WACI HEALTH
Champions for Health

CSO Commentary on the Africa Scorecard on Domestic Finance for Health

Analysis of the gaps in the African Union's Africa Scorecard on Domestic Financing for Health in measuring the three equity dimensions of service coverage, population coverage, and financial risk protection

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Acknowledgments

We are extremely Grateful for all the hard work that went into this report, especially GFAN Africa collegues who provided their expertise and leadership; we would like to thank particularly Evaline Kibuchi, Maziko Matemba, Olayide Akanni, James Kamau, Cecilia Senoo, Olive Mumba, Olivia Ngou and Rahab Mwaniki.

Overview

Structure of this report

This report is structured in the following manner:

About this assignment and report

Purpose /objective of the study: to support domestic resource mobilisation (DRM) advocacy. This report is intended to offer insights/arguments to strengthen the effectiveness of DRM work in health and health financing in the region.

The Africa Scorecard on Domestic Financing for Health, otherwise known as "the Scorecard", has been instrumental in guiding the advocacy of CSOs for increased country (domestic) budget allocations for Health. However, the Scorecard only presents quantitative data.

The Scorecard does not represent country performance on the three dimensions of the Universal Health Coverage (UHC) cube, namely: service coverage, population coverage, and financial coverage or financial risk protection. The purpose of this report is to highlight these gaps and to provide a "CSO Commentary" on these qualitative dimensions of the UHC cube.

Following this report, and based on its findings, an infographic document – named "Gap 1.0" – will be produced, focusing on national budgetary shortfalls for HIV & AIDS, TB and Malaria responses.

The product to be delivered:

- *CSO Commentary – this report – which will establish the missing features of the Scorecard; the three dimensions of UHC coverage: service coverage, population coverage, and financial coverage or financial risk protection; and*

- *Gap 1.0; which reflects on the budgetary shortfalls towards HIV & AIDS, TB and Malaria to inform advocacy strategies aimed at persuading governments towards more efficient allocation at National levels. The Gap 1.0 will focus on four countries: Cameroon, Kenya, Senegal and Tanzania.*

2 Introduction

The purpose of this report is to highlight the gaps in the African Union's Africa Scorecard on Domestic Financing for Health, with specific reference to country performance on the three dimensions of the UHC coverage cube, namely: service coverage, population coverage, and financial coverage or financial risk protection.

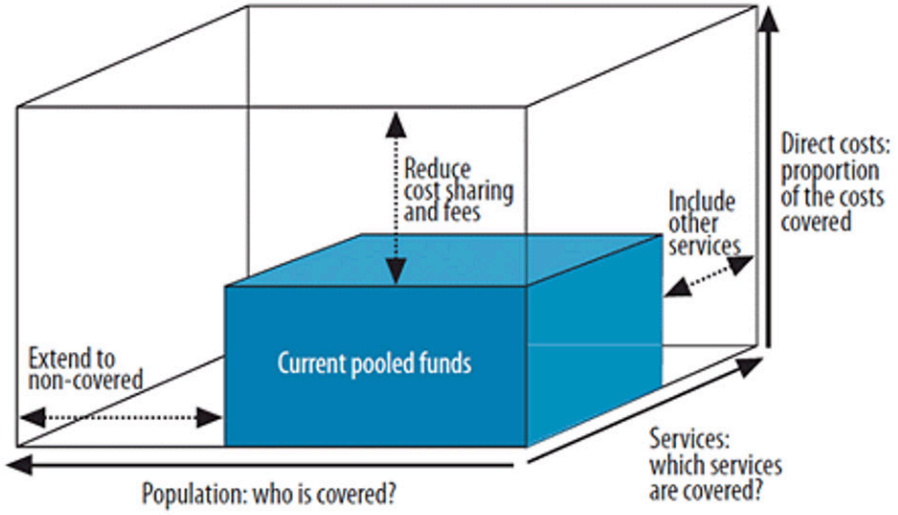


Figure 1: Three dimensions to consider when moving toward universal health coverage

This "CSO Commentary" will then suggest possible ways to remedy these shortfalls or alternatives for producing this critical information on a regular basis.

3 Methodology

- A comprehensive desktop review of a broad range of documentation relevant to the study including peer-reviewed articles, NGO reports, official government documents, UN and AU reports, the text of speeches, media articles, etc. This will include written material relevant to the issue of the responsibility of African governments to invest in health;
- A review of the published as well as forthcoming editions of the AU's Africa Scorecard on Domestic Financing for Health;
- A review of the African Union's forthcoming (embargoed) Health Financing Tracker;
- Semi-structured interviews (KII and FGD to be undertaken remotely) with key stakeholders (individuals or groups) to be selected and approached in consultation with WACI Health;
- Informal discussions and e-mail exchanges with key stakeholders as necessary;
- Workshop with WACI in which initial findings are presented and in which remaining gaps and the final phases of investigation determined.

1 Literature review – Summary version

A desktop review was conducted of relevant literature related to health financing and/or catastrophic health expenditure and household impoverishment due to out-of-pocket (OOP) payments for health. The literature consulted included official government documents, UN and AU reports, peer-reviewed articles, NGO reports, and the text of speeches. The analysis is provided below while an extended literature review is provided in "*Annexe 2: Literature Review – extended version*".

The analysis included review of the published as well as forthcoming editions of the African Union's Africa Scorecard on Domestic Financing for Health.

What is the Africa Scorecard on Domestic Financing for Health?

The purpose of the African Union's Africa Scorecard on Domestic Financing for Health (hereafter, the Scorecard) is to provide Africa's Heads of State, Ministers of Finance and Ministers of Health with a management tool that might assist with financial planning for the health sector. The Scorecard attempts to consolidate within a single table the health financing performance of each of the 55 AU Member States against both key health financing benchmarks and of the performance of peer AU Member States. This is towards Africa's intention of meeting the health vision set out in Agenda2063 and to achieve the overall objective of the Africa Health Strategy, 2016-2030:

> *"To strengthen health systems performance, increase investments in health, improve equity and address social determinants of health to reduce priority disease burdens by 2030".* [1]

The Overall Objective of Africa Health Strategy, 2016-2030

Realising the objectives set out in the Africa Health Strategy will require significant new investment as well as improvements in the efficiency and effectiveness of current health spending. The 55 AU Member States have made multiple commitments to this end – a number of which are set out in "*Annexe 1: Commitments to improve and* increase domestic investment in health made by the 55 AU Member States since 2001[1]" .

1 African Union: Africa Health Strategy 2016-2030; 'Overall Objective'

Universal health coverage (UHC)

Universal health coverage (UHC) can be defined as:

"all people receiving quality health services that meet their needs without being exposed to financial hardship in paying for the services. Given resource constraints, this does not entail all possible services, but a comprehensive range of key services that is well aligned with other social goals."

The objective of achieving UHC was firmly endorsed by the World Health Assembly in 2005 and further supported in the World Health Report 2010 as well as in World Health Assembly resolutions in at least 2011 (WHA 64) and 2015 (WHA 68). The United Nations General Assembly also held a High-Level Meeting on Universal Health Coverage in 2019.

