Study to Review the Existing Health Financing Systems of Four Sub-Saharan African Countries and Measuring Their Progress Towards Achieving Universal Health Coverage

By

Sourav Ganguly

Dissertation submitted in partial fulfillment of the requirements of the degree

MBA Hospital and Health Management

Academic year, 2018-2020

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Reinsurance

Date: 18th May 2020

TO WHOM IT MAY CONCERN

The certificate is awarded to **Dr. Sourav Ganguly,** Management Trainee in the Claims and Investigation Department at AXA France Vie – India Reinsurance Branch in recognition of having successfully completed his dissertation from February 3rd, 2020 to May 3rd, 2020.

He has successfully completed his Project on **"A study to review the existing health financing systems of four Sub Saharan African Countries and measuring their progress towards achieving Universal Health Coverage."**

During the period of his dissertation programme, he was found punctual, hardworking, committed, sincere & diligent person who has a strong drive and zeal for learning.

We wish him all the best for future endeavors.

For and on behalf of **AXA France Vie – India Reinsurance Branch**

Ankur Nijhawan
Chief Executive Officer

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I would like to express my gratitude to the management of **AXA France Vie- India Reinsurance Branch** who helped me gain cognizance during my internship period. I am thankful to **Mr. Anil Kumar** (**Head Claims and Investigation- AXA France Vie - India Reinsurance Branch**) who gave me the golden opportunity to do this wonderful project on **"A study to review the existing health financing system of four Sub Saharan African countries and measuring their progress towards achieving Universal Health Coverage".** I would like to extend my thanks to **Dr. Amit Rajoriya (Assistant Vice-president Claims and Investigations- AXA France Vie – India Reinsurance Branch)** who also guided me along my path of completing this project.

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Abstract

The World Health Organization has defined Universal Health Coverage as a situation where all people who need health services receive them, without incurring any financial hardship. African countries are developing nations and owing to Abuja declaration each country has committed to contribute 15% of its GDP o health. Despite a few nations like Namibia, who were recently declared as a UMIC, the country's progress to UHC is still far away from its target. Besides, it is important to track country-level pooled resources for health to understand how the availability of resources (human resources, infrastructure, others) and their distribution, government budget allocation to health, contribution by donors, revenue and pooling mechanism, insurance coverage and its penetration, policy reforms and mass schemes influences health indicators of a country. This will help not only measure progress to UHC but also help identify the gaps and analyse them.

Methodology – A situational analysis of different countries followed by a comparative analysis was performed to identify and then compare each country's profile which included demography, geographical, economical, political, health care reforms and policy initiatives, a detailed review of health system along with health financing and health insurance coverage. Lastly based on above a gap analysis was conducted, that identified the gaps in existing systems of a country and provided future recommendations.

The key results suggested that there was a direct association with spending on health expenditure and improvement in health indicators. The prevalence of communicable disease like HIV, Tuberculosis and Malaria has been high in sub-Saharan African countries, however since changing policy reforms, increased donor funding in managing the epidemic of such disease and an increasing insurance coverage suggested that there is a scope for progress in UHC and achieving its targets. As financial protection has shown to play an important role and introduction of a common mass insurance schemes by countries like Ghana and Zambia have shown promising results, large proportion of population is still not covered and this remains a long standing issue. Besides this, countries that relied heavily on donor funding performed poor when there was asudden reduction in donor contribution to health expenditure. Also, the health systems of all four countries have an inequal distribution of health infrastructure, human resources concentrated around cities where only 30% of population resides. All these findings suggested that there is a need to a system focusing on financial protection along with addressing inequity within the health system and among the population.

Contents

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List of Symbols and Abbreviations

UHC: Universal Health Coverage

WHO: World Health Organization

IMF: International Monetary Fund

GDP: Gross Domestic Product

NHI: National Health Insurance

CHPS: Community Based Health and Planning Services

DAH: Developing Assistance for Health

CHS: Community Health Funds

CFS: Consolidated funds service

HIV/AIDS: Human Immunodeficiency virus/Acquired Immune Deficiency Syndrome

HSHP IV forth: Health Sector HIV and AIDS strategic Plan

Ichf: Improved Community Health Funds

LGA: Local Government Authorities

MOHSW: Ministry of Health and Social Welfare

MHCDGEC: Ministry of Health Community Development, Gender, Elderly and Children

PEPFAR: Presidents Emergency Plan for AIDS Relief

PORLAG: President's office Regional Administration and Local Government

PHU: Primary Healthcare Unit

NHIF: National Health Insurance Fund

SNHI: Social National Health Insurance

SWAPO: South West Africa People's Organization

TIKA: Tiba Kwa Kadi

TZS: Tanzanian Shilling

TSAF: Tanzanian Social Action Fund

TB: Tuberculosis

1. Introduction

Since “The World Health report 2010” was published, the word Universal Health coverage (UHC) has been the topic and target for all the policy discussions and decisions. The World Health Organization has defined UHC as a situation where all people who need health services receive them, without incurring any financial hardship. This definition focuses on two main components: first is the coverage of quality health services and second, access to financial risk protection, for everyone (1).

To make health care accessible to all, African governments are considering or have implemented policy reforms with a focus of achieving universal health coverage (UHC). Over the years, many parts of Africa have experienced rapid economic growth and significant reduction in poverty levels. A study conducted by African Development Bank, found that real gross domestic product (GDP) grew by five percent between 2001 to 2014 compared to only two percent increase during the 1980’s and 1990’s (2). Despite the progress African countries still struggle with large unmet health needs, basic human security in health and impoverishment due to catastrophic health expenditures.

Achieving UHC requires financing systems that provide pooled resources which are already paid or prepaid for key health services by any insurance scheme without placing undue financial stress on family. It calls for all populations the harmonisation of political, social, economic, and health leadership, in addition to mature health systems capable of ensuring efficiency and equity. The world health report 2010 contains the following definition of health financing for universal coverage: “Financing systems need to be specifically designed to: provide all people with access to needed health services (including prevention, promotion, treatment and rehabilitation) of sufficient quality to be effective; [and to] ensure that the use of these services does not expose the user to financial hardship” (1).

Several African countries have started implementing health policy reforms that help mitigate the financial risk and protects against catastrophic health expenditure which are in the forms of Pooled resources consisting of prepaid revenues through government financing, or other programs such as development assistance for health (DAH) and scaling up such programs into one scheme like a National Health Insurance Schemes (NHIs). Examples include, the Community Based Health and Planning Services (CHPS) and National Health Insurance Scheme in Ghana (3); National Health Insurance Scheme in Zambia among others (4). Schemes like these, in several ways aim to provide health

financing to protect populations from impoverishment due to catastrophic health expenditure. Tracking country-level pooled resources for health and understanding how trends in the availability of resources, the budget allocation to health, insurance coverage and penetration in the markets and their effects on health indicators can affect achieve UHC and how these performances play vital role into policy dialogues and budgeting processes related to UHC. Thus, this becomes rationale of my study.

1.1 Research Question

i. What are the existing health financing options in different Sub-Saharan African countries?
ii. What is the impact of the existing schemes in achieving universal Health Coverage?
iii. How different class of economies (World Bank classification of countries) can proceed forward in their way towards UHC?

1.2 Research Objective

i. To understand and study the existing health system, the health financing mechanism and insurance coverage of various Sub-Saharan African countries.
ii. To measure the progress of countries in achieving UHC based on health indicators and financial protection reforms.
iii. To identify the gaps and suggest recommendations in filling the lacunae.

2. Review of Literature

S. No.	Title of the study	Author of the study	Date of Publication
1.	**Ministry of Health**	**Ministry of Health, Zambia**	
1.	**2020 Budget, Zambia, Namibia, Tanzania and Ghana**	**PwC**	**March, 2020**
2.	**Health Financing Profile Zambia, Namibia, Tanzania, Ghana**	**Health Policy Project, USAIDS**	**2016**
3.	**Health Financing in Zambia**	**Felix Masiye and Collins Chansa**	**2019**
4.	**National Health Insurance Scheme**	**Ministry of Health, Zambia**	**2019**
5.	**Zambia DHS 2018**	**Zambia Statistics Agency**	
6.	**Country Statistics – Zambia, Ghana, Tanzania and Namibia**	**World Health organization**	**2019**
7.	**Economic Outlook- Zambia, Ghana, Tanzania and Namibia**	**African Economic Development Bank**	**2019**
8.	**Country Disease Profile- Zambia, Ghana, Tanzania and Namibia**	**Institute of Health and Matrix Evaluation**	**2018-19**
9.	**Namibia Public Health Expenditure Review**	**World Bank**	**2019**
10.	**Namibia Health Accounts Reports**	**Ministry of Health and Social Services**	**2017**
11.	**Medical Aid Funds Act**	**NAMAF, Namibia**	**1995**
12.	**National Health Policy, Tanzania**	**Ministry of Health, Community development, Tanzania**	**2017**
13.	**Health sector Strategic Plan**	**Ministry of Health and Social Service**	**2015**
14.	**National Health Insurance Framework, Ghana**	**Ministry of Health, Ghana**	**2004**
15.	**Ghana Demographic and Health Surveys**	**Ministry of Health, Ghana**	**2017**

3. Methodology

i. **For research question "**What are the existing health financing options in different Sub-Saharan African countries?"

Study Methodology: A situational analysis of individual country was done based on WHO's Health system in transition (HiT's) health system reviews. A comprehensive search was conducted and an in-depth review was done to provide detailed description of each country's profile which included demography, geographical, economical, political, health care reforms and policy initiatives, a detailed review of health system along with health financing and health insurance coverage.

Data Sources

The study involved review of research papers from the research databases. Published research articles, national and international reports on health finacing systems, National Health surveys, Demographic health surveys and review of conference proceedings were collected from online databases namely Google scholar, Emerald and PubMed and government websites.

Keywords used were: Health Financing, UHC, Health indicators, Health expenditure, Health care systems, Health Insurance and financial risk protection.

Inclusion criteria: On the basis of strikingly contrasting economies and myriad health systems and similar disease profile along with expert's opinion five countries were selected. These include Zambia, Namibia, Tanzania and Ghana.

Exclusion Criteria: Any country other than mentioned above shall be excluded from study.

ii. For second research question "To measure the progress of countries in achieving UHC reforms."

Study Methodology: To measure the improvement of health of population over time and changing health reforms, we used a comparative analysis of health status indicators among the four sub-Saharan African countries. For comparison between countries, rate of change of health indicators from one fixed data time point (year 2000) to other fixed time point was done (year 2018) to highlight how the health indicators have changed over time.

To measure the financial risk protection of population of given countries, we again used a comparative analysis of health financing indicators. Data was compared to measure change in government spending on health and out of pocket expenditure from year 2000 to 2018. Change in GDP and economic growth rate of countries were also tracked.

Data Source: Data was collected from recent Demographic health surveys, National health reports and World Bank report.

Based on Sustainable development Goal 3 health targets and also on availability and comparability following health indicators were selected.

Child Health Indicators: Neonatal Mortality, Under-5 Mortality, and Infant Mortality.

Maternal Health Indicator: Maternal Mortality Ratio

Reproductive Health: Total Fertility Rate

Disease profile: HIV prevalence, Antiretroviral coverage, TB incidence, Rate of TB treatment coverage and Incidence of Malaria.

For measuring health financing, following indicators were selected: Current Health Expenditure (CHE), Total Health Expenditure (THE), Out of Pocket expenditure (OOPE), Domestic General Government Health Expenditure (DG GHE) and Gross Domestic Product (GDP).

Data Extraction: Indicator data for the different population groups in the four selected countries were extracted from the respective survey reports into a matrix, and relevant details associated with the measurement and computation of these indicators were also noted.

iii. **For research question "**How different class of economies (World Bank classification of countries) can proceed forward in their way towards UHC"

Methodology: A gap-analysis measuring the gaps in health system of countries within themselves and between countries was made.

Setting: AXA France Vie- India Reinsurance Branch office, New Delhi

Duration: February to May 2020(3 months)

4. Situational Analysis

Background of study

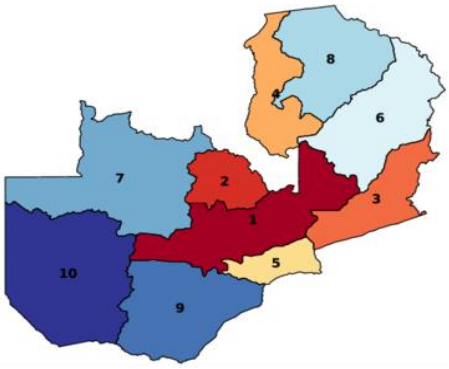
The growing demand of health and healthcare need along with the United Nations global agenda to achieve UHC, has forced many countries to adept to growing demands and change the existing health reforms. Various Sub Sharan countries have already started with measures in initiating health reforms as a way forward to achieve UHC. Health financing play an important role in UHC and over the years, the financing strategies have shifted from being funded majorly by external funding agencies to being financed by government. The need to financial risk protection (FRP) has led to increase demand of health insurance and forced government to look at the equity aspect of health. FRP checks for the catastrophic health expenditure leading to impoverishment and also emphasises the need for health insurance. Various countries have started with implementation of health reforms for FRP either in form of a Social Health Insurance Scheme, A community health insurance scheme, private health insurance and most recently there has been a wave of securing all by providing with National health insurance.

The financing strategies are directly attributed to the economic growth of countries, the total amount spend on healthcare by government, demography and most importantly political will. In my study, I have chosen four different economies, indifferent to each other in ways of their policies, their demography and geography, and their socioeconomic and political situation.

In coming sections, I shall discuss in depth about each country and how they have performed over the years in achieving UHC reforms.

Chapter 4.1 Zambia

Table 4.1. Country Context

COMPONENT	DETAILS	DATA
Population	Total Population	17,351,822
	Rural vs Urban	56.48% Rural 43.52% Urban
Geography  	Republic of Zambia is a landlocked country located in Southern-Central Africa. With an area of 752,614 km^2 (290,586 sq mi) it is the 39th-largest country in the world. The capital city is Lusaka. The capital city witnesses huge concentration of population. The Copperbelt Province to the northwest is the core economic hubs of the country. Zambia is divided into 10 provinces, which are further divided into 117 districts, 156 constituencies and 1,281 wards (5).	
Government	Zambia is a multiparty democracy. The Patriotic Front (PF) is the ruling party. The main political parties in opposition include: Movement for Multiparty Democracy (MMD); the United Party for National Development (UPND); Forum for Democracy and Development (FDD); United National Independence Party (UNIP); Heritage Party (HP) and Zambia Republican Party (ZRP) (6)	
Economic Situation	GDP per Capita	USD 23.17 billion

	Economic Growth	3.8%
	Gini-index	57.1
	HDI	0.59
	Number of people living on < USD 1/day	58%
	Unemployment	7.2%
	Adult Literacy	86.75%
	Average Family Size	4.9 per household
	% Population access to sanitation	31%
Health	Health as % of GDP	4.5%
	Annual total health expenditure (%)	9.3%
	$ health expenditure per person	USD $90
	No. doctors/ 1000 population	0.091
	No. nurses/ 1000 population	0.07
	% births with skilled attendance	80%
	Infant mortality rate	42 per 1000

	Under 5 mortality-rate	61 per 1000
	Average life expectancy	63.26 years
	Maternal mortality	183 per 100,000 live births
Disease burden	HIV/ AIDS prevalence	11.3%
	Deaths from HIV AIDS	18.42%
	Deaths due to Maternal conditions	1.53%
	Deaths due to Chronic Disease	26.83%
	Deaths due to Violence	2.77%
***The vision of Zambian government in healthcare spending is 15% of the total government expenditure as per Abuja Declaration 2001, of Organization of African Unity.** **The country's Medium-Term Expenditure Framework projects a sharp increase in the allocation to health in the national budget to 14.8% by 2021.**		

(7) (8) (9)

4.1.1 Country history and political context

Zambia one of the most politically stable countries in Africa, was a British colony from 1888 until October 24, 1964 when it was liberated. Kenneth Kaunda led Zambia under single-party socialism for three decades since independence. He initiated central planning of the economy and nationalised key sectors, notably the copper industry. Under popular pressure in 1991, a constitutional change took place allowing a multi-party system(5).

Current Zambian president is **Edgar Chagwa Lungu of the Patriotic Front (PF)** who came into power in January 2015 in a presidential by-election.(10) His party has focused

since then on key efforts to improve accessibility of hospitals, alleviating shortages of medical HR, ensuring its fair distribution, developing a well- functioning health information system and most importantly investing in a National Social Health Insurance (SHI) Scheme to ensure adequacy of funds (11).

The Parliament, headed by the Speaker of the National Assembly, comprises 150 elected members and up to 8 members nominated by the President. The Supreme Court is the highest Court of Appeal and is headed by the Chief Justice.

Population

Zambia has a growing population of just over 15 million people. Its population is very young with a median age of 17 years. Predominantly, Zambia's population is of African descent with diverse ethnic groups the largest group being the Bembas at 21%, Tonga 13.6% and Chewa. English is the official language of the land (12).

Economic Environment

Zambia is a lower-middle income country with a GDP of USD 27.0 Billion and an annual growth rate of 3.0%. Current estimates place the poverty levels in rural areas at 70% compared to those in urban areas like Lusaka, which stand at between 20-30%. The economy is largely driven by the mining sector which contributes about 20% of the GDP. Zambia is the largest producer of diamond and forth largest of uranium in the world (13) (14).

