

# Freeing up Healthcare

## A guide to removing user fees



**Save the Children**  
UK

# Freeing up Healthcare

**A guide to removing user fees**

We're the world's independent children's rights organisation. We're outraged that millions of children are still denied proper healthcare, food, education and protection and we're determined to change this.

Save the Children UK is a member of the International Save the Children Alliance, transforming children's lives in more than 100 countries.

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Cover photo: Makalaghe, a Save the Children Community Development Officer, with Fatuma Salum Nasuma, two, in Mnolela village, Lindi district, Tanzania. (Photo: Firew Bekele/Save the Children)

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# Abbreviations

|        |  |
|--------|--|
| DFID   | Department for International Development (UK)            |
| EHP    | Essential Health Package                                 |
| FTE    | Full-time equivalent                                     |
| GNP    | Gross national product                                   |
| HIPC   | Heavily Indebted Poor Countries                          |
| HMIS   | Health Management Information System                     |
| HR     | Human resources  |
| IMF    | International Monetary Fund                              |
| MDG    | Millennium Development Goal                              |
| NGO    | Non-governmental organisation                            |
| PEPFAR | United States President's Emergency Plan for AIDS Relief |
| PRSP   | Poverty Reduction Strategy Paper                         |
| STI    | Sexually transmitted infection                           |

# Introduction

## Why remove user fees?

User fees reduce people's access to healthcare. They limit the uptake of services by poor and rural populations, and particularly women and children, contributing to high rates of infant, child and maternal mortality. These are the very people who suffer the greatest burden of disease, and who need to be reached if global targets like the health-related Millennium Development Goals (MDGs) are to be met.

Removing user fees has proven to be an effective strategy to increase access to healthcare. In Uganda and other countries, fee removal combined with other health policy reforms resulted in dramatic improvements in the utilisation of health services. These reforms helped poor people in particular to gain access to health services, and contributed to better health equity.

This is a guide for policy-makers and technical staff in developing countries who are planning to remove user fees, or are considering doing so. It sets out a five-step process that will help you plan for and successfully implement a policy to remove user fees. Furthermore, it will help you maximise the support available from donors, civil society organisations and other institutions working with governments on fee removal.

## A consensus has emerged

Most key players in the health arena now recognise that user fees constitute a significant barrier to access to health services. Even when set at a

relatively low level, they prevent poor people from accessing healthcare.

Consequently, a consensus has emerged that removing user fees is an essential step towards ensuring universal access to healthcare. This consensus has led to a number of sub-Saharan African countries removing fees over the last decade. Furthermore, several development partners, including the UK Department for International Development (DFID) and the World Bank, have committed to extending technical and financial support to countries that develop policies for removing user fees, and that request such support. The maps overleaf show how fee-removal policies have become more popular in Africa since the year 2000.

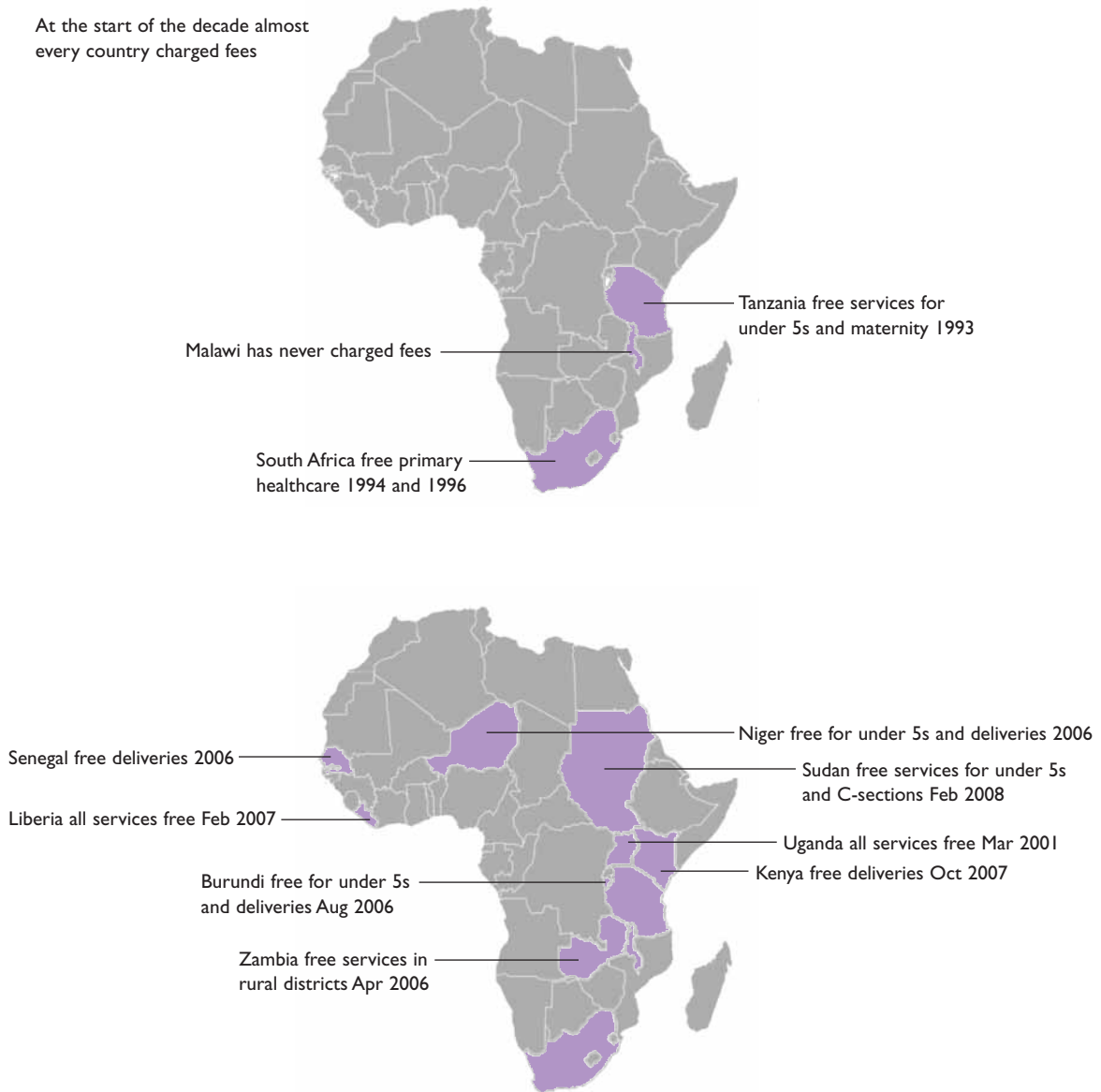
## Using the evidence base

The evidence is clear: fees are a key factor in preventing poor people from accessing health services. At the same time, removing fees has proven to be an effective strategy in improving access. The next chapter looks in detail at the case of Uganda, which removed user fees (discontinuing the policy of 'cost-sharing') in 2001. But evidence is by no means restricted to Uganda. Save the Children UK carried out a series of studies in 2005 in East and Central Africa, which found that, on average, one-third of people who are ill do not seek any kind of treatment, and another third self-prescribe. The most commonly cited reason for not seeking care is lack of money.

In Ethiopia, for example, the cost of health services went up by nearly twice the rate of inflation

### The rapid removal of health user fees in Africa

At the start of the decade almost every country charged fees



Source: Robert Yates, Department for International Development

between 1984 and 1994. The likelihood of someone seeking professional medical care instead of using self-care declines significantly with the service provider's price.<sup>1</sup> Fees charged by public health clinics were concluded to have the greatest impact on people opting for self-care. For every 10% increase in clinic fees, reliance on self-care increased by 2.4%.

Morocco faces a serious maternal health problem, with limited funding available and a high dependence on out-of-pocket expenditures to finance health services. One study found that increasing

out-of-pocket payments would further reduce the uptake of maternal care by poor and rural households, to the extent that for the poorest 50% of women, a 10% increase in health fees would reduce their access to a trained healthcare worker by 6.2%, and reduce their access to a health facility by 8%.<sup>2</sup>

In rural Zambia, children under five are exempt from user fees. One study compared the gender effects on children's uptake of healthcare when fees come into effect at the age of five.<sup>3</sup> At age three–four, girls were twice as likely to be

admitted to hospital as boys; but at age five–six, only two-thirds as likely. This suggests that fees disproportionately reduce girls' uptake of health services.

## Removing fees is cost-effective

User fees were brought in because, in theory, they serve several purposes, such as providing incentives for health workers and covering recurrent costs at facility level. But, in practice, they contribute only marginally to overall health expenditure; what's more, they rely on costly administration systems.<sup>4</sup> It is estimated that user fees contribute on average no more than 5% of total health sector revenue.<sup>5</sup>

At the same time, it is clear that removing fees, especially when accompanied by health reforms to improve capacity to respond to increased utilisation, will entail additional resource requirements. It is

therefore important to ensure that additional funding is available for countries that want to remove fees. For example, investment in health reforms (including the removal of user fees) that enable poorer sections of the population to access services can deliver a critical element of the Poverty Reduction Strategy Papers (PRSPs), on which debt relief under the Heavily Indebted Poor Countries (HIPC) initiative is contingent.

## Leadership and communication are key

In countries where removal of user fees has been particularly successful, the policy was supported and often spearheaded by national leaders. In Uganda, for example, President Museveni was at the forefront of the policy change, which ensured goodwill and support from all other levels of

## Addressing other barriers to healthcare

While user fees are a very obvious and important barrier to poor people's ability to access health services, they are not the only barrier. Save the Children UK carried out a recent analysis of the key factors affecting children's healthcare utilisation. At household level, socio-economic characteristics such as poverty, women's level of education and empowerment, and perceptions of illness are the key barriers to people accessing healthcare. Within health systems, and alongside user fees, transport costs, availability and cost of medicines, (perceived) poor quality of care and opportunity costs are the most important barriers. It is vital that policy-makers understand the full range of barriers that prevent people from accessing healthcare in their particular context, to ensure that removing user fees is successfully implemented.

For example, studies from Burkina Faso, Indonesia, Ethiopia, Sri Lanka and Tanzania have shown that transport costs account for 17%–50% of total direct costs involved in accessing healthcare (ie, all medical and non-medical costs incurred when seeking healthcare, including transport, fees and drugs costs). Furthermore, household expenditures on medicines have been estimated at between 29% and 62% of total household healthcare expenditures per treatment episode. One review of six African countries described how, regardless of whether services were fee-based or not, improvements in quality led to increased use of services, and poor quality led to decreased use.<sup>7</sup> Finally, a number of studies conclude that the opportunity costs involved in both illness and care-seeking are often as great as, if not greater than, the combined costs of fees, drugs and transport.<sup>8</sup>

government and society. In South Africa, Uganda, Zambia and Nepal, the successful removal of user fees has had strong political support, and the policy was often tied in to national elections and campaigns. Political leaders – ideally, heads of state – need to be fully engaged in plans to remove health fees, to ensure commitment to the policy at all levels of government.<sup>6</sup>

Getting high-level commitment to a policy to remove user fees is crucial. But it is also essential

to communicate the policy change and to engage key stakeholders, especially those who might be opposed to it. This will involve using mass media to inform people about their right to free basic healthcare, as well as other means of communication, with tailored messages for more specific audiences. These might include government stakeholders, health workers, and others who are instrumental in the successful implementation of the policy.

# Uganda and beyond

## The Ugandan case

The case of Uganda – where user fees were removed in March 2001 – is the best-documented case of fee removal, and there are large amounts of data available. Therefore, the Ugandan experience will be cited frequently in this guide.

User fees were introduced in Uganda gradually from the late 1980s. By the late 1990s, reports increasingly indicated that people were not using basic health services because they could not afford the fees. Reflecting the level of popular discontent, the removal of health fees was announced as part of President Yoweri Museveni's election campaign in 2001.

