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Mapping user fees for health care in high-mortality countries: evidence from a recent survey

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In recent years several countries have introduced reforms to user fees; a growing number of countries are also introducing basic health care free at the point of use. In many cases, the focus has been on making health care more accessible for priority groups, particularly pregnant women and young children.

However, despite the high interest in user fee removal, there are many information gaps on the current status of user fees in low-income countries, particularly for those interested in carrying out international comparisons. This paper presents a useful snapshot of some patterns in this changing area of health financing from 49 countries in Africa and Asia.

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1. Introduction

Recent UN and other international initiatives have highlighted the importance of addressing the financial barriers to accessing health care, including user fees, which represent one of main barriers for poor people (Yates 2010).[1] Several countries have reduced or removed user fees, and more are planning to do so. However, user fee removal can have many implications for the wider health system, and is likely to require other policy and management reforms, to ensure for example that health facilities are prepared for increased demand for services and supplies.

Despite the high interest in user fee removal, there has been limited synthesis of current payment arrangements at point of use in low income countries. This paper is based on work commissioned by DFID in 2009 to analyse current practices in relation to user fees in low income countries to help inform decision-making and strategy development at both global and country levels. It draws upon a wider study to develop a health systems typology conducted by McPake et al (2009), which included a survey of key informants from a large number of low-income countries.

Key findings

- User fees are extremely prevalent – only six out of the 50 health systems included here (high mortality countries in Africa and Asia) do not have some form of user fees in the public sector. There is no particular economic pattern to these six countries, though a large number are recently post-conflict.
- Of those with fees, all bar two offer a range of exemptions, mainly focused on communicable diseases but also vulnerable groups such as the very poor. On the whole these are seen as only 'somewhat effective'.
- Estimates for income raised from user fees as a proportion of public resources for health care vary, but the most common estimate is 0-9%.
- A third of respondents thought that informal payments were 'common but low' – this was the most common opinion. There is no clear pattern of relationship between reported informal payments and reported levels of user fees, though five of the six countries with no fees reported informal payments to be rare.
- In terms of overall health financing, out-of-pocket payments are the largest single source for the group as a whole, followed by tax, aid and then pooled private finance (only 9% of the total).
- There have been considerable reform efforts in the past few years in relation to user fees – more than half the countries had introduced some kind of national changes, the most common of which has been to remove fees for deliveries (sometimes all deliveries, sometimes focused on emergency obstetric care) and sometimes also for children. There has also been a growing number of countries introducing free basic health care (by level or service type).

2. Background: the changing role of user fees

User fees for health care have been a feature of the health financing mix in most countries, but increased in importance and frequency, especially in low-income countries, from the 1980s onwards in response to financing gaps for public health provision. There has been considerable controversy about their role, with advocates putting the case for user fees based on the need for additional resources, investment in quality services and reduction of frivolous demand (Litvack and Bodart 1993; World Bank 1987), and opponents providing evidence of negative impacts on utilisation and equity, as well as disappointing performance in relation to revenue collection (Gilson, Russell, and Buse 1995; Witter 2005).

The emerging consensus view emphasises the need for health financing mechanisms which increase risk pooling, move towards the goal of universal coverage and reduce out-of-pocket payments by users (Arhin-Tenkorang 2001). In this context, much of the debate has moved towards the ways in

[1] For example, one of the five pillars of the Consensus for Maternal, Newborn and Child Health, agreed in 2009, includes: 'Removing barriers to access, with services for women and children being free at the point of use where countries choose' (see www.pmnch.org for more details).

which user fees can be rolled back while avoiding further shocks to fragile health systems (Save the Children 2008). While user fees are recognised by most as the 'last resort' method for raising funds for health services, they do provide flexible resources at facility level. If these are lost but not replaced by resources of adequate quantity and quality (e.g timely and flexible), then service quality and effectiveness will deteriorate (Gilson and McIntyre 2005; James et al. 2006; Pearson 2004).

