

USER FEES IN AFRICA: FROM THEORY AND EVIDENCE, WHAT NEXT?

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User fees are defined as amounts levied on consumers of government goods or services in relation to their consumption. They are also the amounts of money levied on individuals for the use of goods and services from which they receive 'special benefits' (Duff, 2004). Arguments in favour of user fees include: (i) increasing economic efficiency whereby scarce resources are allocated to their most valuable uses both within the public sector and between the private and the public sectors; (ii) the levies charged enhance the accountability of the public sector, making it more responsive to differing preferences and changes in the demand for publicly provided goods and services; (iii) cost recovery and increased equity; and (iv) the idea of benefit taxation is applied based on the principle of 'fairness' as every payer pays only for the goods and services that they use.

For the opponents of user fees, it may impose a heavier burden on the poor who are most likely to face a higher burden of disease (Nyanator and Kutzin, 1999; Gilson, 1997) where in this case, the distribution of publicly provided health care services on the basis of these fees contradicts the very purpose for which public provision was intended and budgetary flexibility will be limited where revenues are earmarked to health expenditures on the publicly provided health services from which the revenues are derived. This has led to sustained decreases in service utilization (Nyanator and Kutzin, 1999). Also, attitudes of individuals towards user fees can adversely impact on government revenues as well as their political viability.

Based on economic theory and on the ground of efficiency, imposition of user charges in public health centres is justified only where the value of the publicly provided service that are financed by the user fees exceeds the value of the health care service that the payer could otherwise obtain in the private sector. This simply implies that user fees are appropriate only where the marginal value of an additional dollar of user fees on health services in the public sector exceeds the marginal value of an additional dollar in the private sector (Duff, 2004). Evidence has shown that increased user charges have acted as signal for private sector providers to increase their fees (Jacobs and Price, 2004)

In the early 1980s studies showed that prices may not be important determinants of the demand for health care or worse still, a positive impact on the demand (Akin *et al.*, 1984). Later studies show that previous studies were bereft of quality data and that prices do have a significantly negative impact on the demand for health care especially in developing countries (Gertler and van der Gaag, 1988; Mwabu, 1986) and on the poor. Studies in Africa have shown user fees not to be viable considering over 15 African countries over a range of time (Vogel, 1991). This is because the poor are usually very sensitive to small changes in prices even for goods that are necessities such as health care. With the strong link between health and poverty, there is no doubt that user fees are likely to induce the medical poverty trap phenomenon. This is because the poor who cannot afford private health care services due to the high costs can also no longer afford to use the public facilities. This leads to untreated morbidity, reduced access to health care, long-term impoverishment, and irrational drug use (Whitehead *et al.*, 2003). Evidence has further shown increased inequities associated with user fees (Nyanator and Kutzin, 1999).

Experiences in some African countries such as Uganda where user fees were abruptly removed in 2001, South Africa in 1994 during the period of transition to democracy has led other similar countries such as Rwanda, Zambia, Burundi, Democratic Republic of Congo and Niger to implement similar reforms though on selected facilities or services. These have been instructive in increasing the utilization rates of public health services (Yates, 2007) and women are also likely to benefit from reduction in user fees (Lawson, 2004). In other countries such as Ghana, it is difficult to monitor the

impact of fees on the population as facility managers duplicate and establish their own pricing and fee collection system (Nyanator and Kutzin, 1999).

The elimination of user fees in some African countries was driven mainly by political motivation for vote maximization in line with William Nordhas' submission¹. Even at these instances, utilization rates increased. It is most likely that the poor show 'internal' resentment but due to their low representation, it is often difficult for their views to be considered in Africa. A case of efficiency can be made if the revenue from user fees are channeled into provision of good quality health care, increase availability of drugs, and prompt services which should mitigate the negative effects created by lack of access to quality care (Nyanator and Kutzin, 1999). However, it is usually not the case that such revenues are well accounted for. Sometimes, certain conditions and policy measures need to be put in place for implementation of user fees to have a minimal undesirable effect (Gilson, 1997) but these could in themselves reinforce the adverse effect of user fees which is suffered by the poor. While some of the policies are good, they are often open to abuses that render them ineffective in achieving the aim in the African setting. Outside Africa, experimentation of user fees has also been a poor experience.

In Africa specifically, the bulk of the problem is financing health care for the poor and predominant rural dwellers. While the poor are more sensitive to price changes, it is not to say that utilization of health care services should be 'free-of-charge'. In pure economic sense, under competition, every economic agent should be made to face the marginal cost of their actions. The case of health care is special given that health care is a right, a necessity and possesses externalities. Poor individuals cannot face both their private and social costs. In this regard, the use of community health insurance or prepayment schemes have been found to be viable even from experiences in parts of Africa and they are further viable when integrated into the broader perspective of national health insurance schemes or to microfinance institutions.

The idea of universal coverage is likely to increase access of the poor to health care most especially when cross-subsidization is possible. This is because user fees have generated questions of equity and efficiency and we need a way forward. While we argue that there is hardly any fit-it-all solution for most societal problems, there is likely to be solutions that increase buy in from most stake holders. We need, therefore, indigenous and innovative methods of financing health care that imposes financing health care according to ability to pay but at the same time benefits and access to care are distributed according to 'need' for care. This will involve a form of 'internal' private bargain such as that achievable under the Coase Theorem such that the demand for health care does not depend on the distribution of income². This is more related to social solidarity which is very likely to produce valuable results in the African setting.

Conflict of Interest (COI)

Professor Diane McIntyre was a lecturer to the authors and also a colleague of one of the authors.

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¹ This is based on the theory of political business cycle.

² This simply imply that we assume that consumers' preferences are quasi linear.

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