Selling out Rights

How policy affects access to health services in East and Central Africa

Selling out Rights focuses on the impact of cost recovery systems in East and Central Africa, in particular how households try to cope with paying for health care and the trade-offs to which they are forced to resort.

It provides key evidence from field experiences and research findings gathered from projects in Burundi, the Democratic Republic of Congo, Ethiopia, Rwanda, Sudan, Tanzania and Uganda.

Save the Children UK works in partnership with governments as well as local, national and international organisations in its community-based work in East and Central Africa. *Selling out Rights* provides an overview of our experience, mainly drawn from household level. There is also a literature review of recent debates on public spending on health.

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How policy affects access to health services in East and Central Africa

Moa Råberg, Harry Jeene

Save the Children

This is part of a series of reports and briefings by Save the Children (SC UK) that will focus on the implications of health sector cost recovery policies on the poor and vulnerable, particularly children. Every child has the right to access to basic services and the 'Coping with the costs of illness' series will seek to examine current policy and practice with a view to ensuring the most equitable outcome for the poor.

Save the Children UK works with governments, UN agencies, NGOs and communities for the benefit of children and children's rights throughout the world. In our work with health in East and Central Africa we:

- **support the provision of basic health services to communities, refugees and internally displaced people**
- **respond to outbreaks of epidemic disease, eg. cholera and malaria**
- **train and support health workers and communities**
- **work with national authorities to rehabilitate and equip health facilities, mainly in poor rural areas**
- **support partners and local authorities to implement decentralisation, cost recovery mechanisms and promote equity of access to quality care.**

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Abbreviations

CBO	Community-Based Organisation
CHW	Community Health Worker
CRC	Convention on the Rights of the Child
DRC	Democratic Republic of Congo
EPI	Expanded Programme of Immunisation
FfDC	Financing for Development Conference
FGD	Focus Group Discussion
GDP	Gross Domestic Product
GAVI	Global Alliance for Vaccines and Immunization
GNI	Gross National Income
GNP	Gross National Product
GoU	Government of Uganda
HALE	Healthy Life Expectancy
HCFS	Health Care Financing Strategy
HDI	Human Development Index
HIPC	Heavily Indebted Poor Countries
ICRC	International Committee of the Red Cross
IMF	International Monetary Fund
INGO	International Non-Governmental Organisation
IO	International Organisation
LDC	Least Developed Country
MCH	Mother and Child Health
MoH	Ministry of Health
NGO	Non-Governmental Organisation
ODA	Official Development Assistance
PHC	Primary Health Care
PPS	Pre-payment Scheme
PRSP	Poverty Reduction Strategy Paper
RDF	Revolving Drug Fund
SAP	Structural Adjustment Programme
SC UK	Save the Children UK
SP	Special Pharmacies
SPP	Special Pharmacies Programme
SSA	Sub-Saharan Africa
SWAP	Sector Wide Approach
UNICEF	United Nations International Children's Fund
WB	World Bank
WHO	World Health Organization

Glossary

Equity

"Principle of being fair to all, with reference to a defined and recognized set of values" (WHOTERM, 2000).

Straightforward as this definition might seem, there are contradictory "defined and recognized set(s) of values" as the interpretation of equity is charged with value.

"Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential, and, more pragmatically, that no-one should be disadvantaged from achieving this potential, if it can be avoided" (Whitehead, 1990, in EQUINET Steering Committee, 1998).

"Access to health care is equitable if, and only if, there are no information barriers, financial barriers, or supply anomalies that prevent access to a reasonable or decent basic minimum of health care services" (Daniels, 1982, in EQUINET Steering Committee, 1998)

NB: **Equality** is the "principle by which all persons or things under consideration are treated in the same way" (WHOTERM 2000), ie, a stricter principle than equity.

Health

"A state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities" (WHOTERM 2000). It is also "a result of both social and economic opportunity and health sector inputs (including preventive and promotive as well as medical services)" (EQUINET Steering Committee, 1998).

Health system

"The people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health.

Health systems fulfil three main functions: health care delivery, fair treatment to all, and meeting non-health expectations of the population" (WHOTERM 2000).

Household

"There is a variety of possible defining characteristics – joint residence, joint consumption, joint production – yet no one attribute fits all situations. Imposing the notion of a coherent and discrete household has generated misleading images of domestic life that tend to ignore the importance of inter-household linkages, and intra-household divisions in resource and labour allocation" (Goudge & Govender, 2000).

Financing

"The function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system" (WHOTERM 2000).

Cost recovery

is implemented through *mobilisation*, which is "one of three sub functions in the financing of health systems which aims at identifying and getting the money required to meet the health needs of the people, individually and collectively, in a given health system." (WHOTERM 2000)

In this report, cost recovery is understood to mean the charging of fees for health services, whether through taxation, at the point of service utilisation, or through insurance schemes. Although taxation is relevant here, we are referring to the different types of private contributions paid outside of the tax system, ie, mainly:

User fees
"…the payment of out-of-pocket charges *at the time of use* in health centre…It prescribes the timing of the contribution relative to the time of needing and receiving health care." (Arhin –Tenkorang, 2001 p.3). Another term for user fees is *out-of-pocket payment* which is defined as: "Fee paid by the consumer of health services directly to the provider at the time of delivery" (WHOTERM 2000).

Risk pooling
"The practice of bringing several risks together for insurance purposes in order to balance the consequences of the realisation of each individual risk" (WHOTERM 2000).

Prepayment schemes
"Fee paid by a potential consumer of health services in anticipation of services that may be required" (WHOTERM 2000).

Revolving drug funds
is a system whereby drugs are provided to the supplier in the first instance either via donor, government or private funding. Revenues are meant to be kept within the system, as this is a feature of decentralisation. One example is *Special Pharmacies*.

Exemption system
A precondition for the equity of cost recovery especially in the form of user fees is that there is a system in place which, for example, exempts the poorest, chronically ill and/or children from paying any of or the full fee for health services.

Quality

The dimensions of quality include equity, accessibility, appropriateness, acceptability, comprehensiveness, effectiveness and efficiency of a health service (WHO 2000).

Opportunity Cost

The opportunity cost of accessing and using health services can be estimated by asking the question 'what is the next best thing I could do rather than travelling to a clinic and what would the benefit be if I did it instead?'. In the case of a mother with children and dependants, one of the next best things she could do is tend the family livestock or crops, or sell her produce at market (for which she would get money), or collect water (which she could give to give to livestock or crops, from which the family earns an income). She could go out to paid work, or stay at home to look after the children herself instead of keeping older children away from their work to look after younger siblings while she is away. The opportunity cost in this case is the income that would be earned doing these things rather than using health services.

Gross National Income (GNI) per capita, Atlas method, US$

GNI per capita (formerly GNP per capita) is the gross national income, calculated in national currency and converted to US dollars using the World Atlas method, divided by the mid year population. GNI comprises the total value of goods and services produced within a country, together with income received from other countries (for example, interest) less similar payments made to other countries (World Bank 2002, DFID 2001).

Human Development Index (HDI)

The Human Development Index (HDI) is a simple measure of human development, devised by the United Nations Development Programme (UNDP). HDI measures "the overall achievements in a counry in three basic dimensions of human development - longevity, knowledge and a decent standard of living. It is measured by life expectancy, educational attainment (adult literacy and combined primary, secondary and tertiary enrolment) and adjusted income" (UNDP).

5

INSTITUTIONAL ISSUES, OBJECTIVES AND GOALS WITHIN THE HEALTH SECTOR

The first two strategic issues of the SC UK Health Sector Operational Plan 2002 – 2004 are:

- *a lack of resources and the use of existing resources*
- *equity, access and quality of services .*

Objective no. 2 within the core area 'Health' in the SC UK Programmes Strategic Plan 2000-2004 is: "To reinforce the capacity of governments to regulate equity of access to quality health services for the whole population."

Meanwhile, there is the stated intent to use SC UK's institutional memory to influence and advocate on different levels. SC UK Operational Advocacy Plan 2001-2005 objectives:

- To ensure that the World Bank, IMF, key donors and national governments implement **national poverty strategies** that reflect understanding of the impact of liberalisation and structural adjustment on children (through livelihood analysis and consultation with poor people) and support for inclusive basic services and social protection.
- To ensure that governments (with the support of IFIs and the international community) implement appropriate mechanisms for sustainable **national domestic financing of basic services** for all children, especially the most marginalised.
- To ensure that the international community provides appropriate **aid for 'silent emergencies'** (ie, those that receive little media attention) to meet the survival & protection rights of children in equitable, appropriate & sustainable ways.
- **To encourage donors to increase financing for basic services** (including funding for long-term recurrent costs).
- To encourage donors to support, rather than undermine, the efficient use of equitable and appropriate services (and to include in this aid from private sources) ie, to encourage donors and ministries to support approaches which strengthen health systems and which result in improved quality and accessibility of all services for all children, including the most marginalised.

Executive Summary

Background

The countries in East and Central Africa utilise different types of cost recovery systems to help finance health care. Each country has varying experiences of the success or otherwise of these systems. The revenue financed by these user fees, which are paid by the patient at the point of health service delivery, places a disproportionately heavy burden on poor households. There are however other more sustainable ways households can contribute to their health service expenditure based on mutual solidarity and preparedness. But in order for these approaches to flourish they need to be encouraged by bilateral donors as well as financial institutions such as the World Bank.

It is time to rethink policies and look for other ways of financing health care. Decision-makers are increasingly requested to act upon empirical evidence rather than dogma and SC UK can help realise the right of all children to basic health services by drawing on its extensive experience.

Save the Children considers health to be a right as well as a valuable long-term investment. We hope that *Selling out Rights* will be of interest to planners and implementers of health in countries facing a hardening health financing climate, low utilisation rates and inequities of access to health.

Selling out Rights highlights poorly documented aspects of illness costs, particularly strategies adopted by households trying to cope with costs and the trade-offs they are forced to make.

When trade-offs are being made it is often children, usually girls, who draw the shortest straw - if not directly then indirectly as the family impoverishes itself trying to come up with money to pay for children's health care.

Selling out Rights provides key evidence from field experiences and research findings gathered from projects in Burundi, the Democratic Republic of Congo, Ethiopia, Rwanda, Sudan, Tanzania and Uganda. These are all Least Developed Countries (LDCs), but with very different political contexts.

Save the Children UK works in partnership with governments as well as local, national and international organisations in its community-based work in East and Central Africa. This is an overview of our experience, mainly drawn from household level. There is also a literature review of recent debates on private spending on health.

