

User Fees as a Form of Cost Sharing In Developing World

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Abstract

1990's were marked by massive introduction of user fee health care plans as a mean of improving efficiency by moderating demand, containing cost, and mobilize more funds for health care than existing sources provided. Introduction of user fees raised a lot of controversy with common claims that their implementation reinforced the poverty trap in developing world, which has considerable health and livelihood impacts. Opponents of user fees argue that their introduction decreases service utilization, do not improve the quality of care and cause medical services to be priced higher than those charged by private healthcare providers. Proponents of user fees relate *inter alia* to cost recovery, improved equity and greater efficiency. This paper will examine the effect of user charges on the medical care.

I. Introduction

User fees are charges for health care at the point of use. User fees were intended to combat three aspects within health service sector: improving efficiency by moderating demand, containing cost, and mobilize more funds for health care than existing sources provided. The introduction of user charges in many East Asian and Sub-Saharan African countries raised a lot of controversy with common claims that user fees reinforce the poverty trap by decreasing service utilization by poor, which has considerable health and livelihood impact. In addition, opponents of user charges argue that they do not improve

the quality of care and cause medical services to be priced higher than those charged by private healthcare providers¹. This view relies on studies indicating drastic and sustained decreases in health care service utilization following the introduction of user fees in Zambia, Cambodia, Rwanda and Uganda in the early 1990's. Waddinton and Enymayew (1990) and Mwabu et al. (1995) found that introduction of charges for medical services decreased demand in the range of 15-45% in most developing nations.

Audibert and Mathonnat (2000) and Chawla et al. (2000), as well as Ha et al. (2002) confirm that user fees divert those who cannot afford the medical service to other sources of health care or away from the health care system in general. Other studies came to a conclusion that user fees reduce service utilization only when they fail to result in substantial and sustained improvement in the quality of care and/or when health care services are priced higher than those charged by private providers.

Proponents of user fees relate *inter alia* to cost recovery, improved equity and greater efficiency. The view is mainly supported by several studies, which found that hospital facilities that “retain revenues generally performed better than facilities that sent all their revenues to the treasury”¹. The claim advocates that user fees avoid the provision of subsidies to those who can afford to pay all or a portion of costs of services for those less capable of paying. The dominant perspective behind user fees is that charging attaches value to a service, i.e. increasing demand by increasing perception of quality and deterring inadequate use of health care services.² According to this view free services

¹ Shaw RP, Griffin C. Financing health care in sub-Saharan Africa through user fees and insurance, Washinton DC: World Bank, 1995.)

² Jacobs B, Price N. Improving access for the poorest to public sector health services: insight from Kirivong Operational Health Distric in Cambodia. *Health Policy Plan* 2006 21: 27-39

reduce utilization because of inefficiencies leading to quality, and because of low value attached to free service.³

Levels of national income and the condition of health systems vary widely among countries, and local context needs to be considered when making comparisons in user fee outcomes. In most of the very poor countries of sub-Saharan Africa fees have been raised or introduced after years of commitment to "free health care", as a way to provide small but critical supplements to government health spending of less than \$5 per capita. In these extreme situations fees have been a mechanism of additional funding for health care sector. Income from user fees remains at about 10 percent in most African countries, although it seems to be somewhat higher in Asia and has risen to 36 percent in China and 18 percent in Vietnam.⁴

This paper will review the case studies from Sub-Saharan Africa and Asia, as well RAND Health Insurance Experiment (RAND HIE) of North America to evaluate the consequences of user fees in health care.

II. RAND Health Insurance Experiment (RAND HIE)

The RAND Health Insurance Experiment (RAND HIE) was a comprehensive study of health care cost, utilization and outcome in the United States between 1971 and 1982. Although it was completed over two decades ago, the HIE remains the only long-term, experimental study of cost sharing and its effect on service utilization, quality of care, and health.

