

# Measures to Protect Poor Sudanese Households from the Risks of Catastrophic Health Expenditures<sup>1</sup>

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## In a nutshell

- Due to the absence of universal health insurance coverage in Sudan, particularly among poor, out-of-pocket (OOP) health expenditure consumes a high portion from households' incomes forcing them to cut budget's shares allocated to education, food and other items.
- Cutting expenditures on such necessary items pushes huge numbers of households, mainly those who live in a situation close to poverty, into extreme poverty with its all undesirable consequences.
- Based on National Baseline Household Survey (2009), the evidence proves that factors such as households' income, high illness rates, education, household's size, number of elderly and children among household's members and distance to healthcare providers increase households' OOP health expenditures.
- Based on these facts, many policy actions can be proposed in order to protect households from being victimized by catastrophic OOP health expenditures. These actions include lowering illness rates; accommodating poor population under health insurance umbrella, reducing patients' transportation costs and preserving good health status by enlighten people about the benefits that can be generated from implementing preventive measures.

## Some facts on health spending in Sudan

It is well known that OOP health expenditures represent a heavy burden on households' resources, particularly in a developing country like Sudan in which poverty and illness are widespread. According to the World Bank's statistics, 46.5 % of the country's population lives in poverty. Under such circumstances, the occurrence of OOP health expenditures would enlarge poverty incidence especially among disadvantaged groups. Specifically, if increases in OOP spending cross some limits and become catastrophic they might force households to cut expenditures on food, education and other items that are necessary for human survival.

<sup>1</sup> This policy brief is based on the paper entitled: Determinants and Impact of Household's Out-Of-Pocket Healthcare Expenditure in Sudan: Evidence from Urban and Rural Population. The paper is prepared for ERF's research project on "Economic of healthcare in the ERF region".

The problem has been deepened by the sudden economic transformations initiated by Sudanese government in 1990s. Complying with these transformations (i.e. economic liberalization and privatization policies), the government executed bundles of austerity measures. In the field of healthcare it turned her back to health sector and user-fees system had been implemented to finance healthcare services. Consequently, public expenditure on health, which was already poor, diminished back and remained rotating around 1% throughout the period extended from 1995 to 2014 (World Bank, 2014). By cutting government's participation healthcare services' provision, households' expenditure has gone up. According to World Bank's report, OOP health expenditures in Sudan (% of total expenditure on health) grew from 61% in 2004 to 75.51% 2014. Likewise, OOP expenditures on health (% of private expenditure on health) rose from 89% in 2004 to 96% in 2014. Breaking data down, as reported by Sudan Households Health Utilization and Expenditure Survey (SHHUES) conducted in 2009, the burdens of per capita OOP health expenditure spent on primary healthcare level were 46% and 38% among urban and rural residents, respectively.

To mitigate the negative effects resulting from user-fees system as a mode to finance healthcare provision, policymakers adopted the Economic Treatment Scheme. However, due to its huge administrative health expenditures, this scheme did not succeed in elevating the misery experienced by citizens specially the poor. Thus, after the failure of this system, and in response to the skyrocketing health spending, the government launched community-based health insurance scheme. The scheme began by establishing the General Corporation for Health Insurance in 1994. In 2003, however, the act of General Corporation for Health Insurance was amended and the corporation has been transformed to the National Health Insurance Fund (NHIF). Based on these new amendments, admission to health insurance services became open to all population categories based on a unified subscription ratio of 4% for employees and workers with regular salaries and flat rate subscrip-

tion according to actuarial estimates for those with irregular incomes. However, despite the expansion in health insurance, maintaining universal coverage for all population remain unattainable target. As shown by Baloul and Dahlui (2014), compared to 25.3% of the urban dwellers, 16.9% of rural population are insured. The failure to accommodate a large portion of population under health insurance coverage occurred due to the fact that the incidence of high poverty constrained majority of population from maintaining the flat rate requested for insurance subscription. Thus, the OOP health expenditures climbed up and the percentage of population suffering from these expenditures grew rapidly, particularly in rural areas where most of people live in poverty, lacking health infrastructures, and don't possess regular jobs.

