DFID HEALTH RESOURCE CENTRE

International Experiences in Removing User Fees for Health Services – Implications for Mozambique

Author: Rob Yates

Date: June 2006

DFID Health Resource Centre
5-23 Old Street
London EC1V 9HL
Tel: +44 (0) 207 251 9555
Fax: +44 (0) 207 251 9552

The DFID Health Resource Centre (HRC) provides technical assistance and information to the British Government's Department for International Development (DFID) and its partners in support of pro-poor health policies, financing and services. The HRC is based at HLSP's London office and managed by an international consortium of five organisations: HLSP Ltd, UK; Ifakara Health Research and Development Centre, Tanzania (IHRDC); ICDDR,B - Centre for Health and Population Research, Bangladesh; Sharan, India; Swiss Centre for International Health (SCIH) of the Swiss Tropical Institute, Switzerland.

This report was produced by the Health Resource Centre on behalf of the Department for International Development, and does not necessarily represent the views or the policy of DFID.

Title: **International Experiences in Removing User Fees for Health Services – Implications for Mozambique**

Author: Rob Yates

DFID Health Resource Centre
5-23 Old Street
London EC1V 9HL
Tel: +44 (0) 20 7251 9555
Fax: +44 (0) 20 7251 9552

Table of Contents

1. SHOULD AFRICAN GOVERNMENT'S CHARGE USER FEES FOR HEALTH SERVICES?

Whether Governments should charge patients fees to use public health services has become one of the most contentious social policy issues worldwide. Sadly for policy makers, in recent years, the quality of debate in this area has often been poor, with opposing camps usually resorting to unproven theory and emotive rhetoric. Perhaps a new perspective should be brought to this debate. How would the world of business deal with this problem; which in effect, is an issue of what (if any) price one should charge for health services?

A business case study: A strategy to increase sales of basic health services

Imagine you are the chief executive of Kenzamia Health Services Inc. Your organisation's mission is simply to **increase the consumption of effective health services**, especially in your target market of the poor and vulnerable. You are not in the business of making money but financing is an important issue for you, as more funds will help you achieve your mission. Your main shareholders of Treasury Ltd. and Donor Corp. contribute 98% of your finances. Unusually your direct customers only contribute 2% and market research has shown that they are unwilling to contribute more. Indeed since customer charges were formally introduced (following pressure from a powerful shareholder) you have seen sales stagnate. Some of your customers have gone to the competition but there also appear to be millions of potential customers not even participating in the market.

Clearly the strategy of the last two decades has not been working. This has involved trying to increase sales by gradually improving quality, using small increments in your funding levels. Your target market has not responded, leaving you with poor sales figures and excess capacity in the form of under-utilised buildings and staff.

Now your job is on the line. The shareholders have made it clear to you that more funds will be made available only if you can demonstrate improved outputs. Radical action is required to increase sales but what should you do?

Answer: Make your services free! Sales figures will undoubtedly soar and you will be able to use this evidence to secure more funding than you lost from your principal financiers. Rather than lose your job, you will have turned around the fortunes of the organisation.

2. IS THIS RELEVANT TO GOVERNMENTS IN AFRICA?

We may like to think that providing public health services is a long way from the world of business, but is it? Firstly, if health services are to make any contribution towards the MDGs, we must increase "sales" (consumption) of effective preventive and curative services. It is not good enough supplying services, which we believe are good quality, if our target populations do not use them. So what drives demand for health services?

Research has shown that health care users in developing countries are like other consumers and shop around for health services, basing their choice of provider on their perceptions of quality and price. People choose services which, for them, represent the best **value for money**. If health care providers want to increase their outputs, they have two main strategies open to them: to improve quality as perceived by the user and/or lower their prices. Perhaps we have been concentrating exclusively on the first option and underestimating the importance of prices to poor people who, by definition, have very little money.

3. A VERY BRIEF HISTORY OF USER FEES IN AFRICA

User fees were introduced in Africa at a time of widespread downward pressure on public expenditure and dwindling aid flows during the late 1980s. Realising that health services were woefully underfunded, it suited both donors and Governments to shift some responsibility for health care financing to the population through "cost sharing". The rationale for charging user fees was set out in a World Bank document in 1987, which argued that user fees would:

- Raise substantial additional revenue for the health sector which could be used to improve efficiency and equity
- Improve targeting of resources by reducing frivolous demand
- Improve efficiency by encouraging people to use low cost primary health cares services instead of more expensive hospital services.

Initially, in the 1990s, some research literature appeared to support this theory, in demonstrating that introducing fees and improving management systems could increase the consumption of services (Litvack J and Bodart C, 1993). However most of these studies relate to small scale projects and do not take into account the high management costs associated with user fee systems.

An overall assessment of the extensive literature on user fees over the last twenty years, giving a higher weighting to countrywide data, shows that this policy has not fulfilled its objectives. In summary: fees have raised very little additional revenue[1]; fee levels have been sufficiently high to suppress demand from poor people and exemption schemes have been ineffective. (Gilson 1997, Arhin-Tenkorang 2001, Witter 2005) Readers may wish to refer to the bibliography at the end of the paper which includes references to some of the vast volume of literature published on this topic in recent years. It is beyond the scope of this paper to review all of these findings. Rather, the purpose of this paper is to review the experiences of countries that have acted on these results and have abolished user fees. Specifically what can the Government of Mozambique learn from these experiences?

4. RECENT INTERNATIONAL EXPERIENCES IN REMOVING USER FEES

In addition to the obvious and powerful equity arguments (increasing access for the poor), there are strong efficiency grounds to abolish patient fees. This is because user fees raise very little revenue and when administration costs are taken into account their overall impact is often negligible.

However, it appears counterintuitive to remove an income stream for the health sector when resources are already very constrained. Wouldn't this be risky and make matters worse? The evidence from the following case studies would suggest not. In every case but to varying degrees, one can see that the benefits of this policy in terms of increased consumption of services outweighed any costs related to small losses in revenue.

4.1. South Africa

As a means to improve access to health services and build national unity, one of the first actions of the ANC Government in South Africa, in 1994, was to remove health

[1] It is debatable whether the revenue realised was additional at all, if ministries of finance felt less pressure to increase health budgets.

care user fees for: all children under six and pregnant and lactating women. In a British Medical Journal paper in 1997, Wilkinson et al reported the impact that this policy change had on the utilisation of mobile primary health care services in Hlabisa health district. They found that whereas there was little change in the use of preventive services where utilisation rates were already high (eg antenatal care and immunisations) there was a large increase in the use of curative services. Here outpatient attendances increased by 77%.

Based on these findings and similar experiences across the country, the Government realised that the health sector was coping with these additional demands and that it could and should expand access for all population groups. Therefore in 1997, the Government introduced a policy of universal access to free primary health care by removing fees for everyone. In a second WHO paper, Wilkinson et al report on this two phase implementation of free primary health care services. They found that before the first policy change (1992-1994) attendance rates for curative services were stable. However the moment free services were introduced in 1994, this triggered a substantial and sustained increase in out-patient attendances **which continued into 1998.** This pattern of increasing use over a sustained period was later repeated in Uganda (see below). Regarding preventive services, in South Africa, the policy change did not appear to have any statistically significant impact but according to the authors this was not surprising given that most preventive services had been free in the first place.

