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Healthcare Financing in Low and Middle-Income Countries and Achieving Universal Health Coverage

Amadou Boubacar
Murdoch University
amabz09@gmail.com

Abstract

Using a comparative healthcare system approach, this paper discusses the existing healthcare financing methods in low-and middle-income countries in the move towards achieving universal health coverage (UHC). The article finds that traditional channels of financing the health sector in these countries include government's budget, donors' aid, national health insurance, and out-of-pocket model. Moreover, the paper explores other alternative mechanisms for raising resources for the health sector including tax on demerit goods, remittances, and sovereign wealth funds' revenues. This paper is of particular interest to policymakers in low-and middle-income countries targeting to achieve UHC.

***Keywords**: healthcare financing, low-middle income countries, universal health coverage*

Introduction

The role of good health in socioeconomic development and its essentialness to human wellbeing is recognised by every country. The United Nations (UN) has identified the universal health coverage (UHC) as one of the most effective ways for achieving the health-related sustainable development goals (SDGs) by 2030 and for provisioning of better health and protection for developing countries (World Health Organisation, 2017). Despite the financial capacity gaps, in 2005, all WHO member countries, including low- and middle-income countries (LMICs), endorsed UHC as a primary goal to achieve.

Using a comparative health systems analysis, this paper aims to discuss the existing health financing models and potential alternatives in LMICs in order to progress towards achieving UHC by 2030. In this regard, the essay will first define the concept of UHC, its main objectives, and implications. The second part will explore the health financing strategies in LMICs. In the last part, key recommendations will be provided for maintaining a strong healthcare financing system to achieve UHC.

Universal Health Coverage (UHC) and its main objectives

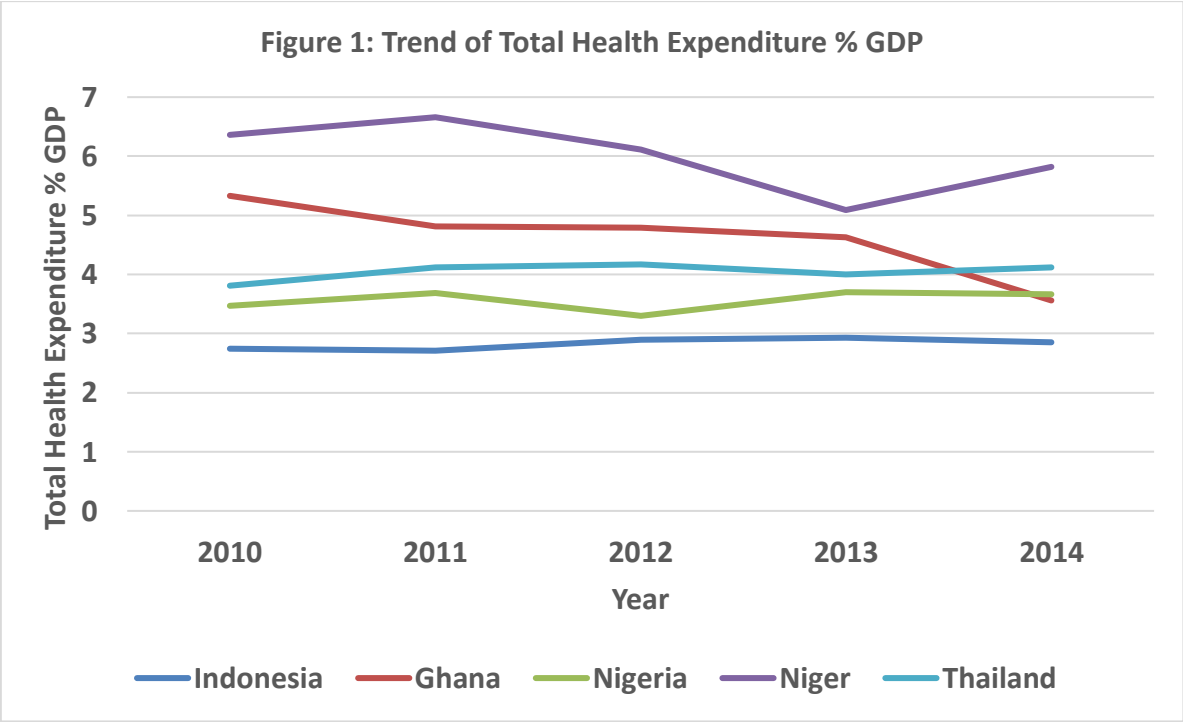
According to the WHO Consultative Group on Equity and Universal Health Coverage, UHC is defined as "all people receiving quality health services that meet their needs without being exposed to financial hardship in paying the services" (WHO, 2014, 10). UHC has three main objectives. The first objective is to ensure equity in access to health services that means "people's needs guide the distribution of opportunities for wellbeing" (WHO, 1998, 17). The second objective is to ensure that the quality of health services is adequate to improve the health of people receiving them. The third objective is to protect people against financial-risk by ensuring that health expenditures not put people into poverty. From these key components of UHC, and given the scarcity of resources in LMICs, a comprehensive understanding of UHC is to provide essential health services to people but not all beneficial health services at an affordable cost. UHC is rooted in the WHO Constitution of 1948 which states that a right to health is "one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition"(WHO, 2014, 7), and the Health for All agenda adopted by the Alma Ata Declaration in 1978 in Kazakhstan.

