A MODEL OF GOOD HEALTH

While half of sub-Saharan Africa has no access to modern healthcare facilities, debate still rages over which system is best, private or public. Lanre Akinola reports

One of the most high-profile challenges facing sub-Saharan Africa today is the question of who has access to healthcare and on what terms. It is estimated that more than 50 percent of the region's population does not have access to modern healthcare facilities. While the objective of universal coverage is widely supported, opinion is polarised on exactly how this is to be achieved. A nascent market for high-end private healthcare among Africa's growing middle classes and calls by some for a new paradigm in the financing of healthcare on the continent have stirred up renewed debate about public versus private provision of healthcare.

One example of the private market, the newly opened Dar Es Salaam Trauma Centre, is located in the affluent Peninsula district of Dar Es Salaam, Tanzania. Owned by UK-based African Medical Investments plc, it is managed through its subsidiary VIP Healthcare and, according to AMI chief executive Dr Vivek Solanki, it is the first centre in East Africa to offer such a wide range and high level of health services under one roof.

Equipped with the latest technology, the 30-bed hospital's facilities include a full trauma and emergency department, a major and minor operating theatre, two delivery rooms, a radiology department with CT scanner, digital X-ray and 3D ultrasound, as well as a women's clinic.

The centre caters to the city's large expatriate and non-governmental organisation community, as well as upper and middle-class Tanzanians and government officials. Mr Solanki attributes the emergence of hospitals like the Dar Es Salaam Trauma Centre to the growing demands of a more confident and affluent segment of African society, and sees this as a sign of a deeper trend. "Twenty years ago it would not have been possible to do this, because that segment did not exist. With education and growing economies comes awareness, and people want to lead healthier lifestyles. It is a natural progression," he says.

AMI is already building another centre in Maputo, Mozambique. In the next three to five years, the company plans to build 10 more such centres across the continent, with Algiers, Accra, Nairobi and Alexandria on the list of possible locations.

"Just on the back of an increase in the volume of the middle classes, there is definitely a viable market for anyone who is in the healthcare space," says Tiwonge Mkandawire, healthcare analyst at international consulting firm Frost & Sullivan. "People can now actually pay for it and, better yet, they are demanding it because they recognise it as a right they can finally afford."

A specialist consultation at the hospital costs $100, with membership payable monthly at $40 plus an extra $10 per month per additional family member. Mr Solanki expects to break even within three months on the $3m that it cost to build the Dar Es Salaam site. The targeted annual net return for each of the company's planned clinics is between $2.5-$3m, with a targeted annual group return of between $25-$35m.

Mr Solanki believes that AMI's activity in the healthcare market will attract bigger international players that are currently keeping out of Africa due to the perception that the risks are too high. He believes that Indian group Apollo Hospitals and South Africa's Netcare are among those well

placed to enter the wider sub-Saharan African market.

AMI offers an insurance package through a partnership with an African affiliate of UK-based insurance company BUPA. Health insurance coverage is still lacking in sub-Saharan Africa, particularly from international providers. "It is a high risk for these companies to insure their clients in countries where the facilities are not available, because you end up flying everybody out. So now that they that there is a service available, they want to be here as well," Mr Solanki says.

Nevertheless, AMI's brand of high-end private sector care with clinics and trained, qualified doctors is, realistically, only open to the niche markets in which they operate.

Out-of-pocket payments – made in cash at the point of treatment – expose people to unmanageably large expenditures and constitute one of the most pressing issues for healthcare in sub-Saharan Africa. In 13 of the 46 countries in the World Health Organisation African Region, out-of-pocket payments constitute 100 percent of all private expenditure on health, with 18 countries in the 50-89 percent bracket. In only seven countries is this figure below 50 percent.

Average expenditure on health in sub-Saharan Africa rarely exceeds 5 percent of gross domestic product, and most countries spend less than $10 per person per year when at least $27 is needed.

PharmAccess, a Dutch NGO, is proposing the use of low-cost health insurance as part of new paradigm to break away from what it considers a historical over-reliance on public health systems. In 2006 it was awarded €100m from the Dutch government to invest in African healthcare, and in 2007, the organisation bypassed the Nigerian government, with its approval, by providing direct funding to Hygeia, a private health care provider.

Onno Schellekens, PharmAccess's managing director, says health systems are stuck in a vicious circle. "Out-of-pocket payments are so high because the supply side is not functioning. People are not willing to pre-pay; and because people do not pre-pay there is no risk pool; and because there is no risk pool there is no supply side.

"We are not saying that the state or the public sector is necessarily bad," he says, "but if a government is not able to implement health systems nationwide, there is no other alternative than to go private. That is not a political opinion, it is a fact."

PharmAccess provides a subsidised basic insurance package for the provision of primary and limited secondary care to economically active groups who do not currently have health insurance, and cannot afford to pay a full premium. So far the scheme has been applied to market workers in Lagos and farmers in Kwara State, Nigeria, for an average cost of $38 per head over two years. The organisation also manages the Health Insurance Fund and is co-founder of the Investment Fund for Health in Africa, which aims to provide risk capital for medical investments on the continent.

Mr Schellekens hopes that the level of subsidy for health insurance will be reduced over time as people become more willing to pre-pay for the service and risk pools increase, and that these schemes can eventually be consolidated into nationwide health systems with governments sharing the burden. PharmAccess plans to develop similar schemes in Tanzania and Kenya and is currently conducting research in Namibia.

