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Cost Sharing: Towards Sustainable Health Care in Sub-Saharan Africa

Background

In 1987, the World Bank recommended that the principle of cost recovery be incorporated into an agenda for financing publicly provided health services in developing countries. Concern remains widespread, however, that the introduction of user fees in government operated facilities or costly membership in insurance plans could deny the poorest people access to modern health services

The debate over cost sharing and related issues has yielded several new insights. In the past, too much emphasis has been placed on raising revenues and too little on how cost sharing might contribute to the efficiency, equity, and sustainability of national health systems. Utilization statistics show an increase in attendance at health facilities in 4 countries (Benin, Niger, Liberia and Zaire) after cost-recovery was introduced, mixed results in 3 countries (Guinea, Nigeria and Senegal) and across-the-board decreases in utilization in 1 (Ghana).

A long-standing concern of governments and donors in Africa has been to strengthen the quantity and quality of health care at the local and district level. This implies :

- larger budgetary allocations to health;
- the reallocation of public funds from tertiary to primary levels of health care;
- cost recovery at public facilities where health services are often provided free of charge; and

- self-financing health insurance to cover catastrophic illness and major medical bills associated with such illness.

However, aside from symbolic pledges of support of such reforms, progress has been slow in most countries.

Private out-of-pocket expenses account for more than 40 percent of total health expenditures while government expenditures account for 37 percent financed through imports, sales and income taxes. Most donor funding goes to capital or development budgets rather than to finance recurrent operating expenses such as salaries, drugs, equipment and maintenance. This underscores the importance of shifting revenue collection and retention to the lower levels of health care services delivery.

The World Bank study *Better Heath in Africa* (1994) proposed several reforms for health care systems. These included increasing spending by governments on health care from $8 per capita to $13 per capita. This level is considered necessary to provide a cost-effective package of basic preventative and curative services, including safe drinking water and improved sanitation in low-income African countries. These countries represent 60 percent of the continent's population.

User fees

Users fees are a necessary precondition for self financing as otherwise the public would lack an incentive to participate when no- or low-cost health care is available through government facilities. Also, self-financing health insurance and user fees allow governments to: (i) to allocate scarce funds from curative services to preventative measures to combat such epidemics as HIV, tuberculosis, and malaria and (ii) to reallocate resources to needed subsidies for the poorest segments of the population with the worst access to health facilities. The two strategies of user fees and self-financing health insurance are mutually reinforcing.

Many of the 29 African countries that have some kind of national system of user fees participate in the Bamako Initiative, a cost sharing scheme launched by African Ministers of Health in 1987 that aims to involve communities in managing and financing health care. An important principle of the initiative is that everyone is expected to pay at least something and proceeds are used to improve primary health care services.

Moreover, evaluations of users of facilities participating in the Bamako Initiative estimate that only 10 to 30 percent of households have difficulty paying minor fees.

The Central African Republic has adopted, since 1991, four different user fee schemes: a charge for services rendered; a flat charge for each episode of illness; a flat fee per visit; and prepayment for a year of service.

A study of the Bwananda District in Zaire showed that, between 1986 and 1988, user fees accounted for 109 to 111 percent of the operating costs of the health centers. In Bwamanda Hospital, between 1986 and 1988, the share of operating expenses covered by user fees was 24-30 percent. The fees were then supplemented by insurance payments, which accounted for 22-33

percent of operating costs, and employer billings, which accounted for another 13-22 percent. Revenues from cost sharing at this tertiary level therefore ranged between 59 percent and75 percent of total operating costs between 1986 and 1988.

In Kasongo District in Zaire, user fees have simultaneously reduced use of the district hospital as a first point of service and have increased attendance at local district health centers. The number of patients using the hospital outpatient clinics as the first point of service fell from 11,800 in 1973 to 1,050 in 1989 and there were corresponding increases in the number of people visiting health centers from 13,522 in 1973 to 54,400 in 1987.

