User fees for health services are not new in Africa. A few countries in anglophone Africa, for instance, Ethiopia, Namibia, and South Africa, have had national user fee systems for years, while in many others, charges have historically been applied in both governmental and nongovernmental facilities (Nolan and Turbat 1995; Russell and Gilson 1995). However, since the 1980s the number of African countries implementing some form of user fee system has grown considerably. Governments have come to see user fees as a critically important alternative to tax-based financing for government health services in Africa, even in countries such as Kenya and Tanzania, which had previously provided government care free at the point of use. Recent surveys show that most African countries have now introduced some form of fee system for government facilities. Fourteen of the 15 African countries Russell and Gilson (1995) surveyed and 28 of the 37 African countries Nolan and Turbat surveyed (1995) have done so.

This chapter focuses on African countries’ experience with introducing and implementing user fees for health care to draw lessons concerning their potential as a mechanism for supporting sustainable health care financing and the critical issues that need to be considered in implementation. It draws heavily on a number of cross-country reviews of user fee experience. These reviews emphasize that countries have not realized many of the theoretical benefits of user fees because of implementation difficulties. Thus presenting case studies of good practice is difficult. Rather, the most discernible lessons pertain to implementation problems and requisites for surmounting them.

**Objectives of Fee Systems**

National policymakers cite raising revenues as their main objective for introducing user fees. Subsidiary objectives stress that revenues are needed to improve services, for example, by improving drug availability and the general quality of health care and extending coverage (Nolan and Turbat 1995; Russell and Gilson 1995).
Although never explicitly identified as an objective of user fees, the desire to raise revenue and improve services can presumably be related to a concern to enhance the sustainability of health systems. Financial sustainability can be defined simply as generating sufficient reliable resources to enable continued and improved provision of health care for a growing population. However, a broader definition, rooted in review of the role of external support to health systems, suggests that system sustainability is the capacity of the health system to function effectively over time with a minimum of external inputs (La Fond 1995). Achieving sustainability in this sense requires the capacities to

- Secure sufficient resources to enable improvements in the effectiveness of health care
- Use resources effectively and efficiently to meet health needs
- Perform these functions on a continuous basis
- Perform these functions with minimum external inputs.

In other words, generating revenues through some sort of financing mechanism is insufficient by itself to ensure sustainability. Additional measures to redress existing inefficiencies in resource use and to enable any additional revenue to be used effectively over time are vital elements of a sustainable and effective user fee system (Adams and Harnett 1995; Gilson 1995).

International analysts have also suggested that using revenues from user fees to improve the quality of services will generate efficiency and equity gains through their impact on utilization (Griffin 1992; Shaw and Griffin 1995; World Bank 1987, 1993).1 However, while some countries have employed user charges to foster efficiency-related objectives, such as discouraging unnecessary use and preventing by-passing of lower level facilities, only one of the countries surveyed by Nolan and Turbat (1995) explicitly identified improving equity as an objective.

**Fee System Models**

Nolan and Turbat (1995) identify two broad models of user fee systems that African countries have adopted. The differences in these models may underlie some of the differences in country-specific objectives.

The standard model is rooted in concern about existing inefficiencies and inequities within health care systems around the world. It assumes that fees not only produce resources, but also offer efficiency and equity benefits. Efficiency benefits result from the introduction of price signals, which offer patients incentives for using the referral system appropriately, and facilitate the reallocation of resources to more cost-effective primary health care. The equity benefits result from the use of resources in ways that benefit the poorest (such as improvements in the coverage and quality of primary-level care), and from the use of exemptions or differential charges within fee systems to protect the poor from their full burden (Gilson, Russell, and Buse 1995). This model might be applied nationwide within a country initially for curative hospital services, but also accompanied by decentralization over the control of resources to regional or district levels. This would facilitate the use of revenues in ways that promote efficiency and equity.

