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Action for Better Health in Africa

AN EXECUTIVE SUMMARY OF THE WORLD BANK PUBLICATION

Better Health in Africa

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Better Health in Africa

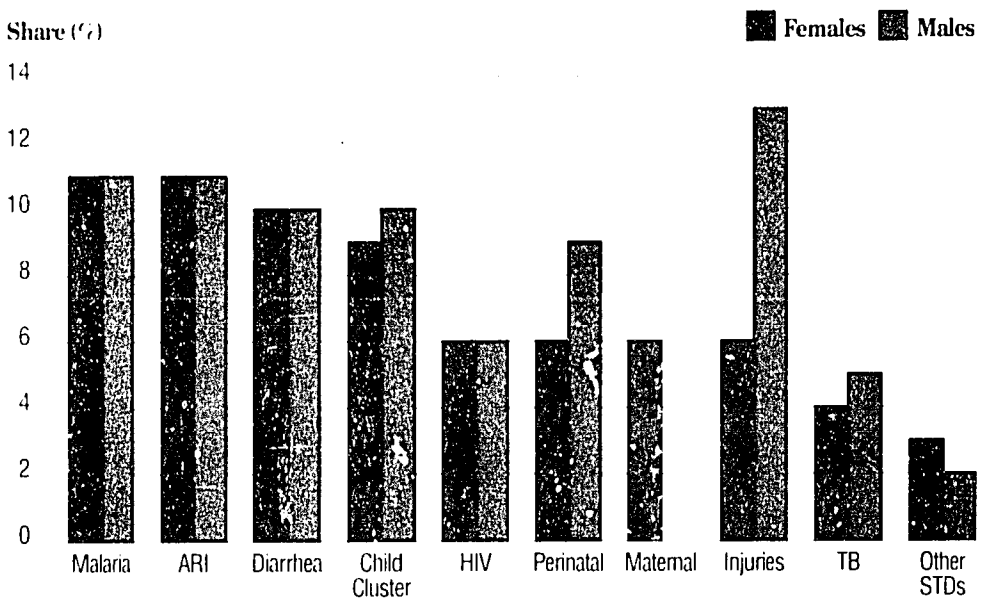
HEALTH IN AFRICA[1] has improved dramatically in the decades since independence—the infant mortality rate has been cut by one-third and life expectancy has increased by more than ten years. But health outcomes in African countries still lag behind those in other developing countries. Maternal mortality is twice as high as in other low-income developing countries. Malaria is becoming more prevalent and tuberculosis is on the rise. AIDS/HIV threatens to create an enormous economic and social burden in some countries and to overwhelm their health care systems.

Beyond the hardship and suffering caused by poor health, the high incidence of disease takes a heavy toll on economic and social development. The benefits of education are reduced, entrepreneurial and productive activities are diminished.

Improved health would likely have a powerful effect on economic progress. Studies have shown that productivity could rise 15 percent if illness and disability were attacked more strenuously. Reduction in maternal illness and death would increase women's contribution to the economy. Increased individual life expectancy would make education more valuable.

FIGURE 1

The Share of Major Diseases in the Total Burden of Disease and Injury in Africans, 1990



Source: The World Bank, *Better Health in Africa*

The majority of Africa's health problems are not caused by the diseases that are most prevalent in industrial countries—heart disease and cancer—which require intensive, tertiary care. The greatest threats to better health in Africa—contagious and parasitic diseases—can be largely overcome by low-cost primary and preventive care. See Figure 1.

Better Health in Africa offers proposals that would vastly improve health, even at current low income levels. These goals can be achieved partially by education, especially of girls, and by focusing on factors that influence health, such as securing food, safe drinking water, and sanitation.

[1] Africa refers to sub-Saharan Africa

The basic premise of *Better Health in Africa* is that countries whose citizens are generally healthy are those that improve household health care management and ensure access to health services. The essence of this strategy is based on creating an enabling environment for health by giving households and communities more control over their own health services.

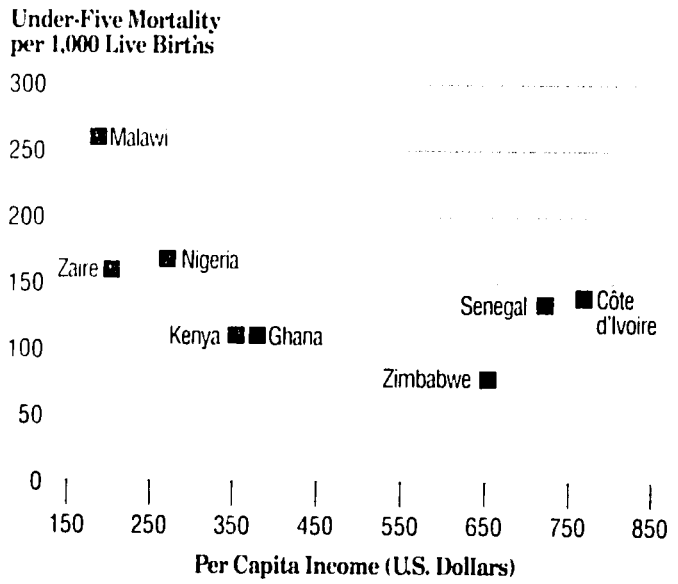
Some countries are already taking important steps toward creating an enabling environment for health. In other countries, however, progress has been inhibited by a lack of government commitment to health and by poor management of health services.

Creating an Enabling Environment

GOVERNMENTS CAN IMPROVE HEALTH, despite financial constraints, by creating an enabling environment for health. Child mortality in Zimbabwe, for example, is about half that of Côte d'Ivoire, which has a higher per capita income. See Figure 2.

