

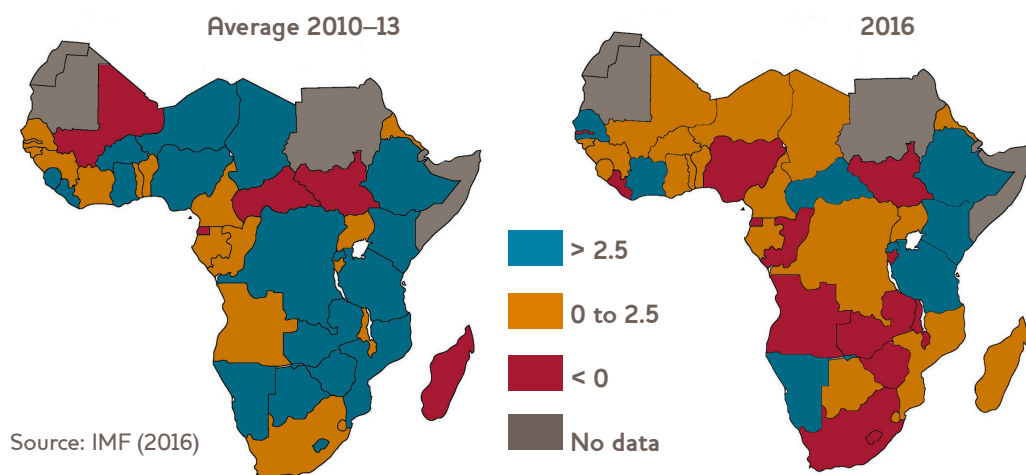
WHAT DOES THE END OF AFRICA'S BOOM MEAN FOR UNIVERSAL HEALTH COVERAGE?

Achieving universal health coverage by 2030, as stated in UN Global Goal 3, will require substantial increases in health spending and the proportion funded through taxation or social insurance to make health care affordable for all. Not only will institutions need to be established to ensure sustainable arrangements for social finance, it will also be vital to ensure that health financing is resilient to economic and other shocks if Global Goal 3 is to be realised. This presents a major challenge in Africa, where an economic downturn is projected in a number of resource-dependent countries, such as Mozambique and Guinea Bissau and where countries such as Sierra Leone have weakened health systems. The response to these challenges by governments and development partners, will have important effects on how well people, and the health services on which they rely, cope in the short term and longer-term evolution of health coverage.

Economic shocks in sub-Saharan Africa

Since the Ebola outbreak of 2014–15 and the consequences of the virtual collapse of health systems in the affected countries, there has been a lot of international interest in strategies for increasing the resilience of health systems. An IMF publication in October 2016 on the regional economic outlook of sub-Saharan Africa highlights the importance of this issue. The report predicts a bleak economic outlook for resource-dependent African countries, and identifies four kinds of shocks that are affecting them: (a) a dramatic fall in the price and volume of exports by 23 countries that are highly dependent on minerals; (b) a major slowdown in the continent's economic growth (see Figure 1); (c) falls in employment, and; (d) falls in household purchasing capacity linked to inflation. In addition, the severe drought associated with El Niño affecting Eastern and Southern Africa, the Ebola outbreak in West Africa, and the deterioration in the security situation in a number of countries are making the situation worse. The report emphasises the likelihood that climate change will increase the frequency and size of these shocks.

Figure 1: Sub-Saharan African countries' past and present GDP percentage growth



Source: IMF (2016)

The implications of economic crises for health – lessons from history

Africa has experienced recurrent crises associated with changes in global commodity prices. This is not the first time that individuals and health systems have had to cope with serious financial constraints. In the late 1970s and 1980s many countries in sub-Saharan Africa were hit hard by the combination of high oil prices (which was then imported) and low prices for key export commodities, compounded by natural disasters and political instability. Structural adjustment programmes to open up markets to competition worsened the situation for their fragile economies. This prolonged crisis was associated with falls in the value of health sector salaries, frequent drug shortages and neglect of infrastructure and equipment maintenance leading to the introduction of user-fees and/or community drug finance to supplement public finance.

These past experiences suggest possible repercussions of the current economic downturn on health and health systems. Falls in household income, increases in poverty and vulnerability, rises in malnutrition, and decreased capacity of individuals to pay for health services can be expected to act directly on the determinants of health and on the ability to pay for health services. At the same time, the supply of health services is likely to be reduced as cash-strapped national governments tighten health budgets and private providers see their access to capital curtailed. In countries with security and governance concerns, international aid may be withheld, exacerbating the squeeze on the social sector.

