ABOLISHING USER FEES

HEALTH POVERTY ACTION

MAKING IT WORK IN SIERRA LEONE AND BEYOND

INTRODUCTION

Free health services are a crucial way to increase access for the poor and ultimately improve their health. The emerging consensus on this, while long overdue, deserves recognition as well as praise for those instrumental in bringing it about. However, the next set of questions is proving much more difficult.

For example:

- **How and when should user fees be removed from health services?**
- **What else needs to be in place for this to happen effectively?**
- **Where will the money come from to offset lost revenue and pay for increased demand?**

User fees limit access to health services in some of the world's poorest countries.

International momentum has been gathering for several years around the abolition of user fees. 189 countries pledged to move away from their use at the 2005 World Health Assembly, and in the same year the G8 group of wealthy nations agreed to assist countries that wanted to stop imposing charges.

A high point was reached on 23 September 2009, when leaders met at the United Nations General Assembly for a high-level event on health. The event in New York was co-hosted by UK Prime Minister Gordon Brown and World Bank President Robert Zoellick. It committed $5.3 billion in new financing measures for maternal and child health. Six countries – Sierra Leone, Liberia, Nepal, Malawi, Burundi and Ghana – committed to abolish user fees with support from the international community.

What happened next?

Removing user fees is important, but it is not a simple process nor can it be seen as a silver bullet to improving access to health services. This briefing looks at the issue of user fees, especially the case of one of these countries, Sierra Leone, and investigates what can be done to ensure a smooth transition to removing fees, within a wider agenda for better health for the poor.

Sierra Leone is on the verge of abolishing user fees for maternal and child health, set to be rolled out on 27 April 2010. Health Poverty Action, which works to improve maternal and child health in Sierra Leone as well as other countries in Africa, Asia and Latin America, fully supports the aim of removing fees that prevent the poor accessing healthcare. Health is a human right and, for many in the developing world, a desperate need. However, we want this new policy to be introduced smoothly, without unintended negative consequences, and recognising that abolishing user fees must be just one part of a wider strategy of strengthening health systems and financing those systems.

FINANCE FOR HEALTH AND THE USER FEES DEBATE

Mind the gap

There are huge financing gaps in providing health services in developing countries. The World Health Organisation (WHO) Commission on Macroeconomics and Health has calculated that between $27 and $38 billion extra is needed every year to meet the health-related Millennium Development Goals.[1] This is equivalent to international donors multiplying their current aid commitments for health by five times.

The impact of this funding gap is clear for maternal and child health. Over nine million children die each year before their fifth birthday, while half a million women die annually from pregnancy-related causes.[2] Progress on addressing these stark figures is slow: the international community is way off track in meeting the Millennium Development Goals to cut maternal mortality by three-quarters and infant mortality by two-thirds by 2015. Indeed, maternal mortality decreased by less than 1% a year between 1990 and 2005, much slower than the 5.5% decrease needed to reach the target.[3]

Fee or free?

User fees – charges made in order to access health services – were meant to provide extra funding for health systems, promote cost-sharing, increase efficiency and provide a more sustainable health service. They were often introduced as conditions attached to loans from the World Bank and International Monetary Fund in the 1980s and 1990s – known as Structural Adjustment Programmes. In some countries patients were also asked to pay informal fees, levied by health workers, to boost the income for their clinic or to supplement their own low salaries.

In recent years strong evidence has emerged that user fees disproportionately damage the health of poor and marginalised people. The costs result in millions of people not accessing the healthcare they desperately need. Of those who do, the World Health Organisation calculates that 100 million people each year are driven into poverty by the extra costs.[4] Moreover fees have generally not made a significant contribution to health finance. Where they exist in Africa, fees fund less than 5% of the total cost of health services, with significant administrative costs.[5]

But the removal of user fees raises a second set of problems, such as:

- How to ensure health workers do not need to charge fees informally at the local level to cover the costs of supplies or salaries;
- How to meet the contribution to state health budgets that did come from user fees;
- How to ensure that removing user fees actually benefits the poor and improves their access.

