Abolition of User Fees to Promote Equity in Health Care Access in Sub-Saharan Africa: a case study of Uganda

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Introduction

In 1946, the World Health Organization (WHO) declared that, “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.” However, millions of people across the world remain disproportionately burdened by morbidity and mortality due to failing health systems. Sub-Saharan Africa (SSA) experiences the greatest burden of disease, and more deaths occur in children under the age of fifteen (46%) than in adults over 60 (20%). Due to the disproportionately high burden of preventable and treatable communicable diseases in SSA, there has been much debate as to the best means of achieving universal access to critical health services.

The health sector operates in a very complex market and an abundance of market failures necessitate public intervention. However, the optimal method of financing health care in low-income countries, either with or without cost-sharing, has been extensively debated. The argument for cost-sharing is based on the premise that fees control moral hazard and excess demand of services, and are a critical financial component of providing quality services. To address inequities in accessing fee-based services, proponents of user fees argue for exemptions for vulnerable populations or pre-payment schemes, and claim that free services still provide greater benefit to the wealthy. On the contrary, proponents of free health care argue that user fees negatively affect the most vulnerable populations and lead to rationing of health care within the household. Additionally it has been argued that exemptions for vulnerable populations are inefficient and ineffective, may be ignored due to perverse financial incentives for health workers, and that other financing mechanisms such as social insurance are ineffective at eliminating informal fees. This paper focuses on the abolition of user fees as a government led policy innovation to increase equity in access to health care in SSA.

Addressing Market Failures Through the Abolition of User Fees

The WHO called out-of-pocket payments the most inequitable form of health care financing and urged SSA to not rely on user fees. This came in response to well demonstrated market failures following privatization and decentralization of health services in the 1980s though World Bank reform whereby morbidity and mortality in SSA increased. Neoliberal reforms pervaded development projects in all sectors, but when it came to health care, “people did not merely fall through the net of social provisioning – they died” (p. S44). In 2000, it was shown that 48% of Sub-Saharan Africans lacked access to basic health services, compared to 20% in low-income countries on average. Market failures in the health sector include public goods, positive externalities, information asymmetries, imperfect information, and monopolies. These failures occur in all health markets, however the effects in SSA are exacerbated due to poorer institutions, regulatory laws, and limited resources compared to industrialized countries.

Public Goods and Positive Externalities. Many aspects of health services are public or merit goods, that require public intervention to ensure adequate provision. Consumption externalities, whereby the benefit of consumption is greater for the population than the
individual, result in insufficient demand. Examples of merit goods include vaccinations and family planning. Abolishing user fees has been shown to increase the use of merit goods in addition to curative services. Increased utilization of health services also exposes individuals to greater amounts of health knowledge, which is a known public good.

Asymmetric Information. Asymmetric information between a patient and an “expert” provider leads to a lack of consumer sovereignty whereby patients do not have the power to choose which services they need. Because the provider has information that the patient does not, clinical decisions are made by the provider, which can lead to abuses by providers to recommend unnecessary services for personal financial gain. This phenomenon of supplier manipulation of market demand is referred to as supplier induced demand and is particularly a concern in markets in SSA where health care providers can also sell medicine. Additionally, the very time-sensitive nature of most health care decisions can further underscore the patient-provider information asymmetry because a patient usually needs to make decisions quickly and in SSA, where there are 2.3 health workers per 1,000 people, the lowest density by nearly 50% of anywhere in the world, the option to seek another opinion is essentially non-existent.

Information asymmetries also exist in the health insurance and credit markets. The lack of information available on the behaviors and actions of the poor and vulnerable members of society makes providing insurance or credit highly risky, leading to high costs and adverse selection. Health care represents a significant proportion of household expenditure and catastrophic health care costs force 100 million individuals below the poverty line annually. A lack of access to credit to cover large out-of-pocket costs of health care creates a financial barrier to accessing care, which for some leads to forgoing preventative and curative health care entirely, turning to traditional medicine that accepts payment in-kind, or selling off limited assets. Additionally, the health insurance market operates sub-optimally even when information about risk is available through selection bias which limits access to insurance to those most likely to be healthy and excluding those with higher risks in order to increase returns. However, through abolishing user fees, in theory, the out-of-pocket expenditures decrease and credit or insurance are no longer necessary to cover the costs of health care for the household.

