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Issues Paper: The Case for Abolition of User Fees for Primary Health Services

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EXECUTIVE SUMMARY

i. Improving access to basic health care can help accelerate progress towards the MDGs. Cost is usually the major obstacle preventing the poor from accessing basic health care. Improving the affordability of essential health care services requires measures aimed at reducing *all* costs - whether they are official fees, informal out of pocket payments or indirect costs such as transport. User fees contribute to the financial burden although in many countries they are not the most significant financial barrier to access. In most countries a high proportion of basic services are provided by the private sector at market prices and although the poor are more likely than the better off to use lower cost services provided by the public sector they still make heavy use of the private sector This comes at a cost with such health expenditures driving many into poverty. Overall public funding for health is extremely low in most of DFID priority countries; it is also poorly targeted. This partly explains the fact that the better off have much better access to services and enjoy better health outcomes. In around a quarter of the countries the problem is not the lack of progress towards the MDGs – it is that health indicators are actually getting worse.

ii. The case for removing official user fees for primary health services is strong. They raise little money and rarely meet their stated efficiency and equity goals. They are often associated with reduced utilisation of services especially by the poor and vulnerable (resulting in greater reliance on often inappropriate forms of self treatment), a failure to complete treatment (resulting in problems of drug resistance) and delays in seeking treatment (resulting in worse health outcomes). Although, user fees rarely present the most important financial barrier they are the one most amenable to policy action. As the recent experience in Uganda shows that with sufficient political commitment the elimination of fees can play a catalytic effect in forcing Government to confront other issues such as financial management problems and drug supply and procurement which pose further barriers to progress. In some countries abolishing user fees is seen as the only viable exemption policy. Nonetheless they tend to be kept in place by powerful vested interests – e.g. by health workers whose rewards are directly affected by user fee revenue.

iii. Removing fees needs to be accompanied by a range of actions including increased and well directed funding (above and beyond the loss of fee revenue) if it is to lead to sustained improvements in access for the poor. It would require additional funding to allow quality to be maintained in the face of increased demand and to increase health worker pay to increase productivity as well as an effective communications strategy to make the case to those likely to be affected by the changes. If Governments abolish fees and do absolutely nothing else (and ignore the caveats and requirements for complementary reforms) it is highly unlikely to lead to sustained improvements in the long term as experiences in Zimbabwe, South Africa and Kenya suggest. It could even make things worse.

iv. Clearly removing user fees is not a panacea. In many circumstances, though, it could reduce the currently unaffordable financial burden faced by poor people. Where user fees are undermining equity or efficiency goals DFID should be willing to support Governments wishing to implement such a policy as part of a balanced and well considered programme to improve access and address poverty.

v. The case for having a blanket DFID policy on user fees for basic health is highly questionable. Firstly, user fees can, in some circumstances, improve access. User fees have been associated with increased utilisation of services in some settings. The Bamako initiative appears to have improved the relative affordability of services in many settings. Experience with equity funds in Cambodia also suggests that user fees with effective (and

fully funded) exemption systems can improve quality of services, increase access and also offer significant protection to the poor. This approach also has the potential to address indirect costs and this is currently being piloted. Secondly even if user fee abolition does make sense it can be argued that it is actually a relatively minor issue in terms of the overall poverty reduction agenda (see para viii). Indeed in a number of countries advisers felt that abolishing user fees would make no difference. Thus, whilst it may make some sense to support user fee abolition as "a" DFID policy it does not necessarily warrant being the" next big DFID policy". (Why not the push the Abuja Declaration target of 15% of Government spending on health which would more than pay for the abolition of user fees if that's what Governments want?). There is general consensus from advisers against a blanket approach to the extent that it would be seen as DFID trying to impose its views on others. However, there is some support for the view it would help as Governments would at least know where DFID stood and could still choose to ignore the position if they chose to do so. Views on Government response to a blanket policy ranged from the very positive "a helpful signal which can help break the log jam" through "bewilderment" to very negative "we risk losing credibility and losing our seat at the table" or "they work reasonably well, Government is committed to them and we'd be better off working with them to improve their implementation".

vi. The issue is clearly context specific depending heavily on where Government is coming from and on its capacity and commitment to implementing such reforms. There will be many countries where user fee abolition is well recognised as sensible policy and could potentially play a catalytic role opening the door to a wide range of reforms, where Government is receptive to policy change (presumably with financial assistance) and where a strong DFID statement and funding could make a difference. There are also countries such as Nepal and Zambia which are not convinced that eliminating user fees make sense now but would be interested in entering into a dialogue on the issue and building up a body evidence to support future policy changes where a clear line would help. In a number of countries there are no formal user fees for primary services anyway and the issue is irrelevant. However, there will be countries who, rightly or wrongly, believe user fees are playing a positive role or where alternative approaches are being followed. There will be cases where Government is committed to continuing or increasing its reliance on user fees - sometimes even in the face of clear evidence that it reduces access for the poor. Advocacy for abolition could be, at best, a waste of time and at worst counterproductive. It also has to be recognised that there are alternative, and arguably more effective, ways of achieving equity objectives. Countries such as India, for example, emphasise the importance of channelling budgetary resources towards primary health care. Others focus their efforts on the development of risk pooling mechanisms or on system strengthening. Ghana, for example, is attempting to replace user fees with premiums through the development of a national health insurance scheme. Where such participation is voluntary user fees can provide an incentive to enrol in risk pooling schemes. Here, user fees need to be seen in the broader context – the real question is whether insurance type mechanisms are capable of promoting better access for the poor. In short the case for user fee abolition needs to be assessed on a case by case basis.

vii. Are there rough rules of thumb to suggest where user fee abolition might work? Some suggested that abolition may make sense in settings where spending is at reasonable levels, with a sensible balance between prevention and cure, primary, secondary and tertiary care with prospects for future increases, where systems are reasonably robust, where there is a community/civil society voice and there is strong political commitment. This may be true in Uganda, South Africa and Tanzania, possibly in Ghana and Zambia, probably not in Kenya and almost certainly not in Nigeria and Ethiopia and countries emerging from crisis

viii. The case for promoting a specific policy advocating for the abolition of user fees for basic health care would therefore seems to be as much a tactical one as a technical one. Whilst it will almost always be a sensible technical measure in itself its main value would be as a possible entry point into the broader reform agenda providing a "quick early win" to kick-start any reform process. The policy could be seen as symbolic having an impact well out of proportion to its own limited scope. It would generally be highly popular with the public and easy for politicians to grasp and run with.

ix. Do we completely miss the point by focusing on user fees for basic health care? Firstly, it is the fees associated with hospital care and chronic illness and not at primary care levels which cause the greatest financial problems. Secondly, other financial constraints such as indirect costs and informal user charges are often far more important. Thirdly, there are also significant non financial barriers to accessing health care. Fourth, and perhaps most importantly, the private sector delivers most primary health in most countries and even poorer groups are more likely to use the private than public sector. Lastly, it can be argued that user fees have typically been seen as residual funding or as gap filling. As such they are a symptom of an underlying problem – the failure to allocate adequate resources to primary health. This would suggest DFID focus on the causes (lack of budgetary support for primary health care) rather than the symptom (the need for user fees).

x. An alternative approach would be to put forward a broader message – that DFID policy is to make essential services more affordable to poor people. This would clearly highlight the underlying concern but be more open to different country led approaches to addressing the issue. Within such a policy it would still be possible to say that, in general, DFID does not support user fees for primary care.

xi. In considering a line to take DFID needs to be clear on:

- what is meant by essential or basic services? A narrow definition could be taken to mean services with significant public health benefits (externalities) and preventive services provided at primary care level and exclude curative services provided at primary care level where the benefits accrue only to the individual. A broader definition might include all services provided at primary levels. An even broader definition might include selected additional services, such as essential obstetric care, which can only be provided at higher levels but which are essential for the achieving the MDGs. It also needs to be recognised that much primary care is delivered at hospital level

- what is actually meant by user fees and where we draw the line?

  - if we are talking about primary care – do we also consider water and sanitation, nutrition and education as set out in the Alma Ata Declaration?

  - how do we deal with current issues of under funding in the public sector? We can abolish fees for drugs but if they are not available in health facilities people will still have to go to purchase from pharmacies? So are we talking about advocating for the abolition of the Bamako initiative and fully funding drug requirements for PHC? What about social marketing?

  - are we just talking about fees for services provided in the public sector? What about services provided by NGO or mission facilities on behalf of Government as is the case in a number of DFID PSA countries? Should

people be disadvantaged just because they live next to an NGO rather than a Government facility? Taking this argument further – what about the vast majority of primary health services which are typically delivered in the private sector?

xii. Estimates of the cost implications are crude and highly dependant upon how the issue is defined and likely take up at the country level. Some countries also expressed an interest in *how long* additional funding would be available as opposed to *how much* on the grounds that reforms always have unintended consequences which may required additional funding to address. In broad terms if it were a sensible policy and if all countries were responsive to the approach the cost of reimbursing countries for lost user fee revenue would be of the order of $80m for all countries except China. In China the cost could be huge ~ $2.7bn given that fees account for at least 80% of facility spending in rural areas. Support to meet additional demand could cost *up to* 5 times these amounts.

xiii. This might be enough to deliver the current *inadequate* range of services. Funding to provide a *decent* package of essential services free at the point of delivery would cost much more. Increasing spending on essential drugs could cost up to $4bn and increasing public spending to levels required to deliver a comprehensive package of essential services anything from $17bn (WDR 1993) to $88bn per year (CMH 2001). Costs of making NGO services free would also be significant in a number of countries. More work would be required at country level to estimate actual needs; more needs to be done at country level to track expenditure levels and allocations (through NHA type exercises).

xiv. Would it make sense for DFID to link the issue with direct financing? Countries would presumably expect it but would such an earmarked and "projectised" approach be consistent with broader moves towards promoting Government leadership and the use of unearmarked budget support? Again views varied from it being "absurd" to link the policy change with direct funding to a more pragmatic view that it would not happen unless more resources were on offer There are also concerns about how such resources would be channelled where there is little confidence in financial management arrangements. The lack of data and different practices mean that it would be difficult to estimate how much would be required and the decentralised or federal systems in place in many countries would add further complexity to any negotiation process.

xv. The pros and cons of a range of policy stances are spelt out in the paper. A possible alternative line to one focused solely on user fees would be to take a broader approach which, although less succinct, may have more global relevance:

- DFID supports countries' efforts to ensure universal access to essential/basic health services that deal with the major causes of ill health, disability and death;
- DFID recognises that reducing the financial barriers which currently prevent access could make a major contribution to this goal and will support countries in their efforts to this end.
- DFID believes that in low income countries such services should be provided free of charge at the point of use where current approaches compromise equity goals and where the necessary complementary actions are adopted and it forms part of a balanced and well considered programme to improve access and address poverty.

This would still raise questions: how are essential services defined? would the policy apply to all countries or only low income countries and would it apply for all of the population or just those whop cannot afford to pay

1. INTRODUCTION

This paper addresses the following issues:

- Do formal user fees for basic health care present a major financial barrier preventing the poor accessing basic health services?
- Is there a case for the abolition of formal user fees for “basic health”?
- What impact might such a policy have and what would it cost?
- Should DFID proactively advocate for the abolition of such fees and be prepared to finance any costs associated with this?

The paper was developed with inputs from health and population, economic and governance advisers in the 25 PSA countries in Asia and Africa, other key informants in these regions, key donors and on a review of the available literature.

2. BACKGROUND

2.1 Approaches to Health Financing

Private expenditure dominates the financing of health services in both Asia and Africa. The vast majority of private expenditure is accounted for by out of pocket expenditure which has long been recognised as an inefficient and inequitable way of financing health care. Risk pooling is generally minimal and confined to the better off. There is some evidence that health spending is increasing as a share of GDP in both regions and that the public share of health spending is increasing in Africa - probably reflecting greater aid flows and resulting in increasing levels of aid dependence. Financing patterns vary widely *within* regions and averages are highly skewed by China and South Africa. Detailed country level data are at annex 1.

