The health challenge for Afghanistan's new leader

Since the US led invasion of Afghanistan, foreign aid money has greatly improved basic healthcare. But will the funds dry up when the troops are gone? **Kate Adams** reports

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When the Taliban was forced out of power in 2001, many of Afghanistan's health indicators were among the worst in the world. Today, after more than a decade of substantial aid effort, basic health services have dramatically improved.

In 2003, the newly elected Afghan government introduced the basic package of health services. The package, mostly funded by international donors and aid agencies, focuses on child health and immunisation, public nutrition, the supply of essential drugs, disability, mental health, control of communicable diseases, and maternal health services.

Seventy five per cent of Afghanistan's health budget is currently funded by overseas aid

The result is that today maternal mortality is down by an estimated 75% to 327/100 000, mortality among under 5s is down to 97/1000 live births from 257/1000. For the first time the government is providing mental health services across the country.[1 2]

Health services still have a long way to go. According to the World Health Organization, 35% of Afghans have no access to healthcare. Security and the geographical terrain are both major factors. The lack of female health workers also stops rural women from attending local health facilities. In Kunar province, for example, 19% of government health facilities do not have a female health worker. But, Suraya Dalil, Afghanistan's minister of public health, says pregnancy is now safer and the country "is a better place for children to be born."

Maternity services

At Malalai Hospital, the main public maternity hospital in Kabul, midwives in clean white overcoats and purple hijabs deal calmly with anxious relatives as the hospital's operating theatre works flat out and women in labour (around 25% arrive with a fully dilated cervix) wait in side rooms for their turn. This hospital was built in 1965 to serve 40 patients a day but now sees on average 120 women a day, up to 90 of whom give birth. The rate of caesarean section is 21-25% (similar to that in developed countries). Despite limited facilities, shortages of staff, and a high risk of complications because many women present late to the unit often malnourished, only 12 patients died from obstetric complications last year, according to the medical director of the hospital, Hafiza Amarkhel.

In rural areas, things are less good. In some places, health facilities do not exist or equipment and staff are not available to perform caesarean sections. Government figures presented at a conference in Kabul in May show that in 64 rural districts the average caesarean section rate over the past year was only 3%, and five districts reported no caesarean sections at all.

Although infant and child mortality has also improved as a result of vaccination programmes, Afghanistan is one of three countries where polio remains endemic. The government led programme reports polio vaccine coverage to be 95%—though this has not been confirmed by independent sources. However, there are some areas, mainly Taliban controlled and bordering Pakistan, where it is too dangerous for vaccination teams to go.

The four confirmed cases of polio so far this year have all been in these areas and have been found to originate from Pakistan. Fourteen check posts have been set up on the border, and all children aged under 5 years entering Afghanistan are being immunised.

Mental health

Perhaps one of the most important improvements in healthcare is that most people now have somewhere to go for help with mental health problems. The mental health unit in Herat regional hospital, western Afghanistan, gives a snapshot of the kind of problems the population has and the care they now receive. Qadim Mohammadi, a psychiatrist, set up this 25 bed unit six years ago. The corridor running through the unit is dark, and the patients are in small side rooms lying on beds on concrete floors.

Most patients are women, who often present in an agitated state, commonly associated with their experiences of poverty, family violence, and 30 years of war and conflict. After discharge these women are followed up at regular intervals by psychosocial counsellors.

In 2006 mental health services were virtually non-existent. There was just one public 60 bedded psychiatric hospital in Kabul and two psychiatrists. Today the ministry of public health is integrating services into primary care so that all staff working in the community should have some basic training in mental health. Seventy four psychiatrists have been trained, and 15 are in training.

Funding uncertainty

But Afghanistan is about to enter a new era. Foreign troops will no longer provide security from 2016 and the country has just voted for a new president. Many expect international aid to dwindle in coming years and the new president faces a huge challenge to fill the gap.