FIGURE 2

Per Capita Income and Under-Five Mortality in Eight Countries, 1990



Source. World Bank data

A Rockefeller Foundation study on how China, Costa Rica, and Sri Lanka dramatically improved health outcomes, despite their low per capita incomes, found that their success was due to a strong political commitment to improve nutrition, education, and basic health services.

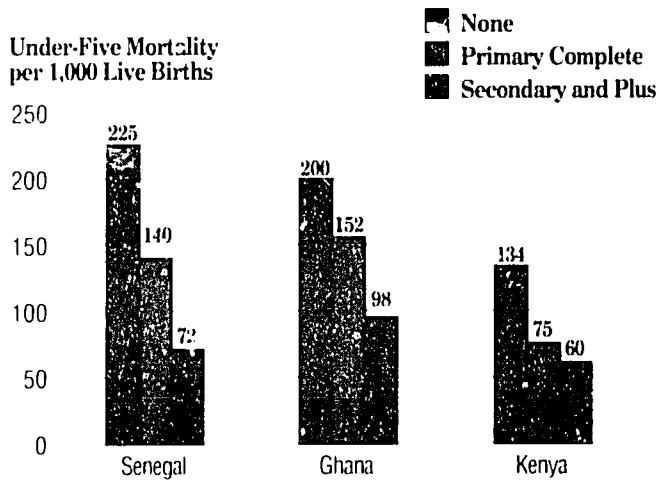
These countries followed an approach that focused on several factors. Though increased incomes may lead to increased calorie consumption, a good nutrition policy makes a significant difference by offering education on food preparation and facilitating access to critical micronutrients. According to UNICEF, a breast-fed baby is only one-twentieth as likely to die from diarrheal disease as one who is bottle-fed.

Improving women's education was also found to be central to improving health. Studies in Ghana, Nigeria, and Sudan have shown that a mother's level of education is the most important single influence on her children's health. A mother with secondary-level education may lower infant mortality in a family by as much as 50 percent. Data for 13 African countries show that a 10 percent increase in female literacy rates reduced child mortality by nearly 10 percent, while improvements in males' education had little influence. See Figure 3.

Household information programs on health also play a significant role in improving knowledge about sound health practices. The Happy Baby lottery campaign in The Gambia taught mothers to use oral rehydration salts (ORS). After two years the use of ORS in diarrhea cases increased from 22 percent to 94 percent. In Tanzania two million adults followed the "Man Is Health" radio program to educate villagers on disease control. The program led to construction of hundreds of thousands of latrines and a significant increase in sales of mosquito nets.

FIGURE 3

Under-Five Mortality and Level of Female Education, 1985-1990



Source Demographic and Health Survey data

Setting the Stage for Health Reform

Countries can demonstrate their commitment to better health by formulating comprehensive health policies with explicit operational goals. They also need to emphasize more cost-effective and equitable use of public funds.

A first step would be to correct the most obvious inequity—relatively excessive public financing of curative medical care and inadequate public support for primary and preventive care. Ensuring quality care and establishing appropriate fees would be incentives for households to use the cost-effective services at health centers rather than seeking treatment at hospitals.

Strategies to improve health should also include encouraging households and communities to make sound health care management decisions. Decentralization of health services will give greater authority to regional and local health staff, and magnify the role of the community, whose members not only should be the recipients of services, but also active participants in monitoring and managing these services.

Better use of donor funding is also integral to health reform. Donors' large contributions to health care in Africa—about 20 percent of total expenditures—have given them an important voice in determining health policy and programs. In some countries, the donors' dominant role has prevented development of coherent national health systems. It is time for African countries to ensure long-term benefits by putting donor funding to work in sustainable ways, within a coherent national program of health care services.

Revitalizing National Systems of Health Care

IN MOST AFRICAN COUNTRIES access to health care is inequitable between rural and urban areas. In Nigeria three-fourths of the country's public and private health facilities are located in urban areas, where only 30 percent of the population lives. Lagos State has one health facility for every 200 people, while Benue State has one for 129,000.

This geographic imbalance is echoed in the imbalance in public spending on health care. Major urban hospitals often receive more than half the public funds spent on health and employ the highest proportion of highly trained staff.

Because of the lack of well-functioning facilities in rural areas, clients tend to seek primary health care at urban hospitals. Though the quality of care may be good, these patients are deprived of the personal attention and frequent follow-up visits that would be available at a local, rural facility.

Moreover, the patients who come to these hospitals often have conditions—malaria, TB, respiratory infections—that could have been managed or prevented by primary care in health centers or first-referral hospitals. In the mid-1980s, for example, the leading causes of admission to hospitals in Malawi and Nigeria were parasitic and infectious diseases.

Hospitals' main functions are not to provide primary care. Congested outpatient departments and overworked laboratories lessen the effectiveness of their real purpose. Using hospitals for primary care inhibits development of community health programs: resources are channeled to the hospital instead of to the community. Another reason hospitals should not provide primary and preventive care is that costs for care can be 10 to 25 times higher in hospitals than in local clinics.

■ Underpinnings of a Cost-Effective Approach

Experience has shown that well-functioning health centers, working with first-referral hospitals, can manage most health care demands with a flexible, cost-effective package of basic services.

The health care services that stand out as being most cost-effective constitute the core of the basic health package: pregnancy-related care, family planning services, control of STDs, tuberculosis control, immunizations, and care for children's serious health problems—diarrhea, acute respiratory infection, measles, malaria, and acute malnutrition.