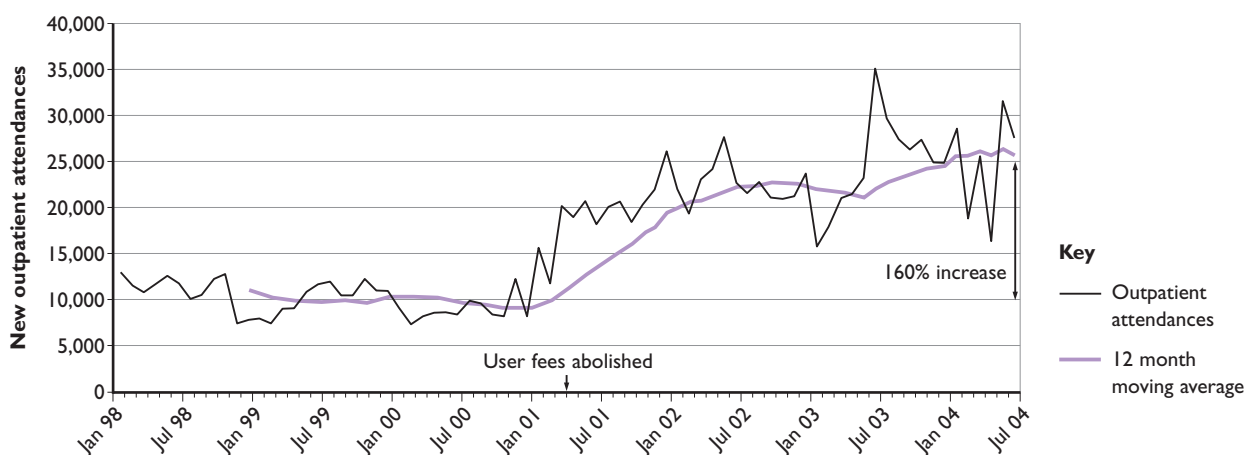
There is a great deal of evidence documenting the trends in utilisation that followed implementation

of the policy of fee removal. The routine Health Management Information System (HMIS) showed a marked increase in new outpatient attendance in all government and PNFP (private not-for-profit, mainly mission) health units in one district (see Figure 1 below).

Furthermore, a study conducted in the period immediately after the removal of fees showed that poorer people were using public health services to a greater degree than rich people: the subsidy for public services was achieving a progressive distribution (see Figure 2 opposite).

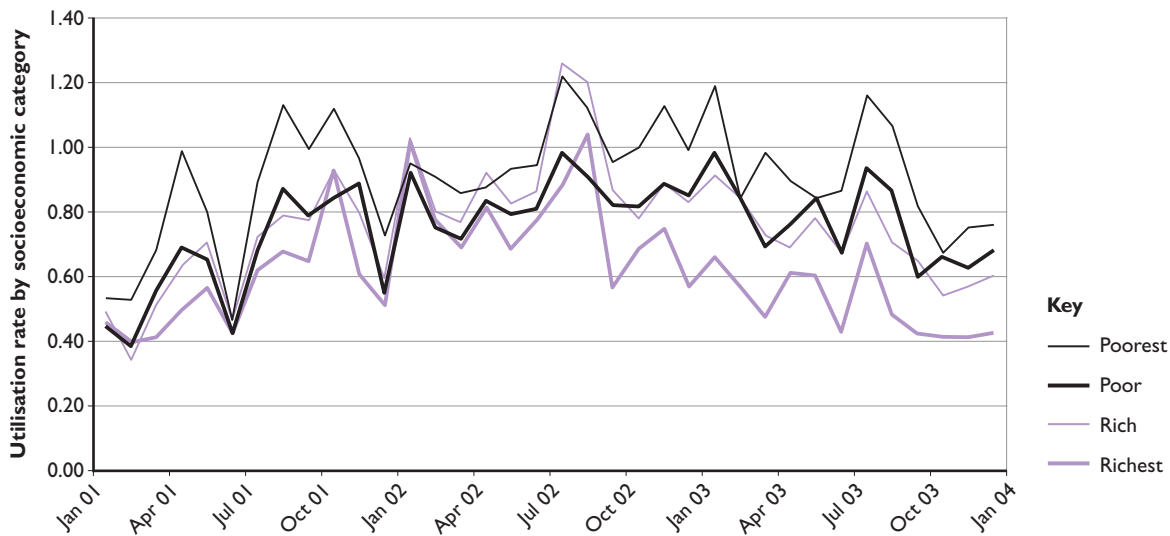
Figure 2 shows that health service uptake increased after the removal of user fees, especially among poorer sections of the population. An analysis of Uganda National Household Survey data from before and after the removal of fees (1999–2000

**Figure 1: Monthly new outpatient attendances for all the health units (government and PNFP) in Kisoro District 1998–2004**



From Kirunga-Tashobya et al, 2006

**Figure 2: Outpatient utilisation rate at public lower-level health units by socio-economic category 2001–2003**



Source: Kirunga-Tashobya et al, 2006

and 2002–2003 respectively) begins to demonstrate a causal link with user fee removal. Respondents were asked why they did not use health services, despite having reported an illness. The surveys found that while levels of reported illness had remained the same, the share of households reporting inability to use health services because of cost declined from 50% to 35%.<sup>9</sup> The increase in utilisation of services was highest for those in the poorest two income quintiles. This shows that it was the removal of fees that led to improved access, rather than other factors.

Data from Uganda clearly document dramatic increases in health service utilisation over a sustained period of time following the removal of user fees. This was also facilitated by the implementation of quality improvement measures that were put in place following a temporary drug stock-out, and a resulting temporary decrease in utilisation. Thus, it was ensured that increased health service utilisation could be accommodated.

### Examples from other countries

Numerous studies from other countries demonstrate that removal of user fees significantly increases health service utilisation. In Madagascar,

user fees were removed temporarily after a period of political turmoil in 2002, in which the economy had been severely disrupted and a significant number of households pushed into poverty. But user fees were still charged in a quarter of public health facilities because the new government did not have effective control over all areas of the country.

Nevertheless, one study showed a significant impact on average levels of utilisation across 138 health facilities surveyed. Controlling for many factors that could affect utilisation, it was concluded that the removal of user fees had been associated with a 16% increase in utilisation.<sup>10</sup>

In Niger, after user fees were removed for children under five and pregnant mothers in 2006, consultations for under fives quadrupled and antenatal care visits doubled.<sup>11</sup> A study in Burundi showed that utilisation for under fives increased by 40% within a year of user fees being removed. And in Bo, Sierra Leone, removal of user fees led to a tenfold increase in consultations for under fives.<sup>12</sup> Other countries, such as Nepal, have recently removed user fees. While some data is available to indicate improvements in health outcomes as a result, more research is needed to demonstrate links between fee removal and health outcomes at scale.

# The five steps

This guide describes five steps you need to follow to successfully remove user fees and maximise utilisation of health services. Using data from a range of countries and worked examples, it demonstrates how to estimate the effect of removing fees on utilisation and the resulting resource requirements.

Here are the five steps:

## 1: Analyse your starting position

Develop a clear picture of the current situation in your country.

- Work out whether fees are high, medium or low.
- Identify any exemption and waiver policies – how effective are they?
- Determine the effects of fee revenues at the facility (health centre) level, especially in terms of staff remuneration and supply management of medicines.

## 2: Estimate how removing fees will affect service utilisation

You need to estimate what effect removing fees might have on utilisation. Utilisation is likely to increase in any case. The extent of the impact of removing fees in your country will depend on:

- the level at which user fees were set and, thus, how much of a barrier to utilisation they represent (see Step 1)

- whether complementary policy measures are put in place to maximise the impact of removing fees (see Step 3).

## 3: Estimate additional requirements for human resources and drugs

You need to estimate the probable additional human resource and drug requirements to ensure that sufficient resources are available to cover demand from increased utilisation, while at the same time maintaining quality of care, as people may be less likely to use services if quality declines.

- For human resources, you will need to consider workforce structure, skill level and distribution of tasks.
- On the drugs side, you need to take into account price levels, the underlying epidemiology of infection, and disease, among other things.<sup>13</sup>

## 4: Mobilise additional funding

While loss of revenue associated with removing user fees may be fairly modest for the health system overall, the cost of providing increased health services might be relatively substantial at the facility level. Therefore, you will need to identify and mobilise additional sources of funding.

- Additional funds may be available in-country – for example, through reallocations within the health sector.
- Alternatively, external sources such as donor funds will need to be sought.



## 5: Communicate the policy change

Planning to implement the successful removal of user fees does not end with reliable data and estimates and the securing of additional resources. You will need to develop a communication plan early on, especially for stakeholder groups that can influence successful implementation, such as health

workers and ministry staff. The communication process needs to be carefully managed, and will involve:

- engaging and managing key stakeholders
- using mass media to inform beneficiaries, including poor and rural households who may be difficult to reach.

# Ensuring quality

Before going on to look at the five steps in more detail, it is important to consider issues around quality of healthcare provision. Service quality is a key determinant of health service utilisation and health outcomes. Quality considerations are thus a key factor in removal of user fees; without additional policy measures to ensure that quality is maintained, the effects of fee removal cannot be maximised and, at worst, may have no positive long-term effects at all.

## Dimensions of quality

People's utilisation of health services depends not only on whether there is a fee, but on whether they expect to find qualified health staff who are responsive, knowledgeable and friendly, and whether they can access the medicines prescribed for them. Other dimensions of quality also have a bearing – for example, waiting times and the condition of facilities. But evidence from a range of settings suggests that availability of adequately trained staff and drug supply are two of the most important influences on people's utilisation of services.

One study conducted in Guinea identified and classified the range of criteria that users consider to assess the quality of primary healthcare on offer.<sup>14</sup> After conducting 21 focus groups with 181 participants, the most frequently mentioned criteria were:

- availability of drugs
- accessibility of the facility
- availability of 'good' drugs
- presence of 'good' doctors
- conditions of buildings and rooms
- presence of doctors.

Another study in Zimbabwe focused on the views of women and nurses about quality of care.<sup>15</sup> Participants identified the same problems as nurses: poor infrastructure, staff shortages, shortages of drugs and supplies. When asked about trends in nurse attitudes, the general response in urban areas was that there had been a steady deterioration in nurse behaviour. However, it should be noted that patients' perceptions and definitions of quality do not necessarily match objective quality criteria.

These and many other qualitative and quantitative studies of users' views in sub-Saharan Africa and other low-income countries show that availability of trained staff and drug supply feature strongly in people's perceptions about quality of care.

## The need for complementary policies

One study in Mali found that doubling the number of drugs available in a public hospital would increase the likelihood of a service user choosing the location by 35%.<sup>16</sup> This study also created a measure of whether or not different types of facilities were providing a 'good' consultation. It concluded that at the dispensary level, achieving the rate of 'good' consultations available in private facilities would increase the chance of users choosing them by 136% – ie, it would more than double the probability that a user would choose a public dispensary. In this context it is important to note that both perceived and actual poor quality in the public sector can drive households – including poor households that can least afford it – to spend money on private treatment instead.

If user fees are removed without introducing additional measures to offset revenues that were retained at facility level – for example, to fund staff bonuses or to support drug supplies – the policy change will not be successful in increasing utilisation and improving health outcomes in the long term. Health facilities will experience two trends: increasing user demand, and decreasing availability of funds for staff bonuses and drug stocks. This means that, unless there was a surplus of staff and drugs before, facilities will not be able to maintain service standards, and patients will be dissatisfied with the quality of service. Consequently, utilisation is likely to decrease again and, in the longer term, might go back to levels similar to those before the policy change was implemented.

Uganda experienced similar problems initially, but was able to turn this trend around through specific policy interventions (see Figures 3 and 4 below). It is clear that where additional measures are taken to support drug stocks as well as availability of adequately trained and remunerated staff, quality levels may be maintained or even improved, thereby sustaining increased service utilisation in the longer term.