The importance of advancing UHC has been acknowledged by the UN during the Millennium Development Goals (MDGs) era, where UHC served as a global health response, covering three out of the eight MDGs including *reduce child mortality*, *maternal health*, and *combat HIV, malaria and other diseases*. Similarly, the 2030 agenda for Sustainable Development also made the achievement of UHC as one of the most fundamental targets of the seventeen SDGs. Moreover, the UN argues that UHC provides an avenue to unite global health and combat poverty. In addition, UHC is the common denominator for all the health-related SDGs. In LMICs, UHC is likely the best solution for providing essential health services to all people while preventing them from catastrophic health expenditures. The way LMICs finance their healthcare system determines their effort in moving towards UHC. Also, reaching UHC depends highly on nature of the healthcare financing system, that is, the flow of financial resources from patients to healthcare providers in exchange for healthcare services (Uzochukwu et al., 2015). A sound healthcare system provides quality services to all citizens wherever they are and at any time they need the services. Nevertheless, this requires countries to set up a strong and robust financing mechanism associated with qualified, well paid, and motivated health professionals. LMICs use several models to finance their healthcare systems to achieve UHC.

Existing Healthcare Financing Mechanisms in LMICs.

National budgetary allocation

The primary source of financing the health sector in LMICs is the government budget through taxes collected from the formal sector. Behera and Dash (2019) find a positive and significant relationship between the elasticity of public health expenditure and LMICs macro-fiscal determinants. Although the essentialness of health to the accumulation of human capital and the commitment for achieving UHC, healthcare spending is very low in LMICs. Adequate resources need to be allocated to the health sector to meet the increasing health-related financial needs. For example, in 2015, health spending represented less than 5% of the state budget in Nigeria (Uzochukwu et al., 2015). This low financial support is likely common in most LMICs. The following figure displays the trend of total expenditure on health (TEH) as a percentage of gross domestic product (GDP) in five LMICs.



Source: World Health Organisation. Global Health Data Platform 2020

Figure 1 shows that all five countries allocated less than 7% of their national budget on healthcare from 2010 to 2014. Depending on each country's context, it appears that Niger had the highest government's contribution to the health sector compared to the other countries with an average TEH as a percentage of GDP of 6% from 2010 to 2014. Indonesia, in contrast, had the lowest contribution with an average TEH of 2.82% over the period. Ghana and Thailand spent on average 4% of GDP on health, while Nigeria's average TEH was around 3%. For a rapid progress towards UHC, these countries need to raise sufficient revenues from the government to strengthen their healthcare systems to deliver essential services to all citizens.