The effort to progressively realise UHC involves extending health coverage in at least three dimensions:

1. Expanding service coverage
2. Expanding population coverage
3. Expanding financial [risk] protection

The pace at which countries chose to extend health service coverage along each of these three dimensions reflects a set of policy choices about benefits and their rationing that are among the most important decisions that countries make in the effort to reform of their health financing systems towards the progressive realisation of universal coverage. They are necessarily taken with a mind to achieving certain objectives and after considering the financial needs and the political contexts.

We will briefly explore each of the three dimensions in turn:

Expanding service coverage:

This involves expanding the range of priority health services provided. It answers the question, WHAT priority health services are provided?

Selecting which health service are included on the list of priority health services provided as part of a minimum package requires a selection process / criteria that considers, among others: disease burden, the cost-effectiveness of the intervention, and the vulnerability of certain populations (e.g. children, pregnant women, etc). [The process of determining the selection criteria / setting out a selection processes should ideally involve participatory procedures and a process of public deliberation. Countries will also benefit from establishing a standing national committee on priority setting.]

Expanding population coverage:

This involves expanding coverage of priority health services to more and more of the population until, ultimately, everyone has access. It answers the question, WHO has access to priority health services?

Fair and equitable selection of who should have access to free priority health services requires targeted selection of disadvantaged groups. Priority health services should ideally be progressively extended to low-income groups, rural populations, and other groups disadvantaged in terms of service coverage, health, or both.

Expanding financial [risk] protection:

This involves providing financial risk protection to reduce the financial impact of accessing health services. It answers the question, WHO PAYS.

Many countries rely on out-of-pocket payments (OOP) to finance government provision of health services; however, OOP payments present a barrier to access to health services, particularly for the most vulnerable. Such barriers can result in people foregoing the treatment they need, increasing morbidity and mortality. In addition, for those who do access health services, OOP payments are often a substantial financial burden on them and their families and can lead to financial hardship or even financial catastrophe and impoverishment.

To ensure that people access the health services they need requires that countries provide financial coverage or financial risk protection, all of which are designed to reduce the direct (out-of-pocket) costs of accessing health services. Often this is done by shifting from OOP payments toward mandatory, progressive prepayment and the pooling of funds. In this regard, the principle of equity encourages that mandatory prepayment should increase with ability to pay (i.e., should be progressive). At the same time, the access to services should be based on need and not ability to pay.

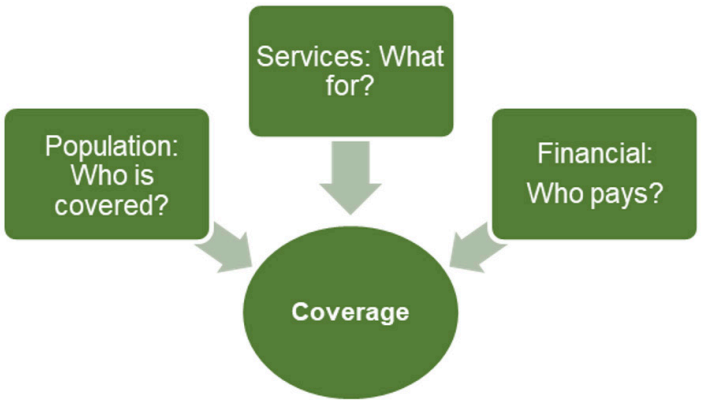


Figure 2: Aspects of coverage in financial protection

The incidence of catastrophic health expenditure, defined as large OOP spending in relation to household consumption or income (and which is now tracked as SDG indicator 3.8.2), increased continuously between 2000 and 2015. As will be explored in the literature review section, the WHO has emphasised that when people suffer financial hardship due to OOP, it is impossible to get to universal health coverage.

The goal of universal health coverage is ambitious. It is also achievable. UHC is first and foremost a political choice. It is because UHC is a political choice that strong political commitment from world leaders is essential for overcoming barriers and making progress on the road to a healthier, safer and fairer world.

Financial Risk Protection and the SDGs

Improving 'Health' falls within objective 3 of the Sustainable Development Goals (SDGs). Within these, SDG 3.8 is "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. Indicators to measure country progress against SDG 3.8 are:

> 3.8.1: Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population).
>
> 3.8.2: Proportion of population with large household expenditures on health (greater than 25 percent) as a share of total household expenditure or income (percent).

3.8.2 thus covers the objective of achieving financial risk protection in health.

Out-of-pocket (OOP) health spending, catastrophic health expenditure (CHE) and medical impoverishment

Many countries rely on out-of-pocket payments (OOP) to finance government provision of health services; however, OOP payments present a barrier to access to health services, particularly for the most vulnerable. Such barriers can result in people foregoing the treatment they need, increasing morbidity and mortality. In addition, for those who do access health services, OOP payments are often a substantial financial burden on them and their families and can lead to financial hardship or even financial catastrophe and impoverishment. As the WHO has emphasised, when people suffer financial hardship due to OOP, it is impossible to get to universal health coverage.

The proportion of households in Sub-Saharan Africa (SSA)[1] that are impoverished due to health spending has increased over time both across countries as well as within countries. The incidence of CHE is reported to be higher in low-income countries that rely on OOP payments, and lower in countries that have some prepayment mechanisms. The study also highlights that those patients with HIV & AIDS, TB and malaria experience the highest incidence of catastrophic expenditure. Furthermore, it shows that CHE/impoverishment is pervasive across SSA, and highest in West African countries.

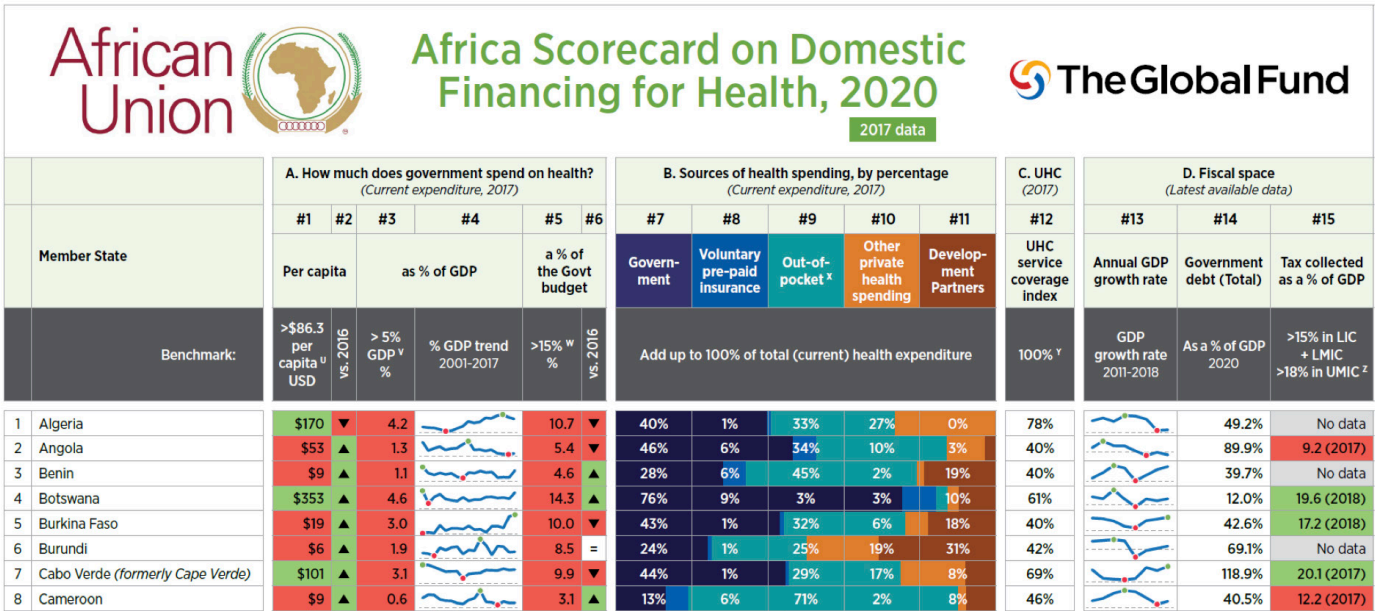
Non-medical related cost like transportation costs, food related costs, non-routine tests, and inadequate care (due to shortages of drugs and medical services) in public primary health care facilities largely influence CHE, revealing that non-medical expenditures are much higher than medical expenses.

