage in Africa

AfHEA 2nd Conference – 2011

Palm Beach Hotel, Saly – Sénégal: 15th - 17th March 2011

Key issues

from the 2011 AfHEA conference

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This policy brief is produced by AfHEA and draws on the proceedings of the Second AfHEA conference, held in Saly – Senegal from 15 to 17 March 2011. It is supplemented by relevant literature where necessary. It was compiled by Drs Irene Agyepong, Chris Atim, Francois Diop, Travor Mabugu, Diane McIntyre and Alice Soumare.

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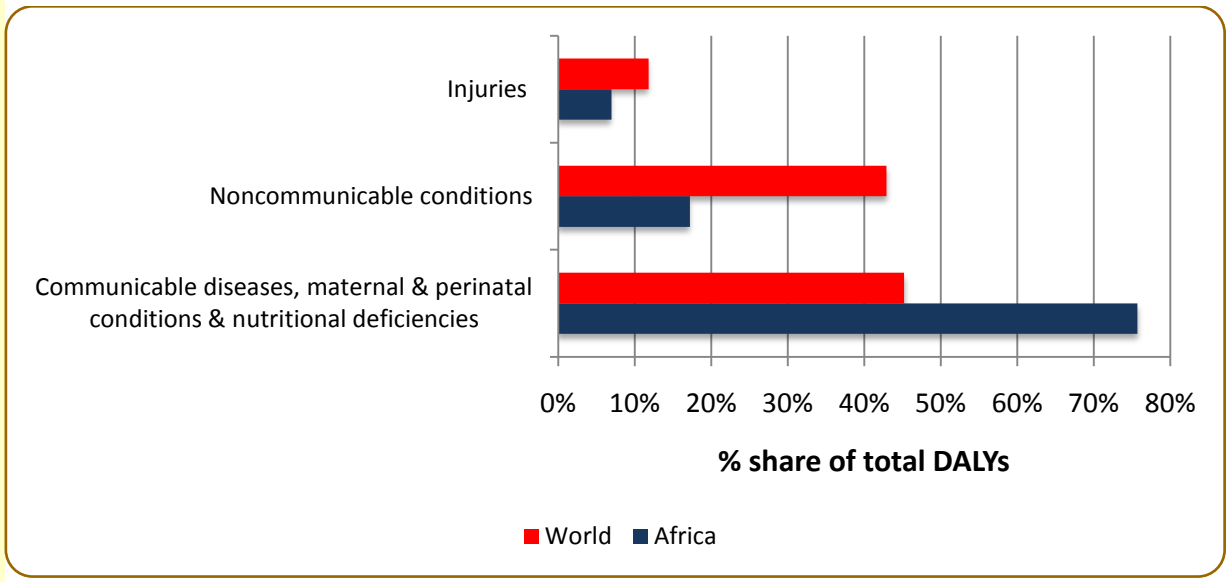
Why is universal coverage important for African countries?

African countries face the greatest burden of disease in the world; while the population in low- and middle-income countries in Africa account for 11% of the world's population, these countries account for 27% of global disability-adjusted life years (DALYs). Figure 1 shows that African countries have a far greater burden from communicable diseases, maternal and perinatal conditions and nutritional deficiencies (accounting for 76% of DALYs in Africa) than the global average (45% of global DALYs). The leading contributors to this burden of disease in Africa are:

- respiratory infections (accounting for 13.2% of total DALYs in Africa);
- perinatal conditions (12.3% of DALYs);
- HIV/AIDS (11.7% of DALYs);
- diarrhoeal diseases (10% of DALYs);
- malaria (9.6% of DALYs).

Figure 1: Distribution of DALYs according major causes of ill-health and premature death (Africa compared with global average)

