A Review of the Appropriateness of User Fees and Social Health Insurance to Fund the Health Care Systems in Low and Middle-Income Countries

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ABSTRACT

Background: User fees and social health insurance (SHI) are key strategies of healthcare funding. These strategies which have been widely adopted in low and middle-income countries have been shown to be rarely beneficial to poor people. There has been doubt on their capability to facilitate improved access to healthcare services especially for the poor. Hence, this paper discusses the appropriateness of user fees and SHI in the funding of healthcare systems by critically appraising their strengths and weaknesses. It will also draw attention of government to alternative methods that can help deal with healthcare funding especially for the poor population.

Materials and Methods: A search of some standard books and relevant articles on the appropriateness of user fees and social health insurance to fund health systems was carried out using the Google, Yahoo search engine, EMBASE and OVIDMEDLINE data bases.

Results: The main goal of a healthcare system is to improve the health of the whole population and meet the key needs of the healthcare system. User fees have been described as the most regressive way to pay for health. In countries where SHI is the predominant source of funding the poor people are likely to be excluded from participating because they do not have regular employment for meeting regular payments.

Conclusion: User fees and SHI funding mechanisms seem inappropriate to fund healthcare systems of low and middle-income countries because of extreme poverty. Governments should explore other alternative methods of healthcare funding that can help tackle healthcare funding especially for the poor population.

Key words: User fees, Social health insurance, Healthcare funding

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INTRODUCTION

Healthcare policy makers all over the world are faced with competing alternatives for healthcare financing. Regardless of the particular option, the choice of financing should mobilize resources for healthcare and provide financial protection to the populace [1]. The World Bank has classified low-income countries as countries whose Gross National Income (GNI) per capita was $935 or less; lower middle-income as countries whose GNI per capita was $936 - $3,705; upper middle-income as countries whose GNI per capita was $3,706 - $11,455; and high-income as countries whose GNI per capita was $11,456 or more. The economies are divided according to 2007 GNI per capita which was calculated using the World Bank Atlas method. Examples include: Nigeria (low-income), China (lower middle-income), Costa Rica (upper middle-income) and France (high-income) [2].

Over the past two decades, low-income countries like Nigeria and middle-income countries like China have found it increasingly difficult to sustain sufficient financing for healthcare. Recent estimates of national healthcare spending show that the group of least developed countries on average spent US$11 per person per year in the period 199799, compared with US$23 for other low-income countries, US$93 for the group of lower middle-income countries, and US$1907 in high-income countries [3].

No definite answer exists to the question as to how much a country should spend on healthcare. Recent policy oriented work suggests that a country spending less than an estimated threshold value of US$80 per capita per year would fail to achieve its potential of care compared to similar countries whose spending per capita is at or above this value [1]. Public health systems in most low and middle-income countries are unfair to poor people because preventive and curative public healthcare services, especially hospital services, are accessed by poor people less frequently than rich people. This inequity has made the international community to place this injustice high on their agenda [4]. Spending on healthcare also varies with people in low, middle and high-income countries; most times people in low and middle-income countries pay for healthcare at the time of need out of pocket (OOP), while high-income countries have made arrangements for various types of pre-payment and health insurance for the populace [5]. It has been reported by World Bank in 1999 and WHO in 2000 and 2001 that OOP expenditures for healthcare can be 'catastrophic' in the sense of leading to or aggravating poverty by crowding out other essential consumption items such as food, housing and clothing [1,3,6].

To address the situation, national and international policy and decision makers have suggested a range of different measures, including user fees, insurance and other cost sharing arrangements [7-8]. A key strategy in the 1980s was user fees, which have been widely adopted in low and middle-income countries. Some researchers have shown that the introduction of this policy has rarely been beneficial to poor people [9, 10]. There was also a doubt on the

capability of social health insurance (SHI) to facilitate improved access to services for the poor in low and middle-income countries [4]. The countries that desire to achieve the millennium development goals (MDGs) should make their healthcare services accessible and affordable to all and sundry. It is on this background that this study seeks to discuss the appropriateness of user fees and SHI by critically appraising their strengths and weaknesses in terms of funding the healthcare systems and meeting the healthcare needs of the population. It will also draw attention of the government to alternative methods that can be used to address healthcare funding especially for the poor population.

Healthcare needs of low and middle-income countries

The main goal of any healthcare system is to improve the health of the whole population and meet the health needs of the people. This needs adequate resources to enable the government to fund the system and address major healthcare challenges such as human immunodeficiency virus/ acquired immunodeficiency syndrome (HIV/AIDS) and tuberculosis (TB); reduction of maternal and infant mortality; improved access to healthcare; as well as combating emerging diseases like bird and swine flu and lastly, to acquire new technology to aid diagnosis and treatment and the reduction of health inequalities [7,8].