When these interventions are provided by well-functioning health centers and first-referral hospitals, they can manage more than 90 percent of health care demands and reduce the national burden of disease by 30 percent.

The Two-Tiered System

Health centers, working with first-referral hospitals, can lower the number of hospital admissions significantly. In Kasongo, Zaire, admission rates for clients from rural areas with health centers were 50 percent lower than in areas without centers, and patients who needed to be hospitalized also had easier access to hospital care.

Improved efficiency in health centers and first-referral hospitals means that central hospitals will no longer compete with them in providing primary care. Much public financing can be directed away from large hospitals, which should be financed through cost recovery and insurance. These hospitals can then be responsible for providing technical backup and training personnel in district-based facilities.

HIV/AIDS

The HIV AIDS epidemic underlines the urgent need to implement health care reforms. The two-tiered system can facilitate coping with the burden of caring for HIV and AIDS patients. Health centers can provide drugs, counseling, and treatment; patients eventually may seek treatment at first-referral hospitals in the disease's later stages.

A *WHO* STUDY carried out in the mid-1980s suggests that about 60 percent of the population of sub-Saharan Africa lacks regular access to the drugs they need. Drug shortages are common, particularly in public facilities, and drug stock-outs are frequent.

The solution to drug shortages in Africa is not to increase funding but to address inefficiency and waste in the health system. A study has found that patients in public sector facilities may consume only $12 worth of drugs for every $100 of tax money spent on drugs. See Figure 4.

The poor return on public drug expenditures is due to several factors. First, countries do not use cost-effective criteria to select drugs. Prices for different drugs to treat the same condition can vary by as much as five to ten times, and in some cases, by 130 to 150 times. A study in Nigeria found that drug expenditures were sometimes 30 times higher than necessary because doctors prescribed high-dosage specialty drugs.

Second, little attempt is made to quantify the amount of drugs that will be needed over a given period. When drug needs are quantified, large amounts can be bought at substantial savings.

Third, noncompetitive buying practices significantly raise prices. A study on buying practices in Nigeria found that buying generic drugs rather than brand names would reduce costs by 25 percent.

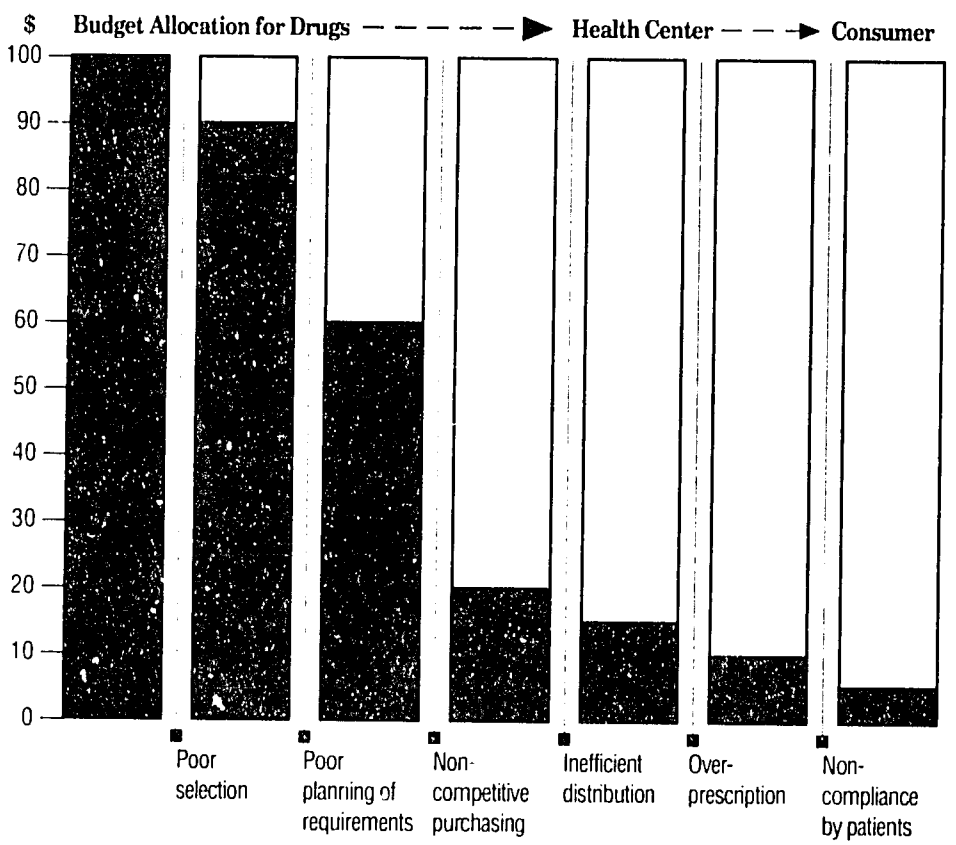
Fourth, inefficient distribution is a widespread problem, as well as poor management and storage practices that decrease drugs' shelf lives. A study in Cameroon found that central medical stores lost more than one-third of their drugs because of poor storage and poor inventory control.

Fifth, overprescription of drugs contributes to further inefficiencies. A survey in Mali found that, on average, doctors prescribed ten drugs, sometimes with duplications; in nearly all cases, one or two drugs would have been sufficient. Another study in Kivu, Zaire, found that the cost of a typical prescription was about equal to one month's income.

Sixth, incorrect use of drugs by patients reduces the proportion of effectively-used drugs. In Zimbabwe it was found that self-medication with chloroquine for malaria was common, but the drug was often wrongly used, leading to the conclusion that better public information was needed to ensure effective drug use.

