User Fee: An Alternative Financing Method of Health Care in 21st Century

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Section I

Introduction

Rapid population growth, the global economic recession of 1980's, the increasing prelevalence of HIV related and non curable diseases, and also lower mortality rate increased the financial hardships encountered in the public health sectors of undeveloped and developing countries. Government has failed to support the financial demands of health systems with its limited resources (taxes and donations).

Many underdeveloped countries charged user fees in the past – usually small amounts at token levels as an entrance or registration fee. As more and more governments have found it increasingly difficult to finance public sector health care, user fees have come to be seen as a specific policy tool for addressing the resource gap in health sector financing.

The World Bank in particular advocates user fees as a possible solution. Assuming that individuals are both willing and able to pay for health care that benefits them, the Bank argues that fees should be targeted at curative care and drugs in particular, because their benefits are easily associated with their monetary value. Charging patients would generate substantial additional funds while eliminating the inefficiencies of free care such as excessive utilization ("frivolous use").

From different articles published on the subjict, some of which are cited in the Bibliography, it is found that user fee was implemented in different countries without considering the concept of equity, quality and efficiency. These articles suggest that user fee could be a source of welfare transfer if fees were based on ability to pay and channeled into improvements in service quality and accessibility.

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The objective of this paper is to introduce a model of financing health care considering user fee as a policy tool for broader health care and financing package, Different aspects of user fee are critically evaluated for its implementation.

To prepare this paper, secondary data on health care financing by government and non-government organizations have been used. Available literature on the subject has been reviewed to develop a conceptual framework. The feasibility of user fees in financing health care has also been reviewed For all these purposes, arailable research papers, secondary statistical information and different reports of Government and non-government organizations have been consulted.

Section 2

What are user fees?

User fees, also known as cost recovery, cost sharing and community financing, are fees charged for the use of services such as health or education. The World Bank and IMF have strongly supported user fees and often made them a condition of lending. Services now subject to charges were often provided free or at a nominal cost before World Bank and IMF involvement. In 1998, according to the Bank's Operations Evaluation Department (OED) "about 40% of projects in the Bank's [health, nutrition and population] portfolio-and nearly 75% of projects in sub-Saharan Africa-included the establishment or expansion of user's fees."

The World Bank has promoted such schemes to achieve the dual goals of generating financial resources for under-funded programs and to encourage better quality and more efficiency. Cost-recovery schemes, the World Bank asserts, can succeed in achieving these goals, only if governments take complementary measures, 1) to ensure that services are accessible and of reasonable quality, 2) to redirect the freed revenues to under-funded health programs that provide public benefits and into increasing the number and quality of facilities to serve the poor and 3) to provide protection to the poor who cannot afford new or higher charges (Akin, 1987).

The term "User Fee" refers to the charges levied on users of public sector health services with the aim of recovering some or all of the costs pf providing such services. The two main objectives of user fees are to generate revenue and to deter "frivolous" use of services.

Advantages of "User Fee"

User fee can perform several useful functions in a government health system. They can:

- Raise revenue
- Improve quality, especially through improved drug availability
- Extend service coverage
- Promote appropriate or efficient use of health services, including strengthening of the referral system, reduction in frivolous demand, and limiting the growing demands on health services
- Improve equity
- User fees help to finance staff and non-staff costs in government health facilities, and therefore make provision possible
- Reflect the economic theory, payment=MC
- Improve equality between public and private services in terms of payment of fee.
- Increase decentralization and sustainability

Section 3

Some lessons of experience

Despite the World Bank's claim that user fees increase quality and effectiveness, evidence suggests that the system does not benefit the poor because of corrupt practices of health care staff and the poor working of administrative mechanisms. The introduction of user fees tends to dissuade the poor more than the rich from using health care services, also tends to delay care and shift people to self –meditation and informal forms of care. There is also some evidence that utilization increases where the poor consider the treatment as quality treatment. Opponents of user fees point to the fact that charging for services denies access to those who are most in need of health care, namely the poor. Economic hardships in underdeveloped countries prevent the majority of the population from paying fees, so the objective of user fees to raise funds for the public health sector is not likely to be achieved. With quality however, improvements, the price effect on utilization may be offset, and there may even be increases in utilization. The poor

have even been found to be willing to pay high amounts when services are good quality.