In contrast, the Bamako initiative (BI) model is rooted in Africa’s experience of poor primary-level care (Jarrett and Ofosu-Amaah 1992). The model emphasizes that revenues should be raised and controlled at the primary level through community-based activities that are national in scope, and so are distinguished from “more isolated attempts to initiate community participation and financing in health services” (McPake, Hanson, and Mills 1992, p. 10). The BI model sees community participation in management as the critical mechanism for ensuring that revenues are used in ways that address the persistent quality weaknesses of primary care, and that the health system is accountable to the users of health care. Thus under this model,

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1. Shaw and Griffin (1995) cite evidence of people’s willingness to pay in several contexts, whereas other analysts emphasize the difference between willingness to pay and ability to pay and the need to investigate these two dimensions separately (for example, Gilson 1988; McPake 1993; Russell 1996).
the community should determine the financing mechanism that is adopted, which might be a user fee system (with or without a community-determined exemption mechanism), prepayment, or some form of local taxes. Overall, “the attainment of sustainable financial resources, assured essential drugs and sound management, and decentralized decision-making in which the communities themselves are fully involved, are the principal strategies” of BI programs (Jarrett and Ofosu-Amaah 1992, p. 166).

Francophone countries appear to be more likely to implement the BI model of community financing than the standard model (Nolan and Turbat 1995), while anglophone and lusophone countries may implement both models at once. For example, Kenya has both a BI program to initiate, fund, and sustain community-level pharmacies in some districts, and a national cost-sharing program in which the government has gradually introduced user fees across all levels of government facilities except dispensaries. Both programs were first initiated in 1989. The BI programs built on earlier experience with community-based health care initiatives, whereas the cost-sharing program reversed the previous policy of no charges at government facilities.

The design of both models suggests that sustainability is an implicit objective. Its proponents see the BI model in particular as a strategy “towards the long-term sustainability of PHC [primary health care] into the next century” (Jarrett and Ofosu-Amaah 1992, p. 165). It is intended to raise revenues and ensure effective resource use through the development of community management capacity, and thus permit self-reliance. Although less strongly emphasized, the decentralization of control over resource use to regional or district levels, identified as an element of the standard model, can also be seen as a strategy for developing the capacities necessary to ensure sustainability. Nonetheless, no country, even those engaged in implementing BI programs, has identified actions important for sustainability, such as developing community management or enabling community participation, as ultimate objectives of their fee systems (Nolan and Turbat 1995; Russell and Gilson 1995). The failure to emphasize such objectives for fee systems may explain some of the implementation difficulties that countries have experienced.

Impacts on Efficiency, Equity, and Sustainability

The available evidence about the potential impact of fees is both limited and equivocal. The most commonly available information concerns the impact of fees on utilization levels and patterns and the amount of revenues raised through fees.

Utilization, Efficiency, and Equity

The efficiency and equity impact of fees depends partly on their influence over utilization patterns. In addition, fees may influence provider behavior, and so have consequences for efficiency, while fee systems may be associated with parallel actions that influence the distribution of benefits and burdens associated with using health care (which is critical for equity). The evidence about these effects is, however, conflicting, because fee systems have been implemented in different ways in different countries, and often not as theory suggests would be best practice. The following summary of impacts is largely drawn from four recent reviews of experience: Gilson and Mills (1995); Gilson, Russell, and Buse (1995); Kutzin (1995); Nolan and Turbat (1995).

With respect to efficiency, the impacts are as follows:

- Although the supporting evidence is limited, in theory, fees may encourage more efficient utilization patterns if
  - They are graduated by level of the system
  - A by-pass fee is introduced in areas where the primary care network is adequate, and referred patients are exempted at higher levels of the system
They are associated with quality improvements that promote utilization at the primary level.

- Lack of coordination within a fee system may generate inappropriate utilization patterns. For example, when lower levels of the health system charge higher fees than higher levels of the system, this is likely to encourage greater use of less cost-effective care. Again, limited evidence is available to support this contention.

- Investigators have shown that fees encourage inefficient provider behavior, such as overuse of unnecessary services or polypharmacy, when the resulting revenue is retained at the point of collection (see Kutzin 1995 on China; McPake, Hanson, and Mills 1992 on BI programs).

- As the travel and time costs of seeking care are usually high, there is unlikely to be any unnecessary utilization ("frivolous use") to discourage through fees (Abel-Smith and Rawall 1992).