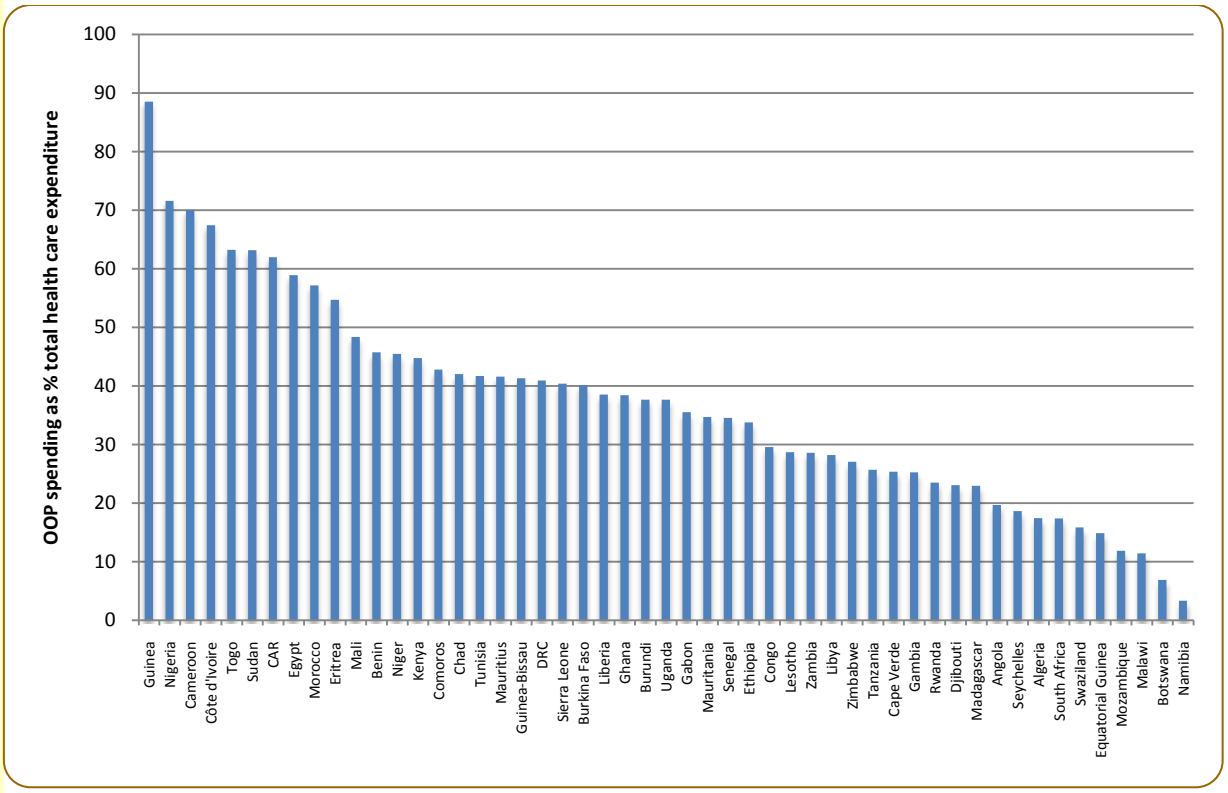


Source: WHO health statistics database

Despite this massive burden of disease, African countries have limited financial, human and other resources to provide health services to meet these health needs. Of particular concern is the heavy reliance on out-of-pocket (OOP) payments to fund health services in many African countries.

Figure 2 shows that OOP payments account for nearly 90% of health care expenditure in extreme cases, and exceed 30% in most African countries. Thus, the burden of funding health care is borne quite directly by individual households, who have very limited financial protection against the costs of using health services.

Figure 2: Out-of-pocket payments as a percentage of total health care expenditure



Source: WHO National Health Accounts database

In recent years, there have been growing calls for countries to move towards universal coverage in their health systems. While there are a number of definitions of universal coverage, all definitions have two core elements in common:

- Providing financial protection for all from the costs of health care; and
- Enabling access to needed health care for all.

Universal coverage was firmly placed on the global policy agenda when the 2005 World Health Assembly adopted a resolution calling on member states to pursue universal coverage. A major focus of this resolution was to reduce the reliance on out-of-pocket payments and to promote pre-payment health care financing mechanisms (such as tax and health insurance).

This emphasis was related to the growing evidence of the catastrophic effects of out-of-pocket payments, particularly that large numbers of households were being pushed into poverty as a result of paying for health care on an out-of-pocket basis. For example, nearly 400,000 people were impoverished in Ghana in 2005/06 as a result of paying for health care. This evidence highlighted the urgency of providing financial protection through pursuing pre-payment funding mechanisms. While considerable attention has been devoted to the financial protection component of universal coverage, it is also recognised that one needs to go further than creating entitlements to services funded through pre-payment mechanisms to ensuring that the population is able to access these services when needed.

What progress has been made towards achieving UC and what are the remaining challenges in moving towards universal coverage in Africa?

To date, relatively limited progress has been made in achieving universal coverage in African countries, with a few notable exceptions (such as Rwanda and Ghana). However, the goal of moving towards universal coverage is now high on the health policy agenda in most countries and important steps are being taken in this direction.

In particular, many countries have sought to reduce the reliance on out-of-pocket payments through removing user fees at public sector health facilities, either for all health services (such as in Uganda) or services for particularly vulnerable groups (such as pregnant women and children). While user fee removal can promote financial protection, the implementation of this policy has led to several unintended adverse consequences in many countries (see Box 1). The key lessons from experience of user fee removal in African countries are that:

- implementation must be carefully planned and implemented – health managers and front-line providers need time to prepare for the increased use of health services that will inevitably occur when financial barriers are reduced; and
- this policy must be accompanied by increased funding through pre-payment mechanisms to increase staffing levels, purchase additional drugs and other supplies needed to cater for the increased patient load.

Box 1: Adverse consequences of poor implementation of user fee removal policies

- Staff workload increases dramatically, with staff often already being overextended. This can contribute to declining staff morale and long waiting times for patients.
- Discontented staff may begin to charge 'under-the-table' or unofficial fees, which translates into patients continuing to bear the burden of out-of-pocket payments.
- There are frequently widespread drug stock-outs at public sector facilities. This means that patients will either not get the treatment they need, or will continue to incur out-of-pocket expenses due to having to purchase drugs elsewhere.

Two countries that have made great strides in improving financial protection are Ghana (see Box 2) and Rwanda (see Box 3). This progress is linked to focussing on expanding pre-payment funding (through rolling-out health insurance schemes in both countries, supplemented by a dedicated health levy as part of VAT in Ghana) rather than simply on removing user fees.

