THE STATE OF HEALTHCARE IN AFRICA

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Overview

Africa is not a healthy continent. On all indicators of health, Africa lags behind the rest of the world, and behind poor countries of South-East and South Asia that were behind Africa when measured on these metrics a few decades ago. Much of this gap, which has widened since the 1980s, is a consequence of the Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome (HIV/AIDS) epidemic which has hit Africa harder than any region on Earth, but much of it (as well as the sometimes sluggish and ineffective responses to HIV/AIDS) can be blamed on other factors. African governments focussed on direct payment, and continue to do so to a large extent, after most countries started to move more towards facilitating health insurance schemes. Widespread and rapacious corruption has meant that large slices of health budgets have gone missing. Infrastructure problems have made it difficult to provide services to many people in more remote areas. Poverty has slowed the emergence of private healthcare initiatives outside of a few cities. Conflict has directly affected Africans’ health through high numbers of death and injuries, and indirectly by hampering healthcare provision. All these problems, as well as Africa’s sheer size and its position on the globe – most of it is in the tropics where the nastiest germs and parasites flourish – have made Africans unhealthier and worse looked after medically, than the inhabitants of any other continent on earth.

If one looks at the state of Africa’s healthcare as a unit in 2012, the picture is still one of a generally poor population, subject to diseases that have been eradicated or brought under control on most other continents, neglected by private healthcare providers and underserved by governments, reliant on irregular help from abroad. Part of the aim of this report is to look at the current state of the healthcare sector in Africa, to identify the reasons for its underperformance, to note the geographies where the picture is less gloomy and to try to explain why those countries perform better. But the whole continent is not blighted: there are success stories here and there, some countries or cities in which multilateral institutions, governments, private firms or non-governmental organisations (NGOs) have come up with ideas or programmes that have had a big, positive impact on a local population. The other aim of this report is to see what was done right in those places, and to estimate how fast the successful ideas are spreading to other communities. Finally, the report will explore some macro-scale trends in Africa and in the world which should be kept in mind when thinking about the future of healthcare in Africa.

Africans’ Health and Africa’s Healthcare

As mentioned above, health indicators in Africa are shocking. Africans live, on average, 14 years less than the average world citizen, and 21 years less than the average European. The maternal mortality and the mortality rate for children younger than five years are more than double the world average. There are only 2.3 doctors per 1,000 people in Africa, less than one-tenth of the figure in Europe and less than half the figure in South-East Asia.

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>WORLD</th>
<th>AFRICA</th>
<th>EASTERN MEDITERRANEAN</th>
<th>EUROPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth, 2009</td>
<td>68</td>
<td>54</td>
<td>66</td>
<td>75</td>
</tr>
<tr>
<td>Physicians per 1,000 people, 2010</td>
<td>14.0</td>
<td>2.3</td>
<td>11.0</td>
<td>33.3</td>
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<tr>
<td>Under-5 mortality per 1,000 live births, 2011</td>
<td>51</td>
<td>107</td>
<td>58</td>
<td>13</td>
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<tr>
<td>Maternal mortality ratio, per 100,000 live births, 2008</td>
<td>260</td>
<td>620</td>
<td>240</td>
<td>21</td>
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Source: WHO, UNICEF. ‘Eastern Mediterranean’ includes North Africa except Algeria

Not only are the absolute levels of all indicators low, but progress on almost every indicator is slower than in any other region. Maternal mortality in Africa, for instance, decreased 27% over the past two decades, which is certainly a good outcome, but the global figure over the same period was 35% and in South-East Asia it was 58%. Mortality in children under five is declining by 2.5% a year in Africa, compared to 2.7% worldwide and 5.6% in the European region (which for the WHO includes a number of former Soviet republics). Maternal mortality in Africa is declining at a rate of 1.7% a year, against 2.3% worldwide and 5% in South-East Asia. As a consequence, Africa will lag behind the rest of the world on health indicators for many years to come.

