Health Economics

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Financing health for all

What is the most practicable system of charging people for health care? This article discusses the problem in the context of countries in Asia and Africa.

Thirteen years after the health-for-all programme was launched, the availability of the necessary finance remains a formidable obstacle to further progress in many developing countries. The hope that governments would increase spending on health care to 5% of the national income is in most cases unlikely to be realized. Nor is there evidence that donors are willing to increase their aid to developing countries or to divert more of it to the health sector. Ministries of health are being left to find their own solutions. Is the way forward to be found in user charges, community financing, private insurance, or some system of formal compulsory insurance? How does one decide which are the more promising options for a particular country? What has been learnt from the experience of countries which have tried to go down particular roads? These questions are discussed here in the context of Asia and Africa.

Under-financed health services

While a few developing countries have achieved high rates of economic growth in the 1980s, for most the growth rate has been much lower than it was in the previous two decades and in a number of cases lower than the rate of population growth. The attempt to service past debts has created formidable deficits in the balance of payments, and the inevitable devaluation of local currencies has increased the cost of debt servicing in national terms and strained government budgets still further. Some countries have diverted their revenue from the social sectors to projects that promise short-term economic gains. For all these reasons, the health sector has often found itself with a budget which has declined substantially in real terms.

This downturn in the fortunes of the health sector came at a particularly unfortunate time. Among the priorities of the sixties and seventies had been the need to increase trained health manpower. There had been a
rapid expansion of medical schools and the costly hospitals associated with them. The lack of trained manpower, which had appeared to be an obstacle to further development in earlier periods, was at last being overcome. The new problem which

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Ministries of health seem to respond to a decline in real resources in a similar way (1)—the maintenance of buildings is postponed indefinitely, equipment and vehicles are not repaired or replaced, bills are paid late, and there is a reduction in the supply of drugs and petrol. At the same time the pay of staff is allowed to fall in real terms. Countries appear to be very reluctant to cut staff, though those who leave may not be replaced.

At the extreme, the deterioration becomes cumulative. Owing to the absence of vehicles and petrol, peripheral staff are no longer supervised. Patient numbers fall when the supply of drugs and other essentials becomes uncertain. Staff respond to the lack of demand and the fall in their pay by spending less time at their work; instead they engage in other activities to support themselves and their families, including illicit private practice. Patients who can afford to do so make greater use of the private sector or traditional practitioners, depending on their income.

User charges

If the situation has deteriorated to the extent described above, user charges would seem to be the only way in which it can be remedied in the short term. This is assuming that all possible economies have already been made, the efficiency of services maximized and a list of essential drugs instituted so that products of assured quality can be bought at the most favourable prices on the world market. It is better for the poor to pay user charges, provided they can obtain the care they need (including drugs), than to go to the private market where the costs are almost certainly higher and the drugs may be inappropriate. As the World Bank points out, charges are likely to be collected much more assiduously if the money is retained locally and spent on the improvement of local services. But this is easier said than done. First, there is the problem of seeing that the money is not misappropriated. Some countries place the money under the control of committees of local people. This is a good basis for building local participation, but there is still the problem of keeping the money safe if there are no local banks. Second, there is the logistic problem faced by distant health units which do not have functioning transport when they wish to obtain drugs from a central or regional store. The best answer will depend on whatever other systems of transport are available. Third, there is the problem that drugs normally involve foreign exchange.

The purpose of charges in this situation is simply to raise revenue. This will hopefully enable a reliable service to be re-established so that a cheaper way of meeting health needs is offered to all income groups than resorting to the private sector. The aim is not to discourage frivolous use, as people rarely know the seriousness of their health need until they have been diagnosed. It is not argued that this is an equitable solution
but only that it is less inequitable than leaving people to go to the private sector—either directly or with a prescription provided by the health services which those services are unable to dispense.

Charges for what?