Imperfect Information. Imperfect information affects both the demand and supply sides of health services, and is primarily unaddressed through abolishing user fees. Demand for health services can be limited by lack of information about when to seek health care services, what diagnostics or treatment to request, and time-inconsistency problems. This information deficit can be exacerbated by household power dynamics that may limit the agency of individuals within the household for seeking costly services, most notably women, children, or the elderly. By reducing fees, the effect may be reduced because people do not need as much knowledge to seek care if the financial barrier is eliminated, which on the other hand can lead to concerns of moral hazard and over-use. On the supply side, there is imperfect information between the end-users and the stakeholders in health care delivery in SSA. There is a lack of data on inputs and outputs at health facilities limiting the health systems understanding of demand and needs.

Monopolies. Due to the expert nature required to provide health care, the creation of monopolies is considered to be a market failure of the health sector allowing for even greater abuses of the patient-provider information asymmetry and inflated prices. Low elasticity of demand for health services, less than one even in low-income countries, allows for providers to increase their prices without great loss in demand. Through providing free public health care, private sector providers are faced with competition that helps control price inflation and those unable to pay have their demand met through free services.
Implementing Policies to Abolish User Fees in sub-Saharan Africa

Policies abolishing user fees have been implemented in several countries across SSA, however only a few countries provide all health care services free of charge whereas most offer targeted exemptions to specific populations.\textsuperscript{29, 30} While no randomized control trial has been conducted to look at the effects of abolishing user fees on a national scale, the observational evidence suggests large increases in utilization of curative services when fees are removed and some evidence of long-run increases in uptake of preventative services, though the effects tend to vary depending on context.\textsuperscript{31} Rates of seeking care from private providers have risen simultaneously with increased utilization in the public sector when fees are abolished, helping to address concerns of crowding out the private market.\textsuperscript{32, 33} On the contrary, an increase in public sector fees led to decreased utilization of public health services in Lesotho, but had no effect on private sector utilization,\textsuperscript{34} suggesting that introducing financial barriers in the public sector leads people to not seek care altogether rather than sending them to the private sector. Introducing or increasing existing fees decreases utilization of inpatient and outpatient services in Southern, Eastern, and Central Africa.\textsuperscript{35} However, the opposite was seen in francophone West Africa, which is believed to be a result of the Bamako Initiative that introduced user fees and community management of health facilities to control corruption.\textsuperscript{10} This is the only region of SSA where there have been positive effects of introducing fees and it is important to note that the positive effect was not seen among the poorest and most vulnerable populations for whom user fees created a financial barrier to accessing care.

Despite generally positive effects on utilization in observational studies when fees are abolished, particularly among the poor and vulnerable populations,\textsuperscript{33} concerns remain regarding quality of care, persistent cost burden of seeking services, and most importantly the health impact of increased service utilization. In an attempt to address these concerns, the case of Uganda is analyzed to understand the impact of implementing universally free health care that is funded through a combination of public and donor financing.

Abolition of User Fees Case Study: Uganda

Despite economic growth following Uganda’s emergence out of civil war in the 1980s, health outcomes remained grim for key indicators such as maternal and infant mortality rates, and the uptake of preventative and curative services remained low. Decentralization and market-based reforms in the 1990s, including the introduction of fees in 1993, had negative impacts on health outcomes and led to regional variability in service availability.\textsuperscript{34} Uganda abolished user fees for public health services in March 2001, accompanied by providing additional funds for salary increases and medicines, modified drug procurement processes, allotting some discretionary funds to health facilities to compensate for the loss of user fee revenue, and also a provision whereby those able to pay for hospital services were expected to do so.\textsuperscript{35} However, the monumental reform decision was made rather quickly, with highly politicized motivations as the incumbent president was facing re-election and pressures in light of poor health indicators.\textsuperscript{14}

