

Accelerating Sustainable Domestic Health Financing in Africa

Overcoming the Financial Crisis - The imperative to Move from 15% to 15% + :

Presentation at 4th Conference of African Ministers of Health (CAMH4) , 4-8 April 2009, Addis Ababa
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All Protocols duly observed.

Thank you to African Union Social Affairs Division and the Health Ministers Bureau for organisation of CAHM4 and kind invitation to make this presentation.

Introduction / Overview

Long term and sustainable Health Financing is one of the most crucial pillars of building viable health systems and ensuring Universal Access to Prevention, Treatment and Care for a wide range of diseases and health conditions. Without adequate resources, and efficient management of those resources, all health systems will fail and eventually grind to halt.

This is not without consequence. The slow progress on increasing sustainable health financing in Africa has led to Africa's disease / health burden reaching record-breaking levels especially with infectious diseases, Maternal and Child death [Which constitute the basis for MDG's 4, 5 and 6]. At the turn of the Millennium, Healthy Life Expectancy in Africa was 41.4 years [38.7 for Sub Saharan Africa] compared to between 66.1 and 72 years for more developed countries.¹

In December 2006, the Africa Public Health Alliance underlined at the launch of the 15% Campaign that Africa is losing at least 8 million lives annually to only 5 main causes: Malaria; TB; HIV and AIDS; Child Mortality and Maternal Death.

1. **Malaria:** There were an estimated 247 million global episodes of malaria in 2006 of which 212 million cases were in the African region. From these, there were an estimated 881 000 deaths of which 91% were in Africa, and 85% were of African children under 5 years of age.²
2. **Tuberculosis:** By 2006, there were an estimated 4,233,723 (4.2 million) cases of TB in Africa of which 2,807,688 (2.8 million) were new cases. This resulted in 639,089 African deaths.³
3. **HIV and AIDS:** In 2007 there were an estimated 22 million People living with HIV in Africa out of a global figure of 33 million. Of these new infections in Africa were 1. 9 million. And 1.5 million Africans died in the same year of AIDS related causes.⁴
4. **Child Mortality:** An estimated 5 million African children under the age of 5 died in 2006 mainly of neonatal diseases, pneumonia, Malaria, diarrhoeal diseases, AIDS and meseales 5 A staggering average of 14,000 infant deaths a day.
5. **Maternal Death:** Over half a million women die each year because of complications related to pregnancy and childbirth. Of the estimated 536,000 maternal deaths worldwide in 2005, developing countries accounted for more than 99 per cent, and about half or 265,000 Maternal Deaths, which are almost 100% preventable, were in sub-Saharan Africa.⁶

¹ WHO 2003. Healthy Life Expectancy (Hales) is the average number of years that a newborn can expect to live in "full health." HALEs try to measure a health system's effectiveness in reducing the burden of illness.

² World Malaria Report 2008

³ WHO Report 2008: Global tuberculosis control

⁴ UNAIDS/WHO, 2008 Report on the Global AIDS Epidemic

⁵ State of the Worlds Children Report 2008, UNICEF

⁶ WHO, UNICEF, UNFPA and The World Bank. 2007.

Despite these poor indicators on population and health, and tragic prevalence and mortality figures, the funding gaps for meeting Universal Access Targets and Health MDGs is still greatest in Africa.

For instance:

For Malaria: US\$ 2.2 billion is needed in 2009 and US\$ 2.7 billion in 2010 to scale-up preventive and curative interventions to reach universal coverage. Preventive costs comprise approximately two thirds of these costs in 2010, case management costs are approximately 20% of the costs, and the remainder is for malaria control program costs. Expected declining costs through 2015 are due to lower treatment costs needed due to preventive efforts.⁷

For TB: Africa is the region with the largest funding gap of US\$10.7 billion. The funding gap is the difference between total needs for full implementation of the Global Plan to Stop TB 2006-2015 and projections of the funding that will be available over the next 10 years.⁸

