East, Central and Southern African Health Community (ECSA-HC)

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Health Care Financing Profiles of East, Central and Southern African Health Community Countries, 1995–2009

October 2011

East, Central and Southern African Health Community

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1995 - 2009

Foreword

The way a health system is financed is a key determinant of population health and wellbeing. This is particularly true in low income countries where levels of health spending are generally insufficient to ensure equitable access to needed health services and interventions. All countries must make decisions about how best to raise sufficient funds for health and how to pool those funds together to spread the financial risks of ill health among others, using available evidence.

It is for this reason that the ECSA Health Community Secretariat, with the support of its partners, promotes the institutionalization of National Health Accounts in member states, including the use of such evidence to promote health financing policy decisions.

Using evidence from NHA, ECSA-HC member states will be in a position to track progress towards the achievement of the Abuja Declaration targets, and advocate for increased government funding for health services. Policy makers will be in a position to assess the adequacy of financial resources available to the health sector, the coverage of risk pooling and hence the extent to which households are protected from the adverse effects of paying for healthcare. These are all important issues of concern to health policy makers.

This report provides to health policy makers and planners of ECSA-HC member states, a health financing situational analysis of fourteen countries that may form the basis for health financing policy design in those countries. It is believed that policy development based on such evidence could contribute towards better performing health systems in the region.

It is my hope that this report will be found useful as we grapple with the many health system challenges in our region.

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Director General, ECSA-HC
October 2011

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We gratefully acknowledge the contribution of Mr Thomas Maina, the consultant who compiled the draft country profiles. These benefited from the review and comments from Dr Sambe Douale from the AH 2010 Project and Ms Jennifer Kaahwa from the ECSA-HC Health Systems and Services Development Programme. Also acknowledged is the ECSA-HC Editorial Committee which provided a final review of the finished document. We also wish to acknowledge the Africa's Health in 2010 Project Team, led by Dr Doyin Oluwole, for the financial and technical contributions made in the preparation of this report.

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
CHF	Community Health Fund
CMH	Commission on Macroeconomics and Health
ECSA-HC	East, Central and Southern African Health Community
EHP	Essential Package for Health
GDP	Gross Domestic Product
HDI	Human Development Index
HIV	Human Immuno-deficiency Virus
IMF	International Monetary Fund
IMR	Infant Mortality Rate
KDHS	Kenya Demographic and Health Survey
LMI	Lower Middle Income
MDGs	Millennium Development Goals
MoH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
NCDs	Non-Communicable Diseases
NDP	National Development Plan
NASA	National AIDS Spending Assessment
NHA	National Health Accounts
NHIF	National Hospital Insurance Fund
NHSSP II	National Health Sector Strategic Plan two
OOP	Out Of Pocket
PMTCT	Prevention of Mother to Child Transmission
PPP	Purchasing Power Parity
SHI	Social Health Insurance
SSA	Sub-Saharan Africa
STATSSA	Statistics South Africa
SWap	Sector-Wide Approach
TB	Tuberculosis
THE	Total Health Expenditure
UMI	Upper Middle Income
UNDP	United Nation Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US$	United States Dollar
USA	United States of America
WB	World Bank
WHO	World Health Organization

Executive Summary

Introduction

The East, Central and Southern African Health Community (ECSA-HC) is a regional intergovernmental organization that was established to promote regional cooperation in health. Its mandate is to promote and encourage efficiency and relevance in the provision of health care services in the region. Key programmatic areas include Health Systems and Services, Human Resources for Health, Family and Reproductive Health, Monitoring and Evaluation, HIV and AIDS, Food and Nutrition, and Research, Information and Advocacy.

ECSA is supporting the profiling of health care financing of its member countries in order to understand the health financing situation, and identify the key policy issues and concerns that require attention. Understanding the key health care financing policy issues will also assist the Secretariat in designing focused and evidence-based activities, and in mobilizing appropriate technical support for member countries.

Specific tasks of this profiling assignment included a write up, with background information, on each member country's epidemiological profile, an assessment of key health system challenges, and a description of the trends in total health expenditure and its sources, including private, out of pocket (OOP) expenditures, government health expenditures and external sources of funds. The expenditure analysis was undertaken within the context of key policy issues such as protection from catastrophic expenditure, the Abuja Declaration, the recommended minimum expenditure and sustainability of financing. The final product of the analysis is a report detailing each country's health care financing situation and context, NHA status and progress made towards National Health Insurance.

Health financing indicators analysis

The total expenditure on health per capital in ECSA member countries varied significantly from a low of US $19 to a high of US $612 (using an average exchange rate). Only three countries were unable to meet the conservative recommendation of US $30-40 made by the Commission on Macroeconomics and Health (CMH) intended to provide a basic package of cost-effective health interventions. Countries in the southern region (South Africa, Botswana, and Namibia) fared better than countries in the east and central region.

Government per capita expenditure on health varied widely, with ECSA members in the southern region (South Africa, Namibia, Lesotho, Botswana, Mauritius, Seychelles and Swaziland) reporting relatively higher government per capita spending on health, while member countries in the east and central region reported an average of US $15. Countries with a higher government per capita expenditure on health, coupled with the efficient use of those resources, are more likely to achieve better health outcomes.

Only two countries have met the Abuja target of allocating at least 15% of the government budget to health, although it is worth noting that most member countries in southern Africa were doing well in terms of allocating more government resources to health. In low-income countries where government budgets are seriously constrained, the 15% target may not result in a significant change to the health financing situation. The target may, however, be taken as a proxy to government commitment.

In terms of total expenditure on health as a percentage of GDP, performance has varied considerably with upper middle-income countries faring better than low-income countries. In 2009, four of the 14 member countries of ECSA spent less than 5% of their GDP on health. Only four countries spent above 8% of their GDP on health, with one country spending more than 10% of its GDP. Government expenditure on health as a percentage of total health expenditure within the ECSA community varied widely from less than 20% to over 80%.

In most countries, private expenditures on health constituted less than 50% of the total health expenditure, a large proportion of which consisted of household out-of pocket expenditures. In six countries, OOP expenditures accounted for more than 50% of private health expenditure. This may potentially result in catastrophic spending, and drive households further below the poverty line (impoverishing expenditure).

External funding for health, as a percentage of total expenditure on health, accounted for a substantial proportion of expenditures in some member countries. In 2009, eight ECSA countries received between 15% and 99% of their total health funding from external sources. While donors are an important funding source in many African countries, it is often unreliable and unsustainable in the long term.

Conclusion and way forward

The slow pace of shifting government resources towards the health sector warrants sustained advocacy and monitoring in order to translate the shifts into attainment of the Abuja target. Although some effort on advocacy has been noted, much remains to be done, with ECSA-HC playing a critical role.

Although available resources have generally increased, a number of ECSA-HC member countries have relied on external health funding resources. Coordination and harmonization of development partnerships has also been noted to be inadequate. To address this concern, there is a need to increase domestic financing of health, as well as ensuring that donor activities are coordinated and harmonized in line with the Paris Declaration framework.

Although progress has been made towards universal coverage and access to health services by a number of ECSA-HC member countries, strengthening policy dialogue to facilitate the implementation of the resolutions by Health Ministers Conference relating to healthcare financing in the region should take centre stage. The ECSA-HC Secretariat should lead this process through advocacy.

Introduction

The East, Central and Southern African Health Community (ECSA-HC) is a regional intergovernmental organization that was established to promote regional cooperation in health. Its mandate is to promote and encourage efficiency and relevance in the provision of health care services in the region. Key programmatic areas include Health Systems and Services, Human Resources for Health, Family and Reproductive Health, Monitoring and Evaluation, HIV and AIDS, Food and Nutrition, and Research, Information and Advocacy.

The Health Systems and Services Development Programme is one of the key programmes, with the sole objective of supporting member countries to strengthen their health systems within the context of health reforms and increased burden of disease. Within this context, the programme focuses on strengthening financing, quality and health care sustainability among member states.

In line with these objectives, the ECSA Secretariat is developing a health care financing profile of member countries in order to understand the situation of their health financing, and to identify key policy issues and concerns that require attention in the short and medium term. Understanding these issues will assist the Secretariat in designing focused and evidence-based activities, and also in the mobilization of appropriate technical support for member countries.

The profiles will also enable the ECSA Secretariat to carry out a comparative analysis of health care financing in the region, and document successes and challenges and facilitate the sharing of experiences among countries. It is expected that the sharing of experiences will play a catalyst role in supporting health care financing reforms in the region. They will also help strengthen policy dialogue that may fast track the implementation of the resolutions of the Health Ministers Conference relating to healthcare financing within the region.

The specific tasks of the profiling assignment included:

1. Developing a summary of each country that included the following information:
    - 1a. Background information, including a brief epidemiological profile with key health system challenges identified
    - 1b. Description of the trends in total health expenditure and its sources, including private out of pocket expenditure, government health expenditure and external sources of health funding
    - 1c. Analysis of expenditure trends in terms of key policy issues such as protection from catastrophic expenditure, the Abuja Declaration, recommended minimum expenditure and sustainability of financing
2. Identifying the extent to which member states have conducted NHA studies and their key policy recommendations
3. Establishing which countries have made progress towards National Health Insurance

with documentation of their current status

1.1. Expected output

A report that analyses each country's health care financing situation and context, NHA status and progress towards achieving National Health Insurance.

1.2. Methodology

The analysis is based on health expenditure data from the WHO NHA website for the period 1995 to 2009, and on health financing literature. The WHO NHA database is also complemented by secondary information from other sources such as the internet. The information gathered was then collated, analyzed and used to generate the health financing profile of each country.

2.0 Member Countries Health Financing Profiles

This section provides an analysis of the health care financing situation of each ECSA-HC member country. The analysis presents the country's background information to provide the health care financing context, followed by an analysis and discussion of key health care financing indicators. These indicators include total health expenditure per capita, government expenditure on health as a proportion of general government expenditure, government health expenditure per capita, private expenditure on health, OOP spending on health as a proportion of private expenditure and total health expenditure, health expenditure as a percent of GDP and external resources for health as a proportion of total health spending. The analysis for each country ends with a discussion of possible policy implications of the health care financing situation and key recommendations.

2.1. Botswana

Background

Botswana is a landlocked country with a population of just over two million people. Botswana was one of the poorest countries in Africa when it gained independence in 1966 with a Gross Domestic Product (GDP) per capita of about US $70. Botswana has, however, transformed itself into one of the fastest-growing economies in the world. The 2009 Human Development Index (HDI) report by the United Nations Development Programme (UNDP) reported Botswana's GDP per capita at US $13,000 (PPP), the highest in the region. Botswana has managed to reduce the number of people living under US $2 a day from 55% to 49% of the population. The estimate compares less favourably with South Africa, which has 42% of its population living on less than US $2 a day.

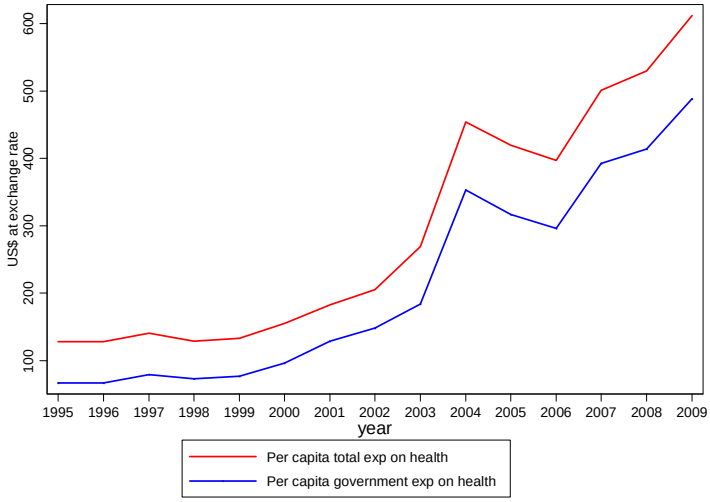
Like other countries in sub-saharan Africa, HIV/AIDS is one of the major public health challenges in Botswana. It is estimated that one in six people is living with HIV, giving Botswana the second highest HIV infection rate in the world, after Swaziland.[1] The government of Botswana is well aware of the negative impact of HIV/AIDS on various sectors of the economy and has put in place interventions to combat the epidemic, including the provision of free anti-retroviral drug treatment (ART) and a nation-wide Prevention of Mother-to-Child Transmission (PMTCT) program.

Per capita indicators of expenditure on health

The total expenditure on health per capita in Botswana shows an increasing trend and was estimated at US $612 in 2009 at average exchange rates. Government spending on health per capita in 2009 was US $489 at average exchange rates, implying that the government is contributing close to 80% of total spending on health. The trend in per capita total expenditure on health, and per capita government expenditure on health, is presented in Figure 2.1.1:

[1]Avert (International Aids Charity), http://www.avert.org

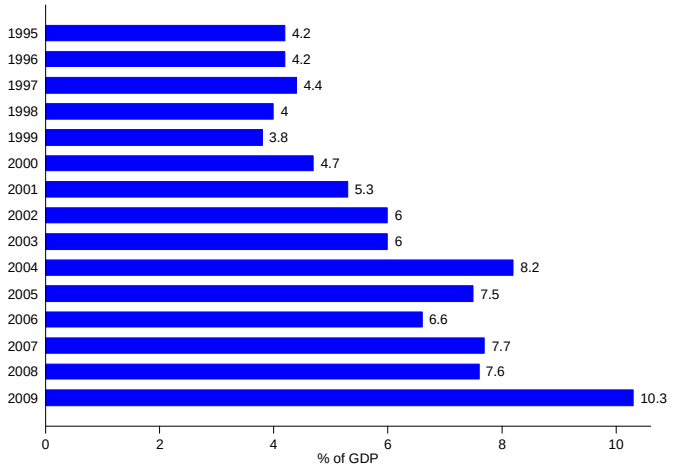
Figure 2.1.1: Per capita total and government expenditure on health 1995-2009



Total expenditure on health as a percentage of gross domestic products (GDP)

Total expenditure on health as a percent of GDP has also shown an increasing trend from 4% reported in 1995 to 10.3% in 2009. Figure 2.1.2 shows the trend in total expenditure on health as a percentage of GDP.

Figure 2.1.2: Total expenditure on health as a percentage of GDP

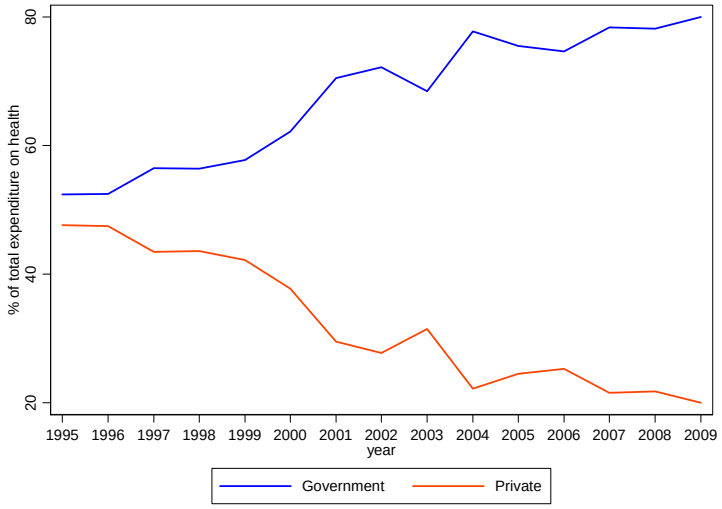


Private and government expenditure on health as a percentage of total expenditure on health

Private expenditure on health has shown a declining trend from 47.6% in 1995 to 20% in 2009. The decrease in the private component of the total health expenditure was coupled with a corresponding increase in the government expenditure on health as a proportion of total

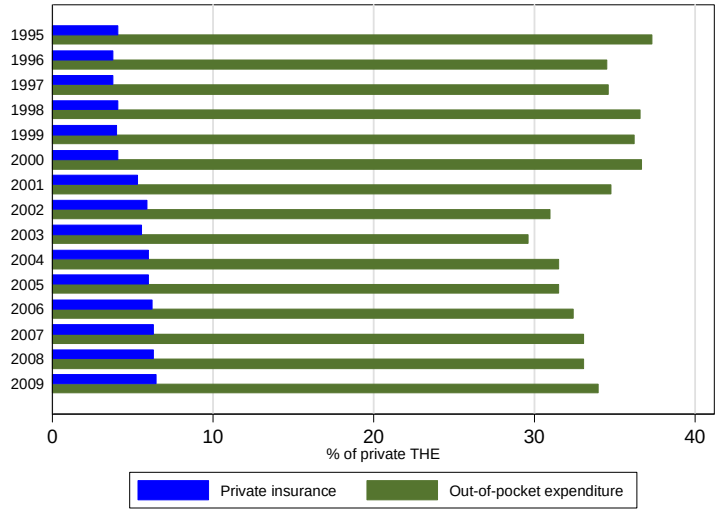
expenditure on health. In 2009, government expenditure on health accounted for 80% while in 1995 the corresponding government expenditure was 52.4%. Figure 2.1.3 shows the trend in private and government expenditure on health as a percent of total health expenditure.

Figure 2.1.3: Government and private expenditure on health as a percentage of total expenditure on health



The decline in private expenditure on health is a desirable trend, as most of the private expenditure is in form of OOP payments (Figures 2.1.4 and 2.1.5) which may potentially subject households to catastrophic expenditure due to their financing of health care.

Figure 2.1.4: Private insurance and out-of-pocket payment as a proportion of private expenditure on health

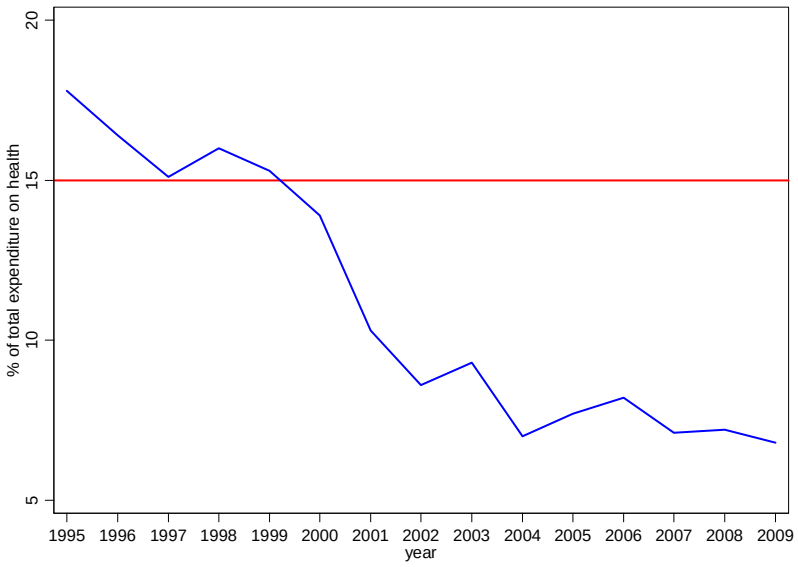


OOP expenditure as a percent of private expenditure on health was reported to be 34% of private health expenditure in 2009. Over the period 1995 to 2009, OOP expenditure has been relatively high, fluctuating between 29.6% and 37.3%. Figure 2.1.4 indicates that private expenditure on health was mainly from household out-of-pocket payments.

Out-of-pocket payment as a percentage of total expenditure on health

Over the years 1995 to 1999, OOP payments contributed significantly to the total expenditure on health and were higher than 15%. When OOP expenditures exceed 15% of total health expenditure, the likelihood of catastrophic expenditure increases. This is a situation where households spend a large part of their incomes on healthcare, at the expense of other needs such as clothing and education of their children. In 2009, OOP expenditure was 7% of the total expenditure on health. From 2000 to 2009, the OOP payment percentage dropped to below 15%, implying that the likelihood of catastrophic expenditure may have decreased significantly as a result of increasing government allocation and donor funding. The decline in the share of OOP payments is in the right direction and ought to be sustained.

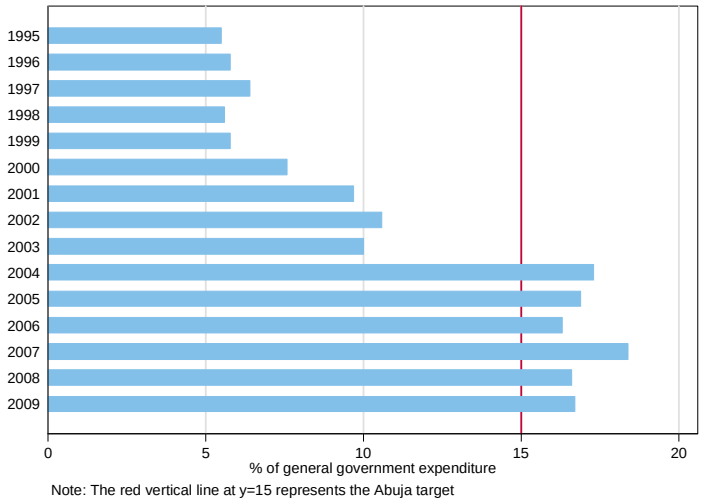
Figure 2.1.5: Out-of-pocket payments as a percentage of total expenditure on health



General government expenditure on health as a proportion of general government expenditure

There has been an overall increase in public spending on health as a proportion of total government expenditure over the period under review, with the country surpassing the Abuja target over the years 2004 to 2009 inclusive. In 2009, public spending on health constituted about 16.7% of general government expenditure (Figure 2.1.6).

Figure 2.1.6: General government expenditure on health as a percentage of general government expenditure

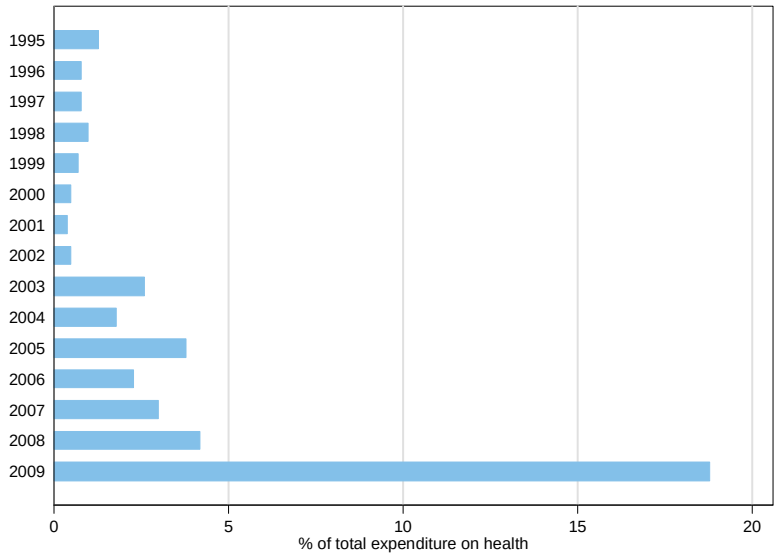


The trend between 2004 and 2009 should be sustained so as to enable the country to progressively increase resources provided to the health sector and help achieve its health goals.

External resources on health

Botswana has generally been less dependent on donor funding. However in 2009 external resources accounted for about 19% of the total expenditure on health, with the increased donor resources financing HIV/AIDS programmes. This share of external resources is lower than the SSA average of 21%. Figure 2.17 presents external resources spent on health as percentage of total health spending over the years 1995 to 2009 inclusive.

Figure 2.1.7: External resources on health as a percentage of total expenditure on health



Conclusion and policy implications

Although Botswana invests a relatively large amount of resources in health, there is a need to convert the OOP spending into pre-payment schemes as a means of protecting households from catastrophic expenditures due to seeking medical care.

2.2. Kenya

Background

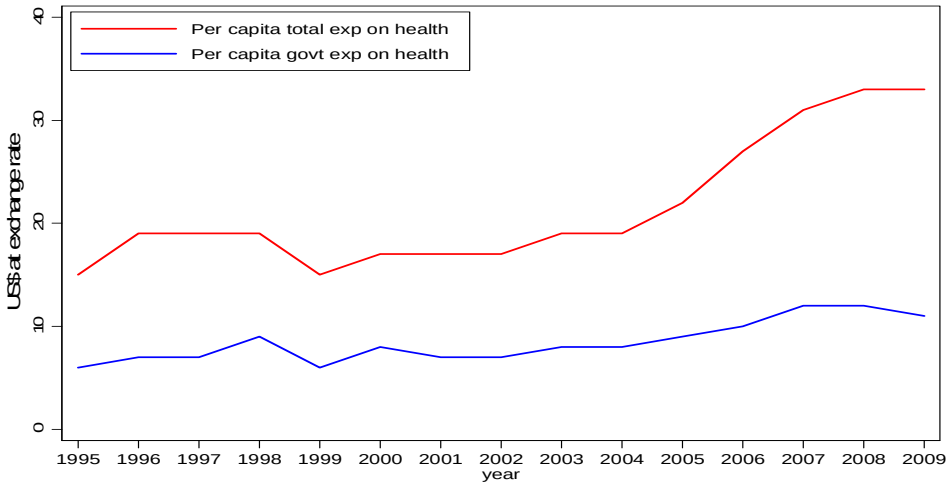
Kenya is a low income country with an estimated population of 38.6 million, as reported in the 2009 Census. The 2008/9 Kenya Demographic Health Survey (KDHS) reported remarkable improvement in the infant mortality rate (IMR) and the under-five mortality – from 77 to 52, and from 115 to 74, per 1,000 live births, respectively. The gains recorded by these two indicators are a result of economic growth experienced in that period, along with increases in immunization rates, increased use of bed nets, and the prevention of mother-to-child transmission of HIV/AIDS. However, maternal mortality increased from 414 per 100,000 to 488 per 100,000. Achievement of MDG 5 will therefore remain a huge challenge. Although the KDHS of 2008/09 indicates significant improvement in child health, Kenya is still unlikely to achieve MDG 4.

The prevalence of underweight, stunting and wasting has not improved much and malnutrition remains a key contributor to child and infant mortality in Kenya. Life expectancy, which has been on the decline, is estimated at 54.2 years and this is expected to fall further due to the rising incidence of HIV (UNDP, 2009).

Per capita indicators of expenditure on health

The per capita total expenditure on health in Kenya was US $33 in 2009, up from US $15 reported in the 1990s. This shows an increase of US $18 per capita between 1995 and 2009. However, government per capita spending on health over the period under review has stagnated between US $6 and US $10 during the same period. The trend in per capita total expenditure on health and per capita government expenditure on health is presented in Figure 2.2.1.

Figure 2.2.1: Per capita total and government expenditure on health 1995-2009



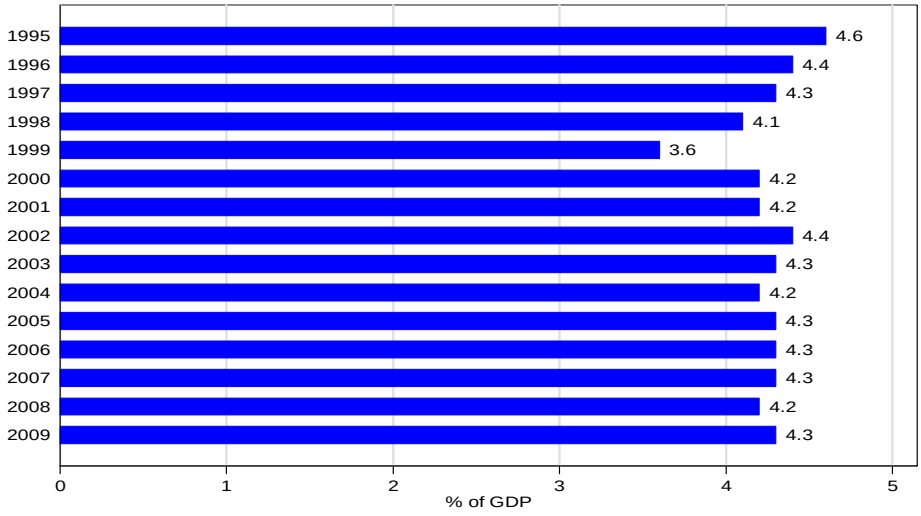
The total per capita expenditure on health experienced an overall upward trend. In purchasing power parity (PPP) terms, the increase over the 15 year period was less than 100%. The government per capita expenditure on health also had an overall trend of growth, with an estimate of US $11 per capita in 2009, implying that the government was financing only 33% of total health spending in Kenya.

Total expenditure on health as a percentage of gross domestic product (GDP)

Total expenditure on health constituted 4.3% of GDP in 2009[2]. This expenditure was equivalent to approximately Kshs 2,060 or US $30 which was short of the estimated cost of delivering the National Health Sector Strategic Plan II (NHSSP II) which was estimated at US $33 per capita annually.

[2]Kenya PER 2010.