Table 1: Key Health Financing Indicators: DFID PSA Countries

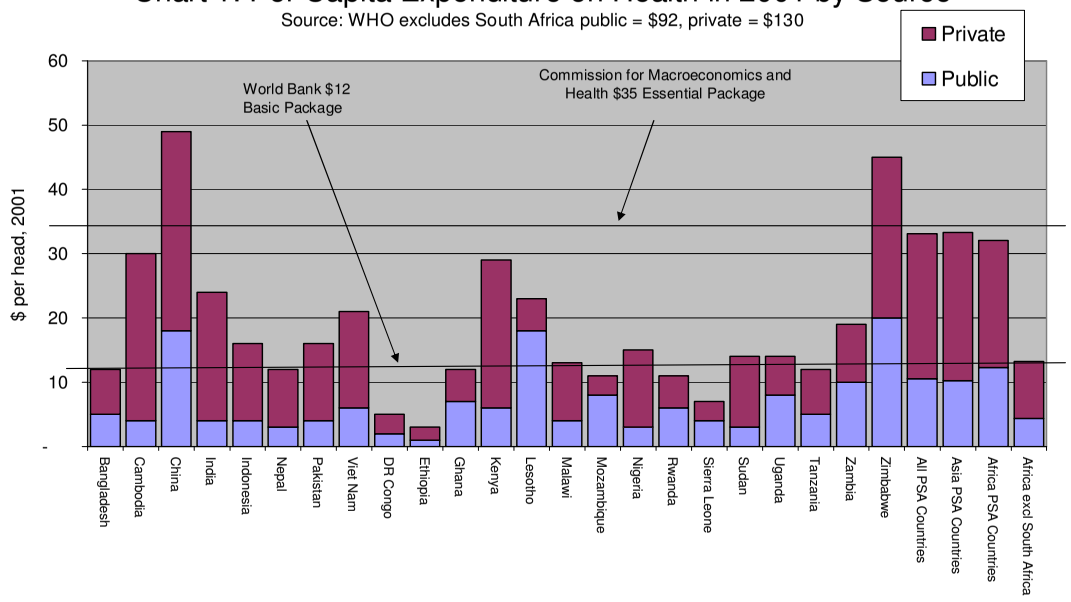
Indicator	Average by Region	1997	1998	1999	2000	2001	Ranges and Comments
Health as % of GDP	Asia PSA Countries	4.60	4.61	4.83	4.93	4.98	<2.5% in Indonesia to >11.5% in Cambodia
	Africa PSA Countries	4.53	4.70	4.57	4.68	4.78	
Public Share of Total Health Expenditure	Asia PSA Countries	28.84	29.86	29.14	28.35	28.77	<15% in Cambodia to >75% in Lesotho
	Africa PSA Countries	33.12	34.63	34.08	35.29	37.69	
Health as % of Total Public Expenditure	Asia PSA Countries	8.28	8.10	7.38	6.93	6.66	<5% in India, Nigeria, Sudan to >15% in Mozambique, Uganda and Cambodia
	Africa PSA Countries	7.91	7.86	7.22	7.68	7.60	
External Resources as % of Total Health Expenditure	Asia PSA Countries	2.05	2.30	2.47	2.51	1.64	<0.2% in China to >45% in Zambia
	Africa PSA Countries	9.43	12.82	13.72	15.70	16.92	
Out of Pocket Expenditure as % of Private Expenditure	Asia PSA Countries	96.60	96.20	96.25	96.54	96.62	<25% in South Africa to 100% in many countries
	Africa PSA Countries	80.62	81.03	79.71	79.66	79.76	
Per Capita Public Expenditure on Health (current exchange rate)	Asia PSA Countries	8.11	8.46	8.98	9.91	10.22	<$5 in Ethiopia to >$220 in South Africa
	Africa PSA Countrie35s	17.53	15.43	13.95	13.75	12.27	

Source: WHO World Health Report 2003 – note figures do not necessarily correspond to country led figures

Lack of Government funding for health is a major constraint. Within the African context only Uganda and Mozambique were reported to exceed the Abuja Declaration target of allocating at least 15% of Government spending to health. Public spending in the 25 PSA countries averaged only $10.5 per head in 2001 (and only $4.3 per head in the African PSA countries once South Africa is excluded). This is well below that required to deliver any package of basic health care. Spending in Uganda and Tanzania, for example, is around a third and a half of that required to deliver the locally defined minimum essential package of care respectively. There are only 4 countries in which estimated public spending in 2001 exceeded the $12 to fund the World Bank essential health package (China, Lesotho, South Africa and Zimbabwe) and only in South Africa did it exceed the $35 package identified in

2001 by the Commission for Macroeconomics and Health Ethiopia spends around $1 per person per year on health through the public sector.

Chart 1: Per Capita Expenditure on Health in 2001 by Source

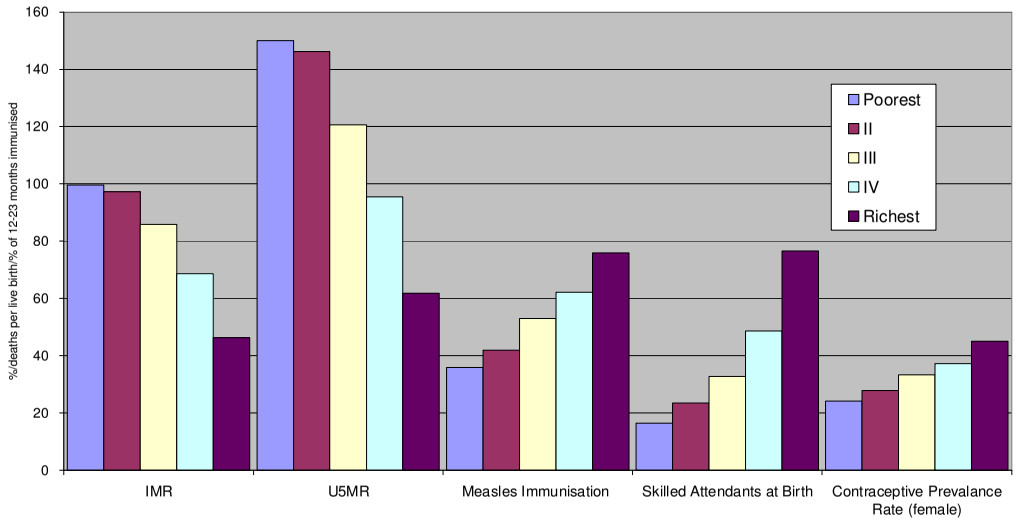


2.2 Health Outcomes and Access to Essential Services

Health indicators and coverage of MDG relevant health services vary widely both between countries and between socio economic groups within countries (see Chart 2):

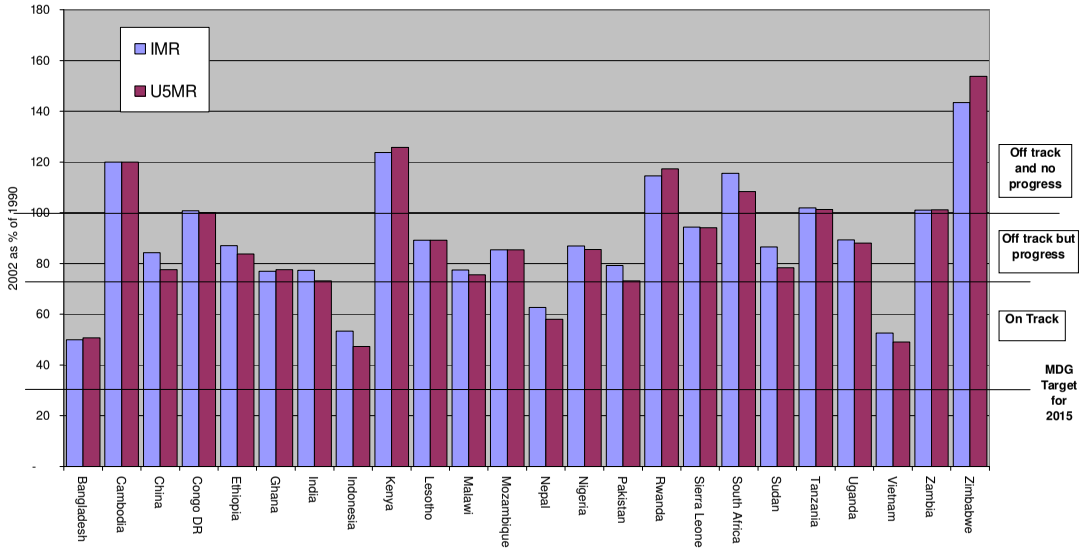
- overall infant mortality rates vary from 20 per 100,000 live births in Vietnam to 165 in Sierra Leone and Afghanistan whilst the share of attended deliveries varies from around 12% in Afghanistan to around 85% in Vietnam and South Africa.
- infant mortality rates for the poorest quintile are 130% higher than for the richest quintile (153% for child mortality) whilst the poorest quintile are less than half as likely to use modern contraceptive methods and immunise their children against measles and a fifth as likely to have an attended delivery

Chart 2: Differential Health Outcomes and Access to Essential Services by Socio-Economic Group
15 DFID PSA Countries Source: DHS various years, weighted according to 2001 population



- outcomes and access have generally improved though not for some countries and rarely at rates necessary to achieve the MDGs. Of the 24 PSA countries for which data are available, infant mortality has actually *increased* in 8 and only in 4 is the IMR MDG likely to be achieved if present trends are maintained.

Chart 3: Progress Towards the MDG
Improvements in Health Outcomes between 1990 and 2002



2.3 Who Benefits from Public Spending?

The benefits from public expenditure mainly go to the rich. Benefit incidence studies in 7 African countries found that 30% of the public subsides went to the richest quintile and only

12% to the poorest quintile. Spending on primary care is more pro poor but even here only 15% of the benefits go to the poorest 20%. Only in rural Kenya and South Africa did the share of primary health benefits going to the poor quintile exceed those going to the richest (Castro Leal 2000). Even where there are no user fees for primary health services (e.g. India) benefits still go mainly to the better off. Nonetheless, spending on health still tends to be more progressive than spending on education.

3. USER FEES AS A BARRIER TO ACCESS

3.1 What Are The Main Barriers to Health Care?

It is fairly clear that financial cost represents a significant barrier, and often the most important barrier, preventing the poor from accessing essential health services. However, it is by no means the only barrier.

A WHO review[1] found that financial cost was raised as an issue (though rarely discussed in detail) in 15 out of 21 PRSPs. Examples include :

- Ghana: "Nearly 70% of the sample population cited cost as a key reason for not using medical services. Poor physical access is also an important factor. (p. 18) For 20% of the urban and 61% of the rural population, the nearest health facility at least 30 minutes away. Lack of geographical access to health facilities (more than 30 minutes) among rural population is 51% for the non-poor and 70% for the two lowest income"

- Rwanda: "Cost is a higher deterrent than distance and is the cause of dissatisfaction in 80% of the cases where people are dissatisfied (followed by the failure of treatment and long queues)"

Weiser (2003) found that the cost of ARV therapy is the most significant barrier to adherence (44%) ahead of stigma (15%), travel/migration (10%), and side effects (9%). It was estimated that if cost were removed as a barrier, adherence is predicted to increase from 54% to 74%.

An important distinction also needs to be made between willingness and ability to pay. Even where people do use services the financial cost of doing so can have major implications as they may need to resort to savings, borrowing (often at high levels of interest) or even worse sale of assets. This is generally[2] less important for primary care where the costs of services tend to be lower but more of an issue for inpatient care or chronic ill health. The seasonal availability of cash resources is also a factor in communities relying heavily on agriculture.

Other barriers to health care use include:

- lack of transport/distance from facility
- lack of medicines,
- long waiting times,
- doubts about the quality of treatment perceived benefit
- attitudes of service providers
- education,
- cultural factors especially gender

Some of these are directly related to financial cost (e.g. cost of transport) whilst other reflect under funding of primary care services (lack of drugs and health staff).

[1] PRSPs and their Significance for Health, WHO 2003

[2] There is evidence of this in India and Sierra Leone although experience in Vietnam (Wagstaff) suggests the opposite.

3.2 Is Access To Basic Health Care a Priority for the Poor?

A rapid review of findings from Participatory Poverty Assessments (PPAs) suggests that access to adequate health services is one of a number of priorities issues identified by the poor and, within this, cost is a major problem.

