Provisional agenda item 3

UNIVERSAL HEALTH COVERAGE IN AFRICA: FROM CONCEPT TO ACTION

CONTENTS

Paragraphs

BACKGROUND ................................................................................................................................. 1–10

THE CURRENT SITUATION AND LESSONS LEARNED FROM UHC EXPERIENCES ............................................. 11–21

CHALLENGES ........................................................................................................................................ 22

CONCRETE ACTIONS TO ACCELERATE PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE .................................. 23–28

CONCLUSION ...................................................................................................................................... 29–30
BACKGROUND

1. Africa bears a heavy burden of communicable diseases and noncommunicable diseases. It harbours 69% of the world’s HIV cases, 26% of TB cases and 80% of malaria cases. It also accounts for 47% of global under-five mortality and 56% of maternal mortality. Most countries in Africa are not on track to attain the health MDGs. While this situation prevails, effective interventions to improve health outcomes exist. A major reason for this situation is that most of the populations are not covered by these effective interventions.

2. Accessibility and coverage of essential health services is currently low: only 43% of pregnant women have four antenatal care visits compared with the global average of 55%; only 49% of births are attended by skilled attendants compared with the global average of 70%. In order to improve the situation there is need for a significant improvement in the coverage of essential services to the population. Universal health coverage has been proposed as the means to achieve this goal.

3. Universal Health Coverage is defined as ensuring that all people can use the needed promotive, preventive, curative, rehabilitative and palliative health services of adequate quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

4. Moving towards Universal Health Coverage is a gradual process. It involves making progress on several fronts for all people: the range of services available (consisting of the medicines, medical products, health workers, infrastructure and information); the proportion of the costs of those services covered; and the proportion of the population covered.

5. This requires an efficient health system that provides the entire population with access to good quality services, health workers, medicines and technologies. It also requires a financing system that protects people from financial hardship and impoverishment due to health care costs.

6. The World Health Report 2010, entitled: Health systems financing—the path to universal coverage, urges WHO Member States to move towards Universal Health Coverage whereby all people have access to the needed health services of good quality without suffering financial hardship.

7. Universal Health Coverage has been advocated for and endorsed at the global and regional levels and it has been acknowledged as essential to achieving and sustaining the health MDGs. It is increasingly considered as an integral part of the post-2015 sustainable development agenda.

8. Several low- and middle-income countries have made tremendous progress towards reaching Universal Health Coverage with lessons learnt, challenges identified and recommendations made. They have shown that Universal Health Coverage is an attainable goal and a legitimate aspiration of all countries.

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1 The 15th Session of the Assembly of the African Union (AU) on 24 July 2010 in Kampala, Uganda; the AU Conference of Ministers of Economy and Finance on 28 March 2011 in Addis Ababa, Ethiopia; the interministerial conference of 4-5 July 2012 in Tunis, Tunisia; the ministerial level roundtable on UHC organized jointly by WHO and World Bank, 18-19 February 2013, WHO headquarters, Geneva, Switzerland; the Africa Health Forum 2013: Finance and Capacity for Results, hosted by The World Bank in collaboration with Harmonization for Health in Africa, April 18-19, 2013, Washington, DC; the Panel Discussion –Towards UHC in the African Region during the Sixty-third session of the WHO Regional Committee for Africa, 2–6 September 2013, Brazzaville, Congo; the MDG forum during the UN General Assembly on 24 and 25 September, 2013. The Rio+20 Declaration.
9. Many opportunities for moving towards Universal Health Coverage exist in the African continent, such as the global drive in support of Universal Health Coverage. The international community and development partners have agreed that ensuring universal access to quality, affordable health services is the key to ending extreme poverty. Africa’s economy grew by 4.8% in 2013 and is projected to grow by 5.3% in 2014. That provides an opportunity for increased government spending on health and for increased commitment of national governments, spurred by the results achieved by African countries already engaged in the pursuit of Universal Health Coverage. Other encouraging developments include the availability of several tools and proven strategies to move towards UHC, the increasing involvement of civil society and the demand of people for better health services.

10. Access to health services ensures that people are healthier while financial risk protection prevents people from being pushed into poverty. Therefore, Universal Health Coverage is a critical component of sustainable development and poverty reduction, and a key element of social inequity reduction.

THE CURRENT SITUATION AND LESSONS LEARNED FROM UHC EXPERIENCES

11. There is no single step-wise blueprint or linear process for implementing Universal Health Coverage. Although the key ingredients for ensuring Universal Health Coverage are in place in most countries, countries are performing at different levels and the approaches to progressing towards Universal Health Coverage are country-specific. Fortunately, no country is starting from scratch and the efforts towards Universal Health Coverage can build on existing health systems and social protection mechanisms. Several lessons have been learned globally and regionally that can inform and accelerate the move towards Universal Health Coverage. These lessons include ensuring equitable access by removing financial barriers especially direct payments (user fees); making prepayment compulsory; establishing large risk pools; and government financial coverage of the health costs of people who cannot afford to contribute.