Figure 2.2.2: total expenditure on health as a percentage of GDP

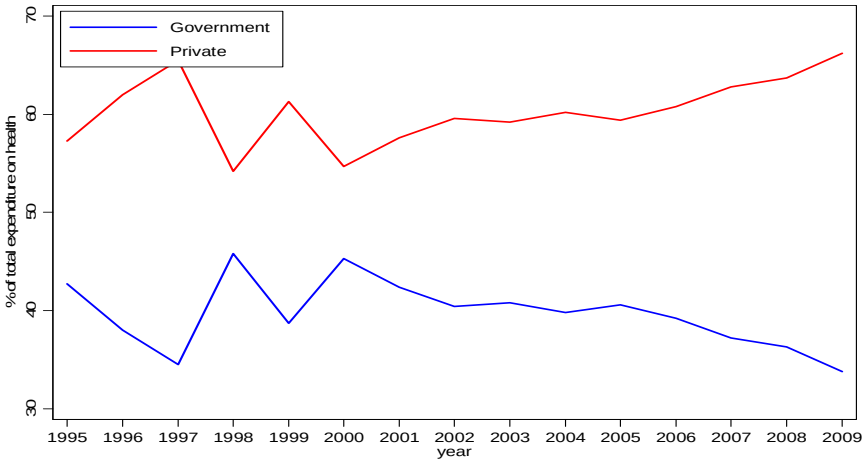


It should be noted that if Kenya was to meet its health objectives as articulated by the HSSPII, it should devote at least 5% of its GDP to health.

Private and government expenditure on health as a percentage of total expenditure on health

In 2009, private expenditure on health constituted about 66% of total health spending. Out-of-pocket expenditure accounted for most of the private expenditure on health over the entire period at 78% of the total health expenditure. The increase in the private component of the total health expenditure was coupled with a corresponding decrease in the government component, as is demonstrated in figure 2.2.3 below.

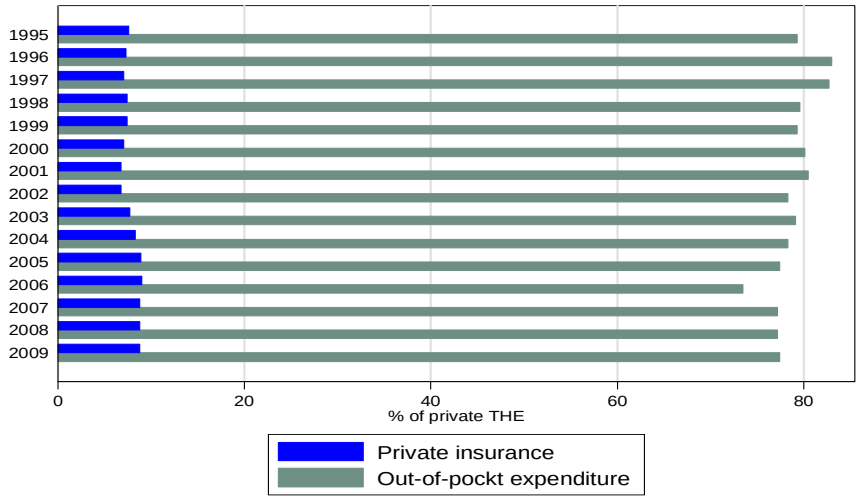
Figure 2.2.3: Government and private expenditure on health as a percentage of total expenditure on health



The increase in private expenditure on health is a worrying trend, as most of the private expenditure on health is attributed to OOP payments (Figures 2.2.4 and 2.2.5) which may potentially result in catastrophic spending and help move households into poverty.

Out-of-pocket expenditure accounted for most of the private expenditure on health over the entire period. In 2009 it was at 78% of the total health expenditure. This indicates that households were spending a larger proportion of their incomes on health, which could lead to catastrophic expenditure.

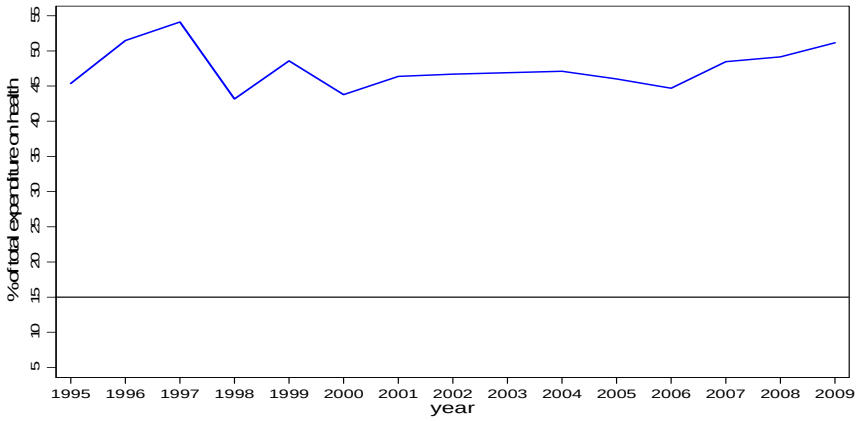
Figure 2.2.4: Private insurance and OOP payment as a percentage of private expenditure on health



Out-of-pocket expenditure on health in Kenya was significantly above the 15% cut-off mark over the period under review (1995 to 2009 inclusive) as demonstrated in Table 2.3.5 below.

The high OOP expenditure may potentially result in catastrophic spending by households and therefore push them further below the poverty line.

Figure 2.2.5: Out-of-pocket payment as a percentage of total expenditure on health

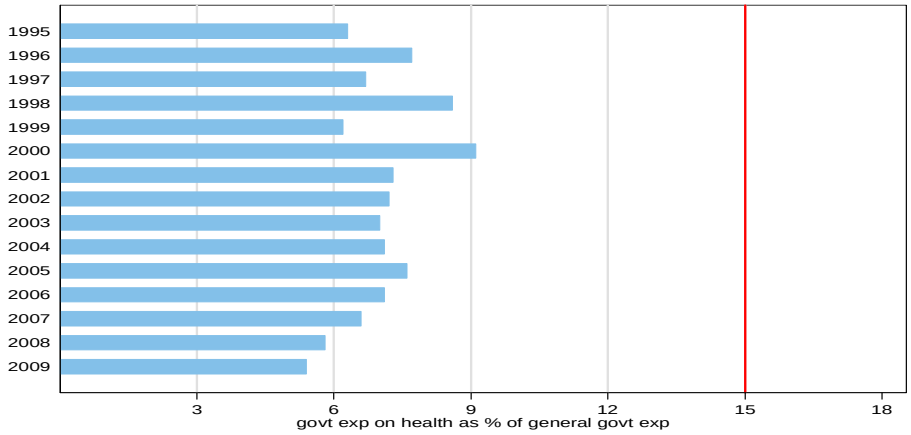


The trend in the share of OOP payment needs to be addressed in order to protect households from catastrophic spending on health. The introduction of pre-payment mechanisms, such as the proposed social health insurance, will help ensure access to health care by all. This is in line with the World Health Assembly Resolution of 2005 which addresses sustainable health financing, universal coverage and social health insurance.

General government expenditure on health as a proportion of general government expenditure

On average, government expenditure on health was about 7% of total government expenditure. It may be discerned from Figure 2.2.6 that government expenditure on health has remained below the Abuja Declaration target of 15%. The trend suggests that Kenya is not making progress towards the achievement of the Abuja target.

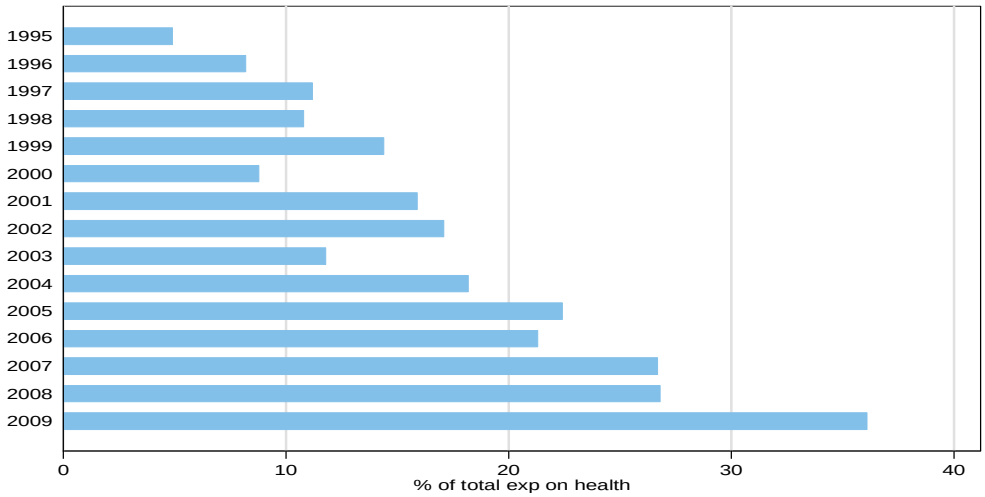
Figure 2.2.6: General government expenditure on health as a percentage of general government expenditure



External resources for health

External resources for health in Kenya have been increasing over the years from about 4% in 1995 to about 36.1% in 2009 without a proportionate increase in central government expenditures. This is a result of increased donor funding which will assist in better coordination of services. Kenya has now established a SWap mechanism as a means of improving the management of financial inputs from various sources. Table 2.2.7 below shows external resources for health flow for the period under review.

Figure 2.2.7: External resources for health as a percentage of total expenditure on health



Conclusion and policy implications

The government of Kenya is investing relatively less in the health sector as evidenced by total government health spending remaining consistently below 8% of GDP between 2001 and 2009.

Government expenditure on health as a percent of total government expenditures was also very low, at 5.4% in 2009 and quite far from the Abuja target of 15%.

External resources for health in Kenya have also increased significantly over the years, without a proportionate increase from central government expenditures. This has increased the country's dependence on external resources to finance health care which may not be sustainable. Given the increased resources from development partners, the government ought to strengthen its stewardship role in coordinating donors, ensuring alignment to country strategies in line with the Paris Declaration principles, and towards more effective aid.

The Government of Kenya should also consider increasing resources to the health sector while exploring alternative pre-payment mechanisms, such as the introduction of social health insurance to increase resources and protect households from catastrophic expenditures. Kenya needs to finalize and implement their health financing strategy, which will guide progress towards universal coverage for all citizens and improve access to health services.

2.3. Lesotho

Background

The Kingdom of Lesotho is a landlocked country and has a population of slightly more than two million people. Lesotho is a lower middle income (LMI) country with a GDP of US $516 per capita.[3] Lesotho's population is growing at a rate of 0.87%, compared to the regional average of 2.35%. Lesotho's population growth trends mirror those of neighboring South Africa, demonstrating strong economic and epidemiological ties between the two countries. The marked slowdown in population growth, which began in 1999, is attributable to increased mortality due to HIV/AIDS.

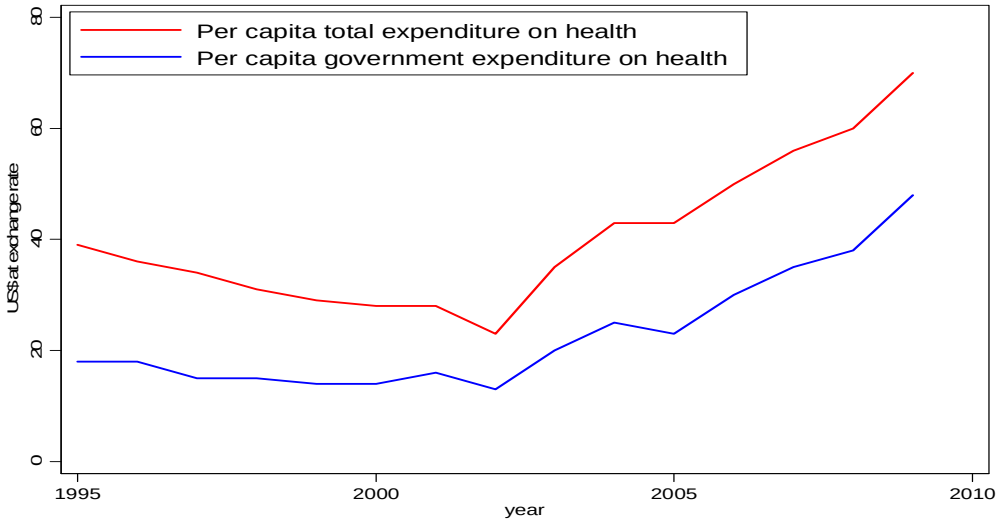
Compared to other countries, Lesotho has a higher contraceptive prevalence rate (although still low at 29%), lower total fertility, and higher utilization of antenatal care (ANC). Lesotho has a low life expectancy rate (45 years), compared to the regional average of 55 years. The low life expectancy is due to high levels of HIV and tuberculosis. The infant mortality rate was 61 per 1000 live births (2009) while under-five mortality rate was 84 per 1000 live births (2009) and the maternal mortality ratio was 530 per 100 000 live births (2008). Inadequate healthcare services during pregnancy and through the post-partum period are among the underlying causes of high maternal mortality alongside other health system weaknesses[4].

Per capita indicators of expenditure on health

Lesotho's health expenditure per capita declined from US $39 in 1995 to US $23 in 2002. This trend however changed and the expenditure significantly increased from US $35 in 2003 to US $70 in 2009. The per capita health expenditure is therefore two times higher than the US $34 recommended for providing a basic package of cost-effective health interventions in low-income countries. Although such expenditure doubles the recommended minimum of US $34, it still falls below the average of its peers in the low middle income group[5] of US $74. The trend in per capita total expenditure on health and per capita government expenditure on health is presented in Figure 2.3.1.

[3]World Bank Data source,2010.
[4]World Health Statistics,2011.
[5]World Health Organisation statistics,2009.

Figure 2.3.1: Per capita total and government expenditure on health 1995-2009

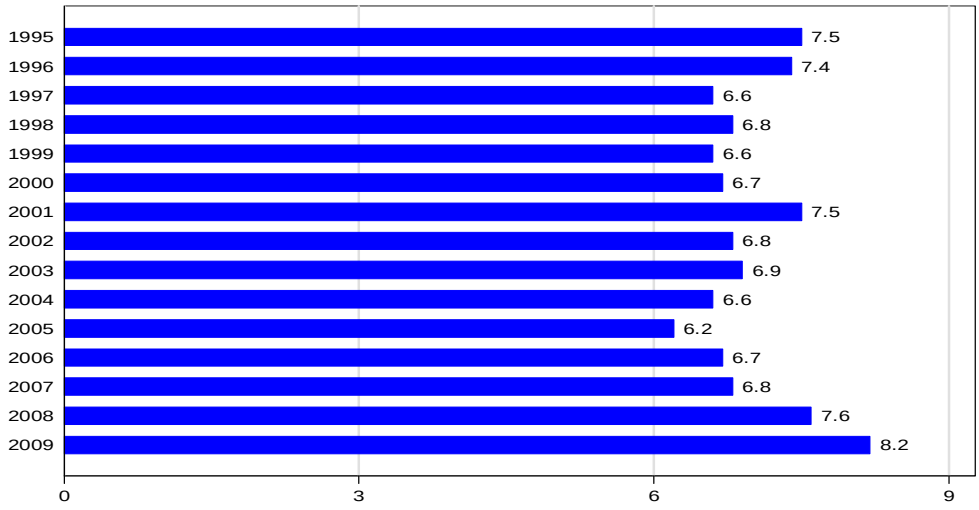


Government per capita expenditure on health has taken an upward trend, increasing from US $18 in 1995 to US $48 in 2009. The 2009 estimate of US $48 indicates that the government of Lesotho's expenditure on health was close to 68% of the total health expenditure in 2009.

Total expenditure on health as a percentage of Gross Domestic Product

Total expenditure on health as a percentage of GDP in Lesotho was oscillating between 6.2% and 8.2% for the period under review - 1995 and 2009. However, total health expenditure as a percent of GDP increased steadily from 6.2% in 2005 to 8.2% in 2009, as shown in Figure 2.3.2 below.

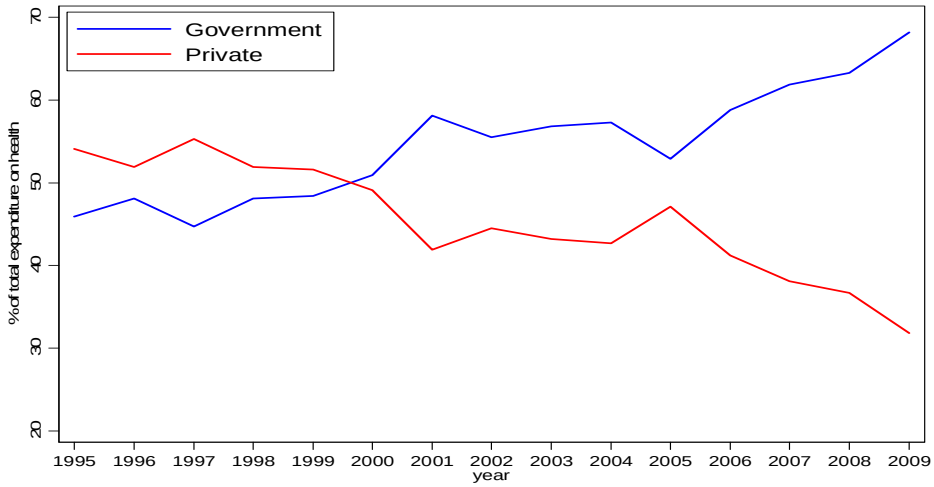
Figure 2.3.2: Total expenditure on health as a percenatge of GDP



Private and government expenditure on health as a percentage of total expenditure on health

Private expenditure on health was 31.8% of total health expenditure in 2009. This represented a decline from the 54.1% that was reported in 1995. This trend is desirable as it shows that the government is taking up the role of financing basic healthcare for its citizens. Figure 2.3.3 shows government versus private spending on health as a percent of total health expenditure.

Figure 2.3.3: Government and private expenditure on health as a percentage of total expenditure



Private insurance and out-of-pocket payment as a proportion of private expenditure on health

In 2009, OOP payments constituted about 70% of the total private expenditure on health. When out-of-pocket spending represents a large share of health spending, pooling of resources is limited. It means that most of the time households have to pay for health services at the point of consumption which can act as a barrier to accessing care and can therefore threaten the financial status of households.

Fig 2.3.4: Private insurance and OOP payment as a percentage of private expenditure on health

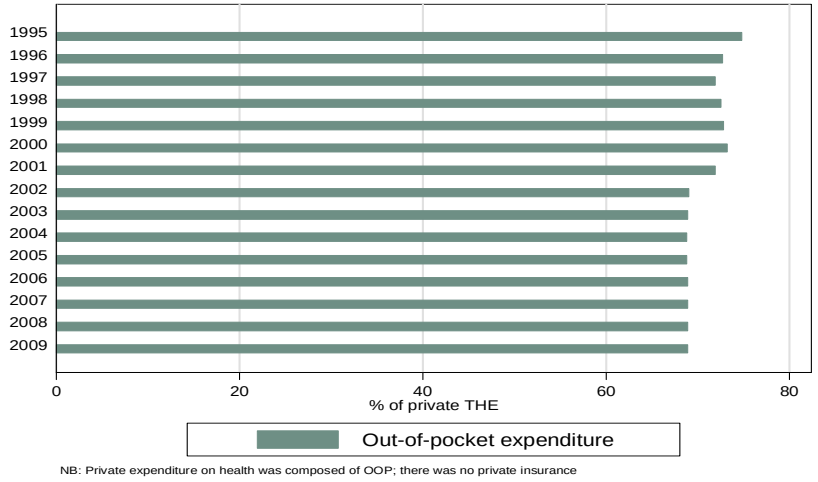
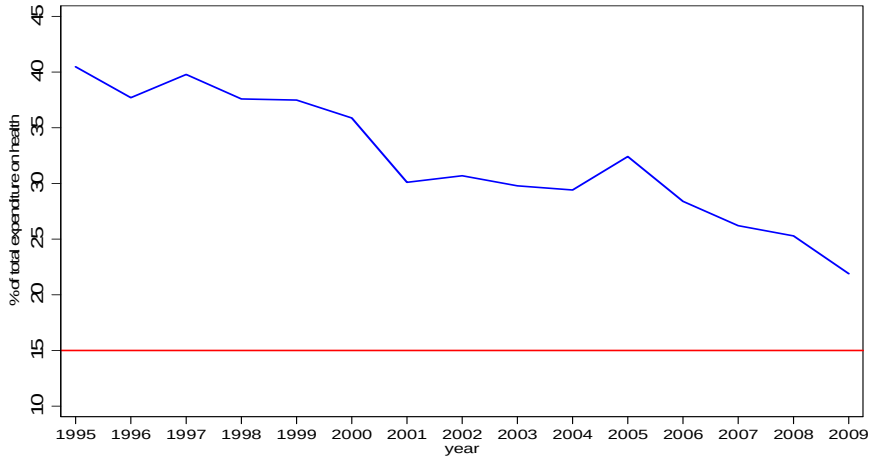


Figure 2.3.4 indicates that most of Lesotho's private expenditure on health was from OOP expenditure, although there were other sources which were less significant.

Out-of-pocket payment as a percentage of total expenditure on health

OOP spending in Lesotho decreased significantly from about 40% in 1995 to about 21.9% in 2009. This trend is desirable and if sustained in the coming years, OOP expenditures on health would be below 15%, meaning that the risk of catastrophic expenditure occurring would be minimized.

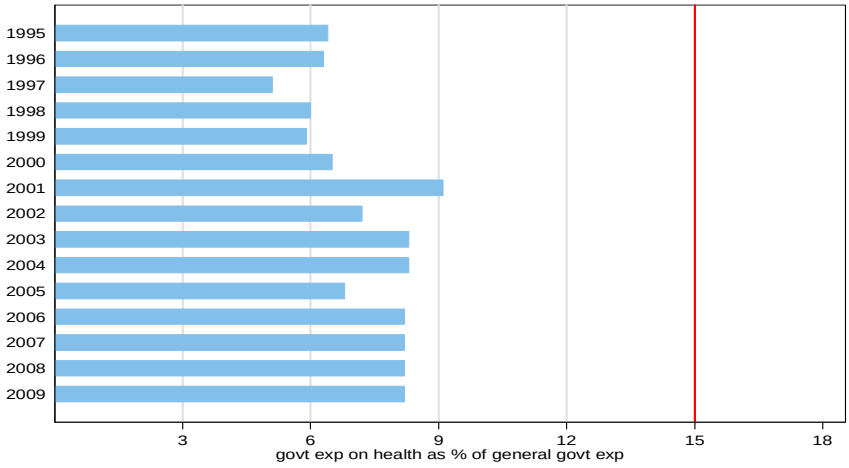
Figure 2.3.5: Out-of-pocket payment as a percentage of total expenditure on health



General government expenditure on health as a proportion of general government expenditure

Figure 2.3.6 shows that government expenditure on health as a percentage of general government expenditure was below 9% during the period 1995 to 2009. This expenditure level is below the Abuja Declaration target where African governments committed to allocate at least 15% of government expenditure to health.

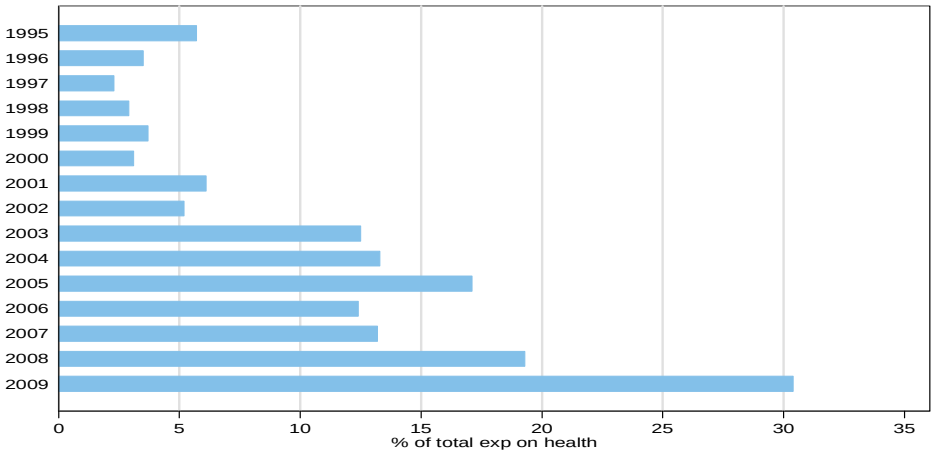
Fig 2.3.6: General government expenditure on health as a percentage of general government expenditure



External resources for health

External resources for health have increased from a low of 2.3% of total health expenditure in 1997 to a high of 30.4% of total health expenditure in 2009. This trend shows that Lesotho has, over time, increased dependence on donors to finance health care. While donors are an important financier of health care, donor funding is often unpredictable and unsustainable in the long term. Lesotho should consider increasing domestic resources to finance health care. Figure 2.3.7 presents a time line of donor spending on health as a percentage of total health spending.

Figure 2.3.7: External resources on health as a percentage of total expenditure on health



Conclusion and policy implications

Government expenditure on health as a percentage of general government expenditure has remained below 9% during the period under review. Lesotho should consider renewing its commitment to the Abuja Declaration target by increasing the share of domestic resources committed to the health sector. A financing system that increases resources from pre-paid mechanisms to the health sector will enhance the protection of households from the impoverishing effects of paying for healthcare. As such, Lesotho needs to explore the possibility of moving towards social health insurance, in line with WHO recommendations on universal health coverage and sustainable health financing.

2.4. Malawi

Background

Malawi is a low income country with an estimated gross national income per capita of US $ 290 in 2008. The estimated population in 2008 was 14 million with an average annual growth rate of 2.6%. The HDI in 2010 was 0.385.[6] Like many other countries in sub-Saharan Africa, Malawi faces a growing burden of diseases and critical shortage of health system resources. The epidemiological profile is characterized by a high prevalence of communicable diseases including malaria, tuberculosis and HIV/AIDS; high incidence of maternal and child health problems; increasing burden of non-communicable diseases and resurgence of the neglected tropical diseases.[7]

Although there has been a significant reduction in infant and under-five mortality rates and the maternal mortality ratio, the figures are still high. In 2009, the infant and under-five mortality rates were 69 and 110 per 1,000 live births respectively.[8] The estimated maternal mortality

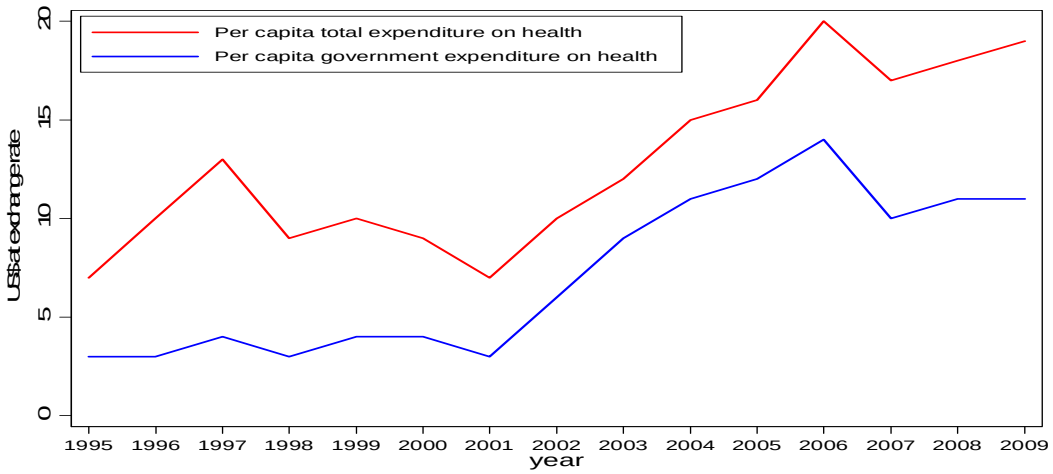
[6]UNDP (2010) *Human Development Report 2010*. New York: United Nations Development Program.
[7]WHO/AFRO (2009).*Malawi: WHO Country Cooperation Strategy 2008-2013*. Brazzaville: WHO/AFRO.
[8]UNICEF (2011).*The State of the World's Children 2011*. New York: UNICEF.

ratio was 510 per 100,000 live births in 2008.[9] Access to health services is limited. To address the prevailing health system problems, the government of Malawi started implementing a health SWAp since 2004 and designed an essential health package (EHP) comprising key health interventions against 11 diseases/conditions.

Per capita indicators of expenditure on health

Total expenditure on health per capita, provides information on the overall availability of resources for health care. The total expenditure on health per capita at average exchange rate was US$ 19 in 2009. This is seriously short of even the conservative recommendation of US $30-40 made by the CMH to provide a basic package of health services in low-income countries.[10] Government spending on health per capita in 2009 was about US$ 11 at average exchange rate, implying that public funds accounted for about 58% of the total expenditure on health. The trend in per capita total expenditure on health and per capita government expenditure on health is presented in Figure 2.4.1.

Figure 2.4.1: Per capita total and government expenditure on health 1995-2009



The total expenditure on health had an overall trend of growth. However, during the 15 years period considered, it only increased by US $12, from US $7 in 1995 to US $19 in 2009. In purchasing power parity (PPP) terms, the increase over the 15 years period was less than 100%. The per capita health spending in 2008 was also less than the estimated cost of delivering the Malawi EHP, which was estimated at about US $29 in 2008.