1 Njagi et al. Understanding variations in catastrophic health expenditure, its underlying determinants and impoverishment in Sub- Saharan African countries: a scoping review (2018) 7:136 https://doi.org/10.1186/s13643-018-0799-1

5 What dimensions of coverage does the Scorecard include?

As the purpose of this report is to highlight within the African Union's Africa Scorecard on Domestic Financing for Health the gaps in measuring service coverage, population coverage, and financial coverage / financial risk protection it is necessary to review the Scorecard and how it presents coverage against each of these three dimensions.

The Scorecard used for this analysis is the 2020 edition of the Scorecard. It is anticipated that the African Union will release a 2021 edition of the Scorecard following consultation with AU Member State in November 2021. This 2021 Scorecard is expected to restructure the presentation of the data and the 15 indicators presented below, however the same indicators are expected to be retained.



African Union

Africa Scorecard on Domestic Financing for Health, 2020

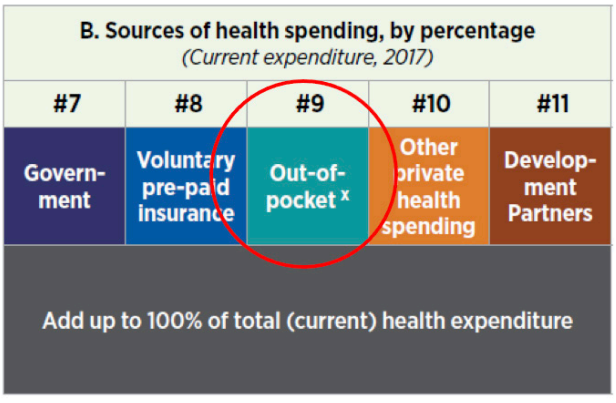
2017 data

The Global Fund

	Member State	A. How much does government spend on health? (Current expenditure, 2017)						B. Sources of health spending, by percentage (Current expenditure, 2017)					C. UHC (2017)	D. Fiscal space (Latest available data)		
		#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12	#13	#14	#15
		Per capita		as % of GDP		a % of the Govt budget		Govern-ment	Voluntary pre-paid insurance	Out-of-pocket [x]	Other private health spending	Develop-ment Partners	UHC service coverage index	Annual GDP growth rate	Government debt (Total)	Tax collected as a % of GDP
	Benchmark:	>$86.3 per capita [u] USD	vs. 2016	> 5% GDP [v] %	% GDP trend 2001-2017	>15% [w] %	vs. 2016	Add up to 100% of total (current) health expenditure					100% [y]	GDP growth rate 2011-2018	As a % of GDP 2020	>15% in LIC + LMIC >18% in UMIC [z]
1	Algeria	$170	▼	4.2		10.7	▼	40%	1%	33%	27%	0%	78%		49.2%	No data
2	Angola	$53	▲	1.3		5.4	▼	46%	6%	34%	10%	3%	40%		89.9%	9.2 (2017)
3	Benin	$9	▲	1.1		4.6	▲	28%	6%	45%	2%	19%	40%		39.7%	No data
4	Botswana	$353	▲	4.6		14.3	▲	76%	9%	3%	3%	10%	61%		12.0%	19.6 (2018)
5	Burkina Faso	$19	▲	3.0		10.0	▼	43%	1%	32%	6%	18%	40%		42.6%	17.2 (2018)
6	Burundi	$6	▲	1.9		8.5	=	24%	1%	25%	19%	31%	42%		69.1%	No data
7	Cabo Verde *(formerly Cape Verde)*	$101	▲	3.1		9.9	▼	44%	1%	29%	17%	8%	69%		118.9%	20.1 (2017)
8	Cameroon	$9	▲	0.6		3.1	▲	13%	6%	71%	2%	8%	46%		40.5%	12.2 (2017)

The Scorecard presents country performance against 15 indicators. Of these, two indicators (13%) measure 'service coverage, population coverage, or financial risk protection' in some form:

Indicator #9: Household out-of-pocket (OOP) spending



B. Sources of health spending, by percentage
(Current expenditure, 2017)

#7	#8	#9	#10	#11
Govern-ment	Voluntary pre-paid insurance	Out-of-pocket [x]	Other private health spending	Develop-ment Partners
Add up to 100% of total (current) health expenditure				

- Measures: the % that household OOP spending contributes to total health (current) expenditure
- Benchmark: The WHO advises that OOP spending should be below 20%
- Note: OOP is a considered a good proxy indicator of financial coverage / financial risk protection. A study by Di McIntyre & Filip Meheus calculates that reducing OOP expenditure to <20% is equivalent to government spending 6% of GDP on health. Spending at least 5% of GDP on health is considered sufficient to provide an absolute minimum package of basic health services.

Indicator #12: UHC Service Coverage Index

C. UHC *(2017)*
#12
UHC service coverage index

- Measures: the % that household OOP spending contributes to total health (current) expenditure
- Benchmark: The WHO advises that OOP spending should be below 20%
- Note: OOP is a considered a good proxy indicator of financial coverage / financial risk protection. A study by Di McIntyre & Filip Meheus calculates that reducing OOP expenditure to <20% is equivalent to government spending 6% of GDP on health. Spending at least 5% of GDP on health is considered sufficient to provide an absolute minimum package of basic health services.