It is important to consider the reasons why this is so. By far the most important reason is the way in which healthcare in Africa is funded. As The Economist puts it, healthcare funding in Africa is a “patchwork of meagre public spending, heavy reliance on foreign donors and a large dependence on out-of-pocket contributions and user fees that place the greatest burden on the poorest members of society.” African governments’ budgets are insufficient to address the issues, and are often further reduced by corruption. The aid that does come from external sources is usually imprecisely and often...
unproductively targeted, focussing overwhelmingly on high-profile causes like HIV/AIDS or malaria, and neglecting other health issues, like child and maternal health, nutrition and the spending necessary to build up health systems. Lastly, and obviously, systems that rely on out-of-pocket spending in a poverty-stricken region can be expected to fail. Other relevant reasons are the small size of the domestic pharmaceutical industry, and the low number of trained doctors (exacerbated by a brain drain of doctors who do qualify, then choose to pursue their careers abroad).

It is possible to overcome the limitations above: African healthcare has a number of success stories, which this report will consider. Those successes have all been the result of dedicated organisations overcoming structural limitations by doing things in novel and often unpopular ways. Delivering effective healthcare in Africa usually means doing things differently.

Mortality and causes of death

Africa has the lowest life expectancy of all the regions in the classification of the World Health Organisation (WHO): 54 years, compared to 65 in South East Asia, the next shortest lived region, and 76 years in the Americas, the region where people live longest. The figure for Africa is up only marginally from its level of 51 years in 1990, as the devastating effect of the HIV/AIDS pandemic has undone all the successes achieved in extending life expectancy through other measures. The main contribution to longer lives in Africa has been through conflict resolution: the countries that have made the most remarkable progress are simply those in which wars have been resolved. So Eritreans have seen their life expectancy go from 36 to 66 years in barely two decades (an improvement of over 80%), while in Liberia the figure went from 37 to 56 years and in Angola from 42 to 52. There have been other countries in which advances in longevity have been impressive, and due to factors other than conflict resolution: in the past two decades life expectancy in Egypt has increased 15% to 72 years, and in Morocco it has gone up 12% to 73 years over the same period. These advances are purely the outcome of improvements in healthcare delivery and basic living conditions.

To better understand why lives in Africa are so short, in relative terms, it is important to see what ends lives. (At 34 per 1,000 people per year, Africa’s crude death is by far the highest in the world and more than quadruple the global average.) The table below shows the leading causes of death worldwide, in Africa, the Eastern Mediterranean and Europe:

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>World</th>
<th>Africa</th>
<th>Eastern Mediterranean</th>
<th>Europe</th>
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<tr>
<td>Communicable diseases, maternal and perinatal conditions and nutritional deficiencies</td>
<td>27.5</td>
<td>65.0</td>
<td>36.3</td>
<td>5.8</td>
</tr>
<tr>
<td>Of which infectious and parasitic diseases</td>
<td>15.3</td>
<td>63.7</td>
<td>15.7</td>
<td>2.6</td>
</tr>
<tr>
<td>Non-communicable conditions</td>
<td>63.5</td>
<td>28.3</td>
<td>53.1</td>
<td>87.0</td>
</tr>
<tr>
<td>Of which cancers</td>
<td>13.3</td>
<td>4.0</td>
<td>7.5</td>
<td>20.3</td>
</tr>
<tr>
<td>Of which cardiovascular diseases</td>
<td>30.5</td>
<td>12.4</td>
<td>28.5</td>
<td>49.7</td>
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<tr>
<td>Injuries</td>
<td>9.0</td>
<td>6.8</td>
<td>10.6</td>
<td>7.2</td>
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Source: WHO. ‘Eastern Mediterranean’ includes North Africa except Algeria

As can be seen from the table, Africa’s mortality profile is almost the exact opposite of that of the world as a whole. Under a third of global deaths are caused by communicable diseases, maternal and perinatal conditions and nutritional deficiencies; in Africa the figure approaches two thirds. Only 28% of Africa’s deaths are caused by non-communicable conditions whereas the global figure is 64% (and in Europe the figure is 87%). Causes of death in Europe reflect a process that Africa is barely starting on: as a society grows more prosperous it is better able to control infectious and viral diseases, the hazards of unhygienic living conditions and the dangers of unsupervised childbirth. People in rich countries eventually die either of the inevitable consequences of ageing or from conditions brought on by unhealthy lifestyles.
This trend is already relevant to certain sections of Africa’s population and will gradually start to apply to the entire population in the coming decades. Until it does, the graph on the left shows some of the most important challenges that face healthcare policymakers in Africa: the breakdown of the infectious and parasitic diseases that kill 4.1 million people in Africa every year, almost half of all deaths. HIV/AIDS fully deserves its reputation as the scourge of Africa killing more than 1.3 million people a year. It is the leading single cause of death on the continent. Furthermore, almost a million deaths are caused by the diarrhoeal diseases which adequate primary healthcare addresses through the provision of improved water supplies. In turn, malaria, which has almost been eradicated in most of the world, causes another 750,000 deaths a year in Africa, and tuberculosis just under half a million.

