Towards Universal Health Coverage
Lessons from Africa

Leo Devillé
Economic growth

- Per capita growth in Africa is falling back despite having some of the fastest growing economies in the world
Health

- Largely off track for reaching the health MDGs
- Challenge to strengthen health system in an environment of severely restricted fiscal space

Context: Insufficient progress in health
No “one size fits all”

Context: Major differences in health financing
A useful framework for analysis – but it does not reflect the inter dependence of the components

**Burundi / Ghana**
- Financing reform / service delivery (HR; EM; ...)

**South Africa**
- Reform of pharmaceutical supply / governance (decentralisation)

**Lesson**: Health system building blocks are inter-linked
The human resources building block

- Lesson from Ethiopia

Lesson: Individual building blocks are complex
Lesson: Individual building blocks are complex (II)

The building block of medicines and technologies

- Lesson from South Africa

Correctly assessing the need

Procuring and stocking the right medicines

Timely supply to facilities in correct quantities

Prescribing and dispensing the correct medicines

Taking the medicines as prescribed
Main sphere of influence / action: Global Level

Main sphere of influence / action: Regional Level

Main sphere of influence / action: Country Level

- Global & national policies; economic interests; political processes; social values

- NMRA capacity constraints
- Lack of (access to) information
- No incentives to apply (small markets, low purchasing power)
- Interference / political pressure (government, donors)

- Low/variable financing
- High prices
- Inadequate QA systems
- Lack/poor use of market intelligence
- In-transparent (corruption)

- Poor clinical practice
- Unregulated private sector
- High prices
- Perverse incentives
- Unethical promotion

- Market failure (lack of incentives for private sector investment)
- Linkage R&D cost and product price / inadequate financing mechanisms

- IPR issues
- Limited dev. country capacity (e.g. GMP)
- Production capacity (sole source)
- Unstable demand

- High mark ups
- Logistics inefficiencies
- Leakages (accountability?)
- Poor coverage (urban/rural)

- Lack of social financing
- Poor health literacy
- Information asymmetry
- Social/cultural norms
- Unethical promotion (DTCA)

- Poor coverage
- In-transparent (corruption)
- High mark ups
- Logistics inefficiencies
- Leakages (accountability?)
- Poor coverage (urban/rural)

- Main sphere of influence / action: Global Level
- Main sphere of influence / action: Regional Level
- Main sphere of influence / action: Country Level
Responding to complexity

Interrelationship of health systems building blocks and sub-components require comprehensive planning

- **Ethiopia**: Expansion of HR for primary care generates reforms of secondary level services, infrastructure, equipment, drugs, etc.
- **DRC**: De-fragmentation of service delivery generates human resource reforms, rationalisation of staff, “suffocation” of uncontrolled private sector
- **Burundi**: Finance reform (PBF) changes staff retention, motivation and performance, increases service demand

**Lesson**: Reforms require comprehensive planning
The limits of planning

Reforms require constant review and fine tuning to adjust for unpredicted outcomes

- **DRC**: CAG created to reduce the fragmentation of development assistance became itself fragmented by different partner interests; nb of provinces 12 =>26
- **Ethiopia**: Innovative medical curriculum did not transfer the required skills
- **Ghana**: National expansion of a district mutual health insurance scheme failed to reach the required population coverage

**Lesson**: Reform is a process of iteration
Bringing the private sector on board

You cannot assume that the priorities of the private sector are aligned with the logic of public sector reform

- **DRC**: The commercialisation of professional training and service delivery is a major obstacle to reform

- **South Africa**: Standard treatment guidelines and essential drug lists are a threat to some commercial interests

**Lesson**: Private and public sector incentives differ
The limits of fiscal space

Increasing the efficiency of the health system will expand availability and equity of services, but it cannot expand the available fiscal space

- **Ghana**: Risk of Health Insurance Fund becoming insolvent

- **DRC**: International support does not necessarily increase fiscal space to implement reforms (80% of international health sector contributions in 2012 spent on mass campaigns)

What is the potential of increasing domestic funding?