Indicators #9 & #12 together: OOP spending and UHC Service Coverage Index combined

- When read in combination indicators #9 and #12 provide an interesting insight that is not immediately apparent when considering each indicator separately.
- OOP may be low – below the benchmark of <20%. This does not necessarily indicate that OOP spending is not a barrier to accessing health services. OOP spending could present a significant barrier to accessing health services such that citizens forego access to health services because of an inability to pay.
- Across the two indicators, there are 4 possible permutations: Both indicators could be low; one indicator could be low while the other is high; one could be high while the other is low; or both indicators could be high:

1. If OOP spending (#9) is low while country performance on the UHC Service Coverage Index (#12[1]) is low, then OOP spending may present a barrier to accessing health services.
2. If OOP spending (#[2]9) is low while country performance on the UHC Service Coverage Index (#12) is high, then OOP spending is not a barrier to accessing health services.
3. If UHC Service Coverage (#12) is high and OOP (#9) is low, then coverage is good and OOP spending is not a risk for impoverishment.
4. If UHC Service Coverage (#12) is high and OOP (#9) is high, then while OOP is not a barrier to accessing health services it presents a threat that is likely to push more people into poverty.

1 Meheus, F., & McIntyre, D. (2017). Fiscal space for domestic funding of health and other social services. Health Economics, Policy and Law, 12(2), 159-177. doi:10.1017/S1744133116000438

2 3.8.1: Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population).

In other words, indicators #9 (OOP spending) and #12 (UHC Service Coverage Index) tell their own story. However, when they are read in combination with each other, OOP spending (#9) and UHC Service Coverage Index (#12) together provide an indication of whether a lack of financial risk protection is causing the population to choose to forego accessing health services.

Assessment: Does the Scorecard measure:

Expanding service coverage: Yes
However, only in overall terms and for a basic package of services (as measured in SDG indicator 3.8.1.) rather than measuring any expansion in the range of services provided. This is achieved through Scorecard indicator #12: UHC Service Coverage Index.

Expanding population coverage: No
Scorecard indicator #12: UHC Service Coverage Index measures the expansion of services to a greater proportion of the population. In these terms it provides some measure of the expanding population coverage, however only in very broad or general terms. It is not possible from this indicator to determine who services are being expanded to.

Expanding financial risk protection: Not directly, but #9 is a good proxy indicator.
Scorecard indicator #9: Household out-of-pocket (OOP) spending provides a good proxy indicator of financial risk protection. Moreover, when indicators #9 (OOP spending) and #12 (UHC Service Coverage Index) are read in combination with each other, together they provide an indication of whether a lack of financial risk protection is causing the population to choose to forego accessing health services.

Conclusion – evaluating the 'gaps' in the Africa Scorecard

The question at the heart of this research paper is whether there are gaps in the African Union's Africa Scorecard on Domestic Financing for Health; in particular, gaps in the Scorecards ability to measure country performance against the three equity dimensions of service coverage, population coverage, and financial risk protection. In attempting to answer this question we need to be clear what is being asked:

The first question is whether the Scorecard contains appropriate indicators to measure progress in these three dimensions. In answer to this question, we have seen that the Scorecard provides a measure in some form for at least two of the three dimensions. Neither of the two measures are themselves perfect measures of either 'service coverage' or 'financial risk protection', however they are well grounded indicators.

The second question is whether, were the Scorecard not to include these three dimensions, it should be considered a 'gap' in the Scorecard? This question is harder to answer. At its heart is 'what problem is the Scorecard trying to solve?' and, therefore, what is its purpose? This paper will not attempt to answer this question. It will merely pose its own question: Is the African Union's Africa Scorecard on Domestic Financing for Health – a tool for Heads of State to measure levels of domestic investment in health – the appropriate tool through which to measure country progress against these three dimensions of equity, all of which are necessary for realising Africa's ambitions of achieving Universal Health Coverage?

6 What dimensions of coverage does the AU Tracker include?

During the 2019 African Union Assembly of Heads of State and Government, AU Leaders adopted the ALM Declaration ("Declaration Assembly/AU/Decl.4 (XXXII)", acknowledging that domestic investments in health are not growing fast enough and establishing the mechanisms through which to coordinate and implement a continent-wide response. Among these mechanisms is the Health Financing 'Tracker'. The Tracker is intended to:

- "Complement the Scorecard with a domestic health financing 'Tracker' that will track more granular 'enablers' of progress towards the desired Scorecard outcomes.[1]"

The Tracker is intended to bridge the gap between the 'outcomes' countries must achieve (as measured by the Africa Scorecard on Domestic Financing for Health) and 'How to get there'. The Tracker is therefore intended to sit between the Africa Scorecard on Domestic Financing for Health – which measures country progress against high-level outcomes – and the WHO Health Financing Progress Matrix – which involves an in-depth assessment of a country's health financing situation. It is also intended to relate to the Global Accelerator process – the effort by development partners to improve coordination amongst themselves and align to country priorities, and of which there is a 'Health Financing Accelerator' effort led by the WHO.

Following wide consultation, a preliminary draft Tracker was produced in December 2020. It remains under embargo until adoption by AU Member States through the AU-led consultation process.

The preliminary draft Tracker comprises 24 preliminary indicators that measure country performance on highest impact 'actions' across 12 areas of health financing and PFM reform. These 24 preliminary indicators fall within and 12 'Action areas' – where country 'actions' across health financing, revenue, raising and PFM will realise the greatest return on effort across 4 overarching objectives.

Figure 3: AU draft Tracker : 4 Objectives and 12 'Action areas' where country actions are required for progress (embargoed)

1 AU Assembly "Addis Ababa Commitment towards Shared Responsibility and Global Solidarity for Increased Health Financing Declaration", otherwise known as the ALM Declaration.

Equity is a key objective against which the Tracker supports country efforts to make progress, as can be seen in the fact that "Equity / improved financial protection in health" is one of the 4 objective areas for the Tracker. Indeed, 3 of the 12 'Action Areas' (25%) measure progress against Equity targets.

The Tracker aims to both track progress towards these objectives and to guide ministries of finance and ministries of health in their efforts to achieve them by indicating a suggested 'direction of travel'. The Tracker, therefore, must be both practical and actionable, with a strong focus on stimulating or enhancing evidence-based policy reforms. As per the AU Assembly ALM Declaration, it must set out "'enablers' of progress".