This area of health financing is very dynamic, with many countries introducing reforms to user fees in recent years. The aims of these reforms have typically been to reduce the overall burden of direct payments for users, and/or to target benefits to priority user groups and services. In many cases, with an eye to slow progress towards the Millennium Development Goals, the focus has been on pregnant women and young children (Yates 2009). User fee reduction or removal is one such approach. Many of these policies are still in their early stages and a body of evidence based on thorough evaluations has not yet emerged (Richard, Witter and De Brouwere 2008; Witter 2009).

In addition, there remain many information gaps on the current status of user fees in low-income countries, particularly for those interested in carrying out international comparisons. Which countries charge user fees for health care? What level of fees do they charge? What sort of exemptions do they offer? Are these exemptions effective? How do the official fees interact with informal payments by users? These are all questions of great practical importance as development partners and researchers work to support health financing reforms in these health systems. There is no easy source of answers at present.

In 2008, a survey of key informants from a large number of low-income countries was conducted as part of an exercise to develop a health system typology (McPake et al. 2009). The survey focused on a wide variety of health system variables, identified through literature and discussion; a subset was concerned with user fee policies. In this paper, the responses to the user fee questions are explored in order to provide some empirical answers on the scale and scope of user fees today in low income countries. This information is supplemented with some background data from WHO, which allows us to set the policies in an overall health financing context.

3. Research methods

Selection of countries
The original survey covered 41 high mortality countries[2] and five Indian states. Data were added for the DFID Public Service Agreement (PSA) countries not covered in the survey (using external key informants and published literature). Of the resulting 49 countries 38 are in Africa and 11 in Asia.

Selection of key informants
To identify appropriately knowledgeable respondents, personal contacts of the original research team were approached and 'snowball sampling' was used to further extend the list of potential experts in each country (McPake et al. 2009). The aim was to approach one expert from government, one from an NGO, and one from a donor agency in each country. A number of difficulties were encountered in securing the targeted sample size; in the end 92 respondents were interviewed, including 33 from 11 countries where the full three experts had been successfully interviewed. Many more countries (21) had two respondents, and in 13 countries they only managed to interview one expert.

The survey
The overall survey contained questions on a wide range of features of the health system that could be identified with performance and which might affect maternal, neonatal and child health outcomes. This included variables related to the provision of services, stewardship, financing and integration of services. These were identified through literature reviews and focus group discussions with health systems experts.

The few questions on user fees asked whether there were user fees in the health system, and then whether there were any exemptions. Respondents were asked about the categories of services and users for which exemptions were offered. They were also asked whether the exemptions were effective (with three possible answers); what proportion of public resources were raised from user fees (with five bands of answers); what the situation was in the country in relation to informal payments (with four possible responses) and whether public facilities charged for malaria diagnostics.

[2] Defined as those with an under-five mortality rate of 90 per thousand or above in 2005.

The survey was administered by telephone, though copies of the questions were sent in advance so that informants could prepare themselves. Interviews took 36 minutes on average. Answers were entered into the statistics software, SPSS.

Sources for background information
In order to set the user fee information in a wider health financing context, we supplemented the survey data with background information on health financing, taken from the WHO Statistical Information Service (WHOSIS) in September 2009 (with data mostly drawn from the year 2006), and with information on recent reforms of user fee regimes, based on personal knowledge, available literature and discussion with specific experts.

Study limitations
Researchers from the original study noted some limitations linked to the key informants – namely, that the choice of key informants was based on reputation, rather than any test of expertise; that the range of questions was broad and individuals might not be expected to be able to respond accurately on all areas; and that responses might have been biased towards 'official' answers rather than more realistic assessments.

In addition, the data obtained had problems of :a) incompleteness (particularly for some areas, such as the private sector); b) disagreement between respondents from the same country; and c) an unbalanced design, in that the number of respondents per country varied, ranging from one to four. Using tests for concurrence between different respondents from the same country, the study authors retained the answers to questions about user fees, exemptions and malaria diagnostic charging, but rejected the responses on informal payments.