With respect to equity, the impacts are as follows:

- Fees by themselves tend to dissuade the poor from using health services more than the rich and are associated both with delays in accessing care and with increased use of self-medication and informal sources of care (Booth and others 1995).

- Evidence suggests that if fees are associated with quality improvements, as in community financing schemes of the BI type, this offsets their negative impact on utilization, and the introduction of fees plus quality improvements may even generate utilization increases among the poorest (Litvack and Bodart 1993).

- A few studies show that the nature of the payment mechanism has an important influence on its utilization and equity impact. Pure user fee systems are more likely to enhance inequities in access to health care than those that allow for risk sharing and/or prepayment (Diop, Yazbeck, and Bitran 1995), but fees levied for services received (such as drugs) are less likely than general consultation fees to discourage utilization (Collins and others 1996).

- Fees do not appear to generate adequate revenue or to be associated with the resource reallocations necessary to enable substantial and sustained improvements in health care for the poor.

- The implementation of both formal and informal exemptions or sliding scales that could protect the poor from the full burden of fees is usually ineffective, because they do not in practice protect the poor, and may instead benefit more wealthy groups, such as civil servants.

- The differential implementation of fees between geographical areas within a country can create geographical inequities, particularly if regions whose income levels differ are expected to recover similar proportions of their costs.

- No investigations have been carried out of poorer households’ ability to pay fees, that is, of the impact of fees on household budgets, on consumption and investment decisions, and therefore on the processes contributing to sustainable livelihoods and the household production of health. Yet the limited available evidence suggests that in Zambia, for example, “sizable numbers of people who require medical attention and have previously obtained it are staying at home, and in some cases, dying, because they cannot afford to pay” (Booth and others 1995, p. xi).

Overall, therefore, fee systems represent weak mechanisms for improving the efficiency of utilization, and may promote inefficiencies in provider behavior. At the same time, the way that fee policies have been implemented in the past has prevented the realization in practice of the potential benefits of fees plus quality improvements. Instead, fees have sometimes had the unintended and undesirable effect of exacerbating existing inequities.

**Revenue Generation and Sustainability**

Experience indicates that national user fee systems have generated an average of only around 5 percent of total recurrent health system expenditures, gross of administrative costs (Gilson, Russell, and Buse 1995;
Table 3.1. Cost Recovery Levels in National User Fee Systems, Selected Countries and Years (percent)

<table>
<thead>
<tr>
<th>Country and year</th>
<th>Cost recovery level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belize, 1989</td>
<td>2.0</td>
</tr>
<tr>
<td>Botswana, 1983</td>
<td>2.8</td>
</tr>
<tr>
<td>Burkina Faso, 1981</td>
<td>0.5</td>
</tr>
<tr>
<td>Burundi, 1982</td>
<td>4.0</td>
</tr>
<tr>
<td>Côte d’Ivoire, 1986–93</td>
<td>3.1, 7.2</td>
</tr>
<tr>
<td>Ethiopia, 1984–86</td>
<td>15.0–20.0</td>
</tr>
<tr>
<td>Ghana, 1987–90</td>
<td>12.0–13.0, 5.0–6.0</td>
</tr>
<tr>
<td>Guinea Bissau, 1988</td>
<td>0.5</td>
</tr>
<tr>
<td>Kenya, 1993</td>
<td>2.1</td>
</tr>
<tr>
<td>Lesotho, 1991–92</td>
<td>9.0</td>
</tr>
<tr>
<td>Mali, 1986</td>
<td>1.2–7.0</td>
</tr>
<tr>
<td>Mauritania, 1986</td>
<td>12.0</td>
</tr>
<tr>
<td>Mozambique, 1985–92</td>
<td>8.0, 1.0 or less</td>
</tr>
<tr>
<td>Senegal, 1986</td>
<td>4.4–7.0</td>
</tr>
<tr>
<td>Swaziland, 1984–85</td>
<td>2.2, 4.6</td>
</tr>
<tr>
<td>Zimbabwe, 1991–92</td>
<td>3.5</td>
</tr>
</tbody>
</table>


Kutzn 1995; Nolan and Turbat 1995). Experience also suggests that revenue levels vary over time, sometimes increasing because of improved implementation practices, but sometimes falling as a result of inflation or such problems as war or economic recession. Thus while some countries have achieved higher levels of cost recovery than others, their sustainability is unclear. Ghana, for example, initially managed to recover more than 10 percent of total recurrent government expenditure, but this fell to around 5 percent after a few years (table 3.1).