Nearly as deadly as HIV/AIDS, but with a substantially lower profile, are respiratory infections. These infections almost exclusively represent lower respiratory tract infections (pneumonia and bronchitis). These infections cause more than 1.1 million deaths a year in Africa, 11% of all deaths. They require reliable supplies of antibiotics to effectively address, although they remain major causes of death even in developed regions. Then there are the diseases with relatively modest death tolls but with serious health impacts. The Carter Center calls bilharzia (or schistosomiasis) “second only to malaria as the most devastating parasitic disease in tropical countries in terms of socioeconomic and public health impact.” The mortality rate from the disease is low but it has debilitating effect, especially on children who are particularly susceptible to contracting it. In Nigeria 20 million people require treatment for the disease.

Effective basic healthcare can be expected to make a big difference in the area of maternal and perinatal mortality. Almost 900,000 African babies die in the time around childbirth every year, 9% of all the deaths on the continent. Maternal mortality claims 190,000 mothers’ lives every year, half of all maternal fatalities in the world. It is these deaths that can be addressed at relatively low cost by establishing clinics in rural areas and by training midwives.

The pandemics: AIDS, tuberculosis and malaria

HIV/AIDS, tuberculosis and malaria together cause nearly 2.5 million deaths a year in Africa, a quarter of all deaths. The first of the three in particular has caused governments and NGOs to mobilise massively against it. After mortality from the virus peaked and began to recede in developing countries in the early 1990s, these organisations turned their focus on Africa. As noted above, HIV/AIDS remains a major killer in Africa, especially compared to other regions. In 2007 the HIV/AIDS mortality rate in Africa was 147 per 100,000 people; the region in which it was the next highest killer, South East Asia, the figure was only 13. Africa bears more than two thirds of the global HIV/AIDS burden, with an estimated total of 23 million people living with the disease (of 34 million worldwide) and 1.9 million new infections every year in sub-Saharan Africa alone. That said, the fight against AIDS has been successful by most measures: in the past 10 years the HIV/AIDS incidence has dropped in 37 out of the 51 countries in which the WHO measures it. In four countries the figure has been cut by half. The most successful programmes have been awareness programmes, usually ‘ABC’ programmes telling people to ‘abstain, be faithful and condomise’. The other main leg of the fight has been in lengthening the lives of people already living with the disease, and here the biggest contribution was made by the organisations that fought to provide affordable antiretroviral drugs. Thanks to these efforts, living with AIDS is now more in the nature of a treatable chronic condition than that of a fatal infection.

Africa and South-East Asia are the regions of the world most affected by tuberculosis. In Africa, 2.5 million people have the disease, and it kills 400,000 people a year. (This figure excludes deaths from tuberculosis in which there is a link to AIDS – the final cause of many AIDS deaths is tuberculosis infection.) The number of deaths has fallen by more than one-third since 1990, and ongoing efforts are projected to further reduce the mortality in future. The treatment success rate in Africa is now over 80%, and immunisation of one-year-olds on the continent with the Bacillus Calmette-Guérin vaccine goes up steadily, from 75% in 1990 to 85% in 2010.