- "What matters most to the poor is food, followed by water, good health and, increasingly, some kind of formal education" (Zambia PPA)

- "Low agricultural production, high levels of unemployment, high prices of commodities, diseases, high death rates and illiteracy have been cited as the main reasons that have made most people to decline in their well-being status in the last decade" (Malawi PPA)

- "Expenditure on health emerged to be a major causal factor of impoverishment, which prevented many of the poor people from breaking out of the threshold poverty limits. In large families particularly, and in families with old and disabled people, the problem emerged to be more poignant" (India PPA)

Priorities do tend to differ with the urban poor emphasising unemployment and inflation as their major concerns whereas in rural areas priorities tend to reflect issues related to agricultural productivity. Women often place a higher emphasis on health than men and the needs of the elderly were frequently mentioned. Whilst health was still seen as an important issue it was not always seen as the key issue; indeed, in some settings the problems related to health were seen to be less pressing than in the past.

Other key issues raised in relation to health care include:

- the poor performance of public health services – in particular inefficiency, availability and attitudes of health staff and corruption with the implication that people should not pay for over priced and poor quality services. "Lack of health and sanitation service, according to the participants, is the result of total incompetence of municipal administrations" (Ethiopia PPA)
- that the prospects of ill health made *all* income groups *insecure*
- the impact of population pressure on the capacity to deliver effective social services
- the importance of competing demands on limited funds whether appropriate (farm inputs – where costs are also perceived to be increasing) or inappropriate (spending on alcohol, tobacco and gambling – more an urban feature)

3.3 How Important are Financial Barriers: What do people pay to access public services?

The idea of free health services is a myth - **public health services are never free**. Although they may be provided free at the point of delivery their cost must be borne somehow - whether by Government, donors or patients themselves.

It is important, therefore, to be clear about which fees we wish to remove. The different types of cost are set out in table 2. Official fees in public health facilities are the obvious starting point. But what about fees in Government supported but NGO managed facilities (which often act as designated Government facilities in many parts of Africa)? What about

fees for non health primary health services[3], such as water and sanitation or nutrition. Finally, what about fees in the private sector?

Table 2: Financial Costs Associated with Accessing Health Care

Nature of Cost	Type of Cost
Economic Costs	**Opportunity Cost:** Time which could have been spent in other ways e.g. earning income
Financial Costs (associated with public services)	**Indirect costs:** payments not associated with health care itself e.g. travel, accommodation **Formal user fees**: payment for services at the point of delivery in Government (or Government designated facilities?) **Unofficial fees**: informal payments for services (e.g. bribes.) **Unmet costs**: services or products which Government is supposed to provide but cannot due to under funding leaving patients no option but to purchase privately (e.g. drugs)
Financial Costs (associated with public services)	**Indirect costs:** payments not associated with health care itself e.g. travel, accommodation **Formal user fees**: payment for services at the point of delivery in private for profit (or NGO/mission facilities?)

Furthermore we cannot simply assume that by reducing one type of cost that overall costs are reduced. The relationship between these costs is important. There is no guarantee, for example, that by introducing or abolishing official or formal fees that unofficial fees or total costs to patients will decline though there is some evidence that this happens[4]. Equally, in terms of abolishing user fees there can be no certainty that providers will not compensate by increasing informal fees (a particular concern of the World Bank). Lack of transparency often means patients cannot distinguish between unofficial and official fees and can act as a deterrent to seeking care a point made frequently by DFID advisers.

Whilst it is difficult to estimate unofficial costs it is clear that they are significant. (Box 1)

Box 1: How Important Are Unofficial Fees?

Ghana A study undertaken in Ghana's Volta Region found that the median payment in government hospitals was 8 times higher than the officially sanctioned fees (Bitran)

Mozambique "According to the National Health System regulations, ANC, family planning, maternity/delivery care, and child-related services (0-4) should be offered free of charge. Despite this, 9% of service users paid for ANC, 8% for family planning, 13% for delivery, and 13% for child-related services". Hutton SDC Mozambique 2000 "One of the major issues is the illegal charge to patients, which became pervasive in the 1990s. These "illegal charges are a multiple of the official fees, but because of their very nature, little systematic information exists about them". World Bank on Mozambique

Cambodia: The average monthly income of a government health worker may be as much as $180 compared to an official salary of $10-15 Bitran (2002)

Rwanda: NHA show that almost 80% of spending associated with public health pharmacies is out of pocket spending

[3] The 1978 Declaration of Alma-Ata proposed that core primary health activities should include at least:
1. Education concerning prevailing health problems and the methods of preventing and controlling them
2. Promotion of food supply and proper nutrition 3. An adequate supply of safe water and basic sanitation
4. Maternal and child health care, including family planning 5. Immunization against the major infectious diseases 6. Prevention and control of locally endemic diseases 7. Appropriate treatment of common diseases and injuries 8. Provision of essential drugs.

[4] McPake shows when official user fees were introduced In Uganda, the ability of health staff to charge unofficial fees was diminished

4. WHAT IS THE CASE FOR USER FEES FOR PRIMARY HEALTH CARE?

4.1 Case for User Charges at PHC

The philosophical case for user fees is based on the belief that people should pay if they can afford to do so and especially if they are the only ones to benefit from service in question and if the policy contributes to improving equity and efficiency in the delivery of health services. The following arguments for user fees can be advanced:

- **Pragmatism**. Where systems are dysfunctional user fees may be the only way of getting resources to lower levels. Although they raise little revenue the flexible funds made available are extremely important and can be large in relation to non salary expenditure.

- **People can and will pay for quality services, but won't pay for poor quality services**. The problem is not user fees per se but the way they are implemented. With careful design and implementation user fees can be associated with better quality services and increased utilisation and improved access especially where exemption and waiver schemes are funded.

- **Can promote better governance including improved accountability**. User fee implementation has also helped promote innovation as it can allow institutions freedom to manage resources for the first time (India). It can also raise resource consciousness by helping make people aware of costs. There are also arguments that user fees can make facilities more accountable to users and that it promotes better adherence to drug regimes.

- **They enjoy local support** They are popular with some Governments and well accepted by the population in some countries. The fact that they provide discretionary funds at lower level facilities means they tend to be popular with health workers and district administrations.

4.2 Case against User Charges for Primary Health Care?

The key argument against user fees is they contribute to an already unaffordable financial burden and that their removal is a necessary, though not sufficient condition, for accelerating progress towards the MDGs

- **The benefits of user fees can be achieved with less pain through alternative means**. The benefits outlined above could probably have been achieved had general tax revenues – a far more equitable and efficient revenue raising instrument - replaced user fees as a funding source

- **Fees reduce the utilisation of essential services -** reducing the likelihood of achieving the MDGs. Some services need to be free to promote access**.** Many basic

Box 2: Impact of User Fees on Utilisation

The Zambia PRSP reports that "after the introduction of user fees in 1993, there was a significant decrease in the utilization of health services. Antenatal and family planning attendance dropped and there was a marked drop in new attendees at the under-five clinics than for re-attendees. Most alarmingly, attendances for treatment of sexually transmitted infections (STIs) dropped by 76%. Although Government policy calls for free referrals from the first level of care, the resource gap has resulted in hospitals charging even for those who have been referred"

health services have broad public health benefits (e.g. immunisation) or simply cannot be charged for (e.g. vector spraying). For preventive services the cost of *not* providing services (expensive treatment required later) exceeds the cost of providing free services. (Box 2)

- **Poor countries cannot implement user fee programmes effectively**. Even where there may be a theoretical case for charging for some services delivered in a primary care setting in practice :

    - effective exemption systems are all but impossible to implement in practice and
    - providing such services free is a price well worth paying to attract people to use health facilities.

- **People have already paid for such services**. In many countries the tax base is expanding and people expect something in return. If not essential health services then what should be free?

- **User fees are an easy way out.** Charging user fees can be a soft option (they only annoy the population) and used as an excuse for not more important addressing supply side issues (which affect powerful vested interests). Allowing facilities to raise and manage user fee revenue is a poor alternative to providing managers with flexible funds through the budget or addressing deep rooted drug supply problems and corruption. As such user fee abolition can play a **catalytic role** in ensuring countries address fundamental problems.

5. WHAT DOES THE EVIDENCE SHOW?

5.1 The Implementation and Impact of User Fees

This issue is well covered in the literature and this is not the place to go into detail[5]. In short:

User fees are not an effective means of raising revenue but can be important at the margin. They generally raise very little and do it inefficiently. User fees rarely account for more than 10% of recurrent costs (see annex 2) although there are some notable exceptions such as hospitals in China, Brazil and DR Congo which are backed up by well developed insurance mechanisms. They are a far more inefficient revenue raising tool than general taxation due to high administration costs. Nonetheless, the modest amounts raised can be extremely important in facilities on the periphery (where alternative non salary funding is very low)

User fees tend to worsen equity outcomes with little, if any, improvement in efficiency

- There is little evidence that user fees have improved health service efficiency. There is little evidence of frivolous demand or that user fee structures have prevented patients bypassing low level facilities.

- User fees have generally proved to be inequitable having a particularly adverse affect on the poor, women and children. Contrary to earlier research findings it is now increasingly accepted that higher prices have a significant impact on utilisation. However, there is evidence that people are willing and able to pay for better quality services and there are cases where utilisation has increased because user fee revenues have been used to fund quality improvements[6].

- Unofficial fees are another key element in assessing affordability and there is little evidence that user fees simply formalise unofficial fees

- Exemption and waiver schemes have generally been ineffective in protecting the poor and vulnerable – much of this is due to the failure to compensate providers for providing exemptions and there is evidence that some countries (generally in Asia) have had some success.

- Lack of capacity to monitor means that national policies are often not translated into practice at the facility level. A lack of transparency means users rarely know whether they are paying officially sanctioned fees or not or what access they have to exemptions

In summary, user fees are very much a second best solution. They have often been pursued for inappropriate reasons – to raise revenue (which they are not good at) rather than to improve quality (where they could make a difference). Poor design and implementation have

[5] For a recent detailed review see annex 2 Charting the path to the World Bank's "No blanket policy on user fees"[5] A look over the past 25 years at the shifting support for user fees in health and education in Africa, and reflections on the future. Guy Hutton. DFID Health Systems Resource Centre. May 2004.

[6] a review of African countries showed that improved quality more than offset price effects of user fees, resulting in net increases in utilisation in health services in Cameroon, The Gambia, Niger, Sierra Leone, Sudan and Zaire
Creese and Kutzin, Lessons from cost recovery in health (general). 1995.

meant limited benefits but high costs and the assumption that exemptions or waivers could protect the poor (still prevalent in many PRSPs) has generally proved to be unfounded.

Better design and implementation has enabled some countries to avoid many, but not necessarily all, of the major pitfalls. Indeed there are cases where user fees have actually been associated with increases in utilisation due to either improvements in quality – showing that people are willing to pay for quality services – or because they reduced the overall cost of treatment[7]. In general, though, these examples tend to be concentrated in the better off countries which do not necessarily need to resort to using user fees as they have alternative funding sources.

Reasonably robust best practice guidance (such as the Addis Ababa principles) is available for countries who are set on implementing user fee programmes and could, if applied, usually reduce the harmful effects associated with user fees. These are summarised in annex 3

5.2 Evidence of impact from countries which have removed user charges

Studies on the effects of abolishing user fees are few and far between and assessment of its impact is complicated by the fact that it is difficult to disentangle the effect of changes in the user fee regime with those of other ongoing reforms and additional financing of the sector. Nonetheless, the evidence tends to suggest that the policy is often associated with improved access for the poor – at least in the short term - but also that it needs to be accompanied with other measures if it is to protect the poor and ultimately improve their health outcomes. The examples also emphasise:

- the need to provide additional resources to ensure initial increases in utilisation are not undermined by falling quality
- possible crowding out of preventative care as providers struggle to meet latent demand for curative care

In March 2001 President Museveni of **Uganda** announced the abolition of user fees for all health services, except those charged in private wings. The need to ensure this policy succeeded forced Government to adopt a series of accompanying measures many of which were previously thought to be unfeasible. These included increased funding for drugs and for health worker salaries (largely funded through existing resources as part of the transition from project support to budget support), measures to improve financial management (especially the need for timely releases) and strengthening payroll systems to ensure staff were paid on time. The abolition policy and the reforms it catalysed contributed to large increases in reported utilisation of basic health services - especially by the poor - as well as a reductions in out of pocket expenditures by poorer groups and better access to essential drugs[8].