Fees may, nonetheless, generate considerable proportions of the total nonsalary recurrent expenditure within individual health facilities, for example:

- In BI districts of Benin, 43 to 58 percent of recurrent costs
- In some health zones of Zaire, 97 percent of nonsalary operating costs (Creese and Kutzn 1994)
- In Guinea, more than 100 percent of operating costs (Knippenberg and others 1990).

This revenue may enable significant quality improvements at the facility level, and has certainly led to an improvement in perceived quality in some community financing schemes of the BI type (Kutzn 1995). Nonetheless, the available information suggests that revenue generation from user fee policies in public facilities will likely be inadequate to address the large and growing resource gap that is causing the quality shortfalls that exist in public (as well as in most private) health facilities in many African countries (Gilson, Russell, and Buse 1995; La Fond 1995; Nolan and Turbat 1995; Russell and Gilson 1995).

In many African countries revenue generation levels are constrained by the need to keep fees low, because household income levels are low. In addition, the administrative costs of implementing a fee system, including the costs of the exemptions necessary to safeguard equity and public health objectives, further reduce cost recovery levels (Gilson, Russell, and Buse 1995). Poorer, rural areas will inevitably generate lower levels of income as a result of both influences.

Weak accounting and resource management practices and skills further undermine revenue generation levels. Assessing the impact of fees on system sustainability, therefore, also requires consideration of the contribution of fee systems to the development of the other capacities required to achieve sustainability. Yet this is an area that few studies have specifically assessed. A few country experiences demonstrate the limited impact of user fees on system sustainability.
Two Tanzanian studies of decentralization (Gilson, Kilima, and Tanner 1994; Mogedal, Steen, and Mpelumbe 1995) suggest that a chicken and egg relationship exists between user fees and decentralization policies, which both fee system models emphasize as being important for sustainability. Although limited financial resources undermine the effectiveness of decentralized administration, the effective implementation of a user fee system to redress that constraint would itself require a strong, decentralized management structure. According to Mogedal, Steen, and Mpelumbe (1995, pp. 363, 366):

The districts are not well equipped for meeting the challenges of diversity, cost effective care, intersectoral action and cost sharing. . . . When new policies are introduced, they are not followed by appropriate attention to structures, and changes in structures and systems are not sufficiently linked, leading to a situation when the desired improvements do not take place. Reforms such as . . . user fees may contribute to lower quality, and weakened accountability and transparency.

In Niger, Diop, Yazbeck and Bitran’s (1995, pp. 234–35) analysis of pilot cost-recovery schemes led to the conclusion that

For access to quality health care for rural populations to be sustained, cost recovery should not only be accompanied by quality improvement measures, but also by cost containment measures. . . [such as] drug policies which promote the acquisition of essential generic drugs in competitive markets, and human resource programs which strengthen management capacities and control drug consumption costs at health facility and district levels.

Kenyan experience (Collins and others 1996; Russell and Gilson 1995) emphasizes the importance of establishing good management systems to complement user fee systems, by guiding local-level decisionmaking and ensuring appropriate control of resource use (box 3. 1).

Overall, therefore, although fees do generate revenues that can make some difference to the perceived quality of individual health facilities, fees must be complemented by a broader range of actions if they are to enhance the sustainability of health systems.

**Bottlenecks to Effective Implementation**

Experience suggests that four groups of constraints undermine the effective implementation of fee systems (Collins and others 1996; Gilson and Mills 1995; Gilson, Russell, and Buse 1995; Kutzin 1995; Nolan and Turbat 1995) as follows:

1. Poor design of fee systems as shown in
   - Complex fee structures that are difficult to administer, for instance, itemized billing
   - Types of fees, such as general consultation fees, that deter patient utilization because they are not linked to care received
   - Failure to revise fees annually in line with inflation, thereby undermining the amount of revenue generated
   - Complex and/or unworkable exemption mechanisms, which require too much information and are costly to administer
   - Fees implemented at low levels within the system where little revenue can be generated
   - Lack of coordination between fee levels across the health system, possibly generating perverse utilization incentives, for instance, to use higher level care before lower level care, and inequities, for example, inappropriately differentiated fee levels between areas.