Determinants of health

The health of all individuals is multifaceted and many factors interact as determinants of health, either in a positive or negative way. The health of individuals and community are affected by determinants which can influence exposure, susceptibility and resistance to infection thereby causing morbidity and mortality. For example; the very young and very old are more susceptible to infective diseases because of the reduced immunity associated with extreme of age. The social and physical environment such as education; income/class; religion; cultural beliefs; local infrastructure; access to healthcare factors have direct impact on the health of the population. These are more applied in vulnerable groups such as poor mothers and children [11].

Notwithstanding, to enable individuals to exert control over these determinants and for them to have effective and efficient healthcare, they need continuous healthcare promotion which remains an essential guide in addressing the major health needs/challenges faced by low and middle-income countries [12]. The lack of adequate resources in low and middle-income countries has been implicated for the poor quality of healthcare services found in these countries [13]. Meanwhile, as healthcare expenditure continues to grow there is constant pressure on the supply side because resources are scarce [13]. Despite major differences among countries as to how healthcare system is funded, no government has been able to satisfy all the needs of the healthcare system. However, there are several factors like poverty, illiteracy, corruption, poor housing, bad roads and lack of healthcare facilities and manpower that are prevailing in low and middle-income countries that make the formulation and implementation of good health policies unrealistic [14].

Methods of Healthcare funding

Healthcare funding systems usually consider both the funding and service delivery arrangement [15]. There are essentially four methods of funding healthcare; they are general taxation, SHI, private health insurance and direct payments/ user fees [13]. User fees or OOP payments have been described as the most regressive way to pay for health and the way that most exposes people to "catastrophic" financial risk. Deplorably, this is the predominant method of funding healthcare in most developing countries [13]. Box 1 shows the Principal financing mechanisms.

Box 1: Principal financing mechanisms [14.]

Tax-based financing: health services are paid for out of general government revenue such as income tax, corporate tax, value added tax, import duties etc.

Social insurance financing: health services are paid for through contributions to a health fund. The most common basis for contributions is the payroll, with both employer and employee commonly paying a percentage of salary. The health fund is usually independent of government but works within a tight framework of regulations. Premiums are linked to the average cost of treatment for the group as a whole, not to the expected cost of care for the individual. Hence there are explicit cross-subsidies from the healthy to the less healthy. In general, membership of social health insurance schemes is mandatory, although for certain groups (such as the self-employed) it might be voluntary.

Private insurance: people pay premiums related to the expected cost of providing services to them. Thus people who are in high health risk groups pay more, and those at low risk pay less. Cross-subsidy between people with different risks of ill health is limited. Membership of a private insurance scheme is usually voluntary. The insurance fund is held by a private (frequently for-profit) company.

User fees: patients pay directly, according to a set tariff, for the health care services they use. There is no insurance element or mutual support. This is the most common way of paying for privately provided services in developing countries, and is also used as a component of financing for public sector services.

User fees

These are official payments made at the point of service by patients. It may also be referred to as cost sharing, cost recovery or co-payment and are widespread around the low and middle-income countries[16]. It has been widely implemented throughout the developing world since the early 1980s under the Bamako Initiative[9,17]. The continuing application of user fees has been a highly controversial issue. The appropriateness of user fees for services used by the poor has become an important point of debate, particularly in the light of commitments made to achieve international development targets [18]. The World Bank, an influential source of healthcare financing in developing countries, has confirmed its analysis that user fees could be a necessary evil [19].

User fees were advocated for cost sharing and community participation to increase the sustainability and quality of healthcare services and can be used as a means of fund driving for healthcare services [6]. On the contrary, drawing on evidence from a number of low and middle-income countries including Zaire, Swaziland, Lesotho and Zambia, it is obvious that the policy of user fees has led to significant reductions in use of health facilities. Besides, it placed an impossible financial burden on poor households [19]. Studies in Ghana and Nigeria show poor people relying more on traditional healers following introduction of user fees for public health services because such treatments are more affordable, they allow alternatives to cash payments [20].

Furthermore, the ineffectiveness of user fees system is also demonstrated by its adverse impact on the reduction of maternal and infant mortality rates, which is a major health challenge in developing countries. However the use of state sponsored free maternal and child health services at the primary level has been used in some developing countries like Ghana and Nigeria to reduce the high incidence of maternal and infant mortality rates.

International non-governmental organizations (NGOs) have been campaigning for the abolition of user fees in healthcare and their arguments for abolishing user fees focus on the decreases in utilization rates of healthcare facilities which have been observed after the introduction of user fees and on evidence that they worsen the impoverishing effects of seeking healthcare [21]. Another reason for the abolition of user fees is that exemption and/or waiver mechanisms are not working adequately to assure free healthcare to the poor in countries that have such mechanisms in place [21].

