r

Private sector involvement in health services in East and Southern Africa: country profiles

Nicola Foster
Health Economics Unit, University of Cape Town

In the Regional Network for Equity in Health in Southern Africa (EQUINET)

EQUINET DISCUSSION PAPER 89

March 2012

With support from IDRC (Canada)

Table of contents

Cite as: Foster N (2012) Private sector involvement in health services in East and Southern Africa: country profiles, EQUINET Discussion Paper 89 Health Economics Unit (UCT), EQUINET: Harare.

The author would like to thank Prof. Di McIntyre for her insightful comments on an earlier draft of this report.

Executive summary

In 2005, the member states of the World Health Organisation, committed to “develop their health financing systems so that all people have access to services and do not suffer financial hardship in paying for them”. This is the goal of universal health coverage (World Health Organisation 2010).

There is currently a heated debate about what the best way would be to achieve this, and particularly around the role of the for-profit private health sector in addressing problems in the health systems in low- and middle income countries. While the quality of health care provided by the private sector is often perceived to be good and the industry may fill a gap in services which the government cannot afford to provide, the services are often not affordable to the entire population and thus only available to a privileged few.

In addition, there are concerns that people are impoverished by trying to pay for health care. Sometimes, the quality of care may be affected by perverse financial incentives. In countries with large private sectors there may be a pull of valuable human resources away from the public health sector. Despite these concerns the International Finance Corporation, of the World Bank Group published a report in 2007 on the business of health in Africa aimed at private for-profit investors, highlighting potential areas of investment in health care in Africa.

In response, this report was commissioned by the Regional Network for Equity in Health in East and Southern Africa (EQUINET) to look at the characteristics and extent of private sector involvement in health financing and provision in East and Southern African countries. It follows on a recent report by Doherty which highlighted the signs and trends of increasing private sector activity in the region from a policy perspective (Doherty 2011).

This report synthesises available information on the private health sector in the following ESA countries: Angola, Botswana, the Democratic Republic of the Congo (DRC), Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, the United Republic of Tanzania, Uganda, Zambia and Zimbabwe. For the purpose of the report, a broad definition of private health sector is adopted and is taken to include the (formal and informal) for-profit hospitals, private health insurance, private medical officers, private pharmacies/ drug sellers, not-for-profit/ faith-based organisations. The definition essentially includes private (for- or not-for-profit) funders as well as providers.

A desk-based literature review was conducted and published and grey literature was consulted. For each country the core health financing issues, including available NHA data, are briefly discussed. As external financial resources play a key role in the funding of private sector initiatives (both for-profit and not-for-profit), the extent of external funding is also considered. Thereafter, an overview is provided of the presence (or not) of private health insurance, and different types of private providers. A trend observed in this review is the expansion of South African private health care organisations into other African countries.

The results on these issues are briefly summarised in *Table 1*.

Table 1: Characteristics of the private health sector in ESA at a glance

Country	For-profit private sector				Not-for-profit private sector			
	Private health insurance	Private hospital groups	Informal private sector	Medical tourism	FBO	NGO	External funding	SA health organisations input
Angola	. □		□□		□□		√	
Botswana	□	□					□□	x
DRC			□□□			√	□□	
Kenya	□	□	□	□		□□	□□	
Lesotho	□	□			□□		□□	x
Madagascar	□					□□	□□	
Malawi	□					□□	√√√	
Mauritius	□			□			√	
Mozambique	□		√√			√	√√√	
Namibia	□□	□	□		√		√√	x
South Africa	□□	□				√	√	
Swaziland	□	(√)			□□	√	√√	x
Tanzania	□		□□		√	√	√√√	
Uganda	□	□					√√	x
Zambia	□		□□		□□		√√√	
Zimbabwe	□□		□□				√	(x)

Key: √ small < 10% of THE; √√ medium & increasingly important 10-49%; √√√ large > 50% of THE; x present but no weighting apply**;** (√) & (x) emerging/ there are plans

Sources: Compiled from the country profile data

The review showed that while private health insurance plays a small yet growing role in some of the countries reviewed, very few have any form of mandatory health insurance. There is a considerable burden of out-of-pocket (OOP) payments at point of service by households. Private for-profit hospitals are quite limited in most countries, but some countries are developing these hospitals specifically targeting medical tourism. At present, not-for-profit health services and informal private providers are very prevalent in most African countries.

A key constraint in undertaking this review was the very limited information available on the size and recent growth patterns in private funding and service provision. It is therefore crucial for Ministries of Health to pay greater attention to what is happening in their private health sectors, to create a coherent regulatory framework, and to require private insurance schemes and providers to provide routine information on their activities in order to enhance the monitoring and evaluation of the private health sector.

1. Introduction

A recent Regional Network for Equity in Health in East and Southern Africa (EQUINET) discussion paper on the expansion of the private health sector in East and Southern Africa (ESA), advised Ministries of Health (MoH) to be cautious about fostering the expansion of the private sector and/or public-private partnerships given the South African experience (Doherty 2011). In South Africa, the expansion of the private health sector has resulted in the fragmentation of risk pools, leading to limited income and risk cross-subsidies, rising costs and the migration of human resources for health (HRH) and financial capital out of the public and into the private health sector (McIntyre 2010; Doherty 2011). The paper by Doherty highlights signs and trends of increasing private sector activity in the region from a policy perspective, and considers the possible impact of the support of the World Bank as evident from the 2007 report by the International Finance Corporation (IFC), a division of the World Bank (Doherty 2011). The IFC report encourages the expansion of the private sector by highlighting potential investment areas (IFC 2007). Although the report cautioned that appropriate regulation will be required, it went on to encourage governments to facilitate private sector expansion through more business-friendly policies and donors (external funders) to support this with targeting funds to private sector activities.

This report effectively follows on from Doherty's (2011) report by providing a country-specific account of the nature of, as well as recent changes in, the private health care sector in the following East and Southern African countries: Angola, Botswana, the Democratic Republic of the Congo (DRC), Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa (SA), Swaziland, the United Republic of Tanzania (URT), Uganda, Zambia, and Zimbabwe.

For the purposes of this report, a broad definition of the private sector is adopted, and is taken to include the formal for-profit sector (including private curative services, as well as private health insurance), not-for-profit/faith-based organisations (FBO), and an attempt to explore two of the more elusive categories, namely the informal for-profit sector and medical tourism. In other words, the review includes organisations involved in the financing or provision of health services that fall outside the direct control of the government of the country. The framework used to collect and identify data is an adapted version of the framework proposed by Kutzin, which summarises the key health system financing functions and funding flows through the collection and pooling of funds, purchasing of services and provision of services (Kutzin 2001).

2. Methodology

A desk-based literature review was conducted by searching for published and unpublished studies or accounts on the private health sector in ESA countries. Databases used include Google, Google Scholar, and PubMed. Information was also sourced from Health Systems Trust, EQUINET, World Bank reports, WHO Statistical Information System (WHOSIS) as well as dissertation databases. Search strings used included permutations of *"private health sector"*, *"private health care"*, *"private health care in east and southern Africa",* and *"health insurance"* as well as country specific search strings. In addition, snowball data collection strategies were used to identify further studies of interest by perusing the reference lists of resources identified. Due to the nature of the paper, as a review of *current* private healthcare activities, there was a focus on articles/ sources dated from 2006 to 2011 (i.e. the last

five years). Newspaper articles and online blogs were also identified to provide a current view on the private health sector.

The country profiles also rely heavily on National Health Accounts (NHA) data. In order to make credible comparisons, only NHA data from the World Health Organisation (WHO) was used. This ensures that data collection techniques were comparable and definitions clearly outlined. Where there are concerns about the quality of data presented, these are highlighted and discussed within the country profiles.

For most of the countries reviewed, there is a lack of information on the *informal* private health care sector, such as untrained drug dispensers or unregistered health care providers providing services on a fee for service basis. While for some countries, the existence of this sector was acknowledged, there was rarely information on the extent of activities. Also, few countries had information on the split of health care workers between the private and public health sectors, partly because while there might be regulatory bodies, these only provide information on those who are registered but some of those who are registered may not be working or may be working outside of the country. Very useful reviews of the health system of specific countries were accessed through the United States Agency for International Development (USAID) Health Systems 20/20 project (available from http://www.healthsystems2020.org/section/about/) as well as key reviews commissioned by EQUINET on the South African (McIntyre 2010) and Zimbabwean private health sectors (Shamu, Loewenson et al. 2010). An attempt was made to identify common trends between countries and a critical review of the data is provided in Section 5.

3. The nature of the private health sector

The private health sector is not a homogenous entity but is made up of different dimensions with unique incentives and impacts. It has been suggested elsewhere that it is useful to distinguish between private financing and private health service provision components. So for example, publicly-provided services may be privately financed as is the case for out-of-pocket (OOP) payments made by individuals at public facilities and where there is private health insurance (which may be commercial in nature or voluntary community-based pre-payment schemes, although the emphasis in the review is on insurance via commercial companies).

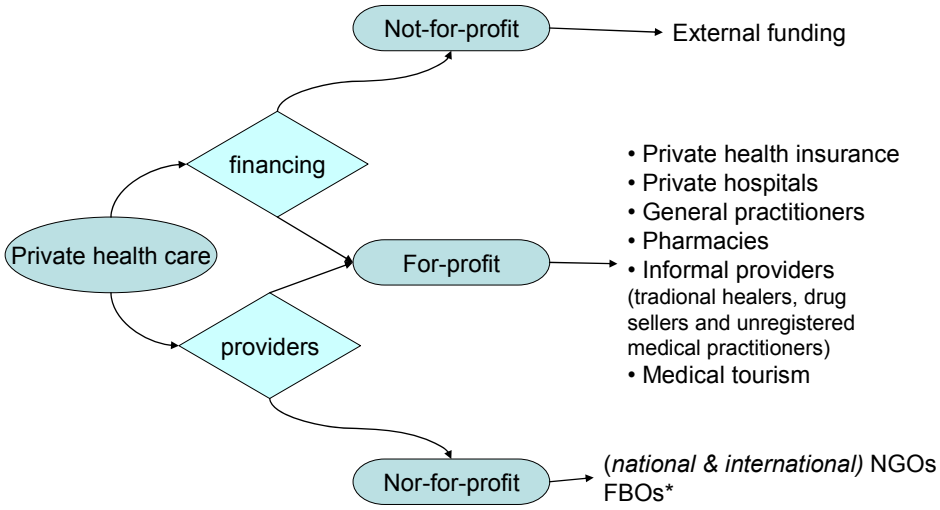
Private health service providers include for-profit providers such as private hospital groups, general medical practitioners, and pharmacies. The definition also includes the informal and often unregulated private sector which relates to traditional healers, informal drug sellers and unregistered health practitioners. Where market failure has occurred in the health sector, demand for health care is not being met and the population has lost faith in the services provided, an informal market often flourishes, as is seen in the Democratic Republic of the Congo and Zambia.

Not-for-profit providers include local and international non-governmental organisations (NGO) as well as faith-based organisations (FBO). It is important to note that services provided by FBOs are often subsidised by public and/or external funding and as such it is not always clear whether data distinguishes between funding flows to public and FBO facilities.

Following Bennett and Hanson this review therefore considers the private health sector to refer to all health care providers working outside the direct control of the

country's government (Bennett and Ngalande-Banda 1994; Hanson and Berman 1994). Despite constrained data sources, this review attempts to provide a broad overview of the private health sector as represented in *Figure 1*.

Figure 1: A graphical representation of components of the private health sector



*may be partially government subsidised

4. The private health sector in east and southern African countries: Country profiles

This section provides country profiles as a brief overview of the current extent and the nature of the private sector, trends in the private health insurance industry as well as direct (out-of-pocket) payments made by households. While the focus of this chapter is on the current situation in each country, there may be new developments not accounted for in the review as the researcher was reliant on information published at the time of the review, as well as available grey literature.

The review is organised by country. Each country profile starts off with a table containing key national health accounts (NHA) data on financing and expenditure. Notable increases (↑) or decreases (↓) in recent years in the percentage of expenditure are denoted by the appropriate arrows. For each country the key functions of health care financing are discussed: revenue collection, pooling of funds, the purchasing of services, and service provision. Revenue collection refers to the manner in which funds are raised to finance health systems. The money ultimately comes from households but may also be sourced from companies and sometimes from contributors from outside the country (referred to as "external sources"). Possible revenue collection techniques include general or specific taxation, health insurance contributions, OOP payments at point of service such as user fees, and donations. The accumulation and management of the funds to ensure that everyone with the ability-to-pay contributes and not only those who are sick is called pooling. The primary aim of pooling is to distribute the financial risk of health service use among a population. Pooling requires pre-payment of funds through taxes or insurance contributions. Purchasing is the process of paying for health services. Health service provision refers to who will be providing health services. There are

different options and could include government run and managed facilities, private for-profit health service providers, national and international NGOs, and a combination of these. For the purposes of this review, the focus will be on private health sector revenue collection, pooling and service provision (World Health Organisation 2010).

