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Impact on the Poor

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Arvil Van Adams
Teresa Hartnett

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Foreword

Diversifying sources of financing for social services is a familiar theme in World Bank lending and dialogue with government clients. Nowhere is this more important than in Sub-Saharan Africa where a decade of economic retrenchment and rising population pressures have lowered the capacity of many governments to finance education and health care for all. Instead, fiscal realities have forced governments to depend more heavily on private financing for expansion of these services and improvements in their quality.

The World Bank encourages governments to target private financing through user fees to those social services that are consumed primarily by the non-poor and divert public spending to basic education and health care for the benefit of the poor. Steps to protect the poor with exemptions from fees have been part of the package advocated to improve their access to basic social services. Whether or not these messages are being heard and translated into effective policies on the ground is a growing concern in the development community.

These issues are at the heart of the present study. Looking through the lens of Sub-Saharan Africa, the advice and guidance given to governments by the World Bank for adopting user fees is examined along with the history of the policy and scope of its application in education and health. The central question addressed, however, is, what has happened on the ground to the poor? Has private financing been adequate to expand access to basic social services for the poor or has it fallen short and what lessons can be drawn from the experience?

The study is a candid assessment of user fees as applied in Sub-Saharan Africa. While sober in its assessment of the practical problems confronted in implementing these fees and protecting the poor, the study is optimistic and suggests a series of interrelated actions to achieve the goals of basic education and health for all. These actions must be part of broader efforts to mobilize resources. Building a consensus around them amongst donors, governments, non-governmental organizations, and civil society will require an open dialogue on the evidence and options for the financing of social services.

Kevin Cleaver
Director
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Abstract

This study reviews the African Region of the World Bank’s current thinking on cost sharing and the poor as applied in Sub-Saharan Africa. It inventories country experiences and Bank activities in cost sharing for education and health, reviews African experiences with the implementation of cost sharing, and assesses the lessons learned. While sober in its assessment of the practical problems confronted in implementing cost sharing and protecting the poor, the study is simultaneously hopeful as it looks to the future and offers a series of interrelated actions to achieve the goals of basic education and health for all.
Acknowledgments

This paper was prepared by Arvil V. Adams and Teresa Hartnett under the general supervision of Mrs. Ishrat Z. Husain, Chief, Human Resources and Poverty Division, Africa Technical Department and Mr. Kevin Cleaver, Director, Africa Technical Department. The authors gratefully acknowledge the advice from within the World Bank of Mark Blackden, Claude Bodart, Theresa Bradley-Fiscilla, Nat Colletta, David de Ferranti, Sakhevar Diop, Edward Elmendorf, Margaret Grecco, Charles Griffin, Ward Heneveld, Andrew Norton, Harry Patrinos, Helen Saxenian, Jacques van der Gaag, and Jack van Holst Pellekaan. The paper has also benefited from the comments of external reviewers including M.G. Foster, Terry Allsop, and Mark Pearson from the British Overseas Development Administration; Kevin Watkins of Oxfam; and Jan Vandemoortele of UNICEF. The views presented in this Report are those of the authors and should not be attributed in any manner to the World Bank, to members of its Board of Executive Directors, or to the countries they represent.
Executive Summary

Cost sharing in health and education is neither new nor rare in Sub-Saharan Africa. Communities, families, and individuals as users pay some of the cost of these services through user fees. The remainder is paid by other sources such as the central government from tax revenue and external aid. User fees, broadly defined, include: cash payments for services; in-kind contributions such as materials or labor for construction of schools or clinics; pre-payment or insurance schemes; and illicit fees that users sometimes have to pay, for example, tipping someone to see a doctor. A 1995 survey of thirty-seven African countries found that thirty-four have fees of some kind for government-provided health services. Fees are also widespread in education.

Both before and during colonial rule in Africa, users bore most or all of the costs of health and education services. With the post-colonial push to provide greater access and improved quality, efforts were initiated to have governments deliver health and education free of charge to users. By the 1980s, however, it had become abundantly clear that governments did not have the financial resources, and never would have, to pursue successfully a policy of free universal services for all. The realities of rapid population growth, faltering economic development, weak institutional capabilities, and limited external assistance could not be avoided. Even the industrial countries have not provided so much of their health and education services free to users and with so much central administration. Africans found that policies of free services for all resulted in poor services for some and no services for many.

As these facts unfolded, established ways of cost sharing persisted or expanded, and newer ways -- including central government fees at schools and clinics -- grew in importance. Greater cost sharing, it was hoped, would help the poor because it would mobilize more resources from better-off groups and those resources could then be used to improve services for poorer groups. For this goal to be achieved, though, the poor needed to be exempt from fees or otherwise protected. Experience in and since the 1980s has shown that the poor have not been effectively protected in many cases. Planning for new or higher fees has frequently outstripped adequate preparation and implementation of exemptions or safety nets.

The challenge now is to determine, in light of much experience, what makes most sense for the years ahead. On the one hand, reverting to notions of no fees for anyone would lead nowhere, since the fundamental problem of insufficient resources would only get worse, choking off prospects for better health and education for millions in need. On the other hand, pressing forward where fees hurt the poor would not help either. A middle ground between these extremes would be the application of more careful and selective cost sharing, and with greater attention to improving the practical aspects of implementation. Under this option, (a) caution would be urged wherever adequate protection for the poor is in doubt; (b) stronger action would be encouraged in cases where there is strong likelihood the poor will benefit, as resources are mobilized from the
non-poor; and (c) a broad range of measures would be used to strike this balance, including, for example, community-based financing, non-government provision of services with public financing, and decentralization of government services.

This paper explores all the foregoing within the context of reviewing the cost sharing experience of World Bank-assisted projects and programs in Africa. It inventories country experiences and Bank activities in cost sharing for education and health in Africa, and assesses the lessons learned. The paper does not attempt to define a financing strategy for the social sectors, although some of its findings may be helpful for that purpose. It is written principally for Bank staff, with the knowledge that the topic will be of interest to a wider audience of policy makers, analysts, and non-governmental organizations.

The paper’s conclusions lead to a number of observations and recommendations:

- As countries strive to mobilize more resources to improve education and health services, there are many questions to ask before focusing on user fees for government facilities. For example, is everything possible being done to:
  ◦ reduce misallocation and waste of public resources in other activities such as subsidies to public enterprises, and spending on military purposes?
  ◦ minimize losses due to ineffective tax systems and administrative inefficiency?
  ◦ ensure that better-off groups pay for services through the special advantages they have (e.g. employers can be asked to provide health coverage for their employees, sharing the full cost between them)?
  ◦ allow providers other than government, whether NGOs or private sector entities, freedom to operate, with enough oversight also to prevent outcomes inconsistent with public needs?

- When fees are considered, every effort should be made to put local communities in charge, rather than having top-down approaches imposed on them by central governments. Local control should determine, as far as possible, whether to have fees, what they should be for, how high they should be, who should administer them, who should get the proceeds, and how the revenue should be used.

- For basic services -- primary education and primary health care -- fees should be discouraged unless adequate protection for the poor is assured. The crucial benefits that these services have for societies require the strongest possible efforts to provide easy access for all. For countries unable to sustain free or highly subsidized basic social services, the way should be left open for cost sharing, but within the framework of placing local communities in charge.

- For higher-level services -- tertiary hospitals, university education, and to a lesser extent, secondary schools -- cost sharing is often inescapable if countries are to
improve services generally. Reallocation of some public spending to primary services should be stressed. Options for helping users cope with fees should also be developed. For higher education, loan schemes can help. For hospitals, giving people choices about the quality of their accommodations (e.g. four persons to a ward or twenty) and charging them accordingly can make a difference. More attention can be given to pre-payment schemes and privately-financed insurance for health care.

- Economic analysis can improve policy design. More analytical work should be focused on the modalities of cost sharing and their impact on households. The actual level of cost sharing for basic services and its gender dimensions should be assessed. The often neglected benefits of cost sharing should be considered alongside the costs in determining the net impact of cost sharing on the poor. Governments should be assisted in monitoring and analyzing the impact of changes in cost sharing arrangements on the poor and disadvantaged.