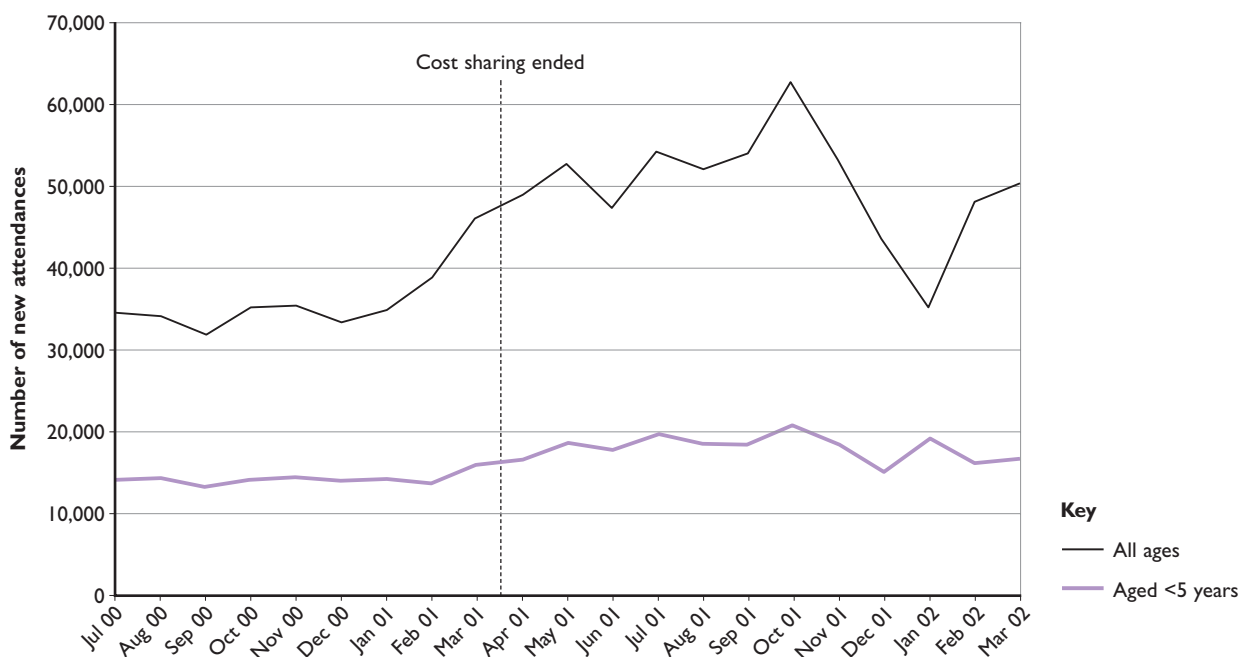
In other words, human resource and drug requirements depend on the level and utilisation of services, but the utilisation of services is interlinked with the availability of human resources and drugs. Trying to create a ‘virtuous circle’ of growing local resource availability and growing use of services is a sensible policy objective where analysis suggests there is under-use of health services by the population in general.

### How quality of care affects utilisation of services

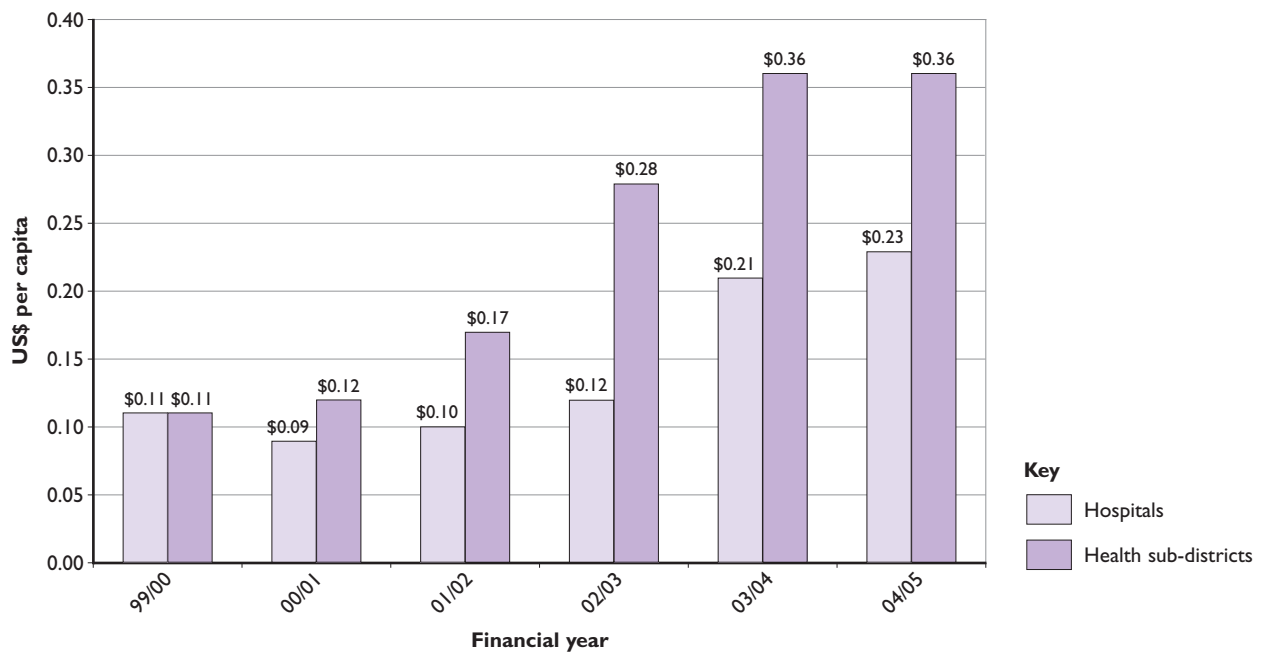
Using the experience of Uganda, Figure 3 below shows the level of new attendances among children before and after the removal of user fees (‘cost sharing’) in April 2001. It clearly demonstrates that the upward trend in utilisation was reversed some time after the policy change. The same phenomenon was reported for user categories analysed in other studies.<sup>17</sup>

This trend may reflect the initial failure of the system to maintain a quality response to increased user demand, particularly in terms of drug supply.

**Figure 3: New attendances in people of all ages and children under five between July 2000 and March 2002**



Source: Burnham et al, 2004

**Figure 4: Ugandan Ministry of Health medicines budget in real terms 1999–2004**

Source: Nazerali *et al*, 2006

The Ministry of Health, recognising the trend, responded by improving and trying to guarantee drug supplies.<sup>18</sup> Figure 4 above shows how the medicines budget was subsequently increased. As a result, the negative trend was again reversed. This measure may well have been instrumental in maintaining higher levels of utilisation in the longer term.

Creating the above-mentioned ‘virtuous circle’ requires some additional resources. This is an important point to consider at the outset when planning to remove user fees. New or redirected resources must replace lost user fee revenue, and must also accommodate increased user demand (see Step 4 on resource mobilisation, page 25).

# STEP 1: Analyse your starting position

Removing user fees sets off a chain of reactions throughout the health system. In order to judge the starting point of that chain, you need to consider your country's current status. If data are scarce, it can also be helpful to review data from countries in the same region or from those facing similar issues, where data are more plentiful.

## Estimate whether fees are high, medium or low

There are two direct effects of removing fees. The first is a loss of revenue, and the second is a change in patterns of service use. In most countries, the loss of revenue is likely to be relatively small, even if it constitutes a somewhat more substantial part of non-salary recurrent costs. Studies in 16 African countries in the early to mid-1980s showed that revenues from user fees contributed between 1% and 12% of total health sector expenditure, averaging about 5%.<sup>19</sup> In Uganda, before user fees were removed, fee recovery rates at public health facilities were about 7%.<sup>20</sup> This was despite the system allowing the bulk of the fees to be retained at facility level. The second effect of removing fees – a change in patterns of service use – is also very important, and will be explored in detail under Step 2 (see page 16).

User fees are also regressive – ie, poor people spend a higher share of their income on healthcare than those who are better off.<sup>21</sup> Hence, the amount

charged to the individual service user is important in determining the extent to which it is a barrier to access. Therefore, it is useful to determine whether existing fees are high, medium or low.

Unfortunately, there is little comparative data available on levels of user fees. The box opposite compares data from the mid-1990s from Ghana and Uganda. These data suggest that fees that amount to less than one day's average gross national product (GNP) per capita might be considered low; up to five days' average GNP considered medium; and above five days' GNP considered high. Fees for one-off or sporadic events (for example, childbirth) that equate to more than five days' GNP might be considered medium or low.

You will need to give careful consideration to the actual total fee. You are comparing not only the consultation charge, but the effective total amount paid for an episode of healthcare. This might include administrative and consultation charges, the costs of prescriptions and drugs, and any other fees that may be paid by a typical user.

For example, a study in Zambia looked at the fees charged for 'bundles' of health services associated with common conditions.<sup>22</sup> While consultation fees were set at a maximum of 2,500 Zambian kwacha in government hospitals, the total fee charged for a typical bundle of care for a cerebral malaria patient was 11,000–13,000 kwacha, and for an acute pneumonia case in a child, 10,000–12,000 kwacha.<sup>23</sup>

## User fee levels: are they high or low?

There are two studies that identified user fee levels as low, medium or high. These may provide some insight into how to judge the level of fees in your country.

In **Ghana** in the mid-1990s, user fees were stipulated at levels ranging from 10 Ghanaian cedis for a haemoglobin test to 1,000 cedis for a Caesarean section or appendectomy. However, these levels were deemed unrealistically low, so a more realistic schedule of charges was introduced, ranging from 475 cedis for the haemoglobin test to 55,000 cedis for a Caesarean. The revised rates were deemed 'reasonable' by hospital authorities (Coleman, 1997). At the exchange rates and GNP levels of the mid-1990s, these work out as official charges of between 0.8 and 76% of daily GNP,

and actual charges of between 26% and 4,179% of daily GNP. In other words, to pay for a Caesarean section, it would take the average person 42 days to earn enough money.

In **Uganda** in the mid-1990s, typical official user charges ranged from 500 Ugandan shillings for an outpatient consultation to 3,000 shillings for a delivery. These rates were perceived as 'reasonable'. However, typical unofficial rates were 2,500 shillings for an outpatient visit, 7,500 for a delivery and 5,000 for an inpatient stay of three days (McPake *et al*, 1999). At the exchange rates and GNP levels of the mid-1990s, official charges worked out as between 93% and 560% of daily GNP; and unofficial charges were between 467% and 1,400% of daily GNP.<sup>24</sup>

## Identify effectiveness of any waiver and exemption policies

Most fee systems include waiver and exemption policies in principle. However, such policies are difficult to implement in a consistent manner in practice. The best way to judge the situation in your country is to assess data on the types and numbers

of waivers and exemptions granted. Data from other settings are provided in the box overleaf. Where a fee policy grants waivers and exemptions to a large percentage of users who successfully claim their entitlement, and where those users represent poorer sections of the population, removal of fees will have less impact.

## Exemptions and waivers: a varied experience

Waivers can be defined as rights that entitle specific individuals, eg, pregnant women or children under five, to obtain health services at certain facilities at no direct charge or at a reduced price (Bitrán and Giedion, 2002). Exemptions, on the other hand, are associated with types of services, such as antenatal care or immunisations.

### Waivers for the poor

In many countries, there are provisions to waive user fees for the poor. Nevertheless, despite such policies, actual granting of waivers on the basis of poverty is rare, and when it does happen it is not often the poorest people that benefit. For example, a Save the Children UK study in Burundi in 2005 found that only 10% of people were aware of a waiver scheme for the poor, and those people mostly belonged to wealthier sections of the population. In **Ghana**, less than one in 1,000 users was granted a waiver on the basis of poverty status, although it is estimated that 15%–30% of the population lives in poverty (Nyonator and Kutzin, 1999). In **Kenya**, when the waiving of fees was left to the discretion of facility managers, some facilities treated patients on credit, some treated patients free of charge, and others turned those with insufficient money away (Mwabu *et al*, 1995).