2. Poor capacity for local-level financial management and fee system implementation as shown in
   - Lack of financial management skills throughout the health system, but especially at the district or community level
   - Absence of appropriate financial management information and audit systems that support management rather than simply seeking to prevent misuse of finances
The Lessons of User Fee Experience in Africa

• Lack of information with which to target the poorest effectively through exemptions
• Limited local authority to take appropriate resource use decisions without reference to higher authorities
• Limited effectiveness in collecting fees, thereby undermining revenue generation rates and revenue use for quality improvements
• Lack of guidance on financial management and control practices, for instance, on how to determine who is eligible for exemptions, on how to account for revenue generated, or on procedures for using revenues
• Failure to retain fees locally, thereby undermining the incentive to collect them and use them for local-level quality improvements
• Total retention of revenues locally, leading to limited redistribution of resources between geographical areas with different capacities to raise revenues
• Absence of procedures that would allow monitoring of the impact of policy implementation.

3. Weak supporting systems as demonstrated by

• Poor quality public services that undermine the population’s willingness to use them, for instance, drug shortages or poor staff attitudes
• Inadequate human resource policies that do not promote or sustain staff morale
• Inadequate drug supply and distribution systems
• Operational inefficiencies within the health system that contribute to quality failures, for example, drug wastage and abuse, leading to shortages
• Limited funding for the supervision and support needed at the primary level
• Inadequate management information systems that do not, for example, allow resource use to be related to services provided
• Organizational structures that generate weak and conflicting lines of accountability, both downward to the community level or upward to technical supervisors.

4. Contextual constraints such as

• The population’s lack of experience in paying for public health services, which generates an unwillingness to pay for them, especially when they perceive the services as providing only low quality care
• The weak banking and communication systems, which undermine local-level financial management and the potential for support

Box 3.1. Kenya’s Facility Improvement Fund

Key design features of Kenya’s Facility Improvement Fund include

• Collecting facilities retain 75 percent of revenues collected and return the remaining 25 percent to the district to be used for preventive and promotive care.
• The Health Care Financing Secretariat of the Ministry of Health provides national guidelines to the district and hospital management bodies responsible for revenue use at the local level.
• The guidelines identify eleven items on which Facility Improvement Fund revenues can be expended within facilities (for example, maintaining building, obtaining emergency drugs, setting up and operating amenity wards for paying and insured patients, preparing public information materials) and prevents their use for items funded by basic budget allocations.
• At the hospital level, the hospital management team prepares an annual Facility Improvement Fund expenditure plan, which is scrutinized and approved by a range of bodies at the district level, some of which include representatives of the wider community, before it is sent to the Health Care Financing Secretariat for final approval.
• A group within the district health management team prepares an annual plan for the use of the 25 percent of revenues submitted to them, which is again scrutinized and approved by various bodies at the district level, some of which include representatives of the wider community, before being sent to the secretariat for final approval.
• New accounting and reporting systems were introduced throughout the system to enable review of total revenues earned relative to services provided (including exemptions).
A variety of sociocultural and political constraints at both the local and national levels that allow richer groups to be incorrectly exempted and prevent the reallocation of resources to primary health care, which would benefit the poorest members of society the most.

Lessons of Experience

Experience has provided some useful lessons in terms of where and when to implement fees, how to design more effective fee systems, and how to implement fee systems.

Where and When to Implement Fees

The first lesson of experience is that the current practice of fee system implementation has clear potential to harm equity, has only a limited impact on the efficiency of utilization, and ensures that fees by themselves are only weak mechanisms for achieving sustainability.

