

# World Bank Seminar

## Waivers, exemptions, and implementation issues under user fees for health care

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B. Mitigating equity problems of user fees

C. Waivers and exemptions



# A. Rationale of user fees



# Economic rationale for user fees in health care

- User fees have been around for decades in developing countries, sometimes as official policy, sometimes spontaneously, sometimes under the table (see Lewis 2001)
- User fees are adopted or promoted on the grounds that they:
  1. Generate additional revenue
  2. Promote efficient consumption
  3. Ration demand
  4. Improve targeting



# 1. Revenue raising through user fees

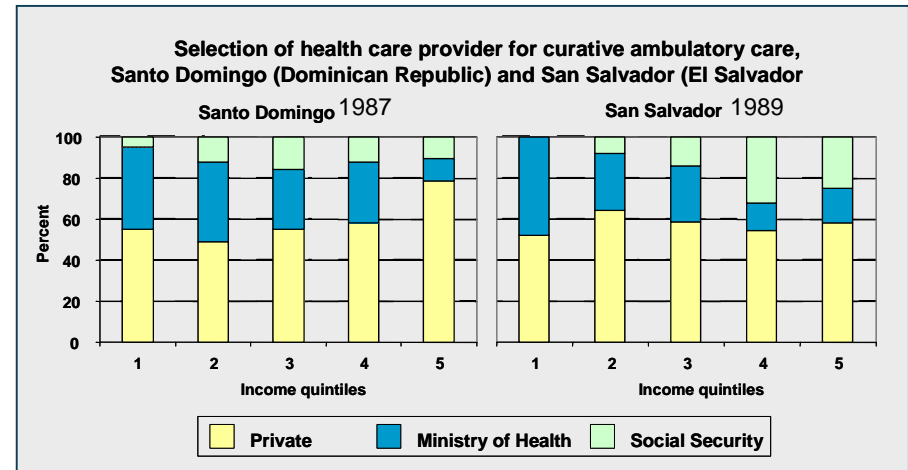
- Insufficient public funding of government health facilities leads to:
  - Low quality of care...
    - Much of public budget used to pay for staff costs.
    - Lack of complementary inputs, especially medicines.
  - ...leading to misuse of existing resources:
    - Lack of complementary inputs leads to low demand and thus under-utilization of human resources and infrastructure.
- Thus user fee revenue is expected to improve efficiency.
- It would also improve equity: modest public fees (compared with private fees) would suffice to make good quality services available to the poor.



# 1. Revenue raising through user fees

The kind of evidence that motivated discussions about user fees in the mid 1980s:

- Under-utilization of public services offered to all at no charge in the Dominican Republic and El Salvador.
  - MOH: “We cover 80 percent of the population and we offer services free of charge. Why don’t they come?”
- High out-of-pocket spending in the private sector by the poor.
  - Under-funding of MOH services results in low quality care and regressive financing of health care



Out-of-pocket payments (pesos)		
Income quintile	Santo Domingo 1987	San Salvador 1989
Quintile 1	41	20
Quintile 2	31	48
Quintile 3	44	46
Quintile 4	57	36
Quintile 5	82	45



# 1. Revenue raising through user fees

- Issues with reliance on fees for revenue generation:
  - a) How much revenue can be raised?
  - b) Can quality be improved through user fee revenue?
  - c) In practice, is it possible to exempt the poor from fees?



# 1. Revenue raising through user fees

a) How much revenue can be raised? Is it worth bothering? Some views:

- Not enough revenue is raised to make a difference.
- How much is enough? To make a difference it may suffice if fee revenue is significant relative to non-staff operating costs.