Findings

- Health charges are denying poor people the medical care they need.
- Charges for health services are not being recovered by the recipient communities (as was the original intention), but nonetheless "cost recovery" schemes continue to be forced upon poor communities.
- Poor families are expected to come up with coping strategies in order to pay for health services, but clearly they do not cope.
- Poverty is the major reason given by members of poor households as to why they cannot access health services.
- Members of poor households either do not

seek care or make fatal trade-offs in order to obtain it.

- Children, especially females, draw the shortest straw and have little, if any influence over their own health care.
- Services are sometimes of such poor quality that patients are unable to get the care they need.
- The major part of the cost of health care is for drugs, but these are rarely available even though people pay for consultations in order to obtain them.
- Exemption systems do not usually work, eg, in Burundi a new-born is expected to pay what an adult pays.
- Health systems, even in relatively peaceful countries in the region, are under-funded, scarce and of poor quality.
- Health systems in countries in conflict/post-conflict in the region barely exist.
- The poorer the individual, the greater the need for affordable health services - but the less likely they are to gain access to them.
- Top-ups (ie, bribes) are common in the countries studied. User fees have not led to the formalising of bribes but have instead become an extra burden on the ill and poor. The root cause of bribe-taking is insufficient staff salaries, as less is being spent on recurring costs of health services.

Policy Recommendations

- Essential services should be free at the point of delivery.
- Options for health funding must include more equitable and flexible policies which buffer against unforeseen economic shocks to households.
- Successful pilot projects need more investment in time and money and should be rolled-out. But it must be remembered that they are not automatically transferable to different countries or different situations.
- Further options for health funding need to be explored, and changes made to those policies which do not work.
- Donors must increase their spending on health in order to help and encourage the efforts of LDC governments to meet their obligations as providers of basic health services. The current figure of 0.011 per cent of bilateral Official Development Assistance (ODA) towards health is not sufficient.
- Donors must demonstrate that their past commitments to aid were genuine (30 years ago 0.7 per cent of donor Gross National Product (GNP) was promised as aid but average spend is less than 0.3 per cent). Donors must meet their commitment to spend 20 per cent of their aid budgets on basic service provision in the poorest countries.

- Donor-driven, disease-specific interventions, such as the Global Alliance for Vaccinations and Immunization (GAVI), should be adapted into multi-sectoral programmes focussing on national priorities, with equitable benefits for the whole national health system.
- It is important to invest in multi-sectoral approaches, such as combined literacy, health and nutrition programmes, rather than on narrow, vertical health programmes. The effect of improved female literacy on children's health is a good example of the importance of this.
- Complex emergencies need to be viewed as just that, and not as targets for short-term humanitarian assistance, leaving little local capacity after the emergency passes.
- User fees in unstable situations increase the equity gap and may thus increase tensions in society. Pre-payment schemes and other forms of community health financing can empower civil society. Development of these participatory mechanisms will contribute to a reduction of the impact of conflict.
- Most of the countries in the region are either involved in conflict or are in transition. This can be used as a window of opportunity for change.
- It is important to invest in human capital, if only for the reason that economic return can be expected.
- A culture of participation and consultation with civic society on major policy issues (especially those that affect the lives of children and women) should be encouraged to allow for greater ownership in planning, resource disbursement and discussion about its use.
- SC UK welcomes the EU member states' commitment to donate an average of 0.39 per cent of their GDPs to development aid by 2006 - but remains concerned that the US is committing to only a fourth of this amount.

Methods

This report is based on a desk study undertaken in 2001/02. It aims to share SC UK experience. In our work in the region we constantly come across the positives and negatives of different types of cost recovery as they are implemented. In this report we hope to provide evidence that some ways of paying for health are more equitable, far-sighted and progressive than others, and these need to be expanded and rolled out widely rather than remain at pilot level.

This section provides background to relevant issues of different types of health financing and its implications for the poor. It is not exhaustive but does highlight the pertinent points. The second and main part of the report is based on experience, analytical papers and 'grey publications' from SC UK field staff. Finally, there is a summary on conclusions from lessons learned in the region, out of which policy recommendations are drawn.

Constraints of the report

- East and Central Africa is a vast region with a variety of political and geographical conditions and complex situations. Different countries are at different levels of development - some are in conflict, some are in transition from conflict and some are peaceful. Some are experiencing positive developments while others are not so fortunate.
- There are however important similarities within the region. While it is not possible to extrapolate results from one district to the whole region, certain trends are emerging that do allow more general conclusions.
- It is difficult to find reliable data on the hidden costs of illness and their long-term effects on households. Data for the region is scattered, often incomplete and tends to be out of date. This is especially true for countries in conflict, where information gathering is hindered by insecurity or for political reasons.
- SC UK often collects data at the household or community level. These data are not necessarily regionally representative. They do however have a depth which national surveys cannot supply and offer important disaggregation and identification of vulnerable groups.
- A study like this can not be all encompassing. There are multiple factors that contribute to access to health care and these need to be taken into account. Prime examples are the environment, education, and the HIV/AIDS pandemic. Of increasing importance is globalisation of trade and services. There is clear emerging evidence that commercial interest can compromise global public goods (for discussion see SC UK 2001).

Introduction

> "Out of a population of 580 million in the mid-1990s, more than 270 million Africans were living on daily incomes equivalent to less than a dollar a day, 250 million Africans did not have access to safe drinking water, and more than 200 million did not have access to health services... More than two million children die each year before reaching their first birthday...The Africanization of world poverty has continued in the 1990s, and has probably accelerated, and there is every possibility of a continuation of this trend."
>
> (The World Bank, 2002)

There is a global debate on who bears the responsibility for financing basic health services in resource-poor countries. Differences in service provision between developed and developing countries are crucial. In developing countries, there is typically a lack of information, and little ability or time to absorb the information that does exist. There is a widespread lack of resources. Disease prevalence is much higher, with HIV/AIDS extracting a terrible toll. Health facilities are too few and are concentrated in urban areas. Public health facilities are often under-funded, the staff are demotivated and underqualified and there is a lack of medical equipment. The quality of services is low due to a variety of factors.

These factors are compounded in East and Central Africa. All countries in this study are LDCs, and all are affected by conflict, whether direct or through the impact of neighbouring strife. As a region, Africa has the highest child mortality rates and the lowest life expectancy rates in the world (SC UK 1996: Hamoudi and Sachs 1999). Many factors contribute to this, notably poverty, HIV/AIDS, conflict, gender and socio-economic inequalities. Poverty is both a reason for and an outcome of all these factors. Still ever more populations are being requested to pay for services and donors are cutting down on aid.

User fees were introduced in many African countries in the late 1980s and early 1990s, often as part of structural adjustment programmes (SAPS). A call for private contributions towards health care is stated in the three global agreements "The Alma Ata Declaration" of 1978, where SC UK was one of the major NGOs, the World Bank "Agenda for Reform" of 1987 and the "Bamako Initiative" of 1988 (Arhin-Tenkorang, 2001). A more recent example of health financing policy is the World Health Organization (WHO) statement in its "Health System Performance".

"Fairness in the financial contributions of households to the health system is considered by WHO as intrinsically valuable... Three distinct concerns: avoiding catastrophic payments, equal payment by equivalent households and some element of progressivity can be captured by examining a household's health financing contribution" (WHO 2001).

SC UK field experience shows that the majority of poor households in East and Central Africa suffer in several ways from a lack of "fairness in financial contribution to health". Often implementation of user fee-schemes is haphazard and unfair, as there are no proper guidelines. Many households have to make irreversible and

often catastrophic trade-offs to pay health fees. The overwhelming number simply cannot afford to pay, especially in households in countries in conflict such as Burundi, the DRC and Sudan, all involved in extended conflicts that have caused total collapse of basic services. Countries such as Rwanda, Ethiopia and Uganda still suffer from past conflicts, which have left many without any social safety nets. Meanwhile, in a relatively peaceful country such as Tanzania, access to health care is declining in a steady manner as governmental and donor spending on social services has been decreasing for the past years.

Context

This section provides the context for the following section, **SC UK field experience**. It is based on a literature review of the issues relating to the quality of health services, including equity, access, efficiency, and their impact on utilisation rates, but begins with an overview of health expenditure.

Health expenditure in numbers

To give a brief overview of each country's health expenditure and health status, a short diagram is provided:

	GNI in US$ per capita per annum (Atlas method, 2000)[1]	Total expenditure on health as % of GDP (1998)[2]	Private insurance for health as % of private expenditure on health[3]	Out-of-pocket payments for health as % of private expenditure on health[4]	HALE Status in years (both sexes, 2000)[5]	HIPC status (September 2002)[6]
Burundi	…	2.3	0.0	100	33.4	Conflict affected/ yet to be approved
DRC	…	1.7	0.0	100	34.4	Conflict affected/ yet to be approved
Ethiopia	100	5.2	0.0	86.1	35.4	Approved
Rwanda	230	5.0	0.2	52.0	31.9	UK Approved
Sudan	320	4.2	0.0	00	45.1	Conflict affected/ yet to be approved
Tanzania	270	4.9	0.0	86.5	38.1	Approved
Uganda	300	3.5	0.5	54.2	35.7	Approved

[1] Gross National Income (GNI) per capita: World Bank, *Countries at a glance, 2001.*

[2,3,4] Selected National Health Account indicators: *World Health Report 2001*, Annex table 5.

[5] Healthy Life Expectancy (HALE): *World Health Report 2001*, Annex table 4.

[6] HIPC (Heavily Indebted Poor Country): www.worldbank.org/hipc

NB: The reliability of data for Sub-Saharan Africa is often questionable, and so should not be over-interpreted. Also, it should be kept in mind that these are all countries with very low GDPs. For example, Ethiopia, having the highest public expenditure on health with 5.2 per cent, is, in absolute terms, spending a minute amount on health services at US$1.50 per capita per year.

[1]GNIs per capita – the average GNI per capita for Sub-Saharan Africa (SSA) is US$500 (WHO 2001), which none of the countries in this study reach. Sudan has the highest GNI per capita of the countries at US$320. However, income levels in Sudan are extremely unequal. A small part of the population earns a considerable amount from the country's oil resources but the large majority is very poor.

[6]HIPC status – five out of the seven countries in this study are conflict affected. While these are arguably the countries in greatest need of debt relief, three of them are on a "yet to be approved"status. One of the conditions for receiving HIPC debt relief is good governance, which means that countries in conflict do not qualify. It might be said that development is not possible without peace – but then peace is difficult to achieve without development.