Malaria has become an essentially African disease since its effective eradication in most of the rest of the world (apart from some parts of Asia). More than 90% of malaria fatalities occur in Africa. The number of deaths peaked in 2004, and has since declined by more than 20%. Namibia, Botswana, Swaziland, Cape Verde and South Africa have set themselves the target of completely eradicating the disease by 2015 and may succeed. Donor groups, notably, of late, the Bill & Melinda Gates Foundation, have been hugely important in contributing to this decline, in particular through the distribution of millions of insecticide-treated mosquito nets. There are signs, however, that the distribution of treated nets is contributing to the rise of insecticide-resistant mosquitoes, and that malaria could rapidly move back to its levels of earlier because of this. Another issue with malaria is that until the disease (or its carrying vector) is completely eradicated, all the success achieved can be undone by less than a decade’s inaction.

Efforts to control these three pandemics have made real differences to longevity in Africa and should be applauded. But there are reasons to think that there is too much focus on these three pandemics. In healthcare this kind of focus on a specific health issue is called a ‘vertical’ focus, and many critics think that it too often prevails in preference to a ‘horizontal’ focus that aims to strengthen health systems in a more general way. As we have seen, pulmonary infections kill nearly as many Africans as AIDS, and almost as many as tuberculosis and malaria combined. But, perhaps because the most effective way of responding is through relatively
un glamor ous promotion of basic medicines and clinics, combating pulmonary infections has been left to African governments. And African governments’ healthcare efforts have not been universally impressive.

Primary healthcare and administrative improvement

Primary healthcare, as per the WHO statement adopted in Alma-Ata in Kazakhstan in 1978, includes health education, promotion of proper nutrition, safe water and basic sanitation, maternal and child health care (including family planning), immunisation against major infectious diseases, appropriate treatment of common diseases and injuries, and provision of essential drugs. With the exception of the high-profile pandemic diseases mentioned above, governments, multinational organisations and NGOs currently prefer to focus on primary healthcare simply because it is the most cost-effective way of improving the health of a population and to deliver high impact interventions at low cost. In order for primary healthcare to receive the necessary attention, some important actors in the sector, especially the NGOs who do so much high-profile work, will have to change their focus from a ‘vertical’ one on high-profile epidemics, to a ‘horizontal’ focus on more humdrum but potentially more effective actions like improving water supplies or supporting vaccination drives.

Administrative projects are often overlooked as potentially transformative healthcare initiatives, but a health ministry which is in control of roll-outs of medicine, aware of the priority areas in which the most urgent action is required, and in contact with external and private-sector partners, can rapidly make a difference to its population’s health. The best recent example of this is Ethiopia, where the success of improving water supplies or supporting vaccination drives.

as much authority as possible to teams working within each health facility, and improved communication structures in order to minimise the delays that emerged in instances where it became necessary to obtain instructions from the next level. In the two decades since 1990, Ethiopians’ life expectancy has gone up by 10 years, and infant mortality has dropped by more than half.

The biggest potential gains in healthcare in Africa are to be made in primary healthcare and in improving the healthcare bureaucracies of government health departments. The former is the most cost-effective way of improving the health of a population, delivering high impact interventions at low cost, and the latter (when properly implemented) can ensure that medical programmes are suited to a particular country. While private hospitals and similar advances in medicine will become increasingly important to Africans in cities and in wealthier countries, the most lives can be saved and improved by focussing on the basics. In Africa, these basics are showing real improvement... but, as in the health metrics examined in the first section, absolute levels are still much lower than in the rest of the world. So the percentage of Africans with access to improved water sources went from 49% to 61% from 1990 to 2010, but that is still far below the global figure of 89%. Measles immunisation coverage for one-year-olds has gone up spectacularly in 30 years, from 6% in 1980 to 76% in 2010, but the global figure is 85%, and in the Western Pacific region, which was behind Africa in 1980, the percentage is 97%.

Secondary healthcare

The challenge for most of Africa’s population is still to implement basic sanitation and medical techniques to address diseases that have been eradicated or brought under control in most of the world. But development, economic growth and urbanisation is driving rapid growth in the number of Africans who live in cities, have high levels of disposable income, and expect good standards of medical care. It is especially this market which has been driving the founding and expansion of private hospitals. The major private healthcare companies in Africa are three big South African operators, all listed on the Johannesburg Stock Exchange: Mediclinic, Netcare and the somewhat smaller Life Healthcare. It is understandable that private healthcare grew fastest in the most prosperous African country, but other cities in Africa are now also viable markets for private hospitals. African Medical Investments operates private hospitals in Maputo, Dar es Salaam and Harare, and plans to expand into other East African countries and Nigeria. In the latter country Lagos state, home to just under 10 million people, boasts more than 80 private hospitals. Not all private facilities are massive hospitals like the Mediclinics in South Africa’s cities: Carego Livewell, for instance, is a Kenyan company which provides fairly basic services through five community-based clinics in the Nairobi region.
The development of private healthcare will continue over the next few years and represents an attractive investment opportunity. The World Bank’s International Finance Corporation (IFC) estimates that $25bn to $30bn will be invested in Africa’s healthcare infrastructure between now and end-2016, and that up to $20bn of that will come from the private sector.

