"PRIORITIES OF HEALTH ECONOMICS IN AFRICA"

Inaugural Conference of the African Health Economics and Policy Association (AfHEA)
10th – 12th March 2009 - Accra, Ghana

Parallel session 6: New trends and debates in international health financing

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PS 06/2

African health priorities and the new international health financing mechanisms

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Introduction:

Africa, with 10 percent of the world's population, accounts for 25 percent of the global disease burden and 60 percent of the people living with HIV/AIDS, as well as the highest disease burden for TB and malaria in the world. Yet Africa accounts for less than 1 percent of global health spending and contains only 2 percent of the global health workforce.

By almost any measure, most African countries are spending far less on health than they need to in order to either ensure a reasonable package of priority health services for their populations, or to meet targets signed on to by African leaders. Given that estimates of the amount of resources required to achieve the Millennium Development Goals (MDGs) all show huge sums are needed, well beyond what the low income countries could possibly afford, the question is: Where should the extra resources come from?

In 2001 African Union (AU) countries set the Abuja target of attaining a 15% share of national budgets for the health sector. Although no corresponding deadline was set for achieving the target, it is significant to note that by 2005 (according to the AU's own data), only about a third of Sub-Saharan African (SSA) countries were allocating 10% or more of their national budgets to the health sector. But even if the Abuja target was achieved, what impact would this make on national health priorities and financing needs? Similarly, in this same connection, how relevant is the Commission on Macroeconomics and Health's (CMH) recommended target for spending on health of $34 per capita?

The international community has been steadily increasing the resources going into health in Africa in recent years, through such mechanism as GAVI, the Global Fund, PEPFAR, etc. Have these investments been targeted at Africa's health priorities, and how do they address the health financing gaps? How sustainable are these new investments?

Aim and objectives:

The overall aim of the study is to analyse the health financing situation in Africa today in terms of the relationship between health (including financing) priorities in Africa and the new financing mechanisms that form the core of several recent global health partnerships. More specifically, we examine the relevance of related international health financing targets, and the role of the new international health financing mechanisms such as GAVI, PEPFAR and the Global Fund. The analysis will explore gaps in health financing and the match between new financing and the needs and priorities of African countries.

Methods used:

We analyse financing data available from international institutions (such as OECD-DAC, WHO, WBI, IMF, the African Union, etc) as well as available national data sets. Data available from the web sites of new international financing bodies such as GAVI and the Global Fund will also be mined for insights related to the paper's theme.

Results:

- While achieving the Abuja target is important to show commitment towards increasing the share of public spending going to health, in many African countries, this would not be enough to assure a decent package of health services to the population. It is not even clear that the CMH target of at least $34 per capita spending on health will be sufficient, however it is a superior approach to thinking about what is required than the Abuja approach. More important though, is the need to move away from universalistic one-size-fits-all, targets to country-specific analyses of what is required to provide a decent health services to their populations.
- The advent of the new global health partnerships and increased bi- and other multilateral assistance for specific health interventions has met with some criticism for accentuating certain problems associated with the international aid architecture: unpredictability and volatility of donor funding; proliferation of disease- and intervention-specific programs, which are often not integrated into any particular country's on-going programs; large numbers of new actors and donors; other macro-economic distortions, and lack of accountability of donors for the absence of results and progress.
- The new financing mechanisms tend to be aligned more with donor priorities for health than with country needs and priorities. Some potentially distort the health financing situation of countries.
- The recurrent costs of GHP investments (human resources required to deliver the new programmes, new treatment centres, costs of vaccines and life-saving drugs, etc) are not sustainable for many African countries.