Punishing the Poor?

A Look at Evidence and Action Regarding User Fees in Health Care

Introduction

User fees for health care were put forward as a way to recover costs and discourage the excessive use of health services and the over-consumption of care. This **did not** happen. Instead, user fees punished the poor. -Dr. Margaret Chan, Director-General, WHO. (2009)

The history of user fees imposed on the poor is a history of the poor being excluded from basic services. – Jeffrey Sachs, Director, Earth Institute, *End of Poverty* (2005)

Pricing helps reduce excessive or unwarranted demand for a service and brings supply capacity more in line with willingness and ability to pay. Put differently, when a service costs money, people will think twice about demanding it.
- World Bank, *Financing health care in sub-Saharan Africa through user fees and insurance*. (1995)

User fees are charges paid by the patient at the time of use of health care in the public sector facilities. The practice of charging user fees in low income countries was given a boost as part of the structural adjustment policies, often as a condition of lending from the World Bank and IMF. Apart from increasing revenue, user fees were ostensibly introduced to achieve the objectives of reducing frivolous demand, improving quality and coverage, and increasing efficiency. They have been in operation in many low income countries for more than twenty years. A World Bank survey of 37 African countries in 1993 found that 33 of them had cost-recovery policies.[1] Since then, however, many African and Asian countries have abolished user fees in health care.[2] In India, the practice continues in many states.[3] This policy brief aims to summarise evidence and discuss various concerns from a low-income perspective.

International Experience

In its influential study of 1987[4] which presented User Fees as an innovative health financing mechanism, the World Bank suggested that to charge patients would have three main benefits. First, it was said that fees would generate added revenue. Second, fees would improve efficiency of health care delivery by reducing *frivolous* demand. Third, such fees would improve equitable health services access, because user fee revenues could be used to cross-subsidise the disadvantaged. Thus, user fees would be "an appropriate financing mechanism because they would be effective (in raising additional funds), efficient (by encouraging an efficient use of services), and equitable (in benefiting poor people disproportionately)".[5]

In the following section, we look at each of these objectives from a low-income perspective, and compare them with results from various country experiences.

Additional Revenue

First, let us examine the claim that user fees would generate additional revenue, much needed for the health sector. It is something to be borne in mind here that for many low-income countries, the degree of *absolute* dearth of funds for the social sectors is more of an imagined constraint rather than a real one. Experiences like that of China, Costa Rica, Cuba and Sri Lanka demonstrate that high investments in the health sector and improvements in health status of the population do not solely depend on the country's economic status.[6] Dearth of recourses for the health sector is, more often than not, a direct result of a lack of political will than anything else.

In the history of humanity, even when the least developed countries fought each other, it has never been heard even once that a war was halted or even postponed for want of funds. There is no reason why the 'war' against disease, to use a popular metaphor of health planners across the globe, be suspended for pecuniary reasons when it is one of the most acceptable of wars.[7] Still, there is no escaping the lack-of-funds argument in any policy debate where healthcare is involved. Even if we take for argument's sake that user fees can potentially play a positive, beneficial role of raising extra revenue, the evidence from the world over including India has been less than comforting.

An early World Bank report noted that between 1975 and 1989, the average cost recovery rate in India was just 3.8% of the medical and public health budget. [8]. It was observed that 1992-1993 the average hospital receipts were 1.4% of the total

hospital expenditure.[9] A later study in 2000 based on NSS data found that for the year 1996, of all states, only three had a cost-recovery ratio over 5 per cent. [10]

In fact, Yates notes that in the 1990s, there were a few studies which indicated that the introduction of user fees in some cases could increase the use of services. This was a result of demand increase as a response to meaningful quality improvements financed by the revenues collected*. However, most studies conducted since 2000 conclude that "user fees reduce usage and this effect is most pronounced in the suppression of demand for health care by poor people".[11]

In the case of Mozambique, it was seen that even while the huge costs of administering it were excluded, user fees contributed only a small fraction of overall spending on health - as little as 0.7%[12]. It was noted that scrapping user fees would result in a net increase in resources for health care services[13]. A study in 2004 which looked at 25 countries in Asia and Africa concluded that user fees generally raise very little money. According to the author, user fees do not normally account for more than 10% of recurrent costs and are "a far more inefficient revenue raising tool than general taxation due to high administration costs".[14] The following table shows user fee collections in selected countries in sub Saharan Africa.