In addition to these practical arguments user fees undermine political support for the goal of universal coverage of basic healthcare services [14]. Meanwhile, the abolition of user fees is not without risks. Even the most powerful advocate of the abolition of user fees agrees that there are preliminary conditions and risks in removing user fees[22]. Removing user fees needs to be accompanied by a range of actions including increased and well directed funding. Although international financing may compensate financial needs in the short term, in the medium term governments will eventually need to draw on general taxation or look for suitable alternative methods [19].

Social health insurance

The Nigerian National Health Insurance Scheme (NHIS) is a good example of SHI in a developing country. It is based on the collective risk of the insured group and considered the second basic type of healthcare funding system as to state involvement. It is based on a concept of social solidarity and characterized in effect by a universal coverage. Germany and France are examples of countries that predominantly use SHI to fund their healthcare system [23].

In any SHI system, some people cannot contribute directly and may likely need government support. It is an earmarked fund set up by government with explicit benefits in return for payment and it is usually compulsory for certain groups in the population and the premiums are determined by income rather than related to health risk [13]. Generally, contributions are set in such a way that predefined entitlements to health services which are guaranteed to those who need care, irrespective of their individual health risk or socio-economic status. The contributions are collected by one or several health funds that have the potential to purchase the health services for their members according to priority needs and other criteria such as cost effectiveness. These health funds generally have some degree of autonomy but operate within a framework of government regulation [23].

The concept of SHI is generally associated with compulsory membership involving basically all of the population. In doing so, SHI steers clear of the pitfalls of health insurance on a voluntary basis. It is recognized to be a very powerful method to grant access to health services to the population in an equitable way. Indeed, it implies that beneficiaries pay according to their means while receiving the right to health services according to their needs [4].

In spite of the merits of SHI, the poor are likely to be excluded from it because they are too poor to pay and do not have regular employment for meeting regular payments. Besides, it may not be easily accessed for the purposes of collecting payments because they may be in the rural areas where the roads are in deplorable conditions. It therefore follows that SHI may have problems in funding the healthcare systems of low and middle-income countries because it covers the employed and better off which does not benefit the poor groups directly.

The key issue is to design ways in which SHI can help achieve national health goals and target the poor and rural populations, but it raises the following questions: can government shift general tax funding to basic, rural services, leaving SHI to fund urban hospital care? Can the government ensure that SHI will not undermine services for the poor by attracting trained staff from rural areas to insurance funded hospitals? Will the poor use the same services with the rich, particularly hospitals? Will there be a positive impact on the health sector? Lastly, will the resources raised by SHI be used to enhance service quality and effectiveness? [4]

Each question poses a challenge to the government and it will be very difficult for SHI to favour the poor people because its introduction will only have little impact in mobilizing additional resources in countries where the economy is in

recession or growth is very slow and incomes are low. More so, its arrangements tend to be more complex and more expensive to administer than tax funding because the scheme will require contracts between the third party institutions and service providers and systems for assessing incomes and collecting contributions. In low and middle income countries most people work in the non formal and agricultural sectors, their incomes are variable, regular payments are a problem and income assessment is difficult. It is more difficult and expensive to operate a contribution system under these conditions.

Alternative methods of healthcare funding

Community-based health insurance: Premiums are commonly set according to the risk faced by the average member of the community i.e. there is no distinction in premiums between high and low risk groups. However, enrolment is generally voluntary and not linked to employment status. Funds are held by a private non-profit entity. Health policies like the use of more efficient community based health insurance schemes covering the basic health packages have been shown to cushion some of the negative effects of user fees [22]. The government can modify SHI by introducing local funds/community health insurance schemes which can create a special fund to cater only for the poor and less privilege in the society while the government carries out health sector reforms to improve the effectiveness and efficiency of services especially to the rural areas [24-28].

Waivers/exemptions: Britran and Giedion presented evidence from a number of countries that have implemented exemption or waiver systems for the poor; they found that the policy was effective but there were some challenges associated with the policy which can be surmounted. Waivers were being claimed by ineligible patients while some are deterred from claiming waivers because they feel ashamed of admitting that they are poor because of stigmatization [21, 29].

In low and middle-income countries the rationale for discouraging user fees and SHI in the funding of healthcare system falls mainly on equity and access to health services [30, 31]. The difficulties in predicting healthcare needs, coupled with the irregular and seasonal character of rural incomes, are strong arguments against continuation of user fees and SHI for healthcare funding despite their few benefits [24-27,32]. Moreover, the developing countries presently do not have the administrative and institutional infrastructure needed to implement a formal national health insurance scheme that provides universal coverage like in developed countries such as Germany and France [4].

CONCLUSION

User fees and SHI funding mechanisms seem inappropriate to fund the healthcare systems of low and middle-income countries. Government should give attention to policies that are aimed at eradicating extreme poverty and unemployment and explore other alternative methods of healthcare funding that can help them meet the healthcare needs of the general population irrespective of their financial status.

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