PUBLIC HEALTH EXPENDITURE ON HEALTH / CAPITA / YEAR

US$6 : Least Developed Countries

US$13 : Other Low-Income Countries

US$2,000 : High-Income Countries

US$4,306 : The United States

(WHO 2001)

Public expenditure on health in LDCs is insufficient, and the remedy recommended by WHO is increased donor assistance. It would take a drastic increase in funding just to reach the US$13 that other low-income countries spend on health, but the WHO Commission report 'Macroeconomics and Health' (2001) aims even higher. It recommends a minimum per capita sum of US$36 in total for basic health interventions in LDCs by the year 2007. In LDCs US$11 is currently spent on health in total; US$8.71 coming from out-of-pocket fees, and the rest from donor assistance. To reach the target of US$36 would mean an increase in donor assistance from today's US$1.5 billion to US$14.3 billion/year in 2007. Domestic resources would have to be raised from today's US$7 billion to US$11 billion in 2007 (WHO 2001). These increases are considered "on the low end of estimates" for LDC's with an annual GNP of around

US$300/person – which in effect excludes most countries in this study.

The WHO in its recent Commission Report 'Macroeconomics and Health' (2001), says that in addition to LDC governments' overall spending on health services being too low, there are two other major problems. Firstly, in high-income countries the public funding for health is 77 per cent out of the total cost, while in LDCs it is just 55 per cent. Secondly, in LDCs the private spending that fills the remaining 45 per cent tends to be paid out-of-pocket, rather than pre-paid, so that there is very little insurance element (ie, risk-pooling). High-income countries have a much higher rate of insurance coverage, leaving them much less vulnerable to shocks. So, ironically, populations in countries that spend the least amount on health are in the greatest need of risk-pooling but lack it, while populations in high-income countries that spend more on health have a much higher degree of insurance.

Today's very small donor assistance towards health in LDCs suggests it is not an issue on top of the list of the donors' priorities.

OFFICIAL DEVELOPMENT ASSISTANCE (1999)

0.20%	ODA to all recipient countries of donors' GNP
0.05%	ODA to LDCs of donors' GNP
0.10%	Percentage of US GNI spent on aid - a third of Europe's amount.
0.011%	Bilateral ODA for health and population programmes (1997–1999) of donors' GNP (WHO 2001)

These figures beg the question whether the WHO recommendations are realistically achievable. However commendable they are, without the necessary dramatic rethinking of donors, what are the options of working with the resources available now to increase equity?

Equity and demands for efficiency

"In the health sector, efficiency driven perspectives have dominated international health policy debates in the last decade (Gilson 1998). There have been rapid developments of approaches aimed at cost effective rationing of scarce resources for health care and measurement tools to support such approaches." "The gap that has been left by efficiency oriented approaches has in some instances been taken to imply conflict between equity and efficiency. There should in the main be no inherent conflict between equity and efficiency, except in circumstances where cost containment or other efficiency measures are given primacy over equity and population health goals."
(Regional Network for Equity in Health in Southern Africa Steering Committee, 1998. www.equinetafrica.org)

There is an increasing demand for cost efficiency in health service delivery, which is all too often at the expense of equity of access. Efficiency may be defined as "the capacity to produce the maximum output for a given input." (WHOTERM 2000). Advocates of user fees claim these will "increase efficiency by making providers cost-conscious and encouraging cost-effective techniques of providing care" and "increase revenues and improve coverage and quality of care through applying increased revenue to service improvements" (EQUINET 1998).

One illustration of the pressure for 'quick fixes', rather than long-term commitments, is Extended Programmes of Immunisation (EPI). Vaccinating children is an intervention that is hard to argue against and parents (taxpayers) in the developed world recognise it as important. EPI statistics are popularly brought forward as indicators of efficiency in health interventions, but numbers are often exaggerated. While vaccinations are necessary to prevent the spreading of communicable diseases, SC UK recommended to the Financing for Development Conference (FfDC) in Monterrey 2002, that "donors should instead ensure that aid supports quality and equity within basic services, moving away from donor-driven targets that prioritise narrow quantitative indicators. Target-driven, high profile inter-national initiatives often benefit the easiest-to-reach children instead of making the structural changes needed to secure the rights of the most marginalised" (SC UK 2002).

Perceptions of what equity entails differ. There are also the concepts of horizontal and vertical equity; the former is where inputs are comparable between those who have roughly the same needs, and the latter is where inputs are different where needs are different. EQUINET argues that focus has shifted from an emphasis on horizontal equity towards attempts at vertical equity, targeting those with the greatest need for health care but the least ability to pay for it (2000). However overseas development aid is being increasingly directed not towards the poorest of the poor, but to the better off (Wilkinson 2000). This re-allocation of funds tends to be towards donors' own 'back yards', such as Eastern Europe, and will most probably make funding for the world's poorest harder to obtain, creating further inequities.

A human right and a human capital

> "The fact that health impacts and is impacted by economic performance raises important policy issues; for example, while some would argue that improved health is among the many positive *results* of successful economic development strategies, other evidence suggests that such strategies must *incorporate* effective health interventions" (Hamoudi & Sachs 1999).

Access to good health care is both an individual and a social human right as defined in the Declaration of Human Rights. For children specifically, this right is provided for in Article 24 of the UN Convention on the Rights of the Child (CRC) (see annex).

The CRC is a Convention signed and ratified by all UN member states except Somalia and the United States. It is not stated anywhere in the document that these are rights dependent on the ability to pay.

In addition to being a human right, health is also a part of human capital, defined by WHO as "human skills and capabilities generated by investments in education and health" (WHOTERM 2000). There are reverse causalities on several levels between education and health, both detrimental and beneficial. As Appleton (2000) points out: "Expenditure on education may affect health and parental education may benefit children. Health expenditures may themselves affect the value of education. These links are important for understanding the potential range of benefits which accrue to expenditures on human capital." An example of such beneficial correlations is how investing in women's literacy is arguably the best long-term investment in children's health (SC UK 2001; Appleton 2000; Hamoudi & Sachs 1999; Goudge & Govender 2000). "The effect of a mother having attained secondary-level education may contribute to lowering the infant mortality in a given family by as much as 50 per cent" (World Bank 1994).

Ill health, especially manifested in extremely high rates of HIV/AIDS in the region, makes governments increasingly hesitant to invest in education and health (Hamoudi & Sachs 1999 Appleton 2000). The are 12 million AIDS orphans in Sub-Saharan Africa today, and this number can be expected to rise to 20 million by the end of the decade if HIV/AIDS prevention does not improve (WHO 2001). These orphans are not considered to be "cost-efficient" enough to invest in so slip out of the safety nets – if there are any. Appleton (2000) mentions that "ill-health inhibits school attendance". This may be true of the ill health of another household member as well as that of the pupil herself. Adult mortality, such as that resulting from AIDS related illness – is likely to pose grave threats to the schooling of bereaved children.

Investing in human capital, like health care, has far reaching benefits both for those 'directly' invested in, and for their children. The positive effects of female literacy on children's health have been researched and documented, but need to be put into action. More research is however needed on the effects ill health has on the ability to gain education – especially for girls.

An inelastic need? Willingness and ability to pay

> "The debates on cost recovery signal the extent to which professionals differ on the extent to which household poverty should trigger social spending. ***Willingness*** to pay has often been equated with ***ability*** to pay, often with inadequate monitoring of how this affects household spending and assets and thus future health risks, or of household impacts of cost recovery measures" (EQUINET 1998).

An argument often given in support of user fees is that the need for *good health* (and thereby *health services*) is inelastic, ie, constant. It can be presumed that people do indeed have a constant desire and a *willingness* to achieve good health. But the ability to pay for health is unlikely to be constant but varies by season, household income etc. (Hamoudi & Sachs 1999; Goudge & Govender 2000). It has been argued that the ability to pay is more elastic than anticipated in the 1980s when expectations on user fees were high (Hamoudi & Sachs 1999). Appleton (2000) refers to studies where “elasticities are found to be markedly higher for the poor and children”, and also provides data on the lower elasticity in demand for education than for health. He also refers to reports that show that “higher consultation charges are negatively associated with child height and weight-for-height”, and that “the price of antibiotics is a significant determinant of child mortality in Ghana: doubling drug prices would increase child mortality by 50 per cent” (Appleton 2000).

In favour of user fees and other types of cost recovery, the World Bank (1994) claimed that they “…are important to ensure the financial sustainability of publicly provided health services. Revenues generated might be moderate at first, but can be expected to increase when quality of services are improved, and households perceive the benefits of paying. Research reveals that even low-income African households are prepared to pay what is necessary to obtain basic curative services, especially if the quality of services is good.”

This definition assumes that the income generated by user-fees stays within the community where it is generated and where it will be ‘re-cycled’ to improve local health services.

The World Bank has since modified its position on user fees and is now slightly more critical in its approach. User fees are however still being implemented, despite convincing claims that households perceive the downward spiral they might put themselves through in making trade-offs to pay fees.

There are several factors in addition to user fees that affect health service utilisation patterns:

- “Despite the greater importance of lost income, *the poor are less likely to have access to either sickness benefit or health insurance* than wealthier groups in the formal sector.
- The poor frequently have insufficient information to make the most cost-effective decisions about health care expenditure. As a result the poor often receive a lower value for money from the health service.

- Economic and health crises (such as structural adjustment programmes and AIDS) impact significantly on the poor.

The regressive nature of health care expenditure is compounded by the fact that:

- The poor have lower health status because of their poorer living conditions (eg, inadequate nutritional intake, poor sanitation, water supply and refuse collection, overcrowding, pollution etc).

- The poor are more dependent on their physical ability as a source of income."

(Goudge & Govender 2000)

Trade-offs between needs – a lose-lose situation

> "A household's response to a health crisis is not only shaped by who is sick, but by household relations and by what resources and coping strategies are available to the different members. Any attempt to understand the barriers to the poor accessing health care must examine the relations within as well as those without the household" (Goudge & Govender 2000).

The most difficult economic hardships for rural populations tend to be between harvests and during droughts or floods. This is also when the exposure to illness is highest, due to stress, endemic diseases and malnutrition, and so the time of the greatest lack of resources coincides with the time of increased risk of illness. Trade-offs take the hardest toll during these times, as resources are already depleted.

There are several trade-offs which take place in a poor household when mobilising funds for health services becomes necessary. Firstly there is a trade-off between obtaining health services and other necessary services and/or commodities. Secondly, there may be a trade-off between paying for health services and keeping the household asset base intact, eg, deciding to sell the family cow. When this happens the ill may be forced to work, which might aggravate the illness, and cause invalidity or even premature death (Appleton 2000). A child attending school while ill might worsen the illness – but a child prematurely pulled out of school is a negative trade-off for both her/him and the family.