Box 2: Ghana's National Health Insurance

In an effort to reduce the very heavy burden of out-of-pocket payments (known as the "cash and carry" system in Ghana), the Ghana National Health Insurance (NHI) law was passed by Parliament in 2003. It requires everyone (whether from the formal or non-formal sector) to enrol in government sponsored district health insurance schemes, referred to as Mutual Health Organizations (MHO). 90-95% of the financing of the NHI is from a single pooled central fund known as the National Health Insurance Fund (NHIF). 70-75% of this fund comes from a NHI levy, which is part of Value Added Tax (VAT). Though VAT is not as progressive as an income tax, VAT is quite progressive in Ghana because of the extensive exemptions on goods consumed predominantly by the poor. A further 20 - 25% of the NHIF income comes from Social Security and National Insurance Trust (SSNIT) contributions. These contributions are made by public and private formal sector workers, and are similar to classic social health insurance funds with employer and employee contributions proportional to income. Non-SSNIT contributors, comprising mainly those outside the formal sector but also workers in organisations like universities that have their own social security system outside SSNIT, pay premiums directly to their District MHO. These are decentralized funding pools compared to the single central NHIF. These direct premiums account for approximately 5% of the financing of the NHIS.

To ensure equity, the poorest of the poor (referred to as indigents) are exempted from premium payments. Difficulties in defining and identifying the poor have made this provision very difficult to implement, and this accounts in part for the continuing problem of lower enrolment in the NHI among poorer income groups. Minors under 18 years are also exempt from premium payments as are the elderly over 70 years. In recent years, all pregnant women are also eligible for free enrolment. These generous exemption clauses mean that over half of enrolees under the NHI are in non-premium paying categories.

Even though enrolment in the NHI is mandatory by law, it has not been possible to enforce this given Ghana's large non-formal sector and poor citizens' documentation. Routine data estimates NHI membership at over 50% of the population. The 2008 Ghana Demographic and Health Survey, a nationally representative sample survey, found that 39% of women and 30% of men 15 – 49 years were members of the NHI with wide variation from a low of 20% for men in the Greater Accra region to a high of 59% for women in the Brong Ahafo region.

The benefit package of the NHI is defined by law, and covers at least 80% of the most common conditions in Ghana. Outpatient, inpatient care and medicines are all covered, as are some dental services. Services not covered are mainly very expensive services like dialysis for chronic renal failure, certain cancer treatments and cosmetic surgery. The services that are covered can be obtained at any health care provider that has been accredited by the National Health Insurance Authority (NHIA). The NHIA also monitors providers' performance and ensures that health care services rendered to NHI beneficiaries is of good quality.

Increasing enrolment in the NHIS over time has been accompanied by increasing service utilization levels.

Box 3: Rwanda's mutual health insurance schemes

In the early 2000s, about a quarter of all health care spending in Rwanda took the form of out-of-pocket payments. In an effort to provide financial protection and improve access to health services, the growth of mutual health insurance (MHI) schemes (called "Mutuelle de Santé") to cover those outside the formal employment sector was encouraged. Over 100 of these schemes were created, with government support, between 2000 and 2003 and covered 27% of the population by 2004. MHIs were expanded in 2005 with external funding, which was used to provide premium subsidies for vulnerable groups and rapidly increase MHI coverage to 74% of the population by 2007. An elected village committee decides who is poor and should receive subsidised membership. In 2008, a law was introduced making health insurance membership compulsory for all citizens and introducing cross-subsidies between MHI schemes. Membership fees are about $2 per person per year for those who do not have subsidised premiums.

These schemes cover basic services (e.g. family planning, antenatal care, outpatient consultations, deliveries, generic drugs and hospital treatment for malaria). MHI members are required to make co-payments when they use health services, with a flat fee being charged for health centre visits (of US$0.4 in 2006) and 10% of the cost of services at hospitals.

Recent studies have found that the MHI schemes provide both financial protection and improved access to needed care. For example, households with MHI cover use health services twice as much as those without such cover when falling ill. In addition, catastrophic health care expenditure is almost four times as high in households without MHI cover than in those who are MHI members.

The Rwandan experience is widely regarded as very impressive and as making an important contribution to the key pillars of universal coverage. While there are clear advantages to having MHI coverage, studies report that there are still high levels of unmet need among the insured and that co-payments can still impose catastrophic payment burdens on insured households. A key lesson from the Rwandan experience is that MHI is a complement to (rather than a replacement of) government and donor funding; in 2006, MHI premiums generated about 5% of total health care expenditure in Rwanda.

Although some progress has been made in some countries and there is growing commitment to pursuing universal coverage across Africa, there are many challenges to achieving this goal. A key challenge for African health systems is how to ensure that those outside the formal employment sector have financial protection against health care costs and access to needed health services. This includes those groups who are generating an income from informal sector activities, those involved in subsistence agriculture and those who are unemployed or not economically active.

These groups are generally reliant on under-resourced public sector services, for which they often have to pay fees, or on private sector services that they pay for on an out-of-pocket basis. The burden of health care funding cannot be borne entirely by those in formal employment, given that the formal sector is relatively small in African countries. The challenge is, therefore, how to secure pre-payment contributions from those outside the formal sector who are able to pay, and how to fund services for those who are not able to contribute financially.

A closely related challenge is how to reduce the level of out-of-pocket payments for health care. While it is desirable over time to reduce user fees at public sector facilities, this requires increased funding from pre-payment mechanisms and improved quality of care at facilities that are funded through these pre-payment mechanisms. If, for example, a facility routinely does not have the drugs needed to treat common illnesses, patients will once again have to incur out-of-pocket expenses by purchasing the drugs they need elsewhere.

Finally, although pre-payment funding (whether tax or insurance scheme funds) are limited, it is possible to use them more efficiently and equitably to provide more health services to a larger number of people. Even if additional funding becomes available, it is only with improved resource use that African health systems will be able to ensure that everyone not only has financial protection but also has access to quality services to meet their health needs.

What pre-payment mechanisms can be considered to support progress towards universal coverage in the African context?