**Lesson**: The constraint of limited fiscal space
Health insurance in an informal sector economy

Lessons from Ghana and Burundi

• Universal coverage not achievable when enrolment is voluntary and enrolment & renewal are cumbersome.
• Partial coverage results in equity and efficiency issues
• Premiums stratification based on income not feasible for informal sector
• Identification of the poor for premium exemption costly and difficult
• What is the alternative? Compulsory de facto enrolment? No annual premium for informal sector?
• Is there enough fiscal space for these alternatives?

Lesson: Health insurance affordability and coverage
Performance based financing

Lessons from Burundi

• **Positive**: access / utilization, quality of care, continuity of services, autonomy, planning / budgeting / governance, staff distribution, stability of staff, quality of information (HIS), availability of EM, beneficiary voice / community participation

• **Risk**: neglect of non-subsidized services

• PBF is no “**mantra**”: it covers a relative small part of health financing and depends on other support / inputs to be in place; but it cuts across all building blocks and is potentially a vehicle for strengthening health systems

**Lesson**: Financing reforms to strengthen health systems
Reforming HR from the “bottom-up”

Lesson from Ethiopia:

• Starting with first level staff

• First results in low technology areas and health behaviour

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive acceptance rate</td>
<td>23%</td>
<td>62%</td>
</tr>
<tr>
<td>Ante-natal care</td>
<td>41%</td>
<td>82%</td>
</tr>
<tr>
<td>Skilled delivery</td>
<td>10%</td>
<td>17%</td>
</tr>
<tr>
<td>Postnatal care</td>
<td>16%</td>
<td>42%</td>
</tr>
<tr>
<td>Access to improved sanitation</td>
<td>29%</td>
<td>86%</td>
</tr>
</tbody>
</table>

Objectives:

- To achieve universal coverage of two health extension workers for each health post by end of HSDP III
- To meet the minimum staffing requirement for delivering essential health services at health centres and primary/district hospitals
- To meet the projected need of medical doctors by 2015

• Then moving to services requiring higher level skills and technology

Lesson: Successful HR reforms require a long horizon
Reforming EML & STG – simple, but ...... (1)

• Evidence-based selection of EM meant to improve procurement processes, efficient use of limited resources, and rational use of medicines

• Pooling procurement as per EML to result in lower prices

  Rational use: Use of injections and prescribing of EML versus non-EML medicines showed considerable improvement (2003)

  No published evidence whether standard treatment guidelines and essential medicines lists improved the efficiency of procurement of medicines; but decline in EM prices; increase in availability of EM

  Private sector: more considerations of cost effectiveness and affordability of EM in managed care; price increase EM in private sector less than for specialist fees and hospitals; but overall effect less clear

Lesson: even simple reforms take time to implement
Reforming EML & STG – simple, but ...... (1)

- **Political and socio-economic environment**: organisational set-up public sector (central / province) & court action against Act (generics; pricing) by private lobby groups
- Stepwise, progressive and **flexible implementation** (regular M&E; regulatory framework)
- Need for **sustainable financing** (competition for resources) – see also Ethiopia, Burundi
- **Transparency** in selection, procurement and regulation of pharmaceuticals is key to keeping all stakeholders on board. This is as a central tenet of good governance

**Lesson**: even simple reforms require careful & flexible implementation
Lesson from the DRC

- Many national interests in the health sector (political, private economic)
- Goals and objectives of international development partners not necessarily aligned with reform agenda
- National political and administrative decentralisation policies impact on reform processes
- Successful efficiency reforms require consistency, strong leadership and ability to negotiate and maintain a shared long-term vision

Lesson: Reform requires national leadership
Efficiency gains / savings

• **Ethiopia**: HR reforms results in increased PHC access and service output (within same resource envelope?)

• **DRC**: public sector reform savings from fictitious staff invested in health; reduction of management costs; alignment of DPs result in reducing parallel supply of EM; ...

• **Burundi**: PBF results in increased access / higher utilisation + numerous secondary effects (HIS, staff stabilisation, improved planning / budgeting); ....

Lesson: causal relation difficult to establish
Efficiency gains / savings

- **SA**: EML & STG & generics & pricing policy results in increased availability of EM, selective improvement of rational use
- **Ghana**: inefficiencies & inequity still to be addressed

Lesson: causal relation difficult to establish
Because they are complex entities, health systems are exposed to the butterfly effect.

A well intended intervention that modifies a component can impact others in a negative way.