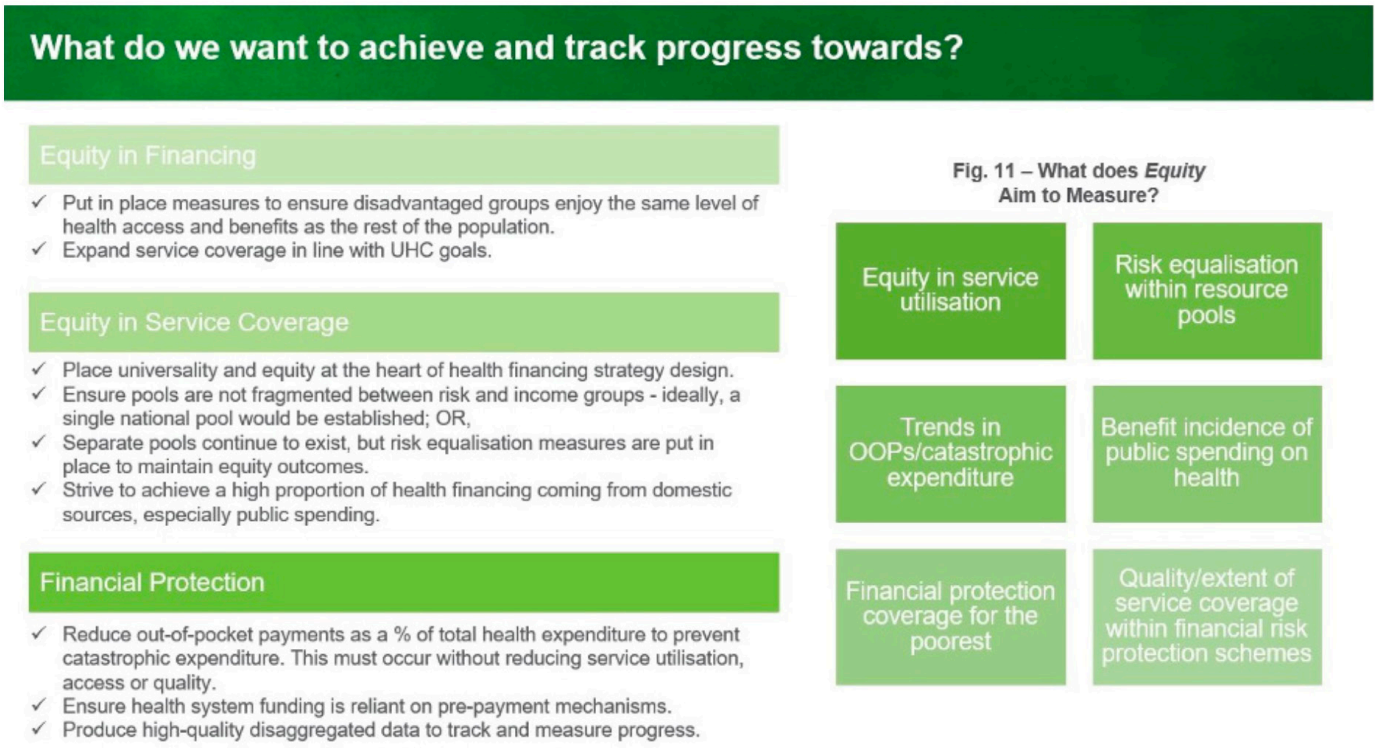


Figure 4: AU draft Tracker: What do we want to achieve and track progress towards? (embargoed)

Figure 5 presents the equity indicators drawn from the Tracker: Draft Indicator Table, listing and explaining the 6 preliminary draft indicators that have been shortlisted to measure progress against these three equity Action areas:

Objective	Action Area	(preliminary) Indicators		Explanation
Equity	Equity in Service Utilisation /Coverage	12	Access to X service by wealth quintile (e.g. RMNCH).	This measures how wealth affects access to essential services and will provide an indication of the equity in distribution of healthcare benefits across the population.
		13	RMNCH Coverage Index	This is a proxy for access barriers to essential health services across the population.
	Equity in Financing	14	Are Benefit Incidence Analyses (BIA) of public spending in health carried out routinely with good quality data?	This is intended as a prompt for countries to conduct a benefit incidence analysis, which remains the best way to measure equity of financing.
		15	Placeholder: Concentration Analysis of Resource Pools	This indicator will assess the level of fragmentation in the health financing system.
	Financial Protection	16	Medical Impoverishment (proportion of population pushed below poverty line ($1.90) by OOP spending).	This measures the proportion of population pushed below poverty line ($1.90) by OOP payments.
		17	Year 1: "What are the key drivers of OOPs". Thereafter, measure the change in these key drivers of OOPs.	This encourages countries to consider not only if/to what extent direct payments are relied upon as a health financing mechanism but provides a diagnostic to evaluate for what is driving them, --> thereby suggesting areas for policy intervention.

Figure 5: AU draft Tracker: Draft Indicator Table – Equity indicators (embargoed)

Finally, Figure 6 presents a high-level overview of the draft Tracker Equity indicators (embargoed).

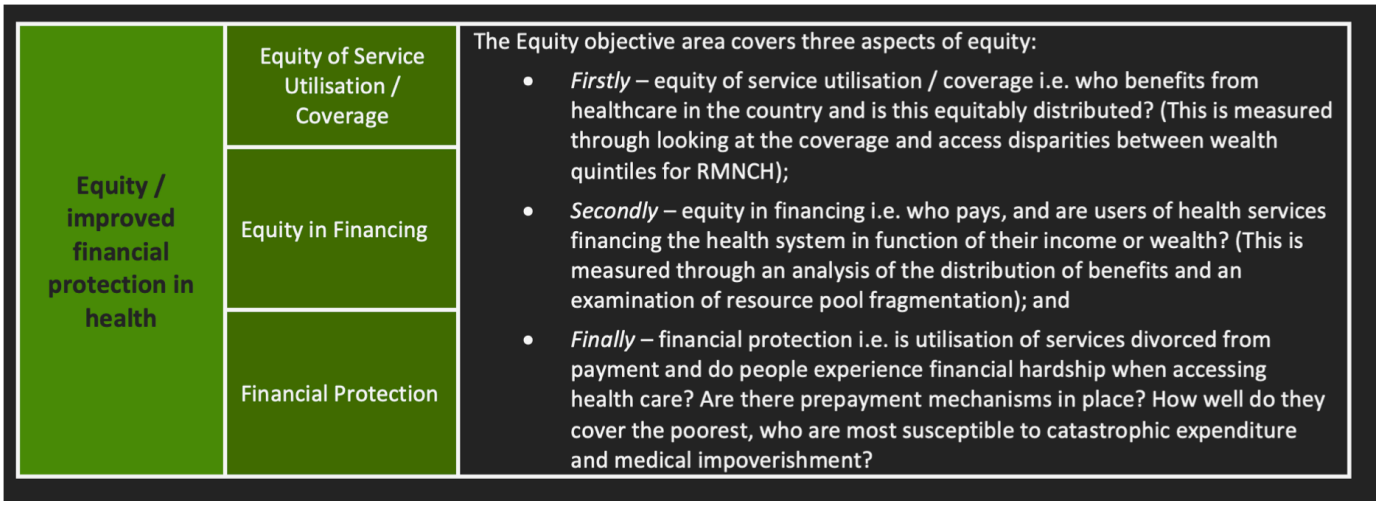


Figure 6: AU draft Tracker: Draft Indicator Table – High level overview of Equity indicators (embargoed)

Assessment: Does the (draft) Tracker measure:

Expanding service coverage: YES, two preliminary indicators of service coverage are included under the 'action area' "Service Coverage". These seek to measure service coverage / utilisation in a specific service line – RMNCH – as a proxy for service coverage more generally.

- Note, these two [preliminary draft] Tracker indicators are in addition to the indicator "UHC service coverage index" that is included in the Scorecard.

Expanding population coverage: No.

- This is partly to avoid duplication with Scorecard indicator #12: "UHC Service Coverage Index", which measures the expansion of services to a greater proportion of the population. [It should be noted, however, the UHC SCI indicator itself provides only a broad measure of expanding population coverage and that it is not possible from this indicator to determine who services are being expanded to.]