4.1 Angola

Table 2: Angola's key health financing indicators (2009)

Total expenditure on health as a percentage of GDP	4.6%
Private expenditure on health as a percentage of total expenditure on health	11%
Out of pocket expenditure as a percentage of private expenditure on health	*100%*
Private pre-paid plans as percentage of private expenditure in health	*0%*
General government expenditure on health as a percentage of total expenditure on health	89%
Government expenditure on health as a percentage of total government expenditure	*8.4% ↑*
Social security expenditure on health as a percentage of general government expenditure on health	*0%*
External resources for health as a percentage of total expenditure on health	2.7% ↓

Source: WHO 2009

The Angolan health system is reported to have made good progress in health financing, human resources, information systems, governance and service delivery since 2005. Progress has been facilitated by continued peace, political stability, rapid economic growth, and major infrastructure investments, including roads, water and housing (Connor, Rajkotia et al. 2005; Connor, Averbug et al. 2010).

4.1.1 Revenue collection (sources of funds; contribution mechanisms & collecting organisations)

Most health financing in Angola, at approximately 89% of total health expenditure (THE) comes from public health spending, funded by taxes and the sale of natural resources. In contrast to many other African countries, Angola is less dependent on external funding at 2.7% compared to its neighbours, Democratic Republic of the Congo (DRC) at 35.8%, Zambia at 50.3% and Namibia at 14.9% (World Health Organisation 2009; Connor, Averbug et al. 2010). Private companies are present, working in partnership with government. External funders co-finance health projects and provide resources towards initiatives, especially in malaria and HIV (Connor, Averbug et al. 2010). In addition, multilateral and bilateral external funders, international NGOs and faith-based organisations finance health services, often in the more remote areas.

It is difficult to estimate the actual extent of the contribution of households to THE. While user fees at public primary health care facilities were abolished in 2008, patients have to pay a 'fee-for-service' charge when utilising secondary and tertiary health care and private sector services.

Since 2005, private health insurance options have emerged that target companies (contrary to the 0% attributed to it in the table above, sourced from WHO NHA data). There is a strong international private company presence in Angola, especially oil

companies. These companies used to have their own clinics to provide health services to employees and their families. However, they now prefer to purchase private health insurance for their employees.

There are two major private health insurance companies in Angola, including ENSA SA (http://www.ensa.co.ao/), and AAA Seguros. ENSA SA is the national insurance company of Angola, and had a monopoly on the insurance industry until 2001 (Aguemon, Mireles et al.). ENSA SA offers comprehensive health insurance packages and contracts six private hospitals, including Climed (Connor, Averbug et al. 2010):

"Angolan and multinational companies use Climed to offer services to their collaborators at all levels of the organization – from factory workers up to the board. Esso, Halliburton, Angola Drilling Company, BAT (British American Tobacco), Camargo Corrêa, Odebrecht, Gamek, DHL, VetcoGray, FMC Energy Systems, Novagest, Sigma Group, Namkwang, Petrobras and Siemens are only a few of the companies that chose Climed as their healthcare service provider".

Source:Climed (2011) at //www.climedweb.com/clients.html

AAA Seguros is part of AAA Financial services, 90% of which is owned by the state oil giant Sonangol EP. Sonangol EP is the sole concessionary of Angola's mineral rights (Aguemon, Mireles et al. [no date]).

4.1.2 Health service provision

There is limited information available on the extent of the private sector, although reports from vertical programmes do give some indication as to utilisation of private sector health services. A knowledge attitudes and practices (KAP) survey conducted by a USAID-supported project found that 42% of men and 29% of women obtain contraceptives at private pharmacies. Conversely, 78.3% of treatment for childhood services occurs in the public sector and 19% in private sector facilities (Connor, Averbug et al. 2010).

Private pharmacies have a high penetration, even in rural areas and it is suggested that they are often better stocked than health facilities in the public sector. There is however very little regulation with only one professional pharmacist association in Huambo province and reported problems with "leakage" of public sector medication into the private sector (Connor, Averbug et al. 2010).

4.1.3 Additional information

In the Luanda province, the DPS (provincial health authority) is experimenting with contracting private clinics to provide services in areas not serviced by public health facilities. They contract with for-profit providers to deliver a pre-defined package of services to a target population for a fixed amount per patient. The DPS then reimburses the provider at the end of the month (to the value of US$10 per patient).

4.2 Botswana

Table 3: Botswana's key health financing indicators (2009)

Total expenditure on health as a percentage of GDP	10.3%
Private expenditure on health as a percentage of total expenditure on health	20%

Out of pocket expenditure as a percentage of private expenditure on health	*34%*
Private pre-paid plans as percentage of private expenditure in health	*6.5%*
General government expenditure on health as a percentage of total expenditure on health	80%
Government expenditure on health as a percentage of total government expenditure	*16.7%*
Social security expenditure on health as a percentage of general government expenditure on health	*0%*
External resources for health as a percentage of total expenditure on health	18.8%

Source: WHO (2009)

4.2.1 Revenue collection (sources of funds; contribution mechanisms & collecting organisations)

The sources of health financing in Botswana include tax revenue (80% of THE), funding from Debswana Diamond Company, private health insurance available through employment in the formal sector, modest but growing contributions by international agencies and the cost recovery system (user fees) in the public sector.

Debswana Diamond Company (Pty) Ltd. is a major contributor to the Botswana health sector. It consists of a 50:50 partnership between the Botswana government and the South African mining company De Beers (www.debeersgroup.com/debswana). Debswana is estimated to contribute approximately 50% of public revenue and 33% of GDP (Wilson 2007).

Private health insurance is available in Botswana to those employed in the formal sector. The three largest health insurance providers include:

- Botswana Medical Aid Society (www.bomaid.co.bw/index.html)
- Botswana Public Officer's Medical Aid Scheme (BPOMAS) (www.bpomas.co.bw/news02.php)
- Pula medical aid fund (www.pulamed.co.bw/)

Pula medical aid fund and BPOMAS are administered by Associated Fund Administrators (AFA) Botswana (Pty) Ltd. AFA is the largest medical aid administrator in Botswana and serves 70% of those who are covered by private health insurance (www.afa.co.bw/index.php). AFA is jointly owned by Matseno (Pty) Ltd (50%), Medscheme (Pty) Ltd (25%), and Medtrack Limited UK (25%). Medscheme is one of the major South African medical fund administrators (https://www.medscheme.co.za).

All three of these health insurance companies are members of the Board of Healthcare Funders (BHF) of Southern Africa (www.bhfglobal.com/). The BHF is a representative organisation for medical schemes which lobbies governments on behalf of the private health insurance industry. Its members include health insurance companies from South Africa, Namibia, Zimbabwe, Botswana and Lesotho. In Botswana, it is estimated that less than 10% of the population is covered by formal health insurance (Yinusa and Okurut 2009). There are discussions around the use of micro-health insurance to cover the cost of health care in private facilities (May and Bonu 2009). A conference was hosted by the Network for Microhealth Insurance Africa in Lilongwe, Malawi in 2009 to discuss these options.

4.2.2 Health service provision

In the private sector, there are two private hospitals available, one in Gabarone (Life Gabarone) and one in Francistown (Global Health Insurance 2007; Oppenheim, Sullivan et al. 2010). The Life Gabarone hospital is part of the Life health care group (www.lifehealthcare.co.za). The Life group is a South African private hospital operator and has been extending its services to Botswana. In addition, health services have been contracted from the private health sector for public patients using a 'fee-for-service' reimbursement scheme (Dreesch, Nyoni et al. 2007). There are however concerns that this is not a sustainable solution as the private sector has limited absorptive capacity.

4.3 Democratic Republic of the Congo (DRC)

Table 4: DRC's key health financing indicators (2009)

Total expenditure on health as a percentage of GDP	9.5%
Private expenditure on health as a percentage of total expenditure on health	49.0%
Out of pocket expenditure as a percentage of private expenditure on health	*76.2%*
Private pre-paid plans as percentage of private expenditure in health	*0.2%*
General government expenditure on health as a percentage of total expenditure on health	51.0%
Government expenditure on health as a percentage of total government expenditure	*17.0%*
Social security expenditure on health as a percentage of general government expenditure on health	*0%*
External resources for health as a percentage of total expenditure on health	35.8↑

Source: WHO (2009)

The second Congo war (sometimes referred to as the African world war) which started in 1998 and ended in 2003, devastated DRC and the after-math of the war is still felt in many sectors. During the war, public services stopped functioning and a large informal sector emerged. At present, health personnel in public facilities charge patients fees (a form of informal taxation) which can be devastating to the poor and impede access to the most basic of health services (Delamalle 2004; Democratic Republic of the Congo Ministry of Health 2006). In addition, a surplus of trained medical staff has resulted in small private practices in health districts (called "health posts"); the quality of care provided is however not always good, (Democratic Republic of the Congo Ministry of Health 2006).

4.3.1 Revenue collection (sources of funds; contribution mechanisms & collecting organisations)

There are three primary sources of healthcare funding: public funds from taxation, external contributions and user fees. External (bilateral and multilateral) contributions have increased since 2001 and are currently the greatest contributor to THE, mostly benefiting vertical programmes without supporting spending on infrastructure. Recovery of the cost of care and services from users has been found to contribute up to 70% of the operating costs of health facilities (Democratic Republic of the Congo Ministry of Health 2006).

4.3.2 Pooling of funds (coverage; risk pools & allocation mechanisms)

There is limited risk pooling in the DRC as most patients have to pay for their own services on an out-of-pocket basis. According to a World Bank report, the average rate of use of health services in the DRC is 0.15 (0.07–0.42) consultations per inhabitant per year, which equates to less than one consultation per person every six years (World Bank 2005). In addition, two-thirds of patients in DRC do not rely on the formal health care system for treatment as services are either not available or of poor quality (Democratic Republic of the Congo Ministry of Health 2006). A study conducted by the Public Health School at the University of Kinshasa (2003) found that 30% of people who fell ill went to a public or denominational health centre, 40% treated themselves, 21% went without treatment and 9% consulted a traditional healer (Democratic Republic of the Congo Ministry of Health 2006).

4.3.3 Health service provision

There are many non-profit organisations involved in service provision, including: Catholic and protestant faith-based organisations; Caritas; the International Rescue Committee; MERLIN; Medicos en Catastrophe; Medecins du Monde; SANRU; Save the Children Foundation; MSF-Spain; and Malteser International. Centre Prive d'Urgence is currently the only private hospital in the DRC. The hospital is French-owned and operated (Global Health Insurance [no date]).

4.4 Kenya

Table 5: Kenya's key health financing indicators (2009)

Total expenditure on health as a percentage of GDP	4.3%
Private expenditure on health as a percentage of total expenditure on health	66.2%↑
Out of pocket expenditure as a percentage of private expenditure on health	*77.4%*↓
Private pre-paid plans as percentage of private expenditure in health	*8.8%*↑
General government expenditure on health as a percentage of total expenditure on health	33.8%↓
Government expenditure on health as a percentage of total government expenditure	*5.4%*↓
Social security expenditure on health as a percentage of general government expenditure on health	*11.8%*
External resources for health as a percentage of total expenditure on health	36.1%↑

Source: *Global Health Observatory data repository*, available from http://apps.who.int/ghodata/?vid=1901# (last accessed 18 July 2011)

4.4.1 Revenue collection (sources of funds; contribution mechanisms & collecting organisations)

Since 1995, Kenya has experienced a decrease in government expenditure on health, a decrease in OOP expenditure (83% in 1996 to 77% in 2009), an increase in private health insurance and a dramatic increase in external resources for health expenditure (from 4.9% in 1995 to 36.1% in 2009) (World Health Organisation 2009).

Financing for health care in Kenya comes from tax funding, user-fees, grants from developed countries (external sources) and private health insurance (Weisburst 2008). Kenya has a small private health insurance industry, covering about 2% of the

population, predominantly the higher-income groups who are employed in the formal sector. According to Barnes and others (2010) the Kenyan insurance industry has a poor public image due to the collapse of several managed-care schemes in the recent past (Barnes, O'Hanlon et al. 2009; Barnes, O'Hanlon et al. 2010).

The largest private health insurance company in Kenya is AAR (http://www.aarhealth.com). AAR has 18 health centres in Kenya, Uganda and Tanzania and provides preventative, curative as well as evacuation cover (includes 10 facilities in Kenya, three in Uganda and five in Tanzania).

