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Research Article

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Assessing Lesotho's Financial Burden of Household Payments and Access to Healthcare, 2022

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Abstract

Background: *Health care financing is primarily about paying for health care. It motivates health care providers to increase the supply of health care goods and services to ensure that all individuals have access to effective public health and personal health care services and goods. The ultimate intent is to improve the health of individuals and the general population in line with the principles of Universal Health Coverage. When patients' OOP reaches a certain level, some people forgo health care due to the price, and others who access services face financial difficulties.*

Objective: *The specific objective of the present study is to determine access to essential health services by households and the financial burden posed as a result of their intent to utilize theses services.*

Methods: *The paper uses data from the national household income and expenditure survey (2018/19). It provides an insight into the health care expenditure and evidence on whose health service needs the health system meets and the household financial burden by health payments.*

Results: *Out-of-pocket health expenditure (OOP) as a share of total health expenditure on average stands at 11.1% in 2018/19. About 3.3 % of households or 4,295 households that corresponds to about 17,180 individuals spend 52.1 % of their net of food income (non-subsistence income) on healthcare – a catastrophic level of household spending.*

Conclusion: *Despite the low rate of out-of-pocket investing by families, and moderately expanding domestic investing in health care, Lesotho health care system requires a combination of policies to ensure fair financing of health care.*

Keywords: Access To Healthcare, Financial Burden, Household Payments, Lesotho

Introduction

In a health care financing systems, revenues from primary and secondary sources are gathered through the health care finance system. Out-of-pocket payments (OOPs), indirect and direct taxes, donor money, co-payments, voluntary prepayments, and mandatory prepayments are examples of such sources [1-3]. These sources are accumulated in fund pools to distribute risk among sizable participation groups [3,4]. The money will be used to meet the population's specified requirements by paying public and private providers for health products and services.

Healthcare funding is the exchange of money for services between patients and healthcare providers. The financial structure of a health system reveals whether or not people receive the necessary medical care and whether they are financially harmed while obtaining care [1,2]. However, an effective healthcare financing strategy should be able to mobilise enough resources for healthcare, and achieve equity and efficiency in the use of healthcare spending [1,2]. It could guarantee that healthcare is affordable and of high quality, guarantee that essential healthcare goods and services are adequately provided for, and most importantly guarantee that the funds are used wisely to achieve the objectives of Universal Health Coverage (UHC).

A health care financing system should offer enough financial security to ensure that no household suffers financial hardship as a result of having to use health care and services. By including a risk-sharing plan in the health care finance mechanism, this protection can be provided [1,2,4]. In this manner, neither the person nor the household bears the risk of unforeseen medical expenses. How to guarantee that everyone has appropriate access to their healthcare requirements without placing significant financial burdens on patients is one goal of UHC. Yet, progress differed significantly between nations.

The way a country finances its healthcare system is a critical determinant for reaching UHC. This is because they decide whether or not there are health services and whether or not individuals can afford to use them when they're needed. One way to achieve this is through risk pooling either through tax-funded or social health insurance sscheme [1,2]. However, recent recommendations urge governments to think about operating well-planned combinations of the various healthcare finance mechanisms rather than standalone schemes [1,2]. Tax-based finance, OOPs, health insurance, subsidies, and donor money are examples of possible combination strategies.

This paper begins by presenting a descriptive analysis of the country's existing situation with respect to health care financing and resources allocation mechanisms. It is intended to help viewers to understand set of existing reforms, policies and experiences in relation to the existing organization, and institutional arrangements of the country's health care system. It further describes the predominant source of funding for health care, including the organizational structure of the health sector in Lesotho, the mechanisms by which resources are allocated as well as the entitlements to benefits by the citizens. The goal of the current study is to examine the policy opions that can be used as effectively as possible to increase population access to care and financial risk protection, while also highlighting the interaction of different policies and the necessity of a comprehensive rather than piecemeal approach to reforms.

Brief Country Overview

Lesotho is a small, landlocked nation with a population of about 2,2 Million people that is surrounded by South Africa [5]. Approximately 23% of the population resides in urban areas. Lesotho has a nominal per capita GDP of $1,299, making it a lower-middle income nation (MoDP). The country is topographically mountainous, and information does not easily penetrate. Inequality and poverty in Lesotho's socioeconomic system continue to be fundamental issues. Approximately 49.4% of the population of Lesotho, one of the poorest nations in sub-Saharan Africa, lives in poverty, making up more than one million people (MoFDP, 2018). 2019–20 saw a very high level of 33 percent unemployment and a fairly high 6.2 percent inflation rate [5]. The government's investment in various high priority areas has been impacted by declining revenue.