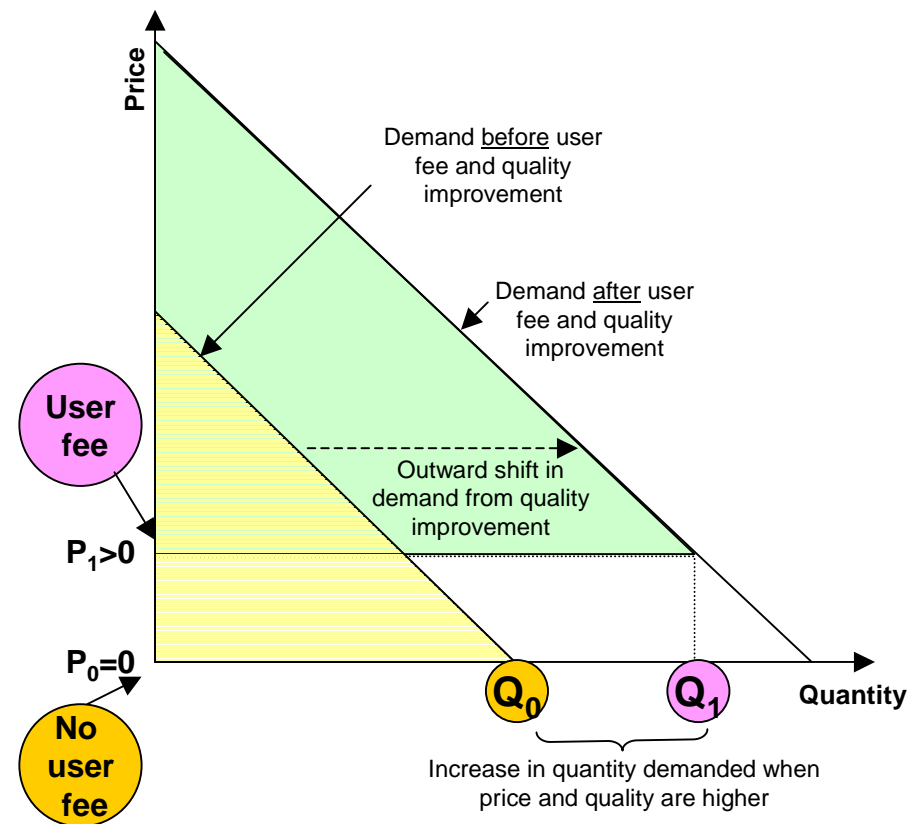
# 1. Revenue raising through user fees

- **Creese (1991):**
  - Actual cost recovery experiences in African countries: on average fees yield around 5% of operating costs; lower or negative net yields when collection costs are considered
- **World Bank (2002):**
  - In Cambodia out-of-pocket household spending = 82%-84% of total sector financing; government = 4%-5% of total. User fees account for up to 95% of government health staff income.”
- **Thailand MOH (2002)**
  - Cost recovery revenue accounts for 60% of hospital revenue and 70% of health center revenue, 1/3 from user fees and 2/3 from insurers.
- **USAID (1987)**
  - Zaire’s health zones recovered 80% of total costs through user fees, in hospitals and in health centers.



# 1. Revenue raising through user fees

- Can quality be improved through user fee revenue?
  - The assumption: Revenue from user fees is used to improve quality and this boosts demand among all, including the poor. Welfare of the poor increases with fees.
  - Through price discrimination (higher price to non-poor, lower price to poor), a small enough fee can be charged to the poor unambiguously to improve their welfare.
  - Will revenue be kept locally?
  - Will it be used for better quality?



# 1. Revenue raising through user fees

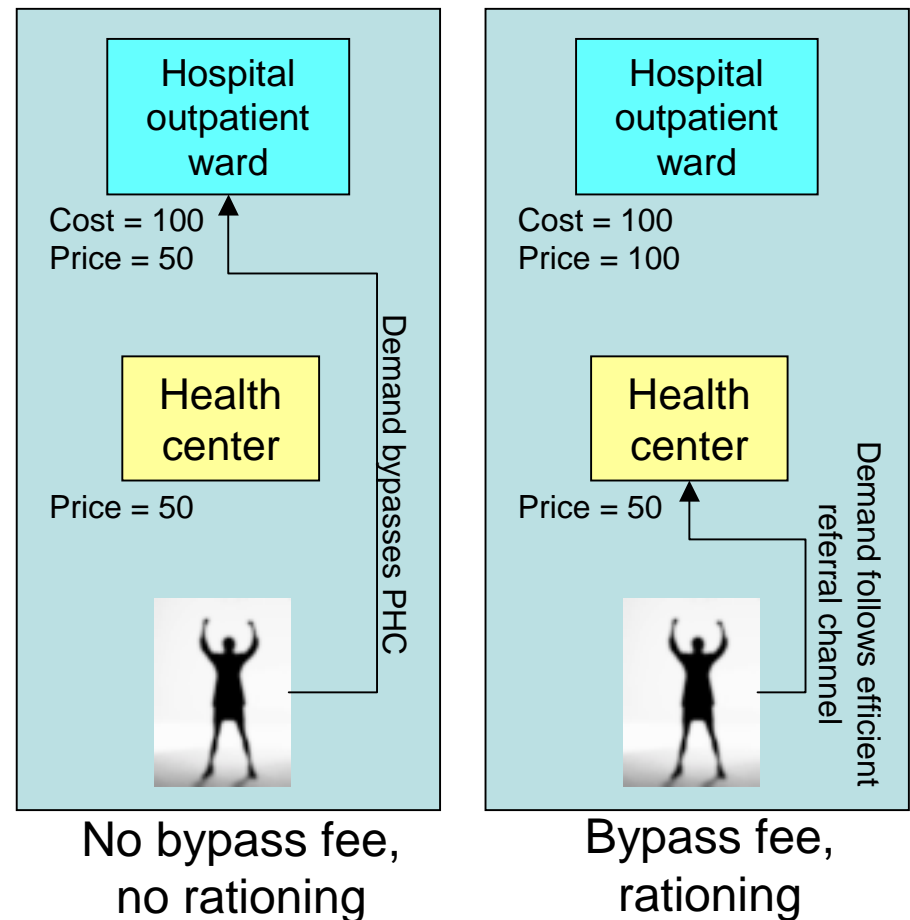
c) In practice, is it possible to exempt the poor from fees?