Focusing on the standard model, (Gilson, Russell, and Buse 1995, p. 391) conclude that “reaching the poor through public policy is not a simple process of aiming at a target. Numerous factors will mediate and alter policy outcomes, ensuring that effective implementation does not follow rational analysis.” In their review of schemes of the BI type Nolan and Turbat (1995, p. 45) also suggest that “concentrating the implementation of meaningful cost recovery at the health center or health post means that the greatest potential source of revenue is not being exploited. Moreover, such an approach is likely to have adverse efficiency and equity implications.”

In addition, the potential impact of fees on absolute affordability is critically important to their equity impact, and yet this issue remains underresearched. In the constrained economic contexts many African countries face, household strategies for coping with the parallel demands of reduced household income and increased prices for basic household needs are already overstretched (Kanji and Jazdowska 1993; Pinstrup-Anderson 1993). Thus payment of increased health care fees will represent an unacceptable burden on households that may lead them to delay seeking treatment, to use informal, and less effective sources of health care, or to marginalize impoverished families further (Booth and others 1995; Gilson 1988; Russell 1996).

According to Russell and Gilson (1995, p. 68), researchers should pay more attention to understanding better the mechanisms mediating the impact of fees on ability to pay:

In particular, their [fees’] potential effect on different types of household and user behavior needs to be assessed. This may involve willingness and ability to pay studies and more qualitative research exploring community responses to user fees. Such research may indicate, for example, that fees in some rural settings within a country are inappropriate due to the large proportion of patients who would need exemptions, the lack of revenue such fees would generate, and the impact that such fees would have on financial access to essential services in the area (see also Adams and Harnett 1995).

Generating higher revenue levels without harming equity only appears possible where risk-sharing arrangements allow fees to be charged that cover costs for those insured against the need for hospital care (Nolan and Turbat 1995). Studies indicate that hospitals in Brazil, China, Korea, and Zaire can recover close to 100 percent of total hospital recurrent expenditure by setting fee levels that are high relative to costs, and by having fairly widespread insurance systems that reimburse hospitals for insured patients (Barnum and Kutzin 1993). A longitudinal survey of Kenya’s experience with user fees indicates that between 1991 and 1992, the level of fee revenue generated by provincial hospitals tripled and that generated by district and subdistrict hospitals doubled. This occurred as a result of increased prices and strengthened billing systems that, in particular, tapped resources from those covered by health insurance. In the first six months of 1993, 62 percent of the total revenue generated at provincial hospitals and 48 percent of that generated at district hospitals came from National Hospital Insurance Fund claims and cash fees.
As a result of such experiences, various analysts suggest that fee implementation should focus on the hospital level and should be associated with risk-sharing mechanisms and exemptions (Adams and Harnett 1995; Barnum and Kutzin 1993). Nolan and Turbat (1995), for example, propose the following three alternative strategies for increasing cost recovery at this level:

- The imposition of substantial in-patient fees, combined with the promotion of insurance for the formally employed and the provision of generous exemptions
- The imposition of substantial fees for private wards in public hospitals selected only by those willing to pay more for better hotel-type services, possibly combined with the promotion of insurance coverage for the formally employed
- The imposition of affordable fee levels using simple fee systems, such as a per day fee up to a maximum level, in conjunction with some exemptions and much improved collection procedures.

The choice of strategy depends on the extent of institutional capacity, and the first option requires much greater capacity than the other two.

Overall, therefore, the evidence suggests that governments should exercise caution in introducing fees for three main reasons. First, reviewing the level of the health system at which to introduce fees remains important, even where the alternatives seem limited. Second, seeing fees as part of a wider package of health care financing policies rather than as the central or only strategy for addressing current resource constraints is also important. Within this package, fees may be a first step toward, for example, developing risk-sharing mechanisms, but should not be seen as an end in themselves. Third, as “managerial and organizational factors are central determinants” (Kutzin 1995, p. 16) of the impact of fees on key health sector goals, any fee system must be devised carefully.

Designing More Effective Fee Systems

The bottlenecks to designing and implementing effective fee systems point to various lessons for the design of any fee system (see table 3.2). However, these lessons also have more general relevance, because they emphasize the need for a policy package to complement and support the introduction of fees.