Expanding financial risk protection: Yes, two preliminary indicators under the Action area "Financial protection":

- Indicator #16: "Medical Impoverishment (proportion of population pushed below poverty line ($1.90) by OOP spending). "
- Indicator #17: "Year 1: "What are the key drivers of OOPs". Thereafter, measure the change in these key drivers of OOPs."
- These two preliminary indicators under the Action area "Financial protection" are supplemented by a further two preliminary indicators under the Action area "Equity in Financing". While these two indicators don't specifically measure financial protection they provide information on who pays for health services and whether the users of health services are financing the health system in function of their income or wealth?:
- Indicator #14: "Are Benefit Incidence Analyses (BIA) of public spending in health carried out routinely with good quality data?"
- Indicator #15: "Placeholder: Concentration Analysis of Resource Pools"

7 Main findings and Recommendations

1. The African Union's Africa Scorecard on Domestic Financing for Health

- The AU's Scorecard has proven to be a useful tool, both in supporting countries to monitor implementation and for civil society to hold governments accountable to their commitments.

- While the Scorecard provides some insight into service coverage and equity, this is not enough to gain a comprehensive insight into the extent of coverage within any AU Member State, and particularly not across the three dimensions of expanding service coverage, expanding population coverage and expanding financial risk protection.

- The indicators within the Scorecard that provide some insight into equity and service coverage are:

    - Scorecard indicator #9: Household out-of-pocket (OOP) spending, which measures the percentage that household OOP spending contributes to total (current) health expenditure, with a benchmark of keeping OOP spending below 20%. OOP is a considered a good proxy indicator of financial risk protection in that where OOP spending is above 20% populations are at risk of being pushed into poverty through health expenditure. [See footnotes 4 & 5].

    - Scorecard indicator #12: UHC Service Coverage Index, which measures the first dimension of coverage, namely Service Coverage. This measures "the % of the population that has access to essential health services" and is the same indicator used to measure SDG 3.8.1: "Coverage of essential health services".

    - Scorecard indicators #9 and #12 in combination: when read together, the two indicators provide an indication of whether a lack of financial risk protection is causing the population to choose to forego accessing health services. This provides another measure of financial risk protection.

- The Scorecard does not provide insight into country performance across the three dimensions of expanding service coverage, expanding population coverage and expanding financial risk protection. However, the Scorecard is a tool with a specific purpose – to provide Africa's Heads of State with country-level data to answer the question of whether countries are investing sufficient levels of their domestic budgets into health[1], which is a necessary condition for the continent to achieve its ambitious health objectives. The Scorecard is also limited to 15 indicators. This paper thus recommends that it would not be advisable to suggest expanding the Scorecard to adopt this additional focus (primarily because of the recommendations in the next section).

1 3.8.1: Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population).

2. The African Union's health financing Tracker (forthcoming)

NOTE: Findings and recommendations in this section are limited to consideration of the AU's preliminary draft Tracker, which remains under embargo and is subject to consideration by AU Member States during ongoing negotiations. It is also expected that the preliminary draft Tracker will be amended, refined and improved as it is field tested and piloted by countries.

- The AU's preliminary draft Tracker is a new tool that is intended to "complement the Scorecard and to track more granular 'enablers' of progress towards the desired Scorecard outcomes." (AU Assembly ALM Declaration, 2019) The process envisioned by the Tracker for supporting the 55 AU Member States in implementing the Tracker is geared to encouraging countries to adopt the 4 'Objectives' and 12 'Action Areas' of the Tracker as key domestic priorities.

- Equity / improved financial risk protection features among the 4 'Objectives' of the Tracker. The three 'Action Areas' within the Tracker's Equity objective cover two of the three dimensions of expanding service coverage, expanding population coverage and expanding financial risk protection:

  i. Expanding service coverage: YES, two preliminary indicators of service coverage are included under the 'action area' "Service Coverage". These seek to measure service coverage / utilisation in a specific service line – RMNCH – as a proxy for service coverage more generally.

Objective	Action Area	(preliminary) Indicators		Explanation
Equity	Equity in Service Utilisation /Coverage	12	Access to X service by wealth quintile (e.g. RMNCH).	This measures how wealth affects access to essential services and will provide an indication of the equity in distribution of healthcare benefits across the population.
		13	RMNCH Coverage Index	This is a proxy for access barriers to essential health services across the population.

  ii. Expanding population coverage: No.
  This is partly to avoid duplication with Scorecard indicator #12: "UHC Service Coverage Index", which measures the expansion of services to a greater proportion of the population.

  a. [It should be noted, however, the UHC SCI indicator itself provides only a broad measure of expanding population coverage and that it is not possible from this indicator to determine who services are being expanded to.]

  iii. Expanding financial risk protection: Yes, two preliminary indicators under the Action area "Financial protection", supplemented by a further two preliminary indicators under the Action area "Equity in Financing":

Objective	Action Area	(preliminary) Indicators		Explanation
Equity	Equity in Financing	14	Are Benefit Incidence Analyses (BIA) of public spending in health carried out routinely with good quality data?	This is intended as a prompt for countries to conduct a benefit incidence analysis, which remains the best way to measure equity of financing.
		15	Placeholder: Concentration Analysis of Resource Pools	This indicator will assess the level of fragmentation in the health financing system.
	Financial Protection	16	Medical Impoverishment (proportion of population pushed below poverty line ($1.90) by OOP spending).	This measures the proportion of population pushed below poverty line ($1.90) by OOP payments.
		17	Year 1: "What are the key drivers of OOPs". Thereafter, measure the change in these key drivers of OOPs.	This encourages countries to consider not only if/to what extent direct payments are relied upon as a health financing mechanism but provides a diagnostic to evaluate for what is driving them, --> thereby suggesting areas for policy intervention.

- c. The [embargoed] Tracker short-list of preliminary draft indicators provides detailed indicators of country performance across two of the three Equity dimensions of the UHC Service cube. Implementation of the Tracker will help to provide a comprehensive lens into how countries are: expanding service coverage, expanding population coverage, and expanding financial risk protection. If adopted and if implemented across all 55 AU Member States, The Tracker has the potential to provide long desired insights into equity and service coverage.

- This paper thus recommends that civil society support the AU in its efforts to refine and then pilot the preliminary draft Tracker and in developing the series of informative modules which are to accompany each of the Tracker objectives. Critical to this process will be the effort to collect data for the preliminary draft indicators and working to improve the quality of this data. Civil society efforts can lend support to governments on the continent to strengthen their data collection methods and the integrity of the data and provide encouragement to the development partners who support governments in these efforts.

Annexe 1: Commitments to improve and increase domestic investment in health made by the 55 AU Member States since 2001

The 55 AU Member States have made multiple commitments to increase domestic spending on health, including:

- Universal Declaration of Human Rights (Article 25.1)
  Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including medical care and necessary social services;
- Abuja Declaration (2001)
  Heads of State commit to spend at least 15 % of govt budget on Health.
- Abuja +12 Declaration (2013)
  Generate innovative financing solutions and make smart investments.
- Africa Health Strategy, 2007-2015
  Set per capita target required to provide the essential package of health services (US$34-40 in 2007).
- AU Roadmap on Shared Responsibility and Global Solidarity for HIV, TB and Malaria (2012)
  Roadmap for countries to diversify sources of finance, ensure access to affordable and

quality-assured medicines, and to enhance leadership and governance.

