Can cost Sharing Mechanism in Service Delivery be an option for Somalia to Sustain Health Service Provision

Mohammed Assair discusses the pros and cons of cost sharing in health, a case for Somalia.

Somalia has been in conflict for over 30 years, since the collapse of Siyad Barre's government in 1991. All health legitimate institutions were destroyed and this created widespread vulnerability resulting in massive displacement, deaths and famine affecting thousands of Somalis. With years of conflict and low investments in the social sector, Somalia is ranked lowly globally on various human development indicators and is off-track to attainment of Social Service-related Sustainable Development Goals (SDGs). For instance, Globally, it ranks second highest for Total Fertility Rate (6.32), fourteenth lowest for life expectancy at birth (51), and second highest for Maternal Mortality Ratio (1,000 per 100,000 live births). Coverage of essential health services is very low with the contraceptive prevalence rate of 14 percent. Additionally, skilled birth-attendance is 33 percent with the lowest enrolment rate and survival rate of the primary and secondary schools.

According to Somali Health and Demographic Survey 2020, the maternal mortality rate, which has been one of the worst worldwide, has reduced from 732 in 2015 to 692.- /100,000 live births respectively. Only 3.3% of women attend Antenatal Care (ANC1) and only 2.5% attend ANC4. Facility-based deliveries are as low as 9.2%. In 2011, 70% of children did not receive any vaccination and only 1.4%, received all antigens. Acute Watery Diarrhea and pneumonia are major causes of morbidity and mortality among children under five, however, only 40% of children with diarrhea received Oral Rehydration Salts (ORS), and only 43% who sought care for pneumonia received antibiotics. Global Acute Malnutrition (GAM) rate ranges between 5-15%; only 2.6% of infants are exclusively breastfed, and just half of children 6-23 months receive the recommended minimum meal frequency[1]. The main barriers to accessing health care in Somalia is the: cost, distance and accessibility of health facilities, low reliability of health service provision including lack of drugs, poor quality services exacerbated by socio-cultural beliefs. Treatment is sought only when the illness is severe or advanced and decision making such as when to travel to the nearest clinic for treatment resides solely with male family members. These contributes to delays in seeking health care.

Somali Federal Government is fighting for its existence despite security, political and economic challenges. Thus, could not afford to provide health and education services to its people for over three decades, all health and education services are dependent on donor funding from International Development Partners (IDPs) with limited institutional capacity building process at state and federal level. The health and education services mainly provided by private institutions with out-of-pocket expenses has become expensive for the poor vulnerable and marginalized communities that cannot afford to either pay the cost or reach to its destination. The Federal Governments invest more in the security sectors as opposed to health and education. This has formed overreliance to donor funding and inability to look for possible options and sustainable policies that invest in social services. Having alternative approaches and options aids to think outside the box. In this article we are trying to look at the best options implemented by post conflict states and how this could be experimented or could be replicated in Somalia.

What is cost sharing?

Cost sharing is the financial contribution that service clients are required to make when they use health care services, amounts that are not reimbursed by their health plan. A cost-sharing charge is the amount an individual must pay for a medical item or service, that is to say health facility or hospital visit or prescription. The direct forms of cost sharing include; (i) Co-payments (a flat amount that the consumer must pay per service or item), (ii) coinsurance (a percentage of the charge that the consumer must pay), and (iii) deductibles (an amount the consumer must pay out-of-pocket before coverage begins, usually applied for a specific period, such as yearly). In addition, individuals may incur other out-of-pocket health care costs related to their health care.

According to the world bank discussion paper on cost sharing in the social sector of sub-Sahara Africa, it is highlighted that the widening of cost sharing with the expansion of user fees in the 1980s presented new threat to the poor and their ability to afford basic education and health care. User fees offered a means to recover some of

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the costs of publicly financed social services. Experience shows that while protecting the poor from the cost of user fees is achievable, it is not a simple task. Careful attention must be given to design and implementation issues, including which services should be highly subsidized by the public, what role communities should play in cost sharing, how fees are reinvested, and how the gender dimensions of the policy are handled[3].

