SELECTED SUMMARY

Alternatives to user fees for public health care

BASHIR MAMDANI[1]

[1]**Retired physician, 811 N Oak Park Avenue, Oak Park, Illinois 60302 USA e-mail: bmamdani@comcast.net**

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Poor people use preventive and curative public health care services far less than the well-off. User fees, a widely used strategy to supplement governmental resources, further aggravate the situation. Five years after Uganda eliminated user fees at government health facilities, outpatient attendance, particularly by the poor, doubled. In Cambodia too there was increased use of health services by the poor in hospitals participating in third-party insurance schemes, or health equity funds, which waived fees selectively. This demonstrated that there was a huge unmet need for health care.

Should scarce health resources be provided to all or selectively to the poor in a low-income country? The authors discuss the experience of Uganda, which eliminated user fees, and Cambodia, which established a health equity fund to finance care for the poor. They identify some key issues that national policy makers should consider before formulating a strategy.

Barriers to health care

One barrier to health care for the poor is the cost; any reduction in the price of health care will increase demand provided there is adequate capacity. Hence, Uganda provided additional manpower and resources when eliminating user fees. However, "free" health care is not really free: the user has to bear the cost of transportation, food, loss of time from work, etc. These costs are probably the main reasons why even after user fees are abolished, the better off benefit more from the subsidised services than the poor. Cambodia's health equity funds attempt to mitigate these hidden costs by not only paying for hospital fees but also reimbursing patients for transportation, food, and other necessary expenditures. A social worker assures that assistance is tailored to the patient's needs and guarantees that no informal fees are charged, or that patients are not referred to private clinics by corrupt health personnel.

Targeting beneficiaries

When health care at public clinics was made free for all, the Ugandan government hoped that poor people would use the free health care more often than the better-off. On the other hand, the Cambodian health equity funds relied on a proxy means test applied to the applicant household. If the intent of a policy is to target benefits only to the poor, the universal exemption in Uganda is inefficient as the better-off got more care than the truly poor. However, the Ugandan policy was able to gain wide political support; it limited administrative costs by eliminating means test; and it avoided stigmatisation of the target group. The proxy means testing is costly and when most of the population is living in poverty, sorting out the very poor from the marginally better-off is not cost-effective. The means that the test becomes more cost effective if the proportion of poor people in the society is not overwhelming; if it is easy to identify the socio-economic status of the households; and if a differentiated response between poor and rich is culturally and politically acceptable.

Resources

With limited resources, rationing of health care is inevitable. User fees are the main mechanism for rationing of access to largely under-funded health services. Abolishment of user fees without a compensatory increased funding would create alternative rationing mechanisms - e.g. the exclusion of some geographical areas, limited benefits, queues, or drug shortages. This rationing might be unacceptable for those able to pay, which would result in bribes and non-transparent payments. Uganda tried to assure adequate funds before abolishing user fees nationally, yet the overwhelming demand resulted in a shortage of resources, which brought about corruption.

User fees are an output-based payment because the health facility gains income only if services are delivered, whereas in an input based system, the government pays fixed wages and supplies drugs. Thus the health facility gains resources irrespective of its output. In terms of quality of care, responsiveness to users, and efficiency, the difference in payment methods is important. If the health care staff can keep a part of the income raised by their output, they have an incentive to secure user satisfaction. But a focus on quantity of services neglects quality of care and emphasises income-generating curative care activities rather than preventive care services, which are less lucrative. Under input based payment, the income of the staff is constant and unrelated to performance. Under this model the staff tends to improve their own well-being by reducing their workload - e.g., by hampering use of health services through long queues or drug shortages or by degrading the quality of services such as under-investment in amenities.

In Cambodia, the health equity funds relied on an output-based payment regimen while Uganda followed the input-based model. One option is not necessarily better than the other. In some settings, the under utilisation of services is largely attributable to the poor quality of these services, which can be partly explained by little accountability through the civil service hierarchy. Output-based payment can then contribute positively. In other settings, the general governance of the health system allows the community to have enough voice in the operation of health facilities, and therefore an input-based approach would be preferable.

Process of reform

We can also compare implementation of policies, largely funded by international aid, between Cambodia and Uganda. In Uganda, the abolition of user fees was a decision by the government. The policy changes were introduced rapidly on a national scale. Factors that facilitated this approach included reforms in governance that secured additional foreign aid, and firm commitment of the central government to ensure a uniform nationwide distribution. Conversely, the initiative in Cambodia first came from projects of international agencies and local NGOs. Recently a national policy for health equity funds has been written and the Cambodian government plans to contribute to fund the strategy but the resources committed to the strategy do not allow for a nationwide extension.

Conclusions

Unfair public health systems are not inevitable. Before formulating a policy, we need an in-depth understanding of the local needs, constraints, and opportunities. In Cambodia, external stakeholders, suspicious of the government, relied on local NGOs. With the health equity fund model, donors, the government, and the civil society found a way to work together. The Cambodian model showed that user fees could be waived selectively so that only the poor benefited and failure of similar waiver programmes in other low-income countries could be due to poor policy design and under-funding. But the speed, scale, and scope of the reform are important. A gradual progressive building of capacity, like in Cambodia, runs the risk of never being completed. Also, the Cambodian model of selective waiver may not be acceptable in many countries. Abolition of user fees is more likely to be accepted and is also desirable but was felt to be unachievable in a poor country. Yet, Uganda showed that this is not necessarily the case. A financing policy favourable to poor people is much more about national politics, political economy, and social justice. National political resoluteness will remain the key resource to improve equity in health systems.

