HEALTHCARE AND ECONOMIC GROWTH IN AFRICA

Preview of the report
at the
High Level Dialogue on
Africa’s Health and Financing: Pathways to Economic Growth and Prosperity

GBCHealth
Aliko Dangote Foundation
and
United Nations Economic Commission for Africa (UNECA)
New York, 27 September 2018
Central premise of the report

• Health matters for economic growth
  – mostly through impact on labour productivity, reduced absenteeism, and reduction of catastrophic expenses on healthcare.

• Considerable evidence of a robust link between health outcomes and economic growth
  • Life expectancy at birth
  • Child mortality rate
  • Maternal mortality rate
  \[ \rightarrow \] GDP per capita growth

• ECA’s preliminary empirical results (with data from 48 countries) demonstrate that a 1 year increase in life expectancy at birth results in a 0.1% increase in GDP per capita.

• According to WHO estimates, investing an additional average of US$21 to US$36 per capita per year over five years in Africa would
  • save 3.1 million lives (of which 90% would be among mothers and children),
  • prevent between 3.8 million and 5.1 million children from stunting.

• Economic gains in five years can be up to $100 billion from additional health investment.
Key questions

Within the overall context of a young, rapidly increasing, and urbanizing population

• Can healthcare systems in Africa respond to the challenges against a backdrop of already stretched budgets and competing demands?

• Can countries in Africa deal with another epidemic?

Why are these questions important?

• Health threats never far away in Africa (return of Ebola in DRC; cholera in Zimbabwe)
  - So how resilient are our health systems?
  - To what extent is healthcare accessible and affordable to those who need it the most?

• Africa needs healthy (also educated and skilled) labour force to increase productivity and reap the demographic dividend
  - Low labour productivity in Africa that grew at 1.4% per year in 2000-2018.
Africa has made considerable progress on health outcomes in 2000-2015

- Life expectancy at birth increased from 54 to 61 years
- Infant mortality rate down by 22%
- Maternal mortality reduced by 36%

But

- Health outcomes in Africa still lag behind other regions in the world
- Large inequalities in access to healthcare
- High out-of-pocket expenses on healthcare
THE CONTEXT

Africa is the youngest region in the world ...

- Median age of 18 years, though variation in population age distribution across sub-regions.

- In 2015, 50% in NA; 59% in SA; 63-64% in other sub-regions are below the age of 24 years.

Nearly 60% of Africa’s population is under 24 years of age

Source: UNDESA Population Division. World Population Prospects. The 2017 Revision
... with a high, though declining, burden of disease

Africa has about 15% of the global population but carries one-fourth of the global disease burden

Communicable diseases as proportion of total disease burden has declined across all countries in 2000-2016

Source: Chart prepared by ECA based on data from WHO Global Health Observatory
Communicable diseases dominate disease burden among children and the youth; chronic diseases among older age groups.
Who is the healthiest of us all?

Non-communicable diseases (NCDs) predominate in countries with low disease burden

Source: ECA calculations based on data from WHO Global Health Observatory
Africa is urbanizing rapidly

Lifestyles are changing, so are disease patterns

• Africa is the fastest urbanising region in the world. In many countries, urban population is growing at more than 3% per year.

• In rapidly urbanizing areas, the growth of slums forces more people to live in conditions with substandard sanitation and poor access to clean water, compounding the problem.

• Nearly 60% of Africa’s population lives in slums
  • In Chad and the Central African Republic, 88-93% of the population lives in slums.
  • Both countries have the highest disease burden, and mostly communicable diseases.

• Urbanization means more people live in close quarters, amplifying the transmissibility of contagious diseases.

• Danger of spreading of an epidemic because of high population densities.
Africa’s high rate of extreme poverty is declining, but only slowly
Catastrophic health expenditures often push households below the poverty line

- Extreme poverty has fallen in the region since the 1990s, but more than 40% of Africa’s population continue to live below the extreme poverty line.
- In absolute terms, the number of people in extreme poverty has increased since 2002.
- DRC, Ethiopia, Nigeria and Tanzania constitute almost 50% of Africa’s poor.