This means removing user fees must go hand in hand with measures to strengthen health systems, including training enough health workers and ensuring sufficient supplies of medicines, and to provide increased funding.

User fees background

User fees are in place in most sub-Saharan African countries and many countries in Asia and Latin America. The type of fees can vary. There may be registration fees when first seeking help, charges for medicine, treatment and diagnostic tests and charges to stay in a hospital bed. Patients may need to pay informal fees as well, levied by health workers to boost the income for their clinic or to add to their own low salaries.

The rationale was that they would provide extra funding for health systems at a time when aid flows were low, debt repayments were high and many developing country governments were feeling the squeeze on their national budgets. There was also an ideological shift in thinking on health systems in the 1980s and 1990s which promoted the idea that getting patients to pay for treatment would help motivate healthcare workers and increase efficiency. This was expressed most famously in the Bamako Initiative, an agreement between African Ministers of Health, the WHO and UNICEF in 1987, calling for community participation in managing and funding supplies of essential drugs. While incorporating some positive goals, the Bamako principle of fee charging is now widely acknowledged to have had hugely negative consequences.

User fees mean that many people in the world's poorest countries simply do not seek treatment when they are ill, or delay getting help. This can be fatal for conditions that require urgent attention, such as malaria in children. Research has suggested that abolishing user fees could prevent over 230,000 child deaths each year, across 20 African countries.[6]

Fees disproportionately damage the health of poor and marginalised people. They can push families into debt and poverty, forcing them to borrow money informally or from moneylenders, or to sell or mortgage livestock or assets that they rely upon to make an income. The charges can especially penalise women who have fewer resources to draw on.

The situation can become a vicious cycle where increased poverty results in poorer nutrition and living conditions, poorer health, and even greater problems next time there is a sudden need to pay for urgent healthcare.

Studies suggest that when fees are introduced, take-up of services drops by an average of 40-50%.[7] For example, use of health services halved in Rwanda when health fees were introduced in 1996.[8] This is not surprising when one considers the costs for ordinary people. One study has suggested that the cost of giving birth in Sierra Leone is equivalent to six weeks' income for the average person.[9]

Olivette is a community health volunteer in Sierra Leone. She could use her communication skills to pass on messages about user fees being removed.

The cost of removing fees

The costs of abolishing fees are hard to calculate but simply replacing lost revenue would require about $100-120 million per year for many low income sub-Saharan African and Asian countries.[10]

A bigger question is the cost of increased demand. When Uganda made its public health services free of charge in 2001, against the advice of the World Bank, the use of outpatient care facilities leapt by up to 90% across the country.[11] Likewise Zambia, which had introduced fees in the mid 1990s, abolished rural healthcare fees with support from the UK government in 2006. The result was that use of health services went up by 30% nationally and by 100% at some clinics.[12] Strategies are therefore needed ahead of removing fees to ensure this extra demand can be met.

Changing times

There has now been a sea change in attitudes towards user fees, based on the evidence that they present a barrier to access, are inequitable, and are ineffective in generating income. Health fees have been removed, at least for some population groups, in countries including Zambia, Burundi, Liberia, Kenya and Ghana.

2005 saw a particular change in the debate. 189 countries committed to move away from their use at the World Health Assembly in 2005, and that summer the G8 agreed to assist countries in removing charges.

The World Bank is also now willing to support countries that want to remove user fees from public facilities, provided that the lost revenue is replaced with sustainable, well-managed funds.

The UK government formally renounced the use of fees, with the then Chancellor, Gordon Brown, declaring: *"there must be universal and free schooling and healthcare as the beginning of justice for the poorest countries of the world"*. In the summer of 2009 Brown, now as Prime Minister, wrote to some of the poorest countries who still impose user fees, offering UK support, both in aid and technical assistance, to those who wished to abolish the fees.

