Enhancing industrial productivity, health sector performance and policy synergies for local health in Kenya and Tanzania

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The study: Industrial productivity and health sector performance

Collaborative ESRC-funded research project between:

- REPOA, Tanzania
- African Centre for Technology Studies (ACTS), Kenya
- The Open University (OU), UK

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Research question:

Can improved local supply of medicines and other health sector requirements strengthen health system performance while contributing to industrial development?

The intellectual and policy puzzle

1. A major reason for poor health sector performance in low and lower middle income African countries, such as Tanzania and Kenya, is chronic shortage of supplies.
2. Many of those supplies are, or could be, produced within those countries; both Tanzania and Kenya have long standing industrial sectors including pharmaceuticals.
3. So what are the conditions under which local industrial production of supplies can improve to the benefit of the populations requiring health care;
4. and if there are mutual benefits to be extracted by sellers, buyers and users, why isn't it happening?

Health sector supplies problems continue

In both countries, public sector stock-outs continue:

Availability of tracer essential medicines on day of visit (2012/13)

Country	Public hospitals	Public health centres and dispensaries
Kenya	60%	46%
Tanzania	86%	58%

Frequently missing items included medicines for chronic illnesses, and anti-haemorrhage medicine for maternity care; also basics including gloves, syringes, disinfectant.

Shortages worsen ill health and poverty

In both countries private out-of-pocket (OOP) purchase of medicines worsens impoverishment.

- In Kenya about 80% of medicines are bought privately, mainly OOP;
- In Tanzania patients rely heavily on drug shops for access to medicines.

Total supplies available have expanded through rising imports in both countries, but access remains a challenge.

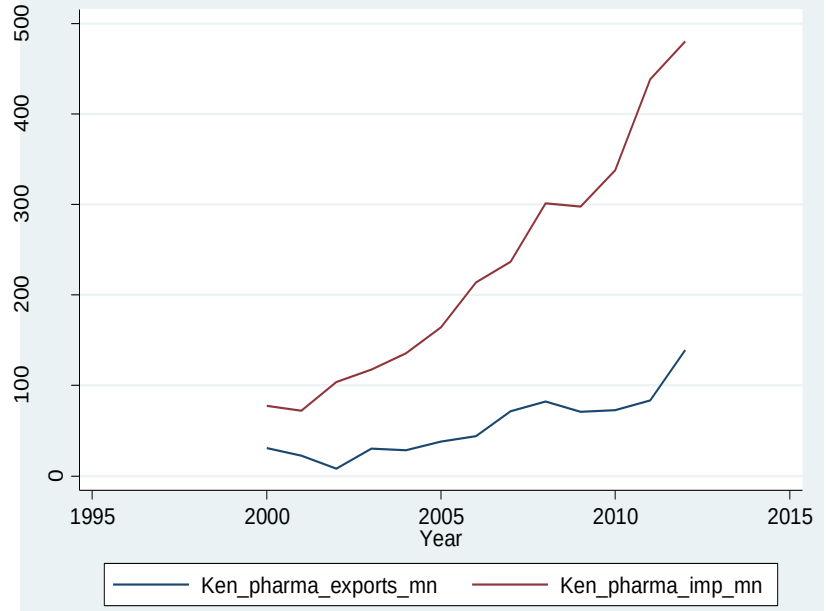
Industrially, the health market expansion is an opportunity not being seized

The East African health supplies market is large and expanding, but is not benefitting locally based manufacturers as it might. In pharmaceuticals:

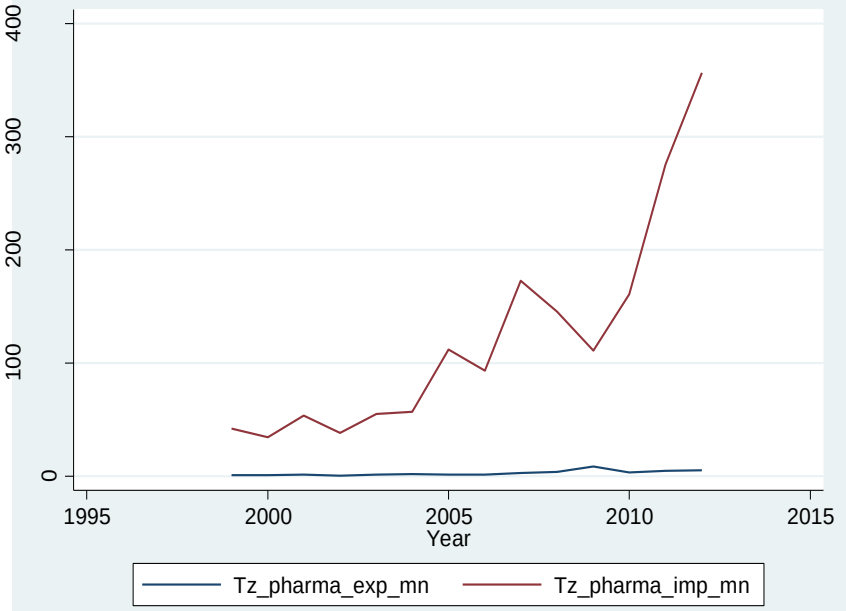
- Kenya is the leading COMESA pharmaceutical producer, with ~50% of regional production and rising exports, yet supplies just 25% of the Kenyan market and only 0.2-0.3% of the COMESA market;
- Tanzania supplies a declining share of its own domestic medicines market, down from 35% in 2009 to less than 20% today, and exports are flat-lining.

Contrasting industrial experiences in pharmaceuticals

Kenya expanding both imports and exports ($m)



Tanzania expanding imports, exports stagnating ($m)



However both could do much better in integrating improved access with industrial development .

It’s not just about talking to each other…

More health-industry policy discussions needed.

But the real challenge is innovation and transformation in both sectors, to allow then to work together :

- Structural transformation in health sector to sharply reduce reliance on OOP purchase by patients
- Transformation in procurement incentives and management
- Industrial innovation and investment to serve population needs better.

In the health sector:

- A much lower proportion of medicines access needs to go through private shops in both countries;
- More access needs to be free or at very low cost, implying more public and NGO/FBO supply;
- Access needs to be increasingly associated with proper diagnosis and dispensing;
- Implies more and more reliable public and donor funding for the whole range of essential medicines and supplies, including antibiotics and chronic disease medicines, gloves and test kits.

In procurement:

Reducing barriers to entry for local firms, by revising:

- Private sector importer/wholesaler incentives and challenging business links with overseas exporters;
- Public procurement rules and practices : trade credit, tender size, contract length and structure, payment reliability, accreditation of suppliers, decision rules;
- Role of NGO/non-profit/FBO wholesalers, and pattern of wholesale competition;
- Preferences of donors for large overseas orders, and role of donors in setting procurement systems and fragmenting supply chains;
- Involvement of local procurement officers and clinicians in supply chain design.

In the industrial sector

All firms interviewed were constantly upgrading to meet competition and regulatory rules. Requirements for supplying more of the expanding market:

- Investment in process and product improvement
- Improving supply times and reliability;
- Improving local marketing and distribution;
- Incentivising improvements in upstream input suppliers
- Making accessible new product investment e.g. labour intensive assembly, lower technology start-ups;
- Identifying scope for moving up technological ladder, including moves into active pharmaceutical ingredients (API) production;
- Improving supply offer for donor-financed markets.

In industrial policy

- Revision of taxes and duties to incentivise local production over imports;
- List of products for local supply only, and criteria for retaining or removing items;
- Work with donors to support step-up in technological capabilities of local firms;
- Public pricing policies that ensure local supply can be profitable for basic items, given infrastructure weaknesses and dumping episodes;
- Strategic investments in technical training and support for firms that train effectively;

Generating mutually supportive improvement in health system, industrial and government/regulatory capabilities