Seventy five per cent of Afghanistan's health budget is currently funded by overseas aid, the bulk of which comes from USAID, the World Bank, and the European Union.

Gozara hospital, a district hospital in Herat province is impressively clean, organised, well staffed, and able to provide comprehensive services, including dental services. This hospital is funded by the Danish Afghanistan Committee, a non-govermental organisation. But there is uncertainty about future funding. The government is considering options, including raising revenue to fund healthcare itself through taxation, health insurance, and user fees. But it is not yet clear how successful that strategy would be.

Kate Adams is a general practitioner and journalist, London, UK **kateadams@doctors.org.uk**

Competing interests: None declared.

Provenance and peer review: Commissioned; not externally peer reviewed.

References are in the version on bmj.com..

Cite this as: *BMJ* 2014;348:g3950

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PRESCRIPTION CHARGES: ARE THEY WORTH IT?

John Appleby assesses whether the policy of charging for prescriptions in England is helping or harming the NHS

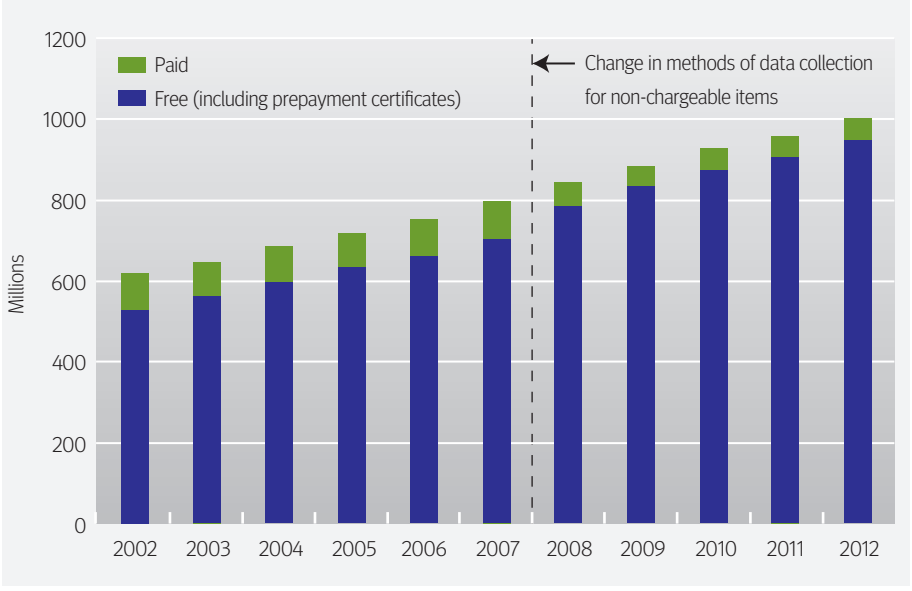

Fig 1 | Number of prescription items (paid for and free), England 2002-12 (methods for collection of data on payment exemptions changed in 2007)[2]