The implementation of out-of-pocket fees for health services is often based on experiences from the developed world (Arhin-Tenkorang 2001). However assets are much greater in the latter and are usually in monetary form. This is not the norm in the pastoralist or agricultural societies that predominate in poor countries.

If not enough cash is freed up, a third trade-off is between traditional medicine and modern medicine. For example in Tanzania, the ability to pay for modern medicine is significantly lower than for traditional medicine. The reason for this is that traditional treatments allow alternatives to cash payments (such as in kind, in work, or credit) and more importantly invoke a much greater degree of kinship support (Arhin-Tenkorang 2001). The ill might be pushed

towards traditional medical care that is less effective than modern medicine – and in some instances even harmful (SC UK 1996; WHO 2001).

Bebbington's framework gives a broad picture of different "types of capital", as described below.

TYPES OF CAPITAL	DESCRIPTION
Productive	Equipment, machinery, livestock etc.
Natural	Soil, water, fuel, clean air etc.
Human	Health, education, physical capabilities etc.
Social	"The norms and networks facilitating collective action for mutual benefit." (Woolcock 1998 quoted in Bebbington 1999).
Cultural	Interaction/activities that provide meaning and identity, that can be empowering and "a source of power to question, challenge, propose, and ultimately usher in a new way of doing things".

(Goudge & Govender 2000).

Some of these resources are more likely to be available in the developed world, than to a household in a developing country. Even if they were, non-monetary payments are not valid for health services - it is not until they are sold off that they actually become *available* "types of capital". So households are forced to resort to adaptations:

THREE TYPES OF GENERAL ADAPTATIONS / TRADE-OFFS USED IN RESPONSE TO ILLNESS EVENTS

- **Primary adaptation**
Where resources are re-allocated and reserves depleted without substantially affecting future productivity, eg,using savings or selling an unproductive asset.
- **Secondary adaptation**
Choosing between neglecting a sick person and compromising the household's ability to withstand future shocks. For example, foregoing funds for food, education, borrowing from a commercial lender, or selling productive assets in order to find the funds for treatment. There is considerable evidence of the poor, despite higher rates of sickness, not seeking available care or taking time off work, due to the loss of productivity and income that will result, suggesting that productive activity has a higher priority than attending to health needs.
- **Tertiary adaptation**
Here, coping requires either migration in order to find food or work, or reconstituting the household, for example a wife and children going to live with her birth family.

(Lucas and Bloom 1999, quoted in Goudge & Govender 2000).

Better-off households tend to use "primary adaptation", which puts a lesser strain on the

household economy than "secondary" and/or "tertiary adaptations", to which poor households are often forced to resort. Secondary and tertiary adaptations have dire long-term consequences for the household economy, which are likely to have long-term negative impacts on the household health status, forcing further trade-offs.

"Frivolous" utilisation – rates and quality

Health facility utilisation rates in developing countries at a minimum of 2.0 visits per capita per year is recommended by the WHO (2001).

Health facility utilisation rates in East and Central Africa are 0.25-0.40 visits per capita per year (SC UK grey reports; SC UK 2002).

One of the arguments in favour of user fees is that they reduce over-utilisation of health services. This argument rests upon several assumptions:

- That service quality increases when costs do – this is however far from reality because of financial leakage, bureaucracy, corruption and lack of clear guidelines.
- That there was indeed a problem of over-utilisation before user fees were introduced. It is important to note that utilisation rates in East and Central Africa are very low - none of the countries in this study reach even a utilisation rate of *1 visit per capita every second year*.
- That user fees are the major financial outlay during ill health and thereby serve as the major deterrent against over-utilisation. However, evidence shows that *approximately 70 per cent of the cost of illness is lost income* (Goudge & Govender 2000). There are also the additional costs of transport to and from the health facility; lodging in and/or outside of the health facility and "social costs" in the form of the stigma some diseases carry with them.

There are several factors, apart from user fees, that determine whether health services are utilised, and to what degree.

SOME OF THE FACTORS DETERMINING UTILISATION RATES

- **Cost and type of service available**

Relationship between ***costs of health services*** and utilisation of services has been extensively evaluated in relation to the introduction of user fees, as impacting on vulnerable groups. Results have been equivocal in part due to methodological issues.

Distance and physical access are important barriers to seeking care. Relevant factors are physical access, convenient opening times, availability of transport, travelling time and opportunity cost of time.

Perceived poor quality, eg, inadequacies in drug provision; staff attitudes and interpersonal skills.

Primary versus hospital services. Hospitals are generally perceived to have a better quality of services than primary level. The poor tend to use mission hospitals when available, and wealthier groups tend to opt for private facilities.

- **Age and gender bias**
- **Type and severity of illness**
- **Socio-economic variables**

(Goudge & Govender 2000).

As already mentioned, 'increased quality of services' is one, if not the most common argument for user fees. Appleton (2000) however points out that "measuring the quality of health services is problematic: there are many possible indicators of quality, only some of which may actually objectively improve outcomes and only some of which may be subjectively valued by users." The quality determinant commonly referred to in the literature is that of drug availability. If one had to highlight one particular indicator, availability of drugs might be the most important for health care demand" (Appleton 2000). Drug availability is however not the most reliable indicator, as a full stock of aspirins does not make a good pharmacy or health facility – although it might well be perceived so. A lack of resources, and thereby a lack of ability to access health services, is not solved by good quality services. In other words, it does not matter if services are of good quality (which they are far from in East and Central Africa health facilities) if patients have no access them.

The user fee system may inhibit improved quality by:

- neglecting the quality of primary care or inhibiting budget allocations at this level
- generating insignificant additional revenue
- weakening the impacts on the use of the referral system without corresponding changes in quality of care (EQUINET 1998).

Exemption systems are promoted as necessary for a credible attempt at equity in user fee systems. However, they have been poorly implemented throughout Sub-Saharan Africa. Awareness of the regulations and hence utilisation is generally low and they often fail to exempt those who should be exempt. "Poor functioning of exemption mechanisms because of leakage of non-exempt groups into free care, and groups meriting exemptions not accessing them due to lack of information, excessive bureaucratic demands, lack of formal proof of earnings, etc" (EQUINET 1998).

Community participation - power or payment?

SC UK assists in the implementation of cost recovery systems in several health projects, mostly by training health committees to take over the management of administrative and financial responsibilities. This is an attempt to grasp the implications of user fees by gaining a better understanding of what takes place at the 'point of transaction', as user fees are often seen as a way of increasing community participation. 'Community participation' tends to be seen as the solution to the devolution of states' responsibilities. But does community participation allow participation in actual decision-making?

SC UK field experiences

In this section, evidence gathered by SC UK in our fieldwork is presented and analysed. Different features of user fees, and alternatives to them, are presented both by issues and by countries, to make comparisons between similar or differing experiences. The issues presented above, such as exemption systems, are described in the case studies, as they are features of health financing.

The effects of household trade-offs

Burundi

"Sustainable coping strategies are exceptionally hard to find for households affected by HIV/AIDS in a collapsed economic environment. The most severe constraint for affected households remains the total absence of social and economic safety nets. A safety net would insure household access to credit, basic services, and essential food and non-food products in times of acute or moderate shock. The absence of such a net is meanwhile partly compensated by an informal network of family and community support" (Ceesay & Jeene in press).

In Burundi, the civil war, which started in 1993, continues to rage and creates insecurity, acute poverty, family separations, high levels of malnutrition and a failure of the state to provide even minimum basic services. Children have been hit hardest by the ever-worsening humanitarian situation. Public health expenditure has increased from 4.3 per cent of the annual budget in 1999 to 4.7 per cent in 2001. This should however be compared to the 17 per cent of the annual budget spent on debt servicing, and the high amount spent on 'security'. Burundi is "not yet approved" for debt relief under the HIPC initiative.

Malaria epidemic

Malaria in Burundi is endemic and is the leading cause of mortality and morbidity among the entire population. Pregnant women and children are most vulnerable, particularly in the highlands. Prevalence has been increasing over the past 10 years, partly because of the prolonged civil conflict, which has aggravated difficulties in health service delivery. Malaria is one of the major causes of morbidity for children under five at 25 per cent, and is the single main cause of mortality at 30 per cent of all under-five deaths.

Treatment for malaria was, in principle, free during the most recent epidemic in 2001-2002. Despite this, SC UK research shows that, in the highland areas of Gitega and Mwaro where 90 per cent of the population live off subsistence farming, there has been a massive economic impact in terms of labour days lost. Agricultural productivity has decreased and malnutrition has increased, as households have been forced to sell off assets such as livestock and land to support health service costs. This shows that, although the costs of drugs are the biggest costs in health, other costs also force trade-offs. In interviews, expenses mentioned were "labour lost, transport and malnutrition". After trade-offs are made to finance these expenses, the ill are taken to a health facility and given chloroquine, which in Burundi is still the first line treatment for malaria. However, a study by the Burundi Ministry of Health, supported by SC UK, Médecins sans Frontières and UNICEF, showed that 80 per cent of cases

did not respond. So, even after trade-offs had been made, most patients received poor quality care (Ceesay & Jeene in press).

Ethiopia

> "For the 'poor' - about 70 per cent of the population - livelihoods are seasonal and vulnerable, food security precarious, and cash availability limited to post-harvest times. Any financial contingency requiring cash would be beyond daily or monthly budgets except after harvest, and would inevitably require asset sales or borrowing which could further undermine livelihoods" (Abdella 2002).

Ethiopia is one of the most under-aided countries in the world, receiving just over half the average per capita aid given to LDCs. Government health expenditure in Ethiopia was just US$1.35 per capita in 2000. The Ethiopian Government would have to spend 100 per cent of its total annual budget to meet the US$36 per capita per year recommended by WHO. The government is honouring its commitment to spend 20 per cent of its national budget on basic services but the international community is lagging far behind, as only 5 per cent of average lending by the Organisation for Economic Cooperation and Development and only 11 per cent of World Bank lending (during 2000) went towards basic services (SC UK, FfDC 2002).

User fees were implemented in Ethiopia five decades ago. "There has been a long history of fee-for-service in [the] health sector but [it] lacked periodic revision. Surprisingly, it has not been revised for the last 47 years (Ethiopia's Health Care Financing Experience 2001).

