

## Poverty and user fees for public health care in low-income countries: lessons from Uganda and Cambodia

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Public health systems in most low-income countries are unfair to poor people. Clearly preventive and curative public health-care services, especially hospital services, are accessed by poor people less frequently than by those who are better off.<sup>1,2</sup> This injustice is now high on the international agenda. A solution for this issue has some global dimensions, such as the need for a large transfer of resources from high-income to low-income countries.<sup>3</sup> Yet, in terms of the best use of these supplementary resources, definite solutions should be developed in every country. National policy makers have strategic choices to make in their efforts to reach poor people.<sup>4</sup>

One option that policy makers might consider is the removal of the fees charged to users by public health facilities. A key strategy in the 1980s was user fees,<sup>5</sup> which has been widely adopted in low-income countries. However, many studies have shown that the introduction of this policy has rarely been beneficial to poor people.<sup>6,7</sup> Abolishment of user fees in low-income countries has caused much debate,<sup>8-10</sup> and international and aid agencies have been forced to take a position.<sup>11</sup> However, a difference of opinion remains. The World Bank, an influential source of health-care financing in developing countries, has confirmed its analysis that user fees could be a necessary evil.<sup>12</sup> This debate leaves national policy makers and financial donors in disarray. The decision by the government of Burundi to remove user fees for pregnant women and children under 5-years old draws attention to an important point—user fee removal could result in sudden and radical policy changes, creating new hazards such as overcrowded wards, drug shortages, and overburdened staff.<sup>13</sup>

We identify some key issues that national policy makers will have to consider when making their own choices in policies for health-care finance that are favourable to poor people. We extract insights from the comparison between two experiences—the abolition of user fees in Uganda and the establishment of health equity funds in Cambodia. Although these two strategies are not the only alternatives, they mark the range of possibilities within the public sector and address a strategic question: should we allocate supplementary resources to universal solutions, or to interventions that target poor people?

### Experience from Uganda and Cambodia

In March, 2001, Uganda removed user fees at all government health facilities. 5 years later, we can record some key findings. Outpatient attendance has more than doubled, and several studies have confirmed that the abolition has been especially beneficial to people living in poverty, at least in terms of health service use.<sup>14,15</sup> Over the

same period, the establishment of health equity funds in Cambodia has provided some evidence that making access to public hospitals easier for poor people is possible, even when user fees are maintained.<sup>16,17</sup> The policy is achieved by putting aside substantial resources for poor people and establishing a third-party payer arrangement to ensure that the scheme is accurate in its targeting. In all hospitals where such a scheme was established, use by poor people rose dramatically. We can thus avoid the weak performance of waiver schemes reported so far.<sup>18-20</sup> However, instead of merely relying on laws that request public hospitals to treat poor patients for free, governments need to establish mechanisms to ensure that hospitals are fairly compensated for the marginal cost of doing so.

We should note some important caveats from comparison of the two policies. For example, these two strategies took place in different countries, and quality of governance is not equal. According to the 2004 World Bank survey on governance,<sup>21</sup> government effectiveness and control of corruption are better in Uganda than in Cambodia. Yet, similarities between the two countries do exist—eg, around 40% of the population below the international poverty line of US\$1 per day, a health sector largely dependent on donors, a public health system built on the health district model, and some achievement in terms of containing the HIV/AIDS epidemic. We should also acknowledge that the two policies were not implemented as stand-alone policies. In Uganda, the abolition of user fees was accompanied by a substantial investment in the health-care system. In Cambodia, the health equity funds were introduced in hospitals whose performance had been improved by contracting arrangements, establishing higher staff motivation, and improved quality of care.<sup>16,22</sup> However, in both countries the two strategies did not address all the difficulties of the health sector.