Anna Marriott, health policy adviser at UK-based NGO Oxfam, questions the sustainability of PharmAccess's model. She estimates that the organisation's €100m ($136m) funding translates into an expenditure of €72 per person annually. "The Nigeria project only covers one tenth of one percent of the population. Scaled up to cover the whole population this would cost $9.9bn. Our concerns are that this is a high-cost yet very small-scale project, and the question is, could the money be better spent and reach more people at lower cost?"

She argues that a rejection of the public sector in favour of private care on the grounds that it is inherently failing is based on an inaccurate understanding of the context in which many of sub-Saharan Africa's public health systems have developed. An emphasis on privatisation by organisations such as the World Bank and the International Monetary Fund in the 1980s and 1990s put a cap on public spending, and introduced measures such as user fees for healthcare, she says. These programmes lead to widespread exclusion within the public sector, she argues, and continue to be problematic for public health systems.

> *"People are not willing to pre-pay; and because people do not pre-pay there is no risk pool. And because there is no risk pool, there is no supply side"*
> **Onno Schellekens**

Ms Marriott stresses that Oxfam does not oppose private sector activity, but is critical of what she says are myths that surround the effectiveness of private health services. "Across Africa, 40 percent of all private providers

RIGHT: AMI's new Trauma Centre in Dar Es Salaam

used by poor people are actually unqualified and untrained shopkeepers." She argues that there is a role for the private sector, but that the only viable route to achieve universal coverage lies in the provision of public services. "If you look at the countries that have been successful, the only ones that have achieved universal access are those that have scaled up their public healthcare systems; and that evidence is indisputable."

Dr Joses Muthuri Kirigia of the WHO argues that the private sector should play a complementary role to existing public systems in cases where public facilities are not readily available. He argues that many people cannot afford private services, and that private facilities are often concentrated in urban centres, away from sub-Saharan Africa's large rural populations.

He also argues that public health systems offer the most viable vehicle for the provision of health services on a mass scale, and points to increasing steps towards introducing pre-paid assistance in sub-Saharan African countries. Ghana's government, for example, contracts private facilities based on an accreditation system to determine which facilities meet government requirements and are licensed to provide services to people registered on the National Health Insurance scheme. While pricing remains a contentious issue between the government and private providers, the scheme now covers almost half of the population.

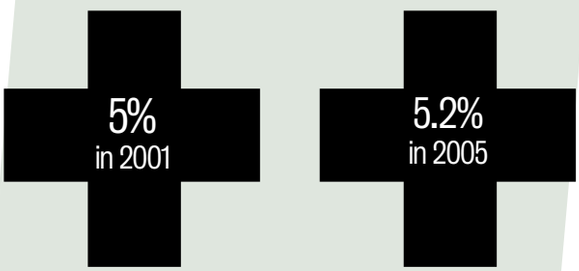
50%
of Ghana's population is covered with the National Health Insurance scheme

Social insurance has been used to great effect in Rwanda. Each family member has to pay about $2 per year with the government making a matching contribution, followed by donors who pay premiums for the people who can not afford the minimum. This has lead to an increase of coverage to approximately 80 percent of the population, according to Mr Kirigia.

The issue of access to healthcare in sub-Saharan Africa is not one that will be resolved quickly, a point on which there is little disagreement. There is, however little agreement on how best to expand healthcare coverage across the continent. With populations ranging from 1.7 million in The Gambia to almost 150 million in Nigeria, and average per-capita government expenditure on health ranging from $1 in Burundi to $166 in Equatorial Guinea (2005 figures), solutions are likely to be as varied as the continent's geography. Historically state-run health systems are slowly opening up to the idea of private participation in healthcare provision, but precisely how the relationship between the two will develop is yet to be determined.

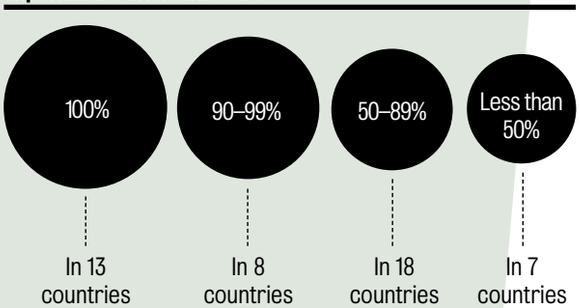
SPENDING IN WHO AFRICA REGION

Total expenditure on health as percentage of gross domestic product

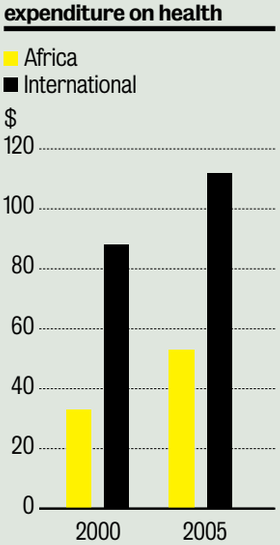


Expenditure on health

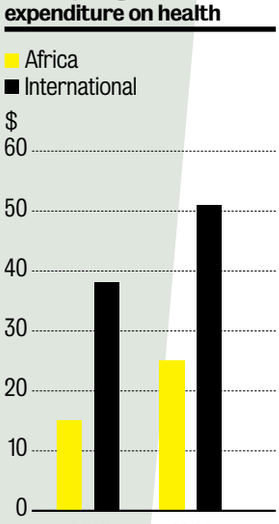
Out-of-pocket expenditure of all private expenditure on health care



Per-capita total expenditure on health



Per-capita government expenditure on health



PHOTOS: AFP/GETTY IMAGES/ALAMY