Household economy

SC UK has done a cross-sectional study on the effects of user-fees on poor households in East Hararghe district, and is doing a longitudinal study on illness in relation to household economy in South Wollo district. The cross-sectional study shows that in East Hararghe, better-off households (seasonally 'relatively cash rich') make up about 20-30 per cent of the population.

The poorest households, 40-50 per cent of the total population, have no livestock assets. Their most important source of income is labour for cash. For most of the year these households are in food deficit and have very little or no cash to pay for non-food essentials. During June-September, a time when there is severe monetary shortage, the poor in this district rely mainly on "credit from, selling off livestock, selling off firewood and finally selling off labour in that sequential order. The ultimate implication of adopting these strategies is renting out land to the better-off and being bound to sell labour to pay off debts" (SC UK 2002).

Tertiary adaptation (migration) is a final solution in Ethiopia. When resorting to this, the most common trade-off is sending away healthy children, rather than a spouse (wife), to stay with family members living elsewhere.

Responses to illness

The most common first acute illnesses are common cold (5.4 per cent), scabies (1.7 per cent), malaria

(1 per cent), diarrhoea (2.2 per cent) and cough (1.2 per cent).

members in the previous two weeks. It is estimated that an Ethiopian is ill 7.7 times per

Household responses to acute illness episode:	Frequency	Percentage*
No action/treatment	245	47.9
Self treatment/traditional medicine	95	18.6
Government health post/station	50	9.8
Self treatment/western drugs	36	7.0
Private rural clinic	35	6.8

*of total acute illness episode in previous 2 weeks (n=514)

Reported reason for household responses to illness episode:	Male	Female	Total percentage
No money/resources to mobilise	78	116	38.4
Not serious/not necessary	40	64	20.5

As illustrated above, almost half the people with a first illness took no action or treatment for their first acute illness. The major reason given for this was "no money/resources to mobilise". In other words, *in 38.4 per cent of the cases, the need for health care is there, but the resources are not.*

The survey recorded a high burden of illness across households (n=643). Eighty per cent had at least one member with either a chronic or an acute illness. Moreover, 38 per cent of households had to cope with at least two sick

year. Health service utilisation rates however are at 0.25 times per year – or one visit every four years. This is remarkable, as Ethiopia has one of the highest public health expenditure rates in this study.

SC UK held focus group discussions (FGDs) on illness costs and treatment seeking behaviour. These were held with men, women and children (male and female, 10-12 years old) separately in East Hararghe district. Although evidence is not conclusive, some interesting points emerged.

"The majority (both male and female adults) agreed that there is no discrimination between boys and girls in terms of presenting the sick to medical attention. However, careful discussions with children proved the contrary. Children, both from 'cash poor' and 'cash rich' households, argued that parents favour male children as they are the heirs of family and girls often leave the family getting married to an outsider" SC UK (2002).

The participants of the same FGDs also discussed which family member had the decision-making power over when medical attention should be sought.

"Generally both the female and male groups (adults and children) agree that the father is the decision-maker in the household. However, they believe that is the mother who closely knows her child and often initially detects a child is sick and reports to the father for a decision as to when and where the sick should be taken for health care. The reason noted by both groups, including children, as to why the father is the decision-maker in the household was that he is the breadwinner. He is economically dominant in terms of deciding on major household expenses and also has the cultural privilege to decide on all the assets shared by the household" (Abdella 2002).

The current study in South Wollo district (SC UK, report in progress) reveals that this tighter control system is already being implemented. In FGDs and interviews poor people claim they must sell off all they own to obtain a health exemption certificate. Even a single mule is considered an asset that prevents the owner from obtaining a certificate, even though such assets are not actually accessible but locked in commodity, cattle, or land. This forced selling off of assets will be counter-productive, as assets normally have more long term value than the one-off cash they bring in.

Revolving Drug Funds and Special Pharmacies

Sudan

"The implementation of a cost recovery and free market system impies that the local communities have to pay for and support their health services, but due to poverty in the rural areas, local communities fail to support these - ***80 per cent of rural children in North Darfur State do not have access to quality basic health care***" (SC UK 2000).

North Darfur State, Sudan, has a population of 1,364,000, and 80 per cent of this population live off agriculture and livestock herding in rural areas. Successive droughts in 1980-90 and floods in 1998-99 affected the children in particular and increased malnutrition rates. SC UK has been working in the health sector in the area since 1991, and is now involved in the delivery of primary health care with local authorities and communities. The Ministry of Health (MoH) has introduced a Revolving Drug Fund (RDF) in North Darfur, based on the principles of cost

recovery, but access is determined by cash payment, which gravely restricts access for rural people. As with much of the basic service delivery in Sudan, health services have, to a certain degree, collapsed. SC UK attributes this to the following factors:

- Poor economic base of this marginalised and politically isolated area - any support goes to the main towns' hospitals. The poorest are excluded from the planning and control of health services.
- Structural adjustment programmes and the implementation of a free market system has stopped all support and subsidies formerly provided by the central government, threatening equity and excluding the poorest.
- Poor Primary Health Care (PHC) infrastructure, management, planning, monitoring, accountability and follow-up systems, undermining the limited support offered to the health sector.
- Lack of reliable information and analysis of the needs, disease prevalence and impact of poor PHC on the lives of rural populations and children.

This has led to:

- A low attendance rate at health facilities, eg, a nutritional survey carried out showed that 60 per cent of those who reported having ill children two weeks before the survey claimed not to have taken them for consultations at a health facility. The majority reported having instead used drugs from the market, herbs or traditional healing.
- Poor technical capacity and a lack of resources to deal with emergencies and widespread endemic diseases. Poor Mother and Child Health (MCH) care and environmental sanitation (SC UK 2000).

* For an introduction to SC UK work on RDF in Khartoum State, Sudan, see *Poor in health* by SC UK London, 1996.

Ethiopia

> 'Special Pharmacies' are first and foremost retail pharmacies. They do not offer exemptions or reduced prices to those unable to pay, which raises concern about affordability." (SC UK report in progress)

The Government adopted the Health Care and Financing Strategy (HCFS), as a part of its Health Sector Development Programme. A key component of the strategy is the Special Pharmacies Programme (SPP). This is a type of revolving drug fund being introduced as an alternative to government-owned and private pharmacies. "The main objective is to ensure a sustainable supply of essential drugs at affordable prices, to support other areas of health service improvement with the revenue generated, and to improve staff motivation by providing incentives" (SC UK 2002).

Previous experience from Special Pharmacies (SPs) show that they are often better stocked than governmental pharmacies. Their prices range somewhere in between these and the more expensive private pharmacies, which makes it debatable whether SPs are a solution to the low health service utilisation rates in Ethiopia. The biggest obstacle by far is cost. There is evidence that drugs are expiring in storage because poor people cannot afford them. The SPs are likely to provide drugs that are not available at governmental pharmacies, but providing them at a higher price will further reduce equity in access.

The SPs have separate receipts and revenue is deposited in a separate bank account. The financial autonomy of SPs is likely to lead to success in terms of revenue generation and the sustainability of drug supply. A key concern in a livelihood context of poverty, vulnerability and seasonality, however, is the question of people's ability to pay.

The Health Care Financing Strategy states that "In order to increase user fees without decreased utilisation, it must be preceded by an increase in quality of services". Increasing availability of pharmaceuticals would supposedly do this. According to the strategy, increased user fees might not help the situation in Ethiopia. If people do not have the resources to access care then they cannot experience an eventual increase in quality.

In East Hararghe the 'seasonally relatively cash rich households' make up 20-30 per cent of the population. It is this group for whom fees at Special Pharmacies may be affordable, but only as long as costs are not too high and illnesses are not serious or chronic. However, for the remaining 70-80 per cent of the population, cash availability is limited to post-harvest times, and it will be hard for them to benefit from the SPs.

Exemption policies

There is, in theory, an exemption policy in Ethiopia. The fee for consultation is exempted for those who cannot afford to pay and they may apply for an exemption paper at the *Kebele* office (the lowest administrative unit in the governmental structure). However, focus groups held with 'poor' as well as 'relatively rich' community members have shown the following obstacles to obtaining this paper:

- Firstly, one must be informed that the exemption policy exists; this information is rarely spread in rural areas.
- Secondly, *Kebele* executives responsible for evaluating who is entitled to a paper as well as distributing them are in session only twice a week.
- Thirdly, one must overcome the fear of the social taboo in claiming indigence or the taboos the sickness itself might carry and the shame of showing an exemption card to health staff.

It is estimated that around 5.0 per cent of people who visit health facilities have exemption cards. The reasons given for not having one (other than the above) are that they only exempt the holder from the consultation fee, which even for the poorest is negligible – whereas the real problem is the shortage and price of drugs. Many respondents also thought the exemption paper did

not cover children. On a positive note, there was minor leakage in the distribution of papers (this might however be related mostly to their lack of real value), and once you are able to apply for them, they are relatively easy to obtain. These opinions varied very little between the 'relatively cash rich groups' and 'poor groups' in focus group discussions.

The downside of this 'loose arrangement of issuance' is that all agree that with the present exemption and waiver procedure it is difficult to distinguish the poor from those who can afford to pay and still come up with the poverty certificate. As a result, in some facilities the rate of free patients reaches up to 95 per cent. But as correctly put in the Strategy "…no service is free, there's always a third party paying for it". It is taxpayers' money that finances the public facilities and why should one pay tax and pay for health care services as well, while others are getting free services while being able to pay?" Ways suggested to solve this are 'credit services by facilities' and 'budget allocation for free patients under, for example, the municipality'.

Credit services are not likely to be sustainable as the poor have no way of repaying and would not benefit from credits. While the exemption system reduces the fee for a consultation, it has no effect on the fee for drugs, which constitutes the main cost of health care at individual level in the whole region, including Ethiopia.

Traditional safety nets

Eder is a traditional social safety net that exists all over Ethiopia. In Bebbington's framework above, it would fall under the category "social capital". Most households are members of the *Eder* in their village or area. They pay a certain amount in kind each year to its fund, which is then used for funerals and weddings. There were plans to extend the system to include health costs but a lack of regular income, fluctuation of cash availability and varying economic capacity of villagers blocked these plans. Also, contributions to *Eder* are made in kind, and the principle can therefore not be transferred to the health service domain where cash is required. *Eder* does however contribute labour both to transport of the ill to a health facility and to manage (till) land in the absence of the person taken ill (SC UK 2002).

