

**The
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Unit

A report from the Economist Intelligence Unit.

THE FUTURE OF HEALTHCARE IN AFRICA:

PROGRESS, CHALLENGES
AND OPPORTUNITIES



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1

Progress on five healthcare scenarios for Africa

Introduction

When The Economist Intelligence Unit published *The future of healthcare in Africa* (see www.economistinsights.com/analysis/future-healthcare-africa) in 2012¹, the continent's health systems were confronting a diffuse set of challenges: the familiar threat from communicable and tropical diseases; increasing pressures on health budgets caused by the increase in chronic medical conditions; and growing violence and other problems associated with persistent poverty.

The lethal Ebola epidemic currently spreading through West Africa has been a reminder of the continued vulnerability of African populations to infectious disease. Yet there are signs that increasing education and investment is lessening the burden of communicable diseases in many countries. Africa has made progress in a number of important health-related areas. For example, maternal mortality has declined significantly, although it remains far short of the 2015 target (see chart).²

This chapter will look at progress on the five future scenarios for healthcare in Africa that

¹ *The future of healthcare in Africa*, a report from the Economist Intelligence Unit sponsored by Janssen, www.economistinsights.com/analysis/future-healthcare-africa, 2012.

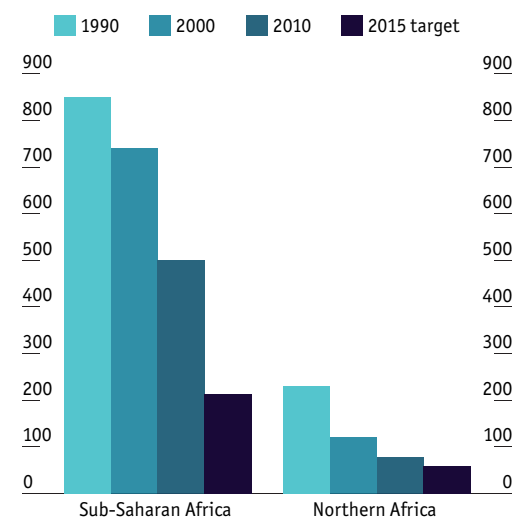
² *The Millennium Development Goals Report*, UN, New York, 2013, p. 28.

³ *Global Burden of Disease 2013*, Institute for Health Metrics and Evaluation, www.healthdata.org/gbd [accessed on September 16th 2014].

Chart 1

Maternal mortality ratio

(maternal deaths per 100,000 live births, women aged 15-49)



Source: United Nations, *The Millennium Development Goals Report*, 2013.

we explored previously: an increasing focus on primary and preventive care; empowerment of communities as healthcare providers; the extension of universal healthcare; the spread of telemedicine; and a reduction in the role of international donors.

1. Preventive care improves, but rural-urban divide persists

The first future scenario from our 2012 report envisioned a refocusing of African health systems on primary and preventive care, and this development is clearly underway.

Rates of chronic conditions, such as hypertension and diabetes, continue to increase, and data from

the 2013 Global Burden of Disease survey from the Institute for Health Metrics and Evaluation suggest that they will increasingly take precedence as medical priorities.³

In fast-growing countries with large urban populations, such as Kenya, demand for primary

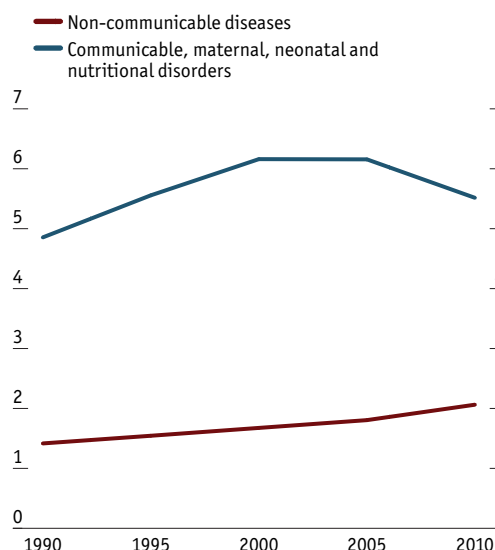
care and outpatient services is rising. Viva Afya, a chain of outpatient private health clinics targeted at lower- and middle-income clients, has expanded from five clinics to 12 in the past two years and is exploring regional growth in Uganda and Ethiopia, according to its chief executive officer, Liza Kimbo. Focusing on the way that care is delivered can have clear benefits. In South Africa, better implementation of primary care (including improved primary-care HIV intervention following the launch of a national antiretroviral treatment programme in 2004) is credited for an increase in life expectancy from a low of 54 years in 2005 to 60 years in 2011.⁴

