Health Economics

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Community financing of health care

Policy-makers in developing countries may wish to guide communities as to how they should go about choosing a method for the financing of health care. With particular reference to the provision of essential drugs in sub-Saharan Africa, the author examines the pros and cons of direct payment, fee-for-service, and prepayment systems. Before advice is offered to a community, detailed information should be gathered about its preferences, socioeconomic status, and administrative know-how.

Health status in sub-Saharan Africa is still a far cry from the goal of health for all. Life expectancy for males and females in low- and middle-income countries (those with gross national products per capita below and above US $ 400 at 1983 values) is about 46-49 and 48-51 years respectively. The average shares of public health expenditure in gross national product are only 0.95% and 1.9% for these two categories of country; in 1983 these figures corresponded to $ 2.1 and $ 13.4 per capita. There is a general constraint on public sector budgets, and the situation is exacerbated because health has to compete for resources with defence, education, housing, general administration, and so forth. The question arises as to whether there are ways of lessening the restrictions on health development caused by limited public health budgets.

Financing health improvements

Methods for speeding up and funding health improvements include the implementation of health insurance, the use of foreign aid, the raising of taxes, and the reallocation of public money. Furthermore, direct contributions can be made by users or households, in the form of either charges for services received or prepayments for future services. A cost-recovery scheme can be operated nationally, although the administrative costs may prove excessive. Even at local level there are appreciable costs associated with the collection of fees, accounting, the safeguarding and storing of revenues, and supervision. With a regional or national bureaucracy in addition, overheads inevitably rise.

Community financing may well be preferable. This involves direct financing of health care by households in villages or distinct urban communities. Financing can be arranged either by payment on receipt of care or by prepayment. Local control of

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revenues may encourage health workers to collect fees, whereas if fees have to be
transferred to a higher bureaucratic level
there may be a lesser inclination among
these people to enforce payments by
patients. If fees can be retained locally,

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health workers may be more committed to
the financing scheme, since they will expect
to have a say in the allocation of revenues.
Furthermore, a community financing scheme
may respond better to the preferences and
demands of the local population, and
encourage their compliance with
cost-recovery measures.

The lack of resources at household level is
often given as a reason against community
financing. However, despite low purchasing
power, there is generally a certain ability
and willingness to pay for medical care.
Considerations of equity may require limits
to be set on the charges that people pay.
Moreover, far from it always being necessary
to stimulate private expenditure, in some
cases it may be imperative to decrease the
cost of care in order to give people a better
deal.

Both public and private resources are used
more efficiently if an essential drugs policy
is pursued. Such a policy stimulates access to
health care by means of a steady supply of
low-cost drugs. Community financing may
encourage a more prudent and less wasteful
use of drugs, and, as most of these are
imported, it will result in a more
economical use of foreign exchange.

It is important to note that shortages of
essential drugs may prevent the full
potential of village health workers from
being realized. People may be willing to
participate in community financing schemes
that are intended to achieve satisfactory drug
supplies and enhance the efficiency of these
workers. Also, community financing of
essential drugs may lead to broader
involvement in the financing of health
services if patients come to understand that
there is a link between their monetary
contributions and regular supplies of drugs.

When the idea of community financing is
accepted, a choice has to be made between
the direct payment, fee-for-service, and
prepayment (insurance) systems.

Direct payment

Full cost recovery

In many cases, governments provide
rationed drugs free of charge to patients.
Suppose that a government abolishes
rationing and switches to a policy of full
cost recovery. Theoretically, patients will
then be able to reach their optimum
demand: they will pay for the drugs and
enjoy an improvement in health. They will
understand that paying for and receiving all
the drugs needed is better than obtaining an
inadequate amount of drugs without charge.
Of course, this reasoning does not apply
where the poor are concerned.

Pricing

In most developing countries, patients do
not necessarily have to consult a physician
or health worker in order to receive drug
treatment. They often have direct access to
drugs in pharmacies or general shops.
Patients may lack adequate information about the characteristics of the drugs they want. They may underestimate the usefulness of a drug and take less than the optimum dose. One way to induce them to take more is to supply them with suitable information. However, the organization of information campaigns may prove to be quite difficult or costly. Another possibility would be for the state to provide subsidies. This, of course, would work only if demand were sufficiently sensitive to price changes.

The common good

People other than patients may derive benefit from the consumption of drugs by patients. For example, in malarial areas people gain from other people’s use of chloroquine if this reduces the prevalence of the disease. Similarly, the Expanded Programme on Immunization depresses disease transmission.

According to economic theory, if people experience benefits from other people’s consumption of drugs, the optimum demand for drugs from society’s point of view is greater than the demand that would be forthcoming from individuals. This is because individual patients underestimate the social value of their own consumption.

Equity

If prices are charged for drugs the demand for them by poor people may fall and the health situation may deteriorate. Concern about equity may dictate policies whereby the poor pay only a fraction of the cost price of the drugs they use, the subsidy coming from government. In combating important diseases it may even be socially desirable to provide drugs free of charge to the poor. A major difficulty resides in determining who should be given the right to free drugs. It is frequently suggested that local authorities, having the best information about people’s economic status, should be responsible for devising criteria in this connection.

Fee-for-service

This means charging for a consultation or a course of treatment. A fee-for-service system may be better, from the patients’ point of view, than a system of government-financed and rationed health care. A sliding scale of fees can be used or discounts can be allowed for specific types of consultation. For instance, in order to encourage pre- and postnatal consultations, fees can be set below the cost price. Similarly, in order to improve the coverage of oral rehydration, consultations related to episodes of diarrhoea can be subsidized. Furthermore, equity considerations may justify setting fees according to economic status; the poorest patients can receive free consultations, which is certainly rational from the standpoint of social welfare.