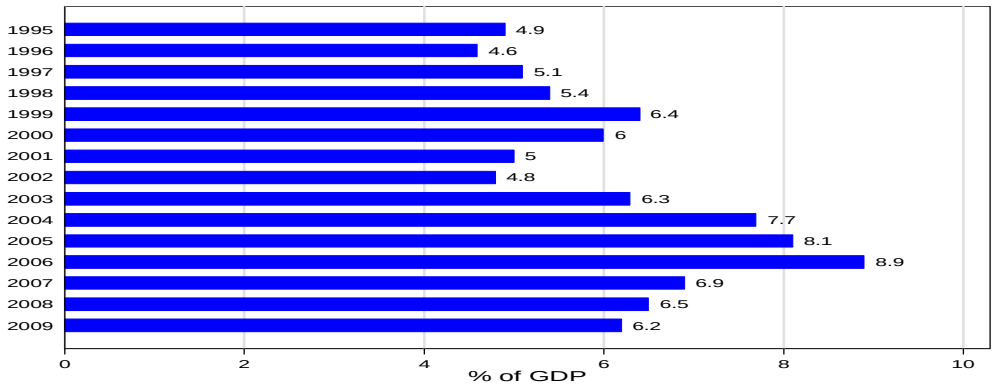
Total expenditure on health as a percentage of gross domestic product

Total expenditure on health constituted about 6.2 % of the GDP in 2008. This is a little higher than the figure for low-income countries. However, it should be noted that in order to reach a

[9]WHO, UNICEF, UNFPA and the World Bank (2010).*Trends in maternal mortality: 1990-2008*. Geneva: WHO.
[10]WHO (2001).*Macroeconomics and health Investing in health for economic development*. Geneva: WHO.

level of about US $29 required to deliver the Malawi EHP, total expenditure on health should increase to about 10% of the GDP. This is more than 50% increase and may not be realizable in the short run given the fiscal context.

Figure 2.4.2: total expenditure on health as % of GDP

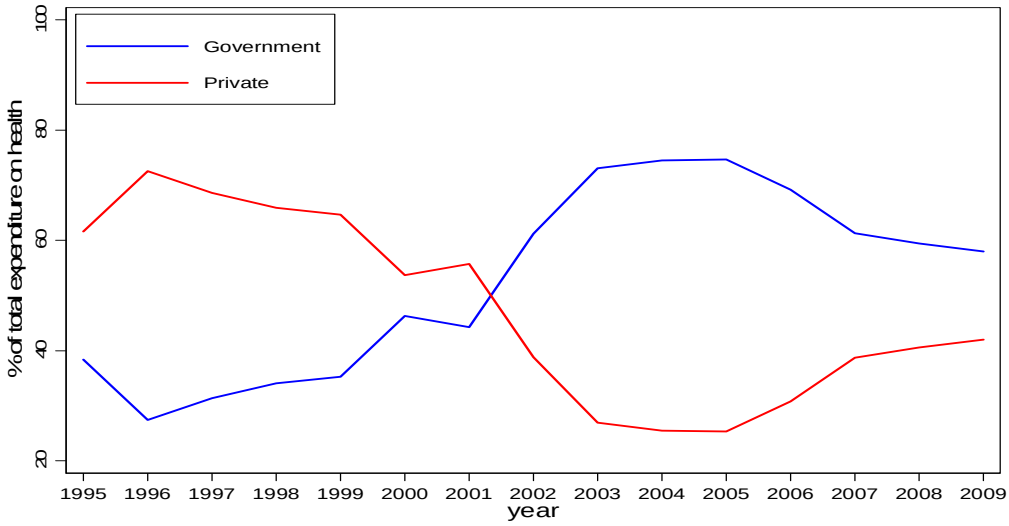


The Figure 2.4.2 above shows that the health component of the GDP has decreased from 8.9% in 2006 to 6.2% in 2009. The corresponding figures for some of the neighboring low-income countries were: Mozambique (5.7%); Tanzania (5.1%); and Zambia (4.8%). There is no benchmark against which to compare a country's health spending as a proportion of its GDP. However, it is observed that countries with higher GDP devote a greater proportion for health care. For example, total expenditure on health accounted for about 16.2% of the GDP in the United States of America in the year 2009. The corresponding figures for Botswana and South Africa, upper middle-income countries, were 10.3% and 8.5% respectively.

Private and government expenditure on health as a percentage of total expenditure on health

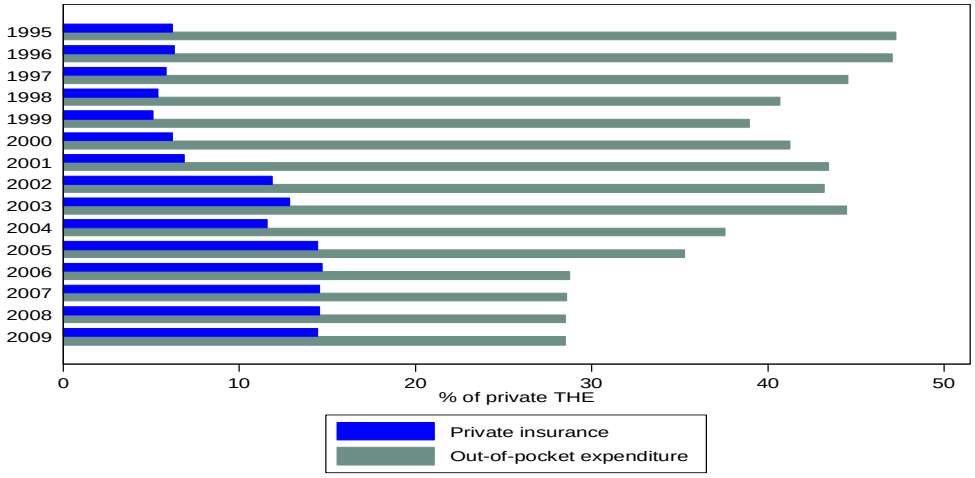
In 2009, private expenditure on health constituted about 42% of total health spending. This is a significant decrease from its 1995 level of 62%. The decrease in the private component of the total health expenditure was coupled with a corresponding increase in the government component as can be seen from figure 2.4.3 below.

Figure 2.4.3: Government and private expenditure on health as % of total expenditure on health



The decline in private expenditure on health is a desirable trend, as most is attributed to OOP payments (Figures 2.4.4 and 2.4.5), which may potentially result in catastrophic spending and drive households further below the poverty line. Catastrophic expenditure is an indicator of financial risk protection. WHO defines financial catastrophe as direct OOP payment exceeding 40% of household income net of subsistence needs. Subsistence needs are taken to be the median of household food expenditure in the country.[11]

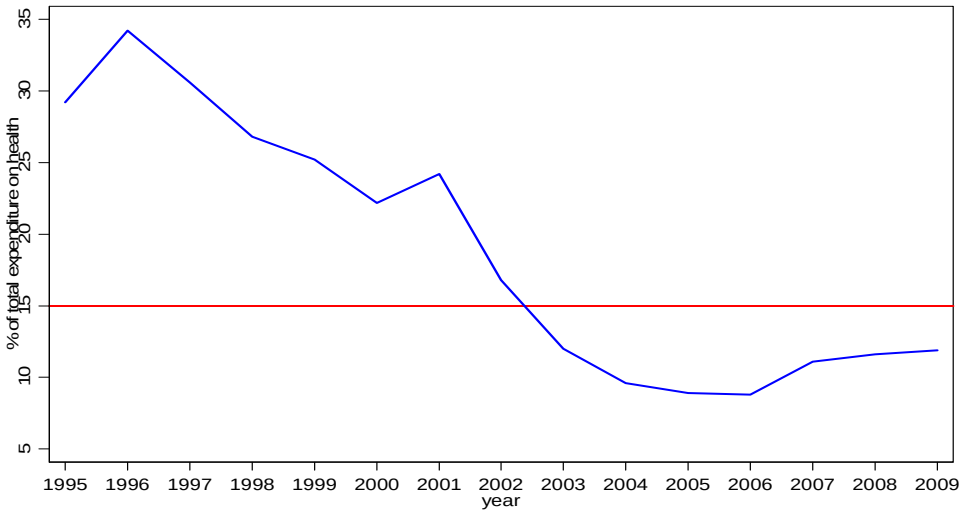
Figure 2.4.4: Private insurance &OOP as a proportion of private expenditure on health



[11]WHO (2010).*Monitoring the building blocks of health systems: A handbook of indicators and their measurement strategies*. Geneva: World Health Organization.

Figure 2.4.4 indicates that private expenditure on health was mainly from household OOP payments and that private health insurance accounted for less than 15% of the private expenditure on health. However, private health insurance has more than doubled compared to its 1995 level of 6.2%. Over the years, there was no social security contribution to the total expenditure on health. From 1995 to 2002, OOP payments contributed significantly to the total expenditure on health and were higher than 15%, which is the threshold for the occurrence of catastrophic expenditure (Figure 2.4.5). After 2002, the percentage of OOP payment dropped below 15%, implying that the likelihood of catastrophic expenditure may have decreased significantly, as a result of increasing government allocation and donor funding.

Figure 2.4.5: Out-of-pocket payment as a percentage of total expenditure on health



NB: The horizontal line at Y=15% is the cut-off point above which the likelihood of catastrophic expenditure increases
Source of data: computed from WHO NHA database

The decline in the share of OOP payment is in the right direction and has to be sustained, while raising more revenue to cover the Malawi EHP through pre-payment mechanisms that may include tax funding and health insurance in line with the World Health Assembly Resolution of 2005 on sustainable health financing, universal coverage and social health insurance.

General government expenditure on health as a proportion of general government expenditure

In 2009, government expenditure on health constituted about 12% of general government expenditure (Figure 2.4.6). An increase was observed in the period 1995-2004, when it reached 21%. It then started declining and reached the level of 12% in 2008. This corresponds to the time when the country started to implement the SWAp and may possibly indicate that pooled donor funds were replacing government expenditure.

Figure 2.4.6: General government expenditure on health as a percentage of general government expenditure

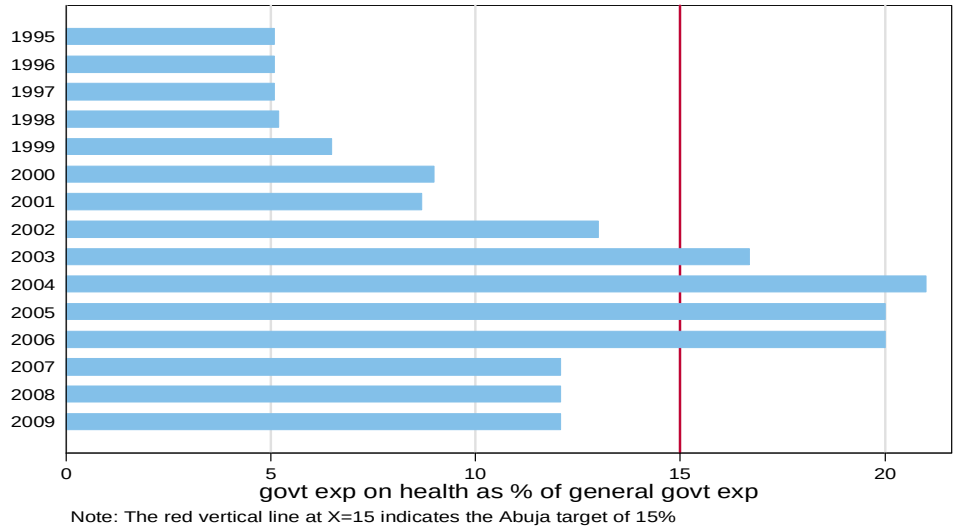
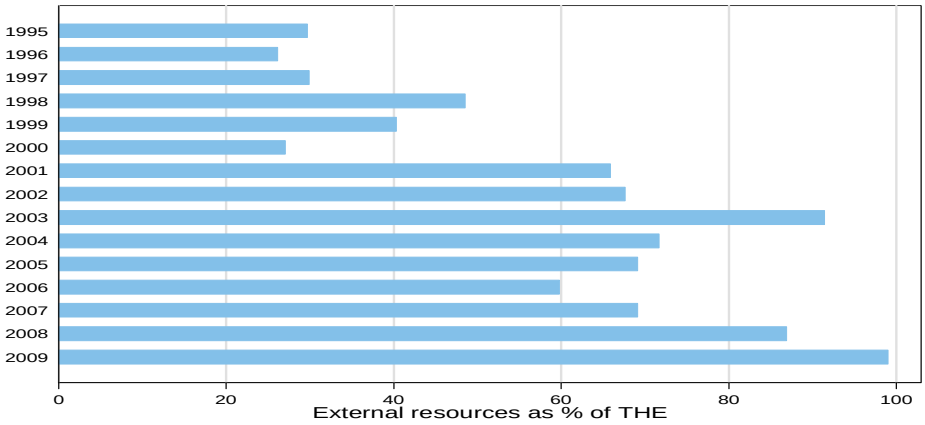


Figure 2.4.6 further indicates that although government met the Abuja target of allocating at least 15% of the national budget for health in the years 2002-2006, a decline was observed thereafter. In 2009, if 15% of the general government expenditure was spent on health, this would only have increased government expenditure on health by less than US $4. Hence, in low-income countries were government budget is seriously constrained, the 15% target may not result in a significant change in the health financing situation. The target may, however, be taken as a proxy to government commitment.

External resources on health

On average, external resources accounted for about 60% of the total expenditure on health in the period 1995-2009 (Figure 2.4.7). This indicates that the health system in Malawi significantly depends on donor finance. In such a scenario, it is very important that the country established the SWAp as a mechanism of coordinating the financing and activities of development partners.

Figure 2.4.7: External resources on health as a percentage of total expenditure on health



Given the significant dependence on external resources on health and the prevailing fiscal context, a sustained donor support to the country's health sector is important to avoid reversal of the modest gains in health outcomes that the country has achieved. For example, with an average annual reduction rate of 6% in the period 2000-2008, Malawi is one of the few countries in sub-Saharan Africa on track to achieve the MDG 4 target of reducing the under-five mortality rate by two-thirds between 1990 and 2015.

Conclusion and policy implications

There is a critical shortage of funds to cover the costs of delivering the Malawi EHP and meet global and regional health financing targets. The data indicate that a significant proportion of the total expenditure on health is attributed to donor funds signifying a heavy reliance on external resources that may adversely affect the sustainability of the health system. OOP payments, which constituted more than a third of the total expenditure on health decreased to less than 15% in 2009. This is likely to reduce the likelihood of catastrophic expenditure. There has been an increase in the proportion of private insurance as a share of private expenditure on health. However, there was no social security contribution to health spending.

The government needs to increase its contribution to the total expenditure on health to meet the EHP cost. Meeting the Abuja target would enable it cover the conservative estimate of delivering the Malawi EHP. Given the fiscal context, weaning from donor funds may not be possible in the foreseeable future. It is therefore necessary to develop a strategic partnership with partners for a sufficiently longer period and for predictability of funds so as not to jeopardize sustainability of the health system. Prepayment schemes are at a nascent stage. Hence to facilitate progress towards Universal Coverage, it is necessary to develop and implement a comprehensive health policy and strategy as recommended in the 56th WHO Regional Committee for Africa Resolution on health financing and the Ouagadougou Declaration.[12]

[12]Zere E, Walker O, Kirigia J, Zawaira F, Magombo F, Kataika E (2010). Health financing in Malawi: Evidence from National Health Accounts.?BMC International Health and Human Rights, 10:27

2.5. Mauritius

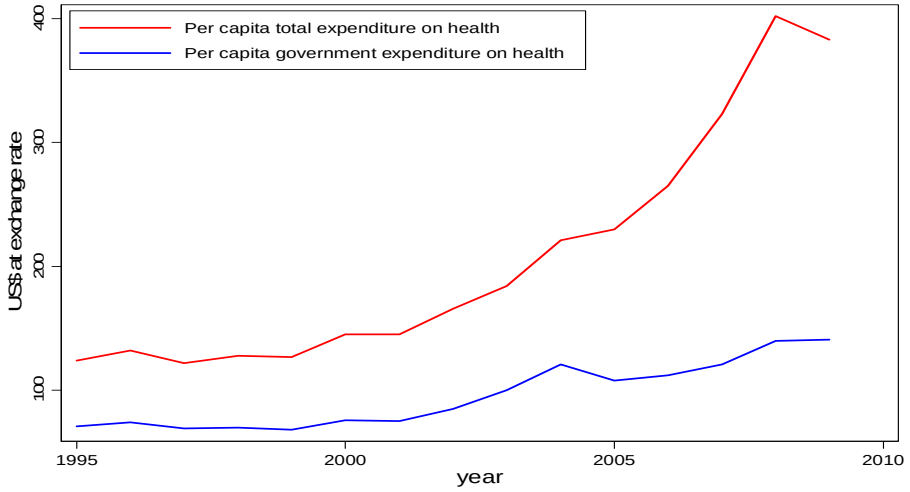
Background

Mauritius, with a GDP per capita of US $4,814 (2008), is an Upper Middle Income (UMI) country in the SSA region. The country has a population of 1,268,854 of which 58% live in the rural areas. The adult literacy rate is 88%. Mauritius has better access to the improved water and sanitation (99%) compared with the peer countries in the same region (68%) but similar to the countries in the same income group (97%). Life expectancy at birth is 73 years, higher than SSA average of 55 years. Life expectancy is considered one measure of overall health status of a country's population and of their quality of life[13,14]. The maternal mortality ratio was 36 per 100,000 in 2008, compared with 575 for SSA[15]. The percentage of births attended by skilled health personnel was 99% in 2010 compared with 55% for SSA.[16]

Per capita indicators of expenditure on health

The total expenditure on health per capita at an average exchange rate increased from US$ 124 in 1995 to US$ 402 in 2008. The trend in per capita total expenditure on health and per capita government expenditure on health is presented in Figure 2.5.1.

Figure 2.5.1: Per capita total and government expenditure on health 1995-2009



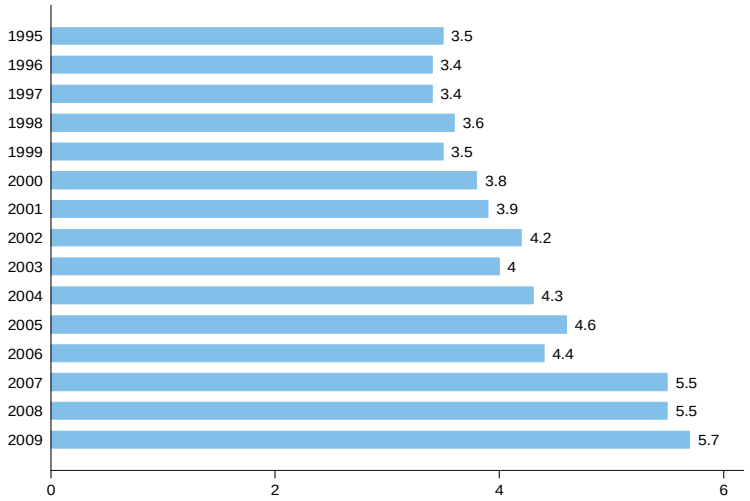
Total expenditure on health as a percentage of Gross Domestic Product

Mauritius's total expenditure on health as a percentage of GDP was 5.7% in 2009. This is lower than the average for countries in SSA (5.8%) and the UMI countries (6.6%). Total expenditure on health as a percentage of GDP had an overall growth trend, increasing from 3.5% in 1995 to

[13] *healthsystems2020.healthsystemsdatabase.org/reports/Reports.aspx*
[14] *Country Cooperation Strategy Mauritius 2008-2013.*
[15] World Bank, 2008.
[16] World Health Statistics,2011.

5.7% in 2009. Figure 2.5.2 below shows trends in Total expenditure on health as a percentage of GDP from 1995 to 2009.

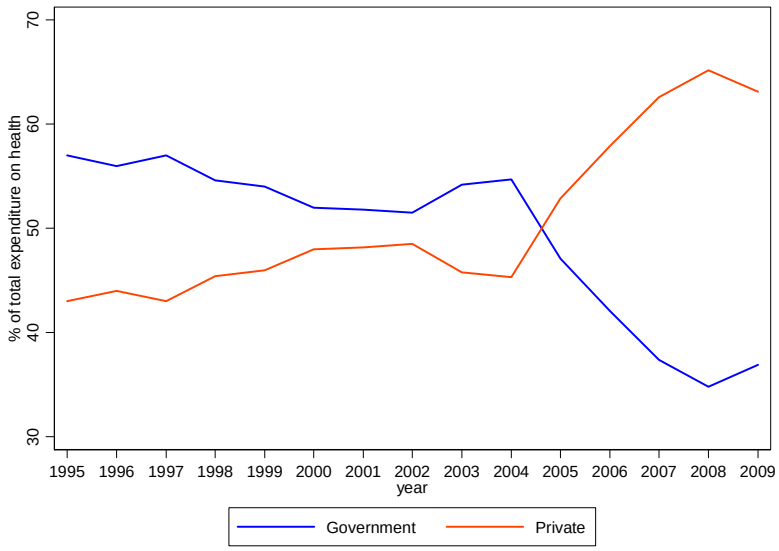
Figure 2.5.2: total expenditure on health as % of GDP



Private and government expenditure on health as a percentage of total expenditure on health

In 2009, private expenditure on health constituted about 63.1% of total expenditure on health. This is a significant increase from its 1995 level of 43% of total expenditure on health. The increase in the private component of the total health expenditure was associated with a corresponding decrease in the government component as can be seen from the figure below.

Figure 2.5.3: Government and private expenditure on health as % of total expenditure on health



The increase in private expenditure on health is not desirable; most of the private expenditure on health may be in the form of OOP payments as shown by figures 2.5.4 and 2.5.5.

Figure 2.5.4: Private insurance and out-of-pocket payment as a proportion of private expenditure on health

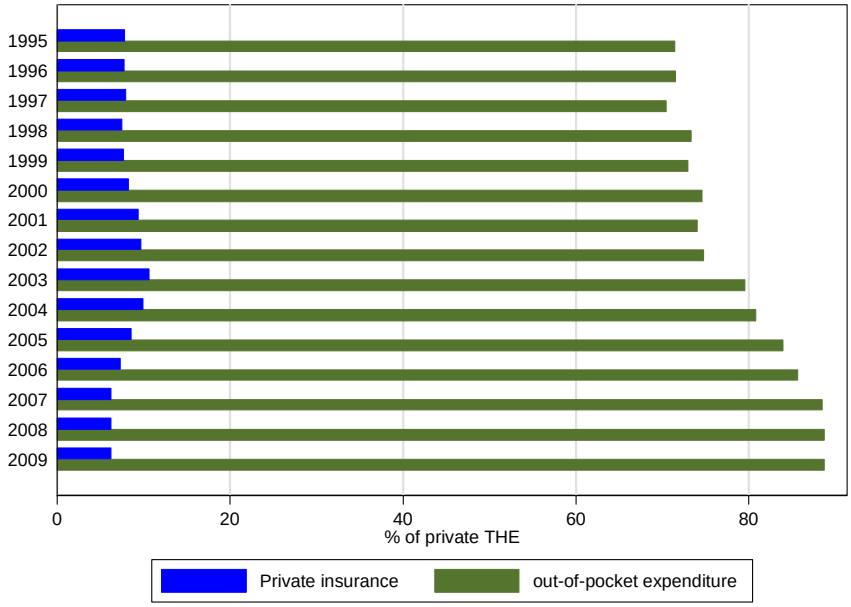
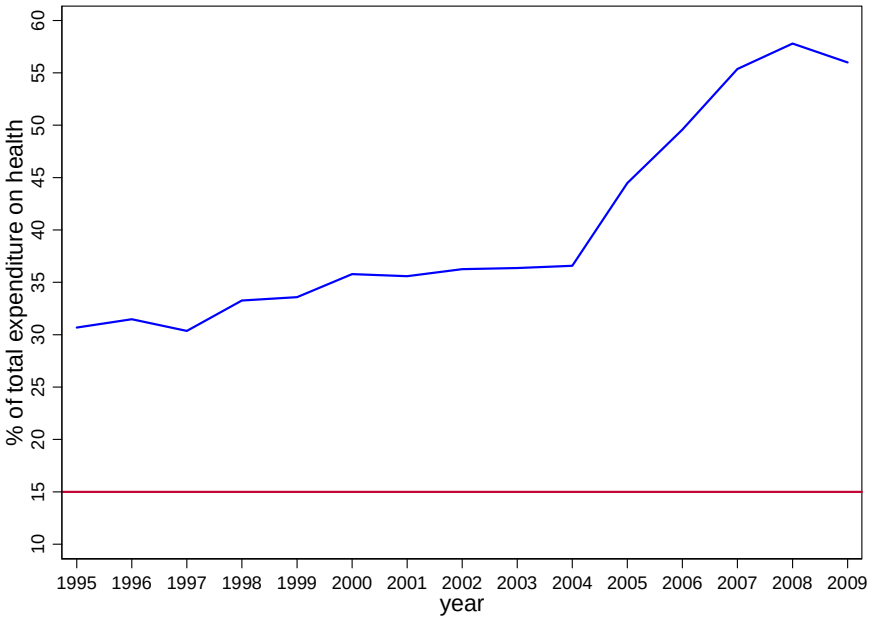


Figure 2.5.4 indicates that private expenditure on health was mainly from household OOP payments with limited private insurance expenditure.

Figure 2.5.5: Out-of-pocket payment as a percentage of total expenditure on health

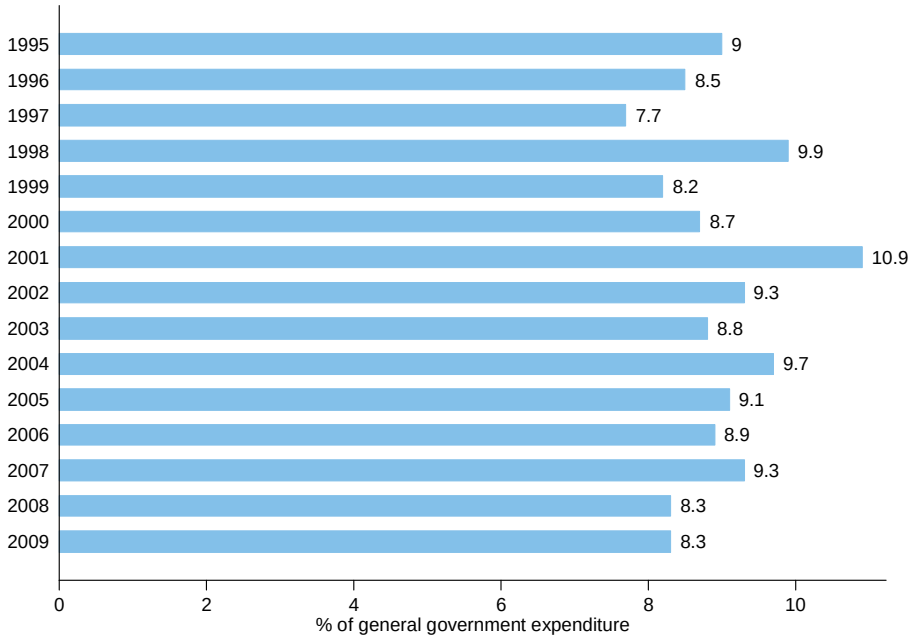


In 2009, households in Mauritius financed close to 56% of total expenditure on health through out-of-pocket spending at the point of consuming health care services. When out-of-pocket spending represents a large portion of health spending, pooling of private resources is limited. It also means that most of the time households need to produce funds at the time of seeking care, which can be a barrier to accessing care and can threaten the financial status of the household (e.g., push some into poverty).

General government expenditure on health as a proportion of general government expenditure

In 2009, government expenditure on health was 8% of general government expenditure as indicated in Figure 2.5.6. This was a decline from 9% reported in 2007. Mauritius needs to commit more resources to health to achieve the Abuja target.

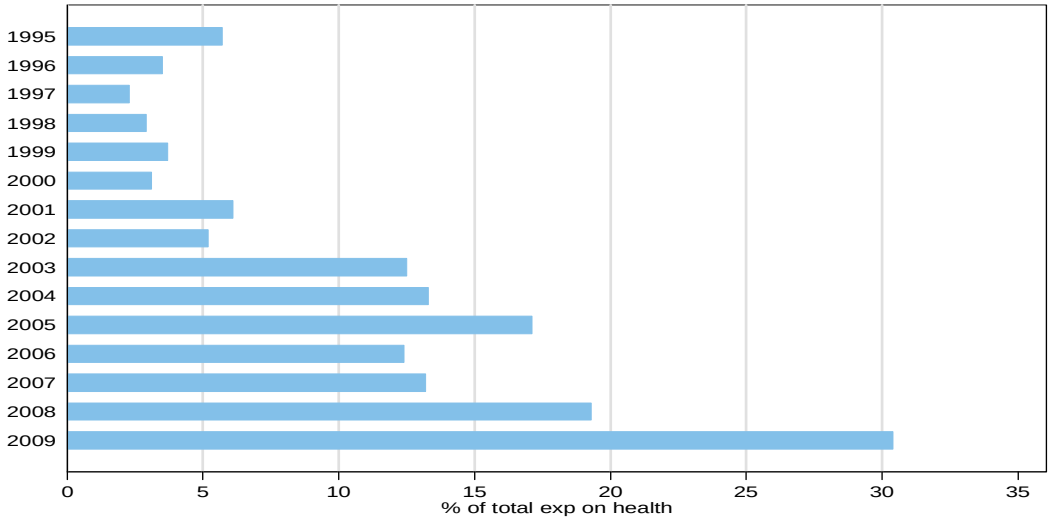
Figure 2.5.6: General government expenditure on health as a percentage of general government expenditure



External resources on health

Donor spending on health as a percentage of total expenditure on health in 2009 was 31% in Mauritius. Figure 2.5.7 presents a time series of donor spending on health as percentage of total health spending.