Yet, in most parts of sub-Saharan Africa, variation between urban and rural areas has made progress uneven. Rural areas are hampered by long distances from services, poor road infrastructure and low population density, making it more difficult to attract healthcare workers and specialists and undermining the economic viability of services.⁵ Eliminating these inequalities remains a key step towards better care provision. As the Ebola epidemic has underscored, increasing investment in public health infrastructure is a crucial part of eliminating gaps in health coverage and creating a broader system able to identify health targets and collect and monitor data, rather than merely reacting to health crises as they arrive. While there are few overarching programmes, a number of organisations are active in this area, including the African Healthcare Development Trust, which sponsors projects primarily in northern Nigeria designed to improve healthcare delivery and training, and the African Development Bank, which is investing in public health infrastructure projects across the continent. The World Health Organisation's African regional office has also worked closely on health policy development, using the

Chart 2

Communicable vs non-communicable diseases in Sub-Saharan Africa

(deaths, in m)



Source: Institute of Health Metrics and Evaluation, *Global Burden of Disease 2013*.

2008 "Ouagadougou Declaration on Primary Health Care and Health Systems in Africa" as the framework for a range of projects; targets included support for Benin and Swaziland in developing their health strategic plans and help for ten other African countries looking to strengthen district health system capabilities in the areas of planning, management, supervision, and monitoring and evaluation.⁶

There is also a pressing need for national governments to form their own targets and strategies for promoting health, alongside international targets for healthy life expectancy. The health strategy of the New Partnership for Africa's Development (NEPAD)⁷ and Jembi Health Systems, a non-profit organisation focusing on the development of e-health and health information systems⁸, are two Pan-African initiatives in this area.

⁴ Mayosi B.M., Lawn J.E., van Niekerk A., Bradshaw D., Abdool Karim S.S., Coovadia H.M.; Lancet South Africa team, "Health in South Africa: changes and challenges since 2009," *The Lancet*, Vol. 380, No. 9858 (December 8th 2012), pp. 2029-2043.

⁵ Visagie, S. and Schneider, M., "Implementation of the principles of primary health care in a rural area of South Africa," *African Journal of Primary Health Care & Family Medicine*, Vol. 6, No. 1 (2014).

⁶ World Health Organisation, Health Policy Development, www.afro.who.int/en/clusters-a-programmes/hss/health-policy-a-service-delivery/programme-components/health-policy-development.html [accessed on September 16th 2014].

⁷ New Partnership for Africa's Development (NEPAD), NEPAD Health Strategy, www.sarpn.org/documents/d0000612/NEPAD_Health_Strategy.pdf [accessed on September 16th 2014].

⁸ Jembi Health Systems, "About", www.jembi.org/about/ [accessed on September 16th 2014].

2. Business input and community empowerment

Our 2012 report envisioned an Africa where new tiers of community healthcare workers would fill the gap created by a global market for highly skilled medical staff. While this is happening in some countries, especially in remote areas with sparse populations, private-sector and public/private partnerships are also helping to deliver health services and work more closely with communities.

Kenya's creation of county-level government structures with budget-setting powers over the past few years has provided new opportunities for the private sector better to target healthcare investment, allowing investors to be "closer to the decision making," Ms Kimbo observes.

Private or donor-financed healthcare providers are finding new approaches to bridging workforce

vacancies, in some cases using physicians' assistants, who have similar training to doctors and are able to provide routine care and some basic surgery, but lack a medical degree. This process is accelerating as some governments raise salaries for doctors at public hospitals in order better to compete with both private-sector health providers and overseas employers.