In **Madagascar** following a 6 month-long blockade of the central highlands associated with the dispute result of the Presidential elections user fees in schools and health centres were

[7] Soucat reports findings from six sentinel communes of the Bamako Initiative in Benin and finds that the introduction of user fees has in fact reduced the cost per illness episode from US$2.70 to between US$0.50 and US$2.30, and resulted in increases in utilisation rates EPI coverage from 9% (1987/8) to 32% (1989) and 70% (1993); ANC utilisation from 36% (1987/8) to 65% (1993); curative care utilisation from 0.09 (1987/8) to 0.31 (1993) visits per capita per year.

[8] Household surveys confirm the pro poor impact of the reforms though they do suggest lower increases in the use of public facilities. MoH/DFID view is that the survey instrument is poorly designed and underestimates the use of the public sector

temporarily suspended. This resulted in a large increase in health centre attendance and school enrolment with econometric analyses showing a 16% increase in the number of visits to health centres to be associated with the elimination of user fees.

Experience from **Zimbabwe** highlights the importance of increasing financing flows once user fee revenue disappears. Having abolished user fees in rural health centres in March 1995 out patient attendance increased rapidly peaking in July 1995 but subsequently declined "probably due to lack of drugs and general shortage of essential inputs"[9]

In urban **South Africa** following abolition of user charges in 1996 initial increases in ANC uptake were not sustained – with a 3.8% increase in the first 6 months followed by a 10.5% decrease in the second 6 months. In rural areas there were concerns that rapid increases in curative primary care (up 93%) were crowding out preventative care (ANC attendance declined by 20%).

Evidence from **Sri Lanka** suggests that even where user fees are abolished their original imposition can still have long term effects**.** "In contrast to the negligible contribution to revenue mobilization, the impact on utilization was significant, with a 30% reduction in outpatient episodes at MOH facilities from 2.39 per capita in 1970 to 1.71 per capita in 1972. Total numbers did not return to 1970 levels until after 1977, when the fee was abolished". "The "token" fee seems to have not only reduced visits during its imposition, but also to cause a permanent reduction in utilization levels, which has persisted into the 1990s, some two decades after the fee was abolished" (IPS 1997).

5.3 Overall Conclusion on the Case for User Fees at PHCs

There is a very strong case for not having official user fees at PHC. Even where such approaches have met with some success these benefits could usually have been achieved (and probably exceeded) using alternative methods of funding.

But does this mean DFID should proactively advocate for abolition of user fees at PHC in all settings? The costs of DFID adopting such an approach and the case for and against doing so are set out in the following sections.

[9] Zigora TA; Chihanga SL; Makahamadze RB; Hongoro C; Hongoro F An evaluation of health financing reforms with special focus on the Abolition of user fees at rural health centres and rural hospitals In fact this may underestimate the impact on utilisation as there was also a general increase of referrals from rural health centres and rural hospitals to district level and the district level out-patient attendance increased though other factors may have contributed

6. COST IMPLICATIONS

6.1 What Costs Would be Associated with a Policy to Finance the Cost of Abolishing User Fees?

A number of costs could potentially be involved *in addition* to the cost of simply replacing lost user fee revenue:

- **maintaining quality** – if the abolition of user fees were to increase demand additional funding would be needed to maintain quality. The additional funding required would depend on the increase in demand and the extent to which such demands can be met using existing underutilised capacity.

- **extending the policy to the NGO/mission sector** Costs would also increase (especially in Africa – Lesotho, Uganda, Malawi but also other countries involved in extensive contracting out in Cambodia and Gujarat) if the policy was extended to NGO/mission providers who currently provide services at subsidised rates in exchange for Government subventions or in countries where NGOs currently receive little or no support from Government. NGO/mission facilities provide a significant share of total services and are often located in rural areas serving poor populations. In Lesotho NGO facilities run half the hospitals and 60% of clinics. In Uganda and Malawi NGO provide around 40% of services. In many countries NGO facilities act as district designated facilities (Tanzania, Swaziland and Uganda) and account for a significant share of the Government recurrent budget. They often charge significantly higher fee – for instance, CHAM facilities in Malawi raise around a third of their revenue through fees, in Uganda it is more like a half through it is declining as Government has provided more direct support to this sector

- **covering currently unmet costs** – there is little point in offering free services if those services are not available when people present. Underfunding (and other problems) mean that drugs are often unavailable in public facilities. This is a key reason for low utilisation of public services and increased access to drugs is likely to increase demand and further add to costs. Currently funding levels are typically well below those required to deliver an essential service package. Analysis of DFID PSA countries (Table 3) indicates that public expenditure of pharmaceuticals is extremely low – around $3.2 in Asia and $1.7 in Africa in 2000 (and just over $1 if South Africa is excluded). Moreover, spending declined in sub Saharan African countries between 1995 and 2000 especially in South Africa and in broad terms is less than half private spending on pharmaceuticals in both Asia and Africa. No attempts have been made to cost and essential drug package though Uganda estimates its needs to be roughly $3.6 per head roughly three times what is being spent now.

Table 3: Current Levels of Funding for Pharmaceuticals

	Government		Private	
$ per head	1995	2000	1995	2000
All PSA Countries	2.31	3.06	5.09	7.48
Asia PSA Countries	2.34	3.24	4.99	7.82
Africa PSA Countries	2.07	1.66	5.83	5.00
Africa excl South Africa	1.17	1.09	2.03	2.39

Source: World Medicines Situation Report, forthcoming

- **increasing the role of the public sector in the provision of basic health care** – in many countries the majority of the population (including the poor) still use the private sector for some of their basic health needs. Though such services may have largely private benefits and can usually be funded out of current income (rather than borrowing or sale of assets) the rationale for such a move would be that if these services should not be charged for in the public sector it is equally inappropriate to expect people to pay for them in the private sector. Private patients may shift back to public sector if it is free, good quality, and convenient/accessible.

Additional costs would also depend on the extent to which funds could be raised through reallocation of existing resources or results achieved through better utilisation of existing capacity rather than the need for new resources.

The estimates presented below – and more detailed country estimates shown in annex 4 - are extremely crude and are intended only to give some indication of the relative importance and magnitude of such costs. More detailed work would be required at the country level to give any real degree of precision. Data on current user fee revenues from primary health is weak – it is rarely disaggregated from other user fee revenue and is often underestimated.

Table 4: Likely Impact and Costs of Abolishing User Fees

Type of Cost	What Would This Do?	What Wouldn't This Do?	What Would This Cost?
Directly reimbursing Governments for the revenue lost from the abolition of user fees	Ensure Government is no worse off financially Remove formal payments by patients	Cover costs of maintaining quality in the face of possible increases in utilisation Would not remove other costs – indirect costs, unofficial fees, unmet costs	Relatively little – depends on current fee levels. Ballpark if 5% of recurrent costs and PHC accounts for 40% of spending – 2% of current health spending (i.e. less than $0.50 per head)
Costs involved in maintaining (or improving) the quality of services in the face of possible increases in demand associated with user fee abolition	Allow quality to be maintained in the faced of increased demand	Would not remove other costs – indirect costs, unofficial fees, unmet costs	Could be significant – depends on the size of the increase in demand. Ball park – if abolition resulted in 25% increase in demand and PHC accounts for 40% of overall spending maintaining unit costs would require a – 12.5% increase (i.e. say $0.50 per head in Africa, up to $1 per head in Asia)..
Financing costs currently incurred in accessing public services associated with general under funding of basic health services	Reduce or remove unmet costs	Would not address the indirect costs or unofficial fees (uncertain impact on overall costs)	Modest. Drugs – if we assume minimum requirement of $3 per head (no current guidelines - additional $2 per head in some countries)\
Expanding and strengthening the public health system the compete more effectively with the private sector	Reduce costs for those switching from private to public sectors	Uncertain effect on costs for still utilising the private sector	Huge – to bring expenditure up to levels set out in WDR 1993 $12 per head, meeting countries own essential packages ($28 in Uganda excluding ARVs, $12 in Tanzania, $19 in Malawi) and CMH $35 per head – anything from $5 - $30 per head

It also needs to be recognised than any reform such as this is likely to have unintended consequences. Funding to deal with problems which cannot be anticipated also needs to be taken into account.

If supporting user fee abolition were a sensible policy and if all countries were responsive to the approach the cost of reimbursing countries for lost user fee revenue would be of the order of $2.7bn – but only $80m when China is excluded. Increasing support to meet additional demand could cost up to 5 times that excluding China. Funding to provide a decent package of essential services free at the point of delivery would cost much more. Increasing spending on essential drugs could cost up to $4bn and increasing public spending to levels required to deliver a comprehensive package of essential services anything from $17bn (WDR 1993) to $88bn per year (CMH 2001). Costs of making NGO services free would also be significant in a number of countries although no attempt has been made to quantify this.

6.2 Which services should be free?

The terms primary care, basic health and essential services are used loosely**.** Basic health packages often include non-primary health services. The most obvious example is essential obstetric care which, although essential for achieving the MDGs, are not delivered within a primary care setting. Another question is whether access to anti retroviral therapy would be included in any basic package. Any expansion of the interventions to be covered would have major implications on costs (especially ARVs if they are considered part of basic health and uptake is high). If we are talking about primary health care the Alma Ata declaration covers education, food and nutrition and water and sanitation.

7. WHERE DO DONORS CURRENTLY STAND ON THE ISSUE?

7.1 Current DFID Policy

Current DFID policy on user fees stresses the importance of affordability rather than fees per se and the need to consider local circumstances and type of service (box below)

Box 3: DFID Policies in Relation to User Fees

HIV AIDS Strategy 2004

Many vulnerable people cannot access the services they need because of cost. This is why the UK Government is committed to ensuring that affordability is never a barrier to accessing health and education, or to services such as HIV testing and contraception.

Making Services Work for Poor People

"when governments can afford it, poor people should have free access to basic health services…but that poor countries cannot always afford free universal public services, and because informal charges are levied by poorly paid and corrupt officials, governments may do better to formalise fees at an affordable level"

DFID Health Target Strategy Paper 2000

"The best method of financing a particular health activity depends on a variety of issues, including local circumstances and culture, the nature of the health activity and the strength of the public system….. Cost recovery may be more relevant to the operations of district health systems rather than national public health actions"

There is general consensus from advisers against a blanket approach to the extent that it would be seen as DFID trying to impose its views on others. However, there is some support for the view it would help as Governments would at least know where DFID stood and could still choose to ignore the position if they chose to do so. Views on Government response to a blanket policy ranged from the very positive "a helpful signal which can help break the log jam" through "bewilderment" to very negative "we risk losing credibility and losing our seat at the table" or "they work reasonably well, Government is committed to them and we'd be better off working with them to improve their implementation".

7.2 Other Donors

Other donors policies are generally anti-user fees ranging from a "blanket ban and advocate against user fees" stance (USAID policy in relation to World Bank and IMF programmes) to a more pragmatic "against user fees generally unless there are exceptional circumstances" stance (AsDB and World Bank and DFID). There seem to be few instances where donors play an active role in promoting the abolition of user fees. In many cases, though the issue may be raised privately, it is rarely taken forward for fear of undermining the relationship with the Ministry of Health or is not seen as being of sufficient priority to take such a risk. In practice, much of the debate tends to be about making the existing user fee systems work better. The fact that actual decisions about user fees may be taken at local level with little or no national guidance means that it is sometimes difficult for donors to engage effectively with Government on the issue. Lack of interest in the issue on the part of Governments is also a major factor

Table 5: Views on User Fees

Donor	Current User Fee Policy
World Bank	No blanket user fee policy – recognition of user fees as a necessary evil in some situations Framework is set out in WDR 2004 – actual practice depends on how this is interpreted
Asian Development Bank	The Bank will address cost recovery on a project-by-project basis taking into account concerns about both equity and efficiency. The Bank's interest in improving PHC services for the poor will be jeopardized if user charges discourage their use of such services. Thus, while the Bank will consider user charges for PHC services, it will not insist on them unless there is some compelling, context-specific reason for employing cost recovery. Nonetheless, the Bank will ensure that PHC services are efficient and cost effective.
WHO	See out of pocket expenditure as an inequitable and inefficient way of funding health care and promotes the use of prepayment (WHR 2000)
USAID	Pragmatic – no blanket approach. USAID emphasis is more on improving the quality of public services and on working with the private sector[10].
GAVI	"in the absence of compelling country or regional data unequivocally documenting their value, user fees should not be levied in publicly financed national immunization services" GAVI Board
Oxfam	"user fees should not be imposed for either education or basic health services"
Equinet	Have called for primary health care fees to be removed. Not as a cure–all measure but accompanied by actions that increase overall national resources for public sector health services and that deal with international conditions and policies that undermine this.