- Practical considerations matter. Different solutions may be required for rural and urban areas, and for highly and poorly literate regions, but also for regions with strong and weak traditions of private sector provision of social services. Piloting cost sharing initiatives should be encouraged to avoid costly mistakes and to learn from consumers what works best for them. Monitoring and evaluation programs are critical to learning on the ground from pilot initiatives.
I. Introduction

Rich and poor countries alike have adopted policies to share some of the costs of publicly-financed social services, and countries in Sub-Saharan Africa (SSA) are no exception. These policies assumed increasing importance in Sub-Saharan Africa in the 1980s, as governments throughout the region faced slower economic growth and rising deficits that made public expenditure levels unsustainable. The need to diversify financing and reshape public spending became widely evident as governments found it increasingly difficult to pay for the social services demanded by citizens. This situation posed a threat to the poor’s access to basic education and health care.

The steps taken by governments to diversify the financing of social services and share the cost with communities and users have produced their own risks for the poor’s access to basic social services. Cost sharing refers in this case to all contributions and fees paid by communities and users, whether in-kind or in cash, for the delivery of social services. The result of both is to lower the demand for government spending. Excluded are the opportunity costs of the user’s time in acquiring the services. Cost sharing was already well established in the post-colonial period with communities providing in-kind contributions to the construction and maintenance of schools and health clinics.

The widening of cost sharing with the expansion of user fees in the 1980s presented a new threat to the poor and their ability to afford basic education and health care. User fees offered a means to recover some of the costs of publicly-financed social services. Experience shows that while protecting the poor from the cost of user fees is achievable, it is not a simple task. Careful attention has to be given to design and implementation issues, including which services should be highly subsidized by the public, what role communities should play in cost sharing, how fees are reinvested, and how the gender dimensions of the policy are handled. The World Bank addresses these and other issues in its lending and dialogue with countries.

This paper examines the outcome on the ground of cost sharing for the poor. It reviews the African Region of the World Bank’s current thinking on cost sharing and the poor as applied in Sub-Saharan Africa. The paper inventories country experiences and Bank activities in cost sharing for education and health, reviews African experiences with the implementation of cost sharing, and assesses the lessons learned. It does not, however, attempt to define a financing strategy for the social sectors. The paper is written principally for World Bank staff, with knowledge that the topic will be of interest to a wider audience of policy makers, analysts, and non-governmental organizations.
II. The World Bank on Cost Sharing

In the 1980s, several Bank reports analyzed the potential role of cost sharing in the social sectors. Cost sharing through user fees was seen as improving social equity, protecting the poor's access to services, and increasing ownership, accountability and economic efficiency. The reports recommended that user fees be designed to fall mainly on social services consumed by the non-poor. These included tertiary and secondary education and tertiary health services. Placing user fees on these services would make consumers more cost-conscious and providers more efficient and allow the shifting of public expenditures to basic education and health care. Providing free or highly subsidized basic education and health care would expand the consumption of cost-effective services that contain positive social externalities.

Health

The first major World Bank health policy paper that gave serious attention to cost sharing was the document *Financing Health Services in Developing Countries: An Agenda for Reform* (World Bank 1987a). User fees were recommended as part of a package of reforms that countries could consider to improve the equity and efficiency of services, including the introduction of insurance or other risk-pooling mechanisms, the encouragement of non-governmental organizations as service providers, and the decentralization of government health services. The main arguments for user fees were that these fees, if applied properly, could increase resources available to the health sector, permit increased spending on under-funded programs, encourage better quality and more efficiency, and increase access for the poor to basic health services.

In the *World Development Report: Investing in Health* (World Bank 1993b), user fees were discussed in the context of how to finance national packages of essential public health and clinical services. The *Report* advocated that countries focus public spending on highly cost-effective public health and clinical services, at least for the poor. Targeting public spending on these services promised improvements in both equity and allocative efficiency. User fees were discussed as one instrument for targeting public spending. The *Report* also recognized the administrative and political costs of imposing user fees. It highlighted the role that user fees could play in improving the quality of services if these fees were retained at the local level and used to ensure, for example, the availability of drugs and other supplies.

*Better Health in Africa: Experience and Lessons Learned* (World Bank 1994a) supported user fees as part of a series of measures to finance basic health care in an environment of severe fiscal constraints. Taking into account the regional context and the limited capacity of countries to finance basic services, it offered support for user fees as one method of financing a package of basic health services. It emphasized that a client's willingness to pay fees depends on whether the fees are accompanied by improvements in
the quality of services. Retention of a substantial portion of fees at the collection site is seen as an important prerequisite to improving quality, particularly where community representatives monitor collection and use of the funds. And it emphasized how important good administrative and managerial practices are to successful cost sharing. Further, the report reviewed the economic arguments for determining what services should be subsidized.

**Education**

A 1987 study by the World Bank on the financing of education emphasized that primary education, because of its high social rate of return, should receive the highest public investment priority (World Bank 1987b). The study recommended that fees be introduced or increased for higher education, supplemented by student loan schemes and selective scholarships, and that the fiscal resources thus raised be reinvested, in the case of Sub-Saharan Africa, in primary education. The paper also advocated the decentralization of education management and the expansion of private and community-supported schools. The paper does not comment on the existence of fees at primary schools, nor on the potential impact of community cost sharing on the enrollment of poor children.

More recent Bank policy documents on education explicitly discourage cost sharing at the primary level. Some fees and various forms of cost sharing are, however, recommended in cases where the provision of schooling of an acceptable quality is unattainable with public funds alone. A study of education in Sub-Saharan Africa noted that:

...there may be situations in which the judicious use of modest fees might be used for the explicit purpose of increasing accountability in education. For example, a purchase fee or rental charge for textbooks and other materials that are crucial to high levels of pupil achievement would help to ensure that these inputs are not eliminated from the budget during times of fiscal austerity (World Bank 1988, p. 53).

Similarly, a policy paper on primary education, while stating that “cost sharing is more appropriate at higher levels than for primary education,” noted that significant sums have been generated at the local level by school-based organizations through school fees, voluntary contributions, and social fund-raising events (World Bank 1990, pp. 44-45). The World Bank’s 1995 education policy overview makes the strongest statement against fees at the primary level: “Cost sharing with communities [in school construction and maintenance] is normally the only exception to free basic education” (World Bank 1995b, p. 105). It goes further to encourage targeted subsidies for the poor to cover indirect costs.
The 1995 paper declared, "more educational attainment could be achieved with the same or even less public spending, particularly by...focusing public spending on lower levels of education and increasing its internal efficiency while relying more on private financing at the higher levels" (World Bank 1995b, pp. 67-68). The paper calls for selective charging of fees for upper-secondary education combined with targeted scholarships for the poor. For higher education, it recommended fees combined with student loans and scholarship programs to ensure that all who wish to borrow for their education are able to do so and to guarantee financial support to academically qualified low-income students.

The emphasis on public spending for primary education has led some to view the Bank as being opposed to higher education. The Africa region, however, has supported a balanced approach to public financing for higher education:

*Expansion of cost recovery at tertiary levels does not mean that governments should lessen their financial support to the subsector. Rather, promotion of broader financial participation should be seen as one way in which governments can help ensure the increase in financial flows needed for the improvement and ultimate expansion of higher education* (World Bank 1988, p. 80).
III. Cost Sharing in Sub-Saharan Africa

Cost sharing in health and education is widespread in Sub-Saharan Africa as well as in other regions of the world. User fees are not the only source of cost sharing as in-kind contributions also play an important role, especially in education. In the health sector, privately-financed insurance and pre-payment schemes have emerged as instruments for cost sharing in an environment where there is uncertainty about the timing of service needs and the availability of incomes with which to pay. Illicit fees exploiting access to social services are also evident in some cases. These direct costs are also joined by indirect costs in the form of the value of time spent by household members in acquiring education and health services. Although these opportunity costs do not influence government expenditures, they must be included in any cost analysis concerned with access of the poor to basic services.

Health

User fees for publicly-financed services are widespread in the health sector. A 1995 World Bank survey (Shaw and Griffin 1995), covering thirty-seven African countries, found that national systems of user fees are operating in seventeen countries. These fees play a relatively small role or are not enforced effectively in another eleven countries. In six countries, user fees are collected by individual facilities or communities and are not part of a national system. Only three countries do not have user fees in the government sector. Given the number of non-governmental organizations and private health care providers in Africa, households have considerable experience in paying for health services.