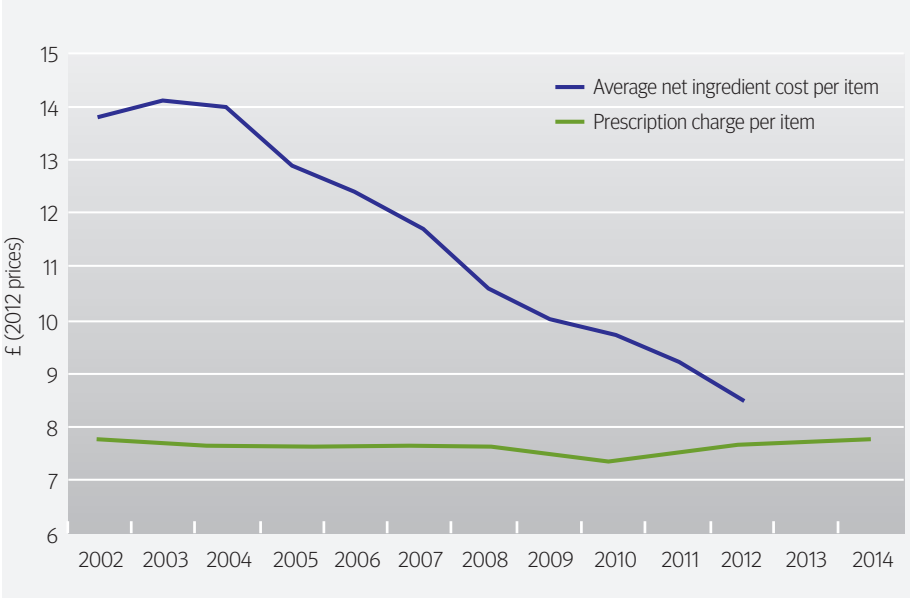

Fig 2 | Average net ingredient cost per item and prescription charge per item, 2002-12 (standardised at 2012 prices using GDP deflator (general measure of inflation in the economy)[2]

While Wales, Northern Ireland, and Scotland have abandoned charges for prescriptions, in April the English saw prescription charges rise once again, to £8.05 (€10; $13.5) per prescribed item. Labour peer David Lipsey has suggested that the charges are, "a dog's dinner lacking any basis in fairness or logic and stuffed with anomalies and inconsistencies."[1] But apart from unfairness, illogicality, and anomalies, is there a fundamental problem with such charges?

Although prescription charges have been rising, the latest data show that the number of pharmaceutical items prescribed in England reached its highest level yet—over one billion in 2012—equivalent to nearly 19 per person and an increase of 62% since 2002 (fig 1).[2] But as fig 1 also shows, the proportion of prescribed items that attracted a charge was small (around 10%) because of exemptions—for children, elderly people, those in receipt of welfare benefits, and others. Moreover, in real terms the prescription charge has hardly changed in recent years—at least relative to price changes in the economy as a whole (fig 2).[2]

But while prescription charges have held up, the actual cost of drugs has been falling in real terms since 2004 (fig 2).[2] Then, the average "net ingredient cost" (list price) of all prescribed items was around £14 (at 2012 prices). Since then it has dropped steadily to around £8.50—only fractionally more than the prescription charge. This fall has been good for the NHS, and is partly due to greater use of cheaper generic drugs rather than branded drugs (fig 3).[2] But as charges for an increasing number of drugs start to exceed their price—and especially for prescribed drugs out of patent that can be bought over the counter—increasingly it looks as though there are limits to future increases in charges.

Although charging does raise money for the NHS—around £400m in gross revenue in 2012 (although a change in methods of data collection complicates things from 2007 onwards; revenue could be more like £700m, see fig 4)[2]—this represents around 0.4% (to 0.7%) of total NHS spend in England. Abolishing charges would mean losing this revenue, but perhaps the loss is worth it if charging dissuades some people from seeking care or cashing in prescriptions, increasing their risk of needing emergency treatment in the future.

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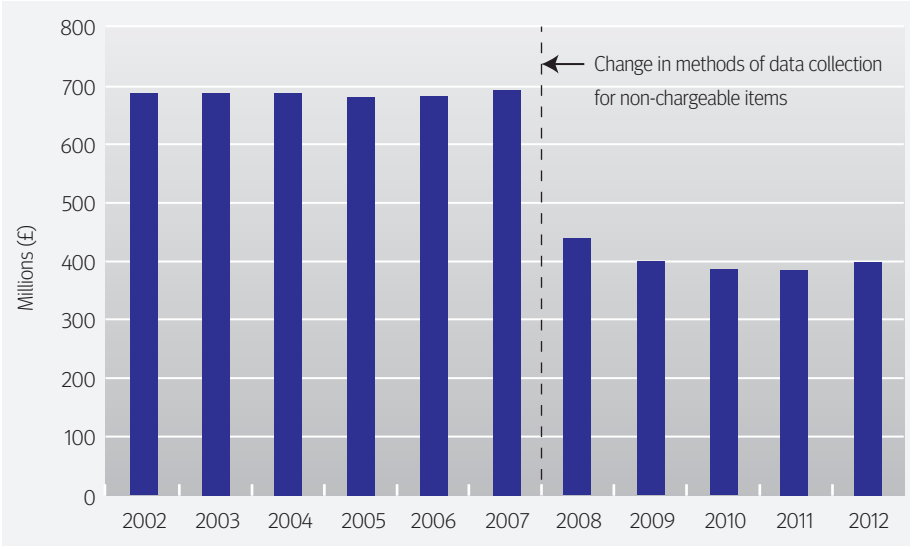

