Development and health in Africa

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IFC Nairobi
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Contents

Yusuf – development economics through the decades

- "Aid [and debt relief] appear to have had virtually no effect on investment or growth or poverty reduction"

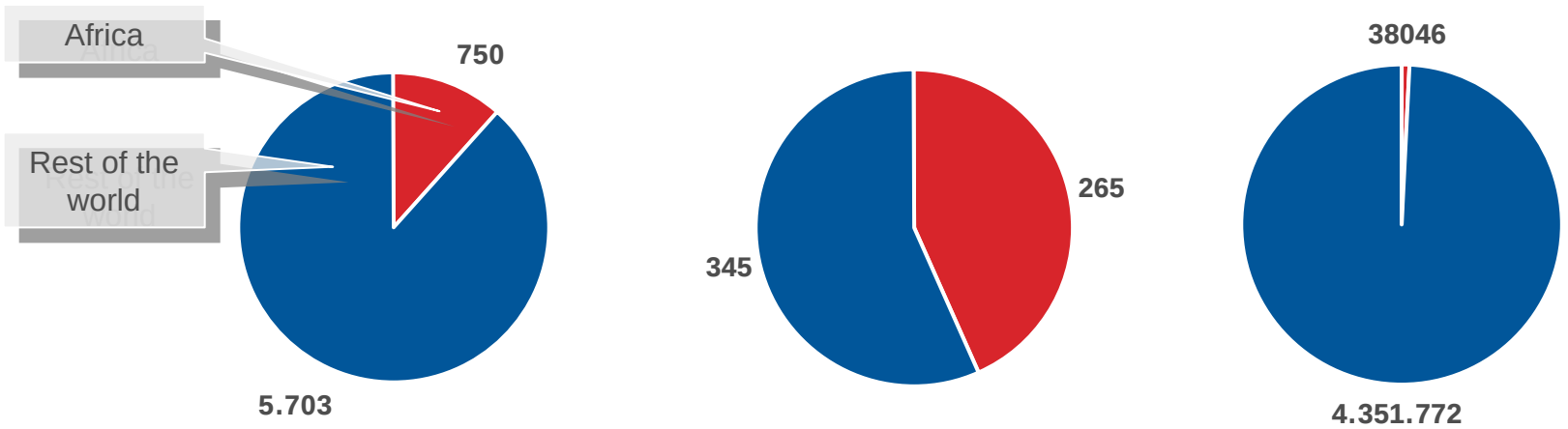
- "Providing health [and education] services is a task of daunting complexity"

Africa spends very little on health care

Population
X mio

Burden of communicable diseases
DALYS

Total health expenditure
x $ mio



Health in Africa is underfunded

Source, WHO 2008

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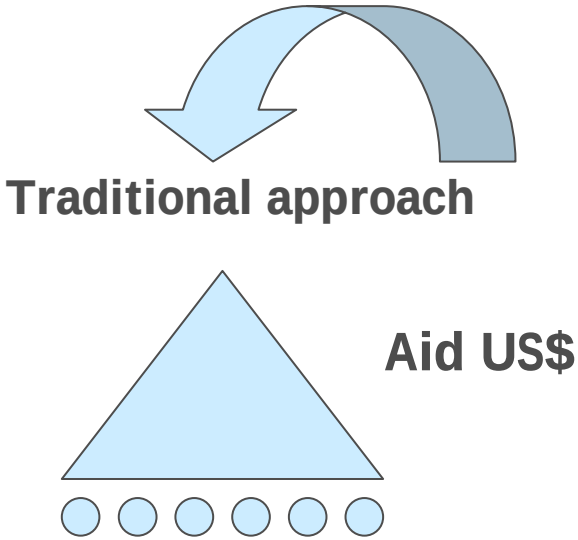
Traditional approach: public sector based, with donor support



Traditional approach is top-down (trickle down)

Supply/input driven

Patient is passive receiver

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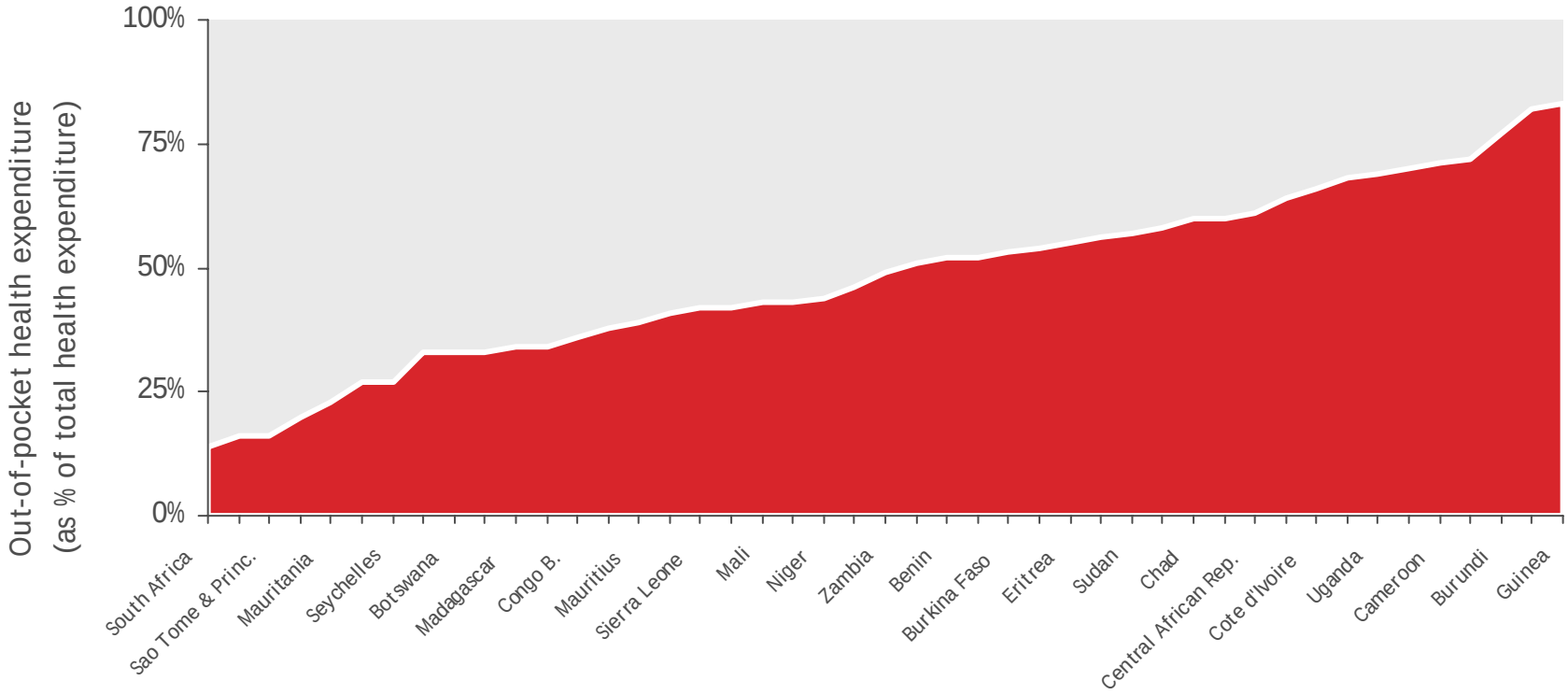
Private out-of-pocket expenses are ~50% of total health expenditure