Brown was also a key player in bringing leaders to the table at the UN high level meeting in September 2009, where Sierra Leone and five other countries committed to remove user fees, at least for some vulnerable groups like pregnant women and children.

THE CASE OF SIERRA LEONE

Sierra Leone is the first country of the six that made a commitment in September 2009 to start its roll-out of removing user fees for maternal and child health. President Koroma of Sierra Leone announced his plan to ensure free access to health care for pregnant women, lactating mothers, and children under 5 from 27 April 2010, Sierra Leone's Independence Day.

The new programme, which will receive £34 million from the UK, should benefit some 230,000 women and 950,000 children, as well as strengthening the healthcare system for the wider population. The programme is part of the country's six-year strategy to make healthcare free for all vulnerable groups such as the elderly and the very poor by 2015.[13]

Sierra Leone is one of the poorest countries in the world. It currently ranks 180 out of 182 countries in the UN Human Development Index. Between 1990 and 2002, military takeovers and civil war led to the displacement of over half of the population and the deaths of tens of thousands of people. Many hospitals and health centres were looted. The country's health system is still recovering, and in the short-term Sierra Leone is dependent on international organisations to help deliver healthcare. It has one of the highest rates of maternal mortality in the world and the highest rate of infant mortality, at 123 per 1,000 live births.[14]

If user fees are abolished with a carefully implemented plan, it could make a significant impact on a country with some of the worst health outcomes in the world. While Sierra Leone has one of the highest maternal mortality rates in the world, with one in eight women facing death through pregnancy related causes during their lifetime, patients pay amongst the highest out-of-pocket health care costs in Africa.[15]

"The community used to be frightened when a mother was pregnant and nearing the time of birth: now we feel happier knowing the mother and baby have a chance to survive."

Village leader in Tambakka, Northern Bombali

Health Poverty Action in Sierra Leone

Health Poverty Action is working to improve maternal and child health services and providing health education and outreach in the remote district of Northern Bombali. We are increasing awareness of preventable diseases which kill young children, such as malaria and diarrhoea, and improving emergency obstetric services. We are also encouraging women to access prenatal and postnatal care.

In Northern Bombali we have succeeded in reducing the maternal mortality rate from 7.3% to 1.8%; doubling the number of women accessing emergency care at the hospital through providing ambulances; training hospital staff on emergency procedures; and doubling the number of women able to receive caesareans. We also set up a renewable emergency loan fund for women on low incomes, enabling women to access emergency care and repay the loans gradually. In rural areas we train health workers on providing skilled birth assistance, which has so far almost tripled the number of women from surrounding villages coming to give birth at the facilities.

HOW TO MAKE IT WORK

We welcome the efforts Sierra Leone is making to ensure free access to healthcare for pregnant women and young children. The Government's strategy was presented to an international donors' conference in November 2009 and sets out priorities of ensuring sufficient drugs and equipment; human resources; co-ordination; and communication of the policy, which are laudable. It is also apparent that planning and preparation is underway. For example a working group with representatives of the Health Ministry, donors, development organisations and non-governmental organisations (NGOs), is working on how to implement free care in a sustainable way.

However, there are concerns that a roll out without significant preparation could cause major problems within the health system, as well as causing a lot of confusion.

What might go wrong?

The Government has made pronouncements of free care in the past but these failed because they were not backed up with the necessary planning and infrastructure. It is important that this does not happen again.

In particular, we believe communities must be properly involved, informed and educated about the change. Otherwise when fees are abolished, as was experienced in other countries, confusion and increased demand could outstrip the ability of services to cope.

People may try to stockpile drugs, fearing that the increased demand for now-free medical supplies will inevitably lead to shortages. A clear, and clearly communicated, strategy to fund sufficient supplies of drugs and facilities is therefore essential. There should be a prioritisation plan, for example for emergency cases, to safeguard supplies of essential drugs.

