

Equitable health care financing and poverty challenges in the African context

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**In collaboration with EQUINET,
the Regional Network for Equity in Health in Southern Africa**

Paper Presented to Forum 9, Global Forum for Health Research
Mumbai, September 12-16th, 2005

Introduction

This paper is based on a detailed and critical review of the literature relating to health care financing in the African context. The objectives are to:

- Provide an overview of the equity challenges, particularly in relation to poverty concerns, of current health care financing mechanisms in Africa;
- Provide a brief critical review of major recent developments in health care financing in Africa; and
- Identify key issues in promoting equitable and poverty-reducing health care financing options in the African context.

It is important to stress that health care financing mechanisms differ in each African country and that there are no 'one-size-fits-all' solutions. This paper attempts to identify some common trends and challenges, illustrate important issues in relation to particular health care financing options through reference to specific country experience and propose principles and possible actions that require further consideration within each country-specific context.

Key issues related to current health care financing

The World Health Organisation's 2001 National Health Accounts (NHA) database¹ highlights the following key issues in relation to health care financing in Africa:

- The current level of health care funding from government tax revenue is relatively low in most African countries. In the majority of countries (about 60%), the health sector share of total government expenditure is below 10%.
- There is still a reasonably high level of reliance on donor funding in African countries. Donor funding accounts for over a quarter of total health care funding in about 35% of countries, with 5% of countries having more than half of all health care funding coming from external sources.
- There is limited insurance coverage in African countries, especially in relation to mandatory health insurance. However, community pre-payment schemes have been on the increase in recent years.
- One of the single largest sources of financing is that of out-of-pocket payments, which exceed 25% of total health care expenditure in more than three-quarters of sub-Saharan African countries. Out-of-pocket payments include user fees at public sector facilities as well as direct payments to private providers, ranging from doctors working in private practice to informal drug sellers and traditional healers.

From a poverty-related perspective, the most concerning aspect of current health care financing in African countries is the large share of out-of-pocket payments. Concerns about the adverse equity impact of user fees have been growing throughout the 1990s, but a more recent research focus on the effect of health care costs on household livelihoods has placed this financing mechanism in the international spotlight.

For those who seek health care when they are ill, the direct costs of obtaining such care can account for a substantial proportion of total households' income. Payments for health services and medicines accounted for an average of 4-5% of household incomes in the African countries included in one study (Makinen et al., 2000). When other direct costs associated with obtaining care (such as transport costs) are included, some studies have found that total direct costs can be as high as 10% of household income (Lucas and Nuwagaba, 1999). The direct costs of long-term fatal illness, particularly AIDS, have the most devastating effects on households. A study in Tanzania has estimated that the direct costs of treatment for a person living with AIDS during a six month period is about 64% of per capita household income for the same period (Tibaijuka, 1997). There is consistent

¹ Accessed from <http://www.who.int/nha>

evidence that the heaviest burden of health care costs, particularly those that are considered catastrophic, falls on the poorest households (Xu et al., 2003). For example, a study in Malawi found that the cost of malaria to households was over 7% of their income on average, but for the poorest households, these costs were as much as a third of their income (Ettling et al., 1994).

One of the first strategies of coping with the costs of illness is to try to avoid these costs altogether “by modifying illness perception (the phenomenon of ignoring disease)” (Sauerborn et al., 1996). The poor often delay seeking care until an illness is severe, which may ultimately lead to higher costs of treatment (e.g. if the person has to be admitted to hospital). Self-treatment using allopathic or traditional medicines available at home, or purchased from a drug seller or traditional healer at a relatively lower cost than at public facilities (and sometimes on credit), is another frequent strategy for avoiding or at least minimising costs (McIntyre et al., 2005, Save the Children, 2005). Where costs are incurred, households use coping strategies such as reducing consumption (including of basic necessities), selling assets and borrowing (McIntyre et al., 2005). A recent study in Ethiopia found that households which had used available cash to pay for health care had intended to use the money for basic consumption needs including food, fuel, clothes and education (Russell and Abdella, 2002). Assets sold may include those that are essential to the household’s future livelihood such as livestock and land. Borrowing to cover health care expenses is extremely widespread in Africa, and while some are able to access loans from family and friends at low or no interest, others have to accept loans at ruinous interest rates.

There is growing international evidence that health care costs can plunge households into poverty and that the likelihood of a poor household ever being able to move out of poverty diminishes when confronted with illness-related costs (Whitehead et al., 2001). Recently, the WHO has estimated that 100 million people become impoverished by paying for health care each year and that a further 150 million face severe financial hardship from health care costs (World Health Organisation, 2005). While household impoverishment through health care costs is particularly related to catastrophic illness, even routine ambulatory care with so-called nominal fees can worsen the situation of extremely poor households.

