Progress towards universal coverage: the health systems of Ghana, South Africa and Tanzania

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A desire to enhance protection against health care costs and improve equity of access to health care lies at the core of many health sector financing initiatives. Until recently, international debates about financing and health equity have focused primarily on mechanisms to promote equity in relation to very specific elements of health systems. However, in recent years there has been growing interest in considering these equity challenges from a more systemic perspective. In this context, universal health coverage is becoming a rallying call, with a focus on how best universal coverage can be financed. This paper is the first in a special issue which presents a body of research whose overall aim was to critically evaluate existing inequities in health care financing and provision in Ghana, South Africa and Tanzania, and the extent to which health insurance mechanisms (broadly defined) could address financial protection and equity of access challenges. In this first paper we introduce the countries’ health systems, with a special emphasis on existing mechanisms for financial protection. We also identify in broad terms the key challenges for universal coverage, setting the scene for the subsequent papers.

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Key Messages

- Insufficient emphasis has been given to analysis of equity of health care financing at the systems level.
- Studies are needed which explore how financial protection can best be expanded by building on the mix of financing mechanisms currently found in many low- and middle-income countries.
- Financial protection against the cost of ill health remains a key and acknowledged problem in all three of the countries reviewed in this paper—Ghana, South Africa and Tanzania.
- Key issues are how to reduce the share of out-of-pocket payments, provide financial protection to the informal sector, reduce the fragmentation of financing arrangements and allocate public resources more equitably.
- Detailed assessment of the equity of current and potential health systems financing arrangements in these countries is needed to help identify which approaches might best serve equity objectives.
Introduction

A stated desire to improve equity lies at the core of many health sector financing initiatives. In this context, equity can be broadly defined as distributing the burden of financing health services according to ability to pay, and promoting a distribution of health care benefits according to need for, or the capacity to benefit from, such care.

Until recently, international debates about financing and health equity have focused primarily on mechanisms to promote equity in relation to very specific elements of health systems: for example, user fee exemption mechanisms (Lagarde and Palmer 2006); allocation of limited public sector resources through needs-based formulae (Mills et al. 2006); mechanisms for regulating private providers (Patouillard et al. 2007); and incentivizing equity improvements through the design of contracts between public purchasers and private providers (Lagarde and Palmer 2006). However, in recent years there has been growing interest in considering these equity challenges from a more systemic perspective (Mackintosh 2001). In this context, universal health coverage is becoming a rallying call, with a focus on how best universal coverage can be financed, to ensure financial protection against the costs of ill health and access to needed health care for all (World Health Organization 2010). While the emphasis is universality, within that there is specific concern for the position of the poorest, with recognition of the need to address explicitly the socio-economic divisions that exist in many health systems (World Health Organization 2005).

Financial protection can be ensured through various financing mechanisms. These fall under the overall heading of health insurance, in the sense that they protect people from the costs of ill health. However, it is important to distinguish the ‘insurance function’, i.e. financial protection, from specific ‘insurance schemes’, such as social health insurance or community-based health insurance, not least because funding health care from general taxation provides insurance in the sense of financial protection, but not through a specific insurance scheme involving individual or group enrolment (Kutzin 2007).

A common feature of low- and middle-income countries is the fragmentation of health financing (Mills and Ranson 2005). Hence in considering equity and universal coverage, it is imperative to take a systems view of health financing, looking comprehensively at who pays and who benefits. Moreover, it is similarly important to look comprehensively at the whole health system, and not just at the financing element. While financing is conventionally taken to cover the three functions of raising, pooling and spending money, many other aspects of system design will affect who ultimately benefits from health care.

It is also important to recognize that technical design by itself is insufficient to achieve desired objectives. The importance of the policy process as an influence over health policy change is increasingly recognized (Walt and Gilson 1994; Reich 1996). The specific influence of the processes of health financing policy development and implementation over its impacts has been reported in countries such as the Dominican Republic, Egypt, South Africa and Zambia (Glassman et al. 1999; Nandakumar et al. 2000; Gilson et al. 2003). Earlier work on health insurance in South Africa has specifically demonstrated how the opposition of key stakeholders to the particular equity goals and key design features within insurance proposals, and the failure to manage this opposition, resulted in a policy stalemate (Gilson et al. 2003; Thomas and Gilson 2004). Better understanding of who are the key stakeholders around financing reform, the views and perspectives they have about goals and design, and the power they have to influence the implementation of new financing arrangements, is essential in developing acceptable policy proposals.