Source: WHO 2008

Many fall in a poverty trap; Inequity

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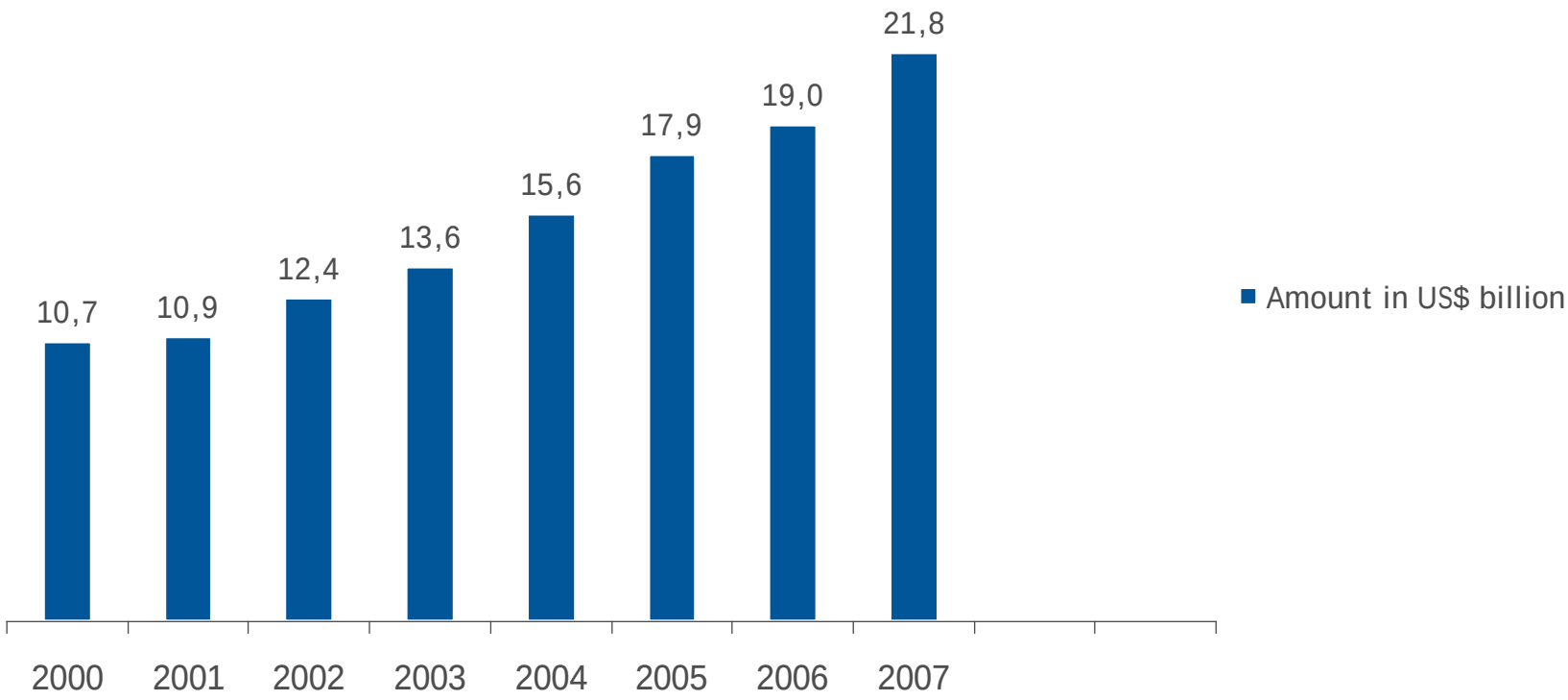
Donor funding has increased rapidly



Source: Financing of global health: tracking development assistance for health from 1997 to 2007, Lancet 2009

Increase is to a large extent due to vertical programs for HIV/AIDS, tuberculosis & malaria

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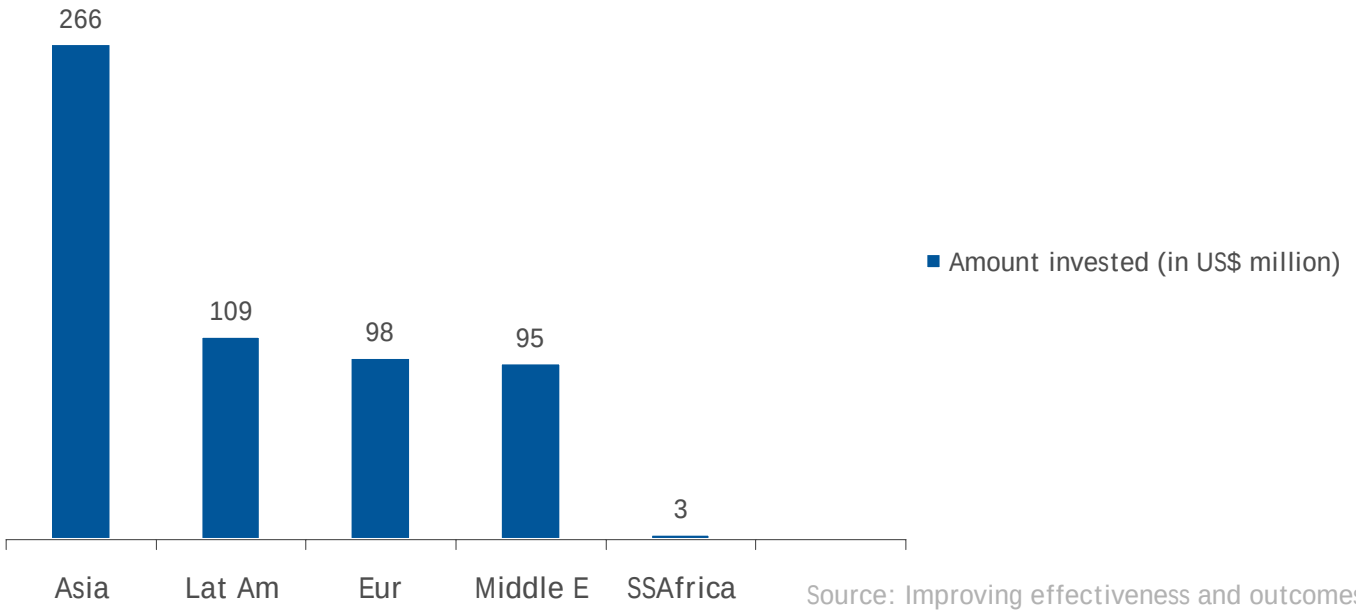
Investments in the private health sector in Africa are ~non-existent

