



**Charting the path to the World Bank's
"No blanket policy on user fees"¹**

**A look over the past 25 years at the shifting
support for user fees in health and education,
and reflections on the future**

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ABBREVIATIONS

ART	Antiretroviral Therapy
ARV	Antiretroviral (drug)
BI	Bamako Initiative
DAC	Development Assistance Committee (OECD)
DFID	Department for International Development
EFA	Education For All
EHP	Essential Health Package
GDP	Gross Domestic Product
GF	Global Fund
GFATM	Global Fund for HIV/AIDS, TB and Malaria
GHI	Global Health Initiative
GNP	Gross National Product
HAART	Highly-Active Antiretroviral Therapy
HFA	Health For All
HNP	Health, Nutrition and Population
HIPC	Highly-Indebted Poor Country
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IMF	International Monetary Fund
LSHTM	London School of Hygiene and Tropical Medicine
MDG	Millennium Development Goal
MOF	Ministry of Finance
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NGO	Non-Governmental Organisation
OECD	Organisation for Economic Cooperation and Development
PHC	Primary Health Care
PRS	Poverty Reduction Strategy
(i)PRSP	(Interim) Poverty Reduction Strategy Paper
PRSC	Poverty Reduction Support Credit (World Bank)
SAP	Structural Adjustment Programme
SSA	Sub-Saharan Africa
SWAp	Sector Wide Approach
TMAP	World Bank's Tanzania Multi-Sectoral HIV/AIDS Project
UK	United Kingdom
UN	United Nations
UNICEF	United Nations Children's Fund
US(A)	United States (of America)
WB	World Bank
WDR	World Development Report (World Bank)
WHO	World Health Organization
WHR	World Health Report (World Health Organization)

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SUMMARY

In the current climate of international development targets and global initiatives to lift the poor out of poverty and achieve universal health and education coverage, social sector financing is at the heart of the current debate on approaches to meet these targets.

Social sector financing is a subject rife with controversy, and after over two decades of experiences with a wide range of financing approaches in developing countries, there is still as much division as there is agreement.

The financing sources that currently dominate the health and education sectors in Africa are a result of a tumultuous history. Their roots can be found in the economic shock and recession of the 1970s, and the policies that were adopted on a wide scale in the 1980s to 'correct' the distortions that were apparent throughout the African economy. As part of the corrective measures peddled by the IMF/World Bank, known as structural adjustment programmes, countries were required to cut back government spending on social sectors, and fill the financing gap by raising revenue from the users. These policies were not merely an imposition, recipient governments also – gradually – believed in this remedy themselves. User fees were justified on many grounds, so that they were not seen as austerity measures, but providers of stable, efficient, equitable and participative social sector financing. Furthermore, considerable support for user fees was found from other parts of the UN, such as the WHO and UNICEF, as well as bilateral donor organisations. The vehicle for user fees in the health sector was the Bamako Initiative, launched in 1987.

In the years that followed, almost every country in sub-Saharan Africa implemented the Bamako Initiative or some variant of it, and fees for education also became widespread. During the last two decades, user fees have been shown to supply essential funds for the operation of health facilities and schools. Even though the percentage of overall resources for the sectors is usually relatively low, their actual impact on service provision is more important as user fees have provided the liquidity for essential items for an effective services, such as drugs, books for schools, and salary supplements for staff. Also, through their financial contributions communities have become more interested to hold service providers accountable for the funds, and management organs like health facility boards and parent associations are common throughout Africa.

However, when user fees are objectively evaluated against their stated goals, and using the huge evidence base that has accumulated, the picture is less encouraging. In fact, most of the findings weigh against user fees: they have raised less revenue than expected, they have acted as a disincentive for poorer groups to use social services, and they have not lead to the degree of community participation that was originally envisaged under the Bamako Initiative. User fee revenues are often mismanaged or siphoned off due to lack of accountability. Also, what is rarely mentioned alongside revenue figures are the sometimes considerable resources used in raising and managing the fee revenue.

As the evidence base has grown, so has the support amongst NGOs, academics, and even donors to question whether user fees are still appropriate. While some vulnerable groups such as children and women have been exempted from paying user fees for health with varying success, it has become clearer over time that poor and vulnerable groups are heavily disadvantaged by the existence of user fees, either because not all services are exempted (e.g. curative), or because the

exemption mechanisms themselves are not effective in targeting those deserving free health care. Furthermore, in education, exemptions have been the exception rather than the rule, and there is a strong correlation in most countries between family income/wealth and probability of enrolment. In education more than in health, there is a strong gender bias against girls where user fees exist.

These and other concerns about user fees have been aired in many fora, including UN and academic publications, conferences, government meetings, donor groups, NGO websites and parliaments. The situation came to a critical point in 2000, when NGOs in the USA managed to pressure US Congress to threaten withdrawal of IMF/World Bank funding if loan conditionalities continued to require developing countries to charge for basic social services. This was seen as a landmark victory. The World Bank was pushed into a retreat on user fees, and made statements to the effect that the World Bank does not support user fees on primary education, or basic health care for poor people. Since then, the World Bank and partners have been working on ways to maintain a system of user fees for secondary education and health care, but designing better ways of ensuring poor people are exempted from the costs of these services. In the World Development Report 2004, the World Bank importantly unveiled its new policy on user fees, which was that there should be 'no blanket policy on user fees'.

For anyone with critical insight, this new policy could be interpreted as providing old wine in new bottles. The message is generally the same as the rhetoric of the 1980s, but the emphasis has changed. Before, user fees were justified unless there was a very good reason for providing the service free, whether as a type of service (e.g. vaccination) or for certain people (pregnant women, poor people). Now, the new policy reads more like "you should provide the service free unless there is a good reason to charge for it". Depending on how you apply the framework, you could have exactly the same result as the previous approach, just with a different justification. As before, public services that you cannot exclude from the population should be provided free to everyone. The critical point of the framework comes at the question whether you can distinguish poor people from the non-poor. If the answer is yes, as before, then you can exempt them. If the answer is no, then you need to decide whether the service can be adequately delivered without user fees. Given the current funding shortages in health and education in sub-Saharan Africa, the general answer to this is that services cannot be adequately delivered without user fees. Basically, it means business as usual, unless massive injections of funding arrive.

There is a ray of hope on the horizon. There have been a number of recent experiences coming from some health and education sectors in Africa. Some of these ministries, with the help of the finance ministry and donors, have taken the brave step to eliminate user fees altogether on primary education and basic health services. These include Uganda (in health) and Tanzania, Malawi and Uganda (in education). The results are generally astounding. Service utilisation has increased enormously, showing a huge unmet demand for these services. Where this new policy has been met with additional funds from the centre, as well as logistical support, the experience so far is generally very positive.

So can other countries follow suit? It is certainly possible financially, as the actual amount of lost revenues could easily be picked up by a combined effort of donors and Ministries of Finance. However, such a decision must be made with a long-term vision, not only of financing, but also of planning and ensuring rationing mechanisms still exist. At a time when international agencies are focussing their attention on prepayment mechanisms, as well as stimulating the private sector (World Bank, World Health Organisation), this idea of abolishing user fees does not come as good

news. Without user fees, there is little incentive for consumers to take out insurance or use private providers, unless seeking a better quality or closer service. Therefore, abolition of user fees is a grave threat to the agendas of these organisations, and there is little doubt that they will do their utmost to oppose these moves, as they have already tried to do Uganda. For now, however, it is useful to bring into the debate evidence and arguments for user fee abolition, remembering that to achieve the Millennium Development Goals we as a development community need to find and implement ways of boosting demand for social services. Let us begin a real debate that is free of interests other than the interest to serve the underserved populations of Africa.

1. INTRODUCTION

1.1 Why another paper on user fees?

There are few subjects in political economy as controversial as that of the government demanding payment for public services, especially services such as health and education. These services are seen widely as being the right of every individual, regardless of status in society or ability to pay. Economic theory also supports, to some extent, the provision of free or subsidised services where there exist market failures, public goods, or social safety net arguments.

Of course, in the end, public services must be financed by someone, whether the taxpayer or the consumer of services through direct fee for service or insurance. However, the financing mechanism chosen has important implications for who in society bears the burden of payment, and how efficiently services are delivered and consumed. Over the last two decades, there have been massive changes in financing and payment mechanisms, but the models chosen have differed between the richer countries and the poorer countries. To pay for health services, in general richer countries have tax-based (e.g. UK) or social insurance based models (e.g. Germany), with an important private insurance sector in some countries (e.g. USA, UK). Also, as countries have developed they have tended to move towards these systems (e.g. Thailand, South Africa). Poorer countries, on the other hand, have relied increasingly on direct fee for service payments, a policy which has been advocated by the development ministries of OECD governments and the multilateral institutions which they support.

As poorer countries adopted this user fee system from the 1980s onwards, a considerable amount of research has accumulated that has shown the effects of this approach. The evidence base is even sufficient to have supported the publication of several review articles on the subject, giving the feeling perhaps that the issue of user fees has now been over researched, and that there is nothing left to prove or say. Hence the question: why another paper on user fees? There are, in fact, some very good reasons. First, despite the huge amount of evidence accumulated that has weighed against user fees, countries still cling closely to them for various reasons:

- However meagre the revenue, user fees are still seen as crucial for social service provision at decentralised levels.
- Countries may feel that services should be charged for so that service users appreciate that they have a value, and that as a result services are not overused.
- Countries, or rather Ministries, do not want to change user fee policy every few years. Keeping up with fashions of international agencies has its benefits (such as credit ratings), but regular changes of policy affects credibility with the population. Furthermore, charging for public services is a highly political issue that has many dimensions.

Therefore, if user fees really are a bad thing, countries still need to be persuaded to give them up. This needs to be done, not so much through further presentations of the negative impact of user fees (which are mainly circulated amongst academicians and donor agencies), but instead through dialogue at the highest political level with players the government can trust.

A second reason why the subject of user fees needs to be revisited relates to the current developments in social sectors in many countries (e.g. second phase of poverty reduction strategies, sector-wide approaches) combined with the dawning realisation that many of the international development goals (e.g. MDGs) are at risk of not being achieved. Therefore, it is relevant for donor agencies and the

governments they support to be considering whether user fees are still appropriate. If user fees are no longer appropriate, then what steps are needed to phase them out? If user fees are still appropriate, then how can their functioning be improved to ensure they enable rather than frustrate attempts to meet development targets?

A third reason for such a paper can be justified through a better understanding of the shifting support for user fees since they became widespread: why they became popular from the early 1980s, what evidence has been gathered over the last 2 decades on their impact, and the shifting positions of international agencies and national governments. Such a historical perspective will help stakeholders understand the current position and what future courses make the most sense. In particular, observing the internal workings and motivations of some major 'players' in social sector financing in the developing world – the World Bank and other UN agencies – will provide insights into how other donor agencies and recipient governments may wish to support new initiatives or recent policy shifts in this area.

At the same time, the importance of user fees should not be overemphasised, and therefore the arguments and findings of this paper should be interpreted in the light of the broader issues facing social sectors presently. First, user fees should be seen in the context of a range of social sector financing mechanisms. For example, Annex 1 shows the contribution of out-of-pocket payments for health compared to other health financing mechanisms in 2001, which averaged 26% of total health sector financing in Africa. Therefore, other health financing sources account for on average three quarters of health sector financing. Second, user fees are not the only constraint for populations accessing social services, and other financial access costs (e.g. transport), distance, and cultural access issues are all important determinants of the demand for public services. Therefore, for these and other reasons, user fees need to be seen in a broader policy environment.

1.2 Overview of payment mechanisms

As already stated, there are many sources for financing social services, including tax sources, user fees, donor grants and loans. Insurance is also an important financing mechanism in health (de Ferranti 1985). Each source or mechanism has different characteristics in terms of mechanics of raising revenue, volume of funds raised, sustainability, equity and efficiency. Financing experts generally agree on desirable characteristics of financing mechanisms. For example:

1. They should raise enough funds to meet the minimum needs of the population, such as services provided in a 'minimum' health package.
2. They should be sustainable – e.g. guaranteed for the coming 5 years.
3. They should be equitable in terms of who the financing burden falls upon.
4. They should not involve highly burdensome or costly administration.

These 'criteria' are assessed in Table 1 for seven potential sources of funds for the health sector. It is evident that the financing mechanisms vary according to the criterion being assessed. While it is recognised that all these criteria are important, the one that receives the most focus is the level of funds raised. In terms of volume of funds raised, in SSA this is mainly donor funds, government taxes, and out-of-pocket payments (which may be via community health insurance schemes). From a sustainability point of view, government taxes, social insurance and out-of-pocket payments are preferred. From an equity perspective, a tax-based system or social insurance system are preferred, and donor and NGO funds assuming they are given with conditionalities for reaching poor and vulnerable groups. The cheapest system for collecting revenues (with the least 'deadweight loss' as described by economists) is the government tax-based system as it already exists and does not involve

additional costs to ensure health sector financing. On the other hand, most other health financing sources require systems for collection and monitoring, whether insurance, donor projects, or user fees.

In choosing between health financing options, it should be recognised that usually a mixture of financing sources is optimal, as in many ways the different sources complement each other (e.g. some are better for providing large volume of funds such as tax sources and donors, while others are better for ensuring functioning of decentralised services such as user fees). The contribution of direct user fees cannot be ignored, but shifts from this source to prepayment or sustainable subsidized sources (e.g. Ministry of Health budget) is currently receiving considerable attention in Africa. While donated funds (external or NGOs) should be welcomed, their level and spending focus depends on the choices made by external agents, which cannot be heavily influenced by the health system.

Table 1. 'Performance' of health and education financing sources in Africa

Source	Funds raised	Sustainability	Equity	Admin. cost
HEALTH and EDUCATION				
1. General taxation	Limited due to low tax base	With economic growth, higher social sector allocations	Depends if targeted to poor and vulnerable populations	Additional revenue collection costs negligible
2. User fees (fee for service) either in public or private facilities	Depends on use of paying services. Generally a small proportion of total funds	Perceived as assuring sustainable income for social services	Tends to be inequitable when exemptions are not applied. Overcharging occurs when health fees not advertised	Requires simple receipt and financial management system to avoid corruption
3. Local NGO or mission organisations	Potentially important	Sustainable if NGO has L-T commitment	Usually targeted at disadvantaged groups	Usually managed by NGO or mission organisation
4. 'External' donor grants	Potentially substantial	Not sustainable, but depends on commitment of donors	Funds can be given conditional on targeting P&V groups	Depends on level of accountability required. Can be substantial
5. Government loans	Potentially important	Loans must be paid back by future generations	Depends on use of loan	Same as general taxation, unless parallel systems required
6. Personal savings accounts and credits	Negligible in SSA setting	Depends on popularity of schemes	No redistributive effects	Minimal costs associated with bank transactions
HEALTH ONLY				
7. Social insurance (% contribution from salary)	Coverage limited due to low formal employment	If compulsory & growing formal sector employment	Those with formal jobs tend to be better off & less vulnerable	Special system of collection and provider payment required
8. Community health insurance (also relevant for private insurance)	Potentially substantial if uptake high	If well managed and popular, these funds assure financing	Benefits are to members only, leading to greater equity only if P&V are members	Can be efficient, depending on mechanism. May benefit from unpaid volunteer input

P&V – poor and vulnerable groups; L-T – long-term.

1.3 DFID and public service financing

The UK Department for International Development (DFID) has never formally taken a position on user fees for basic social services in developing countries. However, this is not due to a lack of realisation of the importance of the subject, and over the years DFID has financed a large number of research projects and briefing papers on topics related to user fees and reaching the poor². DFID tends to take clear lines on priority areas that have implications for user fee policy, but it does not commit itself on the actual issue of whether user fees should be applied or not. There is recognition of the need for improving the revenue base and sustainability of public services, at the same time recognising that user fees as a means for achieving this has its drawbacks. For example, in DFID's paper "Better Health for Poor People", no single health financing strategy is recommend over any other. Instead, the paper suggests that all methods of financing have their strengths and weaknesses and should be evaluated against five basic criteria: volume of revenue generated, incentives for service delivery, health care provided according to need, impact on the poor, and administrative ease. What emerges from this is the conclusion that a single blueprint of financing mechanisms for health should not be sought, but financing mechanisms should be selected based on national and sub-national conditions. In other words, user fees for health are neither explicitly ruled out nor encouraged.

In the later paper "Making Governments Work for Poor People", DFID goes a step further towards taking a position on user fees, where it states that donors can reasonably expect governments to make pro-poor policies and resource allocations, such as social safety nets (para 2.3.11). Also, the paper states that governments must be responsible for ensuring essential services are of a good quality, affordable and accessible (para 2.4.2). The dilemma faced by poor countries is raised concerning whether they should provide free services which are fairer for poor people, or charge for services this improving coverage and quality (para 2.4.5). However, it is suggested that even poor people are willing to pay for some services, such as drugs, although the same people can often be excluded from services because they lack the money to pay (para 2.4.13). Importantly, DFID states that, 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 (para 2.4.14). Therefore, the DFID position, albeit informal, is towards 'affordable' user fees.

While official DFID documents and papers appear to be short on details, DFID has in fact financed considerable amount of research on health financing in general, and user fees specifically, through DFID-funded research programmes and resource centres. These programmes, especially the former, have been active since the 1980s in researching the impact of user fees, developing mechanisms for reaching poor people and improving user fee mechanisms, and in supporting the development of sustainable and equitable health financing mechanisms more generally.

Furthermore, through the shift in DFID's support since the late 1990s towards sector programmes, poverty reduction strategies and budget support, it appears that DFID wishes to address the root cause of inadequacies in public sector financing, which under the right conditions potentially allows for a reduced burden on the population in terms of user fees. In recent years, DFID has been one of the first bilateral donors to

² For example, the Health Economics and Financing research programme at the London School of Hygiene and Tropical Medicine; and commissioned papers provided by the DFID Health Systems Resource Centre.

give general budget support in preference to sectoral support, to help the government solve its financial management problems and increase unearmarked liquidity in the government system. More recently, through the International Finance Facility, developed by HM Government Treasury (UK), DFID is positioned to play a leading role in helping boost funds available to help governments meet the MDGs.

These initiatives have marked DFID as largely a supply-side player, preferring to working through the highest levels of government departments. Perhaps it is time too, to give greater attention to demand side financing issues, which although they do not have the same resource mobilisation potential, the demand side may be the major bottleneck to increasing coverage of basic public services to the entire population, and the link with supply side and external financing needs to be made. In fact, with some of the previous work funded by DFID (IHSD 1998, Bennett 2001, Pearson 2002a,b, Diamond 2001, Falkingham 2002), DFID can contribute valuably to this debate.

1.4 Key questions to answer

A central question this paper seeks to answer is “what are the shifts observable over the past 25 years in international support for user fees for basic health and education services in Africa, and what explains these shifts?” A further key question addressed is “what are the implications of these findings for user fee policy at the present moment, and in the current climate of global initiatives and slow progress in reaching international development targets in Africa?” The answers to these questions are expected to provide some basis for a bilateral agency such as DFID to decide whether to go along with these changes, and how. Specific questions to be addressed include the following:

- Why did international agencies and governments become so dedicated to user fees for public services, starting in the early 1980s? What were the philosophical underpinnings and underlying principles of user fee implementation? What were the arguments for adoption of user fees? Are these arguments still valid in 2004?
- How widely were user fees implemented, and what conclusions can be made about their overall impact in the health and education sectors in Africa?
- What is the current atmosphere with respect to user fees for public services? What explains policy shifts? And how should these shifts be interpreted?
- How workable is an ‘open’ policy to user fees, as proposed by the World Bank? What is the feasibility of changing user fee policies in the social sectors of African countries? How, where, and when can these changes feasibly happen? Where have policies already changed and with what impact?