Under fee-for-service systems, patients are not confronted with the real cost of drugs and there is consequently a danger that they will press for excessive prescribing.
form of risk-sharing: because the cost of drugs is financed by fees, ill people who receive costly treatments are subsidized by patients whose treatments are relatively inexpensive.

Insurance
Risk aversion

Schemes can be designed whereby potential patients pool their risks and share in the financing of health care. The basic economic rationale for prepayment or health insurance follows from patients’ aversion to risk. Risk-averse patients prefer to shift the risk, for instance to an insurance firm or the state, by paying an insurance premium.

Insurance contracts are not, however, very easy to draw up. An insurer does not have all the information about an insured person’s risk situation. This asymmetry of information is particularly marked when the insured’s behaviour is characterized by moral hazard, in other words when the insured’s demand for health care is sensitive to the price of services. The lower the price, the greater is the likelihood that patients will demand “too much” medical care. In the case of completely insured persons, health care is costless and this may lead to excessive demands for medical attention. Clearly, if insurers do not make adequate allowances for such behaviour, premiums may be too small to cover treatment costs.

A second major difficulty in organizing insurance is the occurrence of adverse selection. In the absence of knowledge about the risks of illness in different population groups, insurers are compelled to charge a uniform premium that is likely to be higher than what people in low-risk groups are willing to pay. This leads to an upward movement of the premiums and eventually many people may no longer find insurance worthwhile. Thus a situation may arise in which the premium is too high even for high-risk individuals.

The extended family

Because of the two problems cited above there is a general lack of a market for health insurance in sub-Saharan Africa. However, members of an extended family may help each other when health care costs have to be paid. The family has three important advantages over the market and the state. Firstly, adverse selection is limited because people cannot easily withdraw from their families and outsiders cannot become members of a family. Secondly, families generally have more information about members’ behaviour than do professional insurers or the state. The ease with which families can monitor their members’ behaviour may decrease moral hazard. Thirdly, moral hazard behaviour may be especially constrained by feelings of family loyalty (1).

Extended family insurance also has disadvantages. Because the size of the family is limited, risks cannot be spread widely. Small losses do not present special problems,
but large losses with small probabilities cannot be adequately insured in a family context. Correlation between family members’ health risks may make family insurance particularly deficient. If parasitic or infectious diseases spread through a family, its income or wealth may be insufficient to finance the resulting health care costs.

Compulsory insurance

An important substitute for market or extended family insurance is compulsory collective insurance, organized by enterprises, cooperatives, communities or governments. This avoids the adverse selection problem of neglecting people at high risk who would like to insure but for whom premiums are too large. In the absence of adverse selection there is a tendency for premiums to be lower than in private market arrangements because the base on which they are calculated is comparatively broad. Collective insurance reduces collective health risks. It stimulates demand for health care, and may thus help indirectly to lower the prevalence rate of certain diseases. For example, the expanded use of an antiparasitic drug may diminish the prevalence of ascariasis. Compulsory insurance may also help towards the achievement of equity, redistributing resources in favour of high-risk individuals, who are predominantly found in the poorest households.

However, collective insurance has to cope with the moral hazard phenomenon. If there is adequate coverage, people may consume medical care excessively, perceiving it to be virtually free. In that case, the collective insurance scheme may wish to avoid providing full risk coverage by the introduction of deductibles, i.e., insurance against all expenses beyond a predetermined amount, and/or co-insurance, i.e., payment by the insured of a predetermined percentage of costs out of pocket. Another possible weakness is that schemes may neglect individual preferences for insurance.

Indeed, some individuals may wish to pay more than others. In certain instances, people may consider the amounts covered to be excessive. It should also be noted that the way equity is dealt with in collective insurance may run counter to people's preferences. If premiums are graduated in relation to income the resulting implicit transfers from the rich to the poor may overstate the degree of altruism in the population. Clearly, there is a danger of noncompliance if collective insurance schemes deviate too much from what people require. Careful study of a community’s economy and preferences is therefore needed before an insurance scheme is launched.

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The method of direct payment is usually fairly simple to administer and efficient in supplying drugs to the community on a regular basis. One important drawback may be that the high cost of some drug treatments inhibits low-income patients from demanding health care. Here the prices of drugs may have to be adjusted in the interest of equity. The fee-for-service method has the advantage that it includes a form of risk-sharing among the ill. However, in order to guarantee access to health care...
for the poor an equitable fee schedule may be required.

Prepayment or insurance schemes involve risk-sharing by all members. Here it is important to emphasize that, if a scheme is not widely accepted by the population it is intended to cover, it may fall into the trap of adverse selection. Indeed, too many refusals to insure by people with so-called good health risks may result in excessively high premiums, thus rendering the scheme unworkable.

It is essential that the population be involved in establishing the rules of a financing scheme. When selecting a scheme, consideration should be given in particular to the people's capacity and willingness to pay for drugs and health care and to their notion of equity. Account should also be taken of the degree to which people trust various types of scheme. For instance, where people have lost money as a result of embezzlement there will be very little enthusiasm for paying in advance. If the people's preferences are disregarded there will be serious problems of compliance with a scheme's rules.

Careful consideration should be given to the administrative skills available in a community when a financing method is being chosen. Although direct payment schemes are said to be simple to administer, a minimum knowledge of accounting and the management of revenues is nevertheless required, as it is for the other two methods. The fee-for-service scheme demands the additional ability to cost the various inputs in the operation of a health centre, and, subsequently, to set the appropriate fees. For a prepayment scheme to be feasible, some actuarial knowledge is indispensible.

Thus in-depth information about a community's socioeconomic status, preferences, and administrative know-how should be gathered before advice is formulated on policy concerning the financing of drugs and health care.

Reference