A survey in Tanzania indicates that 84% of rural and 81% of urban dwellers did not have sufficient funds to pay for health services, while in Kenya user fees had to be suspended for causing a "one-third drop in the number of patients seeking health care". There is growing consensus that user fees will reduce access to health care: the main issue of debate relates to the groups most vulnerable to this, and the extent to which utilization declines.

Furthermore, few underdeveloped countries recover more than 15% of health expenditure through user fees. Vogel's comparisons of revenue collected through fees in sub-Saharan Africa indicate a range of less than 1% of recurrent government health expenditure in Burkina Faso to approximately 15% in Ghana. In Africa, fee systems currently yield a gross average of around 5% of operating costs.

Creese (1991) suggests that user fees could be a contributory rather than a deterring force in financing public health. It can contribute to the improvement of the financial base of the health sector. The review article (Vogel, 1998) reports that in Sub-Saharan Africa around 5% operating costs are recovered on average by user fees in public facilities. Ghana has the highest cost recovery rate and recouping 15% of the current government expenditure in the form of user fees. Mwabu and Mwangi (1986) using simulation model showed that a 100% increase in user fees at government rural health clinics in Kenya would result in an initial fall of utilization by 9%. However, if the extra revenue generated by increased charges were used to improve the quality of the services, the use of services subsequently would rise to past level.

Litvak and Bodart (1993) found that in Cameroon the user fee along with quality improvement (with regard to the availability of drugs) increased access to health care facility utilization. In fact, the lowest income group, which is often said to be hurt by user fees, was found to seek more care in Niger than others groups.

Section 4

Problems associated with the implementation of user fee system

A main finding arising from the available analysis of health services utilization by socioeconomic status (World Bank, 1999) is that the poor use health services significantly less than the non-poor, and that the main obstacle to use by the poor

seems to be the private costs of health care (mainly user fees). Other important obstacles to consumption of health care by the poor are physical access to qualified health care providers, quality of care, and educational levels. The relatively lower health status of the poor may be explained in part by their comparatively lower accessibility to health services Similarly, children with acute respiratory infections (ARI) or suffering from diarrhea are significantly more likely to be taken to a health care provider if they are non-poor than if they belong to low income households. Similar contrasts arise with regard to maternal and obstetric health services. And the members of lower-income households are significantly less likely to seek care from public and private providers than those with higher socioeconomic status, and more likely to self treat or to go without any treatment.

Who will be exempted?

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 equity impacts of such a policy. The poor people who are unable to pay the user fees should be separated properly under an efficient managerial skill so that there are no reductions in utilization because of the imposition of the user fee.

Some services such as family planning and sterilization services, immunization and other measures to combat infectious diseases, examination of and taking of samples from assault and rape victims, person suffering from communicable or /and notifiable diseases (e.g. tuberculosis, leprosy, cholera, venereal diseases), public sector health personnel injured in the performance of their duties should not be incorporated under the user fee schemes.

Conflict between viable exemption scheme and viable salary incentive

There is a systematic conflict between a viable exemption scheme and a viable salary incentive scheme. There is an inherent tension in a facility seeking to operate a viable exemption scheme and a viable salary incentive scheme. If the hospital is operating at full capacity and is striving towards improving efficiency, then granting exemptions would be virtually intolerable. Ironically, exemptions are more likely to be granted in facilities, which are performing less well, and where serving a patient for free does not necessarily mean excluding a fee paying patient. The competition, outlined above, between patients for more exemptions and staff for greater salary incentives is actually part of a broader systemic tension, inherent in the design of the health-financing scheme, between equity and efficiency. There is a real danger that increasing equity, by lowering costs and

providing more exemptions to the poor will undermine efficiency. Conversely, as facilities strive towards greater efficiency, there is a real danger that the poor will become even more marginalized. If the tensions outlined above are to be relieved, it is clear that the mechanism for financing exemptions must be completely separated from the mechanism for financing salary supplements and operating costs.