The supplementary information also suffers from lack of completeness, particularly in terms of the user fee reforms. These are based on published literature and the author's knowledge. There may therefore be other policy reforms which have been omitted.

Reliability and completeness of information
Most of the information (other than the health financing breakdown) is taken from key informants, personal knowledge and literature. It is therefore not guaranteed to be accurate. However, where responses have been checked against known contexts, they have been found to be accurate for most of the questions.

The two questions which elicited the greatest variety of response were those on proportion of public revenue raised by user fees and on informal charges. This is perhaps easy to understand, as in many contexts the extent of informal charging is not publicly disclosed, while the proportion of revenue is quite a technical question.

In addition, the list of countries is not comprehensive, focusing as it does on high-mortality countries in Africa and Asia, with the addition of PSA countries in those regions.

Overall, the survey and additional material reveals a useful snapshot of some patterns in this changing area of health financing, which require further investigation. Table 2 in the Annex shows the country findings on fees and health financing.

4. Overview of findings

Most countries – 88% of those reviewed – continue to apply user fees. Those that do not span a variety of income levels.
The first striking finding from the survey is how few of the countries in this group report that they do not have user fees. Of the 50 countries included (if we count North and South Sudan as two different health systems), only six do not have any form of user fees in the public sector[3]. These are: Angola, Liberia, Malawi, South Sudan, Uganda and (sole in Asia) Timor-Leste. Two countries (Myanmar and Gambia) are undecided about whether they have fees or not. All others apply some form of user fee.

[3] Some countries, such as Sierra Leone, have introduced new free service policies since the survey was undertaken.

On the specific issue of malaria tests, roughly half of the countries report charging for these in their public facilities.

The countries which do not have user fees are not linked by income level. Looking at GDP per capita (in Purchasing Power Parity terms), they range from two of the wealthiest in the group (East Timor, at $5,100 per capita and Angola at $3, 890 per capita) to one close to average (South Sudan, at $1,780, at least for north and south combined), to two below average (Uganda at $880 and Malawi at $690), as well as the poorest of the whole set (Liberia, at $260). Most have recently emerged from conflict, but not all (Uganda and Malawi).

Virtually all of the countries that apply user fees try to exempt at least some users. The effectiveness of this strategy is limited.
Of those with user fees, all bar two (Central African Republic and Mauritania) offer exemptions of some kind. A wide variety of categories are mentioned as exempt, though informants often disagree on which ones. The most commonly cited categories are the poor and TB patients (54% of respondents say 'yes' to these categories), followed by HIV (53%), immunisation (42%), leprosy, maternal conditions and children (35% each), malaria, the elderly and orphans and vulnerable children (17% each), ex-servicemen (10%), the disabled and civil servants (6.5%), the unemployed (3%) and adolescents (1%).

The overall focus of exemptions, then, appears to be on infectious disease control, with the addition of some priority social groups. Some of the responses are surprising. For example, it seems likely that a higher proportion of countries offer free immunisation services than the reported 42%. This may reflect low awareness on the part of key informants, but that, in itself, would be a matter for concern.

Of course, it is well known that exemptions can be theoretical, with poor realisation when patients arrive for services – hence the question of assessing their effectiveness. Overall, the most common verdict is 'somewhat effective' – neither completely ineffectual nor fully effective, which accords with the literature (Bitran and Giedion 2003). Only four countries report a unanimous verdict of 'very effective' – Burundi, Gambia, Niger and South Africa. For some, there is not enough evidence yet (Nepal), while others emphasise that the system works for official fees but not informal barriers (Indonesia) and unofficial charges (Bangladesh).

Reported revenue from user fees tends to be relatively low – but there are exceptions.
The estimates for proportion of public resources raised from user fees vary across informants. Most fall in the lowest band, but a significant clump at higher ranges too. The most common response is 0-9% (43% of respondents – 83% overall responded to this question), followed by 10-19% and 50%+ (12%), 30-49% (9%) and 20 – 29% (6.5%).