4.4.2 Health service provision

The Kenyan private sector delivers 49% of health services, half of which by religious and non-governmental organisation (NGO) facilities and the rest by small- and medium-size commercial health enterprises (Marek, O'Farrell et al. 2005). In 2006, there were 5,129 health facilities in Kenya, 2,217 of which were in the private commercial sector, 792 run by non-profit organisations, and 2,120 facilities in the public sector (Barnes, O'Hanlon et al. 2009). While the private sector delivers 49% of services, 60% of health workers are reported to be employed in the private health sector (Arur, Sulzbach et al. 2010). A survey conducted in 1998 suggested that 47% of those who were sick went to the private sector, 47% to the public sector and 6% indicated “other” (Marek, O'Farrell et al. 2005). In the *Kenya Private Health Sector Assessment* (2009), the private sector supply chain was described as “highly fragmented and inefficient” and it was suggested that there are too many suppliers in the market, *which drives down the price and quality of goods* (Barnes, O'Hanlon et al. 2009 p xv). There is apparently a large market for counterfeit drugs in Kenya which the government has limited capacity to monitor.

There is some evidence of medical tourism, whereby those from developed countries, seeking non-essential medical treatment might prefer to access treatment in a setting where treatment might be less costly and in a holiday setting. For example the Diani beach hospital is located on the south coast of Kenya and specialises in aesthetic surgery (http://www.dianibeachhospital.com/, accessed 28 July 2011).

4.4.3 Additional information

A recent purchasing initiative implemented in Kenya is the voucher programme for the provision of reproductive health services to young people. Funds are transferred (by government trying to advance certain priorities) to a voucher agency that then produces and distributes the vouchers to the target population. The voucher recipient presents it at the service provider of his/her choice in exchange for specified goods/services. The service provider returns the voucher to the voucher agency, which pays the provider an agreed upon price per voucher and reports programme outputs/outcomes to the government or external funder that is providing subsidies (Marek, O'Farrell et al. 2005).

4.5 Lesotho

Table 6: Lesotho's key health financing indicators (2009)

Total expenditure on health as a percentage of GDP	8.2%↑
Private expenditure on health as a percentage of total expenditure on health	31.8%↓
Out of pocket expenditure as a percentage of private expenditure on health	*68.9%↓*
Private pre-paid plans as percentage of private expenditure in health	*0%*
General government expenditure on health as a percentage of total expenditure on health	68.2%↑
Government expenditure on health as a percentage of total government expenditure	*8.2%↑*
Social security expenditure on health as a percentage of general government expenditure on health	*0%*
External resources for health as a percentage of total expenditure on health*	30.4%↑

* From 5.7% in 1995 to 19.3% in 2008 and 30.4% in 2009
Source: WHO (2009)

4.5.1 Revenue collection (sources of funds; contribution mechanisms & collecting organisations)

Financing for the Lesotho health sector comes from tax revenue, grants and loans from foreign governments and international NGOs, private health insurance contributions by formal sector employers and OOP payments by households. User fees were removed from all health facilities in 2009 and an assessment of the feasibility of a social health insurance (SHI) was conducted. Prior to the removal of user fees, direct OOP payments made by households were estimated at 24% of total health spending; thus, these measures will greatly improve access to health care in Lesotho (Mwase, Kariisa et al. 2010).The major private health insurance companies in Lesotho include Mammoth health medical aid scheme (http://www.mamothhealth.com/about.html) and Bophelo medical scheme (http://www.momentumafrica.com/lesotho/health/options/lesotho_health_options.html). Bophelo is a product of Momentum Africa, a division of Momentum (Pty) Ltd which provides health insurance in South Africa and a subsidiary of the FirstRand Group.

4.5.2 Health service provision

An estimated 42% of health centres and 58% of hospitals are government owned, while 38% of the hospitals and 38% of the health centres are managed by the Christian Health Association of Lesotho (CHAL). CHAL is a partner of Global Ministries and according to its website, supports eight hospitals and 70 health centres (http://www.globalministries.org/). The Lesotho government purchases health services from CHAL by allocating a subsidy to support the health facilities. The remaining facilities are either privately owned or operated by the Lesotho Red Cross Society. In addition, there is an extensive network of private surgeries, nurse clinics and pharmacies providing care and/ or medicines (Global Ministries).

4.5.3 Additional information

Lesotho has embarked on a public-private partnership (PPP) to upgrade Queen Elizabeth II hospital under the advisement of the International Finance Corporation (a

member of the World Bank Group). In September 2008, Tsepong Limited (led by Netcare SA) was awarded the contract to replace the hospital and three local clinics. The new 425 bed hospital is scheduled to open in October 2011. The government of Lesotho will then purchase healthcare for its citizens from the hospital group, and patients will reportedly be charged no more than what it already costs them to access public healthcare. Eighty-five percent of the equity for the project is supplied though a loan from the Development Bank of South Africa (Wearden 2009; Makholwa 2010).

4.6 Madagascar

Table 7: Madagascar's key health financing indicators (2009)

Total expenditure on health as a percentage of GDP	4.1%
Private expenditure on health as a percentage of total expenditure on health	32.9%
Out of pocket expenditure as a percentage of private expenditure on health	*67.8%*
Private pre-paid plans as percentage of private expenditure in health	*15.1%*
General government expenditure on health as a percentage of total expenditure on health	67.1%
Government expenditure on health as a percentage of total government expenditure	*15.1%*
Social security expenditure on health as a percentage of general government expenditure on health	*0%*
External resources for health as a percentage of total expenditure on health	28.3%

Source: WHO (2009)

4.6.1 Revenue collection (sources of funds; contribution mechanisms & collecting organisations)

The government of Madagascar is the primary purchaser and provider of health care through tax funding at 67.1% of THE (Ministere de la Sante et du Planning Familial 2003). Bilateral, national and international NGOs contribute about 28% of THE. Global Health Ministries (the Lutheran church) support eight hospitals, 22 health centres and 14 clinics, as well as donate medical equipment to the Malagasy MoH in collaboration with Salfa Overseas Assistance (SOA) (Global Health Ministries [no date]).

The National Health Accounts (NHA) data presented in *Table 7* highlights the burden of health expenditure on households, with 32.9% of all expenditure on health being privately funded, 67.8% of which relates to OOP payments made by households. Figures quoted in the International Finance Corporation's '*The Business of Health Report'* shows that 30% of rural and 36% of the urban population in Madagascar uses private for-profit providers of modern medicine (IFC 2008). Approximately 70% of direct payments by households go towards the purchase of drugs (Ministere de la Sante et du Planning Familial 2003).

4.6.2 Pooling of funds (coverage; risk pools & allocation mechanisms)

In 2005, USAID assisted the Malagasy MoH in piloting five community-based health insurance (CBHI) schemes, called *mutuelles* (directly translated to mean "mutual") in five provinces of Madagascar. The mutuelles work by asking members to make an annual contribution in either cash or alternatively in crops after harvesting time. In exchange, they are then entitled to receive health care all year round. The pilot project was deemed to be very successful and within the pilot provinces, the <4

years old mortality rate dropped from 15% in 2003 to less than 5% in 2006/2007, partly because all CBHI members were required to immunise their children and parents were encouraged to bring children to the health facilities at the first onset of illness. Following the success, the MoH has started to roll out CBHI schemes to more provinces. In terms of risk pooling, the CBHI does provides some risk pooling within a community but only among those who are economically active, and does not provide any real protection to those who are poor, have no agricultural produce or are unable to work due to ill health. In fact, this policy could quite conceivably place the burden of income generation on children who might be forced to tend the land to subsidise health care for family members who are chronically ill rather than attending school. It also does not provide for cross-subsidising between provinces/districts where some districts might inherently be less affluent.

4.6.3 Health service provision

Given the challenges in Madagascar related to a lack of road infrastructure and very remote rural areas, some of the NGOs involved in the provision of healthcare in Madagascar have focused their attention on novel ways to provide healthcare to communities with limited access to healthcare due to their geographical location. An example is Hoveraid, a NGO that provides health care to the town of Ankavandra (230 km east of the capital, Antanarivo) by hover craft. The town of Ankavandra is cut off from surrounding areas due to poor transportation infrastructure as well as the cessation of aircraft landing. The town only has one doctor looking after 13,000 people and there is limited ability to evacuate those needing emergency care. NGOs such as Hoveraid and Mission Aviation Fellowship provide surgical and basic medical care to these communities in Madagascar (IRIN News 2011).

4.7 Malawi

Table 8: Malawi's key health financing indicators (2009)

Total expenditure on health as a percentage of GDP	6.2%
Private expenditure on health as a percentage of total expenditure on health	42%
Out of pocket expenditure as a percentage of private expenditure on health	*28.5%*
Private pre-paid plans as percentage of private expenditure in health	*14.5%*
General government expenditure on health as a percentage of total expenditure on health	58%
Government expenditure on health as a percentage of total government expenditure	*12.1%*
Social security expenditure on health as a percentage of general government expenditure on health	*0%*
External resources for health as a percentage of total expenditure on health	99.1%

Source: WHO (2009)

4.7.1 Revenue collection (sources of funds; contribution mechanisms & collecting organisations)

In Malawi, health services are provided for free in all government facilities but user fees are charged at facilities run by faith-based organisations, such as facilities managed by the Christian Health Association of Malawi (CHAM) that are heavily reliant on government subsidies and external funders. Private services are provided in separate private wings in government facilities' outpatient departments, and for

inpatient care in district and central hospitals where patients pay on a fee-for-service basis. The key revenue collection strategies for health services in Malawi include:

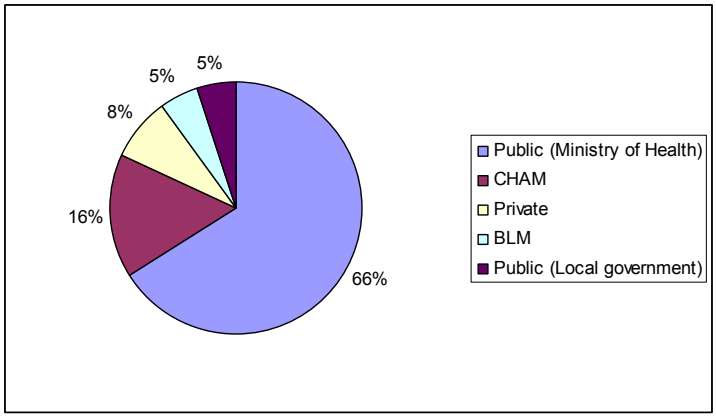
- Public institutions funded primarily by tax contributions;
- Donor funding;
- Local and international NGOs and community-based organisations (CBO);
- Private health insurance;
- Employers by providing healthcare in onsite facilities, reimbursements to employees, contributions to an outside health insurance scheme and in-house health insurance;
- Households contribute through user-fees, and out-of-pocket payments.

Private health insurance companies are represented by the Medical Aid Society of Malawi (MASM) (http://www.masmw.com/#)

4.7.2 Health service provision

Malawi has seen a boom in the private health sector with private health expenditure currently at 42% of THE. As depicted in *Figure 2*, the Ministry of Health is responsible for approximately two thirds of all facilities, local government about 5% of all facilities, and CHAM 16% of all facilities, while a large NGO Banja la Mtsogolo (BLM) provides a further 5% of facilities and the balance is provided by the private for-profit sector. It is difficult to estimate the full extent of the private for-profit sector as not all providers are registered with the MoH or the Medical Council of Malawi (Mtonya and Chizimbi 2006) The NGO BLM was founded in 1987 and was initially funded by Marie Stopes international. It has since grown to 298 clinics and has expanded services to incorporate more than just family planning and is receiving support from several external funders (Mtonya and Chizimbi 2006).

Figure 2: Graphic representation of health service provision by provider



Sources: Mtonya and Chizimbi 2006

4.8 Mauritius

Mauritius consists of two islands: Main Island and self-governed Rodriques. Since independence in 1969 the country has gone from an under-developed to a middle-level and stable country (World Health Organisation 2008).

Table 9: Mauritius' key health financing indicators (2009)

Total expenditure on health as a percentage of GDP	5.6%
Private expenditure on health as a percentage of total expenditure on health	64.0%
Out of pocket expenditure as a percentage of private expenditure on health	*88.7%*
Private pre-paid plans as percentage of private expenditure in health	*6.3%*
General government expenditure on health as a percentage of total expenditure on health	36.0%
Government expenditure on health as a percentage of total government expenditure	*7.9%*
Social security expenditure on health as a percentage of general government expenditure on health	*0%*
External resources for health as a percentage of total expenditure on health	1.7%

Source: WHO (2009)

4.8.1 Revenue collection (sources of funds; contribution mechanisms & collecting organisations)

The Mauritian health system is modelled on the UK's National Health System (NHS) in that it is universal: public services are free at the point of service and funded by taxes.The main funding sources for the health service of Mauritius are taxes, OOP payments, private health insurance and external funding. Due to the good performance of the health sector, external funding is limited, however there are concerns that as the burden of need increases due to HIV, the Department of Health may not be able to meet the increased demand (Devi 2008).