### Waivers based on demographic criteria

Waivers for population groups such as children under five or pregnant women have been more successful. This is partly because it is easier to identify age groups or pregnancy status than to

determine someone's income. In a way, the introduction of waivers equates to removal of user fees for certain sections of the population, and has been presented as such in a number of countries. In **Niger**, for example, waivers for specific population groups or services (antenatal care, children aged 0–5, pregnant women requiring Caesarean sections) effectively meant removal of fees for a large portion of primary healthcare services. They were very successful in improving utilisation rates.

### Exemptions for specific services

Where exemption policies for specific services are well managed and funded, it has proved possible to make them work. For example, in **Sudan**, in a carefully managed experimental study, exemptions were shown to increase utilisation, improve treatment-seeking behaviour and promote early diagnosis (Abdu *et al*, 2004).

The case of **Sierra Leone** shows how important it is to plan and resource both waivers and exemptions. The country has had a policy that exempts children under five and pregnant women from paying fees for several years, and there are provisions for exemptions for certain health conditions and services. But the policy was unclear and there was inadequate planning to implement the system of waivers. Moreover, with the health system severely lacking resources, there was simply no money to cover all the exemptions and waivers included in the policy. As a result, they were applied at the discretion of individuals, and many patients who should have benefited had to pay.

## Offset any loss of revenue at health-centre level

In some countries, loss of revenue from removal of fees accrues to the national Treasury. In these circumstances, the amount is usually not substantial enough to warrant concern.

But in countries where a significant share of fee revenue is retained at or close to the point of collection, the loss will need to be offset. You will need to give careful consideration to this process. Fees may have been used to finance a proportion of staff income,<sup>25</sup> to supplement drug stocks in

case of stock-outs (as in Ghana), or to cover other operating expenses.<sup>26</sup>

In this case, it will be necessary to find additional funds to cover revenue reductions. In settings where funds are routinely transmitted from the central to the facility level, such funding flows need to be protected and increased to offset lost revenue. In those rare settings where no such systems are in place, they need to be created.

Step 2 provides guidance to help you estimate the impact of removing fees on service utilisation.



# STEP 2: Estimate how removing fees will affect service utilisation

Removing user fees has had a varied impact on health service utilisation rates. This is not surprising, given the range of factors involved. The Ugandan experience shows the impact of removing fees on service utilisation in a context where fees have clearly acted as a barrier to access, and other measures have been put in place to support the fee-removal policy. The Ugandan case suggests that annual increases in utilisation of 20%–50% are achievable in the first few years, and that the resulting level of utilisation can be sustained. Where fees are less of a barrier, or where supportive measures are not introduced, there is likely to be a less marked, less sustainable impact. Table 1 below provides an overview of three possible scenarios and their likely impact on utilisation.

The likely impact of removing user fees on service utilisation is one of the main factors you will need to consider. While there is no simple formula for determining this, we outline some approaches to estimating the level of impact. Below, we review the experience of a number of countries that removed, introduced or changed the level of user fees, and

the impact this had on service utilisation. We then go on to consider the key factors that seem to influence users' responses to fees and their removal.

## Direct effects of removing user fees

We have compiled a summary of 22 studies that reported changes in utilisation as a result of changes in user fee policy (see Appendix 1, page 33). Because the studies employed different methodologies and focused on different population groups, it is difficult to identify any average or universal effect of the introduction or removal of user fees on service utilisation. This reflects the diversity of user fee policies and their consequent implementation on the ground. Some studies focused on exemptions or the removal of fees for specific population groups only. Even where several studies look at the same policy change, as is the case for Uganda, the differing methods and geographical scope make it difficult to compare the results directly.

Nonetheless, there are some clear patterns that emerge. When other factors are controlled, price

**Table 1: Possible scenarios following fee removal**

| Scenario  | Impact on health service utilisation   |
|---|--|
| <ul style="list-style-type: none"> <li>• High level of fees and limited exemptions</li> <li>• Supportive policy measures put in place</li> </ul>  | 50%–70% increase over two years, level sustained thereafter                    |
| <ul style="list-style-type: none"> <li>• Low level of fees and effective exemptions</li> <li>• Supportive policy measures put in place</li> </ul> | 20%–50% increase over two years, level sustained thereafter                    |
| <ul style="list-style-type: none"> <li>• High or low level of fees</li> <li>• Limited supportive policy measures</li> </ul>                       | Initially a potentially large increase in utilisation, but often not sustained |

elasticities are negative. Price elasticities measure the effect of changing the price or fee level on service use. Negative price elasticities indicate that service use declines as fee levels increase. Where analysis allows for the identification of different utilisation effects by socio-economic or income group, poorer groups generally exhibit a greater effect than richer ones. In other words, poor people are most affected and least likely to use services.

It should be noted that change in service utilisation is determined by a number of factors. The underlying epidemiology of infection and disease, as well as other costs associated with care-seeking behaviour (such as transport, drugs, etc.), are important determinants of increased utilisation after removal of user fees. Furthermore, utilisation is influenced by subjective perceptions of disease and illness as well as other social factors, including status of women as decision-makers about their own and their children's healthcare.

### Other effects to consider

There are other possible effects of removing user fees that are less straightforward. First, one or more services might be 'crowded out' by the increased demand for another service. In South Africa, it appears that when user fees were removed, the increased demand for curative services may have made it more difficult to access preventive services.<sup>27</sup>

Second, services other than the one(s) directly involved in the policy change may also be affected, sometimes in unexpected ways. For example, in Kenya and Ethiopia, when user fees were introduced in public facilities, private facilities experienced an increase in demand.<sup>28</sup> As users face charges in the public system, the private system looks relatively more attractive. Therefore, it is possible that when demand for public services increases due to removal of user fees, private sector providers – who are charging fees – see a reduction in demand.

Third, where fee revenues are retained locally and used for the direct benefit of health workers who collect them, or whose individual decisions

determine how much will be paid, it is possible that there will be increased utilisation of services they provide or manage. This is often called 'supplier-induced' demand. In Vietnamese hospitals, for example, length of stay was found to increase in response to the introduction of fees.<sup>29</sup> Where the user's decision is most important – for example, in making the initial contact with the health system – this kind of effect is not likely. In the same Vietnamese hospitals, numbers of inpatients declined when fees were introduced.

These observations suggest that the correlation between removing user fees and increased service utilisation is not a straightforward one. The relationship between the two requires management of staff incentives; it may also require specific measures to protect preventive services as demand for curative services increases.

### Use Uganda as a benchmark

Evidence suggests that the greatest overall success in terms of removing fees and improving utilisation has been achieved in Uganda. We are therefore using Uganda's experience to show what is possible when support measures are taken alongside the removal of user fees in a context of high financial barriers to access (high user fees and ineffective exemptions system).

Table 2 overleaf is an extract of some of the relevant data from the summary of studies in Appendix I. The data could be interpreted to suggest that it is possible to achieve an increase of 20% in utilisation rates across the board in the first year, and larger increases still (of up to 70% in total) in the second and subsequent years.

No studies are yet available that consider the longer-term pattern. We have therefore undertaken some further analysis of Ugandan data to look at the long-term impacts on utilisation, using 2006 Household Survey data that allow for a clear picture of the situation five years after user fees were removed. The data show that Uganda has been able to sustain and further promote the utilisation of health services to benefit the poorest groups

**Table 2: Impact on utilisation in Uganda**

| Study                        | Impact on service utilisation  |
|------------------------------|--|
| Deininger and Mpuga (2004)   | Comparing 2002 and 1999:<br>18.5% increase in new cases treated (children under five)<br>31% increase in new cases treated (children over five)<br>26% increase in referrals<br>28% increase in deliveries<br>34% increase in postnatal care   |
| Burnham <i>et al</i> (2004)  | Comparing 12 months after with eight months before cost-sharing was discontinued:<br>53.3% increase in new cases treated, all ages<br>27.3% increase in new cases treated (children under five)<br>17.2% increase in immunisation (was free beforehand)<br>25.3% increase in antenatal care<br>32.3% increase in family planning |
| Nabyonga <i>et al</i> (2005) | Increase in overall utilisation 2000–2001:<br>25.5% public hospitals<br>44.2% health centres<br><br>Increase in overall utilisation 2001–2002:<br>53.3% public hospitals<br>77.1% health centres   |
| Xu <i>et al</i> (2006)       | Comparing 2000 and 2003:<br>Overall increase in likelihood of utilisation in the case of illness is 125% (which would translate into a 125% increase in utilisation for a constant illness level and population size)  |

relative to richer ones. The tendency to use healthcare in the case of illness continued to increase after 2002. Furthermore, while utilisation rates improved for all groups of the population, the most marked increases were among people in the two poorest quintiles. Table 3 below shows healthcare utilisation rates for those who reported illness in 2002 and 2006, respectively, by wealth quintile.

Among those who had reported an illness but were not utilising healthcare services, those citing 'high cost' as a reason declined from 34.2% to 30.8%, while those citing 'illness mild' increased from 40.7% to 45.5%. In other words, the positive trend continued. Analysis that controls for the impact of population, geographic, and economic variables confirms that this trend is due to the removal of user fees and supportive measures.

**Table 3: Utilisation of healthcare in the case of illness by quintile**

| Quintile    | 2002 (%) | 2006 (%) | % increase |
|-------------|----------|----------|------------|
| 1 (poorest) | 72.6     | 79.3     | 9.2        |
| 2           | 79.5     | 86.9     | 9.3        |
| 3           | 83.7     | 88.7     | 5.9        |
| 4           | 86.7     | 90.8     | 4.7        |
| 5 (richest) | 87.0     | 91.6     | 5.3        |
| Overall     | 81.7     | 87.3     | 6.9        |

Source: Uganda Household Survey data 2002, 2006

These results suggest that, in Uganda, it has been possible to sustain a low-cost but reasonably high-quality health system under conditions of increasing utilisation rates, without income from user fees. This was made possible by government investment in the health system, designed to compensate for lost income due to removing fees. It also helped overcome teething problems of the new system, including regular supply of drugs and the impact of increased user demand on staff morale.

Early increases in utilisation have been sustained, with an increase of 20% in the first year after the removal of fees, and 50% in the second year. While utilisation is therefore levelling off at about 70% above the level when user fees were in place, Uganda is still seeing growth rates of 1%–2% per year in the probability of people using healthcare in the case of illness.

Data from some other countries included in the summary in Appendix I does not entirely match Uganda's experience. There are two likely explanations for this. First, the financial barriers to access posed by user fees may not have been as extreme as in Uganda. This may have been the case in South Africa, for example, where the results of removing fees on overall utilisation have been positive, but not as great. Second, supportive policy measures may not have been put in place. This is likely to have a greater effect on long-term as opposed to short-term impact on utilisation rates. Table I (page 16) summarises the three different scenarios to help you estimate the potential impact on utilisation rates in your country.

Step 3 shows you how to estimate additional requirements for human resources and drugs.

# STEP 3: Estimate additional requirements for human resources and drugs

Having carried out Step 2, to estimate the likely increase in service utilisation in your country, you will need to estimate the additional human resource and drug requirements. This may involve a significant data collection exercise if data are not already available.

Data collected in Tanzania, Chad and Malawi are used here to generate estimates, and they may also provide rough estimates for use in other countries. A worked example shows you how to generate accurate estimates. These will, of course, be context-specific and depend on a number of factors outlined below. However, it is possible to say that in general terms, the cost for drugs for every additional user can be estimated at US\$1.5–\$2.

## Human resources

One study has estimated the human resource requirements needed to deliver a package of healthcare capable of achieving the health-related Millennium Development Goals (MDGs).<sup>30</sup> The estimate was based on a review of the tasks involved in delivering basic health services in Chad and Tanzania. The government of Malawi seeks to deliver an Essential Health Package (EHP) similar to the one in Tanzania and Chad, and has specified the target populations and interventions involved.

