1. INTRODUCTION

Many low- and middle-income countries continue to search for better ways of financing their health systems. Common to many of these systems, is that current financing methods do not mobilize sufficient resources to provide the desired levels of health care for the whole population, too many of the available resources are not pooled to provide protection against household expenditure variance or channelled through some form of pre payment mechanisms, and the scarce resources that are mobilized often do not lead to value for money in terms of the health care on which it is spent. The poor and other vulnerable groups who need health care the most are the most affected by these shortcomings, especially the high reliance on user fees and other out-of-pocket expenditures on health which are both impoverishing and provide a financial barrier to needed care. It is within this context, and in light of recent policy initiatives, that a debate on the role of user fees in health financing systems has recently re-emerged.

Although there are no standard accepted definitions and authors use terms differently in different settings, for the purpose of this article we will use the term “user fees” to refer to official fees charged by public health providers for basic as well as higher-level services as used in one form or another in most countries and contexts. We will distinguish such official user fees from other out-of-pocket (OOP) expenditures outside the public setting. The latter include charges from private, NGO and community-managed services and may include fees paid for consultation, drugs, lab tests and informal payments to providers.

A major reason for the introduction of user fees has been financial pragmatism: in many developing countries, central government expenditure is simply not reaching peripheral level health facilities, and thus user fee revenue has been the only source of finance for non-salary recurrent costs. This was particularly pronounced in the late eighties and nineties, when the fall of the price of commodities on which many developing countries relied led to economic recession. Improved consumption efficiency, demand rationing (to counter moral hazard) and better targeting were the other main arguments used in favour of user fees, as discussed in the World Bank’s 1987 Agenda for Reform. Soon after, the Bamako Initiative, adopted by the African health ministers in 1987 (with subsequent support from UNICEF) to improve primary health care, focused on the link between community participation in management and improved use of essential drugs and basic service delivery as vehicles for mitigating the negative effects of fees. From the early 1990s, a limited number of studies showed that where...
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user fee revenue is used to increase quality, utilization by the poor could actually increase, suggesting that fees might not always reduce access for the poor. 6,7,8

The political momentum towards achievement of the Millennium Development Goals has revitalised the debate around sustainable health sector financing and adequacy of current arrangements in low-resource settings. Within this wider context, debate on user fees is now back on global and national agendas, driven primarily by the recent experience of fee abolition in Uganda where an initial increase in outpatient utilisation was observed, with strong indication that the poor benefited the most. 9,10,11,12 Utilisation also increased following fee removal in Madagascar and South Africa, although concerns about drug availability for the poor and the effects on preventive services have made these more qualified successes, leading in the case of Madagascar to a reintroduction of user fees. 13,14

Based on these experiences and the adverse effects of user fees on access for basic services in many other countries (see table 1 below), a number of organisations and initiatives have advocated for the removal of user fees, including EQUINET (a southern African equity research and advocacy network), Save the Children – UK, the UN Millennium Project and the Commission for Africa. Development agencies, such as DfID and UNICEF, are engaged in internal debate about whether they should adopt a blanket policy in favour of user fee abolition, with financial support to countries which remove fees. The WHO urges countries to move towards prepayment as a more equitable solution than over-reliance on OOP expenditures.15,16 Further, WHO technical briefs emphasise the need for universal coverage while reinforcing prepayment, thereby avoiding catastrophic health expenditure in households.17,18 A WHO discussion paper advising countries to adopt a policy of free access for HIV/AIDS treatment and care at the point of service delivery.19 Several recent World Bank reports recommend that countries introduce various forms of insurance and prepayment mechanisms to protect vulnerable populations against the impoverishing effects of expenditure variance.20,21 The issue is also on the political agenda: in 2001, the US government required the US Congress to oppose any World Bank, IMF or other multilateral development bank loan or grant which mandates user fees for basic health or education services as a conditionality (US Network for Global Economic Justice, 2003 3). In the UK, statements by leading cabinet members have urged patient charges to be removed. And at this year’s G8 summit in Gleneagles, the leaders pledged to support countries wishing to eliminate user fees: “We support our African partners’ commitment to ensure that by 2015 all children have access to and complete free and compulsory primary education of good quality, and have access to basic health care (free wherever countries choose to provide this).” 22

This paper provides some reflections on the recent user fees debate, drawing from the evidence presented and subsequent discussions at a recent UNICEF consultation on user fees in the health sector, and relating the debate to the wider issue of access to adequate healthcare. During the consultation, the pros and cons of user fees were extensively debated, as were a range of policy options to deal with the negative consequences of such fees in addition to fee abolition policies.