In order to answer these questions, it will be important to answer some fundamental questions about user fees in health and education, such as how their commonly cited benefits (e.g. additional resources, improved quality, community ownership) compare with costs and disadvantages that have been reported in the literature (e.g. reduced service utilisation, especially by the poor). It will also be interesting to understand more fully what is the likely effect of user fee removal, and examine some countries that have abolished user fees in health and education sectors. For example, can the experience in these countries be replicated elsewhere? Furthermore, current events in social sectors and their impacts on user fee policy should be more fully understood. For example, what is the impact of changes in the way donor aid is provided, such as through budget support and sector-wide approach (SWAp)? What implications of the massive increases in funds through global health initiatives and the International Financing Facility proposals? How do the decentralisation processes ongoing or completed in many African countries affect financing of social sectors?

In other words, it could be argued that the current environment is different to the environment of the 1980s where the widespread implementation of user fees in social sectors could be easily justified. For example, the recently launched global initiatives and increases in donor aid have important implications for the comparative performance of the different financing mechanisms presented in Table 1.

1.5 Paper outline

Chapter 2 charts the rise of user fees: the economic crisis in Africa during the 1970s; the solution to the crisis in the form of the structural adjustment programmes; the need for user fees to replace government tax financing; the goals of user fees; the vehicle for the widespread implementation of user fees, and how user fees were implemented.

Chapter 3 details various reasons why user fees are being questioned: the gathering evidence against them; the role of pressure groups; shifting opinion within the organisations that have supported and implemented user fees; and the renewed focus on the international development goals, in the realisation that there are major bottlenecks to their achievement.

Chapter 4 outlines and discusses the World Bank's new policy on user fees: the completeness of the framework; the application of the framework's principles; the administration of the framework; and the general improvement of user fee systems.

Chapter 5 describes some case studies of health and education sectors in Africa that have recently abolished user fees: what has been the impact; and how decisions about user fees should be made taking into account broader financing considerations.

Chapter 6 concludes and makes some recommendations.

2. THE RISE OF USER FEES

2.1 Introduction

If an alien were to land on earth and do a comparative analysis of social sectors across the world, she might well wonder at the mechanisms chosen by the human race for financing some of the basic services such as health and education. Moreover, she would probably fail to understand why the population in the poorest of the earth's countries are made to pay for these services directly, while the richer countries where the populations are much better off do not face the same level of direct expenses for consumption of services.

In fact, the alien should be forgiven for being a little puzzled, for without instruction in World History, at least since the 1940s, it is impossible to understand how this situation came about. But does a history lesson, in fact, help us, as social sector advisers and academics, to understand what must be done in the present time? Do we need to know about the decay of public sector services in sub-Saharan Africa during the 1970s and the subsequent search for a 'solution'? Do we need to know what factors and justifications helped push through user fees as the solution? Do we need to understand what initiatives were born that helped scale up the adoption of user fees throughout the developing world?

The answer to all these questions is an emphatic 'YES'! Learning from history is supposed to be what makes humans different from the rest of the animal kingdom. It is supposed to make us wise, wise to test new solutions, and wise not to fall into the old mistakes and traps that have troubled our past. But what lessons are we supposed to learn from a brief view of history on this subject matter? First, it is useful to see the shifting support for user fees over recent decades, to understand why certain influential global players have spent considerable time and effort to reposition themselves regarding social sector financing. Certainly, if other international agencies and African governments are going to continue following fashions in policy, they need to understand what is driving the agendas. Second, we need to understand if the same factors as were justifying user fees back in the 1980s are still present, and therefore what continuing justification exists for their use. Third, the performance of user fees should be understood to make judgements about whether they are an appropriate means of raising resources for social sectors – whether they were an appropriate policy to adopt in the first place (ex post), and whether their continued existence can be justified. Answers to these questions will help us, as independent observers, to decide whether new policies, such as the World Bank's "No blanket policy on user fees", are useful for the current time, or whether they are just old policies in new skins.

2.2 Economic decline and the debt crisis of the 1980s

In the late 1970s, rising oil prices, rising interest rates, and falling prices for other primary commodities left many poor African countries unable to repay mounting foreign debts. In the early 1980s, Africa's debt crisis worsened. The ratio of its foreign debt to its export income grew to 500%. Balance of payments problems worsened and foreign debt burdens became unsustainable, requiring new loans to pay outstanding debts and to meet essential domestic needs. The World Bank and the IMF became key providers of loans to countries that were unable to borrow from elsewhere, taking over by the early 1980s from OECD governments and private banks as the main source of loans for poor countries. Conditions attached to loans gave the World Bank and IMF great leverage over domestic policies. Loans were given to debtor countries based on strict conditionalities, which meant adopting a

comprehensive programme of macro-economic stabilisation and structural economic reform. Conditionalities favoured heavily the free market ideology, influenced by the US Reagan Administration which threw itself behind the IMF/World Bank's new-found importance.

These conditionalities can be summarised by the name given to the standard policy package required of recipient governments: **structural adjustment programme** (SAP). SAPs entailed sweeping economic and social changes designed to siphon the indebted countries resources and productive capacity into debt repayments and to enhance international competition. They included massive deregulation, privatisation, currency devaluation, social spending cuts, lower corporate taxes, export driven strategies, and removal of foreign investment restrictions. SAPs were applied throughout almost the entire 'Third World', an out of fashion term that was used in those days to indicate those countries not in the First World (OECD countries) or Second World (Communist countries). Consequently, the development agenda of almost the entire Third World was set by the IMF/World Bank through SAPs.

Throughout the 1980s, debt service payments in Africa grew rapidly. In 1970 African debt was US\$6 billion, growing to US\$300 billion in 1993. Of 41 highly-indebted poor countries, 33 of them are in Africa. Debt service payments exceed annual expenditure on health and education in nine HIPC's, and they exceed health spending in 23 sub-Saharan African countries who are highly indebted (Hong 2000).

2.3 Impact on social sector spending

With structural adjustment came belt tightening in terms of government spending. Social sectors suffered heavy cuts in workforce and decentralised budgets. Social sectors suffered the most because other 'productive' sectors where government spent money (agriculture, energy, transport, etc.) were seen as the way countries would be able to increase economic growth in order to get themselves out of their current predicament. This 'trickle down' theory was one of the main reasons why the economic hardship policies of the 1980s became so heavily supported, and it still has many proponents.

The effects on health and education spending were dramatic, although countries varied. By 1990s, real per capita government expenditures on **health** were below their 1980 levels in 64 percent of countries for which data was available. In Tanzania, for example, per capita expenditure on health care fell from US\$7.00 in 1980 to US\$2.00 in 1990. This trend has continued in countries like Zimbabwe, where per capita expenditure fell from nearly US\$6.00 in 1990 to US\$3.84 in 1994. In Senegal, public spending has declined sharply from the mid-1970s to the end of the 1980s, whereas in Côte D'Ivoire public spending in health maintained a roughly stable share of a declining GDP between 1980 and 1995. In Somalia, the situation was particularly stark where health expenditures declined by 78% between 1975 and 1989. The economic decline and reductions in health spending lead to insufficient resources to meet health sector goals and expectations, deteriorating quality, insufficient spending on maintenance, sectoral budget deficits, low operational efficiency, and huge disparities in current allocation of resources (de Ferranti 1985).

A UNESCO 'World Education Report' in 1998 reports that per student spending on primary **education** in Africa fell between 1985 and 1995, at which time it increased almost threefold for every other developing region. Total public spending on education in sub-Saharan Africa fell in real terms between 1980 and 1988 from US\$11 billion to US\$7 billion. For a sample of 26 countries, this translated into a decline in spending per pupil from US\$133 to US\$89. The impact on school

enrolment and quality of schools has been widely cited. For example, in Somalia school enrolment dropped by 41% between 1981 and 1989, and nearly one quarter of primary schools closed down. In many countries, the whole infrastructure of support services has deteriorated, including school inspection and supervision, in-service teacher education, curriculum development, school health services, and maintenance of school furniture, equipment and physical facilities (McGow 1995).

Even at the time, Structural Adjustment policies had many critics. For example, in 1989 the UN Economic Commission for Africa issued a document "African Alternatives Framework to Structural Adjustment (AAF-SAP)". This document argued that SAPS had not achieved their macro-economic objectives in Africa, and moreover that the World Bank was oblivious to the social costs of adjustment: increased poverty and unemployment. The AAF-SAP argued that "debt service obligations have become unbearable...starvation and malnutrition, abject poverty, and external dependence have worsened, while other structural weaknesses and deficiencies of the African economies have weakened".

NGOs have also been vocal in their criticism of these austerity policies, especially pointing out inconsistencies in the way in which they were applied. For example, the Third World Network note that SAPs did not target military spending of debtor countries. From 1972 to 1982 Third World countries' military expenditures rose from US\$7 billion to over US\$100 billion while spending on health and education fell. By 1986, the 43 countries with the highest infant mortality rates spent three times as much on defence as on health (Hong 2000).

Others point out that women and children have been hardest hit by the budget reductions required under SAPs (McGow 1995). Infant mortality rates are argued to reflect the economic, health and social status of the mother and thus serve as a proxy variable for measuring the impact of policies on women. During the 1980s and 1990s, the United Nations report that in Zimbabwe maternal and infant mortality rates are "unacceptably high" in rural areas and are increasing in Harare, the capital. The World Health Organization reports that maternal mortality rates are increasing across East, Central and West Africa.

Even the World Bank has criticised how SAPs were applied. In the 1993 World Development Report the Bank states that early government spending cuts in adjusting countries tended to be indiscriminate and failed to preserve those elements of the health system with the strongest long-term benefits for health. Drugs were often cut more heavily than personnel. While countries with adjustment loans had a more rapid reduction in per capita health spending during the period 1980-1983, they also had a quicker recovery in the period 1985-1990, when compared with non-adjustment loan countries.

A recent study carried out under the auspices of the Commission on Macroeconomics and Health in 2001 reviewed the literature and debate on structural adjustment programmes and their impact on health. The study found that both theoretical and empirical studies were negative towards SAPs and its effects on health outcomes, mainly through user fees, reduced access to care and deteriorating quality of care (Breman 2001). However, the evidence on health expenditures is mixed, with declines reported in some adjusting countries and increases in others. Despite this, in all countries represented, child mortality declined, considerably in some and less so in others. The conclusion is that there are multiple determinants of health outcomes, and a narrow focus on analysing trends in health expenditures is not helpful.

In conclusion, health and education sectors across Africa generally found themselves in even greater trouble following the introduction of structural adjustment programmes than before, with falling budgets and losses of personnel. Clearly a solution was needed. The solution was user fees.

2.4 User fees as the solution

It is widely documented that user fees were adopted as a direct result of the reductions in social sector spending required by the structural adjustment programmes throughout the developing world. For example, Creese points out that cost recovery initiatives in health resulted in Ghana and Mozambique directly from the implementation of structural adjustment packages (Creese 1995).

The main and original proponents of user fees were the World Bank and its sister organisation the IMF. During the early to mid-1980s, a considerable amount of effort went into justifying user fees as an appropriate policy tool in settings with limited government resources. Both theoretical justifications were put forward as well as empirical literature drawn upon that showed user fees to be appropriate for basic social services such as education and health. The World Bank pushed for user fees on the grounds that low demand for poor quality services, not the cost, was the principal barrier to expanding access. Some landmark World Bank papers justifying the imposition of user fees are described briefly below, and include the following:

- A 1983 Staff Working Paper “Charging user fees for social services. The case of education in Malawi” (Thobani 1983).
- A 1985 Staff Working Paper “Paying for health services in developing countries: an overview” (de Ferranti 1985).
- A 1987 Policy Study “Financing health services in developing countries: an agenda for reform” (Akin et al 1987). This publication provided the main thrust for including user fees in health as a conditionality for structural adjustment loans.

In the **1983 paper**, using the example of education in Malawi, the World Bank argues that although full cost recovery is not optimal in social services, the insufficiency of government subsidies means a user fee is necessary to top up the revenue to the required level (Thobani 1983). The paper moreover argues that if user fees were not charged, excess demand would lead to some people being denied the service and/or the quality of service would deteriorate. The latter is illustrated with the case example of Malawi, where class sizes of 66 are well above the maximum of 50 set by the government. Both these phenomena are argued to typically hurt the poor more than the rich. Therefore, it is hypothesised, raising user charges will result in relatively more of the poor benefiting as compared to the rich. Full cost recovery is recommended on the most visible aspects of primary education – books, supplies and maintenance. Greater excess demand in secondary education suggests pricing should be closer to the marginal cost. However, discriminatory pricing is also suggested to ensure the very poor are not excluded on financial grounds.

Although the **1985 publication** “Paying for health services in developing countries: an overview” (de Ferranti 1985) was later eclipsed by the 1987 publication “Agenda for reform”, it was important as a first test of the World Bank’s new direction on user fees. This publication claims that the Bank has been called on increasingly to provide advice on health financing and allocation questions through its lending operations and its country economic work. The economic rationale was clearly put at the centre of the World Bank’s approach to charging and price setting for public health services.

In his paper, de Ferranti argues that starting from the position of “providing care free unless compelling reasons indicate to the contrary” lacks a persuasive conceptual

foundation. He argues that, by starting instead with the strict efficiency price, one has a clearly defensible initial benchmark, and if there are good reasons for setting prices below that benchmark it should be possible to show that convincingly.

The author points to the problem of efficiency pricing³ in a number of different health services which have different characteristics, given that they will have different external effects, public- or merit-good characteristics, costs of fee collection, equity effects and supply effects. Therefore, he asks, how can an agency such as the World Bank develop guidance to aid planners in finding their way through the myriads of possible combinations of different services and different circumstances?

De Ferranti proceeds to ask a series of pertinent questions for deciding which services should be considered below (or even above) efficiency pricing, taking into account household's ability and willingness to pay, impact on demand and subsequently health status, substitution effects of spending on health, and arguments for keeping charges low or zero (externalities, public good, limited information, collection fees). As he states, there is no simple formula, and even if there was one, the data are extremely limited for making such adjustments to efficiency prices. In order to try to make some general rules, services are classified into curative (70-87% of spending), patient-related preventive services (10-20%) and other preventive services (3-10%).

'Other' preventive services are not related to the individual patient, and include disease control programmes, sanitation, IEC, pest control, and monitoring disease patterns. As there is no direct (face-to-face) transaction between the provider and beneficiaries, it would be very costly to try and collect fees for these services. It is also difficult or even impossible to exclude people from this service, and the marginal cost is negligible or zero. Furthermore, these services can have external benefits. Conclusion? Provide these services free of charge to the entire population.

'Patient-related' preventive services present a different problem, as services are given to individuals and in measurable amounts, and there exists exclusivity. It is claimed that immunisation services are the only service for which there are considerable potential externalities (in terms of reducing disease transmission). Also, the fact that patients do not know enough about the true benefit of a service may warrant a below marginal cost price. However, as de Ferranti points out, the key question relates to the population's ability to pay for the service, and whether those unable to pay are a small or large proportion of the total. Where small, then exemptions should be applied. Where large, the case for fees would need to be reconsidered. Conclusion? In general, fees set at marginal cost are still affordable to most households, at about 0.5% of household income for reaching the WHO's target of two outpatient visits per person per year.

Curative care is split into the first contact of the patient with the services for a given episode (where it is the patient's or guardian's decision to seek care) and follow-up contacts or referral (where the health provider plays a more important role). While supplier-induced demand is recognised in the latter case, it is generally not strong enough to argue for providing below efficiency price. Another argument is also made, that if services are free and the provider (under the Hippocratic Oath) continues providing care while there is a net benefit to the consumer, this is beyond the socially optimal level. A fee brings in the incentive to ration services (curtailing excess

³ Efficiency pricing in economics means that the price is first set to equal the marginal private cost, and then adjusted if there are good reasons for departing from that price level (see above).

consumption), although this effect is from the patient's side and not the provider's⁴. The only problem mentioned by the author of charging fees at referral level is that many patients might have to choose between going without care or suffering financial ruin, due to the generally higher costs of care at this level.

A central tenet of the argument for user fees is the evidence available from some developing countries that suggests health care is substantially price-inelastic in developing countries (an increase in price does not cut back demand significantly), at least within the price ranges typically found in many countries. Two studies demonstrating this, from the Philippines (Akin 1982) and Malaysia (Heller 1976), have been used widely to support user fee imposition. Even a positive correlation between fees and utilisation was quoted for one study conducted in Indonesia: the higher the fee the greater the increase in utilisation (Ascobat 1981). Evidence of this phenomenon was also quoted for several African countries too (Cameroon, Côte d'Ivoire, Lesotho, Rwanda and Zaire) with reference to an internal working document of the World Bank (de Ferranti 1983).

Evidence such as discussed above had a great deal of influence, and lead to the following conclusion: *"if some of these findings (on price inelasticity of demand) are valid generally, it could be hypothesised that when households in developing countries make decisions about when to seek medical help and when not to, they are unaffected by fee levels (within the policy relevant range); but once they have decided to get help, fees influence which provider they select"* (de Ferranti 1985, page 40). Furthermore, *"at present there does not appear to be good cause for arguing against user charges on the grounds that many users would be unwilling to pay and hence deterred from seeking care"* (de Ferranti 1985, page 41).

De Ferranti recognises the need for discriminatory pricing, to ensure that the whole scale application of user fees would make the poor worse off overall. For inpatient care, the solution is the offer of private or semi-private rooms for those willing to pay, which would in turn subsidise the considerably cheaper public wards.

Moving onto the World Bank's **1987 document** outlining their proposals for an agenda for reform of health financing, health sector problems are summarised under 3 headings:

1. Insufficient spending on cost-effective interventions (the 'allocation' problem)
2. Wasteful public programmes of poor quality (the 'internal efficiency' problem)
3. Inequitable distribution of the benefits of health services (the 'inequity' problem)

The Agenda argues that four policies will help address these problems, which can be adopted flexibly by any country depending on current policies and other factors:

1. Charging users of public health facilities, especially for curative care
2. Encouraging risk-coverage programmes (i.e. insurance)
3. Strengthening NGO provision of health services, with user charges
4. Decentralising the public health system

The one general conclusion that can be made from these four policies combined and individually is "shift the emphasis of health financing to the payer". Such a conclusion is justified on the basis of mobilising revenues to expand service coverage, encourage efficient consumption of services (reduce frivolous use, and encourage demand at the appropriate level through use of bypass fees), making services more responsive to the patient, and ensure government subsidies and cross-subsidisation from the rich reach poor people. The paper argues that the persisting problem of low

⁴ The problem being that the patient is less informed about the added benefit of more care.

coverage of health services in rural areas would be solved by charging for services, by redistributing resources from urban and secondary/tertiary facilities to rural and primary facilities. With an appropriate pricing structure, it was expected that excessive use of health services would be curtailed, and that higher charges at higher level facilities would introduce incentives for an efficient system of health seeking and referral.

In terms of pricing rules, the same arguments and guidelines are presented as in the 1985 paper – charge marginal cost unless otherwise convinced that this is not efficient due to externalities, incomplete information, public or merit good, and market failure in insurance markets for high cost hospital care (catastrophic costs). Fee levels are probably too high if demand drops by more than 20% after change in fee levels. The public sector is also encouraged to use private sector fees as a benchmark, although these are recognised to be higher than the costs of public health care (depends on efficiency). However, other determinants are cited as being more important for choice of provider: quality and proximity. Various waiver mechanisms are proposed, including vouchers given to the poor, staff discretion over allocation of exemptions, a means test, or the word of someone with a position of authority (e.g. headman).