The EC Health Experts Working Group has been established to look at fair financing. It is due to report shortly. In broad terms it adopts a pragmatic stance - to work for the removal of user fees where politically feasible and dependant upon country circumstances. The emphasis is more on the transition of user fee approaches towards social insurance type models rather than the abolition of user fees per se reflecting the European tradition of financing health services. (Have been unable to follow in detail)

[10] In 2001 Congress passed a law requiring the US Executive Director to the World Bank and IMF "to oppose …… user fees or service charges on poor people for primary education or primary healthcare, including prevention and treatment efforts for HIV/AIDS, malaria, tuberculosis, and infant, child, and maternal well-being, in connection with the institutions' lending programs". This does not govern USAID's own activities.

8. WHAT ARE THE POSSIBLE LINES TO TAKE?

Table 6 below sets out some of the pros and cons of adopting different lines to take in relation to improving the affordability of health care

The key choices appear to revolve around the extent to which the line should:

- focus narrowly (on user fees) or more broadly (on financial barriers)
- reflect a policy position only or should take a stronger position in relation to financing

Table 6: Pros and Cons of Different Lines to Take

Broad Line to Take	Pros	Cons
Abolish user fees for primary health services and DFID will pay (with caveats)	• Clear, simple statement to guide UK policy but also greater clarity and predictability for Government • A "human" policy which can be closely linked to impact on patients • Policy is generally sound • Linked to action (funding) • Easy to implement and simple to monitor • Starting point for thinking more broadly about financial barriers • Possible catalytic effect – raises debate about corruption/supply problems associated with drugs and provision of greater autonomy • Distancing DFID from other donors e.g. World Bank?	• Needs many caveats (which if addressed become increasingly expensive and if ignored could even harm the poor) • Risk of downplaying more important barriers (unofficial fees, indirect costs, non health factors) and policies (improved resource allocation) which could be more effective • Would do nothing for those impoverished by hospitalisation or chronic care needs • Seen as blueprint approach • Represents a contingent liability • Incentives for policy distortion • Policy is too rigid and may be a missed opportunity where Government wishes to improve effectiveness of user fees rather than abolish them • Distancing DFID from other donors e.g. World Bank?
Abolish user fees for primary health services (with caveats)	• Clear, simple statement to guide UK policy but also greater clarity and predictability for Government • Policy is generally sound • Easy to implement and simple to monitor	• Needs many caveats (which if addressed become increasingly expensive and if ignored could even harm the poor) • Risk of downplaying more important barriers (unofficial fees, indirect costs, non health factors) and policies (improved resource allocation) which could be more effective • Would do nothing for those impoverished by hospitalisation or chronic care needs • Seen as blueprint approach • Credibility – seen as policy without action • Missed opportunity where Government wishes to improve rather than abolish user fees
DFID will support measures to reduce financial barriers to basic health care and will fund efforts to do so	• Recognises complexity • Consistent with country leadership • Could embrace a range of relevant reforms including user fee abolition • Consistency with HIV/AIDS strategy	• Complex message • No clear starting point for dialogue • Difficulties in tracking impact of policy • Risks supporting policies (e.g. exemptions) which are not effective
DFID will fund increases in spending on basic health care (or on MDG relevant interventions)	• Clear link of policy to funding • Consistent with country leadership and with user fee abolition (where it is relevant) • Relatively simple message	• Weaker link to issue of financial barriers • No clear starting point for dialogue • Questions over how to define basic health care • Difficulties in tracking impact of policy • An "impersonal" policy difficult to show impact at the individual level

Any decision on line to take needs to consider what is happening at country level. An overview of what is happening in the DFID priority countries is shown at annex 5. This illustrates the fact that current policies and policy directions range from countries which have already abolished user fees for primary care, those which are increasing reliance on user fees as a financing source perhaps with some emphasis on improving their effectiveness and those countries which are developing alternative financing approaches (such as community health insurance) which rely on user fees being in place or those which consider alternative approaches are being a more effective way of meeting their equity objectives. Some examples of these are shown in annex 6.

In considering a line to take DFID needs to be clear on:

- what is meant by essential or basic services? A narrow definition could be taken to mean services with significant public health benefits (externalities) and preventive services provided at primary care level and exclude curative services provided at primary care level where the benefits accrue only to the individual. A broader definition might include all services provided at primary levels. An even broader definition might include selected additional services, such as essential obstetric care, which can only be provided at higher levels but which are essential for the achieving the MDGs. It also needs to be recognised that much primary care is delivered at hospital level

- what is actually meant by user fees and where we draw the line?

  - if we are talking about primary care – do we also consider water and sanitation, nutrition and education as set out in the Alma Ata Declaration?

  - how do we deal with current issues of under funding in the public sector? We can abolish fees for drugs but if they are not available in health facilities people will still have to go to purchase from pharmacies? So are we talking about advocating for the abolition of the Bamako initiative and fully funding drug requirements for PHC? What about social marketing?

  - are we just talking about fees for services provided in the public sector? What about services provided by NGO or mission facilities on behalf of Government as is the case in a number of DFID PSA countries? Should people be disadvantaged just because they live next to an NGO rather than a Government facility? Taking this argument further – what about the vast majority of primary health services which are typically delivered in the private sector,

A possible alternative line to one focused solely on user fees would be to take a broader approach which, although less succinct, may have more global relevance:

- DFID supports countries' efforts to ensure universal access to essential/basic health (which services?) services that deal with the major causes of ill health, disability and death;

- DFID recognises that reducing the financial barriers which currently prevent access could make a major contribution to this goal and will support countries in their efforts to this end.
- DFID believes that in low income countries (why not all countries?) such services should be provided free of charge at the point of use (for all users?) where current approaches compromise equity goals and where the necessary complementary actions are adopted and it forms part of a balanced and well considered programme to improve access and address poverty.

ANNEXES

Annex 1: Country Level Financing Data

Table 1a: Total expenditure on health as % of GDP

	1997	1998	1999	2000	2001
Bangladesh	2.9	2.9	3.1	3.6	3.5
Cambodia	10.9	10.8	10.8	11.8	11.8
China	4.6	4.8	5.1	5.3	5.5
India	5.3	5.0	5.2	5.1	5.1
Indonesia	2.4	2.5	2.6	2.7	2.4
Nepal	5.4	5.5	5.3	5.2	5.2
Pakistan	3.8	3.9	4.0	4.1	3.9
Viet Nam	4.4	4.9	4.9	5.2	5.1
Democratic Republic of Congo	3.3	3.0	3.1	3.2	3.5
Ethiopia	3.4	3.6	3.5	3.2	3.6
Ghana	4.1	4.3	4.2	4.3	4.7
Kenya	8.0	8.4	7.9	8.7	7.8
Lesotho	5.3	5.9	6.1	6.1	5.5
Malawi	8.7	8.5	8.7	8.2	7.8
Mozambique	5.0	4.9	5.0	5.7	5.9
Nigeria	2.8	3.1	3.0	3.0	3.4
Rwanda	5.0	5.0	5.5	5.6	5.5
Sierra Leone	3.3	3.0	3.7	4.3	4.3
South Africa	9.0	8.7	8.8	8.7	8.6
Sudan	3.5	3.7	3.7	3.9	3.5
Uganda	3.9	4.0	4.1	5.6	5.9
Tanzania	4.1	4.4	4.3	4.4	4.4
Zambia	6.0	6.0	5.7	5.5	5.7
Zimbabwe	9.3	11.4	7.9	7.4	6.2
All PSA Countries	**4.6**	**4.6**	**4.8**	**4.9**	**4.9**
Asia PSA Countries	**4.6**	**4.6**	**4.8**	**4.9**	**5.0**
Africa PSA Countries	**4.5**	**4.7**	**4.6**	**4.7**	**4.8**
Africa excl South Africa	**4.1**	**4.3**	**4.1**	**4.3**	**4.4**

Source: WHO WHR 2003

Table 1b: General government expenditure on health as % of total expenditure on health

	1997	1998	1999	2000	2001
Bangladesh	34	36	37	45	44
Cambodia	10	10	10	14	15
China	40	39	38	37	37
India	16	18	18	18	18
Indonesia	24	27	28	24	25
Nepal	31	33	30	30	30
Pakistan	27	29	26	25	24
Viet Nam	32	33	33	29	29
Democratic Republic of Congo	47	42	42	45	44
Ethiopia	38	39	38	35	41
Ghana	48	54	54	56	60
Kenya	22	24	19	24	21
Lesotho	76	78	81	81	79
Malawi	36	36	38	37	35
Mozambique	61	62	64	67	67
Nigeria	12	15	16	14	23
Rwanda	49	51	54	53	56
Sierra Leone	47	44	54	60	61
South Africa	46	42	43	42	41
Sudan	20	24	23	29	19
Uganda	29	38	41	56	58
Tanzania	46	47	43	47	47
Zambia	55	57	55	53	53
Zimbabwe	59	56	49	51	45
All PSA Countries	**29**	**31**	**30**	**29**	**30**
Asia PSA Countries	**29**	**30**	**29**	**28**	**29**
Africa PSA Countries	**33**	**35**	**34**	**35**	**38**
Africa excl South Africa	**32**	**34**	**33**	**35**	**37**

Source: WHO WHR 2003

Table 1c: General government expenditure on health as % of total government expenditure

	1997	1998	1999	2000	2001
Bangladesh	5.6	5.9	6.3	8.6	8.7
Cambodia	12.5	11.8	11.3	15.7	16.0
China	14.2	13.3	11.8	10.8	10.2
India	3.2	3.5	3.3	3.1	3.1
Indonesia	2.8	3.2	3.6	3.2	3.0
Nepal	9.3	9.9	9.0	9.0	8.1
Pakistan	3.8	4.2	3.7	3.3	3.5
Viet Nam	5.6	7.1	6.7	6.1	6.1
Democratic Republic of Congo	10.3	8.3	8.7	9.7	10.3
Ethiopia	5.8	5.9	4.3	3.2	4.9
Ghana	9.4	9.0	9.2	8.1	8.6
Kenya	6.1	7.2	5.1	8.6	6.2
Lesotho	12.4	11.5	11.9	12.0	12.0
Malawi	12.2	12.9	13.9	12.2	12.3
Mozambique	15.1	15.5	16.5	18.2	18.9
Nigeria	2.1	2.3	1.7	1.7	1.9
Rwanda	12.5	13.8	13.5	14.8	14.2
Sierra Leone	8.9	9.4	9.4	9.3	9.4
South Africa	12.4	11.3	11.1	11.2	10.9
Sudan	9.1	12.0	9.5	9.3	4.6
Uganda	6.5	8.1	8.4	16.4	16.4
Tanzania	14.4	13.1	12.4	12.1	12.1
Zambia	13.1	12.5	13.7	13.6	13.5
Zimbabwe	15.4	12.2	10.0	7.1	8.0
All PSA Countries	**8.2**	**8.1**	**7.4**	**7.0**	**6.8**
Asia PSA Countries	**8.3**	**8.1**	**7.4**	**6.9**	**6.7**
Africa PSA Countries	**7.9**	**7.9**	**7.2**	**7.7**	**7.6**
Africa excl South Africa	**7.5**	**7.5**	**6.8**	**7.3**	**7.3**