Policy Environment

The policy environment in Zambia, is inclusive. The major stakeholders who dominate the process of policy making are the executive, Members of Parliament, local councilors, and traditional village councils. Other smaller stakeholders include professional bodies, church bodies, and Commerce and Industry associations (Zambia Chamber of Commerce, Chamber of Mines, Zambia Association of Manufacturers) (15).
Following are the health policies that are currently followed:

The National Health Strategy Plan (2017-2021): It mainly outlines strategies for healthcare reform in Zambia, to meet its SDG targets (16).

Vision 2030: outlines long term strategies for Zambia that cut across all sectors of governance to achieve sustainable development by focusing on areas to attain health-related SDGs, access to health facilities and availability of human resources (17).

Human Resource for Health Planning and Development framework (2017-21): focuses on increasing the availability of Health care workers by establishing medical colleges, ensuring their equitable distribution and allowing for generous monetary allowances (18).

SWAp: The Sector Wide Approach (SWAp) is an agreement between various stakeholders in the health sector and government along with their partners (NGO's/ FBO). This outlines processes of reporting and monitoring, meetings and working groups (19).

4.1.2 Healthcare in Zambia

Health System Overview

The Ministry of Health (MoH) (20) with the Ministry of Community Development, Mother, and Child Health (MCDMCH) are the sole bodies responsible for delivery of health care services.

Zambia has a four-tier pyramidal referral set-up, with primary healthcare at the bottom. It consists of a network of health posts, health centres and district hospitals managed under the District Health Office (DHO). Above the primary healthcare level are secondary level hospitals designed to serve as the highest referral hospitals at provincial level. Next are the third level hospitals which provide tertiary level healthcare and, in some cases, medical training and research. Finally, at the apex of the health system are specialized hospitals (21).

Figure 1 Chart of Public Health System at the central, provincial and district level, Zambia

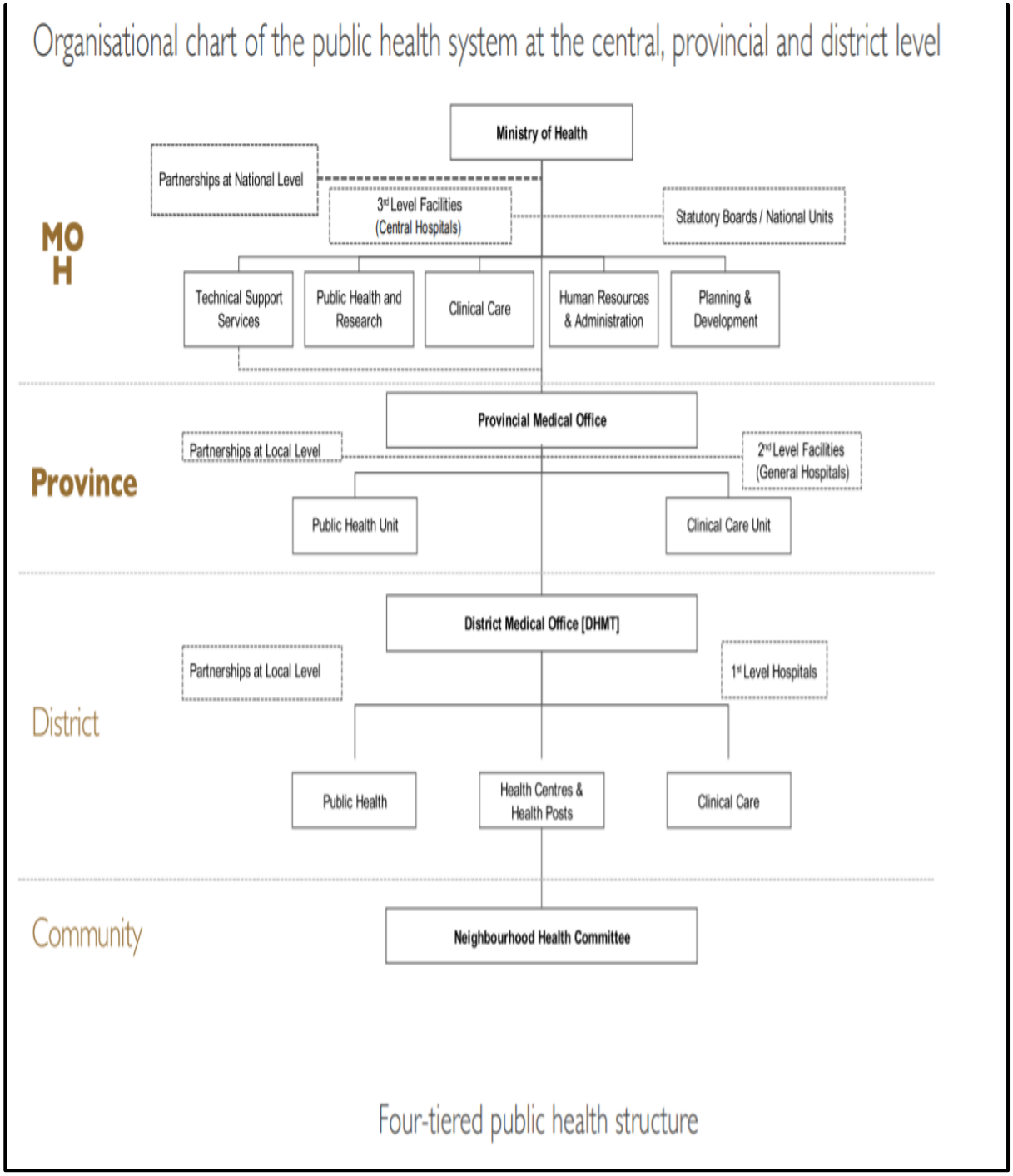


Table 4.1.2 Healthcare Reforms in Zambia: 1992-2017 (7)

Period	Organization	Financing	Financing Modality
1992-1993	Sector wide approach programming	Pooling of government and donor funds for districts Medical user fees introduced with exemptions for the poor	
1995-1996	Provider–purchaser split CBoH created as an autonomous institution responsible for purchasing health services Functions of Medical Stores Limited restricted to storage and distribution	Basic health care package Population-based resource allocation formula	Country-wide performance-based contracting
1998-1999	Functions of CBoH and MoH streamlined Medical Stores Limited contracted out under a lease agreement		
2003-2004	Medical Stores Limited contracted out under a management contract Reorganization of sector-wide approach programming coordination mechanism	Medical Stores Limited contracted out under a management contract Reorganization of sector-wide approach programming coordination mechanism	
2006-2007	Dissolution of CBoH MoH assumes role of provider, purchaser, and regulator	Dissolution of CBoH MoH assumes role of provider, purchaser, and regulator	Performance-based contracting discontinued
2011-2013	Transfer of the primary health care function from the MoH to the Ministry of Community Development	Medical user fees removed at the entire primary health care level Medical levy abolished	RBF in 11 districts
2015-2017	Remerger of the primary health care function to the MoH (2015) Structural reorganization of the MoH (2016–2017)		RBF in 53 districts in five out of ten provinces

Zambia's Disease Profile

Zambia has an elevated burden of disease, due to high prevalence of HIV/AIDS, Tuberculosis, and sexually transmitted infections, communicable disease come are upfront. The country is experiencing a HIV/AIDS epidemic, with an HIV prevalence of approximately 11.3% of adults (22). Apart from this there is a rising burden of NCDs. In 2017, 29% of deaths were accounted to NCDs (23).

The top 10 causes of Deaths/Mortality are (24)

1. HIV/AIDS
2. Neonatal disorders
3. Lower respiratory infections
4. Tuberculosis
5. Diarrheal diseases
6. lschemic heart disease
7. Malaria
8. Stroke
9. Congenital defects
10. Cirrhosis

The top 10 causes of Morbidity are (24):

1. HIV/AIDS
2. Headache disorders
3. Low back pain
4. Depressive disorders
5. Dietary Iron deficiency
6. Neonatal Disorders
7. Vitamin A deficiency
8. Anxiety disorders
9. Diabetes
10. Diarrheal diseases.

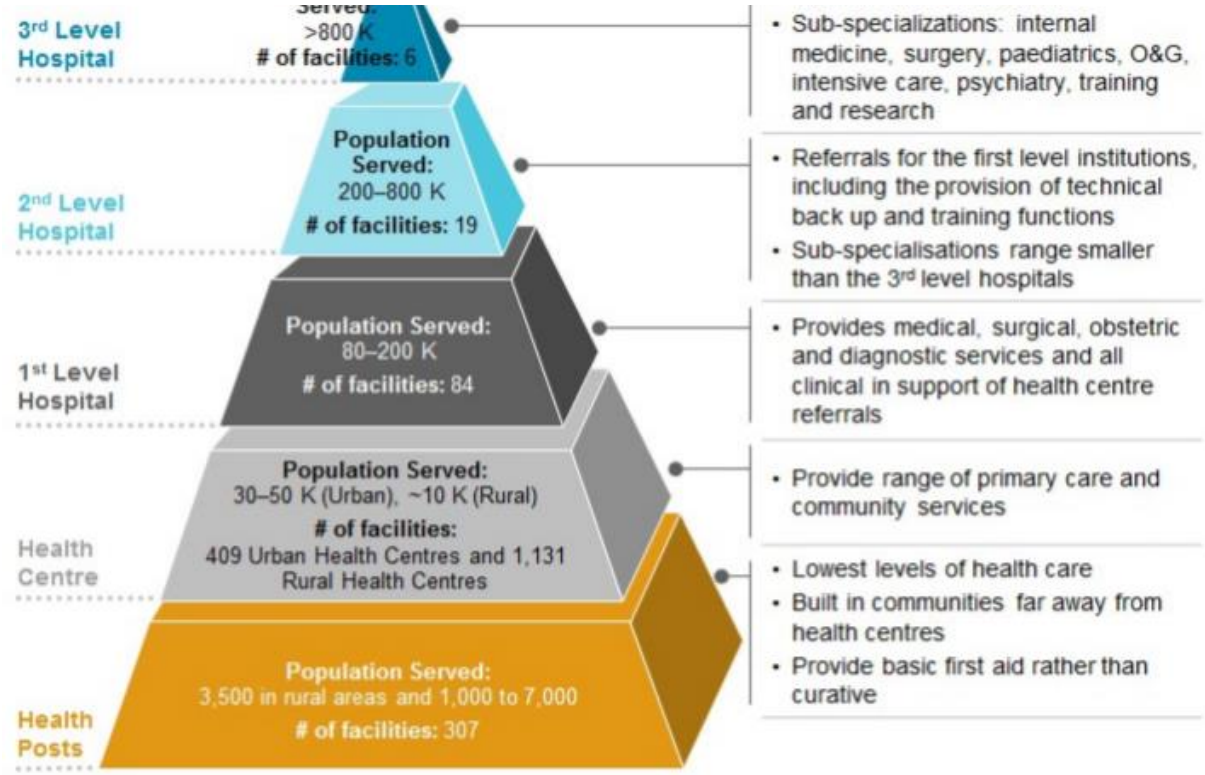
Healthcare Infrastructure

Zambia is divided into 10 administrative provinces and 118 districts. Health is managed through provincial health offices (PHOs) (10), DHOs (105), and statutory bodies. The country has 8 tertiary level hospitals, 34 secondary level hospitals, 99 first-level hospitals, 1,839 health centres, and 953 health posts (16). All tertiary hospitals are Government owned. Some of the secondary level hospitals owned by the Churches Health Associations of Zambia (CHAZ) .

Hospitals in Zambia are divided into three main categories: (1) Specialist Hospitals (Tertiary Referral Hospitals or Third Level Hospitals) (2) General Hospitals (Provincial Hospitals or Second Level Hospitals) and (3) District Hospitals (First Level Hospitals).

The private infrastructure constitutes only 6%, whereas public infrastructure is the largest contributor of healthcare services.

Figure 2 Health Service Delivery Pyramid, Zambia



4.1.3 Health Financing

The financing system of Zambia is hybrid, that includes public, external, and private financing. Public financing (government health expenditure) comes from taxes collected by the central government which are then executed by the Ministry of Health (MOH) and other government agencies (25)

External financing comes from bilateral and multilateral development partners in form of grants or loans to government or nongovernmental organizations where these institutes act as funding partner. Private financing is in the form of direct health expenditure by households (out-of-pocket expenditure) and by private employers and private third-party insurers.

The Government Health Expenditure (GHE) as % of Total Health Expenditure (THE) on health increased significantly from years 2006 to year 2018, from 38% to 68% (26).

Financing by Disease Area

In 2016, infectious diseases, including malaria, tuberculosis, and HIV/AIDS and other sexually transmitted diseases accounted for 59% of total health expenditure, with HIV and other sexually transmitted diseases and malaria alone accounting for 48% of total health expenditure (MOH, Unpublished).

Revenue contribution and collection

The Government of Zambia (GRZ) collects the revenues in form of general taxes and budget support without any proper revenue stream it later channelizes the funds to MOH. External donors have an on- and off-budget support. In 2018, external resources provide 42% of total resources for health (25) (27)

Pooling

To begin with pooling mechanism the government proposed NHI scheme that aims to cover all citizens under a single pool (11). The first phase of implementation that started recently, aims to cover an estimated 4.5 million Zambians who are employed in formal sector along with their dependents, and vulnerable populations. The second phase will extend coverage to the general population, bringing more than 11 million people in the informal sector under the scheme. It is estimated that these schemes may cover as many as 500,000 Zambians (28).

Purchasing

In 2015, MOH received 57% of the GRZ health budget, compared to 42% for MCDMCH. Other line ministries received less than 1% of the total health budget, primarily for infrastructure development and HIV and AIDS mainstreaming (16).

Costing of Services

The NHSP has identified and estimated total costs for services in 33 priorities areas at US$14.3 billion (ZMK 139.8 billion) (16). These areas that are major cost drivers are Human resource US$3.2 billion (22.6% of the estimated total); infrastructure US$2.4 billion (17.1% of the estimated total); pharmaceuticals and supply chain management (essential drugs, commodities, and supplies) US$2.2 (15.8% of the estimated total); HIV/AIDS US$ 1.0 billion (7% of the estimated total); and malaria US$0.9 billion (6.5% of the estimated total) (16).

4.1.4 Health Insurance

Insurance at-a-Glance

The Zambian insurance industry is mainly divided into two: 1) Non-life Insurance 2) Life Insurance.

By the end of December 2018 Non-life insurance constituted about 60% of the insurance business and life insurance constituted about 40% of the same. As an industry, GWPs have increased from ZMW 2.7 billion in 2017 to ZMW 3.1 billion in 2018, representing an increase of 15%. The Zambian insurance industry penetration ratio was 1.13% in 2018. This is higher than in both Uganda and Tanzania, who saw penetration of 0.84% and 0.55% respectively

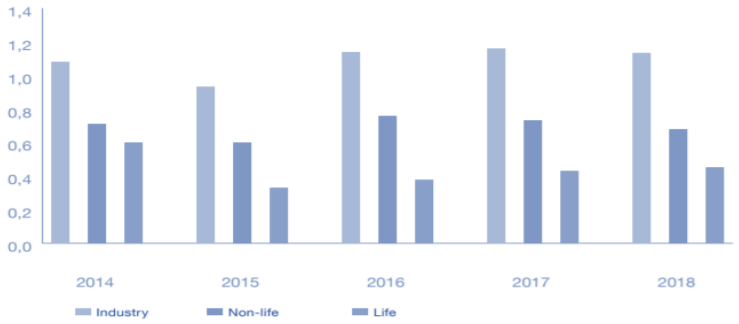
The non-life industry accounted for the bulk of the GWPs in 2018 at ZMW 1.9 billion. This represents an increase of 6% from the ZMW 1.8 billion recorded in 2017 for the non-life industry. Meanwhile, there was significantly higher growth recorded in the life industry in 2018, although it still lags the non-life industry in absolute terms. GWPs for the life industry was recorded at ZMW 1.3 billion in 2018. This was a 35% increase from ZMW 0.9 billion recorded in 2017.

Insurance Market Penetration

Penetration is calculated as GWPs as a percentage of GDP. Penetration for the industry has remained relatively low over the past five years, hovering around the 1% (1.13%)

mark for the industry. Life insurance recorded a penetration of 0.45% in 2018 compared with 0.43% in 2017. The non-life sector recorded a penetration of 0.68% in 2018 compared with 0.73% in 2017.

Figure 3 The trend in insurance penetration in Zambia



Public vs Private Insurance

Out-of-pocket expenses associated with facility-based deliveries are a well-known barrier to health care access. These expenses account for approximately one third of the monthly household income of the poorest Zambian households. However, the abolition of user fees has reduced the direct costs of delivering at a health facility for the poorest members of society.

Private Health Insurance

The private insurance market in Zambia is primarily composed of four main prepayment and insurance schemes: private health insurance, employer-based insurance, government facility high-cost schemes, and private facility medical schemes. According to the Zambia Household Health Expenditure and Utilization Survey, these schemes only cover 3.9% of the total population (MOH, UNZA, and CSO, 2016).

The largest of these is the employer-based scheme, which accounts for 44% of all covered individuals. Under this type of scheme, an employer manages a group scheme for its employees (and their dependents) who contribute a payroll-based premium, entitling them to insured care in selected health facilities.