While these papers discussed above were massively influential in terms of convincing people that user fees were necessary in health and education, by no means was the World Bank alone in their enthusiasm for user fees. They were soon supported by other UN agencies – most notably UNICEF and WHO – who together played a crucial role in selling the idea of user fees as the solution, and designing the vehicle for widespread user fee implementation (see below). For example, Creese from WHO argues that the most compelling case for user charges has been “their capacity to provide an emergency boost for the recurrent (usually non-salary) costs of health care provision, which have been most depleted by declining real expenditure” (Creese 1987). Also, Abel-Smith in 1991 discusses a practical system for charging people for health care to meet the Health For All targets, accepting user charges in health as a necessary measure to address the deterioration of the health sector across much of the developing world (Abel-Smith 1991).

Furthermore, despite some early critiques of user fees as an appropriate way of raising additional resources for social sectors, the World Bank has continued to fine-tune its approach to implementing user fees. For health, the 1993 World Development Report outlined a three-pronged approach for governments to follow in the health sector, which have been given various interpretations by the critics.

- “Foster an enabling environment for households to improve health” essentially means that the population covers the costs of its own health care, and reinforces the World Bank’s assumption that encouraging economic growth will give families more purchasing power to finance their own social services.
- “Improve government spending in health” means targeting government spending to a narrowly selective and cost effective approach (selective PHC).
- “Promote diversity and competition in health services” means giving greater weight to the private sector to deliver health care and thereby taking responsibility off the government. In other words, a further shift in financing responsibility to the population, but at prices beyond the means of most families.

At the same time, the 1993 report interestingly reveals its desire to defend user fees against criticism, by criticising research that has shown user fees in a negative light, arguing that these studies failed to examine the true costs of services – bribes, transport costs and time costs – which play a more important role in health service

demand (WDR 1993, page 118). The report hypothesises that official user fees may reduce overall costs, thus sparking increases in utilisation when official fees are introduced, citing evidence from four African countries where this has been observed. Again, it is argued that if fees can be kept at less than 1% of annual income, then user fees will have little impact on utilisation.

Despite this rush to user fees, there were some voices in the wilderness questioning the wisdom of user fees. In a paper comparing health financing options in the face of public budget cuts under structural adjustment, Korte concludes that user fees based on populations' ability to pay would raise limited resources (10-15% of health budgets) and the existing information does not justify the introduction of fee-for-service schemes on a large scale (Korte 1992). Instead risk sharing is proposed as the most important pillar for sustainable health care systems in sub-Saharan Africa, and this at the decentralised level as opposed to the national level.

2.5 Vehicles for user fee implementation

As already mentioned, a conditionality of many structural adjustment loans provided by the IMF/World Bank was that basic social services should be charged for to complement the governments own meagre resources. For example, an internal World Bank report widely quoted by NGOs is the one reviewing HNP lending, which showed in 1998 that 75% of ongoing WB projects in sub-Saharan Africa included the establishment or expansion of user fees. This, in essence, was the vehicle for upscaling of the application of user fees. However, the "how" of user fee implementation was not spelled out in these agreements. One issue that had to be dealt with was to reverse the trend observable in many African countries until the early 1980s which was to reduce or eliminate fees at public facilities in developing countries⁵. Therefore, the IMF/World Bank needed to promote, implement and monitor user fee implementation through another 'vehicle'. For health, this vehicle was the Bamako Initiative.

By 1986, it had become clear that developing countries, most especially African nations, lacked the necessary resources to provide comprehensive primary health care to all. The African Health Ministers subsequently met in Bamako in 1987 to review the implementation and gains achieved so far through the comprehensive PHC approach. This was to stimulate a series of discussions that eventually led to the adoption of the Bamako Initiative.

The goal of the initiative is universal accessibility to primary health care. The process of attaining this goal is based on substantial decentralisation of health decision making to the district level through the district development committee, a realistic national drug policy and provision of basic essential drugs, leading to a self-sustaining primary health care. In the context of the Bamako Initiative, priority is given to child survival, safe motherhood and overall family welfare thereby encouraging intersectoral coordination and collaboration with other sectors that influence health, such as food supply, education, water, sanitation, and social welfare (WHO 1988).

The Declaration also stressed the need for promoting maximum community and individual self-reliance and participation in the planning, organization, operation and control of PHC, making fullest use of local, national and other available

⁵ However, many African countries were applying user fees in the early to mid-1980s, including Botswana, Burundi, Ghana, Lesotho, Malawi, Rwanda, Sudan, Togo, Tunisia, and Zimbabwe (de Ferranti 1985, page 11).

resources. Community involvement can range from the setting up of village pharmacies, to implementation of disease control activities, to decision making, to management of health facilities. One key factor in the increased use of health services is restoring the communities' confidence in the services by ensuring the availability of sets of basic essential drugs and supplies at the levels of the community health worker, the dispensary, the health centre and the district hospital. Therefore, the three main components of the BI were to:

- Strengthen community capacity,
- Strengthen the essential drug supply system, and
- Ensure the financing of recurrent costs.

The BI advocated a system of financing by users, communities, districts and the central Government in a satisfactory country-specific combination which allows for the regular availability of the resources needed for operating expenses, salaries and the provision of the necessary supplies, including basic essential drugs, vaccines, syringes and needles. The collection of fees from the population should not lead to the substitution for any part of the present budget provisions for health. The community would control locally generated funds with consideration for protecting the poorest. The equity problem of low-income districts or households for whom payment to the public system would constitute a barrier to treatment is dealt with in different ways. While keeping charges for episodes of illness modest in relation to household income, they still may be set at a level that allows for a proportion of free patients (e.g. about 30 per cent in Benin). Alternatively, the community health committee may undertake to pay for them, or the provincial, district or central government may provide a subsidy for this purpose. Preventive care, such as vaccinations, may be given free or is largely highly subsidized. Charges for less essential but very popular treatments, such as injections, may be higher than for vital treatments. In the case of low-income areas, a larger subsidy from government sources is needed.

The emphasis of the BI is on the process and outcomes that are envisaged, whereas the actual activities to be implemented under the BI are difficult to formulate. For example, UNICEF lists a number of areas where countries have to make decisions⁶. This was argued by one review article as being a deliberate flexibility in the conceptual framework to enable individual countries to define programmes in the contexts of their own health care systems, and to enable changes of the programme over time (McPake 1992). For example, while the BI envisaged various financing mechanisms (payment for drugs, payment per episode, and pre-payment schemes), the focus of countries has been on the fee-for-service mechanism as this is easier to implement. Targets recommended for SSA countries covered universal child immunization, oral rehydration therapy, antenatal care, safe delivery, child-spacing, treatment for severe diarrhoea, malaria and ARI, and child growth. UNICEF funding was offered for initial launching or development costs of BI, drug costs for a limited number of basic essential drugs, support costs during the programme period.

The emphasis of the resolution adopted by African health ministers was on the revitalisation of PHC through community participating in the financing of health services, through drug revolving funds. This was criticised at the time on various grounds: negative equity implications; lack of specification of health system level

⁶ These are: (a) the mechanism for community financing that is most appropriate; (b) user charges for treatment per episode of illness; (c) direct payment for drugs; (d) local insurance or other risk-sharing schemes; (e) subsidies by industrial enterprises for their staff; (f) community subscription; (g) district-level taxation; (h) subsidy from the central Government; or (i) a combination of several of these.

where the BI should apply; implementation difficulties; and increased dependence on UNICEF for financing.

2.6 Goals of user fees

The arguments for user fees for health services have been variously justified, and with different emphases depending on which document source is drawn on. A total of seven goals have been put together based on documentation of the World Bank Bamako Initiative and others (de Ferranti 1985, Akin 1987, UNICEF 1988, Anon 1993, Penrose 1998):

1. *'Mobilising revenues'*. This is seen as the primary objective of user fees in many countries, and there is some evidence to support that revenues rise over time after introduction due to improved billing and collection procedures, more strictly imposed exemptions, increasing prices, and increased utilisation as populations become habituated with paying for social services.
2. *'Promoting efficiency'*. In the health sector, efficiency is encouraged through setting higher prices at higher levels of care, thus providing incentives for a proper referral system to work. This is conditional upon quality improvements at the lower levels of the health system, to encourage increased use there. It is also argued that 'frivolous' use of health services is reduced when services are not free, and the population only demands health care when it is really necessary. For education, efficiency is promoted if the demand for education moves closer to the socially optimal level of education provision. This is because the private demand may be less than the social optimum due to ignorance about the benefits of education. Also, where education and training are considered to be necessary conditions for economic growth, society and therefore the state have a common interest in increasing the educational level of the population.
3. *'Fostering equity'*. This argument is based on the assumption that public services used and paid for by the richer segments of the population in secondary and tertiary facilities cross-subsidise the use of services by the poorer segments of the population in lower level facilities (who, it is assumed, receive subsidised or free services). In effect, this policy frees up more government resources for providing social services at lower cost (or free) to the poorer segments of society. In health, this means providing heavily subsidised essential interventions at community level that have the biggest impact on the poor, such as immunisations, malaria control, safe drinking water and health education. Furthermore, equity is argued to be enhanced when revenue from user fees is retained at the point of collection, and can be used for improving the quality of service, thus improving the outcomes of the poor.
4. *'Decentralisation and sustainability'*. In health, these is enhanced through an appropriate pricing structure to encourage use of district based health facilities close to the home of the patient, thus redirecting funds to the decentralised levels and away from tertiary centres. This is further helped by allowing retention of user fees at the point of collection (such as a drug revolving fund). The combined effect of these is to increase the resource envelope and thus spending at lower levels of the health system, and improve the sustainability of those services. Sustainability is also enhanced in education if school budgets are increased from the users, assuming the population served is able and willing to pay to send their children to the school.

5. 'Fostering private sector development'. When public facilities are free of charge, it is argued that the private sector cannot compete, unless there is a quality difference for the private sector to exploit (i.e. the population willing to pay for better quality services). When the population has to pay for social services, they begin to take an interest in other options for meeting their need, whether it be private service providers, or in the case of health, an insurance against illness.
6. 'Improving quality of service'. Assuming revenues are retained at the health facility and are available for use at that level, they can be spent on different aspects of service delivery that improve the quality of care. In education, user fees can improve the availability and quality of teaching materials, and increase the motivation of teachers. This is an important justification for user fees where receipts from central and local government are inadequate to maintain the essential elements of a public service.
7. 'Encouraging accountability and community participation in management'. It is argued that the community has more interest in public services when they contribute financially to these services. Arguably it shortens the chain of accountability between the providing agencies (schools or health facilities) and the users of the service. In education, parents and pupils are expected to value schooling more and place direct pressure on schools and teachers to maintain quality (Anon 1993), for example through school boards. In health, communities can be involved through feedback mechanisms (e.g. complaint boxes), community representation on district and facility health boards, and election of these representatives by the community. Communities play a monitoring role, and contribute to decisions about the use of funds. This has a direct effect on not only quality, but ensures that public services are responsive to community needs.

2.7 Implementation of user fees – design and coverage 1980s & 1990s

As suggested by the flexible framework of the Bamako Initiative, user fees were implemented in a variety of ways in health, and the same is true also for education. Cost sharing takes a variety of forms. In health, fees at the point of use can include the cash cost of a consultation, payment for medicines, and inpatient stay charges. In education, cost sharing ranges from official fees and levies for activities such as registration, examinations and sports, to indirect charges for uniforms, books and pencils, and contributions to school construction and repairs.

Also, the pattern of coverage across Africa of user fee implementation varies according to what time period is chosen. Table 2 below shows the various types of user fee coverage achieved in African countries by 1993 in health. In 1993, 37 African countries were surveyed and 33 had cost recovery schemes in place or about to be introduced in health, most of which had been implemented or overhauled since 1980 (Creese 1995). There are no major differences to note between Anglophone or Lusophone countries and Francophone countries, as shown in the table. Later in the 1990s, most countries without a national system of user charges for health (left column) shifted towards adopting user fees.

Table 2. State of cost recovery in health in Africa in 1993

Cost recovery is in place and dominated by national system of user charges	Some national system of fees but minimal or not enforced effectively	No national system of fees but some facilities or communities collect fees	No apparent forms of user fees or cost recovery in place
Anglophone/Lusophone countries			
The Gambia Ghana Kenya Lesotho Malawi Namibia Mozambique Swaziland Zimbabwe	Equatorial Guinea Ethiopia Guinea-Bissau Nigeria Sierra Leone Sudan Tanzania Zambia	Uganda	Angola Botswana Malawi Sao Tome
Francophone countries			
Benin Burundi Cameroon Côte d'Ivoire Guinea Mali Senegal	Burkina Faso Mauritania Togo Rwanda	Central African Republic Congo Madagascar Niger Zaire	
16 countries	12 countries	6 countries	4 countries

Taken from Shaw and Ainsworth (1996), page 9. Note an adjustment was made for Tanzania, where fees were applied in hospitals from 1992, but at that time not in health centres.

2.8 Conclusions

In conclusion, the scale of user fee adoption in health and education in Africa was quite remarkable. In health, this was driven by the joint effects of conditionalities of structural adjustment loans, and the guiding principles of the Bamako Initiative. In education, there was no such promoter as the Bamako Initiative. However, the extreme shortfall in government budget for education made it an absolute necessity that schools charge their pupils, whether through official government policy, informally, or both. Given the large number of goals of user fees, which act as some kind of a priori justification, it could be interpreted that user fees were seen as a single solution for the woes of the social sectors. They would not only mobilise essential revenues for the improved quality, coverage and responsiveness of services, but they would also allow redistribution of public resources to the more remote, underserved and poverty-stricken areas, at the same time promoting a diversity of providers which would eventually mean more public money for the less well off.

Did user fees live up to this long list of expectations? Did the user fee bandwagon continue to roll? Or were expectations dashed, leading to the loss of widespread support for them as a central pillar in social sector financing policy? The next chapter attempts to deal with these questions, under the title "Questioning payments for public services".

3. QUESTIONING PAYMENT FOR PUBLIC SERVICES

3.1 Introduction

In recent years, an international consensus has been gathering that user fees for health and education – whether cost sharing or complete cost recovery – are not appropriate in all developing country settings. Some opponents of user fees argue that they are not appropriate at all, or that the evidence does not justify their implementation. What explains this shift in position? While the impact of the various influences cannot be determine exactly, it is possible to make links between various explanatory factors and the gradually changing position of some of the key actors in this field. These factors are grouped under three main but linked sets of arguments, which are covered in detail in this chapter:

1. The weight of academic and policy arguments against user fees, related to the gathering evidence of the negative effects of user fees, the failure of waiver and exemption mechanisms to lessen the burden on the poor, and the disappointed expectations regarding the performance of user fees as a financing mechanism.
2. The influence of stakeholders driven by political or ideological motives, which have forced a shift in user fee policy of major global players in social sectors. These groups have received much of their fuel from the academic and policy arguments in 1. above.
3. Renewed focus on the international development targets relating to reduced inequalities, poverty reduction, the millennium development goals for health and education, and other initiatives such as Education For All and Health For All in the 21st Century. The strength of this argument is based on the premise that these targets may not be achieved if public services continue to be charged for.

The Chapter closes with a section describing some important initiatives that have taken place in the last few years, to shift the debate in social sector financing away from user fees, or to shift the design of user fees themselves. These initiatives give an important background for Chapter 4 which analyses the latest position of the World Bank on user fees, and Chapter 5 which considers the potential for user fee abolition.

3.2 Gathering evidence weighing against user fees for health and education

There is a massive evidence base on the implementation and impact of user fees, as well as a fast growing literature reporting various mechanisms to reduce the adverse effects of user fees. Experience of user fees in health in Africa has already been reported in a large number of review articles (Brunet-Jailly 1991, McPake 1992, McPake 1993, Creese 1995, Nolan 1995, Chawla 1996, Reddy 1996, Russell 1996, Shaw 1996, Gertler 1997, Gilson 1997, Russell 1997, Wang'ombe 1997, Ahrin-Tenkorang 2000, Cattaneo 2000, Poletti 2003, Hutton 2004), and the number of published articles and grey literature are in the hundreds. If this is the major reason for the shift in policy, as investigated in this chapter, it has certainly taken a long time for the penny to drop.

With such a huge evidence base, and the diversity of ways user fees have been implemented in a diversity of settings, there is naturally quite some variation in evidence. Furthermore, evidence has been compiled and used by non-academics which either does not tell the whole truth (partial reporting) or is simply unscientific. Concerning the latter, for example, direct links are often made between policies and their outcomes without an examination of the wider range of factors that could have affected the outcome.

Therefore, an objective presentation of the evidence base is essential to make correct conclusions about the overall impact of user fees. It would be dangerous to make conclusions based on one or two country studies (e.g. user fees did not work in XX and therefore they will not work in YY, or the converse), or to read reports that clearly set out from the start to show only one side of the picture. Neither would it be correct to count the number of articles/voices/agencies/websites taking an opposing position to user fees, and compare these with those still advocating user fees. Such an approach may be instructive, but it is not scientific. Furthermore, when considering the range of goals associated with user fees, neither would it be scientific to take a position completely for or completely against user fees, as the truth clearly lies somewhere in-between. It is more a matter of determining where on the scale the truth lies for the various criteria against which user fees are to be evaluated.

Given these arguments, but also in the interests of space, it is most informative to draw on the reviews of evidence already reported in the literature that have attempted to capture the various experiences of user fees. These studies are reported more fully in Annex 2 (with more emphasis on the health sector), and is summarised below and in Table X3

Evaluated against the seven stated goals of user fees (Chapter 2.6), it is probably true to say that the evidence weighs more against user fees as an efficient and equitable financing mechanism, than the evidence supporting user fees. In **health**, user fees have in general raised less revenue than expected, they have acted as a disincentive for poor and non-poor groups alike to use health services, and they have not lead to the degree of community participation that was originally envisaged under the Bamako Initiative. There is mixed evidence of quality improvements resulting from having more funds at decentralised levels, and user fee revenues have often been mismanaged or siphoned off due to lack of accountability. Also, what is rarely mentioned alongside revenue figures are the health system resources of raising and managing the fee revenue, which can be considerable.

Strong arguments have also been levelled against user fees for **education**. For example, based on a review of theoretical arguments and empirical evidence, a Senior Policy Analyst at UNICEF argues that user fees in education:

- Have not guaranteed greater efficiency and effectiveness because basic social services are public and merit goods,
- Have only mobilised modest amount of resources compared with total resources,
- Have lead to a reduction in the utilisation of services, particularly amongst the poor,
- Are difficult to exempt for the poor due to the poor functioning of waiver and exemption mechanisms which are costly to administer,
- Have tended to aggravate gender biases, seasonal variations and regional disparities.

As argued by one education expert, user fees have been imposed to make up for other failures: “The common economic justifications for cost sharing in education are contradictory and inconsistent, and their rationalist assumptions do not reflect reality, either of how people behave or how public finance systems react. The politics and economics of cost sharing in developing countries are rather founded in fiscal crisis and in the ideology of 'low' public spending and budget deficits. They are also heavily influenced by foreign aid policies, which are themselves unstable over time and frequently inconsistent between donors and lenders, and which impose additional fiscal burdens on countries. As a result, there has been a general failure to

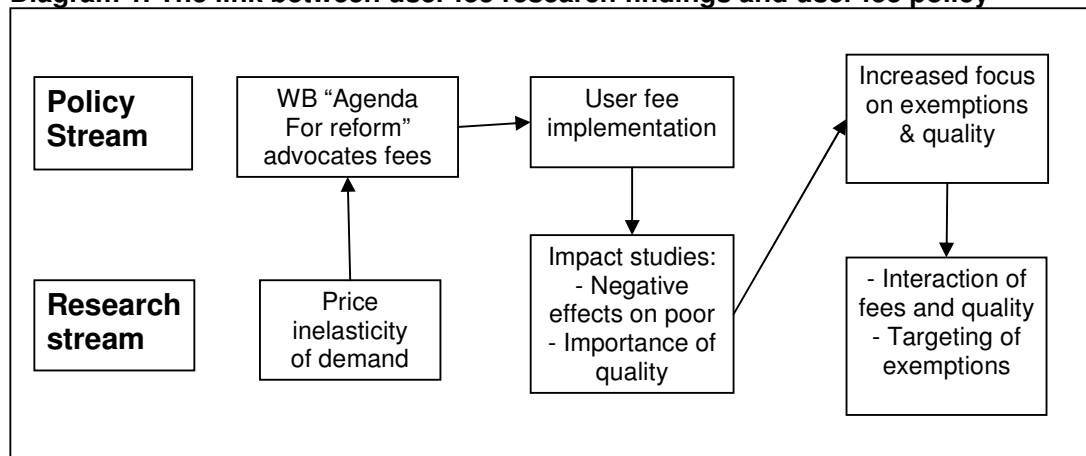
understand the content, pacing and sequencing of financial reforms which improve the resource flows to education” (Penrose 1998).