■ FIGURE 4

Inefficiencies and Waste in Drug Supplies from Budget Allocation to Consumer



Source: The World Bank, *Better Health in Africa*

■ Making Pharmaceuticals More Cost-Effective

Inefficiencies in the supply of drugs mask the fact that far more is being spent on pharmaceuticals than is necessary. *Better Health in Africa* shows that full drug coverage could be achieved at a cost of $1.60 per capita. A package of essential drugs for the most common health problems—perinatal, infectious, and parasitic diseases—can help reduce drug spending. One study has found that a stock of 30 to 40 drugs in a well-organized health center can be used at a cost of about $.30 per treatment.

Prepackaged kits of carefully selected drugs provide a cost-effective way to improve drug distribution in low-income areas. Several countries, such as Kenya, Tanzania, and Uganda, are using kits that contain drugs determined by patterns of use.

A growing number of countries have also adopted cost-recovery and self-financing schemes. In Benin patients pay about three times the actual cost for their drugs and user fees cover 85 percent of operating costs, excluding salaries.

Another popular method to promote self-financing is for a donor to contribute an initial drug supply. Revenues from drug sales are then used to replace supplies and finance other costs.

■ Role of National Governments

Governments should promote policy reform and establish a national drug authority, composed of health professionals and resource managers, to supervise drug distribution and estimate drug needs. The group will also share decision making with health providers and users at community, regional, and national levels.

They should encourage the private noncommercial sector, including religious and humanitarian organizations, to help make pharmaceuticals more available. In Zaire church groups endorsed establishment of a nonprofit group to purchase pharmaceuticals.

Governments should turn their attention to ensuring education, training, and adequate information for practitioners and consumers in pharmaceutical use.

Managing Human Resources for Health

THE NUMBER OF HEALTH CARE PROVIDERS in Africa has grown since independence, but there are still fewer health workers per capita there than anywhere else. Between 1980 and 1986 Africa was the only region where the number of doctors per 10,000 people fell.

■ Undersupply and Underuse in Personnel Management

The lack of trained workers, especially in health policy and program analysis, planning, and budgeting, is an obstacle to implementing a cost-effective approach. High rates of attrition, partly due to low salaries, have also weakened research and management capacities.

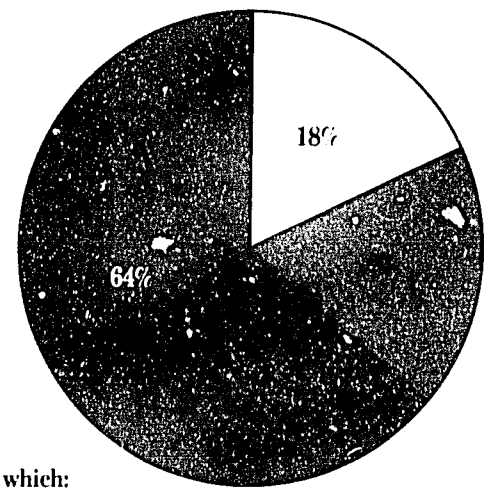
At the same time trained personnel are not used appropriately. High level administrative positions tend to be filled by physicians rather than health management professionals. In Uganda doctors working in public facilities are under-utilized and see far fewer patients than private doctors.

A study in Rwanda found that about 36 percent of all deliveries would be assisted by trained staff if the country's 500 trained midwives were used adequately. In fact, only 18 percent of all deliveries were attended by trained personnel. See Figure 5.

Underuse of personnel stems from poor planning and lack of coordination between actual health needs and training content. The public sectors in Benin, Madagascar, Mali, and Zaire employ only a fraction of their health school graduates. In some cases there are too many health care specialists, but a shortage of health care administrators.

■ FIGURE 5

Undersupply and Underuse of Human Resources in Health Services: Percentage of Deliveries Attended and Not Attended by Trained Personnel, Rwanda, 1985



Deliveries for which:

- Trained personnel unavailable
- Trained personnel available but not in attendance
- Trained personnel available and in attendance

Source World Bank data

Achieving Effective Management of Health Care Personnel

Since the 1978 Alma Ata Conference only a handful of countries have developed comprehensive health personnel policies. Tanzania is one country that has been relatively successful in implementing plans for health personnel. That country's Arusha Declaration set explicit targets, including the training of 13,000 new health workers between 1972 and 1980. These targets have been met and, in some cases, surpassed. Their planning for personnel, however, did not foresee all staffing variables and needs, and the health sector's current resources cannot meet more recent staffing standards.

As health systems decentralize, personnel at the community and district levels will have more authority and be more accountable for their decisions. Though much depends on individual skills and personalities, district medical officers and their teams can benefit from government-sponsored training and supervisory support.

In Ghana the government gave local health workers in Tema an unusual opportunity to improve their health services. A medical officer with outstanding leadership skills was appointed to raise low staff morale and improve health care delivery. He established an agenda to visit the factories in Tema and discuss workers' health problems, and to visit all health centers. An ad-hoc management advisory

group, composed of Tema residents and management experts, began to meet regularly. Monthly staff meetings of senior clinicians and managers were organized to discuss patients, staff problems, and management of health services. Within six months improvement in health delivery was noted by staff, the region's health director, the Ministry of Health, and hospital users. Identifying and analyzing the problems was an essential step toward implementing change. Information systems and management policies can help providers and clients identify problems and analyze them locally.

Other countries also have made progress in developing information systems.

- In Zaire, an information system was introduced in the mid-1980s for 60 health centers for less than 2 percent of health care costs.

- Guinea and Benin have revised their management information systems under the Bamako Initiative. Although staff spend considerable time entering data on patients and drugs, most see the system as an important part of improving health.