In private health insurance schemes, which cover 19% of covered individuals, individuals (and possibly their dependents) are covered by a commercial insurance company in exchange for premium payments made either by the individual or their employer. Government facility high-cost schemes and private facility medical schemes

are prepayment schemes where policyholders deposit a minimum amount of money into the scheme and the medical services rendered are charged against that account. These schemes account for 19% and 17% of covered individuals, respectively. In general, the private insurance market covers primarily formal sector workers and those with relatively high incomes.

Top Insurance Companies

1. Sanlam Life Insurance Zambia
2. Madison Life Insurance
3. Professional Insurance
4. NICO General
5. Liberty Life Insurance Zambia

Government Health Insurance Schemes

After user fees were introduced at public health facilities in the 1990s, policy discussions began to focus on the need for developing a National Health Insurance (NHI or social health insurance) scheme to provide financial risk protection and improve healthcare financing.

However, progress on developing an NHI scheme stalled for more than 20 years due to a lack of political will and support (Freedom to Create, 2016). In 2012, the National Health Policy affirmed the need to create an NHI scheme and the government removed user fees for all primary care as a first step toward providing financial risk protection (ROZ, 2011). Evidence shows that removing user fees from primary care services may not have significantly improved financial risk protection as hoped (Hangoma, Aakvik, and Robberstad, 2018; Hangoma, Robberstad, and Aakvik, 2018).

In 2015, government renewed its proposal to implement NHI, and the creation of NHI was included as in Seventh National Development Plan 2017-21.

National Health Insurance Program

In lines of Universal Health Coverage, the Zambian government announced National Health Insurance Scheme. The scheme came into force after passing of National Health Insurance Act no. 2 of 2018.

The board of the National Health Insurance Management Authority was inaugurated on 15th March 2019 in accordance with the NHI act (29).

As per this scheme, deductions of 1 per cent of earnings of formal employees and matched by a 1 per cent employer contribution will begin by August, 2019. These contributions will be paid into the National Health Insurance Fund (28). A four months waiting period is needed before commencement of service provision.

The scheme will be phased, starting with the formally employed both in public and private sectors and will be expanded to include informal sectors and vulnerable groups. The Government will make contributions on behalf of indigent persons as identified by existing systems under the Ministry of Community Development and Social Welfare.

Essential Health Care Benefit Packages

Members will have access to an essential health care benefit package at primary, secondary, tertiary and specialized level. This will include medical services ranging from registration or consultation fees, investigations, pharmaceuticals, inpatient services, surgical services, ambulance, mobile and referral services, annual medical checkups, medical health, mental health, health promotion activities, maternal and paediatric services, dental and vision care.

Accreditation and Publication of Accredited Facilities

Contracting public and private providers shall be accredited in conjunction with the Health Professionals Council of Zambia (HPCZ). These are the facilities to which members will go for services. Members will further be able to access services countrywide from accredited public and private providers.

Registration of Members

Following the commencement of deductions, a registration drive will aim to capture in excess of 700,000 formally employed individuals in both public and private sectors in the initial phase. This exercise will subsequently be expanded to a community-based registration of self-employed individuals.

Chapter 4.2 Namibia

Table 3.2.1 Country at Glance, Namibia

COMPONENT	DETAILS/INDICATOR	DATA
Population	Total Population	2,540,905
	Rural vs Urban	49.97% Rural 50.03% Urban
Geography 	The Republic of Namibia, is a country in southern Africa named for the Namib Desert that is bordered by the Atlantic Ocean, Angola, Zambia, Botswana, and South Africa. Although it does not border Zimbabwe, less than 200 metres of the Zambezi River separates the two countries. At 825,615 km^2 (318,772 sq mi), Namibia is the world's thirty-fourth largest country (after Venezuela). Being situated between the Namib and the Kalahari deserts, Namibia has the least rainfall of any country in sub-Saharan Africa. The majority of Namibians are rural dwellers (about 55%) and live in the better-watered north and northeast parts of the country.	
Government	**Politics of Namibia** takes place in a framework of a semi-presidential representative democratic republic, whereby the President of Namibia is both head of state and head of government, and of a pluriform multi-party system. Executive power is exercised by both	

	the President and the Government. Legislative power is vested in both the Government and the two chambers of Parliament. The judiciary is independent of the executive and the legislature. he **Government of Namibia** consists of the executive, the legislative and the judiciary branches. The Cabinet is the executive organ of government, implementing the laws of the country. It consists of the President, the Prime Minister and his deputy, as well as the Ministers.	
Economic Situation (30)	GDP	USD 27.1 billion
	Economic Growth	3%
	Gini-index	59.1
	HDI	0.645
	Number of people living on < USD 1/day	33%
	Unemployment	23.1%
	Adult Literacy	91.5%
	Average Family Size	4.4 per household
	% Population access to sanitation	34.4%
	Median Age	21.2 years

Health	Health expenditure	**N$ 6.8 B**illion
	Annual total health expenditure (%)	11.4%
	$ health expenditure per person	USD $403
	No. doctors/ 1000 population	0.37
	No. nurses/ 1000 population	2.8
	% births with skilled attendance	80.3%
	Infant mortality rate	31.8 per 1000
	Under 5 mortality-rate	44.2 per 1000
	Average life expectancy	63.4 years
	Maternal mortality	195 per 100,000 live births
Disease burden	HIV/ AIDS prevalence	11.8%
	Deaths from HIV AIDS	2700
	Deaths due to Maternal conditions among total female deaths	7%
	Deaths due to Chronic Disease	41%

***The vision of Namibian government in healthcare spending is 15% of the total government expenditure as per Abuja Declaration 2001, of Organization of African Unity.**

4.2.1 Country Context

Country History and Political System

Namibia's history has passed through several distinct stages from being colonised in the late nineteenth century to Namibia's independence on 21 March 1990.(31) Namibia has transitioned from a white party apartheid rule to a Multiparty democracy. South West Africa People's Organization (SWAPO) party has won every election since 1990 (32)

Ever since independence, the country's economic growth has also progressed. Namibia's gross domestic product (GDP) of US$27.1 billion, places it in the Upper Middle-Income category. However, this status quo masks significant poverty and one of the highest levels of social and economic inequality in the world (33). The Government of Namibia has developed a Vision 2030 aims to transform Namibia into an industrialized nation and redress income gaps through a series of developmental processes (34).

Population

Namibia is a densely populated country with a growing population of 2.54 million. It is growing steadily at 2% per year. The largest city and capital is Windhoek, with a population of about 268,000. This is the only city with a population exceeding 100,000 (31).

Most Namibian people are of Bantu-speaking origin. The largest ethnic group is the Ovambo (49.8%), who live mostly in the north of the country and throughout Namibia. Other ethnic groups include Kavango (9.3%), Damara (7.5%), Herero (7.5%), white (6.4%), Nama (4.8%) Caprivian (3.7%), San (2.9%), and Basters (2.5%) (35).

Economic Environment

The World Bank recategorized Namibia as an **Upper Middle Income Country (UMIC**) in 2009. The economic growth is largely due to growth in the sectors of mining, fisheries, large-scale farming and high-end tourism.

GDP growth had been moderately good for the past five years, but in 2018 due to lower government spending and less demand for Namibian exports to South Africa the GDP had slipped, however in following years it climbed back Currently the country boasts a GDP USD $27.1 bn and has shown 2.4% of 5-year compounded growth with $11,229 per

capita income(30). Despite the significant contribution of the mining sector to the economy, this sector employs only 3% of the working population, while agriculture accounts for about 12% of GDP but employs 70% of the working population, primarily through subsistence farming.

Policy Environment

In 1998, the first National Health Policy Framework document was introduced. It provided the overall orientation for health and health action in Namibia. Various important programme policy documents have been developed over the years such as the National Policy on HIV/AIDS and the National Malaria Policy, among other.

Then came the National Health Policy 2010-20 (NHP) which is a continuation of efforts started at the time of independence. The most important policy change that was introduced in 1990, was the introduction of the **PHC approach** for providing public health services to the population. The focus of NHPF outlines and set out general priorities to its vision of**, "A healthy nation, which is free of diseases of poverty and inequality"** (36).

The ambitious Vision 2030 based on framework of NHP 2010-2020, places emphasis on the country free of the diseases of poverty and inequality; providing Namibians a healthy lifestyles and equal access to a comprehensive preventive and curative health service (34)**.**

The Ministry of Health and Social Service (MoHSS) (37) is the sole custodian of the health of the people in the country. The MoHSS ensures universal coverage and access to health care through adequate policies such as emphasis on PHC and formulation of policies.

4.2.2 Healthcare Structure of Namibia

Healthcare System Overview

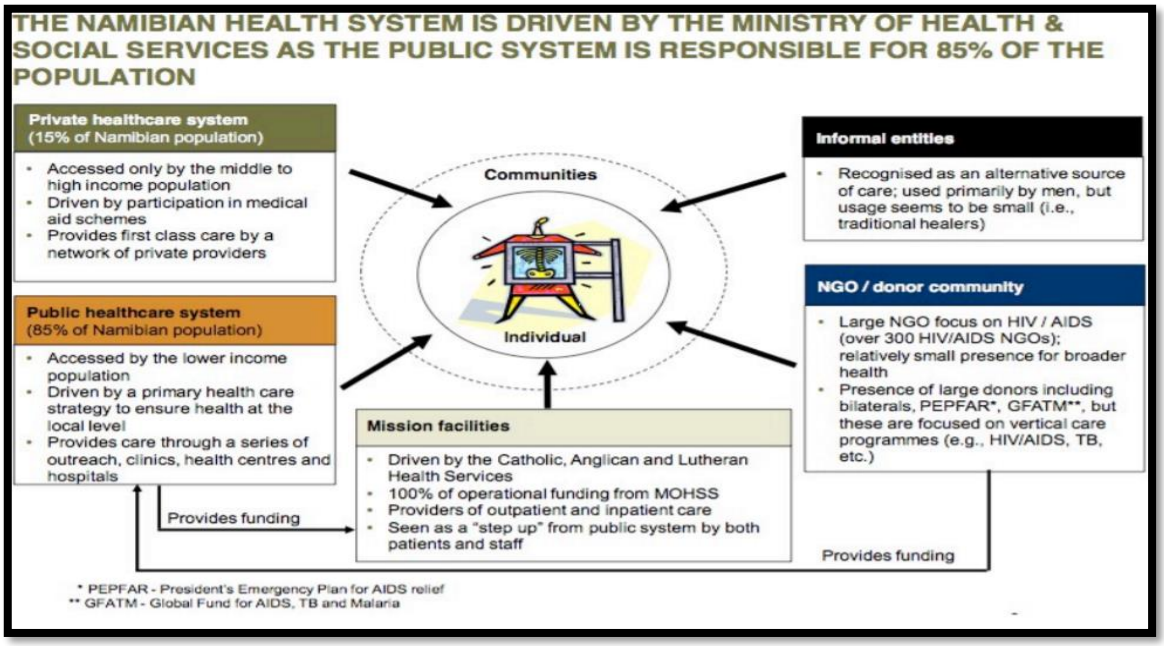
The Namibian Health system is driven by Ministry of Health and Social Services (MoHSS). Health has been a priority for the government since independence. The number of health sector reforms and development such as strengthning Primary Health sector remains an evidence to this. The orientation of public health services is toward primary health care, focusing mainly on community health, preventative measures, and treatment

that is available at any time and place, accessible and affordable by all. Most of these services are provided through public clinics, outreach points, and district public hospitals. Medicines are generally affordable due to highly subsidized flat user fees.

The Namibian public health sector consists of three levels: central, regional and district levels. The central level has 13 regional directorates and 34 districts. Each region has health centres and outreach points, while each district has a district hospital and a referral centre. The public health care facilities constitute the core of health system in Namibia and is accessed by 85% of lower income group population. The private for-profit healthcare system mostly serves the remaining 15% of the population, consisting of middle- and high-income groups (38).

Namibia has four tiers in the public health system: 1150 outreach points, 309 health centers, 34 district hospitals, and four intermediate and referral hospitals.

Figure 4 Namibian Healthcare structure



Health Indicators and Targets

The MoHSS in its five year strategic action plan for 2017-18 to 2021-22 has laid out certain health targets aligned to the broader national and global development plans such as Vision 2030, Harambee Prosperity Plan (HPP); Fifth National Development Plan (NDP5), Agenda 2030/Sustainable Development Goals (SDG) (39).

Table 3.2.2 Health Indicators and targets: Namibia

Key Performance Indicator	Indicator Definition	Baseline	Annual Targets				
			2016-17	2017-18	2018-19	2019-20	2019-21
Maternal Mortality Rate	Per 10000 live birth	385	348	311	274	237	200
Infant Mortality Rate	Deaths in 0-28 days per 1000 live births	20	18	16	14	12	10
Adult Mortality Rate	No. of adult deaths per 100000 live population	0.12%	0.11%	0.11%	0.10	0.94%	0.88%
HIV prevalence	New case per 100000 population	374	345	288	271	271	271
Reduction in mortality for HIV	Reduction in mortality rate HIV per 100 000	134	120	106	94	92	90
Reduction in morbidity for TB	New cases per 100 000 population	489 396 356 321 289 260	396	356	321	289	260
Reduction in mortality for TB	Reduction in mortality rate for TB per 100 00	73	68	63	58	51	47
Reduction in morbidity for Malaria	New malaria cases per 1000 population	10%	5%	3%	1%	1%	1%
Birth attended by skilled health personnel		88.2%	90%	92%	95%	95%	95%

Country's Disease profile

Namibia's disease burden is gradually transitioning from communicable to non-communicable diseases and this trend is reflected in the shares of health expenditures by disease. Spending on infectious and parasitic diseases decreased from 33 percent in 2012/13 to 26 percent in 2016/17, whereas spending on NCDs increased from 5 percent to 19 percent in the same period.

Top 10 causes of deaths/mortality (40)

1. HIV/AIDS
2. Ischemic Heart Disease
3. Lower respiratory infections
4. Stroke
5. TB
6. Neonatal Disorders
7. Diarrheal disease
8. Diabetes
9. COPD
10. Road Injuries

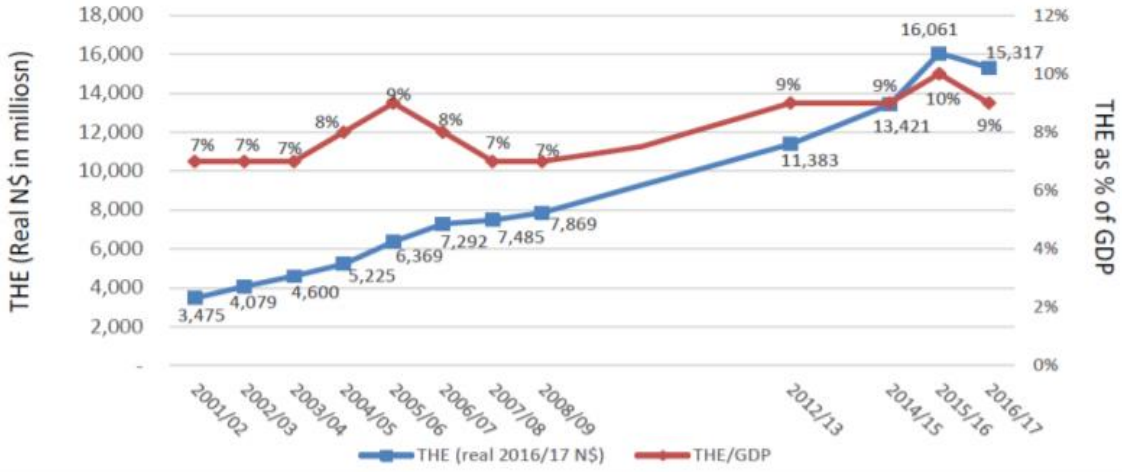
Top 10 causes of Morbidity (40)

1. HIV/AIDS
2. Neonatal Disorders
3. Diarrheal disease
4. Lower Respiratory
5. TB
6. Road injuries
7. Diabetes
8. Ischemic Heart disease
9. Stroke
10. Interpersonal violence

Healthcare Expenditure

The total health expenditure allocated for year 2019-20 is allocated **N$6.8 billion or 11.4 percent** of the total non-statutory budget of N$60.1 billion (41).

Figure 5 Total Healthcare Expenditure (THE) of Nambia: 2001-2017



Source: Health Accounts data 2001/02-2016/17.

THE as a percentage of GDP indicates the level of health care expenditure relative to the country's economic development and as per 2019 report, Namibia's total annual Health expenditure was 11.4% which is very close to meeting the Abuja Declaration target of 15%. Health expenditure is expected to increase by 2.3 percent from 2019 to 2020 and is the second largest expenditure (41) (42).

4.2.3 Health Financing

Namibia's health system is financed from three sources of revenues that are pooled in three special schemes to finance care for different population groups:

(i) Government revenues are pooled within the government budget to finance all health schemes managed by MoHSS, such as Public Sector Employee Medical Aid Scheme (PSEMAS).

(ii) A compulsory contribution payment for all government employees (payroll taxes) pooled via PSEMAS, and

(iii) Lastly voluntary contribution payments by private employers and households in form of individual Medical Aid Fund (MAF) pools.