Informal payments are most commonly described as routine but low. There is no clear pattern of linkage between user fees and informal payments.
Of the 95% of survey respondents to the informal payments question, 33% reported that 'they are common or routine but are levied at low rates that are of limited significance for access to services'. 26% said that 'they are sometimes levied but are confined to a few areas or a few service types'; 21% reported that 'they are very rare - patients normally receive services free or pay only the formal charge'; 15% reported that 'they are common or routine and levied at high rates with considerable significance for access to services'.

There is no clear pattern between the revenue raised from user fees and the pattern of responses on informal payments. For example, where people report informal payments to be 'rare', they include contexts with no user fees (such as Timor Leste) as well as those with high proportions raised through user fees (e.g. Ethiopia). On the other hand, of the six countries with no user fees, all report informal payments to be rare (with the exception of Uganda, where they are said to be 'common but low').

A range of health financing approaches is in place – but heavy reliance on out-of-pocket expenditure is a common feature (just under 50% of the total for the group as a whole).
All health systems have a mix of financing approaches, but the dominant health financing mechanism (taking into account all sectors, public and private) is out-of-pocket payments, which accounts for 49% of health finance overall for the group, followed by public (domestic) funding (24%), external aid (21%), and finally private risk pooled funding (9%).

It is hard to link the health financing patterns with user fee reforms, given that the health financing data is from 2006 and many of the reforms have taken place since that date. Out-of-pocket expenditure in public sector facilities is also not distinguishable in the total, which often reflects a heavy usage of private facilities (and is also averaged across all socio-economic groups).

The user fee picture is changing rapidly – more than half of the countries have modified user fee policies in recent years.
More than half of the countries in this selection (28 out of 50) have, in recent years, introduced reforms to their user fee regimes. In many cases (see Table 1 and Table 3 in the Annex), the focus has been on priority groups, particularly pregnant women and young children. There is a clear regional focus for this in West Africa, but the approach extends beyond the region. Of the 28 countries, exactly half focus on delivery care (either exclusively or together with curative services for young children).

Table 1. Recent reforms to user fee regimes in the selected countries

Type of reforms to user fee regime	Countries	Number
Fee exemption for priority groups (delivery care; under-fives; in Senegal also for elderly)	Senegal, Ghana, Mali, Niger, Benin, Burkina Faso, Burundi, Kenya, Madagascar, North Sudan, Nepal, Sierra Leone	12
Making all basic health care free (either defined by health service level or by a package of care)	Nepal, Zambia, South Africa, Lesotho, Liberia	5
Addressing financial barriers via social health insurance and community health insurance	Tanzania, Kenya, Rwanda, Ghana	4
Insurance programmes targeted at/subsidised for the poor	Indonesia, China, Vietnam	3
All care in the public sector free	Uganda, South Sudan	2
Vouchers for demand-side costs of deliveries	Bangladesh, Cameroon	2
Area-based exemptions	Afghanistan	1
National programmes free (and demand-side incentives for priority areas such deliveries)	India (and Nepal for deliveries)	1
Health equity funds	Cambodia	1

5. Conclusions

This dataset is based largely on interviews; therefore it cannot be presented as entirely reliable. Moreover, there are disagreements between respondents, even from the same countries, on a number of the variables. However, there is sufficient evidence to suggest some broad patterns, which are interesting for policy-makers and researchers, particularly given the lack of comparative information on some of these topics.

Annex

Findings by country

Table 2 presents the findings by country. Column 1 relates to the question of whether official user fees were in place in the health sector. There was very rarely any disagreement between respondents on this, but where there was, this is indicated.

Column 2 reports on official exemptions where these were in place (clearly, countries with no user fees will not offer exemptions). Respondents were requested to report policies in relation to a range of specified services but were asked to comment on practices in relation to other services. Where there is only one respondent, the categories are taken from their response. Where there are two or three, at least two positive responses to a category are needed for it to be listed here. Column 3 reflects respondents' views on whether exemptions worked or not.

