

The abolition of user fees for health services in Africa Lessons from the literature

Florence Morestin & Valéry Ridde (Université de Montréal, Canada)

This document is one in a series of four policy briefs on mechanisms to promote access to health services for the poor in low-income countries (abolition of user fees, health equity funds, special health insurance provisions, and targeting of the poor).



BACKGROUND

In the 1980s, nearly all African countries imposed user fees on patients using health services. However, many studies have demonstrated that this type of payment excludes vulnerable populations from access to health services and places them at risk of further impoverishment. These situations raise important ethical issues and impede both the attainment of the Millennium Development Goals and the war against poverty. One solution proposed from the beginning has been case-by-case exemptions for the indigent. Few countries have actually implemented such systems, however, and the rare attempts have been ineffective.

Faced with these problems, the solution that certain African countries have tried over the past several years has been to abolish payment for everyone, or at least for easily identifiable categories of persons or services, as opposed to case-by-case exemptions. Many international cooperation organisations have also aligned themselves with this approach (World Bank; ECHO; WHO; British and Danish aid agencies; and several NGOs), even though it is well-known that abolishing user fees does not reduce overall direct costs.

However, before abolishing fees for health services for broad categories of persons, it would be important to know the **lessons learned from current experiences of abolition, i.e., what are their results, and how best to proceed?** The objective of this document is to consider some possible answers to these questions by synthesising what the published scientific studies on experiments with fees abolition in Africa have taught us.

METHODS

To present decision-makers with the most reliable information possible, we conducted a systematic review* of studies on fees abolition in Africa, retaining only “peer-reviewed” studies, i.e., those that were evaluated by a committee of experts in the field of study before being published. Peer review is one guarantee of content quality.

A search of all peer-reviewed studies published between 1988 and 2008 on the abolition of user fees for health services uncovered 20 scientific articles on five African countries: Uganda (seven articles), Ghana (six articles), South Africa (four articles), Kenya (two articles), Madagascar (one article). [See references to these articles at the end of this paper.]

*** Systematic review :** Systematic review: A systematic review involves identifying, analysing and synthesising all scientific studies published on a topic. Comparing the studies allows us to see whether their results are in agreement and whether they are similar in different contexts. The conclusions drawn are thereby much more reliable than if we consulted a single study, whose results might be due to particular conditions or influenced by the evaluation method used, etc.

It should be noted that these articles do not reflect all experiences of fees abolition, but only those on which scientific studies have been published. Also, these articles do not all touch upon every aspect of fees abolition. Finally, these articles reflect the situation as it was at the moment of their writing. These limitations of any systematic review of peer-reviewed studies are counterbalanced by the main advantage, which is the reliability of the information reported.



The content of the 20 articles was analysed and synthesised following the order of the four “stages” of public policy development: emergence (the conditions under which the decision is taken); formulation (the policy content); implementation (how the policy is planned and applied); and effects (direct and indirect, expected and unexpected).



EMERGENCE OF FEES ABOLITION POLICIES

Decision-maker In the countries studied, abolition of fees was decided at the highest levels of government, often by the President himself (Uganda, South Africa, Madagascar). The fact that funding agencies supported abolition also appeared to play a role in the decision.

Context In many cases, abolition was decreed either just before or just after elections, as an electoral promise (Uganda), a symbolic departure from previous policies (South Africa after apartheid), or a means of helping the population through a politico-economic crisis (Madagascar in 2002).

Arguments Countries that abolished user fees justified the decision on the basis of their negative impact on the utilisation of health services and on the population’s health status (Uganda, Kenya, Ghana), their failure to bring in substantial revenues and improve the quality of services (Uganda, Kenya), the war against poverty (Madagascar, Ghana, Uganda), and public dissatisfaction (Uganda).

FORMULATION OF FEES ABOLITION POLICIES

Services or groups affected The abolition of fees can be focused either on health services or on population groups. Among the countries studied, the approach most often adopted was to abolish fees for certain services, for all users of those services. Only South Africa initially decided (from 1994 to 1996) to focus abolition on certain groups (children and pregnant women), for whom all services became free-of-charge.

Level of care Abolition can be limited by level of care, as in Uganda, where hospitals continue to charge “those who have means”, and in Ghana, where childbirth in regional hospitals is only free if the woman has been referred there.