The research study included 3,958 people between the ages of 14 and 61 who were free of disability that precluded work and had been randomly assigned to a set of

³ Lewis MA. 1986. Do contraceptive prices affect demand. *Studies in Family Planning*: 126-35

⁴ Dezhi Y. *Changes in health care financing and health status: the case of China in the 1980s*. Florence: Innocenti, 1992. (Occasional Paper No 34.)

insurance plans for three or five years. The experiment included four basic types of fee-for-service plans. One type offered free care; the other three types involved 25 percent, 50 percent, or 95 percent coinsurance (the percentage of medical charges that the consumer must pay). The fifth type of health insurance plan was a non-profit, HMO-based group plan. Those assigned to the HMO received their medical care free of charge.

The study showed that patients in the group that had to submit co-pays made approximately one-third fewer visits to a physician and were hospitalized about one-third less often. Cost sharing reduced the use of almost all health services. Specifically, participants with cost sharing made one to two fewer physician visits annually and had 20 percent fewer hospitalizations than those with free care. Declines were similar for other types of services as well, including dental visits, prescriptions, and mental health treatment (see Figures 1 and 2). Participants in the HMO-style cooperative had 39 percent fewer hospital admissions than consumers with free care in the fee-for-service system, but they had similar use of outpatient services.

Figure 1
Participants with Cost Sharing Visited the Doctor Less Frequently

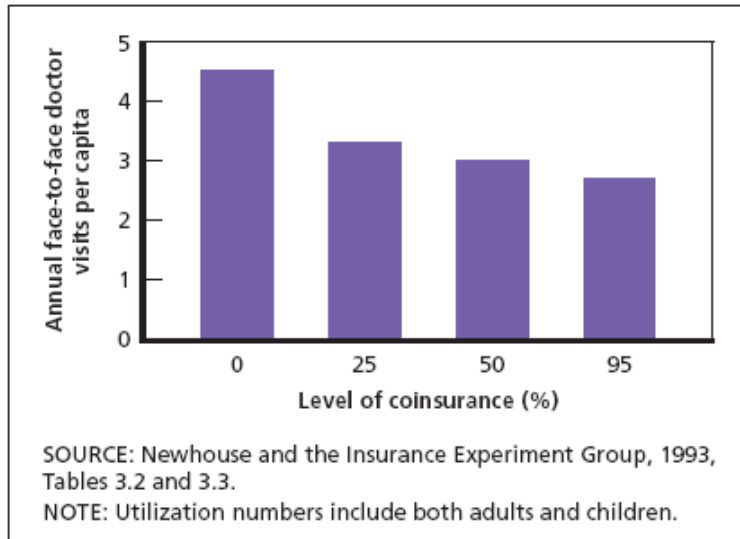
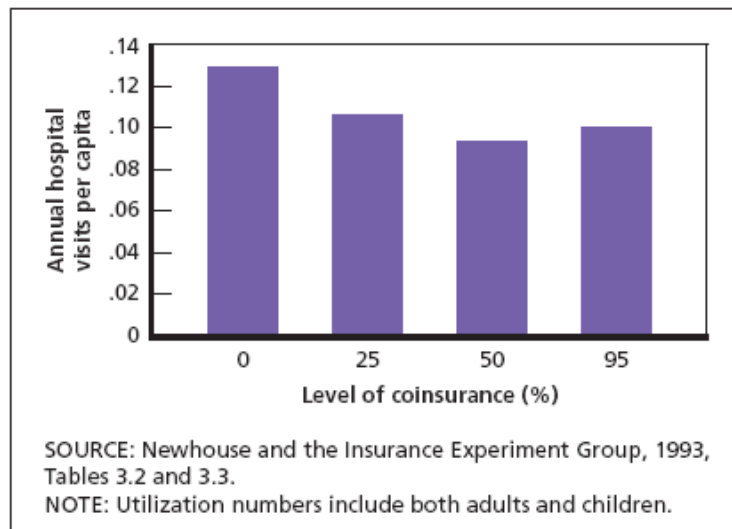
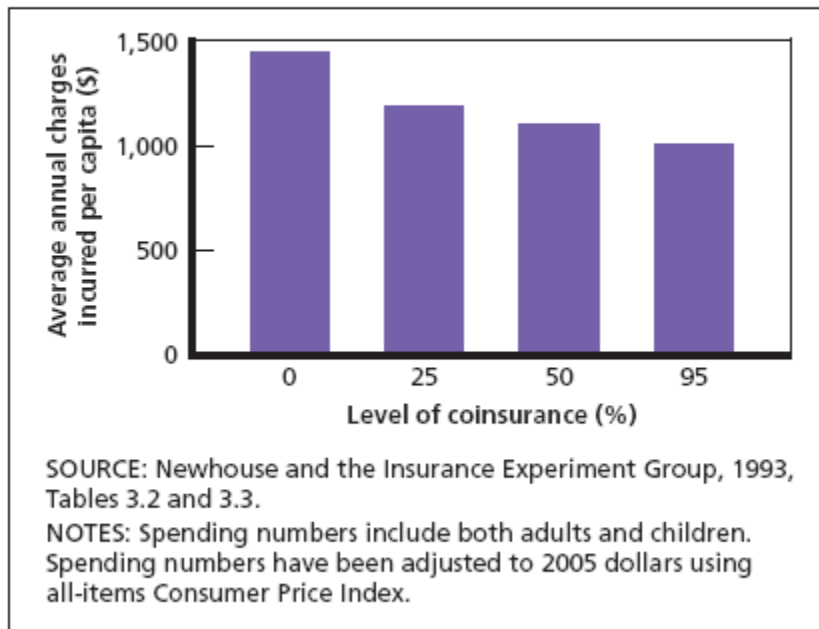