Evidence does also point, however, to some positive impacts of user fees, such as the increased availability of drugs and medical supplies, which in turn have a positive impact on people’s willingness to pay for health care and in some settings this has lead to increased use of health services. In many settings, user fees are the main way of maintaining some liquidity in the lowest tiers of health systems, thus acting as essential life blood to these systems. Also, it is argued that when formal user fees exist, there is reduced opportunity for health providers to charge informal fees.

An important point to note is that the proponents are very ready to point out the weaknesses of user fees, and propose various ways of reducing the negative impacts or incentives. This is evident from the first World Bank publications on user fees, which raised the problems of reaching the poor under user fees, how to deal with services which have externalities or are public or merit goods, and the importance of mechanisms to ensure that quality is improved (de Ferranti 1985, Akin 1987). Later, in the 2000 World Development Report ‘Attacking Poverty’ some studies are cited reporting the negative effects of user fees for essential public services, such as reduced levels of service use, and families being forced to sell assets to pay for hospital care. This was interpreted more as failure to properly apply the mechanism that a fundamental failure of user fees. Hence the continued conviction that user fees can continue to be applied selectively, working on improving the mechanisms to reduce the negative impacts.

So what is the direct effect of the gathering evidence base on policy? The influence of the gathering evidence on international and national policies was examined in a presentation on the link between user fee research findings and user fee policy (Bennett, undated). As already mentioned, research studies suggesting inelasticity of demand to price were used to justify user fee policies across the developing world. However, within a decade research was demonstrating the negative impact of user fees on equity, and the importance of quality improvements. This gave increased emphasis to exemption mechanisms, quality and health systems in the mid- to late-1990s. However, more recent research has shown that exemptions do not work well, and that there are specific conditions necessary to achieve quality improvements.

Diagram 1. The link between user fee research findings and user fee policy



Source: Bennett, undated.

Table 3. Summary of evidence weighing for and against user fees in health and education

Criterion	Item	Health	Education
Mobilising revenues	Revenues raised	Generally funds raised are small proportion of overall sector budget, but have significant impact on decentralised service provision	
	% financing	Hugely variable, from insignificant amounts to 100% of recurrent expenditure	Up to about ¼ of sector expenditure, but usually significantly less
	Comment	Official figures may not reflect full costs to users due to siphoning off of funds, and unofficial fees	
Promoting efficiency	Being seen at the appropriate service level	Prices do not always give right incentives, and often patients perceive better quality of care in hospitals	N/A
	Reduced frivolous use of services	Highly unlikely that frivolous use of health care would occur in absence of user fees in Africa	Use of fees constrains demand below socially desirable levels of education
	User fees give incentives for provider to over-treat	Evidence limited, but quite possible in relation to drug prescriptions	N/A
Fostering equity	Better services improve outcomes for the poor	Mixed evidence, but generally lower use of services when charged for, especially amongst poor	Poor are generally constrained from attending school, even if quality is better
	Fees redirected from higher to lower facilities	No evidence to suggest this occurs	No evidence to suggest this occurs
	Formal fees reduce informal fees	Limited evidence, but some evidence from Uganda supports this hypothesis	No evidence to suggest this occurs
	User fee exemptions ensure poor are protected	Exemptions by service type (e.g. MCH) generally much more successful than waivers involving means testing	Usually exemption systems are informally applied, and application highly variable
Decentralisation and sustainability	Number and quality of services provided at primary care level	Population more likely to use local facility if drug supply assured by user fees, but government spending may decline. Services sustained at minimum level	In most settings, given the government budget for education, user fees contribute to sustainable financing
Fostering private sector development	Population shops around	Choice is extremely limited, except in urban areas	Highly unlikely
	More use of private or fee paying NGO services	Private sector grown in last 2 decades. Private pharmacies much more common than private clinics	No evidence to support this
	Flight of staff from public to private sectors	Dual practice more common in urban areas, as work in public sector assures client base	No evidence to support this, but private schools not widespread (except mission)
Improving quality of service	Service improvements	Generally true where fees retained at point of collection	Minimum level of service usually afforded
	Chain of accountability ensures quality improves	This is partially true, such as drug revolving funds	Some evidence to show that parents associations can play a role
Community participates in management	Community management	There is widespread evidence of this	Limited evidence to support this
	Services more responsive	There is some evidence of this	Limited evidence to support this

3.3 Influence of different stakeholders

The intention of this section is to examine the influence of different stakeholders on the policies of the World Bank, which are seen as heavily influencing the policies countries adopt and implement. Stakeholders are recognised to have agendas which they try and push, agendas which are based either on an ideology, a political interest, convictions supported (partially) by an evidence base, or a mixture of these. For the purpose of this paper stakeholders are classified into 3 main types: (1) governmental (donor) or supra-governmental organisations (e.g. UN, OECD); (2) NGOs and coalitions of NGOs; and (3) academic institutions. All of these players have played a key role in the shifting policy on user fees for health and education, as described below. NGOs have focussed their campaigns on the IMF and World Bank, whose loan conditions and policy advice have often resulted in fees for basic services. Likewise, the US Congress targeted the IMF/World Bank specifically with the threat to withdraw US financing if user fees were conditional for new loans. Academic institutions have played more of an evaluative role, describing the strengths and weaknesses of user fees, and in so doing have supplied ammunition to both opponents and proponents of user fees.

3.3.1 *NGOs and coalitions of NGOs*

As is expected in an area that touches upon human rights, there is no shortage of statements in briefing papers and internet pages of NGOs or coalitions of NGOs calling for the end of user fees for basic social services in developing countries. There are also a large number of civil society organizations in developing countries themselves that have a strong influence on their governments and donor organizations. Figures are banded around about how many people are denied access to basic services due to user fees, and draw direct links with the poor health and education status of a large proportion of the developing world's population. For example, the Coalition for Health and Education Rights⁷ reminds us in their policy brief for the UN Special Session on Children that the Universal Declaration of Human Rights is violated daily on a massive scale: 113 million children are out of primary school, and 35,000 children in low-income countries die every day from preventable conditions. Some NGOs go further and heavily criticize those institutions that have advocated user fees, calling them irresponsible, and even questioning whether they deserve to continue to exist⁸.

In general, the most active NGOs working in this area tend to agree on the main problems and solutions. A common theme of the material produced by these NGOs is that they draw heavily on the evidence that supports their arguments, and rarely report any real benefits of user fees. They often draw on research evidence reported by the main proponent of user fees, the World Bank, that shows some negative impacts of user fees, and question how the World Bank could have supported user fees for so many years.

After many years of campaigning, NGOs claim as their victory the pressure the US Congress put on the IMF and World Bank to withdraw user fees as a loan condition (see below)⁹.

3.3.2 *Academic institutions*

While the output of academic institutions is summarised in the above section, and more

⁷ Made up of Actionaid; Globalization Challenge Initiative; The Power to End Hunger RESULTS; TEN/MET; ELIMU Education Campaign.

⁸ "50 Years is Enough" campaign to bring an end to the IMF and World Bank.

⁹ "Responsible reform of the World Bank" presented by a US Civil Society Coalition, 2002.

fully described in Annex 2, these institutions have played more of a role than simply holding a mirror up to user fees. For one, as the findings of research are usually mixed – showing both strengths and weaknesses of user fees – it has meant that the findings can be drawn on to suit the side of the argument one is wishing to support. This fact highlights the rather crucial, even political, role of academic institutions, who are supposed to be objective and scientific purveyors of all they see. Their assumed importance has even lead some academics to stray from the more positive role of presenting the evidence in a straightforward and objective manner, to taking sides or positions on what outcomes are desirable in society. Thus the research questions are moulded to suit the intended outcomes, for example, what evidence they wish to uncover. This pattern is observable if one examines the marked differences in general conclusions on user fees coming out of different research institutions.

What this problem highlights is the need not only for well conducted research, but for appropriate interpretation of results, as well as well thought-out conclusions about the generalisability of findings. In the latter case, what is important is not to make conclusions based on indicators of success, but instead to examine what factors determine success. Why did quality improve in some settings, and not others? Why did resource mobilisation work much better in some settings than others? The answers to all these questions will, in the end, be much more instructive for deciding whether user fees should continue to be applied, or whether they are fundamentally inappropriate in financing health and education sectors in Africa.

3.3.3 Governmental or supra-governmental organisations

There are several examples of governmental or supra-governmental organisations having an influence on user fee policy and practice in developing countries. Notable examples discussed below are the Addis Ababa Consensus on cost sharing (1997); the US Foreign Aid Bill (2000); the World Health Report (2000) and the World Development Report (2000/1); WHO guidelines; EFA Dakar Principles (2000); the OECD Poverty and Health Guidelines (2003); World Bank social protection policy; and the World Bank's "no blanket policy" on user fees (2004).

Addis Ababa Consensus on Principles on Cost Sharing in education and health in sub-Saharan Africa (1997). Two essential recommendations of the Consensus include:

1. 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.
2. Cost sharing should be a stepping stone towards other financing options for health care. 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.

Specific objectives of cost sharing were defined as: (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, and (ii) to overcome the practical and managerial obstacles that have prevented an adequate level of resources from reaching basic education and basic health. A summary of the principles is as follows:

- 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.

- 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. Revenue generated through cost sharing must be retained, with the spending authority at the local level.
- Cost sharing must be accompanied by special measures that effectively protect the poor. Non-discretionary exemption schemes should be preferred from the point of view of efficiency and reduced leakage. Caution must be exercised in introducing cost recovery wherever there is doubt about the ability to protect the poor.
- 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. 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 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.

A second good example of a stakeholder having a measurable impact on user fee policy is a [US Foreign Aid Bill](#) in 2000 which helped push the World Bank into a reversal of its position on user fees in education in 2001, and has sparked a major debate on fees for health care. The Bill required the conditionality to be lifted on IMF/World bank loans that required a blanket user fee policy¹⁰. However, the US Treasury was opposed to the Bill, and has worked to block inclusion of the amendment in the final foreign operations appropriations bill. Later, a new provision in 2001 closed the loopholes that the US Treasury found to avoid following the law. Furthermore, new provisions call for more transparency asking for release of more information, and legislation has been passed in the US urging the Asian Development Bank and other lenders to prevent poor countries from charging school or health fees.

Also, the year 2000 saw an important emphasis in the annual publications of two major players. Both Chapter 5 of the WHO's [World Health Report](#) (2000) and Chapter 8 of the World Bank's [World Development Report](#) (2000/1) emphasized the importance of developing risk sharing mechanisms almost at the complete exclusion of direct fee for service mechanisms at the point of use. However, the WHR contains a loophole, that "some direct contribution at the moment of utilization may be required in low income settings or settings to increase revenues where prepayment capacity is inadequate".

The WDR 2000/1 argues that free primary education for poor people is critical for expanding their human assets, especially for girls. The report goes on to say "similarly, subsidising prevention of infectious diseases and helping poor people finance the costs of catastrophic health episodes need to be key elements in strengthening poor people's

¹⁰ Section 596. "The Secretary of the Treasury shall instruct the United States Executive Director at each international financial institution and the International Monetary Fund to oppose any loan of these institutions that would require 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. The managers direct that the Committees on Appropriations be notified within 10 days if any loans, community financing, cost sharing, or cost recovery mechanisms requiring the imposition of user fees are approved by any multilateral development bank or the International Monetary Fund.

health assets and reducing their vulnerability to health shocks.” The World Bank’s *Voices of the Poor* study gives many examples of families who have slipped into poverty, or been driven deeper into poverty, due to poor health. The report recognises that often, for poor families, it is a matter of choosing between health services and paying for education.

As the WHO body responsible for immunization services, the WHO Department of Vaccines and Biologicals, in their 2001 document “Practice and policies on user fees for immunization services in developing countries” (England et al 2001), argue that user fees discourage people from seeking immunization and that public funding is the most equitable way to finance essential immunization (influenza, meningitis, polio, rabies, rubella, typhoid, yellow fever). This viewpoint draws on a UNICEF meeting in 1999 where consensus was reached that, in heavily resource-constrained settings, it is preferable to cross-subsidize immunization services rather than to charge directly for it. There is strong international support (e.g. GAVI, World Bank, Addis Ababa Consensus, PAHO, UNDP) to exclude immunization from user fees, and immunization has long been held up as an example of a positive externality where low or zero prices should be charged. However, unofficial charges were recognized as being a barrier to receiving immunization, and that more information is needed on this.

Education For All, adopted in Jomtien in 1990 and reaffirmed in Dakar in 2000, makes it clear that primary education should be free in Africa. Alongside making primary education free for everyone, governments and donors are called on to increase funding to the education sector, improve service quality, and remove other barriers to education.

Another major player is the Development Assistance Committee (DAC) of the OECD, which in their 2003 “Poverty and Health Guidelines” states that an equitable health financing strategy should ensure financial protection for everyone and eliminate the possibility of poor people being unable to pay for their health care, or become impoverished as a result. Special consideration should be given to women as they have less access to resources and insurance is biased against them (actuarial risk). Financing policy should be closely related to broader issues of social protection. The DAC recommends that, subject to fiscal constraints, ‘essential’ services should be free (primary-level services, targeted groups or communities, priority diseases and conditions) with exemption systems for hospital services.

Also worth mentioning is the important ongoing work in the Social Protection Department of the World Bank, who have produced a number of documents outlining approaches to risk management in Africa. Questions are raised relating to direct instruments for social protection, such as which government body should be responsible for social protection (e.g. financing of health care for the poor), and how to develop appropriate social safety nets for the entire population. Three strategies are for the public sector to help reduce or prevent risk, to ensure better coverage and lowering the cost of insurance against risk, and promoting low-cost coping mechanisms for the poor during their times of need. However, given the scarcity of public resources in Africa, the scope for such direct redistribution measures is limited.

Finally, the World Bank’s “no blanket policy on user fees”, outlined in the World Development Report 2004, could be seen as a landmark in user fee policy. Stepping down from their original stance “Charge fees unless you can prove otherwise”, the World Bank’s policy is more one of “Provide free care unless there are good reasons to apply user fees”. On its website, the World Bank says it does not support user fees for primary education and for basic health services for poor people. More generally, the Bank

supports selected free services for all people: immunization, maternal and child care and certain programmes for tuberculosis, HIV/AIDS and sexually transmitted infections and malaria. Furthermore, the Bank works with countries to find ways to subsidize the premiums of poor people (for community health insurance schemes in low-income countries where taxation revenues are very limited). However, where government funds are very limited, user fees applied to better-off groups can be used to improve services for poorer groups. Due to its importance, the content and implications of the “no blanket policy on user fees” are discussed more fully in Chapter 4.

3.4 Renewed focus on the international development targets

The argument that international development targets such as the MDGs will not be met without a drastic change in financing situation is these days a familiar refrain, and has not gone unheeded. Hence the new large-scale international financing initiatives such as the Global Fund for HIV/AIDS, TB and malaria, the Clinton Foundation, more and more World Bank loans (e.g. TMAP), and the International Financing Facility. However, these are largely supply-side initiatives that see the solution as throwing money at countries. The demand side has been inadequately tackled, most notably the concern that if user fees remain then a significant part of the population is prevented from accessing basic services.

If one believes that user fees are an important constraint to people using basic social services, then it follows that the continuation of user fees and the poorly functioning waiver and exemption mechanisms are a major barrier, or bottleneck, to the level of service utilization required to meet the MDGs. As stated rather strongly by the Coalition for Health and Education Rights, until now there has been a resounding failure to translate MDGs in health and education into action. For example, on current trends 75 million children – three-quarters of them in Africa – will remain out of school in 2015. They conclude “it is clear that these goals can only be realized if basic services are made genuinely free and accessible”. This is a clear enough statement, but few so far have joined the battle.

User fees have several important implications for the MDGs. For example, user fees will prevent the achievement of the poverty and hunger MDGs if they prevent poor individuals from remaining healthy, becoming more educated, or from eating, especially where ill health leads to catastrophic costs. Second, if ill people are kept in a poor state of health, they do not have the same productive capacity to generate the income that will help them climb out of poverty. Furthermore, financially inaccessible health services for children, women and people suffering priority diseases means delays in treatment or non-treatment. Payment for drugs will mean that fewer are consumed than may be the optimal level, especially if cost recovery on more expensive drugs (malaria, HIV and AIDS drugs). Finally, user fees for basic education have been proven to be a major disincentive for poor and also non-poor families. Removing user fees have been shown to increase enrolment and completion rates significantly (see Chapter 5).

However, as has been raised by some NGOs, there are counter-developments in the general trend away from widely applied user fees. One notable example is the World Bank’s private sector review. Among the concerns are that (1) the poor and disadvantaged will be excluded, especially as targeting and exemption mechanisms have not been proven to work well, (2) public sector personnel will be drawn to the private sector, thus reducing the human resource pool for public service, and (3) conflicts

of interest between commercial pressures and public health and education goals¹¹. The proposed private sector review in 2001 raised quite some opposition from various corners. For example, a coalition of almost 100 NGOs appealed to the World Bank's board for recasting the Private Sector Development Strategy, arguing that governments with weak capacities to provide public services also have weak capacities for regulating the private sector.

As an observer of various World Bank policies, it appears that the World Bank is promoting conflicting policies. On the one hand, the Bank is increasingly advocating for a limited role for user fees, and even complete removal of user fees (primary education). On the other hand, the World Bank is strongly advocating for the reduction in government, with the privatisation of state-owned enterprises and services, as well as pushing for insurance in health¹². It is difficult to see how these policies, in the social sectors of Africa, are compatible, and which side, in the end, will win.

3.5 Conclusions

While the shifting position on user fees has been going on for some years, changes have proven to take a long time to implement. For example, the Coalition for Health and Education Rights observes that progress in implementing the World Bank's policy changes on user fees remains slow and uneven. Only few countries have gone ahead and abolished user fees in education, and even fewer for basic health care (see Chapter 5). They claim that, in most poor countries, the World Bank and other donors are failing to provide the decisive support that is needed to end fees. Furthermore, the World Bank procedures are not transparent enough to allow monitoring the content of the Bank's adjustment programmes. In fact, there has been one reported case since the US Congress Bill in 2000 where user fees have been included in a loan package, despite the legislative language. As stated by the Coalition, this seriously calls into question the commitment of the World Bank to ending user fees as part of the World Bank and IMF prescriptions.

¹¹ Save The Children's Policy Briefing on the World Bank's private sector review

¹² "How IMF-World Bank make Africa sick" by Anne-Louise Colgan.

4. THE WORLD BANK'S "NO BLANKET POLICY" IN PRACTICE

4.1 Introduction

As discussed above, the appropriateness of user fees has been widely questioned for some years, even within the World Bank¹³. Since around the year 2000 a major shift away from user fees has taken place within the World Bank. In September 2001 the World Bank issued a revised user fee policy, saying it "supports the provision of free basic health services to poor people" and discourages user fees in the cases of immunization, maternal and child health care, and efforts specifically targeting tuberculosis, HIV/AIDS and certain other diseases. However, the World Bank has not shifted from its position that user fees can be mobilised from better-off groups that can in turn be used to improve services for poorer groups.

