

Should low income countries increase health system funding by increasing user fees?

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Health systems in low income countries are confronted with a seemingly impossible task - to provide healthcare to rapidly expanding populations with inadequate human resources, poor infrastructure and lack of essential drugs. In particular, the rising financial costs significantly limit capacity to deliver both curative and preventative interventions to those populations in greatest need.

In most low income countries, the government acts as both the provider and purchaser of healthcare services. However, public expenditure on basic amenities, such as health, is limited by high levels of debt re-payment and loan conditions that erode state autonomy over budgetary decisions at a national level. Ethiopia, for example, has external debt amounting to more than 100% of its gross domestic product, which significantly limits funding of public services [1]. As a result, governments in poor countries often feel they have no alternative source of additional

finance than the users of the health system [2].

What are user fees?

User fees were first introduced during the 1980s and 1990s to compensate for fiscal shortfalls created by the broader economic 'structural adjustment programmes' instituted by the World Bank. These programmes outlined certain requirements, such as limits on public healthcare expenditure, which had to be met in order to qualify for a loan. The term 'user fees' refers to official charges for specific medical services at public health facilities, with such charges intended to improve the quality and efficiency of healthcare services as well as raise revenue. However, the ability of user fees to achieve these outcomes has varied and studies have shown that contributions to health funding may be minimal [3]. Furthermore, it has been argued that the regressive nature of such charges contributes to inequity within health systems [4]. So do user fees actually increase funding for health systems and if so, under what circumstances is such a policy acceptable?

Do user fees increase revenue?

In most low income countries, healthcare was formerly provided at nominal cost and so it should be axiomatic to state that introducing user fees increases revenue gains. The ability of user fees to provide 'profit' for reinvestment is often used as a measure of policy success, with initial modelling for

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user fee efficiency predicted cost-recovery ratios approaching 15% of recurrent expenditure. However, this has not been achieved in practice and often the actual revenues raised from user fees are far less than the predicated estimates [5]. In addition, if income generation becomes the sole objective, rather than an outcome, of user fee policy it is often to the detriment of spending on preventative interventions which lack immediate cost recovery potential [4].

Previously, Ghana proved to be an exception, achieving more than twice the average figures for revenue from user fees. This made a significant contribution to budgets of health facilities in the country [6]. Some small-scale studies have demonstrated markedly higher revenue generation, implying that inefficient cost-recovery may simply be a reflection of poor implementation rather than an inherent failing in the user fee policy [7]. Significantly, Ghana has now abolished a user fee system in favour of a social insurance scheme which has been more successful in providing universal healthcare coverage [8].

In practice, the ability of user fees to efficiently raise revenue appears to be partially dependant upon the operational circumstances within which the policy is applied. Administrative capability is crucial in achieving maximal cost-recovery, as inefficient systems consume a larger proportion of resources which, in turn, limits the amount available for direct reinvestment in healthcare provision [9]. However, administrative expenditure is also determined by the pricing structure of user fees and if a system of waivers or exemptions are employed. A sliding-scale involves some method of determining eligibility. This is more complex and thus administratively more expensive than charging a simple flat fee for services [7]. Similarly, identification of individuals who qualify for free healthcare imposes an additional administrative burden on healthcare staff, which in itself requires extra funding. Nevertheless, these mechanisms are necessary to preserve equity within health systems and so must be factored into calculations of cost-recovery.

Do user fees improve health services?

The success of user fee policy is influenced by both the distribution of revenue gains and the level of

community involvement in managing facilities. If a significant proportion of the revenue from user fees is retained at the local level, it may be used to directly improve service quality or provide incentives for staff to increase efficiency. A high level of community participation can also ensure greater accountability amongst health service providers [10]. This in turn promotes utilisation of services, therefore generating greater financial gains from user fees.

Arguably the most important factor in determining the capacity of user fees to improve service provision is the extent to which price dictates the level of utilisation of health services. This 'price elasticity of demand' exhibits considerable variation across age ranges, income groups, geographical area and level of healthcare [9]. It describes the critical balance between the charge for access to services and the number of people willing to pay. However, user fees are not intended to increase the amount individuals spend on healthcare— rather, the aim is to re-capture money spent in the private or informal sector as a result of poor service and scarcity of drugs in public facilities [11]. Nevertheless, it has become clear that the increased costs associated with user fees adversely impacts demand for health services, particularly among lower income groups [12]. This is to the detriment of health systems as they precipitate a decline in utilisation. If this falls below a certain critical threshold, targets for revenue capture are not met and the quality of service provision deteriorates further.

Do user fees provide any advantages?

User fees may provide more indirect financial benefits to health systems in low income countries. If user fees recover a significant proportion of recurrent costs for curative services, then a greater proportion of resources could be directed towards the expansion of preventative interventions. Extending immunisation coverage, for example, provides health gains at population-level and reduces the burden of treating communicable disease. Another advantage, highlighted by the proponents of user fees, is that charging for services deters "frivolous" use. However, this has been strongly refuted as in many countries, the costs associated with accessing care are often substantial [13]. In other words, given

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that users were already committing considerable personal resources to accessing healthcare, they were unlikely to be 'misusing' services. In such circumstances, user fees could be seen as an added burden rather than a justifiable 'gatekeeper' preventing the inappropriate use of health services.