The main forms of pre-payment are tax revenue and insurance schemes. All African countries have some tax funding for health services, but there is wide variation in the magnitude of such funding. Tax funding is important not only because it is a visible demonstration of government's commitment to providing financial protection against health care costs for its population, but also because all residents of the country contribute to tax funds. Although the focus is often only on those who pay personal income tax, it is important to recognise that everyone pays certain taxes such as VAT and fuel levies.

Unfortunately, no comprehensive data are available on tax funding of health services in Africa. For example, the WHO National Health Accounts (NHA) database combines tax and donor funding which is directed through government channels in what is called 'general government expenditure on health'. While the WHO NHA database also reports on donor funding as a percentage of total health care expenditure, only some of this is given to government while the rest is given to private providers. However, a combination of these two pieces of data (as indicated in Table 1) provides some indication of the extent of tax funding.

About 45% have government spending (tax and donor funded) of 2% of GDP or less, which is quite low by international standards. Some of these countries (such as the DRC, Eritrea, Guinea-Bissau, Uganda and Sierra Leone – all of which are low-income countries) have quite high levels of donor funding, suggesting that tax funding levels in these countries are particularly low. Some of the low-income countries in which government spending is reported to be at the higher end of the scale also have very high levels of donor funding (particularly Niger, Malawi, Mozambique, Liberia, Rwanda, Tanzania, Ethiopia and Burundi), again suggesting somewhat limited health care spending from tax funds. The only African countries that have relatively high levels of government spending on health care, but limited donor funding, indicating that tax funding is quite high are Botswana, Swaziland, the Seychelles, South Africa, Lesotho and Djibouti (all of which are middle-income countries).

Table 1: Indicators of tax and donor funding in African countries (2007)

Country	Tax plus donor funding as % GDP	Donor as % of total health care expenditure
Low-income economies		
Malawi	5,9	60
Rwanda	4,7	52
Burundi	4,4	40
Zimbabwe	4,1	18
Zambia	3,6	33
Mozambique	3,5	58
Burkina Faso	3,4	28
Tanzania	3,4	50
Senegal	3,1	9
Mali	2,9	20
Liberia	2,8	58
Niger	2,8	75
Madagascar	2,7	18
Chad	2,7	11
Gambia	2,6	24
Benin	2,5	21
Ethiopia	2,2	44
Ghana	2,2	10
Comoros	1,9	21
Kenya	1,8	24
Nigeria	1,7	2
Uganda	1,6	32
Mauritania	1,6	13
Guinea-Bissau	1,5	35
Eritrea	1,5	46
Central African Republic	1,4	26
Sierra Leone	1,4	31
Togo	1,3	10
DRC	1,2	48
Côte d'Ivoire	1,0	5
Guinea	0,6	11

Country	Tax plus donor funding as % GDP	Donor as % of total health care expenditure
Lower middle-income economies		
Djibouti	5,0	13
Swaziland	3,8	8
Lesotho	3,6	11
Namibia	3,1	11
Algeria	2,5	0
Cape Verde	2,4	16
Angola	2,0	4
Egypt	1,7	1
Tunisia	1,7	1
Congo	1,7	5
Cameroon	1,3	5
Morocco	1,2	1
Sudan	1,2	10
Upper middle-income economies		
Botswana	4,3	4
Seychelles	3,5	2
South Africa	3,5	1
Gabon	2,9	2
Mauritius	2,0	2
Libya	1,9	0
High-income economies		
Equatorial Guinea	1,7	5

Source: WHO National Health Accounts database

For many years, the emphasis in Africa has been on introducing and expanding community-based health insurance (CBHI) (sometimes called mutual health organisations). CBHI schemes have been particularly important in trying to provide financial protection for those outside the formal employment sector. Some CBHI schemes have focused on those involved in informal sector activities in urban areas (such as TIKA in Tanzania which covers informal traders), but most have been developed in rural areas to serve subsistence farmers. However, the percentage of the population afforded financial protection through these schemes remains very low (less than 5%) in most countries. Box 4 summarises some of the challenges in relation to CBHI in Africa.

Box 4: CBHI challenges

- The poorest are often excluded from CBHI schemes. CBHI schemes often state that those who cannot afford the contributions will be exempted. However, in reality this seldom happens, partly due to difficulties in identifying the poor and partly due to lack of subsidies to cover the costs of membership for exempted groups.
- CBHI schemes sometimes only cover primary care services; those that do this do not therefore provide financial protection against the costs of inpatient care, where the potential for catastrophic spending is great. Some CBHI schemes however, tend to begin life by offering coverage for catastrophic care.
- CBHI schemes tend to charge a flat contribution to all members. Recent studies have highlighted that CBHI scheme contributions are regressive (i.e. CBHI contributions as a percentage of household income is greater for poorer than wealthier groups).
- CBHI schemes tend not to generate much net revenue – contributions need to be kept low to ensure affordability to those outside the formal sector, but the costs of collecting these contributions on an annual basis are quite high.
- As enrolment in CBHI schemes is generally voluntary, membership levels are influenced by the perceived benefits of the scheme (e.g. whether the services covered by the scheme are regarded as important, if the facilities covered are regarded as providing high quality care and are physically accessible, etc.).