The 2004 World Development Report (WDR), entitled "Making Services Work for Poor People", now advocates for a new approach. In the context of widespread criticism of Bank-financed policy reforms that impose commercial pricing on the poor, the WDR emphatically states that there should be "no blanket policy on user fees." Instead of universally recommending user fees, the bank acknowledges that user fees in a lot of cases have led to exclusion of poor people and recommends that the situation has to be analysed in each policy context and decision-makers have to choose from a variety of options regarding user fees. It provides an analytical framework for helping policy-makers determine when user fees are appropriate, and with what kinds of complementary measures to protect the poor. In brief, the decision about whether and how to apply user fees should balance (a) protection of the poor, (b) efficiency in allocation, and (c) ability to guarantee that services can be implemented and sustained. The decision tree that appeared in the WDR 2004 is reproduced below (Box 4.4).

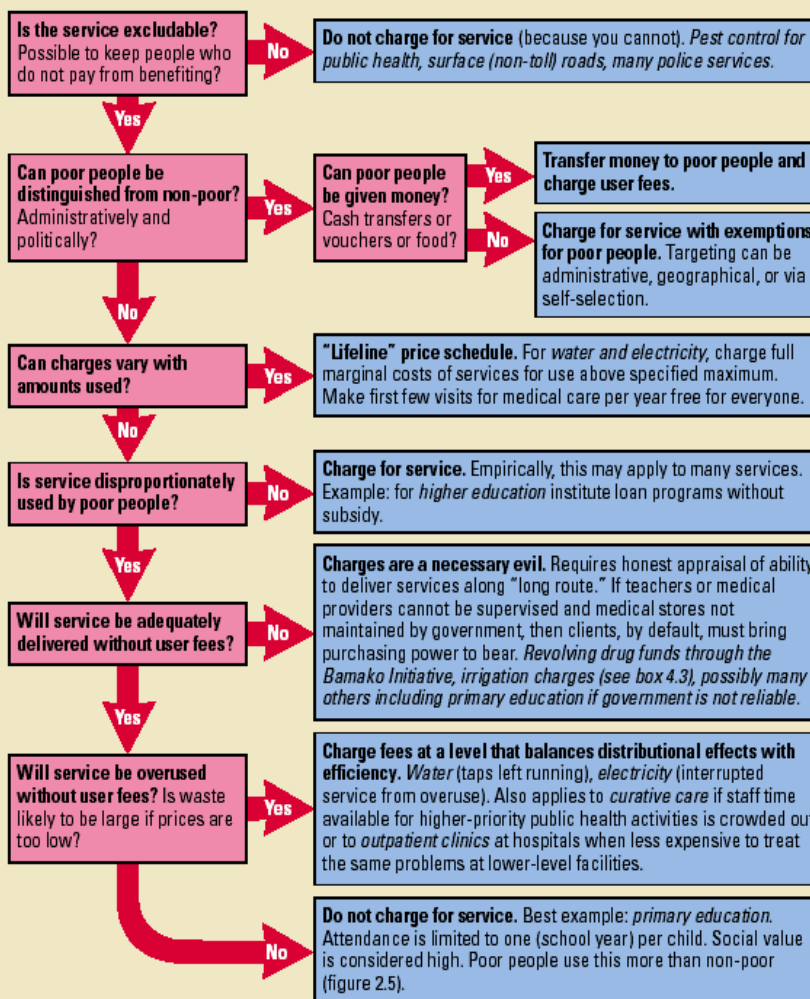
The underlying basic philosophy of the approach is that user fees not only create additional funding for under-financed health services which should be used to improve quality of care (this is the basic argument of the World Bank in advocating for fees since 1987), but additionally that they are an instrument of establishing a market relationship between provider and client which can empower the client. The client in such a market relationship through direct payment of fees becomes entitled to receive a service and cannot be easily turned away without adequate service as in tax-funded systems where deficiencies can always be blamed on a far-away government. One way of sustaining such a relationship is the distribution of vouchers to pay for public services, thus giving poor people an earmarked but tangible purchasing power with which to exercise their rights as consumers. By giving the poor person a voucher in hand which for the provider becomes the equivalent of cash demand, a market mechanism is installed linking the income of the provider to the demand of poor clients. With this mechanism, the poor not only passively receive access to basic services as in exemption policies but, if options for choice of providers are included in the scheme, become active "players" who become able to demand minimum standards of quality of care.

¹³ For example, a 1988 World Bank Living Standards Measurement Survey "Measuring the willingness to pay for social services in developing countries" (Gertler 1988) showed that in the Côte d'Ivoire the impact of user fees introduced in public facilities would reduce the welfare and utilisation of poor people, and increase the welfare and health service utilization of the top half of the income distribution. A World Bank Working Paper discussing the implementation of user fees in health in Mali highlights the ambiguity with which user fees were promoted, the very low levels of revenue, the lack of evidence for knowing what prices to charge, inappropriate exemption policies, and variability in fee charging throughout the country (Brunet-Jailly 1991).

BOX 4.4 *No blanket policy on user fees*

The wide range of services and country circumstances discussed in this Report makes it impossible to claim that a particular level of user fees or none at all is appropriate in every case. User fees, as with other public policy decisions, must balance protection of the poor, efficiency in allocation, and the ability to guarantee that services can be implemented and sustained. The following flowchart summarizes the arguments and references in the text and raises most of the issues necessary in determining whether user fees of any sort are appropriate in a given case. Three points:

- First, "efficiency" is shorthand for standard principles of public economics (see any textbook) that often but not always require prices that equal social marginal cost and may include subsidies, taxes, or other interventions independent of their distributional effects. For example, infectious disease control measures will have a subsidy element because of their external effects regardless of their impact on poor people.
- Second, it is assumed that all subsidies are paid for by taxes. The net effect on poor people depends on their contribution to tax revenue (possibly substantial when taxes are based on agricultural exports) and on their share of the deadweight loss that taxes impose on the economy.
- Third, even when prices are not charged at point of service, communities may want to make contributions to capital costs by, say, helping to construct or maintain schools.



This Chapter dissects the World Bank's new position, questioning whether and how it is workable in practice, and how it needs to be set in a broader health financing strategy. Furthermore, given many developing countries' (as well as some donors) continued commitment to user fees, how might new international pressure be viewed by these countries? Are they likely to change their policies? How might change come about? And what arguments can be used to persuade governments to change?

4.2 Knowing what services to levy user charges on

The WDR 2004 suggests an analytical framework for helping decision makers to determine under what conditions user fees may be useful and with which measures they may be accompanied. In a decision tree, a number of questions are posed, and the respective answers lead to differing policies on user fees. What implications for the range of basic health and education services? When the decision tree in Box 4.4 above is reformulated, the following recommendations are made:

Services should be free to all when:

- Services are not excludable.
- Services can be given at a 'lifeline' rate to all, with consumption above this rate charged for.
- Services are disproportionately used by the poor, and services are likely to be delivered adequately without user fees, and services will not be overused without user fees.

Waivers and exemptions should be given to poor people when the poor can be distinguished from the non-poor, and it is feasible administratively and politically to do either of the following:

- Give the poor cash transfers or vouchers to help them finance the service, or
- Give the poor waivers and exemptions when they show up for the service.

User fees should be charged to all when the service is excludable, and the poor cannot be distinguished from the non-poor, and when any one of the following conditions apply:

- The service would be overused without a user charge, or
- The service would not be adequately delivered without a user charge, or
- The service is not disproportionately used by the non-poor.

The implications for different types of health and education services are examined in Table 4 below.

Table 4. Implications of the framework for user fee policy for different health and education services

Criteria	Health	Education
1. Services should be free to all when:		
1.1 Services are not (easily) excludable	Pest control, sanitation, IEC campaigns	Not applicable
1.2 Services can be given at a 'lifeline' rate to all, and consumption beyond that rate is charged for	Vouchers are given that cover a basic package, but this approach is largely untested	Not applicable
1.3 Services are disproportionately used by the poor, <u>and</u> service is likely to be delivered adequately without user fees, <u>and</u> service will not be overused without user fees	Typically for low cost PHC activities, possibly ANC, immunization, and curative care for low cost treatments for priority diseases	Primary education
2. Exemptions should be given to poor people when the poor can be distinguished from the non-poor, <u>and</u> it is feasible administratively and politically to either:		
2.1 Give them cash transfers or vouchers to help them finance the service	Items within the essential health package	Primary and secondary education
2.2 Give them exemptions when they show up for the service	Items within the essential health package	Primary and secondary education
3. User charges should be charged to all when the service is excludable, <u>and</u> the poor cannot be distinguished from the non-poor, <u>and</u> when any one of the following applies:		
3.1 The service would be overused without a user charge	Curative care if shortage of staff; hospital outpatient clinics	Secondary education when very limited places
3.2 The service would not be adequately delivered without a user charge	Revolving drug fund	Primary education if very low tax base
3.3 The service is not disproportionately used by the non-poor	Non-PHC items and less essential items typically not in national essential packages	Higher education

For each possible financing outcome, an attempt has been made to fill in the types of health and education services that would fall under each one. Some guidance was given in the WDR itself. There is some uncertainty, however, about some types of service, and the optimal approach will vary between settings, depending on amount of subsidies possible, what is defined as essential care at the national level, and the cost of curative care for priority diseases (and therefore the extent of subsidies needed).

4.3 Completing the framework

To the World Bank's credit, their "no blanket policy" on user fees has been well captured in the decision tree presented in the WDR 2004. However, it is clear that some considerations have been left out, or some aspects not fully described or taken into account.

4.3.1 *What is consumption efficiency?*

Efficiency in consumption has been reduced to 'overuse' of a service, assumed to mean frivolous demand. As argued in Annex 2, frivolous demand is unusual in African settings where other barriers to **health** services are so great that people only use the services if they really need to. Furthermore, user fees may discourage people from seeking treatment early or preventing disease, when they are willing to accept the risk of getting better or avoiding the disease without health care. Therefore, this part of the decision tree has limited relevance for sub-Saharan Africa. In the context of **education**, proponents of universal education would argue that there is no such thing as frivolous demand, although early World Bank papers suggest that socially optimal levels of education provision may well be below universal coverage.

The concentration of the "no blanket policy" on frivolous demand also means that two other aspects of efficiency have been ignored. The first aspect – consumption of **health** services at the right level of care – would justify the setting of higher charges at the hospital level, or bypass charges when a patient shows up at a hospital clinic without a referral. The second aspect – supplier-induced demand – also has important implications if providers are tempted to persuade the patient to buy more drugs than necessary, or to return for care when not medically indicated. This is more likely to happen the bigger the profit margin on these services (price minus cost), and when the provider personally benefits from inflating the provision of medical care. The implication is that drugs and consultations should have a minimal profit margin, unless prices are intentionally raised to enable cross-subsidisation of services.

4.3.2 *What happened to public and merit goods?*

Public goods and merit goods are essentially those services that would be under-consumed if the consumer was faced with their full price, due either to the consumer being unaware of the benefits of consumption, or due to positive external effects of consumption. This is the common argument for providing free immunization to children, for example. Without this consideration in the framework, one has to wonder where else these services would apply for a waiver or exemption.

4.4 Applying the framework

The framework presented by the World Bank more or less corresponds to the set of decision rules that have already been applied by many African governments, especially those implementing the Bamako Initiative. For example, services that cannot be excluded are simply not charged for, while most services are charged for whether nominally or at full cost recovery thus reducing frivolous demand. Further, health

services operate within tight budget constraints, and therefore deciding what services can be charged for and which not, are questions constantly being faced by national policy makers as well as district personnel. So, what is new about the framework? Perhaps with new frameworks, it is true that there come new expectations for what they can achieve. Therefore, one has a right to question the makers how, exactly, they imagine the criteria should be applied.

4.4.1 'Excludability'

Excludability depends, to some extent, on how willing you are to invest time into identifying the beneficiaries, setting up a service contract agreement, and charging them. Economically it may not make sense, as the marginal cost of reaching one more person is zero, such as in the case of mass media and IEC campaigns. Many non-excludable items are also public goods, which have wider societal benefits than just the private benefit. Furthermore, sometimes it may simply not be worth the effort to try to charge for these services.

Conversely, in some circumstances a service that is traditionally seen as non-excludable could bring in valuable funds. Perhaps efforts to control mosquitoes through environmental means may have been more sustainable throughout Africa if the government could have found a way to charge communities that benefit. Perhaps health regulations would be more widely applied if their monitoring could be assured through passing the costs onto the end users. Therefore, it is worthwhile if governments think through the implications of not charging for services which have private as well as social benefits.

4.4.2 'Inadequate' funds

Further down in the decision tree, a decision criterion is introduced which seems to be of little practical value and may provide decision-makers with a loophole for full cost recovery for virtually any poorly performing service. The criterion reads: "Will service be adequately delivered without user fees?" If a decision-maker answers this question with 'no', the recommendation is to charge user fees. This tautological argument leaves the policy makers with the discretion to decide that user fees are necessary because without user fees services cannot be rendered adequately. The formulation of the criterion does not define when this situation arrives and does not provide the need to scrutinise the feasibility of other alternatives. It depends heavily on the availability of sufficient funds to provide a minimum quality of service, and leaves an open door for financing overspending through imposing user fees, rather than trying to increase operational efficiency.

4.4.3 'Proportion' of poor users

One of the key decision nodes in the framework is that relating to whether the service users are dominated by the poor or not. This consideration first appeared in an early World Bank paper (de Ferranti 1985), which read "...whether those unable to pay are a small or large proportion of the total. Where small, then exemptions should be applied. Where large, the case for fees would need to be reconsidered". Therefore, one would be right to question whether the World bank has really shifted policy in the last 20 years.

On a practical level, what corresponds to a 'small' or a 'large' proportion of service users? While it may have been incorrect to provide a hard figure for what is 'high enough', it leaves local policy makers with huge discretion as to which services merit free provision. In decentralized system, this may lead to inter-district differences in what is provided free to all the population, thus frustrating national goals of having an

equitable and fair social system. Ironically, where poverty rates vary between districts, it would also lead to inter-district inequalities if the national level applied a standardized user fee waiver policy.

4.4.4 Ability to distinguish poor from non-poor

It is always possible to distinguish the poor from the non-poor, it just depends on what criteria you use and what you are willing to invest into the exercise. In some societies, it may be possible for service providers to do this simply by looking at the patient or child. In other more homogeneous societies, it may be necessary to collect information on a household's wealth status, disposable income, and basic costs, to know whether they are able to pay for health or education services. In other societies, such a detailed assessment may be unnecessary, but instead the community members or leaders may know the relative wealth status of its members. Clearly the World Bank could not give exact specifications for how to go about this, but the evidence is building now on which mechanisms are more sensitive (including those who are poor), which are more specific (excluding those who are non-poor), and what the relative administrative costs are of the different approaches (see Section 4.5.2) (Bitran 2003, among many others).

4.5 Administering the framework

Given the many ways in which social services, especially health services, are to be financed by the local population, there is a considerable amount of administrative work if the framework is to be applied to the letter. A number of major concerns are discussed below.

4.5.1 At what level is the framework applied, and by whom?

In theory, the framework could be applied at any number of levels – national, regional/provincial, district, health facility or community. The lowest realistic level is the one where budgets are set, planning carried out, expenditures accounted for, and books balanced. However, in countries where communities are playing a role in health management at the facility level, it may be wrong to impose decisions on user fees that have been made at higher levels. On the other hand, it may be considered wrong to allow different user fee policies to be applied within the same country, because where populations and financing situations vary, the outcomes of the decision tree will also vary. Consideration of this dilemma is largely ignored in the WDR. Where the balance should lie between local and national levels in granting waivers and exemptions should be openly discussed.

4.5.2 Mechanism of targeting poor

Targeting the poor may be progressive in principle, but in practice can be extremely difficult to do with precision and equity. Studies of “targeted” subsidy and voucher schemes show high levels of “leakage” (benefits going to the non-poor) and exclusion of the poor. Particularly in countries or areas where a large proportion of people are poor, targeted subsidies are likely to be administratively overwhelming and economically unfeasible. Given the levels of poverty in most African countries, this will be a major barrier to targeting. For example, in South Africa – a relatively rich nation – experience with exemptions for social services has shown that (a) exemptions are not applied for by families who need them (user fee exemptions are stigmatising and de-humanising); (b) they do not cover all the related costs of education and health; and (c) they only cover the very poorest groups, but there are uncovered groups who are disadvantaged by having to pay for school fees.

Gwatkin at the World Bank also paints a black picture concerning the effectiveness of government services to reach the poor, citing evidence from Benefit Incidence Analysis studies and household survey data (Gwatkin 2003). Various broad categories of targeting mechanisms are listed, including (Bitran 2003):

1. Individual or direct targeting: identification of the poor themselves and giving them free services.
2. Group targeting: targeting groups with specific characteristics, including geographical areas which may have higher incidence of poverty, ethnicity, gender, age, or facilities most used by the poor.
3. Targeting by service type: targeting disease types, specific services most used by the poor, or services that are low cost to provide.
4. Self-selection targeting: programmes more likely to attract the poor, such as public and low cost facilities. In a sense, this involves encouraging a two-tier system, where the better-off self-select based on quality and convenience criteria, such as accessing private wards in public hospitals, or seeking care in the private sector (e.g. quality selection). This also occurs with voluntary private insurance, or through obligatory social insurance schemes. However, these only tend to be feasible policy options at higher levels of development than the average SSA country.

The WDR 2004 reports successful application of targeting under the Bamako Initiative in Benin, Guinea and Mali, with significant improvements in health outcomes in the years since implementation. Poorest groups were covered by a variety of mechanisms, including disease targeting (disease suffered disproportionately by poor people), geographical targeting of subsidies (poorer regions and rural areas), cross-subsidies from lower priority services (i.e. higher mark-up) and exempting the poor using the discretion of the communities, including groups such as widows and orphans.

In general, evidence shows that the more targeted the approach is, the more services are likely to reach the truly poor (Bitran 2003). However, important pre-conditions such as political commitment and efficient and sensitive administrative systems should not be ignored.

Quite some work on targeting the poor is on-going in Poverty Reduction Strategies, where a range of health policies have been designed with the aim of enhancing distributive equity. These policies include: direct targeting (65% of countries with the measure explicitly identified in the PRSP or iPRSP), targeting by age (87%), targeting by disease (95%), targeting by level of care (100%), increasing personnel for pro-poor services (52%), urban/rural targeting (48%), and other geographical targeting (35%). Improving geographical distribution of personnel was low at 18%. Also, the World Bank's "Reaching the Poor" program is assessing more fully the record of health initiatives in reaching the poor; and identifying ways of designing health programs that can reach disadvantaged groups more effectively.

4.5.3 Making transfers to the poor

Voucher schemes and cash transfers are suggested as a means of enabling access of poor people to basic services. Quite some investment of resources is required in administering and managing voucher and cash transfer schemes, including the action of distributing the transfers, and managing the vouchers (e.g. redemption). Positive experiences have been made with voucher schemes (or externally funded pre-payment cards) entitling the poor population to free minimum services. Cash transfers have found to be less acceptable for the population not eligible and more difficult to implement.

Although this approach is by far the most convincing venue for addressing the problems of access for the poor to basic health services, empirical evidence shows that targeted subsidy and voucher schemes face considerable problems of “leakage” (benefits going to non-poor) and exclusion (of the poor). In countries with a vast majority of poor people, targeted subsidies may become administratively overwhelming and economically unfeasible.

This, however, points to the need for having sufficient government budgets allocated for subsidizing the poor. One may add that even sufficient budgets cannot solve the problem alone, but are a necessary prerequisite of such an approach. The other essential element apart from budget allocations is the establishment of checks and balances between government and community organisations in overseeing the selection of poor people eligible for subsidies and the establishment of transparent criteria for such eligibility, being acceptable both for the community and the government in their respective definitions of poverty.