User Fee Collections in Selected Countries in sub Saharan Africa

	% of recurrent budget covered by user fees	Year
Benin	20	1993
Botswana	2	1983
Burkina Faso	14.8	1999
Burundi	4	1992
Cote d'Ivoire	7.2	1993
Ethiopia	9	1996/7
Ghana	5-6	1991
Guinea	20	1993
Guinea-Bissau	5	1995
Kenya	2	1984
Lesotho	7	1998
Malawi	3.3	1983
Mali	2.7	1986
Mauritania	9	1999
Mozambique	8	1996
Rwanda	7	1984
Senegal	4	1990

* According to Sundari Ravindran,(2005) such successes were "only because the fees have been retained at local level and earmarked for specific items such as drugs".

Swaziland	2.1	1984
Zimbabwe	3.5	1992
Unweighted Average	6.9	
Source: Pearson (2004)		

While the revenues have been meagre, the costs have been immense – both in terms of financial and more importantly of equity terms. A study from Zambia in 2005 showed that administrative costs were almost equal to the user fees revenue.[15] It was seen that 67% of the revenues collected in Honduras was absorbed by administrative costs.[16] Watkins observed that when a large section of the population is poor, the costs of administration rise and revenue-potential falls, reducing net returns[17]. Costly administration of user fees affects health care access in many ways.

After User fees was removed in Nepal, a nurse at the Kathmandu Hospital observed; "When user fees were removed by the government in January, the numbers of women coming to give birth here almost doubled. It did not overwhelm our staff, because they no longer had to deal with the red tape of administering the fees"[18]. Citing a UN study, Ravindran (2005) observes that the argument that revenue generated could be used to improve services in such a way that it benefits the poor and vulnerable groups is misleading for its lack of evidence. She maintains that there is no evidence to date to suggest that this has indeed occurred in any country where user fees have been introduced as part of health sector reform.[19]

Frivolous Demand and Efficiency

Another objective of user fees was to reduce *frivolous* demand in low income countries. This objective itself is an example of the characteristic over enthusiasm of the health policy-expert to apply textbook principles to low income settings without caring to take into account the tenability of the strong assumptions. *Frivolous* use, even theoretically, is a possibility only when the typical 'consumer' faces zero prices at the point of use, by virtue of having insurance coverage or other advantages.

It is public health commonsense that in low income countries, indirect costs like time and transport can be large and that they significantly suppress demand for healthcare. In a situation like that of India, where middle and high middle income groups have already abandoned the public sector, it takes a complete lack of familiarity with the health care supply situation as well as the gap

between the actual supply and norms to even suggest that the public health facilities are crowded and that it is because of the *frivolous* demand by the masses. The place where 'moral hazard' has any public health significance in low income settings is in the case of health care suppliers. There has however been evidence that introduction of user fees incentivises the suppliers to 'induce' demand, thus reducing efficiency substantially.[20]

In many low income countries, low demand for health services is seen to be a major public health challenge and improving it is seen as a pre-condition to reach the health –related MDGs. For example, it was seen that in the Democratic Republic of Congo people visit a health facility only once every 6·7 years.[21] In such situations, promotion, rather than rationing would be the correct policy to follow. In fact, the recently published Mid-term evaluation of the National Rural Health Mission has identified the creation of "a much higher level of demand for public health services from the ground up" as *the* accomplishment of NRHM so far[22]. One author of the NRHM review even went on record to say that queues outside PHCs, were for the most part 'a good sight to watch'.[23] It is interesting that the same ministry is simultaneously promoting mechanisms with the stated aim of reducing demand for public health services. Such contradictory policy objectives tend to have an adverse impact on equity.

