Report

April 2020

Health Care Spending in Sub Sahara Africa. A cross-country comparison

Gloria Afful–Mensah, University of Ghana, A-id

Email: gafful-mensah@ug.edu.gh

Background. Every year, many people die from diseases which could have been cured if formal health care services had been sought early; many households are moved into poverty because of high health care costs; and some younger household members drop out of school because the limited resources are used to finance health expenditures. The 2030 deadline for achieving the SDGs and hence universal health coverage is not very far away as it may seem and requires increased efforts and commitment.

Goal. This report provides cross country evidence by comparing shares of health care spending and mortality levels in SSA. The purpose is to project useful relationship(s) that may necessitate further research and policy directives.

Sample. 44 countries in SSA

Data. 2016 data (most recent) on health indicators by WDI

Method of analysis. Descriptive

Major finding. OOP health expenditure remains high with dwindling governments' share of health expenditures across the region; and declining donor support to the health sector.

Conclusion. The realities are not satisfactory and may thwart efforts to achieve SDG 3 and UHC. Unfortunately, many countries in the region do not have well functioning risk pooling schemes in the health sector. Countries in SSA must step up actions; show "good fate" to declarations made earlier; and increase commitment to the health sector.

This series of reports provides an independent commentary on current themes associated with the debate on international development.

Agenda for International Development

is an independent non-profit policy research institute focused on development and humanitarian issues.

Introduction

Every year, thousands of people die from preventable diseases ostensibly because they did not seek any formal treatment, sought treatment late, or were unable to keep up with the burden of paying for treatment. Many households are pushed into poverty because households' limited resources are used to finance health care expenditures of sick members. According to the World Health Organisation (WHO), approximately 100 million people are pushed into extreme poverty (living on at most $1.90 a day) because they have to pay for health care.[1] Some young people drop out of formal education because households' limited resources are used to care for sick household members. The fundamental function of an efficient health system is its ability to put in place health financing systems that protect citizens against financial risks associated with ill health (The World Health Report, 2000). Therefore, a successful health system is one that meets the population needs by *inter alia* improving the health status, protecting the individuals and communities against health threats, guarding the people from catastrophic health expenditure and providing equitable access to healthcare (Xu et al., 2005). With this in mind, how far have countries gone in terms of prioritising health financing? To what extent are citizens protected against financial risks associated with ill health? What is the extent of governments' commitment to the health care system in terms of share(s) of health expenditures? Does increasing government share of health expenditures necessarily imply lower shares incurred by individuals, increased health care service utilisation and lower mortality rates? What kinds of risk sharing mechanisms and coping strategies are available in the health care systems? These are just a few of the questions that have been and continued to be addressed by researchers and policy makers given the dynamics in the health system. In developing countries, the relatively lower living standards even worsen the problems and make people more vulnerable.

Scope and Aim of Study

This articles focuses on 44[2] countries in Sub-Sahara Africa (SSA). SSA is characterised by low and lower-middle-income countries. The utilisation of formal health care services is generally low in the region resulting in many needless deaths. Even among those who seek formal health care, many have adopted several strategies such as partial purchase and/or sharing of prescribed drugs to avoid paying health care service directly from the pocket. Risk sharing schemes in the health system is rare. In the last decade, a number of countries (e.g. Ghana, Kenya, Tanzania) have successfully implemented health insurance schemes and a few more countries are also at various stages of implementing similar schemes. Even that, health insurance schemes in implementing countries typically cover only primary health care needs and hence do not cover non-communicable diseases and/or lifestyle diseases such as diabetes, kidney and lung related problems despite steadily becoming a major public health concern. Consequently, financial barrier remains a major obstacle in accessing health care services in many countries in the region. This article thus provides some detailed descriptive regards health care expenditures in SSA by looking at out-of-pocket (OOP) health expenditures and governments' commitment to the health systems in terms of share of total health expenditures and further relates them to the mortality level. The main aim here is to project the existence of (if any) and the nature of correlation that exist among these health variables using evidence from data provided by The World Bank's world development indicators (WDI). Though countries in SSA share many economic similarities, the reforms in the health systems and the level of governments' commitment vary. By comparing these variables across countries, we see countries with greatest commitment to their health systems and this is expected to provide valuable insights useful to assess the reality of attaining the UHC from SSA perspective.