For HIV and AIDS: Based on the country-defined targets for 2010, it is estimated that an investment of US\$ 25 billion will be required for the global AIDS response in 2010. Of the \$25 billion, one third will go towards strengthening health systems in low- and middle-income countries. Another one third will fund HIV specific health services, and the remaining for other multi-sectoral programmes. HIV prevention programmes will require \$11.6 billion, while providing treatment would cost \$6.9 billion. **Sub-Saharan Africa requires nearly half of the total global resource needs (of about US\$ 12.5 billion).**⁹

For Maternal and Child Health: In 2008 The Partnership for Maternal, Newborn and Child Health asked for US\$10 billion to meet previous commitments to global health. **Of this, a total of some US\$1 billion per year would be needed to improve services in the African continent alone between 2009 and 2015 (US\$ 6 billion).**¹⁰

Implications for Delayed Increases in Domestic Health Financing

The more we delay - the more we will have to spend: The greater the delay in rapidly accelerating domestic health financing, the more Africa will have to spend to reduce on even bigger and widespread disease burden. In other words “Universal Access” now - will cost less than in the future.

Increasing convergence of diseases / conditions in both countries and individuals bring new challenges for treatment and health systems: The increasing convergence of the countries most affected by multiple diseases and health conditions, and consequently the overlap between these means that prevention; treatment and care will become more complex and expensive per person - as people are diagnosed with multiple concurrent conditions. For instance, increasing and combined incidents of Malaria and HIV, or HIV and TB or all three have become deadly cocktails of death.

In the case of HIV and AIDS, Africa is now at a critical point where the number of annual deaths and number of new infections (1.9 million and 1.5 million respectively) are also converging. AIDS orphans are now over 12 million and since poverty and disease are mutually reinforcing, most of these 12 million will increase Africa’s disease burden and mortality.

The consequences for African social and economic development are dire as no sustainable development can happen in any country where children are dying at an unprecedented rate, and most adults are dying before they reach their prime due to inaccessible health care and services.

⁷ Roll Back Malaria Global Business Plan

⁸ The Global Plan to Stop TB 2006 - 2015

⁹ What countries need – investments needed for 2010 targets, UNAIDS February 2009

¹⁰ PMNCH / Countdown 2015 Cape Town 2008 Conference

Recommendations on Health Financing in Africa / Overcoming the Financial Crisis

In addition to having the biggest funding gaps for meeting Universal Access Targets and Health MDG's, African governments are spending huge amounts of money on the effects of rather than the causes of most health conditions. At any time, but especially in times of global financial crisis it is even more crucial to invest in preventive health and social determinants of health especially: vaccinations; clean water; sanitation; environmental health and sustainability; and nutrition. In one stroke, more investment in these can eliminate a wide range of diseases and complicating factors. The medium to long term Financial, Economic and Social Development gains will be enormous.

In 2001 African leaders pledged to allocate at least 15% of national budgets / domestic resources to health. 8 years later, only two countries have apparently done so excluding external resources.

One of the justifications for this commitment was that globally, countries with the best indicators on health were spending between 11% and 21 % of national budgets on health.

The imperative to move from 15% to 15% +:

However what AU Abuja commitment did not take into consideration, is that those countries in combination with percentage allocations to health, are also spending between 333\$ (Cuba) and \$6,350 (US) per capita / per person on health. The lowest performing countries spend between 17\$ and \$150 per capita.

1.) Percentage + Per Capita: *We therefore recommend that African governments scale up per capita expenditure on health to necessary levels in combination with percentage allocations of 15% or more of national budgets to health.*

But 'money' alone in these terms does not tell the whole story. Cuba for instance is considered to have a more efficient and equitable health system per dollar spent than the US even though both countries are in the same life expectancy bracket of 75 to 85 years. A major reason for this is its globally recognised long-term investment in overall social protection, and also in health systems and education that, has guaranteed it more health workers per patient than more developed countries.

2.) Investment in Overall Social Protection and Determinants: *We urge African governments to note and act on the fact that In addition to improving domestic health financing through higher percentage allocations and higher per capita expenditure on health, long term and sustainable investment in: Overall Social Protection in Health; General and Specific Pre-requisites for improved Access to Health (health systems and health workers); and Diverse Social Determinants of Health including Gender Equity in Health are key to low disease burden in the best performing countries.*

These include ensuring: ratios of between 19-60 per 10,000 for doctors, 70-195 per 10,000 for nurses and midwives and equivalent numbers for pharmacists and other health workers; evenly distributed access to health services between urban and rural areas including access to especially essential medicines; 90% - 100% of sustainable access to clean water; 95% to 100% of sustainable access to improved sanitation; elimination of malnutrition for children and undernourishment for adults; 95% - 100% vaccine coverage; 100% accessibility to public health education and so forth.