By combining the data from Tanzania, Malawi and Chad, we are able to estimate the human

resource requirements needed to deliver basic health services; we can also estimate how these requirements might be affected by greater utilisation of health centre-level services.<sup>31</sup> Given the sources, the data can be considered indicative, specifically for countries in sub-Saharan Africa. Ideally, adjustments would be made to reflect the differences in presenting disease burden from Malawi and service delivery details from Chad and Tanzania.

Table 4 opposite shows the skill categories that were used in the task analysis. These skill categories do not correspond to 'jobs' or cadres of health workers. Rather, it is recognised that cadres are differently structured in different health systems and that each country may combine skill categories differently in identifying a cadre. In the Tanzania and Chad case studies, the 18 skill levels were merged into five broader categories consisting of unskilled, nursing and midwifery, clinical, technical, and managerial and administrative.

Table 5 on page 22 shows the total human resource (HR) requirements of the Malawian EHP at health-centre level, expressed in terms of these 18 skill levels (not all of which were applicable in the Malawian context). It shows the total number of minutes required at each skill level. To make this slightly easier to interpret, we have translated these into full-time equivalents (FTEs) or an estimate of the number of workers required. We have done this

**Table 4: Definition of skill categories**

|    |   |
|----|---|
| 1  | Essential nursing care, including monitoring of vital signs and basic maintenance tasks – for example, cleaning of equipment  |
| 2  | Directly observed treatment   |
| 3  | Basic and advanced nursing care of inpatients   |
| 4  | Birth attendance, syndromic management of STIs among female adults  |
| 5  | Diagnostic and patient management of uncomplicated adult cases of infectious diseases such as tuberculosis, malaria, STIs among male patients; basic palliative care; continuation of complex treatment courses initiated at higher levels of the service delivery system |
| 6  | Diagnostic and patient management skills for cases of complicated and severe infectious diseases such as tuberculosis, malaria and HIV/AIDS among children and adults and for emergency care  |
| 7  | Basic laboratory procedures and maintenance of equipment  |
| 8  | Basic radiological procedures and maintenance of equipment  |
| 9  | Distribution (giving out) of drugs  |
| 10 | Management of drug storage and supply at the facility level   |
| 11 | Supervision and management of district health system  |
| 12 | Supervision and management of health facility (other than drug related)   |
| 13 | Counselling of cases of infectious disease, provision of patients with supplies (eg, insecticide treated nets)  |
| 14 | Counselling of pregnancy related risks and family planning, basic obstetric physical examination, monitoring of vital signs, ordering and performance of simple diagnostic tests (eg, urine protein), provision of basic drugs (eg, iron) and supplies (eg, condoms)      |
| 15 | Syndromic management of paediatric diseases   |
| 16 | Emergency obstetric surgery   |
| 17 | Basic anaesthetic procedures, including epidural anaesthesia  |
| 18 | Assistance in the operating theatre   |

Source: Kurowski and Mills, 2006

on the basis of a 35-hour working week, a 46-week working year and by making an allowance of a further 10% of time for professional development activities. This gives a total of 86,940 minutes in a working year. To adjust to local conditions, take the number of minutes in a working year on the basis of national or local terms and conditions and divide the total minute count accordingly.

The total number of users at health centre level associated with this calculation was approximately 7.4 million. The third column of Table 5 shows the number of FTEs at different skill levels required per 10,000 users. These numbers can be multiplied by the utilisation increase estimate (in tens of thousands of users) to generate an estimate of the total requirements for health workers.

**Table 5: Total HR skill requirements for Malawian EHP at health-centre level**

| Skill level | Estimate in minutes | Estimate in FTEs | FTEs per 10,000 health centre users |
|-------------|---------------------|------------------|-------------------------------------|
| 1           | 33,548,589          | 386              | 0.52                                |
| 2           | 8,531,704           | 98               | 0.13                                |
| 4           | 670,123,649         | 7,708            | 10.48                               |
| 5           | 47,710,376          | 549              | 0.75                                |
| 6           | 523,771,797         | 6,025            | 8.19                                |
| 7           | 920,227,857         | 10,585           | 14.39                               |
| 9           | 82,168,133          | 945              | 1.29                                |
| 13          | 473,638,046         | 5,448            | 7.41                                |
| 14          | 27,710,344          | 319              | 0.43                                |

### A worked example: estimating human resource requirements

In country X, the skill levels represented in the health centre are considered to best equate to the local cadres as follows:

- Levels 1, 2 and 13: Basic trained nurse
- Levels 4, 5 and 6: Medical assistant
- Level 7: Laboratory technician
- Level 9: Pharmacy technician
- Level 14: Midwife

Country X has estimated that the increase in utilisation as a result of removing user fees in the average health centre will be 5,000 users per year. Hence, in each health centre, country X will need:

- Basic trained nurse  $(0.52 + 0.13 + 7.41) \times 5,000/10,000 = 4.03$
- Medical assistant  $(10.48 + 0.75 + 8.19) \times 5,000/10,000 = 9.71$
- Laboratory technician  $14.39 \times 5,000/10,000 = 7.20$
- Pharmacy technician  $1.29 \times 5,000/10,000 = 0.645$
- Midwife  $0.43 \times 5,000/10,000 = 0.21$

In principle, all these numbers should be rounded up, implying that each health centre will require the following new staff: five basic trained nurses, ten medical assistants, eight laboratory technicians, one pharmacy technician and one midwife.

This guide focuses on increased utilisation as a result of removing fees at the health-centre level. Similar calculations of HR requirements for community<sup>32</sup> and hospital levels are included in Appendix 2 (see page 41). These will be relevant for countries removing fees at community and hospital level or considering possible implications for hospitals of increased health centre utilisation.

## Drugs

Based on the Malawian Essential Health Package (EHP), an exercise similar to the one on human resource requirements was conducted to estimate the drug requirements associated with increased service utilisation.

For the Malawian EHP model, interventions, treatment lines and associated drug regimens have been defined. These are likely to differ from those

in other countries. The mix of users requiring different interventions will also differ, depending on the epidemiological profile of countries, and the uptake of services by different users. Finally, prices at which drugs are procured and retailed vary greatly, even within the African continent.

Table 6 below estimates the drug costs at health-centre level in the Malawian EHP. (For community and hospital levels, see Appendix 2.) The results show that the drug budget requirement per additional user is US\$1.76.<sup>33</sup> However, because of the reasons stated above, this estimate can only be used as a guide. The table below shows the distribution of users associated with each condition, and the relative drug costs. These can be used as a basis to estimate how drug costs might differ in your country.

The box overleaf gives a worked example, showing how a specific country might use the data.

**Table 6: Malawi EHP national drug costs at health-centre level (US\$) for one year**

|  | Number of users   | Total drug costs  | Drug cost per user |
|--|-------------------|-------------------|--------------------|
| Vaccine-preventable disease                          | 613,357           | 214,675           | 0.35               |
| Acute respiratory infection (ARI)                    | 1,303,942         | 74,139            | 0.05               |
| Malaria  | 2,512,550         | 3,525,544         | 1.40               |
| Adverse maternal/neonatal conditions                 | 2,409,595         | 3,016,453         | 1.25               |
| Tuberculosis   | 284,390           | 581,423           | 0.28               |
| Acute diarrhoeal disease                             | 854,959           | 189,488           | 0.22               |
| Sexually transmitted infections (STIs) including HIV | 2,289,212         | 11,419,979        | 4.99               |
| Schistosomiasis                                      | 477,056           | 138,346           | 0.28               |
| Nutritional deficiencies                             | 0                 | 0                 | 0                  |
| Eye, ear and skin conditions                         | 128,916           | 54,106            | 0.42               |
| Common injuries and poisoning                        | 56,583            | 65,598            | 0.40               |
| <b>Total</b>   | <b>10,930,560</b> | <b>19,279,751</b> | <b>1.76</b>        |



## A worked example: estimating budgetary requirements for drugs

Country X has estimated that the increase in utilisation as a result of removing user fees in the average health centre will be 5,000 users per year.

As a starting point, country X might estimate the additional drug budget per health centre per year to manage this additional workload as:

$$5,000 \times \text{US\$}1.76 = \text{US\$}8,800$$

However, looking at the Malawian drug price list, health planners in country X consider that they are paying prices 20% higher on average than in Malawi in January 2008. This might be because prices have risen since then, or because country X faces procurement difficulties. The planners will look into the efficiency of procurement; it may be that loss of revenue from removing user fees could be offset to some extent by savings in procurement.

Looking at the distribution of service users across country X's health system, differences are not substantial, except that country X has a lower rate of utilisation for STIs, including HIV. This is probably because country X has a lower prevalence of HIV, but it might also be because its AIDS treatment programme is less developed. Country X has approximately half the number of users in this category in proportionate terms (Malawi has about 20% of users in this category, country X about 10%). This category has by far the highest drug cost, so this will reduce the overall average drug cost per user in country X. Entering only half the users and half the drug cost into Table 5 reduces the drug cost estimate to US\$1.38.

Country X therefore estimates its drug cost per user to be  $\text{US\$}1.38 + 20\% = \text{US\$}1.66$ , and the cost for the additional workload to be:

$$5,000 \times \text{US\$}1.66 = \text{US\$}8,300$$

To sum up, generating estimates for additional human resource and drug requirements at health centre level is relatively straightforward, provided that you have access to some key data and have made a sound estimate of increased utilisation as a result of removing user fees. You can estimate how many and what type of additional health staff will

be needed in each health centre, and what the additional demand will mean in terms of increased drugs budget.

Step 4 deals with mobilising additional funding for complementary policies to support the removal of user fees.

# STEP 4: Mobilise additional funding

Options for identifying new sources of finance will vary greatly from one country to another. Uganda, for example, benefited from the Heavily Indebted Poor Countries (HIPC) initiative, which enabled it to invest in improved health systems at the same time as removing user fees. This kind of investment, focused on enabling poorer sections of the population to access services, can deliver an important element of a Poverty Reduction Strategy Paper, on which debt relief under the HIPC initiative is contingent. If your country is eligible, your government will already be engaged in dialogue with the International Monetary Fund (IMF) towards achieving irrevocable debt relief, and it may be useful to propose a user fee removal policy within that framework.

Other potential funding sources include those with a disease-specific focus. Measures to strengthen health systems, such as the removal of user fees, are now eligible for funding from The Global Fund to Fight AIDS, Tuberculosis and Malaria. Your country's application to the Global Fund may therefore provide another framework through which an adequately funded user fee removal programme could be supported.