The paper is structured as follows. Section two briefly summarises the main evidence on user fees, with section three highlighting other key barriers to access. Section four details the experience with fee abolition, along with other recent policy initiatives aimed at improving access for the poor. Key lessons and conclusions derived from these experiences are presented in section five.
2. USER FEES: WHAT CAN RECENT EXPERIENCE TELL US?

Numerous studies have analysed the impact of user fees across a range of different settings. The core messages from this research are summarised below.

2.1 USER FEES AND ACCESS
User fees impede access to healthcare: they typically add to the cost of health services faced by patients, resulting in poor and vulnerable population groups not always seeking appropriate care when it is needed. However, fees have the potential to improve access to better quality services: if the extra revenue generated from fees is re-invested into the health system (for instance, to improve drug availability), or if fee payment allows consumers to insist successfully on better service, demand is likely to increase, partially or fully offsetting the negative price effect. This revenue can be significant when government systems fail to adequately move funds to the peripheral level. Figure 1 illustrates the effect of these two conflicting factors:

Figure 1: Introduction of user fees – price and quality effects

The situation before user fees is represented by $P_0$, $Q_0$, with $Q$ representing the uptake of health care at a particular level, and $P$ the average total cost to the user. Note that $P_0$ is greater than zero, as there are other costs incurred when seeking care, particularly travel costs and the purchase of drugs not supplied by the health facility. The situation after user fees is represented by $P_1$ and $Q_{1a}$, $Q_0$ and $Q_{1b}$, the exact point depending on how much (if at all) the introduction of fees improves quality. Furthermore, if user fees are replacing informal / under-the-table fees, the price faced by patients following introduction may be only slightly higher, or in extreme cases, fall (i.e. $P_0$ in figure 1 would be higher).

The impact of user fees on access is, therefore, an empirical issue. A wide literature on the effects of implementing user fees, particularly in Sub-Saharan Africa, documents these experiences. Table 1 summarises some of the main evidence on the equity impact of user fees in Africa and Asia. It represents the majority of published studies on user fees in Africa and Asia from 1990-2005, being based on a PubMed search of main keywords for user fees (“user fees”, “user charges” and “cost recovery”), supplemented by a recently published review paper. It excludes studies which focused primarily on OOP expenditures as a whole, although these are discussed briefly later.
### Table 1: Evidence on user fees implementation and its impact on access (both for the poor and the general population)