Pre-payment schemes and Community health funding

Rwanda

Rwanda has experienced increasing poverty and aid dependency since the genocide in 1994. It has a per capita GNI of US$230 (World Bank 2001) and 70 per cent of households now live under the poverty line. Ninety per cent of the population live off subsistence agriculture, which is highly seasonal and has the lowest productivity. Cost recovery for health services has a long tradition in Rwanda, but was temporarily abolished during the post-genocide transition years. Charges were re-introduced by the MoH in 1996, which led to declining PHC utilisation rates. These remain low, even within the regional framework, at 0.25 per capita (1999), but have increased in the three districts that have piloted pre-payment schemes (PPS) since 1999.

SC UK intra-household research looked at households health financing in districts that have not implemented a PPS, and found that:

- a health centre consultation costs between 150 and 250 Rwandan Francs (depending on the quality of the health facility)
- a referral to a specialist costs RwFr600
- the average salary for a house girl is RwFr600/month (Personal communication with SC UK Kigali field staff, 09/01).

As the above figures show, it may be financially difficult, not to say impossible, for a house girl, or someone on the same income level, to afford a health specialist.

In Rwanda, the person who takes a person to a health facility is responsible for paying their fee if the ill person cannot do so. Also, taking an ill person to a health facility is something of a gamble, as the ill might not get the necessary treatment.

FGDs and interviews held by SC UK revealed that "distance/lack of transport" was perceived to be the gravest obstacle to accessing quality health care by the poor (followed by "use of ineffective traditional medicine" and "health staff's lack of motivation"). These also showed that when the ill are taken to a facility for treatment, the common practice is to work off their debt after they have been discharged to the person who paid their fees. For those whose fees have not been paid, and who cannot afford to pay them, the practice tends to be to work off their debts at the health centre after discharge.

Implementing pre-payment schemes

The pre-payment schemes (PPS) were introduced as a pilot-scheme in 1999, after FGDs, district workshops and community gatherings were held, where "participants expressed concerns about their deteriorating access to health services, the poor quality of care and their strong interest in participating in trustworthy mutual health organisations" (Schneider & Schneidman 2001). Before the introduction, communities and local authorities were sensitised through several community meetings, radio spots and articles. The rationale behind PPS was to improve equity in access to quality health services for the poor rural population. This in turn was expected to raise quality, efficiency and community participation in service delivery. The scheme was "based on the premise that even the poor are willing to pay for health care. Nevertheless, they need a mechanism for pooling risks and for addressing seasonal fluctuations associated with a subsistence economy" (Schneider & Schneidman 2001). The three pilot districts were chosen on the following criteria: "*commitment* of the population and of local authorities; availability of a *functioning district hospital* with a network of health centres; and some prior experience in implementing PPS" (Schneider & Schneidman 2001).

The annual premium for PPS is 2,500 Rwandan Francs per family, entitling members to a basic health care package covering all services and drugs provided in their health centre, ambulance transfer and a limited service package at the district hospital. There is an additional 100 Rwandan Francs per person payable at each health facility visit.

Reviews of pre-payment systems

Results from reviews of the first stages of PPS performance are overall positive:

- Enrolment was 8 per cent of the population in pilot districts, out of which about 4 per cent were indigent people (orphans, widows, persons living with HIV/AIDS etc) whose fees were paid by religious authorities.
- New case consultations were up to seven times higher for PPS members than for non-members. Members had a utilisation rate of about 1.40 per capita, while non-members had a rate of only 0.20 per capita.
- PPS members reportedly seek care earlier and need fewer drugs than non-members.
- PPS members contributed three times more per capita to health facilities revenue than non-members.

The PPS was introduced as Rwandan authorities faced declining health utilisation rates, while foreign aid was declining. As this threat is posed to other countries in the region, the overall positive, if still tentative, experiences in Rwanda are worth keeping in mind for possible replication. Though utilisation rates still do not reach the WHO target of 2.0 per capita per year, there was a dramatic increase.

The PPS in Rwanda did not just pre-suppose the *willingness* to pay. By anticipating income fluctuations, it also took into account the *ability* to pay by pooling resources. It might be supposed that the commitment of the population and local authorities was due to the information campaign preceding implementation. The comparatively high membership rates indicate that informing communities was worth the effort. However, pilot projects tend to be successful because they are given extraordinary resources in terms of preparation, implementation, funding and attention. They are therefore not automatically transferable to different circumstances that might lack the same scrutiny and funding. The challenge is to find ways to sustain pre-payment schemes in the long term.

A positive aspect of PPS is that they might fill a function of solidarity building in Rwanda, ie, serve as a common goal towards which the population can strive.

Tanzania

Tanzania has experienced economic growth rates over the past years. GNI per capita rose from US$160 in 1995 to US$260 in 1999 (SC UK report in progress). However, this has been accompanied by increased inequity and a decline in the quality and accessibility of Tanzania's health system over the past two decades. Its Human Development Index (HDI) rating dropped from 126 in 1992 to 156 in 1997. Over 50 per cent of the population live below the poverty line of US$0.35 per day, and about 40 per cent of the population live in abject poverty.

Tanzania has been the object of a number of WB/IMF interventions through privatisation, liberalisation, and decentralisation policies. The country has one of the LDCs' heaviest debt burdens and has qualified for debt service relief of US$3 billion under the HIPC initiative. Tanzania

reached eligibility for debt relief by completing and implementing a Poverty Reduction Strategy Plan, continuing to implement strong macroeconomic policies, and implementing a set of social, structural and institutional reforms (World Bank HIPC Initiative).

In the health sector, Tanzania has fulfilled the task to "implement a program to ensure immunisation of at least 75 per cent of children under the age of two against measles and diphtheria, and implement a national campaign against HIV-AIDS, including visits to three-quarters of all districts" (World Bank HIPC Initiative). Notably, the indicators are two donor-driven campaigns that tend to be one-off interventions to show quick results. Neither of these interventions increases access, quality and equity in health service delivery. They are vertical, one-off interventions.

Before deregulating its economy in the 1980s, Tanzania had established what, in a regional context, was a well-functioning health service delivery system. This was because foreign aid was spent on basic services. Foreign aid to Tanzania is decreasing as a strengthened economy is expected through liberalisation and privatisation policies. At the same time, governmental spending on health services is decreasing (WHO 2001). The health policy for Tanzania was published for the first time in 1990 and focused on the current health reforms. These are decentralisation, improvement of central health systems, health management, financing, human resources, and partnership.

A 'very poor' household in Lindi rural district (30-40 per cent of the population) generates an income of US$105-158. A 'poor' household (20-30 per cent of the population) generates US$211-263 and a 'rich' household (6-10 per cent of the population) obtains around US$1,052. With an average family size of six members, the GDP for the poor is about US$35 which is lower than the country average.

Health Financing schemes

Due to decreased spending on the health sector, Tanzania has introduced different cost recovery schemes.

- **User fee schemes** were introduced in public hospitals in 1993, and in 1999 those PHC facilities wanting to do so were allowed to introduce fees. In Lindi district, user fees were introduced in the district Missionary hospital. Some health centres and dispensaries also introduced user fees and charge about US$0.7 per illness episode.
- **Community pre-payment funds** were introduced in one pilot district in 1996 and are now being expanded to 37 more districts. Contributions are paid on an annual basis, per household, and allow a basic package of preventive and curative care. Membership is between 7 per cent and 30 per cent in pilot districts. In Lindi, the Community Health Fund will begin in the second half of 2002 in all dispensaries and health centres. So far the community has not been informed or consulted about the fund. The aim of the community health fund and cost sharing is to establish a self-financing system for drug supply and other

running costs, including salary for village health workers and watchmen.

- **Health insurance schemes for civil servants** were initiated for central government employees in 2001. They are intended to be national schemes covering all formal sector employees. Contribution rates are 6 per cent of salary, shared 50/50 between employee and employer, allowing members a minimum service package at a public or private institution accredited by the insurance fund, which is a semi-private institution.

Tentative SC UK evaluations of all these schemes show that:

- although *user* fees do not seem to have affected utilisation rates, the expenditure on fees has not resulted in an increase in drug and medical supplies. Revenues are spent instead on fuel, allowances and salaries for watchmen and village health workers rather than on the purchase of drugs and essential medical equipment. There is in theory an exemption system fixed by the MoH for children under five, MCH, the poor, those with chronic or epidemic diseases. But it is used in an 'informal', random fashion across institutions. There is no established financial management system and the community has a minute role

- the membership rate of 7 - 30 per cent for *community health funds (CHF)* is considered low. Five years after the first piloting, 7 per cent may be considered low, but 30 per cent seems reasonable

- the *health insurance schemes for civil* servants have been criticised for not delivering on its promise of a "minimum package of services". Reportedly, teachers have dropped out of the scheme for this reason, leaving them to either join a community health fund or pay user fees.

SC UK research shows two major weaknesses in the CHF schemes. Firstly, people tend to wait until they are ill to join. This in effect takes away the element of anticipation that is the rationale behind CHF as they are likely to go straight to the health facility and pay the smaller fee for that one consultation rather than invest more in the fund. More needs to be done to attract people to the CHF, in order for it to fulfil its potential. Also, many members are referred on to a second hospital or health clinic from the first facility and, as the CHF is not valid there, they are required to pay in the end.

Enrolment for PPS in Rwanda is much lower at 8 per cent than the 7-30 per cent membership rate for community health funds in Tanzania. Still, many more benefits are documented from the Rwandan pilot experience. This might be because positive developments have come about faster in Rwanda, which introduced PPS just three years ago and already has significantly increased service utilisation rates. In Tanzania, utilisation rates have reportedly not been much affected by either of the schemes. The same rate of health service use has been maintained in Tanzania despite the introduction of user fees, in contrast to the experience from other countries where utilisation

of services has dropped with the introduction of user fees. However in the case of community health funds and national health insurance Tanzania's use is lower in comparison to Rwanda's increased utilisation rates (SC UK 2002).

User fees in complex emergencies

Burundi

> "The bulk of revenue obtained from user fees are fees paid at the point of delivery by parents, often mothers, seeking treatment for their children. Children as young as one week are charged the same fees as an adult" (Ceesay & Jeene, in press).

The Ministry of Health of Burundi in 1988 adopted a health sector decentralisation and reform policy intended to solve financial and management problems in the various public health facilities and administrative structures, as well as improve quality of health services. Introduction of this policy was difficult because of the war, but implementation began in 1998.

It aimed to:

- increase community contributions to the provision of their health services by the introduction of user fees
- gradually implement a cost recovery scheme in all health facilities
- harmonise the management structures of provincial health offices
- reduce bureaucratic decision making structures
- establish an autonomic management structure for health care delivery at provincial level
- create structures at local level to facilitate dialogue, greater collaboration and partnership between the provincial heath management team and the communities.