The stated aims of cost sharing in these countries are: raising revenue, improving the supply of drugs, and improving services or, more specifically, primary health care (Nolan and Turbat 1995). These objectives are not mutually exclusive and countries often list all three. Of the twenty-one countries that include improving the availability of drugs as one of the main objectives, nineteen participate in the Bamako Initiative, a cost sharing scheme that aims to involve communities in managing and financing health care. An important principle of the Initiative is that everyone is expected to pay at least something, and proceeds are used locally to improve primary health care services.

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1 National systems are operating in Benin, Burundi, Cameroon, Cote d'ivoire, The Gambia, Ghana, Guinea, Kenya, Lesotho, Malawi, Mali, Mozambique, Namibia, Senegal, Swaziland, Tanzania, and Zimbabwe. National systems are either minimal or not enforced effectively in Burkina Faso, Equatorial Guinea, Ethiopia, Guinea-Bissau, Mauritania, Nigeria, Rwanda, Sierra Leone, Sudan, Togo, and Zambia. Fees are collected only locally in the Central African Republic, the Congo, Madagascar, Niger, Uganda, and Zaire. User fees are not in place in Angola, Botswana, and Sao Tome and Principe.
User fees are complemented by other methods of cost sharing. In most African countries, local communities share the cost of health financing through in-kind contributions for the construction and maintenance of health facilities. Formal health care insurance, whereby a pool of funds held by a third party pays for the members’ health care costs, is available in six of twenty-one Anglophone and eight of sixteen Francophone countries surveyed in 1995 (Nolan and Turbat 1995). These services typically cover a low proportion of the population, and generally a higher-income segment, such as civil servants or other formal sector employees.

Pre-payment schemes, which limit the effects of fluctuations in seasonal income on people’s ability to purchase care, are operating successfully in a small number of countries at the health center level. In Guinea-Bissau, villages are participating in a prepayment scheme for drugs and basic services through annual collections made shortly after the harvest, when cash is readily available. The pre-paid plans enroll 75 percent of the villagers studied in selected communities (Griffin and Shaw 1995). These schemes are often built on existing traditional, community-based, informal safety nets (Parker and Knippenberg 1991).

Illicit fees also add to the costs paid by consumers. In Kenya, a poverty assessment revealed that while in theory the poor get fee waivers, people reported having to pay a small fee for registration and another small fee to get a prescription. They often had to tip someone to be seen by the doctors (World Bank 1995a).

Education

Cost sharing in education in Africa pre-dates the World Bank’s interest in the issue. During the colonial era, the economic changes that the colonial powers set in motion in Africa helped create a demand for Western-style education that, in many areas, seemed nearly insatiable. Both since independence and before, families and communities were required to contribute to efforts to expand education by bearing not only the direct costs associated with their children’s attendance, but also the costs of building school facilities. Local communities, especially in rural areas, expended substantial efforts at the lower levels with the clear understanding that the tertiary level was the exclusive responsibility of the state (Assié-Lumumba 1995). This system continues as governments respond to the articulate elite.

Cost sharing in education is extensive. Unlike the health sector, however, information about its scope is less systematic and consists mainly of country case studies. In Kenya, a 1992 household survey of direct costs (including uniforms, stationery, books, and *harambee* contribution), exclusive of in-kind payments, indicates that households contribute 34 percent of the total cost of primary education, 66 percent of secondary education, and only about 20 percent of higher education (World Bank 1995a). In Madagascar, households account for about a third of public spending on education (World Bank 1995c), and in Uganda, primary education would collapse if it were not for
the contributions of parents, which range from 65 percent to 90 percent of the total funding required by these schools (World Bank 1993a).

In Tanzania, in 1993, the government contributed nearly $15 per primary student, allocated almost entirely to teachers’ salaries and benefits. Parents added just under $8 to this sum. Without the parents’ contribution, there would have been no local funds for non-salary expenses (World Bank 1995g).

Tuition is only a small fraction of cost sharing in education. In Lesotho, government regulations prevent charging tuition, but a 1992 survey of primary schools revealed that a wide variety of other fees are charged and collected by virtually all primary schools (World Bank 1994b). In many African countries, communities traditionally have full responsibility for construction and maintenance and for providing teaching materials, while governments assume responsibility for providing teachers. This approach enabled Zimbabwe to reach universal primary education soon after independence.

Illicit fees are also a factor in education. Informal interviews in Mozambique with parents and teachers in Maputo reveal that high unofficial admission fees are charged in some schools, mainly at lower and higher secondary education, due to high demand and a limited supply of facilities (World Bank 1992). A fine line exists in many schools between teachers tutoring students outside the classroom to supplement their meager incomes and fees that become a quid pro quo for passing grades. Similar conflicts arise in the use of students in work activities to generate income for teachers or schools. In Cameroon (World Bank 1995d) and Zambia (Booth and others 1995), parents complain about the impact of student labor on learning.
IV. Bank-Supported Operations

Against a background of widespread cost sharing, just under half of Bank-supported operations in health are designed with cost sharing components. And surprisingly, less than one in five education projects include these components. These figures refer only to design. Thus, the actual number of cost sharing components implemented may be lower. The role of the Bank in cost sharing, however, is larger than its involvement in project lending, and includes the Bank’s dialogue with the large number of countries that maintain cost sharing policies. It is also evident in adjustment operations where the Bank is more likely to focus on protecting public spending on social services.

Health Investment Operations

Out of fifty population, health, and nutrition World Bank-supported projects currently under supervision in Sub-Saharan Africa, twenty-three include components related to cost sharing in the health sector (Table 1). These cover twenty-one countries. Annex 1 details the cost sharing element in each project. About half include components to improve institutional capabilities in cost sharing, including accounting, financial management procedures, and fee collection systems. One (Kenya) includes support for an information campaign to explain to the public the rationale for cost sharing.

<table>
<thead>
<tr>
<th>Country</th>
<th>Cost sharing dominated by national system of user charges</th>
<th>Some national system of fees but minimal or not enforced effectively</th>
<th>No national system of fees but some facilities or communities collect them</th>
<th>No apparent form of user fees or cost sharing in place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>Burkina Faso</td>
<td>Niger</td>
<td>Sao Tome &amp; Principe</td>
<td></td>
</tr>
<tr>
<td>Burundi</td>
<td>Equatorial Guinea</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cameroon</td>
<td>Mauritania</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Gambia</td>
<td>Nigeria (2 projects)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guinea (2 projects)</td>
<td>Sierra Leone</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Kenya</td>
<td>Togo</td>
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<tr>
<td>Malawi</td>
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<tr>
<td>Mali</td>
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<td>Senegal</td>
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<td>Tanzania</td>
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<tr>
<td>Zimbabwe</td>
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</tbody>
</table>

*Source of categorizations: Shaw and Griffin, 1995.*

In addition to lending, the Bank is active in the policy dialogue on cost sharing through poverty assessments, sector reports, and macroeconomic public expenditure reviews (PERs). The dialogue varies across countries. In some cases, Bank documents
simply encourage governments to implement or improve cost sharing systems, while in other cases, more detailed guidance and support is offered. A review of recent PERs concludes that cost sharing strategies overwhelmingly receive the most attention in the health sector section, and that most prescribe implementation initially for tertiary health care in urban areas (McGrory 1993).

Other Bank documents take a holistic approach to support the interrelated aspects of equity, efficiency, and sustainability of cost sharing schemes. For example, in Kenya, the Bank recognizes inequities in the health care system and recommends four major policy reforms directed at reducing these inequities: (a) significantly increase cost sharing in the hospitals, with appropriate and effective targeting for the poor; (b) shift budgetary spending towards health centers and away from hospitals; (c) encourage the use of health centers by the poor through improving quality of service; and (d) encourage development of the health insurance sectors through removal of the monopoly status of the state insurance company, thereby reducing the drain on tertiary health (World Bank 1995a).