Japan's government is helping to train and retrain 100,000 health workers for Africa; nonetheless, staff shortages remain a chronic problem. Around half of Egypt's annual output of newly trained doctors leaves the country in search of higher salaries, and Sierra Leone has been forced to send many of its professionals abroad for training, while importing doctors and nurses from Cuba and Nigeria to meet demand.⁹

⁹ Report on the ministerial level roundtable on Universal Health Coverage, WHO/World Bank Ministerial-level Meeting on Universal Health Coverage February 18th-19th 2013, Geneva, Switzerland.

¹⁰ Lagomarsino, G., Garabant, A., Adyas, A., Muga, R., Otoo, N., "Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia," *The Lancet*, Vol. 380, No. 9845 (September 8th 2012), pp. 933-943.

¹¹ "South Africa: Health care overhaul," *Oxford Business Group*, May 29th 2013.

¹² Doherty, J., "Getting South Africa ready for NHI: critical next steps," presentation to Economic Research Southern Africa (ERSA) Symposium: critical choices regarding universal health coverage, February 6th 2014.

3. Universal health coverage advances

Another scenario in our 2012 report predicted that most African governments would be closer to extending health coverage to all of their populations by 2022, and this remains a priority for policymakers.

An article in *The Lancet* identified five African countries—Ghana, Rwanda, Nigeria, Mali and Kenya—that have made the most progress towards developing universal healthcare.¹⁰ Over 90% of Rwandans are now enrolled in health insurance programmes, as are around half of Ghanaians and 20% of Kenyans, but just 3% of those in Mali and Nigeria, which are at an earlier stage of reform. South Africa, frequently touted as a potential leader in this area, has made slower progress; its National Health Insurance programme is still in the pilot phase,¹¹ and there are questions about future financing.¹²

Governments are looking at different ways of financing reforms, including ring-fencing a portion of state budgets, raising extra money

through value-added taxes (VAT) and setting up prepayment systems. Some countries have started by building up partial coverage, often including public insurance for civil servants and private insurance for the wealthiest and those working for companies able to provide cover. In Kenya, meanwhile, larger insurance companies are showing increasing interest in developing micro-products for the middle classes. Ms Kimbo notes that these developments have led to an increase in the percentage of Viva Afya clients with some form of health coverage to 30% from just 5% in 2011.

Policymakers continue to debate how best to cover the poor or those who work in the informal sector and are least able to afford adequate coverage without government subsidies. Ghana has helped to boost healthcare funds by imposing an additional VAT rate of 2.5%, known as the National Health Insurance Levy, on selected goods and services, with the additional revenue

going to its national health insurance scheme.¹³ However, universal coverage, the World Health Organisation (WHO) and World Bank ministers

observed, will be ineffective if the care provided is of such poor quality that it discourages people from seeking it.¹⁴

Table 1: Health insurance coverage

| Country | Coverage targeted | Population enrolled (% of total) | Scope of services | Out-of-pocket expenditure (% of total health expenditure, 2010) |
|---------|--|----------------------------------|-----------------------------------|---|
| Ghana | Entire population | 54 | Comprehensive | 27 |
| Rwanda | Entire population | 92 | Comprehensive | 22 |
| Kenya | Formal sector, expanding to informal sector | 20 | Inpatient (with pilot outpatient) | 43 |
| Mali | Entire population | 3 | Comprehensive | 53 |
| Nigeria | Civil servants, expanding to informal sector | 3 | Comprehensive | 59 |

Source: Lagomarsino et al, The Lancet, September 8th 2012.

4. New applications for technology

Our 2012 report imagined an Africa in which telemedicine is ubiquitous. This vision has yet to be fully realised, partly due to patchy information and communications technology (ICT) infrastructure across the continent. Countries such as Ethiopia and South Africa have nevertheless made significant progress, and the Pan-African e-network, the continent's biggest project for distance education and telemedicine, covers 12 African countries.¹⁵

While many patients still prefer to deal with clinicians face to face and direct consultation may still be required depending on the disease, telemedicine can play an important role in

helping specialists to support local providers, especially in large cities such as Nairobi, where it can take two hours for a specialist to travel from their hospital to a clinic on the city outskirts.