Despite these challenges, CBHI has played a key role in reforms in both Rwanda and Ghana, the two countries that have taken the boldest steps towards universal coverage. Prior to the introduction of CBHI schemes, or Mutual Health Organisations (MHOs), the focus in relation to health insurance had purely been on covering formal sector employees, a small minority of the population, either through social security type schemes or private commercial schemes. The introduction of MHOs raised the possibility of introducing pre-payment funding mechanisms (other than tax funding) for the rural population and others outside the formal sector and focused attention on the needs of the majority of the population. Ghana in particular, by requiring formal sector workers and those outside the formal sector to register with the same district MHO, drew on its experience with MHOs before the introduction of NHI to pool funds and risks across the entire population. There is also some evidence that both Mali and Burkina Faso intend to draw largely from their MHO experiences in building their proposed universal coverage programs.

If CBHI schemes or MHOs are to play a role in moving to universal coverage in more African countries, there is consensus that tax (and donor) funding is required to subsidise contributions for low-income groups and to fully pay the contributions of the poor (as is being done in Ghana and Rwanda – see Boxes 2 and 3). Unless such resources are made available, it will not be possible to cover all community members for a reasonably comprehensive basic package of care through CBHI schemes. Making subsidy resources available is not sufficient; the target beneficiaries of these subsidies need to be identified. While demographic or similar targeting (e.g. exemptions for children under 5, pregnant women, etc.) can lead to a significant portion of the poor receiving needed care, evidence shows that a considerable number of the very poor still tend to remain uncovered under such schemes. It is now generally accepted that traditional methods of means testing (attempting to estimate and verify household income) are ineffective. A number of frameworks and tools have been developed that use reliable proxy measures of a household's socio-economic status (i.e. instead of relying on reported income, verifiable indicators such as the type of materials from which a house is built, ownership of assets etc. can be used as a proxy). Another approach is geographic targeting of subsidies, by evaluating poverty levels in small areas (such as enumerator areas or villages) and providing subsidies for entire communities that have very high poverty levels.

Other than CBHI, there are also some voluntary private health insurance schemes that cater for formal sector employees. These are extremely limited in most African countries, primarily serving a small elite. However, these types of schemes are more prevalent in certain Southern African countries, particularly South Africa, Namibia and Zimbabwe where, according to the WHO's National Health Accounts database, private insurance schemes account for 39%, 37% and 16% of total health care expenditure respectively.

Mandatory health insurance, i.e. where there is legislation requiring certain groups or the entire population to belong to an insurance scheme, is quite limited in Africa at present. Those with the highest level of health care expenditure funded through mandatory insurance (called social security funding in the WHO NHA database) are located in North and West Africa: Algeria and Ghana (where mandatory insurance accounts for 25% of total health care expenditure); Tunisia (22%) and Cape Verde (21%). However, there is growing interest in mandatory health insurance in Africa. Some countries (such as Tanzania and Nigeria) have started such schemes by covering civil servants. While the intention is to gradually extend mandatory insurance to other sectors of the population, a concern about prioritising coverage of civil servants is that limited tax funding is used to secure financial protection for a relatively privileged section of the population. Others, such as Ghana and Rwanda, have legislated from the outset that all citizens should become members of mandatory insurance. As indicated previously, the key challenge in making universal coverage through mandatory insurance a reality is to make available sufficient tax (and donor) funding to provide financial protection for those who are unable to pay mandatory insurance contributions.

The final form of funding that can provide financial protection from the costs of health care is donor funding. As indicated in Table 1, there is a heavy reliance on donor funding in many African countries. About 20% of African countries have donor funding which is equivalent to 40% of total health care expenditure or more, while over 40% of African countries have donor funding levels of 20% or more of total health care expenditure. While donor funding will continue to play an important role in funding health services in African countries, there is a growing awareness of the importance of increasing domestic pre-payment funding for health care, given concerns about the possible lack of stability and long-term sustainability of donor funding.

How can additional resources be mobilised to support progress towards universal coverage in the health sector?

There is a range of options for increasing domestic pre-payment funding of health services. A key focus in Africa in recent years has been on extending insurance scheme cover, whether through voluntary community-based schemes or through mandatory health insurance schemes. The two African countries that have made progress towards universal coverage (Ghana and Rwanda) have used a combination of these insurance scheme mechanisms. Mandatory health insurance can generate additional resources for health care through the payroll deductions for formal sector workers and the contributions of those outside the formal sector who are able to pay such contributions, as well as earmarked taxes that may be acceptable to the populace only because the extra tax burden is clearly targeted at improving everyone's access to quality health care. Indeed, if universal coverage is to be achieved through mandatory health insurance that includes both those within and outside the formal employment sector, extra funding will be needed to pay for subsidies for those with limited or no ability to pay insurance contributions. Therefore, health insurance contributions are complementary to, rather than a replacement for, tax funding. Indeed, the largest share of revenue for the Ghanaian National Health Insurance (NHI) Fund is from a dedicated tax (the NHI levy, which is an additional 2.5% on VAT).

An issue that requires further debate within the African context is the most efficient way of generating revenue from those outside the formal sector. There is a widespread view that there are many people outside the formal employment sector who are in a position to contribute to the costs of health care and that the funding burden should not be placed largely on formal sector employees and employers. However, it is recognised that it is preferable to facilitate pre-payments as opposed to funding health services through out-of-pocket payments. One option is to legislate for those in the informal sector to join a health insurance scheme (usually through the equivalent of a community-based insurance scheme). This has proved to be an important way of generating resources for local health facilities to cover the costs of drugs and other medical supplies. However, revenue generation is relatively limited (i.e. accounts for a small amount relative to total health care expenditure requirements) and net revenue is even lower when the costs of collecting these insurance contributions are taken into account.

