

Who should pay for health care?

The Kenyan government's decision to offer free basic health care and medicines to poor citizens has reawakened the debate over how to pay for health care in Africa. Analysis by **NEIL FORD**.

At independence many African countries, particularly those in anglo-phone Africa, sought to provide health and education services free of charge, but the continent's poor economic performance in the 1970s and 1980s prompted many governments, under IMF advice, to introduce some level of payment for services.

Now, however, the pendulum seems to be swinging in the other direction as more African politicians are coming round to a belief that only compulsory, free to access education can help the continent's hundreds of millions of poor people escape poverty. At the same time, the expense of providing anti-retroviral medicine to people with HIV/Aids seems to have focused minds on the difficulties experienced by poor Africans in accessing any form of medical treatment.

A variety of systems have been adopted across Africa. Some countries have opted to offer free primary school education and charge fees only for secondary schooling, although governments, religious organisations and non-governmental organisations (NGOs) often offer bursaries to pay for the fees of very talented scholars. Some countries do not charge fees but require the parents of pupils to foot the bill for uniforms, books and stationery.

A similar mix of approaches has been adopted with regard to medical care, where the same argument applies: most African governments find it almost impossible to provide all health care without charge. However, this does not mean that no medical care can be provided free of charge. Indeed, the most basic medicines and procedures are often those that do most good, as can be seen in the relatively low cost of successive anti-polio campaigns in relation to the number of lives saved.

Kenya's National Rainbow Coalition (Narc) government originally promised to provide free basic health care at clinics around the country in its 2002 election manifesto. In June, Health Minister Charity Ngilu announced that the promise would now be put into



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A healthy country is a wealthy country. Free medical care can transform health delivery in Africa.

practice and would cover almost a third of the country's 30m people, although the government is yet to give full details on the qualification criteria. Those receiving free health care will also qualify for free medicines.

The first free treatment was offered in July, resulting in long queues outside many urban health centres and, perhaps not surprisingly, a long wait before many people could receive a consultation.

Although the treatment is described as free, patients are still required to pay a KSh10 registration fee at pharmacies and a KSh20 fee (\$0.25) at health centres for each visit. The levels of these fees have presumably been set high enough to deter people who are not really ill but low enough to ensure they are not beyond the means of many people.

The majority of Kenyans who fail to qualify for the scheme will be expected to pay for their treatment and all patients will continue to have to pay part of the cost of treatment at major hospitals. Funding for health services

fell during the 1990s while demand increased and although the Narc government has increased spending it will take a long time to catch up with the backlog of hospital maintenance and clinic construction. Nevertheless, Ngilu insists that \$50m has already been put in place to fund the free medical care scheme for the year to come.

The current move to provide free basic health care should not be confused with Kenya's determination to set up a National Health Insurance scheme. If passed, a bill, under debate in Parliament at the time of going to press, will establish a KSh40bn compulsory health insurance scheme. (See page 34)

BURUNDI HIT BY END OF HEALTH FUNDING

A report by Médecins sans Frontières (MSF), published last May, revealed that 20% of Burundians have been unable to access any form of medical treatment since the government stopped funding free health care in

2002. Although the state still finances the wages of nurses and doctors, plus the construction of hospitals and clinics, patient fees have to cover everything else in 12 of the country's 17 administrative provinces, although foreign donors cover costs in the other five provinces.

MSF also found that many more people sought treatment only once a disease or other ailment became serious, while many of those who paid for medical care were often forced to take out loans to cover the cost of medicines. To put the cost of Burundian medical care in context, the fee for a standard check-up at a rural health centre was equivalent to two and a half weeks' paid agricultural work.

Even in Africa's richer economies, where health services tend to be more ambitious in terms of their scope, funding is proving a major headache. In South Africa, a combination of currency fluctuations over the past two years and the rising number of HIV/Aids patients, has placed a huge strain on medical services. Most types of operations were suspended in Gauteng Province at the end of last year because of overspending by the province's main hospitals.

It is likely that better management could produce some efficiency savings but there is no way to regulate the number of patients requiring treatment other than through rationing.

Many richer South Africans opt for private sector medical care but the bulk of the population relies on state-funded hospital treatment. However, the falling value of the Rand during 2002 and into 2003 increased the price of imported medicines and depleted hospital budgets. Although the Rand has since recovered strongly, the period of high prices has left its mark on the budgets of health authorities.

At the same time, Greater Johannesburg continues to grow as people move in, meaning that the city's two biggest hospitals, Johannesburg Hospital and Chris Hani Baragwanath, must serve a larger population than was originally predicted.

IMF SOFTENS STANCE ON FREE MEDICAL CARE

It is too soon to confirm that the argument over funding education and health care has swung away from payment on delivery. However, the IMF and other multilaterals have certainly softened their line on the issue in negotiations over financial policy over the past couple of years. As a result, governments are not nearly so fearful about

the implications of offering selective free health care to those who would otherwise be unable to pay for it. It is difficult to overcome the fact, however, that very many Africans – perhaps most of the continent's population – have little or no access to medical treatment, with the exception of the kind of inoculations provided to young children.