More broadly, technology is helping to make healthcare more efficient and accessible. In a continent where most people own a mobile phone, providers such as Kenya's Safari.com and Nigeria's MTN are experimenting with micro-insurance products using mobile payments. Mobile operators are also offering other sorts of mobile airtime credits that patients who are ineligible for traditional credit cards can use to pay for healthcare.

5. International donors look for value

The final scenario of our 2012 report suggested a future with scarcer donor funding. International donors still play a crucial role in helping to support cash-strapped governments, but they are increasingly looking to deploy aid where it will have the greatest impact, particularly universal

health coverage. At a 2013 WHO/World Bank meeting, representatives from the Rockefeller Foundation, Save the Children and national government aid departments focused on the ways in which health systems are financed.

¹³ "Doubtful clouds hung over Ghana Infrastructure Fund," February 24th 2014, www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php?ID=301664 [accessed on September 16th 2014]. See also Bagbin, A. S. K., "Earmarked Value Added Tax (VAT): The Experience of Ghana," presentation to "Value for Money, Sustainability and Accountability in the Health Sector: A Conference of African Ministers of Finance and Health," July 4th-5th 2012, www.hha-online.org/hso/system/files/3earmarked_vatghana.pdf [accessed on September 16th 2014].

¹⁴ Report on the ministerial level roundtable on Universal Health Coverage.

¹⁵ Wamala, D. S., and Augustine, K., "A meta-analysis of telemedicine success in Africa," *Journal of Pathological Informatics*, Vol. 4, No. 6 (May 30th 2013).

¹⁶ The World Bank, "Three Nigerian States Inject New Life into Healthcare for Mothers and Children," April 13th 2012, www.worldbank.org/en/news/feature/2012/04/13/three-nigerian-states-inject-new-life-into-healthcare-for-mothers-and-children.print [accessed on September 16th 2014].

¹⁷ The African Development Bank Group, Health in Africa Fund, www.afdb.org/en/topics-and-sectors/initiatives-partnerships/health-in-africa-fund/ [accessed on September 16th 2014].

¹⁸ AVERT, Funding for HIV and AIDS, www.avert.org/funding-hiv-and-aids.htm [accessed on September 16th 2014].

¹⁹ "Press Release: African Health and Finance Ministers pledge to increase domestic spending on health," November 13th 2013, www.safaids.net/content/press-release-african-health-and-finance-ministers-pledge-increase-domestic-spending-health [accessed on September 16th 2014].

²⁰ The Global Fund to Fight AIDS, Tuberculosis and Malaria, Fourth Replenishment, www.theglobalfund.org/en/replenishment/fourth/ [accessed on September 16th 2014].

To this effect, the World Bank is sponsoring a number of reform projects under its "Results-Based Financing" initiative, which promotes greater autonomy, better management training and financial incentives directed at primary care centres that carry out pre-agreed services, such as safe delivery of babies and child immunisation. The initiative also applies to state and local government bodies that provide health centres and district hospitals with similar support. In Rwanda, initial evaluations of the initiative's performance-based incentives have found that they contributed to "rapid nationwide health gains."¹⁶ Similarly, the Health In Africa Fund, which the African Development Bank launched with other donors in 2009, is measured not just by its financial results but also by its ability to help develop businesses serving the poor.¹⁷

At the same time, African countries are increasingly tapping into their own funding to tackle some of the most intractable diseases,

such as HIV/AIDS, tuberculosis and malaria. A UK-based international AIDS charity, AVERT, notes that in 2012, domestic African sources already accounted for 53% of global HIV funding. Countries such as Kenya, Togo and Zambia dramatically increased their domestic spending on HIV/AIDS during the same period, the organisation noted, while South Africa was covering most of its HIV/AIDS programme with US\$1bn in annual investment.¹⁸ In November 2013, African health ministers pledged to increase domestic spending on health at a meeting sponsored by the African Development Bank and the Global Fund to Fight AIDS, tuberculosis (TB) and Malaria, in which the Global estimated that domestic financing could cover US\$37bn of the US\$87bn required to combat the three diseases in low- and middle-income countries between 2014 and 2016.¹⁹ In December 2013, the Global Fund announced a successful fourth replenishment of funding commitments.²⁰

Conclusion

While recent epidemics demonstrate that the continent's traditional health threats are not yet in abeyance, an increasing number of African countries are already moving to address the new maladies that come with greater wealth.