Considering that increased demand for services would have created an additional workload for health units, it is interesting to note that Wilkinson et al conclude that the introduction of free services was popular with communities and health workers. However it would also appear that many saw these reforms as being “hurried and unplanned” (Durban Health Systems Trust (1996). This suggests that the implementation of the policy could have been more successful had there been better planning and management before fees were scrapped.

The need to address such supply side measures has been highlighted by a number of health economists based in South Africa. For example, the Equinet conference in June 2004, whilst promoting a clear message that user fees should be scrapped, emphasised that this policy should be complemented by other health sector reforms. Specifically they argued that to maximise the long-term effects of removing fees there must be: “actions that increase overall national resources for public sector health services and that deal with international conditions and policies that undermine this.”

4.2. Madagascar

Since the start of the decade, Madagascar has had a troubled history and this has had a profound impact on the provision and uptake of essential social services. One effect of the political turmoil in Madagascar in 2002, was to give researchers an opportunity to study the impact of supply side and demand side shocks on the public health system. In particular, it shed light on the relative importance of quality issues and prices of services for the Madagascan population.

In a 2003 paper, Fafchamps and Minten show that following a disputed Presidential election, there was a blockade of part of the island of Madagascar, which resulted in a suspension of supplies to health facilities. Using output statistics (out-patient attendances) the authors conclude that the health system was surprisingly resilient against these shocks. Indeed, they conclude that the 26% reduction in the numbers of patients visiting health centres was not so much due to problems of the supply of services but mostly due to increased levels of poverty meaning that patients could no longer afford services.

To emphasise the importance of demand side factors, the paper looked at the period after the blockade was lifted and the new Government **temporarily abolished user fees.** Once services became free, there was a significant increase in the consumption of services to the extent that "monthly visits post-crisis almost doubled compared to the previous year". In trying to assess the relative importance of supply side and demand side factors on the population's consumption of services, the authors conducted structured interviews with health centre staff. They found that "the main perceived reason for increase in the number of visits [was] the elimination of user fees" (Fafchamps and Minten, p11).

In addition to the obvious lesson about the importance of removing fees, one can learn other lessons about Madagascar's experiences. Firstly, that this policy was successful even when it was suddenly introduced, in an unstable environment where presumably there had been little pre-planning. Obviously this is not a recommended strategy but it does indicate the robustness of the policy.

Secondly, the authors of the paper noted that despite the Presidential decree abolishing fees, it took a while for this policy to be implemented effectively throughout the country. Around the capital, 93% of health centres were not charging patients 3 months after the decree, but in another, more distant Province, this figure was only 55%. These figures show that there is a tendency for health workers to want to retain user fees and that mechanisms need to be established to monitor and encourage compliance and take action against those who break the law.

5. TWO RECENT AND HIGHLY SIGNIFICANT CASE STUDIES FOR MOZAMBIQUE

The two examples given above, show that removing user fees was effective in very different contexts. However, it could be argued that the relatively high income context of South Africa and the turmoil in Madagascar in 2002 are quite different environments to Mozambique in 2005. The following two case studies though, appear to be much more relevant to Mozambique's situation and again show how scrapping (or in one case, reducing) fees has led to an increase in the consumption of services. However these studies also demonstrate that the impact of this policy can be greatly enhanced by effective management and planning: before, during and after the policy change.

5.1. Kenya

The Kenyan Government, and in particular the Minster of Health, has realised the importance of reforming health financing mechanisms as a means of improving overall health sector performance. In particular, the MoH has been actively engaged in establishing systems which shift the burden of financing services from poorer, sicker members of society to the more healthy and wealthy. As part of this process, the Government of Kenya (GoK) implemented a major change in its user fees policy in July 2004.

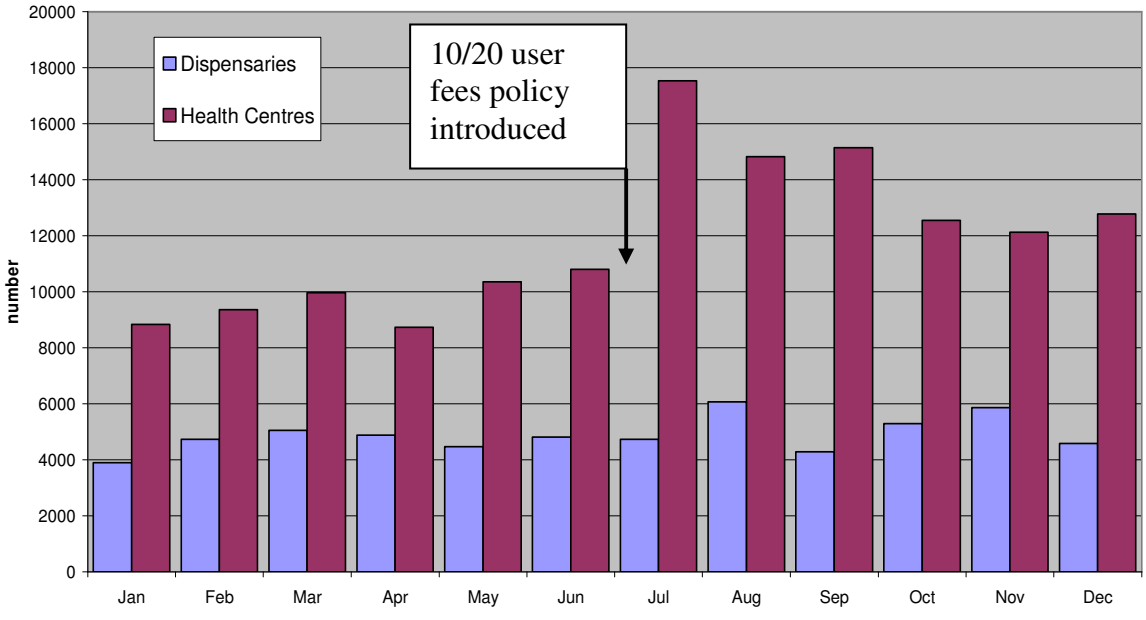
A recent paper by Pearson, has documented the changes in this policy and its effect on service utilisation. It also provides an in depth analysis of how the policy was implemented and argues that insufficient attention was paid to addressing supply side factors which therefore diminished the impact of the reform (Pearson, 2005).

Pearson shows that rather than abolish patient fees, the GoK chose to **reduce** fees by introducing a simplified fees system called the 10/20 policy (see box below):

Kenya's Change in User Fee Policy in July 2004
Pre 10/20 Policy: Prior to July 2004 the Government of Kenya's cost sharing policy allowed facilities to set fees locally. Facilities were required to return the revenues raised to the district level and develop a plan for spending 75% of the balance with 25% of the revenue was retained at the district level. This plan was approved at both district and provincial levels. In parallel, dispensaries, but also many health centres, also raised community funds, which were totally under the control of the facility. This approach although unofficial was generally tolerated by the authorities
Post 10/20 Policy: The 10/20 policy, introduced in health centres and dispensaries on July 1st 2004, set a standard fee of 10 K Shs at the dispensary level and 20 K Shs at health centres. The policy was introduced at short notice and little guidance was given on its implementation. The requirement to return funds to the district level appears to have been dropped with resources spent as they are raised. The 10/20 policy has also effectively resulted in the abolition of community fund approach.
Source: Pearson 2005

Pearson's research measured the impact of the 10/20 user fees policy on the utilisation of services in 60 health units in 6 different health districts. The data collected covered the 2004 calendar year. He found that there was a significant increase in utilisation in July 2004, with attendances up around 70% compared to the average of the previous six months. Again this demonstrates the scale of the previously unmet demand for free health services in the population. However the graph below shows that this demand was not sustained at these much higher levels and that in the final quarter of the year, on average, utilisation was 30% higher than the first half of the year. Clearly one must be careful in drawing definitive conclusions from data over such a short time scale but there are potentially a number of very interesting lessons to be learnt from the Kenyan experience.