Source: WHO WHR 2003

Table 1d: External resources for health as % of total expenditure on health

	1997	1998	1999	2000	2001
Bangladesh	10.0	12.6	11.8	13.8	13.3
Cambodia	13.5	12.0	13.4	18.8	19.7
China	0.3	0.2	0.3	0.2	0.2
India	2.3	2.4	2.2	2.2	0.4
Indonesia	2.9	6.4	9.5	8.3	6.5
Nepal	10.6	9.9	10.2	8.3	9.4
Pakistan	2.7	2.2	2.0	3.8	1.9
Viet Nam	5.6	2.8	3.4	2.7	2.6
Democratic Republic of Congo	11.0	12.6	5.7	6.6	18.0
Ethiopia	9.3	23.5	27.6	29.6	34.3
Ghana	6.8	8.2	8.6	13.2	23.2
Kenya	7.3	7.9	9.6	9.7	9.8
Lesotho	5.3	3.9	3.2	4.7	6.0
Malawi	22.8	20.4	22.9	32.3	26.5
Mozambique	53.1	44.2	40.3	38.2	36.9
Nigeria	1.3	1.2	3.8	7.2	7.1
Rwanda	30.1	25.6	26.5	33.2	24.7
Sierra Leone	19.3	18.8	22.2	25.4	25.1
South Africa	0.2	0.2	0.1	0.4	0.4
Sudan	1.4	2.4	4.1	2.4	2.7
Uganda	24.4	41.7	22.9	41.2	24.8
Tanzania	16.0	22.0	35.3	30.0	29.5
Zambia	23.5	26.1	40.1	33.5	48.7
Zimbabwe	2.3	17.2	13.0	12.5	7.8
All PSA Countries	**3.1**	**3.8**	**4.1**	**4.4**	**3.9**
Asia PSA Countries	**2.0**	**2.3**	**2.5**	**2.5**	**1.6**
Africa PSA Countries	**9.4**	**12.8**	**13.7**	**15.7**	**16.9**
Africa excl South Africa	**10.3**	**14.1**	**15.1**	**17.2**	**18.6**

Source: WHO WHR 2003

Table 1e: Out-of-Pocket expenditure as % of private expenditure on health

	1997	**1998**	**1999**	**2000**	**2001**
Bangladesh	94	93	93	93	93
Cambodia	90	90	90	85	85
China	94	94	95	95	95
India	100	100	100	100	100
Indonesia	96	93	90	92	92
Nepal	94	94	94	94	93
Pakistan	100	100	100	100	100
Viet Nam	94	90	87	88	88
Democratic Republic of Congo	100	100	100	100	100
Ethiopia	86	86	85	85	85
Ghana	100	100	100	100	100
Kenya	70	71	69	70	68
Lesotho	100	100	100	100	100
Malawi	40	40	41	40	44
Mozambique	43	41	39	39	39
Nigeria	100	100	100	100	100
Rwanda	66	67	65	61	66
Sierra Leone	100	100	100	100	100
South Africa	20	22	22	22	22
Sudan	99	99	99	99	99
Uganda	54	54	55	56	53
Tanzania	87	88	84	83	83
Zambia	71	74	71	71	72
Zimbabwe	67	75	45	48	52
All PSA Countries	**94**	**94**	**94**	**94**	**94**
Asia PSA Countries	**97**	**96**	**96**	**97**	**97**
Africa PSA Countries	**81**	**81**	**80**	**80**	**80**
Africa excl South Africa	**87**	**87**	**85**	**85**	**85**

Source: WHO WHR 2003

Table 1f: Per capita total expenditure on health at average exchange rate (US$)

	1997	1998	1999	2000	2001
Bangladesh	10	10	11	13	12
Cambodia	30	25	28	30	30
China	33	36	40	45	49
India	23	22	23	23	24
Indonesia	26	11	17	20	16
Nepal	12	11	12	12	12
Pakistan	19	19	18	18	16
Viet Nam	16	18	18	21	21
Democratic Republic of Congo	4	4	8	10	5
Ethiopia	4	4	3	3	3
Ghana	15	17	17	11	12
Kenya	29	33	28	30	29
Lesotho	31	30	31	29	23
Malawi	21	15	14	12	13
Mozambique	10	11	11	12	11
Nigeria	35	37	10	12	15
Rwanda	16	15	14	13	11
Sierra Leone	7	5	6	6	7
South Africa	315	270	264	253	222
Sudan	13	14	12	14	14
Uganda	12	11	11	14	14
Tanzania	10	11	11	11	12
Zambia	24	20	19	18	19
Zimbabwe	66	59	35	42	45
All PSA Countries	**29**	**29**	**30**	**32**	**33**
Asia PSA Countries	**27**	**26**	**29**	**32**	**33**
Africa PSA Countries	**46**	**43**	**34**	**34**	**32**
Africa excl South Africa	**20**	**20**	**12**	**13**	**13**

Source: WHO WHR 2003

Table 1g: Per capita Government expenditure on health at average exchange rate (US$)

	1997	1998	1999	2000	2001
Bangladesh	3	4	4	6	5
Cambodia	3	3	3	4	4
China	13	14	15	17	18
India	4	4	4	4	4
Indonesia	6	3	5	5	4
Nepal	4	4	3	4	3
Pakistan	5	6	5	4	4
Viet Nam	5	6	6	6	6
Democratic Republic of Congo	2	2	4	5	2
Ethiopia	1	1	1	1	1
Ghana	7	9	9	6	7
Kenya	6	8	5	7	6
Lesotho	24	23	25	24	18
Malawi	8	5	5	4	4
Mozambique	6	7	7	8	8
Nigeria	4	6	2	2	3
Rwanda	8	8	8	7	6
Sierra Leone	3	2	3	4	4
South Africa	145	114	113	106	92
Sudan	2	3	3	4	3
Uganda	3	4	5	8	8
United Republic of Tanzania	4	5	5	5	5
Zambia	13	12	11	10	10
Zimbabwe	39	33	17	22	20
All PSA Countries	**9**	**9**	**10**	**10**	**11**
Asia PSA Countries	**8**	**8**	**9**	**10**	**10**
Africa PSA Countries	**18**	**15**	**14**	**14**	**12**
Africa excl South Africa	**5**	**6**	**4**	**5**	**4**

Source: WHO WHR 2003

Table 1h: Expenditure on Pharmaceuticals by Source

$ at current exchange rate	Government		Private	
	1995	**2000**	**1995**	**2000**
Bangladesh	-	1	5	5
Cambodia	-	1	7	10
China	4	6	8	14
India	1	1	2	2
Indonesia			4	5
Nepal	1	1	2	3
Pakistan	4	3	2	2
Viet Nam	1	2	4	8
DR Congo	n/a	n/a	n/a	n/a
Ethiopia	1	1	1	1
Ghana	n/a	n/a	n/a	n/a
Kenya	1	-	6	6
Lesotho	n/a	n/a	n/a	n/a
Malawi	1	-	2	2
Mozambique	1	1	1	1
Nigeria	1	1	2	3
Rwanda	1	1	3	2
Sierra Leone	n/a	n/a	n/a	n/a
South Africa	9	6	35	25
Sudan	n/a	n/a	n/a	n/a
Uganda	1	-	2	2
Tanzania	1	1	1	1
Zambia	3	3	3	2
Zimbabwe	4	7	1	2

	Government		Private	
All PSA Countries	2.31	3.06	5.09	7.48
Asia PSA Countries	2.34	3.24	4.99	7.82
Africa PSA Countries	2.07	1.66	5.83	5.00
Africa excl South Africa	1.17	1.09	2.03	2.39

Source: World Medicines Situation Report

Annex 2: User Fee Collections in Selected Countries in sub Saharan Africa

	% of recurrent budget covered by user fees	Year
Benin	20	1993
Botswana	2	1983
Burkina Faso	14.8	1999
Burundi	4	1992
Cote d'Ivoire	7.2	1993
Ethiopia	9	1996/7
Ghana	5-6	1991
Guinea	20	1993
Guinea-Bissau	5	1995
Kenya	2	1984
Lesotho	7	1998
Malawi	3.3	1983
Mali	2.7	1986
Mauritania	9	1999
Mozambique	8	1996
Rwanda	7	1984
Senegal	4	1990
Swaziland	2.1	1984
Zimbabwe	3.5	1992
Unweighted Average	6.9	
Source: Soucat, various PER documents		

Annex 3: Addis Ababa Principles on Cost Sharing in the Social Sectors – How To Minimise the Damage

Cost sharing in the form of user charges should be considered only after a thorough examination of other options for financing social services, including tax reform, budget restructuring and expenditure targeting within the government budget and aid flows. General taxation and other forms of government revenue are more effective, efficient and equitable methods of raising revenue for the financing of social services than cost sharing mechanisms.

Though general: taxation is a more cost-effective way to raise revenue there are two specific objectives for cost sharing: (i) to limit the financial burden on the budget. that stems from the rapid increase in demand for, non-basic services, which the state cannot meet on its own without the diversification of, providers, and (ii) to overcome the practical and managerial obstacles that have prevented an adequate level of resources from reaching basic education and basic health.

Efforts to reduce costs in the delivery of social services, as well as to increase the efficiency in resources allocations to the primary level, must be considered prior to the introduction of cost sharing.

Basic social services should be provided either free of charge or be substantially subsidised. Basic education should be free and other out-of-pocket costs to parents such as school uniforms and school supplies should be minimised. Cost sharing in health should exempt preventive care whose benefits extend beyond the users (e.g. immunisation) and selected primary services. Cost sharing should be a stepping stone towards other financing options for health care.

When considering cost sharing it should be as part of a comprehensive sector strategy: for both health and education, formulated by government with all stakeholders. The sector strategy should specify clear, measurable and verifiable objectives, the resources required to meet-those objectives, and ways of mobilising and allocating them among competing priorities. .

Resources generated through cost sharing should be additional and should not be a substitute for existing resource allocations to the education and health sectors.

To be successful and sustainable cost sharing must lead to immediate and measurable improvements in the access and quality of services. In this regard, revenue generated through cost sharing must be retained, with the spending authority. at the local level. Disadvantaged regions and communities may need extra financial support to avoid cost sharing leading to a widening of regional, socio-economic and gender disparities.

Cost sharing must be accompanied by special measures that effectively protect the poor. Experience shows that the poor have not been effectively protected against the negative impact of cost sharing on their access to basic education and basic health. While cost sharing may be necessary because of severe constraints in terms of financial resources and/or institutional capacities, caution must be exercised wherever there is doubt about the ability to protect the poor. No one child should be deprived of his or her right of access to basic education and basic health.

Non-discretionary exemption schemes should be preferred from the point of view of efficiency. Discretionary exemption schemes have not succeeded in identifying and protecting the poor. Although more benefits may leak to the non-poor non-discretionary exemption criteria such as age, gender, region, and type of service are less likely to affect the access of the poor to services. Moreover, discretionary criteria, such as income and physical assets can be difficult and costly to administer.

Involvement of beneficiaries is critical to the success and sustainability of cost sharing. Community participation and control of resources must be a fundamental characteristic in the

process of designing appropriate cost sharing mechanisms and their management. The role, rights and responsibilities of local communities vis-à-vis government and service providers must be discussed and clarified prior to the implementation of cost sharing.

Community participation and management must not be considered as a substitute for government's responsibility in the financing and management of the social sectors but should be seen as an essential element in improving service delivery.

Communities should be made fully aware of the principles and implementation mechanisms of cost sharing. Training and capacity building of community management committees and service providers is essential to its success.

Local management committees should be locally elected and fully accountable to the community and should ensure adequate representation of all stakeholders, including a balanced gender presence.

Cost sharing mechanisms should be carefully tested through phasing and/or piloting before applying them on a large-scale. Testing is meant to assess their impact on effectiveness, efficiency and equity at the local level. The administrative costs of implementing cost sharing must be kept to a minimum.

Cost sharing mechanisms must be regularly monitored and evaluated with a view to ensuring quick feedback on the consequences of cost sharing, particularly regarding the impact on the poor, women and children.

Annex 4: Back of the Envelope Estimates: Costs of Covering Financing Gaps

	User Fee Revenue at PHC (1)	Demand Generation (2)	Increasing Public Expenditure on Drugs by $2 per head (3)	Cost of Making Essential Mission/NGO Services Free (4)	Funding Required to Achieve $12 Basic Package (5)	Funding Required to Achieve CMH Basic Package (6)
Bangladesh	0*		276	?	967	4,143
Cambodia	1.1	5.4	27		107	415
China	2,782.9	869.7				21,903
India	0*		2,129	XXX eg Gujurat	8,515	32,996
Indonesia	17.2	85.8	644		1,716	6,650
Nepal	1.5	7.4	49	XXX	222	790
Pakistan	11.9	59.4	-		1,187	4,600
Viet Nam	9.8	48.8	81		488	2,358
DR Congo	2.1	10.6	?	XXX	532	1,756
Ethiopia	1.4	6.9	137		755	2,332
Ghana	2.9	14.3	?		102	571
Kenya	5.6	19.1	?		191	925
Lesotho	0.6	3.2	?	XXX		31
Malawi	0.9	4.4	?	XXX	88	341
Mozambique	3.0	15.0	38		75	508
Nigeria	8.1	40.7	271		1,220	4,339
Rwanda	1.0	5.0	17		50	241
Sierra Leone	0.4	2.1	?		42	164
South Africa	0*					
Sudan	2.0	10.1	?		302	1,072
Uganda	0*		?	XXX	101	683
Tanzania	3.6	18.0	72	XXX	251	1,077
Zambia	2.1	10.4	-		21	260
Zimbabwe	5.2	26.2				197
Total	2,863.3	1,262.4	3,740		16,933	88,352

Assumptions:

Given the lack of data on user fee revenue at primary care level the basic approach is to extrapolate the situation in Uganda.