Private health insurance is available in Mauritius and is mostly targeted at employers of medium- to large-sized businesses wanting to provide health insurance to their employees. Providers include:

- Swan Insurance (http://www.swan.mu/corporate_profile.aspx): the group provides a full range of insurance products and the company has been quoted in the Mauritian Stock Exchange
- Mauritius Union General Insurance (http://www.mauritiusunion.com/en/commercial_insurance_group_insurance.aspx)
- CIM insurance (http://www.ciminsurance.mu/corporate_group_health.aspx)
- BAI insurance (http://www.bai.mu/Default.asp)
- The Momentum Africa group provides the Bonne Sante health plan, designed for the Mauritian market (http://www.momentum.co.mu/)
- Medicaid health insurance provided by Maritius Union General Insurance (http://www.mauritiusunion.com/en/personal_insurance_health_insurance.aspx)
- MEF provident association (http://www.mefpa.org/).

4.8.2 Health service provision

The private health sector in Mauritius is made up of private practice medical and dental practitioners as well as about 13 private clinics with in-patient beds. The private sector is however relatively small and the total number of beds in the private sector are 562, which is approximately 16% of all beds (World Health Organisation

2008). In 2009, one of Asian's largest hospital groups, Apollo, in partnership with British American Investment Co., opened a 220-bed hospital in Mauritius, the Apollo Bramwell Hospital (http://www.apollohospitals.com/news_detail.php?newsid=21).

4.8.3 Additional information

In Mauritius, the MoH is promoting medical tourism. The country provides some medical tourist niches including in-vitro fertilisation and hair replacement (Devi 2008). The industry is supported by the MoH. According to Satya Veyash Faugoo, Mauritian Minister of Health: "We have beautiful hotels, beautiful beaches, first-class services. Why not make Mauritius a hub, a place where people can combine a holiday and medical treatment" (Devi 2008: 1568).

4.9 Mozambique

Table 10: Mozambique's key health financing indicators (2009)

Total expenditure on health as a percentage of GDP	6.2%
Private expenditure on health as a percentage of total expenditure on health	24.5%↓
Out of pocket expenditure as a percentage of private expenditure on health	*43.6%*
Private pre-paid plans as percentage of private expenditure in health	*1.5%↑*
General government expenditure on health as a percentage of total expenditure on health	75.5%↑
Government expenditure on health as a percentage of total government expenditure	*14.2%*
Social security expenditure on health as a percentage of general government expenditure on health	*0.3%*
External resources for health as a percentage of total expenditure on health*	65.7%

* From 24.5% in 2001
Source: WHO (2009)

4.9.1 Revenue collection (sources of funds; contribution mechanisms & collecting organisations)

Mozambique is heavily reliant on external funding, in excess of 40% of THE (Ministry of Health Mozambique 2006; USAID 2007) It has been proposed that increasing internal funding and entering into long term public-private partnerships would be more desirable (Ministry of Health Mozambique 2006).Most private funding comes from households in the form of user fees and the sale of medication (Ministry of Health Mozambique 2006; USAID 2007). The tax-funded/public-provided NHS is the main provider of health care. User fees are, in principal, not charged on the primary care package including child immunisations etc. User fees vary and are inconsistently applied between facilities. Of patients charged user fees, 46% have difficulty paying (USAID 2007).The private commercial health sector was legalised in 1991 and is small and concentrated in urban areas. Successful public-private partnerships are conducted through the National AIDS Council, which awarded more than 1,200 grants to over 200 NGOs. There is a very limited uptake of private health insurance in Mozambique (Ministry of Health Mozambique 2006).

4.9.2 Health service provision

The NHS is the main provider of health care, providing care through 1,277 health units but only reaching 60% of the population (USAID 2007). Use of the for-profit

sector is constrained by household incomes (Ministry of Health Mozambique 2006). Not-for-profit services are provided by foreign NGOs and religious entities, and 70% of the population consider non-allopathic services such as traditional healers to be a alternative health care service (USAID 2007).

4.10 Namibia

Table 11: Namibia's key health financing indicators (2009)

Total expenditure on health as a percentage of GDP	5.9%↓
Private expenditure on health as a percentage of total expenditure on health*	33.4%↓
*Out of pocket expenditure as a percentage of private expenditure on health**	*17.8%↑*
*Private pre-paid plans as percentage of private expenditure in health***	*61%↓*
General government expenditure on health as a percentage of total expenditure on health	66.6%
Government expenditure on health as a percentage of total government expenditure	*12.1%*
Social security expenditure on health as a percentage of general government expenditure on health	*2.6%*
External resources for health as a percentage of total expenditure on health***	14.9%↑

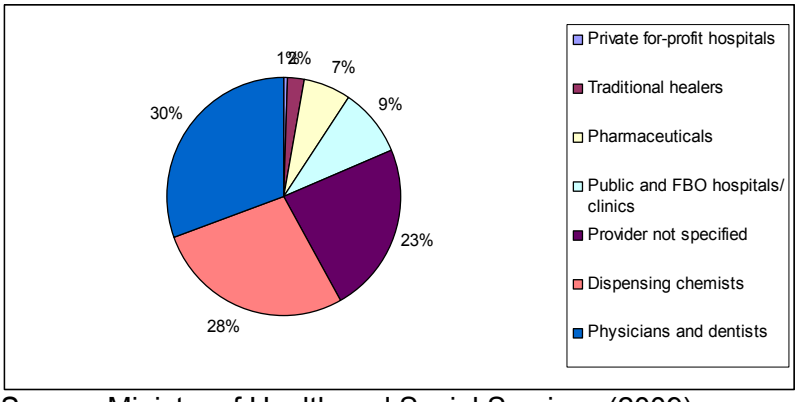
* Since 2005; ** From 86% in 2002; *** Since 1995

Source: WHO (2009)

4.10.1 Revenue collection (sources of funds; contribution mechanisms & collecting organisations)

Government funding for health contributes more than half of total expenditure on health (53.8%), while donor spending has been on the increase in recent years and is currently at 21.7%, and households and private companies contribute similar amounts at 12.2% respectively. Looking at where household spending on health goes, graphically presented in *Figure 3*, it is clear that the bulk is spent on private physicians, dentists and dispensing chemists, followed by fees at public and faith-based organisations facilities, purchasing medication, and the smallest percentage on traditional healers.

Figure 3: Use of household spending on health



Source: Ministry of Health and Social Services (2009)

4.10.1 Pooling of funds (coverage; risk pools & allocation mechanisms)

Namibia has a well-established private health insurance sector, organised in open and closed health insurance funds. Closed funds limit membership to those employed by a certain firm or industry. In the Windhoek area (the capital of Namibia), more than 30% of the population is enrolled in a health insurance scheme, but coverage is much lower in other areas. However, effective risk pooling cannot take place as private schemes do not distribute risk throughout the population but rather divide people into small fragmented risk pools. For example, while enrolment is equally likely for males and females, enrolment levels are substantially higher for male-headed households compared to female-headed households. There are also large discrepancies across socio-economic groups, with only 5% of people in the lowest socio-economic quintile enrolled in a health insurance fund. In reality, those most likely to be insured are where the head of the household works in the government or defence industry and, as would be expected, those who are unemployed are unlikely to be insured (www.iss.nl/DevISSues/Articles/A-Unique-Low-cost-Private-Health-Insurance-Program-in-Namibia-Protection -from-Health-Shocks-Including-HIV-AIDS).

There are nine Namibian health insurance providers that are members of the BHF (Board of Healthcare Funders 2011). These include:

- Bankmed Namibia
- Nammed medical aid fund (http://www.nammed.com/)
- Namibia medical care (http://www.nmcfund.com/management/index.htm)
- Namibian health plan (http://www.medscheme.com.na/index.jsp)
- Renaissance health medical aid fund (http://www.renaissance.com.na/company_profile.php)
- Namdeb medical scheme (a restricted team for employees of De Beers Namibia)
- Napotel medical aid fund (for employees of Telecom Namibia and Namibia Post)
- Transformed medical scheme for employees of Air Namibia
- The road contractors' medical aid fund
- The civil servants' health insurance fund, PSEMAS, which is the largest in Namibia, insuring 43% of insured individuals.

Bankmed Namibia, Namibia medical care and PSEMAS are administered by Methealth Namibia administrators (Pty) Ltd while the restricted medical schemes – Namdeb medical scheme, Napotel medical aid fund, Renaissance health medical aid fund, the road contractors' medical aid fund and Transformed medical scheme – are administered by Prosperity Health Africa (Pty) Ltd, which reportedly controls 70% of the health insurance market share in Namibia (Struwig 2004).

Prosperity health has subsidiaries in multiple Southern African countries (http://www.prosperityhealth.com/prosperityweb/namibia/Display.jsp?ad_id=37&category_id=78). The company was started in Namibia in 1994. Then, in conjunction with Namhealth holdings, it acquired the administration contracts for five Namibian medical schemes and started Prosperity Life, which is a long-term insurance company. In 2002, the company extended its services to Lesotho and Mauritius, where it trades under the name of Worldwide Prosperity Limited. The company also has a South African branch called Prosperity Health Managers (South Africa). In 2003, the company started Prosperity Health Botswana and in 2004 the Prosperity group bought E-Med Rescue 24, a Namibian emergency rescue and ambulance services company, from the South African company Netcare 911 (Struwig 2004).

In 2004, the Dutch company PharmAccess started a low-cost private health insurance fund for low-income workers specifically including HIV/AIDS care and services. Private providers were contracted in and paid on a capitation basis. In addition a risk-equalisation fund was established for HIV-related expenditures to which all insurance companies contributed in order to share some of the risk related to the high HIV prevalence in Namibia (www.iss.nl/DevISSues/Articles/A-Unique-Low-cost-Private-Health-Insurance-Program-in-Namibia-Protection -from-Health-Shocks-Including-HIV-AIDS).

4.10.2 Health service provision

Faith-based organisations (FBOs) still play an important role in health care delivery in Namibia (Government of Namibia 2010). The for-profit health industry is substantial and provides about 22% of health services in Namibia. Private-for-profit facilities include 13 hospitals and 75 primary health care clinics, as well as eight health centres, 557 medical practitioners (including dentists, psychologists and physiotherapists) and 75 pharmacies. Medi-clinic, the world's sixth largest private medical group – which also owns private hospitals in South Africa – owns and operates three hospitals in Namibia: one in Otjiwarongo, one in Windhoek and one in Cottage (www.mediclinic.co.za/hospitals/Pages/default.aspx).

4.11 South Africa

Table 12: South Africa's key health financing indicators (2009)

Total expenditure on health as a percentage of GDP	8.5%↑
Private expenditure on health as a percentage of total expenditure on health	59.9%
Out of pocket expenditure as a percentage of private expenditure on health	*29.6%*
Private pre-paid plans as percentage of private expenditure in health	*66.1%*
General government expenditure on health as a percentage of total expenditure on health	40.1%
Government expenditure on health as a percentage of total government expenditure	*9.3%*
Social security expenditure on health as a percentage of general government expenditure on health	*2.9%*
External resources for health as a percentage of total expenditure on health	1.9%↑

Source: WHO (2009)

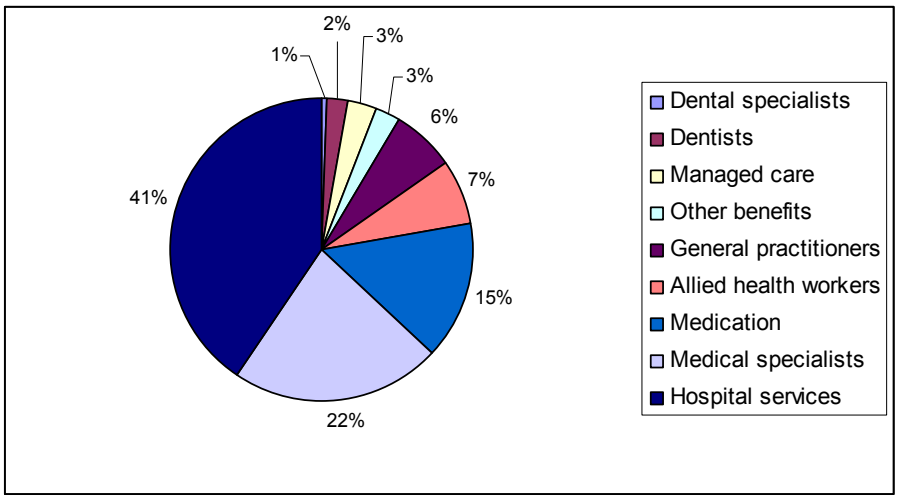
4.11.1 Revenue collection (sources of funds; contribution mechanisms & collecting organisations)

In South Africa, public sources, predominantly from taxes, account for only 40% of health expenditure as opposed to private expenditure which is approximately 60% of THE. Of private expenditure, approximately 30% comes from OOP payments made by households, and 66% is collected by private health insurance schemes. The health insurance sector is regulated by the Council of Medical Schemes (CMS), which was established through the Medical Schemes Act (131 of 1998) (http://www.medicalschemes.com/). While health insurance schemes are not-for-profit organisations, the funds are managed by for-profit administrators. The number of registered medical schemes in South Africa has declined from 144 in 2000 to 110 in 2009 and 100 in 2010 due to consolidation, amalgamations and liquidations. Of the 100 medical schemes currently registered in South Africa, 27 are open schemes and 73 are restricted, i.e. only those employed in defined sectors are allowed to join. By

the end of 2010, the combined membership for all medical schemes stood at 8,315,718 people of an average 31.5 years old (Council of Medical Schemes 2011). In 2010 gross contribution income amounted to R96.7 billion (US$ 14.3 billion), of which R84.9 billion (US$ 12.5 billion) was paid out.