It is also worth exploring the extent to which other HIV and AIDS programmes, such as the Clinton Foundation HIV/AIDS Initiative and the United States President's Emergency Plan for AIDS Relief (PEPFAR), may be willing to support plans to increase people's access to the health system. If you can demonstrate that people's failure to use the health system in general is constraining success in the fight against HIV and AIDS in your country, this may be more likely. Moreover, the GAVI Alliance

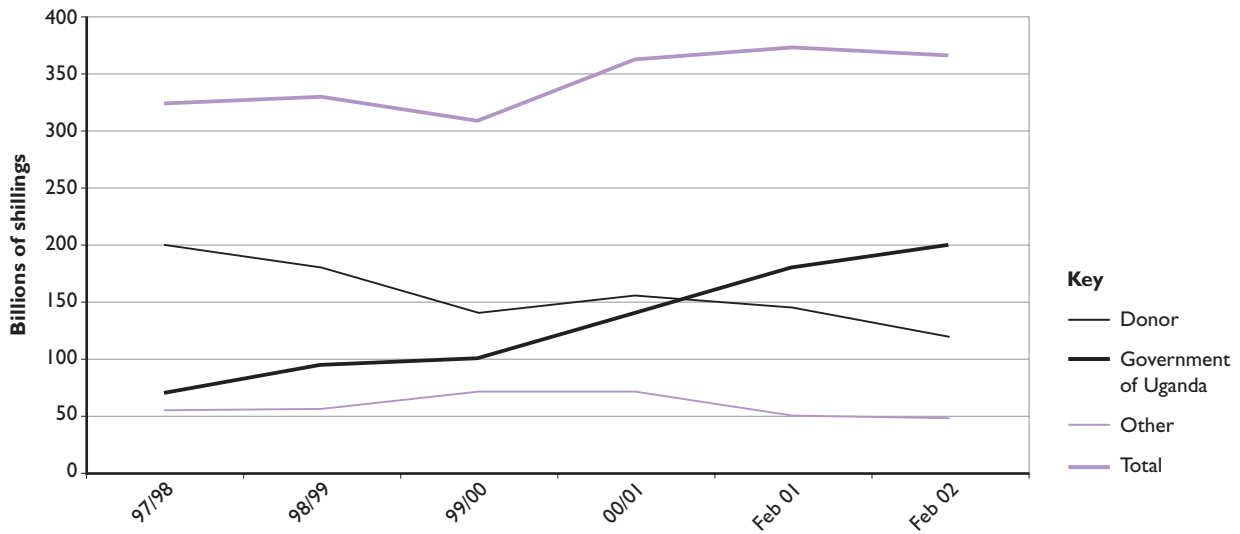
has recently made a substantial amount of funding available for health systems strengthening that focuses on the provision of child and maternal health services. And the International Health Partnership, while not a funding mechanism per se, provides an important opportunity as it helps member countries with good health sector plans to access funding, particularly to accelerate progress towards MDGs 4 (reduce child mortality) and 5 (improve maternal health). The ten fully inaugurated countries are: Burundi, Cambodia, Ethiopia, Kenya, Madagascar, Mali, Mozambique, Nepal, Nigeria and Zambia.

Even if additional funds from external sources are not available, there may be scope for reallocation of resources within the national budget or within the health budget. Uganda's user fee removal programme benefited from increased public expenditure for the health sector and a growing public sector budget overall. These were, in turn, supported by a sector-wide approach that emphasised support for primary healthcare, in line with the intentions of the policy to remove user fees. Resources were reallocated towards primary healthcare at the same time.

## The case of Uganda: accessing resources to offset removal of user fees

Figure 5 overleaf shows the trends in funding sources in the Ugandan health system before and after user fees were removed.<sup>34</sup> It demonstrates that total resources were increasing, and that there was a marked increase in government spending

**Figure 5: Trends in funding sources contributing to the Health Sector Strategic Plan 1997/98 to 2002/03**



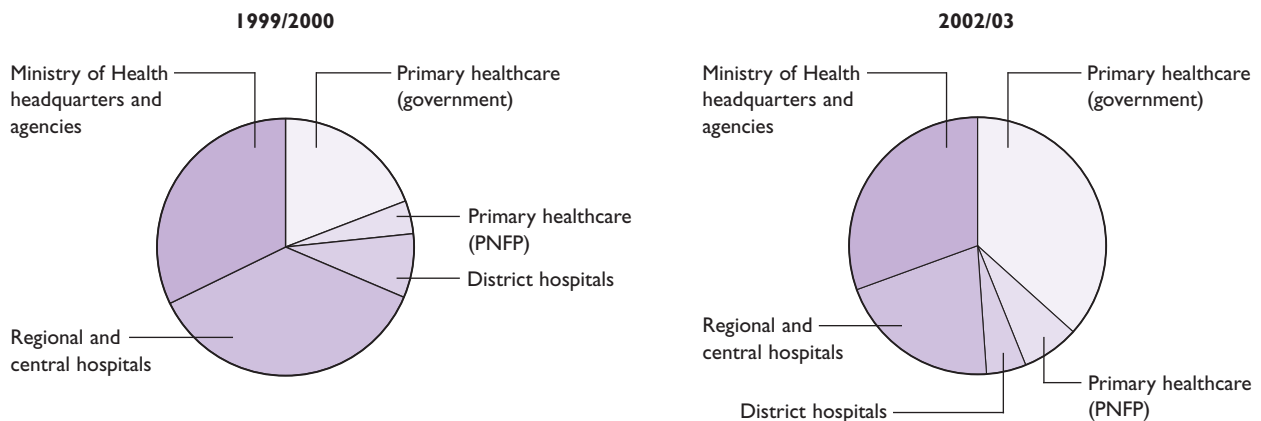
when fees were removed (2001). Resources channelled through the government’s own budget (some originating in external general budgetary support), increasingly allocated to the health sector, ensured a supportive environment for the policy, rather than funds generated from donors. This may have been important because it allowed the government to control how additional funds were spent in the health system as a whole.

Figure 6 shows that in addition to further allocations for the health sector overall,

reallocations within the health sector over the same period increasingly favoured primary healthcare (where increased utilisation was most evident) over hospital care.

Once you have identified additional sources of funding, whether external or from reallocations within national or sector budgets, there is another key step to follow. Step 5 deals with effective communication, including engaging key stakeholder groups to ensure that the policy of removing user fees is successfully implemented.

**Figure 6: Ugandan national health budget allocations by sector, 1999/2000 and 2002/03**



# STEP 5: Communicate the policy change

Communication is also key to success in effecting a policy change to remove fees. It ensures that users know about the policy and demand their right to free healthcare. It is also crucial for healthcare providers to know exactly which services are free at the point of use and which ones are not. And it is critical for building and sustaining political support. The process of communicating the policy change should begin at the very start, when the initial planning is being done.

By ‘communication’, we mean more than just a one-way process of giving information. Across a wide range of contexts it has been shown that behaviour change – such as encouraging people to seek treatment when they are ill – cannot be achieved on the basis of giving information alone. Other elements are required to engender confidence in the exchange, and hence in the information communicated. Nevertheless, in reality, attention is often focused on one-sided provision of information and, thus, communication overall is not as successful as it could be. Good ‘public engagement strategies’ focus on achieving all of the following:<sup>35</sup>

- communicating information
- consulting
- achieving active participation
- attracting and managing wide public representation
- dealing with all involved parties fairly
- enabling a three dimensional flow of information and questioning
- assuring that recommendations of participants will be used in decision-making.

## Engage and manage stakeholders

Policy reform is an inherently political process. As such, its outcome is influenced not only by the contents of the planned policy change, but by the actors that have an interest or stake in the issue. Therefore, you need to give full consideration to both aspects. It is important not to restrict policy dialogue to health sector stakeholders, as health financing decisions typically have political and financial implications that reach far beyond the health sector. A strategy to remove user fees needs to identify and seek support from like-minded actors, while minimising resistance from those who might be opposed to the policy reform.

Actors who typically play a prominent role in shaping decision-making regarding health financing include the presidency or office of the prime minister, ministries of health and finance, local government authorities, the World Bank and other development partners. Some UN agencies, NGOs and academic institutions have considerable expertise on this issue, but their power in shaping the course of action varies. They can nevertheless be important allies, providers of technical support, and otherwise facilitators in implementing a fee-free policy.

One of the key stakeholder groups to get on board are health workers. They are the patient’s first point of contact with the health system, and they strongly influence how a patient perceives the quality of care, whether this is objective or not. Where health workers do not support a policy of fee removal –

for example, because they fear loss of income – they can act as gatekeepers and prevent the policy from being implemented by continuing to charge fees at their own discretion. You may need to develop effective staff communication strategies that provide opportunities for dialogue, in order to enhance acceptability of the new policy and maintain morale.<sup>36</sup> Meetings between senior health managers and local-level health workers, as well as supervision visits and newsletters, are recommended in this regard.

## Inform the public

The removal of user fees in Uganda, as we have seen, has been one of the most successfully implemented policy changes, as well as one of the best documented. Some attribute its success to the effective policy of information dissemination. The policy was supported at the highest level (it was an initiative of the President himself), which resulted in its wide dissemination through the media and other channels. This ensured that Ugandans were made fully aware of the policy change, and that they knew about their right to free healthcare when they arrived at health facilities. It also helped that the message to be communicated was a simple one – all government health services were to be free to everyone.<sup>37</sup>

In other countries, if at all possible, the launch of the policy by the head of state in a blaze of publicity is highly recommended. Failing that, a communication strategy may require careful planning because it may be more difficult to garner interest from the media. You should try to engage all forms of media to let people know that they now have the right to free healthcare – for example, an advertising campaign could use posters and radio, and the Minister of Health and other health officials could use radio interviews to promote the message. It may also be appropriate to advertise a mechanism by which members of the public can report instances where fees are still being charged.

To sum up, communicating the policy change effectively and engaging key stakeholders is crucial. You will need to involve the mass media to inform the public about their new right to free basic healthcare. Your communication strategy will also need to identify other means of communication for government officials, health workers and others who are instrumental to the success of policy implementation. In order to be effective, communication must take a consultative approach and ensure that stakeholders feel heard and taken seriously.

# Summary and conclusions

There is a great deal of evidence to show that user fees prevent people accessing health services, and that poor people are affected the most. It is both necessary and feasible to remove user fees in order to help poorer people – and in some countries that means the majority – access basic healthcare. In turn, this will help your country accelerate its progress towards achieving the health-related MDGs. It will also bring wider benefits, as a healthy population is key to driving economic growth and development.

Removing user fees requires careful planning, including supportive policies to address increased service utilisation and loss of revenue. Removing fees without giving adequate consideration to these associated impacts means that the policy change may fail to achieve the desired results. When uptake of health services increases as a result of fee removal, it affects other parts of the system, from staff workload to demand for drugs and medical supplies. While lost revenues are likely to be relatively insignificant overall, extra resources will be required at local level to fund the additional human resources and drugs required, and to cover items currently funded through user fee revenues, especially at health centre level.

It is important to remember that a policy change to remove user fees will not, in itself, improve people's access to healthcare – the policy needs to be *implemented* successfully to have a real impact on people's health. Furthermore, implementation is about more than technical considerations. You are likely to achieve the greatest impact

where the whole process – from early planning to implementation – is backed by political commitment and good communication.

This guide has explained the five steps you need to follow to successfully remove user fees. Here is a summary of the key considerations involved:

## Increased service utilisation

Removing user fees means that service utilisation is likely to increase. While the rate of increase needs to be estimated for every country individually, the Ugandan experience suggests that increases of as much as 20% in the first year and 50% in the second year can be achieved, with further moderate growth thereafter.

## Resource implications of increased utilisation

Increased utilisation of the health system has resource implications, particularly for human resources and drugs. For human resources, our estimates suggest you will need about four health workers for every additional 1,000 patients using your health system per year. For drugs, our estimates suggest you will need US\$1,500–\$2,000 for every additional 1,000 patients using your health system. However, to arrive at good estimates you will need to follow the process for making calculations based on data from your country as outlined in Step 3.

## Mobilising additional funding

It follows on that increased utilisation of the health system will require additional funding. You may need to seek external funding, from sources such as the HIPC Initiative, the Global Fund, the GAVI Alliance, etc. Or you may be able to make efficiency savings internally or reallocate expenditure within the national or health sector budget.

## Finding a balance

It is important that you find the right balance between rushing the policy reform and taking an over-cautious approach, as both extremes can result in failure. The benefits of removing user fees on a larger scale are likely to outweigh any difficulties that arise during implementation, even if the preparatory work has been limited. Therefore, it is desirable to plan to implement the policy throughout the country, rather than pilot it in a few districts only.

## Political commitment

The Ugandan case shows that fee removal, like almost any policy change, is most effective when there is strong political commitment demonstrated by high-level leadership. This helps the people responsible for implementing the policy change, and the people who will benefit from it, to take it seriously, which increases the likelihood of success. However, political leaders will depend on the support of – or at least absence of resistance by – important stakeholder groups.

## Informing the public of their right to free healthcare

The people who use health services are one of the most important stakeholder groups, and they need to be made fully aware of the policy change so that they can demand their right to free healthcare. This is most easily achieved by publicising the policy change through a mass-media campaign. Having the highest-level politicians leading the campaign – as was the case with President Museveni in Uganda – can go a long way in attracting media interest and opening other channels for communication and campaigning.

