USER CHARGES FOR HEALTH CARE: 
PROGRESSIVE REFORM OR REGRESSIVE SOCIAL POLICY? 
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Introduction

The theme of this session is the impact of user charges on child poverty, and I am billed to present Plan’s research on health care user charges. Let me start with a slight correction. We did not conduct any research on user charges for health care. I will present some original and unpublished research data relevant to the subject. But these data were generated in a three country study we undertook last year in order to explore our own record, as an NGO, in addressing health inequities in our partner communities.

Health or health care?

No matter what I will tell you today, I will not be able to fix the intellectual short circuit that makes you think of health care services when I talk about health. No matter how enlightened we are, we all have a model in our heads that looks something like this graphic.

We all know that things are a lot more complex than that, but when somebody reminds us of the complexity, somebody who is an outsider or even a politician (like Thabo Mbeki), we shout blue murder.

There is a big difference between consuming health care and producing health. (Evans 1994) This is the reason why we have ever-growing health care bills in industrialised countries without marginal returns in terms of better population health.

It is important to remember this in a discussion of user charges. Because user charges in industrialised countries have little to do with health care financing. They are imposed in order to remove the ‘moral hazard’ of a free services. The main point of user charges in the industrialised world is that they are supposed to eliminate ‘excessive use’ of health care services.

In West Africa, where I work, the situation is quite different. More resources to increase the supply of health care would indeed make a huge difference in the health of the population, and especially the health of children. User charges in West Africa are an issue of health care financing – among others.

A brief history of user charges for health services

State involvement in financing health services dates back about 120 years to the enactment of a law in Germany in 1883 requiring low-income workers to enrol in state-sponsored health...
insurance. This was the start of ‘social insurance’ which spread quite rapidly throughout Europe.

Derived from these insurance schemes were the national health insurance systems financed from general revenue. Usually, they provided comprehensive benefits for all citizens, on the premise that access to health care was a social right. These systems were first found in the USSR and the former communist countries of Eastern Europe, and were then introduced to New Zealand, later to the UK, and, with some modification to Canada.

Some user charges were always part of national health insurance systems. The following arguments are usually raised in their support:

- They limit the overall cost of health services (for instance by creating an incentive to buy generic rather than proprietary drugs);
- They limit abuses or “frivolous use” of health services by patients;
- They limit the over-servicing of patients by providers;
- They increase the patients’ sense of responsibility;
- They improve the quality of care (by making providers more accountable to patients)

In 1979, the Ontario Council of Health commissioned an international review of user charges for health services (Badgley 1979). The main findings of this very extensive study were:

- User charges decrease utilisation of health services, at least in the short term. The decrease is selective, and affects primarily the poor and the elderly.
- User charges produce a rebound effect with partial displacement of care from less to more expensive categories of service.
- There is no information on the efficiency of collecting user charges (i.e. the cost of fee collection is generally not known, nor is it taken into account).
- There is no evidence that user charges reduce unnecessary use of medical services.
- Market models of supply and demand do not apply to health services, because the service a patient receives is generally determined by the provider (referrals, laboratory tests, return visits, etc.)

In Africa, the introduction of user charges for health services took a somewhat different course. Following decolonisation, most countries adopted a model of financing health care from general government revenue. However, it soon became evident that they did not have sufficient tax income to meet the competing needs of social and economic development. During the 1970s and 1980s, there was a strong push for the introduction of user charges for health services. It came from two sources:

- The Alma-Ata Declaration for Primary Health Care (1978) and the Bamako Initiative of the African Health Ministers (1988) aimed at increasing the community governance of peripheral health services. Community financing was one way of reaching this objective.
- The World Bank Report *Financing Health Services in Developing Countries: An Agenda for Reform* (1987) reflected a process of sector reforms pursued by the international development agencies and linked to structural adjustment policies. Its focus was on cost recovery and health sector financing.

Over time, the policies pursued under the two approaches began to merge and became indistinguishable. With time, even the NGOs who were highly critical of the structural adjustment policies of the international financial institutions began to accept that user charges were the only means to achieve sustainable health services.

Ghana was one of the first countries in Africa to introduce health care user charges in the early 1980s. By 1987, Ghana had reached its target of recovering 15% of its recurrent health care budget through user charges. The government authorised facilities to use this additional income to make service improvements and buy drugs. However, the level of cost recovery
was not sustained. In subsequent years, cost recovery level fell back to between 1% and 12% (Gilson 1995).

The net revenue gains from user charges are determined by utilisation rates and by the cost of revenue collection. A review of health service utilisation rates in Ghana following the introduction of user charges found the following: (Waddington 1990)

- After one year, outpatient attendance dropped by 50 percent in rural and urban areas. After four years, urban utilisation rates were back to original levels, while rural rates had not changed.
- The share of health care utilisation by the 15-45 year age group increased from 27% to 42%, the main fall in utilisation was among the elderly.