Donor funding

Given the limited resources and the increasing needs for healthcare services, for LMICs to successfully achieve UHC, the engagement of the international development community is crucial. The external aid may help LMICs in three broad dimensions including: The provision of financial resources, the creation of enabling health policies, and the transfer of technologies, and expert assistance. Since the adoption of the Paris Declaration on Aid Effectiveness and the subsequent Accra Action Agenda in 2005, donors contribute in financing healthcare systems in LMICs to facilitate the progress towards UHC (World Health Report, 2010). This contribution is made through bilateral or multilateral co-operations. LMICs benefit from external aid disproportionally. For example, Niger and Ghana received on average 14.61% and 13.79% of external resources for health as a percentage of total expenditure on health from 2010 to 2014, respectively (World Health Statistics, 2017). Thailand, and Indonesia, in contrast, received less external resources for health as a percentage of total expenditure on health. Their external aid for health was 0.39% and 1.11%, respectively, over the same period. Yet external aid constitutes an important component of healthcare financing systems in LMICs. However, given the volatility and unpredictability of these funds and their highly political nature, LMICs would not rely on these resources to finance their health sectors. These funds should be a catalyst for raising more funds for the healthsector.

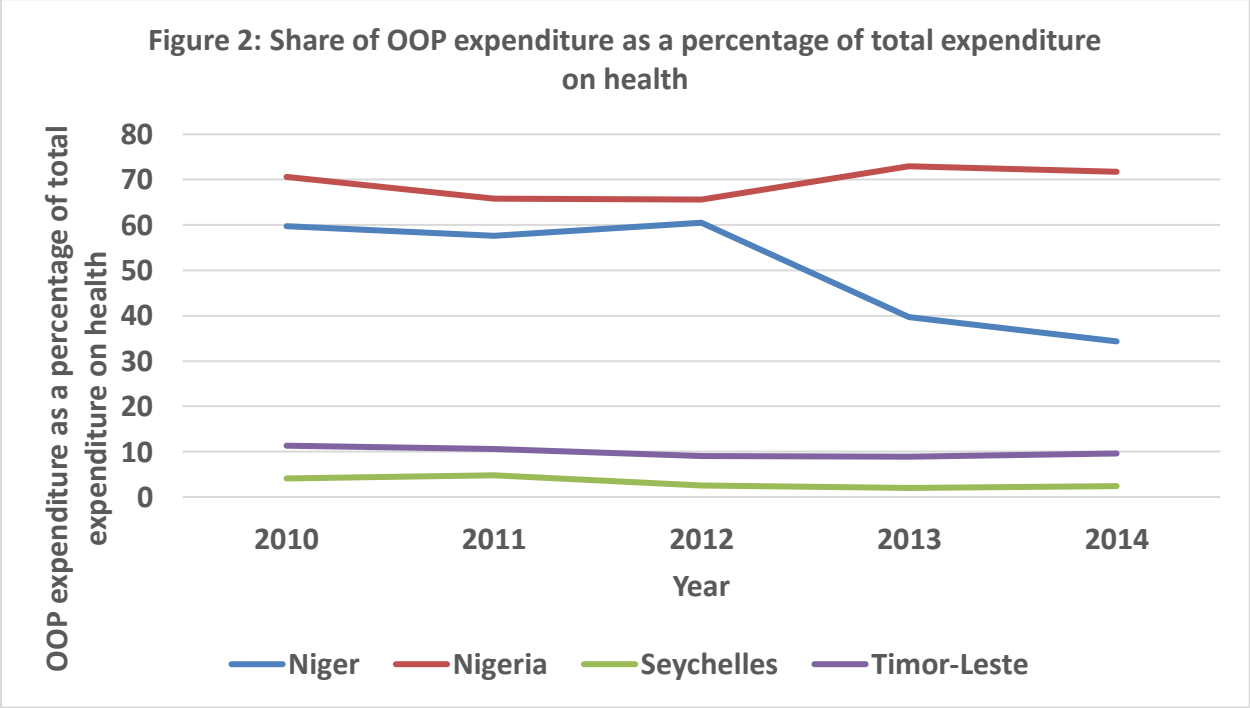
National Health Insurance (NHI) model

This strategy of healthcare financing is common in LMICs. Although private sector providers are used, the payment comes from a national-run insurance scheme that people pay into. Among the multiple advantages of this model is its ability to manage healthcare costs by using specific instruments, such as, the limitation in medical services to be paid for by patients, and the waiting time for treatment. Some LMICs have used this model to make rapid progress towards UHC while in other countries the implementation of NHI is not effective. For example, Thailand is an illustrative successful case of NHI utilisation. According to Tangcharoensathien et al. (2015), more than 98% of the Thai populations were covered using the three national health insurance schemes. These include the Civil Servant Medical Benefit Scheme (CSMBS), which covers all government officials and their dependants, the Social Health Insurance (SHI) devoted to insure the private sector workers, and the Universal Coverage Scheme (UCS), which covers the remaining citizens. Likewise, Ghana's National Health Insurance Scheme (NHIS) also produces significant results in covering more Ghanaians. Kipo-Sunyehzi et al (2019) find empirically that, since its inception in 2004, Ghana's NHIS did well in accessing more people exempted from annual premium payments compared to all citizens. The authors argue that greater progress towards UHC can be made by shifting from voluntary financial support to a

