

To Retain or Remove User Fees?

Reflections on the Current Debate in Low- and Middle-Income Countries

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Abstract

Many low- and middle-income countries continue to search for better ways of financing their health systems. Common to many of these systems are problems of inadequate resource mobilisation, as well as inefficient and inequitable use of

existing resources. The poor and other vulnerable groups who need healthcare the most are also the most affected by these shortcomings. In particular, these groups have a high reliance on user fees and other out-of-pocket expenditures on health which are both impoverishing and provide a financial barrier to care.

It is within this context, and in light of recent policy initiatives on user fee removal, that a debate on the role of user fees in health financing systems has recently returned. 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 relates the debate to the wider issue of access to adequate healthcare. It is argued that, from the wealth of evidence on user fees and other health system reforms, a broad consensus is emerging. First, 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. However, this is offset to some extent by potentially positive impacts on quality. Secondly, user fees 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. Thirdly, 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). Fourthly, 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 that are replacing user fees. Fifthly, context is crucial. For instance, immediate fee removal in Cambodia 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 perhaps more viable policy options. Conversely, in countries where user fees have had significant adverse effects on access and generated only limited benefits, fee abolition is probably a more attractive policy option.

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 how best to dismantle the multiple barriers to access in specific contexts.

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 mobilise sufficient resources to provide the desired levels of healthcare for the whole population, too many of the available resources are not pooled to provide protection against household expenditure variance or chan-

nelled through some form of prepayment mechanisms, and the scarce resources that are mobilised often do not lead to value for money in terms of the healthcare on which it is spent. The poor and other vulnerable groups who need healthcare the most are the most affected by these shortcomings, especially the high reliance on user fees and other out-of-pocket (OOP) expenditures on health which are both impoverishing and provide a financial barrier to needed care.^[1-4] It is within this context, and in light of recent policy initiatives on user fee removal, 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 use the term 'user fees' to refer to official fees charged by public health providers as used in one form or another in most countries and contexts. We distinguish such official user fees from other OOP expenditures outside the public setting. The latter include charges from private, non-governmental organisations and community-managed services and may include fees paid for consultation, drugs, laboratory tests and informal payments to providers. Informal or unofficial payments to healthcare providers are made in some settings and would be included in OOP payments.

A major reason for the introduction of user fees has been to raise revenue for the health sector. Although the revenues raised are typically small in absolute terms,^[5] they can be an important source of revenue in peripheral areas where central government expenditure is not reaching peripheral-level health facilities, provided they are locally retained. This was particularly pronounced in the late 1980s and 1990s, when the fall in 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^[6]). The Bamako Initiative, adopted by the African health ministers in 1987 (with subsequent support from UNICEF) to improve primary healthcare, 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 user-fee revenue is used to increase quality, utilisation by the poor could actually increase. This suggests that fees might not always reduce access for the poor.^[7-9]

The political momentum towards achievement of the United Nations' Millennium Development Goals has revitalised the debate around sustainable health sector financing and the adequacy of current arrangements in low-resource settings. Within this wider context, debate on user fees is now back on global and national agendas. An important influence has been the recent experience of fee abolition in Uganda in 2001, where an initial increase in outpatient utilisation was observed, with strong indications that the poor benefited the most.^[10-13] 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. In the case of Madagascar this led to a reintroduction of user fees.^[14,15]

Based on these experiences and the adverse effects of user fees on access for basic services in many other countries (see table I), a number of organisations and initiatives have advocated the removal of user fees. These include EQUINET (a southern African equity research and advocacy network), Save the Children – UK, the United Nations Millennium Project and the Commission for Africa. The UK Department for International Development (DFID) is also actively examining how it can best support countries that want to eliminate fees.^[16] In

Table I. Evidence on user fees implementation and its impact on access (both for the poor and the general population)