Public / private While abolition in other countries applies only to the public sector, Ghana made childbirth services free even in the private sector.

Country	Scope of application of the abolition	Date of adoption
Kenya	All public-sector services except adjunct services (laboratory tests and others)	1990
South Africa	1994: All public-sector services for children under the age of six and pregnant or nursing women 1996: All public-sector primary care services, for all patients	1994 and 1996
Uganda	All public-sector services except hospital services for patients able to pay.	2001
Madagascar	All services in public health care centres	2002
Ghana	All childbirth-related services in both public and private sectors	2003 and 2005



Duration of abolition

Madagascar decided to implement abolition only as a temporary measure during the 2002 politico-economic crisis. Elsewhere, abolition was not time-limited, although its application was occasionally jeopardised by funding difficulties (Kenya, Ghana).

IMPLEMENTATION OF FEES ABOLITION POLICIES

Implementation

In many cases, implementation was precipitous. In Uganda, the plan for gradual implementation was not followed because immediate abolition became an electoral issue. In South Africa, there was very little planning for abolition of fees. In Ghana, abolition was first applied in half the regions and then generalised 18 months later; however, this expansion was carried out without the first phase having been evaluated and without funding.

Sometimes, as in certain regions of Ghana and Madagascar, it was only several quarters after the official date of abolition that fees were actually abolished. On the other hand, in Ghana, its application was intermittent: when funding was unavailable, some health facilities temporarily reinstated user fees.

Funding

The abolition of fees led to a loss of revenues for health facilities that then had to be compensated. Uganda, Madagascar and Ghana mobilised supplementary funding to implement the abolition policy and particularly to buy medicines. However, the speed and persistence of this mobilisation varied by country. Uganda quickly released these funds and continued to increase its health budget over many years. In Madagascar, free medicines were only distributed several months after abolition was announced. In Ghana, the additional funding was rapidly released in the beginning but was not maintained over time.

Planning for the necessary funding requires a cost analysis. We know Ghana's method of calculation for the additional funding. Funds were allocated to the regions based on their population, with a higher per capita rate applied to the poorest regions. However, there was no plan that would set the duration and total cost of the fees abolition program. The funding proved inadequate for the level of activity in the health facilities.


For issues related to funding, the health ministries need to work with other actors. On the one hand, the funds come from outside sources (World Bank in Uganda, debt relief funds in Ghana). On the other hand, budget allocation decisions are under the aegis of the finance ministries. In Uganda, these decisions benefited the health sector, but in Ghana, the Ministry of Finance ultimately withdrew funding for the free childbirth program, partly because of "competition" from another emerging program, national health insurance.

Management approach

In Madagascar, the management of funds allocated to abolition remained centralised, whereas it was decentralised in Uganda and Ghana. The Ugandan government even relaxed the rules for the utilisation of these funds by health districts so that they could redirect them toward expense items previously funded through cost recovery. In Ghana, districts received funds from the central government to reimburse health facilities retroactively according to the number of deliveries carried out. However, they did not always respect the prices for deliveries as set out by the Ministry of Health. In addition, many health facilities and local health authorities did not report to the central government on how they had used the funds received.

Communication

Health care workers and managers in Uganda, South Africa and Ghana complained they were not consulted during the process of decision-making and planning for abolition and did not get the support required for its implementation. In Ghana, it appears that the communities did not understand the abolition measure very well, despite various types of publicity.



Complementary measures

These helped to facilitate the implementation of abolition by motivating health personnel or improving the functioning of the system: salary raises for health workers in Uganda (14% to 63%, depending on the profession) and in Ghana; workload-related incentive bonuses in certain regions of Ghana; and, in Uganda, reorganisation of the drug supply system and a shifting of international aid toward sectoral funding.

Overall, we can see that the implementation of abolition was inadequately prepared. This should be kept in mind as we consider the effects produced.

EFFECTS OF USER FEES ABOLITION

→ Effects on health care services utilisation

Primary care curative visits

All the studies show an **increase** in the number of visits between the periods before and after fees abolition: from 17% in Madagascar, up to 84% in Uganda.