**Education Investment Operations**

<table>
<thead>
<tr>
<th>Table 2. Bank-Supported Education Projects With Cost Sharing as Percentage of All Education Projects, FY63-FY94</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total No. of Projects</td>
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<tr>
<td>---</td>
</tr>
<tr>
<td>Africa</td>
</tr>
<tr>
<td>E.Asia</td>
</tr>
<tr>
<td>ECA</td>
</tr>
<tr>
<td>LAC</td>
</tr>
<tr>
<td>MENA</td>
</tr>
<tr>
<td>S.Asia</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

*Source: PHREEBASE, World Bank*

*Note: Cost sharing refers to "structures built into the project to recover some of the costs associated with education." There is no way to tell what type of mechanism is included, nor at what level of education it applies.*

A review of thirty-seven on-going Bank-supported education projects in Sub-Saharan Africa (Annex 2) indicates that fifteen contain some form of community participation in the construction of schools.2 The communities’ roles usually involve the

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2 These include projects in Benin, Burkina Faso, Chad, The Gambia, Guinea, Lesotho, Malawi, Mali, Mauritania, Senegal, Tanzania, Uganda, Zambia as well as two projects in Ghana.
Cost sharing in the Social Sectors of Sub-Saharan Africa: Impact on the Poor

cost contribution of labor, materials, or cash. In Lesotho, for example, communities are responsible for providing 40 percent of the materials and labor for walls. Similarly, a project in Senegal calls for communities to contribute in-kind or through cash 25 percent of the costs of rehabilitation and maintenance. A few projects, such as those in Benin and Burkina Faso, include measures to improve managerial skills and establish institutional frameworks.

<table>
<thead>
<tr>
<th>Table 3. Textbook Components in 37 On-Going Bank-Supported Education Projects, Africa Region, By Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projects with Textbook Component</td>
</tr>
<tr>
<td>----------------------------------</td>
</tr>
<tr>
<td>Primary 5</td>
</tr>
<tr>
<td>Secondary 7</td>
</tr>
</tbody>
</table>

*All seven of these cost sharing schemes at the primary level refer to low or symbolic rental fee.

Cost sharing is found in seven of eighteen Bank-supported primary education projects with textbook components (Table 3). In all seven cases, however, rental schemes are used and books are loaned out at a small, sometimes symbolic fee. The importance of the fee is in the sense of ownership it provides leading to better care for the books.

Cost sharing emerges in other forms in Bank-supported projects. Projects in Guinea, Mali, and Mauritania support policies to foster private sector education by removing barriers and modifying legal frameworks. Furthermore, projects in Kenya require limits to student loans and a loan scheme reform plan for higher education as conditionalities for Bank funding. Finally, several projects support implementation of increased fees at the secondary and tertiary levels. A project in Malawi requires an increase in fees at universities from 3 percent to 7 percent of costs. In Ghana, the government has agreed to implement cost sharing mechanisms by introducing student hostel fees and ensuring that by 1995/96, 5 percent of tertiary academic recurrent costs are borne by students. A government loan program will be established to help students and families absorb the additional costs.

The focus of much of the Bank dialogue on cost sharing in education is related to the imbalance between primary and tertiary levels. In twenty-four Sub-Saharan African countries reporting in 1990, approximately 17 percent of the education budget was being spent on the roughly 3 percent of the relevant population enrolled in tertiary-level institutions (DAE 1995). According to the 1995 World Bank overview of the education sector, public spending per student in higher education in Africa is generally about forty-four times higher than the spending per student at the primary level (World Bank 1995b). Bank policy dialogues have supported a shift in budgetary allocations in favor of primary education.
In Zambia, a recent Public Expenditure Review states that “although there has been some shift of resources toward primary education, too large a proportion is still dedicated to higher education and to the personal welfare needs of a relatively small number of students in secondary schools and universities” (World Bank 1995f, p. 90). The report recommends that fewer and smaller bursaries be awarded at the university level and a student loan system be instituted to recover a significant part of the awards made, and that a greater share of secondary school boarding costs be transferred to beneficiaries, with the institution of a safety-net for the poor (World Bank 1995f).

Similarly, in Nigeria, the Bank notes that parents already make significant contributions for instructional materials and other items at primary and secondary levels, and cautions against the introduction of additional cost sharing measures at these levels. A recent sector report states that:

…it does not seem justifiable that the proportion of total costs borne by students at the higher education levels, where private benefits can be significant, should be lower than at the primary and secondary levels. Given the urgent demand for resources to increase access and improve quality at the primary and secondary levels of education, it seems that a larger proportion of public resources should be devoted to these levels while private resources are mobilized to support higher levels of education (World Bank 1994c, p. 112).

In Uganda, the Bank recommends that “financing the essential elements of primary education should be recognized squarely as a Central Government responsibility,” stating that it is too essential to be left to the variability of parental financing and/or local government financing (World Bank 1993a, p. 46).

Adjustment Lending

There is considerable concern about cost sharing in the context of structural adjustment lending by the Bank. Cost sharing in the social sectors, however, is infrequently included as a condition for the release of funds in the Bank’s adjustment lending. Only one of thirty-three Bank-supported structural adjustment programs approved since FY90 includes a condition requiring cost sharing in the social sectors (Table 4). As a condition for release of the second tranche of Burundi’s third structural adjustment credit (FY92), the government was required to implement a financing strategy for education and health, including cost sharing, that was satisfactory to the Bank. Cost sharing may be recommended in adjustment lending in some cases, but not as a condition for tranche release.
Instead, adjustment lending is more likely to focus on the preservation of social sector spending as a share of the national budget. About half of the thirty-three adjustment programs since FY90 include conditions that protect health and education expenditures. Less attention is given in adjustment lending to the distribution of these expenditures between basic and non-basic services. Only three programs include protection for spending on basic social services.

Empirical evidence on whether social sector spending is preserved during adjustment programs is mixed (for example, see Berg and others 1994, Pio 1994, Reimers and Tiburcio 1993, Sahn 1994, Serageldin, Elmendorf and Eltigani 1994, and World Bank 1995h). Appropriately, the Bank’s expanding emphasis on human resources development in the macroeconomic dialogue is expected to focus more attention on protecting this spending.
V. Experience on the Ground

In projects and dialogue with governments on cost sharing in the social sectors, the World Bank emphasizes expanding access to basic education and health care and protecting the poor. The results on the ground in Sub-Saharan Africa with cost sharing have shown that these goals are achievable, but that reaching them is not a simple task. The willingness of consumers to pay for basic health and education services is not the same as the actual ability to pay for these services. Protecting the poor’s access to basic social services is essential. Community-based approaches to targeting exemptions for the poor have been found to be an effective means for taking consumers’ ability to pay for basic social services into account. Careful attention has to be given to design and implementation issues. Learning on the ground is important.

Health

User fees for health services with exemptions for the poor have proven difficult to implement. Nolan and Turbat (1995) in their survey of thirty-seven African countries found that eight of nine Anglophone countries described exemptions for the poor as infrequent. Amongst Francophone countries, data for Burundi and Mauritania indicate that these exemptions are rare, but in Mali up to 50 percent of the patients in some public hospitals are exempted. The exemptions, however, are not necessarily based on an inability to pay. A poverty assessment in Benin found that, although the project design called for protecting the poor, the local community management committees failed to take steps to reduce fees or waive charges for the poor.

Where they occur, however, community-based approaches to direct targeting have seemed to work well in protecting the poor. Evidence of this exists in Ghana where missionaries and private health care facilities identify and exempt the poor from user charges by investigating the financial standing of the patient’s extended family. In Malawi, the government has created a fee schedule in consultation with the communities served; the core poor, identified according to landholding structure, are exempted from user fees. Community-based approaches in Senegal are particularly successful in rural areas where health officials find it easier to identify the poor because of the greater knowledge in villages of other peoples’ incomes.

Exemptions for the poor are more difficult to implement where cost sharing policies are implemented in haste. UNICEF reports that most countries have not implemented cost sharing schemes in a phased manner enabling households to adjust to new or modified charges (Parker and Knippenberg 1991). A recent study in Zambia concludes that a legitimate zeal for reforms has unfortunately led to imposing user charges before the necessary safety nets could be put in place. In practice, there is no system in place in clinics and health centers to exempt the poor, as intended in the reform program. Without the benefit of proper information and introduction, people are not
aware -- or do not believe-- that all infectious diseases will be treated free of charge (Booth and others 1995). Widespread information dissemination can also improve program transparency and reduce opportunities for collecting illicit fees.