4.5.4 Pricing of services to be charged for

Setting the levels of charge for the services that will be charged for is more than a matter of balancing the books, but one of encouraging efficient consumption of services, and ensuring the poor are not prevented from accessing services for which they are not exempted. It is most usual for Ministries of Health or Education to issue standard price lists for services. However, at implementation level these guidelines are not always followed, if at all. One common problem is that user fee levels are not updated to take into account inflation, and therefore health centres and schools have to raise fees to cover their costs. After a few years of this approach, a highly heterogeneous set of prices may develop across the country, as has happened in Rwanda. Some prices may be set based on mark-up from purchase cost, but this is mainly applicable for drugs. However, stringent price setting by central levels can reduce the discretion that may be important for local levels to fine-tune prices to account for the strength of local demand, and the ability and willingness to pay for different services. The cross-subsidisation that develops means that marginal cost pricing (efficiency pricing) suggested by economic theory is no longer useful.

4.5.5 Administering lifeline services

“Lifeline” price schedules are suggested where charges can vary with amounts used, providing the poor with a guaranteed minimum quantity they are entitled to receive free of charge. This is clearly a progressive option, and is likely to avoid administrative difficulties associated with targeted subsidies. While free and lifeline rates are good ideas in principle, they are tough to do right in practice. Simply determining “how much” of a service satisfies basic needs of the poor is fraught with political and economic controversy. In situations with budgetary constraints and within a mechanism demanding a large share of costs to be recovered by fees, the government officials determining this minimum level may be tempted to provide less than the realistically needed amount for free in order to maximise the revenues of their organisation and stay within their budget limitations. Without a strong “voice” mechanism representing the interests of the poor their needs may still not be fulfilled. Lifeline price schedules thus require sufficient budgets to afford the costs of free service provision along with strong “voice” mechanisms of the poor. The WDR does not discuss this point in relation to the continuing demand of the World Bank and IMF for financial austerity of developing countries. In conclusion, despite the WDR’s insistence that “more money isn’t enough,” poor countries will obviously need a lot more money to make lifeline rates a reality.

4.6 Other design issues in user fee systems

Many publications make recommendations for how user fees can be designed to ease ability to pay, increase efficiency in collection, increase amounts raised, etc (Shaw 1996, Addis Ababa Consensus 1997). It is clearly important to take these into account in applying the “no blanket policy”, and be reminded what these essential design features cover.

User fee collection. For example:

- Prices should be advertised to discourage over charging by providers.
- Better to collect fees at single point than multiple service points.
- Flexible payment mechanism can be useful to enable ability to pay and reduce the immediate financial burden on the service user (credit, installments for high charges, in-kind payments for societies where cash is limited) (Lucas 1999).

User fee management. For example:

- Retention of user fees at facility level to spend on quality improvements, and increases the motivation of the personnel to collect and record the revenue.
- Adequate system of receipts and follow up to minimize corruption.
- Community involvement in revenue management and use to increase the transparency and responsiveness to community demands for services.
- National guidance on how the revenue can be spent, to ensure that health facilities are aware how user fee revenue can be spent, and give ideas for how to improve service quality.

4.7 Conclusions and next steps

The World Bank website on user fees categorically states that it does not support user fees for primary education and for basic health services for poor people. The “no blanket” policy gives some indication of how such a policy can be implemented. In the light of the above discussion, it is commendable that the WDR advocates for pursuing a “no blanket policy” on user fees, critically discussing the access problems arising with fee systems, and not “prescribing” a specific solution. The proposed analytical framework is helpful, but does not grasp all relevant factors for policy-makers, especially by leaving out the two critical aspects of the role of community level decision-making in a user fee context and the availability of sufficient tax funding to replace fee funding for ensuring a minimum level of quality. Elsewhere the World Bank has stated that it accepts that local communities may levy charges that give greater access to education, which must be designed carefully so that they do not keep the children of poor families out of school. However, this requires administrative systems that can cope with this, and the problems of this are discussed above. For health as well as education, any policy on user fees must be taken after a broader consideration of financing options. Perhaps a menu could be used for financing options, with a summary of the evidence base for the performance of each one, to allow countries to compare the different financing approaches in their country setting, and an open discussion held.

5. ABOLISHING USER FEES AS A POLICY OPTION

5.1 Introduction

A UNICEF survey in 30 countries found that governments under-invest in basic social services due to the fiscal weight of the external debt burden. Two-thirds of the countries spend more on external debt serving than on basic social services (up to five times more on debt) (Vandemoortele 1999). The shortage of public budget has meant governments are forced to provide narrowly targeted programmes. Usually the non-poor are those that benefit more from the increased availability of public services, as shown for the education sectors in Mali and Morocco (Vandemoortele 1999) and many other benefit incidence studies in health and education. It is only when services are fully scaled up that poor children gradually share in the benefits. High achieving countries are those that have invested most in social services. Likewise, when there are cuts in education coverage it is the poor who invariably lose out. In cross-country comparisons, the poor tend to fare significantly worse in Africa (examples Côte d'Ivoire and Kenya) than in Latin America (examples Brazil and Bolivia) (Penrose 1998). In summary, the evidence strongly suggests that it is only when access to basic social services becomes universal that the poorest children will be reached. This is especially true for Africa.

An interesting alternative view is that aired by Penrose in an academic education bulletin. "Foreign aid projects have played a significant role in expanding education systems beyond a size which can be supported by domestic tax finance. Perhaps one of the most destructive initiatives has been Universal Primary Education (UPE) and the huge costs associated with it. Many countries expanded their systems too rapidly to maintain any quality, creating a large pool of untrained teachers, a stock of poorly built schools and large equipment and materials deficits. They also created raised expectations of employment which, not materialising, have prompted withdrawals from schools rather than increased enrolments, the opposite of what was intended. A current example is the education reform and consequent free compulsory universal basic education policy in Ghana which extended the cycle from six to nine years in a fiscally stressed country" (Penrose 1998).

A similar critique has been made for providing government health services free of charge, due to the fact that in most settings where Benefit Incidence Analysis studies have been carried out, the majority of subsidies go to the relatively better-off segments of the population (Gwatkin 2003). The argument is made that with the current funding constraints it is unrealistic to expect government health services to expand to achieve universal coverage. It is more common for governments with equity objectives to focus their universal coverage efforts on a few cost-effective interventions to target the priority diseases (especially of the poor).

Therefore, where does the truth lie? Can user fees be feasibly abolished, while clinging to hopes of universal coverage? Can sectors cope with the surge in demand? This chapter presents briefly some case studies of health sectors (Uganda) and education sectors (Uganda, Malawi, Tanzania) where user fees were abolished during the 1990s.

5.2 Country experiences with abolishing user fees

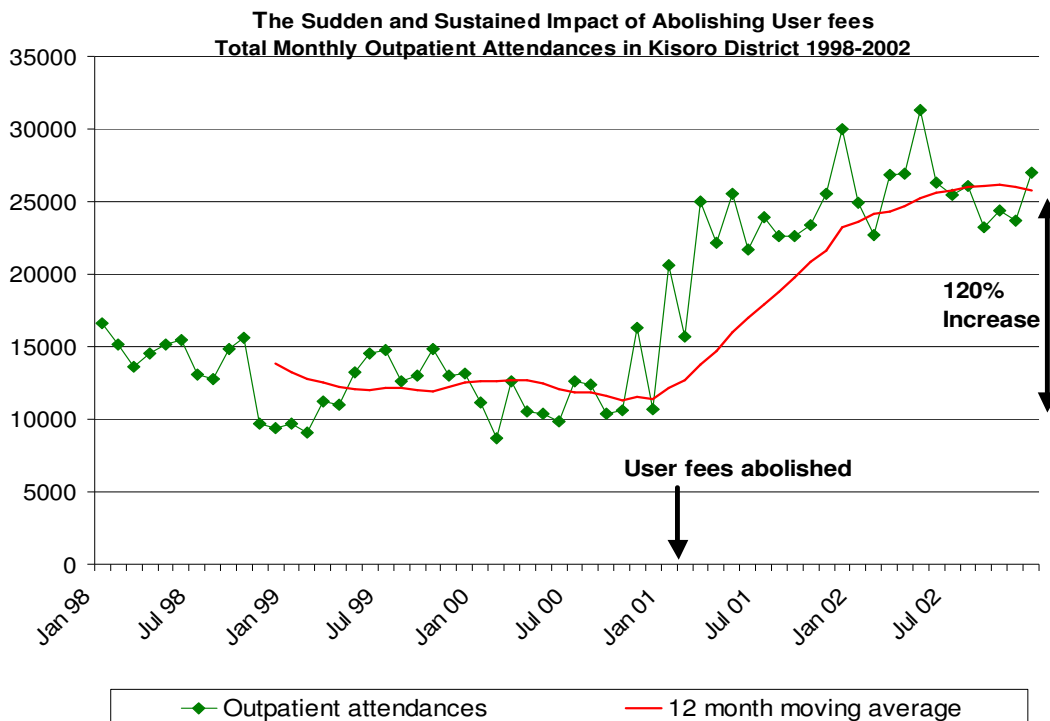
In the **education** sector in Uganda in 1996, the requirement that parents pay half the cost of primary school fees was lifted and parent-teacher association levies were lifted. The impact on primary enrolment was remarkable, with rates nearly doubling, which was an addition of almost 2-3 million additional children enrolled in that year. By 2003 it was reported that the poorest Ugandan children are as likely to complete primary school as

the richest children, and girls are almost as likely to attend school as boys. The policy is naturally very popular, and has received considerable donor support to help fill the funding gap. However, the quality of education is reported to be very low still, with children frequently in classes of over 100, by poorly paid teachers, often in buildings without roofs or sanitation. Many lack the reading materials needed to acquire literacy and numeracy. Furthermore, parents continue to face charges for building materials, school watchmen, sports, stationary, and uniforms.

Malawi saw similar levels of increased enrolment when they eliminated school fees in 1994 and relaxed the requirement for uniforms. There was an immediate increase by 50% primary enrolment from 1.9 to 2.9 million school children. The main beneficiaries were girls.

A third country where user fees have been abolished for primary education is Tanzania, in 2002. In fact, formal user fees for primary education have had a short life in Tanzania, having only been introduced in 1995. However, since the economic decline of the 1970s and 1980s, informal fees have been gradually creeping in and reducing enrolment rates. The World Bank Institute reports a marked increase in enrolment rate (Terme 2003), although detailed reported experiences could not be identified for what has happened in the education sector in Tanzania since 2002.

The only current example used in this paper to illustrate the impact of removing user fees in a **health** sector is in Uganda in the year 2000. Research showing the impact of user fee abolition has now been released, comparing selected indicators pre- (1999/2000) versus post- (2002/2003) user fee abolition (Deininger 2003). The results show improved access and increased use of services, less work days lost due to sickness, and a tendency for wealthy households to opt out of public services. The Figure below shows the trend in monthly outpatient rates in a district, a trend which is reflected across virtually the whole of Uganda (the North is an exception, where there is still great insecurity).

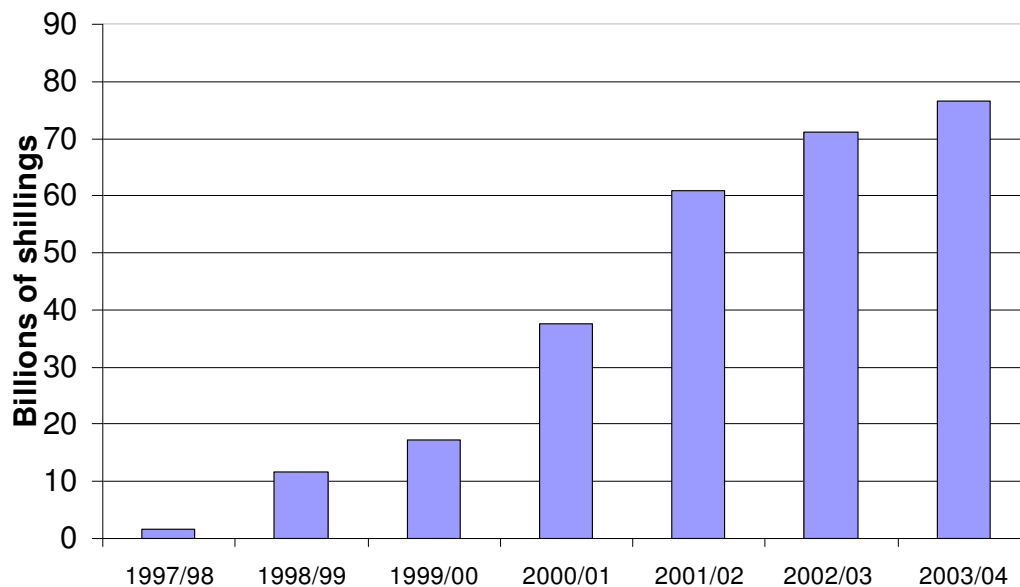


Nationwide, the number of new cases treated by health centres increased, on average by 18.5% for under-5s and 31% for the over 5s, and referrals increased by 26%. Monthly attendance figures are considerably higher now, but variations are evident which are due to the availability or non-availability of drugs. When the drugs run out attendance rates drop. However, these outcomes are significantly better than those predicted by the World Bank, who predicted around 2% increase in utilisation, based on which the World Bank advised against the policy of user fee abolition.

Although this is excellent news for proponents of user fee abolition, the evidence so far is that the impacts on illness reporting, use of preventive services and the quality of services are limited. Drug stock-outs have increased, due partly to increased demand for services and the fact that the supply system was not fully reactive to the high level of demand. Also, there have been some delays in fund disbursement from central level. Early reports also point to a deterioration in staff attitudes, due to the massively increased number of patients and therefore workload, and the fact that reduced user fee revenue means that salary top-ups have been lost.

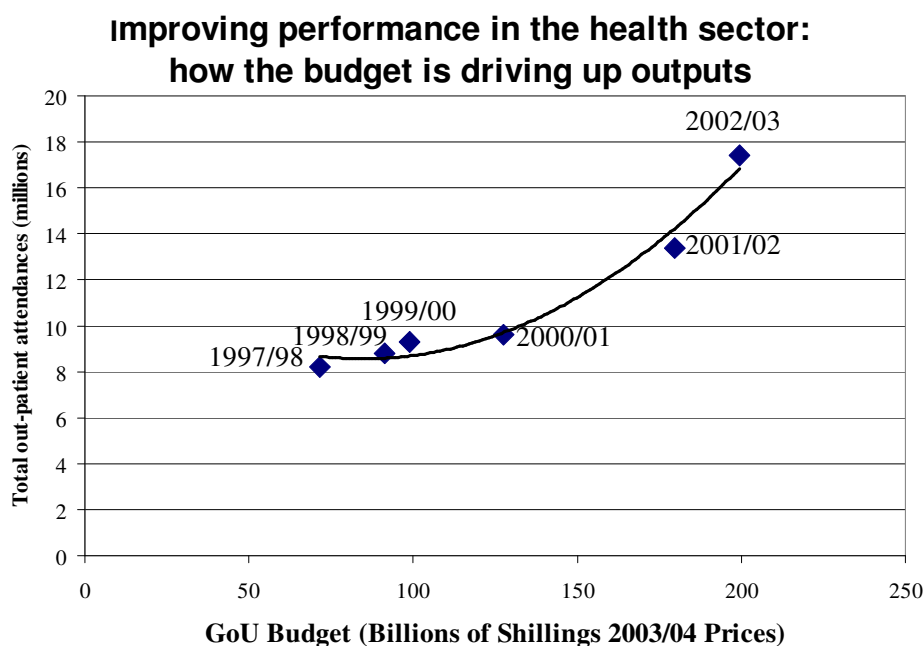
A crucial action that has helped the Ugandan health sector cope with the removal of user fees for primary health care services, was that at the point of abolishing user fees political decisions were taken to increase the health budget and replace the now missing user fee revenues by additional government funding. Great efforts have been undertaken by the revenue authorities to broaden the tax base by including urban populations, airport taxes, among others. Therefore, simultaneously with abolition came extra release from the Government of Uganda for drug purchase of 1 bn U.Shs, and for FY01/02 an extra budget allocation was made from Government of Uganda for districts to make up for the predicted lost revenues of 25 bn U.Shs. The rapidly increasing decentralised health budgets in Uganda are shown in aggregate in the Figure below.

Maximising the efficiency of the budget - allocations to district primary health care services



It is pertinent to ask “what explains the success of user fee abolition in Uganda?” Two major factors are discussed briefly. First, lost revenues were generally replaced with extra government spending (also aided by the fact that donor budget support to the

Ministry of Finance has increased). Therefore, services did not suffer greatly as a result from the shock. Second, over the 1990s Uganda has been implementing a very far reaching decentralisation policy devolving governmental budgets and supervisory powers to community level. Management Committees who have become active in co-management of community level health centres first by administrating user fee revenues now have been equipped with (tax-funded) government budgets they can utilise in their discretion. The combined effect of these and other factors explains the impressive expansion path of the Ugandan health sector, shown in the Figure below.



In conclusion, only through pursuing this decentralisation policy strengthening the community level and through providing additional budget funding Uganda was able to avoid falling back to the situation of fund-starved, centrally administered health services which in the first place lead to the introduction of user fees. In order to be a feasible approach for other governments, solutions would at the same time have to be found for expanding government health budgets and for involving communities in the decision-making over these funds. Given the government contributions for health care in Africa, shown in Table 5 below for 1998, this appears to be a high priority for African governments if the international development targets and universal coverage are to be achieved.

Table 5. African country per capita expenditures on health, US\$ in 1998

Number of countries	Amount of spending (US\$)
6	> \$60
3	\$34 - \$60
10	\$12 - \$34
27	< \$12

5.3 User fees and the broader financing debate

The social sector financing debate has shifted away from a focus on user fees which are increasingly seen as rather a side issue. In health, attention has shifted to out-of-pocket payments as a whole and the need to move away from excessive reliance on out-of-pocket payment as a source of health financing towards a system which incorporates a greater element of risk pooling through, for example, health insurance. This is a central premise of the WHO World Health Report "Health Systems: Improving Performance" (WHO, 2000) and features heavily in the World Bank's HNP Strategy document (World Bank 1998) and the PRSP Sourcebook (World Bank 2000). It is increasingly recognised that financing systems need to be viewed in a more holistic manner given the degree of interaction between the various financing mechanisms.

Given this broader debate, what implications for the removal of user fees in health and education?

One question relates to the implications for financing social services in the absence of user fee revenue. While theoretically the loss of user fees could also be (partially) covered by improving the efficiency of public services, National governments will be concerned about finding alternative and sustainable sources to replace user fee receipts, in the case of user fee abolition. Projections of future tax revenues and sector spending commitments in MTEFs may not give line ministries confidence to call for the removal of user fees. If international targets are to be met, huge increases in funds are needed. For example, UN estimates show that US\$10-15 billion is needed annually in additional aid to provide every child with free quality basic education, and approximately US\$20 billion extra is required to provide the universal health coverage necessary to reach child and maternal mortality targets.

As stated by the Dakar Framework for Action adopted in 2000, the broad vision of Education For All must be reflected in national government and funding agency policies, and more resources must be provided for by national governments and funding agencies to meet the EFA targets. The Dakar Framework for Action makes a number of recommendations for meeting EFA:

- SSA countries should devote at least 7% of GDP to education by 2005 and 9% by 2010.
- Stabilisation programmes must protect education budgets.
- User fees must be removed so that every child has access to free, quality basic education.
- Commitment and political will from all levels of government is needed.
- Wider social policies, interventions and incentives should be used to mitigate indirect opportunity costs of attending school (reference to child labour).