- Catastrophic health expenditures often push whole families below the poverty line.
- For instance, in Sierra Leone over 10% of the income of the poorest quintile of the population is spent on medical care.
- Impoverishment and financial hardship from health payments and the subsequent illness-poverty cycle is an important obstacle for economic development.

Source: ECA (2017) based on data from World Development Indicators, 2014
PRELIMINARY FINDINGS

1. Financing of healthcare in Africa

2. Private sector in health
1. FINANCING HEALTHCARE IN AFRICA

KEY ISSUES

i. How much do countries spend on healthcare?
   • Is health a priority?

ii. Are countries spending enough? How much should they spend?

iii. Does health expenditure make a difference to health outcomes?

iv. What is the composition of health spending?

v. Where does the government money to spend on health come from?

vi. How can countries spend better?
How much do African countries spend on healthcare?

• Average total health expenditure was 6.1% of GDP in 2015.

• Since 2000, a consistent increase in total spending on health in most countries.

• 29 countries have increased total health spending (as % of GDP) in 2000-2015.
  • Total health spending declined in 13 countries in this period.
  • West and Southern Africa sub-regions spend the highest on average (7% of GDP); Central Africa the least (4.7%).

• The number of countries spending more than US $44 per capita per year has doubled from 15 to 31 in 2000-2015.

• In 2000, 23 countries spent less that US $20 per capita per year. By 2015, only Central African Republic was below this threshold.

• Mauritius, South Africa, Algeria, Botswana and Namibia are the top 5 spenders on health (in 2015), in terms of US $PPP.
How much do Africans spend on healthcare?

Globally, average OOP expenditure declines in countries with higher GDP per capita. No clear trend in Africa.

- Out-of-pocket (OOP) spending was more than half of total health expenditure for 23 countries of the 50 countries with data in 2000, with un-weighted average of 45%.

- In 2015, this had dropped to 13 countries with the (un-weighted) average of 36%.

- On average, OOP spending per capita is high - in Sudan is US $96; in Cameroon US $44.

- A large proportion of population has no access to needed health services as they cannot afford to pay for them.

Out-of-pocket payments as a share of total health expenditure, 2015 (%)

Note: The size of each bubble represents the relative size of the country’s population. Source: Chart prepared by ECA using OOP expenditure data from WHO Global Health Expenditure Database; data on GDP per capita from World Development Indicators.
Is health a national priority?

On average, African governments spend 6.5-7.8% of the government budget on health, though with wide variation. Until 2010, the spending was uneven. Since then all sub-regions show an increase of budget allocation for health.

Source: Chart prepared by ECA using OOP data from WHO Global Health Expenditure Database
Are countries spending enough? How much should countries spend on health?

<table>
<thead>
<tr>
<th>Declaration</th>
<th>Year</th>
<th>Amount</th>
<th>Purpose</th>
</tr>
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<tbody>
<tr>
<td>Abuja Declaration</td>
<td>2001</td>
<td>15% of budget allocation for health</td>
<td>Heads of state of African Union countries set a target to improve the health sector and meet the MDGs</td>
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<tr>
<td>WHO Commission on Macroeconomics and Health</td>
<td>2001</td>
<td>US $34 per capita per year</td>
<td>Minimum per capita sum needed to introduce essential health interventions to reach increased coverage rates by 2007 (at 2002 prices in USD).</td>
</tr>
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<td>High-level Task Force (HLTF) for Innovative International Financing for Health Systems</td>
<td>2009</td>
<td>US $44 per capita per year</td>
<td>To fill national financing gaps to reach the health MDGs through mobilising health resources.</td>
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- Only five countries have achieved the Abuja target so far (Botswana, Rwanda, Zambia, Madagascar and Togo). Of these, only the first three met the HLTF target of spending $ 44 per capita.
- Prioritization of health in the use of public funds can have a negative impact on other social services, such as education and social assistance, all of which compete for the same budget.
- Trade-offs involved in resource allocation of resources between competing social priorities.
Can spending targets make a difference?