Health Financing schemes
In October 1999 a joint memo from the Ministry of Public Health and Finance was circulated to all provincial governors and health centres. Burundi was to start a pre-payment scheme and a user fee scheme for all services at public health facilities. These have been implemented and their features are as follows:

- **Pre-payment scheme:** Every individual (from new-borns upwards) is expected to pay US$0.7 per year for an insurance card which gives the cardholder an 80 per cent discount on all services at the health facility. The exception is the consultation fee at the point of delivery - a compulsory fee of US$0.05. This payment is made at the Communal Administrator's office. The proceeds are used for *other community and management needs outside the health sector.* Neither the provincial health management team nor the health committees have access to these funds.
- **User fees:** In reviewing outpatient registers at the health facilities, it was found that the bulk of revenue obtained from user fees are

fees paid at the point of delivery by parents, often mothers, seeking treatment for their children (aged 0 – 15). These form over 60 per cent of total general outpatient attendance each month. *Children as young as one week are charged the same fees as an adult.* Non-card holders of all ages are charged the consultation fee of US$0.05. In addition they pay for the total cost of all drugs and other services. Only immunisation and treatment of tuberculosis are free.

- **Exemption policies:** Although there are no clear criteria in the circulated government memo on exemption mechanisms, the office of the communal administration is charged with issuing exemption certificates.

Reviews of pre-payment schemes, user fees and exemption policies
Save the Children, in partnership with the provincial health management teams of Gitega and Mwaro provinces, agreed to pilot the feasibility of these policies. This was done through the formation of community management structures and an informal cost-sharing scheme in some public health centres, and fixed bank accounts for user fees at point of service.

The findings from this pilot are as follows:

- *Conflict arose in decision-making* as few administrative and relevant provincial administrative structures had been involved in the process. None of the health staff interviewed clearly understood the objective of the health reforms being implemented by the MoH. Nor were they able to explain the cost recovery strategy.

- *The actual charging of tariffs differed*, even though a standardised tariff system was given for all drugs and services provided at health facilities.

- *Lack of clear definition* of the MoH policy of decentralisation, coupled with limited human and logistical resources, led to major constraints in co-ordination and management of resources.

- *The quality of services in some facilities was found to be unsatisfactory.* Most importantly, the non-existence of treatment protocols, the neglect of boiling of needles or of using disposable syringes and needles for immunising children and pregnant women, poor sterilisation techniques for deliveries and poor monitoring of the cold chain system for vaccines.

In January 2002, another memorandum was released from the office of the Minister of Public Health, indicating the receipt of funds from the World Bank as part of the *Credit d'urgence de rehabilitation* (CURE project). The memo requested all provincial health management teams to commence a countrywide "cost recovery" scheme, but failed to indicate any strategy to be used.

Recovering costs.
As there are no clear financial management and expenditure procedures, the revenue collected and expenditures are determined by the provincial health management teams. In one province,

30 per cent of all monthly revenue is paid directly to this team. About 40-50 per cent of revenue collected at the facilities is being used for payment of staff salaries and other management costs not directly related to the facility. Reviewed public facilities were noted to be charging at varying rates between 50-100 Burundian Francs (equivalent to US$0.05-0.1) for a consultation, and costs of medicines were determined by cashiers using varying tariffs.

Revenues collected from pre-payment schemes (community and public sector employees and insurance schemes) are not utilised by the health sector, nor are communities involved in its management. Health insurance schemes are being implemented in all facilities, but their management and expenditure processes are still ill –defined. Both the communal administrators and the provincial health management teams have marginalised the community health management committees formed to manage financial proceeds from the facilities. These are only involved in social mobilisation issues in times of epidemics and other health issues in communities, eg, health education.

In Burundi, as in neighbouring Rwanda, civil society structures have been severely damaged due to conflicts and mistrust. However, the presence of national NGOs and community based organisations (CBOs) is increasing in Burundi (Ceesay & Jeene, in press).

The Democratic Republic of Congo (DRC)

> "In the context of an acute crisis, such as in the DRC, the goal of improving access to services for the poorest must not be lost. Whatever the system of cost recovery utilised, it must fulfil three criteria: economic efficiency; administrative efficiency and equity. But in reality, it is not always possible to incorporate the notion of equity in a system of cost recovery. A financing system works according to the principles dictated by the community, health institutions and the government. The efficiency of this partnership depends on the defined roles of each party – but in the RCD there is no government" (Elongo 2002).

The Eastern part of the Democratic Republic of Congo is under rebel rule. It has formally been in conflict since 1997, but has, like the entire country, suffered severe political and socio-economic difficulties for decades.

A study on financing mechanisms and access to basic health care was carried out in the Kivus area in the easternmost part of the country by Save the Children UK in 2002. A majority of the population lives under the poverty line of less than US$1/day and 37 per cent do not have any access at all to basic health services (SC UK 2002). The cost recovery system was already in place in the RDC before the introduction of the Bamako Initiative. The succeeding wars, the Government's disengagement, the ongoing poverty of the population and the cost recovery system have compounded the breakdown of the socio-economic fabric. Most households are incapable of fulfilling their basic health service needs.

Fee payment
The types of fee payment used in the East DRC are:

- tariff for each separate consultation, intervention and drug
- fixed tariff per illness episode
- insurance system (Mutual Health schemes, pre-payment schemes etc).

In focus group discussions, adults from the three study-sites claimed they pay:

- US$0.10–2.00 for consultations - the fee for children under 5 is half this price.
- US$0.25–8.00 for less than one week's hospitalisation - the fee is between half and five-sixths of this amount for children.
- US$0.75–25.00 for surgery - the fee is half to four-fifths of this amount for children.

Price differences within sites are normally not dramatic, but differences between sites often are, which is what the above examples show. The differences correspond with income differences between sites. In the more expensive site, the income from one day's work in the field is US$0.66, while in the second less expensive site it is US$0.22/day. Therefore, in one sense, costs correspond in relation to income. However, the cost of hospitalisation for an adult in the most expensive site is US$6–8. This is twice the amount earned in that time during which the patient is of course not earning. The cost for surgery for a child in the second most expensive sites ranges from US$12-25. With a median income of US$0.66/day it would take 20 to 40 working days to earn that amount – not counting household running expenses.

Recovering costs is dependent on a degree of purchasing power of the population and the availability of basic services. Both these are lacking in this extended conflict situation. Before the present war, the utilisation rates for DRC was 0.25-0.40 new cases/year/citizen in three health zones studied. The insecurity makes it extremely difficult to assess present utilisation rates, but it is estimated that mothers and children bear the heaviest burden of the breakdown of socio-economic networks. This is illustrated by the following figures: in 1998, the maternal mortality rate in DRC was 1,837/100,000; in 2001, in the Kivus, it was 3,000/100,000.

Focus Group Discussions were held with a total of 65 children in school and 17 children not in school to discuss reasons why they cannot utilise health services.

These were:

- lack of financial means
- bad quality of services offered and unfriendly staff with a high turnover and lack of concern in the patients.

Household economy and utilisation rates
Utilisation rates depend on several factors. While distance does not appear to be a determining factor, household poverty has been identified as a major barrier to basic health services. These claims are compatible with a household survey carried

out within the SC UK study in the North Kivu province to establish the capacity of urban and rural households to pay for services:

- 98 per cent of the households live below the poverty line, which is set at US$1 per capita per day by the World Bank.
- 71.1 per cent of households have difficulties in accessing basic health services, mainly because they lack the financial means to do so.

In FGDs held with representatives from the church, CBOs, 'caretakers' and children in the three sites studied, 'the poor' were identified as internally displaced persons, homeless, widows, orphans, families without land or cattle, malnourished individuals, chronically sick, war returnees and soldiers' wives. Added up, these categories constitute the greater part of the population. The FGDs revealed that the first line of treatment for both 'poor' and 'better-off' is normally 'traditional' care because 'modern' treatment is too expensive. Hospital is therefore not an option, but "prayer room", "self-treatment" and "no action" are – because they entail little or no cost. Poor quality of services is also a major deterring factor in treatment seeking – a lack of drugs rather than medical material or equipment, being cited as important.

Exemption systems without government
Normally, the State has three functions in health service delivery:

- supplying (a part of) health care services
- financing (a part of) the services
- assuring regulations between public and private services.

The situation in the DRC, however, requires the engagement of different actors as drugs are often supplied by IOs/NGOs such as the International Committee of the Red Cross, SC UK and UNICEF. The major constraints facing households in accessing health services are distance and, more importantly, household income. In the rural areas, the main source of income is from agriculture, often raised on an annual basis, and changing from one year to another. Access to quality health services for the poor, women and children is not guaranteed.

The chronically sick or those who need expensive drugs, or intensive or specialised hospital services are exempt from user fees in the DRC. However, those with anaemic diseases, those who have had urgent surgery or a caesarean are not exempt. The policy of reducing charges for services should place particular importance on 'survival interventions' such as blood transfusions, emergency obstetric care, surgery and other urgent medical interventions. The label 'unforeseeable events' is the most serious and almost always necessitates survival interventions. A possible solution is to fix the tariffs for services for these 'unforeseeable events', making them cheaper than the others. (Elongo 2002)

Decentralisation and abolition of user fees

Uganda

> "User fees, intended to replace "informal payments" to under-paid health workers, instead became an addition to these, and the exemption system didn't work. This, rather than giving communities a sense of ownership, instilled a sense of alienation from health services" (Mwesigye, 2001).

Uganda has been heavily aid dependent for the past three decades, and during that time has experienced conflicts and a heavy debt burden. Meanwhile, spending on health services declined by around 40 per cent. The Government of Uganda (GoU) now spends 8-10 per cent of its GDP on the health sector.

The objective of delegating responsibilities and resources through decentralisation is to make basic health services more efficient, equitable and effective, as well as to include the community to a greater degree. However, we have demonstrated with evidence from East and Central Africa that, although the responsibility for health care has been delegated, the power and the resources required to carry through the delegated work do not necessarily follow.

SC UK is part of the Uganda National NGO Consortium which has researched the effects of health care decentralisation and the abolition of user fees in nine districts that fairly well represent the four regions of Uganda.

Implementing fees

In 1987, the GoU received an economic package from the World Bank and the IMF, which demanded a decentralisation policy and a reduction in public expenditure on basic services, including health. There was much controversy around the adoption of user fees proposed in the package, and in 1990 Parliament vetoed their implementation.