Revenue contribution and collection

Namibia finances more than 75% of its THE through domestic resources. The government is the largest funder of healthcare, at 54%. Employers contribute which is 11% of THE, by making contributions to medical aid schemes like PSEMAS on behalf of their employees. The household prepayment contributions have increased, with households now paying 16% of THE through prepayment schemes thus leading to an increasing OOP expenditure from 6% to 11% with donor contributions down to 8% as per the recent rounds of the National Health Accounts (NHA) (43).

OOP expenditure is mainly on curative health services that are mostly private, although a larger proportion (approx. 13%) is dedicated to pharmacies.

Pooling

Namibia offers two other risk-pooling mechanisms: a medical aid scheme for public sector employees and private medical aid schemes. The state run PSEMAS is one of the largest schemes, open to civil servants only.

Overall, access to financial risk protection is limited, with only 19% of the population covered through some form of health insurance (MOHSS, 2015) (43) (44).

Purchasing

Government-managed resources are spent heavily on curative care (70%, including public and private providers), whereas for purchasing drugs and medical goods, and preventive services the health expenditure has declined to 7% and 6%, respectively.

Government, through PSEMAS, uses a **fee-for-service model,** in which it purchases services from providers who are directly recruited vis a contract mode (44).

HIV Financing

Since HIV accounts for the largest proportion of lives lost (28.6%) in the country, it is important to understand HIV/AIDS financing. The total HIV/AIDS expenditure from government was only 13% of THE in 2016-17. This is because HIV/AIDS response in Namibia remains strongly funded by donors**.** 45% of funding for HIV/AIDS health interventions in 2015/16 and 2016/17 was from donors and 38% to 44% from government (45).

4.2.4 Healthcare Infrastructure and Human Resource

Health care facilities in the country are sufficient but not well distributed. These are seldom accessible to sparsely populated parts which is either remote or belong to poorer section of society. Certain services like dialysis and organ transplantations are only available from private medical centres, putting them out of reach for the majority of Namibia's citizen. Dual practice in the public and private sector is not regulated for physicians. (Appendix 2) (Please add physician distribution and health facility from
There are 1200 physicians in public and private sector and the health workforce comprises of 0.33 physician per 1,000 inhabitants. Majority of physicians are based in Khomas- the capital of Namibia. There are 6,145 midwives and ratio for nurses is 2.02 per 1,000 population. This number is significantly larger than in the rest of Africa and slightly exceeds the minimum density recommended by WHO. However, although high ratio, it fails to reflect the unequal distribution of physicians and nurses which are more in private as compared to public sector and also concentrated more around the cities like Khomas and Oshana. Urban sector absorbs more than one-third of physicians and about 20% of nurses. In 2018, hospital beds per 1,000 population was reported at 3.2 in public sector. Again, there is a large regional inequality and most health facilities are in few cities of Namibia. With roughly around 101 health facilities, the private sector has total 1144 beds (46).

4.2.5. Health Insurance

Health Insurance Overview

Namibia is among the top tier of African countries when it comes to health expenditure. The Namibian health insurance industry is relatively well developed and primarily organized into medical aid funds that are either open or closed.

The medical aid fund is a legal entity established under the Medical Aid Funds Act, which defines a fund as " Any business carried out under a scheme established with the objective of providing financial or other assistance to the members of Funds and their dependents in defraying the expenditure incurred by them in connection with rendering of any medical services."

Closed funds limit membership to employees in a particular firm or industry: the closed

government health fund PSEMAS is the largest such scheme, insuring 43 percent of all insured individuals.

Membership in an open medical aid fund “is optional, with employers usually providing some subsidy for premiums, a fringe benefit that is subject to individual income tax.”

There are total ten Medical aid fund, six closed and four open MAF: -

1. Renaissance Health
2. BankMed Namibia
3. Nammed
4. Roads Contractor Company Ltd.
5. Napotel Medical Aid Fund
6. Heritage Health
7. NAMDEB medical Scheme
8. Namibia Health Plan (NHP)
9. Namibia Medical Care (NMC)
10. Public Sector Employers Medical Aid Scheme

Health Insurance Utilization

a.) The beneficiaries:

The Number of lives covered by MAF’s has grown steadily over the last five years from 17.63 million in 2014 to 20.22 million in 2018. The average total claim in 2018 was 4.13 billions and benefit amount was 3.78 as compared to 2.77 bn claim amount and 2.49 Bn benefit amount in 2014 showing a two fold increase in five years. As per 2018 annual report of Namibian Association of Medical Aid Fund (NAMAF), about 80% of population don’t have a medical insurance cover of any form (state or private). Only 490, 229 people are enrolled. Rest of population depends on government facilities or pay cash (47) (48).

The Public Employee Medical Aid Scheme

Insured individuals are wealthier and more likely to use care when sick. Namibia offers public health insurance for government employees and their family members through PSEMAS, which is administered by Methealth Namibia (49).

The public employee medical aid scheme (PSEMAS) is an extra-budgetary public entity that covers health care for government employees and their families(50). Until recently, PSEMAS contribution was of N$250 per month per employee independent of income however it increased to N$500 (45). PSEMAS cover healthcare bills of 293,953 i.e. 98% of insured population. It covers 130 000 members and 155 000 dependents. PSEMAS members represent only 12.5% of the population.

The PSEMAS revenues have more than doubled since 2012. Government financing to PSEMAS introduces inequity in health financing towards the general population as it amounts to one-quarter of government health expenditures.

Since April 2019, the Namibian government has doubled employees' contribution to PSEMAS; however, this increase does not address the inequity of financing of PSEMAS. PSEMAS covers 95 per cent of medical expenses for public servants and it received a N.dollars 2.8 billion allocation for the 2019/2020 budget(51).

Table 3.2.3 Trends in PSEMAS finances, in millions N$, 2012-2020

PSEMAS financing	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**
Government transfers[5] to PSEMAS	1,279.4,	1,584.8	1,775.3	2,273.6	2,212.8	2,537.1	2,515.5	2,413.6
Public employee contribution payment to PSEMAS	103.5	111.0	114.6	595.5	455.2	420	420	820
Total PSEMAS revenue	**1,382.9**	**1,695.8**	**1,889.9**	**2,869.2**	**2,667.9**	**2,957.1**	**2,935.5**	**3,233.6.**
Annual change		*23%*	*11%*	*52%*	*-7%*	*11%*	*-1%*	*10%*

PSEMAS shows that Namibia already pays 12% of public sector wages to PSEMAS. In 2019, the total transfer is expected to increase to 12.6%, which is comparable to high-income countries.

Household survey findings suggest that health insurance mainly caters to higher-income groups and provides better access than the government health system. Individuals in higher socio-economic groups are considerably more likely to live in a household with all household members insured. Sick individuals who live in households with all or some members insured are more likely to access care than those in a household with nobody insured.

Percentage population Taking Health Insurance

Overall, access to financial risk protection is limited, with only 19% of the population covered through some form of health insurance (MOHSS, 2015) (44). MAFs provide health insurance coverage to about 7.5% of population who work in the private formal sector

Future-plans of Government in launching any mass scale scheme

To achieve UHC, the government is considering several health financing reform options including establishing a National Medical Benefit Fund (NMBF) within the Social Security Commission (SSC) as a risk pool for the employed population that could be expanded over time to cover the entire population. The government is also exploring options on how to leverage the private sector for UHC and mechanisms for raising additional revenues for health. The Ministry of Finance has increased excise taxes on tobacco and alcohol in 2019. UHC reforms will require additional analysis to estimate its impact on access, financing, and the government's fiscal situation, and to ensure the NMBF or any other health financing option will contribute to improved financial risk protection.

Top Health Insurance Companies

1. Methealth **Namibia** Administrators **Windhoek**
2. PROSPERITY **HEALTH NAMIBIA** (PTY) LTD. c/o Feld & Thorer Street, **Windhoek Namibia**.
3. Renaissance **Health Medical** Aid Fund.
4. Futuregrowth Financial Consultants CC, FGN
5. **Namibian** Chiropractic Association.

Chapter 4.3 Tanzania

Table 4.3.1 Country at a glance

COMPONENT	DETAILS/INDICATOR	DATA
Population	Total Population	54.2 million
	Rural vs Urban	66.2% Rural 50.03% Urban
Geography 	Known for its mountainous regions and dense forest, geographically Tanzania comes in the eastern side of Africa and bordered by countries like Zambia, Kenya, Rwanda, Burundi, Malawi and Republic of Congo. On its eastern side lies the Indian ocean hence it levies on opportunity for trade. The total area covered is 945,087 sq. km which includes 62,000 sq. Km of inland water(52)	
Government	Tanzania is a one party dominant state with the Chama Cha Mapinduzi (CCM) party in power. From its formation until 1992, it was the only legally permitted party in the country. This changed on 1 July 1992, when the constitution was amende. John Magufuli won the October 2015 presidential election and secured a two-thirds majority in parliament. In Zanzibar, the Civil	

	United Front (CUF) is considered a main opposition political party(53)	
Economic Situation	GDP	USD 62.22 billion
	Economic Growth	5.4%
	Gini-index	40.5
	HDI	0.528
	Number of people living on < USD 1/day	33%
	Unemployment	2.2%
	Adult Literacy	77.89%
	Average Family Size	4.9 per household
	% Population access to sanitation	57%
	Median Age	18 years
Health	Health expenditure	**TZS 0.84 B**illion
	Annual total health expenditure (%)	5.9%
	$ health expenditure per person	USD $827

	No. doctors/ 1000 population	0.04
	No. nurses/ 1000 population	2.8
	% births with skilled attendance	80.3%
	Infant mortality rate	37.6 per 1000
	Under 5 mortality-rate	53 per 1000
	Average life expectancy	63.9 years
	Maternal mortality	576 per 100,000 live births
Disease burden	HIV/ AIDS prevalence	4.6%
	Deaths from HIV AIDS	2700
	Deaths due to Maternal conditions among total female deaths	7%
	Deaths due to Chronic Disease	41%
***The vision of Namibian government in healthcare spending is 15% of the total government expenditure as per Abuja Declaration 2001, of Organization of African Unity.**		

4.3.1 Country context

Country History and Political System

Tanganyika as a part of today's Tanzania was conquered by Imperial Germany in the 19th century. Germany ruled over Tanganyika from 1891 to 1919 and later was transferred to Imperial Britain after their defeat in World War II. In 1953, under the leadership of Mwalimu Julius Kambarage Nyerere, Tanganyika African National Union (TANU) was formed. Tanganyika gained independence on December 9, 1961 and a republic in 1962 (52).

After the Zanzibar revolution, in 1964 the Republic of Tanganyika and Republic of Zanzibar entered into an agreement to form a new sovereign state of United Republic of Tanzania. Thus Tanzania became a union of two-tier system of government.

The democracy in Tanzania remains a *de facto* one party system, despite it being a unitary, presidential, multi-party and republic nation.

Population

As per 2012 census, total population of Tanzania was 44,928,923 with an annual growth rate of 4.2%. The average age of population is 18 years and approximately 70% lives in rural area. The population consists of about 125 ethnic groups with Sukuma, Nyamwezi, Chhagga, and Haya having more than 1 million members each (54).

Tanzania is a linguistically diverse country with more than 100 languages spoken. Bantu, Cushitic, Nilotic, and Khoisan. Swahili and English are Tanzania's official languages.

Economic Environment.

Tanzania is an agrarian country and agriculture employs 77 percent of working age adults. The economy has steadily grown since 200, with an average annual growth of 7%. Real GDP growth was estimated at 6.8% in 2019. Growth is projected to be broadly stable at 6.4% in 2020 and 6.6% in 2021. Diamonds, gold, kaolin, gypsum, tin, and various gemstones, including tanzanite, are mined in Tanzania. Gold is an important resource and the country's most valuable export (55).

Policy Environment

The health sector reform proposals accelerated the liberalization of private health care provisions that was allowed in 1991. The Tanzanian Government banned private for-profit clinical practice in 1977. The liberalization of the health care sector was also associated with the introduction of user fees in the public health care provision and re-introduction of private sector.

The reforms proposed by Ministry of Health and Social Work (MOHSW) are the Health Sector Strategic Plans (HSSP), 2003-08 and 2009-2015, which emphasize on implementation of public-private partnership. This is confirmed by the third Strategic Plan which is titled "Health Sector Strategic Plan III: "Partnerships for Delivering the MDGs" July 2009 – June 2015. The HSSP IV 2015-2020, objective is to s to reach all households with essential health and social welfare services, meeting, as much as possible, the expectations of the population, adhering to objective quality standards, and applying evidence informed interventions through efficient channels of service delivery (56).

Apart from this the MOHSW also proposes National Health Policy. The NHP 2017 (57) is consistent with implementation of the National Development Vision 2025, the National Five Year Development Plan 2016/17 – 2020/21; the Sustainable Development Goals 2030; and the Health Sector Strategic Plan 2015 – 2020.

The main objective of NHP 2017 is to provide essential health services attaining to the needs of population, adhering the quality standards and applying evidence informed interventions through intersectoral coordination and addressing crosscutting issues.

4.3.2 Healthcare Structure of Tanzania

Healthcare system overview

The public sector in Tanzania is divided into two government levels:
Central government level and Ministerial Tier, Regional administration Tier and Local government level. At the ministerial level, the Ministry of Health and Social Welfare (MOHSW) is the lead authority for the health sector (58).
Tanzania is divided into 25 administrative regions. The Regional Medical Officers in each region are accountable to the MOHSW for providing regional health services and for supervising the delivery of health services. The local government level is divided into 158

district-level (urban and rural) Local Government Authorities (LGA) which is led by an elected local government council. Most senior local official in the health sector is the District Medical Officer (DMO).

Over two-thirds of Tanzanians reside in rural areas and rely on local health facilities (such as Dispensaries and Health Centers) run by their Local Government Authorities (LGAs) More precisely, the country's health system follows a hierarchical system to cater the population hence, is divided into various levels

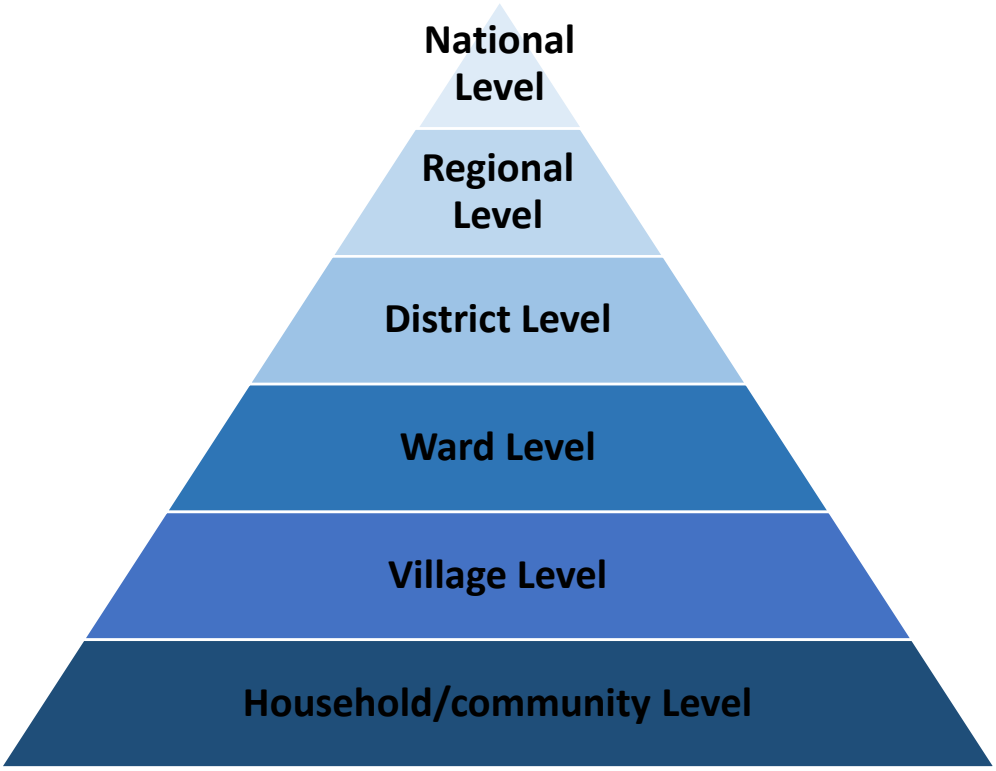


Figure 6 Hierarchical referral system, Tanzania

Health Indicators and Targets

The National Health Sector Strategic Plan 2015-20 outlines certain targets and goals to be achieved some of which are a 20% reduction in maternal mortality ratio and neonatal mortality rate in 5 poorly performing regions, 100% balanced distribution of skilled health workers at primary level in targeted underserved regions, 80% of primary health.(56)

Table 4.3.2 Health Indicators and Targets as per the NHSS 2015-20

Health Indicator	Definition	2015 Baseline	2020 target	Data Source
Neonatal Mortality	The number of new-born deaths that occur within the first 28 days of life per 1000 live births in a given period	26 (TDHS 2010; 2006-2010)	16	TDHS, census intervals
Infant Mortality	The number of infants who die within the first year of life per 1000 live births in a given period.	45	35	TDHS Census SPD SAVVY
Under-5 mortality	The number of children who die within the first five years of life per 1000 live births in a given period	81	55	TDHS Census SAVVY
Maternal Mortality	The number of women who die of causes related to pregnancy, delivery, and postpartum per 100 000 live births in a given year or another period.	432	292	TDHS Census SAVVY (CoD)
Life expectancy at Birth	The average number of years that a new-born could expect to live, if he exposed to death rates prevailing at the time of his or her birth.	61 F: 63 y M: 60 y (Census 2012)	Trend	Census
HIV prevalence	Percentage of young people aged 15–24 years who are living with HIV	15-19: 1.0%; 20-24: 3.2%	15-19: 0.8%; 20-24: 2.4%	THMIS
ARV coverage	Number and percentage of eligible adults and children currently receiving antiretroviral therapy	Adults: 60%; Children: 25% in 2012	Adults: 95%; Children: 80% by 2017	RHIS
Case detection rate of TB	The proportion of estimated new and relapse tuberculosis (TB) cases detected in a given year	56%	72%	NTLP
Treatment success rate of TB	Proportion of all TB cases, all forms successfully treated among all TB cases.	90%	>90%	HMIS
Percentage deliveries assisted by skilled health attendants	Percentage deliveries assisted by skilled health attendants (doctors, clinical officers, nurses, nurse midwives)	51%	60%	HMIS

Country's Disease profile

Tanzania's disease burden is gradually transitioning from communicable to non-communicable diseases and this trend is reflected in the shares of health expenditures by disease. Spending on infectious and parasitic diseases decreased from 33 percent in

2012/13 to 26 percent in 2016/17, whereas spending on NCDs increased from 5 percent to 19 percent in the same period.