Hospitalisation and childbirth

The number of **hospitalisations** remained steady in Uganda after abolition; however, the number of patients referred to hospitals rose by 26%. This situation may reflect hospitals' limited capacity to accept patients, or it may be that some patients decided not to use hospital services because of uncertainty about costs, since "those who have means" must still pay. For **assisted deliveries**, all the studies in Ghana show increases in the number of assisted deliveries (between 10% and 36%) and caesareans. The results in Uganda are unclear (increase according to some studies, slight decrease in others).

Services already free before abolition

In several countries, some health services had been free for a long time (vaccination, pre- and post-natal visits, family planning). We examined whether the abolition of fees for other services might have had an indirect effect on their utilisation. Three different scenarios were observed:

- **Stability** : This was the case for prenatal consultations in Uganda.
- **Increase** : According to Ghanaian health professionals, postnatal coverage is better since deliveries were made free. In Uganda, increases were observed in many preventive services. One explanation for this may be that the greater use of curative services after the abolition of fees allowed health workers to raise people's awareness and to direct them toward preventive services.
- **Decrease** : In South Africa, utilisation of free preventive services is on the decline. It appears that utilisation of curative services occupies too much of the health workers' time, to the detriment of preventive services.

Services still charged

In Kenya, the number of private-sector consultations went down by 32%. Traditional childbirth attendants experienced a reduction in their clientele.

However, unexpected trends emerged elsewhere, such as in Uganda, where the utilisation of private health care services is on the rise. It appears that the newly-free services have created more demand than can be accommodated, inciting some patients to turn to the private sector.

Utilisation by socio-economic category

In many countries, health care workers consider that the abolition of fees has especially benefited the poor. In Ghana, the proportion of assisted deliveries increased in every quintile*, but the two poorest quintiles experienced the greatest increases. In Uganda, the greatest increases in utilisation of health care services after abolition occurred among the poor; however, unexpectedly, the poor also greatly increased their utilisation of private services. Non-poor Ugandans tended, after abolition, to stay away from public health facilities, preferring private facilities.

* **Quintile** : A 20% slice of a whole that is organised in increasing order. Example: In a group of 100 households, the 20 poorest households make up the poorest quintile.



→ Other effects of fees abolition

Quality of services

Problems related to quality were raised, mostly attributed to the lack of preparation for the implementation of abolition. All the countries experienced problems with availability of drugs after fees were abolished. Cases in point were the lack of planning in South Africa and the late distribution of medicines in Madagascar. Ghanaian health care workers appreciated the greater availability of funds for purchasing drugs at the start of the new policy, but this was not sustained. In Uganda, drug shortages were more frequent in the year after abolition was introduced, but the situation subsequently improved.

In South Africa, the substantial increase in visits led to a reduction in the time devoted to each patient and a lack of privacy. Some studies in Uganda mention long wait times, negative attitudes on the part of health care workers, and a deterioration of cleanliness in health facilities. However, studies in other regions of Uganda conclude that the cleanliness of facilities and the attitudes of the workers have not changed.

Workload

Studies in Uganda, Ghana and South Africa show that workload has increased (for example, 47% more visits per worker in Uganda). In fact, the increase in service utilisation has not been accompanied by an increase in staff. To deal with the situation, the workers have sometimes had to cut back on health promotion activities. Managers in Ghana also complain of an increase in their workload due to new funding channels and systems of reporting.

Other actors in the system have seen their functions disappear, such as the management committees and the health mutuels in Uganda.

Health system revenues

- At the societal level, the abolition of fees represents a loss of about \$3.4 million US per year for the Ugandan health system. However, it generates economic gains of nearly \$9 million US per year, because improved access to services translates into less work time lost to illness, especially among the poor.

- At the level of the health facilities, they must deal with the loss of user fees that were sometimes a significant source of funding. In Uganda there were temporary problems with meeting recurrent expenses, until such time as the facilities received their compensatory funding. In Ghana, for as long as the compensatory funds were available, administrators of health facilities were relieved to no longer have to pursue women unable to pay for their deliveries. However, as the compensatory funds became inadequate, health facilities became indebted to their suppliers, to the point where some had to reinstate payment from women for deliveries.