Another option is to explore taxation mechanisms that capture revenue from those working in the informal sector, such as VAT and fuel levies (given that various forms of taxis are a key component of the informal sector in many countries). While net revenue from these sources will be far greater than community-based scheme contributions, the key challenge of this option is that many of these indirect taxes are regressive (i.e. the poor pay a greater percentage of their household income in such taxes than higher income households). However, the extent of regressivity can be limited with careful design, whereby goods that are used most by poorer households are exempt from these taxes. Recent research indicates that tax mechanisms have been used in preference to community-based insurance schemes to provide pre-payment cover for the informal sector in Asian countries. While the context differs between Asia and Africa, the Asian experience suggests that the alternatives for providing prepayment cover for those outside the formal sector, of either contributory (health insurance) mechanisms or tax funding, should be critically considered by African countries.

Some attention has also been paid to increasing the allocations to the health sector from government budgets. In particular, African heads of state committed to devoting 15% of government funds to the health sector in the Abuja Declaration of 2001. This commitment was reaffirmed at the African Union meeting of heads of state in Kampala in July 2010. Despite these commitments, limited progress has been made towards the Abuja target in most African countries. Calling for the health sector to be awarded greater priority in the use of government budgets and holding heads of state to the Abuja target commitment is an important way of increasing domestic funding for health care.

There have also been some developments in introducing taxes that are earmarked for the health sector. For example, Zimbabwe introduced an AIDS levy of 3% of personal and company income, with at least half of the revenue from this levy being used to purchase anti-retroviral drugs. The Ghanaian NHI levy, which is an additional 2.5% on VAT, is also a form of dedicated tax. However, these initiatives have been relatively limited in African countries, particularly in terms of introducing new taxes (as in Zimbabwe) or increasing existing ones (as in Ghana). Instead, there is much discussion of dedicating existing taxes (particularly 'sin taxes' such as excise on tobacco and alcohol) to the health sector. Where this approach is used, a frequent problem is that the dedicated tax simply displaces allocations from general tax revenue to the health sector so that there are no additional funds for the health sector. Dedicated taxes may only be worth pursuing if they relate to *new* taxes or *increases* in existing ones.

A final way of increasing domestic funding for health care is what is termed 'innovative financing'. As the name suggests, this focuses on sources of funding that have not previously been considered and which would largely be borne by the richest in society, such as solidarity levies on airline tickets and currency transactions. One country that has recently embarked on this path is Gabon. Box 5 describes these innovative ideas.

Box 5: Gabon shows innovation in health financing

Gabon has a population estimated at 1.5 million in 2011, and is highly urbanized (about 86% urban) with a literacy rate of just over 63%. Life expectancy is 52.5 years with an infant mortality rate of 49.9 deaths per 1,000 live births. It enjoys a per capita income four times that of most sub-Saharan African nations, but due to high income inequality, a large proportion of the population remains poor. Gabon is dependent on oil discovered offshore in the early 1970s. The oil sector now accounts for more than 50% of GDP although the industry is in decline as fields pass their peak production. Health spending accounted for 6% of the national budget and 4.3% of GDP in 2006, according to the 2008 World Health Statistics.

The country introduced a social health insurance regime in recent years designed to combine funds derived from taxes with a contributory regime where additional resources are raised from workers, self-employed, employers and the state. In terms of implementation, Gabon decided on a phased approach starting with coverage for the most vulnerable first, before adding on the public sector, then the private sector and parastatals and finally the self-employed. Another distinctive feature of the Gabon approach is the funding mechanisms for the poor and vulnerable groups. They are funded by means of a new tax called the Compulsory Health Insurance Levy ("Redevance Obligatoire à l'Assurance Maladie (ROAM)"). This fund comes from 2 sources:

- Mobile phone companies must pay 10% of their income into the fund;
- Foreign exchange transactions are also taxed at 1.5% for the fund.

Collection of the above taxes began in 2008. It is intended that formal sector employees will contribute 6.6% of salaries, of which 2.5% will be paid by the employee and 4.1% by the employer, while pensioners will contribute 1.5% of their pension. The self-employed will make flat contributions that are expected to be fixed according to ability to pay.

Contributors will be entitled to 80% coverage for medical expenses (third party guarantee) with a co-payment of 20% of the costs except for long illnesses where the part paid by the patient falls to 10%.

It is not only additional financial resources that are required, but also human resources (and other resources such as drugs). The scarcity of human resources (HR) is a well-recognised within African countries. A range of initiatives such as introducing mid-level workers has been introduced to address this challenge. The mal-distribution of HR, particularly between urban and rural areas, is also an ongoing problem. Recent research has highlighted the while financial incentives to work in rural areas are of some importance, other factors such as providing free housing and offering priority in educational opportunities are of even greater importance. In addition, this research has once again highlighted the importance of recruiting trainee health professionals from rural areas as they have a far greater likelihood of returning to work in rural areas than those recruited from urban areas. A number of countries, such as South Africa and Zimbabwe, have introduced a year of compulsory community service for health professional graduates, with an emphasis on this service being provided in rural areas. In Zimbabwe, if you choose to do your community service in an urban area, you are required to serve for two years instead of one year in a rural area.

How can existing resources be used more efficiently and equitably?

While there is an absolute shortage of resources in African health systems, it is also possible to improve efficiency and equity in the use of existing resources to better meet the health needs of the population.