Traditional Healers and Modern Health Care Providers

Greater collaboration between traditional healers and other health care providers could lead to stronger ties with the community. More than 20 African countries have established associations of traditional healers. However, more emphasis could be placed on training traditional healers to increase their skills. For example, appropriate training for traditional birth attendants would give them a greater role in the community health care systems. In Ghana, Nigeria, and Zimbabwe traditional healers have learned practices such as oral rehydration and HIV/AIDS prevention.

Role of the National Government

As health care becomes more diversified, governments will have to establish mechanisms to compensate health personnel adequately. Local retention of fees is one means to ensure regular payment. Some health centers in Congo, Kenya, Guinea, and Nigeria are using incentive payments to finance their health care facilities. In Guinea resources mobilized by the communities to pay incentives have ranged from around 10 percent to nearly 50 percent of normal salary levels.

Governments also will need to set up training for health care workers and other community members. Training should be multidisciplinary and adapted to community needs. Managing health personnel in Africa depends primarily on better supervision at the district level. Preparing personnel policies and job descriptions is central to this work and requires a genuine collaboration among the ministries of health, education, finance and planning, and civil service commissions.

Management of Infrastructure and Equipment

MUCH OF SUB-SAHARAN AFRICA faces high infrastructure and equipment costs, especially the Sahel countries where construction costs are double, or even more, than those in other African countries. Some of the most common infrastructure and equipment problems include:

1. Underfinancing of maintenance and repairs, particularly in the public sector. A study in Nigeria found that public hospitals spent only 5 to 8 percent of their budget on nonpersonnel costs, compared with private sector spending of 17 to 18 percent.

2. Low priority given to recruiting and training maintenance personnel, which exacerbates deterioration of physical infrastructure, especially in the public sector. See Figure 6.

3. Imbalances between rural and urban areas. Money spent on infrastructure has tended to focus on improving tertiary facilities in urban areas, which benefit mainly the relatively well-to-do.

4. Weak central government planning. Lack of coordination among the public sector, nongovernment organizations, and community initiatives has led to uneven distribution of health facilities.

FIGURE 6

Health Care Equipment Not in Service in Nigeria, 1987

Item	University Teaching Hospitals	State-Owned Hospitals	Non-Government Centers	Primary Health Centers	Total
Pieces in use	69	57	78	90	70
Pieces out of order	31	43	23	10	30
% of equipment out of order for given duration:					
< 2 years	19	22	33	40	20
2-4 years	40	24	67	60	38
> 4 years	41	54	—	—	42

Source: Erinosho 1991.

— Not available

The same factors that result in poor maintenance have made it difficult for African countries to expand their health sector infrastructure. Assuming that a health center serves about 5,000 people, Mali will have to increase the number of its health centers by 242 in the 1990s, which is nearly five times the actual increase of 52 during the 1980s. See Figure 7.

Some countries, however, have continued developing their community health facilities. Botswana expanded the number of its clinics from 40 to 150 between 1974 to 1986; in Tanzania the number of dispensaries increased from 1,847 in 1976 to 2,935 in 1988.

Improving Infrastructure Management

Experience has shown that governments can improve management of infrastructure and equipment inexpensively by rehabilitating equipment and facilities rather than making new investments. In selecting facilities and equipment for rehabilitation, preventive and primary care should be priorities.

In tertiary facilities, which usually absorb large portions of health budgets, managers should set up specific targets to improve efficiency without an increase in government spending. The Kenyatta National Hospital, for example, has established performance targets to reduce length of in-patient stays.

FIGURE 7

The Growth of Health Centers in Selected African Countries and the Challenge Ahead

	ACTUAL NUMBER		NUMBER NEEDED IN 2000	
	1980	1990	To maintain 1990 coverage	To reach 60 percent coverage
Burkina Faso	169	860	1,100	1,400
Mali	470	522	760	1,300
Niger	240	460	630	1,270
Senegal	470	690	900	1,200

Source: World Bank 1992a.

Community involvement is crucial in successful management of health care facilities and equipment. Studies have shown that partnerships with communities can promote local initiatives and foster a community's sense of ownership. In Mali a cost-sharing formula (50 percent government and 50 percent local communities) has been set up that will pay for construction and maintenance of 120 community health centers over a five-year period.

The greatest obstacle to improving technology may be "technology philanthropy," the uncoordinated donation of equipment by external donors. One solution to the problem is "donation protocols," which would establish the kinds of equipment needed, according to a model similar to the essential drugs lists.

Achieving health goals in Africa depends on improving infrastructure management. One concrete step would be to make a senior Ministry of Health official responsible for managing facilities, equipment, and technology. Another would be to establish norms for facilities at different levels in the system. Increased funding to rehabilitate and maintain infrastructure and equipment can be drawn from the closer budget controls that should be imposed on tertiary care.

Management Capacity and Institutional Reform

EVEN AFTER REFORMS in public administration made in the 1980s, many African governments are still highly centralized, giving local governments little autonomy.

Steps toward Initiating Reform

In decentralizing, roles and responsibilities should be clearly defined, specific country conditions assessed, and a timetable established. Experience has shown that successful decentralization is built on clear definitions of functions at each level. In the two-tiered system, the district health team (DHT) carries out day-to-day management of health services and has an important role to play in ensuring availability of the basic package of health services.

Studies have shown that DHTs have a greater chance of success when the district has the authority and capacity to manage its own resources. When the community is involved, health needs and expectations are identified more rapidly and the work is carried out with greater flexibility. Local management also improves health care systems by making health providers accountable to clients.