Column 4 gives estimated proportion of public revenue for health which comes from official fees. These estimates varied considerably in some cases. Answers are given as a range. If one respondent reported '0-9%' and another '50%+', then the answer here would be given as '0-50%+'.

The same approach is taken for informal charges in column 5 – the range of answers is reflected in this column. While for some countries there is consensus amongst respondents, for others there was a wide divergence.

For malaria diagnostics, the answer is simply yes (they are charged), or no, or unclear if there is disagreement between respondents.

Columns 6 to 9 present the overall sources of health financing in country (covering both public and private sectors). These are clearly of interest to see if they are linked to responses on user fees and informal payments. The data is derived from WHOSIS. Public funds are divided into public from domestic resources (taxes of various kinds) and public from external development partners. Private expenditure is broken into out-of-pocket payments and private expenditure which passes through some form of risk-sharing mechanism. Out-of-pocket payments will link to user fees, of course, but are broader, as they include a wider range of costs and also payments made to private and informal practitioners of various types.

Column 9 presents information on any recent changes which have been introduced to user fees. This is drawn from literature and from the author's personal knowledge.

Finally, column 10 indicates the number of respondents per country on the survey. Where an outside expert or documents were consulted (for the eight PSA countries which fell outside of the survey group), this is indicated here. The range of respondents (for all countries bar India) is 1 - 4. For India, the five states have been amalgamated, bringing the total to 9.

Rows highlighted with a box indicate DFID PSA countries (at the time of the research). Where no information was available to answer a specific question for these countries, the box was left blank.

Table 2. Findings on fees and health financing for selected countries

Country	Official user fees?	Exemptions	Are exemptions effective?	% of public revenues raised from user fees	Informal charges	Malaria diagnostics charged in public facilities?	Sources of health financing (overall, public and private sectors)				New policies on user fees recently?	N. of informants
							Out of Pocket	Public (domestic)	Aid	Private (risk pooled)		
AFRICA												
Angola	Officially not	Not applicable	Not applicable	0-9%	Rare	No	13	80	7	0		3
Benin	Yes	Disagreement – one respondent reports for poor and children, TB, HIV, immunisation	Very	50%+	Common but low	Yes	47	40	13	0	Free caesarean policy introduced 2009	2
Burkina Faso	Yes	Yes - poor, maternal, children, TB, leprosy, immunisation, HIV	Somewhat	50+	Sometimes but limited	Yes	39	24	33	4	Experimenting with free or highly subsidised delivery services since 2006	1
Burundi	Yes	Yes - maternal conditions and children, TB, leprosy, immunisation, HIV	Very	30-50%	Sometimes/common but low	Yes	75	11	14	0	Free care for pregnant women and under-fives since 2006	2
Cameroon	Yes	Yes - TB, leprosy, immunisation, HIV	Somewhat	50+	Common - low to high	Yes	68	21	7	4	Some trials of demand-side subsidies, e.g. vouchers for deliveries, but not national in scale	2
Central African Republic	Yes	No	N/A	10-19%	Common but low	Yes	61	14	22	3		1
Chad	Yes	Unclear - possibly for maternal, children, TB, leprosy, HIV, malaria	Not at all/somewhat	0-19%	Common but low	Yes	62	12	24	2		3