The Process of Implementation

Addressing the problems of effective fee policy implementation requires consideration of the process of policy development and implementation. The influence of contextual factors over effective design, for example, requires consideration of how to promote a supportive environment in which to introduce fees. Recent reviews of health sector reforms also point to the importance of a comprehensive, rather than selective, process of reform, based on careful analysis of problems, and leading to the development of appropriate implementation strategies (Frenk 1995; Mogedal, Steen, and Mpelumbe 1995). Possible stages in such a process include the following:

- **Stage 1**
  - Identifying problems likely to affect the implementation of a broad fee system design, such as poor quality health care, lack of willingness to pay, opposition from critical stakeholders
  - Collecting baseline data by which to assess the impact and effectiveness of implementation, for example, ability to pay data

- **Stage 2**
  - Reviewing the fee system design and planning ahead of time how to deal with the problems likely to be encountered during implementation as far as possible
  - Identifying the factors constraining and facilitating effective implementation
  - Developing strategies to offset likely constraints to implementation
### Table 3.2. Lessons of Experience for Policy Design

<table>
<thead>
<tr>
<th>Fee system design</th>
<th>Complementary government policies</th>
<th>Contextual support</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Implementing simple fee structure linked to treatment received, for example, prescription fee</td>
<td>• Implementing a financing policy framework</td>
<td>• Developing institutional capacity within the health system to provide support to local-level decisionmakers</td>
</tr>
<tr>
<td>• Having affordable price levels</td>
<td>• Maintaining existing levels of government funding for the health system as a whole</td>
<td>• Developing adequate leadership and advocacy skills within the health sector to develop political support for appropriate design and policy</td>
</tr>
<tr>
<td>• Using simple to apply exemption categories wherever possible, for example, focusing on users’ characteristics or including some simple procedures for identifying the poorest</td>
<td>• Developing complementary risk-sharing financing mechanisms</td>
<td>• Providing wider institutional support, for example, banking and communication facilities</td>
</tr>
<tr>
<td>• Advertising the price structure within health facilities</td>
<td>• Developing a resource reallocation mechanism favoring relatively underresourced geographical areas and more cost-effective services</td>
<td>• Ensuring consumers’ willingness and ability to pay</td>
</tr>
<tr>
<td>• Coordinating the price structure across health system levels, for example, graduated between levels</td>
<td>• Promoting community solidarity mechanisms that can assist the poorest</td>
<td>• Developing professional ethics to counterbalance health workers’ responsiveness to financial incentives</td>
</tr>
<tr>
<td>• Readjusting prices periodically</td>
<td>• Developing community management mechanisms that ensure accountability at the community level</td>
<td></td>
</tr>
<tr>
<td>• Retaining some revenue at the point of collection for use in quality improvements</td>
<td>• Implementing policies to support sustainability</td>
<td></td>
</tr>
<tr>
<td>• Providing guidelines to promote revenue use for quality improvements</td>
<td>• Developing an effective reward and discipline system for health staff, including training</td>
<td></td>
</tr>
<tr>
<td>• Developing community management mechanisms at the primary level</td>
<td>• Instituting an effective drug procurement and supply system</td>
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<tr>
<td></td>
<td>• Ensuring effective management and clinical supervision and support for the local level</td>
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<tr>
<td></td>
<td>• Putting in place management-oriented information systems that allow monitoring, for example, by providing data on revenue collected and revenue use patterns</td>
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<tr>
<td></td>
<td>• Developing skills and systems to enable decentralization over the control of collected fees</td>
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<tr>
<td></td>
<td>• Establishing effective audit procedures to ensure accountability at the local level</td>
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Stage 3
- Taking steps to develop key prerequisites for effective implementation
- Initiating the initial implementation of fees
- Monitoring the impact and effectiveness of fees
- Instigating operational research to support implementation

Stage 4
- Reviewing and revising the approach to fee implementation
- Starting the next stage of implementation.

Mogedal, Steen, and Mpelumbe’s (1995, p. 366) study of health sector reforms and organizational issues in Botswana and Tanzania emphasizes the importance of stages 1 and 2:

Critical dysfunctions in the system need to be thoroughly analyzed to decide how they relate to policy and structures as well as systems. . . . Our findings may suggest that reform is likely to be more successful if undertaken in a situation where there is public demand on the system for better quality and higher relevance. This will make it more of a political issue, and help to hold health workers accountable.