EXPENDITURE

After effectiveness, the most important criterion in evaluating healthcare systems is probably expenditure. Who pays how much for what determines how many people obtain treatment, and thus the overall health of a population. The world has been taking steps towards a better affordability of healthcare for the poor since 2005, when the (then) 192 members of WHO endorsed a resolution entitled ‘Sustainable health financing, universal coverage and social health insurance’. The resolution urged member states to develop their financing systems to ensure that their populations have access to needed services without the risk of financial catastrophe. This is part of a broader trend away from expecting governments to supply the totality of healthcare in a country, but also away from the equally unrealistic idea that markets would provide adequate healthcare.

Expenditure on healthcare in Africa can be divided into three categories: government spending (which goes into directly supplied healthcare services as well as towards national health insurance schemes), private spending (which is split between out-of-pocket payments for healthcare services at point of delivery and private health insurance), and external sources. The question of how much government spending should account for total health expenditures is to a large extent an ideological one and impossible to resolve. Some African governments can afford to provide good healthcare: in oil-rich Equatorial Guinea, for instance, general government health expenditure accounts for 76% of total health expenditure in the country, and total health expenditure per capita per annum is at the highest level of any country on the continent, at $897. The situation is similar in Botswana and Libya. This model breaks down in poorer countries, however – like Mozambique, where government spending represents 72% of all spending on healthcare, but per capita annual spending on health barely exceeds $20. That is extremely low – the WHO considers $34 per person per year a minimum to provide a population with basic health care.

Countries in which private expenditure on healthcare dominates are of two types: those in which almost all spending is out-of-pocket spending at point of delivery, and those where the private spending is collected on a regular basis and pooled so that provision is made for unexpected health problems. Representative of the first category is Guinea: in that country private health expenditure makes up 89% of total health expenditure, but out-of-pocket expenditure represents 88% of private health expenditure and total health spending per person per year is only $23. The second type is best represented by South Africa: private health expenditure accounts for 56% of the total, but only 17% of that is out of pocket. This is the kind of profile that one prefers to see: it takes the burden of healthcare provision off the state, without leaving people vulnerable to the devastating consequences of large, unforeseen medical bills. The trend in Africa, as elsewhere, is to increase the funds available for private, pooled healthcare by encouraging health insurance schemes.

Government spending

The Millennium Development Goals (MDGs) were adopted at a meeting in September 2000 that brought together 189 heads of state. There are eight MDGs, and three of them relate to healthcare: reducing child mortality rates, improving maternal health, and combating HIV/AIDS, malaria, and other diseases. In order to make progress of achieving the MDGs, the heads of state of African Union (AU) countries met in April 2001 in Abuja, Nigeria, and pledged to commit 15% of their national budgets to health spending. In 2010 only four African countries (Rwanda, Botswana, Zambia and Togo) were compliant with the Abuja pledge. Another 22 countries spent between 10% and 15% of their budgets on health, but 25 countries spent less than 10% of their budgets on health, and five spent less than 5%. A number of countries now allocate a lower proportion of their budgets to healthcare than before Abuja.

General government health expenditure as % of general government expenditure, 2010

While pooling schemes and private healthcare have their place in improving health outcomes in Africa, as will be explained below, clinics providing basic care are still crucially important in addressing the most common causes of illness and mortality, as can be seen by the dramatic improvements observed when fees are waived for medical
services. Removing fees in rural Zambia in April 2006 and January 2007, for example, resulted in a 55% increase in the use of government facilities. Attendance rates at health centres in Uganda jumped 84% when fees were scrapped in 2001. Ghana’s initiative in exempting women from paying for healthcare is credited with reducing maternal mortality from 500 per 100,000 live births in 2000, to 350 in 2008. The same success story does, however, also show up one of the limitations of making healthcare free: because no payment is involved and the measure increased the workload for healthcare professionals while making no effective difference to the supply of healthcare, the number of deliveries attended by skilled nurses actually declined from 2005 to 2007.