Amount of IFC's private investments in health (loans and equity 1997-2007)



Source: Improving effectiveness and outcomes for the poor in health, nutrition & population, World Bank 2009

Investment in hospitals & related infrastructure in Africa is <1% of total IFC investments in health

Because the cost of capital (risk) is too high

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The role of government

- There are good reasons to involve government in health care:
  - Efficiency concerns: market failures, externalities, transaction costs
  - Equity concerns: health as a human right

- However, preconditions for state-led model to work are not met in Africa:
  - **Reasonable level GDP/capita**
  - State capacity to enforce tax payment and income solidarity
  - State capacity to actually deliver services nation-wide

The role of donors

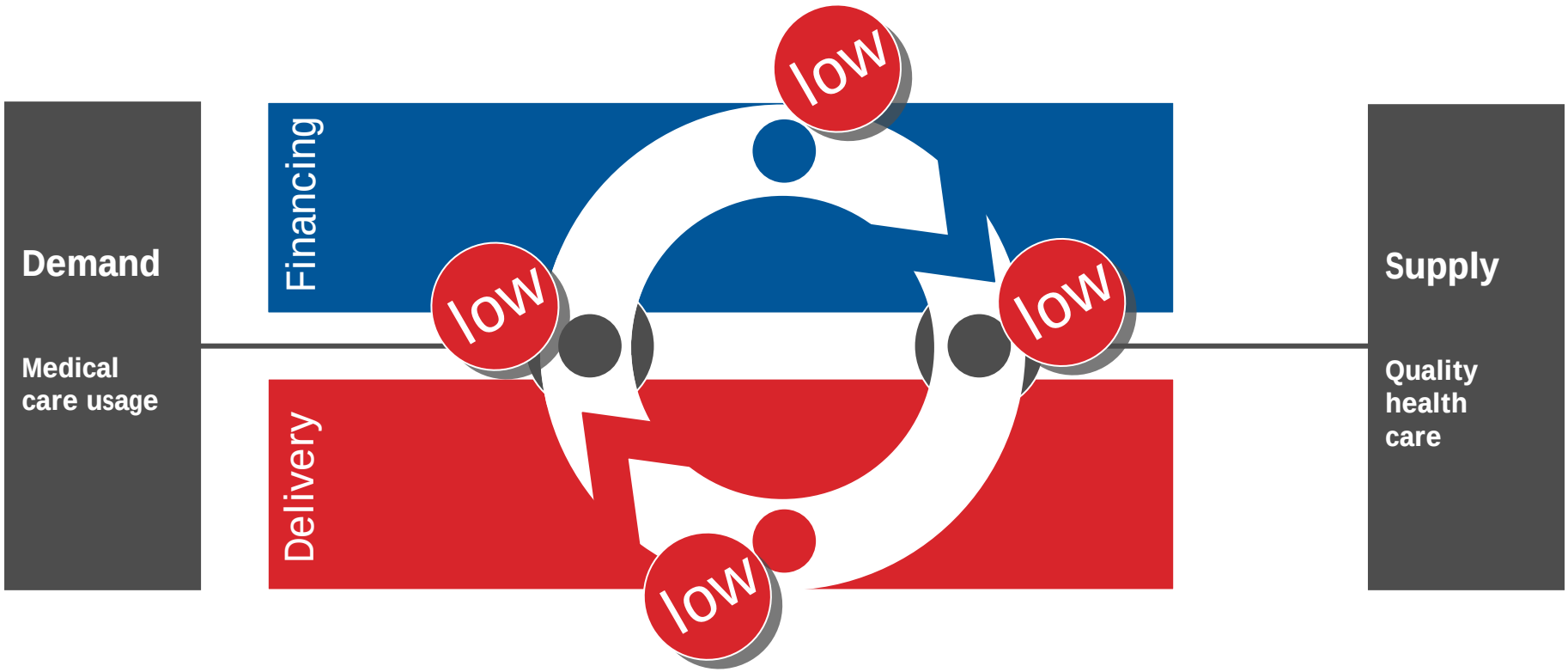
- Donors: Strong focus on public-sector based intervention modalities:
  - Advantage = No explicit choices need to be made
  - Disadvantage = Accountability
  - Big advocate = Oxfam “In the public interest”; Paris Declaration

- Donors are not consistent – examples:
  - Donor sick fund is allowed a maximum profit of 5%, but is financed by the same donor against 25-35%
  - Interest rate of micro-credit often 30-50%: such costs must also be incorporated in premiums of health insurance

A situation of insufficiency

- No risk equalization mechanisms
- Few (actuarial) data: cost, quality, risk, utilization, price elasticity
- Very limited support for insurance companies
- No willingness to pay studies at patient level
- No technology support to identify patients, process claims or clear patient
- Very limited support for group-based schemes