* – no official user fees in place at lower levels

1: User fees cover 5% of costs of primary health care costs which in turn account for 40% of health service costs (extrapolating from Uganda)

2: User fee abolition increases demand by 25%. Expenditure on primary care is increased by this amount to maintain unit costs.

3: Assumes all countries are provided support to ensure they spend at least $3 per head on pharmaceuticals

XXX – no attempt made to cost this but likely to be significant in these countries

Annex 5: Alternative approaches to financing health care

Approach	Examples
Complementary Measures: Increased financing for PHC, measures to strengthen systems	Overall resources for health are not expected to increase rapidly. WHO review found that "health spending as a share of priority spending is not rising dramatically, and where health spending is shown as a proportion of GDP, the projected changes are typically quite small". Indeed in some cases it is declining. Furthermore, there is no guarantee additional resources will be allocated to primary health care Ethiopia: Increase the share of the Government budget allocated to the health sector from 7.3% (in 1999/2000) to 8.2% by 2004/2005; Mozambique: Develop a provincial financial information system and develop evaluation and management tools for primary level care; study the cost of primary level care and review expenditure at the provincial level India: increase share of resources going to primary health to 55% (although no definitions or baselines provided) Cambodia: continue contracting with appropriate providers in poor, remote operational districts; enable incentives to staff working in remote areas through performance-based measures; provide opportunities to recruit and train health staff from rural remote areas
Expand user fees as a funding source	Ethiopia: improve the cost recovery (the amount of user fees collected by public health facilities) from the current level of 12.8% (2001/2002) to 20% (2004/2005) of total public expenditure on health; expand revolving fund schemes for drugs by establishing pharmacies and drugstores in all public hospitals and 50% of the primary health care units; Cambodia: Scale-up official user fee schemes with strong regulatory mechanisms on staff performance and fee exemption to the poor.
Improve Effectiveness of Current User Fee Programme	Ethiopia: Secure retention of at least 50% of the user fees by public health facilities and invest on productive activities Rwanda: The state may selectively increase the level of subsidy for some drugs. Cambodia: Scale-up equity funds with partnerships in poor communities to promote access by the poor.
Develop Alternative Funding Mechanisms	Nepal • Equity based resource allocation to districts. The existing centrally managed resource allocation is crude. A first draft of a new formula – a composite of a number of indicators – is under discussion. This will ensure poorest districts will get proportionally greater resources • Targeting strategies that exempt fees either by groups (all under 5's, all women) or services (all maternity cases). This is under discussion. The feasibility of offering free midwifery and obstetric care (a desired MOH policy) needs exploring • Reforming the role of the state and within that the engagement of the non state as providers in the government's plan and strategy in an intended reform. *Rwanda Mutuelle* schemes (where households prepay for health insurance each year), will be introduced more widely in 2002, building on the lessons of the most successful schemes Cambodia Scale-up equity funds with partnerships in poor communities to promote access by the poor; pilot health insurance to protect the vulnerable and lower income groups from catastrophic expenditures.

Annex 6: Detailed Country Level Information

	Health Financing Policy	Current User Fee Regime	Key Barriers to Access	Views of Other Partners and Likely Response to DFID Blanket Abolition Policy and Costs
Uganda	Emphasis is on strengthening the tax base and domestics funding with a view to reducing dependence on donors in the longer term	All user fees for health abolished in March 2001.	Previously cost sharing but now other factors more important – distance, transport, quality	Not relevant as already abolished. Initially World Bank and WHO hostile to abolition, not high priority for other donors.
South Africa	Public expenditure is already significant Emphasis is on giving budget priority to PHC, more equitable geographical allocation and free PHC to users	Free care for pregnant women and under 6s introduced in 1994 and free primary care in 1996.	General perception is that whilst issues of user fees and physical infrastructure have largely been addressed remaining problems include staff attitudes and drug availability.	Not relevant as already abolished
Ethiopia	Government intends to ensure n a sustainable health care financing system by increasing share of the budget to health, increasing cost recovery including the expansion of revolving drug schemes. Public funding is low ~$1 per head but due to increase significantly through proposed donors support (esp. GFATM, GAVI, PEPFAR)	User fees have been in place since the 1950s. Charges are in place for PHC and have been extended to cover previously exempt areas. Only vaccination is currently free. Currently around 9% of costs are recovered. Government intends to increase this share and also improve effectiveness by allowing retention at the facility level	User fees are a major constraint to access (unofficial fees are reported to be low). Distance and quality of care (as measured though availability of drugs also major factors	Unlikely to be responsive – policy is moving in the opposite direction
Malawi	Government aims to develop and implement an integrated financing strategy for the Essential Health Package.	In 1994 the new government promised and delivered free health care and free primary education. At present MOHP do not formally impose fees but district-designated mission facilities and local-authority health facilities do. PRSP suggests non EHP services will be charged for - either through user fees or insurance - and the approach to financing EHP services will be determined by operational research		May be responsive to case for EHP if evidence supports it but not for non EHP services
Nepal	Health is financed from taxation and out-of-pocket. Expenditure. There is no clear decentralisation strategy yet but this may lead to an increase in (a) community revenue and (b) hospital based revenue. User fees are not seen as a priority issue as they generate so little revenue	Some services are free services - antenatal, family planning, EPI, Vitamin A, leprosy, TB All out-patient care requires a nominal registration fee with free drugs prescribed and in-patients (including maternity care) pay fees as set by the facility. Drugs are free but there is insufficient to cover the needs (except for leprosy and TB) Anecdotal evidence suggests that exemption systems by and large fail the poorest. Revenue collections are low - less than 5% of total spend and negligible for primary care.	User fees are a major barrier to care. Other barriers to accessing care: Gender and intra-household power dynamics, perceived quality of care), Knowledge around health and ill health, cultural/societal behaviours towards health care and providers, Physical barriers (terrain, transport, opening hours) and lack of referral systems	Government may be receptive but would need more evidence before making a judgement. Would want to know not only "how much" but for "how long?" support might be given
India	The National Health Policy 2001 emphasises increasing the share of resources going to health and the share of resources going to primary care interventions. No reference to user fees. Health is a state issue	Practices differ by state but no formal fees for primary care.	Financial barriers are important especially for inpatient care and in rural areas. Other constraints include distance, transport, gender relations etc. Old and disabled face particular problems	Not relevant as no formal charges for primary care. Issue of fees at secondary and tertiary level is relevant but of limited importance. DFID has other priorities (a) increasing public resource allocation to primary and public health interventions, and (b) better coverage of health insurance for the poor to reduce the massive degree of financial risk they bear on account of catastrophic illness.
Indonesia	Health in general is a low priority concern – and seen largely as a private consumption good, - as evidenced by the very low share of public health expenditure in GDP (< 0.8%). Emphasis is on user fees as a residual financing mechanism and the establishment of an	User fees were introduced in early 1990s as rapid expansion in infrastructure put the system under financial strain. Fees are relatively low, vary according to the level of care and across the country. Unofficial fees are pervasive and availability of drugs varies.. In the immediate pre-decentralisation period, it was thought that user fees were equivalent to about 11-12% of the costs of the primary care system; this may have increased since	Cost is by far the major consideration in deterring access to services. Physical barriers are highly significant in some areas	Since decentralisation in 2001, health policy is largely in the hands of local governments so national policy is of relatively little importance. Most of the pressure to protect the poor comes from the international community. Government may be responsive to support (PHER suggests abolition) but key constraint is low budgetary allocation to health

	Health Financing Policy	Current User Fee Regime	Key Barriers to Access	Views of Other Partners and Likely Response to DFID Blanket Abolition Policy and Costs
	effective safety net. Parliament is working on a draft law to set up a Social Security system which will include a social/health insurance component – though this will take time to implement	Fee revenues for primary care are returned to the relevant Government institution with budgets based on expected user fee income. There are strong incentives to retain resources illegally. Self governing hospitals and health centres seem to be allowed to retain user fee revenue. Exemption schemes are seen as ineffective		DFID is only a marginal player. An offer to provide support to abolish fees might be met with "sheer incredulity" followed by concerns about the impact on sustainability and also the response of powerful vested interests
China	There is no nationally recognised basic primary health care package of services (some are being piloted with donor support).	With local authorities expected to fund services from own resources poorer areas have had to place greater reliance on cost recovery. As a result services that disproportionately benefit the poor – such as the Epidemic Prevention Service and Maternal and Child Health Programme – are increasingly reliant on user fees. People have to pay user fees for most primary health care. The exceptions are vaccines (though there is a fee for the injection) and the nationally financed facility based attendance programme (which does not cover the whole country. All drugs are paid for out of pocket by people not involved in government urban health insurance schemes	Government recognises that user fees are a barrier to accessing health care. But its priority to address the impoverishing effects of catastrophic health care costs. Other barriers include: (i) lack of accountability of health service providers – their salaries are largely from sale of drugs and a multitude of formal and informal fees, (ii) absence of effective health budgeting processes and effective cost containment mechanisms; (iii) poor quality providers and (iv) low demand and expectations from users.	The lack of national policy makes it difficult for DFID to press for abolition of user fees and to cover the shortfall resulting from abolishing user fees. The cost would be huge, the time frame unclear, and the impact uncertain. A more pragmatic approach would be twofold. Firstly to build on existing health systems pilots to demonstrate the impact that reducing user fees can have and work with Government on its National Health Accounts and plans for Provincial Health Accounts to enable better estimation of the cost consequences.
Cambodia	In the 1996 MOH introduced the National Charter on Health Financing (NCHF) Government set out its intention to formalize cost recovery in the form of user fees	Health facilities are allowed to charge fees, these are agreed locally and posted in the clinic. 50% of income can be used to top up health workers' salaries at facility level. 49% can be used for improving services and 1% reverts to the National Treasury. Fees at the health centre level are low and some services (e.g. TB diagnosis and treatment) are free. Typically a consultation costs $0.12. There is evidence that user fees have in general increased utilisation, presumably because consumers now know in advance what they will be expected to pay at a clinic. Experience with equity funds (funded exemptions) at hospital level has been positive. They protect the poor against high costs and prevent people into poverty (the poor and near poor patients can receive medical services worth $50 ($10 co-financing by the EF; and $40 financed by the government on average, through the support of recurrent hospital expenditures).They are fiscally efficient as costs < costs associated with safety net programmes. There is virtually no leak of benefits to the non poor	User fees are a particular barrier to use by the poor in hospitals. Health spending for emergency and chronic care is a major cause of poverty in Cambodia	User fees seen as being a "necessary evil" and to be operating reasonably effectively and seen to be the only way of ensuring staff get paid. Innovative approaches currently being piloted are underpinned by user fee approaches
Pakistan	Very low levels of public spending on the social sectors	Health is a provincial issue and with proposed devolution is likely to become a district issues. Cost recovery in public facilities from user charges at all levels amount to about 2-5 % of total government spending on health. Proceeds from almost all user charges accrue to the provincial or federal treasuries. Raising substantial additional resources from general revenues seems unlikely. Institutional capacity is limited for mobilization of additional resources from the system's clients. Poor and women and children have to be protected from user charges through exemptions or cross-subsidies; PHC schemes run by NGOs do charge and achieve significant levels of cost recovery	There are barriers that are more important that user fees in preventing the poor accessing primary care. For example: cultural and societal issues associated with health-seeking behaviour; inadequately staffed centres; inadequate quality of staff; and inadequate supply of drugs, materials and equipment	DFID has more important issues to deal with. Focus on user fees could mean diverting attention away from more important aspects of service delivery – which are being tackled in a joined up fashion through sub-sector poverty reduction budget support (NHF) and our upcoming maternal and newborn health programme

