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User Fees in Swaziland

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This chapter examines the evolution of user fees in Swaziland's health system since independence. The country's health system includes both government and mission operated health facilities at all levels of care, such as hospitals, health centers, and clinics. The chapter does not cover industrial and independent private health facilities, as they operate on a commercial basis.

User fees in public health facilities have been in place since British rule in colonial times. The authorities introduced fees as a form of tax on indigenous people and as another source of government revenue. The criteria for establishing fee levels were independent of the communities affected. Until 1974, the fee schedule used in Ministry of Health (MOH) facilities was the one left behind by the colonial government. The fees charged at different levels of care, such as hospitals and clinics, were almost identical for the same services. They tended to be nominal amounts and did not generate substantial revenue. The revenue collected from fees was remitted to the Ministry of Finance through the Treasury Department and became part of the government's revenues. During this time, income from fees grew by 6.6 percent per year in current prices, but declined by 2.2 percent per year in constant prices. By 1985 the real value of revenues generated from fees was only one-third of its real value in 1970.

During the same time, missionaries had established themselves within communities and were engaged in educational and health activities in addition to religious activities. The mission health facilities operated with funds from overseas donations, supplemented with income raised from user fees. The criteria for setting fees in the mission health facilities were presumably dictated by costs and the flow of donations. Mission health facilities set their own fee levels independent of prevailing MOH fees. Missions revised their fees periodically and submitted them to the government for approval before implementation, so that the authorities could ensure that price levels were not acting as a barrier to health care. The government's prime concern was the affordability of health services to the average citizen and not cost recovery.

Financial pressures compelled mission health facilities to raise their fees regularly. By 1984, mission health facilities were charging, on average, at least 50 percent more for similar services than MOH facilities.

For example, in 1983 the RFM hospital alone had an estimated income from fees equivalent to twice the total of such revenues collected by all government facilities. Higher collection rates at mission facilities were attributed to higher fees, incentives to collect fees (such as retention of fees at the facility level), near cost recovery rates from private patients, and income from providing ancillary services to external doctors.

With higher fees at mission health facilities, MOH facilities were being overcrowded and mission facilities were underutilized. In most places, mission facilities did not coexist with MOH services. Thus, patients either had to use the nearest service, even if it was more expensive, or travel a considerable distance to a cheaper facility. Either way, some people bore a greater financial burden to obtain health care than others simply because of where they lived. The government put a mechanism into place for accommodating patients who were unable to meet the costs of health services. This involved acquiring a letter from a local tribal chief or a certificate of exemption from the district officer. Subventions from the government to mission facilities compensated missions for this group of patients.

By 1981, the much higher level of fees in mission health facilities led to a debate within the government on equalizing mission and government fees either by lowering mission fees or raising those at MOH facilities. A proposal to increase MOH fees was met with resistance from within the government, which viewed the provision of health care services as a public good. Thus the disparity in fees and utilization continued to grow.

In 1983 the government adopted a national health policy whose objectives included

- Improving the health status of the Swazi people by providing preventive, promotive, rehabilitative, and curative services accessible to all citizens
- Ensuring equal access to quality health care by all Swazis by phasing out geographic, financial, and cultural barriers
- Reorienting the health care system away from expensive, urban-based curative services toward rural-based, inexpensive promotive and preventive services.

The disparity in fees clearly stood in the way of achieving these broad health goals. The related policy regarding financial access reads:

> A fundamental MOH policy is that no person should be denied health services because of an inability to pay for them. At present an inequity exists in that financial access to health services may vary among families of even similar socio-economic status, depending upon where they live and which sector provides the services in their area. A uniform fee structure will be established to participate in the financing of their own health services.

In a study commissioned by the MOH to rationalize health service financing, Adu-Boahene (1984) further supported this policy. The study recommended implementing a uniform fee structure for the MOH and mission to

- Increase the financial viability and geographical access to the nation's health services, both government and mission
- Ensure that mission facilities were more fully utilized by reducing financial barriers
- Reduce the intolerable pressure on the government's health facilities, particularly hospitals.