OOP expenditure declines in countries with high government spending on health

Note: The size of each bubble represents the relative size of the country’s GDP per capita in 2015 (in constant 2010 USD).
Source: Chart prepared by ECA using OOP expenditure data from WHO Global Health Expenditure Database; GDP data from World Development Indicators
Does health expenditure make a difference to health outcomes?

Both government and private spending on healthcare significantly improve infant, under-five, and maternal mortality.

• ECA’s preliminary empirical results (with data from 48 countries) demonstrate that a 1% increase in health expenditure per capita results in a decrease in infant mortality of 0.1; in under-five mortality of 0.21; and in maternal mortality of 0.8-1.2.

• Improvement of the selected health outcomes in 1990-2010 mostly due to government and private health spending on health care.

• Consistent with existing literature, improvements in access to safe drinking water, increasing share of births attended by the health personnel, and adult literacy rate also reduce infant, under-five, and maternal mortality rates.
2. PRIVATE SECTOR IN HEALTH

• Private sector in health refers to a range of activities are carried out by non-state actors who are: for-profit or not-for-profit providers and funders; and work through formal or informal mechanisms.

• These can be international or national; or individuals and organizations operating at global, national or institutional levels.

<table>
<thead>
<tr>
<th></th>
<th>Type of Providers</th>
<th>Key feature</th>
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<tbody>
<tr>
<td></td>
<td>Formal</td>
<td>Informal</td>
</tr>
<tr>
<td>For-profit</td>
<td>• Physicians, nurses, midwives, dentists in private practice</td>
<td>• Traditional healers</td>
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<tr>
<td></td>
<td>• Licensed pharmacies</td>
<td>• Traditional birth attendants</td>
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<tr>
<td></td>
<td></td>
<td>• Drug peddlers</td>
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<td></td>
<td></td>
<td>• Clients generally cover costs on a fee for service basis (OOP expense)</td>
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<tr>
<td>Not-for-profit</td>
<td>• NGOs</td>
<td>• Community health workers</td>
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<tr>
<td></td>
<td>• Religiously-affiliated hospitals</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Costs subsidized by government or donations</td>
</tr>
</tbody>
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Source: Adapted from Osewe (2006)

• Despite the perception to the contrary, the private sector is used extensively by the poor.

• Two discourses dominate the discussion of the role of the private in low-income countries:
  • The private sector is a cure-all for public sector inefficiencies.
  • Predatory practices are so endemic in the private sector that it should be regulated, controlled, and possibly replaced by government-funded and -operated clinics.
Public-private partnerships (PPPs) in health

• PPPs in health are becoming common as the private sector increasingly engages with governments in the health- and health-related sectors through a “...deliberate, systematic collaboration” in line with “...national health priorities, beyond individual interventions and programs.”

• This helps “regulate, finance, or implement the delivery of health services, products, equipment, research, communications or education.”

Types of private sector engagement

• Global level Partnerships (typically a multi-country initiative)
• National/country level partnerships
• Institutional/Facility level partnerships
Service provision and health financing predominate private sector engagement in PPPs in health

- Service Provision: 38%
- Health Financing: 13%
- Multi-Area Engagement (Finance, Service, Training, etc.): 12%
- Policy, Dialogue, Governance and Advocacy: 3%
- Human Resources and Education: 6%
- Information and Technical Support: 5%
- Technology and ICT Innovation: 8%
- Medicine and medical products: 1%
- Supply Chain and Logistics: 4%
- Laboratory and Diagnostics: 2%

Source: ECA calculations using data on PPPs from various sources
PPPs often not aligned to disease burden or health priorities

- The number of PPPs and Government Health Expenditure (as % of total health exp.) is mildly and negatively correlated. (Correlation coefficient = -0.22)

- That is, PPPs most likely replace government spending on health.