- Ouagadougou Declaration on Primary Health Care (PHC) and health systems strengthening (HSS) (2008)

  Achieve health related MDGs using the PHC approach for strengthening health systems.

World Health Assembly Resolutions:

WHA 58.33

- Various measures on sustainable health financing, universal coverage and social health insurance; including urging Member States:
- "to ensure that health-financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care;"

WHA 64.9 (2011)

- Various measures, among which include setting out equitable prepayment and pooling as the basic principles for achieving universal health coverage;

WHA 68.5 (2015)

- Establish National Public Health capacity and a reminder of countries rights and obligations under the International Health Regulations.
- Tunis Declaration of the Ministers of Health and Finance on value for money, sustainability and accountability in health sector (2012)
- Enhance value for money, increase accountability improve sustainability of health resources.
- Agenda 2063 development plan (2[1]013)
- Africa's 50-year development framework sets seven aspirations. The primacy of health to the continent's development can be seen in how the vision that Africa be home to "Healthy and well-nourished citizens" is part of the first of these seven aspirations.
- The Busan Partnership for Effective Development Cooperation (2012)

Signatories (including UN Agencies, the Global Fund, the World Bank and most bilateral development partners) committed to provide support to strengthening 'public financial management capacity' and to improve 'country systems' for tracking health expenditure

- 3rd International Conference on Financing for Development Ethiopia (2015)

The use of domestic resources are central to achieving the sustainable development goals (SDGs)

- Africa Health Strategy, 2016-2030 (2017).

"strengthen health systems performance, increase investments in health, improve equity and address social determinants of health to reduce priority disease burdens"

- AU Assembly Decision (27th Ordinary Assembly of the AU Heads of State and Govt, 2016)

Adopted the Africa Scorecard on Domestic Financing for Health and instructed that it be "submitted annually to the Assembly".

- "REQUESTS the Commission in collaboration with WHO and other partners to support countries in strengthening National Health Accounts"
- AU Assembly Decision (32nd Ordinary Assembly of the AU Heads of State and Govt, 2019)

adopted the recommendations of the Africa Leadership Meeting – Investing in Health (ALM), which include, among others, requesting the AU Commission to:

1. Develop of a health financing 'Progress Tracker'.
2. Establish health finding hubs in each of the 5 Regions of the AU
3. Organise a biennial meeting of AU Ministers of Finance and Health

1 Aspiration #1: "A prosperous Africa based on inclusive growth and sustainable development". The health targets under this goal cover: access to quality basic health care and services; maternal, neo-natal and child mortality rates; HIV/AIDS, malaria and TB; child stunting and malnutrition; Africa Centres for Disease Control; African Medicines Regulatory Harmonisation and Domestic Financing for Health.

Annexe 2: Literature Review – extended version

This review includes studies that focus on all population groups including vulnerable groups like people living with disability, the elderly or children in both rural and urban settings. Studies with the foremost purpose of assessing catastrophic health expenditure and household impoverishment due to out-of-pocket (OOP) payments in health care were included.

The search strategy included different types of academic articles, and virtual libraries such as World Health Organisation (WHO) and the World Bank.

Making fair choices on the path to universal health coverage. Final report of the World Health Organisation Consultative Group on Equity and UHC [1]

UHC was firmly endorsed by the WHO Assembly in 2005 and further supported in World Health Report 2010. To support the advancement of the UHC agenda, the WHO developed a guide and action plan on how to move forward. They also established the Consultative Group on Equity and UHC, to address the key issues of fairness and equity that arise on the path to UHC by clarifying these issues and offering recommendations for how countries can manage them.

To achieve UHC, countries need to expand coverage in at least three dimensions: expand priority services, include more people until universal coverage is achieved, and reduce out-of-pocket payments. In each of these dimensions, countries are faced with a critical decision: which services to expand first, whom to include first, and how to shift from OOP payment toward prepayment?

A commitment to fairness—and the overlapping concern for equity—and a commitment to respecting individuals' rights to healthcare must guide countries in making these decisions. When pursuing UHC, the process should be accompanied by robust public accountability and participation mechanisms which should be institutionalised, for instance, through a standing national committee on priority setting, and design of legitimate action plan. Finally, a strong monitoring and evaluation system should be put in place to ensure the accountability mechanisms are working as intended.

Therefore, the WHO recommends a pursuing UHC by progressively expanding coverage in three dimensions:

1. Expanding priority services
2. Including more people
3. Reducing out-of-pocket payments

Fair progressive realisation of UHC requires difficult political and policy choices. Accountability mechanisms and public participatory processes can enable the enforcement of reasonable decisions, including priority setting mechanisms and efforts to demonstrate how trade-offs between the dimensions of progress were adjudicated. To properly play these roles, public accountability and participation should be institutionalised, and the design of legitimate institutions can be informed by the Accountability for Reasonableness framework.

Understanding variations in catastrophic health expenditure, its underlying determinants and impoverishment in Sub-Saharan African countries: A scoping review by Purity Njagi, Jelena Arsenijevic and Wim Groot[2]

1 Making fair choices on the path to universal health coverage. Final report of the WHO Consultative Group on Equity and Universal Health Coverage. I. World Health Organization. 2014.

2 Njagi et al. Understanding variations in catastrophic health expenditure, its underlying determinants and impoverishment in Sub- Saharan African countries: a scoping review (2018) 7:136 https://doi.org/10.1186/s13643-018-0799-1

This scoping review assesses the two (mutually exclusive) approaches that have been used to assess the financial burden due to out-of-pocket (OOP) payments: catastrophic health expenditure (CHE) and impoverishment.

Many countries rely on out-of-pocket payments (OOP) to finance government provision of health services; however, OOP payments present a barrier to access to health services, particularly for the most vulnerable. Such barriers can result in people foregoing the treatment they need, increasing morbidity and mortality. In addition, for those who do access health services, OOP payments are often a substantial financial burden on them and their families and can lead to financial hardship or even financial catastrophe and impoverishment.

This study emphasises that because many countries in Sub-Saharan Africa (SSA) rely primarily on OOP to finance health service provision, they leave their populations vulnerable to the risk of financial impoverishment. As the WHO has emphasised, when people suffer financial hardship due to OOP, it is impossible to get to universal health coverage.

To understand the variations in CHE and impoverishment in SSA, a review of thirty-four (34) studies was conducted, and it showed that CHE was higher in West African countries and amongst patients receiving treatment for HIV & AIDS, TB, malaria and chronic illnesses. The proportion of households facing catastrophic health care payments varies widely between countries. Risk factors associated with CHE included household economic status, type of health provider, socio-demographic characteristics of household members, type of illness, social insurance schemes, geographic location and household composition. This 2018 scoping study concludes that the proportion of households that are impoverished has increased over time across countries and also within the countries. Nonetheless, the study also revealed that non-medical related cost like transportation costs which are invariably greater for the poor living far from the health facilities, food related costs, non-routine tests, and inadequate care (due to shortages of drugs and medical services) in public primary health care facilities largely influence CHE, which is consistent with other studies, revealing that non-medical expenditures are much higher than medical expenses.

