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Sustainable health care financing for low income communities in Sub-Saharan Africa: A review of the options and opportunities

Oyibo P.G[1], *Ejughemre U.J*[2]

[1] Community Health Physician / Epidemiologist, Department of Community Medicine, Delta State University, Teaching Hospital, Oghara PMB 07, Nigeria.
[2] Department of Community Medicine Delta State University Teaching Hospital, Oghara PMB 07, Nigeria.

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ABSTRACT

The purpose of health financing is to make funding available to ensure that all individuals have access to effective public health and personal health care. Private health care expenditures constitute a significant proportion of health care spending in most developing countries and are a major cause of impoverishment. Many communities in sub-Saharan Africa countries are low income countries with most of its people living below US $1 per day. This implies that people in such areas would find it difficult to maintain a good living standard including accessing basic health care services. Poor people use health care services far less than the well-off. Out of pocket payment for health care services; a widely used strategy to supplement governmental resources in sub-Saharan Africa, further aggravates the situation. Wherever access to health services is monetized, the poorest are excluded. Ensuring that people are not denied access to health care services because they cannot afford it has long been a cornerstone of modern health financing systems in many countries. The challenge facing governments in low income sub-Saharan African countries is to reduce the regressive burden of out-of-pocket expenditure on health by expanding pre-payment schemes which spread financial risk and reduce the spectre of catastrophic health care expenditures. This review, therefore intends to examine the options and opportunities for sustainable health care financing for low income communities in sub-Saharan Africa.

Introduction

Health may be seen as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" according to the World Health Organization (WHO).[1] Human success in achieving other basic necessities like food, water and shelter depends largely on their state of health. [3-5] If health is viewed to be this important, it implies that it is a right to be healthy and not a privilege as stated in the United Nations Charter on Human Rights.[6] Although, health may seem idealistic, healthy living can best be achieved within human populations when the 'constellation' of factors that propels its realization is put in place particularly among the

people with greatest need.[7] These factors include the state of health care services delivery, the funding of health systems and payment for health services. It is no doubt that these are critical for healthy living within human societies. With the world becoming a global village, it is obviously ironical that these are still issues bothering some parts of the world particularly countries in sub-Saharan Africa (SSA).[8] The dramatic increase in health care expenditures worldwide has prompted societies everywhere to look for health financing arrangements which ensure that people are not denied access to care because they cannot afford it.[1] In many SSA countries, inability to pay impedes access to needed health care. [9,10] Worse still, most care is paid for by households directly. The poor state of the health systems in sub-Saharan African countries have been traced to several factors especially the gross under funding of their health sectors.[3] These countries rely on a disaggregated mixture of health financing options; including government budgetary allocation, health insurance (social and private), external funding and private out-of-pocket spending to finance health care. Ensuring that people are not denied access to health care services because they cannot afford it has long been a cornerstone of modern health financing systems in many countries.[1] The purpose of health financing is to make funding available to ensure that all individuals have access to effective public health and personal health care.[1] This means reducing or eliminating the possibility that an individual will be unable to pay for such care, or will be impoverished as a result of trying to do so. Evidence have shown that each year, 100 million people are impoverished globally as a result of expenditure on health.[2] Against this background, health systems are therefore not just concerned with improving people's health but with protecting them against the financial costs of illness.[9] While most high income countries rely heavily on either general taxation or mandated social health insurance contributions, low income sub-Saharan African countries depend far more on out-of-pocket financing.[11-13] In 60 % of these countries at GDP below $1000 per capita, out-of-pocket spending is 40 % or more of the total public health care expenditures whereas only 30 % of middle and high income countries depend so heavily on this kind of financing.[14] A good health financing system raises adequate funds for health, in ways that would ensure that people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them. It is now known that health financing through insurance to a very large extent can reduce financial barriers to health care access and provide protection of individuals and families against the risk of unpredictable health care expenditures.[15,16] Pre-payment via health insurance is seen as one of the viable options that are available to broaden sources of health care financing and hence reduce the dependence and pressure on government budget in sub-Saharan Africa.[15]

Taking a closer look at the health system in the SSA region, for instance in Nigeria, a West African country, where the primary health care facilities are often all that rural communities have in form of a formal health system, the utilization of health services at the primary level

in many parts of country has remained low with slight improvement in some parts in recent years.[17] Several studies have shown that community perceptions of poor quality, inadequacy of available services and paying for these services are some of the major reasons responsible for low use of health services particularly at primary health centres [18,19] and this has been the same story for many other countries in the region.[20]

On the contrary, many European and south Asian countries like India, Bangladesh and Afghanistan have developed health financing models through insurance as principal methods of health financing to address these systemic issues bothering the health sector.[21,22] The economic transitions of central and eastern Europe have seen health sector reforms as pillars of these transitions.[23] Countries like Czech Republic and Hungary established national health insurance schemes in 1992 and 1993 respectively, with Poland and Bulgaria following suit in 1997 and 1998 respectively.[23, 24] Although the situation has not been all gloomy for SSA, as some countries in the region have in the recent past made efforts to tackle the health financing challenges through health insurance schemes.[25] However, in most of these countries, large proportions of the population work in the informal sector and live in rural communities, limiting the ability to generate financial resources through payroll deductions for health insurances. Answers to these may be through alternatives such as Community-based health insurance (CBI) which collects resources from individuals who voluntarily enroll and are often employed in the informal sector. This can offer an alternative for health financing in settings where taxes are paid on only a small portion of national income.[26,27] Still, evidence has it that large-scale implementation of health insurance schemes is a complex task and in some instances perpetuates the very inequities it is intended to correct.[23,28] These call for concerted efforts, particularly through adequate and achievable health financing programmes in low income communities in SSA.