The future for African health systems is likely to be defined increasingly by public and private investment that is linked to the improvement of healthcare quality. To this end, government budgets are likely to emphasise the development of both high-performing primary care systems

and the realisation of universal health coverage, which is set to become a key priority for the post-2015 development agenda. By contrast, the widespread penetration of telemedicine looks further off.

On the whole, there are encouraging signs that all stakeholders are taking a broader view of Africa's healthcare challenges and focusing on how to work more closely together to get better value from their healthcare investments. ■

2

Views from five healthcare professionals and leaders in Africa

1. Dr Ernest Darkoh, co-founder, BroadReach Healthcare

Rethinking Africa's healthcare paradigm: shifting the focus from curative action to preventive care

Although the African health establishment has tried to do the right thing by focusing on curative care, prevention has become an afterthought. Africa's healthcare paradigm must be changed, argues Dr Ernest Darkoh, co-founder of BroadReach Healthcare, an African-based health analytics and technical services firm.

In many ways, African health systems are groaning under devastating disease burdens for the very reason that we, the African health establishment, are fulfilling our tacit statement of intent: curing disease.

People fill hospital beds; they receive drugs; we cure disease.

As resource-constrained as they are, many African countries might learn from the practice of setting positive intentions. If the intention is to "cure disease", then you will find yourself with plenty of disease to cure. Country after country in Africa has backed itself into this corner, and has then needed to plead for resources as its hospitals reach capacity.

The World Health Organisation (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".²¹ However, the overwhelming majority of effort (and funding, accordingly), still focuses on fighting infirmity and disease. Worse yet, the social determinants

of health rarely lie within the ambit of the ministries of health, but are scattered across the mandates of multiple ministries, including those for education, housing, social services, police, water and labour. As such, we have barely begun to define what well-being means in a systematic sense, much less develop effective models to deliver it.

Although the African health establishment has tried to do the right thing by focusing on curative care, prevention has become an afterthought. Treating cancer, diabetes, injuries or other conditions is not wrong, but the paradigm that allows them to spiral out of control is. It is reactive, requiring ever-increasing numbers of hospitals, doctors and medicines, in a system that is bound to implode. This flawed paradigm has led to a results framework where "success" is measured by the increase in hospitals or doctors, which is actually a proxy admission of failed healthcare.

Excluding immunisation programmes, most African countries do not have coherent, integrated or effective prevention agendas. Most countries hope that nothing goes wrong to test their already overburdened curative systems. However, when it does, as seen with Ebola and HIV, it reveals the precarious deficits of this model.

Changing the paradigm

So what should be done differently? The paradigm must be changed to reflect what

²¹ World Health Organisation, WHO definition of Health, www.who.int/about/definition/en/print.html [accessed on October 23rd 2014].

is actually wanted, which is healthy people. Concerted thought is required to define well-being, develop a new set of success metrics, create scalable models to deliver it, adapt working modalities to implement it and, most importantly, incentivise and reward prevention.

I call it a “life-cycle well-being-based model”, where for each distinct year of one’s life, the leading risk factors are defined and best-practice preventive interventions are delivered proactively. We must also improve our results frameworks, which are currently limited in their ability to count what “did not happen”. We must redefine the group of entities that own pieces of

the health/well-being pie. Do any ministries of education, housing, labour or police internally define their mandate as “keeping people well”? Currently, most ministries of health are so siloed that internal departments and programmes barely communicate, let alone co-ordinate with other stakeholders on a defined well-being agenda to which they are collectively held accountable.

It will take many decades to turn the corner, but if nothing is done today, the ever-growing inadequacies will persist. It is time to reposition around a new intention, reward prevention and redirect the future towards well-being.