The absence of these, and prevalence of "out of pocket expenses" are the reasons why less than 20% of African countries are on target to meet 2010 Universal Access targets, and 2015 Health MDG's.

3.) Actualising Inter Sectoral Cooperation for Health and Development: *We recommend that the Bureau of Health Ministers and the AU Social Affairs division commence urgent official engagement of and coordination with Honourable colleagues in the following Ministries / Sectors:*

Social Development; Water Resources; Environment and Sanitation; Women and Gender; Children and Youth; Education; Food and Agriculture; Labour and Human Resources - and most importantly Finance, Planning and Economic Development. Efficient deployment of resources from these sectors to tackle causes of many health problems at the roots will ensure there is less need to continuously increase health budgets just to deal with consequences of poor intersectoral collaboration.

We further recommend that the Health Ministers and AU Social Affairs should work to ensure that there is an official Health Bureau delegation to each of the Conference's of these sectors, and that to ensure implementation at the national levels, they come together to form a 'Health and Development Cluster Team' for joint implementation of health and related MDG's.

Crucially we recommend a joint conference of Health and Finance Ministers by 2010 for the review and reinvigoration process for Abuja +10 Commitments, and funding the AU Health strategy.

Some work in this regard has already commenced. The AU Health Strategy for instance underlines the need for intersectoral cooperation. And ***in April 2008, the AU, ECA and Africa Public Health Alliance jointly engaged the Honourable Ministers of Finance, Planning and Economic Development leading to their adoption and restating of the 15% commitment.***

Also ***in November 2008, the AU, ECA and Africa Public Health Alliance organised the first ever conference of Chairs of African Parliamentary Committees of Health/HIV, Gender and Finance, from which emerged the Network of African Parliamentarians for Health Development and Financing*** which will work to ensure parliamentary policy and budget support for the AU Health Strategy, and Africa components of: the global plans of the Global Health Workforce Alliance; Partnership on Maternal Neonatal and Child Health; Roll Back Malaria Partnership; Stop TB Partnership; UNAIDS Global Reports and ECA CHGA Report (on HIV), and other policies of health and development agencies such as ILO, UNDP, UNEP, UNESCO, UNFPA, UNICEF, UNIFEM and the WHO.

4.) Integrated implementation of all MDGs – No Health MDG left behind: We recommend that governments and donors ensure integrated implementation of all health MDGs 4,5 & 6, as there is commonality between MDG's. Reproductive and Sexual Health for instance impacts on both Maternal and Child Health and HIV. TB is the biggest killer of HIV Positive persons and so forth. It is not efficient use of resources if people are saved from some health issues only to die of another. ***In addition, Target 2 of MDG 1 on Nutrition; Target 10 of MDG 7 on Clean Water and Sanitation, and Target 17 of MDG 8 on Access to Essential Medicines are pre-requisites for other MDG's.***

5.) Global Efforts on Health Should Coordinate With and Support / Compliment AU Africa Health Strategy: In order to ensure maximum coordination between global efforts such the International Health Partnership (IHP+) and Providing 4 Health Initiative, and African Initiatives such as the AU Africa Health Strategy and the Abuja Commitments - we recommend urgent and continuous meetings and coordination between them the Health Ministers Bureau and AU Social Affairs.

Finally, we commend the AU on the conference theme of “Universal Access to Quality Health Services and Improvement of Maternal, Neonatal and Child Health”, and the launch of the Campaign against Maternal and Child Mortality in Africa (CARMMA). We commit ourselves to CARMMA just as we have to the AU Abuja Commitments and Targets for HIV and AIDS, TB and Malaria.

Conference Chair, Honourable Commissioner and Director Social Affairs, Eminent Country Delegations and Experts, Distinguished Agency and Development Partners and Representatives, thank you for your most kind attention, and your kind consideration of these recommendations.

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