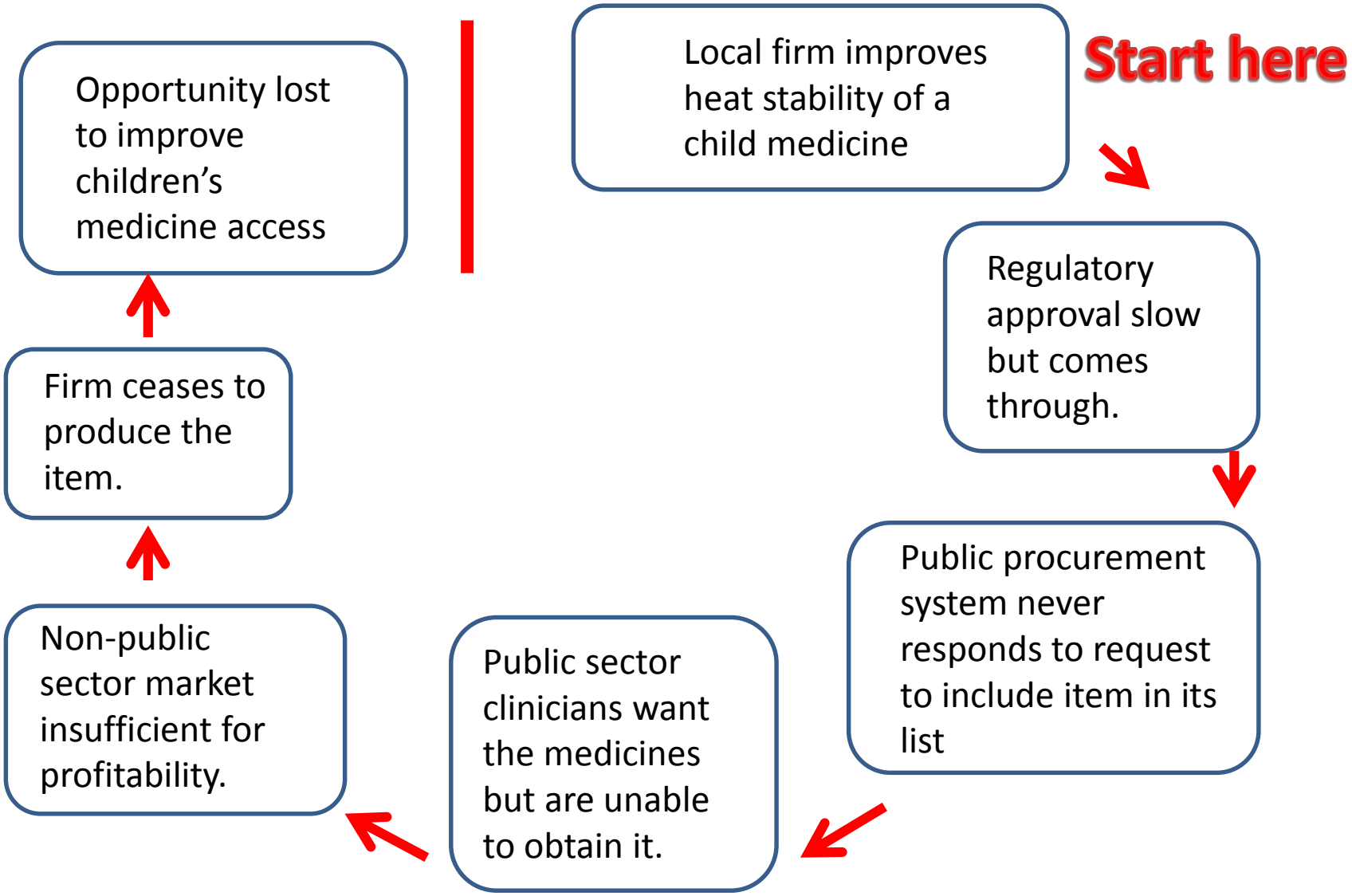
Current interactions generate quite a lot of exclusion from care alongside very high import dependence.

All firms rely on their domestic markets for their core business.