Low Income Communities:

There is no explicit definition for a low-income community. It can be described with reference to the quality of life of the people living in a particular area which is below the generally acceptable standards. For the purpose of this review, low income communities refer to economically deprived communities in developing or low income countries which according to the World Bank,[29] are communities/countries with Gross National Income per capita (GNI per capita) of less than $1,005 per annum. This definition captures many communities in SSA with most of its people living below US $1 per day.[29] This implies that people in such areas would find it difficult to maintain a good living standard including accessing basic health care services. More so, poor people use health care services far less than the well-off.[19] Out of pocket payment for health care services; a widely used strategy to supplement governmental resources in sub-Saharan Africa, further aggravates the situation. Wherever access to health services is monetized, the poorest are excluded.[19]

The Burden of Diseases and State of Health

Care Financing in SSA

In addition to the poor socio-economic indices in SSA where more than 70% of its populace live below 1 dollar per day, [29] estimates of disease burden in the region reflects its economic indices.[29] Basically, as defined by the World Health Organization (WHO), disease burden is measured by Disability Adjusted Life Years (DALYs) per 1,000 which include the years of life lost to premature death (YLL) and years lost from living with disability (YLD).[30] One DALY represents the loss of the equivalent of one year of full health, as this captures both diseases that cause early death but little disability (e.g. measles) and diseases that do not cause death but do cause disability (e.g. poliomyelitis). The WHO [30] also estimated that the global average burden of disease across all regions in 2004 was an average of 237 DALYs per 1000 population, with about 60% due to premature death and 40% to non-fatal health outcomes. It also adds that DALYs in SSA communities is twice higher than any other region of the world. This can be seen from findings reported in 2006, where the UN Joint Programme on HIV/AIDS estimated that 63% of those infected with the virus globally (38 million) lived in SSA communities. Sub-Saharan African communities also accounted for a large proportion (approximately 72%, 2.8 million) of mortality attributable to the disease. More so, an excellent reflection of the region is such that it accounts for 10% of the world's population, 25% of global disease burden, 3% of health care resources and 1% of health workers.[14] In countries like Botswana, Swaziland and Zimbabwe, the estimated adult HIV prevalence exceeds 20% according to AIDS Epidemic Update for 2007. Apart from HIV/AIDS; malaria, helminthic infections and non-communicable diseases (e.g. diabetes, hypertension, cancers and road traffic accidents) also add to the burden in the region. Diabetes is a now a major cause of death and disability in SSA.[31] In 2006, the International Diabetes Federation (IDF) estimated that the prevalence of diabetes in SSA was approximately 10.8 million.[31] This is expected to rise by at least 80% by 2025 to about 18.7 million cases. All these give a reflection of disease burden in SSA and its communities. With this frightening figures in the region, it has been a perennial challenge for the health systems to brace up to these issues as this is partly due to the rising incidence of disease burden that require fund to manage and partly due to the economic situation within communities that makes it hard for people to keep up with the rising health care services expenses they are likely to incur. [32-34] According to the of 2010 health financing score card by the African Public Health Alliance and 15 %+ campaign,[35] only six African countries spend at least 15% of their national budget on health: Rwanda, 18.8%, Botswana, 17.8%, Niger, 17.8%, Malawi, 17.1%, Zambia, 16.4% and Burkina Faso, 15.8%. Still, 32 out of 53 African Union member states spend less than the US $40 recommended per person by the WHO with only 11 of these investing about US $5 or less per capita. [35] Currently health financing trends in many parts of the region are worrisome, pitiable and calls for more concerted efforts in addressing it. However, governments have hitherto come up with models such as national health insurance schemes to ameliorate health

financing issues especially at the primary level [37] as well as non-governmental organizational support. These efforts although complementary are yet to meet up with the needs particularly at the primary health care level in the region, more so the policy makers have at various times developed cold feet towards increased investment in healthcare, partly due to poor economic indices or lack of political will to implement strategies. Against this background there is the need for alternatives to complement governmental budgetary allocation for health.

Health Financing:

In thinking of how to address the issues of health services delivery even at the primary level, it is critical to take into cognizance its financing. There are different options that can be considered when making a decision as to what will be most suitable for low income communities. Some of these include personal health financing; government's funding and public-private-partnership in funding the provision of quality healthcare and contributory schemes or health insurance. These options vary one from the other with respect to organization and sustainability.