<table>
<thead>
<tr>
<th>Country</th>
<th>Study</th>
<th>Impact on access: positive, negative or mixed?</th>
<th>Main finding (with further details in italics)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>Soucat <em>et al</em> (1997)</td>
<td>Positive</td>
<td>Utilisation of both preventive and curative care rose following user fees introduction, due to improved quality. Following implementation of the Bamako Initiative, which included introducing user fees, utilisation increases were observed for both preventive and curative care, due to better quality care (especially greater drug availability).</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>Ridde (2003)</td>
<td>Negative</td>
<td>Utilisation of curative care fell after user fees introduction. Primary-level health and welfare centres charging user fees recorded an average annual decrease of 15.4% in new consultations for curative care, as compared with a 30.5% annual increase for those not charging fees.</td>
</tr>
<tr>
<td>Burundi</td>
<td>Bate and Witter (2003)</td>
<td>Negative</td>
<td>Ineffective exemption mechanisms for user fees. No clear criteria for exemptions, with only a small fraction of the population benefiting (4% of sample had cards, with only half of these benefiting from cards).</td>
</tr>
<tr>
<td>Cambodia</td>
<td>Akashi <em>et al</em> (2004)</td>
<td>Positive</td>
<td>Utilisation increased following user fees introduction, as they replaced informal payments. Before user fees, informal payments were used to boost salaries. After fees, revenues were retained by the hospital.</td>
</tr>
<tr>
<td>Cambodia</td>
<td>Barber <em>et al</em> (2004)</td>
<td>Positive</td>
<td>Utilisation increased following user fees introduction, as they replaced informal payments. User fees guaranteed fixed prices for services, with utilisation increasing by greater than 50% for inpatient and surgical care.</td>
</tr>
<tr>
<td>Cambodia</td>
<td>Jacobs and Price (2004)</td>
<td>Negative</td>
<td>User fees, whilst not adversely affecting overall utilisation, did adversely affect the poor. Increases in user fees created a 'medical poverty trap', with some of the poor deterred from seeking care.</td>
</tr>
<tr>
<td>Cameroon</td>
<td>Litvack <em>et al</em> (1993)</td>
<td>Positive</td>
<td>Utilisation increased following user fees introduction, through improved quality. User fees ensured better quality of services through enhanced drug availability, with increases in utilisation extending to the poor.</td>
</tr>
<tr>
<td>China</td>
<td>Liu and Mills (2002)</td>
<td>Negative</td>
<td>User fees, whilst improving public sector productivity, reduced take-up of preventive services. The increased reliance on user fees worsened allocative efficiency, with over-provision of unnecessary services and under-provision of socially desirable services.</td>
</tr>
<tr>
<td>Democratic Republic of Congo</td>
<td>Haddad and Fournier (1995)</td>
<td>Negative</td>
<td>Utilisation fell after user fees introduction, despite improvements in quality. In 1987-91, service utilisation fell by 40%, with 18-32% of this decrease is explained by cost, despite improvements in drug availability, staff skills and better medical equipment.</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Russell and Abdella (2002)</td>
<td>Negative</td>
<td>Ineffective exemption mechanisms for user fees. Exemption mechanisms limited in breadth (based on income thresholds, yet much subsistence in economy) and depth (only cover minor registration fees and not the more important drug costs).</td>
</tr>
<tr>
<td>Ghana</td>
<td>Nyonator and Kutzin (1999)</td>
<td>Negative</td>
<td>Exemption mechanisms for user fees are largely non-functional. Fees have resulted in a 'sustainable inequity', allowing service provision to continue, but preventing part of the population from using these services, due to ineffective exemption mechanisms.</td>
</tr>
</tbody>
</table>
### Country Study Impact on access Main finding (with further details in italics)