The distribution of health care benefits paid from risk pools as depicted in *Figure 4* suggests an industry which is heavily reliant on hospital services and treatment by medical specialists' (Council of Medical Schemes 2011). This is a very inefficient way of providing health care. A further concern about private health care relates to the demographics of the beneficiaries.

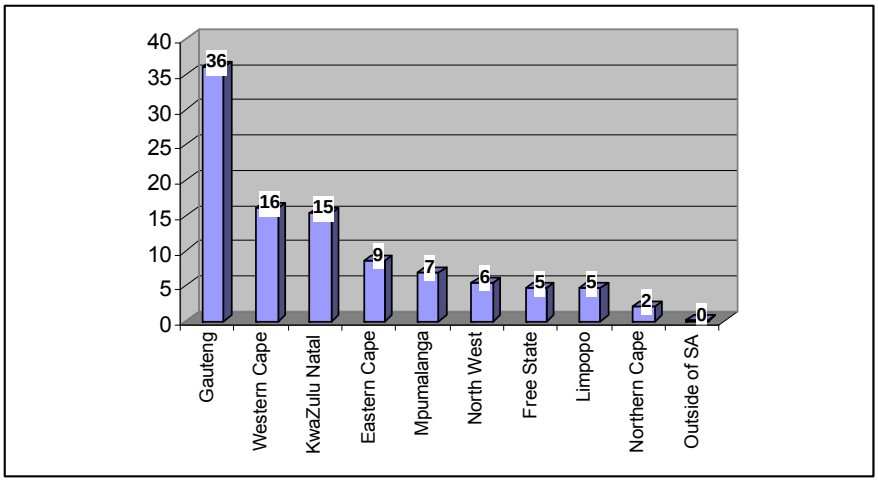
Figure 4: Health care benefits paid from risk pool in 2010



Source: Council of Medical Schemes annual report (2011)

From *Figure 5*, it is clear that there is an emphasis on private insurance coverage for those who are employed and live in urban areas, with most members living in Gauteng, the Western Cape, Kwa-Zulu Natal where the country's three major cities are and the more rural provinces, the Northern Cape and Limpopo being the least represented. The 2010/2011 CMS annual report concluded that the results of the report "clearly shows the need for continued and strengthened regulation of medical schemes" (Council of Medical Schemes 2011). South Africa also receives external funding from multiple partners including PEPFAR and USAID.

Figure 5: Distribution of beneficiaries by province (%)



Source: Council of Medical Schemes (2011)

4.11.2 Pooling of funds (coverage; risk pools & allocation mechanisms)

South Africa has a very fragmented parallel health system with limited risk pooling due to multiple health insurance funds. The private health care industry is supported through health insurance. These schemes serve only 15% of the population but attract over 40% of the country's total expenditure on health (McIntyre 2010). Those who are not covered by health insurance can access public health facilities; primary health care is provided for free but a contribution is required at secondary and tertiary level facilities, based on salary and number of dependents. In September 2011, the South African DoH released a Green Paper for the establishment of a NHI, with the underlying principle of universal health care (Department of Health 2011).

4.11.3 Health service provision

Table 13 provides a sense of the distribution of private facilities by number of hospital beds.

Table 13: Distribution of private hospital beds relative to total population and medical scheme members

Province	Beds	% share of beds	% share of total population	% share of medical scheme members
Eastern Cape	1,522	5.4%	13.5%	8.9%
Free State	1,630	5.7%	5.9%	4.6%
Gauteng	13,550	47.8%	21.5%	36.5%
KwaZulu Natal	4,315	15.2%	20.8%	15.3%
Limpopo	333	1.2%	10.8%	4.4%
Mpumalanga	987	3.5%	7.4%	6.8%
North West	1,564	5.5%	7.0%	5.3%
Northern Cape	343	1.2%	2.3%	2.1%
Western Cape	4,117	14.5%	10.8%	16.2%

Source: McIntyre (2010)

In the private sector, hospital services are primarily provided by three large hospital groups (listed and trading on the JSE), including Netcare, Life Health and Medi Clinic. Netcare also owns the largest private ambulance and rescue service and Medi Clinic owns the largest private HRH recruitment agency (McIntyre 2010).

4.11.4 Additional information

Given the size of South Africa's private health sector as well as the country's economic role in the rest of Africa there are concerns that South African private health companies are extending their operations to other African countries, where there is less regulation of and experience with the incentives created for the private sector (McIntyre 2010; Doherty 2011). Here are a few examples:

- The three big private hospital groups in South Africa, Netcare, Life, and Medi-clinic have all branched out and are developing partnerships in other African countries (discussed in this section of the paper under those countries).
- Momentum Africa, which is part of the Momentum group (SA's 3rd largest insurance company), has extended its operations to include aspects of insurance other than health insurance and is now also operating in Botswana, Ghana, Kenya, Lesotho, Mauritius, Mozambique, Namibia, Swaziland, Tanzania and Zambia (www.momentumafrica.com/company_profile.html)

- Sanlam, a South African insurance giant, acquired African Life Insurance (Aflife) in 2010. The company provides life insurance, health insurance and fund management and operates in South Africa, Namibia, Lesotho, Tanzania, Ghana and Kenya. Aflife specialises in low-cost insurance and is known for its AIDS insurance scheme in Zambia (www.insurance-guide.co.za/pub/ig-african-life-insurance.html).

There is also an increased focus on the market for health insurance to lower income groups. An example is the services provided by Yarona care (http://www.yaronacare.co.za/), which launched a pre-paid healthcare package that allows employers to purchase pre-paid healthcare for employees, to be saved on the beneficiary's cell phone and redeemed at a service provider. This service does not provide any risk pooling (Parker 2010).

4.12 Swaziland

Table 14: Swaziland's key health financing indicators (2009)

Total expenditure on health as a percentage of GDP*	6.3% ↓
Private expenditure on health as a percentage of total expenditure on health	36.7% ↓
Out of pocket expenditure as a percentage of private expenditure on health	*42.3%*↑
Private pre-paid plans as percentage of private expenditure in health	*18.9%*
General government expenditure on health as a percentage of total expenditure on health	63.3%↑
Government expenditure on health as a percentage of total government expenditure	*9.3%*↓
Social security expenditure on health as a percentage of general government expenditure on health	*0%*
External resources for health as a percentage of total expenditure on health**	12.2%↑

* Since 2005; ** From a low of 1.9% in 1995
Source: WHO (2009)

4.12.1 Revenue collection (sources of funds; contribution mechanisms & collecting organisations)

The Swaziland health system is 63% tax funded, 37% funded from private sources and 12% of THE is contributed by external funders. Of the private funding, 6% comes from private health insurance schemes, 15% as OOP payments from households, and 9% from non-profit organisations (Mathauer, Musango et al. 2011). Swaziland has a heavy reliance on external funding for preventive health programmes. There is a concern that this is unsustainable, as 72% of the national health budget is being absorbed by curative health interventions and central administration (Africa Health Workforce Observatory 2009).

4.12.2 Health service provision

There are two non-profit FBO hospitals and 73 other FBO facilities (including health centres, clinics and outreach services) that receive subsidies from the MoHSW. Additionally there are two specialised hospitals (one psychiatric and one TB hospital) in the same region (Africa Health Workforce Observatory 2009; Ministry of Health and Social Welfare 2009). There are also 22 industry-supported (work-based) clinics, 53 private clinics and four NGOs providing health care (Africa Health Workforce Observatory 2009). In terms of HRH, approximately 28.3% of health professionals

work in the private sector (including faith-based organisations) (Africa Health Workforce Observatory 2009).

4.12.3 Additional information

In 2011, Vantage Health announced in a press release that the company planned to establish a pharmaceutical plant as well as a BOOT (build, own, operate and transfer) referral hospital in partnership with the Kingdom of Swaziland (Ramakrishman and Sylvester 2011). Vantage Health also operates in South Africa and Tanzania. The South African subsidiary is called Moxisign (Pty) Ltd., 49% of which is owned by Kopano ke Matla Investment Company, the investment arm of the Congress of South African Trade Unions (COSATU). Likewise, the Tanzanian subsidiary, Vantage Health Tanzania Ltd is 49% owned by Tanzanian investors (Ramakrishman and Sylvester 2011).

In its press release Vantage Health acknowledged that:

> *"... as a new public company since February 2011, Vantage Health has the responsibility of utilising a business model that it believes will return shareholder value at the earliest opportunity. It is my belief that the partnerships and presence we are creating on this continent at this exciting time in Africa's history are critical in terms of recognising the 'first to market' imperative. In every location that we establish a new line of business, we seek to create an early revenue stream with the goal of significantly growing our top line sales on a consolidated basis, as well as achieving the necessary economies of scale that will also boost the future growth of our operating margins"* (Ramakrishman and Sylvester 2011).

4.13 United Republic of Tanzania

Table 15: Tanzania's key health financing indicators (2009)

Total expenditure on health as a percentage of GDP	5.1%↑
Private expenditure on health as a percentage of total expenditure on health*	26.4%↓
Out of pocket expenditure as a percentage of private expenditure on health	*65.1%↓*
*Private pre-paid plans as percentage of private expenditure in health***	*14.5%↑*
General government expenditure on health as a percentage of total expenditure on health	73.6%↑
Government expenditure on health as a percentage of total government expenditure	*18.1%↑*
Social security expenditure on health as a percentage of general government expenditure on health	*3.3%↑*
External resources for health as a percentage of total expenditure on health***	56.5%↑

* From 59.9% in 1995; ** From 4.5% in 1995; *** From 9.3% in 1995
Source: WHO (2009)

4.13.1 Revenue collection (sources of funds; contribution mechanisms & collecting organisations)

There are multiple financing mechanisms in the Tanzanian health system:

- Tax-based funding is managed by the Ministry of Health and Social Welfare, which also subsidises FBOs.

- User fees/cost sharing include OOP payments by patients at private and public health providers. About 93.8% of household health expenditure in 2006 was OOP expenditure.
- Donor funding/development partners include local and international NGOs that channel government, donor and other funding sources. The largest share of the increase in THE per capita can be contributed to the increase in external funding for HIV and AIDS interventions through the Global Fund, PEPFAR and the Basket Fund for Health arrangements.
- The private health insurance industry is well established but its contribution in terms of THE is small at 3.2%, partly due to the large informal employment sector. For those with private health insurance, employers contribute by paying the premiums on behalf of employees.
- Some employers (especially the parastatals) contribute to health care by providing health services at work, and/or reimbursements to employees for health care spending.

4.13.2 Pooling of funds (coverage; risk pools & allocation mechanisms)

The Community Health Fund (CHF), a partnership between communities and government, was introduced in 1996 and involves voluntary pre-paid schemes in each district for rural households. Communities decide how much they will contribute and the government commits to provide the same amount (most commonly US$4–8 per CHF member per annum). Non-member households must pay user fees at the time of service delivery. Similar funds in urban areas are called Tiba kwa Kwadi (TIKA). A limitation is that only about 2% of the population are members of the CHF, but the intention is to roll CHF and TIKA out to more communities.

In addition, Tanzania has a National Health Insurance Fund (NHIF), which is a mandatory health insurance scheme for public servants and their dependents. Members pay 3% of their basic salary and the government contributes another 3% of basic salary. Services can be used in public, faith-based and private health facilities. The NHIF contributes approximately 4% to the total health financing.

Tanzania has taken some steps towards universal coverage although the risk pools are still quite small and there is little cross-subsidisation between the employed and the unemployed or the wealthy and poorer districts and might therefore further entrench existing inequalities in the society.

4.13.3 Health service provision

Since the introduction of user fees, most of the population practise self-medication (Ministry of Health and Social Welfare 2006). This is especially true for malaria medications, which people often collect at private dispensaries to avoid the cost of a doctor’s consultation. In terms of OOP expenditure, most (44%) is spent at dispensaries; in comparison, less than 1% is spent at hospitals, with 20% at private not-for-profit facilities, 15% at private-for-profit facilities and about 5.6% at traditional practitioners, who represent a fast growing component of the private sector.