Tensions between UHC and health system resilience

In recent years global health policy debates have been dominated by the target of universal health coverage (UHC), with the aim of increasing access to health services and protecting users from very high health expenditure. This has involved efforts to expand the fiscal space available for health spending and relying on public financing and insurance schemes to avoid potentially impoverishing out-of-pocket medical expenditures (see Box 1). The efforts to expand health coverage made a lot of sense during Africa's past decade of economic growth; countries are facing enormous difficulties with maintaining coverage in a situation of shrinking budgets and growing concerns about governments' ability to deliver basic goods and services.

UHC was always meant to be a long-term health goal rather than an immediate policy option, and strengthening system resilience and guaranteeing financial protection during adverse circumstances have always been key elements in a strategy for achieving this long-term goal. Nonetheless, the creation of complex financing schemes that are vulnerable to external constraints in public finance, may reduce the resilience of a health system. While still offering a vision for health systems' long-term development, policy analysts need to pay more attention to the reality of non-linear economic growth and economic cycles, particularly for fragile states. As well as periods when services can be expanded and institutions developed, strategies for achieving UHC should take into account periods of retrenchment, during which funds are scarcer and efforts need to focus on consolidating gains from previous phases.

Box 1: Finance for health

Fiscal space for health refers to a government's ability to raise revenues to achieve its sectorial objectives within the existing macroeconomic constraints and taking into account their future sustainability. Revenues for the health sector can be increased through domestic taxes, external assistance, borrowing, printing money, increasing allocation to specific sectors and efficiency savings. Each option has macroeconomic limits, from a government's ability to increase the tax take during economic recession, to risking the excessive appreciation of the currency, or compromising future ability to service debt, or increasing inflationary pressures. Health financing looks at alternative ways of generating revenues for the health system, pooling resources, and paying for services taking these constraints into account. Over the years, innovative mechanisms have been identified for generating extra revenues specifically for the health sector. Health financing for UHC entails selecting the most appropriate mechanisms to achieve UHC goals, attempting to eliminate impoverishing out-of-pocket expenditures and relying on public financing and insurance schemes to protect from hardship.

“Countries are facing enormous difficulties maintaining coverage in a situation of shrinking budgets.”

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Economic crisis and health financing in the field

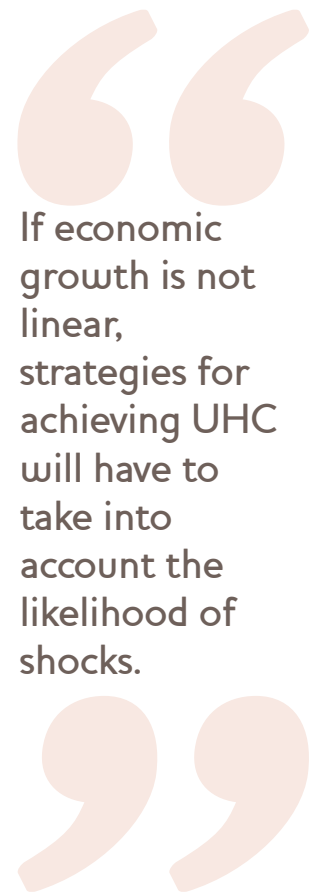
Crisis patterns and health financing policy responses to date have been diverse across the African continent. The Ebola epidemic in Sierra Leone demonstrated the important role of an effective health system in protecting individuals and the wider community from the negative impacts of a major illness. A recent HEART analysis of fiscal space in Sierra Leone concluded that external funding would be needed for a number of years (*Fiscal Space Analysis in Sierra Leone: The Free Health Care Initiative and Universal Health Coverage*). The predicted economic downturn will reduce the fiscal space. The sequencing of health system reforms and the degree to which the health system can meet essential needs during a period of crisis, will strongly influence the eventual pathway of health system development. A review of the evidence identified several priority elements of a health system for resilience (Bloom *et al.*, IDS Practice Paper in Brief 18). National governments need to finance and organise public health measures to reduce exposure to infectious disease and act to protect the population against dangerous practices and sub-standard drugs. People need access to effective treatment of common health problems. They may obtain services from government clinics but they also buy drugs from shops and informal providers. Government policy needs to take this into account. The health sector is highly labour-intensive and health workers are influenced by the financial incentives they face, their opportunities for building a career and arrangements for supervising them. It would appear that a lack of attention to these issues prior to 2014 contributed to the fragility of the health system.