Study (year)	Country	Impact on access: positive, negative or mixed?	Main finding (<i>with further details in Italics</i>)
Soucat et al. ^[9] (1997)	Benin	Positive	Utilisation of both preventive and curative care rose following user fees introduction, due to improved quality <i>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)</i>
Ridde ^[18] (2003)	Burkina Faso	Negative	Utilisation of curative care fell after user fees introduction <i>Primary-level health and welfare centres charging user fees recorded an average annual decrease of 15.4% in new consultations for curative care, compared with a 30.5% annual increase for those not charging fees</i>
Bate and Witter ^[19] (2003)	Burundi	Negative	Ineffective exemption mechanisms for user fees <i>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)</i>
Akashi et al. ^[20] (2004)	Cambodia	Positive	Utilisation increased following user fees introduction, as they replaced informal payments <i>Before user fees, informal payments were used to boost salaries. After fees, revenues were retained by the hospital</i>
Barber et al. ^[21] (2004)	Cambodia	Positive	Utilisation increased following user fees introduction, as they replaced informal payments <i>User fees guaranteed fixed prices for services, with utilisation increasing by >50% for inpatient and surgical care</i>
Jacobs and Price ^[22] (2004)	Cambodia	Negative	User fees, while not adversely affecting overall utilisation, did adversely affect the poor <i>Increases in user fees created a 'medical poverty trap', with some of the poor deterred from seeking care</i>
Litvack and Bodart ^[6] (1993)	Cameroon	Positive	Utilisation increased following user fees introduction, through improved quality <i>User fees ensured better quality of services through enhanced drug availability, with increases in utilisation extending to the poor</i>
Liu and Mills ^[23] (2002)	China	Negative	User fees, while improving public sector productivity, reduced take-up of preventive services <i>The increased reliance on user fees worsened allocative efficiency, with over-provision of unnecessary services and under-provision of socially desirable services</i>

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Table I. Contd

Study (year)	Country	Impact on access: positive, negative or mixed?	Main finding (<i>with further details in Italics</i>)
Haddad and Fournier ^[24] (1995)	Democratic Republic of Congo	Negative	Utilisation fell after user fees introduction, despite improvements in quality <i>During 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</i>
Russell and Abdella ^[25] (2002)	Ethiopia	Negative	Ineffective exemption mechanisms for user fees <i>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)</i>
Nyonator and Kutzin ^[26] (1999)	Ghana	Negative	Exemption mechanisms for user fees are largely non-functional <i>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</i>
Soucat et al. ^[9] (1997)	Guinea	Positive	Utilisation of both preventive and curative care rose following user fees introduction, due to improved quality <i>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)</i>
Collins et al. ^[27] (1996)	Kenya	Negative (neutral)	Utilisation fell after user fees introduction, although by much less after phased implementation <i>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 re-introduced in 1992 was associated with much smaller decreases in utilisation</i>
Mbugua et al. ^[28] (1995)	Kenya	Negative	Utilisation fell after user fees introduction, with exemption mechanisms being ineffective <i>Attendance for outpatient and inpatient care in government facilities was lower when registration fees were charged than when fees were removed. Utilisation by children, exempt from fees, followed a similar pattern</i>
Mariko ^[29] (2003)	Mali	Positive (neutral)	Increases in user fees are likely to have only had a minor effect on utilisation of services <i>Quality of care is an important determinant of demand, with price increases only having a minor effect on utilisation. These could be offset if policymakers improve both the structural and process quality of care</i>