Top 10 causes of deaths/mortality:-

1. HIV/AIDS
2. Lower respiratory infections
3. Malaria
4. Diarrheal Disease
5. Tuberculosis
6. Cancer
7. Ischemic Heart Disease
8. Stroke
9. STD
10. Sepsis

Top 10 causes of Morbidity: -

1. HIV/AIDS
2. Neonatal Disorders
3. Diarrheal disease
4. Lower Respiratory
5. TB
6. Road injuries
7. Diabetes
8. Ischemic Heart disease
9. Stroke
10. Interpersonal violence

Healthcare Infrastructure

Over the period 2009 to 2014, the Government has expanded the number of health institutions with around 500 mainly primary health care facilities and has increased the number of health workers deployed. In 2013, sixty-six thousand (66,000) health workers were employed, out of the 149,000 required.

Services, such as Integrated Management of Childhood Illnesses (IMCI), malaria, tuberculosis, HIV prevention and control, Sexually Transmitted Infections (STIs), Reproductive Maternal Newborn, Child and Adolescent Health (RMNCAH) and Prevention of Mother to Child Transmission (PMTCT), are increasingly delivered in an integrated way at the primary health care level ("one-stop-shop"), while the utilisation of these services is improving. Services for Non-Communicable Diseases are still not yet provided according to the needs of the population, based on epidemiological estimates.

Table 4.3.3 Summary of Public and Private Health Facilities, Tanzania

Public Sector Facilities including FBO (2014)	Number	Total No. Of Beds
National general hospitals	1	1,362
National specialised hospitals	4	1,497
Regional referral hospitals (Gov)	15	3,449
Regional referral hospitals (FBO)	12	4,581
Zonal hospitals	5	2,327
Council hospital	63	7,267
Council designated hospital	37	6,742
Voluntary Agency hospital	103	5,595
Parastatal hospitals and health centres	29	1,214
Health centres	614	14,959
Dispensaries	5,819	
Parastatal dispensaries	168	
Specialised clinics	12	
Total	6,882	48,993
Private Sector Facilities (2014)		
Private hospitals	39	1,187
Private health centres	78	800
Dispensaries	1,123	
Private clinics	40	
Private dental clinics	26	
Private eye clinics	5	
Maternity homes	22	
Total	1,333	1,987
Health Sector (Total)	8,215	50,862

Source: MOHSW, Department of Curative Services, HMIS report 2013/14, CSSC 2015

Key Healthcare reforms in Tanzania

Table 4.3.4 Summary of Healthcare reforms 1990-2010, Tanzania

Year	Reform
1990	The First National Health Policy
1991	The Liberalization of Private Health Care Provision
1993	Government/Development Partners Appraisal Mission on the Health Sector
1994	Proposal for Health Sector Reform Agreement to Enter a SWAP programme in Health
1998	Agreement to enter a SWAP programme in Health
1999	Poverty Reduction Strategy (PRS) identifies health as a priority
1999	Health Sector Reform Program of Work (1999 – 2002)
1999	Health Basket Fund Introduced
2000	National Package of Essential Health Interventions Approved
2002	National Health Insurance Fund (NHIF) Established
2003	Health Sector Strategic Plan 2 (HSSP2)
2004	Emergency Infrastructure Rehabilitation Programme
2005	Tanzania Essential Health Intervention Project (TEHIP) tool rolled out
2006	Joint Assistance Strategy for Tanzania
2007	The National Health Policy 2007
2008	Human Resources Strategic Plan
2009	Health Sector Strategic Plan III (HSSP III)

Healthcare Expenditure

In 2001, the Government of Tanzania committed to the Abuja Declaration, pledging to increase government funding for health to at least 15% of its total budget, but the government allocation for health spending has remained almost constant at about 7 percent since a long time, which is far away from reaching the Abuja declaration (9,15).

For FY 2017/18, the Government of Tanzania allocated TZS 2,222 billion to the health sector which is 7.0% of the national budget inclusive of consolidated funds services (CFS) or 10.0% exclusive of CFS (15).

In 2019/20, 5.9% of the total government budget i.e., $0.84 billion was allocated for health sector out of which maximum allocation was for Ministry of Health Community Development, Gender, Elderly and Children (MoHCDGEC).

Tanzania's health spending as of GDP is lower than that of Kenya, Uganda and Rwanda (35). The HSSP IV estimated total health financing needs to be US$42 per person per year to improve the health condition of the country. LCA are the second highest allocated accounting for 37.69% in 2019/20 budget. These funds are then used for management of health centres and dispensaries. NHIF receives 11.38% of the total budget.

Table 4.3.5 Percentage composition of Health Sector Budget

Institutions/Ministries	2015/16	2016/17	2017/18	2018/19	2019/20
MOHCDGEC	41.60%	38.70%	48.50%	42.20%	49.15%
TACAIDS	0.50%	0.50%	0.30%	0.60%	0.65%
PORALG	0.20%	0.20%	0.80%	0.50%	0.23%
Regions	9.50%	6.00%	5.80%	4.40%	0.89%
NHIF	10.30%	9.80%	9.60%	10.50%	11.38%[1]
LGAs	37.80%	44.80%	35.00%	41.80%	37.69%
TOTAL	100%	100%	100%	100%	100%

Source: Government of Tanzania Budget books 2015/16-2019/20
MOHCDGEC budget

4.3.4 Health Financing System

The Community Health Fund (CHF) and TIKA (a scheme for urban, peri-urban areas) aim at reduction of health care costs in primary care. It is in hands of DMO to determine which centre need to be funded on priority bases hence, there is lack of transparency. The budget allocated to local government is broken down into six cost centres (59):

1. Office of DMO
2. Council Hospital
3. Voluntary Agency Hospitals (VAH) and Service Agreements (SA)
4. Health Centres (public or owned by voluntary agency)
5. Dispensaries (public or owned by voluntary agency)
6. Community health services

The health basket is a funding mechanism initiated in 1999 as part of the Government of Tanzania's decision to pursue a sector-wide approach in the health sector. The basket is currently funded by six development partners (Canada, Denmark, Ireland, Switzerland, UNFPA, UNICEF and World bank), who pool resources to support implementation of the Health Sector Strategic Plan IV at the primary health care level. Foreign funds from donors going into the health basket increased by 16% in FY 2017/18 from the previous year and non-basket foreign funds grew by 67% .

Not only this, Tanzania's certain disease programs, especially HIV, rely heavily on financing from external donors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR).

Pooling

As a major component of its HFS, the GOT is planning to introduce a SNHI scheme. Current insurance coverage is modest, at 25.8% of the population. The National Health Insurance Fund (NHIF) is the largest scheme as defined by premiums collected (US$148.6 million in 2014), and the Community Health Fund (CHF) has the most beneficiaries (8.2 million people by January 2016). The private health insurance sector covers only 1.4% of the population. SNHI will be a mandatory scheme, resulting in increased revenue and risk sharing reducing the burden on the government's health budget and covering its vulnerable, low-income groups that cannot afford to pay.

Purchasing

Government spending on health is dominated by the central level. Centrally, the MOHCDGEC is responsible for national referral hospitals and procurement of the majority of drugs and commodities. Local government authorities are responsible for primary healthcare and district, but not regional, hospitals. Most government spending on health (60–68%) is on recurrent items, such as salaries, commodities, and other charges, indicating less funding for capital improvements and additions. The NHIF uses fee-for-service and capitation models to pay for health services. The poor and those working in the informal sector do not pay for services; facilities tend to use CHF revenue to support service delivery.

4.3.5 Health Insurance at a Glance

34 percent of Tanzanians have health insurance cover, 8 per cent are members of NHIF (National Health Insurance Fund), 25 percent are members of Community Health Fund (CHF), while 1 percent are members of private health insurance companies.

There are some insurance schemes available in Tanzania. National Health Insurance Fund (NHIF), (National social security fund (NSSF)- Social health Insurance Benefit (SHIB) is formal sector while Community Health funds (CHF)/ TIKA, improved Community Health funds (iCHF) are for the informal sectors of Tanzania (60)

National Health Insurance Fund (NHIF)

NHIF is a Social Health Insurance Institution established under the National Health Insurance Act, with its main objective as ensuring accessibility of health care services to people. It is a Government entity that operates under the Ministry of Health Community Development, Gender, Elderly and Children (MHCDGEC) and is operational since June 2001 (61).

Initially this scheme only included public servant whose enrolment is compulsory; however, later this scheme expanded its coverage to include other groups like Councilors, private companies, education institutions, private individuals, children under the age of

18, farmers in cooperatives as well as organized registered groups like Machinga and Bodaboda groups.

The Fund also covers Members of the Zanzibar House of Representatives. According to the NHIF Act, employees in the public sector are obliged to register themselves and contribute to the Fund a total of six percent (6%) of their monthly basic salary which is equally shared between the employer and employee (62)

Total membership as per FY16/17 was 3.5 million and showed increase in 40% in members under five year period. As of December 2019, NHIF's membership coverage stood at 4,856,062 beneficiaries which is equivalent to 9% of the total Tanzanian population.

NHIF also facilitates provision of services that are normally out of standard package under special agreements basing on the need of the employer through Health Insurance Administration or Supplementary arrangements. NHIF provides fee-for service based on market survey.

National Social Security Fund (NSSF)- Social Health Insurance Benefit (SHIB)

The National Social Security Fund (NSSF) was established by the Act of Parliament No. 28 of 1997. The scheme is financed through contributions at the rate of 20% of employees' salary i.e., around 10 % by employee and 10% by employer from the gross salary (63). Is a compulsory scheme that provides cover to:-

1. Companies
2. Non-governmental organizations
3. Embassies employing Tanzanians
4. International organizations
5. Organized groups in the informal sector
6. Government ministries and departments employing non-pensionable employees.
7. Parastatal organizations
8. Self-employed or any other employed person not covered by any other scheme.
9. Any other category as declared by the Minister of Labour

The benefits under this scheme are:- pension, funeral grant, maternity benefit, employment injury benefit and health insurance benefit. The benefits are offered to both indigenous and non-indigenous members. People enrolled into this scheme are only

eligible to enrol into a scheme named Social Health Insurance Benefit (SHIB); although, requires separate enrolment fees hence, the number of beneficiaries covered under this scheme is low. Approximately 50,000 members were registered into SHIB in 2013 (38). The payment made to healthcare facility is based on capitation which is fixed as per urban and rural areas. Provides relief to the employers on employees' medical expenses (37).

There are some limitations of this scheme which are:

i. Emergency services for mobile members (traveling on duty) Outpatient - not more than 4 times/year and Inpatient (48 hours) - not more than 2 times a year.
ii. Hospitalization for a maximum period of 42 days of inpatient care per family per year

Community Health Fund (CHF) and Tiba Kwa Kadi (TIKA)

The Community Health Fund (CHF), a form of voluntary community-based health insurance for the rural informal sector in 2001 and TIKA was launched to insure urban informal sector. Was launched in pilot stage in 1996(64). The contribution rate is decided as per districts for beneficiaries/ members which is generally kept between $4.2 to $12.7. CHF members can get registered at public health facilities where premiums are collected, and member households are subsequently eligible for free primary care at the selected facility. In some districts limited referral health care services are also covered.

After premium collection, the funds are deposited into CHF account at the council level, and in some districts a percentage of the funds goes back to the facility which is used for drug purchases and minor repairs. To supplement the revenue generated through household contributions, the government matches all contributions by members through a matching grant. Matching grants are allocated based on the amount of premium revenue each district collects, thus those less able to generate contributions receive less funds.

For Vulnerable groups such as children under-five years of age, pregnant women, people with chronic diseases like HIV/AIDS and poor, there is a waiver system to protect those who are unable to pay user fees and to join the CHF, although this is poorly implemented. The national CHF coverage remains very low which had enrolment of more than 2.1 million households covering roughly 12.6 million beneficiaries as per FY16/17 and pooled funds at district level. As per a survey conducted in 2014, people doing small business, farming and/or those having cattle were able to participate.

Having vulnerable people in the family was a push factor; these groups were seen to be more prone to multiple concurrent cases of illness or repeated illness, making membership more attractive. Low quality of health care at public facilities was one of the main factors discouraging people from joining or from renewing their insurance membership. The key aspects of quality reported by respondents were the shortage of drugs, lack of diagnostic equipment, long waiting hours. When drugs are out of stock, CHF members must buy drugs at private pharmacies. Many dispensaries have no diagnostic equipment. This resulted in bypassing to higher level referral facilities or private facilities that are not covered by the CHF.

Middle income groups were also more likely to join, with the poorest quintile, defined as having food insecurity, were less likely to join. The district councils were supposed to budget for the poor and provide free CHF cards to poor households; however, identification of poor and insufficient funds, were not able to cover the cost (28).

In FY 2014/15, only TZS 1.05 billion (US$0.52 million), was disbursed from the NHIF to local government authorities (LGAs) for CHF matching funds out of an allocation of TZS 1.9 billion (US$0.94 million).

Due to inadequate benefit packages, poor quality of health services, failure to see rationale to insure, limited benefit package and weak management of the schemes, contributes to the low enrolment in CHF/TIKA.

improved community health Fund (iCHF)

iCHF, intends to cover the informal sector, rural and low-income groups and was launched in November 2014 (31). The iCHF is built on a strong partnership between the National Health Insurance Fund (NHIF), the district councils (local government), public and private healthcare facilities and PharmAccess.

All beneficiaries covered in iCHF are entitled to receive services up to the regional hospital level; although, there is an exclusion list. The contribution by the beneficiaries is of $12.93 in both rural and urban regions and same contribution is provided by the scheme. This scheme covers upto 6 family members i.e., individual, spouse and upto 4 children. Additional adult in the family to cover requires $12.93 and additional child requires premium of $4.31 from the beneficiary. iCHF enrolment for the poor is expected to be subsidized by the government of Tanzania.

As per household budget survey, 28% of Tanzania's total population are eligible for the subsidy. The iCHF's contribution rates and provider payment mechanisms are kept uniform across Tanzania. Tanzania's *Health Sector Strategic Plan IV* emphasises on improving access to health services for the poor and vulnerable, who are expected to be subsidized for iCHF

Based on the iCHF design document, all provider payments will be by capitation. 10% percent of the premiums collected from beneficiaries out of which 9% will be used for administration costs and the remaining 1% will be set aside as reserves. Covering 100 percent of the poor population (15.2 million people) would cost US$85 million in year one. Covering 100 percent of the TASAF poor population (6.5 million people) would cost US$38 million in year one. 2018). Budget allocations to the HBF in FY 2017/18 were estimated to be US$70 million, but as previously mentioned, it is unclear how much funding HBF will continue to contribute for iCHF (31).

Till 2017, only 5% of the rural population was covered which indicates further development and improvements are required (31). The iCHF receives funds from : Corporate Social Responsibility (CSR) from organizations working in the country, Local Government Authorities(LGA), Government Health Basket Funds (HBF), premium from the enrolled people. As per an analysis, it was projected that around 15.4 Million people will be enrolled into iCHF by 2018; although, actual number is still not known.

Single national health insurance (SNHI)

The health system in Tanzania is highly fragmented hence, to end fragmentation, Single national health insurance (SNHI) scheme is to be launched in Tanzania which promises to increase resources for health, provide a minimum benefits package for all, and increase the efficiency of health spending. This scheme will cover both formal and informal sector of Tanzania.

For enrolling the informal sector, there are number of challenges on the way which includes: identification, voluntary enrolment of those who are healthy, lack of education on insurance, insufficient communication on the benefits of membership, low premium collectability, and enrolment lapses (65).

Although, poor will be identified with the help of Tanzania Social Action Fund (TASAF) database, which adopts a two-stage means testing and community identification process.

For the formal sector, Contribution rates are fixed at 6% of total salary, split equally between employer and employee, with 100% collection compliance assumed due to direct payroll deductions.