Descriptive and discussions

With risk pooling scheme(s) absent in many countries, most people incur health expenditures by themselves and are typically required to pay at the point of service delivery. Relative to total income, health expenditure is regarded catastrophic if total health expenditure constitutes 10% of households' total income. Staggering statistics by the WHO indicates that

[1] https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc) Accessed on 22nd September, 2019

[2] These are countries whose most recent data on the variables of interest is 2016

half of the World's population still do not have full coverage of essential health services; such that almost 12% of the world's population (i.e. about 800 million people) spend at least 10% of their household budgets to pay for health care.[3] Health care spending is again regarded catastrophic if it is at least 40% of household's non-subsistence[4] income (Wan and Almualm, 2017; and Xu et l., 2005). Under the current sustainable development goals (SDGs), catastrophic OOP health care spending is an indicator for monitoring the incidence or exposure to financial hardship component of the UHC.

In at least the last decade, the trend in health expenditures shows a decline in OOP payment for healthcare globally but a rising trend as a fraction of income or total consumption (Wagstaff et al., 2017). The OOP expenditure on health may fall for two main reasons; first is if people are not seeking formal health care; and second is if there are well functioning health insurance schemes that address the health needs of the people. Given the morbidity and mortality rates globally every year, the first reason seems unlikely. Then, for low and middle income countries where health systems are still going through reforms, the latter is relatively rare. These possibilities have therefore raised two main concerns regards the UHC. First, there should be universal health service coverage so that everyone (regardless of income status) should receive the needed health care. Second, receiving the needed health care should not put the household involved at financial risk (Wagstaff et al., 2017). Table 1 compares the trend in catastrophic health expenditures (CHE) among regions.

Table 1: Catastrophic Health Expenditure (2000 – 2010)

	2000		2005		2010	
10% threshold (total consumption)	*% of population*	*No. of people (million)*	*% of population*	*No. of people (million)*	*% of population*	*No. of people (million)*
World	9·7	588·5	11·4	741·3	11.7	808.4
Africa	8·7	70·7	10·3	94·1	11.0	118·7
Asia	10·4	381·6	12·2	479·2	12·8	531·1
Europe	6·5	47·4	7·0	51·2	7·2	53·2
Latin America and the Caribbean	13·4	70·5	17·5	98·3	14·8	88·3
North America	5·5	17·2	5·3	17·4	4·6	15·6
Oceania	3·5	1·1	3·4	1·1	3·9	1·4
25% threshold (total consumption)						
World	1·9	112·8	2·4	154·9	2·6	179·3
Africa	1·5	12·3	1·9	17·7	2·5	25·6
Asia	2·1	77·1	2·8	108·7	3·1	128·7
Europe	0·9	6·5	1·0	7·3	1·0	7·2
Latin America and the Caribbean	2·6	13·6	3·2	18·0	2·5	14·9
North America	1·0	3·1	0·9	3·0	0·8	2·6
Oceania	0·5	0·1	0·4	0·1	0·5	0·2

Adapted from Wagstaff et al., 2017

Clearly, from Table 1, at a 10% threshold, we see a general rising trend regards CHE for almost all regions; and Africa is no exception. There is also an upward trend in CHE even with the 25% threshold in Africa and this shows an increasing growth rate. This is certainly a worrying situation that may thwart the UHC agenda. The repercussions of CHE are particularly heavy on low income households and this may further contribute to a cycle of poverty. Thus having members with poor health in such households may lead to poverty through the inability to work and generate income; thereby depriving young children in these households access to formal education (typically in economies where basic education is not free). Given that future earning potential is a function of formal education, children from such households will not be competitive on the labour market and thereby earn lower incomes – continuing the poverty

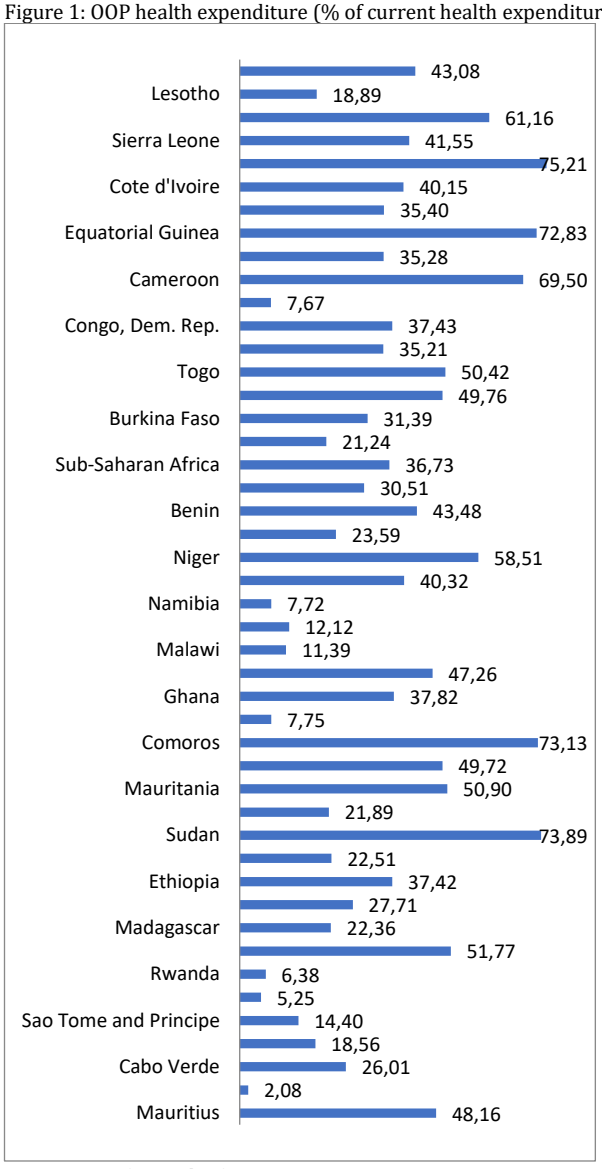
[3] https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc) Accessed on 20th August, 2019

