Dear Editor

It is often said that for public health policy to be credible and acceptable it has to satisfy the criteria of equity, quality and efficiency. However, some studies indicate that many Sub-Saharan African (SSA) countries are unlikely to internally generate the required funding to provide efficient and quality health services. Such countries may be unable to guarantee the required equity in financial contribution to enable universal health coverage (UHC), leading to increasing private spending on health care.

Related studies show that episodic treatment for diseases such as malaria may cost families in SSA between US$17 and US$93 per household, with the impact being greater on rural and remote populations where household income will often be inadequate to meet such expenditure. However, even with private contributions, the quality of SSA health services will be inadequate due to the endemic financial and management challenges such as personnel retention, quality assurance, stewardship and technical inefficiency.
Table 1: Potential revenue streams for a ‘US$10 pre-paid plan’ if 30% of estimated total and rural populations voluntarily enroll for 6 Sub-Saharan African countries

<table>
<thead>
<tr>
<th>Variable [ref]</th>
<th>Sub-Saharan African country</th>
<th>Cameroon</th>
<th>Ghana</th>
<th>Kenya</th>
<th>Nigeria</th>
<th>Senegal</th>
<th>Togo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of pocket expenditure as % of PEOH [15]</td>
<td></td>
<td>94.8</td>
<td>77.8</td>
<td>80.0</td>
<td>90.4</td>
<td>77.0</td>
<td>84.2</td>
</tr>
<tr>
<td>PPP as % of PEOH [15]</td>
<td>N/A</td>
<td>6.0</td>
<td>6.9</td>
<td>6.7</td>
<td>19.3</td>
<td>4.3</td>
<td></td>
</tr>
<tr>
<td>Total estimated population by July 2009 [14]</td>
<td>18 879 301</td>
<td>23 632 495</td>
<td>39 002 772</td>
<td>149 229 090</td>
<td>13 711 597</td>
<td>6 019 877</td>
<td></td>
</tr>
<tr>
<td>Estimated rural population at 2009 [14]</td>
<td>8 281 081</td>
<td>11 737 467</td>
<td>51 083 373</td>
<td>78 787 951</td>
<td>7 189 633</td>
<td>3 792 465</td>
<td></td>
</tr>
<tr>
<td>30% of estimated population</td>
<td>5 663 790</td>
<td>3 521 240</td>
<td>11 700 831</td>
<td>44 768 727</td>
<td>2 156 889</td>
<td>1 137 739</td>
<td></td>
</tr>
<tr>
<td>Potential funding stream from 30% enrollment at $10 pre-paid health fund (US$ million)</td>
<td>56.64</td>
<td>71.5</td>
<td>117.01</td>
<td>447.69</td>
<td>41.14</td>
<td>18.06</td>
<td></td>
</tr>
<tr>
<td>Local equivalent at 4 May 2011</td>
<td>CFA 25.14 billion</td>
<td>e 108.42 million</td>
<td>KShs 9.78 billion</td>
<td>N 69.37 billion</td>
<td>CFA 18.266 billion</td>
<td>CFA 8.02 billion</td>
<td></td>
</tr>
<tr>
<td>Potential funding stream from 30% enrollment at $10 pre-paid rural health fund (US$ million)</td>
<td>24.84</td>
<td>35.21</td>
<td>93.26</td>
<td>236.36</td>
<td>21.57</td>
<td>11.38</td>
<td></td>
</tr>
<tr>
<td>Local equivalent at 4 May 2011</td>
<td>CFA 11.03 billion</td>
<td>e 53.40 million</td>
<td>KShs 7.8 billion</td>
<td>N 8.66 billion</td>
<td>CFA 9.58 billion</td>
<td>CFA 5.053 billion</td>
<td></td>
</tr>
<tr>
<td>Total health expenditure 2007 [16] (US$ million)</td>
<td>303 million</td>
<td>728 million</td>
<td>639 million</td>
<td>2.9 billion</td>
<td>N/A</td>
<td>52 million</td>
<td></td>
</tr>
<tr>
<td>2007 General government expenditure on health as % of total expenditure on health [17] (US$ million)</td>
<td>25.8% (~ 78.5)</td>
<td>51.6% (~ 375.6)</td>
<td>42.0% (~ 268.4)</td>
<td>25.3% (~ 725.1)</td>
<td>56.0% (NA)</td>
<td>24.9% (~ 13)</td>
<td></td>
</tr>
</tbody>
</table>

CFA, CFA Franc; KShs, Kenyan Shillings; N, Nigerian Naira; NA, not available; PPP, private pre-paid plans; PEOH, private expenditure on health; e, Ghanaian Cedi.

Differing approaches have been considered to enable UHC, such as sustainable funding models and advocacy for revenue from hypothecated, sector-specific and excise taxes. However, because private expenditure on health continues to exceed government expenditure in most SSA countries, to ensure the sustainability of UHC in the rural and remote regions of 6 SSA countries (Table 1) a '$10 dollar prep-paid plan' for free basic health services is suggested, with the following assumptions:

- Although $10 is less than the World Health Assembly (Resolution WHA 58.33) ideal, it is better than no contribution.
- Subscribers will be willing to pay this in order to receive better quality health care.
- Subscription contributions can be made easily via dedicated GSM (Global System for Mobile communication) pre-paid cards/starter packs, with postal confirmation certificates to reduce administrative costs.
- The funds generated will increase the sustainability of rural health services provided there are explicit mechanisms to ensure expenditure for specific purposes, such as access to medicines and rural personnel retention.
- All enrollees, including those paid for by family, community members or purpose-specific social welfare grants, are covered irrespective of their demographic characteristics.

Analysis using 2009 total and rural populations for the 6 SSA countries (all with an out-of-pocket health expenditure as a percentage of private expenditure on health of 70% or more, as well as private pre-paid plans less than 20% coverage by 2006), shows that if 30% of the total and rural estimated populations in several SSA countries enroll in such a scheme, the revenue stream would be significant, compared with total government expenditures (Table 1). Therefore, if appropriate mechanisms ensure the retention of such funds for dedicated expenditure on rural health services, and wider
managerial issues are addressed, a significant impact will be made on the sustainability of rural health services, including access to medicines and improved personnel retention.

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References


