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Should African Governments Scrap User Fees For Health Services?

Rob Yates, Health Adviser, Ministry of Health, Uganda

Consider the problem as a business case study

Imagine you are the chief executive of Kenzania Health Services Inc. Your organisation's mission is simply to increase the consumption of effective health services, especially in your target market of the poor and vulnerable. You are not in the business of making money but financing is an important issue for you, as more funds will help you achieve your mission. Your main shareholders of Treasury Ltd. and Donor Corp contribute 95% of your finances. Unusually your customers only contribute 5% and market research has shown that they are unwilling to contribute more. Indeed since customer charges were formally introduced (following pressure from a powerful shareholder – Global Bank) you have seen sales stagnate. Some of your customers have gone to the competition but there also appear to be millions of potential customers not even participating in the market.

Clearly the strategy of the last two decades has not been working. This has involved trying to increase sales by gradually improving quality, using small increments in your funding levels. Your target market has not responded, leaving you with poor sales figures and excess capacity in the form of underutilised buildings and staff.

Now your job is on the line. The shareholders have made it clear to you that more funds will be made available only if you can demonstrate improved outputs. Radical action is required to increase sales but what should you do?

Answer: Slash your prices!

Is this relevant to Governments in Africa?

We may like to think that providing public health services is a long way from the sordid world of business, but is it? Firstly, if health services are to make any contribution towards the MDGs, we must increase "sales" (consumption) of effective preventive and curative services. It is not good enough supplying services which we believe are good quality, if our target populations do not use them. So what drives demand for health services?

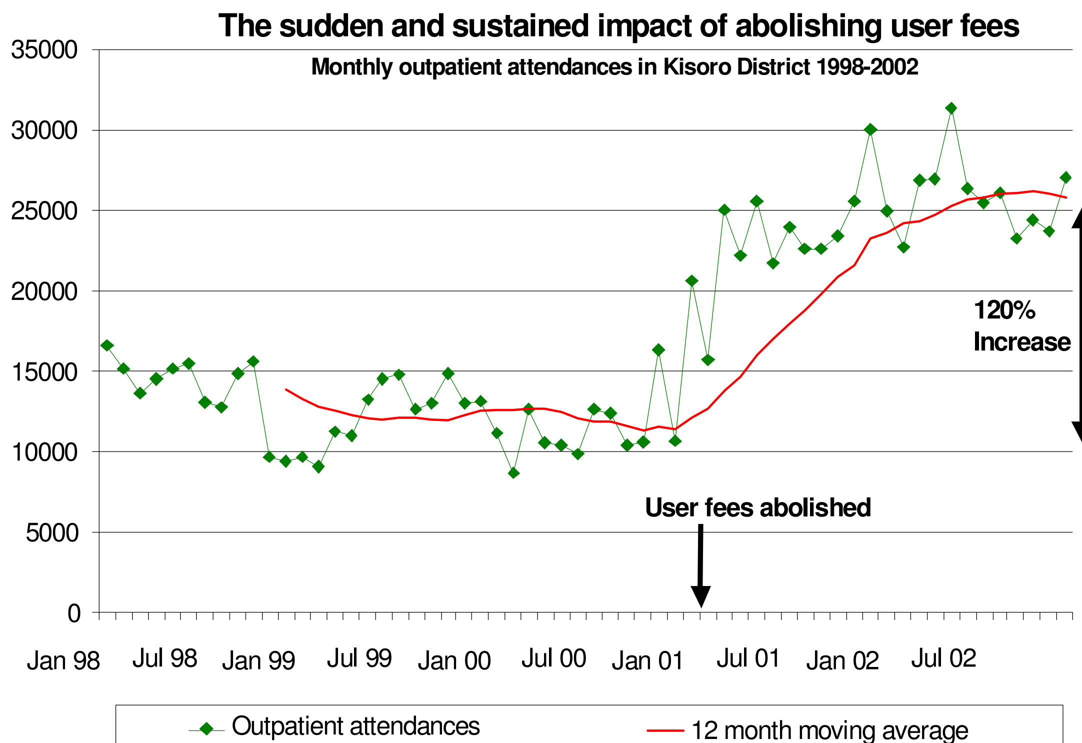
Research has shown that health care users in developing countries are like other consumers and shop around for health services, basing their choice of provider on their perceptions of quality and price. People choose services which, for them, represent the best value for money. If health care providers want to increase their outputs, they have two main strategies open to them: to improve quality as perceived by the user and/or lower their prices. Perhaps we have been concentrating too much on the first option and underestimating the importance of prices to poor people who, by definition, have very little money.