In Mozambique, after years of natural resources-fuelled growth, the dip in commodity prices, a resumption of armed confrontation, a severe drought in parts of the country, and the discovery of hidden debts, have all dented confidence in the country's macroeconomic stability. With growth prospects halved and foreign direct investment slashed, Mozambique's currency depreciated rapidly and inflation picked up, changing the assumptions for public spending and health sector financing. Until 2015, government and health partners had pursued the development of a health financing strategy inspired by UHC principles and expanding health insurance starting from public sector employees; after the discovery of the hidden loans, the International Monetary Fund – a bellwether institution for economic respectability and aid policies in Africa – stopped lending to the country, and public spending was squeezed across the board in the name of fiscal continence. Only the aid-dependent health sector was granted a 10 per cent increase in government funds to face the withdrawal of foreign assistance from key areas such as salaries and medicines. However, talks of overhauling the country's health financing strategy have been put on hold.

In Guinea Bissau – one of the world's poorest and least developed countries – following subsequent coups d'état, most donors suspended direct contributions to the state budget in 2014 to what was widely regarded as an illegal government. However, the economy continued to grow in 2015 and 2016 thanks to the country's relative political stability and sustained prices of key agriculture exports. In 2015, the World Bank resumed financial support issuing grants earmarked to pay for public salaries for the health and education sectors, with the declared objective of avoiding public servants' strikes, to support modernisation of the public administration, and to stabilise a volatile situation among Guinea Bissau's warring political factions. Guinea Bissau's health sector is chronically underfunded, representing just 5.6 per cent of GDP and 8 per cent of public spending, with users typically paying for health-care services largely through out-of-pocket payments. After adopting the cost-recovery principles of the Bamako initiative in the 1980s and 1990s, public health workers these days routinely use revenues from medicines sales to pay for salaries and contract extra staff. With support from the World Bank ended in 2016 and other external funds still suspended, an *ad hoc* health financing arrangement is currently being negotiated with the international health partners to allow the provision of basic health services in the country.

Implications for health investment and finance

If African countries' economic growth is not linear, strategies for achieving UHC will have to take into account the likelihood of shocks and the need to ensure that national health systems are resilient. This will have to involve measures to protect basic health services during low points in the cycle and to build resilience during expansionary periods by strengthening institutions and guaranteeing steady financing for basic services.

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If economic growth is not linear, strategies for achieving UHC will have to take into account the likelihood of shocks.

The present economic downturn offers a window of opportunity and leverage for the international community to support the establishment of sustainable and resilient sources of health finance as part of a programme of countercyclical support. These sources could include the earmarking of revenues from mining and the establishment of sin taxes, as well as insurance and allocation from tax revenues.

There is a need for honest discussion about the role of private out-of-pocket payments during economic crisis; although these payments have been shown to constitute a barrier to access to services or drugs and a contributor to household impoverishment, the reality on the ground is that formal and informal user payments to public and private providers often represent an important source of revenue for health services. Although there is enough evidence that such expenditures have an impoverishing effect on households, it is nonetheless important to acknowledge this reality and to introduce measures for the survival of health services during economic downturns while protecting access to essential public health and primary health care.

Recommendations

The following actions will be needed by governments and donors to counterbalance the negative impact of the projected economic downturn on health and health systems in affected countries:

- Priority to be given to the establishment and protection of primary health-care services;
- Provision of social protection to low-income, vulnerable groups, who are more likely to experience economic hardship and increased risk of disease in times of economic downturn;
- Strengthen basic public health and prevention, as a cost-effective way to protect people from illness;
- Ensure that salaries are paid for key public health service employees;
- Ensure funding for drugs and necessary goods, which are among the first items to disappear when dwindling funds disrupt complex supply chains;
- The introduction of health insurance to be piloted in phases to ensure the scheme is resilient to economic downturn;
- Unsustainable health investments to be avoided during expansionary periods, to reduce the risk that commitments to recurrent expenditure cannot be met during downturns;
- International health partners to focus on stabilising volatile situations through countercyclical measures, to attenuate the impact for health and health services of financial and other crises and to moderate excessive expectations and commitments to recurrent expenditure during expansionary periods.

Further reading

Heller, P.S. (2006) 'The Prospects of Creating "Fiscal Space" for the Health Sector', *Health Policy and Planning* 21.2: 75–79

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Credits

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