Health sector reform

It is commonly believed and recognized that the health system in developing countries needs to be changed for the better. It is a fact that in many countries the health system has undergone intensive reform. There have been many reasons as to why there is a need for change. As Frenk (1994) has pointed out, health system reform stems firstly from economic, political and ideological reasons. Economic crises in developing countries, scarcity of resources, the changing of political and ideological regimes, have led to macro economic reform, which inevitably inspires sectoral reform, including health sector reform as well. Secondly, the health system itself appears ineffective in facing the complexities posed by epidemiological transition. The health sector of developing countries is weak, stagnant, ineffective and inefficient in providing services, let alone coping with newly emerging challenges and new health needs. The disease pattern has changed the constituents for health improvements; these induced health systems have changed in order for these to be more responsive to new demands. In practice, reforms are the concern for all governments at present, Though they have different emphasis in different countries, they share a common goal which is to improve the quality of basic services within very limited institutional capacity and resources (Cassels, 1994)

Gilson and Mills (1995) have summarized that health reform is a package of policy measures affecting the organizations, funding and management of the health system. Obviously, there is no universal package of approaches for undertaking these reforms as each country is in such a different political, social and economic circumstance that requires different ways to tackle the problems. Health reforms, however, can be characterized by a set of main elements:

1. Identifying and responding to major health problems
2. Organizational and management changes, including decentralization
3. Health financing strategies
4. Improving quality of care

Section 5

Decentralization

One of the ways to improve service promotion by the government is decentralization. In recent years, decentralization of primary health care provision has been strongly supported by donors, and many countries have undertaken reforms along these lines. Decentralization may be viewed in narrow and broad terms. In a narrow sense, it may mean delegation or deconcentration of central government functions to lower levels while the central government exercises authority with respect to policy, finance and administration. In a broad sense, decentralization means devolution of central government authority to local levels. It can work in different spheres-administrative, fiscal and political

Cassels (1995) has pointed out, in health, decentralization means the transfer of more responsibilities for the management, policy making and provision of health care to local level or to agencies within the health sector. This assumes that the lower level government is closer to people, hence they have been given power so that the work they do and the result of their work will be more responsive to the local people's needs. Therefore, many writers (Green 1992; Mills, 1994) have argued that decentralization, in whatever form it takes, should work towards common goals. The decision making should be brought closer to field-level service providers, so that their participation will be enhanced, voices will be heard, and, therefore, the government and people will become more responsive to each other.

Why decentralization is needed?

1. The differentiation of fees by income level is difficult to implement because many public sector institutions do not have the infrastructure or managerial capacity to administer the method appropriately. Furthermore, verification of the income declared by patients is often impossible, and the administrative cost there of is high in relation to the revenue gained.
2. Providers have been found to be corrupt in the collection of user fees—when fees are not written down they can charge variable prices; fees are pocketed when there are no mechanisms in place to ensure money is accounted for; and providers do not always exempt those who should be.
3. In many cases, user fees are collected at the local health facility and sent directly to a central authority (Ministry of Health, Treasury), creating serious

obstacles to recycling the revenues to improve quality at the collection facility.

4. The introduction of user fees can introduce both efficient and inefficient medical practices and patient behavior. On the one hand, if health care facility is good, itis likely to enhance demend. This is partially evidenced by the wide reporting of polypharmacy throughout the developing world. On the other hand, the introduction of fees may reduce the 'frivolous' use of health services—health care that is not really needed by the patient.

How decentralization improves quality?

A World Bank study on Vietnam has revealed that in a highly centralized management system, where all decisions and planning are made at the central level and where the lower level just play the role of administrator or policy implementers, the quality of services is often poor. The officials at the lower level often think that they are not responsible for failures occurring locally but the accuse either the finance sector for not providing enough resources for them to fulfill the task or accuse the central ministerial level for their imposed, dogmatic policy and guidelines, which the local officials consider as the root causes of the failures of policy implementation (World Bank, 1996). The study has further pointed out that in practice the local leaders often have to modify the imposed policy unofficially in order to meet the local needs.