It is obviously undesirable to charge for preventive care because the aim is to encourage it. It is better to charge for needs which are not urgent such as most dental care (other than emergency extractions) or the supply of spectacles; unfortunately most of the poorer countries do not provide much of a service of this kind in any event. One possibility is a registration charge at a flat rate levied on persons coming for curative care. An alternative is some system of charging for drugs. Drugs are a suitable target for charges as local people often see them as the main benefit they obtain from the health services. There can be exemptions for certain diseases and a once-and-for-all payment for drugs which have to be taken by certain types of chronic patient. A standard charge per drug item is preferable to charges based on the cost of each item as it is simpler to collect and does not penalize those who need expensive drugs. In time people come to know how much money they need to take on a visit. And most important of all it overcomes the problem of people asking for half the dose to avoid paying the full price for the treatment, as happens in countries that charge according to cost. Moreover charging per item rather than per prescription acts as a prompt to the prescriber to consider whether more than one or two drugs are really necessary. This is particularly important since payments for drugs involve substantial amounts of foreign exchange. A charge per item is better than a charge per visit (a registration charge) because at least it does not discourage the patient from seeing his/her doctor and being told how important the drug is.

Having said all this, it is really for representatives of the local community to decide what should be charged for and how much the charge should be. This assumes that some way can be found of identifying a group which is representative of and in close contact with the community, which would in itself be an important step towards community-financing.

Reducing demand

Not surprisingly, charges reduce the demands on the health services, and those whose demand is most reduced are likely to be the poorest. The extent to which this is so depends on the level of the charge. High charges can lead to a waste of health resources since staff may end up with little to do. Staff cannot be easily reduced without reducing also the accessibility of services. Moreover, as mentioned earlier, countries seem to be very reluctant to lay off staff for political reasons. A large initial drop in demand may be followed by a considerable recovery (2). The yield from the charges may have been successfully used to improve services, and the composition of the user population may have changed. The better-off may have switched back to the government health services, disguising a much larger drop in demand by the poorer section of the population. The evidence on the effect of user charges has been admirably summarized in a recent paper by Creese (3).
He concludes that increasing reliance on direct payments makes “access harder for the poorest—and neediest”.

*How much revenue?*

How much revenue can be raised from charges? The experience of the poorest countries in Africa suggests an average of about 5% of operating costs (3), but this makes no allowance for the administrative cost of collecting the charges.

*Exempting the poor*

The fundamental difficulty with any system of charges is how to exempt the poor. To argue that those who can afford it should pay the full cost of the curative health services they use and that differential fees should be used “to protect the poor” (4) is fine in theory but extraordinarily difficult, if not impossible, to apply in practice. Some mission hospitals may seem to be able to do this, but where they are most successful is where staff have served in a community for long periods and the mission has extensive contact with and knowledge about local families as the result of its other work. Moreover, it is often only those who are in a position to pay who use these services.

It is often argued that because traditional practitioners are able to support themselves, so too can government health services. But this overlooks the fact that traditional practitioners will accept payment in kind, or agree to postponed payment, or use differential charging, and such ways of obtaining payment are practicable only because of the very close links between the traditional practitioners and the community.

It cannot be stressed too strongly that willingness to pay is not necessarily evidence of ability to pay. People may be able to lay their hands on money in what seems a crisis rather than face the humiliation of claiming exemption. But the price they may have to pay is to go without before harvest time or to get into a spiral of debt at high rates of interest and even end up by selling some of their land. It is women who make the most use of health services for themselves and their children, and they seldom have command over all household resources.

Those who advocate “targeting” charges only on the better-off should be able to point to an example where such a system works with tolerable accuracy. At present it seems that a system of granting discretion to health staff is bound to result in very rough justice. Whatever the rules, it seems that in practice exemption is seldom granted. Certificates of indigency issued by village leaders can be subject to political or kinship bias. And a formal system of means-testing by workers trained for the purpose, the cost of which is only justified in the case of substantial bills for hospital care, can result in substantial bad debts from those who are assessed as able to pay in whole or part but fail to do so on leaving the hospital. Moreover the fact must be faced that it is formidable difficult to assess the means of those who work in the informal sector or subsistence agriculture, as most people do in the poorer developing countries. And there is in many cases the further complication of determining who really constitutes the household.