This background provides the context for the research presented in this special issue, which derives from the SHIELD project (Strategies for Health Insurance for Equity in Less Developed Countries). The SHIELD research project was a response to concerns that were common across three sub-Saharan African countries. Ghana, South Africa and Tanzania have all sought to develop health insurance mechanisms as part of health sector reform efforts focused on raising revenue and expanding financial protection. Ghana has been regarded as an innovator in national health insurance, attracting much attention (Agyepong and Adjei 2008; Jehu-Appiah et al. 2010; Sarpong et al. 2010). South Africa has well-established health insurance schemes in the private sector, and at several points has explored the potential for incorporating these into national arrangements. Tanzania has sought to develop separate schemes for different population groups: rural dwellers, civil servants and those employed in the formal private sector. Policy makers in all three countries have been actively seeking to employ specific prepayment financing mechanisms as a tool for strengthening domestic health care financing and reducing out-of-pocket payments.

In this first paper we describe and assess the health systems of the three countries, and situate them in their overall country contexts, drawing on the most up-to-date information available for each country at the time that SHIELD was being completed. We especially review existing mechanisms for financial protection, and public–private interactions. We also identify in broad terms the key challenges that each country faces in developing its path towards universal coverage.

Macroeconomic context

The macroeconomic context is critical for countries seeking to progress towards universal coverage, since it is a crucial influence on how much can be spent on health care both now and into the future, as well as reflecting the distribution of the workforce between formal and informal sectors (an important consideration affecting the feasibility of different pre-payment mechanisms), and the extent of poverty and under-development more broadly. Table 1 shows gross domestic product (GDP) per capita in 2009 in both US dollar and purchasing power parity (PPP) terms, the GDP growth rate in 2009, the Gini coefficient (indicating the degree of income inequality), the informality indicator (the proportion of the labour force in the informal sector), the multi-dimensional poverty index (the proportion of the population that is multi-dimensionally poor and the average intensity of their deprivation) and the human development index (combining indicators of life expectancy, educational attainment and income).
Of the three countries, South Africa is by far the richest, and use of purchasing power values leaves the relative differences largely unchanged. However, 2009 economic growth rates for both Ghana and Tanzania were higher than for South Africa, and both the former countries saw improvements in rates of economic growth over the previous 10 years: in Ghana the GDP growth rate in 2008 was 7% as compared with 5% in 1998; in Tanzania it was also 7% in 2008 compared with 4% in 1998 (World Databank, n.d.). In South Africa, in the decade prior to democracy in 1994, economic growth was low at around 1% per annum. It was also 1% in 1998 but subsequently improved, with growth in 2008 being 4%. In 2009, all three countries saw lower rates of economic growth than in 2008, and in South Africa the growth rate was negative.

Income inequality is much more pronounced in South Africa, which is one of the most unequal countries in the world, with Ghana and Tanzania having rather similar degrees of income inequality. One of the causes of inequality in South Africa is its unemployment rate, which is 25% according to a narrow definition (Statistics South Africa 2011a), and has been estimated to be 40% if discouraged workers are included (Banerjee et al. 2006). In contrast, Ghana and Tanzania still have large sections of their populations in the informal sector rather than the formal labour force, as shown by their informality indicators.