<table>
<thead>
<tr>
<th>Country</th>
<th>Study</th>
<th>Impact on access</th>
<th>Main finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guinea</td>
<td>Soucat <em>et al</em> (1997)</td>
<td>Positive</td>
<td>Utilisation of both preventive and curative care rose following user fees introduction, due to improved quality. [See details on Benin above].</td>
</tr>
<tr>
<td>Kenya</td>
<td>Collins <em>et al</em> (1996)</td>
<td>Negative (Neutral)</td>
<td>Utilisation fell after user fees introduction, although by much less after phased implementation. The initial 1989 registration fee led to an average reduction of 27% at provincial hospitals, 45% at district hospitals and 33% at health centres. In contrast, the outpatient treatment fee reintroduced in 1992 was associated with much smaller decreases in utilisation.</td>
</tr>
<tr>
<td>Mali</td>
<td>Mariko (2003)</td>
<td>Positive (Neutral)</td>
<td>Utilisation fell after user fees introduction, with exemption mechanisms being ineffective. Attendance for outpatient and inpatient care in government facilities was lower when registration fees were charged, as compared with when fees were removed. Utilisation by children, exempt from fees, followed a similar pattern.</td>
</tr>
<tr>
<td>Mauritania</td>
<td>Audibert and Mathonnat (2000)</td>
<td>Positive</td>
<td>Utilisation increased following user fees introduction, through improved quality. Increases in utilisation were observed following user fee introduction, due to better drug availability, with no evidence of severe negative equity effects.</td>
</tr>
<tr>
<td>Niger</td>
<td>Chawla and Ellis (2000)</td>
<td>Positive (Neutral)</td>
<td>User fees only had a negligible negative impact on utilisation of healthcare. No evidence of serious reductions in access following increases in formal user fee charges, due to improved quality of care.</td>
</tr>
<tr>
<td>Niger</td>
<td>Diop <em>et al</em> (1995)</td>
<td>Positive</td>
<td>Utilisation increased following user fees introduction, especially when combined with an annual tax. Utilisation increased markedly in district with small fee plus an annual tax, as compared with a pure fee-for-service method (negligible utilisation impact) and control district without fees (utilisation fell).</td>
</tr>
<tr>
<td>Niger</td>
<td>Meuwissen (2002)</td>
<td>Negative</td>
<td>Utilisation fell after user fees introduction, following nationwide implementation. Although previous pilot studies had shown that user fees would not adversely affect access, due to improved quality, nationwide implementation led to more severe drops in utilisation in a number of health centres.</td>
</tr>
<tr>
<td>Nigeria</td>
<td>Uzochukwu <em>et al</em> (2004)</td>
<td>Mixed</td>
<td>Utilisation of malaria services increased following user fees introduction, although the rich and educated benefited the most. Utilisation of malaria services increased despite the introduction of user fees, due to improved quality (training of health workers and better drug availability), although the rich and educated were the principal beneficiaries.</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>Fabricant <em>et al</em> (1999)</td>
<td>Negative</td>
<td>The rural poor are disproportionately disadvantaged by fees, with exemption mechanisms ineffective. The burden of curative treatment costs came mainly from private and NGO providers, with the rural poor facing a high financial burden.</td>
</tr>
<tr>
<td>Sudan</td>
<td>Abdu <em>et al</em> (2004)</td>
<td>N/A</td>
<td>Introduction of effective exemption mechanisms significantly increased utilisation. Exemptions (financed by the government) from fees for all pregnant women and under-fives with malaria resulted in significant utilisation increases for both population groups.</td>
</tr>
<tr>
<td>Country</td>
<td>Study</td>
<td>Impact on access</td>
<td>Main finding (with further details in italics)</td>
</tr>
<tr>
<td>-----------</td>
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<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Tanzania</td>
<td>Hussein and Mujinja (1997) (^{41})</td>
<td>Negative</td>
<td>Utilisation of outpatient services fell following user fees introduction. <em>Utilisation of outpatient services in government-owned district hospitals fell by over 50%, following introduction of user charges. Private facility use remained constant, mainly because employer’s typically paid for private facility users.</em></td>
</tr>
<tr>
<td>Tanzania</td>
<td>Laterveer et al (2004) (^{42})</td>
<td>Negative</td>
<td>Ineffective exemption mechanisms for user fees. <em>Blanket exemption mechanisms (for under-fives, maternal and child health services, patients with selected conditions) are not working properly.</em></td>
</tr>
<tr>
<td>Uganda</td>
<td>Kipp et al (2001) (^{43})</td>
<td>Negative</td>
<td>Utilisation of outpatient services fell following user fees introduction, although not universally. <em>Utilisation dropped by 21.3%, although it increased in facilities located in remote areas due to better drug supply and other community projects.</em></td>
</tr>
<tr>
<td>Zambia</td>
<td>Blas and Limbambala (2001) (^{44})</td>
<td>Mixed</td>
<td>Utilisation fell for most services where user fees were payable, but rose for fee-exempted services. <em>Hospitals and health centres experienced an approximately 1/3 decrease for general attendances over a two year period, but decreases were less marked afterwards. However, health centre admissions increased by 25%, and fee-exempt measles vaccinations and deliveries increased by 40% and 60% respectively.</em></td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Zigora et al (1996) (^{45})</td>
<td>Negative</td>
<td>Utilisation fell following user fees introduction.</td>
</tr>
</tbody>
</table>
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All but one of the positive examples described in the table above came from West Africa. In these studies, the role of the Bamako Initiative in improving drug availability and accountability of providers to the users alongside the introduction of user fees was stressed as the main explanatory factor. In Cambodia, user fees helped formalise previously informal fees, thereby allowing more predictable prices for services and increasing the amount of revenue retained by hospitals.\textsuperscript{25,26,46} Evidence from Uganda, Kyrgyzstan and other former Soviet Union countries, showed also that the introduction of formal fees or alternative health financing arrangements such as social health insurance did not lead to the disappearance of informal fees.\textsuperscript{47,48,49}