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Table I. Contd

Study (year)	Country	Impact on access: positive, negative or mixed?	Main finding (<i>with further details in Italics</i>)
Audibert and Mathonnat ^[30] (2000)	Mauritania	Positive	Utilisation increased following user fees introduction, through improved quality <i>Increases in utilisation were observed following user fee introduction as a result of better drug availability, with no evidence of severe negative equity effects</i>
Chawla and Ellis ^[31] (2000)	Niger	Positive (neutral)	User fees only had a negligible negative impact on utilisation of healthcare <i>No evidence of serious reductions in access following increases in formal user fee charges as a result of improved quality of care</i>
Diop et al. ^[7] (1995)	Niger	Positive	Utilisation increased following user fees introduction, especially when combined with an annual tax <i>Utilisation increased markedly in district with small fee plus an annual tax, compared with a pure fee-for-service method (negligible utilisation impact) and control district without fees (utilisation fell)</i>
Meuwissen ^[32] (2002)	Niger	Negative	Utilisation fell after user fees introduction, following nationwide implementation <i>Although previous pilot studies had shown that user fees would not adversely affect access, nationwide implementation led to more severe drops in utilisation in a number of health centres as a result of fee introduction</i>
Uzochukwu et al. ^[33] (2004)	Nigeria	Mixed	Utilisation of malaria services increased following user fees introduction, although the rich and educated benefited the most <i>Utilisation of malaria services increased despite the introduction of user fees as a result of improved quality (training of health workers and better drug availability), although the rich and educated were the principal beneficiaries</i>
Fabricant et al. ^[34] (1999)	Sierra Leone	Negative	The rural poor are disproportionately disadvantaged by fees, with exemption mechanisms ineffective <i>The burden of curative treatment costs came mainly from private and NGO providers, with the rural poor facing a high financial burden</i>
Abdu et al. ^[35] (2004)	Sudan	NA	Introduction of effective exemption mechanisms significantly increased utilisation <i>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</i>
Hussein and Mujinja ^[36] (1997)	Tanzania	Negative	Utilisation of outpatient services fell following user fees introduction <i>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 employers typically paid for private facility users</i>

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Table 1. Contd

Study (Year)	Country	Impact on access: positive, negative or mixed?	Main finding (with further details in italics)
Laterveer et al. ^[37] (2004)	Tanzania	Negative	Ineffective exemption mechanisms for user fees <i>Blanket exemption mechanisms (for under-fives, maternal and child health services, patients with selected conditions) are not working properly</i>
Kipp et al. ^[38] (2001)	Uganda	Negative	Utilisation of outpatient services fell following user fees introduction, although not universally <i>Utilisation dropped by 21.3%, although it increased in facilities located in remote areas as a result of better drug supply and other community projects</i>
Bias and Limbambala ^[39] (2001)	Zambia	Mixed	Utilisation fell for most services where user fees were payable but rose for fee-exempted services <i>Hospitals and health centres experienced an approximately one-third decrease for general attendances over a 2-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</i>
Zigora ^[40] (1996)	Zimbabwe	Negative	Utilisation fell following user fees introduction

NA = not applicable, NGO = non-governmental organisation.

2001, the US government required Congress to oppose any World Bank, International Monetary Fund or other multilateral development bank loan or grant that mandates user fees for basic health or education services as a condition (US Network for Global Economic Justice, 2003, as cited in McIntyre et al.^[1]). In the UK, statements by leading cabinet members have urged that patient charges be removed. And at the 2005 G8 summit in Gleneagles, Scotland, the leaders highlighted the specific issue of 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 healthcare (free wherever countries choose to provide this)."^[17]

Other agencies have emphasised the superiority of prepayment and insurance. For instance, the WHO urges countries to move towards prepayment as a more equitable solution than over-reliance on OOP expenditures.^[41,42] Further, WHO technical briefs emphasise the need for universal coverage while reinforcing prepayment, thereby avoiding catastrophic health expenditure in households.^[43,44] A WHO discussion paper advises countries to adopt a policy of free access for HIV/AIDS treatment and care at the point of service delivery.^[45] 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.^[46,47]

This paper provides some reflections on the recent user fees debate. It draws on the evidence presented and subsequent discussions at a recent UNICEF consultation on user fees in the health sector, and relates the debate to the wider issue of access to adequate healthcare. During the consultation, the pros and cons of user fees were debated, as were a range of policy options to deal with the

negative consequences of such fees in addition to fee abolition policies.

2. User Fees: What Can Recent Experience Tell Us?

Numerous studies have analysed the impact of user fees across a range of different settings. Their core messages are summarised in this section.

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, the impact on demand can offset the negative price effect. Providing they are retained by healthcare facilities, revenue from user fees can be significant when government systems fail to adequately move funds.

Therefore, the impact of user fees on access depends on the degree to which they lead to improved quality and also on the relationship between formal and informal fees. A wide literature on the effects of implementing user fees, particularly in sub-Saharan Africa, documents these experiences. Table I 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 to 2005. This is 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.^[2] Table I excludes studies which focused primarily on OOP expenditures as a whole, although these are discussed briefly later.