Following implementation of the cost-sharing reform, huge spikes in utilization were seen in curative services, and increases were seen in preventative services, such as family planning and immunizations, which had always been free, pointing to spillover effects from accessing curative care.\textsuperscript{20} In a review of health records from health facilities in six randomly selected districts, a 77\% increase in utilization was seen between 2000 and 2002 at lower level non-hospital facilities, compared to a 55\% increase at hospitals.\textsuperscript{35} This observation is important, because higher-level facilities are intended to serve more specialized problems that cannot be
addressed at the lower-level facilities. For the health system to operate efficiently, it is essential that patients do not bypass lower level facilities. The greatest increases in access were observed among the poor, pointing to greater health care equity, and studies have shown an increase in utilization of private facilities among the wealthier.

However, in order to understand the success of Uganda’s reform it is essential to look beyond the utilization rates of curative services. Concerns have been raised regarding quality, drug stock-outs, persistent barriers to access, and health impacts. Drug-stock outs have long been a major concern in Uganda and were a contributor to poor quality of care during the cost-sharing era. The initial spike in utilization immediately following the reforms led to increases in drug stock outs in the country. However, the initial increase was followed by a return to stock-out levels that were similar to pre-reform levels, which are still extraordinarily high with an average of 70% of facilities experiencing stock-outs. The persistent stock-outs prior to and after reform necessitate additional interventions to ensure timely and consistent access to essential medicines through improvements in the supply chain. Stock-outs are associated with increased expenditures on medicines from private suppliers leading to concerns of self-medication and prohibitive out-pocket expenditures. While public reforms have resulted in the greatest benefit for the poor in terms of service utilization, the private sector remains a large provider of services for poor and rich alike contributing to continued catastrophic expenditures on health. The private sector includes a wide array of service providers, from private not-for-profit clinics to informal for-profit drug shops; despite reforms to the public sector, a study in several rural districts in Uganda showed that over a third of individuals seek self-treatment from unregulated informal drug shops and a significant proportion also choose private facilities over public facilities. Several studies have also reported quality concerns in regard to insufficient staffing and health workers themselves have reported negative attitudes towards their jobs. However, despite some negative reports regarding health care workers, positive community perceptions of health care workers and satisfaction with illness outcomes have also been reported in qualitative research. Quality issues are tied to the continued underfunding of the health sector, despite the initial funding increase at the time of reform, and would likely be improved with increased financing for staff and investments in proper communication of drug needs to government distributors.

With a mix of success between increased equity of access to services and concerns about quality and continued out-of-pocket expenditures, the greatest question with the fewest answers is the impact of reforms on health outcomes over the past decade. Initial reports showed immediate decreases in health care rationing and in the probability of adults and children getting sick with an estimated $9 million in wages not lost as a result of decreased absenteeism from work. However, the story is not entirely positive because the decrease in probability of getting sick was greater in the wealthiest quintile of children (4.54%) and lowest in the poorest quintile (1.61%). Additionally, malaria, which contributes to a large number of deaths each year, is still poorly diagnosed and treated. Table 1 displays key health indicators in Uganda before and after reform. Despite improvements on many indicators, Uganda is still lagging behind. Particularly concerning are the growing out-of-pocket expenditures, which have actually increased from 41.5% in 2000 to 51.9% in 2009. Additionally, it is important to understand the limitations of the data available to analyze health impacts. It is nearly impossible to causally relate any changes to health reforms as there are countless other factors at play and studies must rely primarily on secondary retrospective analyses. However, based on the best available evidence, abolishing user fees has been a smart policy decision because they achieved an increase in health care equity.
The next key steps for Uganda are developing policies to address current deficits within their system of free care, specifically mechanisms to address drug shortages (ie., addressing imperfect information) and quality of care (ie., performance-based incentives for health care workers).