A review of Kenyan experience (Collins and others 1996) that compared an initial implementation strategy involving the introduction of fees across all facilities simultaneously, and a system in which fees were introduced in a phased manner, also indicates the influence of the implementation strategy on the impact of a fee system. According to Collins and others (1996, pp. 60–61) the first approach did not permit testing of fees and systems, proper training of staff or adequate supervision. As a result, implementation was weak and when problems emerged they were so widespread that the Ministry of Health was unable to take corrective action. In contrast, re-implementation in phases over two years allowed time for testing fees and systems and for proper training and supervision. Phasing down from the referral hospitals was a good strategy in that quick success was demonstrated in generating revenue, senior medical and administrative staff at those hospitals became useful advocates of the program and staff at each level helped in the training and supervision of the next level.

Although few similar studies of fee implementation are available, reviews of other reform experiences have stressed similar lessons. Cheema and Rondinelli (1983, p. 313), for example, specifically suggest that Decentralization can be implemented most successfully if the reform process is incremental and iterative. Those aspects or programs that are least likely to be opposed, and for which there is adequate administrative capacity, should be expanded as political support and administrative competence increase ... Policy implementation, in many cases, must be experimental.

The implementation strategy therefore has a critical influence over the development of an effective policy package. For example:

- Advocacy before, during, and after implementation is a critical element in garnering the political support that is often required to enable effective implementation.
- Information strategies undertaken before implementation of a new fee system can develop community awareness and understanding of such a system, and so offset utilization decreases.
- Prior improvement of the quality of care provided in government health facilities can enhance community acceptance of fees.
- Involvement of a wider range of interested actors or stakeholders in the process of developing and implementing policy can both inform that process better and attract their support for the process. Particularly critical are the service providers, who must implement the policies, and the community, which must accept the policies.
• Gradual implementation, for example, by introduction in hospitals first, can allow policies to be
developed, tested, and adjusted in response to experience, thereby limiting the potentially major
negative consequences for efficiency, equity, or sustainability.
• Gradual implementation also allows development of the capacity needed to enable sustainability through
a process of learning by doing, which is perhaps more effective than simple training.
• Phased or differentiated implementation within a country can allow policies to be developed in re-
sponse to the different circumstances of different geographical areas. However, differential develop-
ment must be monitored to guard against geographic inequities.

Conclusion

The evidence suggests that user fees alone are unlikely to accomplish equity, efficiency, or sustainability objec-
tives. Moreover, when fee policies are poorly designed and implemented, they can actually undermine equity
goals. Fees should, therefore, be seen as only one element in a broader health care financing package that
should, in particular, include some form of risk sharing. Although fees may be a critical step in allowing the
development of other financing mechanisms, for instance, high hospital fees promote insurance coverage, their
implementation must be tied to this broader package to limit the possible equity dangers that are clearly asso-
ciated with them. Within this package fees have a greater potential role within hospitals than at the primary
care level.

Achieving equity, efficiency, and, in particular, sustainability requires implementing a broader policy pack-
age to develop the skills, systems, and mechanisms of accountability critical to ensure effective implementa-
tion. Some local control of revenues, particularly if fees are introduced at the primary level, is an element of this
package, but equally important are supporting systems, such as those associated with drugs and human re-
sources. In addition, the process of policy development and implementation is itself an important aspect of this
package, as it enables the development of the full range of capacities necessary to ensure sustainability.

Policy analysis is a useful tool for strategic management in the health sector and for developing processes
that help the effective implementation of any health care financing reform. A simple analytical model identifies
the four key factors that governments should consider when developing any fee system: the context of imple-
mentation, the actors influenced by implementation, the content of the policy package, and the process of its
implementation (Gilson and Mills 1995; Walt 1994; Walt and Gilson 1994). Use of this model in the early stages
of policy development can ensure that the contextual factors that influence appropriate design of the policy
package are identified and addressed, and that the critical actors who might undermine implementation are
identified and their concerns clarified. Based on such an assessment, policymakers can then judge whether or
not, when, and how to implement a fee policy.

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