- In Ethiopia community groups mobilized people for immunization, traced defaulters, and educated people.
- In Guinea and Lesotho community representatives formed health management committees to develop nutrition and child health programs. They also worked on developing a cost-recovery plan.
- In Ghana community groups formed environment tribunals to enforce the sanitation regulations they had devised.

Institutional reforms will require cooperation with a range of other health providers—private, nongovernment, and voluntary. Benefits from this cooperation are evident in the following examples:

- In Zaire 50 percent of 306 health zones are managed by NGOs or collaborate closely with them.
- Women's groups are working to ensure attention to women's health issues. In Uganda a group of women's NGOs are implementing a program to reduce maternal mortality with funding from The World Bank and other agencies. In Ghana the Registered Midwives Association provides maternal health and family planning services, and advises the government on improving maternal health care.

Costing and Paying for the Basic Package of Health Services

HOW MUCH WILL IT COST to rethink the health care system and how will a new basic package be paid for? Instead of basing estimates on past expenditures, cost-effective approaches can be used to determine future financing needs. Two sets of costs are presented here: one is for low-income countries and the other, based on Zimbabwe's experience, shows how costs will rise as income, wages, and prices go up. See Figure 8.

■ FIGURE 8

Annual Indicative Per Capita Costs for a District-Based Health Care System: Input Approach

Type of Service	COST (US$) Low-Income Countries	Higher-Income Country
Health Care and Facilities		
Level 1: Health Center	4.60	6.72
Operating costs	3.78	4.84
Capital costs	0.73	1.75
In-service training	0.09	0.13
Level 2: District hospital	3.14	4.03
Operating costs	1.75	2.24
Capital costs	1.35	1.73
In-service training	0.04	0.06
Total, health care and facilities	7.74	10.75
Intersectoral Interventions		
Water	2.56	2.19
Sanitation	1.42	1.36
Total, intersectoral interventions	3.98	3.55
Institutional Support		
District health care management team	0.29	0.40
Operating costs	0.15	0.24
Capital costs	0.13	0.16
In-service training	0.01	0.01
National management structure (15 percent of total health care costs)	0.82	1.15
Initial training (5 percent of total health care costs)	0.27	0.38
Incremental salary bonus (15 percent of total salaries)	0.12	0.14
Total, institutional support	1.50	2.07
TOTAL COSTS	13.22	16.37

NOTE: District profile: 150,000 inhabitants; 15 health centers (10,000 in each center).

Source: Adapted from World Bank 1993a.

In a low-income African country, the basic package of health services can be made available for an annual cost of $13 per capita. The $13, based on costs in several African countries, includes health care and facilities (60 percent), intersectoral interventions (30 percent), and institutional support (10 percent).

For the high-income category, Zimbabwe has been chosen as an example because its health care system incorporates many elements of the cost-effective approach and aims to provide a basic health care package for all. Its costs illustrate the type of pattern low-income countries may face in the future.

Total costs in Zimbabwe are only 24 percent higher than those estimated for low-income Africa. Intersectoral interventions are 11 percent lower because widespread demand for safe water and sanitation has made services more economical, but health care costs are 39 percent higher.

■ Public and Private Funding

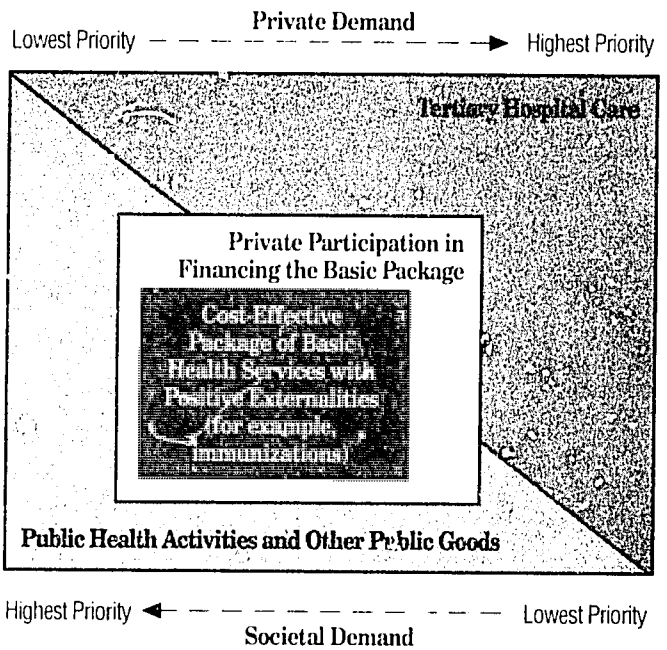
Government's first priority should be to finance cost-effective public health goods and services that have the greatest impact on the enabling environment for health. These expenditures are called public goods because they tend to benefit the community as a whole. See Figure 9.

■ Affordability

The basic health services package — $13 — costs less than what one-third of Africa's population now pays. High-income African countries spend $68 per capita on average for health care. Some are beginning to implement user fees and expand insurance for curative care. Since private expenditures are already about $19, the basic health care package would be affordable. But the question to ask is this: do the other high-income countries receive the same benefits as are widely available in Zimbabwe, where cost-effective measures have been implemented and per capita expenditures are $42. Also, can Zimbabwe itself obtain more health services from existing expenditure levels by increasing efficiency? See Figure 10.

■ FIGURE 9

Priorities for Public and Private Expenditure on Health



Source: The World Bank, *Better Health in Africa*

Medium-income countries spend an average of $16 per capita on health. Private expenditures in these countries are $7, and because per capita income is almost double that of low-income countries, people may be willing to spend more, especially if they are offered a cost-effective package. Although it will require greater resources and effort at reallocation, the basic package should be affordable.