Equity Gains

In terms of evidence, the mechanism of user fees fared worse on the third objective of equity, which is in fact the most important. In this regard, user fees proved to be a failure since the negative implications were disproportionally borne by the poor and the vulnerable. They were affected both by a delayed and reduced access to services and also through being impoverished by the effects of high catastrophic health expenditures. But to make matters worse, the exemption systems which were to address the equity concerns tended not to work in practice.[24] The limited instances of poor actually getting protected, whenever those happened, were because of a cautious approach and of putting in place of elaborate subsidy schemes. Thus, the general experience has been one of decrease in access to care.

It was seen in Sudan, for example, that scarcity of money was cited as the primary reason why 70 per cent of the sick people in disadvantaged areas chose not to seek care.[25] Extensive reviews have shown that exemption systems rarely work and in the case of Zambia, it was observed that only 1% of exemptions were based on poverty status, indicating that either poor people did not access care or were being forced to pay.[26] The principle of equity demands that the paying and non-paying patients be treated as equals. In practice, it was observed

that the process of accessing systems of exemption is often stigmatising and de-humanising.[27] Another related issue affecting equity is related to well-defined guidelines and criteria on exemption policy. Otherwise, lower levels of administration who operationalise them may receive "conflicting signals from higher levels regarding the exemption policy". This will have negative implications for equity as it aggravates the "inherent conflict between attempting to recover costs and seeking to protect the poor".[28] In all this, from being an entitlement guaranteed as a matter of citizenship, free health care increasingly becomes a charity or a gift from individual staff to 'deserving' patients.

Do user fees facilitate cross subsidisation? Evidence has emerged that in excluding poor people from accessing care, mechanisms like user fees actually amplify the existing inequalities.[29] A simulation analysis of 20 African countries published in the British Medical Journal in 2005 calculated that abolition of user fees could prevent approximately 2,33,000 under-5 child deaths *annually*. This amounted to 6.3% of all under-5 child deaths in those countries.[30] As per this estimate, over the last twenty years, about five million child deaths could have been avoided if user fees were not charged.

It is often argued that the user fees charged are low. Nevertheless, as per evidence presented by Gilson and McIntyre[31], such fees can encourage patients to opt for inappropriate self treatment. It was also noted that as a direct result of user fees, patients tend to use partial drug doses , and often postpone or even forgo the use of health facilities altogether. Impoverishment follows the increased morbidity, and the patients who must now pay fees may have to find money by selling key assets, cutting down on other necessary expenditures, or resort to borrowing at very high interest rates. At the very same time, they must also endure the loss of income (Gilson and McIntyre 2005). It was shown in another study that people were being forced to choose self-care. For every 10% increase user fees, reliance on self-care increased by 2.4% (Asfaw et al , 2004).[32] Another study in Morocco showed that for every 10% increase in user fees , the access of the poorest 50% of women to a trained health care worker would drop by a high 6.2%(James et al 2005).[33] It was also observed that user fees accentuate gender based barriers to accessing health services (Ravindran and De Pinho, 2005)[34]

In a recent report about the distributional impact of reforms, the World Bank noted that "The push for introducing user fees to finance improvements in health services in developing countries in the 1990s provides a good illustration of the way invalid empirical results can bring about adverse welfare consequences"[35].

UNDP acknowledges in the latest Human Development Report (2010) that at the global level, health progress has slowed since 1990. In fact, 19 countries have experienced *declines* in life expectancy in the past two decades. Interestingly, in the discussion of the causes for the global life expectancy reversal, HDR 2010 lists the introduction of user fees prominently, along with HIV epidemic and armed conflicts.[36] The WHO Director General, at the International Ministerial Conference on Health Systems Financing in 2010 said:

> "Direct out-of-pocket payments at the time of care are identified as the single biggest barrier to universal coverage. While user fees have been promoted as a way to reduce the overuse of services, this is not what happens.
> User fees punish the poor. They are inefficient. They encourage people to delay seeking care until a condition is far advanced, and far more difficult and expensive to treat. And when people do pay out of pocket for care, financial ruin can be the result.
>
> In some countries, up to 11% of the population experiences catastrophic financial hardship each year because of health care bills, and as many as 5% of these people are pushed below the poverty line because of these costs."[37]

Impact of Removal of User Fees on Access

It is a fact that many considerable demographic/geographic/socio-economic groups in India have worse health indicators than that of Sub-saharan Africa. After 2000 when evidence of the ill-effects of user fees on poor peoples' health and well-being became too great to ignore, policy reversals became politically inevitable in Africa. The good news is that in Africa, as the following figure will demonstrate, many countries have been successfully abolishing user fees with great results.