At the moment the governments which are successfully addressing their populations’ medical needs are combining direct expenditure with other financing models. In some, government chooses to finance the administrative side of healthcare, leaving specific projects relating to the control of epidemic diseases to external donors, and more and more medical services to the private sector. When funding healthcare, governments also increasingly prefer to pay into health insurance schemes, instead of paying directly for medical services as in the past. The future of healthcare in Africa lies in health insurance and private medical companies, although government and external funding will be important for the foreseeable future.

External funding
Because of the inadequacy of government programmes to address Africa’s health emergencies, the continent has long been a big recipient of external aid in the healthcare sector. External donors are of two types: foreign governments and NGOs. While foreign governments have more funds at their disposal, the strings attached to their aid are sometimes onerous, and NGOs’ relative independence (especially from large pharmaceutical corporations) can make them more effective. So the Clinton Foundation’s success in fighting HIV/AIDS had much to do with its willingness to go up against pharmaceutical companies and lobby them to allow generic versions of their drugs to be manufactured. The Clinton Foundation only undertook this initiative when Bill Clinton was no longer president of the United States; it is debatable whether a sitting president could have taken the same position.

One big problem with NGOs is their propensity to adopt a vertical focus on an issue like malaria or HIV/AIDS, to the neglect of potentially more effective efforts in primary healthcare, for example. Experts from the Yale School of Public Health credit Ethiopia’s success in delivering better healthcare to its willingness to negotiate determinedly with donors. Minister Tedros found ways to channel funds earmarked for AIDS, tuberculosis and malaria to systems that treated many other problems as well. In addition to this discrimination between programmes, there is a similar discrimination between countries: some countries attract solid amounts of donor funding while others do not. Often, countries that are on their way to becoming middle-income countries receive more than neighbouring countries that are worse off. In 2007 Namibia, classified as a lower middle income country on the World Bank’s scale, received about $34 per capita for health, while in the same year the Democratic Republic of the Congo (DRC) received $4.40 and Guinea received $2.80.

Health insurance schemes
Direct payment at point of use is the least-optimal way of financing healthcare, as in poor countries in particular, dramatic and expensive ailments can push the poor into bankruptcy, or else high costs can dissuade people from seeking desperately needed medical care. So, according to the WHO, two years after Burundi introduced user fees for healthcare in 2002, four out of five patients in that country were either in debt or had sold assets to pay for healthcare. It is routine for more than 2% of the population of low-income countries to suffer ‘financial catastrophe’—defined as having to spend over 40% of income after food—because of healthcare costs. In the estimation of the WHO, reliance on direct payments has to fall to at most 20% of total health expenditures to bring the incidence of financial catastrophe down to negligible levels.

For an unchanged level of government and external funding, improving Africa’s healthcare expenditure profile will thus mean shifting private expenditure from direct payment to prepaid, pooled expenditure. Analysts see this shift as the most important shift in Africa’s healthcare environment. So the countries most often held up as examples of successful health policy are those in which health insurance schemes cover the greatest part of the population, or where the proportion is growing fast. Two countries often cited in this context are Rwanda and Ghana. In the former country 91% of the population belongs to one of three health insurance schemes, thanks to a government programme to match member contributions one-to-one (with some donor support). Out-of-pocket expenditure now only accounts for 22% of private health expenditure, and the improvements in child and maternal mortality have been impressive. In Ghana the National Health Insurance Scheme (NHIS) was formally launched in December 2004 and since then it has been mandatory for all residents to be members of a district mutual health scheme, a private commercial insurance scheme, or a private mutual health scheme. Coverage of the Ghanaian population is now close to 70% and the scheme’s beneficial effects on health have been evident: infant mortality has dropped 19% since 2000, and the number of infant deaths from malaria has dropped by almost a third since the scheme’s inception (it primarily targets the diseases which affect the most Ghanaians).
CONTINENTAL AND GLOBAL TRENDS

What trends will make a difference to healthcare in Africa? The most important one is already underway: the steady rolling out of primary healthcare into ever more remote areas, providing vaccinations, clean water, midwife assistance and basic health advice to ever larger numbers of people. Another one which has been discussed is taking place in Africa’s cities, where new private hospitals are providing outpatient services and the reassurance of quality emergency care to the new middle class. Listed below are some other drivers which an examination of healthcare in Africa should include.