Country	Official user fees?	Exemptions	Are exemptions effective?	% of public revenues raised from user fees	Informal charges	Malaria diagnostics charged in public facilities?	Sources of health financing (overall, public and private sectors)				New policies on user fees recently?	N. of informants
							Out of Pocket	Public (domestic)	Aid	Private (risk pooled)		
Congo	Yes	Yes - poor, TB, malaria, HIV	Somewhat	0-29%	Sometimes but limited	Yes	59	37	4	0	Free malaria treatment for children and pregnant women since 2008	3
Cote d'Ivoire	Yes	Yes - disabled and possibly some other categories	Somewhat	0-50%+	Rare/common but low	Unclear	68	15	8	9		2
Democratic Republic of the Congo	Yes	Yes - poor, TB, leprosy, HIV (but everyone pays something)	Not at all/somewhat	0-50%+	Rare/common but low	Yes	63	8	29	0	Some free basic care provided by NGOs, but limited coverage	3
Equatorial Guinea	Yes	Yes - poor, TB, HIV	Somewhat	0-19%	Sometimes but limited	Unclear	16	73	5	6		2
Ethiopia	**Yes**	**Yes - maternal, children, TB, leprosy, immunisation**	**Somewhat (mixed for maternal health)/very**	**0-49%**	**Rare**	**Unclear**	**32**	**18**	**43**	**8**		**2**
Gambia	Disagreement - two say yes and two no	Yes - mothers, children, TB, immunisation	Very	0-9%	Sometimes but limited	No	29	18	40	12		4
Ghana	Yes	Yes - poor, elderly, maternal, children, TB, leprosy, immunisation	Somewhat/ very	0-29%	Sometimes/common but low	Yes	50	14	22	13	In new Social Health Insurance, pregnant women get free cards since 2008; also some indigents, elderly, children of members	3
Guinea	Yes	Yes - HIV	Somewhat	30-50%+	Common - low to high	Yes	87	1	12	0		2
Guinea-Bissau	Yes	Yes – TB, leprosy, HIV	Somewhat	0-9%	Sometimes/common and high	Varies	45	-7	31	31		2

Country	Official user fees?	Exemptions	Are exemptions effective?	% of public revenues raised from user fees	Informal charges	Malaria diagnostics charged in public facilities?	Sources of health financing (overall, public and private sectors)				New policies on user fees recently?	N. of informants
							Out of Pocket	Public (domestic)	Aid	Private (risk pooled)		
Kenya	Yes	Yes - poor, unemployed, elderly, orphans, maternal, children, TB, leprosy, immunisation, HIV	Somewhat	0-9%	Common but low	Yes	41	33	15	10	Experimentation with different systems of exemption, subsidy, risk pooling, insurance in recent years; deliveries exempt since 2007	1
Lesotho	Yes			3%			26	47	15	12	Removal of fees for OPD in 2008 and some streamlining of other fees	Document review
Liberia	No	N/A	N/A	0-9%	Rare	No	36	22	42	0	User fees suspended for basic package of health care since 2006	1
Madagascar	Yes	Yes - poor, civil servants, TB, leprosy, immunisation, HIV	Somewhat	30-49%	Common but low	No	19	13	50	18	User fees lifted on emergency post-conflict basis, then reintroduced. Free deliveries since 2008	1
Malawi	No	N/A	N/A	N/A	Rare	No	9	29	43	19		3
Mali	Yes	Yes - poor, TB, leprosy, HIV	Somewhat	10-29%	Sometimes but limited	No	48	33	18	0	Free caesareans since 2005	1
Mauritania	Yes	No	N/A	50%+	Common but low	Yes	31	51	18	0		1
Mozambique	Yes	Yes - poor, orphans, maternal, children, TB, immunisation, HIV	Somewhat/very	0-19%	Sometimes but limited/common but low	No	12	13	57	18		2