The government accepted the recommendations of this study, which were as follows:

- Establish a unified fee structure across all mission and government health facilities
- Equalize fees for all special services, such as X-rays and dental care
- Create a safety net system for those unable to pay
- Implement the new fee structure over a two- to three-year period
- Compensate mission facilities for any losses they incur as a result.

Approaches and Options

The MOH accepted the concept of a uniform fee structure and evaluated ways to design and implement a fair, yet administratively flexible, system. It applied three basic principles when developing the framework: health services provided had to be comprehensive, the inputs required to provide services had to be able to be broken down in some logical way, and the new structure had to be operationally effective. To determine the approach to be used in this rationalization process, the MOH consulted both mission and public sector service providers and consumers of care.

Comprehensiveness included the need for the fee schedule to capture all the main services common to both government and mission facilities, together with capacity to accommodate future changes in the product mix. In relation to the logical breakdown, the inputs required for each service were determined to establish an appropriate price. The location of services was also an important consideration in pricing, because some services were only available in some facilities, thereby making access more difficult. Operational effectiveness essentially concerned the administration of the fee system. The fee structure had to be designed in such a way that revenue collectors had access to simple, clear, and easily available information.

In developing the actual prices for different services, the MOH took five basic factors into account: ability to pay, overall contribution to revenues, administrative effectiveness, acceptability, and resource allocation. The ministry viewed ability to pay as the major factor in the choice of a fee structure, and thus had to determine how much the average Swazi could afford to pay. Lack of data on household savings and expenditure prevented a quantitative analysis, therefore the ministry used a qualitative assessment to estimate affordable prices. In pricing the services, the MOH explored the following three options:

- Option 1. Nurses would screen patients. Those the nurse referred to a doctor would pay more than those who saw only the nurse, but those who saw the doctor without screening would pay even more.
- Option 2. Nurses would screen patients, and those referred to a doctor would pay the same as those who saw the nurse only. Those who wanted to forgo screening and see a doctor only would be charged at the same rate as private patients.
- Option 3. Patients attending health clinics would pay less than those attending health centers, who would pay less than hospital patients, that is, the fee would depend on the level of facility. Most institutions surveyed favored this option as it involved little change in practices in force at the time.

The MOH finally adopted option 2 and set the price for a consultation at E 1 (about US$0.20).

Implementation Mechanism and Strategy

The implications of unifying fees in the two types of facilities were extensive. First, the government would be required to put more resources into health care, particularly through the subventions to mission facilities, and therefore, government support for the proposal was required prior to implementation. Second, the accountant general was required to produce a new set of admission tickets that could be identified with the new fee schedule, and these had to be distributed to all MOH facilities by a set date. Third, all health facilities had to be informed about the changed fee structure. Finally, consumers of health care also had to be informed about the proposed changes.

The actual collection of revenues in the health facilities was identified as one of the areas of concern when addressing the issue of cost recovery. Mission health facilities had a much more efficient system than the MOH facilities. For example, outside normal work hours, nurses in mission hospitals are furnished with cash boxes and receipt books to collect and record money received from patients, which is submitted to accounts clerks the following day. Although this requires nurses' time, it ensures that fees are collected even when patients visit outside the working hours of the office staff.

In MOH clinics nurses routinely attend to patients as well as collect fees. In MOH hospitals, administrative staff collect fees before patients are seen to, but after normal working hours, on weekends, and on public holidays the administrative staff are absent, and levels of collection vary from facility to facility. In the case of Mbabane Hospital, for example, the nurses care for patients and then tell them to return the following day to pay. This results in lost revenue, as no mechanism is in place to follow up on unpaid fees. This has meant that substantial revenues for services rendered beyond normal working hours are lost, and apparently some patients take advantage of this loophole to receive free medical attention.

A study was undertaken to develop a pilot project on fee decentralization so as to evaluate the impact on collection rates (Collins 1991). The Pigg's Peak subregion was selected. Facilities in that region were asked to increase private patients' fees and were informed that they could retain a portion of the revenue collected, and could use these funds to improve the services offered. A further recommendation was that mission facility staff could provide technical assistance through meetings and/or part-time attachment to MOH facilities to help improve their capacity for revenue collection. This, however, has never been implemented.

Impact on Quality, Efficiency, Equity, and Sustainability

The introduction of the unified fee system has some impact on quality, efficiency, equity, and sustainability, though not in the desired direction in all cases.