### Barriers to health care for poor people

The approach in Uganda started from a straightforward observation—since demand for health care by poor people is price sensitive, any reduction in the price charged to the user will induce an increase in demand. To note an increase in service use we need only a second condition to be satisfied—a capacity for supply to respond to increased demand. The Government of Uganda and associated partners were well prepared for the requirement of greater resources, and simultaneous to the abolition of user fees, budgets for drugs and human resources were increased. Whereas this basic requirement for alternative financing might seem obvious, this need

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had been ignored in some previous experiences of user fee abolition.<sup>9</sup>

Such an approach, however, neglects another important reality—that access to free health care for most users is far from free. Indeed, use of this entitlement has associated participation costs, such as transportation, food expenditure, and loss of time. Proximity to urban hospitals and capacity to afford these other costs are probably the main reasons why the better off benefit more from the subsidised services in public hospitals than poor people do. A key empirical issue for universal systems is whether people living in poverty can really afford the so-called free health services they are offered.<sup>23</sup>

Health equity funds in Cambodia try to address the issue of participation costs. The benefit package is fairly detailed—besides paying user fees to the hospital, health equity funds also reimburse patients for transport costs. A few schemes also cover food and other expenditures during hospital stay. A social worker is employed by the health equity fund to assist the patient during their hospital stay, which is a great help to overcoming barriers, such as stigma and social exclusion, and guarantees that no informal fees are charged, or that patients are not referred to private clinics. The presence of a social worker also allows assistance to be tailored according to the individual specific needs of that patient. Thus, health equity funds are much more than a simple exemption system, since their aim is to keep the direct cost for households in poverty to a minimum.

### Targeting of beneficiaries

The Ugandan and Cambodian systems also differ in their way of targeting the poorest users.<sup>24</sup> The approach in Uganda purposely relies on what is called self-targeting—because of the difference in terms of needs, preferences, and opportunity costs, the Ugandan government hoped that poor people would use the free health care more often than would the better off. Conversely, the health equity funds established in Cambodia rely on a combination of methods, but are based on a proxy means test applied to the applicant household (ie, the verification of some key applicant variables, such as the composition of household, type of housing, and productive assets). This method needs a previous definition of eligibility, which is not necessarily straightforward, and a case-by-case examination of the applicants' profiles. Benefits are limited to those who meet the criteria.

Obviously, both methods have advantages and drawbacks. A universal exemption, as in Uganda, will benefit other groups besides poor people, which can be seen as leakage if the only objective is to focus on people living in poverty. The non-discriminatory feature of the policy nevertheless has three main advantages—the policy can contribute to gaining political support within the community, limit administrative costs, and avoid stigmatisation of the target group. The proxy means testing in Cambodia restricts policy benefits to the target

group, but the main drawback is the administrative costs of the process. This system creates a trade-off between the welfare loss in terms of administrative costs and the loss through leakage to those who are not poor.

When most of the population is living in poverty, exemption of everyone will probably be more cost-effective than administration of a user-fee system that includes screening large numbers of applicants for the waiver. A universal free health care approach is justified in all situations with widespread misery or when time does not allow individual assessment schemes to be implemented—eg, during a humanitarian crisis, in post-conflict environments, or in very remote areas affected by poverty. The same rationale of universal exemption has been advocated for treatments that only a few can afford (eg, antiretroviral therapy). Alternatively, identifying people living in poverty (by proxy means testing) and targeting benefits to them could be more attractive than a universal approach if the proportion of poor people in the society is not overwhelming, if it is easy to identify the socioeconomic status of the households, and if a differentiated response between poor and rich is culturally and politically acceptable to both groups. This could be the case for many countries in Asia where inequality is rising by the mere fact that the economic growth does not benefit to everyone.

### What is included in the benefit package?

Although the accuracy of targeting is important, the main aim of the policy is to produce a positive outcome for its beneficiaries. Obviously, the success of this aim depends on the appropriateness, effectiveness, and attractiveness of the benefits. In Uganda, the exemption applies to preventive and curative care in government-owned health centres and hospitals (with a private wing for those who can afford it). In Cambodia, most health equity funds have focused exclusively on the assistance for poor people admitted by public hospitals. Yet, some experts and non-governmental organisations expressed the view that assistance should not be restricted to acute hospital care, but should also improve access to treatment for chronic illnesses, such as HIV/AIDS and diabetes.

Besides the health outcome, another result is one that protects poor people from deeper poverty.<sup>25</sup> In Cambodia, there is evidence that many households are driven into poverty because of high health care costs,<sup>26</sup> largely because of unregulated private practices. A benefit of health equity funds could be that poor households who need health care are redirected towards public health providers, which deliver a higher level of care because of quality assurance mechanisms, such as clinical guidelines and medical supervision.<sup>17</sup> Xu and colleagues<sup>15</sup> reported that user-fee abolition in Uganda has been disappointing in terms of protection against poverty, perhaps because of unavailability of drugs in the health facilities.