Figure 2.5.7: External resources on health as a percentage of total expenditure on health



Conclusion and policy implications

In 2009, private expenditure on health constituted about 63.1% of total health spending. This is a significant increase from the low levels of 43% reported in 1995. In 2009, households in Mauritius financed 56% of total expenditure on health through out-of-pocket spending. When OOP spending represents a large share of health spending, pooling of private resources is limited. The government of Mauritius should therefore consider implementing an expanded pre-payment system with the sole objective of protecting the households from catastrophic expenditures on health care.

2.6. Mozambique

Background

Mozambique is a low income country in southern Africa occupying an area of about 308,642 sq. miles with a population of 20.226 million; 48.2% male and 51.8% female (2009) and an annual population growth rate of 1.9%. About 54% of the population lives below poverty line. The GDP per capita for Mozambique was reported at US $465 in 2009. The average economic growth rate is about 4.5%.

Despite promising progress towards the achievement of the health MDG targets, outcomes are still unsatisfactory with an estimated maternal mortality ratio of 550 per 100,000 live births and a child mortality rate of 142 per 1000 live births in 2008. Malaria continues to be a major challenge. HIV prevention activities have been inadequate to curb the HIV prevalence rate. Dual infections of TB and HIV and the threat of increasing multi drug resistance complicate the national TB program's response[17].

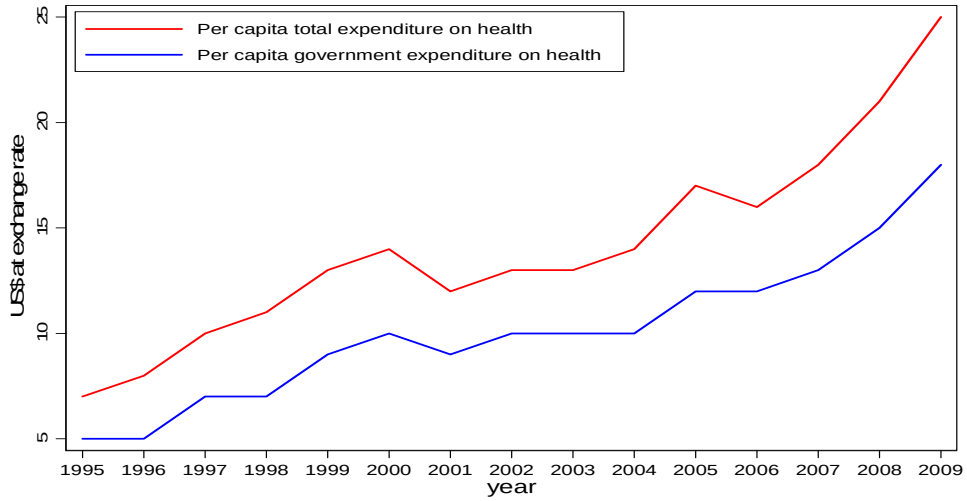
Per capita indicators of expenditure on health

The total expenditure on health per capita at an average exchange rate has increased from US $7 in 1995 to US $25 in 2009. However, this is less than per capita spending of US$ 30-40 recommend by the WHO Commission on Macroeconomics and Health.[18] Government spending on health per capita in 2009 was about US $18 at average exchange rates, implying that public funds accounted for about 73% of the total expenditure on health. The trend in per capita total expenditure on health and per capita government expenditure on health is presented in Figure 2.6.1.

[17]WHO Country Cooperation Strategy,2009.

[18]WHO Regional Office for Africa (2009).*Malawi: WHO Country Cooperation Strategy 2008-2013*. Brazzaville: WHO/AFRO.

Figure 2.6.1: Per capita total and government expenditure on health 1995-2009



The total expenditure on health had an overall trend of growth. However, during the 15 years period considered, it only increased by US$ 18, from US $7 in 1995 to US $25 in 2009. In purchasing power parity (PPP) terms the increase over the 15 years period was less than 100%.

Total expenditure on health as a percentage of Gross Domestic Products

Mozambique's total expenditure on health as a percentage of GDP varied between 4.2% and 6% during the period under review. In 2009, health expenditure as a percent of GDP stood at 5.7%, a decrease from the estimate of 6% reported in 2002.

Figure 2.6.2: Total expenditure on health as % of GDP

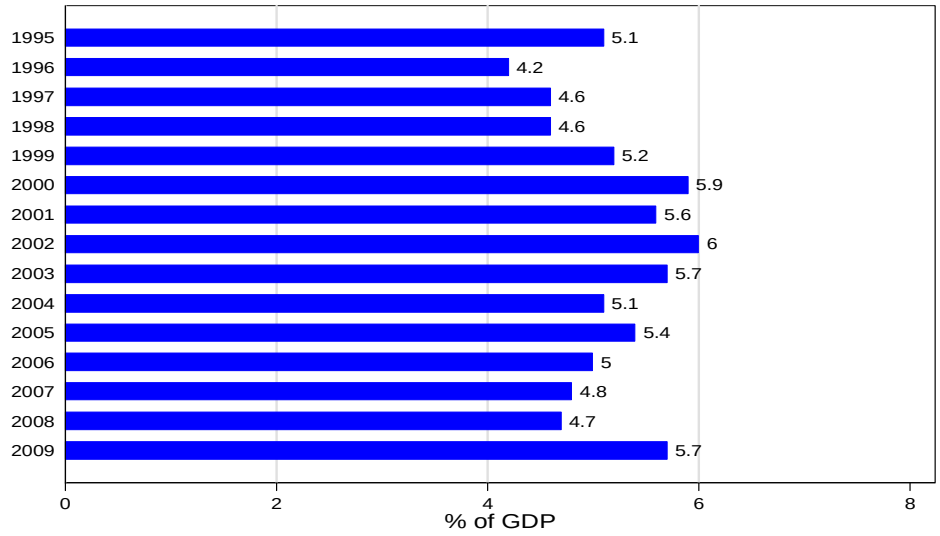
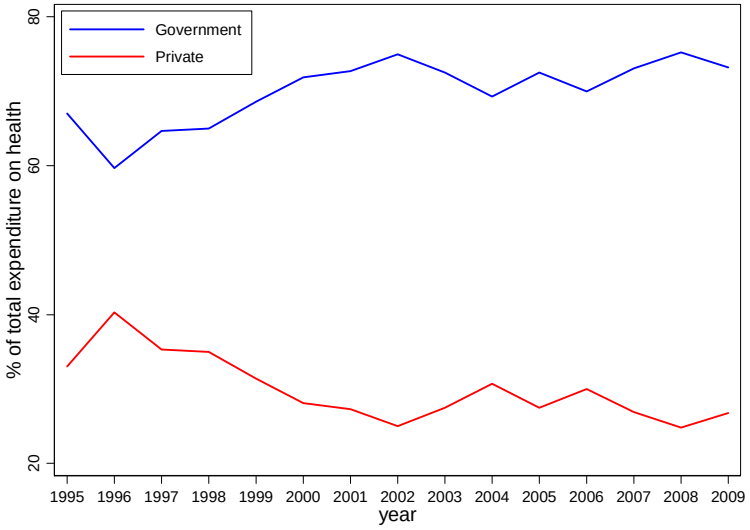


Figure 2.6.2 shows the trend in total expenditure on health as a percentage of GDP for the period between 1995 and 2009.

Private and government expenditure on health as a percentage of total expenditure on health

In 1995, private expenditure on health accounted for 40.3% of total expenditure on health. This has, however, decreased to about 26.8% in 2009. The decrease in the private component of the total health expenditure was coupled with a corresponding increase in the government component as can be seen from the figure 2.6.3 below.

Figure 2.6.3: Government and private expenditure on health as % of total expenditure on health



The decline in private expenditure on health is a desirable trend, as most of the private expenditure on health is due to out-of-pocket payments as shown by figures 2.6.4 and 2.6.5. This may potentially result in catastrophic spending and drive households further below the poverty line (impoverishing expenditure).

Fig. 2.6.4: Private insurance and out-of-pocket payment as a % of private expenditure on health

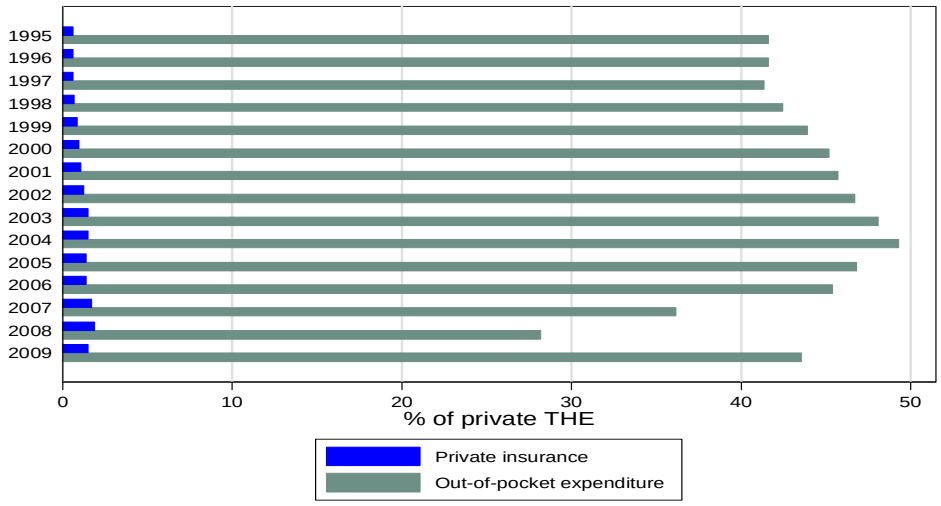
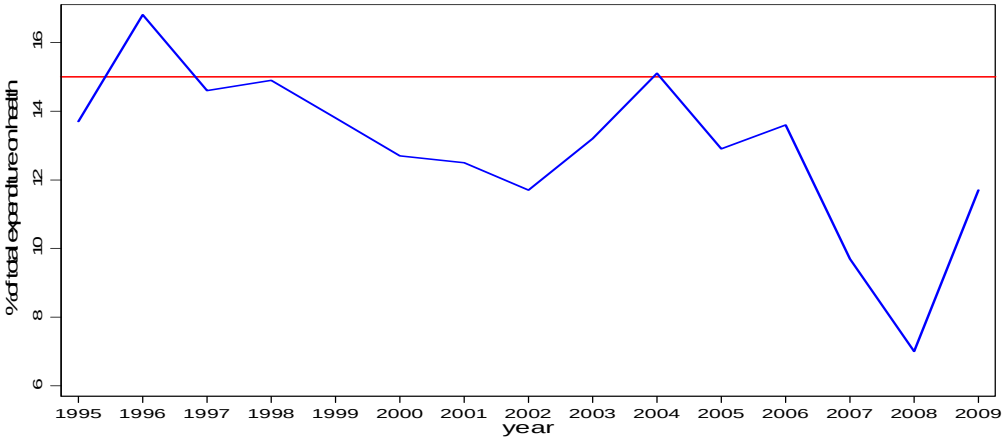


Figure 2.6.4 indicates that private expenditure on health was mainly from household out-of-pocket payments and that private health insurance accounted for less than 10% of the private expenditure on health.

Figure 2.6.5: Out-of-pocket payment as a percentage of total expenditure on health



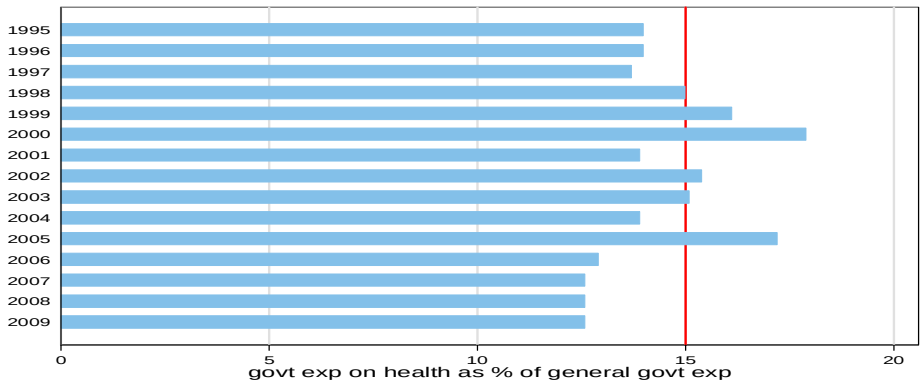
The OOP expenditure has generally remained below the 15% mark that indicates a lower probability of catastrophic expenditure. This could be as a result of increased development partner financing as well as increased government expenditure on health.

General government expenditure on health as a proportion of general government expenditure

In 2009, government expenditure on health constituted about 13% of general government expenditure (Figure 2.6.6). Though the government met the Abuja target of allocating at least

15% of the national budget to health in some years, a notable decline was observed in the years after 2005. Figure 2.6.6 below show the trend in general government expenditure on health as a percent of general government expenditure.

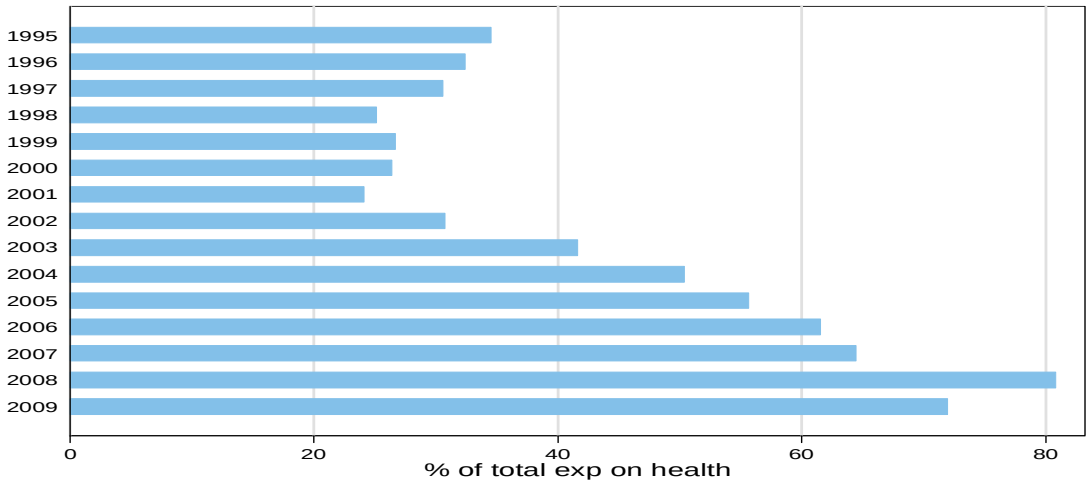
Figure 2.6.6: General government expenditure on health as a % of general government expenditure



External resources on health

External resources on health in 2009 were at about 73% of total expenditure on health. This indicates that over the years Mozambique has increasingly relied on donor funding for its health expenditure.

Figure 2.6.7: External resources on health as a percentage of total expenditure on health



Conclusion and policy implications

Even though the government of Mozambique met the Abuja target of allocating 15% of the national budget for a number of years during the period under review, the public spending on health declined in 2007, 2008 and 2009. The OOP expenditure has also remained below the 15% mark where the possibility of catastrophic expenditure would be high. This could be as a result of increased development partner financing as well as increased government expenditure

on health. External resources on health in 2009 were at about 73% of total expenditure on health. This indicates that over the years Mozambique has increasingly relied on donor funding for its health expenditure. It should be noted that donor funding is unpredictable and unreliable in the long term. It's therefore important for the country to strengthen the SWAp as a mechanism of coordinating, harmonizing and aligning the activities of the development partners.

2.7. Namibia

Background

The Republic of Namibia is situated in the southwestern part of Africa, covers approximately 824,000 square kilometers and is bordered by the Atlantic Ocean on the west. The country is considered an upper middle-income country with an estimated per capita gross income of US $8,880 (PPP).[19] Namibia has an estimated population of 2 million with half living below the poverty line of US $1.25 a day[20]. The objective of the health sector is to reduce morbidity and mortality and also contribute to the aspirations of the National Development Plan (NDP), Vision 2030 and the MDGs. However, Namibia faces an uphill task of achieving this noble objective, especially in the light of challenges posed by the burden of key diseases that include HIV/AIDS, TB and Malaria. Life expectancy has also reduced from 60 years reported in 1990 to the current 49 years mainly because of the compounded effects of the disease burden – HIV/AIDS, TB and Malaria.[21]The three diseases have contributed to the deterioration of the Namibia HDI. The Government's overall objective is to reverse these setbacks, and put the country on a more sustainable path of social and health welfare through reduction and ultimate elimination of HIV/AIDS, TB and Malaria through a well designed and executed health care strategy.

Per capita expenditure on health

The economic growth experienced by Namibia has translated to increased government expenditure which in turn has led to increased spending on health. Spending on health has increased from US $789 million reported in 1995 to US $4,746 million in 2009. The per capita expenditure on health at an average exchange rate was reported at US $258 in 2009, which is 7 times more than what the WHO Commission on Macroeconomics and Health recommended in 2001 for low income countries to spend on health so as to provide a basic package of health services (US $35-40)[22]. Of the total health expenditure per capita of US$258 reported in 2009, the government contributed US$ 172 which is approximately 66% of the total health expenditure. The trend in per capita total expenditure on health and per capita government expenditure on health is presented in Figure 2.7.1

[19]World Bank Indicators,2010.
[20] Human Development Indices, Table 3: Human and income poverty, p. 35. Retrieved on 1 June 2009.
[21]Namibia health and HIV/AIDS resource tracking study of 2007/08 & 2008/09 (NASA)
[22]WHO (2001).*Macroeconomics and health investing in health for economic development.* Geneva: World Health Organization.

Figure 2.7.1: Per capita total and government expenditure on health 1995-2009

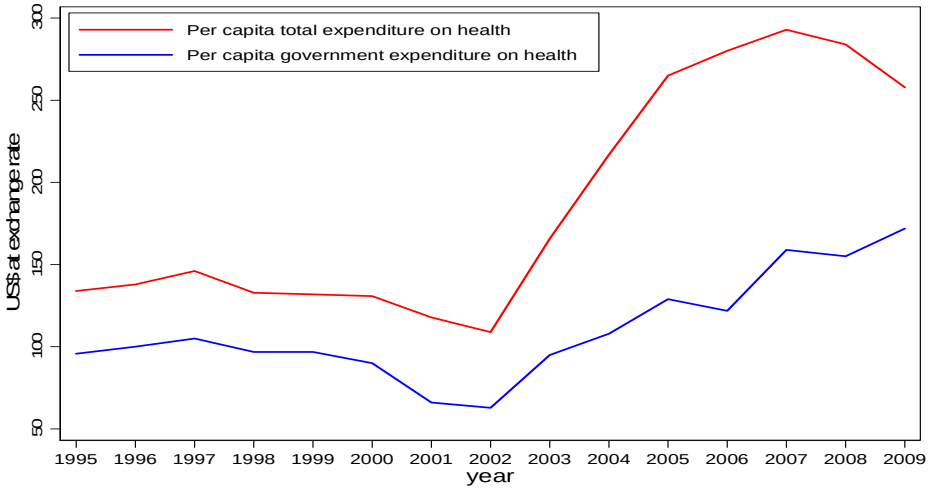


Figure 2.7.1 shows that the per capita total expenditure on health increased from US$134 in 1995 to US$ 146 in 1997 before dropping to US$ 109 in 2002. However, the trend was reversed and the per capita expenditure on health increased from US$166 in 2003 to US$258 in 2009. The per capita government expenditure trend mirrored the same growth trends reported by the total health expenditure per capita dropping from US$96 in 1995 to US$63 in 2002 but later reversing and increased from US$95 in 2003 to US$172 in 2009.

Total expenditure on health as a percentage of Gross Domestic Product

Total expenditure on health as a percentage of GDP fluctuated at between 5.9% and 7.3% during the period under review with the highest estimate of 7.3% reported in 2005 while the lowest estimate was reported at 5.9% in 2009. Figure 2.7.2 shows the trend in total expenditure on health as percentage of GDP for the period between 1995 and 2009.

Figure 2.7.2: Total expenditure on health as % of GDP

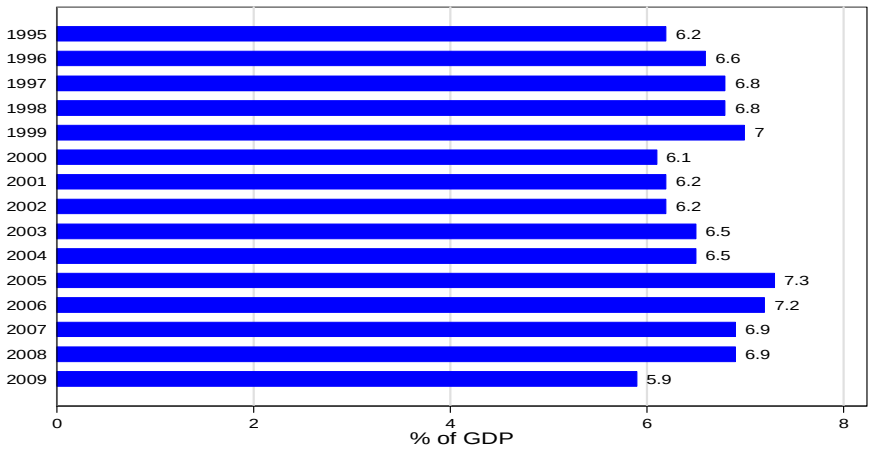
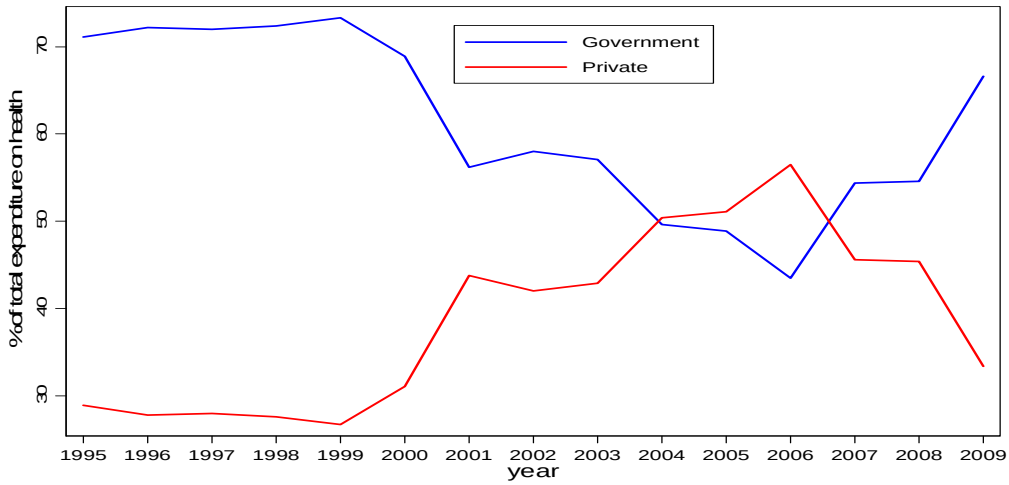


Figure 2.7.2 shows that total expenditure on health as a percent of GDP decreased from 7.3% in 2005 to 5.9% in 2009. Namibia compares less favorably with its peers, the UMI countries that reported higher spending on health as percent of GDP – Botswana (10.3%) and South Africa (8.5%). Namibia compares well with other UMI countries like Mauritius (5.7%) and Seychelles (4.0%). It is worth noting that countries with a higher GDP ideally devote a greater proportion of it to health care, which is not the case with Namibia.

Private and government expenditure on health as a % of total expenditure on health

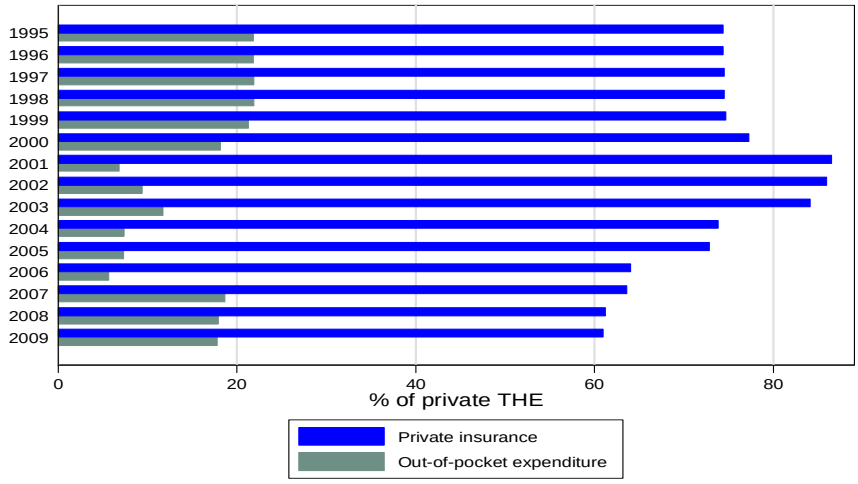
In Namibia, private expenditure on health as percentage of total health expenditure was reported at 33.4% in 2009. This is a significant decrease from 56.6% reported in 2006. However, government spending on health as a percentage of total health expenditure increased over the same period from a low of 43.5% in 2006 to a high estimate of 66.6% in 2009 as shown by figure 2.7.3

Fig 2.7.3: Government and private expenditure on health as % of total expenditure on health



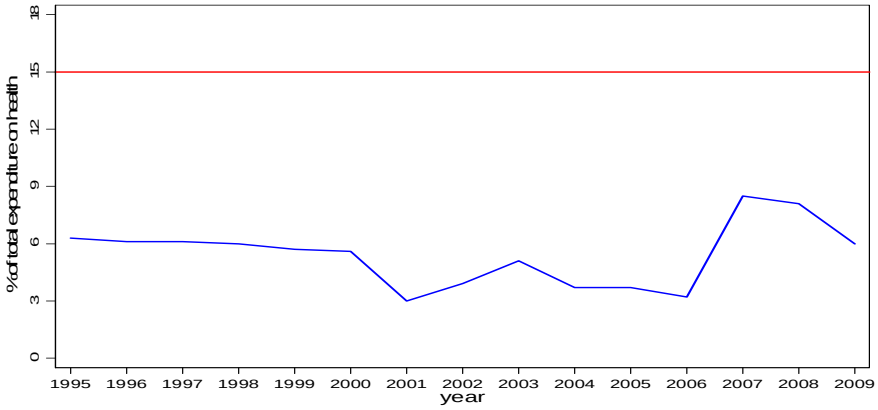
The decline in private expenditure on health is a good indicator of government commitment to reducing OOP spending, which can otherwise subject households to catastrophic spending on health care. It would especially be important considering that 50% of the population of Namibia lives below the poverty line.

Figure2.7.4: Private insurance and OOP payment as a proportion of private expenditure on health



Private expenditure on health consists of private insurance and OOP expenditure. In 2009, OOP expenditure accounted for less than 17.8% of the total private health expenditure. Government spending on health however increased during the same period probably explaining the downward trend in private expenditures on health. The Namibian Government should therefore consider expanding the social security system to cushion the poor from catastrophic expenditures as private insurance may not guarantee their protection. The social security fund has however remained low at 2.6% of general government health expenditures in 2009.

Figure 2.7.5: Out-of-pocket payment as a percentage of total expenditure on health

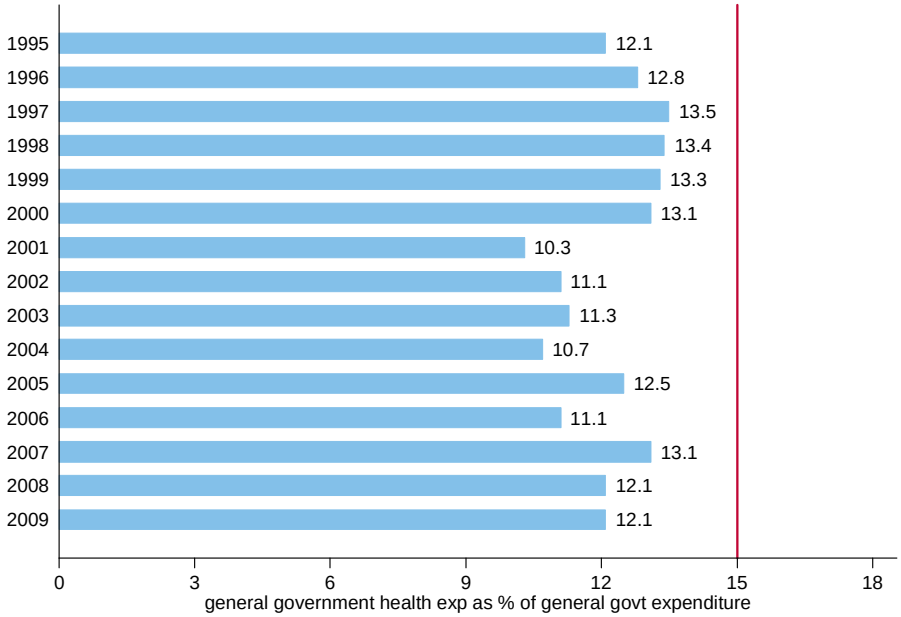


Out of pocket spending in Namibia was 6% in 2009. This indicates that the likelihood of occurrence of catastrophic expenditure is minimal in Namibia which may be attributed to the increased government spending on health.

Government expenditure on health as a proportion of general government expenditure

The percentage of the national budget allocated to health was 12% in 2009. Government expenditure on health as a percentage of total government expenditure fluctuated between 11.1% and 13.1% during the period under review with the highest occurring in 2007 and lowest in 2001. Government expenditure on health as a percentage of general government expenditure was consistently over 10%, albeit lower than the Abuja target.