Cost recovery seems contrary to the humanitarian principle of impartiality and the allocation of assistance based on need alone. Critics argue that in already difficult and constrained environments, charging user fees or cost sharing compounds inequities in access to treatment and contributes to the destitution of the most vulnerable. Yet donors have increasingly made their funding contingent on having these mechanisms. Both donors and national governments see such policies as developmental; they believe that their introduction is inevitable and that bringing them in at an early stage will contribute to building a sustainable, locally financed health system in the longer term[4].

Cost-sharing is a recent innovation in complex emergencies, there is substantial experience with such schemes in the development sector. Cost-sharing became widely accepted as a necessary element of healthcare financing in the developing world in the mid-1980s. At that time, governments were unable to adequately fund public services including health, WASH, education and out of pocket expenditure on health and education was growing rapidly as people (including the poor) were forced to seek care in the private sector. Then, alternative sources of financing were clearly needed, and the World Bank began pushing for the inclusion of national cost-sharing mechanisms as a way of bridging what is known as the health sector resource gap, the shortfall between the funding provided by governments and donors and the level of funding required to provide a basic level of healthcare of acceptable quality[5].

The Bamako Initiative: The ministers of African Countries launched the Bamako Initiative in a conference held in Mali in 1987 sponsored by WHO and UNICEF with the objective of ensuring that the entire population should have access to primary health care at an affordable price. According to the literatures and past program implementations after Bamako Initiative in Africa, there are several challenges and arguments including that the cost-sharing mechanism excludes the poor unless there is an effective system of exemptions and waivers that is necessary to protect the vulnerable social groups. Concerns include whether the revenue cum collected from the beneficiary cost-sharing can be fairly collected and managed.

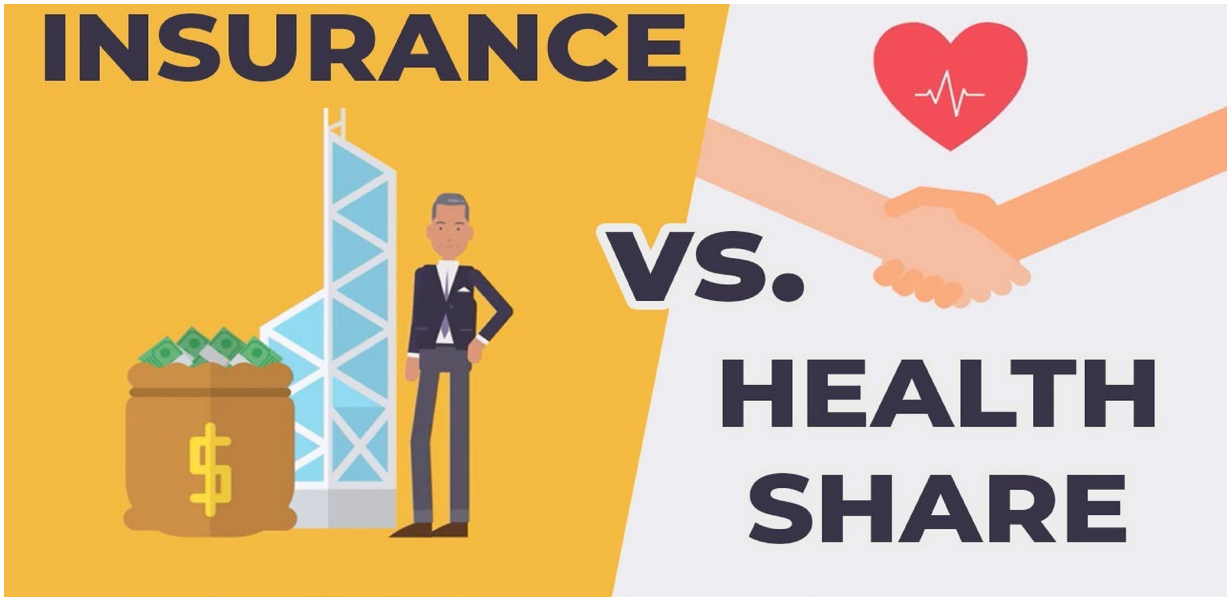
Furthermore, other emerging challenges can be the willingness and commitment from the government to initiate and extend grassroot level health service outlets since cost sharing programs are usually too complex and difficult to be understood by the community and service providers[6]. In remote areas where everybody lives on the verge of poverty, it is not easy to provide health care for the poorest of the poor. But today it is clear that the preventive care offered free and in a decentralized manner with some form of cost-sharing for service sustainability is benefiting the entire population.