Besides the outcomes for the beneficiaries, composition of the benefit package should take into account the

perspective of society. Some prioritisation with respect to cost-effectiveness is inescapable. Furthermore, health authorities might want to use the strategy to consolidate the health system, as is evident in Cambodia, where health equity funds purchase only services from government-owned hospitals. Eventually, politicians might be sensitive to the fact that political pay-offs can vary from one benefit package to another—people might value a reform because they experience some of the benefits themselves. Nearly everyone has contacts with first-line services, but access to hospital admission is a rare event.

### Resources

For any new policy, a crucial issue is the amount of resources necessary to finance the operation, and the experiences of Uganda and Cambodia are quite different in this respect. In Uganda, the abolition of user fees took place nationally from the start and therefore the strategy could begin only when substantial supplementary funds had been secured. These funds were necessary both to compensate the loss of revenue caused by the removal of user fees and to finance supplementary costs incurred by increased service use. However, in Cambodia, the development of health equity funds has been much more incremental. As with implementation, the commitment of resources is decentralised—eg, as a sub-component of a health project.

We should note that whatever the option, the budget will remain insufficient—health care expenditure is driven not only by actual needs, but also by demands, which economists believe to be unrestricted. Although rationing of health care is inescapable, the tension can be more bearable under one policy than the other. The issue is especially crucial if user fees are abolished, since they serve other functions than merely obtaining resources for health services. User fees are also the main mechanism for rationing of access to largely underfunded health services, and their abolishment would create alternative rationing mechanisms—eg, the exclusion of some geographical areas, restrictions to the benefit package, queues, or drug shortages. This rationing might be unacceptable for those able to pay, which would result in the market quickly reappearing through bribes and non-transparent payments. Rationing also exists with health equity funds in terms of geographical exclusion, restricted benefit package, too restrictive inclusion criteria, and interruption of the scheme for lack of budget—all of which have already happened in Cambodia.

### Importance of incentives

An issue that is too often neglected is the provider incentive component of the policy. User fees are an output based payment because the health facility gains income if the services that it is charging for are delivered. Poor performance in terms of provision is directly sanctioned by reduced revenue. However, when a

government pays fixed wages and supplies drugs for free, the health facility gains resources irrespective of its production and is therefore operating under an input based payment regimen.

In terms of quality of care, responsiveness to users, and efficiency, the difference in payment methods is important. If staff can keep a part of the income raised by their output, they have an incentive to secure user satisfaction and an efficient process for their labour. A drawback is that staff could be tempted to neglect the characteristics of quality of care not noticed by the payer and focus their efforts on income-generating activities—namely, curative care in the incentive setups used in many low-income countries. Under input based payment, the income of the staff is constant and unrelated to performance. Economic models predict that staff will tend to improve their own wellbeing by reducing their workload—eg, by hampering the populations' use of health services. This obstruction can be achieved by creating extra participation costs for the users (eg, queues or drug shortages) or by degrading the quality of services (eg, under investment in amenities). Thus, in such a regimen, one should not expect major efforts to improve quality of services.

Health equity funds in Cambodia have relied on an output based payment regimen, with the supplementary condition that the beneficial users are poor. There is no doubt that this system has contributed to acceptance of the poor patients by hospital staff. So far, the Ugandan free system policy has been organised on the basis of input based financing. Drawbacks and advantages of this choice need more empirical scrutiny.

One option is not necessarily better than the other; the main factor is the context in which the regimen operates. In some settings, the under use of services is largely attributable to the poor quality of these services, which can be partly explained by little accountability through the civil servant hierarchy.<sup>22</sup> Output based payment can then contribute positively.<sup>27</sup> In other settings, the general governance of the health system allows the community to have enough voice in the operation of health facilities, and therefore an input based approach would be preferable to an output based regimen.