Unless preventative measures are taken, informal fees may continue to be imposed locally to cover salaries and other costs. There must be a realistic and funded strategy to provide adequate salaries for health workers, especially in hard-to-reach areas where it is difficult to recruit and retain staff.

This might mean the removal of user fees takes longer, but a more gradual, more successful roll out is surely in the best interests of everyone.

Community participation

A community participation model would be extremely useful in the roll out of removing user fees. This model involves harnessing existing human resources, for example community health volunteers and traditional birth attendants, to spread health messages and bring about behaviour change. It also involves setting up and managing communications systems.

This approach could be used to educate and disseminate information about the user fee policy change. The results would be that, for example, instead of a rush on drug supplies as soon as fees

CONCERNS FROM THE GROUND

Maternal and child health aide, Kagbere Village, Bombali District:

"I am aware that the Government has promised they'll bring in free healthcare for some people in April. But I have heard about free healthcare before – the Government have promised to do this and not done it in the past. I am a bit sceptical that it will actually happen, so I'm going to wait and see.

"It all depends if the Government can sort out its procurement system so that there are always enough drugs. Lots of people will come and the PHU (Primary Health Unit) will be very busy if they abolish user fees for mothers and children. I think the Government will need to stockpile a lot of drugs to ensure there is enough to meet demand.

"I remember when they distributed free food. People came from miles around! If they make drugs free, demand will go up a lot, and at the moment we don't even have enough to meet the demand, so if they make the drugs free we will run out of drugs very quickly unless they can supply more drugs to the PHUs.

"I would be happy to give drugs away if there were enough of them, but if the PHU has to buy them, then the PHU has to recover its costs by charging for the drugs."

are removed, volunteers could be used to educate people that there will be enough supplies and that there is no need to stockpile drugs at home.

Local Councils and District Health Management teams should:

1. Map complementary human resources in each district, such as traditional birth attendants, traditional leaders and others capable of disseminating messages at the local level;
2. Develop a coherent communication strategy at a district level, working in partnership with international and local NGOs, community based organisations, traditional leaders, faith based organisations and other stakeholders;
3. Develop a mechanism for regular feedback from partners and District Health Management teams.

Technical assistance

There is also a need for more technical assistance, especially around logistics of purchasing, clearing, storing and delivery of drugs and essential equipment which is currently evident at the national level but less so at the community level.

At the UN meeting in September 2009, Prime Minister Gordon Brown pledged to share UK expertise on creating free health services through a new 'Centre for Progressive Health Financing' which developing countries would be able to turn to for assistance. The centre was launched in March 2010 and it will now be critical for it to become operational quickly in order to assist Sierra Leone and other countries that are abolishing user fees. This will help to ensure these developing countries are properly funded and provided with technical support to remove user fees.

CONCERNS FROM THE GROUND

Teacher, Kagbere Village:

"I remember when another NGO came and distributed free health services in 2005. It was chaos with people coming from miles around to get drugs and medicines. I think getting rid of user fees needs to be slow and gradual. The best first step is to reduce the fees to the minimum to recover costs. The plan should be implemented through the Village Development Councils because they know how best to sell the drugs and how to charge people what they can afford.

"But I do think abolishing the fees is a good idea because it would mean people would be able to get drugs and wouldn't have to go to drug peddlers who charge interest and sometimes sell fake or wrong drugs based on wrong diagnosis."

The cost of giving birth in Sierra Leone is on average equivalent to six weeks' income.

Finding the funds

In its strategy the Government of Sierra Leone itself acknowledges the size of the challenge and the need for funding to cover the costs of this new policy. The Government estimates the cost of delivering free maternal and child healthcare to be $91 million. By its own admission, there was a $20.1 million shortfall in commitments as of November 2009.[16] The Government must work with donors and development partners to ensure that its policy is fully funded, including the cost of necessary drugs, health workers, and coordination, if it is to succeed.