In 1993 Uganda began its decentralisation process, which in the health sector attempts to achieve equity, improved access and quality of health services through Primary Health Care services" (SC UK 1999). The policy was one of devolution, by transferring power, authority and responsibilities to sub-national political entities (ie, local governments), with some elements of privatisation. In 1993, districts were given the mandate to introduce user fees if they wanted. However, there was no training of staff to handle this. Health management committees were not in place and health facilities were more or less left to handle implementation as best they could. This resulted in some facilities implementing user fees, some not, and rates varying between those that did.

User fees, while placing an additional burden on households, brought small revenues but without much impact, at least not within the intended areas. Out of the revenues, 50 per cent were to be earmarked for purchases of drugs. Studies from a typical district however show that only 18 per cent of revenues were used for drugs. Meanwhile, 39 per cent went to "staff benefits" (ie, top-ups) and 22 per cent were used for "sundries" such as soap, paraffin and stationery.

Protests against user fees in Uganda were not simply based on a lack of resources. There was also a moral angle, as the state was not providing what it should. Although taxes are low and poorly administered, citizens felt they had a right to demand something in return for what they paid.

> "If government cannot give us health services then they should not come to ask for tax. What is the government for?" (FGI in Rakai District).

While Uganda has had significant economic success, this has been unevenly distributed. Annual per capita income, is still around US$300, ie, less than US$1/day. Rural, poor populations lag behind in poverty reduction schemes.

> "You see people are poor! People used to get money from coffee but now where do you get money from?" (FGI in Rakai District).

Abolishing user fees

Most of the evaluations on the effects of user fees on utilisation rates came to similar conclusions: rates had decreased, not only for services for which there was a fee, but also for free services such as antenatal care, delivery and child immunisations. User fees, intended to replace 'informal payments' to under-paid health workers, instead became an addition to these, and the exemption system didn't work. This, rather than giving communities a sense of ownership, instilled a sense of alienation from health services. Based on these evaluations and their own field experiences, civil society organisations (led by SC UK, Oxfam GB and the Adventist Development Relief and Development Agency) recommended a slow phasing-out of user fees, while other options were investigated. However, shortly afterwards, in March 2001, the GoU abruptly abolished user fees in all public health facilities. Consequently, there has been a sharp increase in attendance, demonstrating the problems of under-staffing and drug shortage at unprepared facilities. In Uganda, total annual spending on health is about US$10-12 per capita; US$3.95 comes from donors and government, while US$8.05 are private contributions. However, out of these US$10-12, only about US$0.5 actually reaches the target population. It is estimated by the Ugandan government that US$19 per capita is necessary for a basic health services package. This is half the sum of the latest WHO recommendation, but perhaps more realistic, as with the current losses, that would mean US$1 actually reaches the population (Mwesigye, 2001).

Summary of findings

- Poverty is the major reason given by members of poor households for why they cannot access health services.
- Neither the recipients nor their communities are recovering costs for health services, but "cost recovery" schemes are still forced upon them.
- Poor families are expected to come up with 'coping strategies' to pay for health services, but clearly they cannot cope.
- The poorer the individual, the greater the need for affordable health services – but the less access they have to health services.
- Members of poor households either do not seek care or make fatal trade-offs in order to obtain it.
- Children, especially girls, draw the shortest straw when illness strikes the household and have little, if any, influence over their own health care.
- User fees usually decrease utilisation rates, and in Uganda there has been a spill-over effect on services that were free at the point of delivery.
- Poor quality and distance are also given as reasons for not seeking health care.
- Due to a lack of national legislation, guidelines or preparedness, fee systems are poorly understood and implemented. This contributes to a deteriorating sense of trust and ownership in health services.
- Services are still of poor quality even two decades after the introduction of user fees. The argument of 'improved quality' no longer justifies maintaining the system.
- A major part of the cost for health care is drugs, but these are rarely available even though people pay for consultations in order to obtain them.
- The major part of the total cost of illness is lost income, further deterring attempts to access health services.
- Exemption systems rarely work. Information about exemption systems is rarely well communicated and even if it were, it may lead only to more frustration.
- Public health care systems in relatively peaceful countries in the region are under-funded, scarce and of insufficient quality.
- Public health care systems barely exist in countries which are in conflict or post-conflict.
- 'Traditional' safety nets have collapsed to a varying degree: in countries in conflict they are severely damaged, while under 'normal' circumstances they are over-strained by the HIV/AIDS pandemic.
- Top-ups (ie, bribes) are common in many countries. User fees have not led to their formalisation but have instead become an extra burden on the ill and the poor. The root cause is the insufficient amount being spent on the recurring costs of health services.

- Revenues from user fees are too small to fill funding gaps or to free up money for other social welfare programmes.
- Abolishing user fees abruptly, as in Uganda, can overwhelm the health system by the large increase in utilisation and thus further compromise quality.

Conclusions

User fees decrease already low utilisation rates. They are an additional burden on the total cost of illness, the main cost of which is lost income which is often mentioned in interviews as a factor deterring health–seeking behaviour. Poor families cannot cope without that income. When costs are anticipated (eg, pre-payment schemes), shocks to the household through lost income and other illness-related costs are more manageable.

There are alternatives to user fees, and these are desperately needed in the region. Public health care systems in relatively peaceful countries in the region are under-funded and of poor quality. Rural facilities are separated and far away, under-staffed and short of drugs, as are government pharmacies. In countries in conflict and post-conflict, health care systems are stretched beyond limits. While large amounts of funding tend to be available for emergencies, very little of this funding seems to have been invested in supporting running costs of health systems. It is not enough to vaccinate a certain amount of children in an emergency when a large majority of people live in abject poverty and are unable to pay for basic health necessities, such as malaria prophylaxis, essential obstetric care or drugs for the management of AIDS.

Poverty is the main reason given by members of households as to why they have little access to quality health services. This is followed by “poor quality of services” and “long distance to facilities”. Services are often of poor quality even decades after the introduction of user fees. The argument for “improved quality” does not seem to justify maintaining the system. It is hoped that the shortcomings will be redeemed by alternative drug funds such as Revolving Drug Fund (RDF) and Special Pharmacies (SPs). What must be kept in mind however is that, while a lack of drugs is a problem, it is cost that is the greatest obstacle in accessing health care.

Costs for health services are not being recovered by the recipients or their communities but people are expected to come up with ‘coping strategies’ in order to pay for health services. Often they do not have the assets to cope and are either forced to ‘ignore’ their illness or resort to trade-offs. These trade-offs are especially detrimental to children who may be pulled out of school. Children, both from ‘better off’ and poor households say they have little influence over their own health care. They are rarely consulted by parents or by health workers.

There is often a lack of national legislation, guidelines and preparedness when fee systems (and all they entail) are introduced. In Uganda, the implementation of user fees actually had a spillover effect on services which had been free at the point of delivery, due to lack of information. Health staff and users often have difficulty understanding fees. Systems are randomly implemented, decreasing the sense of trust and ownership of health services. Exemptions systems are especially randomly used and information about them poorly disseminated. ‘Traditional’ safety nets have collapsed to varying degrees. In countries in conflict they have been destroyed, while under normal circumstances they are over-strained by the AIDS pandemic. But just possibly, if modifications were made to adjust exemptions to the costs of modern health services, the system could be built on.

Insufficient money is being spent on recurring costs of health services. User fees have not financially supported local health facilities but have instead become an extra burden on the poor and sick. Revenues earmarked for health are too small to fill funding gaps, or to be freed up for other programmes.

The poorer the individual, the greater the need for affordable health services, but the less the likelihood of access. Abolishing user fees led to increased utilisation rates in Uganda. But abolishing user fees without first improving health infrastructure, staff numbers and drug supplies (as was the case in Uganda), will place too heavy a burden on health facilities. Successful pilot projects need to be encouraged and further extended if and when circumstances are appropriate.

Policy and action recommendations

- Explore alternative options for health funding, learning lessons from research.
- The options for health funding need to be more equitable, viable and flexible with regard to unforeseen economic shocks to the household.
- More investment is needed to research sucessful pilot projects. It must however be remembered that they are not automatically transferable to different situations.
- It is important to invest in human capital, if only because economic return can be expected.
- In order to help and encourage the efforts of LDC governments to meet their obligations as providers of basic health services, donors must do their part and increase aid towards public health – the current figure of 0.011 per cent of bilateral ODA towards health is grossly insufficient.
- Donors must demonstrate that their commitments to aid are genuine by committing to spend 20 per cent of their aid budgets on basic service provision in the poorest countries and reaching their 0.7 per cent GNP promise for Aid.
- Aid that does not contribute to the eradication of poverty and the promotion of sustainable development and human rights, such as the right to health, should be stopped.
- Donor-driven, disease-specific interventions such as GAVI and EPI should be adapted into multi-sectoral programmes with viable, equitable benefits for national health systems and their recurring costs. It is important to strengthen a country's health system on their own terms.
- Invest in multi-sectoral approaches, such as literacy, health, and nutrition, rather than on narrow, vertical, disease specific programmes. The effect of improved female literacy on children's health is a good example of multisectoral benefits.
- Complex emergencies need to be viewed as just that, and not as targets for short-term humanitarian assistance, leaving little local capacity when the emergency passes.
- Most of the countries in the sub-Saharan region are either involved in conflict or in transition. This can be a time to start something new and to make changes that might not be possible under 'normal' circumstances.
- User fees for health services bring huge uncertainties and distress for everyone but especially those populations in conflict areas. They may also pitch the rich against the poor. Alternative approaches are discussed in this paper, eg, pre-payment and community health financing schemes. It should be remembered that collective funding might unite communities and encourage co-operation. It may also decrease the risk of conflict resulting from economic shocks to society.

- A culture of participation and consultation with civic society on major policy issues (especially those that affect the lives of children and women), should be encouraged, to allow for greater ownership in planning, disbursement and use of resources.
- SC UK welcomes the EU member states' commitment to donate an average of 0.39 per cent of their GDPs to development aid by 2006, but remains concerned that the USA is committing to only a fourth of this amount.

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Annex

THE CONVENTION OF THE RIGHTS OF THE CHILD: ARTICLE 24

1. States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
   - (a) To diminish infant and child mortality;
   - (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
   - (c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
   - (d) To ensure appropriate pre-natal and post-natal health care for mothers;
   - (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
   - (f) To develop preventive health care, guidance for parents and family planning education and services.
3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realisation of the right recognised in the present article. In this regard, particular account shall be taken of the needs of developing countries.