Country	Official user fees?	Exemptions	Are exemptions effective?	% of public revenues raised from user fees	Informal charges	Malaria diagnostics charged in public facilities?	Sources of health financing (overall, public and private sectors)				New policies on user fees recently?	N. of informants
							Out of Pocket	Public (domestic)	Aid	Private (risk pooled)		
Niger	Yes	Yes - poor, children, civil servants, TB, HIV	Very	0-9%	Rare	Yes	40	26	26	7	Free caesareans (2006) and care of under-fives (2007)	1
Nigeria	Yes	Yes - maternal, leprosy, HIV	Somewhat	0-19%	Sometimes/common but low	Yes	63	24	6	7	Addressed via extension of CHI and subsidies for membership, as well as supply side policies	2
Rwanda	Yes	Yes - poor, orphans, ex-servicemen, HIV, genocide survivors	Somewhat	0-50%+	Rare	Yes	23	25	39	14		2
Sao Tome and Principe	Yes	Yes - children	Not at all/somewhat	0-29%	Common but low	Unclear	15	42	43	0		2
Senegal	Yes	Yes - elderly, maternal, TB, immunisation, malaria, HIV	Somewhat	20-29%	Sometimes but limited	Yes	62	18	14	7	Recent introduction of exemptions for delivery care (2006) and elderly	1
Sierra Leone	Yes	Yes - poor, maternal, children	Not at all/somewhat	0-49%	Common but low/common and high	Yes	51	4	45	0	Free care package for mothers + under-5s planned for April 2010	3
Somalia	Yes	Yes - poor, TB, HIV (both); elderly, mentally handicapped, all preventive care (Somaliland); children, ex-servicemen,	Somewhat/not at all	0-49%	Rare/common and high	Unclear	55	35	9	0		3

Country	Official user fees?	Exemptions	Are exemptions effective?	% of public revenues raised from user fees	Informal charges	Malaria diagnostics charged in public facilities?	Sources of health financing (overall, public and private sectors)				New policies on user fees recently?	N. of informants
							Out of Pocket	Public (domestic)	Aid	Private (risk pooled)		
		leprosy, immunisation (Somalia)										
South Africa	Yes	Yes - all PHC has been free since mid-1990s	Very	0-9%	Rare/sometimes		10	41	1	48	Free public PHC since 1990s	External expert
Sudan	Yes (North); No (South)	Yes - poor, maternal, children, TB, immunisation (North Sudan)	Somewhat (North)	10-29% (North)	Sometimes/common but low (North); Rare (South)	Yes (both)	62	31	6	1	Free care for under-5s and caesareans introduced in north in 2008; South recently removed user fees	3
Togo	Yes	Not really respected - should be for poor, HIV, indigenous	Not at all/somewhat	30-49%	Common and high	Yes	61	13	15	11		3
Uganda	No	N/A	N/A	0-9%	Common but low	No	38	-2	29	35	Free care in public sector since 2001	2
United Republic of Tanzania	Yes	Yes - poor, elderly, maternal, children, TB, leprosy, immunisation, HIV	Somewhat	0-9%	Common but low	Yes	34	24	35	7	Recent experiments with community and social insurance and exemptions	1
Zambia	Yes	Yes - poor, elderly, orphans, maternal, children, TB, immunisation, HIV, all patients in rural areas	Somewhat/ very	0-9%	Rare/sometimes/common but low	Yes	38	10	37	15	User fees were removed from all health services in health centres and district hospitals in rural districts in April 2006 (54/72 districts); policy extended	3

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							Out of Pocket	Public (domestic)	Aid	Private (risk pooled)		
											to cover facilities in peri-urban areas in 2007	
Zimbabwe	Yes						24	34	19	23		Documents
ASIA												
Afghanistan	Yes	Poor, TB, immunisation	Somewhat	0-9%	Common and high	No	70	7	20	2	Experimenting with free care in some areas	3
Bangladesh	Yes, but low	Yes, for essential service package services	Effective for official, not unofficial	0-9%	Common and high	No	56	22	15	7	Some demand-side approaches for deliveries, e.g. vouchers	External expert
India	Yes	Yes - poor, elderly, ex-servicemen, maternal, civil servants, TB, HIV, leprosy, immunisation, malaria (varies by state but anything with a National Programme is exempted)	Somewhat/very	0-9%	Varies by state (sometimes; common but low; common and high)	No	76	19	1	5	Free national delivery programme and other nationally supported priority services	9
Indonesia	Yes	Yes - special insurance for poor; immunisation	Reasonably effective for poor but still informal barriers	1.20%	Common but low	Unclear	33	48	2	17	Askeskin insurance for poor is main vehicle for reducing user fee burden	External expert
Myanmar	Disagreement - yes and no	Yes - but not sure of categories	Somewhat	10-19%	Rare/Common and high	Unclear	83	3	14	0		2
Nepal	Yes	Free care for basic services	No good evidence on	0-9%	Sometimes but limited	Not sure	59	15	16	10	Moving away from user fees	External expert