In terms of the make-up of the economy, both Ghana and Tanzania are more heavily dependent on agriculture than South Africa. In Ghana, until recently agriculture was the largest contributor to the economy in terms of food supply, foreign exchange and raw materials for agro-based industries and also a major employer, providing employment to 51% of the population (Aryeetey and Baah-Boateng 2007). In recent times, however, after a rebasing of the economy, the share of agriculture has fallen to 29.9% of GDP, second to the service sector (51.4%) with industry in third place (18.6%) (Institute of Statistical, Social and Economic Research 2011). In Tanzania, agriculture is the main source of livelihood for about 80% of the population, and experienced an average growth rate of 4.4% between 2000 and 2008 (Bank of Tanzania 2010). South Africa has a more diversified economy, with 2010 data on contribution to GDP demonstrating well-developed financial (22% of GDP), manufacturing (15%) and wholesale and retail (12%) sectors (Statistics South Africa 2011b).

The poverty and development indexes show South Africa to be relatively better off than the other two countries. Tanzania and Ghana are similar with respect to human development levels, though poverty is clearly higher in Tanzania.

### Health status context

Table 2 shows the key demographic and health status indicators of life expectancy, and under-5, infant and maternal mortality. The life expectancies of Tanzania and South Africa are similar, both reflecting the devastating impact of human immunodeficiency virus (HIV). Indeed acquired immune deficiency syndrome (AIDS) is considered to be one of the most impoverishing forces facing Tanzanians, mainly affecting individuals in the prime of their productive and childbearing years with consequent repercussions for their families (RAWG 2004).

Both infant and maternal mortality are high in Tanzania relative to the other two countries, though Tanzania has made marked progress recently in reducing child mortality (Masanja et al. 2008). In contrast, pregnancy-related mortality in Tanzania has not improved much over the last two decades (URT 2005): the maternal mortality ratio for the period 1997–2004 was 578 per 100 000 live births, not significantly different from the 1987–1996 ratio of 529 per 100 000 live births.

In terms of disease patterns, the health picture of Ghana and Tanzania is typical of much of sub-Saharan Africa, with infectious diseases predominating. For example, in Ghana, malaria, upper respiratory tract infection, diarrhoea and diseases of the skin accounted for about 60% of all outpatient attendance between 2001 and 2004 (Ghana Health Service 2008a). Malaria alone in 2008 accounted for 31.2% of all outpatient illnesses, 30.3% of all admissions and 30.3% of deaths in children under 5 (Ghana Health Service 2008b). In Tanzania, malaria was recorded in 2006 as accounting for about 60% of all outpatient attendance between 2001 and 2004 (Ghana Health Service 2008a). Malaria alone in 2008 accounted for 31.2% of all outpatient illnesses, 30.3% of all admissions and 30.3% of deaths in children under 5 (Ghana Health Service 2008b). In Tanzania, malaria was recorded in 2006 as accounting for about 42% of under-5 mortality and 28% of mortality in those aged 5 and above (MOHSW Tanzania 2008a).

South Africa’s patterns of economic inequality are mirrored by patterns of health inequality. The infant mortality rate, for example, is closely correlated with household income (Gilson and McIntyre 2001). The disease burden in South Africa has been characterized as a ‘quadruple burden’ (Coovadia et al. 2009), the four categories being HIV/AIDS, chronic diseases/diseases of lifestyle, poverty-related conditions and injuries.
Health service organization and human resources

The organizational structure and capacity of the government health sector, and the extent of health service infrastructure especially human resources and access to basic health care, are critical in universal coverage policy discussions since they affect both the ability to introduce reforms and the extent to which intended extension of coverage can be a practical reality.

All three countries have a public health system organized as a hierarchy, with a Ministry/Department of Health at the national level, and regions/provinces and districts below that. However, there are some key differences between the countries. South Africa, unlike the other two, has a quasi-federal system of government, with provinces having their own Ministries of Health with considerable responsibility and autonomy. The national level is largely responsible for providing overall strategic direction for the health system, ensuring that health policy is translated into legislation, monitoring the implementation of national policy and developing norms and standards. The provincial level is directly responsible for providing most health services from primary care level to specialist hospital services, and for overseeing all health services within the province. The local government level is directly responsible only for ‘municipal’ health services, largely environmental health services.

In contrast, both Ghana and Tanzania place strong emphasis on the district level as the point where comprehensive preventive and curative services are planned and managed. However, in Tanzania, the district level is managed as part of the local government structure, whereas Ghana has created the Ghana Health Service as a public agency separate from the Ministry of Health, leaving the Ministry with responsibilities similar to those of the national Department of Health in South Africa, but with regional and district services functioning as the lower management levels of the Ghana Health Service.