2. Liza Kimbo, chief executive officer, Viva Afya

Healthcare in the community: how business and policymakers can empower communities as healthcare providers in Africa

Business and policymakers have an increasingly important role to play in improving healthcare provision in Africa, by helping to educate and empower local communities to identify their own healthcare needs, says Liza Kimbo, chief executive officer of the Viva Afya chain of healthcare clinics in Kenya. The Economist Intelligence Unit spoke with Ms Kimbo about the ways of achieving this aim.

Where are businesses and other external groups playing the biggest role in community healthcare provision in Kenya, and how should this role evolve?

Liza Kimbo (LK): Non-governmental organisations (NGOs) are often involved in primary care and many are focused on hygiene, food security and the provision of clean water, all of which have a very significant impact on public-health outcomes.

Larger businesses, especially those operating at a national level, such as sugar- and tea-packing companies, are usually more involved in healthcare, possibly because these industries

are labour intensive. Many have set up in-house clinics to address primary-healthcare needs and are involved with social outreach and other initiatives. A few flower-farming companies in Naivasha, Kenya, have come together to set up a women’s hospital.

Every employer can and should engage in improving healthcare for their workforce and families. It is a worthwhile investment that improves the bottom line through better attendance and productivity. There is also a need to extend healthcare to the wider community by establishing clinics and hospitals or by supporting existing public-health infrastructure, as the government cannot address these needs on its own. Businesses should also extend their existing health education efforts to address the growth of chronic diseases such as hypertension and diabetes, for example by showing people how to improve their diets, monitor their blood sugar and measure blood pressure.

How can outside decision makers help to empower communities?

LK: Our biggest problem is education and the low levels of basic knowledge about healthcare, as exemplified by the Ebola crisis. A lack of education and awareness and the reluctance to

seek help for health problems kills more people than anything else.

Part of this is ignorance: people may have very limited variety in their diets; they may not necessarily seek medical attention at the first sign of symptoms; or they might not consider that the conditions they have are treatable. Another influencing factor is cultural beliefs, which leads people to consult traditional healers or misread symptoms. As a result, people delay getting their health needs attended to, and preventable conditions become expensive to treat.

Health educators can help us make better use of the limited health resources available. Businesses and NGOs can play a big part in showing people what they can do to protect their health in the long term by taking a few preventive measures, such as monitoring their blood-pressure and sugar levels. When one NGO spent a weekend in a rural area of Kenya screening for prostate cancer hundreds came out to be checked.

There is also a need to help communities form their own localised health insurance schemes, whereby they pool their resources into a community fund, much like employers do for their employees.

How crucial is local autonomy in healthcare decisions?

LK: The more locally managed the healthcare, the more in tune it will be with the needs of the community. In Kenya, we are now seeing the benefits of devolution, with increased policymaking at county level. Meru County is focusing on technology for improving malaria diagnosis; by training staff to use readers for rapid diagnostic tests, the county has sharply reduced prescriptions for malaria medication and improved fever management.

Kiambu County has tried to fulfill both training- and data-collection needs by training community health workers and equipping them with basic reporting tools on mobile phones.

Strengthening local health-management structures and bringing them closer to the community allows for better management of the workforce and of the limited resources available, based on actual community needs. Improved management of community health data could be used by counties to employ relevant specialists according to disease burden.

3. Dr Margaret Mungherera, immediate past president, World Medical Association

Building Africa's healthcare leadership capacity: tackling the root causes of weak healthcare systems

The main reason for Africa's weak healthcare systems is neither a shortage of policies, nor road maps, nor even funding. Lack of leadership capacity, reflected in corruption and flawed policy implementation, must be addressed, argues Dr Margaret Mungherera, immediate past president of the World Medical Association.

Since 1990 the Millennium Development Goals (MDGs) have galvanised the world into action.

There is substantial evidence showing remarkable improvement in the health of populations, with many countries experiencing a dramatic increase in life expectancy. However, the positive developments are not equally distributed throughout the world. Only a handful of African countries have achieved one of the three health-related MDGs,²² concerning the reduction of child mortality, improving maternal health, and combating HIV/AIDS, malaria and other diseases. The majority of African countries can probably only expect to meet any of the MDGs after 2050—at least 35 years after the target year of 2015.