### Process of reform

We can also compare implementation of policies between Cambodia and Uganda. Although both strategies have mainly been financed by international aid, their development has greatly differed. In Uganda, the abolition of user fees has been a sovereign decision by the government, parliament, and the President. The policy changes were introduced rapidly and started on a national scale. There were many facilitating factors,<sup>28</sup> including the pre-existence of a sector-wide approach in the health sector that facilitated strong support from the different stakeholders. More general reforms in the governance of the country had convinced donors that

**Panel: Key questions for a health financing policy that is favourable to poor people****Barriers to health care**

- How widespread is poverty within the society? Who are the poor people?
- What are their health seeking behaviours?
- What are the main barriers they face in using public health facilities?

**Targeting**

- What are the preferences of national agencies and populations, including voters and poor people, with respect to targeting? Is it politically acceptable to restrict benefits to a single group?
- Are criteria for eligibility easy to assess and robust to fraud?
- Are there decentralised agencies (eg, office of social affairs, non-governmental organisations, churches) ready to administer any waiver scheme at a low-cost?

**Benefit package, resources, and incentives**

- What are the health problems of poor people?
- To what extent is health-care expenditure a source of poverty? What are the main reasons for high health-care expenditure?
- Are public-health facilities ready to cope, in quantity and quality, with the increased demand? If not, how can they be consolidated?
- What are the financial resources available for the intervention? If they are inadequate, what other rationing mechanisms will take place?
- Is there a need to revise incentives?

**Process of the reform**

- Who supports the policy? What will be their exact contribution?
- Is gradual reform (in scope, scale, and time) desirable?
- How are deep institutional and legal roots given to the policy?

Uganda was prepared and deserved increased assistance for such a bold initiative. The commitment of the central government remains firm which ensures a fairly uniform distribution of the entitlements nationwide.

Conversely, the initiative in Cambodia first came from projects, which mainly relied on the funding and innovative capacity of international agencies and local non-governmental organisations. The emulation between the international agencies explains the rapid dissemination of the approach. A national policy for health equity funds has been written and the Cambodian government plans to contribute to fund the strategy. Yet, the resources committed to the strategy do not allow for a nationwide extension—we do not know whether or when assistance from a health equity fund will become a secured right for all poor households in Cambodia.

**Conclusions**

The technical insights from the comparison between the experiences of Uganda and Cambodia can be summarised as key questions for a health-financing policy that is favourable to poor people (panel). What else can we learn from the comparison of these two experiences?

First, unfair public health systems are not inevitable, since there are solutions. As more funds become available, we can develop strategies to ensure that the poorest people will benefit. Second, the comparison between the two countries confirms that the context in which the policy

operates matters. Before formulating a policy, we need an in-depth understanding of the local needs, constraints, and opportunities. In Cambodia, many external stakeholders were suspicious towards the government and preferred to contract local non-governmental organisations. With the health equity fund model, donors, the government, and the civil society have found a way to work together. In Cambodia, no-one has so far contested the fairness of targeting up to 40% of the population in some areas. However, offering free health care to such a large proportion of the country (and excluding 60% of others from the benefit) might not be acceptable in many sub-Saharan societies.<sup>29</sup>

Third, Uganda and Cambodia show that there are key decisions to take in terms of the reform process. Three aspects especially deserve attention—the speed, scale, and scope of the reform. One option is to reform gradually—eg, start first with health centres only, which would allow for experimentation, lessons to be learnt, and progressive building of capacity. However, the risk is that the reform might never be fully completed (possibly because of the emerging opposition of some stakeholders). Another option is to go through a radical transformation, although this approach is riskier and needs more preparation.

Fourth, in health-care financing, there are no universal easy solutions because the whole institutional arrangement is important. Evidence from many low-income countries was that waivers were ineffective in reaching poor people. The health equity fund policy implies that the cause of this weak performance could stem from poor policy design and underfunding. Similarly, abolition of user fees was perceived as an impossible course of action in a poor African country. Yet, Uganda shows that this is not necessarily the case. There are still many questions pending about the performance of these two strategies. More fundamentally, knowledge of how to undertake the implementation of such policies is crucial for successful replication elsewhere.

Fifth, although we can take inspiration from Cambodia and Uganda, we should acknowledge that a financing policy favourable to poor people is much more than a mere technical issue. The policy is also about national politics, political economy, and social justice. National political resoluteness will remain the key resource to improve equity in health systems.

**Conflict of interest statement**

We declare that we have no conflict of interest

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