broader tax-based model. In Nigeria, however, after 9 years of the launch of the NHIS, only two states adopted it, and less than 5% of government employees were covered (Uzochukwu et al., 2015).

Out-of-Pock (OOP) model

OOP payment is one of the most commonly used healthcare financing channels in LMICs. Given the scarcity of financial resources, governments are unable to provide mass medical care. Consequently, households have to pay for healthcare services at the moment they need services. Direct payments for healthcare have disastrous consequences on a household's budget and limit people's access to healthcare services. It is estimated that globally, around 150 million people experienced catastrophic health expenditures annually, and nearly 100 million people become poor due to health cost (World Health Report, 2010). Countries willing to achieve UHC need to drastically reduce their reliance on OOP payments for healthcare financing. Overreliance on direct payments when services are needed is one of the major constraints from moving closer to UHC (World Health Report, 2010). Unfortunately, OOP payment remains a key component of healthcare financing in many LMICs. The following figure depicts the share of OOP expenditure as a percentage of total expenditure on health in five LMICs from 2010 to 2014.



Source: World Health Organisation. Global Health Data Platform 2020

Figure 2 displays the share of OOP expenditure in the total expenditure on health in Niger, Nigeria, Seychelles, and Timor-Leste from 2010 to 2014. It appears that OOP payment represented more than half of the total expenditure on health in Niger and Nigeria from 2010 to 2012. The share increased from 2012 in Nigeria and

reached 71% in 2014. A drastic drop was observed in Niger, reaching a low level of 34% in 2014. Niger and Nigeria had an average OOP expenditure of 50.37% and 69.32%, respectively. Conversely, in Seychelles and Timor-Leste, the share of the OOP expenditure was very low. Over the period, Seychelles and Timor-Leste had an average OOP expenditure of 3.14% and 9.89%, respectively.

Given that a country that relies highly on direct payments to finance its health system will find it more difficult to achieve UHC (World Health Report, 2010), a country with less reliance on direct payments is more likely to progress rapidly towards UHC. From this perspective, assuming all other factors constant, Seychelles and Timor-Leste are likely to achieve rapidly UHC compared to Niger and Nigeria. The former is less dependent on OOP payments, while the latter are OOP payments dependent countries. The above-mentioned traditional models of healthcare financing should be supplemented by other funding sources depending on potentialities that exist in each LMICs. In this regard, the following alternative channels might be explored to move rapidly towards UHC.

Alternative Mechanisms for Financing Healthcare in LMICs.