- At the level of the health care workers, abolition involved income losses that were more or less compensated by other measures. Thus, in Uganda, bonuses funded by cost recovery disappeared, and the staff soon “forgot” the salary increases awarded by the government. In Ghana, the elimination of fees for deliveries put an end to the unofficial sale of small supplies to women giving birth, and only a few regions instituted an incentive bonus; on the other hand, the health care workers seemed to much appreciate the salary raises they had received.

Health expenses

Despite abolition, patients continued to pay certain expenses:

- When public-sector resources are insufficient (especially medicines), those who are able to pay turn to private services
- Some costs (for example, transportation to health facilities) are not covered by the abolition policies.
- Some health care providers charge unofficial payments.

Thus, abolition does not solve all problems related to health care costs, and so certain unexpected situations have occurred: since abolition, household expenses on health in Uganda have risen slightly; in Ghana, after abolition, more households fell under the poverty threshold due to childbirth expenses. On the other hand, on a positive note, fewer Ghanaian households fell into the extreme poverty* category.



If we look at socio-economic categories, some effects are expected and positive: lower health care expenses in the two poorest quintiles in Uganda; fewer catastrophic expenses (expenses exceeding a substantial proportion of income) related to childbirth in the poorest quintiles in Ghana. Other effects are more unexpected, because they seem to favour the more well-off households. In Ghana, the proportion of income spent on childbirth expenses decreased among the poor quintiles, but decreased even more for the richest quintile. In Uganda, the second-richest quintile experienced the greatest reduction in health expenses, and catastrophic expenses decreased for the non-poor, but not for the poor.

* **Extreme poverty** : The threshold for extreme poverty in Ghana in 1999 was 700,000 cedis, while that for poverty was 900,000 cedis.

Satisfaction Patients appreciate the abolition policies, and overall, health care workers are also in favour of them because they improve access to care and circumvent the problems of cost recovery. The dissatisfactions noted arise more from implementation problems: the health care workers suffer the consequences of a lack of planning (especially insufficient resources) and stressful relationships with unhappy patients whenever fees abolition is suspended or not effective (for example, because of drug shortages). When these problems arise, staff can become demotivated and overworked.

CONCLUSION

What the scientific literature still does not tell us

The scientific literature on fees abolition is still quite sparse and leaves a number of questions unanswered. More research is needed to:

- Further analyse the implementation processes for abolition policies
- Describe and compare different approaches for managing abolition
- Calculate the real cost of abolition policies
- Study the health expenses that households still have to assume
- Understand the policies' effects on professional practice and the provider-patient relationship
- Describe the effects and linkages between fees abolition and community financing systems (Bamako Initiative and health mutual organization)
- Verify whether it really is the poorest who benefit from fees abolition
- Study the longer-term effects

What we can learn – Proposals for action

Despite its limitations, the current scientific literature provides a great deal of information from which we can draw useful lessons for practice. Overall, abolition of fees has achieved its main objective: utilisation of services (especially primary care visits and assisted deliveries) is on the rise, particularly among the poor. The people appreciate the abolition of fees, as do the health care workers, as long as it does not present them with overwhelming problems of implementation. The more or less transitory problems having to do with quality of services (particularly shortages of medicines), excessive workload for health care workers, and patients turning to paid services when the free services are overloaded are not related to the abolition of fees as such. Rather, they are due to inadequate implementation; despite the laudable efforts of government, implementation has often been precipitous, the required resources poorly planned and not available, and follow-up lacking.



The conclusions drawn from the scientific literature—some positive, some more mitigated—suggest the following advice for countries wishing to adopt fees abolition policies:

Proposals for action

- Create political will at the highest levels which is not simply declared, but which ensures that the decision can be implemented.
- Obtain the support of funding agencies.
- Take advantage of all opportunities (elections, negotiations for international aid programs).
- Create alliances between the Ministry of Health and the Ministry of Finance.
- Organise information and consultation processes tailored to specific audiences (health care workers, managers, populations).
- Plan all the processes in detail.
- Estimate the expected additional costs and anticipate all the resources (human, financial, medicines) that will be required to respond to increased demand for services.
- Monitor the utilisation of these resources.
- Provide incentives to promote buy-in by the health care workers if these do not already exist in the health care system.
- Reflect upon the redefined roles of management committees and health mutuals.
- Monitor the utilisation of health care services targeted by abolition, as well as other services.

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