African health systems are stuck in a vicious circle



Access to quality health care among the poor is low

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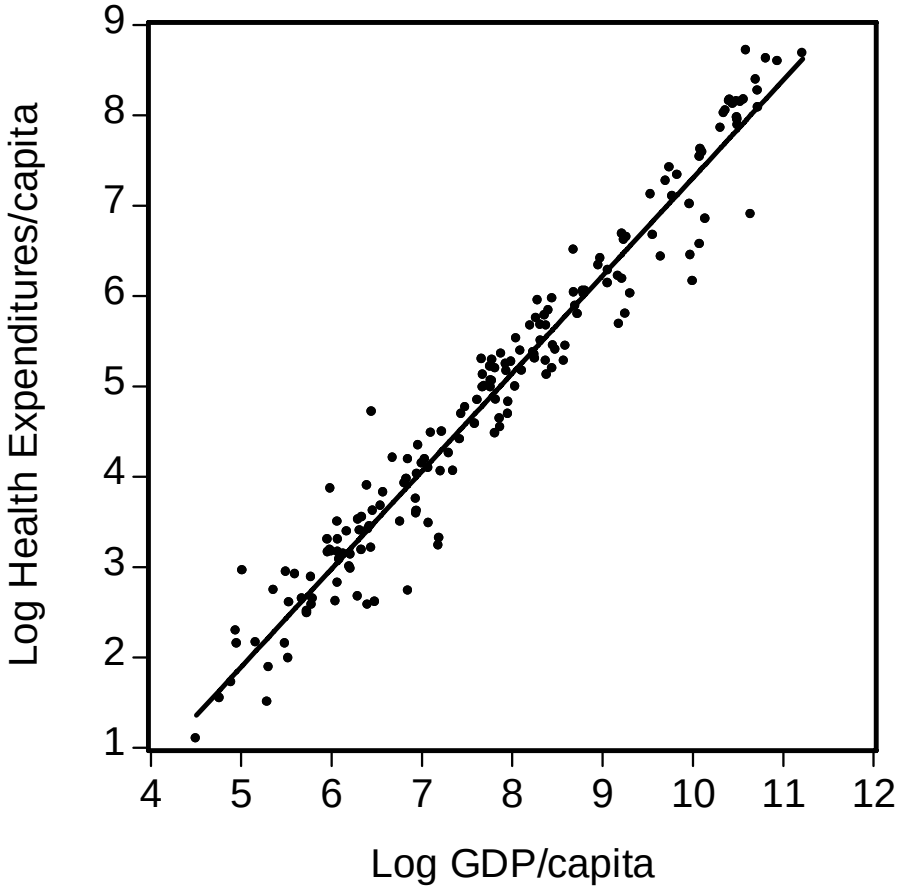
Contents

The first law of health economics



Tight relationship between income and health expenditure leaves little room for impact of policy variables

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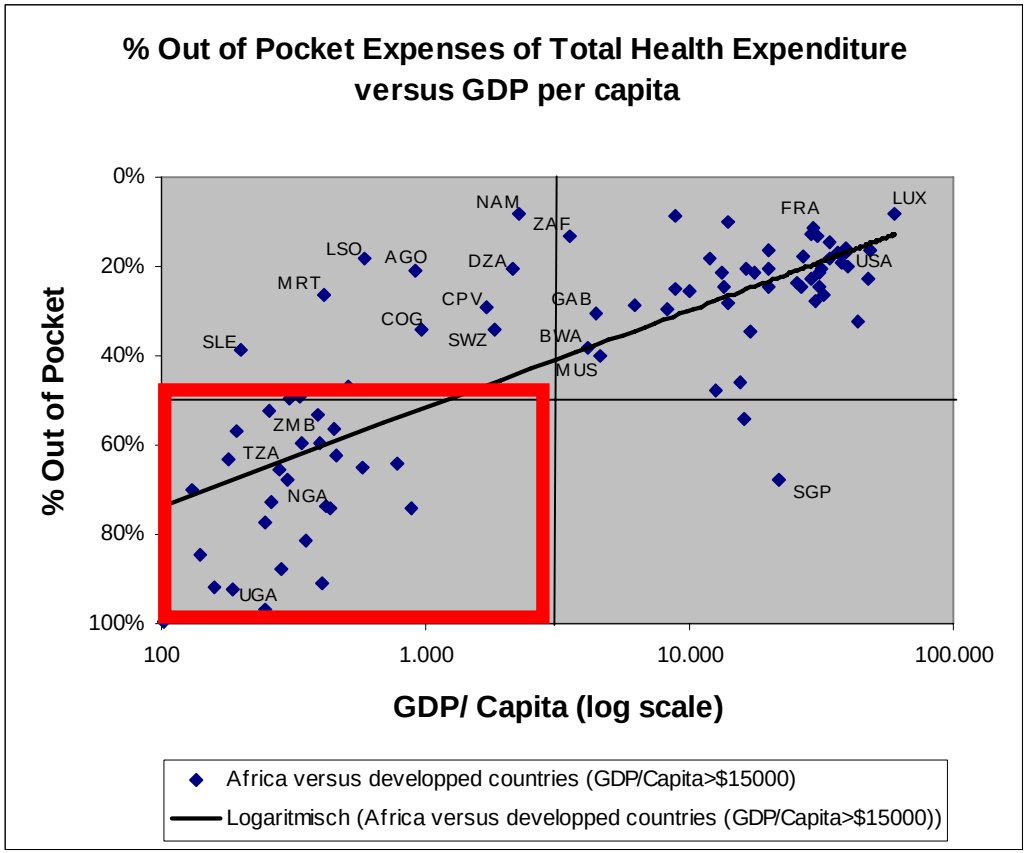
Limitations

- Donor funding for health has hardly any impact on relationship GDP and health expenditure
- Crowding out:
  - Attempts to increase total spending on health through foreign aid lead to “crowding out” private spending
  - The share of public or private spending makes no difference to health outcomes
- Crowding out is a problem because African countries are too poor to forego private contributions for health

The second law of health economics



Rich countries have lower out-of-pocket expenses than poor countries

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Contents

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Conclusions

- The main challenges are therefore:
  - to increase overall resources without crowding-out the existing private resources and
  - to bring down out-of-pocket expenses through risk pooling mechanisms

- We have to face the facts:
  - Explicit choices need to be made: groups, size benefit package, price
  - Demand side: Those who can pay should be made to contribute voluntarily; This requires segmentation of healthcare/insurance market
  - Supply side: Adequate supply needed in order to generate willing to (pre)pay

Contents

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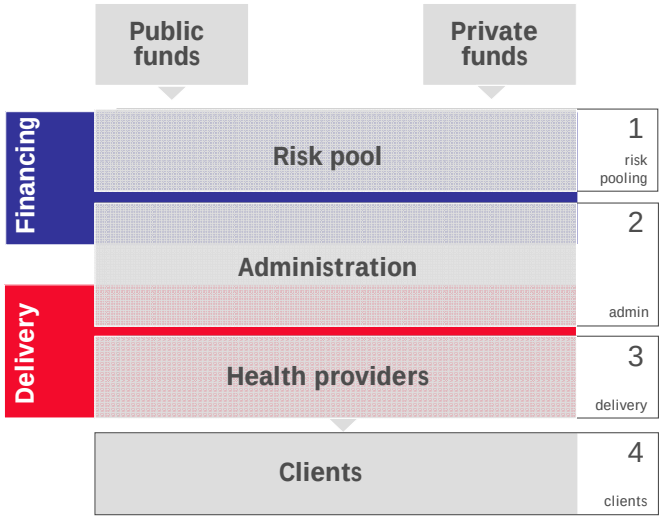
A new model -1



1. Acknowledge that health care is a service industry:

   All elements of value chain must be present

2. Channel private (out-of-pocket) resources through bottom-up voluntary private risk pooling schemes: demand-driven output-based schemes