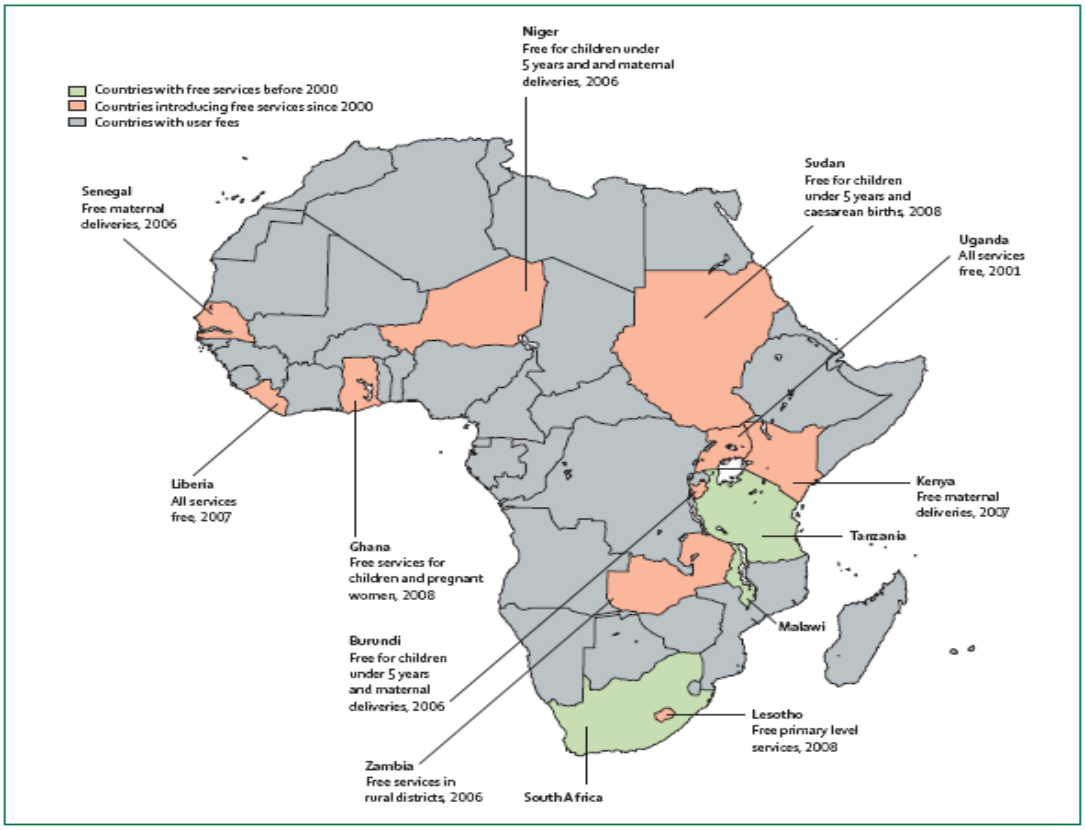

Figure 2: African countries with and without user fees

Source: Yates (2009)

After user fees was removed in South Africa in 1994, outpatient attendances increased by 77%(Yates, 2006).[38] In Madagascar, after a temporary abolition of user fees, monthly visits to public rural health centres almost doubled compared to the previous year. The main perceived reason for the increase in the number of visits, according to staff members, was the elimination of user fees (Fafchamps and Minten, 2004).[39] In the case of Kenya, reduction of user fees resulted in an increase in utilisation averaging about 30% more than the pre-removal period (Pearson 2005). [40]In Uganda, since user fees were scrapped in Government health units in 2001, outpatient attendances increased by an extra 14.9 million visits, amounting to 155% (Yates, 2006)[41]. In Uganda, results of research undertaken by WHO and the World Bank demonstrated that the removal of user fees was very favourable for poor people (Nabyonga et al, 2004).[42]