Total Number of New Visits and
Re-Attendances in Study Facilities during 2004



Perhaps the most important point to realise from Kenya, is that the Government **did not abolish user fees.** Early media coverage may have given the population the impression that services were free but when patients visited health units they found that they were still being charged 10 or 20 shillings per visit. The rationale given for this "registration charge" was that it would raise some additional revenue, discourage frivolous use and that these levels of charges were affordable.

This decision to retain "minimal" fees appears to have been a mistake. Purely on efficiency grounds Pearson predicts that: "it is doubtful whether the policy will generate any significant net revenues." Furthermore, the great volume of international literature on this subject questions the validity of the view that these charges will be universally affordable. In a low-income country such as Kenya even charges in the order of 0.2 US dollars will discourage the poorest members of society from visiting health facilities. In particular, this policy will discriminate against those who have least access to money – namely women and children. For these reasons it would have been more efficient and equitable, had the GoK abolished user fees for these services entirely.

However, looking again at these preliminary figures, one can see that even this limited price reduction did increase the consumption of essential services by 30% (last quarter compared to first half of the year). This is still a remarkable increase over a short time period and most private sector firms would celebrate such an increase in "sales". Furthermore, it is likely that the majority of the increase in patients will have been amongst those who were most price sensitive, in other words poorer members of society. One can therefore be confident that even though the policy change did not go far enough, it did result in better targeting of scarce public health resources to those who needed them most.

In supporting the view that African Governments should abolish user fees, Pearson correctly highlights the need for Governments to implement this policy as part of a package of broader reforms.

Looking at how the 10/20 user fees policy was implemented in Kenya it would appear that the following additional lessons could be learnt:

- Stakeholder interviews showed that the price reductions were generally welcomed amongst communities. In fact, twice as many respondents thought that this had led to a net improvement, compared to those who thought the situation had deteriorated. This proves that in general, the policy was popular with the population.
- Health workers were less enthusiastic about the policy change and were concerned with rising workloads and a lack of funds at the health unit level.
- Before fees were reduced, there were already existing problems with lower level units being allocated insufficient budgets to cover their operational costs. Furthermore these budget resources were not disbursed regularly. Tackling these problems ought to have been a priority reform as user fees revenues were reduced. However this did not happen and units were therefore left with shortfalls in resources as fee incomes fell 50% at a time of increasing demand.
- Many health facilities were using user fees revenue to employ staff, notably laboratory technicians, watchmen and cleaners. The reduced income from the 10/20 policy resulted in some staff being laid off. Greater attention should have been given to increasing funding for human resources inputs, either by a formal recruitment programme or by increasing flexible budget funds for health facilities.
- User fees were providing a useful source of flexible funds for health units to buy essential supplies. Mechanisms should therefore have been put in place

to replace this liquidity and therefore enable units to respond rapidly to fluctuating demands for different inputs.

- Health units were given short notice of the policy change and little guidance on how it should be implemented.
- Early media coverage of the policy change tended to give the impression that the GoK had scrapped cost sharing. This led to unfulfilled expectations in the population when they found that they were still being charged 10 or 20 shillings per consultation.
- It should have been predicted that when fees were reduced, the greatest pressure on resources would have been for pharmaceuticals. However it appears that there was little attempt made to increase pharmaceutical supplies and according to Pearson: "**the receipt of drug kits at the facility level seems to have fallen at the very time that utilisation increased."** This appears to be due primarily to a failure of district supply systems, rather than a lack of overall drug stocks in the country.
- An improvement in the supply of drug kits in December 2004 was associated with a small increase in the demand for services. Like Uganda (see below) this suggests that drug availability at the unit level is the most important factor driving demand for free or heavily subsidised services.
- A drug supply system reliant on fixed drug kits was inflexible at meeting fluctuating demand and it would therefore have been preferable to introduce more, demand-led drug supply systems.
- Prior to July 2004, there had been a wide variation in District performance in collecting user fees so the 10/20 policy affected revenues differently with richer districts seeing the largest falls. This would have resulted in a more equitable pattern of health care expenditure. However it would also have probably led to additional levels of discontent amongst health workers and middle class service users in wealthier districts.
- The 10/20 system appeared to be grossly inefficient (low revenues and high administration costs). In one example a unit was spending 15% of its total user fees revenue on receipt books.
- Stakeholder surveys suggested that local participation had declined since patient fees were reduced. Specifically it was mentioned that management committees were less active when there were fewer user fee revenues to allocate. However if one measured participation in terms of the community's utilisation of services one could argue the participation had increased by 30%.
- Patient surveys showed that despite of the existence of exemption policies, poor patients were no more likely to receive exemptions than other members of society. These findings support the international literature that exemption systems do not meet their objective of improving access for the poor.
- Patient groups expressed concern that fees at mission facilities were too high, suggesting that the GoK should have considered increasing subventions to mission facilities on the understanding that they reduced fee levels. As in Uganda, the increased demand for GoK services, was not at the expense of lower utilisation of NGO services. This demonstrated that the price reduction had led to an increase in the overall consumption of services.

At the time the GoK launched its reduced user fees policy, the MoH announced ambitious plans to implement wider health financing reforms, including the introduction of Social Health Insurance. This policy would have required people employed in the formal sector to make significant contributions to a national health insurance fund. It was planned that these funds would be used to cross-subsidise services for the poor.

Irrespective of the merits of the policy, it would appear that the implementation of these reforms was inhibited by a lack of support across Government. Whereas the MoH thought that the necessary support had been secured, when it came to Parliamentary debates, other ministries, notably Finance, blocked further progress. At this time it also became apparent that the reforms were not receiving the active involvement of the Head of State. These elements of the Kenyan experience provide a salutary lesson, in terms of the need to secure cross Government support for health financing reforms. Given the far-reaching nature of this social policy issue, health financing is a highly politicised issue and any changes must be led by the political elite. In particular, it is a common lesson from all these studies that a greater ownership of the policy change by the head of state, leads to an increased probability of success.