   Include risk equalization

3. Involve the private (for-profit) health sector

   NB: Private = not for everyone

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A new model -2

3. Use donor funding to subsidize premiums;

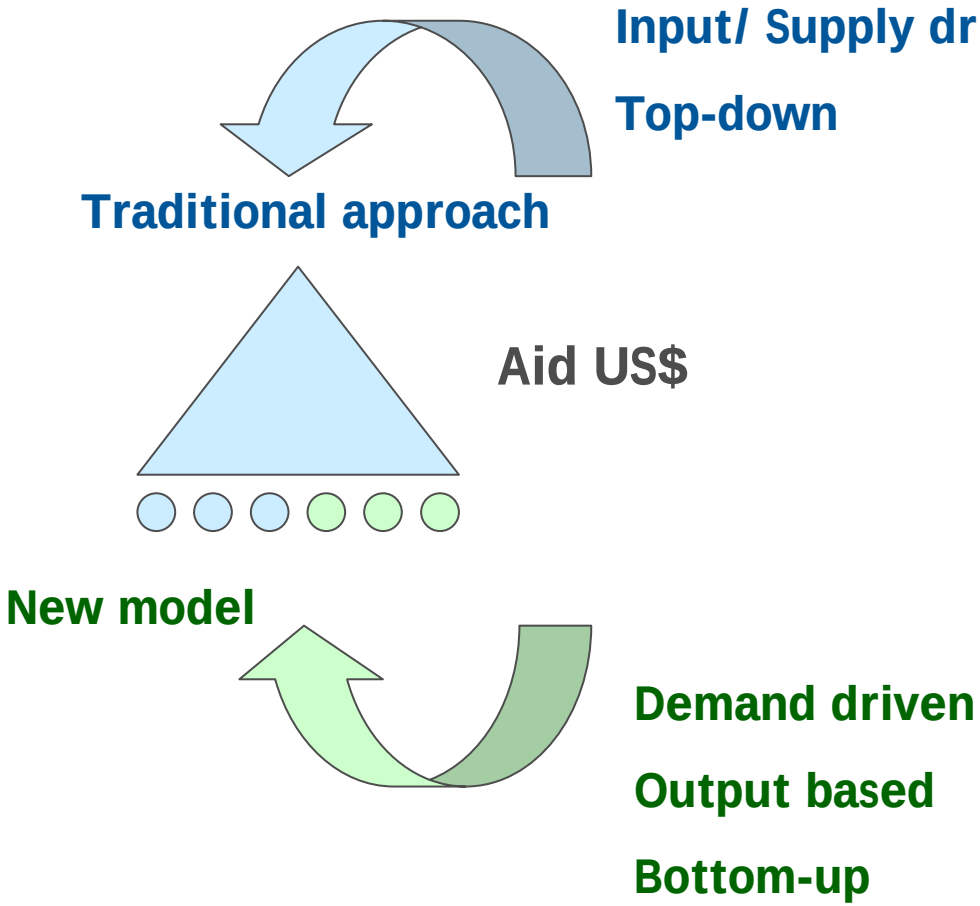
   Use (disease-specific) donor programs to support schemes through risk equalization mechanisms - for HIV/AIDS etc.

   Use long-term donor commitments to reduce the investment risk

5. Enforce quality of care through performance-based contracts
6. Initial segmentation of the market
7. Generate (actuarial) data:

   know cost of insurance, purchasing behaviour of clients, willingness to pay

A new model -3



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Risk pooling spurs a virtuous circle of health care -1

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Risk pooling spurs a virtuous circle of health care -2

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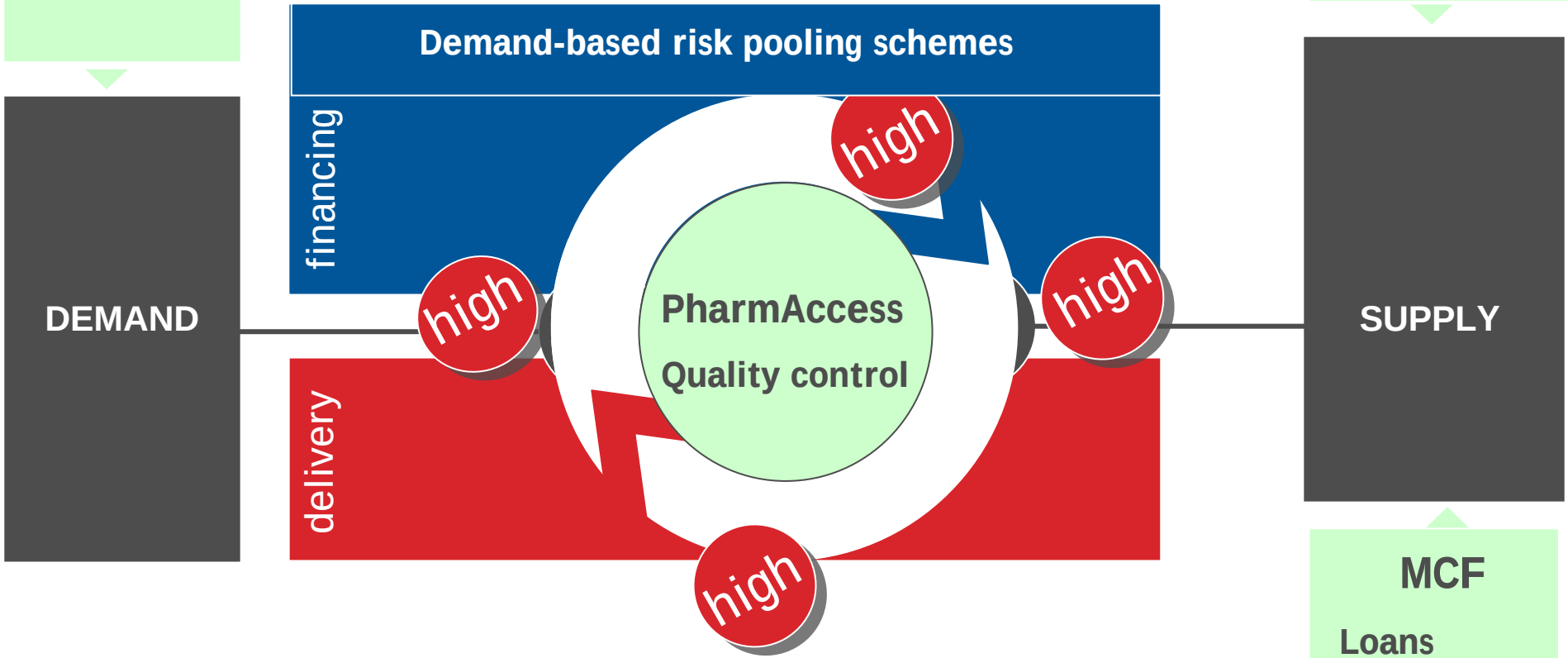
Risk pooling spurs a virtuous circle of health care -3