User fees may promote efficiency in the referral system and allow the burden of care to be more appropriately distributed between primary healthcare facilities and district hospitals [14]. However, this is only successful if a graded fee-scale applies to different levels of healthcare and for different services. By implementing high fees at secondary care facilities, both patients and doctors would be encouraged to use primary healthcare where appropriate, thus allowing hospital staff to treat those with more serious illness. It may be argued that user fees have potential as an effective mechanism for cost-recovery, but only if administrative systems are able to facilitate efficient fee collection and the negative impact on utilisation offset by improvements in the quality of service provision at all levels.

What are the disadvantages of user fees?

The fact remains that low income countries are still unable to mobilise sufficient resources to provide adequate healthcare for all, despite the widespread prevalence of user fees. One explanation for this may be that charges have not been adjusted in line with inflation and so represent a smaller proportion of operational costs [6]. It would be reasonable to assume that the simplest way to supplement existing health budgets would be to increase user fees to reflect the current cost of service provision. However, this may not be the most appropriate solution as the financial gains achieved through user fees are often at the expense of equity.

The introduction of user fees typically produces a marked decline in service utilisation by those in the lowest income brackets, indicating that user fees restrict the poorest sections of society from accessing healthcare. Conversely, abolishing user fees in Uganda removed this barrier which prompted a notable increase in demand for health services, particularly by the poor [15]. The costs of healthcare are often more significant for those in lower income quartiles

as out-of-pocket expenditure consumes a higher proportion of the domestic budget. Therefore, user fees contribute to inequity by excluding vulnerable populations from accessing even basic health services.

This potential for inequity was recognised by the World Bank, which proposed that an effective waiver system would mitigate any negative effects and avert catastrophic levels of spending on health [11]. The success of such schemes, however, is dependant on the ability to distinguish the 'poor' from the 'non poor'. In theory, means-testing should allow targeted subsidy of healthcare for those on the lowest incomes. Evidence from Colombia and Chile indicates that it is often difficult to develop sufficiently stringent criteria, as there may be considerable incentives for 'non-poor' to lie [13]. In addition, poverty levels are often high and so the criteria for exemption must take into account the availability of financial resources to reimburse health facilities.

Inequities are further compounded by widespread corruption in many countries, which diverts revenue from reinvestment in vital services to line the pockets of those responsible for administering the system. This may be multi-tiered, from healthcare workers accepting informal payments to government officials siphoning income from public funds [16]. Effective policy and strong governance is needed to break the culture of endemic corruption and restore capital to healthcare budgets.

To resolve any issues of inequity associated with user fees, mechanisms to safeguard the poor must be in place. Absence of an effective waiver scheme increases the risk that public health systems become orientated towards achieving profit, at the expense of providing care for the most vulnerable groups in society.

What are the alternatives?

Over the last few decades, the political support for user fees has declined and alternative methods of health system financing debated. The World Health Organisation advocates prepayment schemes as a viable solution, providing a risk pooling mechanism to avoid catastrophic spending on health. Similarly, the World Bank now supports the

introduction of community insurance schemes to rationalise private expenditure and increase access to health services [17]. However, the predicted benefits are subject to effective implementation and there is limited evidence of success in practice.

The role of OECD countries in supporting the development of sustainable healthcare financing in low income countries is also a factor. Use of donor money has been advocated as solution, but increased reliance on aid is unstable as a basis for healthcare funding. Further calls have been made for the G8 leaders to follow through on commitments for debt cancellation, thus increasing the proportion of the national budget available for health services. This would also support African countries in achieving targets for tax funding, as set in the Abuja Declaration. Nevertheless, there is evidence to suggest that there may be significant gains associated with user fee abolition - by one estimate, removing fees for basic healthcare could prevent approximately 233,000 deaths (6.3%) in children under the age of 5 across 20 African countries [18]. However, this requires sufficient planning, leadership and resource mobilisation to allow health systems to cope with increased demand for services following removal. The examples of Uganda, South Africa and Ghana have shown however, that it can be done.

Conclusion

The continuation of user fee policy on the basis of financial pragmatism is questionable. Although charges do increase resources for health service provision, the level of cost-recovery achieved is often considerably less than expected. This is attributed to inefficient collection systems and lack of administrative capacity, both of which limit revenue gains. In addition, measures to offset the regressive impact of user fees and preserve equity are largely ineffective as the theoretical basis for waivers and exemptions overlooks the practical difficulties of implementation. If the poor are prevented from accessing basic services, then justification for using fees as a mechanism for improving the efficiency and quality of healthcare is debatable.

Considering the current limitations, it would appear that user fees are not the most appropriate way to maximise funding for health systems in low income

countries. Calls to remove user fees entirely have cast further doubt over their role in healthcare financing. The World Bank now acknowledges that as fees exacerbate inequality and that alternatives such as collective insurance schemes are preferable.

However, it is unlikely that significant policy change will occur in the immediate future as governments that have introduced user fees relatively recently, often as a direct response to requirements for donor funding, are now looking sceptically at the call to remove them [19]. Although several African countries have demonstrated that abolishing user fees is possible, further problems are created in the absence of sufficient planning, political commitment and supplementary funding.

There appears to be no universal solution to achieving sustainable healthcare financing in low income countries. However, it is vital that any policies consider the potential implications on equity as well as the capacity to raise revenue. This is the only way to ensure that health financing is truly sustainable.

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