12. In line with the objectives of Universal Health Coverage some countries in the continent are implementing strategies to improve access to and coverage of health services while many other countries have made commitments to take measures towards achieving Universal Health Coverage. By adhering to the principles of Universal Health Coverage, countries will be able to address their priority health problems especially by scaling up priority interventions aimed at reducing the huge double burden of disease through robust national health systems based on the Primary Health Care approach.

13. Ghana has been implementing health financing reforms since 2004 in order to increase population coverage with prepayment pooled mechanisms, reduce direct out-of-pocket payments (OOP) and increase the range of services provided in the benefit package. The Ghana National Health Insurance Scheme is one of the most comprehensive schemes to be established in sub-Saharan Africa. Under the scheme, exemptions for the poor were included initially. Indeed, relatively poor districts and disadvantaged population groups have higher NHIS coverage. The key design principles are 'equity' in access to a defined benefit package irrespective of the capacity to pay and 'risk equalization' meaning the financial risk of illness is equally shared among all.

\[2\] Botswana, Gabon, Ghana and Rwanda.
14. Making prepayment compulsory is very crucial to achieving Universal Health Coverage. For example, Rwanda has enacted a law regarding the creation, organization, operation and management of a national health insurance scheme. The law stipulates that: “Any person residing in Rwanda shall be bound to health insurance, any foreigner entering the country shall be also be bound to health insurance within a time limit not exceeding fifteen days”. The scheme now covers about 92% of the population and finances medical consumables, services, capital projects, logistics and equipment for service providers. In addition, a strategy to identify destitute people in order to determine national health insurance scheme contribution subsidies and exemptions has been devised, and the Government and development partners pay for groups that have been identified as part of poverty alleviation activities.

15. The current health financing system in Botswana is a tax-based system providing a large risk pool to ensure coverage of the population for a wide range of services. Out-of-pocket spending in Botswana, which is only 4% of total health expenditure, is the lowest in Africa. Government expenditure on health, estimated at around US$ 446 per capita, is also above the average of US$ 228 per capita in Africa and other upper middle-income countries elsewhere in the world.

16. In 2007 Gabon initiated health financing reforms in order to achieve Universal Health Coverage. A Fund was established with resources derived from special taxes paid by mobile telephone and money transfer companies. The Fund is also financed through social contributions by wage earners, independent workers, employers and government contributions. The Government has adopted a gradual approach to membership starting with the poorest. The introduction of compulsory health insurance in Gabon starting with a mechanism to cover the poorest, based on special taxes, is an innovative and promising experience.

17. Morocco and Tunisia have expanded the population covered by pre-payment arrangements that provide access to needed health services by establishing medical assistance schemes funded by government revenues. Morocco’s medical assistance scheme (le Regime d’Assistance Medicale or RAMED) and Tunisia’s free medical assistance (Assistance Medicale Gratuite or AMG) provide coverage for the poor and vulnerable population that are not usually covered by social health insurance schemes. In Morocco, the RAMED and the social health insurance scheme (l’Assurance Maladie Obligatoire de base) have jointly expanded coverage to 62% of the Moroccan population. In Tunisia, the AMG and the social health insurance schemes (Caisse Nationale d’Assurance Maladie) have a combined population coverage of 92%.

18. Instead of establishing separate pre-payment arrangements for poor and vulnerable populations, Egypt and Sudan have expanded population coverage by utilizing government revenues to subsidize the poor and vulnerable population under their respective social health insurance schemes. In Sudan, the Ministry of Finance and Zakat charities have subsidized the National Health Insurance Fund coverage of around 400,000 poor families. In Egypt, the Health Insurance Organization’s coverage of school children is funded from government revenues.

19. Several countries are grappling with the uneven distribution of existing health facilities, with urban areas being better endowed than rural areas. Improving equity in access requires equitable distribution of adequately equipped health facilities between rural and urban areas and availability of a competent health workforce. This calls for renewed emphasis on the Primary Health Care approach of bringing services closer to communities, with well-articulated and reliable referral systems, and possible creation of new cadres of human resources. Increasing the population covered has been achieved by improving geographical access through expansion of
the health infrastructure and use of community-based workers (Ghana, Ethiopia, Tanzania…). Other strategies include waiving user fees for vulnerable groups such as women, children, the elderly and the poor, and providing free services for a defined package of essential services.