A lack of money, whether provided by patients, NGOs or governments means that whole swathes of the continent have no local nurses, health visitors or doctors. These include areas destabilised by war, such as parts of Angola and DR Congo, but also some parts of the Sahel.

A UN report published at the end of last

year highlighted the difference between health services in sub-Saharan Africa and the industrialised world. African women have a one in 16 chance of dying during pregnancy or in childbirth, compared with a one in 6,000 chance for Japanese women. This amply proves the point, although there are also many similar statistics. ■

KENYA'S EPOCH-MAKING NEW HEALTH INSURANCE SCHEME

Kenya's proposed new social health insurance scheme is a bold and timely initiative. If it succeeds in Kenya, it could become the model for the rest of the continent, says **Anver Versi**.

The government of Kenya has embarked on one of the most exciting national health schemes in Africa. If the National Social Health Insurance Bill 2004 (NSHIF) is passed by Parliament, everybody in the country will be entitled to health care services.

The comprehensively drafted bill pools the risks associated with illness across the entire population, thus ensuring that even the poorest are entitled to health care services paid for by this insurance fund.

Contributions will be means based and benefits will be offered to all who need them i.e. those who are ill. It provides mechanisms whereby the rich, the healthy and the young subsidise the poor, the ill and the old. Membership will be compulsory and contribution based. Membership for the poorest will be free, and subsidised from tax revenue.

The distribution of health care services in Kenya, as in most sub-Saharan African countries is very unequally distributed. The poor often have to make a choice between feeding their families or seeking medical treatment.

In March this year for example, a case came to light in which 40 mothers had been forced to stay in hospital for almost two months with their newborn babies because they had been unable to pay for their deliveries. They had been kept locked in a single dormitory where they had to sleep five to a bed.

It was only when the minister for local government, Karisa Maitha, alerted to the incident, had paid the outstanding bills from his own pocket that the women were released and allowed to take their babies home with them.

In other instances, patients have had to pledge their livestock or bicycles

against hospital and treatment bills. Kenya's minister for health, Charity Ngilu, who has been described by health workers as a 'human dynamo' explained the situation thus: "Thousands of Kenyans do not dare to seek treatment in clinics, health centres and hospitals as they are well aware that they cannot raise the monies for meeting the costs of treatment. How do the poor share the costs of treatment when they cannot even afford food?"

In keeping with the philosophy of the new government led by President Mwai Kibaki, she decided to put in place a major policy reform to make health the engine of economic development and increase resource allocation to the health sector.

"Maintenance and promotion of good health is one of the primary responsibilities of a modern state and cannot be left to market forces," she says.

This stance brought her into sharp confrontation with the World Bank which insists the treatment must be paid for and which favours privatisation of the health sector. "The World Bank should come out openly and tell Kenyans which of its programmes has succeeded in improving the lives of the poor," she retorts.

The social health insurance scheme, she says: "will guarantee every Kenyan, poor, unemployed or self-employed access to a basic health care package. This package will include clinic-based preventative services like immunizations for every child, prevention of mother-to-child HIV infection, prevention of malaria in pregnancy and treatment for common diseases like malaria, diarrhoea and acute respiratory infections responsible for most deaths of children in my country."

The NHSIF scheme is based on the discredited National Hospital Insurance Fund, founded in 1966 and the oldest

compulsory insurance scheme in Africa. Since 1966, all employees earning at least \$15 have to contribute 2% of their income to a maximum of \$5 per year. In return – but in theory only – the hospital insurance fund pays a fixed amount for the hospital bed, treatment and drugs. This is then deducted from the bill.

However, the Fund degenerated into one of the most corrupt institutions in the country, with money being invested in dubious property and banking deals.

Health minister Ngilu has ordered a root and branch reform of the institution and inserted a national solidarity clause (based on the Tunisian model) into the new scheme. Since the model closely resembles the German health insurance scheme, Kenya requested German support for the consolidation phase. As a result, the German Technical Cooperation institution (GTZ), the World Health Organisation – which has come out strongly in support of the scheme – and the International Labour Organisation have acted as technical advisors to the programme.

Under the new plan, the country's highest earners, those earning more than KSh150,000, will pay KSh5,000 per month while those earning less than KSh15,000 will pay KSh320 per month. The self-employed will pay a standard annual fee and the poor will pay nothing since their contributions will be subsidized by using 5% of value-added tax revenue.

Employers will match contributions from their employees shilling for shilling.

Kenya's national social health insurance scheme is a bold and very necessary initiative. It is also a vital experiment in the African context. If it succeeds in Kenya and is replicated around the continent, it could be the beginning of a bright and healthy new era for Africa. ■