When communities control revenues from user fees and use the revenues to improve the quality of services and availability of drugs, the result is pro-poor (Litvack and Bodart 1993). Community control of revenues is practiced more in Francophone than in Anglophone countries as found by the Bank’s 1995 survey (Nolan and Turbat 1995). In Cameroon, for example, user fees were increased in some health centers, but the centers were allowed to retain the revenues and improve the drug supply. The use of these centers by the poor increased by more than for any other group (World Bank 1995d). A UNICEF survey of cost sharing in fifteen different settings in five African countries found that for centrally administered systems, the introduction of user fees did not increase patients’ use of services, but in the few cases where resources were managed locally, the use of health services increased as user fees were introduced. Women are typically the beneficiaries of improved services through community control.

While the contribution of user fees to recurrent government expenditures on health in Africa on the whole has been modest, it has played a positive role in the capacity of individual health centers to serve the poor. Nolan and Turbat (1995) conclude that while a few of the thirty-seven African countries they surveyed are raising from 5 percent to 10 percent of their total recurrent expenditures on health, most are not approaching this level. An earlier survey of sixteen African countries indicated that in two-thirds of the cases, user fees accounted for less than 5 percent of recurrent public expenditures on health (Vogel 1988). Yet, in Benin, fees have consistently contributed between 42 percent and 46 percent of the overall operating costs of the forty-four health centers participating in the Bamako Initiative (Shaw and Griffin 1995). In Guinea, this figure has been between 38 percent and 49 percent of operating costs.

Gender is an important issue in the design and implementation of cost sharing for health care. Although women tend to have the primary responsibility in households for health care, they do not necessarily have access to household income and control over how it is used. This is observed in a study of user fees for health services in Uganda (Sengendo and Kigundu 1994). The user fee scheme was introduced without adequate consultation. No mechanisms were put in place either to provide transparency and accountability regarding the use of funds, or for assessing the impact on the demand for health care. No quality improvements or expansion of services accompanied the policy. The result was a reduction in demand for preventative health care and a shift in demand to missionary health facilities. Also, women resorted to the use of traditional practitioners and self-medication.

In addition to influencing the poor’s access to basic health care, cost sharing contributes to improvements in efficiency of the system by providing better signals about appropriate points of entry to the health system. An appropriate structure of fees encourages patients to enter the system at a more cost-effective lower-level facility and, if
they cannot be treated there, they can then be referred to a higher-level facility. Improvements in the quality of care provided must accompany any increase in fees. People must be able to see the value of the services they are receiving, since these services are no longer free (Shaw and Griffin 1995). Where fees are introduced at the community level without improving quality, the impact is likely to reinforce the existing incentives to overuse hospital-level facilities.

The case of Lesotho illustrates how user fees influence patient behavior. Lesotho charges a lower fee at hospitals for those referred by their local health center, but the combined sum of the local health center and hospital fees equals the fee paid by a patient who goes straight to the hospital (Nolan and Turbat 1995). There is no incentive in this case to start at the low-cost local health center. National fee structures can help in countries like Nigeria where the cost sharing policy is determined by each state and local government and by each parastatal federal hospital. National fee structures help coordinate prices, referral requirements, and other features of cost sharing across different providers (World Bank 1994c).

**Education**

Cost sharing in education and its consequences on the poor involve more than tuition. While tuition may be kept low or even eliminated for primary schooling, parents are often asked to pay fees for school development funds, exercise books, uniforms, personal equipment, and to provide in-kind services for the construction and maintenance of primary schools. Malawi illustrates the impact of these requirements on school enrollments. In December 1994, Malawi eliminated all primary school fees, including tuition, uniforms, school building fund, and so on, and saw nearly a 50 percent increase in enrollments (about one million additional students) half of whom were new entrants into Standard 1. A school uniform had cost US$3.00, ten times the amount of the schooling fees. A publicity campaign to boost school attendance and the public’s reaction to increased democratization also contributed to enrollment growth.

Local control of schools and their quality, alongside their cost, are important factors in school enrollment trends. In Tanzania, rural parents have been increasingly disenchanted with primary schooling because they feel they are not getting value for their money. Parental contributions go to the district and urban councils, where they are consumed in mainly non-educational activities. Parents feel powerless to do anything about such practices, and have no sense of involvement in the education process (Cooksey, Malekela, and Lugalla 1993). In 1995, the government changed this rule to allow fees to remain in schools. A study in Zambia found parents bitter that their contributions were going sharply up when government was providing less materials than in the past, and when teaching quality seemed low and still declining (Booth and others 1995). A similar pattern was found in Mali -- the government has since opted to make parental contributions optional (World Bank 1993c).
Community involvement in the management of education and health services is not, however, a panacea. The local capacity needed for successful community involvement can take years to establish, requiring a commitment of considerable energy and resources. Further, communities are not cohesive and homogeneous groups, but are instead characterized by vast differences in power along gender, economic, ethnic or religious lines. In practice, poor people and women often have little voice in community affairs, and little influence in shaping community priorities. Additionally, community participation can in some circumstances be perceived as a euphemism for the transfer, on inequitable terms, of the burden of some aspects of service provision to the labor of poor households.

The impact of cost sharing on enrollments also has a gender dimension. When households are faced with financial constraints, girls are more likely than boys to be held back or withdrawn from school (Odaga and Heneveld 1995). The low expected value of education for girls and the loss of their services in the household -- caring for smaller children and performing household tasks -- are behind the response to cost sharing (Fleuret 1992). In Ghana, girls enter the labor force before boys, indicating a possible higher opportunity cost for their schooling (Beaudry and Sowa 1994). In Kenya, when parents were asked what they would do if they had to make a choice about who stays in school, 58 percent said they would withdraw their girls and 27 percent said they would withdraw their boys. The balance indicated no gender preference. Such statements, however, need to be interpreted cautiously. In Malawi, while parents said cost was a constraint in sending their daughters to school, they were spending at least as much on instructions for their tribal initiation (Kapakasa 1992).

The implementation of cost sharing at tertiary and secondary levels has been slow, thereby limiting the capacity of governments to focus public spending on basic education. A recent survey of fifteen African universities found that, although wide variations exist, only half of them charge student fees, producing revenues averaging about 10 percent of the university’s yearly recurrent budget (Blair 1992, pp. 22-23). In Lesotho, government loans to students cover most fees, but the low recovery rates for these loans mean that they are in fact grants to students and, indirectly, supplemental grants to the university (World Bank 1994b). In Uganda, fees for tuition, accommodations, and boarding at the university are paid by the state (Woodhall 1995). There are, however, encouraging signs as cost sharing through fees for specific services are growing and universal bursaries for students are being reduced. This has happened in Mali, and Kenya has recently raised fees and introduced need-based loans. A significant increase in university tuition was introduced in Mozambique in 1993.
VI. Looking to the Future

The ability of the public sector in rich and poor countries to meet unconstrained social demands for education and health care at all levels has proven to be limited. This is all the more true in Sub-Saharan Africa, where per capita incomes are only about 2 percent of those in industrial countries, and levels of public effort are already in line with the rest of the developing world (Table 5). Increasing pressures on public budgets over the last decade in Africa have inhibited expansion of these services and translated into reductions in their quality in many countries. The result threatened the poor's access to basic education and health care as an effective tool for poverty reduction. The use of private financing through cost sharing was widened to complement the efforts of the public sector. Here, too, steps were needed to protect the poor's access to basic education and health care.

<table>
<thead>
<tr>
<th>Table 5. Public Expenditure on Education and Health, 1988-90, By Region</th>
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</thead>
<tbody>
<tr>
<td>Public expenditure (as % of GNP) on:</td>
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<tr>
<td>Education</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
</tr>
<tr>
<td>South Asia</td>
</tr>
<tr>
<td>East Asia</td>
</tr>
<tr>
<td>Southeast Asia</td>
</tr>
<tr>
<td>Latin America &amp; Caribbean</td>
</tr>
<tr>
<td>Least developed countries</td>
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<tr>
<td>All developing countries</td>
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</tbody>
</table>


Protecting the poor and their access to these services has not proven an easy task. The World Bank in its dialogue with countries and in its lending has advocated the diversification of financing for social services and the protection of the poor's access to basic education and health care. It has called for free or highly subsidized basic education and health care, while expanding private financing through cost sharing for tertiary and secondary education and tertiary health care. The World Bank supports special measures to assist girls, the poor and linguistic minorities to attend school. It has also pursued the access of the poor to these services through scholarships, vouchers, insurance, and pre-payment schemes.