Table 1: Key health indicators in Uganda before and after abolishing user fees

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<tr>
<td><strong>General Health Indicators</strong></td>
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<tr>
<td>Life expectancy at birth</td>
<td>44.87</td>
<td>46.09</td>
<td>49.3</td>
<td>51</td>
<td>53.1</td>
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<tr>
<td>Infant Mortality Rate (per 1,000 live births)</td>
<td>99.7</td>
<td>87.7</td>
<td>77.3</td>
<td>71.8</td>
<td>65</td>
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<tr>
<td>Under-5 Mortality Rate (per 1,000)</td>
<td>166.9</td>
<td>144.3</td>
<td>125</td>
<td>115</td>
<td>102.6</td>
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<td>Maternal Mortality Ratio (estimate, per 100,000)</td>
<td>690</td>
<td>640</td>
<td>-</td>
<td>435</td>
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<td><strong>Curative Health Care Indicators</strong></td>
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<td>Percent of children with an acute respiratory infection taken to a health facility</td>
<td>61.4%</td>
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<td>-</td>
<td>73.3%</td>
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<td>Tuberculosis Case Detection Rate (percent of all forms of TB)</td>
<td>22%</td>
<td>29%</td>
<td>49%</td>
<td>49%</td>
<td>57%</td>
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<td><strong>Preventative Health Care Indicators</strong></td>
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<td>Measles Immunization Coverage (percent of children 12-23 months)</td>
<td>57%</td>
<td>57%</td>
<td>66%</td>
<td>71%</td>
<td>63%</td>
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<tr>
<td>Percent of pregnant women receiving prenatal care</td>
<td>91.2%</td>
<td>-</td>
<td>-</td>
<td>93.5%</td>
<td>-</td>
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<td>Percent of deliveries attended by skilled health staff</td>
<td>37.8%</td>
<td>-</td>
<td>-</td>
<td>41.9%</td>
<td>-</td>
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<td>Contraception prevalence (percent of women 15-49)</td>
<td>14.8%</td>
<td>-</td>
<td>-</td>
<td>23.7%</td>
<td>-</td>
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<tr>
<td>Total Fertility Rate</td>
<td>7.0</td>
<td>6.9</td>
<td>6.7</td>
<td>6.5</td>
<td>6.2</td>
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<td><strong>Health Financing Indicators</strong></td>
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<td>Out-of-pocket expenditures on health (percent of total expenditures)</td>
<td>55.69%</td>
<td>41.49%</td>
<td>42.9%</td>
<td>51.9%</td>
<td>53%</td>
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<tr>
<td>Public health expenditure per capita (current US$)</td>
<td>$15.48</td>
<td>$15.47</td>
<td>$22.30</td>
<td>$31.90</td>
<td>$42.50</td>
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<tr>
<td>Public health expenditure as percent of GDP</td>
<td>1.6%</td>
<td>1.8%</td>
<td>1.9%</td>
<td>1.8%</td>
<td>1.6%</td>
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Source: World Bank, 2011

Conclusion

Broad policy reforms such as abolishing user fees certainly have heterogeneous impacts and testing such policies is extremely difficult and context specific. Accordingly, the evidence in this paper is nuanced and country context can drastically change the outcomes of abolishing user fees. Prior to sweeping reforms in health financing, great considerations should be made regarding historical and cultural contexts within a country. Additionally, piloted randomized control field trials would greatly strengthen the scientific knowledge base and help inform the best methods for formulating and implementing fee-reforms. As outlined in this paper, abolishing user fees addresses a number of the health sector market failures, however, major failures of asymmetric information in the credit and insurance markets are primarily side-stepped and remain pervasive barriers to development requiring additional interventions. However, the increased equity in access to care achieved in Uganda through the abolition of user fees makes this policy approach one of the most promising for achieving universal access to health care in SSA.
References

