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Saskia Wilhelms
Tufts University

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Characteristics and Distribution of Health Care in the United States

The fact that national health care reform in the United States has been stalled is not reason for resign. More than ever, one has to design and implement creative options to achieve satisfactory health service at low costs. The political turnover in Congress shifts more responsibility to local governments. This means less funding and less willingness by the national government to be held accountable for health and social services. On the other hand, this situation may carry opportunity to impact social policies on a local level.

The living conditions in some of our communities equal those in so-called third world countries. It is well known that New York City's infant mortality rate, for instance, surpasses that of Bangladesh.[1] A main reason for these dismal conditions is the neglect by federal and regional policymakers. Another is the sentiment among the general public of not feeling responsible for the well being of their fellow citizens (or "only" fellow human beings, as has been demonstrated by the voters' support for proposition 187 in California). Those affected complain they are forgotten and insist on the government's provision of social services.

Where can one break through this cycle of passing the buck? There is no simplistic solution to determining how much responsibility should rest with the different levels of the government, and how much with the users of health care. That is true especially since the users are characterized by huge income differentials. Answers to the dilemma depend more often than not on one's political opinion rather than on evidence.

So far, national health care systems in countries such as Canada and Germany have been cited as blueprints for an overhaul of the U.S. system. Since an overall health care reform has failed so far, one has to search for meso- and micro-solutions. Many of these have been tried through projects and policy reforms in industrializing countries. Instead of comparing local conditions to the negative conditions in countries in the southern hemisphere, it is more fruitful to make international comparisons in order to analyze the range of experiences with health service in order to derive positive models for improving care here.

Although the overall framework of an industrialized nation versus that of a non-industrialized nation differs, there are parallels that make a comparison worthwhile. The income gap in the United States is characterized by severe inequality, with the total income of the richest ten percent equaling that of the poorest sixty percent. They share this rank, among others, with Togo, Benin, the Sudan, Somalia, and India.[2] This implies huge inequalities in the user pool, that need to be taken into account when planning health care. Both in the United States and in West Africa, for example, disadvantaged communities are situated in impoverished city neighborhoods and remote rural areas. Responsibility for their health care is shifted from one institution to the other. This results in fear of unmanageable bills among potential users, which in turn serves as a deterrent to seeking preventive and curative health care. Besides causing individual suffering, this insecurity leads to high social costs due to losses in labor productivity.[3] The following experiences from West Africa will illustrate options for the improvement of local health care, and thus enhance personal and societal welfare despite incapacities in the national government.

Experiences from Selected West African Countries

Due to a lack of financial resources in the national and communal budgets, West African countries, such as Ghana and Sierra Leone, do not have an encompassing health care system, which is aggravated by a dearth of sanitary systems. Government policies exhibit an urban bias in favoring the urban classes that are vocal, and often affluent and influential, over the comparatively poor and

powerless rural population. In the countryside, the fact that hospitals are far and medication costly makes for mortality rates that are higher than those in urban areas.[4] The governments' health care policies depend heavily on external aid, and are modeled after capital and technology-intensive health programs of industrialized countries. The pursuit of these policies result in gross inequalities among actual and potential users due to the different economic and political realities in developing nations. Social services receive only irregular funding due to budget deficits. The only individuals who can still take advantage of health care are those that can use their political, social, and economic influence. Others are left to treating themselves and to purchasing overpriced, unspecified medication on the parallel market. Itself not adversely affected, the elite does not commit to reorganizing the health care system based on the participation of the entire population—which in turn, expects the government to cater to their health needs free of charge and thereby makes cost-efficient restructuring impossible.[5]

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At this critical point, the debate over user fees must be re-introduced. Should users pay for health service even when they are poor? Some say that in order to avoid hurting the poor and driving up opportunity costs through disease, health care should be free for the financially weak segments of society. This could be accomplished by more effective administration of public health care and the use of preventive rather than curative medicine.[6]

Others argue that a more effective administration and the primary use of preventive health care is needed in any case, and does not drive costs down to a level low enough to allow free service for substantial numbers of people. Only an efficient and enforceable tax collection system with a broad tax base allows the creation of an encompassing health care net that will support the poor free of charge. Such a tax system does not exist in developing nations. Therefore, their governments lack the budgets to maintain, let alone expand, health care. Even if they still can pay their employees' salaries, they cannot meet recurrent costs such as those for medication and gasoline to reach remote areas through mobile services.