This review of the implementation of these messages on the ground in Sub-Saharan Africa reveals that countries, for a variety of political and bureaucratic reasons, have been slow to expand cost sharing at tertiary and secondary levels of services. At the same time, cost sharing legacies of the colonial era for education, imperfect schemes for exemptions of the poor, and haste in the implementation of these schemes have led to circumstances where the poor have been unable to achieve full access to basic education and health care. The impact has fallen disproportionately on the access of women and girls to these services. This review reveals a set of interrelated actions that can be taken to realize the goals of basic education and health for all.
There are, however, many questions to ask before focusing on user fees for government facilities. For example, is everything possible being done to reduce misallocation and waste of public resources in other activities such as subsidies to public enterprises, and spending on military purposes? Are efforts being made to minimize losses due to ineffective tax systems and administrative inefficiency? Are attempts made to ensure that better-off groups pay for services through the special advantages they have (e.g. can employers be asked to provide health coverage for their employees, sharing the full cost between them)? Are efforts being made to allow providers other than government, whether NGOs or private sector entities, freedom to operate — with enough oversight also to prevent outcomes inconsistent with public needs?

**Protecting the Poor’s Access to Basic Services**

For basic services — primary education and primary health care — fees should be discouraged unless adequate protection for the poor is assured. The package of essential health services advocated by the Bank’s study *Better Health in Africa* (1994a) would be an example of services that, in a perfect world, would be provided to all without cost. ‘Education for All’ is already a global goal announced at Jomtien. Reducing or eliminating fees for primary education, including uniforms, textbooks, and school development programs, among others would expand access to primary schooling. A policy of accepting some leakage of benefits to the non-poor for services with high social externalities is preferable to one of tightly-administered cost sharing programs to reduce these leakages with the unintended consequence of inhibiting the poor’s access.

Even with efficiency gains and the reallocation of some resources from non-basic services, however, many countries may yet be unable to afford free or highly-subsidized basic education and health care on a sustainable basis. In these instances, countries and communities should not be discouraged from adopting cost sharing as a means to expand access to basic social services. The Bank, in these cases, should advocate local control over this process and the revenues it provides, while taking into account the difficulties associated with community participation in service provision and management. It should encourage participatory approaches to community decisions and the use of these revenues to improve the quality of services delivered. Community-based approaches to direct targeting for exemptions have worked well in protecting the poor. The Bank should stress improvements in the quality of basic education and health care to build support for cost sharing measures and should assist in building local capacity for implementing community-based approaches.

Putting the foregoing into perspective, free or highly subsidized basic social services must be seen as a goal for the poorest countries of Sub-Saharan Africa. The Bank needs to assist clients with moving forward on a path toward this goal. However, the Bank must recognize that there are severe constraints to be met and competing needs
that governments must sort out in public spending. None of these constraints or needs should prevent households from contributing as they see necessary to acquire the services they need. The task facing the Bank is that of assisting governments in ensuring that the poor are protected to the extent possible and that those who contribute gain a voice in the system.

**Improving Cost Sharing at Tertiary and Secondary Levels**

While the Bank has been a strong advocate of user fees for social services consumed mainly by the non-poor, the evidence on the ground indicates that most countries in Sub-Saharan Africa have made only modest progress toward this goal. There remains considerable potential for diversifying the financing of higher and secondary education, in that order, and tertiary health care services. The Bank, in the future, should take an even stronger stance on this diversification in the country dialogue and promote progress in cost sharing in higher education and hospital care. There are examples in Mali, Mozambique, and Kenya for education, and also in Kenya for health where this process has begun. The Bank should learn from and improve on these models for future dialogue and lending activities.

In light of the limited progress made in adopting user fees for social services consumed by the non-poor, the dividend from the reallocation of public spending on these services to basic education and health care is barely detectable. The Bank needs to advise governments to link reallocation with the quality improvement dialogue for services that are subject to fees, and to assure greater consumer voice in the provision of public services. This has been shown to be important in the willingness of households, including the poor, to pay for these services. Turning to the private sector for the delivery of education and health care in addition to private financing is an option for using competition to promote quality improvements and efficiency gains.

**Developing New Approaches to Cost Sharing**

Pre-payment schemes along with privately-financed insurance for health care deserve further attention as cost sharing measures. The experience in Guinea-Bissau, Kenya, and other informal small-scale schemes supports this view. Part of the problem faced in health care is the timing of demand for services and the receipt of income by households. When illnesses strike, the poor may not be able to manage large service fees. Pre-payment schemes mitigate this problem and ensure access of the poor to necessary health care. These schemes might also be tried for education with regular subscription payments making it easier for the poor to absorb the cost of education.

Privately-financed insurance schemes for health care also serve as a means to spread the risk of expensive illnesses and their cost, allowing the much higher levels of
cost sharing in hospitals that are necessary to widen governments’ options for reallocating hospital budgets to preventative and basic curative services for the poor. Adapting these schemes to the African context is important. The Bank needs to focus research and pilot projects on insurance programs, but also on higher education credit and scholarship schemes to support a broader policy agenda.

**More Emphasis on Economic Analysis**

More analytical work is needed on the modalities of cost sharing and their impact on households. The actual level of cost sharing for basic education and health care and its gender dimensions need to be assessed. There is evidence from the instances cited that the burden of cost sharing, when all costs are considered, is higher than anticipated. Included among direct costs are the large number of non-tuition fees in education, the cost of transportation, and among indirect costs the time in travel to clinics and the provision of in-kind services in the construction and maintenance of education and health care facilities. More attention needs to be given to these costs and their impact on the poor, but also to the often neglected benefits of cost sharing.

A question of some importance is whether high administrative costs in the collection of various fees offsets the expected benefits of cost sharing. For example, do textbook rental schemes improve the availability of books as intended, or do the costs of administration dilute these benefits? How are the poor affected? Similar questions arise with regard to pharmaceuticals. A debate also continues on the benefits and costs of school uniforms. The Bank needs to assist governments in monitoring and analyzing the impact of changes in cost sharing arrangements on the poor and disadvantaged. The findings of this analysis should be considered by governments in a dialogue advocating free or highly subsidized basic social services.

The Bank needs to advocate even more than it does now learning on the ground through monitoring and evaluation of cost sharing. While the need is greater in education than in health, it is essential in both areas. Governments need such information to manage their programs better and to make midcourse corrections as needed. A review of the evidence assembled in this paper demonstrates this. To understand the impact of cost sharing on the poor in education, the review was forced to examine country case studies in an ad hoc fashion. More systematic country surveys and analysis of the issue were available for the health sector. Similar surveys and analysis are needed for education.

**Piloting Before Mainstreaming**

The evidence on the ground demonstrates the complexity of designing and implementing cost sharing policies. Exemption mechanisms for the poor are but one example. In other cases, countries have moved ahead without appropriately preparing for
introduction of the policies by introducing safety nets. The cases of Zambia and Uganda illustrate this. Governments must become more diligent in providing information to consumers. For example, mothers who do not know that immunization and other basic health services are exempted from fees may be reluctant to travel to distant health clinics to find out. In looking at the Bank’s portfolio, there is evidence that more attention needs to be given to these and other details of user fee policies.

Piloting cost sharing initiatives before mainstreaming them should be encouraged to avoid costly mistakes and to learn from consumers what works best for them. The need for piloting, of course, depends on the level of experience and knowledge in the country and externally. The results of these pilots can help guide subsequent policy measures and corrective actions (Gertler and van der Gaag 1990). These pilot initiatives may represent an ideal opportunity to collaborate with NGOs and community groups that have proven successful in these areas.
Annex 1

1. Countries with National Systems

**Benin** (FY89)--Project supports expansion of cost sharing, introduction of financial management and accounting system to handle accounts and to control cost sharing revenue. Condition for third tranche release is nationwide implementation of cost sharing program. Generalization of system nation-wide in late 1990.

**Burundi** (FY95)--Project supports Ministry of Public Health in designing and implementing strategies aimed at managing health sector revenues generated by user fees.

**Cameroon** (FY95)--Maintenance of acceptable cost sharing accounting system.

**The Gambia** (FY87)--Supports establishment of cost sharing system, with a schedule of charges and fees for services. Also extends cost sharing efforts by “improving existing systems for collection and accounting for fees.”

**Guinea** (2 projects, FY87 and FY93)--The 1987 project supports the improvement and expansion of cost sharing activities to all levels of services. The 1993 project supports regular drug supply to health facilities in order to facilitate full cost sharing (excluding salaries). Project objective includes efforts to improve systems for “financial, material and human resource management.”