A pressure group, The Coalition for Health and Education Rights, argues that formally scrapping fees without a major increase in public financing can have a disastrous impact on quality, and is unsustainable. Steps to meet health and education targets therefore include:

- Southern governments to commit themselves to free and universal basic education and health care, with clear time-bound plans developed and implemented in participation with civil society.
- Governments commit themselves to at least 3% of GNP for each of health care and education.
- The World's richest countries provide massive increases in aid, and improvements in aid predictability and donor coordination. A higher proportion than the current 2% of

ODA should be devoted to education. Aid should not have conditionalities for purchase of expensive goods and services in the donor country.

- Deeper and faster debt relief, as increased government spending on health and education is obstructed by high debt repayments.
- The World Bank must move swiftly and decisively to implement its new policy on user fees, with more progress needed at the operational level. On health, the Bank must move immediately to a clear position against health user fees.

A second set of implications is for the relevance of insurance as a financing mechanism in health care, if user fees are abolished. The abolition of user fees in Africa will constrain the option of establishing health insurance systems in the future, as the existence of user fees are a financial incentive for the population to be persuaded that taking out health insurance will lead to welfare gains. Therefore it appears, on the surface at least, that the long term health sector plan hinges on the decision to keep or do away with user fees. Holding onto user fees keeps open the twin options of developing the private sector and enabling insurance markets to flourish, whether it be community based, private, or social insurance. Abolishing user fees, on the other hand, closes the door on these options as important financing sources (except for the better off), and relies on successful mobilisation of resources from national (tax) and international (donor grants, credits) sources. Given the climate of major international financing initiatives, this is not impossible, but in the longer term it will be necessary to be assured of support from national sources, which consist of compulsory social insurance and tax. However, social insurance schemes have tended to focus on the better off and formally employed such as civil servants. Coverage of schemes aimed at the informal sector has been patchy. Uptake rates have often been low, financial performance poor and community involvement low. Making such schemes work effectively requires a number of preconditions which would rarely be met in an African context, although such schemes are beginning to operate in selected African context for the civil service (e.g. Tanzania, Rwanda).

The general consensus which has emerged on user fees is a rather pragmatic one, reflected in the 'no blanket' policy. User fees are seen as having significant shortcomings but are a potential financing source which cannot be ignored especially in extremely resource constrained settings. They will continue to play a role in the foreseeable future and the key is to make them work better. The shortcomings can be minimised by adopting known best practice approaches.

6. CONCLUSIONS AND RECOMMENDATIONS

This paper has reflected a number of viewpoints, which it is important to do when drawing on a diverse evidence base and two decades of debate on a controversial subject. The overall policy recommendation depends on the country context, which brings with it a history of public financing policy, population expectations, and various government financing capacities. The preference for financing of social services also depends on viewpoint – how one sees the situation, what can be expected from the government and the private sector, and what the long-term vision is for the social sectors. For these reasons, there exist many different varieties and combinations of financing approaches that are justifiable, as do different political systems. Some points, or conclusions, however cannot be denied.

First, some brief conclusions from this paper. User fees have been implemented in a variety of ways, and have given a variety of results. The basic justification, however, tends to be the same: lack of joint government and donor capacity to deliver a basic minimum of social services without the additional direct contribution of the population. This applies to both countries that implemented structural adjustment programmes and countries that did not. Virtually the only governments that covered the full costs of social services during the 1980s and 1990s were certain communist governments (e.g. China, Cuba). The importance of user fees as a source of revenue has varied considerably, and where revenues are relatively low there have been questions about the appropriateness of user fees due to costs involved in collecting them. However, even where revenues appear meagre, user fees have proven to be the only guarantee of ensuring a basic minimum of liquidity in the health system. Also, it has been proven the world over that the design of the user fee mechanism is critical in terms of assuring the right incentives for patients as well as providers, for appropriate use of services and appropriate use of revenue for quality improvements. The experience with community participation has been mixed and depends on several conditions, but many positive experiences have been reported. Fee exemptions for specific groups (e.g. children, pregnant women) have generally worked much better than fee waivers targeted to the poor, due to administrative difficulties and fraud.

Second, some ways forward. Many people point out that official user fees are not the major barrier to social services. The population faces unofficial charges, geographical inaccessibility, a poorly functioning transport system (if any), and opportunity costs of time. Therefore, just by removing user fees, access problems will not be solved overnight. If internationally agreed targets such as the MDGs are to be met, massive increases in service use is required in countries that are trailing, as well as quality improvements, thus requiring a positive incentive structure for poorer populations to use services that improve welfare. Even with the application of user fee waivers and exemptions, the very existence of user fees is a negative incentive, and not just for the poor.

The broad question of social sector financing remains a fundamental question in the international debate, and there is no magic bullet. For the countries of sub-Saharan Africa, two main alternatives exist: (1) to abandon user fees and boost revenues from other sources to meet the population's expectations for basic social services; and (2) to reinforce the user fees system, strengthening exemption systems, at the same time promoting a shift to prepayment of services (in health). The latter approach does not guarantee that poor people are saved the costs of basic health services due to imperfect targeting, or that the non-poor will not benefit from subsidies (leakage). In the debate, realism and honesty will be necessary to arrive at the optimal solutions.

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ANNEXES

ANNEX 1: EXPENDITURE FROM OUT-OF-POCKET PAYMENTS (YEAR 2001)

Country	% public health expenditure (HE) out of total HE	% out-of-pocket payments out of private HE	Total per capita HE in US\$ (PPP)	Out-of-pocket payments per capita US\$
Algeria	20	100	195	39
Angola	52	100	62	32
Benin	52	100	27	14
Botswana	30	37	220	24
Burkina Faso	32	100	32	10
Burundi	58	100	12	7
Cameroon	66	82	44	23
Central African R.	49	77	25	9
Chad	21	100	25	5
Congo, Republic	35	100	28	10
Côte D'Ivoire	26	100	15	4
Dem. R. Congo	54	85	46	21
Eritrea	34	100	42	14
Ethiopia	59	88	29	15
Gabon	34	100	197	66
Gambia	21	100	45	10
Ghana	45	100	63	28
Guinea	43	100	58	25
Guinea-Bissau	36	100	34	12
Lesotho	72	74	76	40
Liberia	24	100	96	23
Libyan Arab Jam.	33	100	94	31
Kenya	43	100	17	7
Madagascar	52	91	260	124
Malawi	49	35	41	7
Mali	54	90	28	14
Mauritania	30	100	44	13
Mauritius	49	100	277	135
Mozambique	56	41	28	5
Namibia	54	3	411	6
Niger	49	81	19	8
Nigeria	73	100	14	10
Rwanda	66	62	35	14
Senegal	44	100	61	27
Sierra Leone	59	100	17	10
Somalia	38	100	11	4
South Africa	53	20	770	82
Sudan	79	100	46	36
Swaziland	28	100	148	41
Syrian Arab R.	66	100	74	49
Togo	57	100	40	23
Tunisia	60	91	281	152
Uganda	51	59	42	12
Utd. R. of Tanzania	53	86	21	10
Zambia	57	73	45	14
Zimbabwe	59	67	242	66
Average (by country)	47	86	96	29
Pop. weighted av.	54	85	96	25

Source: Musgrove et al. Data refer to the year 2001.

ANNEX 2: THE IMPLEMENTATION AND IMPACT OF USER FEES

A. Introduction

There is a considerable and growing evidence base on the implementation and impact of user fees for public services worldwide. The evidence is largely focussed on developing countries, where the last 20 years has seen a growing application of user fees on public services, which can be explained by the declining and/or inadequacy of public budgets to meet the population needs. Literature has been especially rich in the health and education sectors, although water supply has also received some attention. For example, experience of user fees for health care in Africa has already been reported in a large number of review articles (Brunet-Jailly 1991, McPake 1992, McPake 1993, Creese 1995, Nolan 1995, Chawla 1996, Reddy 1996, Russell 1996, Shaw 1996, Gertler 1997, Gilson 1997, Russell 1997, Wang'ombe 1997, Ahrin-Tenkorang 2000, Cattaneo 2000, Poletti 2003, Hutton 2004), and the number of published articles and grey literature are in the hundreds. Furthermore, as the negative effects of user fees became apparent by the early 1990s, there has been a fast growing literature testing and reporting various mechanisms that reduce the adverse effects of user fees, such as user fee exemption schemes (Levine 1992, Gilson 1995, Willis 1995, Bennett 2001, Kivumbi 2002, Bitran 2003, Chaudhury 2003, Gwatkin 2003, Laterveer 2003) risk sharing schemes (Gilson 2000, ILO 2000, World Bank 2000/1), and general health policy (Newbrander 2001, Rannan-Eliya 2001, Corbacho 2002, Laterveer 2003, OECD 2003, Pearson 2003, Smith 2003).

This Annex gives a brief overview of the main impacts, both positive and negative of user fees in Africa. It is 'brief' because a detailed review could fill several hundred pages, given the vast evidence base available. Therefore, the main sources drawn upon are the review articles, with selected primary studies also cited. While the concentration of the review is on the health sector, examples and supporting evidence is also provided from the education sector, to show similarities and differences in experience.

The evidence is structured in Part B of this Annex, and in Section 3.2, according to the main goals of user fees, as argued when user fees were introduced, namely to mobilise resources, promote efficiency, foster equity, assist decentralisation and sustainability, foster private sector development, improve quality of care and encourage community participation. Part C provides some conclusions on overall impact of user fees.

B. Performance against goals of user fees

B1. Mobilising revenues

In a survey of African countries, at least one third of countries cited resource mobilization as the primary reason for adopting user fees (Shaw 1996). In general, information on revenue collected is readily available from government reports, as well as national health accounts (where available). However, what these official statistics fail to account for are two potentially important sources of drainage from the system: (a) official revenues collected but not entered in the accounts, either because the fees are spent immediately without being recorded as revenue, or because the fees are pocketed by the service provider; (b) unofficial fees charged by service providers, whether monetary or in-kind. For example, McPake et al have shown that in Uganda there is a huge leakage of resources from the health system in terms of drug leakage, informal charging, leakage of official user fees, and absenteeism of health workers (McPake 1999). Therefore, household budget and expenditure surveys may reveal different (higher) figures when compared to government revenue figures.

A further problem faced by any study reporting revenue figures is that they are, by necessity, time-specific. For example, reporting cross country revenue figures for the period 1985-1990 may reflect a very different picture to the same countries a decade later. This is for multiple reasons, such as change in user fee coverage, changes in prices, population adjustment to the initial shock of user fees, changes in other revenues, changes in health status, etc. Therefore, the fact that the importance of user fees changes over time should be kept in mind in interpreting revenue figures.

1. Contribution of user fees to the total budget. The Table in Annex 1 shows proportion and amount of out-of-pocket payments for **health** care in 46 African countries in 2001 (Musgrove 2001). Note that out-of-pocket payments include payments to private providers, which can be significant even in the poorest SSA countries (mainly urban settings). For all 46 countries, the population weighted average out-of-pocket per capita is US\$25, compared to a total health spending of US\$96, giving a contribution of 26% to the overall health budget. Compared to data more than a decade earlier, these figures seem high. For example, McPake presents evidence from reviews showing cost recovery in Mali to be 2.7% of total revenue, reaching 12% in Ghana (McPake 1993). For **education**, the Ghana Living Standards Survey 1992 showed that household expenditures amounted to about 23% of total (government + household) expenditure. User fees paid for almost all non-salary costs in the education sector, and there is some evidence that user fees partially replaced government spending (Penrose 1998).

2. Contribution of user fees to the recurrent or decentralised budget. User fees raise a relatively more important proportion of the decentralised recurrent **health** budget (which usually excludes salary expenses). McPake reviews early evidence from the Bamako Initiative, finding in Senegal cost recovery to be 4.7% of recurrent costs, 79% of non-salary costs in Zaire, rising to 100% in one pilot area of Benin (McPake 1993). Table A2.1 shows large variations by country, and over time. For example, from 0.5% in Guinea-Bissau (1988) to 12% in Ghana (1987), as well as variations within countries over time (e.g. Ghana, Lesotho, Mozambique, Swaziland). In the **education** sector of Tanzania, the user fee introduced in 1995 only contributed 1% to the government recurrent expenditure.

Table A2.1: Percentage (%) of MOH recurrent expenditure recovered through fees

Country	% raised	Year
Botswana	1.3 – 2.8	1983
Ghana	7.9	1986
	11.8 – 12.1	1987
	7.8	1992
Guinea-Bissau	0.5	1988
Kenya	2.1	1993
Lesotho	5.8	1986/7
	9.0	1991/2
Mozambique	8.0	1985
	<1.0	1992
Swaziland	2.2	1985
	4.6	1988/9
Zimbabwe	3.5	1991/2
Côte D'Ivoire	3.1 – 7.0	1986
Mali	1.2 – 7.0	1986
Senegal	4.4 – 7.0	1986

Table taken from Creese, 1995.

Although most of these figures may seem very low, it is often argued that, even if on paper the share of user fee revenue does not seem important, the liquidity provided by user fees enables purchase of items that would otherwise not be afforded, such as a continuous stock of drugs, incentive payments for staff or additional staff. These have proven to be essential in keeping social services functioning and in improving the quality of care.

3. Net revenue gain and resource leakage. The net revenue gain is also important to note, from an economic perspective, especially for the **health** sector. Collection costs include the time of the staff to collect and write receipt, material costs (receipt and accounting), staff time to manage money within facility and put in bank account, and the processes involved in spending of user fees on target items. Creese argues that little recognition was given in the World Development Reports of 1987 and 1993 to the likely transaction costs and capacity requirements for operating fee collection and exemption systems, and for retaining and managing the proceeds in the interests of the poor (Creese 1995). In fact, there is very little evidence on these costs in Africa. One indication of the inefficiency of user fee systems is from an Oxfam report which finds user fee collection in health costs four times more per currency unit raised than through the tax system. However, the true marginal cost of user fee collection is not clear when staff have multiple tasks, and often a considerable proportion of their time is spent in unproductive activities. Two poles are presented in the literature, and the truth probably lies somewhere in-between. At the one extreme, it is argued that user fees can cost as much to raise as are actually raised through user fees. At the other extreme, it is argued that user fee management may not add much to expenditure, due to underemployment of staff.

B2. Promoting efficiency

Potential efficiency gains in the health sector from user fees include less use of higher level facilities when lower level facilities can be used, a functioning referral system, and less use of services when there is no true need ('frivolous' demand). The efficiency argument is not relevant for education, as the aim is to get all children to attend school. There are no issues of appropriate referral, frivolous use, or supplier-induced demand as in health care.

Early successes cited from the Bamako Initiative, led by UNICEF and WHO: "Nonetheless, experience to date suggests that introduction of user fees at levels that do not discourage the poor is likely to be more useful for improving technical efficiency than for raising substantial revenues on a nationwide basis." (Reddy 1996, page 11).

1. Efficiency gains from patients being seen at the right level of the health service. For this to work, it requires patients to be penalised for using higher level **health** facilities when lower level facilities are adequate, and a system of referral that encourages patients to first seek care at the primary facility (i.e. lower costs at higher level facilities when the patient has a referral slip). The problem has been that often these mechanisms are not put in place under the Bamako Initiative, or are not working effectively to encourage efficient use. Positive experiences are reported from Zimbabwe, Malawi, and the former Zaire. Implementation of user fees has been very different across countries. Sometimes fees have been introduced at lower level facilities first (Korte 1992). Where fees are higher at higher levels of care, the intended incentive sometimes has not worked, partly explainable by the fact that patients perceive the quality of care to be lower in lower level facilities (e.g. lack of doctor). For example, in the Akim Region of Ghana in 1991, the population use of hospitals (248,000 consultations) was much higher

than primary level facilities in the catchment area (137,000 consultations), due to lack of improvement in these latter which would attract people to them (Asenso-Okyere 1998). Also, providers at higher level facilities who are aiming to maximise their income encourage continued use of higher level facilities, irrespective of efficiency concerns. Even when prices are set to encourage appropriate patient referral, the overall improvements in referral may be negligible due to other constraints, such as geographical access or inappropriate advice by health care providers.

To appropriately price **education** services, the efficiency rule is difficult to apply, because the marginal cost of providing education is not easy to determine: it may be the additional pupil, which may be low, or the additional school, which may be high (Penrose 1998). In the absence of any pricing rule for education, the principle of 'excess demand' is adduced. An early formulation of the rules for the mix between tax finance and fees was by Thobani in the case of Malawi, and is sometimes known as the 'Thobani Rule' (Thobani 1983). The Thobani Rule requires a market clearing price of education services, and subsidies are only made in cases where socially desired service provision solutions exceed market solutions, where less education is provided by the market than is socially desirable. If the constraint on resources is such that the supply of services is insufficient to meet the demand, some of those who demand the service in vain will, it is argued, be willing to pay for it. There would be a lower aggregate supply of services in the case of full 'subsidy' than in the case where people paid, because the available resources cannot meet the costs of the full subsidy. If fees are charged, the total level of resources available increases, all other things being equal. Therefore, the argument runs, charging fees *augments* the total level of resources for education, so that all demand can be satisfied, even though the subsidy does not cover the full costs. In this case, the rule is to raise the user charge so long as there is excess demand for the service. However, the converse of the rule can also apply. Where there is a constraint on fee payment, it would follow that fees should be reduced and/or subsidies increased in order to attain the socially desired level of service supply. In reality there are always constraints on both public finance and on household finance.

2. Reduced frivolous use of services. In terms of the impact of user fees on 'frivolous' use of **health** services, there has been very little empirical foundation to support this argument. It first requires the patient to be informed enough to distinguish a serious from a non-serious condition. Second, it requires first an important level of frivolous use, which is highly unlikely in SSA due to the serious underuse of services. Abel-Smith argues that, where there are other barriers to care (e.g. geographical access), there is rarely any frivolous use of services, and therefore this argument for introduction of user fees is not highly relevant (Abel-Smith 1992). Third, user fees instead have the effect of reducing preventive measures (if preventive services are charged for), and reducing the speed with which the patient seeks care. Faced with user charges for curative care it is a rational response in the face of poverty to risk waiting to see if it develops into anything worse. User fees lead to delays in treatment and therefore more severe cases, and also recourse to other treatment options which are less effective (self-treatment, traditional care).

Penrose (1998) argues that user charges in **education** can in principle affect efficiency different ways. Additional resources can permit increased technical efficiency as well as enhanced cost effectiveness. A combination of additional fee finance and reduced tax finance can put pressure for a better and more accountable allocation of public finance. Fees, it is argued, can force consumers to appreciate the value of services and not to use them unnecessarily. Because the costs of higher education to individuals is low in relation to the returns, more people demand it than would do so if they faced the 'true'

costs. The argument is analogous to the concept of 'frivolous' demand for health services, and it is a difficult argument to apply to education: there is little evidence to suggest that the argument has substance even in relation to health services.

3. User fees encourage providers to provide more care beyond the necessary level. A third efficiency argument which can be used against cost recovery mechanisms, whether direct fee for service or prepayment schemes, is that of supplier-induced demand. This essentially means that user fees encourage providers to provide more care beyond the necessary level. Health providers can do this due to market failure, where the patient does not know what medical care is necessary, and is therefore reliant on the judgement of the health professional. User fees can give perverse incentives to health care providers, because they or the facility gain financially from increasing the amount of care they provide. Supplier-induced demand is a controversial issue, receiving heated debate in the literature, more in the context of developed than developing countries, and mainly in the context of prepayment schemes which are particularly responsible for cost escalation in developed countries. While documented examples are rare in relation to user fees in developing countries, a commonly cited story is that of the provider who refers patients to their own private pharmacy for their medication needs, which is partially evidenced by the wide reporting of polypharmacy throughout the developing world.