HIF

Donor subsidy injection

IFHA

Private equity investment



MCF

Loans

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Practice Health Insurance Fund -1

- Contracting of local HMO/insurance company
- HMO contracts public and private providers
- Tackle financing and delivery side

- Target groups: low-income workers, informal sector
- Limited benefit package: primary + limited secondary care including HIV/AIDS treatment

- Output-based: criteria = number of people insured, quality of care improvement
- Rigourous monitoring and auditing

- Prices and profit margins are contractually fixed

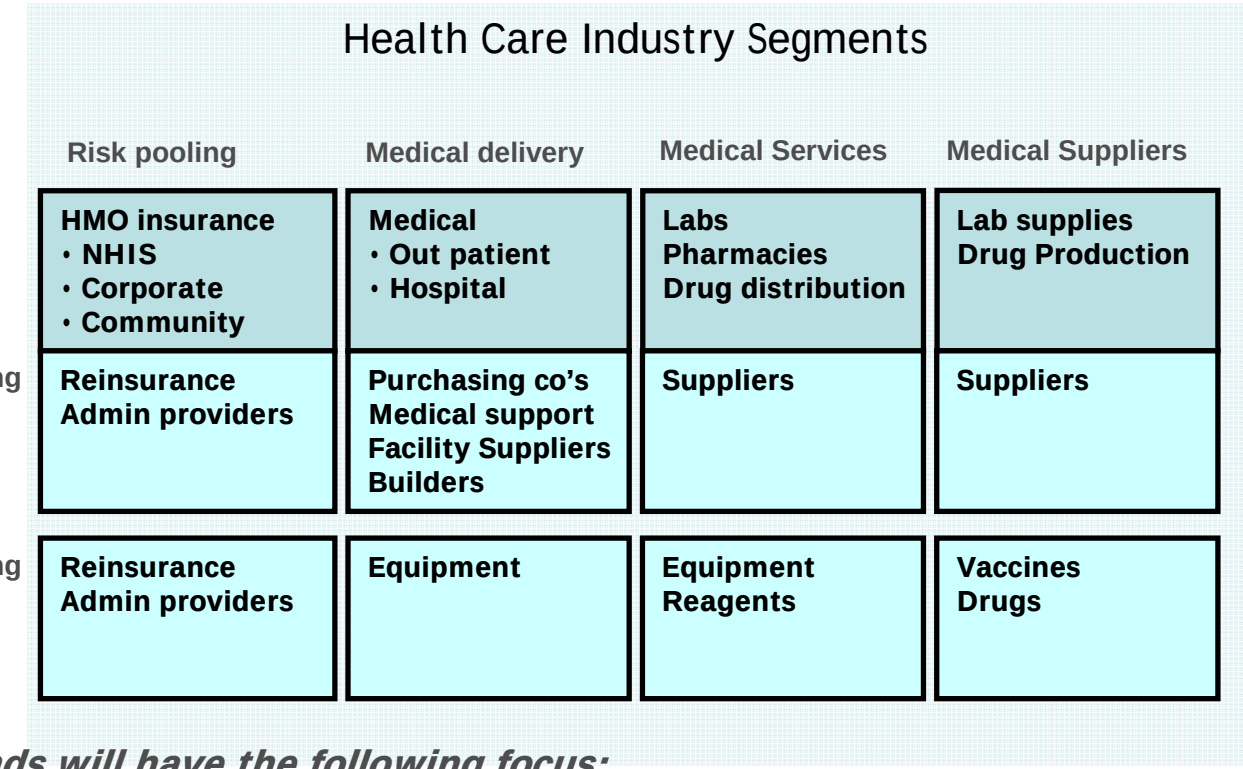
Practice Health Insurance Fund -2

Implementation problems:

- How to organize the target groups
- Patient identification
- Incentives structure – risk/cost mechanism
- How to get to data generation

A new model

Investment Fund for Health in Africa (IFHA)



The IFHA funds will have the following focus:
IFHA 1: Primary health industry with HIF i.e. donor support
IFHA 2: Follow on investments incl. supporting industry
IFHA 3: Financing Global Public Goods initiatives partners and projects

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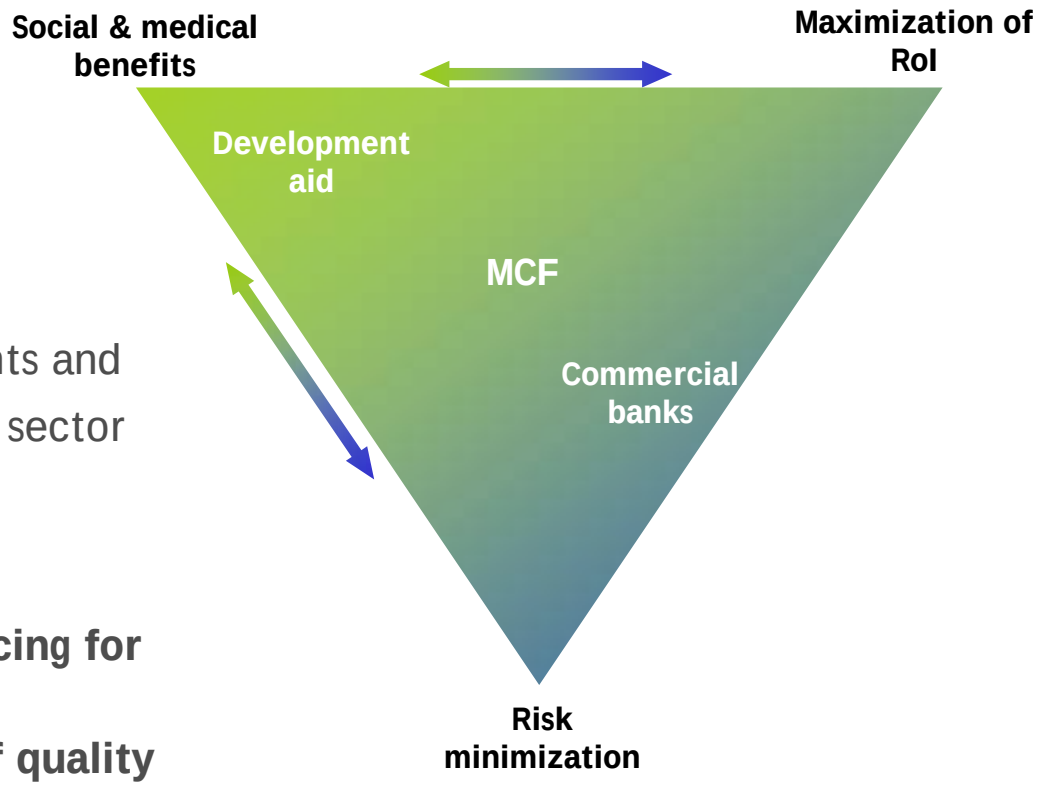
A new model