**Kenya** (FY91)--As of 1991, cost sharing had been very limited. Project supports the reintroduction of outpatient consultation fees which was to be accompanied by an information campaign to explain to the public the rationale for cost sharing. Also included is a graduated structure of user fees and a fee waiver system.

**Malawi** (FY91)--The project would provide resources to encourage innovative health financing schemes within communities.

**Mali** (FY91)--Expansion of cost sharing to newly created Community Health Centers. Supports improvements in the “planning and management of the sector’s personnel, physical and financial resources as well as the provision of essential drugs.”

**Senegal** (FY91)--To revive cost sharing efforts, a subcomponent of the project entails providing drugs to all levels. To qualify for assistance under this subcomponent, each district must fulfill criteria including setting fees for health posts and agreeing to apply
them immediately. Project “aims to develop budgeting and financial management procedures... (including the) establishment of a standardized, simplified accounting system at the district level....”

**Zimbabwe** (FY91)–Increase level of cost sharing from 3 percent of recurrent budget expenditures in 1990 to at least 10 percent by July 1995. Project supports “training and systems development in financial management.”

**2. National Systems but Either Minimal or not Effectively Enforced**

**Burkina Faso** (FY94)–Project scope includes establishing effective cost sharing policy which would ensure a sustained supply of essential drugs at the primary and secondary levels. Finances a one-year stock of essential drugs to provide initial capital for a revolving fund for drug cost sharing.

**Equatorial Guinea** (FY92)–Assurances obtained that appropriate ministerial decrees would be issued to authorize the collection and use of cost sharing funds from drug sales. Supports implementation of stricter enforcement of fee collection policy (at the hospital level) by targeting more narrowly the exemptions (children under 5, pregnant women, etc.).

**Mauritania** (FY91)–Under project, cost sharing efforts would be re-evaluated after three years of country-wide implementation. The government would adopt guidelines for the “establishment of cost sharing systems and the distribution of drugs at the periphery.” Supports strengthening of financial management at the regional level.

**Nigeria** (2 projects, FY89 and FY91)–1989 project objective includes plans to support introduction or strengthening of cost sharing mechanisms at all levels and the establishment of fund. The states have committed to instituting full cost sharing before the end of the project. The project would also support development of educational materials and support public information campaigns to inform public as to why fees for drugs are to be charged. In the 1991 project, drugs and vaccines are provided to serve as a base from which to develop cost sharing.

**Sierra Leone** (FY86)–Project would assist in strengthening cost sharing (including reviews of collection procedures for uniform application; and the role and accountability of dispensers in charging, collecting, and managing drug procurement). The project would provide drugs and equipment to serve as a base from which to develop cost-sharing. Assurances that government would maintain permanent escrow account to maintain money collected under cost sharing.

**Togo** (FY91)–Program would strengthen institutional capabilities in cost sharing, budgeting and financial management. Under the program, the government proposes to design and implement cost sharing measures in a sample of facilities during 1991-92 and to generalize the system in all centers by 1994.
Zambia (FY94)--Project would support R&D of appropriate cost-sharing mechanisms and fees. Ministry of Health will pursue improvement in cost sharing through user fees.

3. Local Fee Collections

Niger (FY86)--A sum of US$ 3.5 million has been earmarked under the project to implement actions based on studies. This assistance will focus on (among other things) improved cost effectiveness of basic health services, financial management, and cost sharing at the hospital and peripheral levels.