Uganda's experience has lead to some kind of a Domino effect across Africa and over the last three years countries like Zambia, Burundi, Niger, Liberia, Kenya, Senegal, Lesotho, Sudan, Malawi, Sierra Leone and Ghana have abolished fees for key primary health-care services as shown on the following figure from Yates (2009)[43]. In Niger, consultations for children under five increased four times and antenatal care visits doubled after user fees for pregnant mothers and children under five were removed in 2006. In Burundi, within a year of user fees being

removed, utilisation for children under five increased by 40%. In Bo, Sierra Leone, a tenfold increase in consultations for children followed (Save the Children, 2008).[44]

It is quite unfortunate that despite the mountain of evidence that exists against charging user fees in government hospitals, Indian government is yet to correct its policy errors. All this, while much poorer countries in Africa are successfully getting rid of the public health *problem* of user fees, thus enhancing access to millions of poor without pushing them into a downward spiral of poverty and ill-health.

The Case of India

Out-of-pocket payments in India consist more than 80% of total health expenditure. A study in 2006 showed that while per capita income grew at 3.76 % per annum, private health expenditure grew at the rate of 10.88 % per annum.[45] Many low income groups in India had negative real income growth in the same period. Since vulnerability to ill-health is higher as one grows poorer, the situation is much worse for the poor than what the general statistics suggest. The World Bank observes:

> 'Based on the National Sample Survey (60th round), in 2004, 63 million individuals or 12 million households fell into poverty due to health expenditures (6.2% of all households). The majority of these households (79%) became impoverished due to spending on outpatient care, including drugs, and the remainder (21%) fell into poverty due to hospital care. In some states, such as Uttar Pradesh, Maharashtra and West Bengal, over 8% of households were impoverished as a result of health expenditures'. [46]

Health Sector Reform initiatives in Indian states started in 1994, with the first World Bank funded project for Health Systems Development in the state of Andhra Pradesh. Other states that followed included Karnataka, Punjab and West Bengal in 1996, Orissa, Maharashtra and Rajasthan in 1998, and Uttar Pradesh in 2000 (Ravindran 2005).[47]

In Maharashtra, user fees were introduced way back in the eighties, and the scope and scale have been steadily increasing with no visible effort of any roll back. By 2000, user fees were extended to all rural and women, cottage, districts and non-project hospitals, while clear guidelines on exemptions have been largely absent.[48] In 2001, the average user fee paid per patient at government facilities in Maharashtra was more than doubled.[49] Recently, there have even been fresh proposals to start charging substantially for medical services at Civic hospitals in Mumbai and also across the state[50].

Evidence from across the country regarding the impact of user fees show that the poor gets affected disproportionately. Common Review Mission of NHRM observed that Chhattisgarh charges user fees for 95% of its public health facility users.[51] In the case of Madhya Pradesh, only 2.47% patients were exempted charges for services on basis of BPL, although the number of BPL population is 37%.[52] A study in Punjab showed that BPL card holders treated free of cost made up only 0.4% of the patients treated in the outpatient department, and it declined further to 0.008% in two years. [53] Second Common Review Mission of NRHM observed that almost every state mission has noted 'the problem in the persistent user fees and the impact on access it has'. The team from Chhattisgarh reports, "In the district hospital in Bilaspur , user charges for most of the services are found to be generally high and are even comparable with private hospitals. All BPL cardholders are excluded from user charges. However for those poor who do not carry a BPL card, the decision for exclusion is made at the level of civil surgeon on case-by-case basis. One would wonder how many poor could access civil surgeon's office to avail of such benefits."[54]

Waivers and exemptions have failed to protect the poor. A study conducted in Bareilley, UP found that in 1999-2000, out of a total of 1,70,087 outpatients at MPDH hospital only 477 were treated free of cost! In 2000-01, out of 1,41,852 outpatients, only 449 were treated free of cost! It was observed in the same study that the implementation of this waiver and exemption rules has been the most serious area of neglect in the administration of the entire user fee structure [55]

While it is clear that waivers are exemptions have failed to protect the poor in India, BPL as a criterion to target the poor who will receive free care is itself based on wrong assumptions. The BPL population does not, by no stretch of imagination, represents the vulnerable population who requires free health care.