However, the majority of studies and countries summarised in table 1 experienced a negative effect on equity of access, through reduced utilisation following the introduction of fees, and/or through the poor being most adversely affected. Other studies on more general OOP expenditures also noted that the poor were particularly sensitive to prices.\textsuperscript{50,51,52} In the case of long-term diseases, user fees could also negatively impact on adherence to expensive treatment, as has been widely documented for HIV/AIDS.\textsuperscript{53,54}

Waivers and exemption policies are a way to deal with the negative impact of user fees on particular client groups. Evidence suggests that these have often been difficult to implement, as some of the studies in table 1 have shown. A recent World Bank study also found that waiver and exemption mechanisms were ineffective in three of the four low-income countries studied. For instance, facilities in Kenya rarely granted more than 2 waivers per month – an insignificant fraction of the 42% of Kenyans living under the poverty line. Waiver systems were somewhat more effective in the 3 middle-income countries studied.\textsuperscript{55} Waivers and exemption policies that target specific geographic regions, client groups (ie children, mothers, households with specific diseases) and services used by the poor have been found to be effective and fairly easy to implement. Waivers for more easily definable groups are often easier to implement – as was the case for a fee waiver system for pregnant women and children with malaria in Sudan.\textsuperscript{40}

A recent review of health care financing highlighted the methodological weakness of many of these studies,\textsuperscript{56} raising the need for a note of caution in the interpretation of the evidence base. Many studies are small in scale; very few have been able to adopt experimental approaches, or even strong quasi-experimental approaches, to overcome problems of selection bias; data are frequently longitudinal in nature but reflect only a relatively short timeframe and often without an appropriate control group; and interventions usually are multifaceted, making it difficult to tease out the effects of individual factors. Furthermore, it is not always obvious what the optimal study design is: while large scale quantitative assessments can help to measure the impact of a particular policy change in a particular context, it is not clear that this is useful if they cannot provide information about the “how and why” questions which determine the effectiveness of a policy in a particular context. Finally, results from facility-based data (in contrast to survey data) should be interpreted cautiously in analysing utilisation trends, whenever there is an incentive to report changes in use. Future research must address these questions of methodology much more systematically than has typically happened in the past before any one policy option can be summarily dismissed.
2.2 USER FEES AND EFFICIENCY OF RESOURCE USE

The reduced use of services detailed above would be less of a concern if this reflected primarily a reduction in frivolous use of health services by the population. However, surveys in lower-income countries typically report significant proportions of populations not seeking care even though they are sick, with a commonly cited reason being the financial cost of healthcare. High travel and other non-health care costs, especially for those living in rural areas, suggest that frivolous use is unlikely even without fees. Still, fees might encourage more efficient use of the referral system if graded according to the level of care, although there is little evidence to support this.

As discussed in the previous section, it is typically the poor who have been most negatively affected by user fees. And even when poorer individuals are able to access care, studies have shown how many of the poorer households have resorted to reducing consumption of food, self-medicating, seeing traditional healers, and using various other coping mechanisms; or had to endure catastrophic health expenditures. In such cases, insurance mechanisms are in principle a more efficient strategy than user fees, since they counter uncertainty by pooling risks.

Finally, health services need a steady revenue stream to function properly. Staff have to be paid and storerooms stacked with drugs and supplies. Paying for health care on an out-of-pocket basis where poor households often do not have the means to pay the full prices of such care, leaves health care providers vulnerable to irregular revenue flows. Prepayment and insurance is a much more equitable and efficient way to finance health care than direct user fees.

2.3 REVENUE GENERATION

Studies on official user fees have rarely found a large share of total revenues for the health sector. For instance, in 16 Sub-Saharan African countries, fees generated an average of around 5% of total recurrent health system expenditure, gross of administrative costs. Similar modest shares were found in other more recent reviews. Still, the revenues have often amounted to important sums at the local level, in the absence of central government investment in peripheral level health facilities and problems with the flow of funds from the centre to periphery of the health care system. In contrast, OOP expenditures typically account for at least 50% of health expenditures in low-middle income countries, and often more: for example, they are almost 80% in India.