[4] Subsistence need refers to the minimum requirement for a household to maintain basic life needs in a society. Therefore, non-subsistence income is the remaining after basic life needs (food, shelter, clothing and other household goods) are met.

cycle. The effects of poor health go beyond the individual and household level; making it a national concern and there is evidence that among countries with well-functioning health insurance policies, citizens (both rich and poor) are protected from financial barriers to health care service utilisation and/or the burden of OOP health expenditure.

Acknowledging the variations among countries in SSA and data constraints regards CHE for individual countries; this study further compares OOP health expenditure among countries.

Figure 1: OOP health expenditure (% of current health expenditure)

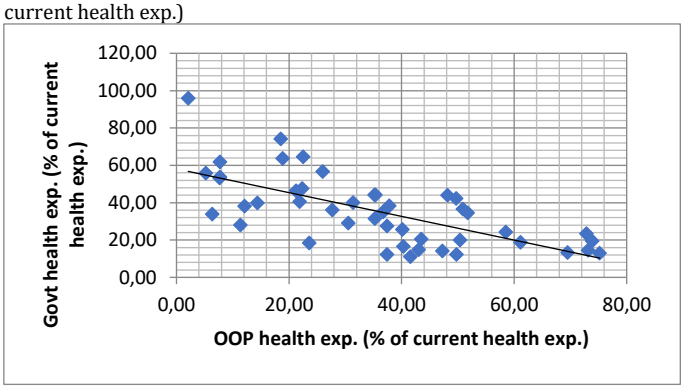


Source: WDI (2016 data)

Based on the data from WDI for 2016, the average OOP health expenditure (% of total current health expenditure) is about 37% in SSA.

Out of the 44 countries considered, 50% of them recorded rates above this average. The statistics are even more worrying when compared to the world's average (18.56%) – i.e. only 9[5] out of the 44 countries recorded OOP health expenditure rates below the world's average. However, there exist appreciable variation in OOP health expenditure among countries in the region; ranging from a very low level (2.08%) in Seychelles to 75.21% in Nigeria. An important question at this level is: is the low OOP health expenditure linked to increased government expenditure on health or a third party paying on behalf of patients? Figure 2 looks at the relationship between OOP and domestic governments' expenditure on health.

Figure 2: OOP and Governments' expenditure on health (% of current health exp.)



Source: WDI (2016 data)

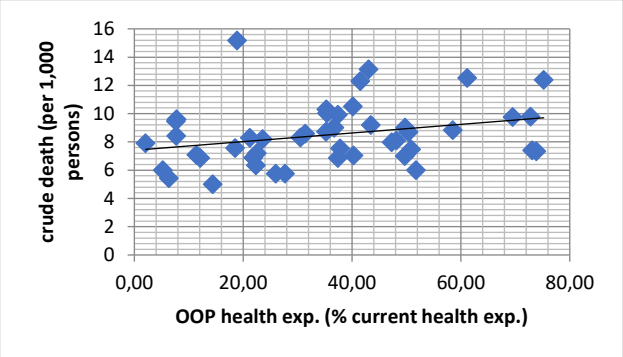
Figure 2 demonstrates some form of negative relationship suggesting that the low levels of OOP may be largely attributable to increase in governments' share of current health expenditure. This is not out of place given that formal health insurance is rare in the region and many households especially low income households also lack access to formal credit arrangements (Leive and Xu, 2008). While Figure 2 demonstrates only a correlation, this is a vital information for policy makers. For instance, in 2016, the domestic government of Seychelles bore as high as 96% of total current health expenditure – a probable reason for the very low OOP health expenditure (2.08%) recorded for the period. The statistics also reveals an interesting trend such that; countries with high domestic government share of expenditure on health and for that matter low OOP health expenditure are typically in the southern part of the region[6].