Fig.2.7.6: General government expenditure on health as a % of general government expenditure.

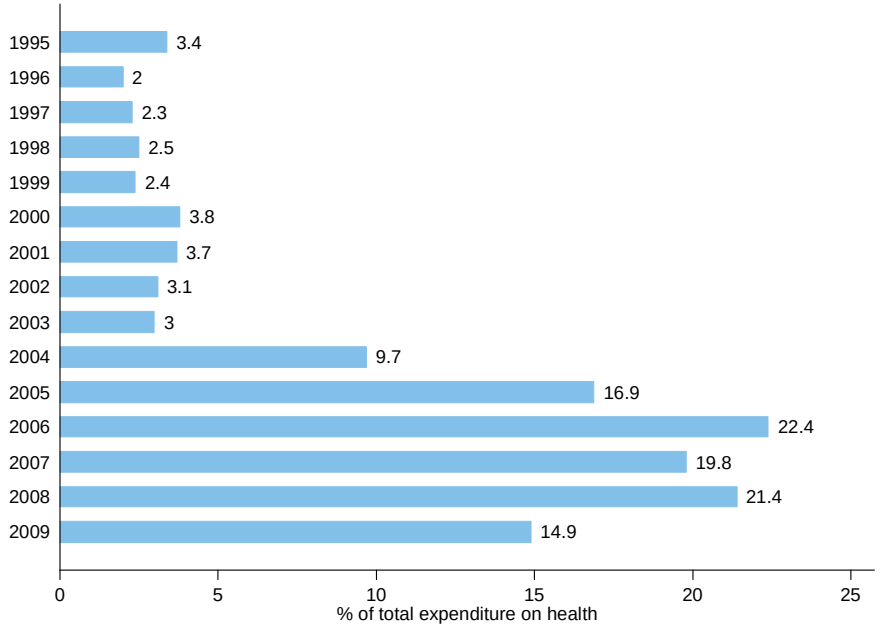


Note: the red vertical line at X=15 indicates the Abuja target of 15%

External resources on health

External resources on health in Namibia have increased from about 2.0% in 1995 to about 22.4% of total expenditure on health in 2006. The external resources increased steadily between 2004 and 2008 but declined in 2009.

Figure 2.7.7: External resources on health as a percentage of total expenditure on health



Conclusion and policy implications

The central government continues to be the major financier of health care in Namibia contributing 67% of the total health spending in 2009. Namibia, like most other countries in SSA, is a signatory to the Abuja Declaration where African governments committed to allocate 15% of their national budgets to health.

The significant role played by the private health sector in financing health may also indicate that the poor are not entirely protected from catastrophic spending for seeking medical care and government needs to promote and strengthen the social security system to protect the poor.

2.8. Seychelles

Background

Seychelles is an UMI country in SSA, with a GDP of US $764.3 million and a GDP per capita of US $8,208 in 2008. Seychelles' population is 86,956, 46% of which is rural (Seychelles National Statistics Bureau, August 2007). Fertility rate is 2.3 while Under-five mortality rate is 12/1,000 and infant mortality rate is 11/1,000 live births.[23]Average life expectancy has increased from 63 in 1960 to 73.1 in 2007, with an eight-year gap in life expectancy between males and females (National Statistics Bureau, March 2008). The burden of disease has gradually shifted to non-communicable diseases (NCDs), injuries and mental health. NCDs currently form the main

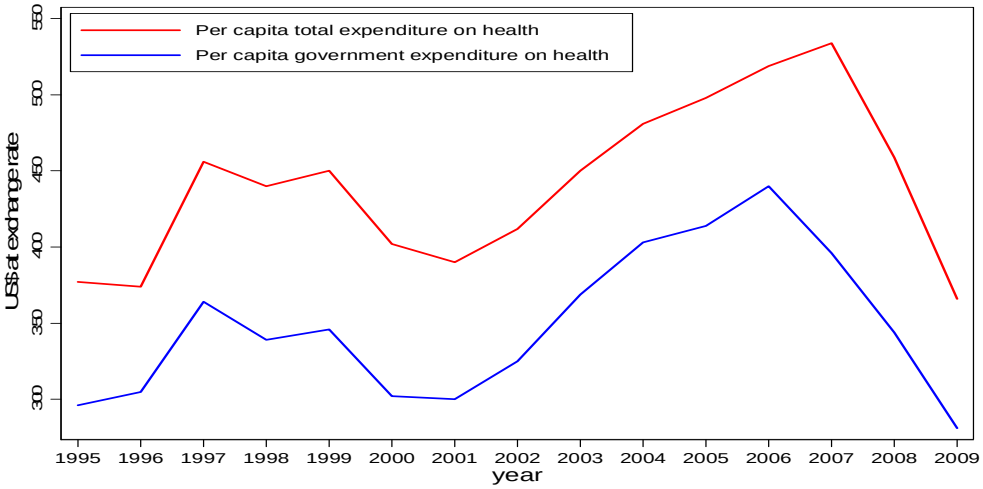
[23]World Bank Indicators.

burden of disease, with an upward trend seen over the last 10 years. The main causes of disease-related morbidity and mortality in 2007 were cardiovascular disease (30%), neoplasm (19%), respiratory system diseases (12%), infectious and parasitic diseases (8%) and external causes (7%).[24]

Per capita indicators of expenditure on health

Total expenditure on health per capita was at its highest in 2007 at US$ 534; however this was reduced to US$ 459 and US$ 366 in 2008 and 2009 respectively. Between 2001 and 2007 total per capita expenditure on health had an overall growth of about US$ 144. The per capita government expenditure on health also showed similar trend, increasing from US $296 in 1995 to US $440 in 2006. The trend, however, was reversed as a decrease from US $396 in 2007 to US $281 in 2009 was observed. In 2009 the per capita government expenditure on health (US $281) was about 77% of the total health expenditure. The trend in per capita total expenditure on health and per capita government expenditure on health is presented in Figure 2.8.1.

Figure 2.8.1: Per capita total and government expenditure on health 1995-2009



Total expenditure on health as a percentage of gross domestic products

Total expenditure on health as a percentage of GDP declined from 6.3% in 1997 to 4% in 2009. The 2009 estimate of 4% of GDP is far below the expenditure of its peers (Botswana, South Africa) in the same period. The total expenditure on health as a percentage of GDP for Botswana and South Africa was 10.3% and 8.5% respectively.

[24]Seychelles Country Cooperation Strategy 2008-2013.

Figure 2.8.2: total expenditure on health as % of GDP

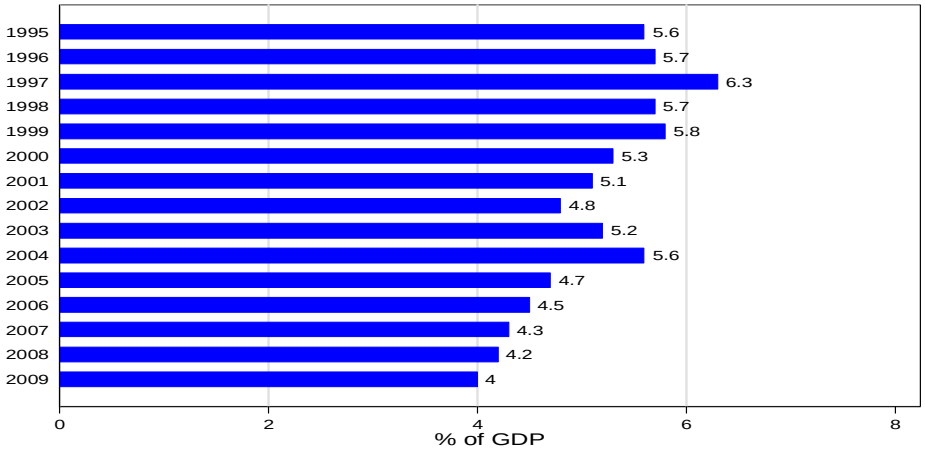


Figure 2.8.2 shows that the GDP health component has decreased from 5.6% in 2004 to 4% in 2009. This corresponds with the decline in total health per capita spending as shown in figure 2.8.1. Seychelles is however one of SSA countries with a high per capita spending on health.

Private and government expenditure on health as a % of total expenditure on health

Private expenditure on health varied between 16.2% and 25.8% between 1995 and 2009 while government spending was between 75.3% and 84.7% in the same period. Government expenditure on health decreased from 84.7% in 2006 to 76.8% in 2009. This trend is indicated in figure 2.8.3 below.

Figure 2.8.3: Government and private expenditure on health as % of total expenditure on health

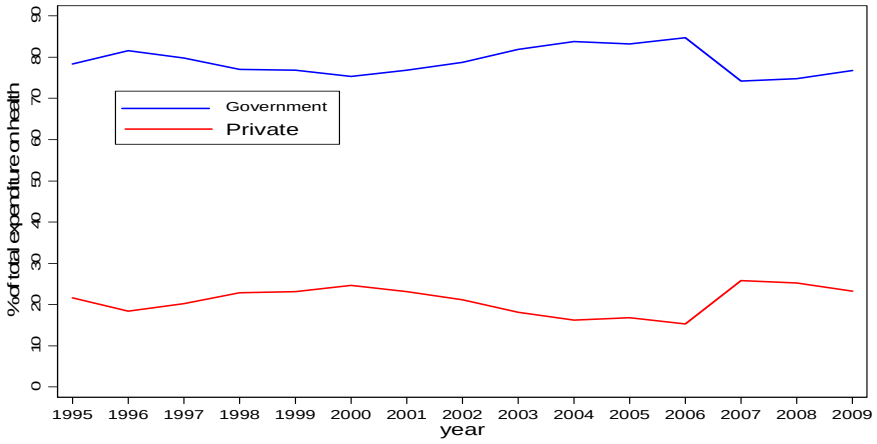


Fig.2.8 4: Private insurance and out-of-pocket payment as a % of private expenditure on health

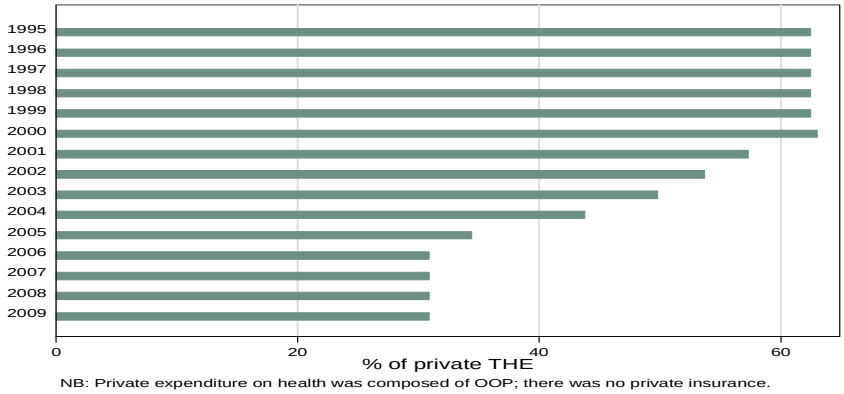
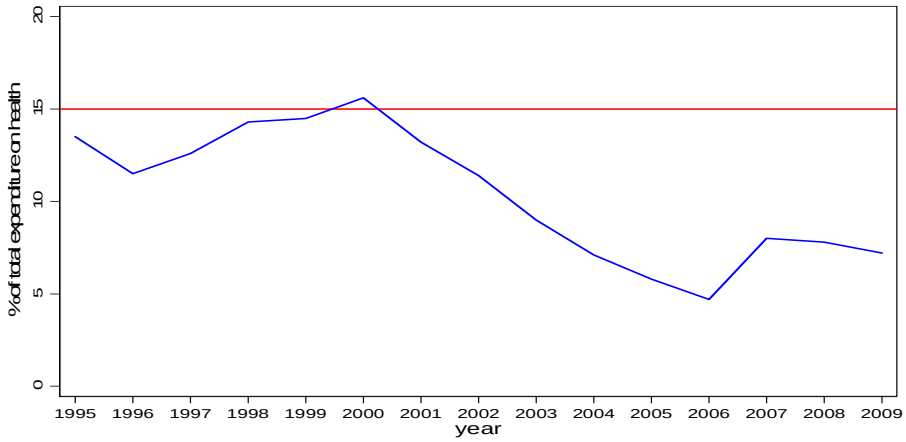


Figure 2.8.4 indicates that private expenditure on health comprised of only household out-of-pocket payments meaning that there was limited private insurance in Seychelles

Out-of-pocket payment as a percentage of total expenditure on health

OOP expenditure is any direct outlay by households, including gratuities and in-kind payments to health providers. It is a part of private health expenditure. Figure 2.8.5 shows the trend in OOP payment for health for the period under review.

Figure 2.8.5: Out-of-pocket payment as a percentage of total expenditure on health

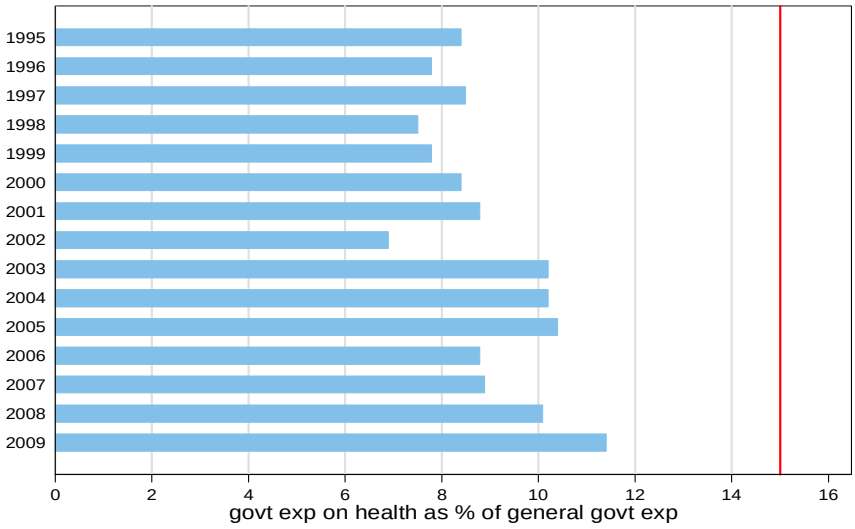


In 2000, OOP payments accounted for 16% of total expenditure on health and were higher than the 15% cut off mark, the threshold for the occurrence of catastrophic expenditure (Figure 2.8.5). After 2000, the OOP payment percentage dropped to below 15%, implying that the likelihood of catastrophic expenditure may have decreased significantly, as a result of increasing government allocation and donor funding.

General government expenditure on health as a % of general government expenditure

Public spending on health as a percent of government expenditure was estimated at 11% in 2009 (Figure 2.8.6). This was an increase from the 8.4% reported in 1995, however, it is below the Abuja target of allocating at least 15% of total government expenditure to health provision.

Figure 2.8.6: General government expenditure on health as a % of government expenditure

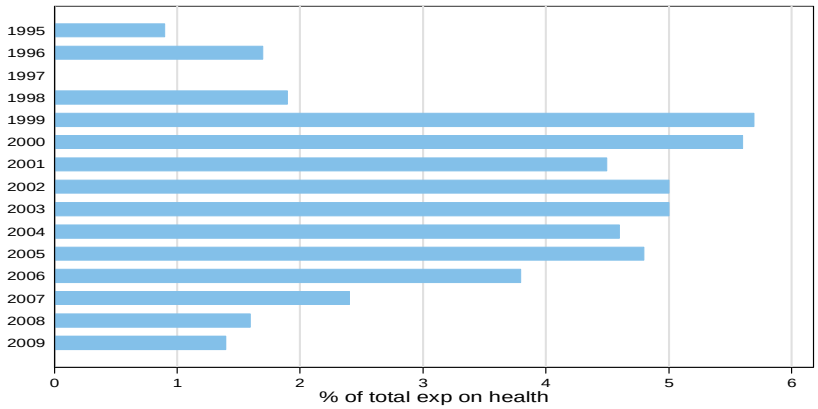


External resources on health

This constituted about 1.5% of total health expenditure in 2009; a decline from the 5.5% in 2000. There was however a sharp increase in external resources for health in 2005 as a result of donor flows associated with the Tsunami calamity that swept the Indian Ocean region in December 2004[25]. The low external resources on health reported reflect positively in terms of sustainability, as donor funding is often unreliable and unpredictable.

[25]Seychelles Country Cooperation Strategy 2008-2013.

Figure 2.8.7: External resources on health as a percentage of total expenditure on health



Conclusion and policy implications

Government expenditure on health as a percentage of general government expenditure has remained below 12% during the period under review. The government of Seychelles may consider renewing its commitment to the Abuja Declaration by increasing resources to the health sector. A financing system that increases resources to the health sector and also ensure protection of households from catastrophic expenditures due to seeking health is also desirable and should be a priority for the health sector in Seychelles.

2.9. South Africa

Background

South Africa is regarded as a MIC with a GDP of US $3,764 million and an estimated total population of 50.5million in 2011 up from the 44.8 million reported by the population census of 2001. South Africa has about 7 million people living with HIV - the highest number in the world. Three million of these are women of over 15 years of age and 280,000 are children. Maternal mortality ratio was approximately 410 per 100,000 per live births and child mortality rate of about 62 per 1000 live births in 2009. There is also a high burden of TB, cardiovascular diseases, violence and road traffic accidents.[26]. In 2009, Statistics South Africa (STATSSA) estimated the life expectancy of South Africans to be 53 years for males and 57 years for females[27].

Per capita indicators of expenditure on health

The per capita expenditure on health in South Africa was one of the highest in the region at about US$ 485 at an average exchange rate in 2009. Government spending on health per capita in 2009 was about US$ 195 at an average exchange rate, implying that public funds accounted

[26]Country cooperation strategy brief WHO 2008-2013.
[27]South Africa National Department of Health Strategic Plan 2010/11-2012/13.

for about 40% of the total expenditure on health. The trend in per capita total expenditure on health and per capita government expenditure on health is shown below in Figure 2.9.1.

Figure 2.9.1: Per capita total and government expenditure on health 1995-2009

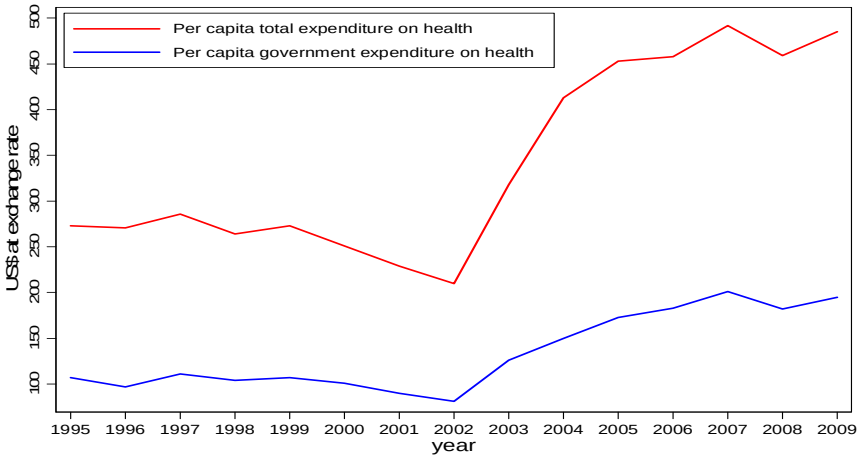
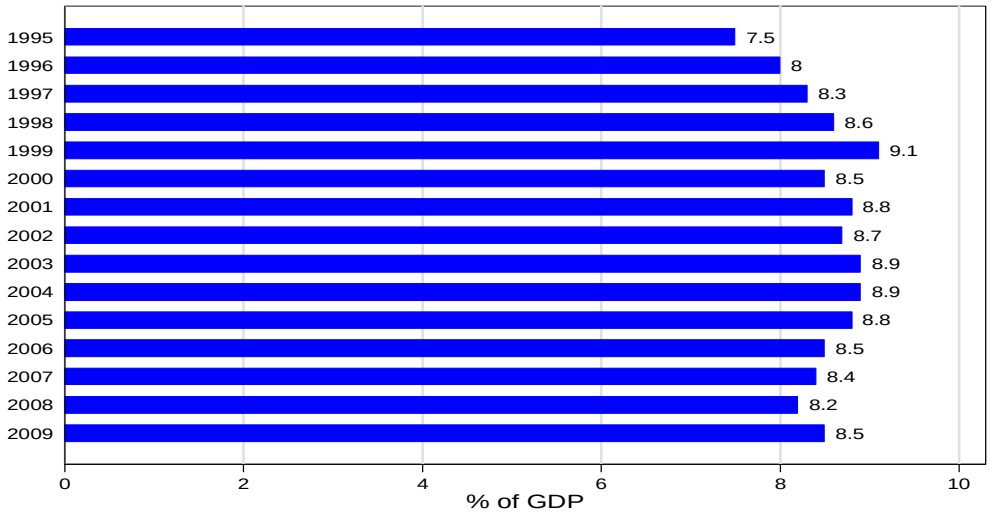


Figure 2.9.1 also indicates that total expenditure on health had an overall increasing trend of growth. Government spending per capita increased by only US$ 87 between 1995 and 2009, while the increase in total expenditure on health between the same periods was US$ 212.In purchasing power parity (PPP) terms the increase over the 15 years period was less than 100%.

Total expenditure on health as a percentage of Gross Domestic Product

In South Africa, total expenditure on health as percentage of GDP ranged between 7.5% and 9.1% for the period under review. In 2009 it was reported at 8.5%, which compares less favorably with Botswana (10.3%) but is higher than estimates reported by other UMI countries – Seychelles (4%), Mauritius (5.7%) and Namibia (5.9%). Figure 2.9.2 show the trend in total expenditure on health as percentage of GDP from 1995 to 2009.

Figure 2.9.2: Total expenditure on health as % of GDP



Private and government expenditure on health as a percentage of total expenditure on health

Private expenditure on health in South Africa has been fluctuating at between 60% and 65% of total health expenditure during the period under review (1995 to 2009) with the government expenditures as a percent of total health expenditures remaining low at an average of 39% of the total health expenditures.

Fig.2.9.3: Government and private expenditure on health as % of total expenditure on health

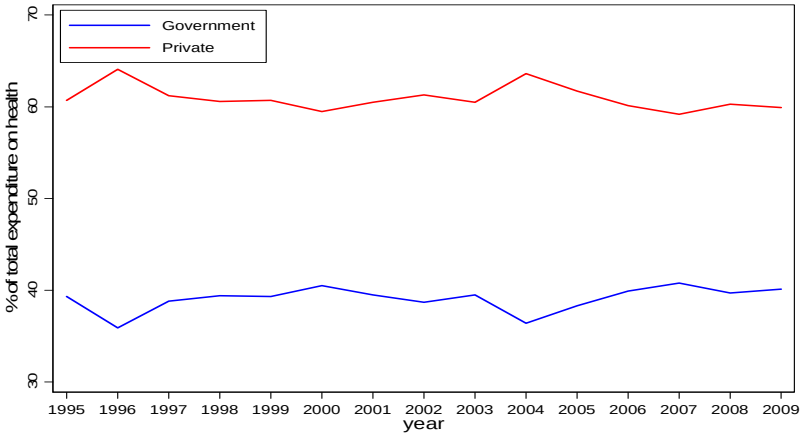


Figure2.9.4: Private insurance and OOP payment as a proportion of private expenditure on health

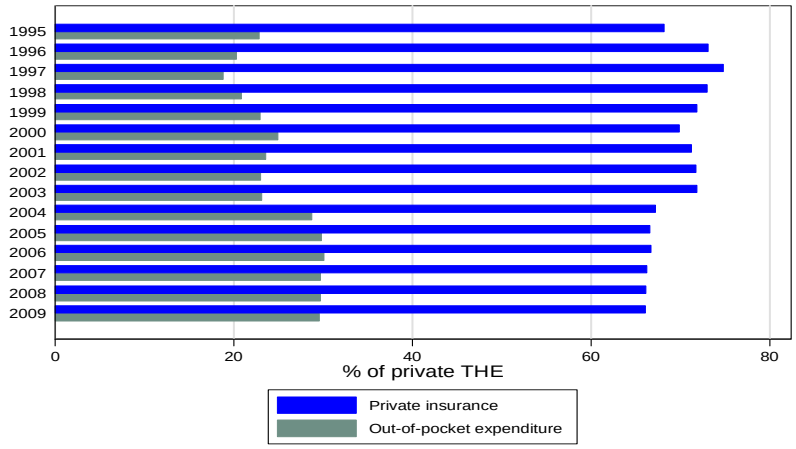
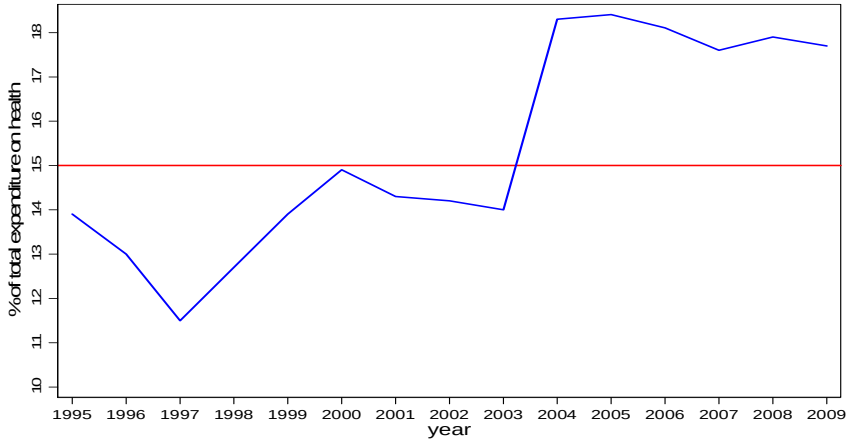


Figure 2.9.4 indicates that private insurance in South Africa played a major role in contributing towards private expenditure on health at an average of 69.7% between 1995 and 2009 while OOP spending was at an average of 30.1% of the total private health expenditure.

Empirical evidence strongly suggests that out-of-pocket spending for health services is the main cause of catastrophic health expenditures. In most low and middle-income countries of the region, OOP spending accounts for more than 50% of total health expenditure[28].

Figure 2.9.5: Out-of-pocket payment as a percentage of total expenditure on health



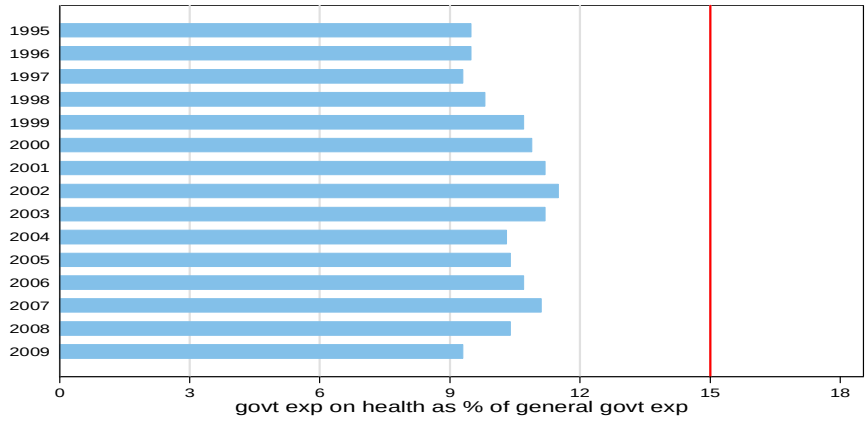
Out-of-pocket expenditure in South Africa was below the 15% cut-off between 1995 and 2003. This however increased to 18% of total health expenditure in 2009. This increase in OOP spending on health is an undesirable trend as the households may be spending a substantial amount of resources on health care, leading to catastrophic expenditure and impoverishment.

[28] www.who.int/health_financing/documents/emrc51-4-healthexpenditureimpact.pdf

General government expenditure on health as a proportion of general government expenditure

Public spending on health as a share of the total government spending has remained relatively constant at an average of 10.3% during the period under review and was therefore way below the target of the Abuja Declaration of 2001.

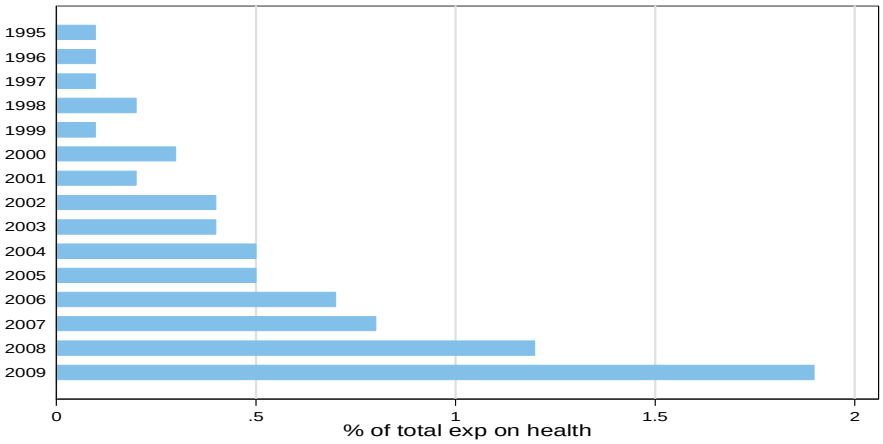
Figure 2.9.6: General government expenditure on health as a percentage of general government expenditure



External resources on health

Figure 2.9.7 indicates that external resources for health have remained relatively low but have, however, increased marginally since 1995 from 0.1% to 1.9% in 2009. This shows that South Africa does not rely on donor funding to finance health care.

