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Independent observer of the Global Fund

Who should pay for healthier and longer lives in Africa?

The World Health Organization (WHO) held its annual World Health Assembly (WHA) between 22 and 28 May in Geneva. The WHA is WHO's decision-making body; it is attended by delegations from all WHO Member States and focuses on a specific health agenda prepared by the Executive Board. The WHA's main functions are to determine the policies of the Organization, appoint the Director-General, supervise financial policies, and review and approve the proposed program budget.

The 75th WHA is the first in-person Health Assembly since the start of the COVID-19 pandemic. The theme of this year's Health Assembly was Health for peace, peace for health.

During the WHA, a series of roundtables are held that cover themes of global importance. At these sessions, WHA delegates, partner agencies, civil society representatives and WHO experts discuss current and future priorities for public health issues of global importance. The Global Fund's Health Finance Department took advantage of the WHA to host a side event on 25 May, a roundtable media webinar on the topic "Who should pay for longer, healthier lives in Africa?". It was attended by more than 40 participants, including over 10 journalists from prominent media outlets.

Context

The COVID-19 pandemic has underscored the substantial gaps in the global financing of healthcare and health systems and exacerbated the decades of chronic under-investment. No more has this shortfallbeen more apparent than in Africa, where we see the highest burden of infectious disease, the vastmajority of the poorest in society, and the most fragile economies. Together with disruption to healthprograms and health systems in Africa, there has been a twin fiscal shock. Revenues have fallen andspending needs have risen. Spending has been maintained by increasing debt and reallocating funds tohealth from other sectors including education and infrastructure.

African countries must rebuild their health systems and strive to get health programs back on track. This comes with additional global challenges because of the ongoing conflict in Ukraine, with the prospects of heightened inflation, rising prices for basic commodities, incipient food shortages due to the scarcity of wheat, and ongoing geo-political instability.

Why hold a media roundtable on domestic health financing?

Using the opportunity of the WHA to organize the media webinar, the Global Fund's Health Finance Department wanted to draw global attention to the need to strengthen countries' efforts to increase their domestic expenditures on health. In exploring the issue of "Who should pay for longer, healthier lives in Africa", prominent panelists discussed some of the key topics related to the sustainable financing of health in Africa. They examined:

- What the post-COVID health financing landscape for Africa looks like in the context of heightened energy and food prices, rising inflation, and debt sustainability risks.
- The roles and responsibilities of governments, development partners, private sector, and citizens regarding sustainable financing for healthcare in Africa.
- What needs to change to reach health goals in Africa.
- Why it is so important to support the Global Fund's Seventh Replenishment.

Panelists

There were five high-level speakers:

- Mathume Joseph Phaahla, Minister of Health, South Africa
- Winnie Byanyima, Executive Director, Joint United Nations Programme on HIV/AIDS (UNAIDS)
- Kalipso Chalkidou, Head of Department of Health Financing, The Global Fund
- Justice Nonvignon, Acting Head of Health Economics Programme, Africa Centers for Disease Control (CDC)
- Githinji Gitahi, Managing Director, Amref Health Africa

Current low levels of government expenditure undermine health programs and cost lives

Public spending on health is under $20 per person per year in more than 50% of countries in Africa.

Using the example of a successful private sector initiative to contribute to funding the COVID-19 response in Ghana, Dr Nonvignon noted that the private sector is able to mobilize funding in its own way. Another funding mechanism is through earmarking funds through, for example, health levies.

“Ministries of Finance face very clear and difficult choices but we cannot afford to let the future of our health sy
on external partners, we need to play our role and then let others help us.”
Dr Justice Nonvignon, CDC

COVID-19 and vaccination: how can Africa become more self-sufficient?

The moderator noted that Africa has the lowest COVID-19 vaccination rate in the world which puts economies at risk from the effects of variants; and asked what the main bottlenecks are to improving vaccination rates and ensuring that the region has the vaccines it needs, when it needs them.

Inequity regarding the supply side is the first issue: vaccines were initially unavailable except in the richer Western countries and, by the time they were availabe in African countries, misinformation and distrust were rife which affected Africans’ confidence in the vaccines.

When vaccines became more readily available the region’s suboptimal, overburdened health systems could not meet people’s needs. Research has shown that people’s readiness to accept vaccination ranges between 70 and 80% (although it is not uniform across countries) — so why do vaccination rates remain at 17% when supplies have increased?

A second challenge is distribution exacerbated by (i) the major absence of health workers and (ii) the exclusion of pharmacies from delivering vaccinations. Pharmacies can open 24 hours a day and at weekends, compared to health facilities (HFs) which are only open during the day in the working week: yet 80% of informal sector workers are unable to leave their work (for example, if they run a kiosk) to visit a HF to be vaccinated. Countries need to look at the design of the health system when it comes to providing vaccines and ask if it is fit for purpose.

Security of supplies is the third bottleneck, manifested by short shelf lives and expiry dates, and resulting in many vaccines having to be destroyed. Despite this, the absorption rate is 71% which is reasonable.

Local manufacturing is another important consideration. Countries need to consider market shaping and the provision of African vaccines for Africa, rather than allowing the supply chain to be appropriated by the private sector. Vaccines are public goods funded by multilateral mechanisms like Gavi or COVAX; hence, once African countries are able to manufacture their own vaccines, they will have to persuade Gavi, COVAX and others to buy and distribute African-made vaccines and enter into multi-year commitments.

Most vaccines are currently being bought from the developed world but vaccine production in Africa is expanding. Dr Gitahi noted that there is a need to convince “our own colleagues” on the continent to support each other’s countries and buy in bulk.