4.14 Uganda

Table 16: Uganda's key health financing indicators (2009)

Total expenditure on health as a percentage of GDP	8.2%↑
Private expenditure on health as a percentage of total expenditure on health	81%↑
Out of pocket expenditure as a percentage of private expenditure on health	*65.4%↓*
Private pre-paid plans as percentage of private expenditure in health	*0.1%*
General government expenditure on health as a percentage of total expenditure on health	19%↓
Government expenditure on health as a percentage of total government expenditure	*11.6%*
Social security expenditure on health as a percentage of general government expenditure on health	*0%*
External resources for health as a percentage of total expenditure on health*	20.9%↓

* Since 2005

Source: WHO (2009)

4.14.1 Revenue collection (sources of funds; contribution mechanisms & collecting organisations)

In Uganda, health care is financed through tax funding, household contributions in the form of OOP payments and contributions to either community-based health insurance (CBHI) or private health insurance schemes. OOP payments have been curbed, as user fees for essential health package services were abolished in 2001. Uganda also receives project funding from external funders and global funding initiatives.

In 2008, Zikusooka and Kyomuhangi completed a review of private medical pre-payment schemes in Uganda, recording 19 registered insurance companies in Uganda, with only two providing health insurance and two providing health insurance plus health services (a health maintenance organisation-type arrangement) (Zikusooka and Kyomuhangi 2008). All insurance companies in Uganda have to be registered with the Uganda Insurance Commission (www.uginscom.go.ug). By 2011, there were 22 registered insurance companies in Uganda of which 17 are now providing health insurance. One of these companies, NIKO Insurance, is assisted by the South African insurance company, Sanlam (http://www.nikoinsurance.co.ug/products.html). The other health insurance providers include:

- APA Insurance (Uganda) Ltd (http://www.apainsurance.org/index.php)
- Chartis Uganda insurance company (http://www.apainsurance.org/index.php)
- Ugamed medical scheme by East African Underwriters Ltd (http://www.ugamed.net/)
- Insurance Company of East Africa (http://www.icea.co.ke/for-individuals/)
- The Jubilee Insurance Company of Uganda (http://www.jubileeholdings.com/jubilee-group/jubilee-insurance/uganda/products/corporate-products/medical/)
- UAP Insurance Uganda Ltd (http://www.uap.co.ug/).

In addition, African Air Rescue (http://www.aarhealth.com/our-services.html) and the International Medical Group (http://www.img.co.ug/aboutus/index.php), the two largest private health care organisations in Uganda, are providing "health maintenance" services. African Air Rescue (AAR) provides services in Kenya,

Uganda and Tanzania and is re-insured by Lloyds, a UK-based insurance company. The International Medical Group (IMG) provides a comprehensive service through their network:

- International Medical Centre, an outpatient based facility;
- International Hospital Kapala, an inpatient facility which provides specialised medical services;
- International Air Ambulance which provides health insurance as well as air rescue and evacuation services;
- IAA managed health care schemes; and
- Uganda health management institute which offers training.

In the case of both of these organisations, patients are not required to pay any co-payments at the point of care (Zikusooka and Kyomuhangi 2008).

4.14.2 Pooling of funds (coverage; risk pools & allocation mechanisms)

There is some risk pooling within the health sector in Uganda through CBHI schemes. CBHI schemes are classified according to Kwanuka-Mukiibi (2005) as either facility-based insurance schemes or as community-based credit/mixed schemes (Kiwanuka-Mukiibi, Derriennic et al. 2005). There are currently 11 CBHIs in Uganda but they are experiencing problems due to low recruitment and retention, high management costs and low uptake by poorer people (Uganda Ministry of Health and Macro International inc. 2008).

4.14.3 Health service provision

Private (for-profit) health providers are more numerous than government and not-for-profit health providers. The private sector focuses on curative services while preventive services are limited. The total number of health facilities is estimated at 4,639, of which 2,154 (46%) are private health providers (Mandelli, Kyomuhangi et al. 2005). An estimated 12, 775 health workers are employed in the private health sector.

A survey conducted in 2005 to poll health professionals found that 54% of doctors in the private sector also work in the government sector (called “dual practice”), compared to less than 10% of private sector nurses, midwives and nursing aides (Mandelli, Kyomuhangi et al. 2005). In other words, 9,500 health professionals work exclusively in the private sector, including more than 1,500 doctors and 3,500 nurses (ibid).

4.14.4 Additional information

Uganda started implementing incentive systems for patients and private providers in 2004 with the support of the German development bank (Kfw) and the World Bank. Its voucher-based project – similar to that described under Kenya’s country profile in this paper – was implemented to increase utilisation of facility-based sexually transmitted infection services and safe motherhood services In Uganda though, the programme also incorporates incentives for providers in the form of a Pay for Performance (P4P) strategy whereby providers are remunerated based on their ability to reach certain targets. The programme also uses private providers, and this has given the MoH greater leverage to regulate the private sector through the use of financial incentives (Bellows and Hamilton 2009).

USAID Uganda has been equipping private health care providers in terms of the capital to start and improve practices as well as business and marketing skills. In 2001, the Uganda Private Health Providers' Loan Fund was started to provide capital to small and large private providers. The repayment rate is said to be 97% and, until 2003, no loans had been written off. The fund is administered by the Uganda Micro-finance Union and the initial bulk stock for loans was provided by the Summa Foundation, a non-profit investment fund created by USAID. The fund has reportedly made loans to more than 500 private doctors, nurses, midwives and clinical officers. Loan recipients are also provided with business skills training (USAID 2003).

4.15 Zambia

Table 17: Zambia's key health financing indicators (2009)

Total expenditure on health as a percentage of GDP	6.1%
Private expenditure on health as a percentage of total expenditure on health	40.5%
Out of pocket expenditure as a percentage of private expenditure on health	*67.2%↓*
Private pre-paid plans as percentage of private expenditure in health	*3.7%*
General government expenditure on health as a percentage of total expenditure on health	59.5%
Government expenditure on health as a percentage of total government expenditure	*15.7%*
Social security expenditure on health as a percentage of general government expenditure on health	*0%*
External resources for health as a percentage of total expenditure on health*	39.1%↑

* From 13.4% in 2001
Source: WHO (2009)

4.15.1 Revenue collection (sources of funds; contribution mechanisms & collecting organisations)

Government expenditure is still the most prevalent funding mechanism in Zambia at 51.4% of total health expenditure and is funded from taxes and external funders, while private expenditure is 48.6% of total health expenditure and includes external funding, private firms and households. Similar to other countries in this review, Zambia has seen increased levels of donor health funding from PEPFAR and the PMI. User fees for basic packages at rural facilities were eliminated in 2006; however user fees for HIV and AIDS care remained. This places an enormous burden on People Living with HIV and AIDS (PLWHA) who spend 12 times more on health care than those who are HIV negative.

4.15.3 Pooling of funds (coverage; risk pools & allocation mechanisms)

Less than 3% of the population in Zambia has private health insurance cover and there is no social health insurance fund (Islam 2007).

4.15.4 Health service provision

In the more rural areas, about 30% of health services are provided by FBOs or the private religious sector. Given the public's poor perception of the allopathic health services provided, the informal private sector of traditional healers is substantial and has historically played an important role, with most household spending on private providers going to traditional healers.

4.16 Zimbabwe

Table 18: Zimbabwe's key health financing indicators (2001)

Total expenditure on health as a percentage of GDP	0%
Private expenditure on health as a percentage of total expenditure on health	61.6%
Out of pocket expenditure as a percentage of private expenditure on health	*50.3%*
Private pre-paid plans as percentage of private expenditure in health	*28.8%*
General government expenditure on health as a percentage of total expenditure on health	38.4%
Government expenditure on health as a percentage of total government expenditure	*0%*
Social security expenditure on health as a percentage of general government expenditure on health	*0%*
External resources for health as a percentage of total expenditure on health	5.5%

Source: WHO (2009)

4.16.1 Revenue collection (sources of funds; contribution mechanisms & collecting organisations)

The recent history of Zimbabwe is characterised by economic instability, hyperinflation, a related devaluation of the funds allocated to health facilities and the consequent inability to pay wages and buy supplies. To some extent, FBOs and private facilities were able to step in and provide services but the combined effect has been an increase in the incidence of preventable diseases (Osika, Altman et al. 2010). Historically, Zimbabwe had a health service fund, which was established in 1996 and provided equalisation grants from the Ministry of Finance (MOF) to districts that were collecting lower than average user fees. This fund was however abolished in 2008 and this has led to an increased dependency by health facilities on user fees. In addition, there is a lack of transparency as to the process of determining the value of user fees charged, so user fees therefore often vary per facility (Osika, Altman et al. 2010). As contributions from the Zimbabwean government were reduced drastically, the financial burden for health care is now covered by external funders and households whose contributions to health expenditure increased from 23% to 62%. This translates into a heavy financial burden on households. The contributions from households are made through user fees, OOP payments, private health insurance premiums and co-payments. Similar to many of the other countries in this review, the private health insurance industry is growing in Zimbabwe (see below).

Due to the constraints on tax based funding and the pressure on households, the health sector is increasingly reliant on external funds (mostly used to purchase medication), including funding from USAID, the UK Department of International Development, the EU, and the United Nations (UN). External funders predominantly provide vertical programme/disease specific support and there are concerns that external funders' interest in specific diseases will be a key determinant of capital flow (Osika, Altman et al. 2010).

4.16.2 Pooling of funds (coverage; risk pools & allocation mechanisms)

The health insurance industry is estimated to cover less than 1% of the population, to provide 80% of income to private health care providers, and to contribute more than 20% of the country's THE. It has been suggested that in 2008, as unemployment rose combined with the economic instability in the country; it caused shrinkage in the industry (Osika, Altman et al. 2010; Shamu, Loewenson et al. 2010).

The BHF lists 11 members that are currently providing health insurance services in Zimbabwe. These include: Blanket Mine Medical Aid; CIMAS medical aid society (http://www.cimas.co.zw/cimas/Home.nsf/Editing+Documents+View+Web/Cimas+History?OpenDocument); Engineering medical aid; Generation health medical aid; Harare municipality medical aid; Kwekwe city medical aid; Medical Aid Society of Central Africa (MASCA); Municipality of Bulawayo medical aid; Northern medical aid; Zenith medical aid; and Zimpapers medical aid. There are concerns in Zimbabwe that due to the lack of regulation of for-profit medical insurance companies, there have been many quick start-ups to make fast money without established business plans or agreements to protect subscribers (Osika, Altman et al. 2010).

4.16.3 Health service provision

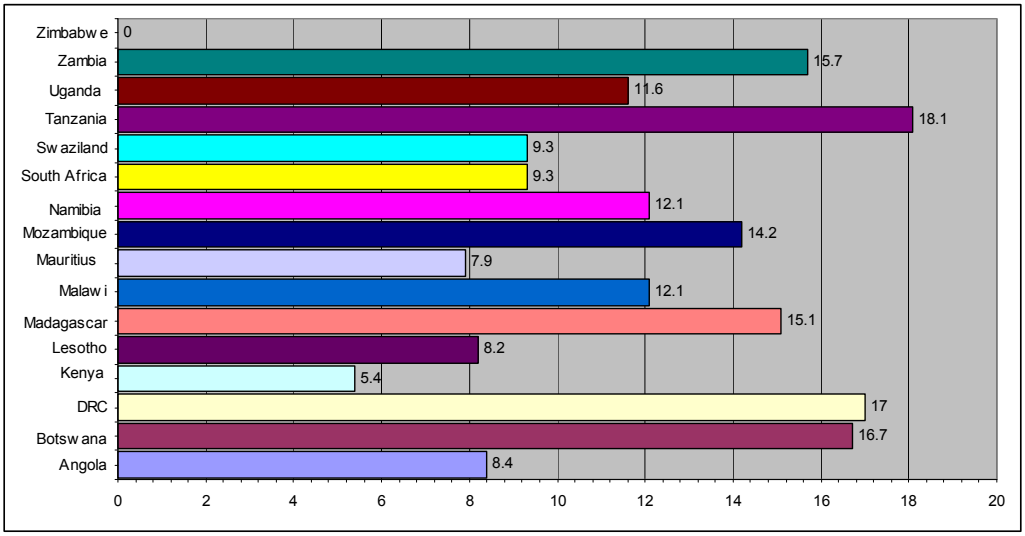
About 6.7% of health care centres in Zimbabwe – including six hospitals functioning as district hospitals – are managed by FBOs. These facilities receive a government subsidy and are purported to be predominantly in the more rural areas. In addition to public- and FBO-managed facilities, non-profit groups also provide services as well as employer-operated clinics and for-profit facilities, which are mostly concentrated in urban areas. There is also a sizeable traditional medicine sector in Zimbabwe (Osika, Altman et al. 2010). When one considers hospital in-patient services, according to the 2010 health service assessment, 39% (4,511) of beds are attributable to FBOs, which are partially funded by the government, compared to 3.7% (421) by the private for-profit sector. (Osika, Altman et al. 2010) There is some indication that Netcare will be expanding and providing services in Zimbabwe (Mzolo 2009).