²² World Health Organisation, Millennium Development Goals (MDGs), www.who.int/topics/millennium_development_goals/en/ [accessed on October 23rd 2014].

Moreover, the African continent continues to suffer from a disease burden that is disproportionate to its population. For instance, despite having just 11% of the global population, Africa has 45% of the world's women dying from childbirth-related complications and 62% of the world's HIV/AIDS patients. This huge disease burden can largely be attributed to weak health systems.

African governments have responded to this challenge by ratifying several international and regional declarations, with a number of countries further incorporating national policies and Health Sector Strategic Plans (HSSPs) into national development plans. Subsequently, significant funds from domestic and foreign sources have been pumped into African healthcare sectors for the purpose of implementing these policies. Unfortunately, it is estimated that 20-40% of these funds are wasted, largely because of endemic corruption and flawed implementation that is not in line with policy.

The importance of capacity building

Africa's health systems have a plethora of stakeholders in the public, private and civil-society sectors, each with specific leadership roles to play. Unfortunately, they have failed to fulfil these, largely because they lack the capability. Developing leadership capacity should therefore be the main emphasis of any effort aiming to reduce Africa's disease burden. It is for this reason that the World Medical Association has embarked on an initiative designed to strengthen the leadership role of African national medical associations in order to enable them to play a more effective part in strengthening the health systems of their countries.

The recent outbreak of Ebola has once again highlighted that it is the weakness of African health systems that is the biggest threat to global health. We must hope that it will not take a greater crisis, or many more deaths—African or other—before the world understands that the key solution to strengthening these systems lies in effective leadership from within Africa rather than from outside the continent.

4. Onno Schellekens, managing director, PharmAccess Group

The potential of mobile healthcare in Africa: mobile phones can succeed where governments have failed

The mobile phone is rapidly transforming Africa's economic and social fabric. Mobile phones can revolutionise the delivery of healthcare in Africa, says Onno Schellekens, managing director of the PharmAccess Group.

With a simple click of a button or a phone call, many Africans can transfer money to support their relatives, traders can compare the most current prices for their goods and people in remote villages can seek medical advice from a doctor through a call centre. The mobile phone is rapidly changing the economic and social fabric of Africa in ways that are difficult to imagine if you grew up in a developed country where everything seems to work.

However, living in Nairobi (the capital and largest city in Kenya) I have also witnessed how inequality is on the increase and how many people are still falling into desperate poverty. Take Grace, a 27-year-old mother of five, who worked as a street cleaner in a leafy area of Nairobi. Following the death of her husband Grace moved to Nairobi with her baby, leaving her other children behind, in order to work and live with her sister. Grace was seriously ill, but did not seek medical help until she collapsed in the street. She was sent home from hospital with only a follow-up appointment in three months' time, when in fact both she and her baby needed closer monitoring and counselling. As a consequence, she was ill several times and, when her contract was not renewed, she subsequently lost her job and eventually her home when her sister threw her out.

Breaking the vicious circle

No home, no work, no money, poor health; it is a vicious circle. People like Grace need help, but African support systems are weak. It is my dream that high-quality healthcare will become accessible to all, and I believe that mobile phones can revolutionise the delivery of healthcare in Africa. Like most Kenyans, both rich and poor, Grace has a mobile phone and uses mobile money. The mobile phone offers unprecedented opportunities to improve access to healthcare for the poor by connecting individual citizens, health providers, as well as donors and local governments who give out health entitlements such as vouchers to vaccinate children, to receive family-planning support or for bed nets to

help protect against malaria. Family members, at home or abroad, can pay into a “health wallet” on people’s mobile phones where their contributions are exclusively reserved to pay for healthcare costs.

By receiving such benefits directly on a mobile phone, people are empowered to take care of their own health. They can use these entitlements to access quality healthcare, while at the same time clinics are paid without delay and transaction costs are radically reduced. It is my hope that in the near future Grace will have a health wallet on her mobile phone, which would give her the certainty that she can afford to seek medical care, at facilities of her own choosing.