Figure 2.9.7: External resources on health as a percentage of total expenditure on health



Conclusion and policy implications

Compared with low and middle-income countries, the total health spending in South Africa is relatively high. However, there may be problems relating to inefficient allocation and utilization of the resources as well as inequity in the financing and access to healthcare. As such, the high level of spending on health may not have translated into better access to healthcare and better health outcomes.

The private health insurance accounts for about 69.7% of total private health expenditures. Total OOP spending on health accounted for 30.1% of the total private health spending. Of much concern is the fact that OOP expenditure in South Africa is reported to have increased to more than 15% of total health expenditure. This implies that households are spending a substantial amount of income on health care, with possible impoverishing consequences.

Public sector spending on health has remained relatively constant at 10% of total government spending. Given the high HIV prevalence rate, high maternal and child mortality rates, the demand for healthcare services provided by the public sector has most likely increased over the years. The country therefore ought to increase public spending on health towards meeting the Abuja target.

The country should also hasten the introduction of the proposed National Health Insurance system – a method for prepayment of financial contributions for health care, with a view to pooling risk in the population and minimizing the incidence of catastrophic healthcare expenditure.

2.10. Swaziland

Background

Swaziland is a LMI country in SSA with a per capita income of about US $2,461 (Central Statistics Office, 2007) and a population of about 1.018 million (2007 Census). Despite a relatively high level of income, 48% of the population lives below the poverty line. Under-five mortality rate is at 83 per 1,000 which is lower than the average for SSA (120 per 1,000) and higher than the average for LMI countries (44 per 1,000). The latest DHS (2006) for Swaziland showed the total fertility rate was 3.9 and the under-five mortality rate was 119.9 per 1000.[29]

HIV/AIDS epidemic continues to pose a major threat to the country and its impact is already being felt in all sectors. It is estimated that about 210,000 to 230,000 (about a quarter of the population of 1.018 million) people are living with HIV/AIDS. The prevalence rate among pregnant women has escalated from 3.9% in 1993 to 39.2% in 2006, having reached a peak of 42.6% in 2004. Tuberculosis is the leading cause of morbidity and mortality among adults in Swaziland. It is estimated that TB kills 50% of HIV infected patients and accounts for more than 25% of all hospital admissions.[30]

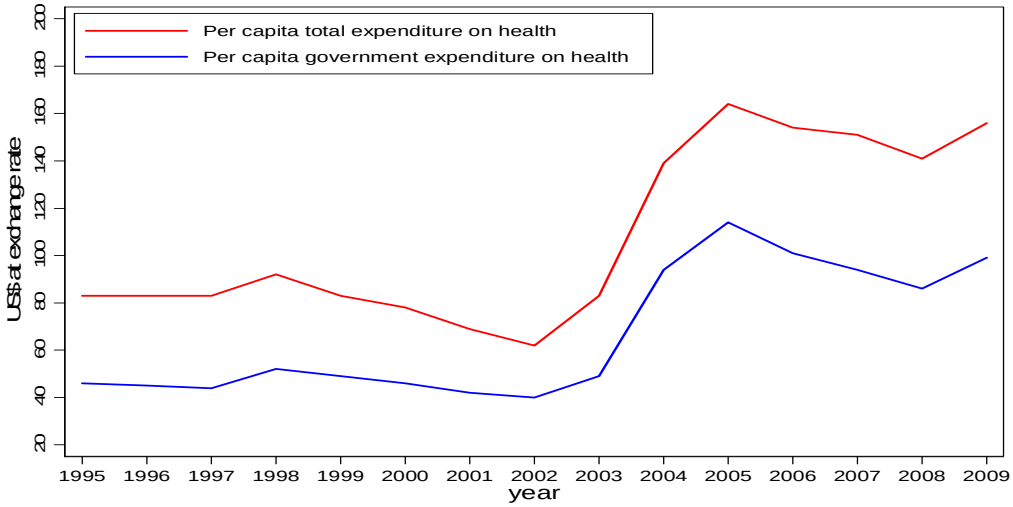
[29] Healthsystems2020.healthsystemsdatabase.org/reports/Reports.aspx

[30] Country Cooperation Strategy (WHO).*www.afro.who.int/index.php?option=com*

Per capita indicators of expenditure on health

Per capita expenditure on health in Swaziland was reported at US$ 156 at an average exchange rate with the government contributing US $99 in 2009. Both total expenditure on health and per capita government expenditure had an overall trend of growth**.** This trend in per capital total expenditure on health and per capita government expenditure on health is presented in figure 2.10.1 below.

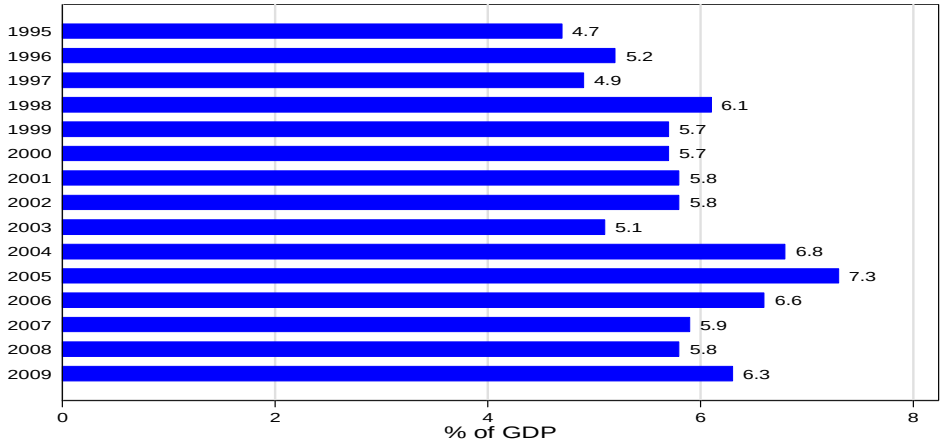
Figure 2.10.1: Per capita total and government expenditure on health 1995-2009



Total expenditure on health as a percentage of gross domestic products (GDP)

Total expenditure on health as a percentage of GDP for Swaziland was 6.3% in 2009. This was an increase from 5.1% reported in 2008. This is comparable with the averages of countries in SSA (5.8%) and the Lower Middle Income group (6.1%) as shown in Figure 2.10.2 below.

Figure 2.10.2: Total expenditure on health as % of GDP

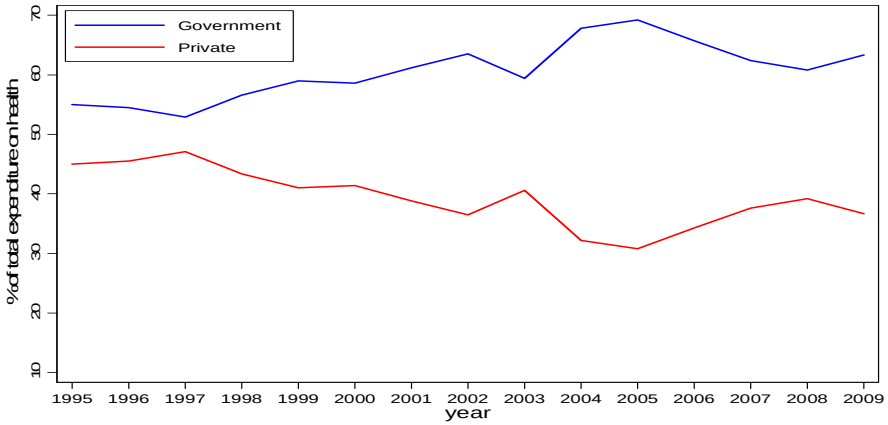


The low percentage of GDP spent on health indicates that fewer resources are mobilized for health from the different sources and therefore compromising access to health care.

Private and government expenditure on health as a percentage of total expenditure

Private expenditure on health has decreased from 45% in 1995 to 36.7% in 2009. The decrease corresponds with an increase in government expenditure on health from 55% in 1995 to 63.3% in 2009. Figure 2.10.3 shows the trend in private and government expenditure on health as percentage of total health expenditure

Figure 2.10.3: Govt. and private expenditure on health as % of total expenditure on health



The decline in private expenditure on health is a desirable trend, as most of the private expenditure on health is attributed to OOP payments (Figures 2.10.4 and 2.10.5), which may potentially result in catastrophic spending.

Figure 2.10.4: Private insurance and out-of-pocket payment as a % of private expenditure on health

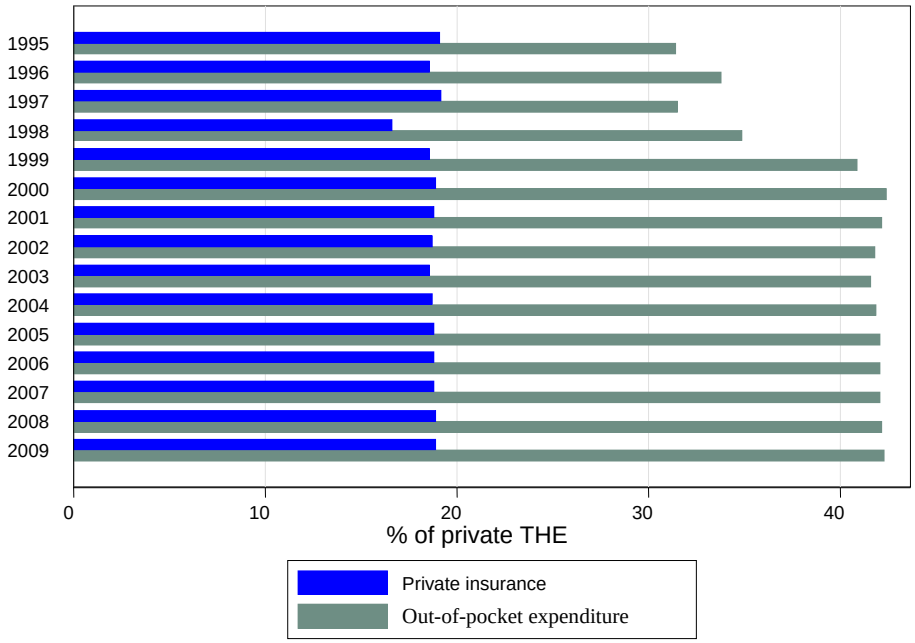
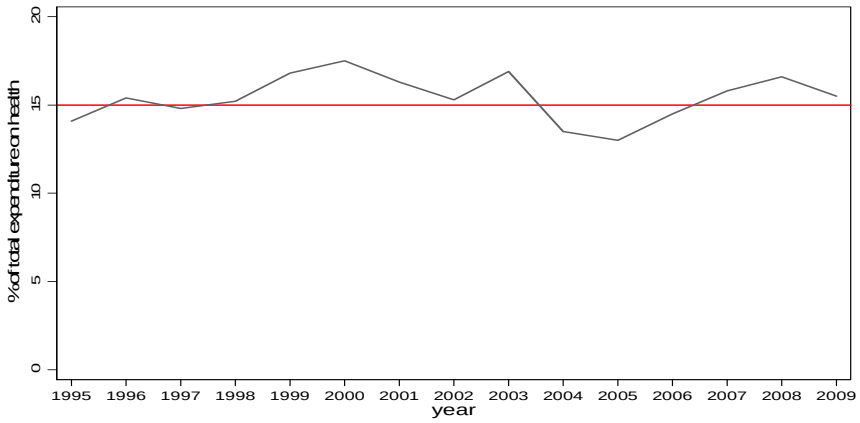


Figure 2.10.4 indicates that private expenditure on health was mainly from household OOP payments. On average, private insurance accounted for about 18.9% of private expenditure while OOP was close to 42.3% in 2009. The social security fund is not fully developed.

Out-of-pocket payment as a percentage of total expenditure on health

OOP spending on health as a percentage of total health expenditure fluctuated between 12%-17% during the period under review. Reliance on private expenditures and other OOP payments leads to health care being provided on an ability-to-pay basis, which disadvantages lower-income households. Swaziland should consider exploring the feasibility of universal coverage through implementation of pre-payment and risk pooling systems in line with the 2005 World Health Assembly resolution.

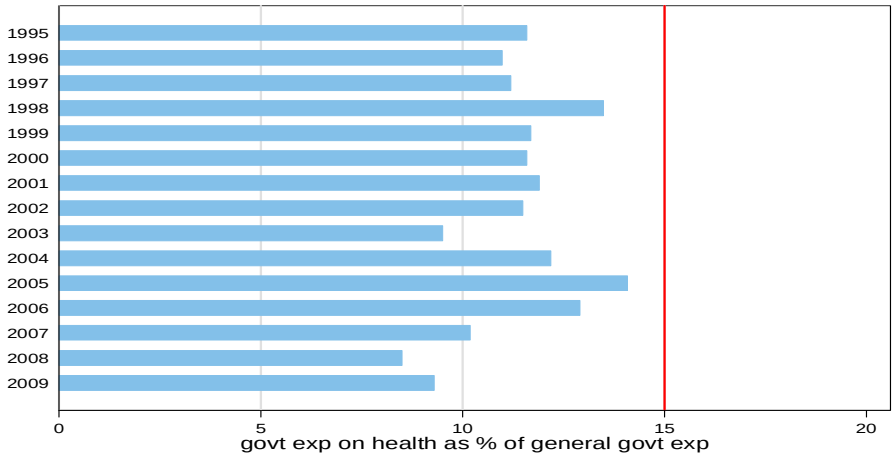
Figure 2.10.5: Out-of-pocket payment as a percentage of total expenditure on health



General government expenditure on health as a proportion of general government expenditure

In 2009, government expenditure on health accounted for 9.3% of general government expenditure (Figure 2.10.6), a significant drop from the estimate of 14.1% reported in 2005.

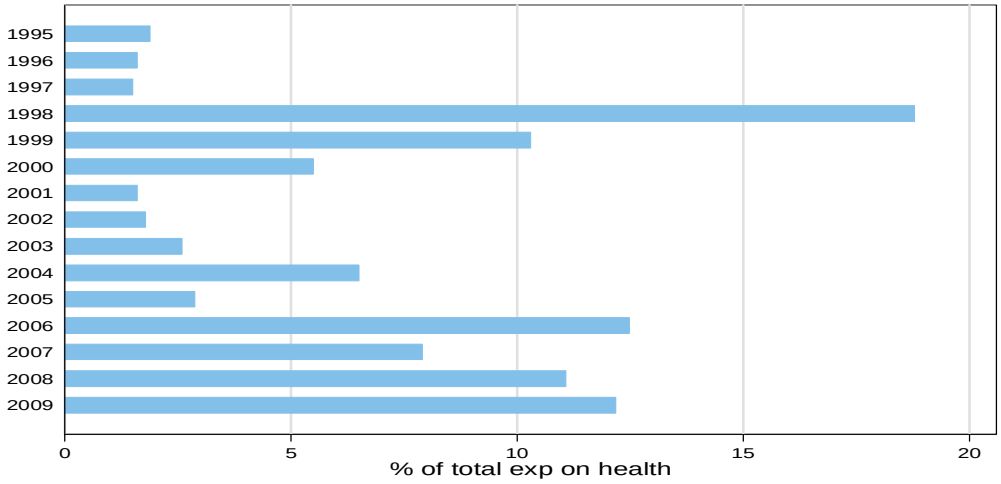
Figure 2.10.6: General government expenditure on health as a % of total spending by the government



External resources on health

Swaziland does not heavily depend on donor support to finance health care. Donor spending on health as a percentage of total expenditure on health in 2009 was 12%, compared with the SSA average of 21%, and the LMI countries average of 8.74%.

Figure 2.10.7: External resources on health as a percentage of total expenditure on health



Conclusion and policy implications

The Swaziland Government's proposal to introduce social health insurance (SHI) towards the achievement of universal access to health services should be applauded as this will reduce the OOP spending on health and therefore provide the much needed protection from catastrophic expenditures due to seeking health care. However, the efforts of developing social health insurance ought to be sustained. The Government of Swaziland may also consider increasing the share of resources allocated to the health sector to at least meet the Abuja target of 15%.

2.11. Tanzania

Background

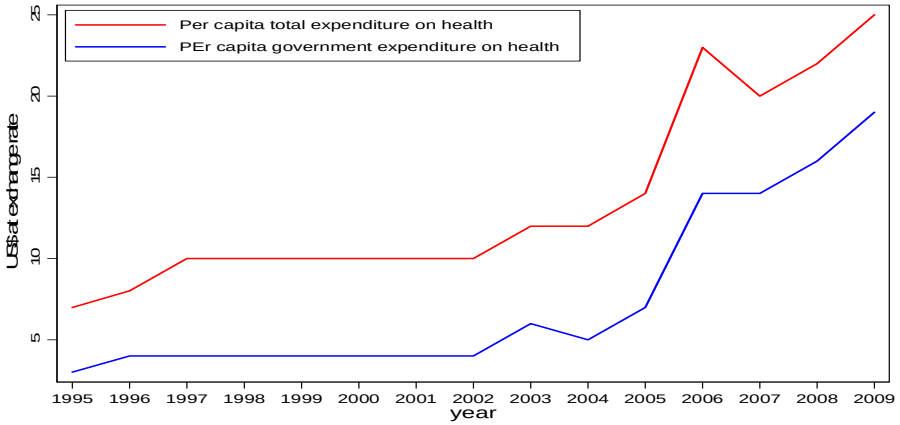
Tanzania is the largest East Africa country with a geographical coverage of 945,087 sq km and a population of 45 million (UN, 2010). Tanzania has made impressive development gains in the past decade with GDP growth rate averaging 7% for the period 2001 to 2009[31]. Tanzania continues to make steady progress towards reducing infant and child mortality. Under-five mortality rate dropped from 147 deaths per 1,000 live births in 1999 to 81 in 2010. Infant mortality rate also dropped from 99 to 51 deaths per 1,000 live births for the same period. Despite progress in reducing child mortality, the country is still facing challenges with regard to maternal health. The maternal mortality ratio in 2010 was estimated at 454 deaths per 100,000 live births. This is a reduction from the ratio of 578 per 100,000 reported in 2004. The rate of reduction may need to be accelerated if the country is to achieve the Health Sector Strategic Plan III target for maternal mortality of 265 per 100,000 by 2015[32].

[31]Country Cooperation Strategy, Tanzania, WHO.2008-2013
[32] Tanzania Health Sector Strategic Plan III

Per capita indicators of expenditure on health

The per capita total expenditure on health at average exchange rates was US$ 25 in 2009. This has been growing over time from US $7 in 1995. Per capita government expenditure on health also exhibits a growth trend from US $3 in 1995 to US $14 in 2009. The trend in per capital total expenditure on health and per capita government expenditure on health is presented in Figure 2.11.1 below.

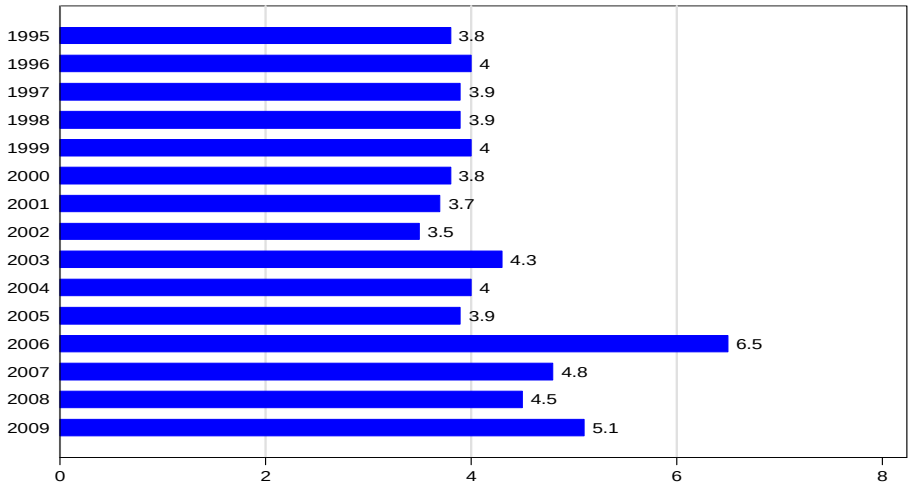
Figure 2.11.1: Per capita total and government expenditure on health 1995-2009



Total expenditure on health as a percentage of Gross Domestic Product

Globally in 2006, expenditure on health was about 8.7% of GDP. In Tanzania, total health expenditure was at 5.1% of GDP in 2009.

Figure 2.11.2: total expenditure on health as % of GDP



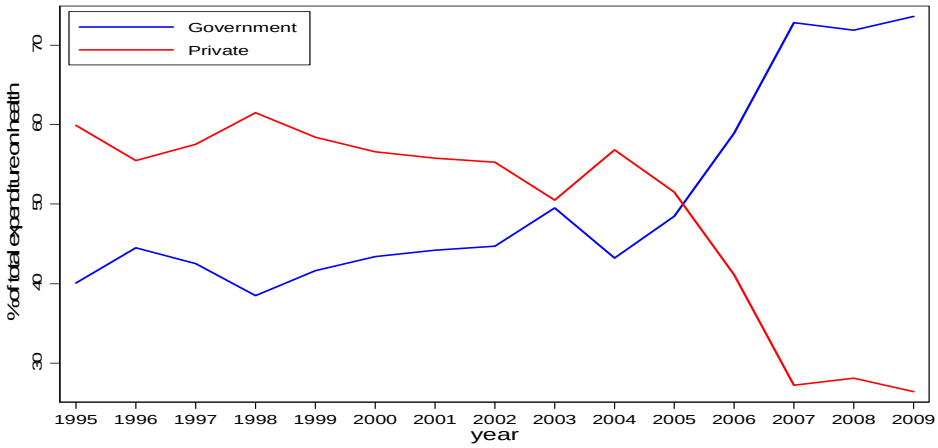
The total expenditure on health as a percentage of GDP shows an upward trend. However, the health component of the GDP in Tanzania decreased from 6.5% in 2006 to 5.1% in 2009. It is

observed that countries with low GDP tend to devote a smaller share of the GDP for health care. For example low income countries Mozambique and Zambia allocated 5.7% and 4.8% of GDP to health respectively while the United States of America, which is a high income country, allocated as much as 16.2% of GDP to health in 2009. Middle income countries Botswana and South Africa devoted 10.3% and 8.5% of GDP to health respectively.

Private and government expenditure on health as a percentage of total expenditure on health

In 2009, government expenditure on health constituted about 73.6% of total spending on health. This is a significant increase from the 40% reported in 1995. However private expenditure on health has decreased over the years from a high of 60% in 1995 to a low of 10% in 2009. The decrease in private total health expenditure was accompanied by a corresponding increase in the government component as can be seen from Figure 2.11.3 below.

Figure 2.11.3: Government and private expenditure on health as % of total expenditure on health



This decline in private expenditure on health is desirable as most of private expenditure on health is funded by household OOP spending (Figure 2.11.4). This trend reduces the possibility of catastrophic spending by householdsand consequent impoverishment. Catastrophic expenditure is an indicator of financial risk protection.

Figure 2.11.4: Private insurance and OOP as a proportion of private expenditure on health

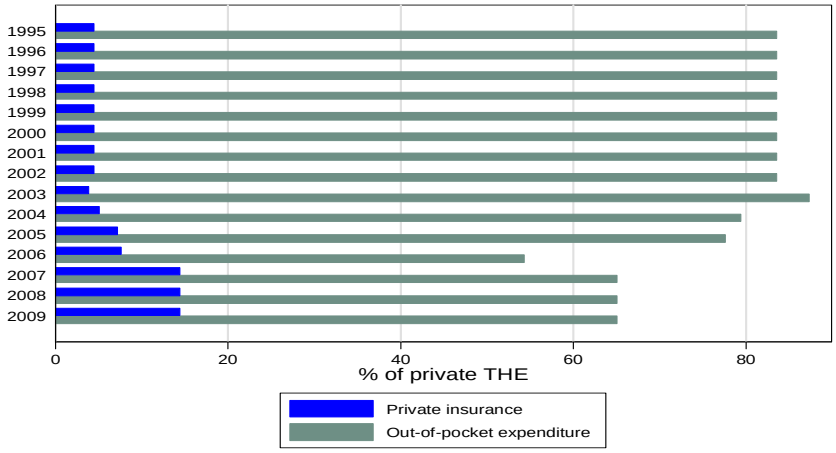
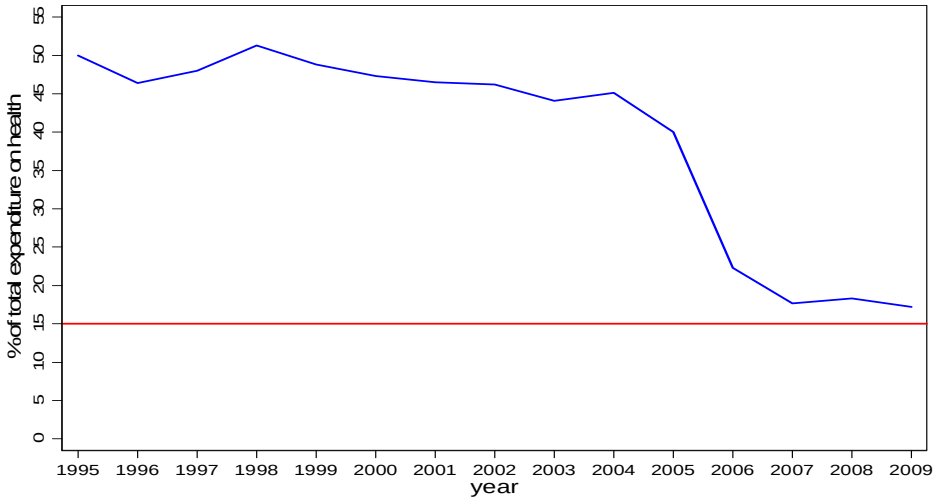


Figure 2.11.4 shows that private expenditure on health was mainly from household OOP payments, meaning that payment is made at the point of accessing health services, which does not allow for pooling of risks. Private health insurance has more than doubled since 1995, increasing in 2007, 2008 and 2009. This is in line with Tanzania Health Strategic Plan II where the MoH introduced complimentary financing options of the National Health Insurance Fund (NHIF) and Community Health Fund (CHF). Availability of insurance cover reduces the likelihood of high OOP expenditures.

Out-of-pocket payment as a percentage of total expenditure on health

OOP expenditures include deductibles, co-insurance or co-payments, and payments for services not covered by insurance. In Tanzania, the proportion of OOP payments on health has taken a downward trend over time to slightly above 15%, implying that the likelihood of catastrophic expenditure has been on the decrease. This could be the result of increased government expenditure on health as demonstrated in Figure 2.11.3. The Figure 2.11.5 below shows the trends in OOP expenditure on health between 1995 and 2009.

Figure 2.11.5: Out-of-pocket payment as a percentage of total expenditure on health

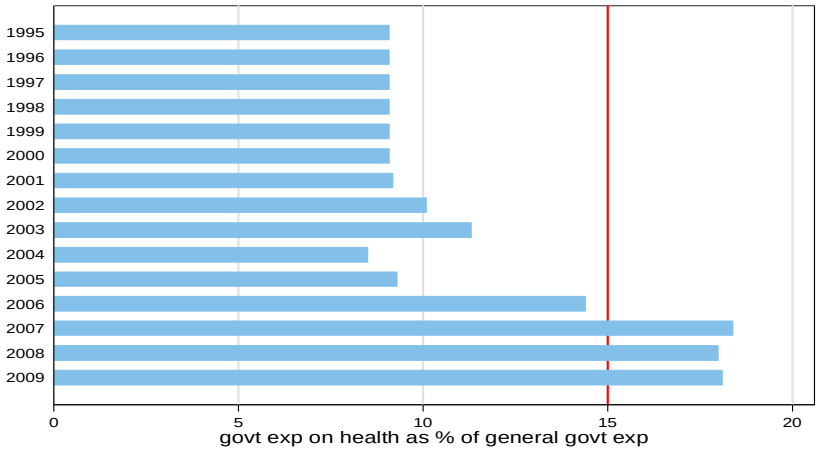


This decreasing trend of OOP expenditures is in the right direction. The Government of Tanzania ought to continue on this path by implementing the health financing strategies that aim at cushioning citizens from the burden of financing health care and making the health services affordable and accessible to all.

General government expenditure on health as a proportion of general government expenditure

In the years 2007, 2008 and 2009, government expenditure on health as a proportion of government total expenditures was 18.4%, 18% and 18.1% respectively. This shows that the share of Government expenditure on health increased two-fold during the period 1995 to 2009. Tanzania is one of the countries in the ECSA region, which has achieved the Abuja Declaration target of spending at least 15% of general government health expenditure on health. Figure 2.11.6 below shows trend in government expenditure on health.