## Engaging other key stakeholders

While users are a very important stakeholder group, health workers, high-level government officials and other groups will play a key role in successfully implementing the policy change. In order to deal with resistance effectively and to gain support for the new policy, those stakeholder groups need to be engaged early on in the policy-making process. Their concerns need to be taken seriously and their needs and motivations understood. Such understanding, facilitated by a consultative approach to communication, will help engender confidence and build support for the new policy, as well as minimising potential resistance.



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# Appendix I: Summary of studies reporting impact of user fees on service utilisation

**Table 7: User fees: effects on utilisation – results from 22 published studies (see page 31 for complete references)**

| Study                          | Country/District             | Change of user fee policy analysed                           | Measure of utilisation used   | Measured utilisation response  | Other variables   | Comments   |
|--------------------------------|------------------------------|--|---|--|---|--|
| Jacobs and Price (2006)        | Cambodia (Kirivong district) | Effect of an equity fund (paying the fees for poor patients) | Use of health services by Equity Fund beneficiaries (EFBs) compared to non-beneficiaries (NBs)  | The proportion of ill adults who sought care the same day as illness started was greater for EFBs (50%) than for NBs (34%). The NBs waited on average 3 days to seek care, whereas EFBs waited 1.5 days  | 38% of the EFBs who did not seek care or delayed seeking care cited the reason as not having money for transport  |  |
| Biritwum (1994)                | Ghana                        | Introduction of fees   | Outpatient attendance   | 40% decrease   |   |  |
| Asfaw, Braun and Klasen (2004) | Ethiopia (4 regions)         | Introduction of fees   | Analyses user fees “demand reduction” (own price elasticity) and “demand diversion” (cross-price elasticity <sup>38</sup> ) among poorest rural individuals. Services analysed: hospitals, public clinics, private clinics, traditional healers and self-care | Own price-elasticities negative for all (highest -1.34 for public clinics followed by hospitals -1.06); cross price-elasticity positive for all (for public clinics and hospitals 0.231, private clinics 0.307 and 0.231 for self-care – reduction effect) | 10% increase in the level of user fees in public clinics will result in an increase in the probability of self-care by 1.67% (richest) and 2.25% (poorest). The same increase will result in an increase in demand for private clinics by 0.76% (poorest) and 1.87% (richest) | Increases in the level of user fees drive out a significant portion of the poorest households from the healthcare market |

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Table 7 continued

| Study                       | Country/District    | Change of user fee policy analysed  | Measure of utilisation used  | Measured utilisation response  | Other variables   | Comments  |
|-----------------------------|---------------------|---|--|--|---|---|
| Mwabu et al (1995)          | Kenya (2 districts) | User fee introduced (1989), suspended (1990) and reintroduced (1990)          | Number of visits in government health centres and dispensaries and in private and non-governmental health facilities | 52.17% decrease of visits in public facilities with the introduction (rise of K.Sh.11.42 in costs) and subsequent 42% increase with the removal (fall of 8.71 in costs). Private attendance: -17.68% with introduction of fees and subsequently -32.26% with their removal | Costs for households with the implementation/ removal/ implementation; analysis of user fees revenue                        | 1.5% of the patients who sought treatment could not afford the fees charged in the public sector (0.9% after their removal)   |
| Willis and Leighton (1995)  | Kenya               | Introduction of fees  | Outpatient attendance  | 27% fall at provincial hospitals; 46% at district hospitals; and 33% at health centres   |   |   |
| Fafchamps and Minten (2007) | Madagascar          | User fee removal  | Outpatient visits at rural health centres  | 25% increase   | Drug availability, household asset variable, health worker availability   |   |
| Pokhrel et al (2005)        | Nepal               | Evaluate the effect of user fees on utilisation of children's health services | Use of formal care (public or private providers), effects on utilisation of subsidies and user fee increase          | Overall price elasticity: -0.16, ranged from -0.11 (richest) to -0.23 (poorest). Price elasticity falls as price increases. Probability of use at current average price: 59* (general), 43 (poorest), 74 (richest).<br>* % of parents seek any type of care for children   | Analysis of subsidy: 100% subsidy will increase overall utilisation by 56%, varying from 95.3% (poorest) to 31.1% (richest) | User fees increase: 100% increase led to an overall reduction of 12% in utilisation, from -25.6% (poorest) to -4.1% (richest) |

continued opposite

Table 7 continued

| Study                       | Country/District                                   | Change of user fee policy analysed                  | Measure of utilisation used  | Measured utilisation response   | Other variables   | Comments   |
|-----------------------------|--|---|--|---|---|--|
| Meuwissen (2002)            | Niger (Tillaberi district)                         | Introduction of user fees                           | Medical consultation (outpatient attendance)   | Immediate decrease in medical consultation after the user fees introduction. Fall of 41% in the number of new outpatients. The number of women delivering at health facilities was slightly influenced by the fees introduction and the number of women attending antenatal care was not affected | Attendance for conjunctivitis (top ten disease) dropped by less than 2% |  |
| Schneider et al (1997)      | South Africa (Soweto community healthcare centres) | User fee removal for primary healthcare (PHC)       | Antenatal visits   | Increase of 3.8% (1994/95) followed by 10.5% decrease (1995/96)   |   |  |
| Schneider and Gilson (1999) | South Africa (13 sites)                            | User fee removal for maternal and child care (1994) | Total visits over 12 months pre- and post-change. Antenatal care and deliveries booked | Antenatal attendance: increased in 8 of 13 sites (average increase 14.9%). Booked delivery increase of 4.6%. Different figures across districts   |   | Increases in antenatal attendance were followed by a decline to levels lower than beforehand |

continued overleaf

Table 7 continued

| Study                   | Country/District     | Change of user fee policy analysed   | Measure of utilisation used  | Measured utilisation response  | Other variables  | Comments  |
|-------------------------|----------------------|--|--|--|--|---|
| Wilkinson et al (2001)  | South Africa (rural) | User fee removal for under 6s and pregnant women (1994) and subsequently for all PHC services (1997) | Numbers of attendances for (Y): antenatal care (ANC), immunisation and growth monitoring (<6), and curative services<br><b>(Y = B1 + B2Time)</b> | <b>BI estimates</b><br>(approximate annual % change, 1992–8)<br>Curative services<br>Total +80.3 (22%)<br>New +13.9 (5%)<br>ANC<br>Total -5.23 (-0.8%)<br>New -1.49 (-0.7%)<br>Under 6 care<br>Total -34.7 (-0.9%)<br>New -3.8 (-0.8%) |  | Increase in the number of consultations for curative services (almost twice) and decrease in the number of attendances for preventive care. User fees removal increased access but the subsequent fall in service quality reduced the numbers of women demanding services (ANC and under 6) |
| Kim, Ko and Yang (2005) | South Korea          | Introduction of fees (cost-sharing in insurance system)  | Estimated the effect of price and time on the number of physician visits in the last 2 weeks   | Price elasticity <sup>39</sup> for whole population: <b>-0.14</b> (highly significant); Time elasticity: <b>-0.2</b> (not significant)   | Price elasticities are higher for low-income individuals <b>(-0.21, -0.16, -0.07)</b> , increasing in income) and general hospital users are less price-sensitive <b>(-0.10)</b> than the users of other health facilities (clinic <b>-0.18</b> ; hospital <b>-0.19</b> ; traditional clinics <b>-0.20</b> ) | Time elasticities are higher for high-income individuals <b>(-0.03)</b> and for general hospital visits <b>(-0.08)</b>  |

continued opposite

Table 7 continued

| Study                      | Country/District | Change of user fee policy analysed   | Measure of utilisation used   | Measured utilisation response   | Other variables   | Comments  |
|----------------------------|------------------|--|---|---|---|---|
| Abdu <i>et al</i> (2004)   | Sudan            | User fee exemption for malaria treatment for children (under 6) and pregnant women | Effect of different levels of exemption (0%, 25%, 50%, 75%) on utilisation and treatment-seeking behaviour                              | Correlation coefficient between level of exemption and relative increase of malaria cases seen: <b>0.80</b> (children + pregnant women); change in relative number of first visits to health centres: <b>0.80</b> (children) and <b>0.63</b> (pregnant women); relative change in early seeking of care <b>0.80</b> (children) and <b>0.40</b> (pregnant women)   | Percentage difference in the number of those who self-diagnose and level of exemption: <b>-1.0</b> (children) and <b>-0.80</b> (pregnant women)   | Exemption from user fees improved utilisation and healthcare-seeking behaviour for both children and pregnant women |
| Deininger and Mpuga (2004) | Uganda           | User fees removal  | Utilisation of ill individuals; number of work days lost due to sickness; and services provision<br><br>Expansion in services provision | Increase in utilisation of 10% by those who fell ill; number of workdays lost decreased by <b>1.3 days</b> ; share of sick individuals reporting high cost as a barrier to use of services fell by <b>15%</b><br><br><b>18.5%</b> increase in new cases treated for under 5 and <b>31%</b> for over 5, <b>26%</b> increase in referrals. <b>61%</b> for Vitamin A supp. <b>28%</b> for deliveries at unit, <b>34%</b> for postnatal cases | Percentage of individuals who visited hospital when sick increased by <b>10.12%</b> . Decrease in availability of antibiotics and malarial drugs in public hospitals<br><br>Results vary across regions | Descriptive evidence<br><br>Econometric results   |

continued overleaf

Table 7 continued

| Study  | Country/District      | Change of user fee policy analysed | Measure of utilisation used  | Measured utilisation response  | Other variables   | Comments  |
|--|-----------------------|------------------------------------|--|--|---|---|
| Deininger and Mpuga (2004)<br><i>continued</i> | Uganda                | User fees removal                  | Probability of individuals reporting both illness and failure to consult for reasons of cost = 'rationing'<br><br>Morbidity (probability of an individual falling ill)   | Probability of being rationed reduced by <b>8%</b> for adults and <b>11.5%</b> for children<br><br>Probability of being ill was not significantly changed on aggregate. However, reduced for specific groups: <b>4.4%</b> decrease for children                              | Results vary across regions<br><br>Results vary across regions (fall in east, north and west) increase in the others  | Econometric results<br><br>Econometric results  |
| Burnham et al (2004)                           | Uganda (10 districts) | User fee removal                   | New visits (total and children aged under 5) and re-attendance (under 5, all ages, antenatal, family planning) <b>8 months</b> before and <b>12 months</b> after removal | Increase in the mean monthly new visits (b-a/b): <b>+53.3%</b> all ages and <b>+27.3%</b> under 5; workload for health workers: <b>+46.9%</b> ; immunisations for under 5: <b>+17.2%</b> (was free before); antenatal visits: <b>+25.3%</b> ; family planning: <b>+32.3%</b> | Increase in the average re-attendance: <b>24.3%</b> all ages and <b>81.3%</b> under 5. The highest increase in new attendance (Oct 2001) was <b>59%</b> and after 12 months the increase was <b>28.18%</b> (Mar 2002) | Health workers perceptions: <b>73.9%</b> interviewed felt people have better access; negative effects: lack of funds for essential drugs ( <b>39.7%</b> ) and staff support ( <b>53.4%</b> ). Had a more negative attitude toward their work ( <b>66.7%</b> ). Under 5 varied much less in the whole period |