All but one of the positive examples of the impact of user fees on access described in table I came from West Africa. In these studies, the role of the Bamako Initiative in improving drug availability and accountability of providers to 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.^[20,21,48] On the other hand, evidence from Uganda, Kyrgyzstan and other former Soviet Union countries showed 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.^[49-51]

The majority of studies summarised in table I found a negative effect of user fees on equity of access. This was through reduced utilisation following the introduction of fees and/or the poor being adversely affected. Other studies on more general OOP expenditures also noted that the poor were particularly sensitive to prices.^[52-54] 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.^[55,56] Indeed, based on a meta-analysis of 18 antiretroviral treatment programmes in low-income countries, free access to antiretroviral treatment appears to be significantly associated with lower mortality.^[57]

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 I 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.^[58] For instance, facilities in Kenya rarely granted more than two waivers per month – an insignificant fraction of the 42% of Kenyans living below the poverty line. Waiver sys-

tems were somewhat more effective in only three countries studied (Thailand, Indonesia and Chile).^[58] Income-related waivers have proved very difficult to implement in low-income countries. However, waivers and exemption policies that target specific geographic regions, client groups (i.e. children, mothers) and services used by the poor have had both successes (e.g. a fee waiver system for pregnant women and children with malaria in Sudan^[35]) and failures (e.g. blanket exemption schemes for specific population groups in Tanzania^[3,4]).

A recent review of healthcare financing highlighted the methodological weaknesses of many of these studies,^[5] raising the need for a note of caution in the interpretation of the evidence base. For example, many of the studies are small in scale and few have been able to adopt experimental, or even strong quasi-experimental approaches, to overcome problems of selection bias. In addition, data are frequently longitudinal in nature but reflect only a relatively short timeframe and are often without an appropriate control group. Interventions are also usually 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 that determine the effectiveness of a policy in a particular context. Finally, results from facility-based data (in contrast to survey data) should be cautiously interpreted in analysing utilisation trends whenever there is an incentive to report changes in use. Future research must address these questions of methodology more systematically than has typically happened in the past before a policy option can be dismissed or promoted.

2.2 User Fees and Efficiency of Resource Use

The reduced use of services detailed in section 2.1 would be less of a concern if this primarily reflected 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. A commonly cited reason for this is the financial cost of healthcare.^[2] High travel and other non-healthcare 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.^[59]

As discussed in section 2.1, it is typically the poor who have been most negatively affected by user fees. Even when poorer individuals are able to access care, studies have shown that many of the poorer households have resorted to reducing consumption of food, self-medicating, seeing traditional healers and using various other coping mechanisms,^[1] or have had to endure catastrophic health expenditures.^[3] In such cases, insurance mechanisms are a more efficient strategy than user fees, in principle, since they counter uncertainty by pooling risks.^[60] In practice, the poor are rarely covered by formal insurance schemes (e.g. because they are limited to formal sector employees or civil servants). While community-based insurance schemes can provide risk protection for the poor, their positive effects in terms of reduction of OOP spending and revenue generation are small in magnitude and their coverage is limited.^[61]

2.3 Revenue Generation

Studies on official user fees have rarely found that they provide a large share of total revenue 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, not including administrative costs.^[59,62] Similar modest shares were found in other more recent reviews.^[63,64] Nonetheless, although the absolute amounts of money raised at the aggregate level are limited, the revenues have often amounted to important sums at the local level in circumstances where governments allocate limited resources to peripheral-level health facilities and where there are problems with the flow of funds from the centre to the periphery. In contrast, OOP expenditures typically account for at least 50% of health expenditures in low- to middle-income countries, and often more; for example, they account for almost 80% of health expenditure in India.^[65]

In addition, health services need a steady revenue stream to function properly. Staff have to be paid and storerooms stocked with drugs and supplies. In low- to middle-income countries where poor households often do not have the means to pay the full prices of such care, paying for healthcare on an OOP basis leaves healthcare providers vulnerable to irregular revenue flows. Prepayment and insurance is a much more equitable and efficient way to finance healthcare than direct user fees in principle,^[4] though in practice coverage of the poor by such schemes is limited.