Discussion

How did the concept of user fees come about? In the early 1980s, the IMF and the World Bank became the major lenders for developing countries. This gave them the leverage to force debtor nations to adopt stringent economic reforms called structural adjustment programmes (SAPs). SAPs mandated "... massive deregulation, privatization, currency devaluation, social spending cuts, lower corporate taxes, export driven strategies, and removal of foreign investment restrictions (1)." Consequently, health and education suffered drastic cutbacks. To compensate for the loss of government funding of health care, the World Bank recommended imposition of user fees on patients. Gradually the recipient governments and indeed the WHO and the UNICEF came to support user fees "... not ... as austerity measures, but providers of stable, efficient, equitable and participative social sector financing (1)." User fees supplemented staff salaries, purchase of drugs, and books, and so on. Theoretically, user fees also gave the users -- the patients -- a say in how services were provided.

However, objective studies showed that user fees raised fewer funds than projected, and were clear disincentives for the poor. Official corruption and a lack of accountability further depleted the available funds. In 2000, these concerns led several NGOs in the US to pressure the US Congress to require the IMF/World Bank to modify loan conditions for developing countries. In 2004, the World Bank came up with "no blanket policy on user fees": "you should provide the service free unless there is a good reason to charge for it ...The main question now becomes: 'whether you can distinguish poor people from the non-poor'. If the answer is yes, you can exempt them. If the answer is no, then you need to decide whether the service can be adequately delivered without user fees (1)." In most cases, with existing resources, services cannot be adequately delivered without user fees.

The article summarised here exemplifies two possible approaches for a country like India. Uganda, as well as Tanzania and Malawi, have abolished user fees altogether. The huge subsequent increase in service utilisation shows the extent of the unmet demand. In Uganda, with the availability of additional funds from donors, the overall experience has been positive. Without the additional funding, the excess demand has led to denial of service to some and deterioration in quality overall. The other possibility is for India to adopt the Cambodian model of selective waiver of user fees in partnership with NGOs to check corruption and assure accountability.

The public health care system of independent India evolved from the colonial heritage of state sponsored free curative services for expatriates in colonial enclaves and, after independence, constitutionally mandated free medical care for all (2). Public health and sanitation have been given low priority in the current structure. The Bhore Committee report (1946) guided the first 30+ years of the government health care system. Emulating the British National Health Service but without the social security net or the public health and sanitation infrastructure of Britain, the five year plans set up a network of primary health centres (PHCs) and district and regional secondary and tertiary care hospitals. The indigenous system of medicine, which a great majority of people relied on, was ignored. Nor was any attempt made to integrate the private sector into the overall health care structure (2). A comprehensive national health policy of a low-cost, decentralised, community-based network of physicians, para-

professionals and volunteers was enacted in 1983 after Alma-Ata. The system was supposed to be self-reliant and respond to community needs. But "under-funded and unfocussed ... the implementation has been patchy with limited community participation. At the same time, benefiting from hidden subsidies, the private sector, providing acute curative care in predominantly urban setting, has flourished (2)."

Health planning in India remains "... centralized, ... top down and largely technocratic and managerial backed by no social imagination (2)." There is no real community involvement. "Indian political and administrative traditions tend to focus on government as the fount of policy financing, ownership and management ... a vast private sector in health care in India has emerged to serve those in urban areas and able to pay fee for service. ...supplemented by indigenous systems of medicine and a network of less than fully qualified practitioners in rural areas dealing with common illnesses at varying levels of competence (2)."

Health spending in India at 6 per cent of GDP is among the highest for developing countries. Public health spending accounts for 25 per cent of aggregate health expenditure; the balance is out of pocket expenditure. After economic liberalisation, government spending declined from 1.3 per cent of GDP in 1990 to 0.9 per cent in 1999. In the various states it has declined from 7.0 per cent to 5.5 per cent of the state health budget. As the poor are forced to pay more for health care at expensive private facilities, many forego care entirely except in dire emergencies, which often lead to indebtedness. The persistent under funding of health care has led to the collapse of primary care in many states (2).

In some states, large public hospitals have been made autonomous to generate additional revenues from user fees, contracting out services, streamlining formularies, and purchasing of drugs and supplies. PHCs have been handed over to NGOs and to private companies. "The key lies in committed public policy backed by national commitment and social imagination, keeping, as Amartya Sen persuasively argues, a balance between growth-mediated or support-led development paths as may be appropriate to the country's current stage of development (2)." With its phenomenal economic growth India can no longer claim to be a low-income country such as Uganda and Cambodia and it should not receive external funding to carry out health reforms. Given the fractured political structure in the country of weak coalition governments at the centre and many regional parties in power in the states, it is difficult to imagine India implementing a coherent policy to provide free or affordable social services to the poor in the immediate future.

As the authors of the article point out, "free care" is not completely free and user fees may not be the major barrier to social service. The user still faces burdens of geographical access, transportation (often non-existent), loss of income, etc. These problems cannot be solved by elimination of user fees. The Cambodian experiment attempts to address these deficiencies. As Hutton (1) concludes, "For poor countries, two main alternatives exist: abandon user fees and boost revenues from other sources or reinforce user fees while strengthening exemption systems. The latter approach does not guarantee that poor people are saved the costs of basic health services due to imperfect targeting, or that the non-poor will not benefit from subsidies (leakage). In the debate, realism and honesty will be necessary to arrive at the optimal solutions."

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