Chapter 4.4 Ghana

Table 4.4.1 Country at a Glance

COMPONENT	DETAILS/INDICATOR	DATA
Population	Total Population	30,950,581
	Rural vs Urban	43.3% Rural 56.7% Urban
Geography	Ghana, a country of western Africa, situated on the coast of Gulf of Guinea is the 50th-largest country in the world. The capital city is Accra. Population is concentrated in southern part of the country with the highest being on or near the Atlantic coast. Ghana is also home to Lake Volta, the world's largest artificial lake. (66) Ghana is divided into 16 administrative provinces, which are further divided into 260 districts and 275 constituencies.	
Government	Ghana has a multiparty Democracy. The New Patriotic Party is the ruling party. It has 20 registered parties amongst which 5 are the most popular that include: National Democratic Congress; the Progressive People's Party; the Convention People's Party; People's National Convention; and National Democratic Party(66)	
Economic Situation (67)	GDP per Capita	USD 66.077 billion
	Economic Growth	6.7%
	Gini-index	43.6
	HDI	0.59

	Number of people living on < USD 1/day	13.3%
	Unemployment	6.7%
	Adult Literacy	Total: 76.6% M: 81.5% F: 71%
	Average Family Size	4.5 per household
	% Population access to sanitation (68)	18%
Health (69)	Health as % of GDP	4.5%
	Annual total health expenditure (%)	8%
	$ health expenditure per person	USD $90
	No. doctors/ 1000 population	0.12
	No. nurses/ 1000 population	1.25
	% births with skilled attendance	78%
	Neonatal mortality rate	8.36 per 1000
	Under 5 mortality-rate	47.9 per 1000
	Average life expectancy	63.26 years
	Maternal mortality	147 per 100,000 live births

Disease burden	HIV/ AIDS prevalence	2.10%
	Deaths from HIV AIDS	18.42%
	Deaths due to Maternal conditions	1.53%
	Deaths due to Chronic Disease	26.83%
***The vision of Ghana government in healthcare spending is 15% of the total government expenditure as per Abuja Declaration 2001, of Organization of African Unity.**		

4.4.1 Country context

Country history and political system

History of independence of Ghana dates back to 1st July 1957, when the country gained its independence from the Britisher's who had their colonial rule over Ghana. It was the first Sub Saharan African country to gain independence, thus becoming a commonwealth republic. The current president of Ghana is a former foreign minister, Mr. Nana Akufo Addo who got elected in 2017 (70).

Population

Like other sub-Saharan African countries Ghana also has a young population with more than half of being less than 25 years of age. The population is also growing steadily at a rate of 2.15%. When it comes to language, Ghanaians are multi-linguistic with more than 80 languages spoken. English is the official language of country after which Akan is most widely spoken (71). It also has a diverse ethnicity with major ethnic groups such as Akan, MoleDagbon, Ewe and Ga-Dangme to name a few.

Economic Environment

Ghana has been classified as a UMIC by World Bank. In recent years, with discovery of oil in Ghana, the economy has grown steadily with a healthy rate of 7.1% and a GDP of USD a Billion as per 2019 reports. The country apart from oil is known for its cocoa produce. Other sectors driving the economy are the nonoil sectors like, agriculture,

manufacturing and services. This was possible because of strong commitment of Ghanian president Jerry John Rawlings who had mapped country's vision.
In its "Vision 2020", the government intends to accelerates its economic growth by providing a life of quality, targeting the poverty through private investment, industrialization, and dedicated efforts in addressing the issues (72).

Policy Environment

The policy environment of Ghana towards health have always been progressive. Back in 2003 the government initiated with Universal Health Coverage by introducing a health insurance scheme that was able to cover all. Thus the National Health Insurance Policy 2003 (NHIP) came into action (73). This allowed the government to set up a fund in which contributions can be done by its citizens and when there is a need at time of illness they can avail services from hospitals without getting financially burdened. Under this policy, three types of health insurance schemes were set up. They were:
The National Health Insurance Scheme.
The Private Mutual Health Insurance Scheme and
The Private Commercial Health Insurance Scheme

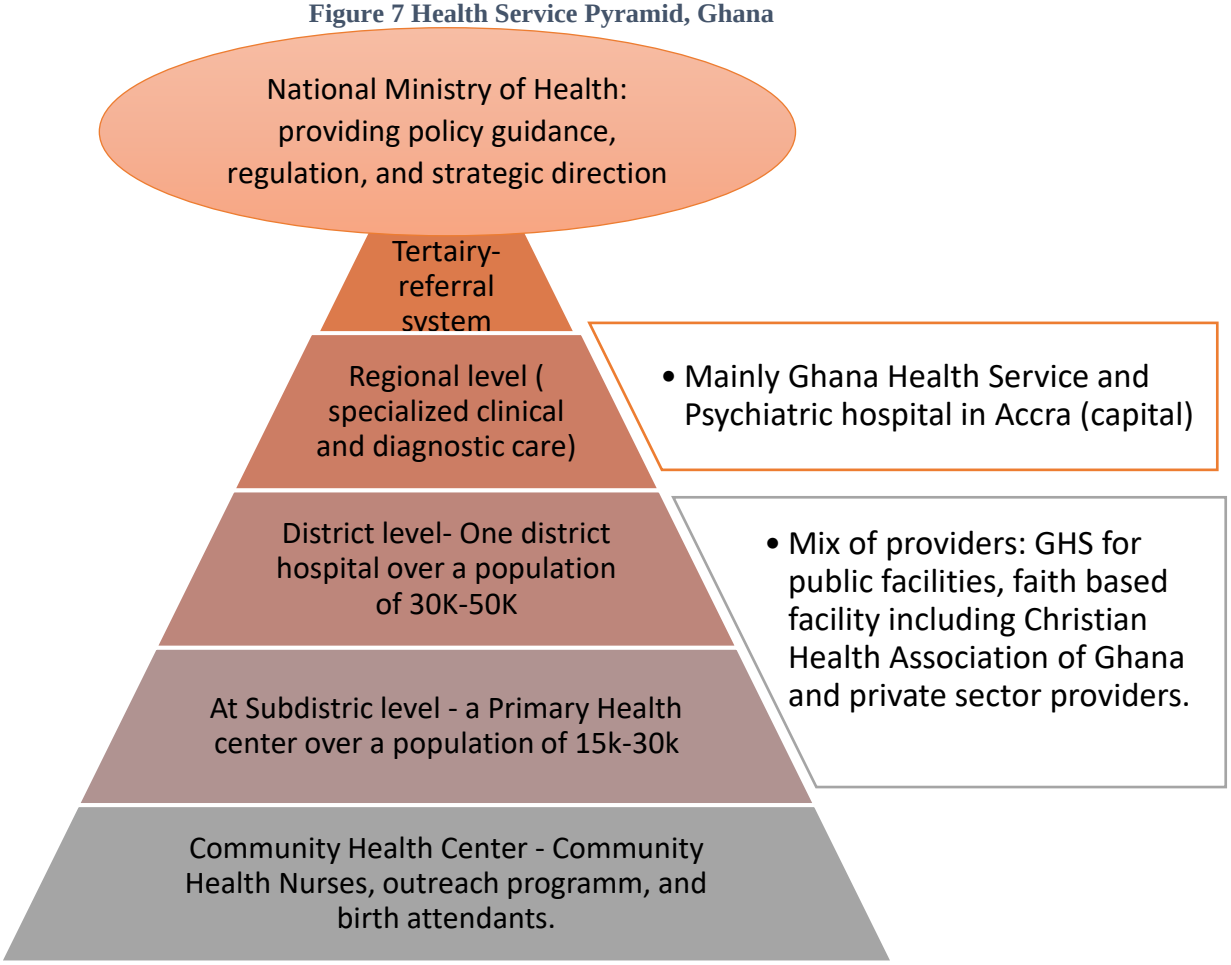
The ministry apart from providing financial protection releases every four years a Medium-term development plan report that sets goals to be achieved, identifying the key partners, ensuring quality and monitoring the progress of services delivered. The last such report was the Health Sector Medium Term Development plan (HSMTDP)for 2015-17 (74).

4.4.2 HealthCare in Ghana

The healthcare system of Ghana is a multilevel pyramidal system, with community-based health planning and services at the bottom most level and at apex is a tertiary level hospital that also act as a referral unit.
All these system works under guidance of Ministry of Health the governing body of Ghana. Since the health system is decentralized, certain NGO's like Christian Health Association of Ghana, private providers and also National Health Insurance Authority (NHIA) act as regulatory bodies at various levels. The private sector Ghana is also well developed and provides with all form of healthcare starting from primary to referral care.

Human resources for health have increased significantly in Ghana, however remain concentrated in certain regions like Appiah.

Figure 7 Health Service Pyramid, Ghana



Health Indicator

Table 3.4.2 Health Indicators from 2012-2018, Ghana

Health Indicator	Definition	2012 Baseline	2015 Indicator	2018 Indicator
Neonatal Mortality	The number of new-born deaths that occur within the first 28 days of life per 1000 live births in a given period	29	26	Na
Infant Mortality	The number of infants who die within the first year of life per 1000 live births in a given period.	44.8	38.9	35
Under-5 mortality	The number of children who die within the first five years of life per 1000 live births in a given period	65.2	54.7	49
Maternal Mortality	The number of women who die of causes related to pregnancy, delivery, and postpartum per 100 000 live births in a given year or another period.	432	292	308
Life expectancy at Birth	The average number of years that a new-born could expect to live, if he exposed to death rates prevailing at the time of his or her birth.	61.5	62.45	63.4
HIV prevalence	Percentage of young people aged 15–24 years who are living with HIV	1.8	1.8	1.7
ARV coverage	Number and percentage of eligible adults and children currently receiving antiretroviral therapy	23	28	34
Incidence of TB	The proportion of estimated new and relapse tuberculosis (TB) cases detected in a given year	173	156	148
Treatment success rate of TB	Proportion of all TB cases, all forms successfully treated among all TB cases.	84%	85%	85%
Incidence of Malaria	Incidence of malaria is the number of new cases of malaria in a year per 1,000 population at risk.	349	271	270

Country Disease Profile

Ghana faces dual burden of disease challenge with on one end there is still high prevalence of Malaria on other there is a rising burden of NCDs which alone contributes

22.2% to overall deaths.

Top ten causes of Mortality (75)

1. Malaria
2. Lower respiratory infections
3. Neonatal disorders
4. lschemic heart disease
5. Stroke
6. HIV/AIDS
7. Tuberculosis
8. Diarrheal diseases
9. Road injuries
10. Diabetes

Top ten causes of Morbidity (75)

1. Dietary Iron deficiency
2. Headache
3. Low back pain
4. Depressive disorders
5. Diabetes
6. Neonatal disorders
7. Age-related hearing loss
8. Vitamin A deficiency
9. Blindness and vision impairment
10. Anxiety disorder

Health Policy reforms

Table 4.4.3 Health policy reforms from 1957-2004, Ghana

Year	Reform	Funding	Coverage
1957	Free Health care for all	Public	Nation-wide
1969	Use-fees	Public-private facilities	Nation-wide
1985	Cash and carry system	Cost-sharing and Cash system	Nation-wide
1992	Community Based Health Insurance	Privately Funded	Community based
2004	National Health Insurance	Partly public and individual payments	Nation wide

Ghana Healthcare Infrastructure

There are over 1800 public hospitals, 1300 private clinics and 200 healthcare centers in Ghana. The doctor population ratio

There is a skewed distribution of health care facilities and healthcare workforce. Highly skilled professionals are concentrated around Accra and Ashanti regions.

There were about 30 registered specialist facilities out of the lot. A divide exists in type of facilities on basis of urban and rural areas. All urban centers are well off, that contain most of hospitals, clinics, and pharmacies in the country. Whereas in rural areas the facilities are not modernized and even lack the basics. Thus, leaving patient unsatisfied who then opt for other form of care such as a traditional African medicine. There are two government bodies that oversee Ghana health infrastructure: Ministry of Health and Ghana Health services. and a growing private sector that serves 40 percent of healthcare needs. Private participation in healthcare delivery has seen a sharp increase and steady growth over the past few years due to the government's encouragement.

Healthcare Expenditure

The government spent GH¢4.2 billion (USD876mn) on the Health sector in 2017, with GH¢56million on capital expenditure. For 2018, a total amount of GHS4.4bn (USD913mn) was allocated towards the healthcare sector in the state budget, highlighting its commitment to increasing investments into the sector. Of this allocation, GH¢63million goes to capital expenditure, while an estimated amount of 400 million cedis is expected from Donor Partner funds to support infrastructure projects and

improvements in healthcare services.

4.4.4 Health Financing System in Ghana

Health financing in Ghana is mainly be the taxes collected from the general population either in direct or indirect form. Those formally employed pay a direct tax for health by contributing 5% of their income for future retirement security. All these taxes are collected in a pool known as a social security organization or SSNIT.

The rates range from 0% for income less than GH¢180 to 28% for income exceeding GH¢720. The personal tax contributes about 5.2% to the total health expenditure of the Ghana health system. Corporate tax is also one of the funding source of the Ghana health care system.

Ghana is one of very few emerging market countries to take serious steps toward demand-side financing of health, pass legislation for universal health insurance coverage, begin implementing it by covering 96 Health Financing in Ghana vulnerable groups while significantly expanding enrollment, and earmarking substantial resources to support the system.

Revenue Base

The revenue base for Ghana's overall health financing system is largely progressive, and the NHIS relies on a diversified set of largely progressive funding sources, resulting in significant and stable sources of revenues. Ghana's approach is built on its existing system of community-based health insurance plans, which transitioned into district mutual health insurance schemes (DMHISs). It is evolving toward a uniform national system.

4.4.5 Insurance at a glance

Insurance overview

Before 2003, Ghana's healthcare was financed through "cash and carry", with out of pocket expenditures (OOPEs) that accounted close to 50% of total health expenditures in the country. There were few community health insurance schemes, but healthcare was largely unaffordable for the poor. Ghana renewed its commitment to Universal Health Coverage in 2003 through the passage of the National Health Insurance Scheme (NHIS) Act 650, the purpose of which was to "*ensure equitable and universal access for all residents of Ghana to an acceptable quality package of essential healthcare"*

As per the 2014 DHS survey, approximately 10.5 million of Ghanaian population was covered under the NHIS which is 40% of total population. The inpatient and outpatient visits to health facility have also risen from being 0.5% per capita in 2005 to 3% in 2014.

The National Health Insurance Scheme

Ghana introduced 10 years ago the National Health Insurance Scheme (NHIS). The National Health Insurance Authority (NHIA)(73) manages the system by receiving and channeling funds from both clients 'premiums and government levies and public resources. It processes claims for payments from the accredited health facilities (both public and private. The NHI Act established three main health insurance schemes:

1. District Mutual Health Insurance Schemes
2. Private Mutual Health Insurance Schemes
3. Private Commercial Health Insurance Schemes

District Mutual Health Insurance scheme

It works by dividing each district into a Health Insurance Communities (HIC). A HIC is a group of adults who live in the same geographical areas and coverage to register and vote at specifically pre-determined polling station or stations in the area. This will form a committee which shall comprise a Chairman, Secretary, Collector, Publicity officer and rest of them will be members. The collector collects contributions from residents of health insurance community.

the NHIS is also dependent on 2.5 per cent value-added tax specifically introduced to support it. The NHIA also sets a minimum premium level 13 for non-SSNIT formal and non-formal sector workers determined by economic groups. Everyone, except pregnant women and children below 5 year of age, pays a registration fee and wait for a three-month mandatory period before accessing services. Memberships are renewed annually. The Act specifies a minimum package that covers 95 per cent of diseases reported in health facilities in Ghana and requires no co-payment.

Who Pays?

Contributions are payable in line with one's ability to pay. For the informal sector, community health insurance committees are to identify and categorize residents into social groups to enable individuals in each group pay in line with ability to pay.

By law, the core poor or indigent who are considered as adults and unemployed and receive no consistent financial support from identifiable sources will be exempted, from contributing to any District Mutual Health Insurance Scheme. Children under 18 years,

whose parent(s) or guardian(s) pay their own contributions, are exempted from paying any contribution.

Table 3.4.5 The contributions payable by the social groupings in the informal sector are shown in the table-below:

Name of Group	Category	Who they are	Minimum contributions
Core Poor	A	Adults who are unemployed and do not receive any identifiable and constant support from elsewhere for survival.	Free
Very Poor	B	Adults who are unemployed but receive identifiable and consistent financial support from sources of low income	72,000
Poor	C	employed but receive low returns for their efforts and are unable to meet their basic needs	
Middle Income	D	Adults who are employed and able to meet their basic needs	180,000
Rich	E	Adults who are able to meet their basic needs and some of their wants	480,000
Very Rich	F	Adults who are able to meet their needs and most of their wants.	

Private Mutual Health Insurance Scheme (PMHIS)

A PMHIS refers to a health insurance scheme operated exclusively for the benefit of its members. Any identifiable group of persons in Ghana may form and operate a PMHIS. For example, membership may be community-based, occupation-based, faith-based or an association. PMHIS shall have individuals (natural persons) as their members and NOT corporate organizations. Under no circumstance shall an employer impose membership of PMHIS on employees.

Private Commercial Health Insurance Scheme (PCHIS)

A PCHIS refers to a health insurance company that is operated for profit based on market principles. Premiums are based on the calculated risks of particular groups and individuals who subscribe to it. Commonly, the ownership of the private commercial health insurance scheme resides with a company and shareholders. A PCHIS shall be owned by its shareholders.