Health Status and System Challenges

The Basotho still have a poor health profile despite major investments being made in the healthcare industry. The average life expectancy is 50 years (47.1 years for men and 53.7 years for women [5]. It is much below the average for sub-Saharan Africa and lower-middle-income nations (68 years) (60 years). The prevalence of HIV/AIDS/TB is still high, with 25% of adults living with the disease (Ministry of Health and ICF International, 2016). Children suffer from severe malnutrition; 10% of those under five are underweight, and 33% of those in this age range have stunted growth (Ministry of Health and ICF International, 2016). Lesotho's access to and quality of care are significantly impacted by imbalances in the skilled labor force and shortcomings in care coordination at the primary health care levels. The primary health care delivery system is a key component of the Ministry of Health's aim to promote, prevent, cure, rehabilitate, and control diseases at all levels. Goals for Universal Health Care coverage have been established [6].

Key Features of the Lesotho Health Financing System

The purpose of health financing is to pay for health care. Healthcare financing in Lesotho is organized predominantly through domestic revenue (taxation) [5]. Lesotho spent 9.5% of its GDP on health in 2019 (Table). Per capita health expenditure is US $ 105.1 (Maloti 1,575.5). The Government of Lesotho covers 60.7% of total health spending (Table) [6]. Voluntary insurance remains on a small scale. It has two schemes – Mamoth and Bophilo, which started in 2000. These schemes cover employees of various private companies and semipublic corporations as well as individuals.
Following the abolishment of user-fee policy in 2008, the out-of-pocket health expenditure (OOP) as a share of total health expenditure on average has gone down from 28.5% in 2007/8 to around 11.1% in 2018/19 [7]. Cost share, referred to as patient fees is low. A ceiling exists on patient fees, with each person liable for up to 15 Maloti (1 US Dollar) for outpatient attendance and 35 Maloti (US$ 2.5) for inpatient attendance. Outpatient and inpatient drugs and supplies are covered as part of the treatment cost.

Overall, government spending has been rising in Lesotho in the recent years and accounted for 12.7% of total health expenditure in 2018/19 fiscal year (Table). The development budget is augmented by foreign funding in the form of grants and loans. The government of Lesotho fully funds the recurrent budget, with taxes serving as the primary source of income (Table).

Table: Main HCF indicators for Lesotho

	2000	2008	2018	2020
GDP per capita (US$)	382.19	516.87	764.3	861.015
Total expenditure on health (THE) as % of GDP	-	7.8	6.4	8.5
Per capita health expenditure in US$	-	143.00	105.1	98
Total government expenditure on health as % of THE	-	77.7	78.6	81.1
General government expenditure on health (GGHE) as % of TGE	14.5	14.5	11.3	12.5
OOP as % of THE	15.6	17.7	14.8	11.1
External resources for health as a percentage of total expenditure on health	26.3	35.1	NA	NA

Health Care System Expenditure

In 2019, 12.7% of all government spending went to the health sector. This is the second-highest allocation, trailing only the 13.2 percent for the education sector. Both as a share of overall expenditure and as a percentage of GDP, the amount spent on health has increased [8].

Recurrent Expenditure

Recurrent spending decreased from 92 percent in 2014–15 to 81.6 percent in 2019–20 as a proportion of overall health spending [8]. On the other hand, between 2014–15 and 2019–20, the rate of expenditure on the capital (development) budget increased by 10.5 percent, from 7.9 percent to 18.4 percent. Only 7.5% of the total health budget for 2019–20 was allocated to primary healthcare. General management and administration account for the majority of health spending (53.2%), followed by secondary health care (15.6%), family health (11.1%), disease control (8.5%), and training services (4.1%) [6].

When the recurrent budget expenditures are broken down by administrative classification, it is clear that operating costs, other purchases, and salaries and wages take up a bigger percentage of the budget [8]. Operating expenses made up 45.7 percent of the recurrent budget for the entire 2019–20 fiscal year, followed by other purchases (20 percent), wages and salaries (17.7 percent), and pharmaceuticals (13.8 percent).

Capital Expenditure

Donors mostly finance the capital health budget, as seen in Figure 1. The President's Emergency Plan for AIDS Relief, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United National Children's Fund (UNICEF), the United Nations Population Fund, and the World Bank are important development partners helping Lesotho's health sector [8]. The capital budget has challenges with trustworthiness [9]. The differences in the government and donor shares during the budget approval stages show that issues with public financial management systems prevent the budget from accurately reflecting the financial resources of the government.