3. What Other Barriers to Access Do the Poor Face?

The evidence summarised in section 2, while mixed, demonstrates that user fees often constitute an important barrier to access to health services, especially for the poor. However, user fees are only one barrier the poor face in accessing adequate health services, as has been shown across a wide variety of settings.^[66-70] The main barriers can be classified into cost barriers, of which user fees are one component, and non-cost barriers.

3.1 Cost Barriers

Besides user fees, there are also a number of other cost barriers. These, detailed below, can make up a significant proportion of the total costs that households face.

- *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,^[71] distribution is relatively equitable and providers exercise an *ad hoc* exemption policy according to ability to pay in others.^[72] 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 section 3.2.1 '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. This 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.^[73]
 - *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, and can be much larger in magnitude than user fees.
- These three cost barriers make up the types of direct OOP healthcare expenditures that patients can be confronted with. Furthermore, there are also:
- *Travel costs*: transport and other costs associated with travel to a health facility can deter or delay individuals from seeking care, especially in re-

mote rural areas without easy access to modern transportation. For instance, transport was found to make up 28% of total patient costs in Burkina Faso. It is also an important determinant of how long patients delay care across a number of other country settings.^[66]

- *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^[1] (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 subdivided into quality, information and cultural barriers. The examples that follow also impede access to services for the poor.

3.2.1 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 services offered being of inadequate clinical quality, particularly in the poorer regions of low-income countries.^[74,75] In the extreme, there can be an absence of services.
- *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.

3.2.2 Information Barriers

- *Lack of sensitisation on medical benefits of formal healthcare*: individuals may not be well in-

formed about the benefits of formal healthcare (both preventive and curative), resulting in underutilisation. This is typically more marked for those with little or no formal education.^[66]

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

3.2.3 Cultural Barriers

- *Stigma*: the poor and other marginalised groups (such as HIV/AIDS patients) may not make use of entitlements because of 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) because of there being no female health staff available.^[76]

3.3 Interactions between Different Access Barriers

Cost and non-cost barriers 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.

User fees can potentially increase the quality of care and, thus, reduce quality barriers (although the evidence summarised in section 2 suggests that more often the negative price effect outweighed any positive quality effect). User fees may also affect charges in private facilities. For instance, fee removal could 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 will reduce any stigma associated with seeking poverty-based exemptions but has no obvious effect on reducing the incompatibility of certain services (e.g. HIV testing) with cultural norms.

These examples demonstrate the significance of interactions between user fees and other barriers to access 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. Policy Responses

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 suggests 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 later in this section. One of the more frequently cited examples of successful recent fee abolition comes from Uganda. In Uganda, significant increases in utilisation of curative and some (but not all) preventive services were observed during the early phase of the reform. Early evidence suggests that improvement in utilisation was most marked for the poor, although the incidence of catastrophic expenditures among the poor did not fall.^[10-13] Interestingly, utilisation also increased in the private sector, where charges fell 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 because of 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 both compensated for loss of user-fee revenue and addressed other supply-side barriers to effective service delivery. These include increased budgets to compensate for lost fee revenue, active recruitment and increases

in salaries, and implementation of a sector-wide approach.^[77]

Other experiences come from South Africa, Madagascar and Kenya. In South Africa, fees were removed for pregnant and lactating women in 1994, and then removed for all people in primary health centres in 1997. Utilisation of curative services almost doubled but there were slight falls in preventive services.^[15] In Madagascar, utilisation doubled in 1997–8 after introduction of user fees but then decreased sharply in 2000 during a period of political turmoil.^[78] Subsequent elimination of fees was associated with a 21% increase in utilisation.^[14] However, upon closer examination of data, part of the reason for the initial increase in utilisation was that many patients were returning two or three times for the same illness because they were not being fully treated during their first visit as a result of the lack of drugs or supplies. Consequently, fees were re-introduced in 2003, mainly because alternative financing mechanisms were not adequate, resulting in drug shortages.^[76] In Kenya, user fees were also removed temporarily in 1990, with a 41% increase in utilisation in government health centres.^[79] Since 1990, fees have been reintroduced (with subsequent financial access problems), then replaced in 2004 by much lower and flat registration fees.^[80] These experiences suggest that the impact of fee policies needs to be assessed over several years and should 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; for example, high impact services such as deliveries or treatment of childhood illnesses rather than general outpatient visits, as well as ascertaining 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.^[81] It estimated that 153 000–305 000 (4.1–8.2%) deaths of