*continued opposite*

Table 7 continued

| Study                 | Country/District                       | Change of user fee policy analysed | Measure of utilisation used   | Measured utilisation response  | Other variables   | Comments   |
|-----------------------|--|------------------------------------|---|--|---|--|
| Nabyonga et al (2005) | Uganda (6 districts, 1 in each region) | User fee removal                   | Overall utilisation pattern and use among vulnerable groups (women, children and the poor)                                  | Utilisation in public hospitals increased by <b>25.5%</b> in 2001 and <b>55.3%</b> in 2002 (both compared with 2000); in health centres the increases were <b>44.2%</b> in 2001 and <b>77.1%</b> in 2002                           | In the villages near the public health centres the increase in utilisation was greater among the poorest. The analysis by age shows that in lower-level facilities the increase was greater among over 5s than under 5s. Outpatient utilisation by gender: there is no significant change after the removal; the same for preventive care | In contrast to outpatient attendance, the inpatient admission trends remained similar over the period (2000, 2001 and 2002). Overall there was a significant increase in outpatient utilisation in public facilities, benefiting the poor: in particular |
| Xu et al (2006)       | Uganda                                 | User fee removal                   | Health services utilisation and catastrophic health expenditures  | Dummies for time: public facility (OR <sup>40</sup> 1997 = <b>0.843</b> ; OR 2003 = <b>2.255</b> ); private facility (OR 1997 = <b>0.759</b> ; OR 2003 = <b>1.782</b> ). For the non-poor, increase in utilisation in both periods | Coefficients: urban (positive in all); age over 65 (less likely to use compared to young); income (weakly correlated with the use of public facility but significantly correlated with private)   | User fees removal made services more accessible (for the poor and non-poor). However, catastrophic health expenditures remained the same for the poor and declined for the non-poor  |
|                       |  |                                    | Health services utilisation for the population reporting illness (percentage of individuals attending each type of service) | Public: <b>+0.27%</b> 2000 and <b>+10.65%</b> in 2003. Private: <b>+7.16%</b> 2000 and <b>+2.49%</b> 2003. No use: <b>-7.9%</b> 2000 and <b>-16.18%</b> 2003   | Analysis for the non-poor showed increase in utilisation for all types of services  | The number of individuals facing catastrophic expenditures among the poor was 6.22% in 1997, 2.35% in 2000 and 3.11% in 2003   |

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Table 7 continued

| Study                      | Country/District                    | Change of user fee policy analysed                  | Measure of utilisation used   | Measured utilisation response  | Other variables  | Comments   |
|----------------------------|-------------------------------------|---|---|--|--|--|
| Sepehri et al (2005)       | Vietnam                             | Introduction of fees 1989                           | User fees impact on providers' behaviour (providers better able to influence length of stay in order to increase bonus earnings, than admissions) | Inpatient admission fell 52% between 1993 and 1998 (length of stay grew 83%)   | Length of stay became more inequitable with the user fee introduction. Richer groups benefited (increased the difference between 1st and 5th quintile from 1993 to 1998) | Possible recall bias in the inpatient admission rates (52% fall in the paper, 25% reported by MoH)     |
| Malama et al (2002)        | Zambia (rural hospital attendances) | Introduction of fees since 1982 for children over 5 | Evaluate healthcare utilisation among children in hospital where user fees in place since 1982  | Utilisation by age and gender were not independently significantly affected by user fees, but were in combination – female children were disadvantaged |  | Analysis suggests user fees selectively decrease hospital admission of female children in rural Zambia |
| Bias and Limbambala (2001) | Zambia                              | Introduction of fees                                | Outpatient attendance and inpatient admissions  | 35% fall of outpatient attendances   | Inpatient admissions remained constant   |  |

# Appendix 2: Tables for calculating HR and drug budgeting requirements at community and hospital level

**Table 8: Total HR skill requirements for Malawian EHP at community level**

| Skill level | Estimate in minutes | Estimate in FTEs | FTEs per 10,000 community users |
|-------------|---------------------|------------------|---------------------------------|
| 1           | 85,297,942          | 981              | 0.89                            |
| 2           | 83,034,984          | 955              | 0.87                            |
| 3           | 60,779,428          | 699              | 0.64                            |
| 4           | 71,239,430          | 819              | 0.75                            |
| 5           | 538,806,764         | 6,197            | 5.60                            |
| 7           | 49,045,600          | 564              | 0.51                            |
| 9           | 91,306,312          | 1,050            | 0.96                            |
| 13          | 270,564,307         | 3,112            | 2.84                            |
| 14          | 35,361,767          | 407              | 0.37                            |
| 15          | 343,149,730         | 3,947            | 3.60                            |

**Table 9: Total HR skill requirements for Malawian EHP at hospital level**

| Skill level | Estimate in minutes | Estimate in FTEs | FTEs per 10,000 hospital users |
|-------------|---------------------|------------------|--------------------------------|
| 1           | 404,900,903         | 4,657            | 31.90                          |
| 2           | 710,975             | 8                | 0.05                           |
| 3           | 1,241,326,249       | 14,294           | 97.90                          |
| 4           | 76,469,857          | 880              | 6.03                           |
| 5           | 166,817,335         | 1,919            | 13.14                          |
| 6           | 200,876,262         | 2,311            | 15.82                          |
| 7           | 729,982,333         | 8,396            | 57.51                          |
| 8           | 24,906,929          | 286              | 1.96                           |
| 9           | 1,751,782           | 20               | 0.14                           |
| 13          | 10,510,691          | 121              | 0.82                           |
| 16          | 300,214,996         | 3,453            | 2.36                           |
| 18          | 195,536,258         | 2,249            | 15.40                          |

**Table 10: Drug costs at community level (US\$)**

|                                      | Number of users   | Total drug costs  | Drug cost per user |
|--------------------------------------|-------------------|-------------------|--------------------|
| Vaccine-preventable disease          | 681,508           | 14,631,981        | 21.47              |
| ARI                                  | 2,238,263         | 52,515            | 0.02               |
| Malaria                              | 4,156,407         | 9,620,603         | 2.31               |
| Adverse maternal/neonatal conditions | 194,295           | 716,420           | 3.69               |
| Tuberculosis                         | 0                 | 0                 | 0                  |
| Acute diarrhoeal disease             | 4,093,338         | 573,067           | 0.14               |
| STIs including HIV                   | 1,660,700         | 637,891           | 0.38               |
| Schistosomiasis                      | 352,647           | 88,162            | 0.25               |
| Nutritional deficiencies             | 4,958,811         | 202,121           | 0.04               |
| Eye, ear and skin conditions         | 533,848           | 229,782           | 0.43               |
| Common injuries and poisoning        | 0                 | 0                 | 0                  |
| <b>Total</b>                         | <b>18,869,817</b> | <b>26,752,542</b> | <b>1.42</b>        |

**Table 11: Drug costs at hospital level (US\$)**

|                                      | Number of users  | Total drug costs  | Drug cost per user |
|--------------------------------------|------------------|-------------------|--------------------|
| Vaccine-preventable disease          | 68,151           | 269,196           | 3.95               |
| ARI                                  | 239,169          | 389,353           | 1.63               |
| Malaria                              | 143,881          | 249,429           | 1.73               |
| Adverse maternal/neonatal conditions | 1,132,887        | 17,316,364        | 15.29              |
| Tuberculosis                         | 284,390          | 447,895           | 1.57               |
| Acute diarrhoeal disease             | 8,384            | 52,651            | 6.28               |
| STIs including HIV                   | 250,255          | 1,705,546         | 6.82               |
| Schistosomiasis                      | 0                | 0                 | 0                  |
| Nutritional deficiencies             | 30,833           | 33,608            | 1.09               |
| Eye, ear and skin conditions         | 0                | 0                 | 0                  |
| Common injuries and poisoning        | 133,917          | 353,804           | 2.64               |
| <b>Total</b>                         | <b>2,291,867</b> | <b>20,817,846</b> | <b>9.08</b>        |

# Endnotes

## Introduction

- <sup>1</sup> Asfaw *et al*, 2004
- <sup>2</sup> Hotchkiss *et al*, 2005
- <sup>3</sup> Malama *et al*, 2002
- <sup>4</sup> Schmidt *et al*, 2008
- <sup>5</sup> Vogel, 1991; Creese, 1991; Hecht *et al*, 1993
- <sup>6</sup> Gilson and McIntyre, 2005; Yates, 2006
- <sup>7</sup> Swiss Agency for Development and Cooperation (SDC) quoted in Hutton, 2002
- <sup>8</sup> Kowalewski *et al*, 2002; Witter, 2005

## Uganda and beyond

- <sup>9</sup> Deininger and Mpuga, 2004
- <sup>10</sup> Fafchamps and Minten, 2007
- <sup>11</sup> Médecins du Monde, 2008
- <sup>12</sup> Médecins Sans Frontières, 2008

## The five steps

- <sup>13</sup> It should be noted that medical supplies such as syringes, gauze, etc, must also be free at the point of access.

## Ensuring quality

- <sup>14</sup> Haddad *et al*, 1998
- <sup>15</sup> Travis-Bassett *et al*, 1995
- <sup>16</sup> Mariko, 2003
- <sup>17</sup> For example, Kirunga-Tashobya *et al*, 2006
- <sup>18</sup> Nazerali *et al*, 2006

## STEP 1: Analyse your starting position

- <sup>19</sup> Vogel, 1991; Creese, 1991
- <sup>20</sup> Singh, 2003
- <sup>21</sup> Van Doorslaer and Wagstaff, 1993

- <sup>22</sup> Nakamba *et al*, 2002

- <sup>23</sup> One USD today equals 3,328 Zambian Kwacha. Source <http://www.exchange-rates.org/currentRates/F/USD> accessed 14 July 2008

- <sup>24</sup> Ghana: GHC 1995 was 1 176 per USD, GNP in 1994 was USD 410; Uganda: UGS 1995 was 1030 per USD, GNP 1994 was USD 190. Sources: World Health Report, 1997; fxhistory: <http://www.oanda.com/convert/fxhistory>

- <sup>25</sup> Sepehri *et al*, 2005; Yates, 2006

- <sup>26</sup> Nyonator and Kutzin, 1999

## STEP 2: Estimate how removing fees will affect service utilisation

- <sup>27</sup> Wilkinson, 2001

- <sup>28</sup> Mwabu *et al*, 1995; Asfaw *et al*, 2004

- <sup>29</sup> Sepehri *et al*, 2005

## STEP 3: Estimate additional requirements for human resources and drugs

- <sup>30</sup> Kurowski and Mills, 2006

- <sup>31</sup> 'Health centre' here is defined in a standard way, ie, indicating a district health system in which health centre level is above dispensary or health post and below district hospital level, serving approximately 5,000–10,000 people.

- <sup>32</sup> Community level refers to below health centre level.

- <sup>33</sup> Calculated using January 2008 prices.

## STEP 4: Mobilise additional funding

- <sup>34</sup> Ssengooba *et al*, 2006

## STEP 5: Communicate the policy change

- <sup>35</sup> Nisker *et al*, 2005

- <sup>36</sup> Gilson and McIntyre, 2005

- <sup>37</sup> Yates, 2006

## **Appendix I: Summary of studies reporting impact of user fees on service utilisation**

<sup>38</sup> Cross-price elasticity compares the proportionate change in the price of one service (for example, public clinic health services) with utilisation response of another (for example, private hospital). Cross-price elasticities are positive if an increase in price in service A leads to an increase in the utilisation of service of B

<sup>39</sup> Price elasticity is a measure of utilisation effect, which compares the proportional change in price with the proportional change in utilisation. A negative number indicates that utilisation falls as price increases – the greater the number, the greater the utilisation change. When elasticity equals 1, the proportionate change in fee and utilisation is the same.



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# Freeing up Healthcare

A guide to removing user fees

Removing user fees is an effective strategy in increasing people's access to healthcare. It can make an important contribution to getting the Millennium Development Goals on child and maternal health back on track.

Using evidence from Uganda and other countries, *Freeing up Healthcare* sets out the five key steps policy-makers and technical staff should take to remove fees for essential healthcare. The guide explains how to:

- analyse your starting position
- estimate how removing fees will affect service utilisation
- estimate additional human resource and drug requirements
- mobilise additional funding
- communicate the policy change.

*Freeing up Healthcare* is a technical guide but it also summarises the key economic and political arguments for removing user fees. It demonstrates that political commitment and effective communication are key ingredients of a successful policy change.

*“... a policy change to remove user fees will not, in itself, improve people's access to healthcare – the policy needs to be implemented successfully to have a real impact on people's health... You are likely to achieve the greatest impact where the whole process – from early planning to implementation – is backed by political commitment and good communication.”*