At least three countries (Costa Rica, the Republic of Korea, and Thailand) operate systems by which poor people can apply annually for a certificate or card which entitles them to free health care. None of them succeeds in identifying all the poor. The system in Costa Rica only applies to the small minority who are not covered by health insurance. A systematic investigation
in Thailand has shown that the cards are issued to 14–20% of the population but that only 60% of card-holders are poor and that 17% are actually wealthy (5). Despite this failure of targeting, it is nevertheless true to say that such systems are easier to administer where relatively stable families are the norm, as is the case in all three of these countries. The possibility of applying such a system was investigated in Jamaica but not implemented, one of the problems being that of defining the household.

Such evidence as is available leads to an inescapable conclusion. Generalized systems of charging are bound to face problems of equity (6): some of the poor are likely to be made poorer when charges are introduced.

**Charges which do not hit the poor**

There are, however, a number of specific types of charge which do not have these effects. The first is a charge levied on employers for the full cost of treating accidents at work. This can be formalized into a system of compulsory prepaid insurance for industrial injuries with the contributions falling wholly on employers. The second is to charge vehicle owners for the whole cost of treating road accident cases. Where owners of vehicles are required by law to take out insurance, this can be one of the risks which must be covered, so that the claim has to be paid by the insurer. Whether it is worth the effort of introducing this system depends on the proportion of cases which are due to road accidents. Thirdly, patients who seek care at hospitals without being referred or being genuine emergencies can be charged the whole cost of their care, provided that they had the option of attending a local health facility which offered free or nearly free care. Fourthly, the health services can offer clinics out of normal working hours for those who are willing to pay and want to avoid the queues. The takings can be divided between extra payments for staff doing overtime and the health facility providing the service (7). Finally, there is often a case for charging patients and relatives for the use of hospital car parks, if parking is forbidden on local roads. Also, some profit might be made by a shop selling refreshments and gifts to visitors and waiting patients.

**Community-financing**

Introducing charges for government health services creates an incentive for communities to organize informal prepayment schemes, under which those who pay contributions become once again entitled to free health care. The prospects of making this operate successfully are greater when payments can be made through a producers’ cooperative which deducts the contribution before paying the producer for his produce. This operated very successfully in China before the agricultural cooperatives were disbanded, and there are many other isolated examples of prepayment schemes operating in different types of community.

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What is not clear is how long they last and how much they depend on charismatic leadership.

It is hard to find an example of a country which has managed to develop prepaid
community-financing into a national system. One country which has made a substantial effort over seven or more years to develop such a system in the rural areas has been Thailand. From the start, volunteers were carefully selected by the villages and extensively trained. There were incentives for villages to promote the system because part of the money gathered was retained in village health funds. But despite the relatively low premium (US$ 4–6 for a family for a year) and the high priority given to the programme by the Ministry, coverage was less than a quarter of the population in the implementation areas (8). Moreover those who joined tended to be the better-off and those with above-average health risks. It has still to be shown that voluntary local prepayment schemes can make a major contribution to health financing. This may not, however, be their main purpose, which may be to develop greater participation in health matters at the local level— a step towards empowerment.

Informal health insurance is, of course, only one of many types of community-financing. Others are extensively discussed elsewhere (9). But, apart from voluntary donations, all face problems of equity.

Profit-making private health insurance

Some have suggested that the spread of private insurance can take a noticeable load off government services. At present, however, it plays an insignificant role in the poorer developing countries. Even where it does have coverage of around 5% of the population, the cost of the premiums limits further expansion. Private insurance has costs which do not fall on a compulsory public programme— not only profit margins but sales promotion costs. Another factor pushing up costs is the fact that those who choose to be insured are likely to be less healthy than those who do not, though this is avoided where an employer enrolls his whole work-force.

The insurer protects himself from bad risks with a whole series of limitations in the policy. A further problem is that each individual insurer is in a weak position to negotiate favourable prices from suppliers or to require participating doctors to observe a list of essential drugs. Thus insurers generally have to reimburse medical bills which may be padded with unnecessary services, since the supplier knows that most of the cost will ultimately fall on the insurer. The potential contributor is faced not only with high premiums but also with flat-rate premiums rather than earnings-related contributions which it is generally the practice to charge in compulsory schemes. On top of this those who would wish to cover their families have to pay substantially higher premiums to do so, which generally means that coverage of dependents is low. Finally, preventive services are often not covered by private insurance because those who pay the premiums are not believed to attach much importance to them.

