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April 30, 2008**

## **User Fees for Health Services in Africa**

The concept of user fees continues to be a “hot topic” in African health financing forums and discussions. In recent years some African countries such as Uganda have done away with the fee requirements. Others have made modifications to their policies. For example, Zambia removed fees only in rural health facilities, in Burundi fees were removed for maternal and child health services while in the Democratic Republic of Congo, Rwanda and Niger fees were removed at selected facilities (Yates 2007).

The controversy started in 1987, when the World Bank recommended that the principle of cost recovery be incorporated into an agenda for financing publicly provided health services in developing countries (Shaw and Griffin 1995). Opponents of the user fees have purported the idea that less utilization of healthcare services has been experienced especially by vulnerable communities such as women and children in poorer societies. Additionally, out of pocket payments are a regressive form of healthcare financing as they capture higher proportion of income among poor households than wealthier ones (Gilson and McIntyre 2005). The elimination of cost sharing fees coincided with an increase demand of government provided healthcare among women in Uganda (Lawson 2004).

There are few examples available from proponents of the user fee policy. Perhaps this is due to the fact that in the past, too much emphasis was placed on raising revenues and too little on how cost sharing a form of user fees, might contribute to the efficiency, equity, and sustainability of national health systems (Shaw and Griffin 1995). This paper’s objective is to present a case for the continual utilization of user fees for health services in Africa.

In Kenya, cost sharing was introduced in December 1989 (Ngugi 2000). From the experience of Kenyatta National Hospital (KNH) a tertiary care and teaching facility in Nairobi Kenya, cost sharing has provided an additional source of funds. Revenue has increased from 1% of KNH recurrent income in 1986/87 to around 10% in 1993/94 (Collins, Njeru et al. 1999). As the funding increases from the user fees, the financial support originally intended for allocation at this hospital by the ministry of health can now be reallocated to other primary care facilities at local and district levels. This would be in line with the longstanding concern of governments and donors in Africa of reallocation of funds from tertiary to primary levels of healthcare (Shaw and Griffin 1995).

Previous studies have suggested that donor funding might be used to support user fee removal (Gilson and McIntyre 2005). Generally, most donor funding goes to capital or development budgets rather than financing of recurrent operating expenses such as salaries, drugs equipment and maintenance (Shaw and Griffin 1995) that user fees provide. Additionally, donor funding would be best utilized for emergency or catastrophic purposes such as the recent election violence experienced in Kenya after the December 2007 elections. The violence resulted in the creation of internally displaced persons that could not provide user fees for care in which case the use of donor funding would be appropriate.

While user fees have been touted as inappropriate due to the exclusion of poorer communities, they have also decreased the phenomenon of moral hazard at hospitals. Before implementation of cost sharing at KNH, it was not uncommon to have would be patients show up for care because treatment was “free.” Although the statistics are not

available it can be assumed that consumption of healthcare increases because it is subsidized (Feldstein 1998). This resulted in inappropriate use of medications prescribed leading to increased prescription costs and in cases of antibiotics, drug resistance. At the same time, these “patients” that did not really require medical attention would request time off from work because they could get documentation that they had been attended to and given medications. Eventually, this would result in overcrowding of facilities, decreased quality of care and escalation of costs of care to society. Costs to society would also be seen in relation to absenteeism from work.

The user fees seen in cost sharing creates the expectation of better services (Ngugi 2000). In a recent Ugandan study where other determinants of health seeking behavior was analyzed, increased levels of education was associated with significant transfer away from government healthcare indicating government provided healthcare to be of an inferior quality (Lawson 2004). The study was conducted after a recent change in policy where user fees were eliminated. Additionally, decrease in morale for the healthcare workers who may see their wages decline as a result of user fee removal, may provide poor quality care related to increases in work load from increased utilization.

To prevent such negative impacts of removal of fees, there are other options of providing healthcare to the poor while maintaining sources of revenues for hospitals. At KNH, patients who cannot afford the user fees are assigned social workers to assist in provision of care. This ensures that no patient in need of care is turned away and at the same time preventing misuse of resources.

Another idea that has been implemented by health systems in India is the provision of community level affordable insurance. In Karnataka region the Yeshasvini

insurance scheme provides insurance for milk cooperatives, teachers and in the future families living in a common area. Such an insurance scheme would help offset user fees and other medical expenses and at the same time ensuring financial sustainability of health systems.

Although not meant as a deterrent to seeking healthcare, user fees have been criticized as creating a barrier to healthcare yet few studies have been done to assess the fees effect on efficiency, equity, and sustainability of national health systems. While user fees may pose a problem to the poor there are solutions to ensuring provision of care to the patients in need. Solutions such as utilization of social workers and implementation of community level insurance projects may provide sustainable ways of meeting healthcare needs of the African communities.

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