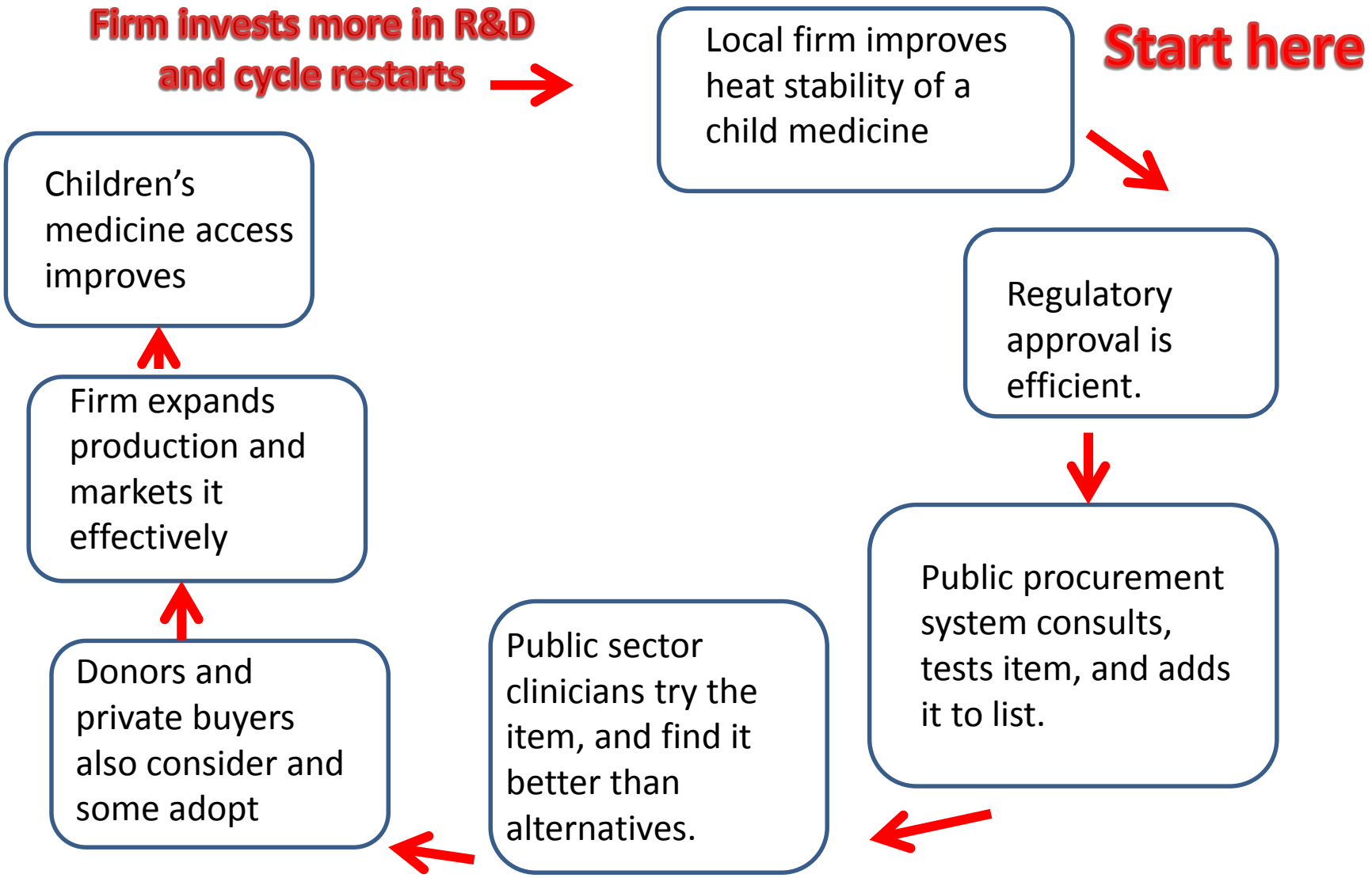
The need is for a virtuous circle in the domestic economy where each element contributes to mutually reinforcing improvement in capabilities.

Discussion could focus on how these virtuous interactions can be kick-started?

The wrong kind of interaction (from an actual case)



Reworking the interaction?



Conclusion

- System of national innovation was disrupted and eroded during policy reform period resulting in de-industrialization largely originating from trade liberalization trade. The fundamental policy question is how to get the NSI started and in some respects restarted.
- Health sector: growing demand/market- large national and regional market not tapped. Role of government procurement, donors and buyers.
- Industrial development (supply capacity, innovations, moving up the technology ladder),
- Interaction between skills and innovations: knowledge-producing institutions (Education and training institutions) and industry produce health supplies.

Conclusion-2

- integrating improved access to medicines with industrial development. Call for structural transformation in health and industrial sectors- how to ick-start virtual interactions.
- Policy (industrial, health, fiscal, procurement, import)
- Financial system (investment, credit, budget)
- Innovation system is a crucial in promoting virtuous interactions and promoting technological learning and innovation for inclusive development (the benefit of the majority of the population).
- The role of aid and aid relationships need to be incorporated in the innovation system in consideration of their important position many African economies.

For further information the project website may be consulted at :
www.iphsp@acts-net.org