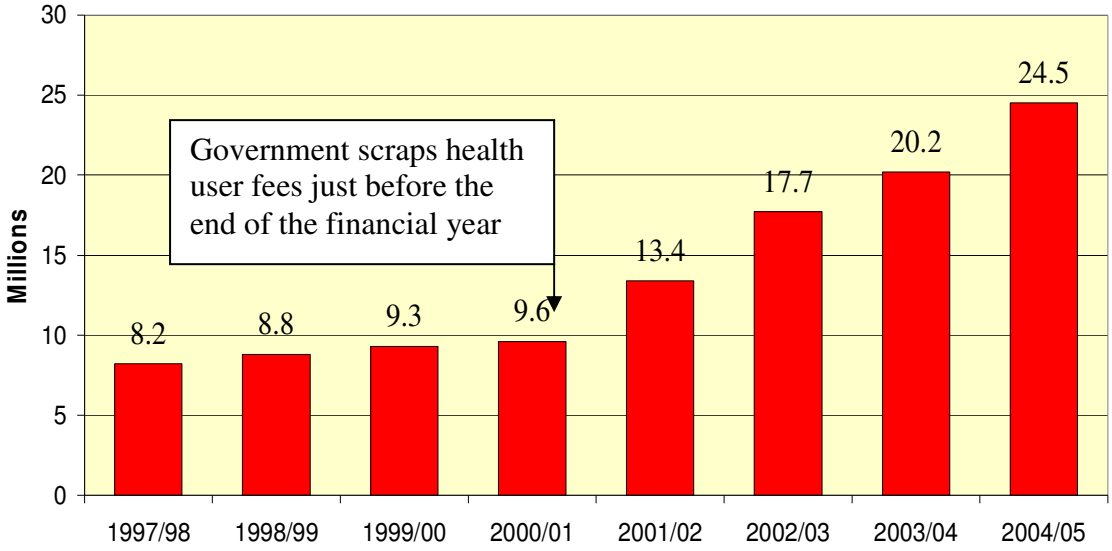
5.2. Uganda

There can be no doubt that the decision to abolish user fees in Uganda was led by the President. Ten days before the presidential election in 2001, the incumbent, suddenly announced that cost sharing would be scrapped in all Government health facilities (with the exception of private wings in larger hospitals). The first time that most people in the Ministry of Health knew about this policy change, was when they read it in the newspapers on the way to work.

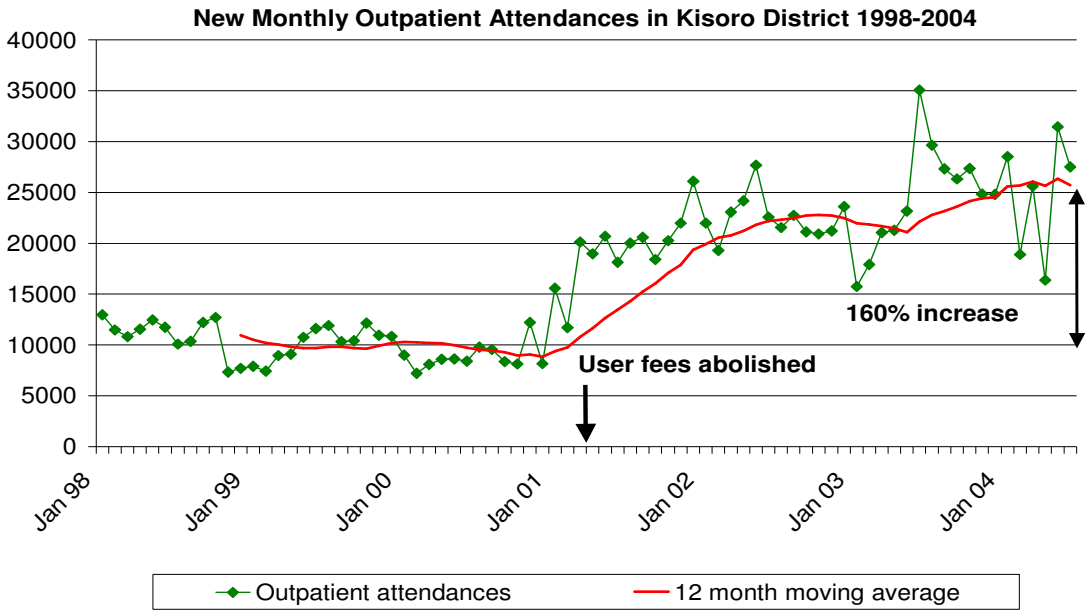
Perhaps the main reason that prompted President Museveni to take this dramatic action was that he knew from his own political rallies and from research conducted by the Ministry of Finance, that cost sharing was very unpopular amongst the population. Indeed one of the key messages from the Uganda Participatory Poverty Assessment Project was that: “Cost sharing is not for the poor”. The President therefore realised that, as when he scrapped school fees for primary education, abolishing health fees would be very popular and would enhance his prospects of re-election. Some commentators have criticised this action, calling it a “political decision” but one could argue that this is a good example of effective democracy - with a politician responding to the needs of the population.

Given the sudden nature of the policy change, not surprisingly, the Ministry of Health, other ministries and local governments were ill-prepared for the huge surge in demand for free health services which followed. However looking back on this period, it is immediately worth highlighting two features of the situation in Uganda, which enabled the policy to work effectively. Firstly, the public health system, despite years of under-investment was surprisingly robust at dealing with such a shock. Large patient numbers did put pressure on resources (especially drugs) but **the system did not collapse** and there was certainly no political unrest against the policy. Secondly, due largely to the President’s personal involvement, all stakeholders in the health system were aware that they had to make the reform work. Over the following weeks and months, there was therefore an amazing acceleration of other health reforms with a focus on increasing health care inputs at the facility level. This included close collaborative working between the Ministries of Health, Finance, Local Government, and Public Service as well as with district officials. There is therefore very strong evidence from Uganda, that rather than derailing health sector reforms, scrapping user fees can catalyse significant supply side improvements. The following graphs show what happened to basic health sector outputs following the abolition of user fees at national, district and facility level:

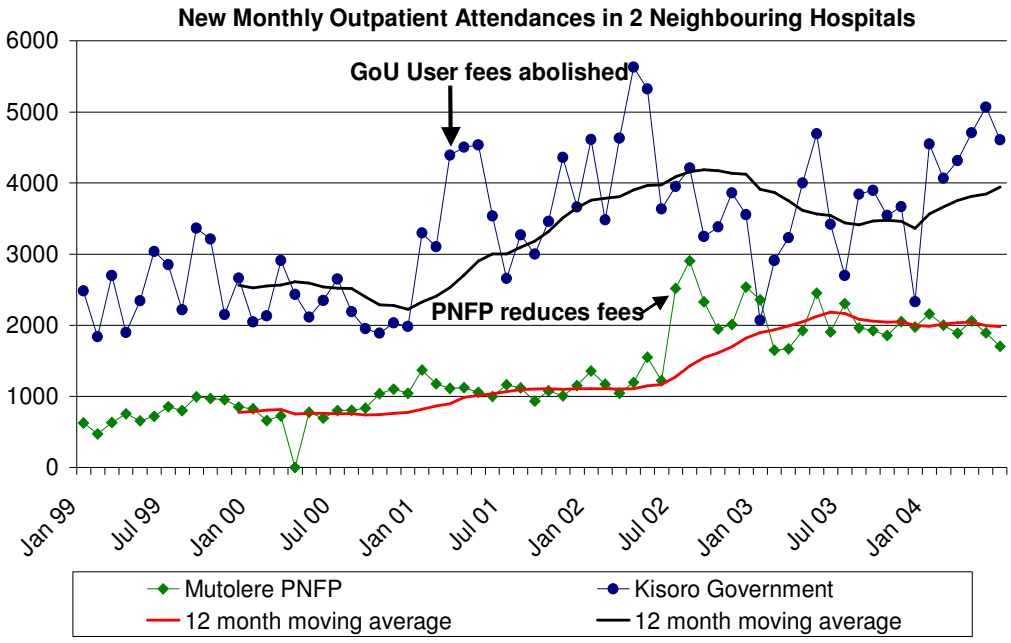
New Outpatient Attendances in Government of Uganda and Private Not for Profit Health Units