All three countries have sought over many years to improve the functioning of public services through a combination of management reforms and infrastructure investment. Ghana has developed a community level of health care delivery, and South Africa and Tanzania have both invested in improved primary care and local district hospital infrastructure. South Africa has in addition sought to redistribute health care funds between provinces in order to reduce disparities in per capita spending levels. All three countries, however, remain concerned about the performance of public health services, and about inequities in geographical distribution of health facilities.

Ghana and Tanzania are similar in having a large faith-based sector, especially important in providing health care outside the main urban centres. Such services are seen as quasi public, since they receive government subsidies, may take on management roles such as district management, and are usually included in public health programmes. The private-for-profit formal health sector is small in both countries, confined largely to a few hospitals in the capital city targeting the high-income groups. The very visible manifestation of private sector activity is retail drug shops and other forms of drug sellers throughout the countries. Both countries also have a traditional sector, especially prevalent in rural communities, using traditional herbal preparations for all manner of ailments.

In contrast to the very limited presence of the private formal health care sector in Ghana and Tanzania, South Africa has seen a very rapid increase in private health care provision and financing since the mid-1980s. Private general practitioners (GPs) are widespread in urban areas, and private for-profit hospitals available in the major cities and provincial capitals. Human resources for health are a key problem in all three countries, with Ghana and South Africa especially affected by out-migration of professionals. In Ghana, the doctor and nurse to population ratios are still low and there is wide variation between the north and the south, though there has been a gradual improvement in recent years (Table 3). It is known that staff shortages and unequal workload have negative effects on access to care, quality of care and on patient demand, contributing to the overall inefficiency in health care delivery. Tanzania similarly struggles both with an absolute shortage of key cadres (Kurowski et al. 2007) and inequitable geographical distribution. Between 1994/95 and 2001/02, the number of active health workers per 100,000 population decreased by 35% from the observed 249.4 to an estimated 162.1 (REPOA 2005). There is major imbalance in the distribution of health workers between urban and rural areas.

South Africa faces an additional challenge, that significant resources are tied up in the private sector and not available for the majority of the population who cannot afford their fees, leading to major inequities in the health care resources used by different population groups. The precise distribution of health professionals between the public and the private sector is currently the subject of considerable debate due to data limitations. Despite this debate, all sources indicate that the majority of specialist doctors, pharmacists and allied health professionals (e.g. psychologists, physiotherapists, etc.) work in the private sector, largely serving the 16% of the population.

Table 2  Health indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Ghana</th>
<th>South Africa</th>
<th>Tanzania^a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth (years)</td>
<td>62</td>
<td>53</td>
<td>53</td>
</tr>
<tr>
<td>&lt;5 mortality rate (per 1000 live births)</td>
<td>76</td>
<td>67</td>
<td>103 (115)</td>
</tr>
<tr>
<td>Infant mortality rate (per 1000 live births)</td>
<td>51</td>
<td>48</td>
<td>68 (67)</td>
</tr>
<tr>
<td>Maternal mortality ratio (per 100 000 live births)</td>
<td>560</td>
<td>400</td>
<td>950 (578)</td>
</tr>
</tbody>
</table>

^aRates in brackets are from United Republic of Tanzania (2005).
that have private health insurance (Van Rensburg and Van Rensburg 1999; Day and Gray 2008; Econex 2010).

Millennium Development Goal (MDG) indicators of access to health care (Table 4) suggest that South Africa faces major challenges despite its higher level of development. Whilst coverage of births by skilled personnel is very high, much higher than the other two countries, it does less well than them with respect to antenatal care and measles immunization coverage. On the latter two indicators, Ghana outperforms Tanzania on antenatal care coverage, and both have high measles coverage.