The presence of such situation leads people to search for other alternatives to meet their health expenditures' commitments. Precisely, to cope with catastrophic health expenditures, Sudanese households pursue variety of strategies each of which contribute with a certain share in financing healthcare purchases. According to 2009's SHHUES, these strategies include buying part of treatment (27%), borrowing from others (21%), cutting other expenditures (19%), selling assets (14%), savings (8%), performing extra work (5%), getting help from relatives (4%), and resorting to charities and Zakat (1%). Adopting such strategies reveals that both the State and health insurance don't perform well in protecting households from incurring back-breaking health expenditures. As reported by 2009's SHHUES, 80% of Sudanese households' funds to encounter health spending were sourced from their own resources, while only 6% were covered by health insurance. This reality connotes the exposure of majority of population to the heaviest burdens of catastrophic health spending. That is, the reduction in public health spending, combined with deficiencies in health insurance, stimulates OOP health expenditures to consume great portion from households' budget pushing them into poverty with its all negative consequences.

With these tough realities in mind, the attention is directed to two important issues concerning health expenditures and health insurance in Sudan. The first issue concerns with the identification of the factors that lead to increases in OOP health spending by Sudanese households, and how this growing expenditures can be lessened. The second issue pertains to the modest progress in achieving universal health insurance coverage to stop health expenditures from pushing more citizens into poverty trap. Putting things together, these issues can be framed into policy questions as follows:

- What are the measures that can be implemented to reduce the financial burden resulting from OOP health expenditures undertaken by poor households?
- How health insurance can be expanded to accommodate poor population, particularly those who are belong to disadvantaged communities.

#### *The factors stand behind high OOP health expenditures*

Based on data from National Baseline Household Survey (2009), the evidence shows that the patterns of Sudanese households' health expenditures are highly affected by a group of factors including households' income, health insurance status, illness rate, education, and household's size, presence of elderly and children members and distance to healthcare centers. Specifically, the analysis by Ebaidalla and Mustafa (2016) confirms that households with high morbidity rates (i.e. the presence of members with illnesses, diseases and disability) tend to have higher OOP health expenditures.

Moreover, the analysis demonstrates that the current health insurance scheme plays a considerable role in lowering health expenditures undertaken by urban households. However, as evidence shows, this scheme doesn't contribute in protecting rural households from incurring OOP health spending. This outcome can be justified based on the fact that most of facilities attached to these schemes (i.e. hospitals, diagnostic centers and pharmacies ...etc.) are adapted to serve urban areas in which media such as newspa-

pers and TVs draw the attention of governments to the health problems faced by urban citizens. In contrast, due to the fact that rural individuals went on believe that their poverty, illiteracy and diseases as something inescapable, the officials are anticipated to give negligible consideration to healthiness of this category of population. What is more, since health insurance is compulsory for both private and public sectors' employees, the dominance of informal jobs (Ali, 2013) among rural residents makes the penetration of health insurance subscriptions very low compared to urban population.

Also, the analysis shows that the far distance between household's residence and healthcare's providers forces households to spend higher percentage from their incomes on transportation for health matters. Undoubtedly, this is expected since population density in Sudan is considered very low and most of the communities are scattered in areas situating far away from each other. According to World Bank, the density of population in the country is 22 people per sq. km of land area (World Bank, 2016). The presence of such situation is expected to increase health spending for two reasons. First, the light density of population discourages both public and private providers to establish healthcare centers in less populated areas leading people to spend more on transportations for these centers. Second, the high costs of transportation may lead to increases in future medical care bills. This occurs because higher transportation costs may drive households to respond reluctantly to the illness of their member(s). Consequently, in the long run, the health of ill members will certainly deteriorate considerably forcing households to incur huge OOP expenditures in the nearer future.

Finally, considering the poverty impact of health expenditures, the evidence on which this policy brief is based indicates that OOP health expenditures pushes about 5% of Sudanese households into poverty trap. This calls for dedicating a great attention towards deploying plans and strategies to lower this type of expenditures so as to lessen their negative consequences on households' welfare.

### *Recommendations*

In light of the above facts, a package of practical actions can be proposed to protect households from failing victims for OOP health expenditures, and to reduce the impoverishment instigated by these expenditures when they cross limits and become catastrophic. These actions include:

#### *(a) Lowering illness rates among population*

According to evidence conveyed by the investigation on which this policy brief is founded, higher illness rate represents one of the causes of incurring catastrophic OOP health spending by Sudanese households. However, illnesses spreading among underserved population can be reduced if precautionary strategies and measures are initiated to stop the episodes of both chronic diseases (i.e. hypertension, diabetic, asthma, cardiac, cancer and psychiatric) as well as acute diseases (i.e. malaria, respiratory, diarrheal, minor injury and typhoid fever). The malaria, for example, which constitutes 4.4 % from total acute illness in the country (SHHUES, 2009), can be easily prevented if stagnant waters and sewerage are managed in a manner that breaks the progression of mosquitoes (malaria-carrying parasites). Similarly, educate people on preventive measures such as adopting healthy diet, performing exercises; fighting obesities can work collectively to shrink the incidence of diseases such as hypertension, diabetes and cancer.