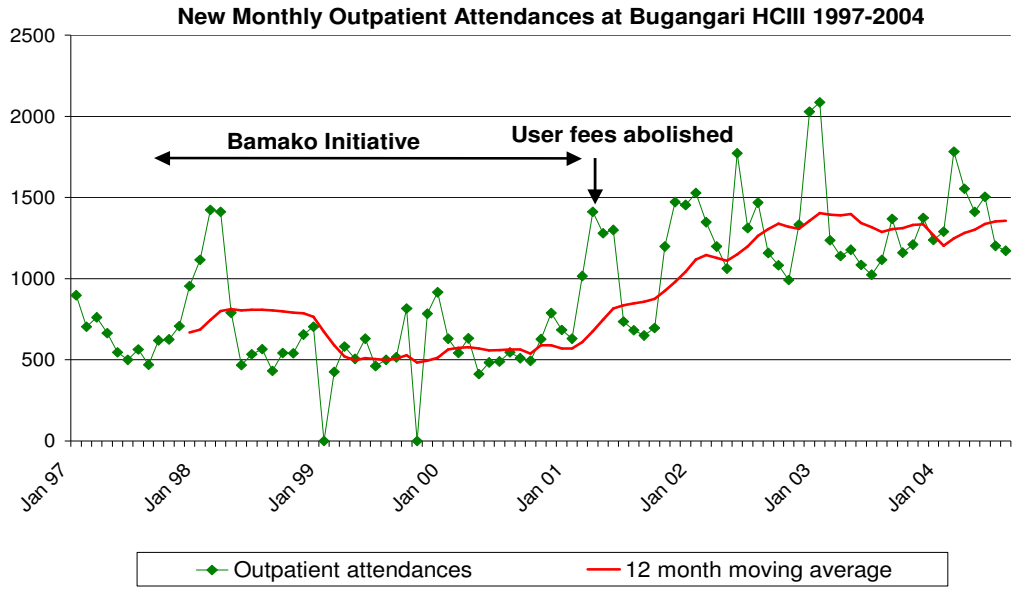
The graph above shows that since user fees were scrapped in Government health units in 2001, outpatient attendances have increased by 155% (an extra 14.9 **million** visits). Immunisation rates, as measured by DPT3 uptake, have increased from 48% to 89%. Disentangling the impact of scrapping fees from the broader reforms is difficult but monthly district and health facility data can prove helpful:



Data from Kisoro District shows a 160% rise in OP attendances since fees were scrapped. The marked step in the figures in March 2001 shows the impact of the policy change. The increase has been very high in this District because poor people from Rwanda and DR Congo are choosing to walk over mountains to receive free health care in Kisoro. The dip in attendances around Jan/Feb 2003 was due to poor drug supplies.

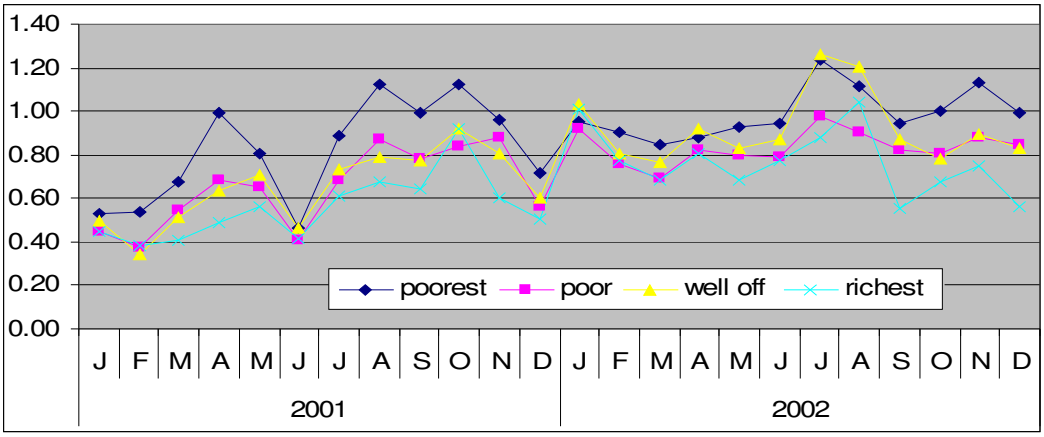


The graph above shows a comparison of attendances at 2 hospitals (one Govt and the other NGO = PNFP) only 4 km apart in Kisoro town. Interestingly in July 2002, the NGO hospital chose to use its rising Govt grant to reduce and simplify its fee structure, rather than plough the money into service improvements. Like the GoU unit attendances immediately doubled. Note that when the GoU unit ran out of drugs in February 2003 the PNFP unit, now with lower prices, treated more patients.



This Graph shows output changes at a health centre in a different district. Rukungiri is an interesting district because in the last decade it has had experimented with virtually every type of financing system. So after a poorly regulated user fees system, it introduced the Bamako Initiative, which attempted to link a well managed fee system with improved drug supplies. As one can see from this health centre the results were poor, particularly compared with what happened when fees were scrapped. Now the District Director who was experienced all these systems and who was a staunch advocate of fees, is totally convinced that, for his population, scrapping fees was the right decision.

The graphs above use data from the Ministry of Health's Health Management Information system but it is important to realise that these results have been backed up by independent research. Nabyonga et al, for example, found that in the two years following the abolition of user fees at Government health units utilisation of rural health centres increased by 77%. Of major significance for improved targeting of health services and poverty reduction strategies they also found that it was the poor who were now using services more. This led them to conclude that "Abolition of cost sharing is pro-poor". The graph below shows how utilisation rates of Government health centres diverged after the abolition of cost sharing, with the poorest quartile using services twice as much as the rich by the end of the study.



These pro-poor findings have been corroborated by a World Bank Working Paper by Deininger and Mpuga. Their study used a different data set (the Household Survey) but their conclusions were basically the same: scrapping user fees had benefited the poor:

"We find that the abolition of user fees significantly improved access to health services especially by the poor whose health spending (at the household level) is significantly lower after the policy change as compared to the situation before."

"... the benefits from the policy change [abolishing user fees] did accrue largely to the poor. In fact, for adults almost half the total benefit accrued to the bottom quintile and more than two thirds of the benefits, according to our estimates, benefited those in the bottom two quintiles. This is consistent with anecdotal evidence which highlights that those who could afford it often switched to private facilities and suggests that, in Uganda, the abolition of user fees was more effective in reaching the poor than the policy of exemptions which was to achieve this goal earlier. A similar pro-poor picture emerges for children" (Deininger and Mpuga 2003)

Given the weight of this evidence the World Bank PRSC Mission in 2004, in its final aide memoire with the GoU said:

"The mission also noted the findings of a recent World Bank study confirming that the government policy to abolish user fees for health services triggered a massive increase in the consumption of basic health services. Of great significance for poverty alleviation strategies, poor people have benefited disproportionately, with the lowest income quintile capturing 50% of the benefits from this policy change. This finding augurs well for maternal and infant mortality interventions and the government is congratulated on this impressive pro-poor initiative."