B3. Fostering equity

In the literature that accompanied the early efforts to promote user fees, user fees were argued to lead to equity through increasing funds at decentralised (especially rural) levels, as well as improving quality of service through greater availability of cash for key resources. The overall impact should be to give the population greater confidence in the service, thus increasing use of education and health services of even poor patients. In the **health** sector, for example, it has for long been known that the middle and higher income groups benefit from subsidised public more than poorer populations, and supported more recently by Benefit Incidence Analysis studies (Castro-Leal 2000, Pearson 2002). For **education**, benefit incidence calculations for Ghana and Tanzania show public expenditures on education to be progressive at the primary levels, regressing at higher levels (Penrose 1998). Therefore, the combined impact of collecting fees on the public services used by higher income groups on the one hand, and giving richer people the incentive to shift their demand to the private sector on the other, in theory increases resources available for the services used by poorer segments of society.

1. Better services from user fees improves outcomes for the poor. The experiences reported in the **health** sector are mixed concerning equity, although the balance is towards the inequitable effects of user fees. Some research has shown that users are willing to pay for improvements in quality, especially when the availability of drugs is improved (Litvack 1993). This is even true for poor patients. However, in general, the evidence reported from time-series studies (before versus after fee introduction) has shown that user fees deter service use, especially by poor and vulnerable groups (Shaw 1996). The higher the charges, the greater the decline. This argument is borne out by statistics that have shown declines in health service use to the very day that they were introduced (Hussein 1997). Furthermore, health service use tabulated by income quintile has shown greater declines in health service use of the poor and very poor.

McPake *et al.*, in a review of five African countries implementing user fees, found that communities, or parts of communities, simply did not use services as a result of user

fees (McPake 1992). A year later McPake reported results of other studies that found large differences in utilisation rates between households with different incomes, and also rural versus urban households (McPake 1993). Gilson also reviewed experiences of user fees, and concluded that the impact of fees are highly dependent on the setting and the fee policies in place with Benin the most positive impact of user fees, Kenya as partially positive, and Zambia with the most negative impact (Gilson 1997). On the other hand, a bulletin "Findings" of the World Bank Africa Region claims increased attendance in four countries following cost recovery (Benin, Niger, Liberia, Zaire), mixed results (Guinea, Nigeria, Senegal) and decreases (Ghana).

However, before and after studies, especially over short time periods, do not allow for quality improvements. Econometric studies have shown that starting the level of quality, and improvements over time, have important implications for the observed changes in utilization rates (Shaw 1996). The most important quality variable is usually the availability of drugs. An important effect has been that user charges, when quality improvements at the same time, increases the likelihood of poor people using local health centres as opposed to traveling to more distant hospitals. Gertler and Hammer reviewed econometric estimates of price elasticity of demand (that is, the percentage change in demand due to a given percentage change in price) from 12 studies examining the impact of user fees on utilization (Gertler 1997). They found a clear negative in all studies, with higher (but variable) impact for children and the elderly as well as for poorer rural households.

User fees at the time of introduction were considerably aided by studies in the early 1980s that showed no strong relationship between income or asset value and demand for health care, thus indicating a high willingness to pay for health services which is not strongly influenced by price level in the ranges studies (Heller 1982, Akin 1995). However, as reported by McPake (1993), later more sophisticated theoretical models and econometric specifications raised doubts about these early conclusions (Gertler 1990).

In Malawi in **education**, enrolment rates fell by over 5% in the two years after fees were introduced. In Ghana, enrolments are 20 percentage points higher for non-poor children than for children in extreme poverty. Tanzania drop in primary enrolment rate from 100% in 1980 to 82% in 1993, following the gradually increasing informal payments towards the costs of education. By 1995, the primary enrolment fee became formal, at the low rate of 2000 Tsh. From another study based on Malawi data it is clear that progressive increases in school fees are associated with declining expectations of continued enrolment (Tan, Lee and Mingat 1984). The proportion likely to continue is higher among students with better educated parents, from high asset owning families, from urban centres, and from more developed areas of the country. Even more serious is the marked drop in gross enrolment rates at the primary-school level, which fell from 77.1 percent in 1980 to an estimated 66.7 percent in 1990. With the introduction of school fees, girls are often withdrawn from school, and at rates higher than for boys (McGow 1995). As well as aggravating gender biases, user fees in education tend to lead to seasonal variations and regional disparities in enrolment rates (Vandemoortele 1999).

2. Resources shifted from fees charged at higher facilities to lower facilities. There is no evidence in the **health** sector to suggest this occurs. Revenue usually stays at point of collection, and redistribution limited. In practice, the introduction of fees has rarely freed up additional resources for targeted assistance to the poor, or for intra-budget reallocations to basic services. Penrose (1998) also claims there is no evidence of reallocations from higher levels of **education** to lower levels: "there are few if any

examples of obvious reductions in public spending at higher levels in favour of lower levels of education, especially where costs per pupil are concerned, partly because in most countries the management of resources for education is weak and the systems are inefficient". In fact, in many countries such as Tanzania when user fees were introduced for primary education, higher education remained free.

3. Implications of formal user fees for unofficial fees. An important determinant of **health** service use with equity implications is also the level of unofficial charges user fee system in place. However, information on informal charges ('under-the-table' payments) is notoriously difficult to get hold of. Therefore, it is difficult to show whether informal fees decline as formal fees are introduced, as argued by the World Bank in 1985. One study from Uganda reported in some health facilities that when official user fees were introduced, the ability of health staff to charge unofficial fees was diminished (McPake 1999). Whether or not unofficial fees are charged, and their level, is largely a cultural issue that often has a cultural heritage (e.g. rent extraction by officials was often legitimised by law and colonial policy, such as under the British East Bengal until the 1950s, and in Indonesia under the Dutch). In **education**, unofficial fees are usually for the purchase of books, maintenance and buildings, as opposed to leakage to teachers.

4. User fee exemptions ensure that poor and vulnerable are protected. In order to avoid the negative incentives of user fees on those who are unable (or unwilling) to pay, user fee exemptions can provide a way of avoiding the negative **health** equity impacts of such a policy, and have already been applied widely throughout Africa (Leighton 1995). A considerable amount has already been written about exemption mechanisms - how well they work (Levine 1992, Leighton 1995, Kivumbi 2002, Bitran 2003, Chaudhury 2003), and how they should be designed (Willis 1995, Gilson 1995). The general picture so far from Africa is that exemption mechanisms and sliding fee scales, applied in about half of African countries do not work well. This is due to difficulties in identification of the poor, corrupt practices of health care staff, and the poor working of administrative mechanisms (Gilson 1995, Gilson 1997). In Mozambique, a survey of health service users who went to health care without money did not receive drugs, and corrupt practices of nurses such as hoarding of drugs and free care for family and friends are widely reported (Anon 2000). In Ethiopia, no relationship was found between income and those receiving free care (Engida 2000). In Uganda, record keeping was inadequate to support a credible or efficient quality control and auditing for user fees and exemptions, and staff were reported to be corrupt (Lucas 1995). In Ghana, less than one in 1,000 patient contacts were granted an exemption (Nyonator 2000), but in Tanzania 4% were exempted (Hussein 1997).

Clearly, how to target those who merit exemption or reduced fees is a major problem in applying such schemes. In their review of user fees in Africa, Russell found that targeting by geographical area or occupational group was not common, whereas targeting by employment status (i.e. the unemployed) or special groups (civil servants, military personnel) were more common (Russell 1997). However, these often lead to no more equity (or increasing inequity), as the groups targeted are not the poorest. While means testing was the most common method of targeting, and is argued to be the best way to identify a person who is 'poor' (Leighton 1995), the criteria were usually vague and income thresholds were barely used (Russell 1997) and can be administratively difficult and costly to process. Leighton also identifies self-selection as a possible means of targeting health services, where everyone who attends a particular clinic receives a free service (Leighton 1995).

Several authors have argued that, in **education**, some of the most detrimental effects of introducing or increasing user fees on the poorest groups can be offset by sliding scales of charges related to levels of family income (e.g. Meesook 1984, Thobani 1983). However, the practicalities of doing this are daunting. Incomes are difficult to ascertain reliably in most developing countries, the costs of administration may be such as to absorb much of the gain from charging fees (Ainsworth 1984); school staff are ill-equipped to make discriminatory judgements about the wealth of families and unable to enforce payment without encouraging drop-out and souring relationships with parents whose cooperation they need. The political difficulties of introducing fees, whether they are means tested or not, should not be underestimated.

Furthermore, charging user fees is likely to have a disproportionate impact on poor families (Anon 1993). Such families generally have more members of school age, have less disposable income and experience greater fluctuations from year to year in income than do rich families. They are more likely to be risk averse in investing in education. User fees are therefore likely to discourage regular enrolment amongst the poorest and adversely affect the enrolment of girls from poor families where they are in competition for declining family income. It may not only reduce access but also contribute to continued poverty since it will exclude the poorest from job opportunities that require educational qualifications which in all societies are positively correlated with income. Where user fees are encouraged they may also have an unequal impact on levels of provision. Institutions with relatively wealthy catchments may generate sums substantially in excess of those which they are obliged to recover. This increases the differences between schools in ways which favour the already advantaged.

B4. Decentralisation and sustainability

It was argued by the World Bank that an appropriate pricing structure encourages use of district based health facilities close to the home of the patient, and combined with retention of user fees at the point of collection enables investments in the decentralised level, thus leading to improved sustainability of those services. The appropriate operation of the user fee policy can greatly strengthen decentralisation processes which are completed or taking place in many African countries, for example Botswana, Ghana, Lesotho, Tanzania, Zaire, and Zimbabwe as reported in Shaw and Ainsworth (1996).

Concerning the number and quality of services provided at primary care level, the implementation of user fees has been considerably more successful than most of the other goals. The experiences reported of improved **health** services at decentralised levels are many, especially key quality indicators such as availability of drugs. Clearly, assuming demand remains constant, user fees provide a reliable source of income to finance these essential components of service delivery.

One possible indirect effect of user fees has been that the centre has become less concerned with financing at decentralised level, due to this positive effect of user fees. This has possibly led to justifications for more budget funds to be spent in the Ministry (to 'support' the decentralised levels) and in tertiary public hospitals, where prices cannot possibly match the cost of providing these services. This argument is supported by the fact that SSA governments continue to spend a large proportion of their budget at the central ministerial level and in national 'flagship' hospitals and referral hospitals, unless there are special drives (usually with donors behind) to decentralise spending as in Uganda, Ghana, and Tanzania. A report by UNICEF concludes "seldom are user fees invested in quality-enhancing interventions. Most often, they substitute for funding from the central ministry" (Vandemoortele 1999).

B5. Fostering private sector development

The argument forwarded by the World Bank is that the population, when faced with charges for public services, begin to take an interest in other options for financing their needs, as well as shopping around for other non-public service providers. When public services are free of charge, the only way the private sector can compete is by providing better quality, more accessible (closer) or more convenient (e.g. longer opening times) services, for which the population are willing to pay. There is very limited research to answer specific questions about the impact of user fees on the private sector (Shaw 1996), although the general development and growth of the private sector can be charted in both health and education.

1. The population shops around for services. Choice of government facilities is extremely limited, except in urban areas where population density is considerably higher and thus the accessibility of different government facilities. While there may be a certain amount of shopping around between government facilities, and between government and private facilities, the main competitor in **health** are the indigenous or traditional health systems (traditional healer, guérisseur, and even Chinese / Indian medicine in some parts of Africa). Quite some literature exists on determinants of health seeking behaviour, reporting that as well as price, patients will compare other characteristics of services, such as payment schedule, proximity, previous treatment habits and experiences, and perceptions about likelihood of cure (Hutton 2004).

2. More use of private or fee paying NGO services. These sectors have clearly grown in last 2 decades, and enabled by user fees in government services. In **health**, the growth in the private sector has been seen mainly in urban areas where both the population purchasing power and the population density are greater, thus making it more profitable for private providers to do business. For example, the number of private health facilities in Dar es Salaam, Tanzania, outnumbers public health facilities by 4 to 1. Generally in Africa, private pharmacies tend to be much more common than private clinics. A different type of private provider in sub-Saharan Africa are the NGO and mission facilities, which tend to be located more in rural areas, and have a different motivation than private providers, although cost recovery may still be an objective. Due to their non-profit status, and the generally positive attitudes of the staff, these tend to be popular with the population. Often these facilities are designated as government facilities where these do not exist, such as in Tanzania and Rwanda. Clearly the adoption of user fees in public facilities will help these not-for-profit facilities to maintain their cost recovery or cost sharing policies, and thus help them to survive.

In **education**, the mission sector is also important. However, the fees charged are usually low, and based on a family's ability to pay. It is common, though, that the general fee level is higher than the public sector, especially when the good quality schools face a high demand. At the same time, an exemption or subsidy mechanism may exist for poorer families or those who are integrated in the faith community of which the school is a part.

3. Flight of staff from public to private sectors. One form of private sector development in SSA has been **health** care workers working in both public and private sectors, either basing both their practices in the same (public) clinic, or working in the public clinic in the morning, and a private clinic in the afternoons, evenings and/or weekends. In the case of the first, this allows the provider to 'attract' private patients to the afternoon session where there is less waiting time. In the latter case, most of the private patients may not

have passed via the public clinic, although this may still provide some client base for the private practice.

B6. Improving quality of service

One of the main justifications and goals of introducing user fees is to increase the resources flowing at the decentralised levels of the government structure, provide the environment for increased accountability, thus improving the quality of service (Creese 1995). However, one of the constraints to a fuller monitoring of the quality impact has been difficulties in the definition of 'quality' in health and education services and the lack of routine data available to measure the multiple measures available.

One key finding of the literature that has shown to be true in many settings is the importance of the retention of collected funds at the decentralised level (i.e. where they were collected). Without this, the link between user fee collection, accountability and quality improvement is broken. However, in many settings there have not been major observed improvements in quality. This is for many reasons, including corruption, bureaucracy, lack of planning for use of funds, insufficiency of funds, difficulties of getting hold of the resources or services to make major quality improvements, and inefficient spending. Also, in a number of countries, revenues collected from **health** institutions reverted to the central treasury (Eritrea, Ethiopia, Namibia, Zimbabwe). Furthermore, as already discussed, once decentralised levels are assumed to be self-sufficient in covering its recurrent expenditure, central government tends to withdraw in terms of a provider of finances, unless there is a strong process of decentralised budget.

It has been argued widely that when there are quality improvements, the negative effect of user charges on utilisation is often off-set, with some increases in utilisation found amongst even the poorest. For example, a study in Cameroon showed that a sick person was 25% more likely to visit a government clinic when fees were charged and quality improvements were also made, compared to no fees and no quality improvement (Litvack 1993).

Gertler reviewed econometric studies and found that people are willing to pay for quality improvements (Gertler 1997). Also, 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 1995). In Ghana the annual outpatient consultations held roughly constant in the years before and after introduction of user fees, with an improvement in drug supply (Nyonator 2000).

UNICEFs 1992 Bamako Initiative progress report shows the use of community health funds in four countries. The main uses of the funds include incentives in Nigeria and Kenya (>40%), drugs in Nigeria (37%), Congo (53%) and Guinea (49%), savings in Kenya (43%) and Guinea (26%), and operating costs and materials (under 10% each for most countries).

Penrose reports that cost sharing policies in the **education** sector in Ghana have had little impact on quality in terms of examination results, although without cost sharing the majority of non-salary costs would not have been covered (Penrose 1998).

B7. Encouraging community participation in management

Whether a good is free or whether it is charged for has major implications for the way the consumer views it. If a good such as health or education is free, but not good quality, the

consumer may not feel motivated or enabled to complain and demand better services. One major contention of the Bamako Initiative is that the community takes more interest in public health services when they contribute financially to these services, thus leading to community involvement, which improves quality of care and makes health services more responsive to community needs.

Community involvement in the **health** sector has been recorded in many ways, for example through community representation on health boards, election of representatives by the community, and patient feedback mechanisms. These have generally been clearly linked to the implementation of the Bamako Initiative. Therefore, it is difficult to say whether these mechanisms developed because of user fees, or more generally because the concept of community participation was being promoted. When examining the literature, there has been mixed evidence of the effects of these mechanisms.

In Sri Lanka, a public opinion poll on user fees in health conducted by the Institute for Policy Studies (Sri Lanka) and Harvard School of Public Health showed that public disapproval for user fees was at least 80% (Rannan-Eliya 1996). This applied to all the categories questioned: fees for medicines, fees for doctor consultation and fees for inpatient treatment).

In **education**, it has been argued that enhanced accountability also presumes that parents and pupils can discriminate between high and low quality educational services. Amongst those who have not had significant schooling this seems unlikely; even amongst those who have, the quality of what they themselves received may result in ill informed conclusions concerning the value of different methods of teaching and learning (Anon 1993).

Along a similar vein, Penrose (1998) argues that user charges, fees and other types of cost recovery, when not centrally administered, bypass the normal budgetary and accountability processes, and therefore offer none of the constraints that tax finance offers. They often bypass the political process, as well as government accounting processes: several countries are beginning to experience problems from the unaccountability of the user charge process.

C. Conclusions on overall impact

To make overall conclusions about the impact of user fees, perhaps other considerations are necessary to have a comprehensive view. For example, their impact on the household economy has not been considered. What proportion of household spending is on health care and education? And is this an acceptable level, given the absolute level of disposable income the majority of families exist on in sub-Saharan Africa? Recent studies on catastrophic health expenditures have shown surprisingly high proportions of families are subject to heavy health care expenditures (e.g. Xu 1992). Furthermore, an ongoing study of 17 Asian countries will show that catastrophic impact is greatest in countries with more reliance on out-of-pocket payments, including both legal and informal user charges in the public sector (Institute of Policy Studies, Sri Lanka). Therefore, this is one important aspect to consider in concluding the overall impact and performance of user fees.

A second consideration is placing user fees in the perspective of other barriers to social services. For example, in the health sector, a number of factors have been found to determine utilisation other than the comparative direct cost of the available health care options. These include time and travel costs, perceived quality, the type and severity of

disease and the perceived benefit of care seeking, income, education, and cultural factors (Leighton 1995, Hutton 2004). Cultural factors include the norms and customs of the population ('group' determinants), and education, habits or previous practices of individuals within the population ('individual' determinants). The income allocated to the head woman of the household was an important determinant of health service use. Therefore, it is important to be aware of other barriers to services before concluding the overall contribution of user fees to constraining access.

As suggested by the long presentation of evidence in this Annex, the number of references made, and as summarised in Table in Section 3.2, there are a range of criteria against which user fees have been judged, for both health and education. Neither is the picture black and white. It is generally shades of grey, deepening and lightening depending on the country context, and the way in which user fees have been implemented. However, some summary lessons are provided. In terms of efficiency, user fees in African settings do little to improve efficiency, due to the incredibly high levels of unmet need in these countries. On the other side, it is not considered efficient if a significant proportion of the population do not seek formal health services when they would otherwise do so without user fee. The efficiency gain for society of having a healthy and productive population should not be underestimated. Second, there is limited evidence to show improvements in equity, as rarely, if ever, are user fees redistributed from non-poor catchment areas to the poor catchment areas, nor is there much documentation of cross-subsidisation from expensive services used by the rich to free services used by the poor. However, where quality improvements are made, and people are prescribed effective drugs which they take according to the schedule, the gain can be great for poor people as well as the non-poor. The argument that user fees foster private sector development holds true in some settings such as urban areas, but the trained human resource base is so limited, especially in rural areas, that this goal falls way short of being achieved. Finally, decentralisation and community participation have been to some degree achieved by the implementation of user fees, and this has improved coverage, quality and responsiveness of services quite widely. However, user fees are not a precondition for these, as has been shown in other, developed, countries. Furthermore, once user fees are shown to maintain liquidity in a decentralised system, it almost gives central governments an excuse to withdraw financially from these levels. Hence, due to fungibility of government funds, user fees threaten to replace tax-based financing.