Fig 3 | Gross revenue from prescription charges, 2002-12 (paid for items×prescription charge, standardised at 2012 prices using GDP deflator)[2]

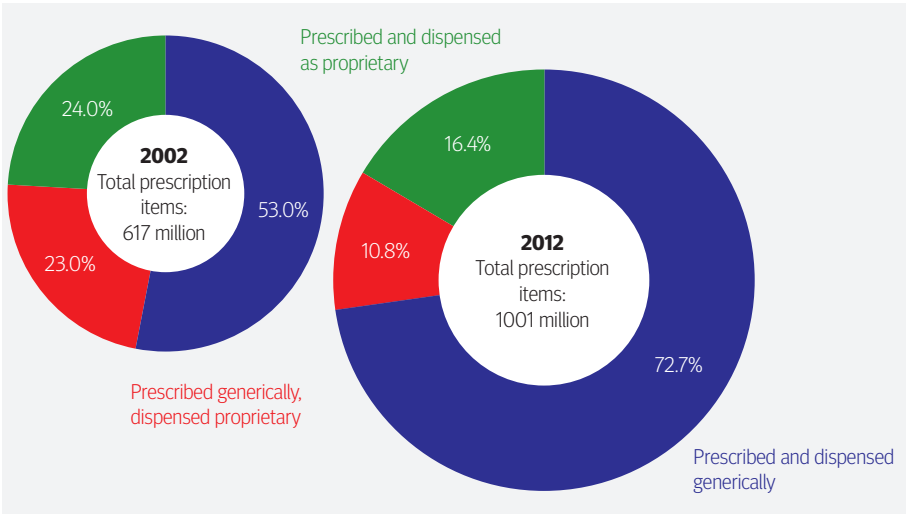

Fig 4 | Percentage of prescription items prescribed or dispensed generically and proprietary, 2002 and 2012[2]

Making prescriptions free for everyone seems to have no effect on access to and take up of care and treatment

A study of the effect of the abolition of charges in Wales is interesting. Overall dispensing rates after abolition were comparable with those before abolition and those in another part of the UK.[3 4] The authors also found that although rates increased for drugs dispensed to those people who would have previously paid for their prescriptions, the increase was not significantly different from that in a comparable region of the UK (the north east of England). They also found no significant increase in visits to general practices or any drop in the sale of paid for over the counter drugs.

Although these results disprove the contention that dispensing rates would rise steeply if the prescription charge was removed, they also suggest that the charging regime was not a substantial barrier to accessing NHS care. The net impact for Wales seems to be only a loss of revenue (around £30m a year).

As David Cohen has suggested,[5] whether people are for or against prescription charges (with extensive exemptions) may boil down to the value they attach to the principle that NHS care should be available on the basis of need rather than the apparent reality—at least in the case of Wales—that making prescriptions free for everyone seems to have no effect on access to and take up of care and treatment. This is not necessarily an argument for increasing or widening the scope of patient charges, of course, and the standard economists' downward sloping demand curve (where higher prices mean lower demand) could well reappear depending on charging levels, exemption arrangements, and other factors.

John Appleby is chief economist, King's Fund, London, UK
j.appleby@kingsfund.org.uk

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Cite this as: *BMJ* 2014;348:g3944