3. WHAT OTHER BARRIERS TO ACCESS DO THE POOR FACE?

The evidence summarised in the preceding section, whilst mixed, demonstrates that user fees often constitute an important barrier to access to health services, especially for the poor. However, they are only one barrier the poor face in accessing adequate health services, as has been shown across a wide variety of settings. The main barriers can be classified into cost barriers, of which user fees are one component, and non-cost barriers. These barriers deter the poor and near-poor from seeking care, or result in them receiving care which inadequately treats the illness or disease.
3.1 COST BARRIERS
Patients not only have to pay user fees when they fall sick, they are also confronted with a number of other cost barriers. These, detailed below, can make up a significant proportion of the total costs that households face.

- **User fees** (see section 2).
- **Informal fees**: unofficial monetary or in-kind transactions between staff and patients have been shown to be important in many health systems, although their impact on use by different socio-economic groups is unclear. While in some settings the poorest income quintiles pay disproportionately more, in others, distribution is relatively equitable and providers exercise an ad-hoc exemption policy according to ability to pay. The impact of informal payments on use is less clear as it is confounded by other factors such as poor quality of care, high formal costs and poor staff attitude to those less well off.
- **Cost of drugs, laboratory and radiology tests not supplied in public health facilities** (see also quality barriers): health centres, other primary health facilities, and to a lesser extent, higher level facilities, often have insufficient drug supplies. This results in patients having to purchase drugs or undergo tests elsewhere, which can lead to patients not completing treatment courses. Evidence from one setting suggests that the poor find being left to purchase drugs elsewhere a greater constraint than other socioeconomic groups.
- **Charges in private facilities**: public facilities often cannot provide adequate care for specific services. Charges in private facilities for these services constitute a further cost barrier, particularly for the poor, and can be much larger in magnitude than user fees.

These four cost barriers together make up the types of OOP expenditures that patients can be confronted with. Further, there are:

- **Travel costs**: transport and other costs associated with travel to a health facility can deter or delay individuals from seeking care, especially in remote rural areas without easy access to modern transportation. For instance, transport was found to be 28% of total patient costs in Burkina Faso; and an important determinant of how long patients delay care across a number of other country settings, especially for the poor.
- **Non-healthcare costs**: patients usually have to pay extra for food, accommodation and other non-healthcare services. This can be significant – up to 20% of direct patient costs in some low-income settings, especially for those with lengthy admissions, and can result in premature discharge from hospitals.

In addition to these different types of financial costs that patients face, the **indirect costs** of healthcare in terms of earnings, education or unpaid (but productive) family/social responsibilities forgone acts as a further cost barrier to health services.

3.2 NON-COST BARRIERS
Non-cost barriers can be further sub-divided into **quality, information and cultural barriers**. The examples below impede access to services for the poor irrespective of cost barriers.
Quality barriers

- **Insufficient and low quality human resources**: in addition to a lack of health personnel, absenteeism and insufficient training of health workers result in the health services offered being of inadequate clinical quality, particularly in the poorer regions of low-income countries.\(^71,72\)

- **Drug, medical equipment and other input shortages**: in situations where there is no alternative health provider, these result in patients not being able to receive adequate quality treatment, irrespective of their budget.

Information barriers

- **Lack of sensitisation on medical benefits of formal healthcare**: individuals may not be well informed of the benefits of formal healthcare (both preventive and curative), resulting in underutilisation. This is typically more marked amongst those with little or no formal education.\(^63\)

- **Imperfect information on entitlements**: individuals may not be well informed about free or subsidised treatment for all or certain health services. This is also typically correlated with education.

Cultural barriers

- **Stigma**: the poor and other marginalised groups (such as HIV/AIDS patients) may not make use of entitlements due to the stigma attached.

- **Incompatibility of services with cultural norms**: an important example of this is when women are deterred from seeking care (especially for intrusive services) due to there being no female health staff available to treat them.\(^73\)

3.3 INTERACTIONS BETWEEN DIFFERENT ACCESS BARRIERS

These cost and non-cost barriers outlined above are not always independent of each other, or from user fees. For example, imperfect information on entitlements may increase uncertainty among patients and their families, enabling staff to solicit informal payments.

In relation to user fees, they can potentially increase the quality of care and thus reduce quality barriers (although the evidence summarised in section 2 suggests that the negative price effect more often outweighed any positive quality effect). User fees also affect charges in private facilities. For instance, fee removal will put downward pressure on private facility charges, assuming there is some degree of price competition between public and private health facilities. In relation to cultural barriers, fee removal reduces stigma problems, but has no obvious effect on reducing the incompatibility of certain services with cultural norms.