Patterns of health care financing and expenditure

Sources of health care financing in all three countries comprise general tax, out-of-pocket payments, insurance contributions and external assistance. Table 5 lists key indicators, notably: total health expenditure as a percentage of GDP, an indicator of how much of national income is being devoted to health; total health expenditure per capita, useful to get a sense of the buying power of what is spent; the share of government expenditure going on health, indicating the relative priority given to health in the government budget; and the relative shares of different elements of health expenditure, notably how expenditure is divided between public and private shares, the extent to which private expenditure is pre-paid or paid out-of-pocket, and the importance of external assistance in total health expenditure. To ensure consistency across countries, these data are taken from the WHO database (see reference in Table 5) and differ in certain respects from country-level data. Total health care expenditure as a percentage of GDP in South Africa and Ghana is quite similar, though the total magnitude and make-up are very different. Health care expenditure in South Africa is relatively high by international standards, exceeding that in the majority of countries of a similar level of economic development and comparable in terms of percentage of GDP to that in many high-income countries (e.g. the UK in 2002). About 40% of total health care funds in South Africa flows via public sector financing intermediaries (primarily the national, provincial and local Departments of Health), while 60% flows via private intermediaries, of which 30% is out-of-pocket expenditure by households and the balance is private insurance arrangements. To promote financial access to public sector health care services for vulnerable groups, user fees have been removed for all public sector primary care services, all health services provided to children under 6 years of age, and pregnant and lactating women. However, outside these groups and services, patients face not insubstantial fees at public sector hospitals. In contrast, those in Ghana who are not insured (see below) face substantial fees in public facilities, helping to account for the 40% (79% of 50%) of total health expenditure paid out-of-pocket.

Tanzania’s lower share of health expenditure as a percentage of GDP is in part because of the lower out-of-pocket expenditure, no doubt a reflection of the lower income level of the country and the lower levels of public health care fees relative to Ghana. While the share of government expenditure on health appears high in Tanzania, this includes external

### Table 3: Distribution and trend in doctor and nurse population ratios by region in Ghana (2006-08)

<table>
<thead>
<tr>
<th>Regions</th>
<th>Population: Doctor ratio</th>
<th>Population: Nurse ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>14732</td>
<td>1537</td>
</tr>
<tr>
<td>Western</td>
<td>32746</td>
<td>2368</td>
</tr>
<tr>
<td>Central</td>
<td>31675</td>
<td>1577</td>
</tr>
<tr>
<td>Greater Accra</td>
<td>5624</td>
<td>993</td>
</tr>
<tr>
<td>Volta</td>
<td>25430</td>
<td>1302</td>
</tr>
<tr>
<td>Eastern</td>
<td>22019</td>
<td>1251</td>
</tr>
<tr>
<td>Ashanti</td>
<td>11681</td>
<td>2136</td>
</tr>
<tr>
<td>Brong Ahafo</td>
<td>25635</td>
<td>2036</td>
</tr>
<tr>
<td>Northern</td>
<td>67154</td>
<td>2126</td>
</tr>
<tr>
<td>Upper East</td>
<td>28897</td>
<td>1298</td>
</tr>
<tr>
<td>Upper West</td>
<td>45568</td>
<td>1315</td>
</tr>
</tbody>
</table>

Source: Ghana Health Service (2008a).

### Table 4: Indicators of access to health care

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Ghana</th>
<th>South Africa</th>
<th>Tanzania</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of births attended by skilled birth personnel</td>
<td>59</td>
<td>91</td>
<td>51</td>
</tr>
<tr>
<td>% of pregnant women with at least 4 antenatal care visit</td>
<td>78</td>
<td>56</td>
<td>62</td>
</tr>
<tr>
<td>% of 1 year olds with measles immunization</td>
<td>93</td>
<td>62</td>
<td>92</td>
</tr>
</tbody>
</table>