Health Insurance (HI):

HI is one of the widely recognized options available for health system financing.[21] Individuals cannot predict when they will get ill as well as the magnitude of their illness and how much of health care they will need. The implication of this is that individuals who are not financially viable are likely not to access health care services when needed. Glaser [37] and Kutzin[38] rightly noted that should an unpredicted adverse event like illness occur, an individual who is not health insured will have to more than often be financially responsible for his/her health bills. It is less of a burden to pay when well, than to pay suddenly and without negotiation when sickness strikes.[39] This further strengthens the concept of HI in funding health systems and health care. Theoretically, the basis for this is that HI allows for risk pooling and therefore ensures that resources follow sick individuals to seek health care when needed. This creates a platform for the poor to consume quality health care services. There are different models for health insurance globally. [34] However, there are key features that are common to all insurance schemes; (i) they are legislated by government and requires regular compulsory contribution by members (ii) premiums are paid (iii) contributions are earmarked for spending on health services only (iv) benefit packages are standardized etc. In addition, HI could have sustainable benefits if these key features were the norm in most instances. HI can achieve the goals of providing health care on the basis of need while paying on the basis of contribution. This tends to promote and sustain the principle of equity as an objective of the Alma-Ata declaration.

In Europe and America, where there are already established ways of addressing health care challenges, a number of HI models are being used to ensure that the quality of health care delivery is maintained and improved upon. [21] There have been reports on the success of health insurance schemes in developed as well as developing countries in Europe and South America.[21] Apparently, it is also possible to reproduce similar models in sub-saharan Africa

where there are biting issues of under-funding and poor health systems.

Options and Opportunities: Sub-Saharan African Experience

Africa's rapid population growth combined with inadequate economic planning, poses a difficulty to health care services delivery and affordability. Although the gain being made in health care delivery in developed countries comes at a cost and still faces some financial constraints, it is well ahead of what is obtainable in SSA. Considering the enormous burden of disease in the SSA region as well as the poor state of its health systems, in the face of dwindling funding and rising costs for health care services, the different models of health insurance schemes comes to bear. [34] For instance, the National Health Insurance Scheme (NHIS) in Nigeria was established under Act 35 of 1999 by the Federal Government to improve the health of all Nigerians at an affordable cost. [25] More so, there are health insurance schemes in other SSA countries such as in Kenya, Rwanda, Ghana, South Africa, [25] all aiming to fund health care costs through pooling of resources and judicious utilization of financial risk protection against the high costs of health care services through pre-payment mechanism, prior to their falling ill. However, in many SSA countries, the bulk of the population, particularly those living in the rural communities, lack access to quality and affordable health care as well as these health insurance financing schemes. [40] In addition, little has being done practically to get these models to work because of wide spread poverty hampering the ability of the populace to pay premiums, over dependence on donor funding by governments in the region and lack of political will to implement such models or programmes that have succeeded in other regions of the world. [25]

The Nigerian experience reveals that policy regulators chose a staggered approach to health insurance scheme implementation starting with the public and private formal sector employees who constitute less than 40% of the working population. It is estimated that currently, the scheme covers less than 10% of the Nigerian population which stands at 150 million (about 3 million Nigerians); with the upper and middle class benefiting more from the scheme. [36,41]

More so, evidence from research studies [25] have shown that Kenya which has the oldest health insurance scheme in the region, implemented a scheme that was limited and compulsory for formal sector workers only to the exclusion of the millions of the rural poor in the informal sector.

Furthermore, the inefficiency in premium collections, limited coverage, bureaucratic obstacles, tedious claiming processes and a high transaction cost that was fuelled by fraud and abuse bedeviled the scheme. [25,41] Similar story goes for Tanzania, one of the poorest countries in the world, having more than half of her population living on less than $0.70 a day and health care expenditure per capita estimated at $8.00 per year. [42] The government of Tanzania established a HI policy which suffered the same fate as the scheme in Kenya. In SSA countries such as Zambia and South Africa where there are existing health insurance schemes to aid health financing among the rural poor, the lack of political will remain a bottle neck to the

successful implementation of these schemes. [43]

While making considerations as to what models of financing through health insurance schemes should be implemented in SSA countries, it is critical to take into cognizance that many previous health insurance schemes globally were faced with some inherent challenges of noteworthy are accountability of the risk managers and demand-side factors, such as adverse selection in the enrollment of individuals.[44,45] It is important to note that the provider payment method has the potential to also determine the sustainability in health insurance. This can be achieved through mechanisms such as provider participation, enrollees' satisfaction and retention; the quantity and quality of services provided to patients in the scheme, and patient demand for insured services. Many previous health financing schemes through insurances in the SSA region do not critically review these and as such run into difficulties in the course of implementation. [46,47]

Conclusion:

Since reducing health inequalities remain at the heart of public health and health care promotions globally, it is now urgent to implement sustainable health financing systems in low income communities in the region. The question we need to ask is who pays, what works and what is sustainable. Health insurance rather than over dependence on government budgetary allocations, out-of-pocket spending or donor funding seem to hold the answer to this question in SSA countries.

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