Figure 2
... and Were Admitted to Hospitals Less Often



Participants in cost sharing plans spent less on health care; this savings came from using fewer services rather than finding lower prices. Those with 25 percent coinsurance spent 20 percent less than participants with free care, and those with 95 percent coinsurance spent about 30 percent less (see Figure 3).

Figure 3
Participants with Cost Sharing Spent Less on Health Care Services



The study has shown that reduced use of services resulted primarily from participants deciding not to initiate care. Once patients entered the health care system, cost sharing only modestly affected the intensity or cost of an episode of care.

III. Lessons from Asia: China

The expansion of free trade in Asia has produced fundamental changes in the way that health care is financed and resulted in disappearance of universal free basic health care in many developing Asian countries. For the purpose of simplification this section will concentrate on China, which has adopted a “fee for service” (health care user fees) system as a strategy for cost reduction in early 1980’s.

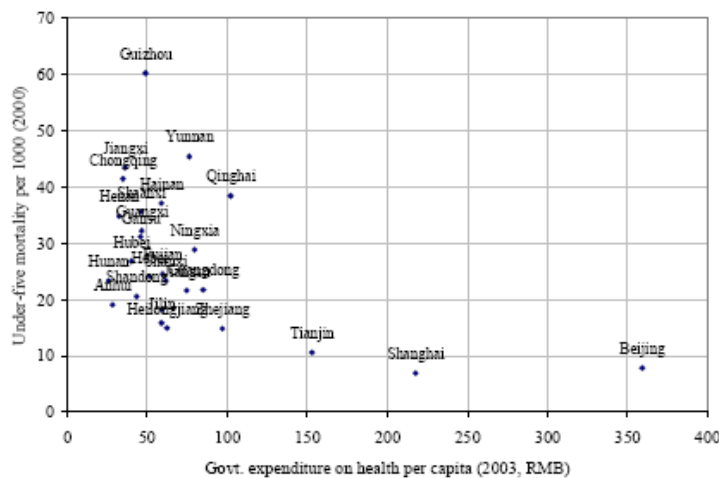
China's old health system provided equal and universal health care for all. The reforms initiated in early 1980’s included drastic central government funding reduction,

which now accounts for less than 1% of total health expenditure. Currently central and regional governments only cover basic salaries of health care workers and new capital investments, totaling around 20-30% of hospital expenditures. The shortfall is funded through user fees.

Immediately after user fees were implemented several studies reported a decline in rural health due to their inhabitants' inability to afford the fees for treatment. The service utilization has dropped by more than 25% and outbreak of serious health conditions and higher infant mortality was observed in many provinces.⁵

The resulting inequality was reinforced by the substantial inequalities in government health spending between poorer and better-off provinces (Figure 1). These inequalities reflect the low share of central government health spending in the national total (just 3 percent) and a set premium rate, instead of a risk-based premium, user charge system currently being in place.