Economic outlook, budgets and regional integration

It is somewhat tautological to point out that smaller budgets will mean smaller healthcare budgets, and it is possible that African governments will have to tighten their belts in the next few years. It is not only the economic environment of Africa itself which is relevant: if the economic slowdown in developed countries persists, then the pressure on their funding commitments (which is already severe enough to have resulted in aid cuts in 2012) may drive governments to tighten their purse strings even more. African governments would do well (and may be forced) to further reduce their reliance on donor funding, as fiscal problems in donor nations fuel isolationist instincts and suddenly indebted Western countries cut the amounts they have allocated to foreign aid. This austerity drive in developed countries will force African governments to improve their revenue collection systems and to come up with “innovative” financing for programmes. “Innovative” financing usually means finding new things to tax: so recent examples are a ‘solidarity levy’ on airfares which funds UNITAID, an international medicine purchasing scheme, special telecoms taxes in Gabon, or the sin taxes raised on alcohol and tobacco in most countries.

On the other hand, and more positively, there are signs that the private sector will be willing to compensate for much of the funding lost as governments cut back. The rise in popularity of corporate social responsibility (CSR) and ‘double bottom line’ or ‘triple bottom line’ accounting, in which corporations keep track of social and environmental achievements alongside their financial performances, will mean that many large international corporations may be happy to participate in helping to improve the state of the healthcare industry in Africa.

Technology

Possibly the most exciting application of technology to the healthcare industry lies in the field of ‘telemedicine’, which usually refers to the use of telecommunications to allow healthcare workers in out-of-the-way places to remotely diagnose patients in conference with specialists. As part of the Pan-African e-Network Project, a co-operation between the government of India and the AU, doctors in India are helping to remotely diagnose patients in 53 hospitals in Africa. The same project makes it possible for African students to study medicine under lecturers at seven universities in India. Technology can also provide more orthodox solutions to bureaucratic issues that can sometimes be overlooked by actors in the healthcare space with a propensity to look for the dramatic fix. Carego Livewell, the Nairobi-based healthcare company referred to above, specialises in providing healthcare facilities with software to simplify their clinical and business processes and for regional and national healthcare organisations and governmental departments to co-ordinate better. Intelligently targeted health awareness campaigns can leverage the high levels of mobile phone (and, increasingly, internet) penetration in order to better communicate with the public; this is already the case with many HIV/AIDS initiatives in Southern Africa.

Advances in chemistry will save and improve lives, as researchers develop drugs specifically for Africa, or at least for low income societies. One good example is the retroviral treatment developed by Indian pharmaceutical company Cipla: unlike previous drug cocktails, Cipla’s fixed-dose combination does not require refrigeration, which played an important part in prompting its uptake in Africa. If heat-resistant insulin is ever developed, for instance, it is certain that its effect in Africa will be tremendous. Of relevance here is the issue of patents. The Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) is an agreement that introduces patent law into world trade, and is binding upon all members of the World Trade Organisation (WTO). Because of the huge beneficial effect that generic drugs have had in addressing health crises in developing countries, most lower income countries were given 10 years in which to comply with the clauses in TRIPS relating to medicines. In this regard, India was allowed to produce generic medicines until 2005 and the least developed countries were given until 2016. When these deadlines are reached, there will again be some difficult debates about profits versus people.