User fees were introduced in Africa at a time of widespread downward pressure on public expenditure and dwindling aid flows during the late 1980s. Realising that health services were woefully underfunded, it suited both donors and Governments to shift some responsibility for health care financing to the population through "cost

sharing". Sadly this policy has not worked. The research literature shows that fees have raised very little additional revenue[1]; fee levels have been sufficiently high to suppress demand from poor people and exemption schemes have been ineffective. The net result has been that supposedly pro-poor health care systems have effectively excluded a large proportion of their target populations. There is therefore a strong *prima facie* case for reversing the policy on user fees. Isn't it risky though to slash prices and therefore income at a time when resources are already very constrained? The evidence from the following, real, case study would suggest not.

Uganda's experiences in abolishing user fees[2]

In March 2001, ten days before the presidential election, President Museveni, in response to considerable public pressure[3], scrapped user fees in Government health units[4]. The public response was phenomenal, with virtually all health units immediately reporting an increase in attendances in the range 50-100%. This completely confounded earlier World Bank modelling in Uganda, which had suggested that such a policy change would result in a 2.3% increase in utilisation. The graph shows what happened in Kisoro District on the Rwandan / DR Congo border. This pattern was repeated across the country.



Despite the complete lack of prior warning, the unprepared sector coped remarkably well with this surge in demand. There was after all, underutilised infrastructure and human resources capacity. However it was realised that if this policy was to succeed (and there was a political imperative that it would) supply side improvements would

1. It is debatable whether the revenue realised was additional at all, if ministries of finance felt less pressure to increase health budgets.
2. This paper concentrates on this case study in the Ugandan Health Sector. Similar results have been observed in health in South Africa and in abolishing fees for primary education in Uganda and Kenya
3. The most celebrated quote from the first Ugandan Participatory Poverty Assessment Project (UPPAP) had been "Cost sharing is not for poor people"
4. With the exception of a few private wings in large hospitals.

have to be made immediately. Suddenly health was catapulted to the top of the nation's agenda and as a result, a whole raft of reforms were introduced or accelerated. This included: increasing the health budget, speeding up releases, increasing health workers salaries, computerising the payroll, and allowing units to run small cash imprests. It is debatable whether these reforms would have taken place so quickly (if at all) had there not been such intense pressure from twice as many patients demanding improved services.

It is perhaps not surprising that there was such an immediate response to the President's policy initiative but now three years on what has been the longer term impact. Previously the MoH and WHO has circulated material showing that between 1999/2000 and 2002/03, there was a 87% increase in outpatient attendances and a 105% increase in immunisation rates. There were also claims in this research that poorer socio-economic groups had benefited disproportionately. This finding has now been confirmed by a remarkable World Bank Working Paper[5] which shows that poor people are consuming more health services, are spending less on health care and are experiencing tangible health benefits. This led the recent World Bank PRSC mission to conclude in its final aide memoir that:

"The mission also noted the findings of a recent World Bank study confirming that the government policy to abolish user fees for health services triggered a massive increase in the consumption of basic health services. Of great significance for poverty alleviation strategies, poor people have benefited disproportionately, with the lowest income quintile capturing 50% of the benefits from this policy change. This finding augurs well for maternal and infant mortality interventions and the government is congratulated on this impressive pro-poor initiative."

Should other Sub-Saharan Countries Scrap User Fees Immediately?

Social policy theory would indicate that this action should be taken if the likely benefits outweigh the costs. The Ugandan case study may be unusual given the scale of the subsequent supply side reforms but learning from this example, the following balance sheet may also apply to other countries.

Likely benefits of scrapping user fees:

- The impact would be immediate
- It would be popular with the population
- Implementation costs would be negligible – maybe a presidential launch followed by free mass media coverage
- It would increase the consumption of services which should impact directly on MDG indicators
- It would benefit the poor disproportionately
- It would increase the disposable income of poor people[6]
- It would result in a system of rationing based more on a willingness to queue (related to need?) rather than a willingness to pay
- It would improve efficiency in the health sector as previously underutilised buildings and staff would be used more productively
- It would accelerate supply side reforms in order to improve service quality
- It would promote health up the country's agenda

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5 . Deininger K and Mpuga P, Economic and Welfare Impact of the Abolition of Health User Fees: Evidence from Uganda. World Bank Working Paper 3276, April 2004.