Quality of Services

The implementation of uniform fees across all health facilities did have an impact on the quality of health care. Because mission health facilities retained the revenues they collected, maximized their revenue collection by charging private patients fees close to cost recovery levels, and provided ancillary services to private doctors at cost, they were able to maintain the quality of care provided to private patients. However, observers note that with the fee level falling behind the inflation rate and the cost of drugs rising, the quality of care available to public sector patients has declined in both types of facilities.

Efficiency

Before the unification of fees, mission facilities had been charging fees that allowed them to at least recoup their costs. As noted earlier, these facilities were accessible only to those who could afford the fees and were underutilized. With increases in output following the standardization of the fee structure, efficiency probably improved at these facilities, even though quality may have declined somewhat. In the MOH facilities, the absence of administrative staff to collect fees after hours caused a direct loss in revenue. A further weakness in the MOH health system is the low cost recovery rate for ancillary services.

In mission facilities, revenue collection increased during 1983/84–1989/90, although a decline was apparent in 1985/86, the year following implementation of the uniform fee structure. By 1988/89, revenues had recovered completely in mission facilities, and even surpassed the pre-unification rate. Mission facilities viewed the unification as beneficial, because removal of the fee barrier improved the utilization of their facilities. They also welcomed the subventions from the government to compensate them for the revenue losses. However, they were concerned that the rate at which the government was revising the subvention was insufficient to cover the replacement of fixed assets. They also expressed concern that they would be faced with cash flow problems while waiting for parliament to approve the government's budget between April and June.

Table 9.1 compares cost recovery rates between MOH facilities and mission facilities represented by the RFM Hospital and Nazarene clinics.

Table 9.1. *Cost Recovery Rates in Mission and MOH Facilities 1982/83–1988/89*
(percent)

Year	*RFM hospital*	*Nazarene clinics*	*MOH facilities*
1982/83	15.3	23.5	2.2
1983/84	13.7	20.0	2.2
1984/85	14.4	24.0	4.4
1985/86	7.2	25.0	6.3
1986/87	7.6	21.6	4.9
1987/88	10.9	19.7	4.8
1988/89	10.7	16.9	4.6

The table clearly shows that mission health facilities had a higher rate of cost recovery. An investigation revealed that this was due to the higher fees mission facilities charged private patients, to the greater numbers of ancillary services done for outside doctors, and to better collection practices. Another contributing factor is probably the mission facilities' incentive to collect fees because they are allowed to keep some of the fees they collect, while MOH facilities must forward revenues collected to the government. One suggestion was to pilot the retention of fees in government institutions. This was never implemented, hence no evidence is available as to how MOH facilities would perform were they allowed to retain a portion of the revenues collected.

Equity

Through the unified fee structure, health care became accessible to all citizens, regardless of where they lived. Exemptions for the very poor were maintained, but they will be streamlined to make the system more efficient, less vulnerable to abuse, and more dignified for the patient.

Sustainability

The increase in government fees was expected to generate sufficient funds to finance the subventions paid to mission health facilities to compensate them for lowering their fees. However, government revenue from fees has not kept pace with the amount required for the subventions. In 1995/96, for example, fees from government facilities amounted to only 10 percent of the amount required for the subventions. The reasons for the shortfall are both the low collection rate in government facilities and the failure to increase fees in line with inflation.

A 1990 study revealed that utilization of government and mission health facilities had increased after the implementation of the uniform fee structure. However, the changes in utilization varied between type of facility, service, and provider. Based on out-patient data, utilization of services appeared to have increased more at mission than at government facilities (table 9.2). This may have been related to the fact that fees had been increased at government facilities, but reduced at mission facilities.

Table 9.2 shows that government out-patient utilization increased by 1 percent while that of mission health facilities increased by 9 percent during 1984 to 1988. An interesting point is that out-patient utilization fell dramatically at both MOH and mission hospitals during the period. However, increased attendance at clinics more than compensated for this. One explanation is that government efforts to rationalize the utilization of primary health care facilities had succeeded.