Medical Credit Fund (MCF)

- **Affordable debt financing**
- **Financing the missing middle:**

  MCF bridges the gap between commercial lending requirements and the needs of the private health sector
- Leading to:
  - **access to affordable financing for medical service providers**
  - **measured improvement of quality of care**



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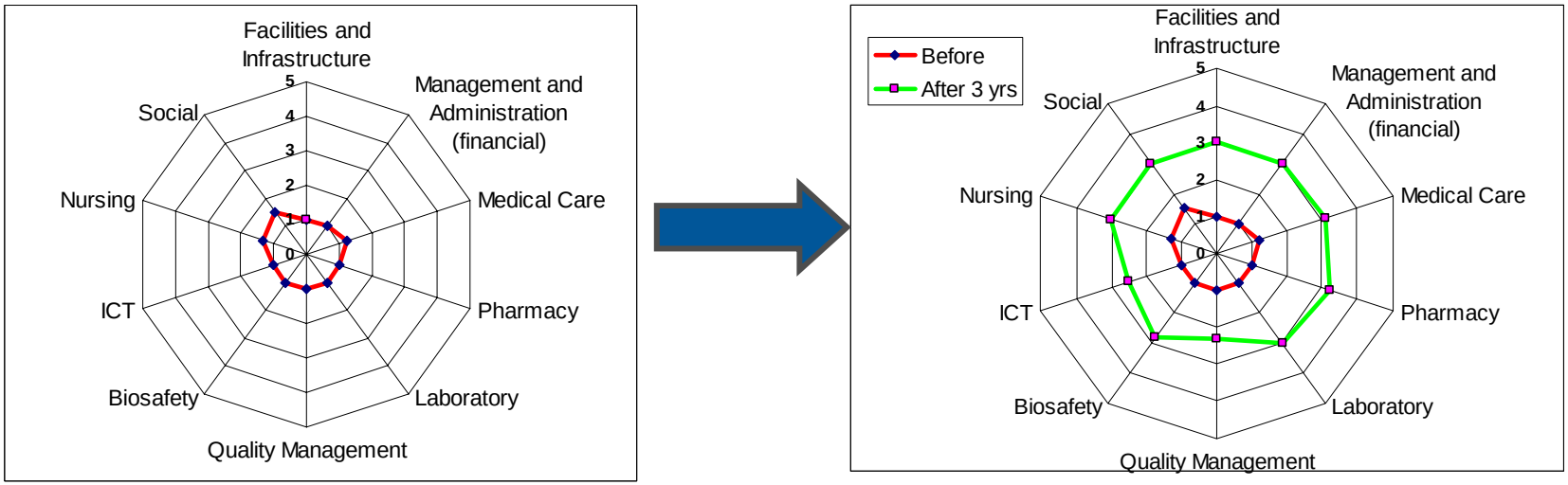
PharmAccess: Quality improvement -1



# docters	"A"
# nurses	"B"
salary doctor	"C" $
salary nurse	"D" $
drug price	"E" $
drug margin	"F" $
equipment costs	"G" $
infrastructure costs	"H" $
training (skills)	"I" $
treatment price	"J" $
turnover	"K" $
profit	"L" $

Total upgrade $ needed:

Training	X $
Infrastructure	Y $
Pharma	Z $

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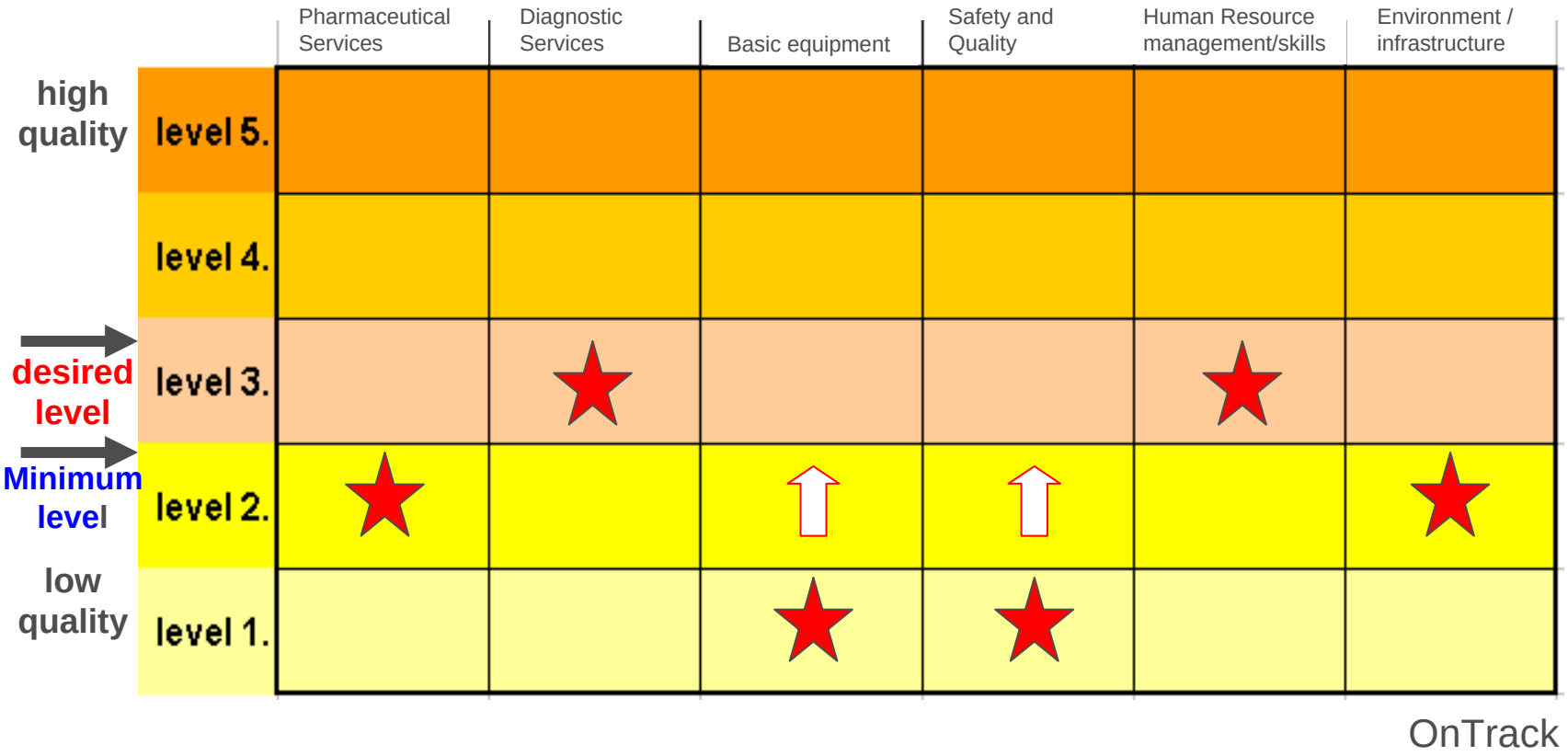
PharmAccess: Quality improvement -2