From the economic point of view, this makes a case for demanding user fees to cover at least part of the expenditures for basic materials and operation. A study in Cameroon shows that in areas where user fees were introduced concurrently with a better availability and quality of health services, the average cost for the poor declined. This cost decrease is due to the fact that the travel time to health centers was shortened, and that they received medication via the health service instead of trying to obtain some form of medication at overrated prices through unofficial channels. Thus, the poor benefitted from the introduction of user fees more than the wealthy, who previously had used their clout to receive inexpensive health care.[7]

What are concerns about the introduction of user fees from a progressive perspective? Well, experience indicates that human beings take more pride in themselves when they are not dependent on handouts. They also tend to ascribe more value to a good with a higher price, irrelevant of its true value. The organization, Population Services International (PSI), based in Washington, D.C., has experienced that goods given out for free tend to be used less, and with less care, than goods for which a fee is charged. Since PSI asks for a nominal fee of a few cents for the condoms it distributes, family planning campaigns in Africa have become more successful. These examples suggest that user fees can have positive social and economic effects on the individual and societal level. Only few would take this to the extreme, however, and argue that user fees should be assessed according to the benefit principle, meaning that the beneficiaries of health care should pay for its real costs. Instead, fees should be assessed according to people's ability to pay. That requires a progressive payment system which furthers equality, although it is more complicated to design and implement than a system based on the benefit principle.

An Agenda for Health Service in Disadvantaged U.S. Communities

In contrast to many developing countries, the United States has the means to provide health care for all. What is needed is an activation of a broad political will. Thus, not only individual hardship could be prevented. Costs that are cut in health services are likely to reappear as multiplied social costs in other areas. Among the most obvious examples are opportunity costs arising from decreased quality and quantity of work (shortened concentration span, illness, shorter life expectancy), and negative externalities due to a spread of infectious and contagious diseases that can be prevented through treatment like vaccination campaigns, or curative treatment with early detection and medication.

Until adequate national solutions are found, there are several concrete steps that can be taken toward satisfactory community health service. The following measures are available at relatively low financial costs and thus can be adapted locally in disadvantaged communities even when the political will and support from Washington are not forthcoming.

Care that significantly decreases short- and long-term private and social costs should include a) emphasis on preventive, rather than curative medicine; b) better access of disadvantaged urban and rural communities to health care through mobile health services or other initiatives;[8] and c) maternal and child care emphasizing health, nutrition, and family planning. Health care can be influenced positively in the long run through raised levels

of education and income. But, additionally, low user fees can be approached to help certain groups develop a sense of ownership over health care policies and practices that will help to ensure these goals.

Notes

[1]*Peter's Atlas of the World*. (New York: Harper and Row, 1990), 178-179.

[2]Ibid.

[3]M. Gillis, D.H. Perkins, M. Roemer, and D.R. Snodgrass, *Economics of Development*, third edition. (New York: Norton, 1992), 248.

[4]M.C. Fyle, *History and Socio-Economic Development in Sierra Leone* (Freetown: Sierra Leone Adult Education Association (SLADEA), 1988), 213-214, 234-238. K.A. Senah, "Problems of the Health Care Delivery System," in *The State, Development and Politics in Ghana*, E. Hansen and K.A. Ninsin (Eds.) (London: Council for the Development of Economic and Social Research, 1989), 242-267.

[5]Senah, "Problems of the Health Care Delivery System."

[6]Ibid.

[7]J.I. Litvack, "The Effects of User Fees and Improved Quality on Health Facility Utilization and Household Expenditure: A Field Experiment in the Adamaoua Province of Cameroon," (Ph.D. dissertation, The Fletcher School of Law and Diplomacy, Tufts University, 1992).

[8]One example is of a local hospital near Yokohama, Japan, offering health care to the poor, including illegal immigrants, for a nominal fee of approximately $30 per year.

Saskia Wilhelms is a graduate student at The Fletcher School of Law and Diplomacy at Tufts University.