A key intervention in many African countries in recent years has been the introduction of performance based financing. More and more countries have been turning to performance based financing (PBF) to improve results in their health sectors due in part to growing recognition that African countries would not achieve the MDGs on current performance and progress, and that health sector financing strategies based on paying for inputs (numbers of personnel on the payroll and for their training, equipment costs, operational budgets, etc.) have not produced hoped-for results in the sector.

PBF can be implemented on the demand or the supply side. On the demand side, this includes conditional cash transfers and voucher schemes where the beneficiaries of priority health services (e.g. maternal and child care services) are provided with cash or vouchers to purchase the care needed from providers. On the supply side, this approach puts the emphasis not on paying for inputs, but rather on the results obtained (numbers of children vaccinated, numbers of assisted deliveries, numbers of women on family planning, etc.). It is premised on the notion that incentive payments to personnel will bring about behavioural and other practical changes that will lead to better productivity and quality health care. Financial incentives may be introduced at different levels of the health system although more often these are targeted at priority health services.

Experience shows that PBF implementation usually involves different actors (Ministries of Health, health facilities, NGOs, health personnel, etc.). It entails establishing either some agreed sets of rules or contracts between the different parties. The incentive payment to be paid to the provider is calculated on the basis of indicators of quantity of services performed, which may then be weighted by quality indicators. The total payments obtained from this process tend to be shared among the personnel in accordance with their contribution to the production of those services, but in some cases, part of the funds will go to investing in facility operational or capital costs to further improve quality.

The idea is that through this additional remuneration of health personnel and the stronger monitoring mechanisms this entails, other end results will include improvements in the organisation of services, in the production and use of data for decision making and also in the utilization of health services as well as greater efficiency and equity in resource utilization.

Like other reforms, PBF is not without challenges or even critics. Box 6 highlights some of the issues in the on-going debate on PBF.

Box 6: PBF challenges and debates

Among the challenges of the PBF approach, mostly related to the supply side PBF reforms, are that:

- This approach may require prior institutional and organisational changes, particularly decentralization and local autonomy for health facilities, to make these reforms effective. The required changes may include purchaser-provider splits, putting in place effective and functioning verification systems, and creating a favourable legal/regulatory environment. The challenges here may also include existing trade union or collective bargaining agreements that may be inconsistent with the new incentives' approach.
- Adequate and sustained funding is needed to back the new system. While some of these resources may come from redirecting existing input-based financing budgets, experience seems to show that significant amounts of new financing is often required, both during the demonstration and rolling out stages, including for new monitoring and evaluation systems and training of the personnel in the new systems, data collection methods, indicators that are monitored, etc.
- It is also argued that while PBF schemes may lead in the short term to desired changes and improvements, evidence also points to the fact that people eventually adjust to new incentive systems and then start to regard them as part of their regular remuneration or 'asking price' for their job, at which point these mechanisms may then lose their incentive effect. This argument highlights one key challenge in mainstreaming PBF reforms within the regular MOH systems. Current PBF schemes in Africa may not however have been in place long enough to test this hypothesis.
- Finally, there is also some debate as to whether the evidence emerging from countries where these reforms have been implemented is sufficiently robust and unambiguous enough to warrant widespread adoption elsewhere without some degree of caution. While Rwanda, and to some extent Burundi, have often been cited as success stories in this respect, it appears that some counter examples from other countries, e.g. Uganda and Cameroon, may also exist.

The debate seems to highlight, at least, the need for careful attention to the design, financial sustainability, the political, social and institutional environment, any necessary accompanying measures, as well as a health systems rather than a vertical approach, in pursuing the PBF approach.

Health professionals are the most important resource within the health sector and if efficiency is to be achieved, careful attention must be paid to the skills mix within health services. An initiative that is being implemented in many countries is that of task-shifting, whereby more mid-level health workers are being trained and tasks that used to be undertaken by more highly-skilled health professionals are being shifted to these mid-level workers. This promotes greater efficiency, in that each service is provided by the lowest skilled (and hence least expensive) health worker qualified to provide that service.

It is also critical to improve the procurement and distribution of drugs. Many countries have introduced essential drug lists, which focus on the use of a limited number of inexpensive generics that can treat the majority of diseases within that country. In terms of procurement, there is a need for policies that ensure that African countries are not charged prices for drugs produced overseas that are higher than are paid in other countries. This is because there is limited local production of drugs, with most drugs being imported. Some national policies do not promote the growth of local drug manufacture. For example, in Zimbabwe, while drugs that are imported are not subject to import duties, local drug manufacturers pay duties on imported raw materials.

It is not only important to use existing resources more efficiently, it is also critical to promote equity in the use of health care resources. A number of recent studies have once again highlighted that richer groups manage to secure a greater share of the benefits from using health services than poorer groups, despite the burden of ill health being heavier on those with lower socio-economic status. Those living in rural areas also receive a smaller relative share of health service benefits than their urban counterparts.

One strategy for addressing these inequities is to allocate health care resources (facilities, financial and human resources) across geographic areas such as regions or provinces and districts in line with the relative need for health services of each area. A growing number of African countries are using a needs-based formula to allocate government budget resources and pooled donor funds. Such formulae generally include indicators of the need for health services in a geographic area such as population size, demographic composition (given that young children, the elderly and women of childbearing age generally have a greater need for health care) and if possible, indicators of the burden of disease.

Recent studies have recommended that the level of poverty in each area also be taken into account, given that there is a strong relationship between poverty and ill-health and that poor households are most dependent on publicly funded health services.