5. Professor Sheila D. Tlou, director, UNAIDS Regional Support Team for Eastern and Southern Africa

Self-sufficiency of African healthcare systems: the role of international donors as a source of funding for African healthcare

African countries are increasingly tapping into their own funding to tackle some of the most intractable diseases, such as HIV/AIDS, tuberculosis (TB) and malaria. However, donor funding will remain an important resource in bridging funding gaps and strengthening healthcare systems, says Professor Sheila D. Tlou, director of the UNAIDS Regional Support Team for Eastern and Southern Africa.

The past few years have seen unprecedented economic growth in Africa. The World Bank’s latest Annual Report 2014 shows that, with real GDP growth projected to rise above 5% in 2015-16, Sub-Saharan Africa will continue to be one of the world’s fastest growing economies.²³ Many countries have also shown improvements in governance, poverty reduction and overall human development, creating opportunities for investments in equitable and sustainable health systems.

However, Africa is far from self-sufficient in the broader healthcare delivery system. The region

continues to rely on donor resources to sustain current improvements and expand health and community services to scale up responses to HIV/AIDS, TB and malaria. The response to HIV/AIDS, however, provides important lessons on how shared responsibility and global solidarity can deliver results. Country ownership, strong political leadership, and reduced dependence on external resources have enabled almost every country in Africa to have success stories—stories of many lives saved and hope for mothers and their babies. For example, domestic resources account for more than 70% of the HIV/AIDS budget in Botswana, Namibia, Mauritania, Mauritius and South Africa.

UNAIDS figures indicated that, thanks to increased investment and unprecedented global and community actions, new HIV infections in Sub-Saharan Africa declined by 33% and AIDS-related deaths fell by 39% between 2005 and 2013. Over 9m people living with HIV in Sub-Saharan Africa are estimated to have accessed treatment in 2013 compared with 6m in 2010.

Bridging the funding gap

However, there are still some challenges. UNAIDS estimates that Africa will require an

²³ World Bank, Annual Report 2014, www.worldbank.org/en/about/annual-report [accessed on October 23rd 2014].

annual investment of US\$11bn-12bn for its HIV/AIDS response in 2015; that same year, the expected funding gap will be US\$3bn-4bn. Donor funding remains an important resource in narrowing the gap and strengthening healthcare systems. African leaders need to increase their commitment to sustainable healthcare systems—and they are doing so.

In 2012 the 19th Summit of the African Union adopted the *Roadmap on shared responsibility and global solidarity for AIDS, TB and malaria response in Africa*.²⁴ This calls on African governments and development partners to raise funding for the three diseases together, investing their “fair share” based on ability and prior commitments. Resources from the international community remain important in bridging the funding gap and strengthening healthcare systems to sustain delivery of integrated HIV and other health services.

The HIV/AIDS response has also taught us that there are ways to maintain healthcare and community systems, including by:

- a) increasing domestic resources;
- b) investing to address the challenges of human resources in the healthcare sector; and
- c) combining the strengthening of healthcare systems with innovative service-delivery models, such as task shifting (“the rational redistribution of tasks among health workforce teams”, according to the World Health Organisation),²⁵ health service integration, and point-of-care and community mobilisation to create demand for access to equitable services that leave nobody behind.

The post-2015 development agenda will also be critical in ensuring that international donors continue to deliver on their commitments to strengthen healthcare systems and fast-track the end of the AIDS epidemic by 2030.

²⁴ African Union, *Roadmap on shared responsibility and global solidarity for AIDS, TB and malaria response in Africa*, www.au.int/en/sites/default/files/Shared_Res_Roadmap_Rev_F%5B1%5D.pdf [accessed on October 23rd 2014].

²⁵ World Health Organisation, *Task shifting: global recommendations and guidelines*, www.who.int/workforcealliance/knowledge/resources/taskshifting_guidelines/en/ [accessed on October 23rd 2014].

While every effort has been taken to verify the accuracy of this information, The Economist Intelligence Unit cannot accept any responsibility or liability for reliance by any person on this article or any of the information, opinions or conclusions set out in this article.

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