Some of the licensed Private Health Insurers are listed below:

1. Acacia Health Insurance Limited
2. Ace Medical Insurance
3. Apex Health Insurance Limited
4. Cosmopolitan Health Insurance
5. GLICO healthcare limited
6. Kaiser Global Health Limited
7. Liberty Medical Health insurance Ghana limited
8. Metropolitan Health Insurance Ghana limited
9. NHM Nationwide Medical Health Insurance Scheme Limited
10. Phoenix Health Insurance
11. Premier Health Insurance Company limited
12. Takaful Ghana Health Insurance
13. Universal Health Insurance Limited
14. Vitality Health Systems Limited

5. Findings

Comparison between countries over time from year 2000 to year 2018 has shown significant improvement in health indicators. The mean change for neonatal mortality between Ghana, Zambia, Namibia and Tanzania remained 34% while that for infant mortality rate (IMR) and under-5 mortality rate (U5M) were 59% and 63% respectively. Namibia showed a significant 80% reduction in IMR and the percentage reduction of U-5M for Zambia was the highest when compared to rest. Reduction in NMR for all remained below 40%. (Figure 5.1)

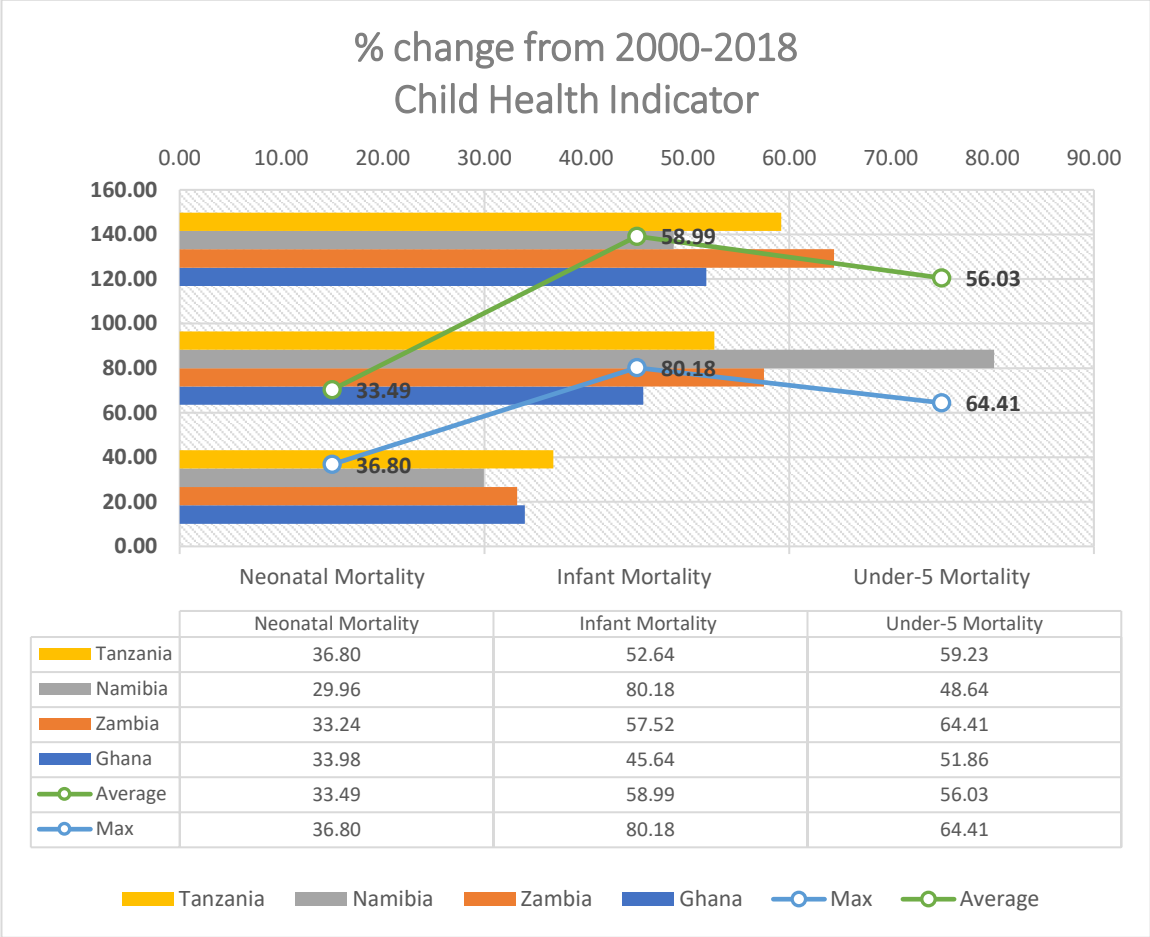
Trends in Maternal mortality ratio (MMR) have also shown a linear regression. Though the MMR for Tanzania still remains high, it has shown a sharp decline from 854 maternal

deaths per 100,000 in 2000 to 524 maternal deaths per 100,000 in 2018. Amongst the four countries, Namibia leads the race towards achieving SDG 3.1 target of reducing MMR to 70. (Figure 5.2)

The incidence of HIV in developing countries of sub-Saharan Africa has been high. Zambia being the worst hit of HIV epidemic records a prevalence of 11.8% of total population and has shown the maximum reduction of 30.25% from 16.2 in 2000 to 11.8 in 2018. It also is close to meeting the target of 90% antiretroviral coverage. This is followed by Namibia whose prevalence rate has reduced from 14% to 11.3%. Although a slow change, Namibia has already met the antiretroviral coverage criteria of 90% (Figure 5.3) The percentage change in reduction of HIV prevalence and increased antiretroviral coverage over the period of 18 years for Ghana, Zambia, Namibia and Tanzania is shown in Figure 5.4.

The TB incidence rate for Zambia showed highest reduction of 54.4% in 2018. For tuberculosis treatment success rate Ghana has shown a net change of 70%. Countries like Ghana and Zambia followed a rather linear drop in incidence rate. Whereas TB incidence rate of Namibia also showed significant reduction over period of time. (Figure 5.5). The trend in incidence rate of all the four country is shown in (Figure 5.6).

Figure 8 Percentage change in Child Health Indicators (2000-2018)



	Neonatal Mortality	Infant Mortality	Under-5 Mortality
Tanzania	36.80	52.64	59.23
Namibia	29.96	80.18	48.64
Zambia	33.24	57.52	64.41
Ghana	33.98	45.64	51.86
Average	33.49	58.99	56.03
Max	36.80	80.18	64.41

Figure 9 Trend Analysis of Maternal Mortality Ratio

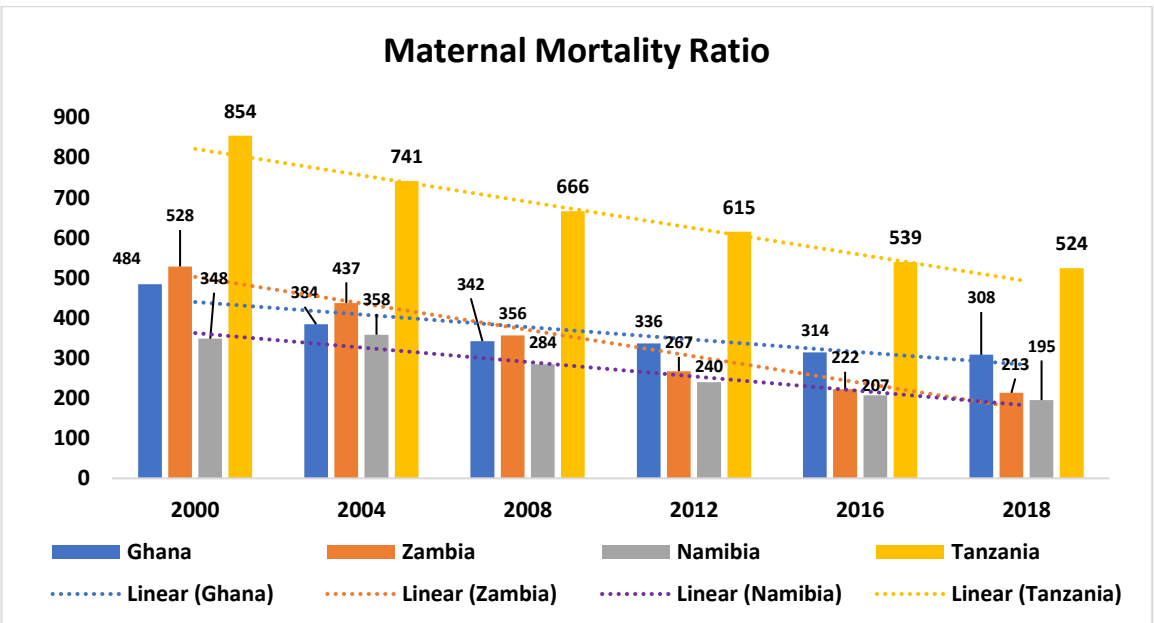


Figure 10 Trend Analysis of HIV prevalence and Antiretroviral Treatment of four countries

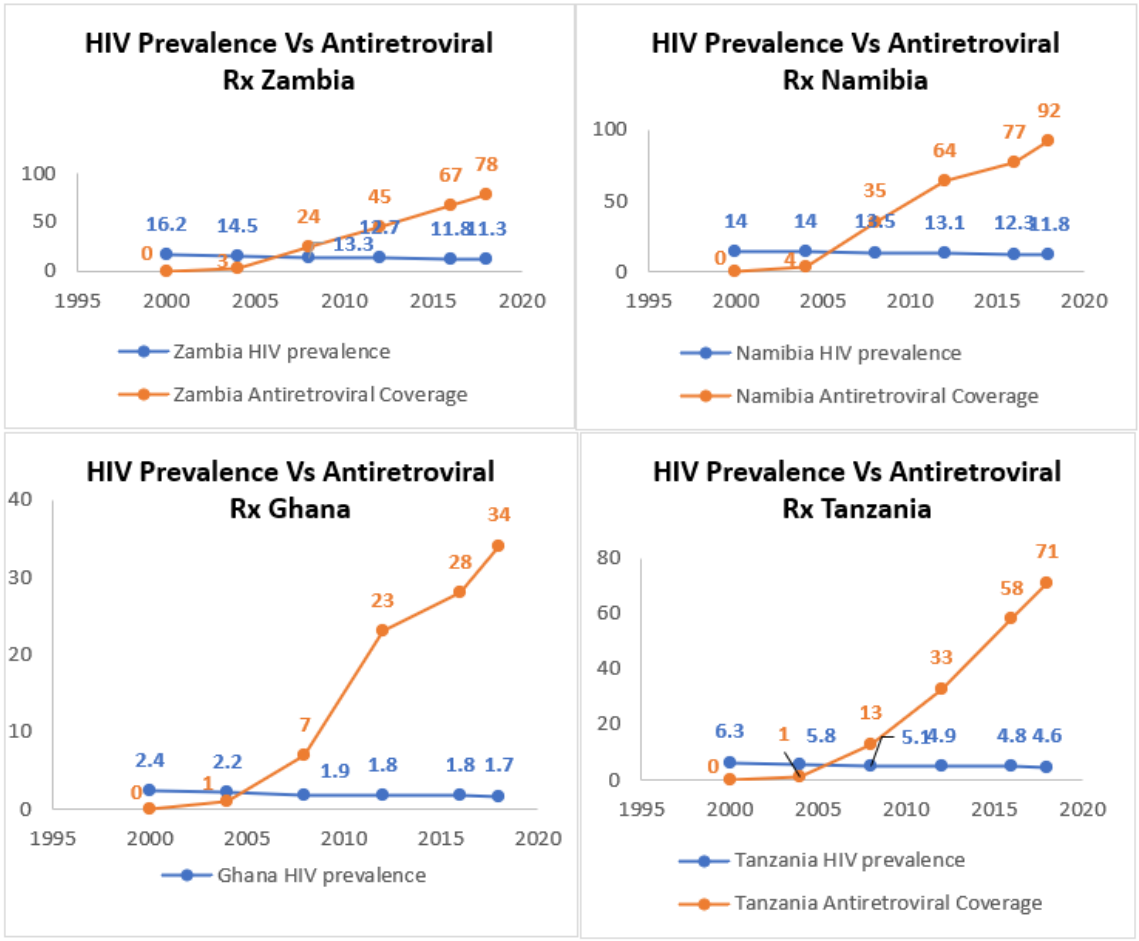


Figure 11 Percentage reduction in HIV prevalence and increase in Antiretroviral coverage

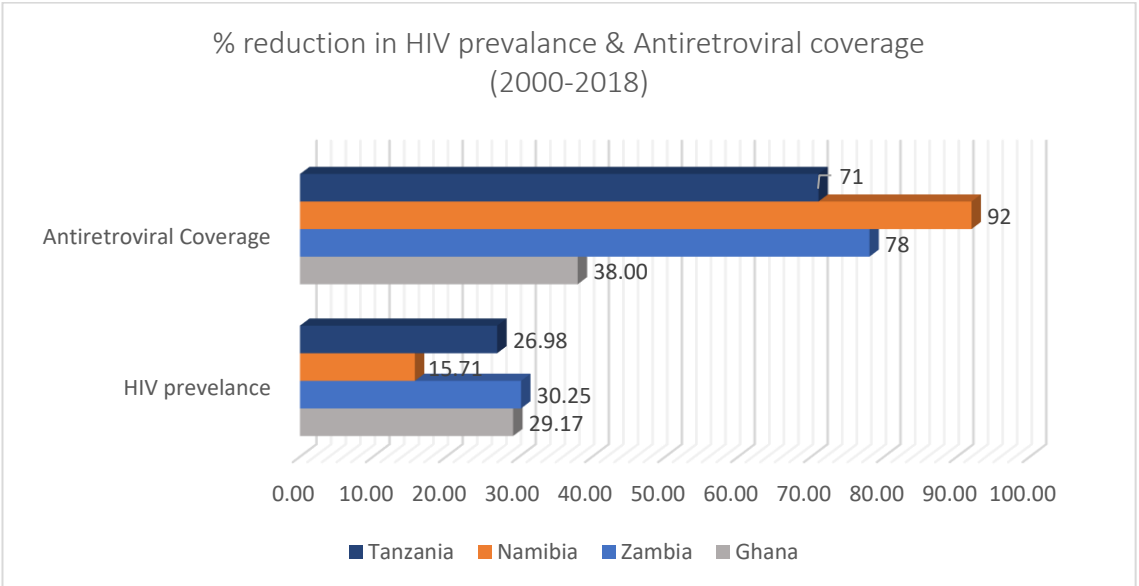


Figure 12 Trend Analysis of Tuberculosis Incidence

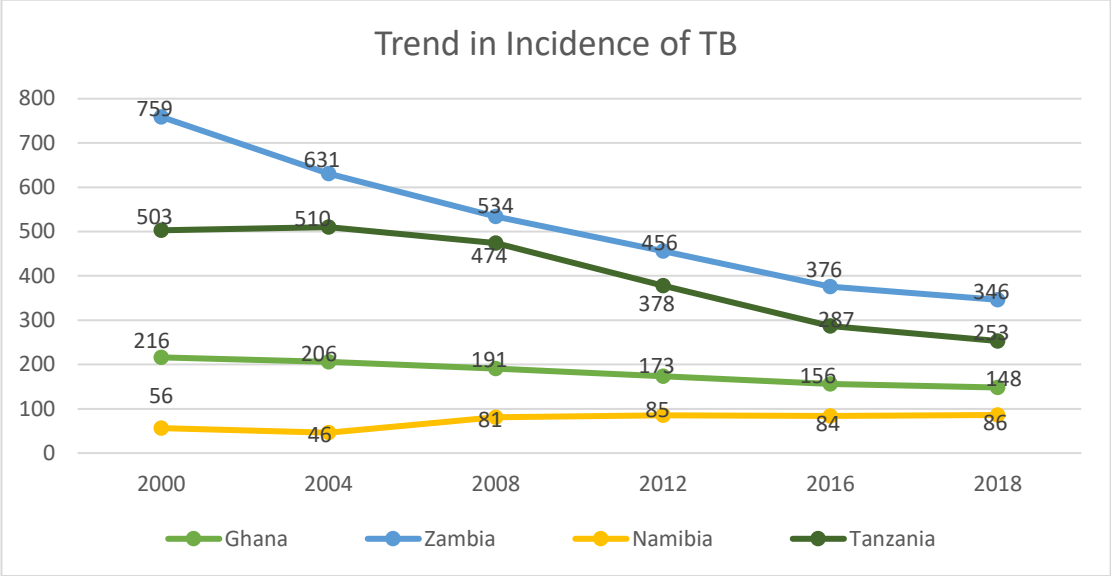
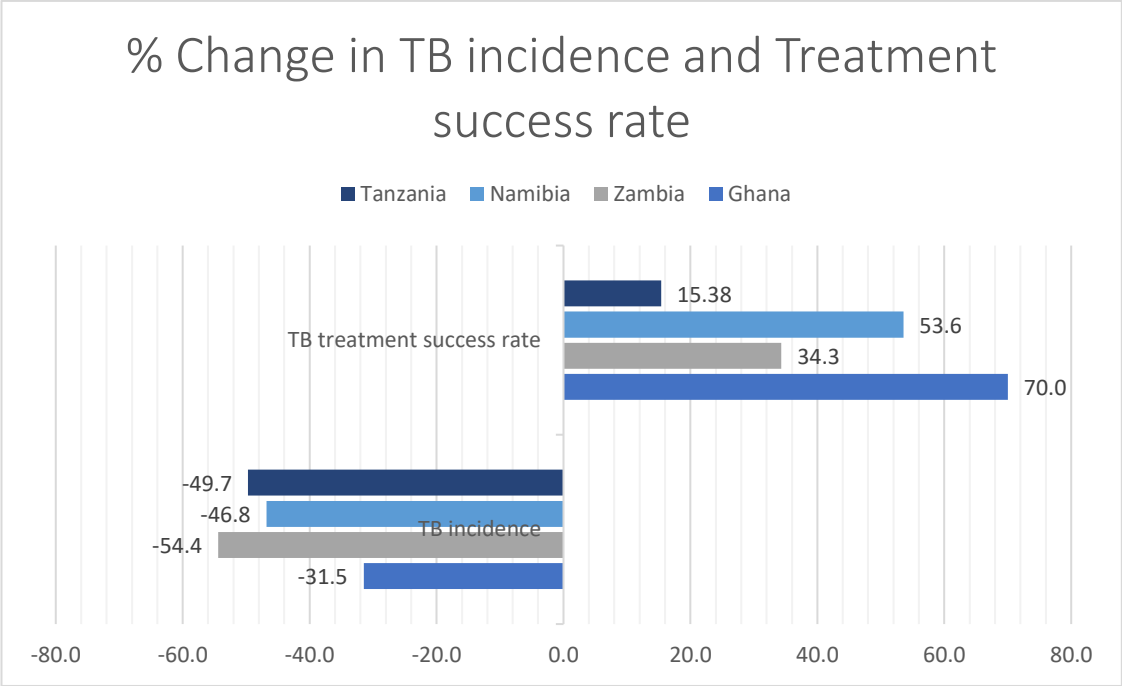


Figure 13 Percentage change I TB incidence and TB treatment Success rate



Health Financing: Trends within country

Since Abuja declaration African countries have tried to meet the goal of allocating upto 15 % of their annual budget to improve the health sector.