However, equity in the use of health services will only be addressed if explicit steps are taken to address the range of access barriers that face individual patients. A number of studies have recently highlighted that the most severe access constraints include the following:

- The distance between communities and health facilities and the sometimes high costs of transport to facilities. There is particular concern about geographic access problems for referral services and in a medical emergency.
- Inadequate staffing, particularly at primary care facilities, forcing patients to seek care at hospitals at higher cost both to the state and the patient.
- Inadequate drug supplies, with frequent reports of drug stock-outs, again particularly at primary care facilities. This means that patients have to then go and purchase drugs from a private pharmacy or drug seller and that patients are reluctant to go to that facility in future.
- Poor staff attitudes towards patients, which is exacerbated by inadequate staffing levels and heavy workloads, but also by limited attention to motivating staff and recognising their efforts.

These access constraints highlight the importance of ensuring that there is an adequate allocation of resources to the primary care level and that sufficient attention is paid to improving the quality of primary care services. These are the services that are located closest to communities and much of the burden of disease in African countries, particularly communicable diseases, can be addressed at primary care level.

What roles should be played by different actors?

Achievements during the past decade in Ghana and Rwanda suggest that progress towards universal coverage could move quite rapidly in Africa if supported by strong political leadership. Ensuring access to quality health care and financial risk protection for all citizens is primarily the responsibility of the state. Translating the vision of universal coverage into reality requires political leadership and a greater role for the state in health care financing. African states should take greater fiscal responsibility for the health care of their citizens and strengthen policy measures to meet the Abuja target of 15% of government spending occurring in the health sector. Increased tax funding is critical for achieving universal coverage in Africa, whether this is used to directly purchase health care (in the case of tax-funded systems) or used to subsidise insurance contributions for those outside the formal sector to achieve an integrated insurance risk pool for the whole population. African states also need to strengthen their regulatory role and capacities to ensure not only the provision of quality health services by public and private health care providers, but also the solvency of health insurance organisations and the protection of citizens. The state should also play a role in promoting social responsibility within the private health sector and ensuring that private providers and insurance groups act in the public interest.

In addition to state actors, including those elected and appointed, politicians and civil servants in Ministries of Health and Finance, there are a range of other actors who will be interested and involved in universal coverage reforms. For example, depending on the extent of donor dependency and influence, international organisations, both multi-lateral and bi-lateral can become major actors. Technical analysts and researchers in academic institutions, private providers (particularly large commercial groups such as private hospitals and pharmaceutical manufacturers), existing voluntary health insurance schemes, front-line health care workers, formal sector employers and trade unions can also potentially be important stakeholders.

Individuals, households and communities are the principal beneficiaries of universal coverage reform. The poorest households often stand to gain the most from successful universal coverage reform. Unfortunately these groups do not always have a voice in universal coverage reform. Civil Society Organizations (CSO), as well as other forums for ensuring adequate participation by the poor, can play a role in making these actors more visible, and their voice better heard.

All reforms have social and economic costs and benefits. These costs and benefits are not evenly spread in society and do not necessarily affect the same groups to the same extent. A stakeholder analysis of actors potentially affected by the reform, the costs and benefits they will experience, their potential position in relation to the proposed reform (i.e. support or oppose) as well as their power in the reform process is therefore a critical part of managing universal coverage reforms. For example, a major source of controversy in the Ghana NHI reform was the proposal that formal sector employees who were members of the Social Security and National Insurance Trust (SSNIT) would have to contribute 2.5% of their SSNIT contribution the NHI fund. Almost all members of organised labour unions in the country contribute to this fund. The initial proposals did not make it clear what benefits would accrue to SSNIT contributors and they felt the deductions would threaten the viability of their pension payments. Therefore, trade unions mobilised to resist these proposals. They were able to secure a concession from policy-makers whereby their SSNIT contributions did not increase and were guaranteed that the 2.5% contribution to NHI would not affect their pension funds. In effect, policy-makers agreed that the SSNIT contributions to NHI would be a 'loan' that will have to be repaid from tax funds when current SSNIT members retire and expect full pension payouts. A more careful stakeholder analysis and the development of effective actor management strategies to inform the design of the reform proposals and the management of policy processes may have avoided some of these complications.

All major reform, such as universal coverage, is political as well as technical. It is essential to have politicians and technical actors engaged and well-informed for successful reform.

How can tools for monitoring and evaluation towards UC be developed and strengthened?

The ability of African countries to improve information and communication infrastructure in order to face the challenges associated with reforming health financing systems, including health insurance schemes, is likely to be the key determining factor of the pace of progress towards universal coverage in the region. Improved monitoring and evaluation mechanisms are necessary to support the reform of health delivery and health financing systems in line with universal coverage goals, within the specific political, social and economic conditions in individual countries. Monitoring and evaluation systems are critical for informing policy decisions and for assessing progress towards universal coverage, based on the goals, objectives and targets set in their country strategic frameworks. This requires setting an explicit, core set of indicators for monitoring and evaluation of progress towards universal coverage.

Strengthening monitoring and evaluation systems could be facilitated in the Africa region by the favourable environment associated with new information and communication technologies. These technologies open new opportunities for strengthening vital registration systems, health information and management systems, referral systems, identification systems, provider payment systems, financial and administrative management systems, and information-based decision-making in health care provider organizations, health insurance organisations, public health administrations and health insurance regulatory agencies. African countries could leverage opportunities provided by the improving information and communication infrastructure in individual countries, in combination with household surveys, facility surveys, public expenditure tracking surveys, actuarial studies and national health accounts to strengthen management capacities, transparency and accountability mechanisms, and monitoring and evaluation systems in the health sector.