The available evidence on the impact of illness and health care costs at household level clearly demonstrates that the most vulnerable households face enormous constraints in accessing care when they are required to pay user fees, particularly where geographic access is poor and other costs of treatment seeking are high (e.g. for transport). With the high levels of poverty throughout Africa, household livelihoods are so fragile that if a member does have to use health services and pay fees at the time of service use (whether to a public or private provider), the household may have to take actions to access cash that could lead to further impoverishment.

The evidence about the adverse consequences of user fees for household livelihoods is so overwhelming that even the arch protagonist of user fees in the 1980s and 1990s, the World Bank, has acknowledged that “Out-of-pocket payments for health services – especially hospital care – can make the difference between a household being poor or not” (Claeson et al., 2001) and indicates that alternative financing mechanisms may be preferable. Within the last year or two, there have been growing calls for removal of user fees at public sector facilities in Africa, particularly at the primary care level, from organisations such as Save the Children and in influential reports such as that by the Commission for Africa (Commission for Africa, 2005). The next part of this paper briefly considers recent developments in health care financing within the African region, particularly in relation to user fee removal initiatives and the extent to which sustainable alternative mechanisms that could afford financial protection for households, including the poorest, are developing.

Recent developments in health care financing in Africa

Tax funding

Tax funding is a core foundation of all African health systems. The availability of adequate tax funding is critical if problems in equitably accessing health care are to be addressed. For example, tax funded health budgets are critical in promoting an equitable geographical allocation of recurrent resources. In particular, general tax revenue (sometimes combined with donor funds) is the only funding source that can be actively redistributed between geographic areas in order to promote equity. Tax funding can clearly also significantly reduce financial access barriers, particularly through reducing out-of-pocket payments. The WHO NHA database shows that in African countries where there is a commitment to devoting a relatively large share of government resources to the health sector, the burden of out-of-pocket payments is kept relatively low.

While it is difficult to increase tax revenue in African countries due to the limited tax base and although it is often not feasible or advisable to increase tax rates any further, it may be feasible to improve tax compliance and the efficiency of the tax system. In addition, there is scope for advocacy for an increased share of budgets for the health sector. No African countries have reached the target of 15% of government budgets being directed to the health sector, as agreed to by African Heads of State in the Abuja declaration (OAU, 2001). One of the main constraints to achieving this is the high level of external debt experienced in many countries that translates into levels of interest payments and debt repayments that consume a considerable share of government budgets. Situations of conflict are often another constraint on increasing health's share of budgets, given that they result in a large share of government resources being directed to defence. It is interesting that the SSA countries that devote less than 5% of their government budget to the health sector (Nigeria, Sudan, Cote d'Ivoire, Eritrea, Ethiopia and Somalia) have very high levels of indebtedness and/or conflict situations. Debt relief efforts in many instances are wholly inadequate. For example, Ethiopia has an external debt amounting to US\$6,845 million, which is slightly more than 100% of Gross Domestic Product (GDP). Debt relief under the HIPC initiative in 2001/02 amounted to \$50 million (0.8 percent of GDP) and in 2002/03 totalled \$62 million (0.9 percent of GDP) (IMF and IDA, 2004). Vastly improved debt relief, and indeed debt cancellation (as has begun to happen), should be advocated for, which would enable governments to devote more of their limited tax funding to the provision of health and other social services.

Donor funding

Donor funding can have a similar, and very important, impact on addressing health service equity constraints to that described above for tax funding, particularly if donor funds are in made available through pooling mechanisms as part of a health sector Sector Wide Approach (SWAp). However, there are concerns about some donors' recent move away from health sector pooled funding to general budget support (i.e. where all donor funds are given to Treasury and allocation between sectors is part of the normal budgeting process). Part of the concern is whether the health sector will receive a 'fair share' of donor funds under this arrangement. Another concern is that this could potentially undermine the role of the Ministry of Health in crucial areas of health policy, particularly in relation to health care financing. Given that Ministries of Finance wield considerable power in many African governments and are frequently more responsive to donor demands than sectoral Ministries, it is possible that donors could attempt to impose their health sector priorities (especially their views on health care financing strategies) by applying pressure on Treasury officials who in turn could apply pressure on Ministry of Health officials. There are also concerns about the unreliability of this particular source of financing and a growing awareness of the need to find sustainable domestic financing alternatives.

Out-of-pocket payments, especially user fees

The key development in relation to user fees in recent years is the removal of fees for some or all health services in some African countries, such as South Africa and Uganda, and the mounting pressure on other African countries to adopt a similar policy. The experience in countries that have removed fees was that there were rapid and large utilisation increases, especially for the poor. For example in Uganda, an extensive study using the first and second Ugandan National Household Surveys (conducted in 1999/2000 and 2002/03 respectively) and data from the Health Management Information System highlighted that the poor had particularly benefited from the removal of fees (Deininger and Mpuga, 2004). A key finding of this study was that although there were substantial differences in use of health services when ill between the rich and the poor while fees were in place, these differences were completely eliminated in the case of children after the removal of fees (although inequities in service use continue for adults).