With so much independent research (see also Burnham et al 2004) including World Bank and WHO reports, backing up the MoH's own findings, there can be no doubt that Uganda's decision to scrap user fees has been very successful in increasing and **sustaining** the consumption of health services especially amongst poor people.

Rather than the experience of Kenya, where there was a surge in utilisation followed by a fall [2], in Uganda, the national output figures show a continuing rise in consumption of services to the present day. What therefore were the elements of the Ugandan reforms which could have led to this sustained improvement in performance.

5.2.1. Specific lessons from Uganda

The activities undertaken by the GoU to enhance the success of the free health services policy can split into short term, one might say emergency measures around the time of the abolition of fees and longer term health systems reforms.

6. SHORT TERM ACTIONS

Political Leadership: It cannot be emphasised strongly enough how important it was that the decision to abolish user fees was driven by the Head of State. This generated tremendous media interest in the run up the elections and therefore provided free publicity to advertise the new free services. Also, leadership by the President meant that all stakeholders were under pressure to deliver a successful outcome and this greatly facilitated collaborative working across Government.

A simple policy message: **The policy launched by the President in March 2001 was very simple:** all Government health services were to be free for everyone[3]. **This straightforward message helped to remove uncertainty in the minds of potential consumers and empowered them to demand free services. It also reduced the scope of health workers to charge unofficial fees.**

An emergency release of funds to districts to buy drugs: **It was immediately realised that drug supplies would come under the greatest pressure from the surge in demand for free services (this was borne out by events). Therefore, contingency funds to the value of $600,000 were obtained rapidly from the Ministry of Finance and released to the districts to purchase drugs.**

A <u>suspension</u> of drug procurement regulations: It soon became apparent that the National Medical Stores (NMS) could not meet the huge increase in demand for free pharmaceuticals. Therefore the Ministry of Health issued a circular to all districts, which temporarily lifted the requirement to purchase from NMS and enabled them to procure drugs from other approved sources using their supplementary funds. After NMS systems were improved this circular was revoked.

An increase in the salaries of health workers: **It was clear that there was a potential risk that the free services policy could be jeopardised by health workers disgruntled by an increased workload and their reduced income from user fees. The President and Minister of Health therefore took the decision to increase doctors' salaries by 60% immediately and other health workers by around 25%.**

[2] Although falling back to levels still 30% greater than when there were user fees
[3] with the exception of easily identifiable private wings in hospitals

Measures to increase cash flows to health units: **It was accepted that one of the few benefits of user fees had been that they provided liquidity (cash) at the health unit to purchase essential goods and services. Initially, when fees were abolished there were no formal attempts to replace this liquidity but units and districts across the country soon started to run small cash imprest systems. Once Central Government officials realised that these systems were operating the financial regulations were changed to formalise these arrangements.**

Emergency negotiations to increase the health budget: **The decision to scrap user fees came towards the end of a financial year, when negotiations for the next budget were in full swing. The Ministry of Health, with Presidential backing, was able negotiate a substantial increase (40%) in its 2000/01 budget by arguing that the Ministry of Finance must meet the expectations of the public for free health services.**

Research to monitor the impact of the policy change: It was realised that HMIS systems would be able to chart overall changes in outputs but that this would not provide information on beneficiaries. The MoH and WHO therefore immediately initiated a research project which would investigate changes in consumption by different demographic and socio-economic groups. A regret of the MoH, was that it did not engage effectively in a revision of the Household Survey at this time which could have provided more useful information on beneficiaries.

7. LONGER TERM HEALTH SECTOR REFORMS

Many of the longer term health systems reforms in Uganda originated in the late 1990s, with the start of the Sector Wide Approach (SWAp) process of health sector development. The intention of the SWAp, was to improve efficiency and equity in the health sector, by improving the coordination of Government and partner interventions. Specifically, the GoU, development partners and NGOs agreed to focus their efforts on implementing a strategic plan for the sector of which pro-poor financing was an integral part.

It is beyond the scope of this paper to describe all the different elements of the reforms, but in addition to removing user fees, the following appear to have been key in improving overall health sector performance:

- Greater efficiency of health financing – notably donors switching from less efficient project financing to providing budget support
- Improved resource allocations – with a far larger share allocated to district primary health care services, including NGO providers
- Improved management systems – especially in drug supply systems
- Improved levels of human resources - including the recruitment of over 3000 health workers
- Decentralised service delivery – with a greater proportion of resources allocated to district health services and capacity built at the district and facility level
- Public Private Partnership – including a $9 M GoU budget allocation to NGOs
- SWAP processes – which encouraged development partners to align their support behind a coherent and appropriate Government led strategy

For a more detailed description of the overall Ugandan health sector reforms please refer to the paper by Yates et al (2005).

Given the scale of the increase in outputs in the Ugandan health sector, there has been considerable interest in disentangling the relative impacts of all the individual reforms. In particular, how much of the output changes can one attribute to the supply side reforms and how much has been due to the stimulus to demand caused by abolishing user fees? In fact, it is likely that rather than being independent factors, these processes have been mutually reinforcing. In other words, it could be argued that a rising health budget and ongoing supply side reforms encouraged the government to take the bold step to abolish fees. Similarly, the sudden abolition of patient fees and the immediate surge in demand could have promoted health up the government agenda and in effect helped catalyse the fledgling health reforms. Whatever the causal links, the monthly outpatient statistics, which show the sudden step up in consumption in March 2001, prove that scrapping of user fees was one of the most important policy decisions taken by the Government as part of the SWAp.

8. SOME VERY RECENT DEVELOPMENTS – ZAMBIA AND BURUNDI

In just the last two months, two other African countries have abolished user fees for some of their essential health services. In Zambia fees were removed for all public health services in rural areas on April 1 2006 and in Burundi fees were removed for maternal and child services (but not drugs) on May 1 2006. As yet no output data has been available to formally assess the impact of these changes but media reports from both countries indicate a large surge in demand and this policy being popular amongst the poor.

The following report from Zambia, highlights the impact removing fees has had on poor people seeking care and that this policy has been acclaimed by international aid agencies.

http://www.reliefweb.int/rw/rwb.nsf/6686f45896f15dbc852567ae00530132/fe34019a1a9d765f4925714500070264?OpenDocument

The following UNICEF report from Burundi shows that removing fees for maternal and child services is seen as an important mechanism to increase the number of institutional deliveries and therefore help attain the maternal and child mortality MDGs.

http://www.unicef.org/infobycountry/burundi_33908.html

9. A SHIFT IN INTERNATIONAL OPINION

As Pearson points out “user fees are internationally recognised as in inequitable and inefficient means of raising revenue” and therefore “there has been a large shift in favour of abolishing user fees for basic health care”. So far though, only a handful of countries have taken the initiative to remove fees. This may be because a strong consensus existed in favour of fees in the 1990s, before it was realised that the benefits of fees were outweighed by costs associated with suppressed demand. Powerful players in this debate appear to have changed their position now but it is taking a while for these views to be disseminated and acted upon. In terms of the ongoing debate the following current positions are noteworthy:

> “The World Bank does not support user fees for primary education and for basic health services for poor people” – World Bank Website November 2005