4. No User Fees in Place

Sao Tome and Principe (FY92)--Project supports program of cost sharing from the distribution of essential drugs and school textbooks.
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<tbody>
<tr>
<td>Angola</td>
<td>92</td>
<td>Education is free at all levels. Students must provide their own school materials.</td>
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<td>Secondary—textbook rental scheme</td>
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<td>Benin</td>
<td>94</td>
<td>At the primary level, communities traditionally pay for all non-salary expenditures (teaching materials, construction, and maintenance). Enrollment began declining in 1983 as parents could no longer afford to pay and govt. could not make up difference, resulting in declining efficiency and quality. Higher education is state-financed with generous subsidies.</td>
<td>Project will finance the rehabilitation of 200 primary schools. Will create institutional capacity to promote and manage community level intervention through norms. Communities will be responsible for maintaining a growing number of primary schools.</td>
<td>Maintenance and renewal of primary books financed by govt.; lower secondary books by govt. and APEs.</td>
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<td>Burkina Faso</td>
<td>91</td>
<td>Communities are largely responsible for school construction, but are inhibited by high costs and limited construction skills.</td>
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<td>Project to finance 60% of rehabilitation and 90% of costs of new construction and fund improvements of community’s school construction and management skills.</td>
<td>Primary—book rental scheme. As number of titles increases, many families would not be able to afford. Thus, need to be subsidized. Estimates to be made annually. Secondary—textbook loan scheme to establish revolving fund.</td>
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<td>Cape Verde</td>
<td>95</td>
<td>Basic education textbooks are sold from 44 to 178 CV Esc., but many students cannot afford them.</td>
<td>Construction and rehabilitation component, but no community participation.</td>
<td>50% of printings under textbook component to be rented to students (revolving fund) so that needy (about 50% of student body) can obtain books. Doesn’t say how much fee will be. Remaining 50% will be sold by bookstores at 15% about cost.</td>
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<td>Chad</td>
<td>93</td>
<td>Communities contribute about 7% of primary budget through APE</td>
<td>10% of cost through in-kind or cash payments, exemptions for over-tapped APEs and schools with low proportion of girls</td>
<td>No cost sharing</td>
<td>Pilot School Improvement Project to increase capacity of APEs to manage their schools</td>
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<td>Country</td>
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<td>Traditions of Cost Sharing (c.s.)</td>
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<td>Textbook Component</td>
<td>Policy Measure</td>
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<td>Cote d'Ivoire</td>
<td>94</td>
<td>Not applicable</td>
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<td>Labor Force Training</td>
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<td>Cote d'Ivoire</td>
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<td>HRD Management Support</td>
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<td>Djibouti</td>
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<td>Manpower Training</td>
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<td>The Gambia</td>
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<td>Community generally responsible for construction of primary schools, but severely limited due to lack of organizational and construction skills. And, the cost of imported materials are more than communities can afford. No primary school fees, but parents must provide uniforms, exercise books, rental fees for 5 texts, and furniture. (1993 PA)</td>
<td>School construction -- project to finance all materials and communities to provide labor. Communities to receive training in basic construction techniques and set of tools.</td>
<td>Rental fee for books at primary level.</td>
<td>Promote private initiatives. Govt. proposes to increase fees at secondary level and introduce levies for technical education and vocational training.</td>
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<td>Education Sector Credit</td>
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<td>Ghana</td>
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<td>Community Secondary Schools Construction Project</td>
<td>Govt. provides two-thirds matching grant. Communities make contribution in labor or materials or cash.</td>
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<td>Community Secondary Schools Construction</td>
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<td>Ghana</td>
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<td>Literacy and Functional Skills</td>
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<td>Ghana</td>
<td>93</td>
<td>Partial c.s. for books at primary and junior secondary, full at senior secondary. No tuition nor hostel fees at university; current charges are about 10% of total costs (including full costs for student feeding). Vast proportion of these payments is financed by highly subsidized student loan scheme.</td>
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<td>Govt. agrees to implement c.s. mechanisms: introduce student hostel fees to cover full cost by 93/94, and ensure that 5% of tertiary academic recurrent costs are borne by students by 95/96. Also intends to extend loans to mitigate some of the additional costs to students.</td>
<td>Project funds study on the socioeconomic composition of the student body, and the ability of students and their families to pay for tertiary education.</td>
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<td>Tertiary Education</td>
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<td>Ghana Primary School Development</td>
<td>93</td>
<td>MOE has tried to keep primary fees to a minimum. But, with devolution of responsibility to local authorities, new fees (and PTA fees) have been imposed. Research shows cost to be a factor in dropouts. Long tradition of community involvement in construction.</td>
<td>Project funds construction of schools. Communities responsible for cladding the pavilions. Any school that wants to be eligible will have to eliminate PTA and other locally imposed fees. Training for local personnel.</td>
<td>MOE requiring that all fees not approved by the ministry must be phased out by January 1997.</td>
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<td>Ghana Development Comm. Pilot</td>
<td>93</td>
<td>Not applicable</td>
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<tr>
<td>Ghana Voc. Skills</td>
<td>95</td>
<td>Trainees to pay fee</td>
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<td>Guinea Education Sector</td>
<td>90</td>
<td>Tuition is free at all levels.</td>
<td>Communities will make annual contribution to purchase local materials. Includes component to improve community capacity for maintenance and upkeep.</td>
<td>Book rental scheme. All students enrolled will receive textbooks regardless of ability to pay.</td>
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<td>Guinea Equity and School Improvement</td>
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<td>Tuition is free at all levels.</td>
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<td>Guinea Voc. Skills</td>
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<td>Kenya Universities</td>
<td>92</td>
<td>Parents provide bulk of investment needs in primary and secondary.</td>
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<td>Kenya Education Sector Adjustment</td>
<td>92</td>
<td>Parents and communities fund most of construction at primary and secondary, and are responsible for funding teaching materials. But, many cannot afford latter. So, evidence that c.s. has gone too far such that essential materials are not in classrooms and participation rates are declining. In contrast, tertiary education is free.</td>
<td>MOE had recently adopted policy to resume some funding of books for primary schools and plans to make a budget allocation in 91/92. Would provide books in economically disadvantage areas of the country. Book provision to remain the responsibility of parents at the secondary level.</td>
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<tr>
<td>Kenya</td>
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<td>C.s. increases as training schemes prove themselves useful.</td>
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<td>Lesotho Education Sector Development</td>
<td>92</td>
<td>Parents bear 30% of total education costs - much higher at primary and secondary. Scope for additional c.s. is limited. Is an option at NUL, but not attempted for political reasons.</td>
<td>40% of communities to provide materials and labor for walls. Remaining 60% of schools to be built by private contractors. Not clear how selected.</td>
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<td>Madagascar Education Sector Reinf.</td>
<td>90</td>
<td>Local authorities and parents' associations contribute to primary and some lower secondary investment costs. Non-salary operational costs almost entirely a local responsibility, but few have needed funds. Parents must buy materials and pay an annual charge of $1-3 directly to school.</td>
<td>Project funds textbooks at primary and general secondary levels at no cost to users. Also requires a decision on arrangements for book cost sharing before second phase of project.</td>
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<td>Madagascar Manpower Training</td>
<td>92</td>
<td>Increasing c.s. for training, but details are scarce.</td>
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<td>Malawi Education Sector II</td>
<td>90</td>
<td>At primary level, communities are largely responsible for physical facilities. Govt. intends to decrease or abolish fees at primary because keeps many children from school; is consistent with Bank policy. Need to carefully monitor impact on enrollment, dropout, and repetition. C.s. is inadequate at universities.</td>
<td>Experience with self-help under 3rd project–communities overburdened (can provide bricks, etc., but not labor).</td>
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<td>1st Education Sector Credit, 1987, introduced c.s. at secondary and university and university loan scheme. Have begun to pay fee equal only to 3% of costs. Conditions: increase in fee at university from 3 to 7%. Increase in secondary school tuition and boarding fees</td>
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<td>Mali Hybrid</td>
<td>95</td>
<td>Less than half of public education budget goes to primary education, and one-quarter to tertiary education (70% of this goes to student subsidies).</td>
<td>25% of construction to be delegated to local communities. Communities would receive a grant of 90% of estimated construction costs, and could do the work themselves or contract out. On competitive basis, if low enrollment ratio, rural areas, urban areas using double-shift, and commitment to education (progress in increasing girls' participation).</td>
<td>Large book component. No cost sharing because of general poverty of population and urgent need.</td>
<td>Containment of post-primary scholarship and subsidies budget.</td>
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<tr>
<td>Mali</td>
<td>95</td>
<td>Severe structural distortions in resource allocation. Past year, govt. has shown commitment. Private sector is limited by regulation.</td>
<td>School construction program, with communities responsible, assisted by mobile construction teams, by either doing it themselves or contracting out. Govt. provides, under ongoing project, subsidies of 50% in urban areas or 75% in rural areas. New project to give uniform subsidy of 70%.</td>
<td>Ongoing project finances textbook program, with 'symbolic' cost sharing. Not going well: sales of primary books have been low as parents cannot afford to buy a full set, poor distribution to rural areas, among other reasons. New project: improves distribution, but does nothing about inability of poor to buy.</td>
<td>Fostering development of private education at post-primary levels. And, application of fellowship award criteria at university.</td>
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<tr>
<td>Mauritania</td>
<td>93</td>
<td>Some employer financing.</td>
<td></td>
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<tr>
<td>Mauritania</td>
<td>95</td>
<td>Primary receives 38% of budget, secondary 34%, tertiary 20% (50% to social services and overseas fellowships). In secondary and particularly higher education, virtually no cost sharing with parents.</td>
<td></td>
<td>Promote private sector provision of education by modifying legal framework.</td>
<td></td>
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<tr>
<td>Mauritius</td>
<td>91</td>
<td>Not applicable</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Mauritius</td>
<td>95</td>
<td>C.s. has been introduced at university for part-time students.</td>
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<tr>
<td>Mozambique Education II</td>
<td>91</td>
<td>C.s. accounts for a very nominal fraction of total resources, and will be unable to increase much in the 1990s. Covers about 6% of recurrent expenditures. Family outlays for supplies and fees have quadrupled between 1986 and 1989, faster than income. Govt. is exploring options for lowering the costs of textbooks. Community participation and private sector is also tiny source.</td>
<td>School rehabilitation and expansion components, with no community participation.</td>
<td>Textbook component added mid-stream. No c.s.</td>
<td></td>
<td></td>
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<tr>
<td>Nigeria</td>
<td>90</td>
<td></td>
<td></td>
<td></td>
<td>Increase user charges at postgraduate</td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td>FY</td>
<td>Traditions of Cost Sharing (c.s.)</td>
<td>Community Participation in School Construction?</td>
<td>Textbook Component</td>
<td>Policy Measure</td>
<td>Other</td>
</tr>
<tr>
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<tr>
<td>Nigeria</td>
<td>91</td>
<td></td>
<td>Project to establish a Revolving Fund for Textbook Renewal. Initial c.s. will be N6 per pupil.</td>
<td></td>
<td>Project to reinforce community participation and decentralization. Govt. promises to prepare action plans in this direction.</td>
<td></td>
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<tr>
<td>Senegal</td>
<td>93</td>
<td></td>
<td>IDA to finance 75% of cost of construction materials, rest by Germans and local communities, in 6 most educationally-disadvantaged regions. Communities to contribute in-kind or through cash 25% of costs of rehabilitation and maintenance.</td>
<td>Primary—textbooks to be sold at 800 CFAF.</td>
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<tr>
<td>Tanzania</td>
<td>90</td>
<td>Govt. has responsibility for school construction. Communities are increasingly responsible for maintenance, but there is no policy or guidelines. Private response to decline in government allocation to education has been substantial. Parents pay 10% at tertiary, 30% at secondary, 50% at primary. At primary, no tuition but fees for uniforms and books plus special contributions for furniture, supplies.</td>
<td>School rehabilitation—project finances material, communities to supply labor. Project also supports development of construction norms and increased capacity to manage community support at local level.</td>
<td></td>
<td>Project funds study on parents' willingness and capacity to share the costs of education.</td>
<td></td>
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<tr>
<td>Uganda</td>
<td>93</td>
<td>Parents provide 65-90% of school's total funding through tuition and locally-set PTA fees. Fees given as reason why kids are not in school. Govt. policy is to bring fees at post-primary in line with costs.</td>
<td>1.4% of cost through labor and maintenance.</td>
<td></td>
<td>Promises to increase cost sharing at secondary and tertiary levels.</td>
<td></td>
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<tr>
<td>Zambia</td>
<td>93</td>
<td>Parents contribute about K1,000, or double per-student govt. contribution for direct and indirect costs of primary. At university, pay 9% of cost.</td>
<td>Social Sharing Fund (another project) rehabilitates schools with communities.</td>
<td></td>
<td>Free textbooks.</td>
<td>Supported study of household expenditures on education and community participation.</td>
</tr>
</tbody>
</table>

Note: c.s. refers to cost sharing.
Source: Various Staff Appraisal Reports, World Bank.
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