Another study found that user charges were a major deterrent to seeking health care, a major cause of delay in seeking treatment, and a cause for Ghanaians to turn to traditional medicine and to self-medication (Asenso-Okyere 1998).

Very few studies in Africa reported an increase in service quality and an increase utilisation rates of health services following the introduction of user charges (Litvak 1993, Wouters 1995) Most studies found that user charges did not achieve the expected benefits for national health service financing, while at the same time increasing health inequities. We are now hearing more and more voices demanding alternate health care financing strategies (e.g. Arhin-Tenkorang 2001):

- In the short term, increased international development assistance and increased government budget allocation for health and social services.
- In the long run, the development of social health insurance.

**Our findings in a three-country study in West Africa**

Plan works primarily in rural communities in 11 countries of West and Central Africa. In 2003/2004 we conducted a study to look at a number of health equity issues in our partner communities. We chose five rural communities in Senegal, Burkina Faso, and Ghana. In each community we conducted surveys of 400 randomly selected families.

We found that even in these universally poor communities, we were able to stratify families into five social classes, based on 11 indicators, like the type of house they lived in, the type of fuel they used for cooking, their diet, and the education level of the head of the household.

The figure shows the social distribution of families in the five communities. The lowest social status is designated as Class 1, the highest as Class 5. The three graphics suggest a correlation between the equity of distribution and the human development index of each country. Ghana having the most equitable distribution, followed by Senegal and then Burkina Faso, a sequence that is repeated in the league tables of UNDP Human Development Index. (UNDP 2004)
Figures A to C present some of our findings on access to health care and on health outcomes by social status.

We observed a strong correlation between social class and the utilisation of health services for obstetric care. Most socially disadvantaged women delivered at home, while most women of higher status in the community delivered in a hospital or health centre.

We also found a similar pattern for curative health care, with a clear trend of the better-off frequenting secondary health care facilities (hospitals and private physicians), while the poorest tended to go for treatment to village health posts, traditional healers, neighbours, or ambulant drug sellers.

However there was no correlation between immunisation coverage and social status. Immunisation is free of charge, and it is also an area of concentration of Plan programs in the surveyed communities. Among the 3280 children under five in the surveyed families, 91 percent were reported to have up-to-date immunisation, and mothers were able to produce immunisation cards for 2,500 among them. Based on inspection of the cards, we had documented evidence that at least 66% of children had up-to-date immunisations.

There was no significant difference in immunisation coverage between social classes, but when we asked about the 242 children who were reported as not immunised we saw some interesting trends. One in 13 poor children in the lowest social class did not receive adequate immunisation because of barriers of access. The families stated that the immunisation services were not available, or that the services were not affordable. This proportion was notably higher than that observed in the other social classes, although the sample size was insufficient for meaningful statistical testing.

The response was somewhat surprising because immunisation is offered free of charge in all of the surveyed communities. It points to an important and often overlooked aspect of health care cost.

The cost of health care to patients and families is not only the user charge, it also includes the access cost (transport, waiting time, etc.) Our study showed that poorer families tend to live at greater distance to health care facilities. They are therefore likely to have greater access costs. This indicates that health services other than immunisation that do attract a user charge may exacerbate already existing cost barriers to equity.
Finally, we analysed the 668 deaths reported by the surveyed families over the past two years. 283 of them could be classified into four presumptive causes:

- 178 deaths from malaria, fever, or anaemia.
- 49 deaths from respiratory Infection, pneumonia, or tuberculosis
- 34 deaths from diarrhoea
- And 22 deaths from complication of pregnancy or child-birth

There are two statistically significant linear trends for death from all causes and for death from diarrhoea. Remarkable is also the large difference in maternal mortality between social classes, although there were too few cases to establish statistical significance.

**In summary**

Our study confirmed many recent reports that social stratification of poor rural populations has an impact on equity in access to health services and health outcomes. From a health equity perspective, it is not sufficient to simply shift resources to rural primary health care services. We also do not know very much about the social stratification of urban populations, and the health inequities that exist in the rapidly expanding cities in Africa.

We did not specifically examine the contribution of user charges for health services to the observed inequities. However, there is sufficient evidence from published research, that user charges contribute to health inequity. Furthermore, user charges are not delivering the promised returns. Plan’s support programs for health centre management committees, community bed-net cost recovery schemes, and similar institutions in West Africa are all reporting the same thing: The external aid resources invested in supporting the management of these cost recovery schemes is invariably higher than the revenue collected. Quality improvements in health services depend on many different factors, and local cost recovery is not necessarily the most important.

Wherever we work, our programs support the Government health policy. It is time that Governments in Africa review their experience with health care user charges and rethink their approach. Given that the general budgets of many Governments on this continent are up to 50 percent donor funded, it is even more important that donors start exploring options other than user charges for the development and delivery of health services in Africa.
References


Word Bank (1987) Financing Health Services in Developing Countries: An Agenda for Reform, World Bank, Washington D.C