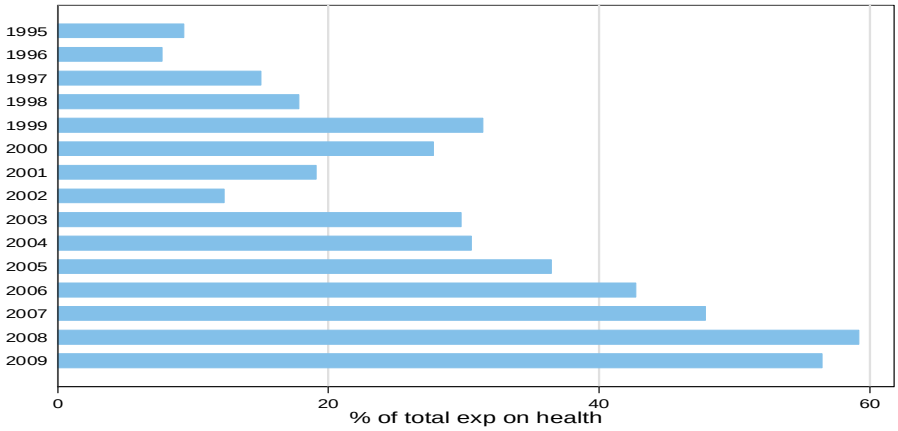
Figure 2.11.6: General government expenditure on health as a percentage of general government expenditure



External resources on health

The share of external resources on health has increased over the years, indicating that Tanzania is increasingly becoming donor dependent. In 1995, external resources constituted approximately 10% of total health expenditure, while in 2009 external resources as a percentage of total health expenditures were 56%, as shown in figure 2.11.7.

Figure 2.11.7: External resources on health as a percentage of total expenditure on health



Conclusion and policy implications

Tanzania has made great strides in reducing child mortality. More needs to be done in the area of maternal health, to reduce the maternal mortality ratio further from the current 454 deaths per 100,000 births. This calls for mobilization of additional resources and allocation to priority programs and interventions. Total health expenditure stood at 5.1% of GDP and compares less favourably with the global figure of 8.7%.

The per capita total expenditure on health in Tanzania at average exchange rates was US $25. This is lower than the US $30-40 per capita the recommended by the WHO Commission on Macroeconomics and Health for basic health services in low-income countries. More investments in the health sector are therefore necessary.

There is a decreasing trend in terms of the share of OOP expenditure for health, which may be attributed to increased donor funding to the sector. While this is good for a developing country in the short to the medium term, the Government of Tanzania should begin to consider more sustainable health financing options for the country for the longer term. In the short term, there is need for strategic partnership with donors in the context of the SWAp, for the predictability of funds, to ensure sustainability of funding.

2.12. Uganda

Background

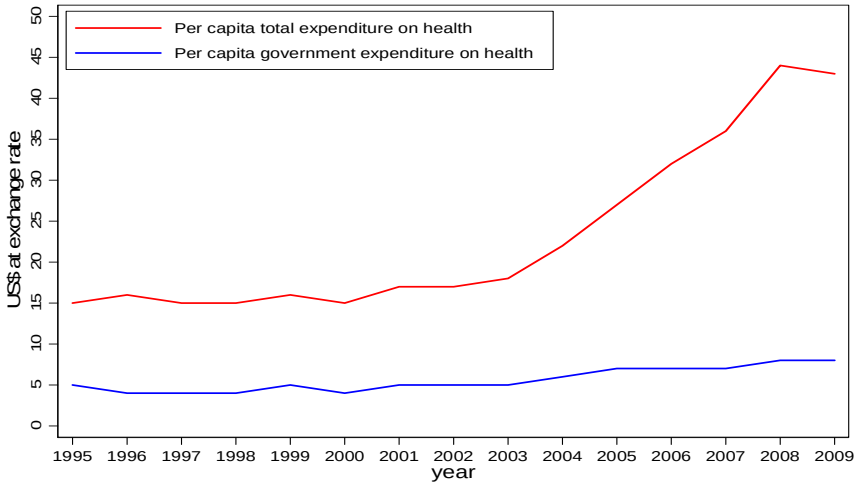
Uganda has a total population of 32.7 million and a GNI per capita of US$1,140. Uganda is one of the developing countries to have successfully reduced HIV prevalence from 30% in the 1980s to about 6.4% by the end of 2008. However Infant mortality rate remained relatively high at 79 per 1,000 in 2005. Life expectancy was at 50.2 for females and 49.1 for males in 2005[33]. In 2001, Uganda abolished user fees at public health facilities, resulting in an 80% increase in hospital visits. More than half of this increased utilization was from the poorest 20% of the population[34]. The user fee removal policy is considered as a key enabling factor towards the achievement of health MDGs and a demonstration of the role of equity in access to health care towards the achievement of better health outcomes, including the MDGs.

Per capita indicators of expenditure on health

The per capita total expenditure on health has been increasing from US$ 15 in 1995 to US $44 in 2009. However, Government spending on health per capita over this time stagnated around US $5. This trend is presented in Figure 2.12.1.

[33]Uganda health financial review,2010.
[34] Country briefing: Uganda – health, 2010.

Figure 2.12.1: Per capita total and government expenditure on health 1995-2009

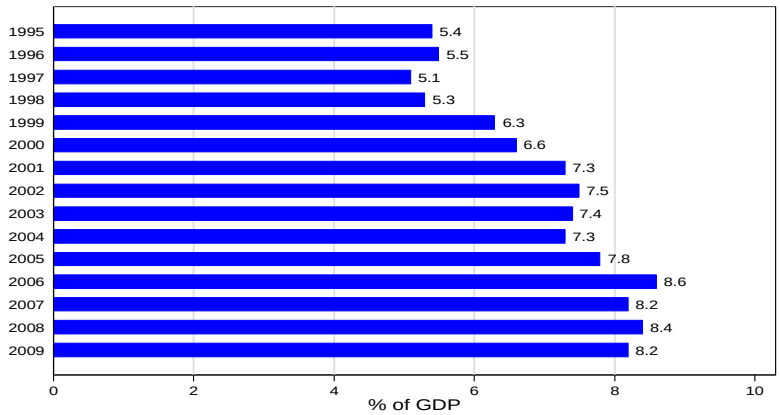


The total expenditure on health had an overall trend of growth. During the 15 years period considered, it increased from US$ 15 in 1995 to US$ 44 in 2008. In PPP terms, the increase over the 15 years period was more than 100%.

Total expenditure on health as a percentage of Gross Domestic Product

Figure 2.12.2 shows that total health expenditure as a percentage of GDP has been increasing over the period 1995 to 2009. In 2009, this was estimated at 8% of GDP. This compares favourably with neighbouring countries, Tanzania and Kenya, whose health expenditure was 5.1% and 4.3% of GDP. The upper middle-income countries, Botswana and South Africa, spent 10.3% and 8.5% of their GDPs respectively on health.

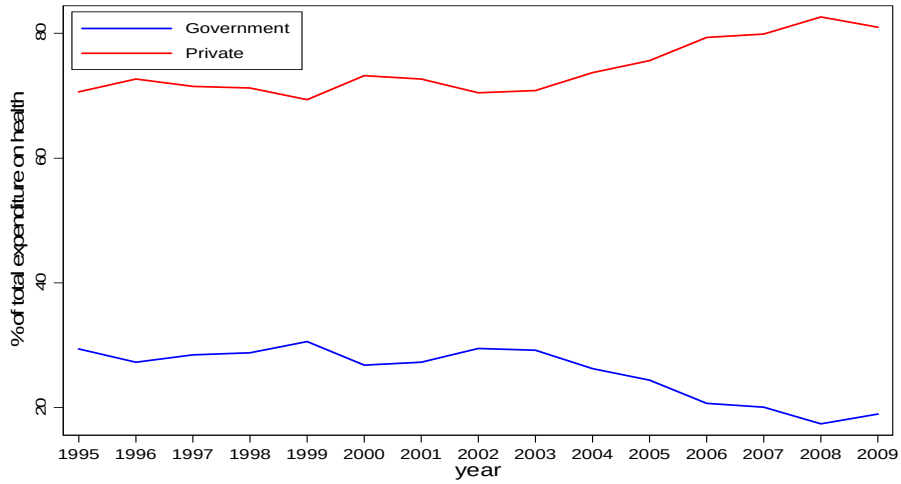
Figure 2.12.2: Total expenditure on health as % of GDP



Private and government expenditure on health as a percentage of total expenditure on health

Private sources play an important role in health care financing in Uganda. In 2009, private expenditure accounted for 81% of the total health expenditure. Private sector contribution has grown over this time while government expenditure on health decreased from above 30% of total health expenditure in 1995 to slightly below 10% in 2009. Figure 2.12.3 shows the trend in government and private expenditure on health as percent of total expenditure on health.

Figure 2.12.3: Government & private expenditure on health as % of total health expenditure



The increase in private expenditure on health is a worrying trend, as most of the private expenditure on health comprise of OOP payments (Figures 2.12.4 and 2.12.5), which can result in households catastrophic spending and push households into poverty.

Private insurance and out of pocket payment as proportion of private expenditure on health

Figure 2.12.4 indicates that private expenditure on health was mainly from household OOP payments. In 2009, OOP expenditure was 65% of total private expenditure which decreased to about 15% during the period 1995 to 2009, implying the likelihood of catastrophic expenditure was still high.

Figure 2.12.4: Private insurance and OOP payment as a % of private expenditure on health

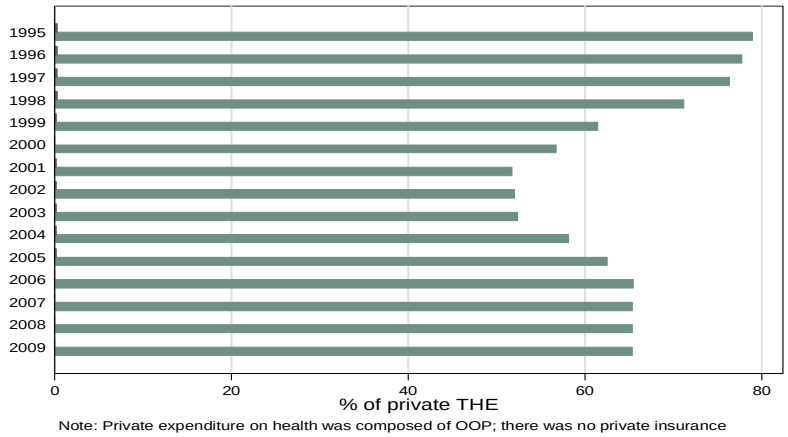
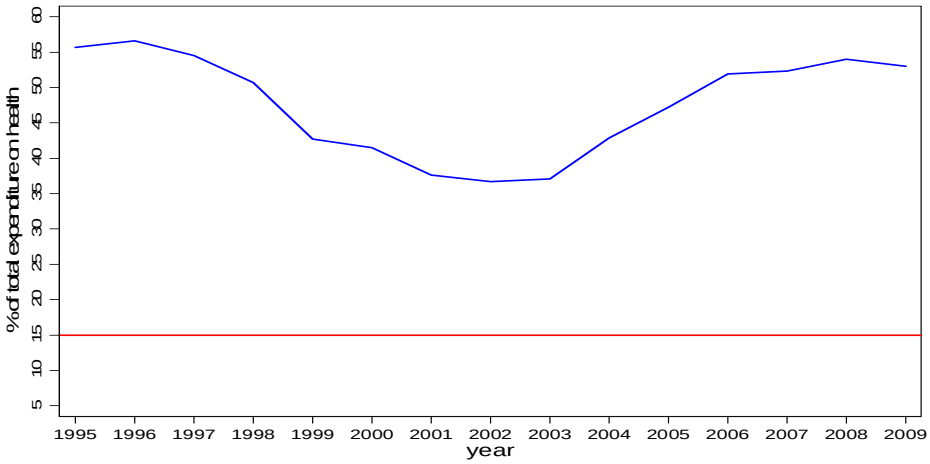


Figure 2.12.5: Out-of-pocket payment as a percentage of total expenditure on health



The increase in the share of OOP payment is a major concern and needs to be addressed by raising more revenue to cover the Uganda health expenditure through, pre-payment mechanisms that may include tax funding and/or health insurance in line with the resolution of the World Health Assembly Resolution of 2005 on sustainable health financing.

General government expenditure on health as a proportion of general government expenditure

In 2009 government expenditure on health was reported at 11.6% of the general government expenditure. This is the highest percentage that Uganda as a country has achieved over the period under review.

Figure 2.12.6: Public spending on health as a % of general government expenditure

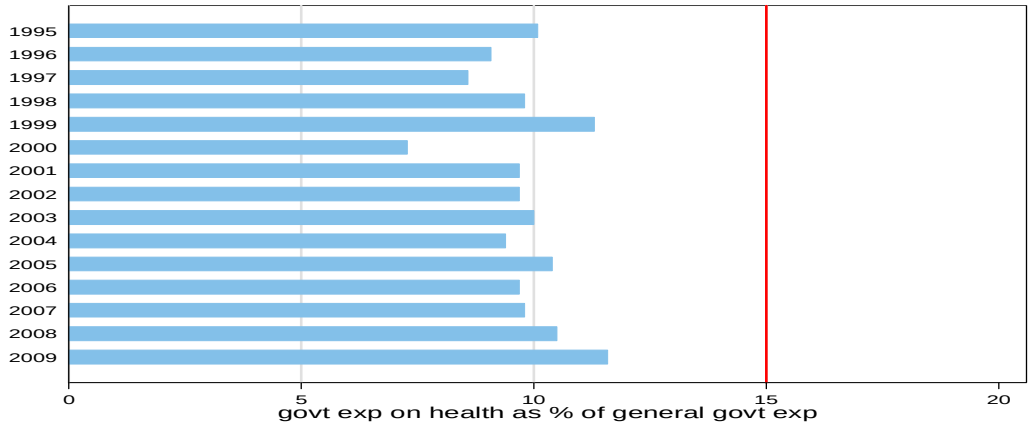
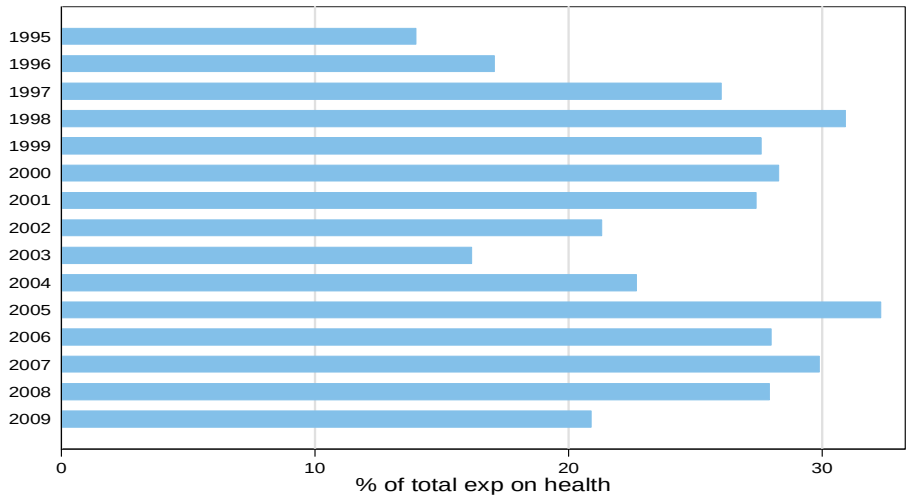


Figure 2.12.6 indicates that Uganda is yet to meet the Abuja Declaration to allocate 15% of government expenditure to health in order to offer basic health care services to its citizens.

External resources on health

On average, external resources accounted for about 27% of the total expenditure on health in the period under review. This indicates that Uganda is, to some extent, dependent on donors. This poses some risk in terms of sustaining the financing for health care.

Figure 2.12.7: External resources on health as a percentage of total expenditure on health



Conclusion and policy implications

It is necessary that the government considers increasing its contribution to the total expenditure on health to meet the cost of healthcare services. This is particularly in view of the removal of user fees in public health facilities. Initially, government could aim at meeting the Abuja target of spending 15% of the total government resources on health. The development of a social health insurance scheme is a step in the right direction, as such a move will, most likely

increase the availability resources to the health sector. Given the high OOP spending on health, the expansion of pre-payment mechanisms through increased government spending on health and social health insurance will provide the necessary protection to households from financial risks associated with seeking healthcare.

2.13. Zambia

Background

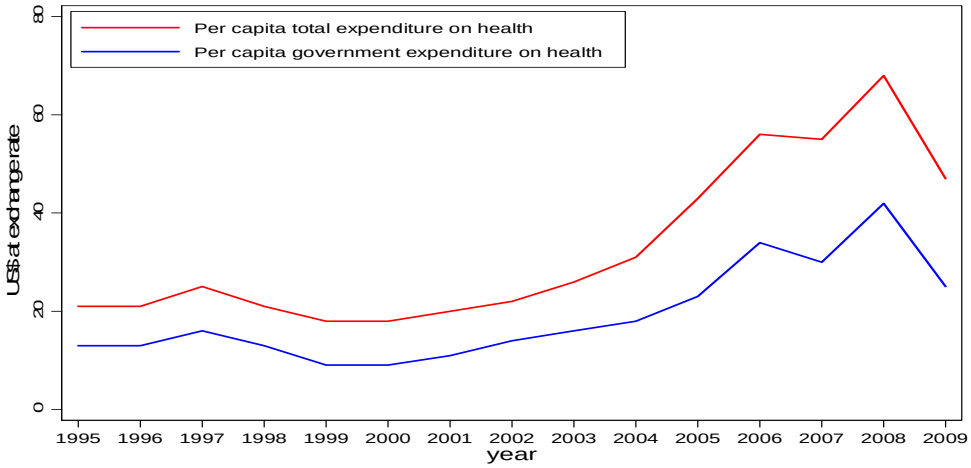
Zambia is a land-locked country with a population of about 13 million people. The country has made noteworthy progress in reducing maternal and childhood mortality since 2002. Maternal mortality has been reduced by 19% and childhood mortality by 29% between 2002 and 2008. Similarly, the prevalence of HIV and malaria is declining. Despite these improvements, Zambia continues to face many challenges in health and human development. With nearly 14% of its adult population infected with HIV, Zambia has one of the highest HIV prevalence rate in the world. Prevalence of HIV, malaria, tuberculosis, childhood infections, diarrhea and complications during pregnancy and child birth are still high. These conditions account for over 80% of Zambia's morbidity and mortality resulting in over 125,000 deaths per year; one-third of which is due to HIV alone[35]. The country was ranked at 164 out of 184 countries in the 2009 UNDP Human Development Index[36]

Per capita indicators of expenditure on health

The per capita expenditure on health in Zambia was estimated at US $47 in 2009 with the government expenditure on health reported at US $25 during the same year. This indicates that public funds accounted for about 53% of the total health expenditure. The trend in per capita total expenditure on health and per capita government on health is indicated in Figure 2.13.1.

[35] www.globalhealthfacts.org/
[36] www.tradingeconomics.com/zambia/

Figure 2.13.1: Per capita total and government expenditure on health 1995-2009



Per capita total expenditure on health in Zambia had an overall trend of growth from US $20 in 1995 to US $68 in 2008. However, in 2009, the total health expenditure per capita declined to approximately US $47. This was due to the decrease in per capita government spending on health, which went down to approximately US $25.

Total expenditure on health as a percentage of GDP

The total expenditure on health as percentage of GDP took a downward trend from 5.6% in 1995 to 4.8% in 2009.

Figure 2.13.2: Total expenditure on health as % of GDP

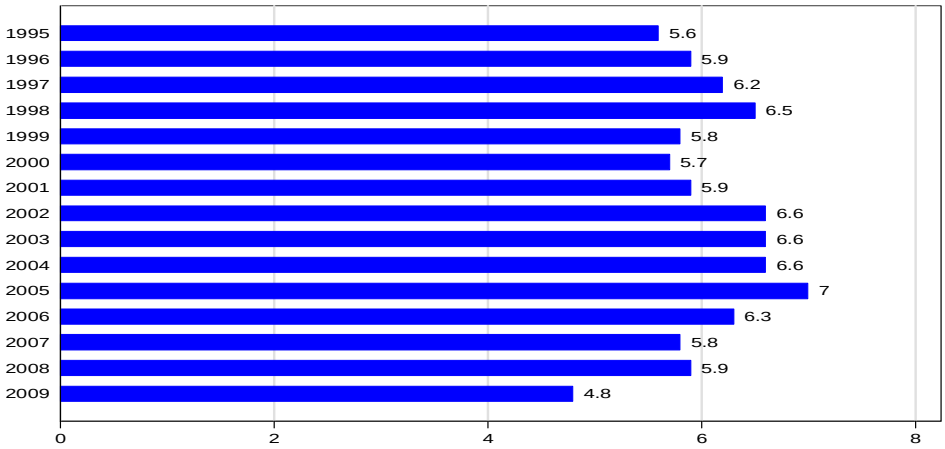


Figure 2.13.2 shows that the total expenditure on health as a percentage of GDP fluctuated between 7% and 4.8% between 1995 and 2009. However it notable that total expenditure on health decreased from 7% in 2005 to 4.8% in 2009.

Private and government expenditure on health as a percentage of total expenditure on health

Government expenditure on health has generally been above the private expenditure on health during the period under review. For instance in 2009, private expenditure on health as a percentage of total expenditure on health was 47% while government expenditure on health as percentage of total expenditure on health was 53%.

Figure 2.13.3: Government private expenditure on health as % of total expenditure on health

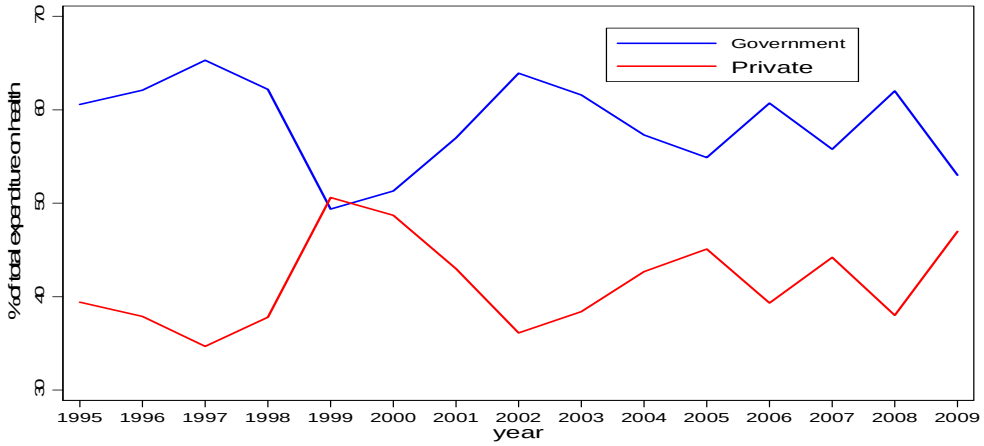


Figure 2.13.3 shows that the Zambian government has been spending more on health compared to the private sector. This demonstrates the commitment of the Zambian Government in providing healthcare services to its citizens.

Figure 2.13.4: Private insurance/OOP as a proportion of private expenditure on health

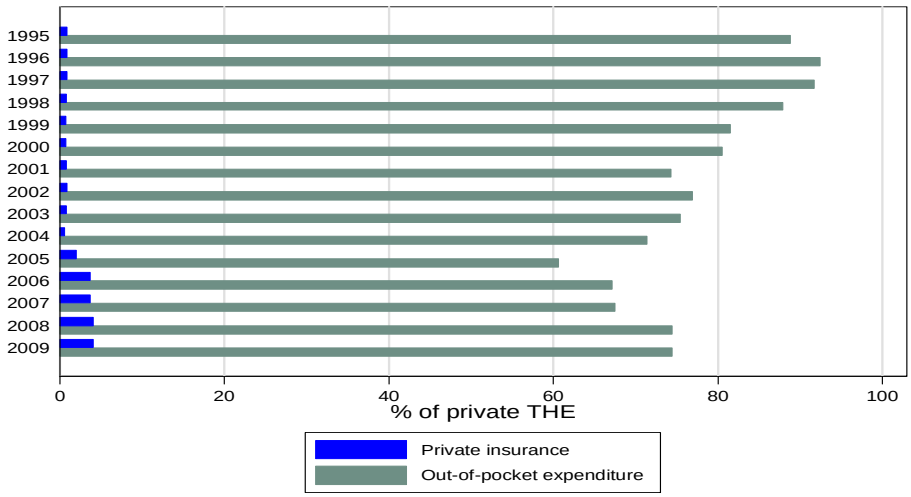


Figure 2.13.4 shows that private expenditure on health was mainly from household OOP payments and that private health insurance accounted for less than 10% of the private expenditure on health.

OOP spending as a percentage of total expenditure on health

OOP spending on health as percentage of total health expenditure fluctuated between 26% and 41% of total expenditure on health during the period under review. In 2009, OOP expenditure on health was 35% of total expenditure on health.

Figure 2.13.5: Out-of-pocket payment as a percentage of total expenditure on health.

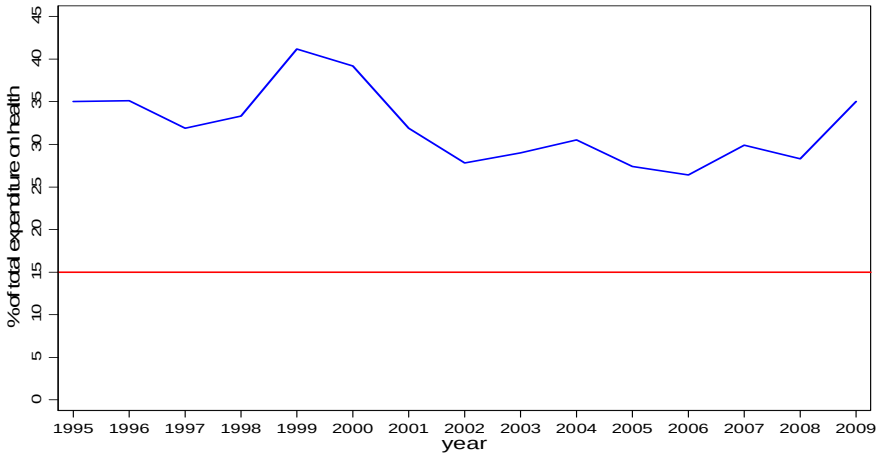
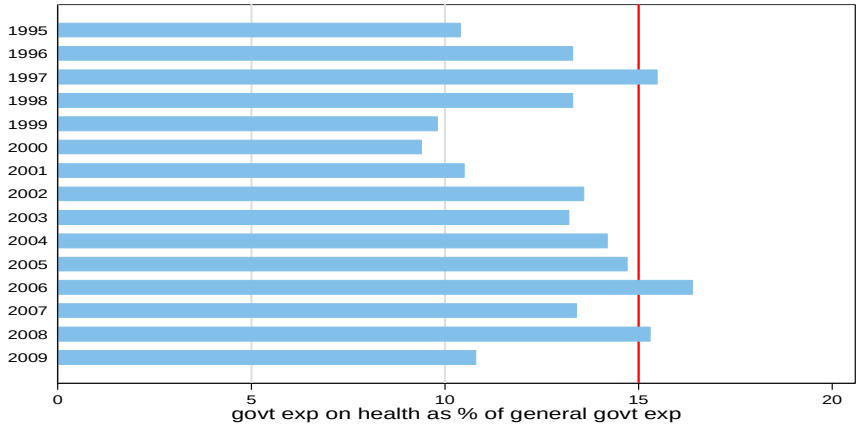


Figure 2.13.5 shows that in the years from 1995 to 2009, OOP payments constituted a significant proportion of the total expenditure on health. During this period, OOP expenditure has been way above 15%, implying that the likelihood of households incurring catastrophic expenditure could be high.

General government expenditure on health as a proportion of general government expenditure

Over the time period between 1995 and 2009, government expenditure on health fluctuated between 10% and 17% of the total general government expenditure. During the years 1997, 2006 and 2008, government expenditure on health as a proportion of government general expenditure reached or exceeded the 15% mark, in line with the Abuja Declaration target. However, such expenditure levels were not sustained in subsequent years.

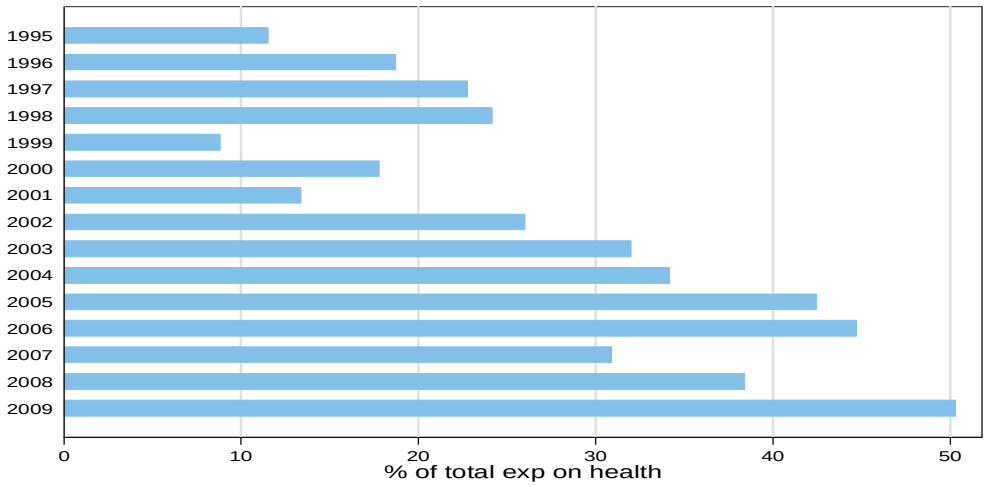
Figure 2.13.6: General government expenditure on health as a percentage of general government expenditure



External resources on health

On average, external resources accounted for about 30% of total expenditure on health during the period 1995 to 2009 (Figure 2.13.7). There generally appears to be an upward trend in the share of external resources to the total health expenditure. This implies that the health system in Zambia is increasingly becoming donor dependent over time. While this is necessary, given the limited resources available, heavy dependence on donor support brings about the issues of financial sustainability and aid coordination.