Debt-for-health swaps may also be an appealing financing mechanism

Professor Chalkidou proposed that, on the question of debt relief countries look carefully at innovative models such as the recent Belize blue bond, a conservation model that could be translated into health bonds. This blue bond for the Ocean Conservation program, the largest to date, enables Belize to convert its existing Eurobond (i.e., foreign currency bonds issued on the international market) into blue debt that it will use to implement its national marine conservation agenda. ‘Debt-for-nature’ could easily be replicated in ‘debt-for-health’.

Four top takeaways for better financing for health

The speakers left the media with four key messages.

1. Use Special Drawing Rights to pay for urgent healthcare needs

African governments need to insist on significant debt relief and the reallocation of the Special Drawing Rights (SDRs) that were created to increase fiscal space. Adding SDRs to a country's international reserves makes it more financially resilient. In times of crisis, a country can dip into its savings for urgent needs (e.g., to pay for importing vaccines). A new SDR allocation supplements countries' reserves, using the collective strength of the International Monetary Fund's membership to make all 190 member countries a little stronger. It provides liquidity support to many developing and low-income countries that are struggling, allowing them to pay for healthcare and support vulnerable people.

Figure 1. SDR Allocations and their Use

Source: IMF website: IMF.org/SDR

The example below shows how SDRs could be used to purchase COVID-19 vaccines. All countries will benefit from a quick eradication of COVID-19 and it is important to make sure they have the financial resources to do so.

Figure 2. Example of SDR allocations used for vaccine purchase

1. Reprioritize African people's health needs by increasing government expenditures on health

Second, African countries must be better at taxing their citizens and reprioritize the health of their people to meet the Abuja Declaration targets for government expenditure on health of at least: (i) the equivalent of 5% of GDP; and (ii) 15% of total government expenditure.

At the heart of Africa's fragile health systems is the perennial failure by governments to prioritize health by allocating adequate resources. The Abuja Declaration sought to correct this by securing a commitment of at least 15% of national budget for the health sector. But this target has proved elusive for most countries. In 2011, ten years after the Declaration, 27 African countries had increased the proportion of their expenditure allocated to health. However, only two countries – Rwanda and South Africa – had reached the 15% target. Seven had actually reduced their health budgets as a proportion of their national budgets.

By 2019, the situation had deteriorated: 21 African government were spending less on health as a percentage of their public spending than in the 2000 and only South Africa had reached the 15% target; and 20 governments were spending less on health as a percentage of GDP than in the year 2000. Again, only South Africa passed the 5% of GDP target.

According to a WHO report, prioritizing health on the continent has no direct relationship to a country's wealth. It found that several countries with high per capita income – such as Algeria, Botswana, Equatorial Guinea, Gabon, Mauritius, Seychelles and South Africa – do not systematically spend more of their budgets on health.

Using the 16 member states of the Southern African Development Community (SADC) as an example, the most recent data from the WHO Global Health Expenditure Database shows that at the end of 2018, all

SADC member states were struggling to meet the 15% annual target.

Figure 3. Current health expenditure in SADC member states (% GDP), 2001 and 2018

Source: Jack Bwalya, SADC and the Abuja Declaration: Honouring the Pledge. 2021.

As suggested in recent empirical studies and a 2019 WHO report on global spending on health, one of the main reasons for signatory countries' (including those in the SADC region) failure to meet the Abuja Declaration targets is their reliance on external aid to cover their expenditure requirements in several sectors, including health.

Furthermore, in countries like Zambia, reliance on external aid is accompanied by various austerity measures that have been introduced to reduce the national debt burden. This makes meeting the 15% target all the more challenging. At present the average annual allocation in the region is 5.3%. Ultimately, the pattern of aid dependency has had unintended consequences for the ability of governments in the SADC region to intensify their efforts, using sustainable funding models, to allocate more public funds to health.

Governments must tax the top earners, both individuals and companies, to be more progressive and allocate more to health to honour their Abuja pledge.

1. Governments need to spend their money more wisely

Public spending for better health in Africa means better public investment, a sentiment echoed by the African Union. Achieving improved health is a costly endeavor and many African countries have limited fiscal space. The current COVID-19 pandemic confuses the health expenditure data but, in 2019, African governments spent between $0 to $610 per capita on health, compared to high income countries that spend above $4,000. In fact, in 28 countries governments spent less than $20 per capita on health. This is due to several factors but most significant among them is a low GDP and low tax collection efficiency among African countries, compounded by low budget allocations to the health sector due to competing priorities.

Even though Africa has had better economic growth in the recent past compared to other regions, when African countries become richer, government spending on health does not automatically increase. Between 2001 and 2015, for example, as African economies grew, government spending on health, as a proportion of overall spending, decreased in 21 countries.

Development assistance for health is said to have crowded out government resources and created donor dependence – which is complicating the transition of countries with declining donor funding and inadequate plans to offset this shift in resources.

Low budget execution and wastefulness further diminishes available resources for health. Low government spending hurts citizens the most and results in high out-of-pocket spending and an inequitable health system that only guarantees access to those who are able to pay.

1. A successful Global Fund Seventh Replenishment is essential

Finally, even as countries struggle to increase their domestic resources for health, they still need to support the Global Fund's Seventh Replenishment in order to maintain progress towards eradicating HIV, TB and malaria and contribute to health systems strengthening.

“Sustainable financing is key: we need to do our part in raising domestic resources for health.”

Winnie Byanyima, UNAIDS

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