However, the experience of fee removal has not been entirely positive and highlights the need for careful planning and adequate resource improvements before such a dramatic policy change is introduced. In the South African experience, the 'free care policy' was publicly announced before it had been communicated to front-line health workers and was introduced with immediate effect. Health workers said they were not adequately informed or involved, and were thus unprepared for the utilisation increases. Many health workers resented the policy as it had increased their workload and because they felt they had not been consulted or had an opportunity to plan for its implementation (McCoy, 1996, McIntyre and Klugman, 2003, Walker and Gilson, 2004). Similar adverse impacts on staff morale were reported in Uganda, related to the loss of fee revenue which had previously been used to supplement staff salaries as well as the fact that workload had increased by about 47% (Burnham et al., 2004). In the South African case, drug supplies were quickly exhausted as utilisation increased. With the introduction of 'free care' in Uganda, there were simultaneous and substantial increases in district health service funding (Yates, 2004) which mitigated some of the problems that arose in South Africa. However, much of these additional resources came from external sources, and there are concerns about the sustainability of these levels of funding if external funds are withdrawn. In essence, the experience to date demonstrates the need for detailed and adequate planning, careful and active management of the responses of health workers and managers, and improved resource availability (particularly domestic resources) if fees are removed, not only to offset any revenue lost, but more importantly to continue to provide adequate quality services in the face of increased utilisation.

While there is growing awareness that fee removal cannot occur overnight and requires more than a 'stroke of a pen', there are also growing calls for African governments' to explicitly commit to moving away from out-of-pocket payments over time and to actively seek to introduce or strengthen alternative financing mechanisms that are more progressive and allow for greater cross-subsidies. This should not be limited to concern for public sector user fees, but should also address those out-of-pocket payments to private providers that arise from poor quality of services in public facilities (e.g. use of informal drug sellers due to inadequate drug supplies at public facilities).

Health insurance

In recent years, there has been a growing emphasis among international organisations on health insurance as a financing mechanism. For example, the principles for fair financing in the WHO's 2000 World Health Report, such as revenue collection in the form of pre-payment, pooling resources to promote cross-subsidies and strategic purchasing, imply that the main alternative to tax funding should be some form of health insurance (World Health Organisation, 2000). The World Bank also explicitly suggests pursuing insurance options, instead of out-of-pocket payments, in its handbook on the health component of Poverty

Reduction Strategy Papers (Claeson et al., 2001). Most recently, the 2005 World Health Assembly passed a resolution encouraging member states to pursue social and other forms of health insurance.

As indicated previously, health insurance is still relatively limited within Africa. Private voluntary insurance schemes for formal sector workers are mainly concentrated in Southern Africa (particularly South Africa, Zimbabwe and Namibia) but also exist to a more limited extent in some East and West African countries. Experience of these types of schemes has not been entirely positive, with very limited coverage levels, fragmentation of risk pools and rapid, uncontrolled cost spirals threatening their sustainability. For these reasons, limited attention is being paid to expanding this form of health insurance within the African context.

Instead, the option of community-based pre-payment schemes is rapidly gaining favour. These schemes are more widespread than formal sector private voluntary schemes, particularly in West Africa but also increasingly in East Africa and to a more limited extent in Southern Africa. As these schemes are funded by annual or more frequent contributions, but do not require payments at the time of using health services, they lower financial barriers to access. In this sense, they are a preferable alternative to out-of-pocket payments. However, some are advocating these schemes as the new 'one size fits all solution' to the health care financing gap in African countries (previously the 'one size fits all solution' was that of user fees). While there are certainly considerable potential benefits of such schemes, there is still quite weak empirical evidence on what works and what doesn't. A recent survey of literature on community-based pre-payment schemes highlights that population coverage by these schemes has remained relatively low and that the most vulnerable households are not currently incorporated (Ekman, 2004). Thus, most of these schemes have small risk pools and limited cross-subsidies. Another recent critical assessment of such schemes highlights the importance of better understanding how they interact with other elements of the health care financing system (Bennett, 2004). This is important to ensure that appropriate links are made between prepayment schemes in individual communities and other financing mechanisms to ensure that equitable cross-subsidies within the overall health system are promoted. More work is required to explore how the viability, sustainability and equity contribution of such schemes can be strengthened before these schemes can be introduced on a wide-scale basis as *the* solution to the health care financing challenges in any particular African country.