In relation to the alleviation of pressure on MOH facilities, data constraints meant that measuring the effect of the fee structure on out-patients in relation to capacity was impossible, although the average utilization per clinic has increased both for government and mission facilities since 1984. In terms of in-patients, the results were mixed. Pressure appeared to have increased greatly at Mbabane Hospital, a government facility, which,

Table 9.2. *Percentage Change in Utilization of Out-Patient Health Facilities 1984–98*

Facility	*MOH facilities*	*Mission facilities*
Hospitals	-23	-26
Health centers	- 8	42
Public health units	1	n.a.
Clinics	13	27
All	1	9

n.a. Not applicable.

according to 1989 data, was operating at 35 percent above bed capacity. Pressure appeared to have decreased at other MOH hospitals, some of which even appeared to be underutilized. Pressure increased at mission hospitals and health centers.

Policy Aspects of User Fees

To date, the government has not explicitly defined the purpose of user fees. Ability to pay and accessibility seem to have been the determining factors, while cost recovery has received little, if any, attention at the policy level. Numerous recommendations have been made to revise fees in line with inflation, but the government has not implemented them. This, in turn, has affected the level of subventions paid to mission facilities over the years. The current fee schedule needs to be revised in line with the cumulative inflation rate, phased in over a three-year period, and thereafter maintained in line with the annual inflation rate.

In addition, MOH facilities offer medical services to private patients at highly subsidized rates. This is the case even when patients are covered under medical insurance, which is tantamount to subsidizing the insurance companies. These fees need to be adjusted to recover the full cost of care.

As noted earlier, revenues from fees in mission facilities have been higher than in government health facilities. Fee retention is believed to be one of the contributing factors to this, as it acts as an incentive for improved collection practices. Collins (1990) suggested the piloting of revenue, retention, and utilization to ascertain whether the impact in MOH facilities would be the same as observed in mission facilities. This recommendation needs to be revisited and implemented.

The consultation fee in MOH facilities includes the cost of medicines. This means that drugs are provided at heavily subsidized prices. Given that the cost of drugs is fairly high, a revolving fund for drugs and catering services should be established, and patients should be charged for these services. The fund will help control costs and may facilitate a reduction in overall costs by reducing wastage and overprescription.

Another improvement would be a monthly revenue reporting system that would show losses due to unrecovered fees and why these fees were not collected. This should be done for each service at each facility, and could include details about revenues earned per service, revenues lost due to exemptions, the number of nonpayers, and total revenues received.

Conclusion

The MOH is currently undertaking a health sector study using a group of consultants who have just submitted their draft report. This presents a number of strategic options, including the following:

- Improve the financial management information system so that effective revenue planning and management can take place.
- Develop capacity for revenue monitoring and evaluation, which will enable appropriate adjustment to the user fee rates to be made over time.

- Establish a joint public and private efficiency working group that will
  - Undertake a comparative assessment of health service efficiency within a referral system oriented toward primary health care
  - Identify strategies for improving efficiency at the health center and hospital level
  - Develop measurable efficiency standards
  - Oversee the implementation of agreed upon strategies.
- Establish management boards at each facility level made up of community and facility representatives who will plan and oversee the implementation of strategies to enhance efficiency and will oversee the collection and use of fees.
- Increase cost recovery rates to their real value at all levels of the service delivery system.

In the medium to long term, the MOH needs to consider developing a private ward capacity at all hospitals. In addition, it should establish the quality and price mix that will maximize revenues and establish an enabling environment for the further development of insurance-based financing of high quality secondary and tertiary hospital care.

Two issues remain that could usefully be discussed, namely:

- Cost recovery is usually the first step toward privatizing public bodies. If the government were to allow the pricing of health services at cost recovery rates, would this not be better handled by private companies? One school of thought goes so far as to say that the government should completely forget about providing curative health care and concentrate on preventive care, which it should provide free of charge.
- Statistics reveal that significant positive changes in health are highly correlated with three factors, namely:
  - Improved education, especially for women
  - Access to clean water and adequate sanitation facilities
  - Availability of nourishing food.

While these three factors have little to do with MOH provision of health care services, perhaps the ministry should think about reallocating the resources currently devoted to fighting the symptoms of ill-health and devote them to the root causes of ill-health instead. This is an issue that most health economists dodge.

References

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