Thus, health awareness among citizens must be elevated and intensified especially on the matters related to preventable diseases. It is worth to mention that per capita OOP expenditure on preventive care in Sudan is accounted for 1.07 SDG demonstrating the weaknesses of this front in fighting illness and diseases. Public health policymakers are demanded to initiate health awareness campaigns to promote population acceptance and utilization for preventive measures. These campaigns must be delivered in languages that can be digested by the average citizen. Specifically, in the areas with distinguished cultural characteristics (e.g. Eastern, Blue Nile, Kordoufan and Darfur States) campaigns' programs can be taught and proclaimed in local languages.

#### *(b) Reducing transportation costs incurred by ill households*

As indicated by evidence, the distance between healthcare centers (providers) and healthcare utilizers (households) raises OOP health expenditures (Ebaidalla and Mustafa, 2016). The low density of population in Sudan makes the course of establishing reachable centers to provide healthcare that above primary levels unfeasible technically and economically. This reality makes 70% of the total healthcare cadres are concentrated in capital city Khartoum serving only 20% of country population (WHO, 2010). Hence, a large portion of households is exposing to catastrophic health expenditures not because of direct payments on healthcare items (i.e. drugs, diagnoses and surgeries,..., etc.) but also due to the costs associated with transportation to places in which appropriate health facilities are available. Accordingly, to exclude the negative effects of health spending, regions and remote areas should be equipped with modern networks of ambulances services. Adopting such measures would help a lot in protecting poor households from financial risk resulting from transportation costs.

#### *(c) Expanding health insurance to include poor population*

According to Public Health Institute (PHI), out of the informal poor population for which insurance is non-mandatory, only 35% are insured (PHI, 2014). Hence, to boost the utilization of healthcare facilities and, at the same time to diminish households' OOP health expenditures, health insurance must be expanded to include the poorest and unfortunates groups in the society (i.e. elderly, disabled and handicapped), particularly those who are residing in rural areas. This action can be executed via the following channels.

##### *(i) Employing banks' facilities to pay insurance health subscription fees*

Financing health insurance subscription can be facilitated by drawing funds from banks. The specialized banks (i.e. Farmers' Commercial Bank, Sudanese Agricultural Bank, Animal Resources Bank and Worker National Bank) that are mostly dominated, and run,

by government can involve in protecting farmers and workers from financial risks arise from OOP expenditures. The argument can be advocated on the ground that these banks are designed to serve farmers and informal workers either by giving them loans and technical guides to execute income-generating activities or by intervening in agricultural products markets as buyers to protect them from declining prices. Accordingly, since these banks aim at protecting part of population from markets' fluctuations and harmful work conditions, their mission can be extended to offer fund for farmers and workers so as become able to cover insurance flat rate payments.

*(ii) Encouraging NGOs to pay health insurance subscription for disadvantaged groups*

Currently, a number of voluntary and charitable NGOs work on alleviating poverty by providing in-kind and cash assistance to the disadvantaged communities in Sudan, particularly in conflicts areas. Thus, the mission of these organizations in combating poverty incidence can be reinforced by encouraging them to provide direct and indirect healthcare to these communities. Directly, these charitable bodies can implement packages of health programs including performing diagnosis tests, medical advices, consultancies and early medical interventions for those who in need.

In addition, NGOs and charities might involve in delivering health enlightenment on the importance of preventive measures against illness using public lectures, brochures and papers. This would contribute greatly in sustaining healthiness by preventing diseases result from unhealthy practices (early marriage and Pharaonic circumcision, unhygienic environment and the complete submission to traditional healers).

Indirectly, charitable NGOs can help in defeating poverty by paying fees for health insurance subscription for poorer individuals. Taking such step would be much better than the provision of in-kind and cash assistances. This is because health insurance would prevent households from cutting expenditures on other items such as food and education; protect them from poverty and keep them in good health status.

*(iii) Directing health insurance to target covering catastrophic medical expenses*

Health policymakers are requested to list illnesses that push households to undertake catastrophic health expenditures among the health items targeted by health insurance coverage.

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