Compulsory health insurance

In view of the difficulties with all the other options, an increasing number of developing countries in Africa, Asia, and the Caribbean are contemplating the development of compulsory health insurance, with the aim...
of covering step by step all those in regular employment and then extending coverage to the self-employed, initially on a voluntary basis. Countries moving in this direction in Asia include Indonesia, Malaysia, Papua New Guinea, Thailand, and Viet Nam. Those in Africa include Ghana, Nigeria, and Zimbabwe. What are the advantages of this approach? What are the prerequisites for making it a viable option and what problems are likely to be encountered?

**A viable option?**

What is required to make compulsory health insurance a viable option? First, there must be sufficient trained health manpower in the private sector to provide the service without robbing the public sector of trained manpower, which it can ill afford to lose. If to make the scheme acceptable it is necessary to have direct access to a doctor on the onset of illness, then there must be sufficient underemployed doctors to operate the scheme. Some countries (such as Sri Lanka) have been faced with high rates of emigration of their doctors because of the much higher earnings offered abroad.

Ensuring that the remuneration available from health insurance is high enough to attract them back would be inconsistent with the aim of retaining sufficient doctors in the public service. One could hardly stop doctors from resigning from the public service to get the higher earnings from health insurance.

Secondly, there must be enough persons working for employers on a regular basis (not daily paid) outside the public sector to make the scheme viable, to take a noticeable load off the public health services, and to justify the major administrative effort needed to establish the scheme. Contributions are generally split between employers and employees. Therefore covering public employees involves extra costs for government in its capacity as an employer.

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**The advantages**

The main advantage of compulsory health insurance is that the insured, with the help of their employers, can be made to pay the whole cost of the services they use, not just a small part of the cost, which in practice is all that user charges can collect. The contribution can be afforded even by those with lower earnings, partly because the employer shares the cost and partly because it can be made a proportion of earnings rather than a flat rate. The cost of covering dependents can be spread among those currently with none and those with many. A unified scheme has the further merit of being able to exercise bargaining power with providers so as to obtain services on favourable terms; it can insist on the use only of essential drugs and make arrangements which do not give any incentives for the provision of unnecessary services. Compelling people to join by law naturally saves the cost of sales promotion, and the scheme can be designed to provide both preventive and curative services, using the same health units. Administratively it is much easier to identify those with regular jobs and make them pay rather than to find those who are poor so as to exempt them from charges. Moreover experience has shown that ministries of finance have not attempted to cut the health budget once health insurance has been introduced.
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If, as is the case in some countries (for example, Indonesia and Thailand) there is already an insurance scheme to cover public servants, this problem does not arise. But some countries would find it difficult to start a scheme and exclude public servants or make the latter join only if they were willing to pay the employer's contribution as well as their own or forego a pay rise and accept instead the employer's contribution to the scheme.

Compulsory health insurance would seem a more attractive long-term option than user charges.

At first sight it may seem that it is not worth the effort if (say) only 10% of the employed population, or 2% of the total population, are in private employment. But this 2% and their dependents may be benefiting from 20% or even 30% of the cost of the public health services. This is because they are likely to be working in the main urban areas where the public health services are best developed. A scheme which could pick up 20–30% of the cost of the public health services would allow a substantial diversion of funds to improve the services and extend them to those underserved or not served at all.

Thirdly, it must be possible to provide insured persons with services which they regard as worth paying for. To work effectively, health insurance should be designed to be self-policing to a considerable extent. Employers comply with the law and pay both their own and their employees' contributions because employees want to enjoy the benefits of being insured and employers appreciate the advantages of healthy workers. It would be unlikely to work effectively if insured persons were offered exactly the same services as were available to those not insured. There are many ways in which this can be achieved, such as ensuring access to doctors in their own private offices or providing special clinics for insured persons at separate times or on separate premises. Where public hospitals have several classes of ward, patients can be given access to a higher class or the option of using an approved private hospital. But in some countries there may not be higher classes of ward (or only on a very small scale) and acceptable private hospital accommodation may be very limited. Insured persons have to be given some privilege, and this at first sight may seem inequitable, but the extent of privilege need not be anything like as great as that enjoyed by people who pay privately for their health care. It is possible to confine the privilege to amenity and convenience and not extend it to the quality of care provided.