### Table 5: Health financing indicators, 2008

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Ghana</th>
<th>South Africa</th>
<th>Tanzania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total health expenditure (THE) as % GDP</td>
<td>7.8</td>
<td>8.3</td>
<td>5.1</td>
</tr>
<tr>
<td>THE per capita US$ (PPP adjusted)</td>
<td>56 (113)</td>
<td>464 (826)</td>
<td>25 (65)</td>
</tr>
<tr>
<td>% of government expenditure on health</td>
<td>7.6</td>
<td>10.2</td>
<td>16.2</td>
</tr>
<tr>
<td>Government expenditure as % THE</td>
<td>49.7</td>
<td>40.3</td>
<td>65.6</td>
</tr>
<tr>
<td>Private expenditure on health as % THE</td>
<td>90.3</td>
<td>59.7</td>
<td>34.4</td>
</tr>
<tr>
<td>Out-of-pocket payments as % private expenditure</td>
<td>79.2</td>
<td>29.7</td>
<td>73.0</td>
</tr>
<tr>
<td>External assistance as % THE</td>
<td>10.0</td>
<td>1.2</td>
<td>55.1</td>
</tr>
</tbody>
</table>

assistance channelled through the government (in accordance with National Health Accounts conventions), and external assistance, at 55% of total health expenditure (according to WHO data, Table 5), is by far the highest of the three countries. Figure 1 uses Tanzanian National Health Accounts data and shows recent changes in the mix of health care financing in Tanzania, with an increase in both government support from taxation and international assistance, and a reduction in the share of household payments (largely out-of-pocket payments). Nonetheless, household payments still contribute a quarter of total health expenditure, and have been increasing in absolute terms even though their share of total health expenditure has been falling.

Per capita health expenditure in Tanzania is half that of Ghana, which is in turn 8 times less than in South Africa. This level of expenditure in Tanzania is below the cost of a basic health care package in low-income countries estimated both by the Commission on Macroeconomics and Health (US$38) and by the recent High Level Taskforce (US$54) (Taskforce on Innovative International Financing for Health Systems 2009). Both Ghana and Tanzania have seen recent development of insurance schemes, and South Africa has historically had a sizable private insurance sector. Ghana has moved over time from a system of free public care to out-of-pocket payment (known as Cash and Carry) and now to a combination of state-sponsored health insurance and out-of-pocket payment. A National Health Insurance Scheme began implementation in 2004, and arose out of an election promise made in 2000 by the incoming New Patriotic Party to abolish user fees (Agyepong and Adjei 2008). User fees had constituted a well-documented barrier to health care in Ghana since the 1980s, and attempts to alleviate them with a system of exemptions were not very successful (Garshong et al. 2002). The main health insurance arrangement is the district mutual health insurance scheme, which includes workers in the formal sector who are members by virtue of their social security contributions, voluntary enrollees and people identified to be indigent whose fully subsidized membership contributions are secured from the national health insurance fund. These schemes receive premiums paid by voluntary members, and funding from the national health insurance fund which receives 2.5% of social security contributions and a 2.5% VAT rate. By December 2009, schemes were operating in all districts and coverage was about 62%, though with significant regional variation (NHIA Ghana 2009). Out-of-pocket payments are contributed both by those who do not enrol in the National Health Insurance Scheme, and by expenditures on services outside the benefit package.

In Tanzania, by contrast, the level of prepayment schemes/insurance coverage and its contribution to total health care financing is still very small. Health insurance was estimated to cover just over 10% of the total population in 2008 (authors’ estimate). The National Health Insurance Fund (NHIF), established in 1999, compulsorily covers all public servants and up to 5 dependants, about 5% of the total population in 2008, and is financed by a 6% of salary contribution equally shared between the employee and employer. The National Social Security Fund (NSSF) introduced a Social Health Insurance Benefit (SHIB) component in 2005 as part of its benefit package for members, who are mainly private sector employees. They and up to five dependants are required to register for the SHIB and part of the NSSF contribution is used to refund health care use by SHIB members. To date only a small proportion of NSSF members have registered with the SHIB (9% in 2009) and at the population level coverage is less than 1%. Both the SHIB and the NHIF cover outpatient and inpatient care, but the NHIF covers access to over 5500 facilities nationally, while the SHIB covers only 264 (World Bank 2011).