Fig 1: Government health expenditure is lower in poorer provinces



Sources: NBS (Statistical Yearbook) and Ministry of Health.

⁵ China's challenges: health and wealth . The Lancet , Volume 367 , Issue 9511 , Pages 623 - 623 . The Lancet)

Chinese experience showed that increasing expenditure per person for health care through user fees and insurance-based schemes did not produced commensurate improvement in health status. Although current revenue from user fee charges is totaling 35 percent in China, the negative effects on the service utilization and the quality of care do not rule in favor of cost sharing.⁶

VI. Bamako Initiative: User fees and medical care demand and quality in Sub-Saharan Africa

In 1987, the Governments of African countries meeting in Bamako with direct involvement of the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO), proposed the introduction of user fees in the Sub-Saharan Africa to improve the under-funded health care system. After years of commitment to free health care, the implementation of healthcare user fees in Sub-Saharan Africa was intended to provide supplements to government health spending of less than \$5 per capita. The meeting decision (later became known as Bamako Initiative (BI)) aimed at formulating a coherent price policy between different levels of the health pyramid, decentralization of empowerment down to appropriate level to reach policy goals and minimization of drug cost through introduction of generic essential drugs policies.

User fees were to combat three aspects within health service sector in SSA: improving efficiency by moderating demand, containing cost, and mobilize more funds for health care than existing sources provided.

⁶ The Chinese health care system: lessons for other nations. Hsiao WC. Soc Sci Med. 1995 Oct;41(8):1047-55.

Many Sub-Saharan countries have adopted the recommendation of BI and others are still considering user fees for implementation. Those countries that have implemented user fees in health care sector observed dramatic and sustained decreases in service utilization following their introduction (Waddington and Enyimayew 1990; Mbugua et al 1995; Mwabu et al. 1995). The studies provide evidence that user fees divert those who cannot pay for services to other sources of health care or away from the organized public health system (Creese 1991). Nonetheless, Daura et al. (1998) found evidence that user charges, which accounted for 10% of recurrent costs by mid 1990's, did not carry substantial medical quality deterioration in many SSA countries.

Despite the negative effect of user charges on equity, some studies have found their positive aspects. The dominant perspective behind user fees is that charging attaches value to a service, i.e. increasing demand by increasing perception of quality and deterring inadequate use of health care services. According to this view free services reduce utilization because of inefficiencies leading to quality, and because of low value attached to free service. One supporting case study evaluated user charges with an option of discount cards (supplements) for people who otherwise could not afford to pay user charges in Zambia.⁷ The study has shown no correlation between user fees introduction and an equity distribution in the country when user fees are accommodated with supplemental funds to help those that cannot pay. Moreover, Palmer et al. (2004) and McPake (1993) confirmed that local facilities in Africa can function better as a result of an increase in revenue from user charges (when accompanied with equity funds), which

⁷ Making choices between prepayment and user Charges in Zambia. Masahide Kondo. Barbara McPake. University of Tsujuba, Japan.

can be used to provide motivational bonus to health workers and maintain a necessary level of drug supplies and other critical inputs.

Thus, it is important to note that positive outcomes tend to occur in countries that facilitate additional programs to help poor people to cope with user charges. These can be in the form of discount cards, prepayment plans or equity funds. Stand-alone policies, on the other hand, are subject to failure as in the case of Uganda, which abandoned its cost sharing program in 2001.

Many East Asian countries, like Cambodia, are implementing equity funds to help poor people with user charge payments. The policy is achieved by putting aside the funds for poor people and establishing a third-party payer arrangement. Cambodia, unlike many other East Asian and Sub-Saharan countries, has proven that access to care can be kept at a desired level even when user charges are maintained.

V. Conclusion

User fees are not a perfect solution to the inadequate funding for the health care sector. User charges have proven to be ineffective as a stand-alone policy. The countries that experienced a raise in revenue flow from user charges have at the same time experienced drastic reduction in care utilization and no improvement in the quality of care. The countries that still maintain the user charge programs have slowly substituted additional health initiatives to help poor people who cannot afford to pay.

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