Senegal adopted the Bamako Initiative in 1991 to help pay for pharmaceutical products through users fees. A representative national sample revealed that the contribution of user fees to public health facilities was 5-11 percent for hospitals, 8-23 percent for health centers, 14-35 percent for health posts, and 87 percent on average for health huts.

Seven public heath facilities were studied in Adamaoua Province, Cameroon. Three facilities introduced users fees with improved quality in services, two introduced fees without corresponding increases in quality and two were held as controls. The results argue that when efficient low-cost care became available locally, people used it rather than a distant facility that might be free.

Exemptions from users fees also pose a problem. In Ghana in 1986 most statutory exemptions to users fees were granted to government employees and their dependents. The revenue that would have been collected had the exemptions not existed would have been about 21 percent of total collections for that year.

Time and experience are required to develop a well-functioning system of fees for health services. A 40 percent cost-recovery rate for public hospitals could free up substantially more public resources for basic services that have broad impact on community health. With a 40 percent recovery ration almost $1 per capita could be freed up for a total of more than $400 million, enough to provide essential drugs to all Africans.

Self-financing Health Insurance

There are both supply-side and demand-side factors facilitating the development of self-financed insurance in African countries.

On the supply side, lower administrative costs may be achieved by initially focusing on areas with denser population and better-developed infrastructure. There is also a need to reduce the negative effects of adverse selection Adverse selection occurs when a group of high-risk individuals dominate an insurance pool, eliminating the benefits of pooling risk through an insurance scheme. Moral hazard is another problem for insurance companies and occurs when the insured individuals use health facilities more than they would have without insurance coverage. This can be accomplished through the assembly of sizable groups to pay for coverage and greater donor involvement in the health system through incentives to invest in new financial systems for private sector development.

On the demand side, higher incomes are strongly correlated with higher demand for insurance. Also, there is greater potential for insurance providers in the private sector where there is a high probability of losses for consumers and reduced prospects for free care from the government.

Successful prepayment schemes operate in Guinea-Bissau and Zaire. In Guinea-Bissau, villages are participating in a prepayment scheme for drugs and basic services through annual collections made shortly after harvest when cash is readily available. In Zaire's Bwamanda health zone, annual collections for a prepayment scheme for hospital services are made during the season when cash incomes are highest. Seventy-five percent of the villages studied in Guinea Bissau and more than 60 percent of the population studied in the Bwamanda health zone were enrolled in the prepaid plans.

The Bwamanda district-based scheme in Zaire is particularly instructive because of its high rates, high premium levels and financial efficiency. The population believe that the scheme provides them with access to high quality health services. As hospital fees are relatively high, there is a real financial risk with a disease requiring hospitalization. The bulk of the population can afford the premiums even though the rates are increased every year to keep pace with inflation. Finally, the revenues from premiums and copayments in the zone are used to finance the operating costs of the local facilities. All hospital costs for beneficiaries were covered by income from premiums over the 1987-88 period and cost recovery in the district hospital jumped from 48 percent in 1985 (before the insurance system was introduced) to 79 percent in 1988.

Recommendations

The key elements for successful policies on user fees to be implemented include:

- the formulation of an explicit policy on user fees;
- a rethinking of targeting subsidies;
- an emphasis on efficient management of facilities;
- permission for lower level care providers to retain a portion of their fees collected;
- community participation in local health facility governance;
- improved procurement practices, especially for drugs
- promotion of the development of private sector providers; and
- the building of an information base for future policy evaluation.

Utilization rate studies have indicated that the fees do not discourage attendance at lower points of delivery of health care services provided quality is improved with the fees'introduction.

The key to implementing successful self-financing insurance programs is to minimize

- adverse selection;
- moral hazard; and
- cost escalation.

The success of self-financing insurance is dependent on the development of viable private sector providers.

Investments in health are critical to the formation of human capital and the sustainability of social and economic development. User fees and self-financing health insurance are important tools in moving towards the optimal delivery of health services to Africa's poor and underprivileged.

R. Paul Shaw and Charles C. Griffin. *Financing Health Care in Sub-Saharan Africa.* Directions in Development Series. Washington, D.C.: The World Bank, 1995