The Tanzanian Community Health Fund (CHF) is a government voluntary scheme which started national roll out in 2001 and targets the informal rural population, with its counterpart, Tiba kwa Kadi (TIKA), for urban areas. Contributions to the CHF are decided at the council level, and each household contributes the same amount regardless of ability to pay, giving them access to free health care at primary public health facilities. Revenues from members’ contributions are matched by a 100% grant from the government. Households that do not participate in the CHF scheme are required to pay user fees at

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Figure 1 Health care financing in Tanzania
Source: MOH Tanzania (2001); MOHSM Tanzania (2008)
health facilities. Coverage of the CHF was estimated at approximately 4% of the total population in 2008. Both Tanzania and Ghana have a small amount of private insurance, mainly linked to employment in private firms. For example, in 2007 Tanzania was estimated to have about 15 registered private insurance companies, of which five had a health insurance component. Information on members who are covered by private insurance and its relative contribution to health financing is very limited.

In contrast, in South Africa, private insurance, the so-called medical schemes, is a key element of the financing system. Initially, there were very few schemes and they took the form of ‘closed’ or ‘restricted’ schemes in that membership was open only to employees of an individual company or group of companies. Over time, many ‘open’ schemes, i.e. schemes allowing anyone to join, have developed. Most care for insureds is provided by the private sector, whose expenditure has increased at rates far exceeding inflation since the 1980s. Membership of medical schemes has thus become increasingly unaffordable for South Africans; as expenditure increases, so do the contribution rates or premiums that are charged by medical schemes. In the late 1980s and early 1990s, contribution rates increased at rates far exceeding inflation since the 1980s. Membership of medical schemes has thus become increasingly unaffordable for South Africans; as expenditure increases, so do the contribution rates or premiums that are charged by medical schemes. In the late 1980s and early 1990s, contribution rates were increasing at 25–30% per year in real terms (McIntyre et al. 1995). The rate of annual contribution increases has reduced dramatically in recent years, but the average annual real increase in contributions of 7% between 2000 and 2005 is still of concern. Although medical scheme membership increased from about 6.3 million in the early 1990s to 6.9 million by 1997, the absolute total number of beneficiaries decreased in some years thereafter and had only reached 6.9 million again by 2005. Medical scheme membership has declined considerably as a percentage of the population, from 17% in 1992 (McIntyre et al. 1995) to only 14.8% in 2005 (Council for Medical Schemes 2006), though it has increased since 2006, to 16%, due to the introduction of the Government Employees Medical Scheme.

An analysis of the South African public–private mix, drawn from analyses specifically conducted as part of the research programme,1 demonstrates substantial inequities in health financing:

- 14.8% of the population is covered by medical schemes and is able to secure most of their health services in the private sector. The per capita annual expenditure on this group, combining both medical scheme expenditure and out-of-pocket payments by medical scheme members, was equivalent to approximately R9500 (US$687) per beneficiary in 2005.
- A further 21% of the population (i.e. 24.7% of the 85.2% of the population who are not beneficiaries of a medical scheme) used the private sector on an out-of-pocket basis mainly for primary care, but are likely to be entirely dependent on the public sector for hospital (particularly inpatient) care. The per capita annual expenditure on this group, including their out-of-pocket payments to private primary care providers and government spending on hospital care, was equivalent to nearly R1500 (US$107) per person in 2005.
- The remaining 64.2% of the population can be said to be entirely dependent on the public sector for all their health care services. For this group, less than R1300 (US$93) was spent per person for government primary care and hospital services.

**Health financing reforms under discussion**

In all three countries, continuing reforms related to expanding financial protection are on the policy agenda. In South Africa, there has been much discussion of how to address the above inequities and reduce the fragmentation of the system. Currently under discussion is a so-called national health insurance scheme, which it is proposed would be financed by increased allocations to the health sector from general tax. Additional revenue sources under consideration include a surcharge on personal income tax, a payroll tax on employers and additional VAT. It is proposed that a relatively comprehensive package of services would be covered and purchased from accredited public and private sector providers. The resourcing levels and quality of care would be substantially improved in public sector facilities, which faced declining real per capita funding levels in the 1990s, a period when health service demands were increasing due to the rampant AIDS epidemic. There will be a particular emphasis on improved primary health care services at facility and community levels. Medical schemes would remain, but would likely lose members to the new public arrangements (African National Congress 2010).