Fourthly, the scheme has to be affordable by employers. It would be perverse to establish a scheme which had the effect of bankrupting employers and creating further unemployment. This is only partly a question of how the total contribution is to be divided between employer and employee. Also relevant is what employers are already spending on the health care of their employees. It is often advisable to investigate this question before introducing a scheme. It was found in Jakarta, for example, that larger employers were already spending on average over 20% of the payroll on health care for employees. Similarly it was found in Thailand that employers were on average already spending more than the contribution they would have to pay. In these cases health insurance would lower, not increase, employers' costs. In practice, experience shows that employers find ways
of shifting their contributions either on to prices or, more likely, on to wages by not increasing them as much as they would have done in the absence of the scheme.

Fifthly, the country must have the administrative capability to operate the scheme with efficiency and without corruption. An accurate record has to be maintained of those entitled to the benefit, administrative costs have to be kept as low as possible, the cost of the benefit needs to be regularly monitored and kept under control, and providers have to be paid without delay. Expert help may be needed from abroad to assist in setting up the scheme and training those who are going to operate it, but success will ultimately depend on the skills of those who are put in charge of it. For many countries health insurance will be one of the most complex administrative tasks ever attempted. Political support at the highest level is needed to see that the scheme is able to attract and retain the key personnel required to run it and to ensure that the considerable start-up costs are fully met.

Finally, the government needs to be committed to the policy of health for all. There is a danger that once the more vocal people in society—their with regular jobs—are provided with an acceptable health service, there will be less political pressure to improve and extend services for those who are not covered. This has happened in some countries in the past. But if a government views health insurance as a step towards health for all, the money released by the scheme can be redeployed to strengthen the public health services.

Some of the problems

One of the key problems is to design a system which meets a number of different criteria. It must lead to services acceptable to those covered by the insurance—in convenience and consumer responsiveness as well as technical quality. There should be built-in cost control. The scheme must be acceptable to providers. In making the choice there is fortunately vast international experience to draw on to find a model that will meet the expectations of both users and providers. There is the important question of how doctors and hospitals are to be paid. This and other detailed questions are discussed in a recent publication of the International Labour Office (10).

It will be necessary to resist pressure from large firms to opt out on the ground that they already provide health services for their employees. Such firms are likely to be those with better-paid employees, such as banks and insurance companies. The viability of the scheme may well depend on cross-subsidization between firms with higher average levels of pay and those with lower average levels of pay.

Another problem is to make sure that the income which doctors can obtain from health insurance is not so large that it induces medical staff to leave the public service and makes it even more difficult to persuade doctors to accept posts in the remoter rural areas. The starting-point for fixing rates of pay should be earnings in the public sector. Doctors with established private practices will argue that the amount they are paid per visit under the compulsory health insurance scheme (whatever the system of payment) is derisory compared with private practice, while underemployed doctors will silently rejoice at the prospect of a reasonably reliable income. This is an area where concessions cannot be made without dangerous consequences. One possibility is to restrict participation in the scheme to doctors who have completed a period of
service in rural areas or to relate the amount of insurance practice they are allowed to their period of rural service.

Conclusion

For countries which can meet the above criteria, compulsory health insurance would seem a more attractive long-term option than user charges. It has the prospect of bringing in more money to the health sector, and it does not place at risk access to health care for the poorest and neediest.

To some the introduction of compulsory health insurance may seem, at first sight, a socially divisive backward step at a time when some developed countries are providing good quality services for all financed out of taxation. What is stopping developing countries from following this better example? The answer is that developing countries cannot raise the same level of taxation in view of the lower level of living and the fact that a high proportion of the working population is in the informal sector where it is extremely hard to operate an income tax. The same was true of what are now the developed countries a century ago. The path they chose was to move step by step from voluntary insurance to a compulsory insurance scheme, which steadily expanded its coverage until finally the whole resident population became entitled to the same benefits. Most of them have, however, retained health insurance contributions as one of the ways of paying for the service.

References


8. GTZ, op. cit., p. 36.