These examples demonstrate the significance of interactions between user fees and the other barriers to access most prominent in a particular country context. They also highlight the importance of considering effects of changes in user fees policy (or any financing policy) on the incentive structure facing providers.
4. DISCUSSION

As was shown in the previous section, improving access for the poor requires the dismantling of multiple barriers to access.

User fee abolition, enacted in a handful of African countries, focuses on removing one key cost barrier. The limited evidence available so far suggest that this policy has been most successful when supported by other measures that account for interaction with other barriers and its potential effect on provider incentives, as discussed below. One of the more frequently cited examples of successful recent fee abolition comes from Uganda, where significant increases for curative and some (but not all) preventive services were observed during the early phase of the reform. Early evidence suggests that improvements in utilization was most marked for the poor, although the incidence of catastrophic expenditures amongst the poor did not fall.\textsuperscript{9,10,11,12} Interestingly, utilisation also increased in the private sector, who reduced their charges soon after the policy change. There were also decreases in the average number of days lost to sickness, and fewer individuals were barred from accessing services due to their cost. Utilisation of other services, such as assisted deliveries, showed no response to fee removal, suggesting that other barriers remain significant impediments to improved access. Importantly, fee abolition was supported by a host of other measures that may have had a simultaneous impact on other barriers, including increased budgets to compensate for lost fee revenue, alongside active recruitment and increases in salaries, and implementation of a Sector Wide Approach.\textsuperscript{74}

Other experiences come from South Africa, Madagascar and Kenya. In South Africa, fees were removed for pregnant and lactating women in 1994, then extended to all people in all primary health centres in 1997. Utilisation of curative services almost doubled, but there were slight falls in preventive services.\textsuperscript{14} In Madagascar, utilization doubled in 1997-8 after introduction of user fees, but then decreased sharply in 2000 during a period of political turmoil.\textsuperscript{75} Subsequent elimination of fees was associated with a 21\% increase in utilisation.\textsuperscript{13} Upon closer examination of data, however, part of the reason for the initial increase in utilization was that many patients were returning two or three times for the same illness because they are not being fully treated due to the lack of drugs or supplies during their first visit. Consequently, fees were re-introduced in 2003, mainly because alternative financing mechanisms were not adequate, resulting in drug shortages emerging.\textsuperscript{76} In Kenya, user fees were also removed temporarily in 1990, with a 41\% increase in utilisation in government health centres.\textsuperscript{77} Since 1990, fees have been reintroduced (with subsequent financial access problems), then replaced in 2004 by much lower and flat registration fees.\textsuperscript{78} These experiences suggest that the impact of fee policies need to be assessed over several years and not be limited to a single aggregate indicator such as number of outpatient visits. More attention needs to be given to the nature of these visits - high impact services such as deliveries or treatment of childhood illnesses for example rather than general outpatient visits, as well as the comprehensiveness and quality of the care provided.

A recent study explored the potential mortality impact of fee abolition, combining these experiences with evidence on the impact of key child survival interventions on child mortality.\textsuperscript{79} It estimated that 153,000-305,000 (4.1\%-8.2\%) under-five deaths
could be prevented annually across twenty Sub-Saharan African countries if fees were abolished. The study stressed that the projected gains would only be achieved if policymakers establish other measures that support the lowering of other access barriers, particularly viable alternative financing mechanisms. Effective implementation strategies are also crucial. Communication with health workers, managers and the general public; and clearly setting responsibilities for different government departments are important practical strategies for managing fee removal, alongside increased budgets to offset lost revenue.

In addition to fee abolition, there are a number of alternative health financing policy options for dealing with the problems associated with user fees. These include *equity funds*, *vouchers*, *conditional cash transfers* and *insurance with partial or total subsidization of the premiums for the poor*. *Equity funds* operate as a means of separating the responsibility for identification of those to be exempted, together with providing a third party source of funding for patients who cannot afford to pay. They potentially offer better targeting of subsidies than fee abolition, but may also have higher administration costs, since the equity fund requires careful management. They have been recently introduced in a few low-income countries, and initial evidence from the district of Sotnikum in Cambodia suggests that they can be successful: results showed that the equity fund markedly improved access for the poor, with little leakage to the non-poor. This will be tested by the current rapid replication throughout the country. *Vouchers* for selected health services have had some success in improving access for vulnerable population groups, although they have typically been small-scale and with only a few examples from low- and middle- income countries. *Conditional cash transfers* in Latin America have also improved coverage of key child health interventions.