[5] Seychelles, Botswana, Rwanda, Mozambique, Namibia, South Africa, Malawi, Zambia and Sao Tome and Principe

[6] i.e. Botswana, Mozambique, South Africa, Namibia and Lesotho

Meanwhile, domestic governments' share of current health expenditures in all countries in the region (except Seychelles) was less than the world's average (74.26%); with the least (11.17%) recorded in Sierra Leone.
Being characterised by high OOP health expenditures, several empirical studies have looked at the effect on health service utilisation and there is almost a unanimous finding that high OOP expenditure on health discourages the utilisation of health care services. The eventual consequence is an increase in death rate. Plotting the OOP health expenditure against crude death rate (per 1,000 persons) confirms this positive relationship (see Figure 3).

Figure 3: Relation between OOP health expenditure and Death rate

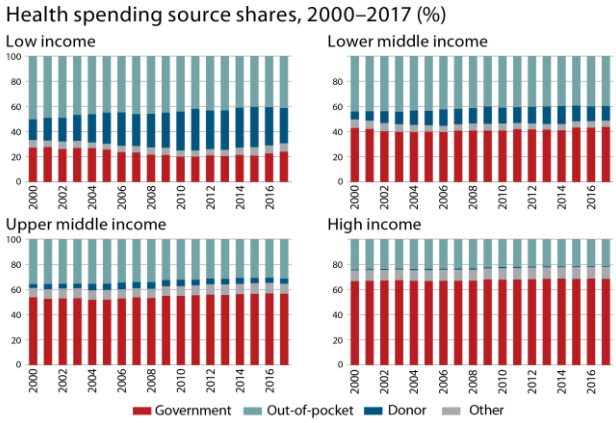


Source: WDI, 2016

What happened to the Abuja Declaration?

In 2001, Africa Union leaders made a bold declaration to allocate at least 15% of their respective annual budgets to improve their health sector; and this was expected to be a major human capital investment projected to yield massive results in the lives of the people they serve. About two decades on, not much can be said as the data still show high morbidity and mortality rates across the region. The region continues to be ranked last for almost all health indicators. This is partly because governments in the region have not shown enough commitment to this declaration by making the agreed allocation. Figure 4, compares the sources of health spending across different income groups.

Figure 4



Source: https://apps.who.int/nha/database/[7]

Most of the countries in SSA are found in the 1st and 4th quadrants of Figure 4 and it is clear from the graph that governments' share of health spending is lower relative to other income groups. With African governments themselves exhibiting "bad fate" to the health sector, they have no moral right to appeal for donor support hence the dwindling donor spending.

Conclusion

While the set deadline for achieving the SDGs seem quite far away, the obvious truth is that a lot need to be done by developing economies especially SSA to make all targets under SDG 3 reality. Governments in SSA must demonstrate increased commitment and prioritise the health sector. After all, the ultimate aim of the UHC entails that all people and communities have sufficient access to promotive, preventive, curative, rehabilitative and palliative health services without being exposed to financial hardship[8]. Therefore, the introduction of risk pooling schemes to the health systems in SSA countries is necessary and requires immediate consideration. The 15% annual budget allocation to the health sector made under the Abuja Declaration must be honoured religiously.

Reference

Leive, A. and Xu, K. (2008). "Coping with out-of-pocket health payments: empirical evidence from 15 African countries". Bulletin of the World Health Organisation, 86(11), 817-908
Wagstaff, A., Flores, G., Hsu, J., Smitz, M.F., Chepynoga, K., Buisman, L.R., Wilgenburg, K., and Eozenou, P. (2017). "Progress on Catastrophic Health Spending in 133 countries: a retrospective observational study. *Lancet Global Health* 2018; 6:e169-79, http://dx.doi.org/10.1016/ S2214-109X (17)30429-1

[7] Accessed on 23rd March, 2020

[8] https://www.who.int/health_financing/universal_coverage_definition/en/ Accessed on 25th March, 2020

Wan, S.E. and Almualm, Y. (2017). Catastrophic Health Expenditure among Developing Countries. *Health Systems and Policy Research*, Vol., 4; No.1:50
World Health Report (2000). "Health systems: improving performance". Geneva: World Health Organization; 2000.
Xu K., Evans D.B., Carrin G., Aguilar-Rivera A.M. (2005). "Designing health financing systems to reduce catastrophic health expenditure". WHO/EIP/HSF/PB/05.02