Malawi's example may provide some guidance. The government is increasing its spending on health by .5 to 1 percent a year. In ten years, the $6 now available for health could be doubled, and this increase might lead donors to greater participation.

Low-income countries will have to carry out a major reallocation of resources and mobilize substantial additional resources to fund the basic package. These countries now spend about $8 per person on health compared with the $13 estimated for the basic package. About half of this $8 comes from private expenditure, with the government and donors each giving $2. However, if these governments raised their spending to the level of other less developed countries, their contribution would increase from $2 to $5. After making this new commitment to health, governments could then ask donors for another $2 per capita. Additional private resources would also have to be mobilized.

To meet basic health needs in low-income Africa, about $1.6 billion a year in additional funds would have to be found. If all countries were engaged in active programs for better health, the donor share would come to about $650 million per year, an increase of about 50 percent over 1990.

■ FIGURE 10

Selected African Countries Grouped by Relative Level of Expenditure on Health, 1990

	COUNTRY GROUPING		
	High Expenditure	Medium Expenditure	Low Expenditure
Country Characteristics			
Population (millions)	14.1	95.5	340.3
Average GNP per capita (U.S. dollars)	757	395	225
Expenditure Per Capita			
Private (U.S. dollars)	19	7	4
Government (U.S. dollars)	40	6	2
Donor (U.S. dollars)	9	3	2
TOTAL	68	16	8

NOTE: High-Expenditure Countries: Botswana, Lesotho, Swaziland, and Zimbabwe. Medium-Expenditure Countries: Burundi, Cameroon, The Gambia, Ghana, Kenya, Liberia, Malawi, Niger, Rwanda, Senegal, and Zambia. Low-Expenditure Countries: Burkina Faso, Ethiopia, Mali, Nigeria, Sierra Leone, Somalia, Uganda, and Zaire.

Source: United Nations Development Program and World Bank 1992; World Bank 1993e.

■ Pace of Reform

In some cases expenditures will be steepest in the initial stages when new facilities and intersectoral services will require capital investment. Donor support will be crucial at this time. After a country has decided on its package of basic services, and established detailed cost data, a group of experts and officials from the public and private spheres could identify the division of public and private goods. The next step would be to determine the roles of government, donors, and households in financing gaps.

Mobilizing Funds for Better Health

THE GOVERNMENT'S SHARE of health spending varies widely across Africa. One study found a 15- to 20-fold difference in government health expenditures between high- and low-income countries, a figure far out of proportion to the nearly fourfold difference in average per capita incomes between the two groups.

Poor economic conditions are clearly a factor in low government spending on health. Another frequently cited reason for reduced government spending on health is the introduction of structural adjustment programs. However, studies have shown that government spending on health remained the same during the years when structural adjustment loans were released as in other years.

Governments determined to do so can change the pattern and level of health expenditures. In Lesotho health and welfare received about 6 percent of total government expenditures in 1982-83, and about 10 percent in the early 1990s;

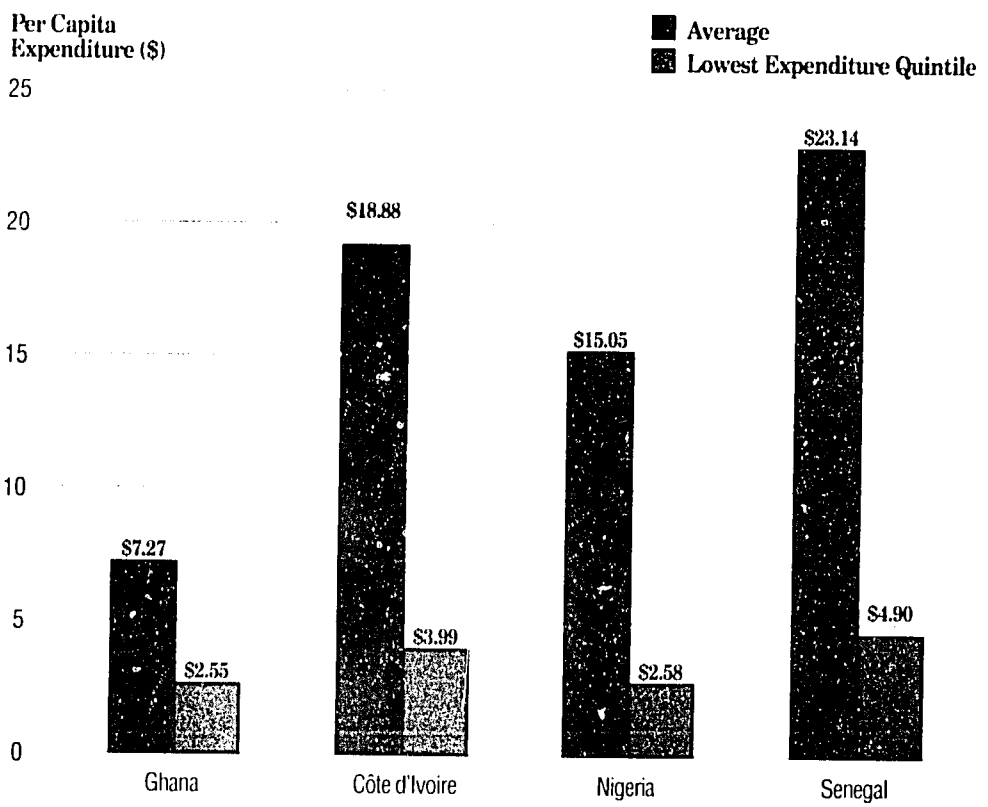
education funding increased from about 15 percent to 20 percent. These increases were made possible partly by cuts in military spending from about 24 percent to 10 percent.