OnTrack

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Utilization and enrolment, by clinic and target group

	Utilization (end year)		Enrolment (average)		Visits per enrollee (end year)	
	2007	**2008**	**2007**	**2008**	**2007**	**2008**
Lagos 1	3,807	22,086	769	4626	4.95	4.77
Lagos 2	410	677	159	340	2.58	1.99
Lagos 3	331	1,122	152	384	2.18	2.92
Lagos 4	1,706	9,553	432	2100	3.95	4.55
Lagos 5	107	527	59	180	1.81	2.93
Lagos 6	174	356	136	209	1.28	1.70
Lagos 7	200	684	80	244	2.50	2.80
Lagos 8	245	1,070	144	517	1.70	2.07
Lagos 9	978	7,222	257	1254	3.81	5.76
Lagos 10	1,140	5,892	442	2239	2.58	2.63
Kwara 1	N/A	1,637	N/A	1930	N/A	0.85
Kwara 2	11,995	17,849	6295	12653	1.91	1.41
Kwara 3	13,312	18,168	7994	14863	1.67	1.22
Weighted Average Lagos					**3.46**	**4.07**
Weighted Average Kwara					**1.77**	**1.28**

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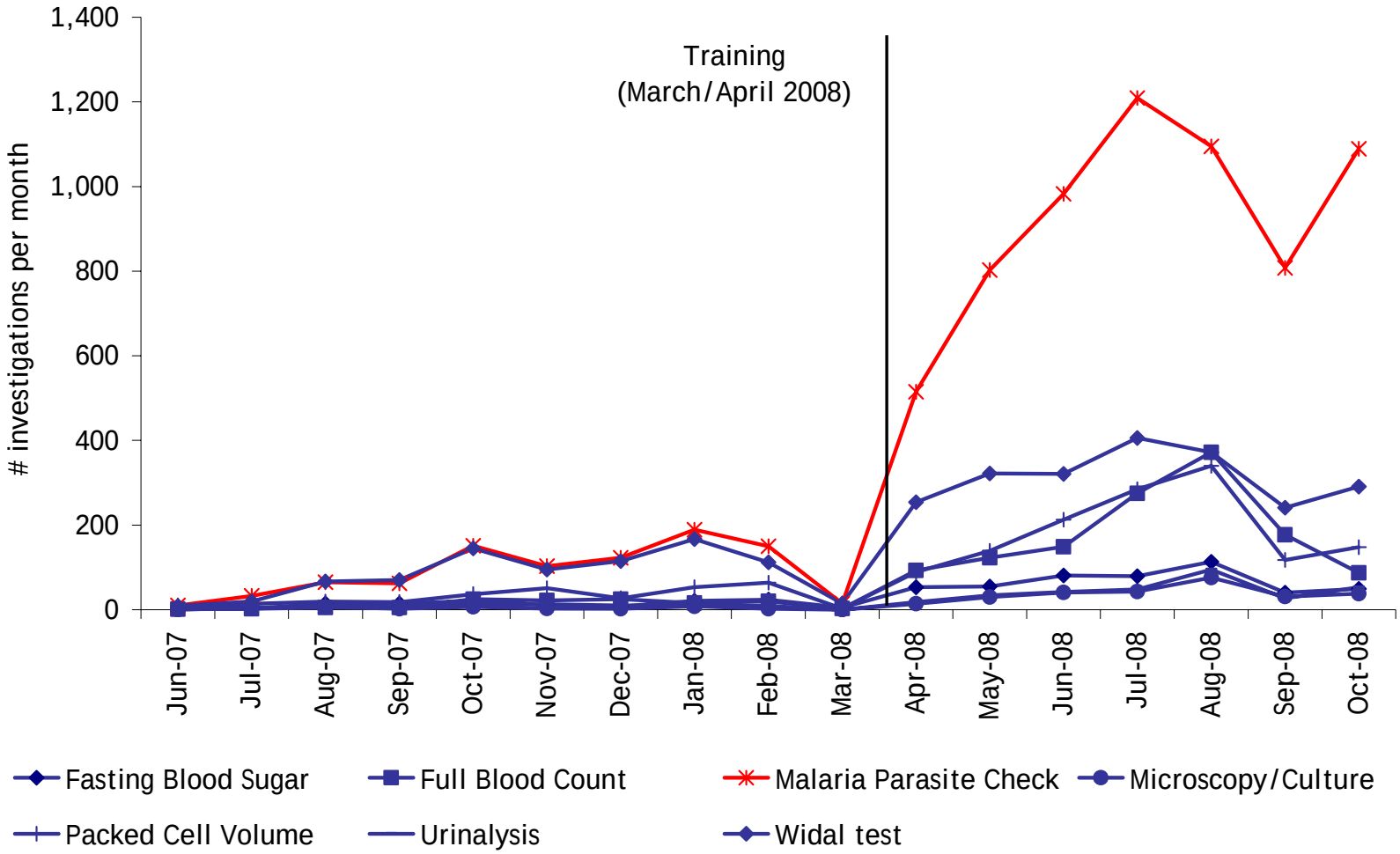
Diagnoses versus prescribed treatments

	Most frequently reported diagnoses (2007)			Prescribed treatments (2007)		
	Diagnosis	n	%	Treatment	n	%
1	Malaria	11462	25.0	Multivitamins	29082	19.2
2	ANC	4802	10.5	Paracetamol	25014	16.5
3	Hypertension	4031	8.8	Folic acid	5811	3.8
4	(U)RTI	3770	8.2	Iron	5349	3.5
5	Follow-up	3633	7.9	Chloramphen.	4836	3.2
6	(Ostea-)arthritis	1634	3.6	Cough syrup	3494	2.3
7	Pain	1329	2.9	Moduretic	3464	2.3
8	Peptic ulcer dis.	1260	2.8	Antihistamine	3345	2.2
9	Enteritis	1219	2.7	Ibuprofen	3211	2.1
10	Enteric fever	1188	2.6	Fansidar	3124	2.1

Treatment practices: impact of training on malaria investigations



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