What brings the issue now?

During our Save the children field visits across the country, we observed many facilities both health and education closed by either lack of running cost or when project support has ended. This shows how our outlook is vulnerable and unsustained. You never find someone thinking about the challenges befalling such institutions, you never find anyone brainstorming and proposing on the best way to ensure the sustainability of the existing public institutions to continue delivering services to the communities. For example, when such cases occur, thousands of the children lose their education, whilst thousands of children die because of preventable diseases or during their journey to accessing health care in the near places, in addition, when schools are closed due to the above-mentioned circumstances, parents send their children to keep goats hence missing out on school and a bright future.

In this point of view, if cost sharing is introduced to both health and education in Somalia, the burden would be taken away from parents or even donors who have been supporting these two sectors for the two decades, why? because it puts a lot of pressure on parents who are struggling to find their livelihood as well as donors who are now affected by Covid-19 and may be exhausted from not achieving the result intended by the SDGs. Cost sharing allows people to feel ownership, contribute a lot and hold the government accountable to deliver what is required and expected. In conclusion, it is the role of government to set the directions to attain their commitments to Universal health coverage (UHC) as well as education for all, governments are obligated to take reasonable regulatory and other measures within available resources to achieve the progressive realization of the right to health care and access to education. This is particularly important in health care markets, which are characterized by such failures as information asymmetry, lack of information on prices and quality that preclude consumer choice, adverse selection, and moral hazard[7]. The intention of this program is to expand the access of the services to the needy people across the country by not putting a burden on their shoulder.

I believe the idea of cost sharing mechanism in service delivery can be applied in Somalia in particular health centres and general hospitals to ensure the substantiality of the health services. Sustaining health service provision is quite challenging and expensive and cannot be run by international organization as its project provision based by putting measures and strategies to be managed and trained on health facility in charges.



Three basic arguments have been developed to support cost-sharing:

1. **Increased revenue**. User fees are one of the few feasible ways of raising revenue to bridge the health sector resource gap in resource-poor environments. There are other ways of raising revenue: for instance, this can be done by asking community to pay the consultation card fee which is not that expensive, that costs collected would help to run the health facilities and prevents close out once donor funding has waned. More work needs to be done in developing policies that contribute to reduction in the health service gaps in remote areas.
2. **Increased efficiency**. User fees, if well designed, should mean that resources are used more efficiently within the health system. They discourage unnecessary use and can create incentives for providers and patients alike to shift the focus towards cost-effective high-priority care for disease prevention; they can also via differential pricing, move the delivery of care away from expensive hospital-based treatment to more cost-efficient primary healthcare.
3. **Increased equity**. If the income they generate is used to improve service quality, user fees could have positive equity outcomes. Even with user fees, a public health system that delivers high-quality care close to where people live would offer poor people cheaper and better care than they would be able to get in the private sector.

This is just an idea and can be examined for further studies to know more about the pros and cons however many countries in Africa and Asia have tested and displayed globally the impact made. Somalia is one of the countries ranked lowest globally with health service provision and the biggest problem is access of health services to the poor vulnerable communities.

Disclaimer: The views written in this article don't represent the views of INGO.

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