Longer-term solutions

Beyond the immediate April 2010 roll-out, there are of course wider questions about how to increase government spending on health and how to provide a stronger, better health service to meet the demands of those who need it.

All 53 countries in the African Union made a pledge in Abuja in 2001 to devote 15% of their national budgets to health, but few countries have come close to being able to commit this sum. According to the UN Development Programme, Sierra Leone currently spends 7.8% of its expenditure on health.[17]

The long-term question specifically for health authorities to address is, what should replace user fees and how can financing gaps be closed to achieve universal health service coverage?

Health financing mechanisms need to raise substantial sums, be efficient in raising and allocating funds, and ensure access for the poor and vulnerable, with less of the financial burden on them. User fees have clearly failed here but it is important for each country to debate which mechanism, or combination of mechanisms, will best suit their needs. This could include social insurance schemes or tax-based finance, or more likely a combination of these.

Much more needs to be done to ensure that developing countries can mobilise their own resources. Taxation could be the most reliable way to boost government budgets so that more money can be spent on healthcare. While aid money can be short-term and unpredictable, taxation can provide governments with a steady flow of much needed income, free from any strings. It is a much more sustainable way of financing development, building accountability 'down' from states to their citizens, rather than 'up' to donors, and helping to break the aid dependency cycle.

Many developing countries lack the infrastructure, systems and personnel to collect taxes effectively. These could be taxes on personal income, on goods or on company profits. At the same time, international measures to clamp down on tax havens and international tax dodging are crucial. Vast sums of money are flowing out of developing countries and into the rich world, as powerful companies make full use of tax havens and legal loopholes. Tackling these challenges could raise tens of billions of dollars a year to tackle poverty and fund healthcare, while building governments' accountability to their citizens and reducing their dependence on aid.

These are long-term solutions. Filling the gap in the meantime will require long-term, predictable external financing, through aid, debt cancellation and innovative sources of finance for some time to come. The current campaign for a Robin Hood Tax – a tax on financial transactions between banks, hedge funds and other financial institutions – could raise billions for international development and be a key component of this external financing.[18]

CONCERNS FROM THE GROUND

Operations Manager at Kamakwie Hospital:

"The Government is stressing that they want to reduce, before eliminating, user fees, and that they want to do it gradually. This is sensible. The challenge will be how they can provide the basic drugs and medical supplies because demand will go up. They need to sort out the procurement and supply system and hire more staff to distribute the increased volume of drugs whilst strengthening the health system infrastructure generally.

"As a mission hospital that buys our own drugs and pays our own staff, if we were to abolish user fees, the government would have to subsidise us at a cost that will enable the Mission hospitals to continue to function – but how they could do that, I'm not sure. I think they should strengthen the health system very gradually, and make sure they include all the service providers in their plans."

RECOMMENDATIONS

The abolition of user fees for health services is an important move in Sierra Leone and other poor countries, and the UK and international community's support for this policy is welcome. Successful roll-out in Sierra Leone is essential in order to encourage similar initiatives elsewhere. It is vital to ensure that this policy is implemented carefully, so it does not have unintended negative consequences, and that it does actually increase access to health for the poor of Sierra Leone and the wider developing world.

In particular we call on the Government of Sierra Leone and donor governments including the UK to do the following:

1. The April 2010 roll-out of removing fees for maternal and child health in Sierra Leone must happen with a community participation model to help prevent confusion and problems in the roll-out.
2. Technical assistance must be provided, not just at the national level, but also at district and community levels, to ensure a smooth implementation of the abolition of fees.
3. Advice and support must also be directed towards longer-term plans to finance health services, in particular looking at improvements in taxation and tax-financed health systems.

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Health Poverty Action works for a world in which the poorest and most marginalised enjoy their right to health.

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Endnotes

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Strengthening Sierra Leone's health system would improve the life chances of young women who currently face a 1 in 8 chance of dying through pregnancy.