5. Review of the nature and extent of the private health sector in ESA countries

The country profiles above provide a brief overview of the nature of the private sector in 16 very diverse east- and southern African countries. There are, however, some distinct trends. Most of the countries have an ageing or insufficient public health infrastructure to provide the health care needed by the population. Many have not benefited from sustained investment in infrastructure or are still struggling with the effects of war, such as Angola and the DRC. In some, decisions were made to contract out specialist health care to neighbouring countries, at the cost of tax-payers. This is true for Botswana, Swaziland and Lesotho. There are concerns that these services are charged for, by the country providing the service, at exorbitant rates, a sentiment expressed by the Botswana government (Mclea 2011).

In 2001, the heads of the African Union (AU) states signed the Abuja declaration and pledged to commit at least 15% of their governments' budgets to health. Ten years later, only five out of the sixteen countries reviewed are spending 15% or more of government expenditure on health (see *Figure 6*), but it should be noted that in many instances, these figures include tax funding as well as external funding channelled via government and are therefore not an accurate reflection of government spending on health.

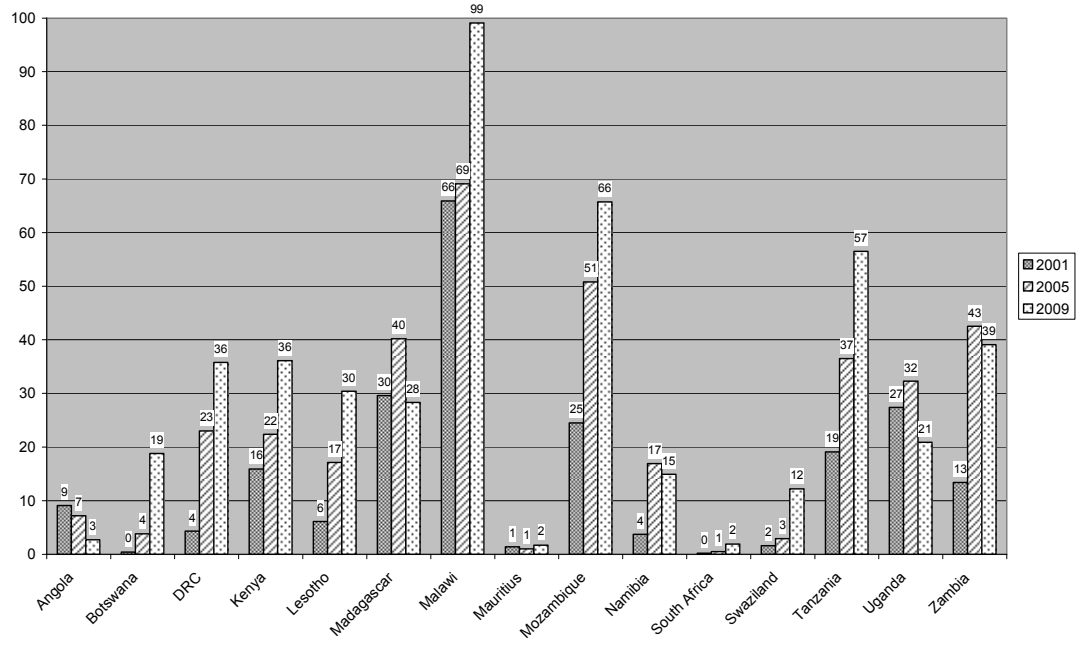
Figure 6: ECSA government (including external funding) expenditure on health (%)



Source: WHO (2009)

Country's contributions to health are often supplemented by external or external funding (which may flow via either government or private channels). *Figure 7* graphically presents the growth of external funding as a percentage of countries' total health expenditure (THE).

Figure 7: ECSA External resources on health as a percentage of THE



Source: WHO (2009)

Reliance on external resources varied between countries from South Africa and Mauritius, with limited reliance on external funding, to Malawi and Mozambique, countries, which are heavily reliant on external funding. The influx of external resources/external funding aimed at helping countries to deal with the HIV and AIDS pandemic is not necessarily providing sustainable relief as it predominantly supports vertical programmes and does not provide funding for much needed infrastructure or

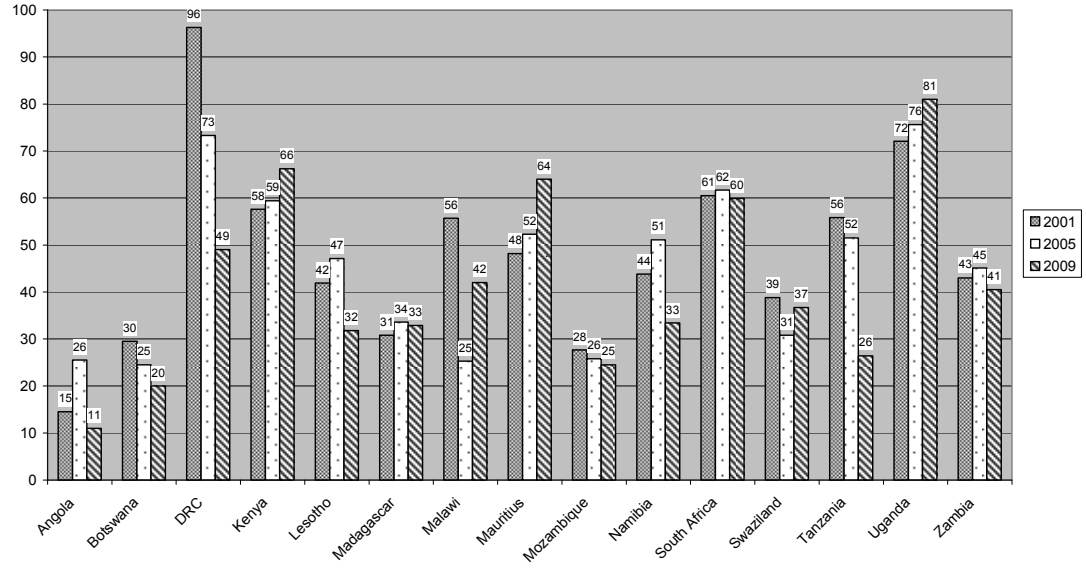
other health system strengthening spending, leaving countries in the same position (if not worse off) once funding is withdrawn.

Very few countries in East and Southern Africa have any form of mandatory health insurance. Even countries such as Tanzania that have introduced a mandatory scheme are generating little revenue and covering very few people through this financing mechanism.

The burden of the shortfall in funding (between what is required to fund health services and that generated from tax, external funders and mandatory insurance schemes) therefore falls on households. This has traditionally taken the form of out-of-pocket payments made at the point of service, either directly to private providers, or with World Bank encouragement in the 1980s, through user fees at public facilities. Out-of-pocket payments can have disastrous effects on households, where people could spend substantial amounts of family resources to purchase healthcare for the ill.

Figure 8 outlines the size of the private sector in terms of share of health care expenditure in each East and Southern African country. In most of these countries, private spending is greater than one-third of total health care expenditure.

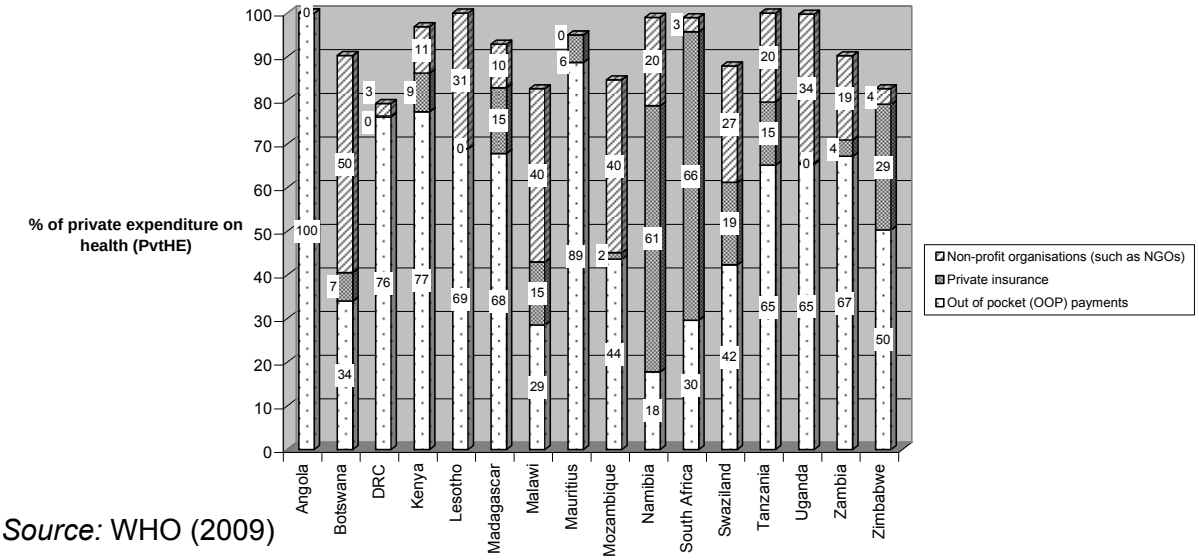
Figure 8: Private expenditure on health as a percentage of total health expenditure



Source: WHO (2009)

Figure 9 summarises the different components of private health sector expenditure in each country. Private health insurance plays a key role in only a few of the countries reviewed, including South Africa, Namibia and Zimbabwe. In most of the other countries, the growth of the private health insurance market is constrained by the population's lack of access to formal sector employment and inability to afford private health insurance.

Figure 9: Overview of the private health sector by country



Source: WHO (2009)

In other countries, OOPs predominate, being well over 50% of private health care expenditure in most countries and particularly high in countries such as Angola, Mauritius, Kenya and the DRC. This has raised considerable concerns about the impact of this form of financing on the livelihoods of individual households. Since the 1990s, some of the countries featured in the review have introduced voluntary private schemes for those outside the formal sector, as an attempt to provide some financial risk protection. These take the form of what is called community-based health insurance (CBHI) or sometimes also called micro-insurance. An example would be the *mutuelles* in Madagascar, whereby people living within a community can contribute towards the fund in the form of agricultural produce at harvest time. These contributions then allow them to receive a limited and predefined package of health care. However, those who do not contribute to the *mutuelles* don't benefit and this system therefore does not promote income and risk cross-subsidies in the overall health system.

The World Bank was the main proponent of such schemes initially. For example, it played a key role in developing the Community Health Fund initiative in Tanzania. More recently, PharmAccess, a Dutch organisation, has been particularly active in promoting CBHI in African countries while micro-health insurance or low cost health insurance options are particularly driven by the University of Cologne (http://www.microhealthinsurance-africa.org/about.html). The latter initiative provides training on micro-health insurance as well as hosts conferences to discuss country-specific solutions (Leppert 2008).

Figure 9 also shows how funding via NGOs, often faith-based organisations, can be very important, especially in some countries such as Botswana and Malawi. In terms of private health care provision, some countries have quite extensive faith-based facility networks. Although information on informal private providers (such as drug shops) is limited, they are known to be very extensive in most east and southern African countries, with the notable exception of South Africa. While South Africa undoubtedly has the largest private-for-profit health care provision sector, this sector is growing rapidly in other countries, spurred on by various internationally funded initiatives (see Doherty 2011 for more details).

6. Conclusion and recommendations

A number of powerful international organisations such as the World Bank and certain bilateral organisations are actively promoting the growth of the private health sector in African countries. Particular emphasis has been placed by these organisations on expanding voluntary health insurance, generally in the form of CBHIs or micro-insurance schemes, but also private insurance for formal sector employees and private for-profit service delivery. There are concerns though that these initiatives may increase health inequities.

A key constraint in undertaking this review was the very limited information available on the size and recent growth patterns in private funding and service provision. It is critical that Ministries of Health pay greater attention to what is happening in their private health sectors, create a coherent regulatory framework within which they operate to protect the public interest, and require private insurance schemes and providers to provide routine information on their activities to enhance monitoring and evaluation of the private health sector. The routine compilation of such information will contribute to the assessment of the equity impact of private sector expansion in health care financing and provision.