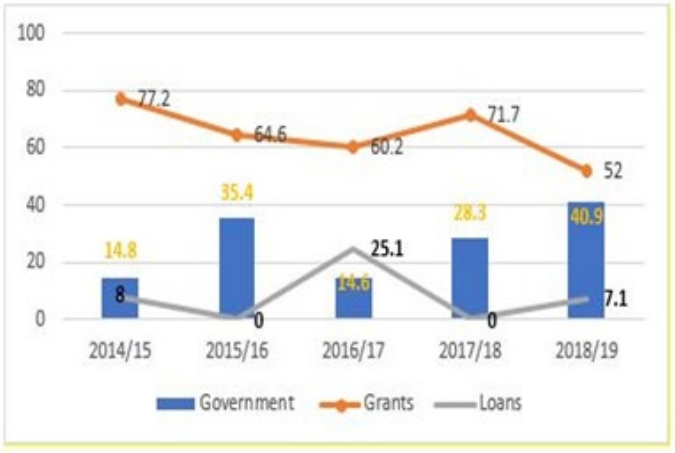

Figure 1: Trend on Lesotho's Health System Revenues

Figure 2 compares the health sector spending in Lesotho to that of its neighbors. Lesotho spends less per capita on health than most of its neighbors, at US$105 per person (Figure 2). Namibia (13.9%) and South Africa (14.2%) spend more than Lesotho as a proportion of total spending [8]. South Africa is the country that spends the most per person and as a percentage of its budget on health.

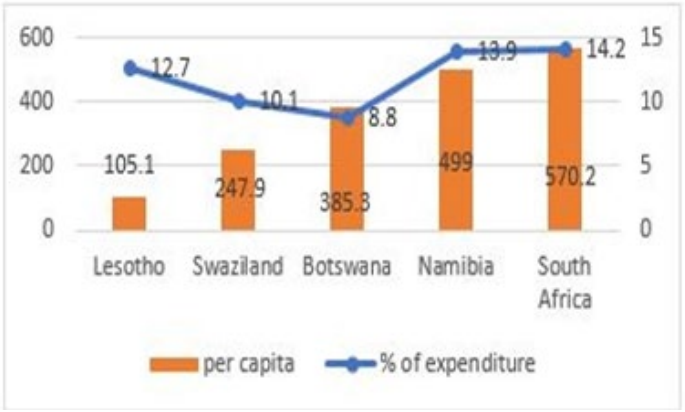

Figure 2: Lesotho's health expenditure in comparison with its neighbors, as per capita expenditure of THE (US$), 2019/20

Despite the existence of a few research that are widely spread, no thorough and systematic investigation regarding household burden

while trying to access needed health services has been carried out in context. By this methodical investigation, we aimed to assess the financial burden of household out-of-pocket healthcare costs on Basotho households and comprehend the implications for policy.

Methodology

This study is quantitative research that aimed at understanding the pattern of healthcare demand and level of spending by households in context.

The secondary quantitative data included

- The Lesotho demographic and health survey data (2014), which were compiled by local and national statistics agencies in cooperation with the ministry of health and development partners [10].
- Information from recent household income and expenditure surveys (2018/19) in the country.
- The electronic health record data (DHIS2), which is a routine set of health services and record data routinely reported through the health information systems.

In order to gather more data for this study, relevant literature, policy papers, and grey literature reviews were conducted. Information about Lesotho's health care financing was available in the documents studied. We conducted searches in PubMed, Medline, The Cochrane Library, Popline, Science Direct, and the WHO Library database using phrases such as "health care funding Lesotho," "public health financing," and "finance health and financing strategies," among others. Data were summarised, patterns of health care financing in the nation and patterns of spending by the various socioeconomic categories in society were described, along with links and barriers to health care access among various socioeconomic households.

Results

Key Evidence for Policy

Unmet Level of Health Services

In 2019, 33.1% of the population did not access the health services they needed [7,9]. Among the reasons for not seeking care, were long distance travelled to health facilities, long waiting time for health services and financial. About 61.8% and 7.7% of the poorest quintile non-users reported distance and waiting time as barriers, respectively (Figure 3). Lower income groups were less likely to access necessary services than higher income groups. Females were less likely to access required services than males. It is important to note that the removal of user fees in all public clinics and health centres and subsidies of hospital fees as well as standardized user fees for public hospitals have been positive measures in improving access to and utilization of healthcare services for most of the Basotho population (Figure 3). However, the poorest quintiles mentioned cost of care as 'too expensive'.

Figure 3: Reasons for non-use by quintile, 2019

Who Pays How Much and on What Services?

Households' OOP spending for health services covers only a fixed consultation fee of 15 Maloti and on non-prescription drugs. In 2018, the average household OOP was M 48.3 (Male – 61.4, Female–40.2) [7]. According to the latest household income and expenditure survey, urban residents spend on average M65.4, while rural residents spend about M38.9. However, rural households tended to spend more on hospitalization than urban households [7].