Conclusions and Recommendations

Over the last twenty years, irrefutable evidence has emerged that user fees play a key role in preventing low income families from accessing health care. It would be reasonable to assert that user fees are the most iniquitous and regressive form of health care financing, since they force the poor households to pay a higher proportion of income than the better-off ones. Hence, user fees remain the least desirable method of financing health care services, particularly in low income countries. Although concrete and unequivocal action on the ground to back it up was few and far in between, the last ten years or so saw a consensus emerging among global and national health policy makers with regards to user fees, as will be clear from Box 1.

Box 1:

The Policy Consensus on User Fees among Key Players

In its *World Health Report 2000*, the WHO agreed with this conclusion: "Out of pocket payments are usually the most regressive way to pay for health, and the way that most exposes people to catastrophic financial risks."

The *World Health Report 2005* acknowledged that user fees are not the most effective way of pursuing universal coverage and the health-related MDGs, while also pulling over 100m families into poverty each year. The report was accompanied by policy briefings, one of which explores financial protection and *the need to move away from user fees* towards more prepayment mechanisms to protect the poor.

Among the 'quick win' strategies recommended by the Millennium Project was the removal of user fees for primary education and essential healthcare by the end of 2006 (Sachs, J et al, 2005).

The Commission on Social Determinants of Health in its final Report (2008) says: The policy imposition of user fees for health care in low- and middle-income countries has led to an overall reduction in utilization and worsening health outcomes. Upwards of 100 million people are pushed into poverty each year through catastrophic household health costs. This is unacceptable.

The World Health Report 2008 says that "As the overall supply of health services has improved, it has become more obvious that barriers to access are important factors of inequity: user fees, in particular, are important sources of exclusion from needed care. Moreover, when people have to purchase health care at a price that is beyond their means, a health problem can quickly precipitate them into poverty or bankruptcy".

There is now a global consensus among organisations like the World Bank, the WHO, the EC and UNICEF that charging fees for health care is one of the most significant barriers to progress in scaling up access to health care in poor countries and that they should be removed. (Oxfam 2009)

A reappraisal of the role of the State has been happening in health - from universal provisioning to nongovernmentalism mixed with a means-tested system of care.[56] The State is increasingly shifting from being the major provider of services to financier for a minority of the poor for a selected and very limited set of needs. International agencies pushing such strategies have always been quick to appropriate concepts and slogans from peoples' movements worldwide. Charging user charges by governments in the name of 'community financing' could be seen one of these instances – the state is placing the onus of poor people's health back in their own hands, or more correctly, their pockets.

Policies that guarantee free health care at the point of use are absolutely essential in low income settings, if we are to achieve anything close to the ambitious

health targets set by national governments and international agencies. Several studies found that even where user fees have been accompanied by some quality improvements, demand for healthcare by the poor who get ''priced out'' of the market drops drastically.[57]

We live in an age of extreme contradictions. At one end of the spectrum in the private sector, 'socialisation of corporate losses' is presented as the only solution to the consequences of what is often retrospectively termed as 'destructive innovation' in the financial markets. At the other end of the spectrum, in the social sector, we have specially designed 'innovations' to preclude what is perceived to be the apparently nightmarish scenario of 'socialisation of health care'. Towards the end, it needs to be emphasised that last half a century's experience, if nothing else, should teach us that the path to government-sponsored 'business of health care' is strewn with bodies of the excluded. It is public health commonsense that in low income settings, public sector must work as the majority provider -of free services- to achieve health care access to all.

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