The rise of non-communicable conditions

As infectious and parasitic diseases and perinatal dangers are brought under control in Africa, the continent’s mortality profile will increasingly come to resemble that of more advanced societies. Non-communicable conditions like cancer, diabetes and heart failure will kill the most people, resulting in a complete change in the demands on healthcare systems. It is estimated that non-communicable diseases, including ‘lifestyle disease’ related to suboptimal lifestyle choices, will overtake communicable and parasitic diseases as the main cause of death in Africa by 2030. It will be a challenge for health departments focussed on the very basic aspects of healthcare – preventing child mortality and eradicating diseases that no longer exist in more advanced countries – to addressing these very modern diseases, for which, moreover, there is usually no cure, only treatment.
Notable territories
This table summarises the African countries which, in our opinion, are notable for some aspect of their healthcare systems, whether it be rapid uptake of health insurance, high levels of total expenditure or innovative governance in the public sector:

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Botswana</td>
<td>8,468</td>
<td>5.1</td>
<td>615</td>
<td>17</td>
<td>30</td>
<td>61</td>
<td>20</td>
<td>Good</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>386</td>
<td>7.5</td>
<td>16</td>
<td>14</td>
<td>n/a</td>
<td>54</td>
<td>52</td>
<td>Excellent</td>
</tr>
<tr>
<td>Ghana</td>
<td>1,517</td>
<td>14.4</td>
<td>67</td>
<td>12</td>
<td>66</td>
<td>54</td>
<td>52</td>
<td>Good</td>
</tr>
<tr>
<td>Libya</td>
<td>7,321</td>
<td>-51</td>
<td>483</td>
<td>5</td>
<td>100</td>
<td>72</td>
<td>13</td>
<td>Good</td>
</tr>
<tr>
<td>Mauritius</td>
<td>8,397</td>
<td>4.2</td>
<td>449</td>
<td>10</td>
<td>89</td>
<td>73</td>
<td>13</td>
<td>Good</td>
</tr>
<tr>
<td>Rwanda</td>
<td>583</td>
<td>8.6</td>
<td>56</td>
<td>21</td>
<td>44</td>
<td>59</td>
<td>38</td>
<td>Excellent</td>
</tr>
<tr>
<td>South Africa</td>
<td>8,090</td>
<td>3.1</td>
<td>649</td>
<td>12</td>
<td>30</td>
<td>54</td>
<td>35</td>
<td>Good</td>
</tr>
</tbody>
</table>


Botswana, a relatively wealthy country, is one of the four countries in Africa which complied with the Abuja commitment in 2010 by spending more than 15% of its budget on health. Botswana is also notable for the health profile of its private healthcare spending: only 30% of private health expenditure was out-of-pocket, which is good news for health outcomes although the high HIV prevalence rate still holds life expectancy down.

Despite very low levels of spending on health – the second-lowest figure in Africa – Ethiopia has made tremendous strides in improving healthcare. Much of this has been the result of improvements in government’s health bureaucracy, which a zealous health minister retooled to address specific and urgent problems, sometimes in the face of resistance from external partners.

Ghana’s success in addressing healthcare issues is only now becoming apparent, as the National Health Insurance Scheme (NHIS) initiated in 2003 bears fruit. The proportion of out-of-pocket spending in total private healthcare spending is in decline, with salutary consequences for the poorest Ghanaians.

We include Libya in this list because we think it is on the cusp of a major change in its healthcare system. While the state-sponsored health system – almost 70% of total health expenditure is still by the state – has achieved excellent basic healthcare, it is at a point where it will start to move towards a more balanced mix, providing better options especially for the upper middle classes. The health economies of Algeria and Gabon have similar profiles and should be watched for the same reason.

Mauritius is a small, rich country in which private healthcare and medical insurance providers can find a lucrative market. Basic healthcare has been achieved, now the demand is for world-class services for the well-off, as well as for solutions to still-high levels of out-of-pocket expenditure in private health spending.

In Rwanda, as in Ethiopia, government has been good at overcoming very low per capita health expenditure (although the health budget as a proportion of the total budget is the highest in Africa) to deliver acceptable outcomes, by combining different modes of financing, by successfully lobbying for external funding and by making the quality of government health bureaucracy a priority.

The state of the healthcare industry in South Africa needs to be watched because it will, in many respects, be a model for other countries in future, and the companies active in the sector will expand north of the country’s borders. While rich, there are deep pockets of poverty where NGOs and government are collaborating in sometimes innovative ways to improve healthcare outcomes.
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