Another option that is being considered or introduced in a growing number of African countries is that of mandatory health insurance, often termed social or national health insurance (i.e. where an Act of Parliament makes it compulsory for all or some citizens – usually those in formal employment – to become members of a health insurance). While there is enormous potential for mandatory health insurance schemes to contribute to improved access to health care, there are concerns that a two tier health system may arise if insurance coverage is not universal – i.e. will result in one system funded through insurance for higher income groups enabling them to purchase a high quality of comprehensive health services and another system funded largely through tax revenue for a minimalistic package of services for lower income groups. A two tiered system reduces the potential for cross-subsidies, particularly between relatively wealthy and poorer groups. A key challenge in moving towards a universal system is to consider at an early stage how those outside the formal sector could be covered.

Some African countries, such as Ghana, are seeking to combine SHI for formal sector workers with district-wide community-based pre-payment schemes in order to implement a universal national health insurance system. The contributions of low income households will be partly or fully subsidised out of tax and pooled donor funds, and there will be risk-equalisation between the individual district schemes and the scheme for formal sector workers. While this approach is extremely innovative in the African context, it has many

similarities to the insurance reforms introduced in Thailand, highlighting the importance of learning from experience in low- and middle-income countries across continents. Ghana's very promising yet ambitious initiative is being closely observed by other African countries and international organisations. Considerable work remains to be done to identify what service benefit package is affordable (within the constraints of feasible member contribution levels, and available government and donor pooled funding subsidy resources), sustainable (in terms of effective mechanisms for containing the cost spirals that are prevalent in health insurance systems) and acceptable (to members, particularly higher income earners if contributions are income-related) before this model can be regarded as being more widely applicable.

Conclusions

Enormous constraints and challenges face African countries in relation to health care financing. From the perspective of pursuing financing strategies that will promote equity and alleviate poverty, rather than contribute to further impoverishment of vulnerable households, the following principles are suggested to guide consideration of alternative financing mechanisms within individual country contexts:

- The mechanism(s) should provide financial protection, i.e. should ensure that no one who needs health services is denied access due to inability to pay and households' livelihoods should not be threatened due to the costs of accessing health care. This implies that health care financing contributions or payments should be separated from service utilisation, which requires some form of pre-payment (government taxes and or health insurance).
- Health care financing contributions should be distributed according to ability-to-pay. In particular, progressive health care financing mechanisms (i.e. where those with greater ability-to-pay contribute a higher *proportion* of their income than those with lower incomes) should be prioritised.
- Cross-subsidies (from the healthy to the ill and from the wealthy to the poor) in the overall health system should be promoted. This implies that fragmentation between and within individual financing mechanisms should be reduced and that mechanisms should be put in place to allow cross-subsidies across all financing mechanisms.
- Mechanisms to ensure that financial resources are translated into universal access to health services should be put in place. This implies that all individuals should be entitled to benefit from health services via one of the funding mechanisms in place, the package of benefits to which they are entitled is explicit, there is active purchasing of services whereby 'value for money' is secured, and there is adequate physical access to services to which one is entitled.

Many of these principles are in line with those proposed by WHO in relation to what constitutes 'fair financing' within health systems (World Health Organisation, 2000). The main area in which we differ from the WHO's interpretation of fair financing is that we propose that progressive financing as opposed to proportional financing mechanisms should be pursued. The WHO clearly stated that it favoured proportional systems, where every individual contributes the same proportion of her/his income towards health care. As has been noted by others, this preference for proportional funding implicitly views regressive funding (where the poorest contribute a higher proportion of their income than the rich) and progressive funding as equally unfair (Wagstaff, 2000). The international health care financing literature and national health policy statements overwhelmingly support the position that progressive funding is the fairest approach. In the African context, with high existing poverty levels and a continual process of further impoverishment due to illness-related costs, we have no hesitation in supporting a preference for progressive health care financing mechanisms.

From a practical perspective, the above principles suggest the following actions in relation to health care financing within the African context:

- Explicit commitments by African governments to move away from out-of-pocket funding mechanisms, and actively pursuing alternative financing mechanisms to make this a reality.
- Urgent efforts to increase the health sector's share of government resources in line with the existing commitment of African Heads of States in Abuja to a 15% share for health, combined with efforts to increase revenue through improved tax compliance and efficiency within the tax system.
- Unconditional cancellation of African governments' external debt, to allow governments to devote limited tax revenue to health care to achieve the Abuja goal, rather than to debt servicing and repayment.
- As health insurance options are most closely aligned with the above principles, along with general tax funding, introducing or expanding insurance mechanisms should be given serious consideration. Critical evaluation of the full range of health insurance options, and creation of a solid evidence base relating to health insurance in the African context, is the greatest research priority relating to health care financing if we are to ensure that health insurance developments promote rather than undermine health system equity in Africa.

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