More generally, the *expansion of various prepayment schemes* has been on the international agenda, including social, private and community-based health insurance, as well as tax-based financing. These all aim to better protect individuals from health expenditure variance. How to ensure that the poor benefit from such schemes is a critical issue, not only with health insurance, but also with government health expenditures, where there is strong evidence that the better-off capture disproportionate shares of government health service expenditures, even where services are free, *de jure*. Recent experience in Ghana indicates that by subsidizing the premiums of the poor, low income populations do not need to be excluded from such schemes. In Rwanda, enrolment in microinsurance schemes recently increased to 55% of the population thanks to a partnership with micro-credit organizations and local banks. Thirty regional pools are being created as well as a national reinsurance scheme funded by a tax on the formal sector. The national budget fully funds the premiums of the very poor, who are identified through a participative process of poverty mapping “Ubudehe”.

Unfortunately, progress towards expansion in prepayment and eventual universal access at low income levels remains elusive. Evidence is now emerging that most countries in the Africa region, with a few notable exceptions, are not progressing towards the Abuja target of 15 percent of government spending on health. In many countries it is still less than 7 percent and in some as low as 3 to 5 percent. Expanding the overall fiscal space is often not an option.
As well as policies aimed at improving how health services are financed, reform of **health service delivery** is also crucial, particularly for reducing quality barriers. This includes a wide range of reforms designed to improve health worker skills, and others aiming to improve the incentive structure, such as contracting and regulation of the private sector. **Information / sensitisation policies**, such as social marketing and greater community participation, are important in reducing information and cultural barriers. 66,75

### 5. **KEY LESSONS AND CONCLUSIONS**

From the wealth of evidence on user fees and other health system reforms, there is now a broad consensus on the importance of addressing the problems associated with user fees, especially in the case of securing access to basic health services for the poor and other vulnerable populations, and in protecting households against the impoverishing effects of expenditure variance that often occurs especially in the case of chronic or catastrophic acute illness.

A number of key lessons can be derived in relation to user fees:

1. User fees are an important barrier to accessing health services, especially for poor people. They also negatively impact on adherence to long-term expensive treatments. This is offset to some extent, though, by potentially positive impacts on quality.
2. User fees, though, are not the only barrier that the poor face. As well as other cost barriers, a number of quality, information and cultural barriers must also be overcome before the poor can access adequate health services.
3. Initial evidence on fee abolition in Uganda suggests that this policy has improved access to outpatient services for the poor. For this to be sustainable and effective in reaching the poor, fee removal needs to be part of a broader package of reforms that includes increased budgets to offset lost fee revenue (as was the case in Uganda).
4. Implementation matters. If fees are to be abolished, this needs clear communication with a broad stakeholder buy-in, careful monitoring to ensure that official fees are not replaced by informal fees, and appropriate management of the alternative financing mechanisms which are replacing user fees.
5. Context is crucial. For instance, in Cambodia immediate fee removal would be inappropriate, given that fees replaced irregular and often high informal fees. In this context, equity funds and eventual expansion of health insurance are more viable policy options.

Removing user fees has the potential to improve access to health services, especially for the poor, but it is not appropriate in all contexts. Analysis should move on from broad evaluations of user fees towards exploring in specific contexts how best to dismantle the multiple barriers to access.
References


TO RETAIN OR REMOVE USER FEES? Reflections on the current debate


Laterveer, L. et al (2004). Equity implications of Health Sector User Fees in Tanzania: Do we retain the user fee or do we set the user free? Leusden, Netherlands, ETC Crystal for REPOA.


TO RETAIN OR REMOVE USER FEES?

Reflections on the current debate

International Conference of the International Health Economics Association, 15-18 June 2003 San Francisco, USA.


TO RETAIN OR REMOVE USER FEES? Reflections on the current debate


75 World Bank (2005). Madagascar Health Sector Note.

76 Honda, unpublished draft.


78 Carrin, G., C. James, et al. (forthcoming). "to complete."


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