In Tanzania and Ghana, changes being discussed are more incremental. In Ghana, the key issue is the introduction of a ‘one time payment’ to replace the current annual premium, in recognition of the difficulties of raising annual premiums from the informal sector. In Tanzania, the discussion has focused on how to expand insurance coverage of the informal sector through the CHF and TIKA. The NHIF has been given the mandate to manage the operation of the CHF and TIKA in order to make use of the well-established NHIF management infrastructure from national to district level. In addition, the SHIB is seeking to expand its coverage of the private and parastatal sectors, though it is struggling to expand its membership base. The challenge remains of the fragmentation of the three main schemes, though the government is in the process of establishing a national health financing strategy to provide an overarching framework.

**Concluding comments**

At first glance, the three countries which are the subject of the research reported in this special issue may seem very different. The structure of South Africa’s economy, and its wealth, differs greatly from the economies of Ghana and Tanzania, where the bulk of the working population is in the informal sector. The volume of financial resources devoted to health care varies enormously across the three countries, with South Africa spending by far the most per capita. However, the health indicators are not so different, with two key exceptions. Ghana performs better on life expectancy, benefiting from the lower AIDS prevalence relative to the other two countries. Tanzania
has substantially worse infant, child and maternal mortality, though it has managed to reduce child mortality greatly in recent years.

Performance in relation to MDG goals differs: both Ghana and Tanzania are likely to meet MDG4 (child health), though neither are on track for MDG5 (maternal health). South Africa is not on track to meet either MDG4 or 5 (Chopra et al. 2009). A recent analysis of the period 1999–2004 in Tanzania suggests that the achievements in child mortality reduction were most likely due to improvements in Tanzania’s health system, including doubled public expenditure on health; decentralization and sector-wide basket funding; and increased coverage of key child-survival interventions such as integrated management of childhood illness, insecticide-treated nets, vitamin A supplementation, immunization and exclusive breastfeeding (Masanja et al. 2008). For South Africa, key explanations as to why its health indicators are not better given its level of income include the legacy of gross inequalities in income and access to health care between population groups, and the impact of HIV/AIDS, combined with poor leadership (Coovadia et al. 2009).

In terms of issues facing the organization and delivery of health care, there are also common concerns across countries. The public health sector (including church services in Ghana and Tanzania) plays a vital role in delivering care to all except the very well off. However, resources are poorly distributed geographically, and concerns persist on efficiency and responsiveness. Human resource availability and distribution are also problems which are common across the countries, except that South Africa faces a much more significant issue of the magnitude of resources in the private sector giving rise to major inequities in access. Poorer performance in South Africa on primary care interventions (i.e. antenatal care and measles immunization) suggests that South Africa struggles more than the other two countries to provide high coverage of such basic interventions.

Financial protection against the cost of ill health remains a key and acknowledged problem in all three countries (McIntyre et al. 2008), and universal coverage, even in South Africa where 8.3% of national income is spent on health, is not yet a reality. Both Ghana and Tanzania have chosen to seek to expand the coverage of insurance schemes, though in a context where only a minority of the workforce is in the formal employment sector and hence can readily be included in mandatory insurance arrangements.

Key challenges faced by the three countries in deciding on how to make progress towards universal coverage are how best to:

- reduce the share of out-of-pocket payments in total health expenditure,
- provide financial protection to the population in the informal sector,
- reduce the fragmentation of current financing arrangements,
- allocate public health resources (both financial and human) more equitably.

Subsequent papers explore in much greater depth the equity of current patterns of financing and use of services, the challenges the countries face in improving financial protection, and the relative merits of the various policy options that are being, and might be, adopted.

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Conflict of interest

The authors declare having no competing interests.

Endnote

1 Data on medical schemes expenditure from the Council for Medical Schemes Annual Reports, on public sector expenditure from Treasury reports, and on out-of-pocket payments extrapolated from the most recent National Health Accounts report.

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