Country	Official user fees?	Exemptions	Are exemptions effective?	% of public revenues raised from user fees	Informal charges	Malaria diagnostics charged in public facilities?	Sources of health financing (overall, public and private sectors)				New policies on user fees recently?	N. of informants
							Out of Pocket	Public (domestic)	Aid	Private (risk pooled)		
		introduced incrementally 2006-9, including for deliveries	this yet								under new interim Constitution	
Pakistan	Yes	Yes - but not disagreement on categories	Not at all/somewhat	0-9%	Rare/Common and high	No	82	13	3	2		2
Timor-Leste	No	N/a	N/A	N/a	Rare/sometimes (no surveys on this)	No	4	44	45	7		2
Cambodia	Yes	Yes - poor, orphans, TB, leprosy, immunisation, malaria, HIV	Somewhat	10-19%	Common and high	No	62	4	22	12	Experimenting with health equity funds to increase access for poor	1
China	Yes	Yes - TB and other categories	Somewhat	30 - 50%+	Common but low/high		54	42	0	4	Extending rural health insurance but financial protection shallow	External expert
Viet Nam	Yes	Yes – TB, under-6s, and other categories	Somewhat	20-49%	Common but low/high		61	30	2	7	Trying to extend voluntary insurance	External expert

Note: rows highlighted with a darker border indicate DFID PSA countries (at the time of the research).

Table 3. Overview of recent user fee policy changes

Country	Recent user fee reforms
Benin	Free caesarean policy introduced in 2009
Burkina Faso	Experimenting with free or highly subsidised delivery services since 2006
Burundi	Free care for pregnant women and under-fives since 2006
Cameroon	Some trials of demand-side subsidies, e.g. vouchers for deliveries, but not national in scale
Congo	Free malaria treatment for children and pregnant women since 2008
DR Congo	Some free basic care provided by NGOs, but limited coverage
Ghana	In new Social Health Insurance, pregnant women get free cards since 2008; also some indigents; elderly; children of members
Kenya	Experimentation with different systems of exemption, subsidy, risk pooling and insurance in recent years; deliveries exempt since 2007
Lesotho	Removal of fees for OPD in 2008 and some streamlining of other fees
Liberia	User fees suspended for basic package of health care since 2006
Madagascar	User fees lifted on emergency post-conflict basis, then reintroduced. Free deliveries since 2008
Mali	Free caesareans since 2005
Niger	Free caesareans (2006) and care of under-fives (2007)
Rwanda	Addressed via extension of CHI and subsidies for membership, as well as supply side policies
Senegal	Recent introduction of exemptions for delivery care (2006) and elderly
Sierra Leone	Free care for mothers and under-fives in April 2010
South Africa	Free public PHC since 1990s
Sudan	Free care for under-fivess and caesareans introduced in north in 2008; South recently removed user fees
Uganda	Free care in public sector since 2001
Tanzania	Recent experiments with community and social insurance and exemptions
Zambia	User fees were removed from all health services in health centres and district hospitals in rural districts in April 2006 (54/72 districts); policy was extended to cover facilities in peri-urban areas in 2007
Afghanistan	Experimenting with free care in some areas
Bangladesh	Some demand-side approaches for deliveries, e.g. vouchers
India	Free national delivery programme and other nationally supported priority services
Indonesia	Askeskin insurance for poor is main vehicle for reducing user fee burden
Nepal	Moving away from user fees under new interim Constitution
Cambodia	Experimenting with health equity funds to increase access for poor
China	Extending rural health insurance but financial protection shallow
Viet Nam	Trying to extend voluntary insurance for the rural poor

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