> "Eliminate user fees for basic health services in all developing countries, financed by increased domestic and donor resources for health" – Jeffrey Sachs et al, Millennium Project Report Quick Win No 8
> "The best way you can defeat poverty is through free education and free health care available to all." Gordon Brown, UK Chancellor of the Exchequer January 2005

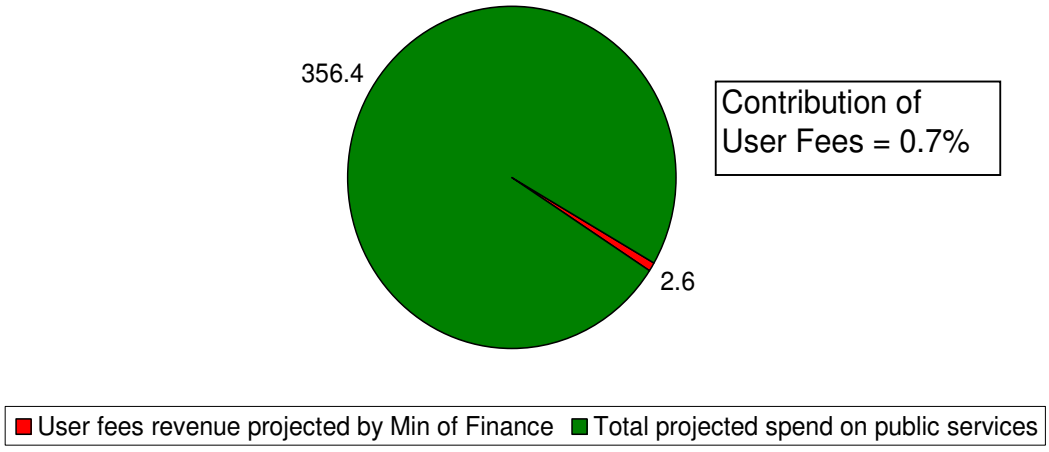
Now that there is less external pressure to impose user fees on poor health care consumers, it is to be hoped that many more developing country governments will take the initiative to remove them.

10. WHAT IS THE SITUATION IN MOZAMBIQUE AT PRESENT?

An analysis of health financing and patient survey data for Mozambique, shows a familiar picture of low benefits of user fees in terms of revenues raised but high costs in terms of suppressed demand for services.

On the revenue side the graph below shows how little user fees are predicted to contribute towards total spending on public health services in 2006.

The Financial Benefits of User Fees to Mozambique (2006, Millions of USD)



Source: Ministry of Finance and the World Bank

Note that these figures do not take into account the administrative costs of collecting fees and managing exemption schemes. Were these included, it is possible that a similar picture to Zambia may emerge where it was found that the costs of raising fees exceeded the revenues collected. If this were the case in Mozambique, scrapping user fees would actually result in a net **increase** in resources for health care services.

In answering the question: could Mozambique afford to lose $ 2.6M of user fees revenue[4]?, it should be noted that the rise in public health spending in the last 4 years has been $178.8 M or 68 times the supposed user fees income.

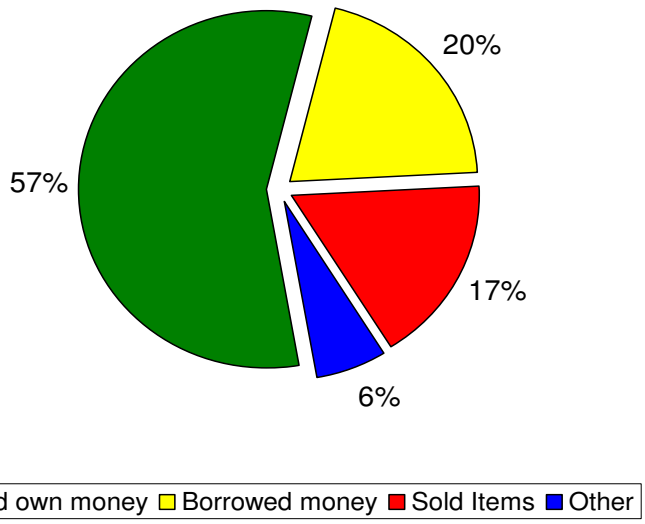
[4] It should be noted that MISAU doubt the validity of this figure and believe it to be too high.

Furthermore, in addition to this policy change being affordable, the environment in Mozambique would appear to be conducive for change for the following reasons:

- The new Government has made clear commitments to put the alleviation of poverty at the top of its agenda and to focus on attaining the MDGs
- The Government of Mozambique allocates a relatively high (compared to many SSA countries) 13-14% of its budget to health
- The Government and its development partners are preparing a coherent pro-poor health strategy
- There have been appreciable improvements in drug supply systems in recent years and more reforms are envisaged here.
- A large proportion in the rise of public financing has been flexible in nature (either budget funding or to the common fund) rather than being tied up in donor projects.
- When presented with the option of abolishing user fees in June 2006 most stakeholders (from MISAU, civil society and development partners) were either enthusiastic / cautious or at worst sceptical about this initiative. No representative was openly hostile to the idea and there was therefore no indication that any agency would actively oppose such a move. Where concern was expressed this tended to relate to **how** this policy would be implemented and whether supply side systems would cope. These are legitimate concerns which should be addressed by all parties in order to maximise the impact of removing fees.

Looking now at the "costs" side of the cost-benefit analysis for user fees, the World Bank Health Financing Review of 2003 indicates that even with relatively low fee rates the population have been finding it difficult to pay for services. A survey of patients leaving health facilities in rural areas in October 2002, found that 52% had found it "difficult or very difficult" to find the money for their health fees. When one looks at how these people financed their care one can see that even with low fee rates these charges: lower disposable income, deplete assets and put households into debt:

Means used by people who reported difficulty in paying



Note that this group is not representative of the population as these people had succeeded in accessing care. One can only speculate about the numbers of people for whom the fees represented an insurmountable barrier.

Given this analysis and the experiences of other African Governments it is strongly recommended that the Government of Mozambique remove user fees for health services.

Even where this policy has been poorly implemented (for example in Kenya) there appear to be overall net benefits for the population in terms of increased consumption of health services. Furthermore, in Uganda where the policy was suddenly sprung on a poorly prepared health sector, the system coped remarkably well with the demand shocks that resulted. International experience therefore indicates that even in the absence of extensive pre-planning a policy of removing fees will be effective and popular.

However this is clearly not an ideal scenario for launching such an extensive social policy change and any Government contemplating these reforms would be advised to plan ahead more effectively. Furthermore, the differences between the Ugandan and Kenyan case studies, show the benefits of implementing simultaneous supply side reforms. In the former case, the decision to abolish fees catalysed a whole raft of reforms which has led to a steady improvement in health sector performance. In the latter case, the surge in demand caused by the reduction of fees was not supported by increases supplies of health inputs. This, combined with persistent fees, appears to have resulted in unfulfilled expectations in the population.

How can Mozambique learn from these lessons and with the benefit of additional months of planning, provide the best example of how to remove health user fees?