Household Financial Burden by Health Payments

Figure 4 shows that although average household health expenditure rises among high income groups, poorer households spent a higher percentage of their net income on hospitalization (52.1%) than did non-poor households (3.9%) (Figure 4). The net-income entails the food net income of every household.

Though the Lesotho healthcare system covers most of health care costs, a high burden of health expenditure was largely observed among people with lowest income. The 2018 Household income and expenditure survey revealed that 3.3 % of households or 4,295 households that corresponds to about 17,180 individuals spend 52.1 % of their net of food income (non-subsistence income) on healthcare. According to the WHO definition, the observed spending is considered catastrophic impact of out-of-pocket spending on poverty. A household is said to have incurred catastrophic payments if the burden of payments (i.e., oop/income) exceeds a specified threshold [11]. The World Health Organization uses 40% as threshold when capacity to pay is used as the denominator. Non-prescription medicines, hospitalization and travel costs are considered as the main drivers. Among the households with catastrophic level of spending, were those households with members over 65 years, female headed households, households headed by an unemployed person or a person with a lower level of education. Persons residing in rural households were among the persons more likely to encounter catastrophic health expenditure (Figure 4).

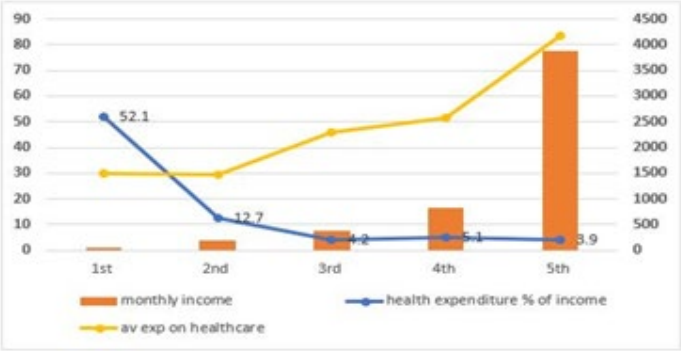

Figure 4: Household health expenditure as % of net-income

Discussion

The findings call for a combination of policy solutions to address the health care financing issues in Lesotho. With 105 per capita (pre-COVID19 pandemic) revenue to the health sector, it appeared that Lesotho had adequate financing to the health sector in comparison to what the WHO recommends ensuring the provision of essential services package to the Basotho [12]. However, Lesotho has never met the target of the Abuja declaration of allocation 15% of the national to the health sector. It also shows that the Lesotho health sector is heavily reliant on prospective payment for health care via VAT and sales tax revenues. Notwithstanding, various external factors, such as macroeconomic shocks, such as the current COVID-19 pandemic, have a negative impact on tax revenues. Demand and supply are highly elastic in such circumstances, and the introduction of sales taxes makes little money.

The VAT rate is often regressive, according to the tax incidence analysis, a sort of economic research that aims to discover where the true burden of a tax resides [13]. Compared to those with higher earnings, those with lower incomes spend a bigger percentage of their income on the purchase of goods that are subject to sales taxes or VAT. Due to their vulnerability, low-income households, households with elderly members, and those living in rural areas require special attention.

Conclusion

To strengthen universal health coverage, health financing arrangements have undergone a number of innovations in recent years. However, much work remains to be done to end catastrophic and impoverishing payments in context, especially for those who are chronically ill and vulnerable populations. Lesotho's healthcare system can reach out to vulnerable groups by pooling risks and resources; reducing fragmentation in th funding channels of the health system (pooling); expanding comprehensive primary healthcare services; adopting purchasing mechanisms that incentivize efficient behaviors among providers and regulating pricing mechanisms. Engaging the private sector, employers, and the rest of the world has the long-term potential to ensure a steady flow of funds to health. It is critical to commit to addressing inefficiencies in the health sector to secure spending even during economic downturns. By exempting necessities like food, medication, and clothing from the VAT, its regressive impact can be lessened. When food consumption increases, corrective taxes and internalities on it can boost social welfare [14].

Ethical Approval and Consent

There was no requirement for an informed consent as there was no direct contact with study participants. However, we got approval from the Bureau of statistics for the use of the government data and reports (open access data on the government website).

Availability of Data and Material

Ethical clearance and consent were only granted for anonymised reporting and write up. Report and Micro-data is available on the following website for the IHSN: https://catalog.ihsn.org › index.php › catalog. LESOTHO 2017/2018 CONTINUOUS MULTI-PURPOSE AND HOUSEHOLD BUDGET SURVEY (CMS/HBS) STATISTICAL SURVEY REPORT August, 2021 Lesotho Bureau of Statistics.

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