The financing in sub-Saharan countries was largely contributed through donors or out of pocket expenditure. But with time government increased their spending hence reducing the OOP. Donors funding however varied from country to country owing to political situation in each of them.

In Zambia, funding from donor agency started from 2004 and increased linearly. In 2018, external agencies contribute 42.5% of Current health expenditure. While on other hand the domestic general government health expenditure also increased except for year 2008. This led to a substantial decrease in OOP thus reducing the catastrophic health expenditure. The Current health expenditure of Zambia 4.47% of GDP. (Fig 5.7)

In Namibia, the domestic government contribution to general health expenditure have remained almost same, with the private contributions (in form of either private insurance or other agencies) increasing linearly from 29.69% in 2008 to 42% in 2018. The Out-of-pocket expenditure contribution is less when compared with other countries. (Fig 5.8)

The health expenditure in Tanzania has always been more of a mixed financing approach, when the donor contribution increased, the spending by government on health expenditure decreased and vice-versa. The out of pocket contribution has also remained substantial over the years despite presence of various health insurance schemes.

Contributions by private sector still remain low. The Current health expenditure of Tanzania is 3.65% of GDP in 2018. (Fig 5.9)

In Ghana, the government is the main financing source along with the citizens who pay in form of out-of pocket. The contributions by external agency and private sector is comparatively low. The current health expenditure for country as per 2018 statistics was 3.26 % of GDP. (Fig 5.10)

Figure 14 Trends in Health Financing, Zambia (2000-2018)

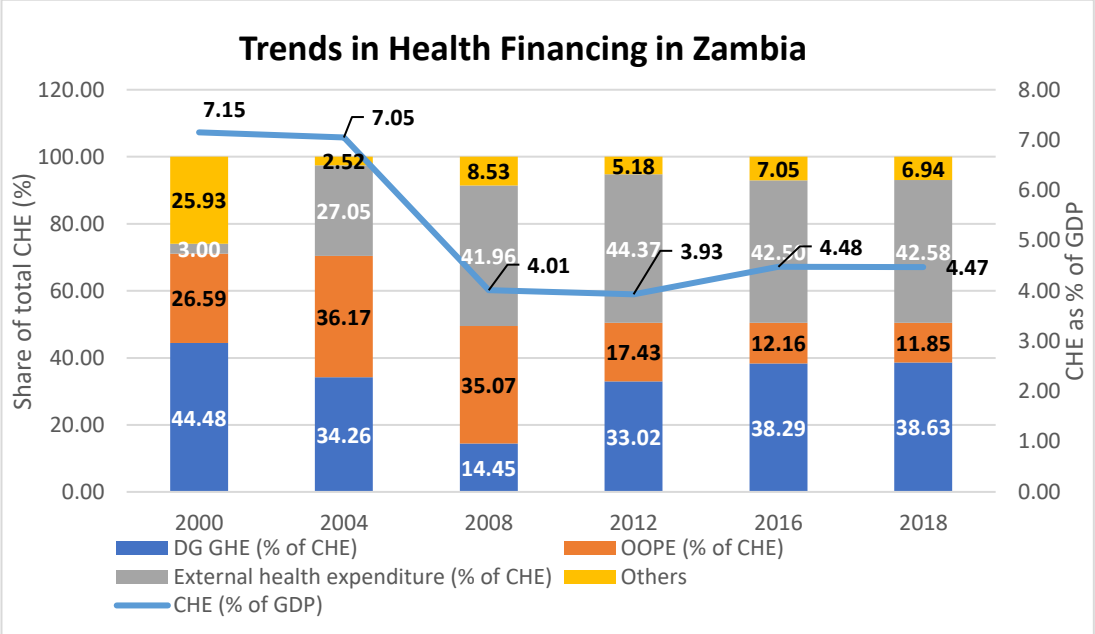


Figure 15 Trends in Health Financing, Namibia (2000-2018)

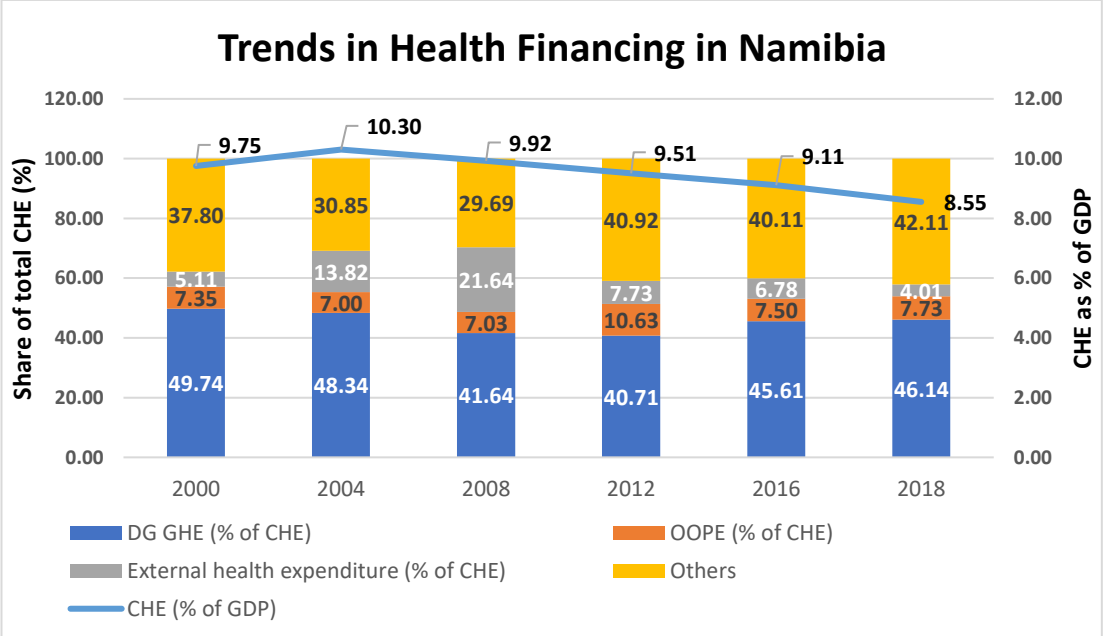


Figure 16 Trends in Health Financing, Tanzania (2000-2018)

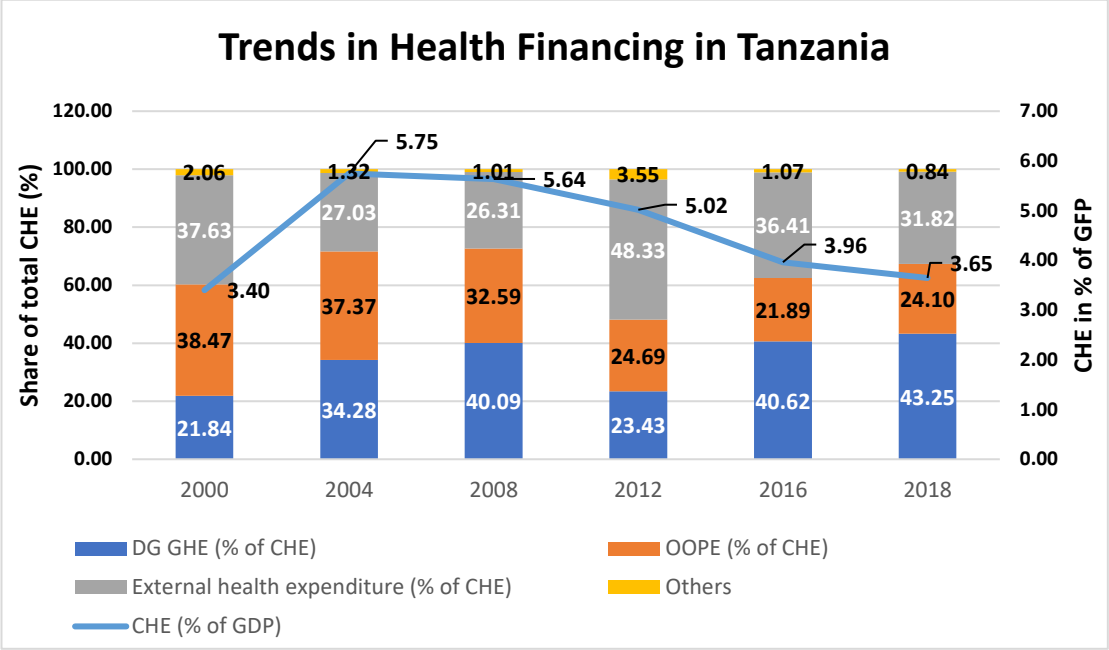
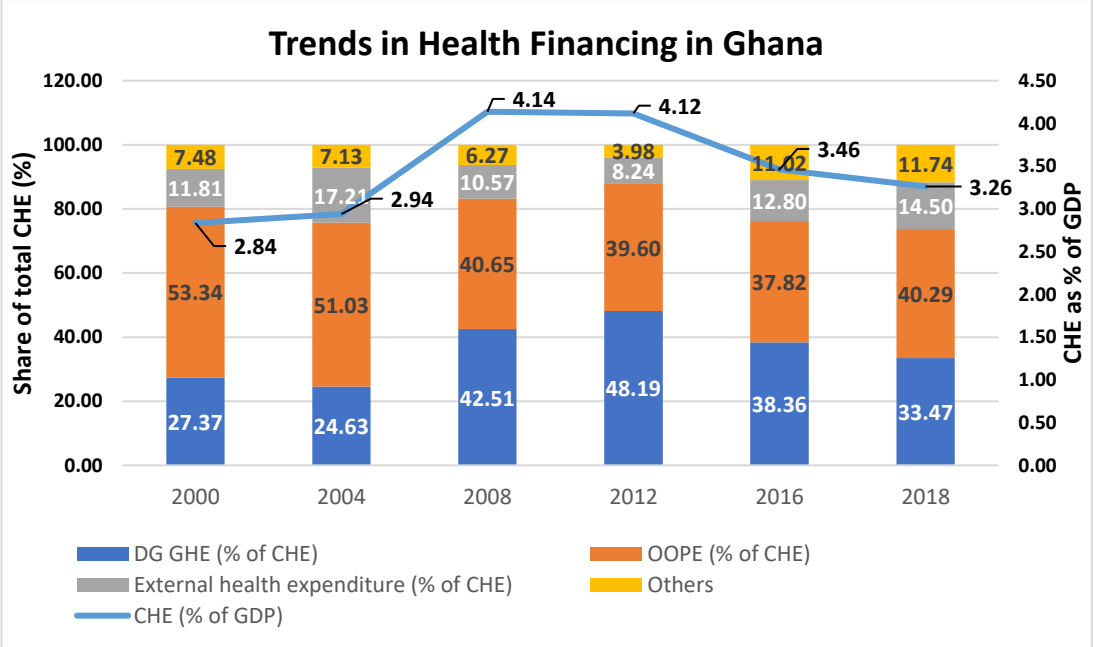


Figure 17 Trends in Health Financing, Ghana (2000-2018)



6. Identifying the Gaps

Gaps in Financial Protection

Despite the Abuja declaration of 2001, countries have still not met the mark in meeting the 15% target of total health expenditure by government. A number of financing reforms have been implemented by each of the country yet there are many challenges in achieving UHC.

In Zambia, 3.9% of population is covered by private health insurance and hence majority of population is required to pay out-of pocket. The User fee removal policy works for rural por and does not cover the urban poor. Also, health budget is funded heavily by donors and relying on them also means expecting suspension of funding anytime. In order to cover this large financial gap, government of Zambia in 2019 introduced the National Health Insurance Scheme that initially proposed to employer based formal sector. Though it targets to cover the entire Zambian population, segregation of Informal sector employees and funding for their financial protection is an issue which still remain in limbo.

Republic of Namibia spends the most on health expenditure, THE was 11.3% of the GDP in 2018 and despite the recent shift in economic status from LMIC to UMIC, Namibia in term of financial protection, shows inequity. The health insurance scheme offered via open and closed aided funds mainly target the formal sector and PSEMAS which is government funded is also employer based. This means that the poorest quintile remains uncovered and people most likely to be insured are those who work either in government sector or industry. Also, there is a need for low-cost insurance scheme. A need for social health insurance still remains.

Tanzania offer financial protection coverage to approx. 34% of population. It has a heterogenous type of insurance sector. Though there are a few community based insurance that target the poor informal sector such as Community Health Fund (CHF) and Tiba Kwa Kadi (TIKA) and improved Community health insurance, these are voluntary based insurance and people who utilize such insurance already have a vulnerable person in family. This leads to lesser penetration of insurance amongst the informal sector and hence financial gap. Also, myriad of health insurance do not offer coverage to all health services and patient despite having a cover faces catastrophic health expenditure.

The Ghanaian population were introduced to a National Health Insurance Scheme in early 2000,'s. Despite being the first Sub-Sharan African country to enroll such a large scal scheme, out-of pocket expenditure still remains the primary source to contribution of health financing profile of country.

The exempt category people identification is difficult and hence the insured poor people end up paying high premiums. However, regardless of affordability of premiums, enrolled individuals still make OOPEs at the point of care in the form of user fees, consultation fees, and payments for medicines that are covered under the scheme.

Gaps in Health Service Delivery

One of the major gaps identified in health service delivery was availability of Human resource, pricing of health service delivery and infrastructure. The healthcare worker density is far less than that recommended by WHO in all these countries. Moreover, healthcare facilities are concentrated more around the cities (urban areas) and less in rural areas and especially the below poverty line population. This leave rural population with limited access to health services. They either have to travel large distances to get care especially when it comes to tertiary level care or not receive a care at all. Countries show a similar pyramidal healthcare structure with primary health center at bottom and tertiary health at top. While there are district hospitals, strengthening and capacity building at primary level is still missing. Inefficient HR management poor retention of health workforce increased migration of health workers into other countries poor health infrastructure. Private sector role in attracting health professionals causing inequity in workforce distribution. Moreover, if we talk about the pricing it is way too high for the poor people to get financial protection and proper health service delivery.

7. Discussions

Universal Health Coverage is a continous process that requires long term commitments towards achieving the set goals. In my research I talked about how the health sector reforms took place and how the priorities were set. Such reforms are influenced by many factors that can be either an internal push or an external push. Internal factors were political will, vision of presidents and prime minister or an outbreak, growth rate of country and geographical location. External factors mainl revolved around trade and how international agencies shaped the health sector reforms. African countries have specially shown development since involvement of international agencies like UNSAID, UNICEF, WHO, PEPFAR to name a few in controlling the AIDS epidemic, reducing maternal mortality rates and improving the child health indicators. This brings me towards the impact of donor's contribution, their role in framing policies and its future in leading these countries towards UHC.

We have seen countries like Zambia, Namibia and to a less extent Tanzania rely for their resource on these external agenecies. Thee wee instances in past when Zambian Health Systme suffered due to withdrawl of support from donors owing to corruption charges. As we move forward, a plan should be constituted wherin countries and government become responsible for complete health expenditures. This will not only allow for a more focused approach but will also make government responsible for health of their own country.

Financial risk protection is crucial pillar of the UHC box, and despite country like Ghana who already implemented a common National Insurance scheme, many loop holes exist which fails the purpose of very existence of such schemes. As mentioned earlier, such policies need to address the inequity and design scheme in ways that penetrate each and every section of society. Taking example of Thailand,

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