Tax on demerit goods

The first potential alternative for healthcare financing in LMICs is to levy taxes on demerit goods and services. Demerit goods are defined as "goods where consumption has negative effects for the society and the individual who consumes them" (Hughes, 2018, 24). These goods include, for example, alcohol, cigarette, tobacco, addictive drugs, and other unhealthy foods and drinks. The author argues that imposing taxes on consumption of such goods provides governments with substantial additional revenues, while at the same time, discourages people for consuming them. In the same vein, Brownell (1994) points out that the idea of taxing unhealthy foods and drinks to fund public health initiatives started in 1990s in the US. Moreover, Sjoquist (2003) argues that sugar-sweetened beverages (SSB) taxation has been one of the main sources of revenue for many states in the US. LMICs could inspire from the US example to raise additional resources from taxes on demerit goods to finance their health systems. Given the sensitive nature (political and resistance form powerful food industry lobby) of the introduction of mechanism that involves taxes, governments may argue the necessity to address the negative externalities caused by the consumption of demerit goods. By externality is meant "a benefit or cost that affects someone who is not directly involved in the production or consumption of a good or a service" (Hubbard et al., 2015, 446). Externalities are at the root of market failures, which only states have the ability to correct, but not the private sector.

Remittances

The second potential way to finance the healthcare system is through remittances. By remittances, it is meant the migrants money sent back to the home country (Arif et al., 2019). Remittances constitute a substantial source of revenues for LMICs reaching a historical level of US$ 551 billion in 2019 (World Bank, 2019). These revenues are viewed as more stable than foreign development investment (FDI) and have a significant positive impact on education in recipient countries (Arif et al., 2019; Ratha, 2005; Hassan et al., 2013). Remittances may also have greater positive effects on health as they provide directly revenues to recipient families. These funds can be used to address the OOP payments at the time health care is needed. At a macro-level, everything else being equal, households will be protected from financial hardship, which is one of the fundamental components of UHC. LMICs such as Nigeria, Pakistan, and Bangladesh, which are among the top remittance-recipient countries, could focus on these stable and reliable revenues to reduce their reliance on OOP payments for healthcare financing.

Sovereign Wealth Funds (SWFs)

Another channel for raising resources for the health sector is the use of SWFs revenues. In well-endowed natural resources LMICs, allocating a specific portion of SWFs could be a good policy option to strengthen the healthcare system financially. Yet, SWFs have multiple functions, but the most common role is to safeguard natural resources wealth for present and future generations. Given that the majority of resource-rich economies in LMICs experience resource curse (Sachs and Warner, 1995), that is, the inability of the country to use its resource wealth to improve citizen's life, investing this wealth in human capital (education and health) accumulation may help to avoid the resource curse. Despite the potential for corruption and the rent-seeking behavior associated with the management of natural resources, Timor-Leste annually allocates 3% of its Petroleum Funds to support the state budget (Petroleum Fund, Annual Report, 2020). If this fund is specially directed to the healthcare system, Timor-Leste would have made rapid progress towards UHC. Besides the above-mentioned alternatives, LMICs may seek other innovative mechanisms for raising additional funds for the healthcare system. For example, Gabon has imposed a tax on mobile phone use to support its health sector (The World Health Report, 2010).

As mentioned earlier, the way countries finance their healthcare systems determines their effort on the path to UHC. Key recommendations for LMICs to move rapidly towards UHC are as follows. First, a focus should be made on expanding priority services, including more people, and reducing OOP payments, as emphasised by the WHO (2014). Second, the health sector should be prevented from any corrupt practices. Third, transparency and greater accountability should be promoted to increase the sector's efficiency. Applying good practices from successful countries

may help. For instance, Thailand has applied the strategic purchasing approach to achieve its UHC goals (Tangcharoensathien et al., 2015). Shifting from free services to capitation system, provider payment management, and accreditation of hospitals were implemented in Thailand in order to achieve UHC.

Conclusion

UHC is an effective way for LMICs to provide essential healthcare services to all citizens based on their needs. However, this requires these countries to foster an enabling environment for the healthcare system through the allocation of adequate financial resources. In this regard, the exploration of innovative channels, such as remittances, taxes on demerit goods, and revenues from SWFs has the merit to strengthen the existing sources (government's budget, external aid, OOP payments, and insurance contribution), therefore creating conditions for strong healthcare systems able to achieve successfully UHC. Given its multiple implications, achieving UHC will enable LMICs to reach all health-related SDGs by 2030 and create the basis for sustainable and inclusive socioeconomic development, as health is a key ingredient for development.

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