	Health Financing Policy	Current User Fee Regime	Key Barriers to Access	Views of Other Partners and Likely Response to DFID Blanket Abolition Policy and Costs
Bangladesh		There are no 'official' user fees at the primary health care level, although there have been pilots to introduce them (with reasonably positive outcomes)		Government would not be receptive. DFID do not believe abolition of user fees would help increase access to services in Bangladesh Concern it would compromise flexibility to promote alternative innovate models for improving health care, including undermining mechanisms to provide local financial incentives to service providers. See improved transparency ass a key goal .
Zambia	Basic health care package at first point of referral level has been identified and costed at US$ 11.5 per capita, yet the health sector has available only US$ 10.5 per capita for the whole system	After the introduction of user fees in 1993, there was a significant decrease in the utilization of health services. There are clear exemption criteria but the system is ineffective. The levels of user fees have never increased and have gradually been eroded by inflation. Little data is available but they probably account for 1-2% of total spend – more in urban areas. Unofficial fees are present but unquantified.	Long distances, lack of transport, user fees and the attitude of service providers are also identified as major deterrents to seeking care.	Government may be receptive but needs evidence to be convinced DFID is working with Government to develop pilots to test the impact of user fee abolition in a number of settings. Abolition could make sense if findings support it, but believe it should be part of a package of reforms including systems strengthening. Would be concerned if it happened overnight There are no champions for such change in Government and few donors have been very supportive (WHO, UNICEF).
Ghana	The POW-2 is built on five strategic pillars which include To improve financing of the health sector through increased financing and increasing financial access of the poor to health care by extending prepayment schemes to replace the "Cash and Carry" systems, while developing an appropriate policy and regulatory environment for health insurance, as well as increasing public expenditure on the poor and vulnerable. Ghana is in the process of establishing a national health insurance scheme financed by an earmarked levy on VAT. A Health Insurance Act was passed in August 2003. Aim is to withdraw user fees as approach is rolled out. Initially the scheme is expected to cover around 20% of costs (similar to current levels of IGF). Aim is to consolidate existing schemes and build the system around district mutual health organisations. Process is at early stages – benefit package is yet to be finalised though pilots are being evaluated to assess costs	User fees were introduced in 1985 and specified fees for most services and aimed to achieve full cost recovery for drugs. Whilst drug fees have been increased, other fees were heavily eroded by inflation. From 1993? facilities were allowed to retain revenue all allocate it to non salary items and to cover the cost of waivers and exemptions for health workers, for some preventive and curative services for women and children (immunizations, pre and postnatal care), and for patients with tuberculosis, leprosy, and mental disorders. Exemption mechanisms are not thought to work well By 1999 fee revenue represented around 12 percent of total funding for public hospitals – around £14m per annum. Actual fees were much higher that national policies allowed. Exemptions are rare - only the blind or the mentally handicapped were covered and exemptions on the grounds of ability to pay are rare. This is due, in large part that facilities are only reimbursed perhaps one fifth of the cost of providing exemptions	Nearly 70% of the sample population cited cost as a key reason for not using medical services. Poor physical access is also an important factor. (p. 18) For 20% of the urban and 61% of the rural population, the nearest health facility at least 30 minutes away. Lack of geographical access to health facilities (more than 30 minutes) among rural population is 51% for the non-poor and 70% for the two lowest income Poor quality of care is said to discourage poor people from seeking state-provided health care. (p. 110) Lack of access to services and the high cost of health care are cited as two key obstacles to health care utilization. (p. 18)	Ghana would, in principle, be receptive to an approach to support the shift in financing mechanisms though there would have to be some recognition of the need to commit long term funding. However, the issue is not one of financial support to help abolish user fees though this is planned. Rather, the financial priority of Government is to find means of subsidising the premiums of the poor who otherwise could not afford to enrol (especially those in the north). Though compulsory membership is anticipated in the longer term in the short term user fees can play an important role in providing an incentive to enrol
Rwanda	Government policy is to expand community based health insurance as a means of reducing costs to the poor.	Public and NGO services are available to everybody who is able to pay out-of-pocket user fees. Exempted groups include civil servants and dependents; and individuals identified as poor by local authorities.	Health services are available but often perceived as too expensive. Perceived quality of care and long queues are other key factors	Unlikely to be receptive due to focus on community insurance model
Vietnam	Aim to increase the funding for health, and increase population coverage of health insurance by mobilizing premium collections among those who can afford to pay with free treatment for the poor;	Out-of pocket payments, whether official or unofficial, have become a dominant feature of the health landscape in Vietnam. They are partly responsible for reduced use of professional health care among the poor.		Unlikely to be responsive due as alternative approaches being pursued
Mozambique	User fees have been in place since independence	User fees were first put in place in 1977 By 1996, it recovered 2.7 percent of the	User fees are not the major barrier to cost. One of the	Government not likely to be receptive

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	and are a condition associated with the HIPC process thus seen by some as an IMF/Bank imposition. Government is committed however, seeing fees as a useful way of raising revenue but also as a means of increasing community participation and on the grounds that those who can pay should pay	government's recurrent health spending and is now somewhat higher and probably growing An exemption system is in place but is complex and rarely functions. Fees are low 1000mc per visit (approx 4 cents) and drugs are highly subsidised (revenue covers around 12% of costs) The 1999 Expenditure Review (MSH 1999) concluded that the fee collection system is highly inefficient, abuse public resources, dissatisfies patients, and thwarts the achievements of public sector goals Collections at primary level amount to around 2% of total budget. Fees for services are returned to the facilities but processes are cumbersome. Fees for drugs are returned to a central revolving drugs fund or for emergency use. Practices, and collections, vary significantly between districts and there is little clarity on how the funds should be utilised. There is evidence of illegal overcharging. Although availability of drugs, on average seems acceptable there is evidence of stock outs	major issues is the illegal charge to patients, which became pervasive in the 1990s. These illegal charges are a multiple of the official fees, but because of their very nature, little systematic information exists about them.	
Tanzania	The draft PRS II is just out for consultation. At present it identifies health care charges as the most significant obstacle to access and states that addressing existing barriers and increasing access to high quality care – particularly for women and children are a priority for the PRS Policy is to expand Community Health Funds and membership of NHIF (public servants only). A recent evaluation shows very low membership with CHF contributions stagnant or declining. GoT and WHO very upbeat about potential of CHF, but situation on the ground suggests otherwise.	Aims were to raise revenue, rationalise use, ensuring availability of drugs, and promoting local level accountability. Immunisation, pregnant women, under 5s, the chronically ill are all eligible for exemptions or waivers – in practice, immunisation seems to be one of the only services actually offered for free. There is huge variation in charges imposed and the use of the exemptions and waivers scheme is limited Drug availability is reported to have increased in the last few years – MoH attribute this to user fees though increased donor funding may also be responsible. The ineffectiveness of exemptions is agreed by all. Little solid data is available on revenue raised.	Charges are one obstacle that deter the poor from accessing healthcare – with many poor people particularly women and children dieing without entering a health facility – any barrier to their access is significant. Other charges and expenses certainly exist, for example, the costs of transport are certainly an issue in referral and in women accessing emergency obstetric care.	Government could be responsive though few donors want to push the issue with Government. Donor community is concerned about the implementation of policy (rather than the policy itself) DFID believes a strong statement in favour of the abolition of user fees (supported by funding) would be very helpful in terms of breaking the current logjam and through catalytic effects. Government is aware of a growing debate on user fees but it is a sensitive issues. Central Govt (MoH and to some degree MoF) very defensive on user fees and district health teams and primary health staff generally supportive (presumably related to the availability of discretionary funds). The forthcoming 2005 election and President Mkapa's position as a Commissioner for Africa and new PRS represent a real opportunity
Zimbabwe	In the run up to the elections next year Government is promising extra support for ARVs and has talked about scrapping charges for women and children	At independence, government eliminated user fees for all those earning less than Z$150 per month. Inflation and weak enforcement meant little revenue was raised In 1995 the government ordered the abolition of user fees in rural health centres < 5 percent of the recurrent health budget (Loewenson, 2000) but did increase when facilities were allowed to retina fees. Facilities were to be compensated for exemptions through the SDF in Harare. However, reimbursement to health units would take up to 8 months since they required authorization from Harare.	There is evidence that cost recovery may be adversely affecting access by the poor and that in some cases it may have had a negative impact on efficiency of health service provision.	DFID currently has no dialogue with Government and is working solely on humanitarian support and HIV/AIDS through non Government channels
Countries in Crisis Sudan, DRC, Sierra Leone	A high proportion of services tend to be provided by international NGOs or faith based organisations who over a 20 year period have established a culture of cost recovery in the absence of any alternative (Government) funding source. Such approaches have established considerable levels of community ownership.	Sierra Leone: Fabricant et al 1999 Waivers and exemptions were almost non existent The lack of transparency and the fact people didn't know how much to bring to a health centre was another deterrent to use DRC Provider based hospital prepayment schemes are relatively well developed (Bwamanda and Masisi). Impact on revenue mobilization has been limited with cost recovery rates around 35%, inconclusive impact on quality and limited positive impacts reported on access Sudan: In the South the SPLM requires	The usual factors compounded by insecurity associated with conflict Sierra Leone ne evidence suggests that most poor households were able to pay the small amounts associated with PHC drugs with little trouble, but the higher amounts usually associated with hospital visits were much more	In humanitarian situations DFID is unable to provide support for more than one year. Support in the past has been based on improving existing approaches e.g. conditional on exemption systems being in place.

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		facilities to raise at least 30% of total costs internally (due primarily to lack of alternative funding sources). Under ongoing peace talks this may change as the Sooth receives access to a proportion of oil revenues	difficult.	
Lesotho	The HSRP (October, 1999) covers a ten year program of policy and institutional reform aimed at increasing access to quality preventive, curative, and rehabilitative health care services in Lesotho. It aims to "increase access to quality preventive, curative and rehabilitative health care & management services in a sustainable manner".	A cost-recovery program has been in place since 1989. Fees are relatively low; cost recovery averages 7% There are leakages and inefficiencies of collection. All revenues collected are remitted to the centre. Some facilities are unable to participate due to lack of qualified staff to collect or transport fees. CHAL facilities rely heavily upon GOL subventions and user. fees. In 1997 around 35 percent of costs were met through fees (which are higher than MOHSW facilities). And they have increased in response to declines in external funding. This has constrained facilities ability to serve the poor	Financial barriers – also distance and terrain	Could be responsive though spending is already at significant levels and could arguably fund domestically
Kenya	PRSP talks about reducing out of pocket expenditure through NHSIS and increasing allocation to health from 5.6% to 12% The Basic Package is costed at around $ 19.	The Minister has announced free health services twice in the last 18 months but with inadequate planning and no increase in budgetary allocation - small increase in utilisation noted and then returns to normal. The problem is that none of this has been done with reference to MOF or other government colleagues. Objective is revenue mobilisation In essence nothing is free. Fees cover around 5% of health budget (PER). Exemption system is considered to be ineffective.	Cost is important but it is not the only problem, distance, opportunity cost, supplies, attitude.	Mixed - most agree the NHSIS is not the answer particularly for the poor. Most agree on the need to reduce charges but key questions are: how do you finance it? and how do you ensure that no informal fees are charged? Government has asked for support but this has not been followed up with a proposal or any figures. We would also wish to see MOF involved. I think it also needs to be planned as part of the overall financing of the health sector and not just treated in isolation. An approach would need to be combined measures to improve supplies and reduce the informal charges, and an alternative source of funds to fund the activities now funded by user fees. In short what is needed is a better analysis of the constraints to access and a plan based on this
Nigeria	At the federal level there is an ambitious reform programme and some degree of success in securing additional funding. At state and particularly local Government levels chronic underfunding and governance failures have resulted in poor quality services which the population are not willing to use	There is a national policy emphasizing the use of revolving drug funds and the provision of services on a fee paying basis. The policy sets out a range of services which are supposed to be provided free and a system of deferrals/exemptions. In practice, they are not followed. Primary care is the responsibility of local authorities which operate with very high levels of autonomy. In practice, immunization is probably the only service which is free. Experience with the Bamako Initiative has been patchy.	Government is more concerned about providing financial protection against catastrophic care. Human resources are less of a constraint. There are medical staff but no patients as there are no services worth paying for. Emphasis is on providing services which people are willing to pay for (curative services) than preventive services	The abolition of fees is unlikely to have any impact on a system which is so dilapidated. There is no service worth paying for and local Government workers, having often not been paid for months operate private practices out of public facilities