The reason for organizational and management reform in health is to improve the capacity of each level, to enable them to work more effectively and spend resources efficiently. With decentralization, local communities are given clear responsibilities, which inspire them to be more concerned about their staff, about the way to get the work done, and to fulfill the targets satisfactorily within the limitation of the budget they have. They are allowed to work flexibly and creatively to utilize and mobilize all potential resources available in their locality. Furthermore, they are replaced in a position where they must be accountable to the higher level of government, from whom they are assigned the work. In addition, it is commonly believed that at the lower level there is a greater potential for multisectoral collaboration, which is important for implementing primary health care programme and contributing to health improvement at the locality (Green, 1992).

Nevertheless, the positive ones included increased participation by less powerful groups in decision-making over the design of services and resource allocation,

improved access and utilization of services by the poor, reduction of disparities in the provision of health facilities, and their use among various geographical regions, improved quality of health services and responsiveness to local preferences in health planning.

Besides, Rondinelli et al (1983), Green (1994) and World Bank (1997) have identified a number of pitfalls of decentralization, such as developing countries that lack capacity strengthening abilities for both local and central government, can lead to negative impacts. Decentralization may also lead to local government vulnerability resulting from control by locally dominant groups or it can lead to the monopolizing of local political leaders. Perhaps the most severe weakness is that decentralization can lead to disparities across regions and communities as well as ignorance of equity in health services.

Section 6

A proposed model for the proper implementation of user fee

Empirical evidence suggests that user fees could be a source of welfare transfer if fees are based on ability to pay and are channeled into improvements in service quality and accessibility (Greese 1991). The vulnerable people should be exempted from charging user fee so that they can get free access in the different levels of health care institutions. Besides user fee should be differentiated according to income level.

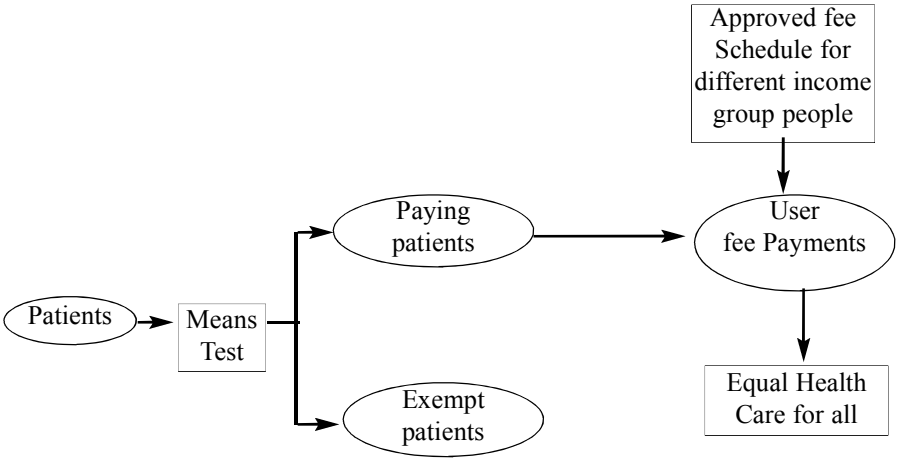
In our model, all the patients interested to take health care have to face a means test to determine their eligibility. Then according to the results we divide the patients into two groups. Patients applying but found not eligible for exemptions, along with patients not applying for exemptions are subject to and must pay the provider's customary fees according to their income levels. Exempt patients, instead, are offered care free or at a reduced price. In this way all the patients can get equal health care under the user fee schemes.

Section 7

Conclusion

The overall analytic view and the available evidence suggest that user fee is unlikely to accrue financial benefit if it is introduced in isolation. It should always be considered as one of the policy tools for a broader health care and financing

Figure: Introducing a Model For the Proper Implementation Of User Fee



package. The concept of equity, quality and efficiency should be the integral part of a user fee implementation package to achieve interactive benefit of this policy tool.

If the user fee can be implemented with the intention of keeping equity between rich and poor; improving the quality of health care and increasing its efficiency, then user fee may provide an attractive alternative to hundred percent government financing of the state health system for the underdeveloped or more revenue constrained countries.

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