20. A review\(^3\) has shown that interventions towards Universal Health Coverage improve access to health care. It has also shown that Universal Health Coverage often has a positive impact on financial protection and, in some cases, on health status. The review further shows that the effect of Universal Health Coverage schemes on access, financial protection, and health status varies according to contexts, Universal Health Coverage scheme design, and Universal Health Coverage scheme implementation processes.

21. Worth noting is that the removal of user fees can create unexpected negative effects. For example, in Uganda, 10 years\(^4\) after introducing free care in public facilities, 29% of households still experience catastrophic health expenditures and out-of-pocket expenditure has increased from 38% in 2001 to 50% 2010 while the percentage of patients choosing private sector providers increased significantly, except among the absolutely poor.

**CHALLENGES**

22. Many challenges exist in the quest for Universal Health Coverage. Notable among them are: (a) lack of sustained political commitment, clear vision and a well-charted road map for universal health coverage; (b) lack of coherent health financing policies, resulting in limited financial resources and absence of financial risk protection arrangements for large segments of population groups; (c) inequitable and inefficient allocation of funds to the appropriate service delivery level for effective interventions to address priority health problems; (d) weak and fragmented health systems, resulting in inequitable and insufficient provision of health services; (e) weak partnership between the private sector and the public sector; (f) weak information systems to assess performance and monitor progress towards UHC.

**CONCRETE ACTIONS TO ACCELERATE PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE**

Member States should:

23. **Affirm sustained high level political commitment to Universal Health Coverage by:**

(a) Developing a comprehensive “equity through Universal Health Coverage” vision and strategy with evidence-based policies and actions that emphasize intersectoral action, financing strategies ensuring financial risk protection, and reorientation of service delivery.

(b) Putting in place mechanisms for coordination and implementation of Universal Health Coverage e.g. establishing a national multisectoral Steering Committee to pilot the project and undertaking advocacy for a sustained national commitment.

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24. **Improve financial risk protection and expand population coverage by:**

(a) Developing/improving comprehensive policies and strategies for health financing to realize aggregate increase in funds for health and to enhance the quality of fund utilization to reduce out-of-pocket payments, at least for vulnerable populations and priority services.

(b) Promoting prepayment mechanisms to cover all the population and introducing prepayment and pooling arrangements that share financial risks across the whole population. This includes mobilization of increased resources for health through government revenue, tax funding and/or mandatory (i.e. social or national) health insurance premiums and/or subsidies.

(c) Implementing public equity funds to cover the health costs of people who are not able to contribute.

25. **Expand the provision of integrated people-centered service delivery for Universal Health Coverage by:**

(a) Undertaking comprehensive and coordinated health system strengthening through improvement of infrastructure and equipment, upgrading of human resources, and procurement and supply of medicines and health technologies.

(b) Developing decentralized health services in order to expand service delivery to reach poor, vulnerable and marginalized populations with quality, integrated people-centered health services, based on national and local priorities responsive to local needs and contexts and based on Primary Health Care.

26. **Implement a monitoring and evaluation framework to monitor progress towards Universal Health Coverage by** monitoring and evaluating progress towards Universal Health Coverage as a whole and across the three coverage dimensions, through, among others, the production of data to monitor evidence of inequalities, and evaluation of the impact of policies and programmes on health equity and progressive attainment of UHC.

**WHO and Partners should:**

27. Provide technical assistance to countries for developing/revising normative documents towards Universal Health Coverage such as policies and strategies; laws and other legislative instruments on Universal Health Coverage; and a framework to monitor Universal Health Coverage.

28. Crucially: (a) build the capacity of countries to undertake necessary diagnostic and analytical work; (b) develop a framework that allows monitoring of UHC along its three dimensions; (c) facilitate national policy dialogue between ministries of health, ministries of finance, ministries of planning and other related ministries to develop evidence-based financing options; (d) facilitate sharing of experience among countries; (e) assist countries to generate and mobilize the resources needed to progress towards Universal Health Coverage.

**CONCLUSION**

29. Universal Health Coverage represents a transformational shift from separate management of multiple pieces (hospitals, private clinics, and community health centres) to a single well-coordinated system able to guarantee equitable access to a diversity of beneficiaries, including the poorest and the vulnerable, while protecting them from falling into financial hardship.
30. Universal Health Coverage is feasible in the context of countries in Africa and is urgently needed to expedite the improvement of the health status of people in an equitable manner. There are challenges being faced and countries have already started to address them. As Universal Health Coverage requires the full involvement of multiple players, sensitization and consensus building will always be necessary to achieve that end. There is a strong momentum for Universal Health Coverage and countries should seize the opportunity to take concrete steps to move towards the achievement of Universal Health Coverage.