References

1. Africa Health Workforce Observatory (2009) *Swaziland Human Resources for Health Country Profile*. World Health Organisation: Geneva.
2. Aguemon H, Mireles I and Ogilvie S (no date) 'Angola Financial Systems.' Retrieved 29 August 2011, from http://fic.wharton.upenn.edu/fic/africa/angola%20final-final.pdf.
3. Arur A, Sulzbach S, Barnes J, O'Hanlon B and Altman D (2010) 'Strengthening health systems by engaging the private health sector: promising HIV/AIDS partnerships'. *USAID HIV/AIDS Policy Brief*. Abt associates Inc: Maryland, USA.
4. Barnes J, O'Hanlon B, Feeley F, McKeon K, Gitonga N and Decker C (2009) 'Private health sector assessment in Kenya'. *World Bank Working Paper 193*. USAID: Bethesda, USA.
5. Bellows B and Hamilton M (2009) 'Vouchers for health: Increasing utilization of facility-based STI and safe motherhood services in Uganda: Maternal and child health P4P case study'. *Health Systems 20/20 Project*. Abt Associates Inc: Bethesda, USA.
6. Bennett S and Ngalande-Banda E (1994) 'Public and private roles in health: A review and analysis of experience in sub-Saharan Africa'. *ARA Paper 6.* World Health Organisation: Geneva.
7. Board of Healthcare Funders (2011) 'Board of Healthcare Funders of Southern Africa: Members.' Retrieved 8 September 2011, from http://www.bhfglobal.com/bhf-members.
8. Climed (2011) Climed Clients at at http://www.climedweb.com/clients.html
9. Connor C, Averbug D and Miralles M (2010) 'Angola Health System Assessment 2010'. USAID: USA.
10. Connor C, Rajkotia Y, Lin YS and Figueiredo P (2005) 'Angola Health Assessment 2005'. USAID: USA.
11. Council of Medical Schemes (2011) 'Annual report 2010/2011'.
12. Delamalle JP (2004) 'Case Study 3: 'Review of the EU intervention in the health sector in the Democratic Republic of the Congo from 1994'. DFID: UK.
13. Democratic Republic of the Congo Ministry of Health (2006) 'Health-system strengthening strategy'. Retrieved 27 February 2012, from http://www.minisanterdc.cd/Articles/srss/srss_rdc_web_en.pdf.
14. Department of Health (2011) 'National Health Insurance in South Africa: Policy paper'. South African National Department of Health: Pretoria.
15. Devi S (2008) 'World report: Mauritius counts health successes.' *The Lancet* 371: 1567-1568. at www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)60674-1/fulltext
16. Doherty J (2011) 'Expansion of the private health sector in East and Southern Africa'. *EQUINET Discussion Paper 87*. EQUINET: Harare.
17. Dreesch N, Nyoni J, Mokopakgosi O Seipone K, Kalilani J A, Kaluwa O and Musowe V (2007) 'Public-private options for expanding access to human resources for HIV/AIDS in Botswana.' *Human Resources for Health* 5(25), 19 October 2007.
18. Global Health Insurance. 'Democratic republic of the Congo: Health insurance advice.' Retrieved 29 August 2011, from http://www.global-health-insurance.com/countries/dr-congo/.
19. Global Health Insurance (2007) 'Botswana health insurance advice.'
20. Global health ministries. 'Madagascar.' Retrieved 3 August 2011, from http://www.ghm.org/countries/madagascar.html.
21. Global Ministries (no date) 'Christian health association of Lesotho.' Retrieved 1 August 2011, from http://www.globalministries.org/africa/projects/christian-health-association-of.html
22. Government of Namibia, Health Systems 20/20 Project, World Health Organisation, and UNAIDS (2010) 'Namibia health and HIV/AIDS resource tracking: 2007/2008 and 2008/2009'. Abt Associates Inc: Bethesda, USA.
23. Hanson K and Berman P (1994) 'Non-government financing and provision of health services in Africa: A background paper', USAID: USA.
24. International Finance Corporation (2007) 'The business of health in Africa'. World Bank Group: Washington, USA.
25. International Finance Corporation (2008) 'The business of health in Africa'. World Bank Group: Washington, USA.

26. IRIN News (2011) 'Madagascar: Health care by hovercraft.' Retrieved 3 August 2011, from http://allafrica.com/stories/201106171107.html
27. Islam M (2007) 'Health systems country brief: Zambia'. *Health systems 20/20 Country Brief*. Bethesda, Maryland, Abt associates Inc.
28. Kiwanuka-Mukiibi P, Derriennic Y and Karungi G (2005) 'The good practice model: Community partcipation in Luweero district, Uganda'. *The Partners For Health Reform Plus project*. Abt Associates Inc.: Bethesda, USA.
29. Kutzin J (2001) 'A descriptive framework for country-level analysis of health care financing arrangements.' *Health Policy* 56: 171-204.
30. Leppert G (2008) 'Financing health care: The role of micro health insurance in sub-Saharan Africa'. Paper presented at Risk and Africa International Symposium, University of Cologne, Germany. Retrieved 27 February 2012, from http://www.microhealthinsurance-africa.org/fileadmin/user_upload/Leppert-2008_Micro-health-insurance-Sub-Saharan-Africa.pdf.
31. Makholwa A (2010) 'Lesotho key to Netcare Africa growth'. *Fin24*, 17 May 2010.
32. Mandelli A, Kyomuhangi LB and Scribner S (2005) 'Survey of private health facilities in Uganda'. *The Partners For Health Reform Plus project.* Abt associates Inc.: Maryland, USA.
33. Marek T, O'Farrell C, Yamamoto C and Zable I (2005) 'Trends and opportunities in public-private partnerships to improve health service delivery in Africa'. *Africa Region Human Development Working Paper series.* World Bank: USA.
34. Mathauer I, Musango L, Sibandze S, Mthethwa K and Carrin G (2011) 'Is universal coverage via social health insurance financially feasible in Swaziland?' *South African Medical Journal* 101: 179-183.
35. May CI and Bonu V (2009) 'Combating HIV/AIDS-related problems in Botswana: The potential role of micro health insurance'. *Paper delivered at Conference of the Network Pro Micro Health Insurance Africa, Lilongwe*. Retrieved 27 February 2012, from http://www.microhealthinsurance-africa.org/fileadmin/user_upload/May_HIV-Botswana.pdf
36. McIntyre D (2010) 'Private sector involvement in funding and providing health services in South Africa: Implications for equity and access to health care'. *EQUINET Discussion Paper 54*. EQUINET: Harare.
37. Mclea H (2011) 'SA hospitals rip us off, says Botswana.' *Sowetan*, 23 March 2011.
38. Ministere de la Sante et du Planning Familial (2003) 'National Health Accounts'. Madagascar government printers: Antanarivo.
39. Ministry of Health and Social Welfare (2006) 'Tanzania National Health Accounts year 2002/2003 and 2005/2006'. Tanzania government printers: Daar es Salaam.
40. Ministry of Health and Social Welfare (2009) 'National Health Policy'. Swaziland government printers: Mbabane.
41. Ministry of Health (2006) 'National health accounts 2004-2006.' Mozambique government printers: Maputo.
42. Mtonya B and Chizimbi S (2006) 'Systemwide effects of the Global Fund in Malawi: Final Report'. *The Partners For Health Reform Plus project.* Abt Associates Inc.: USA.
43. Mwase T, Kariisa E, Doherty J, Hoohlo-Khotle N, Kiwanauka-Mukiibi P and Williamson T (2010) 'Lesotho health systems assessment 2010'. Abt Associates: Bethesda, USA.
44. Mzolo, S (2009) 'Netcare: straddling Africa.' *Financial Mail*, 5 June 2009.
45. Oppenheim G, Sullivan B, O'Neill R and Spital L (2010) 'Botswana healthcare from a public, private and international perspective.' Penn Nursing: Botswana.
46. Osika J, Altman D, Ekbladh L, Katz I, Nguyen H, Rosenfeld J, Williamson T and Tapera S (2010) 'Zimbabwe health system assessment 2010'. *Health Systems 20/20 Project*. Abt associates Inc.: Bethesda, USA.
47. Parker F (2010) 'Pay-as-you-go healthcare launches in South Africa'. *Mail & Guardian Online*, 2 December 2010.
48. Ramakrishman L and Sylvester K (2011) 'Vantage health announces plan to establish pharmaceutical plant, hospital in the Kingdom of Swaziland, in partnership with Swaziland government.' Retrieved 3 August 2011, from http://www.abc12.com/story/15139606/vantage-health-announces-plan-to-establish-pharmaceutical-plant-hospital-in-the-kingdom-of-swaziland-in-partnership-with-swaziland-government?clienttype=printable

49. Shamu S, Loewenson R, Machemedze R and Mabika A (2010) 'Capital flows through medical aid societies in Zimbabwe's health sector'. *EQUINET Discussion Paper 82.* EQUINET: Harare.
50. Struwig B (2004) 'Promosieblad: Van klein Namibiese firma tot Afrika-reus'. *Rapport*. Johannesburg, 30 May 2004. at http://152.111.1.87/argief/berigte/rapport/2004/05/30/R1/31/04.html
51. Uganda Ministry of Health and Macro International Inc. (2008) 'Uganda service provision assessment survey 2007'. Ministry of Health & Macro international Inc.: Kampala.
52. USAID (2003) 'Uganda private health providers reach more clients with better quality services.' *Sub-Saharan Africa success stories.* Retrieved 5 August 2011, from http://africastories.usaid.gov/search_details.cfm?storyID=171&countryID=27&sectorID=0&yearID=3.
53. USAID (2007) 'Country brief: Mozambique'. USAID: USA.
54. Wearden G (2009) 'A public-private approach to healthcare'. *Mail and Guardian Online*, 21 June 2009.
55. Weisburst M (2008) 'Industry insights: The public health crisis in Kenya: an inside perspective on the medical and economic challenges.' *Stanford University School of Medicine Career Centre.* Retrieved 14 October 2008, from http://med.stanford.edu/careercenter/calendar/events/08oct_international_health_weistburst.html
56. Wilson B (2007) 'The private sector response to AIDS in Botswana.' *The Lancet* 7(12): 766, 1 December 2007
57. World Health Organisation (2008) 'Country cooperation strategy at a glance: Maritius'. World Health Organisation: Geneva.
58. World Health Organisation (2009) 'National Health Accounts.' Retrieved 26 July 2011, from http://www.who.int/nha/country/en/.
59. World Health Organisation (2010) 'Health systems financing: The path to universal coverage'. in *The World Health Report*. World Health Organisation: Geneva.
60. Yinusa O and Okurut F (2009) 'Determinants of demand for micro health insurance in Botswana'. *Paper presented at Micro Health Insurance and Health Care Financing conference, Lilongwe, Malawi*. Pro MHI Africa: Lilongwe.
61. Zikusooka CM and Kyomuhangi R (2008) 'Private medical pre-payment and insurance schemes in Uganda: What can the proposed SHI policy learn from them?' *EQUINET Discussion Paper 53*. EQUINET: Harare.

Acronyms

AFA	Associated Fund Administrators
AHWO	Africa Health Workforce Observatory
AIDS	Acquired Immune Deficiency Syndrome
BHF	Board of Healthcare Funders
BLM	Banja La Mtsogolo
CBHI	Community Based Health Insurance
CBO	Community Based Organisation
CHAL	Christian Health Association of Lesotho
CHAM	Christian Health Association of Malawi
CHF	Community Health Fund
CMS	Council of Medical Schemes
COSATU	Congress Of South African Trade Unions
DRC	The Democratic Republic of the Congo (also called Congo-Kinshasa) and not to be confused with it's neighbour to the west, Republic of the Congo (also called Congo-Brazzaville).
ESA	East- and Southern Africa
EU	European Union
FBO	Faith Based Organisation
GDP	Gross Domestic Product
HRH	Human Resources for Health
IFC	International Finance Corporation
KAP	Knowledge Attitudes and Practices
MCC	Millennium Challenge Corporation
MHSW	Ministry of Health and Social Welfare
MoH	Ministry of Health
MoHSW	Ministry Of Health and Social Welfare
MSF	Medecins Sans Frontieres (Doctors Without Borders)
NGO	Non-Governmental Organisation
NHA	National Health Accounts
NHI	National Health Insurance
NHIF	National Hospital Insurance Fund
NHS	National Health System
OECD	Organisation for Economic Co-operation and Development
OOP	Out Of Pocket
P4P	Pay For Performance
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	People Living With HIV and AIDS
PMI	President's Malaria Initiative
RSA	Republic of South Africa
SACU	South Africa Customs Unions
SHI	Social Health Insurance
SOA	Salfa Overseas Assistance
THE	Total Hhealth Eexpenditure
TIKA	TIba Kwa kwAdi
UK	United Kingdom
UN	United Nations
UNDP	United Nations Development Programme
URT	United Republic of Tanzania
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organisation

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair Financing of health systems
- Valuing and retaining health workers
- Organising participatory, people centred health systems
- Social empowerment and action for health
- Monitoring progress through country and regional equity watches

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET from the following institutions:
TARSC, Zimbabwe; CWGH, Zimbabwe; University of Cape Town (UCT), South Africa; Health Economics Unit, Cape Town, South Africa; MHEN Malawi; HEPS Uganda, University of Limpopo, South Africa, University of Namibia; University of Western Cape, SEATINI, Zimbabwe; REACH Trust Malawi; Min of Health Mozambique; Ifakara Health Institute, Tanzania, Kenya Health Equity Network; and SEAPACOH

For further information on EQUINET please contact the secretariat:
Training and Research Support Centre (TARSC)
Box CY2720, Causeway, Harare, Zimbabwe Tel + 263 4 705108/708835 Fax + 737220
Email: admin@equinetafrica.org
Website: www.equinetafrica.org

Series Editor: Rene Loewenson
Issue Editor: P Norden, D McIntyre