The study notes that the incidence of CHE is reported to be higher in low-income countries that rely on OOP payments, and lower in countries that have some prepayment mechanisms, whether low-income or not. It also highlights that patients with HIV & AIDS, TB and malaria experience the highest incidence of catastrophic expenditure. Furthermore, it shows that CHE/impoverishment is pervasive in SSA, and the scale varies across and within countries and over time. Socio-economic factors are seen to drive CHE with the poor being the most affected, and they vary across countries. This presents an opportunity for intensifying health policies and financing structures in SSA to deliver equitable access to all populations, especially the poor and most vulnerable. There is a need to innovate and draw lessons from the 'informal' social networks/schemes as they are reported to be more effective in mitigating the financial burden on poor households.

The burden of OOP payments has encouraged SSA countries to use different financial coverage mechanisms to prevent catastrophic health payments, such as the introduction of health insurance systems with universal population coverage or the removal of user fees. Contrary to the notion that health payments have a higher impact in countries where poverty is high, the study observes variations in the level of impoverishment in relation to the poverty head count before health payments. The proportion of households impoverished increased over time across the various countries, with the increasing population in Africa where the majority live below the poverty line; more people could be pushed into poverty if the right financial risk protection measures are not put in place.

The study concludes that overall, the catastrophic health expenditure (CHE) and health-related

impoverishment are pervasive across all Sub-Saharan African countries, and the magnitude varies across and within countries and over time.

WHO & World Bank: Global Monitoring Report on Financial Protection in Health (2019)[3]

Sustainable Development Goal 3.8 (SDG 3.8) is "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

A key objective of UHC is achieving financial risk protection in health. Financial risk protection has thus been adopted as SDG 3.8.2: "Proportion of population with large household expenditures on health as a share of total household expenditure or income".

Over the past two decades, the WHO and the World Bank have been tracking financial protection in health using household survey data to compare how much people spend out-of-pocket on health care, in relation to their households' ability to pay. This report establishes global and regional 2015 baselines for SDG indicator 3.8.2 and identifies the challenges to come in protecting people from the financial consequences of paying OOP for the health services they need.

Previous analysis revealed that these indicators are correlated with GDP per capita, suggesting that as countries become richer, people may face greater financial hardship due to increased exposure to out-of-pocket payments. Impoverishment due to OOP health spending affected all regions, but the global 2015 values were led jointly by Asia and the African Region, accounting together for 98% of the global population impoverished by OOP health spending at the $1.90 a day poverty line, 95% at the $3.20 a day poverty line and 85% at the relative poverty line of 60% of median daily per capita consumption or income. Globally, between 2000 and 2015 OOP health spending continuously increased poverty, as varying paces depending on the poverty line.

In the global monitoring framework presented by this report to measure financial hardship, out-of-pocket expenditures can be catastrophic, impoverishing, both or none. In summary, between 2000 and 2015, there were mixed improvements at global and regional levels and across income groups in protecting people from incurring financial hardship when spending out of pocket on health at different paces, with progress uneven across regions. Over the same period, a growing number of people and a growing percentage of the population incurred catastrophic health spending as tracked by SDG indicator 3.8.2 and became impoverished as measured by a relative poverty line, due to out-of-pocket health spending[4].

The only way to improve financial risk protection is to reduce households' out-of- pocket health spending. The policy challenge that remains is to secure additional resources for health care through compulsory progressive pooled prepayment mechanisms rather than through OOP spending.

WHO Global Monitoring Report: Primary Health Care on the Road to Universal Health Coverage 2019[5]

This WHO Global Monitoring Report was produced to coincide with the High-Level Meeting on Universal Health Coverage at the United Nations General Assembly in 2019 to assess the progress in expanding access to essential health services. It shows that all regions and all income groups

3 Global monitoring report on financial protection in health 2019. Geneva: World Health Organisation and International Bank for Reconstruction and Development / The World Bank; 2020. Licence: CC BY-NC-SA 3.0 IGO.

4 Globally in 2015, OOP health spending increased the number of people and percentage of the population in poverty, though the level of increase varies depending on the poverty line: 89.7 million people (1.2% of the world population) were impoverished by OOP health spending at the $1.90 a day poverty line, 98.8 million people (1.4%) at the $3.20 a day poverty line and 183.2 million people (2.5%) at the relative poverty line of 60% of median daily per capita consumption or income in their country.

5 Primary Health Care on the Road to Universal Health Coverage 2019 Global Monitoring Report World Health Organisation. https://www.who.int/healthinfo/universal_health_coverage/report/2019/en/

have made improvements, with lower income countries making the greatest gains. However, poorer countries are still struggling, and the overall pace of progress is slowing. Progress requires considerable strengthening of health systems to provide UHC, particularly in lower income countries. Such improvements should also address non-communicable disease services. If current trends continue to 2030, it is estimated that 39% to 63% of the global population will be covered by essential health services.

The report points out three main areas that nations should aim for: accelerate progress in areas where we have seen improvements, remove the barriers that are slowing down access to health services in some countries and among certain populations, and finally, reverse the trend of increasing financial hardship on people when accessing essential health care. It reveals that more people are incurring significant financial hardship to afford essential health care services and that the gains in service coverage have come as a major cost to individuals and their families. As we saw in the previous report, the incidence of catastrophic health expenditure (SDG indicator 3.8.2), defined as large OOP spending in relation to household consumption or income, increased continuously between 2000 and 2015.

Furthermore, the report focuses on gender issues, particularly identifying how gender norms and power influence access to health services. The path to successfully achieving UHC starts with a solid commitment to focus on the most disadvantaged, beginning with women and girls.

The report emphasises the need to invest first and foremost in strong primary health care, mainly on health promotion and disease prevention. Secondary and tertiary services are important parts of every health system, however, no country can afford to rely on curative care. By promoting health and preventing disease, countries can prevent or delay the need for more expensive services. That increases the efficiency of health spending, saves lives and increases healthy life expectancy.

The report concludes with a clear statement for governments around the world to invest an additional 1% of their gross domestic product (GDP) in primary health care, which can be achieved through additional investments or through gains in efficiency and/or effectiveness. Resources for health should be efficiently administer, shared, and prepaid to take us closer to guarantee the right of health to everyone.

Global studies have shown that greater reliance on public spending on health (defined as the share of total health spending channelled through social security funds and other government agencies) inclines to be negatively correlated with the incidence of catastrophic and impoverishing health spending. It has found no significant association between the indicators of financial risk protection and the share of total health spending channelled through private voluntary insurance.

The goal of universal health coverage is ambitious. It is also achievable. UHC is first and foremost a political choice. That's why strong political commitment from world leaders is essential for overcoming barriers and making progress on the road to a healthier, safer and fairer world. The policy challenge remaining is to ensure that any additional resources for health care are channelled through compulsory pooled prepayment mechanisms rather than through out-of- pocket spending.

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