- Kenya and Senegal have approx. the same no. of DALYs and also similar public spending. But Kenya has 61 PPPs to Senegal’s 18.

- The number of PPPs and DALYs are not correlated (Correlation coefficient = 0.09).

Note: The size of each bubble represents the relative size of the country's population.
...and are unequally distributed across the continent

Nearly two-thirds (63%) of PPPs in health are in East and West Africa.

Just 10 countries* account for more than half (51%) of all PPPs.

Source: ECA calculations

* West Africa: Nigeria, Ghana, Senegal
Central Africa: Cameroon
East Africa: Ethiopia, Kenya, Tanzania, Uganda
Southern Africa: Mozambique, South Africa
Why are the top 10 countries with the most health PPPs attractive to the private sector?

**Economic growth and resilience matters**
- Eight of the ten were projected as high growth and high resilience countries in 2018.
- Of the remaining, Mozambique has high growth prospects, and South Africa is considered resilient.
- Kenya (80th) and South Africa (82nd) are in the top half of the global Ease of Doing Business rankings (n=190).

**Infrastructure matters**
- For the 10 countries, internet growth (2000-2017) was 4 times higher and internet penetration 20% higher than the African average.
- The 10 countries together comprise 37% of total Facebook users in Africa.
EMERGING MESSAGES

• **Health matters for economic growth.** Considerable global evidence (also from Africa) that improving health is a driver for long-term economic growth and development.

• The relatively **strong political commitment to health in Africa has not always translated into increased allocation for the health sector.**

• Given the numerous competing demands, **increased expenditure on health depends on political consensus within the country** – it cannot be imposed externally.

• To help prioritise government spending on health, it is also **important to counteract the prevailing misperception of health as a non-productive sector** that does not contribute much to growth and development.
EMERGING MESSAGES...

• **OOP expenditure is a burden on the household**, but increase in government spending does not automatically reduce OOP expenditure, especially where government health spending is low. The structure of total health expenditure matters.

• At the same time, **with rising costs and the ‘double’ burden of disease in Africa, governments cannot meet all health costs**.

• **The private sector has an important role to play** in helping countries in Africa achieve significant improvements in health outcomes.

• The third ‘P’ of PPP – **partnership – is the most important aspect of private sector engagement in health** and can contribute to achieving national health goals.

• **PPPs need to be aligned with disease burdens and health priorities in countries**.

• Strong national public health systems are the foundations for disease prevention and reduced disease burden for which **public and private sectors need to work in tandem**.
ACKNOWLEDGEMENTS
(as on 10 September 2018)

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Adrian Gauci, Melat Getachew (consultant), Myunggu Jung, Martin Kabione, Jane Karonga, Maraki Fikre Merid (consultant), Selahattin Selsah Pasali, Lesego Selotlegeng, Saurabh Sinha (task manager and lead author), Dommebeiwin Juste Metoiole Some, Heini Suominen, Ali Yedan

Helpful comments received from:
Chigozirim Bodart, Hopestone Chavula, Soteri Gatera, Mama Keita, Fatouma Sissoko, Jack Jones Zulu (ECA); Ochuko Keyamo, Mercy Machiya, Nancy Wildfeir-Field (GBCHHealth); Iris Semini (UNAIDS); Innocent Ntaganira (World Health Organisation, WHO)

Guidance and support received from in ECA:
Oliver Chinganya, Inderpal Kaur Kanwal Dhiman, Stephen Karingi, Thokozile Ruzvidzo

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Aigboje Aig-Imoukhuede (GBCHHealth); Vera Songwe (ECA)
Publication Launch

Tuesday, 12 February 2019

at the

Africa Business: Health Forum

in

Addis Ababa, Ethiopia

ALL ARE WELCOME