To answer this question, it could be useful to consider the different challenges that would face the Government and some of the threats which could reduce the impact of the policy change. These challenges and threats, together with some proposed activities to deal with the issues raised, are presented in the following tables. The international evidence shows that even without these actions, the benefits of scrapping fees are likely to outweigh the costs. The indications are therefore that removing fees is an effective and surprisingly low risk policy option. However, by engaging all stakeholders in the planning and management activities listed in the table, the Government of Mozambique will potentially maximise the benefits and minimise the costs associated with the policy change. It would also mean that Mozambique could claim to be the first developing country to plan effectively for the removal of health user fees.

Challenges	**Proposed Activities**
Ensure that the process is led by the Head of State	Present the abolition of user fees to the President as a policy which will be popular with the vast majority of the population.
Secure a substantial increase in the health sector budget	**1.** Initiate budget negotiations with the Ministry of Finance immediately **2.** Prepare budget proposals based on a realistic assessment of lost user fees revenue plus the costs of meeting the additional demand for free services. **3.** Seek the support of the Head of State and other ministries to guarantee Government wide backing for additional health resources **4.** Suggest that additional donor funds (from debt relief?) be earmarked for the provision of free services
Improve the efficiency of budget allocations to meet rising demand for free services	**1.** Increase the proportion of the budget allocated to • district level services, • pharmaceuticals • other essential non-wage supplies • human resources inputs **2.** Ensure that budget disbursement systems are working efficiently to facilitate the flow of funds to peripheral units
Ensure that drug supplies meet rising and fluctuating demand	**1.** Immediately start scaling up central procurements of pharmaceuticals in anticipation of rising demands for free drugs **2.** Improve drug supply systems so that ordering is based on actual demands rather than supplying standardised kits. **3.** If centralised drug supply systems cannot cope with the initial surge in orders, consider allowing districts scope to procure from alternative suppliers **4.** Allocate additional budget monies to improving drug supply systems
Increase the supply of qualified health workers to deal with the large increase in patients	**1.** Accelerate the recruitment of frontline health workers **2.** Increase budgets for staff wages and training
Replace cash income provided by user fees at the facility level	Ensure that all health units receive small cash imprests from district offices to buy essential goods and services
Persuade all stakeholders and in particular the population that the policy is working	**1.** Set up efficient monitoring systems, including the household survey, to measure changes in demand **2.** Adopt a pro-active strategy in selling the reforms through the media.

Threats and Risks	**Proposed Activities**
The population are confused by the policy change and do not respond to the fee reduction	**1.** Ensure that the policy is crystal clear: services should be free for everybody **2.** Implement a comprehensive media campaign spearheaded by the Head of State
There is slow implementation of the policy and there is therefore no dramatic impact	**1.** Set a date when the policy will be launched across the country in a blaze of publicity **2.** Do not launch on a public holiday or in a period of low demand
Dissatisfied health workers undermine the reforms by continuing to charge unofficial fees	**1.** Increase health workers salaries and emphasise that the increase is to compensate them for lost user fees revenue **2.** Improve payroll management systems to ensure that all health workers access the payroll quickly and are paid on time every month **3.** Set up systems to monitor compliance with the policy of free services for all
NGO services become financially unviable if fees are removed	**1.** Initially restrict the removal of user fees to Government health units **2.** Increase subventions to NGO units and link these payments to reductions in charges to the poor and vulnerable
Other line ministries undermine the policy because of political jealousy and competition for resources	**1.** By securing the ownership of the Head of State ensure that the policy is seen as a Government wide initiative **2.** Sell the reforms to sceptics by demonstrating improved health sector efficiency and linking increased health service consumption to better health indicators and therefore improved productivity
External stakeholders undermine the policy	**1.** Use international evidence to persuade doubters **2.** Monitor domestic health care output figures to demonstrate increased consumption. **3.** Ensure monitoring mechanisms disaggregate statistics by socio-economic and demographic groups and demonstrate differential benefits for the poor and vulnerable. Engage in revisions in the household survey instrument **4.** Expect criticism and be quick to respond to this robustly with supporting evidence

BIBLIOGRAPHY

Arhin-Tenkorang, D (2001) *Mobilizing resources for health: The case for user fees revisted* Harvard: Centre for International Development

Burnham, G et al (2004) *Discontinuation of cost sharing in Uganda.* WHO Bulletin, 82, 187-195.

Collins D, Quick JD, Musau SN, Kraushaar D and Hussein, IM (1996) *The fall and rise of cost sharing in Kenya: the impact of phased implementation* Health Policy and Plannin, 11, 52-63.

Deininger, K and Mpuga P (2004) *Economic and welfare effects of the abolition of user fees: Evidence from Uganda* Washington, DC World Bank

Durban Health Systems Trust (1997) *Free health care for pregnant women and children under six in South Africa: an impact assessment* Durban RSA

Fafchamps M and Minten B (2003) *Public provision, user fees and political turmoil* Centre for African Economies, University of Oxford, Working Paper 2003-15

Gilson, L; Russell, S and Buse, K (1995) *The political economy of user fees with targeting: developing equitable health financing policies.* Journal of International Development, 7(3), 69-401

Gilson L (1997) *The lessons of user fees experience in Africa* Health Policy and Planning, 12 273-285

Gilson, L and Russell, S (1997) *User fee policies to promote health service access for the poor: A wolf in sheep's clothing?* International Journal of Health Services, 27, 359-379

Gilson L and Mcintytre D (2004) *Removing user fees for primary health care: necessary but not enough by itself.* Equinet: www.equinethealth.za

Griffin, C (1998) *User charges for health care in principle and practice* Washington, DC World Bank

Litvack J and Bodart C (1993) *User fees plus quality equals improved access to health care: Results of a field experiment in Cameroon* Social Science and Medicine, 37, 369-383

Lindelow M, Ward P and Zorzi N (2003) *Expenditure Tracking and Service Delivery Survey The Health Sector in Mozambique* The World Bank

Ministry of Finance Planning and Economic Development *Report of the Uganda Participatory Poverty Assessment Project: Voices of the Poor* Government of Uganda 2000

Nabyonga J et al (2005) *Abolition of cost sharing is pro-poor: evidence from Uganda* Health Policy and Planning 20(2), p187-195

Pearson M (2005) *Assessing the case for abolishing user fees* Paper for the Conference: Health Financing in Developing Countries at CERDI, France December 2005, HLSP Institute London

Poletti, T (2003) *Health care financing in complex emergencies: A background issues paper on cost-sharing* London: London School of Hygiene and Tropical Medicine.

Sachs J et al (2005) *Investing in development: A practical plan to achieve the Millennium Goals* New York: Millenium Project

Wilkinson, D; Sach, M and Abdool Karim SS (2001) *Impact of South Africa's free care policy for children under 6 years and pregnant women on rural mobile clinic services* British Medical Journal 1997, 314: p940-941

Wilkinson, D; Gouws, E; Sach, M and Abdool Karim SS (2001) *Effect of removing user fees on attendance for curative and preventive health care services in rural South Africa* WHO Bulletin, 79, 665-671

Witter, S (2005). *An unnecessary evil? User fees for healthcare in low-income countries.* Save the Children

World Bank (1987). *Financing health services in developing countries: An agenda for reform* Washington , DC: World Bank.

Yates R, Kirunga C, Oliveira-Cruz V, McPake B and Nazerali H *Health care outputs have doubled in Uganda: What has been the role of health financing reforms?* Paper for the Conference: Health Financing in Developing Countries at CERDI, France December 2005