6. This is very difficult for developing country governments to achieve through benefits systems.

- It would create pressure to increase the health sector budget

Likely costs of scrapping user fees:

- There would be a loss of revenue to the health sector[7]
- It would potentially result in a shortage of cash at health units
- There could be dissatisfaction amongst health workers fearing loss of income and having to work harder.

Scrapping fees would undoubtedly put pressure on the public health system but this is needed if politicians are to take health seriously. Furthermore, even without immediate supply side reforms, the risks of a disaster would be minimal. Existing health centres could accommodate more patients and underutilised staff could treat more patients. Pressure would be most acute on commodities, but when the drugs ran out people would take their scripts to the private sector. Due to chronic drug shortages this situation has often been the reality facing patients in recent years. At least with no fees, patients would benefit from a free consultation and would be exposed to health education messages[8]. Removing the crutch of "cost sharing" would pressurise politicians into financing the expressed demand facing them in their health units. Even in African countries with poor governance problems, the likely benefits of scrapping fees are likely to outweigh the costs. This is because even in the absence of replacement funds, a slightly smaller resource pool would be shared more efficiently and equitably amongst a much greater customer base.

If this is the case, why isn't there greater momentum in this direction? The following stakeholder analysis suggests why there isn't much appetite for change:

Stakeholders in the user fees debate	**Reason for opposition / apathy towards scrapping user fees**
High income health care consumers	Tend to use the private sector
Middle income health care consumers	Are willing to pay but do not want to share scarce resources with masses of poor consumers
Low income health care consumers	Currently do not use formal health services, except in dire emergencies
Health Care Workers	Concern about loss of personal income
Ministry of Health	Concern about loss of sector income and focus on quality and supply side reforms
Ministry of Finance	Will not welcome pressure to increase the health budget
Political Leadership	Out of touch (unconcerned?) with public sentiment
Bilateral Donors	Exclusive focus on quality and supply side reforms
World Health Organisation	Supply side focus and reluctance to drop revolving drug schemes as advocated by the Bamako Initiative
World Bank	Potential embarrassment at abandoning a flagship reform and reluctance to increase public expenditure
NGOs	Tired of being voices in the wilderness

Therefore even though there is a very good case for scrapping fees, there is not an effective constituency of key stakeholders to promote the necessary policy change.

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7. In Uganda this amounted to $3.5 to $ 6 M but this was replaced four times over by the subsequent rise in the health budget
8. UPPAP showed that poor people appreciate this free service but complain vociferously about the shortages of drugs.

How should development agencies respond?

After around 20 years of user fees, there appears to be stalemate in this debate. Perhaps the commonest view is that scrapping user fees is a high risk option and that we must cling onto the "necessary evil"[9], at least for the time being. Uganda's experiences show that on the contrary, there is very little risk involved and that the benefits, particularly for the poor, far outweigh the costs. This evidence also dispels another commonly held view that user fees must be "better than nothing". With fees raising so little and excluding so many, a regime of no fees is actually better in terms of efficiency and equity. In excluding poor people from life saving health services, user fees may well be evil, but they are certainly not necessary.

If development agencies adopt a mildy critical position on user fees, qualified by pre-requisites for wider reforms, it will be far too easy for governments to cling onto the cost sharing crutch. This will perpetuate a system of suppressed demand from poor people, whilst maintaining a semblance of quality for the middle classes. Politicians and conservative macro-economists would then feel little heat from the half-empty health centres and would be able to blame the population for the chronic under funding of the sector. This means business as usual.

As with primary education, development agencies need to be more pro-active and more explicit than this. Quite simply, user fees for basic health services in poor countries are not a legitimate financing mechanism and this message should be stated clearly. It is particularly important that influential donors in health SWAPs and PRSP processes should be saying this.

User fees continue to contribute to an under-consumption of essential services by poor people – this is not a marginal issue for the target population of development agencies. The immediate doubling of attendances in Uganda when fees were scrapped proves this. There can be no clearer expression of the population's preference for no fees than this demonstration of people voting with their feet. Unfortunately though, with a couple of notable exceptions, there do not appear to be effective champions in African governments or the development world willing to act on these preferences. The field is open for pro-poor development agencies to fulfil this role. For partners wishing to make an impact this would be an appropriate initiative, because scrapping health fees is: a) a big issue b) easily understood by the general public c) doesn't cost much to implement d) low risk. Most importantly this is a pro-poor policy that works!

Please send comments to: Rob Yates, Health Adviser, Ministry of Health, Uganda: yatesug@infocom.co.ug

9. World Development Report 2004, World Bank