under-5-year-olds could be prevented annually across 20 sub-Saharan African countries if fees were abolished. The study stressed that the projected gains would only be achieved if policy makers establish other measures that support the lowering of other access barriers, particularly viable alternative financing mechanisms (see below). 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, along with increased budgets to offset lost revenue.^[82] Still, these experiences suggest that user fee abolition can lead to sustained improvements in access if its implementation is properly managed.

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 subsidisation of the premiums for the poor. Equity funds operate as a means of addressing the conflict of interest faced by health workers in managing an exemption system. They use local government or community-based mechanisms for identifying the poor (rather than health workers themselves) and provide a third-party source of funding for patients who cannot afford to pay. This means that there is no direct loss of facility revenue associated with granting an exemption. Potentially, equity funds offer better targeting of subsidies than fee abolition, but may also have higher administration costs, since the equity fund requires careful management. Equity funds have recently been 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.^[83] This will be tested by the current rapid replication throughout the coun-

try. Vouchers for selected health services have also had some success in improving access for vulnerable population groups, although they have typically been small-scale. However, there are only a few examples from low- and middle-income countries.^[66] Conditional cash transfers (although funding users rather than the health system) in Latin America have also improved coverage of key child health interventions.^[84]

More generally, the expansion of various prepayment schemes has been on the international agenda.^[85] These include social, private and community-based health insurance, as well as tax-based financing. All aim to protect individuals from health expenditure variance. However, 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. There is strong evidence that the better-off capture disproportionate shares of government health service expenditures,^[86] even where services are free, *de jure*. Recent experience in Ghana indicates that if the insurance premiums of the poor are subsidised, low-income groups do not need to be excluded from such schemes. In Rwanda, enrolment in microinsurance schemes recently increased to 55% of the population because of a partnership with micro-credit organisations and local banks.

Unfortunately, progress towards expansion of prepayment and eventual universal access at low income levels remains elusive. Evidence is emerging that most countries in the Africa region, with a few notable exceptions, are not progressing towards the Abuja target of 15% of government spending on health. In many countries it is still <7% and is as low as 3–5% in some. Expanding the overall fiscal space is often not an option.^[87]

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 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.^[68]

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 these problems. This pertains especially to the case of securing access to basic health services for the poor and other vulnerable populations, and in protecting households against the effects of expenditure variance that often occurs in the case of acute illness.

A number of lessons relate to user fees:

1. User fees are an important barrier to accessing health services, especially for poor people. They also impact negatively on adherence to long-term expensive treatments. However, this is offset to some extent by potential positive impacts on quality.
2. User fees are not the only barrier that the poor face. As well as other cost barriers, a number of quality, information and cultural barriers are also important.
3. Initial evidence on fee abolition in Uganda suggests that it has improved access to outpatient services for the poor. For this to be effective, fee removal needs to be part of a broader package of reforms that include increased budgets to offset lost fee revenue.
4. Implementation matters. If fees are to be abolished, this requires communication as well as stakeholder buy-in, careful monitoring to ensure that official fees are not replaced by informal fees, and appropriate management of the alternative financing mechanisms that are replacing user fees.
5. Context is crucial. In particular, removing fees will only affect utilisation where cost is a major

barrier. Furthermore, health systems need to be functioning at a level where the quality of services is adequate and the public sector will be able to continue to provide facilities with drugs and other supplies. Political support is important to ensure effective implementation. For instance, immediate fee removal in Cambodia would be inappropriate, given that the current fees replaced irregular and often high informal fees. In this context, equity funds and eventual expansion of health insurance are more viable policy options. Conversely, in countries where user fees have had significant adverse effects on access and generate only limited benefits, fee abolition is a more attractive policy option.

Removal of 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 investigating how best to dismantle the multiple barriers to access in specific country contexts.

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