Domestic Resources

At a meeting in Bamako in 1987, WHO adopted a resolution to introduce community cost-sharing to support primary care. The Bamako Initiative was then launched, which involved from one to 50 districts in 13 countries, some 1,800 health facilities, and about 20 million people. In nearly all cases drugs have been priced to serve as a mechanism of cost recovery and financing of local services.

FIGURE 11

Annual Per Capita Household Expenditures on Health, Late 1980s



Source: The World Bank, *Better Health in Africa*

Cost-sharing in local health centers has significant benefits. In Benin, Nigeria, and Guinea approximately 40 to 46 percent of local operating costs, including salaries, are being covered by fees. Countries can raise funds by increasing user charges and developing community financing schemes. See Figure 11.

Ghana raised user fees in 1985, increasing cost recovery receipts from 5.2 percent to 12.1 percent in only two years; part of the proceeds are reinvested in the health center to improve the quality of service. The plan reinforces the referral system by making curative care more expensive at the hospital than at the health center.

Users Will Pay for Quality Health Care

A study in Cameroon compared two groups of health centers. One group charged user fees and had improved the quality of care; in the other group no changes had been made. Surveys found that households in areas where centers had introduced changes were significantly more likely to use the center. Contrary to previous studies suggesting that the poorest groups are most hurt by user fees, this study found that the poorest groups sought care at a greater rate than the rest of the population.

***Better Health in Africa* suggests that groups with higher incomes should pay a much larger share of costs and low-income groups should get health care at little cost. Although everyone should pay something, some primary care service will be virtually free.**

International Aid

Donor contributions to health care have been growing steadily since 1981. By 1990, they had climbed to almost $2.50 per capita—although there were wide variations among countries.

Although beneficial, this aid has also had some negative side effects. For example, relatively large amounts have gone to urban facilities, while rural regions received little funding. External aid has often been earmarked for nonsustainable projects—nearly every African country has at least one major project, such as a large hospital, that will never function as planned because of lack of money to cover operating costs.

Donor aid has sometimes had the negative side effect of preventing countries from developing coherent national health policies and programs. Donor programs have tended to focus on themes formulated at international conferences while countries' own priorities have been ignored. External financers need to focus on broader long-term programs that support health reform rather than on individual project-based support. Furthermore, sporadic, short-term projects do not build up a country's basic health services. Because the higher-income countries are in a better position to finance their own programs for better health, donor support should be concentrated increasingly on low-income countries with active agendas for improving health.

Governments and donors need to work as partners in establishing overall financial plans and cost-effective packages of basic services. In Ghana, for example, the Ministry of Health has organized a local assistance group on health that meets regularly with donors to resolve health strategy issues.

Timetable for Change

EACH COUNTRY WILL HAVE its own timetable for carrying out reforms, but most of the required restructuring can be divided into three time periods:

- Short-term actions, which demand priority, fall mainly in the public domain. They include formulating health policies, initiating reform, and working with ministries to assess donor participation.
- Some medium-term actions include supporting training programs, reallocating larger shares of funds to health centers and first-referral hospitals, implementing cost-sharing, and ensuring that donor funding is used to reinforce national strategies.
- Long-term actions include progressive expansion of the health system and making health systems more self-sustaining.

The challenge for each country in formulating its own timetable can be illustrated by comparing the situations of three countries—Uganda, Mali, and Botswana.

- Uganda is typical of several countries that have suffered political, social, and economic upheaval in recent years. Health indicators have shown little improvement, health finance is in disarray, and the health system is profoundly disrupted. The government is now faced with the urgent need to rethink the country's health strategies and health system.
- Mali is typical of the few African countries that are gradually improving health outcomes, such as life expectancies and infant survival, despite financial constraints. The Ministry of Health, aided by donors who promote district-level care, is moving away from vertical programs toward expanding district-based care. By 1997, 52 percent of the population should have access to health care. Some of the challenges the government still faces are to increase government health expenditures and promote cost-sharing.
- Health in Botswana has been improving rapidly; access to health is relatively good and, some time ago, the government decentralized to the district and subdistrict levels. The country has a solid tradition of cost-sharing. The challenges now facing Botswana are privatization or full cost recovery at hospitals, encouraging insurance schemes, and reducing donor involvement.

Developing Greater Research Capacity

Improving health research and research capacities will help African countries carry out the steps to reform called for in *Better Health in Africa*—establish their own policy agendas, identify cost-effective packages, target households in need, improve management of decentralized systems, and monitor progress.

Health Research in Ghana

The Ministry of Health in Ghana has created a health research unit to act as a liaison between professional researchers and the Ministry of Health, and to conduct and promote health systems research. Within two years of its founding, the unit had formulated a research agenda and had supported more than 20 completed research projects and conducted workshops for regional and district health teams on research proposal writing and data analysis.

Conclusion

Experts from African countries can play an important role by providing leadership in making compacts for better health between African countries and the international community. An example of such a compact would be for the government to double its resources for health and improve its allocation, and for the donor to provide a comparable increase in targeted support.

A forum could be established to ensure coordination of international initiatives for training and health systems research. It could review and support reforms, serve as a support group for ministries of health and other agents of change, and facilitate the exchange of experience about initiatives for better health in Africa. A consultative group on health in Africa, along the lines of the Donors to African Education — a group that brings together Africans and donors on education issues — could provide this forum to build consensus among African countries and their partners.

The program for better health in Africa represents an unparalleled opportunity for Africans and donors to work together in overcoming intolerable levels of suffering, premature death, and waste stemming from ill health.

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