Figure 2.13.7: External resources on health as a percentage of total expenditure on health



Given the significance of donor funding, the government established a SWAp as a mechanism to better coordinate the financing and activities of development partners and to ensure their alignment to the government priorities in the health sector[37].

[37]Zambia MOH action Plan.

Conclusion and policy implications

OOP expenditure on health remains high in Zambia. Government ought to consider options for reducing this OOP expenditure by scaling up pre-payment mechanisms, thereby protecting households from the adverse effects of paying for health out-of-pocket. The option of social health insurance should be explored and implemented if feasible. Total expenditure on health constituted about 4.8 % of Zambia GDP in 2009. The Zambian government may therefore consider allocating more resources to health and put in place measures that encourage more efficient utilization of the available resources.

2.14. Zimbabwe

Background

Zimbabwe has a relatively well developed economy compared with other ECSA Member States. The country however went through a period of economic turbulence beginning from the late 1990s. Gross Domestic Product fell by half during the period 1998 to 2008. However, in the last few years, there has been a marked improvement in economic performance which has resulted in a reversal of the economic decline that characterized the past decade.

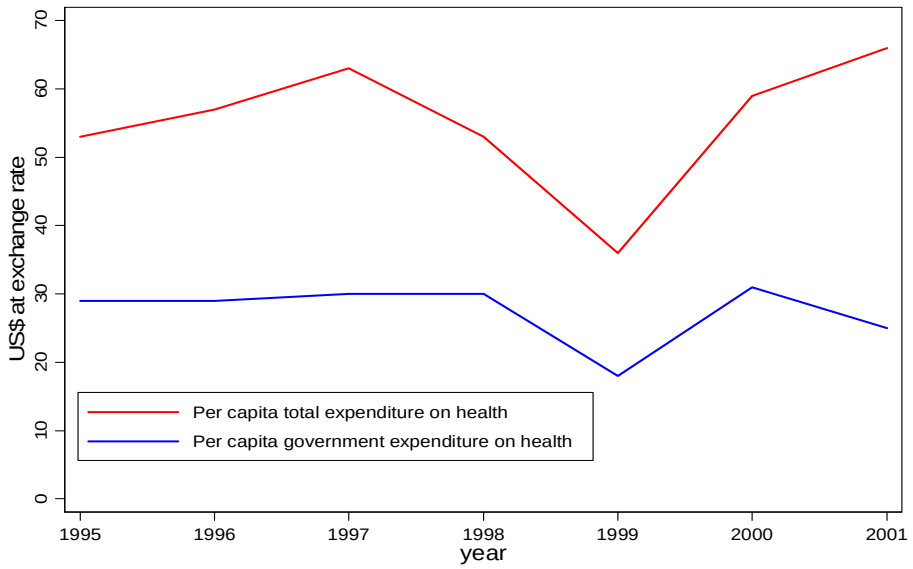
Like other ECSA countries, Zimbabwe has its own health challenges. Life expectancy of 47 for men and 50 for women is one of the lowest in the world. The maternal mortality ratio worsened over the years and was estimated at 790 per 100,000 live births in 2010. This is an increase from 624 per 100,000 in 2008 and 231 per 100,000 in 1990. The under-five mortality rate was estimated at 93 per 1,000 live births.

The analysis for Zimbabwe only covers the period 1995 to 2001. It was not possible to make a meaningful interpretation of the series after 2001 due to hyperinflation, differences between official and parallel exchange rates and other problems associated with the period of economic turbulence.

Per capita indicators of expenditure on health

Health expenditure per capita in Zimbabwe was US$ 79 in 2001. Government's contribution to the total health expenditure per capita was US$ 25 implying that the Government of Zimbabwe was contributing 31% to the total expenditure for healthcare. The trends in per capita expenditure on health is shown by figure 2.14.1 below

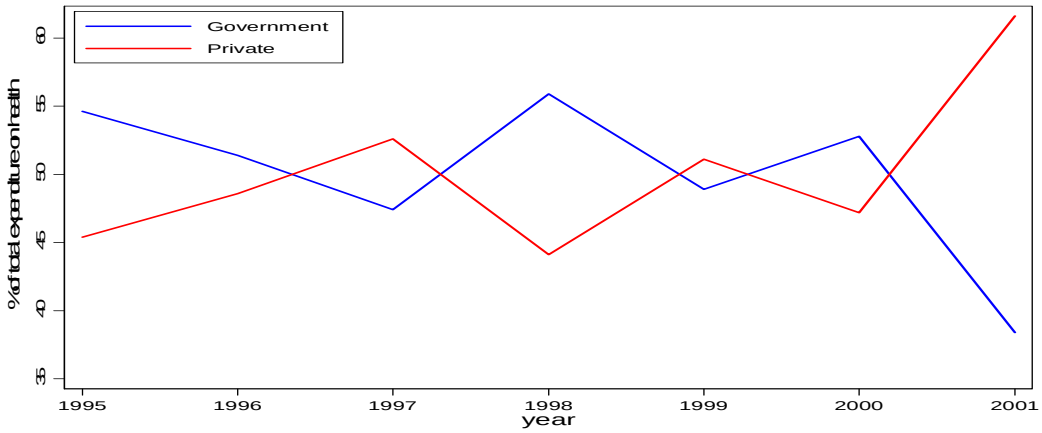
Figure 2.14.1: Per capita total and government expenditure on health 1995-2009



Private and government expenditure on health as a percentage of total expenditure on health

While government expenditure on health shows a declining trend, the opposite was true for private expenditure. In 2001, Government expenditure on health was 38.4% of the total health expenditure while Private health expenditure was 61.6%.

Figure 2.14.2: Government and private expenditure on health as % of total expenditure on health



The increase in private expenditure on health is not a desirable trend, considering that most of it was OOP spending as shown in Figures 2.14.3 and 2.14.4. Such levels of OOP tend to put households at risk of incurring catastrophic expenditures due to seeking healthcare.

Fig.2.14.3: Private insurance and OOP payment as a % of private expenditure on health

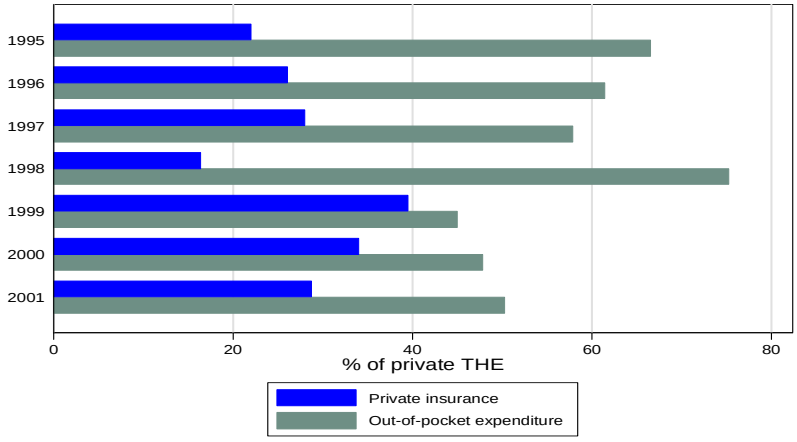
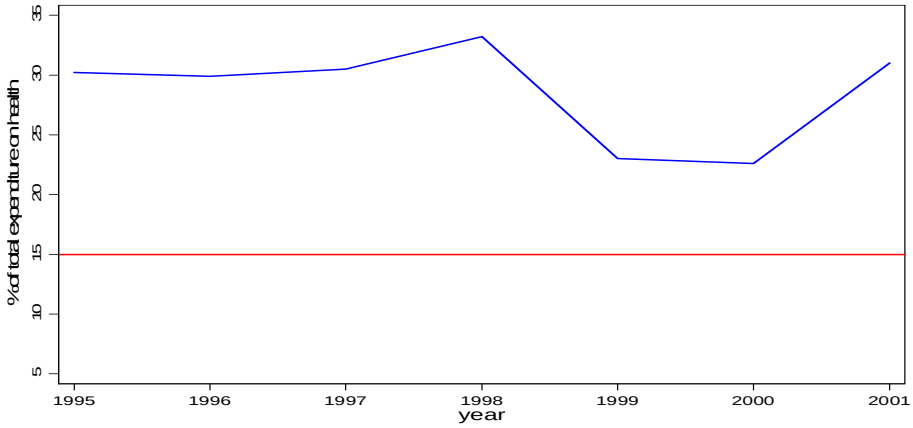


Figure 2.14.3 indicates that private expenditure on health was mainly from household OOP payments and that private health insurance accounted for less than 30% of the private expenditure on health. The fact that households OOP spending accounts for a huge proportion of private spending on health means that payment is usually made at the point accessing health services, which does not allow for pooling of risks. It may also be seen from the Figure 2.14.3 that private health insurance plays a significant role in the management of health resources in Zimbabwe.

Out-of-pocket payments as a percentage of total expenditure on health

Between 1995 and 2001, OOP payments constituted a significant proportion of total expenditure on health, way above 15% as shown in Figure 2.14.4. This may imply that some household could be incurring catastrophic expenditures.

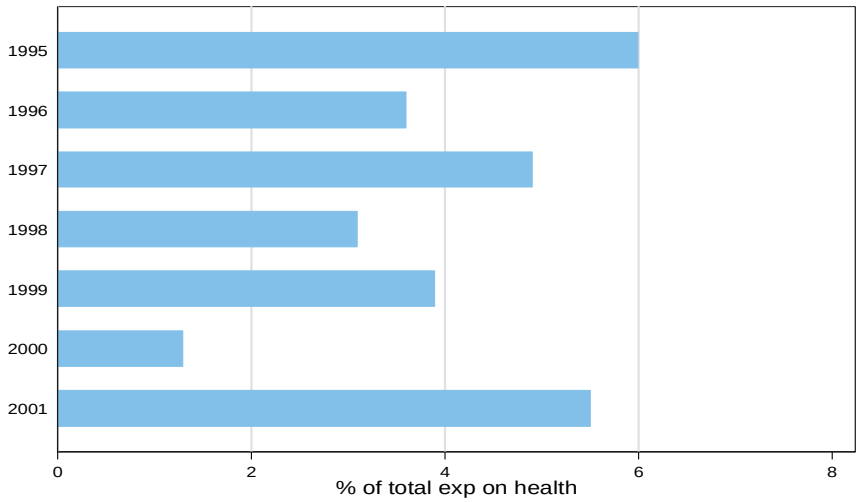
Figure 2.14.4: Out-of-pocket payment as a percentage of total expenditure on health



External resources on health

It may be seen from Figure 2.14.5 below that proportion of external resources to the total health expenditure is very low, ranging from about 1% to 6% in the period under review. Zimbabwe is therefore less donor dependent compared with other ECSA Member States.

Figure 2.14.5: External resources on health as a percentage of total expenditure on health



Conclusion and policy implications

Health expenditure per capita in Zimbabwe was US $79 in 2001 out of which government expenditure contributed US $25 or 32% of the total health spending during the same period. This is well above the recommended minimum expenditure for the provision of a basic package of health services.

Private expenditure on health was mainly from household OOP payments. Private health insurance accounted for less than 35% of the private expenditure on health. The Government of Zimbabwe should consider scaling up pre-payment mechanisms, as a means of reducing OOP payments, which may expose households to catastrophic expenditure and impoverishment. Government should maintain or better still increase spending on health in order to keep the sector less dependent on external funding. This will guarantee financial sustainability of health programmes in the country.

3.0. Conclusion and Way Forward

Total expenditure on health per capital in ECSA member countries varied significantly from a low of US $19 to a high of US $612 at average exchange rates. Only three countries were unable to meet the conservative recommendation of US $30-40 made by the Commission on Macroeconomics and Health to provide a basic package of cost-effective health interventions.

Considerable increase in public spending has been noted in a number of ECSA member countries. At the end of 2009, two member states had achieved the 15% target as pledged in the 2001 Abuja Declaration, with 10 ECSA member countries indicating that they spent 9% or more of their national budgets on health. Kenya is furthest from the Abuja target with 5.4% of government resources going to health care in 2009 and no consistent increase in government spending. Although Malawi, Zambia, Namibia and Mozambique had not attained the Abuja target in 2009, some considerable progress had been made in that regard. Malawi surpassed the target in the years 2003 through 2006, while Zambia surpassed it in 1997, 2006 and 2008. Mozambique attained the target in 2005.

In 2009, four out of the 14 member countries of ECSA spent less than 5% of their GDP on health. Only four countries spent above 8% of their GDP on health with one country spending more than 10% of its GDP. Government expenditure on health as a percentage of total health expenditure in the ECSA community varied widely from less than 20% to over 80%.

Only two countries have met the Abuja target of allocating at least 15% of the government budget to health. However, most ECSA member states in southern Africa were doing well in terms of allocating more government resources to health. In low-income countries where governments are seriously constrained, the 15% target may not result in a significant change in the health financing situation. The target may however be considered as a proxy to government commitment for increased investment in the health sector.

The generally slow pace of shifting government resources towards the health sector calls for sustained advocacy and monitoring, if the Abuja Declaration target is to be attained. Although some advocacy efforts has been made, more needs to done. ECSA Secretariat can play a critical role in this regard.

In most countries, private expenditures on health constitute less than 50% of total health expenditure, a large proportion of which is household OOP expenditures. In six countries, OOP expenditures account for more than 50% of private health expenditure. This may potentially result in catastrophic spending and drive households into poverty. Measures of converting this OOP spending into some form of pre-payments ought to be put in place.

External funding for health as a percentage of total expenditure on health constitutes a substantial proportion in some member countries. In 2009, 8 countries (55% of countries of the ECSA member countries) received between 15% and 99% of their total health funding from external sources. While donors are an important funding source in many African countries, such funding is often unreliable and unsustainable in the long term. Member States ought to put in place strong aid coordination mechanisms in line with the Paris Declaration on aid effectiveness and also explore alternative ways of mobilizing domestic resources to improve financial sustainability of health programmes.

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Annex 2.

A: Total expenditure on health per capita at average US$ exchange rate

Country	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Botswana	128	128	141	129	133	155	183	205	269	454	420	397	501	530	612
Kenya	15	19	19	19	15	17	17	17	19	19	22	27	31	33	33
Lesotho	39	36	34	31	29	28	28	23	35	43	43	50	56	60	70
Malawi	7	10	13	9	10	9	7	10	12	15	16	20	17	18	19
Mauritius	124	132	122	128	127	145	145	166	184	221	230	265	323	402	383
Seychelles	377	374	456	440	450	402	390	412	450	481	498	519	534	459	366
Swaziland	83	83	83	92	83	78	69	62	83	139	164	154	151	141	156
Uganda	15	16	15	15	16	15	17	17	18	22	27	32	36	44	43
Zambia	21	21	25	21	18	18	20	22	26	31	43	56	55	68	47
Zimbabwe	53	57	63	53	36	59	66								
Namibia	134	138	146	133	132	131	118	109	166	217	265	280	293	284	258
Mozambique	7	8	10	11	13	14	12	13	13	14	17	16	18	21	25
South Africa	273	271	286	264	273	251	229	210	318	413	453	458	492	459	485
Tanzania	7	8	10	10	10	10	10	10	12	12	14	23	20	22	25

B: Total expenditure on health per capita at purchasing power parity US$

Country	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Botswana	48	48	46	45	40	47	49	50	50	52	57	62	67	66	68
Kenya	48	48	46	45	40	47	49	50	50	52	57	62	67	66	68
Lesotho	66	69	63	64	64	68	79	73	78	80	78	93	101	119	133
Malawi	26	26	30	33	39	36	28	26	36	47	49	60	49	50	50
Mauritius	202	211	221	249	250	299	318	359	358	417	463	545	632	681	730
Seychelles	650	697	864	846	874	842	807	785	814	891	810	863	944	911	826
Swaziland	135	152	149	189	181	199	209	215	199	280	318	299	283	287	312
Uganda	31	33	33	34	44	45	51	56	60	62	78	95	97	112	115
Zambia	45	50	54	55	49	49	54	62	65	70	79	77	75	80	68
Zimbabwe	57	57	67	83	55	70	56								
Namibia	220	239	257	262	274	248	255	266	294	336	394	421	430	440	384
Mozambique	16	14	17	19	23	26	27	32	31	31	36	36	38	39	50
South Africa	425	471	501	521	564	552	594	613	646	702	744	776	825	843	862
Tanzania	24	26	27	27	28	28	29	29	38	38	40	72	57	57	68

C: Total expenditure on health as percentage of GDP

Country	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Botswana	4.2	4.2	4.4	4.0	3.8	4.7	5.3	6.0	6.0	8.2	7.5	6.6	7.7	7.6	10.3
Kenya	4.6	4.4	4.3	4.1	3.6	4.2	4.2	4.4	4.3	4.2	4.3	4.3	4.3	4.2	4.3
Lesotho	7.5	7.4	6.6	6.8	6.6	6.7	7.5	6.8	6.9	6.6	6.2	6.7	6.8	7.6	8.2
Malawi	4.9	4.6	5.1	5.4	6.4	6.0	5.0	4.8	6.3	7.7	8.1	8.9	6.9	6.5	6.2
Mauritius	3.5	3.4	3.4	3.6	3.5	3.8	3.9	4.2	4.0	4.3	4.6	4.4	5.5	5.5	5.7
Seychelles	5.6	5.7	6.3	5.7	5.8	5.3	5.1	4.8	5.2	5.6	4.7	4.5	4.3	4.2	4.0
Swaziland	4.7	5.2	4.9	6.1	5.7	5.7	5.8	5.8	5.1	6.8	7.3	6.6	5.9	5.8	6.3
Uganda	5.4	5.5	5.1	5.3	6.3	6.6	7.3	7.5	7.4	7.3	7.8	8.6	8.2	8.4	8.2
Zambia	5.6	5.9	6.2	6.5	5.8	5.7	5.9	6.6	6.6	6.6	7.0	6.3	5.8	5.9	4.8
Zimbabwe															
Namibia	6.2	6.6	6.8	6.8	7.0	6.1	6.2	6.2	6.5	6.5	7.3	7.2	6.9	6.9	5.9
Mozambique	5.1	4.2	4.6	4.6	5.2	5.9	5.6	6.0	5.7	5.1	5.4	5.0	4.8	4.7	5.7

South Africa	7.5	8.0	8.3	8.6	9.1	8.5	8.8	8.7	8.9	8.9	8.8	8.5	8.4	8.2	8.5
Tanzania	3.8	4.0	3.9	3.9	4.0	3.8	3.7	3.5	4.3	4.0	3.9	6.5	4.8	4.5	5.1

D: External resources on health as a percentage of total expenditure on health

Country	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Botswana	1.3	0.8	0.8	1.0	0.7	0.5	0.4	0.5	2.6	1.8	3.8	2.3	3.0	4.2	18.8
Kenya	4.9	8.2	11.2	10.8	14.4	8.8	15.9	17.1	11.8	18.2	22.4	21.3	26.7	26.8	36.1
Lesotho	5.7	3.5	2.3	2.9	3.7	3.1	6.1	5.2	12.5	13.3	17.1	12.4	13.2	19.3	30.4
Malawi	29.7	26.2	29.9	48.6	40.4	27.1	65.9	67.7	91.4	71.7	69.1	59.8	69.1	87.0	99.1
Mauritius	1.7	1.5	2.0	1.6	1.6	1.4	1.4	1.6	1.5	1.2	1.0	1.0	1.4	2.0	1.6
Seychelles	0.9	1.7	0	1.9	5.7	5.6	4.5	5.0	5.0	4.6	4.8	3.8	2.4	1.6	1.4
Swaziland	1.9	1.6	1.5	18.8	10.3	5.5	1.6	1.8	2.6	6.5	2.9	12.5	7.9	11.1	12.2
Uganda	14.0	17.1	26.0	30.9	27.6	28.3	27.4	21.3	16.2	22.7	32.3	28.0	29.9	27.9	20.9
Zambia	11.5	18.7	22.8	24.2	8.8	17.8	13.4	26.0	32.0	34.2	42.5	44.7	30.9	38.4	50.3
Zimbabwe	6.0	3.6	4.9	3.1	3.9	1.3	5.5								
Namibia	3.4	2.0	2.3	2.5	2.4	3.8	3.7	3.1	3.0	9.7	16.9	22.4	19.8	21.4	14.9
Mozambique	34.6	32.4	30.6	25.2	26.7	26.4	24.1	30.8	41.6	50.4	55.6	61.5	64.5	80.8	72.0
South Africa	0.1	0.1	0.1	0.2	0.1	0.3	0.2	0.4	0.4	0.5	0.5	0.7	0.8	1.2	1.9
Tanzania	9.3	7.7	15.0	17.8	31.4	27.8	19.1	12.3	29.8	30.6	36.5	42.7	47.9	59.2	56.5

E: General government expenditure on health as a percentage of total expenditure on health

Country	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Botswana	52.4	52.5	56.5	56.4	57.8	62.2	70.5	72.2	68.5	77.8	75.5	74.7	78.4	78.2	80.0
Kenya	42.7	38.0	34.5	45.8	38.7	45.3	42.4	40.4	40.8	39.8	40.6	39.2	37.2	36.3	33.8
Lesotho	45.9	48.1	44.7	48.1	48.4	50.9	58.1	55.5	56.8	57.3	52.9	58.8	61.9	63.3	68.2
Malawi	38.4	27.4	31.4	34.1	35.3	46.3	44.3	61.2	73.1	74.5	74.7	69.2	61.3	59.4	58.0
Mauritius	57.0	56.0	57.0	54.6	54.0	52.0	51.8	51.5	54.2	54.7	47.1	42.1	37.4	34.8	36.9
Seychelles	78.4	81.6	79.8	77.1	76.9	75.3	76.9	78.8	81.9	83.8	83.2	84.7	74.2	74.8	76.8
Swaziland	55.0	54.5	52.9	56.6	59.0	58.6	61.2	63.5	59.4	67.8	69.2	65.7	62.4	60.8	63.3
Uganda	29.4	27.3	28.5	28.8	30.6	26.8	27.3	29.5	29.2	26.3	24.4	20.7	20.1	17.4	19.0
Zambia	60.6	62.1	65.3	62.2	49.4	51.3	57.0	63.9	61.6	57.3	54.9	60.7	55.8	62.0	53.0
Zimbabwe	54.6	51.4	47.4	55.9	48.9	52.8	38.4								
Namibia	71.1	72.2	72.0	72.4	73.3	68.9	56.2	58.0	57.1	49.6	48.9	43.5	54.4	54.6	66.6
Mozambique	67.0	59.7	64.7	65.0	68.6	71.9	72.7	75.0	72.5	69.3	72.5	70.0	73.1	75.2	73.2
South Africa	39.3	35.9	38.8	39.4	39.3	40.5	39.5	38.7	39.5	36.4	38.3	39.9	40.8	39.7	40.1
Tanzania	40.1	44.5	42.5	38.5	41.6	43.4	44.2	44.7	49.5	43.2	48.5	58.9	72.8	71.9	73.6

F: Private expenditure on health as a percentage of total expenditure on health

Country	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Botswana	47.6	47.5	43.5	43.6	42.2	37.8	29.5	27.8	31.5	22.2	24.5	25.3	21.6	21.8	20.0
Kenya	57.3	62.0	65.5	54.2	61.3	54.7	57.6	59.6	59.2	60.2	59.4	60.8	62.8	63.7	66.2
Lesotho	54.1	51.9	55.3	51.9	51.6	49.1	41.9	44.5	43.2	42.7	47.1	41.2	38.1	36.7	31.8
Malawi	61.6	72.6	68.6	65.9	64.7	53.7	55.7	38.8	26.9	25.5	25.3	30.8	38.7	40.6	42.0
Mauritius	43.0	44.0	43.0	45.4	46.0	48.0	48.2	48.5	45.8	45.3	52.9	57.9	62.6	65.2	63.1
Seychelles	21.6	18.4	20.2	22.9	23.1	24.7	23.1	21.2	18.1	16.2	16.8	15.3	25.8	25.2	23.2
Swaziland	45.0	45.5	47.1	43.4	41.0	41.4	38.8	36.5	40.6	32.2	30.8	34.3	37.6	39.2	36.7
Uganda	70.6	72.7	71.5	71.2	69.4	73.2	72.7	70.5	70.8	73.7	75.6	79.3	79.9	82.6	81.0
Zambia	39.4	37.9	34.7	37.8	50.6	48.7	43.0	36.1	38.4	42.7	45.1	39.3	44.2	38.0	47.0
Zimbabwe	45.4	48.6	52.6	44.1	51.1	47.2	61.6								
Namibia	28.9	27.8	28.0	27.6	26.7	31.1	43.8	42.0	42.9	50.4	51.1	56.5	45.6	45.4	33.4
Mozambique	33.0	40.3	35.3	35.0	31.4	28.1	27.3	25.0	27.5	30.7	27.5	30.0	26.9	24.8	26.8
South Africa	60.7	64.1	61.2	60.6	60.7	59.5	60.5	61.3	60.5	63.6	61.7	60.1	59.2	60.3	59.9
Tanzania	59.9	55.5	57.5	61.5	58.4	56.6	55.8	55.3	50.5	56.8	51.5	41.1	27.2	28.1	26.4

G: General government expenditure on health as a percentage of general government expenditure

Country	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Botswana	5.5	5.8	6.4	5.6	5.8	7.6	9.7	10.6	10.0	17.3	16.9	16.3	18.4	16.6	16.7
Kenya	6.3	7.7	6.7	8.6	6.2	9.1	7.3	7.2	7.0	7.1	7.6	7.1	6.6	5.8	5.4
Lesotho	6.4	6.3	5.1	6.0	5.9	6.5	9.1	7.2	8.3	8.3	6.8	8.2	8.2	8.2	8.2
Malawi	5.1	5.1	5.1	5.2	6.5	9.0	8.7	13.0	16.7	21.0	20.0	20.0	12.1	12.1	12.1
Mauritius	9.0	8.5	7.7	9.9	8.2	8.7	10.9	9.3	8.8	9.7	9.1	8.9	9.3	8.3	8.3
Seychelles	8.4	7.8	8.5	7.5	7.8	8.4	8.8	6.9	10.2	10.2	10.4	8.8	8.9	10.1	11.4
Swaziland	11.6	11.0	11.2	13.5	11.7	11.6	11.9	11.5	9.5	12.2	14.1	12.9	10.2	8.5	9.3
Uganda	10.1	9.1	8.6	9.8	11.3	7.3	9.7	9.7	10.0	9.4	10.4	9.7	9.8	10.5	11.6
Zambia	10.4	13.3	15.5	13.3	9.8	9.4	10.5	13.6	13.2	14.2	14.7	16.4	13.4	15.3	10.8
Zimbabwe	0.0	0.0	0.0	0.0	0.0	0.0	0.0								
Namibia	12.1	12.8	13.5	13.4	13.3	13.1	10.3	11.1	11.3	10.7	12.5	11.1	13.1	12.1	12.1
Mozambique	14.0	14.0	13.7	15.0	16.1	17.9	13.9	15.4	15.1	13.9	17.2	12.9	12.6	12.6	12.6
South Africa	9.5	9.5	9.3	9.8	10.7	10.9	11.2	11.5	11.2	10.3	10.4	10.7	11.1	10.4	9.3
Tanzania	9.1	9.1	9.1	9.1	9.1	9.1	9.2	10.1	11.3	8.5	9.3	14.4	18.4	18.0	18.1

H: Private insurance as a percentage of private health expenditure

Country	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Botswana	4.1	3.8	3.8	4.1	4.0	4.1	5.3	5.9	5.6	6.0	6.0	6.2	6.3	6.3	6.5
Kenya	7.6	7.3	7.1	7.4	7.4	7.1	6.8	6.8	7.7	8.3	8.9	9.0	8.8	8.8	8.8
Lesotho	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Malawi	6.2	6.3	5.9	5.4	5.1	6.2	6.9	11.9	12.9	11.6	14.5	14.7	14.6	14.6	14.5
Mauritius	7.9	7.8	8.0	7.5	7.7	8.3	9.4	9.7	10.7	10.0	8.6	7.3	6.3	6.3	6.3
Seychelles	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Swaziland	19.1	18.6	19.2	16.6	18.6	18.9	18.8	18.7	18.6	18.7	18.8	18.8	18.8	18.9	18.9
Uganda	0.3	0.3	0.3	0.3	0.2	0.1	0.2	0.2	0.2	0.2	0.2	0.1	0.1	0.1	0.1
Zambia	0.9	0.9	0.9	0.8	0.7	0.7	0.8	0.9	0.8	0.6	2.1	3.7	3.7	4.1	4.1
Zimbabwe	22.0	26.1	28.0	16.4	39.5	34.0	28.8								
Namibia	74.4	74.4	74.5	74.5	74.7	77.3	86.5	86.0	84.2	73.8	72.9	64.0	63.6	61.2	61.0
Mozambique	0.6	0.6	0.6	0.7	0.9	1.0	1.1	1.3	1.5	1.5	1.4	1.4	1.7	1.9	1.5
South Africa	68.2	73.1	74.8	73.0	71.9	69.9	71.3	71.8	71.9	67.2	66.6	66.7	66.3	66.2	66.1
Tanzania	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	3.9	5.1	7.2	7.7	14.5	14.5	14.5

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