- Maybe, it is hoped, but even if not, public fees would still be lower than private fees.
- Newbrander *et al.* (2001): rather and discouraging results from Africa.
- Current review of experiences...stay through the end.
- Gilson (1988):
  - **Exemption mechanisms have proven difficult to implement and administration costs have been high. The level and type of fee affects both affordability and administrative feasibility –affordable fees are difficult to establish and systems that are easier to administer tend to be less equitable.**



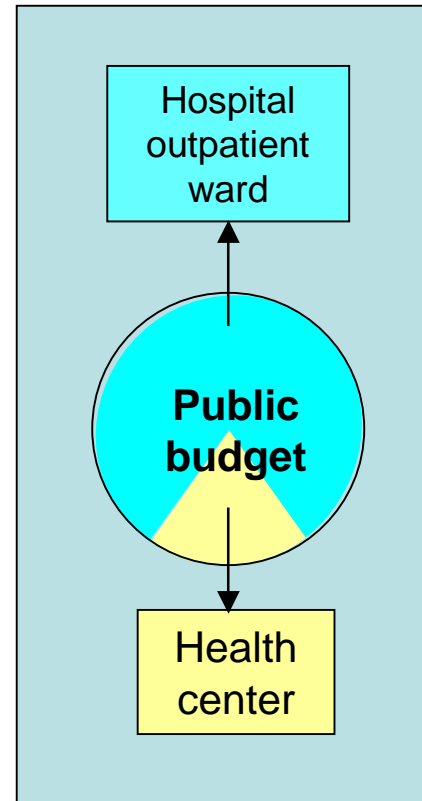
## 2. Fees can promote efficient consumption

- Bypass fees help direct demand through referral system; consumers to make use of primary care as entry point, improving efficiency of public spending.
  - Problem: primary care facilities often under-budgeted; bypass may respond to low quality PHC; fees frequently adopted at PHC level as well (e.g., see Diop *et al.*, (1992) on Niger).

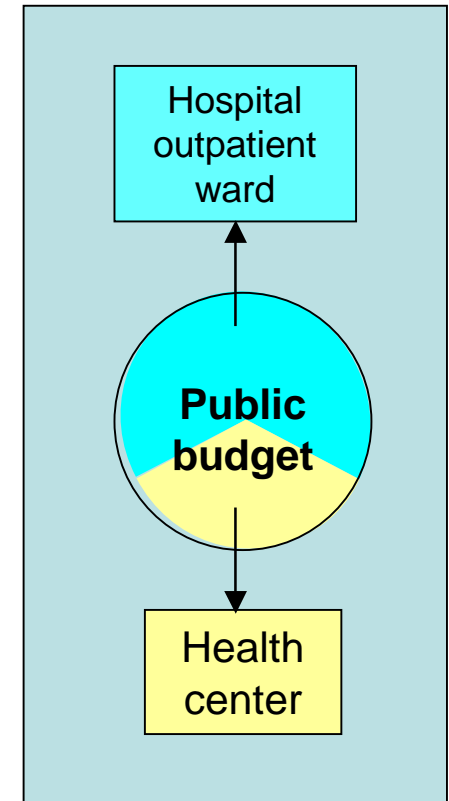


## 2. Fees can promote efficient consumption

- Higher fees (lower subsidies) for services with lower social returns. Lower fees (higher subsidies) for services with higher social returns (Jimenez, 1986).
  - Not all hospital services are less cost-effective than all PHC services.
  - Problem: catastrophic health problems –public subsidization of expensive hospital care that is not necessarily cost-effective. If well targeted, this is implicit insurance for the poor.



Under-financing of socially cost-effective services



Socially more efficient allocation of public subsidies



# 3. Fees help ration demand

- Barnum and Kutzin (1993):
  - Fees can improve the efficiency of resource use by (1) reducing the use of hospital services with negligible benefits; (2) removing excess demand; and (3) producing appropriate allocation incentives. But fees can also impact on equity by impeding the poor's access to the services.
- Abel-Smith (1993):
  - Arguments that clients make frivolous use of services are based on the assumptions: 1) that they can tell whether or not their use of health services is necessary; and 2) that charges for health services will deter unnecessary use. Such arguments are wrong.
- Bloom (1991)
  - User-fees can raise revenue while reducing unnecessary use of services. However, the poorer are less able to pay for essential care, and evidence suggests that utilization of basic services falls after the introduction of user-charges.



# 3. Fees help ration demand

## Annual per capita contacts with health system, selected countries

	Per capita annual contacts with health system
United States (1992)	5.5
Chile (1995)	3.3
Cambodia (2002)	0.1
Zaire (1987)	0.4

- Low utilization in poor countries suggests that excess demand may not a major problem there, and thus rationing through user fees may not be a priority. Rather, for most services, efforts to promote, not ration, demand seem advisable.



## 4. Fees improve targeting

- Griffin (1988):
  - The problems often associated with user fees are surmountable, their benefits are relatively easy to capture; through careful design they can be used to improve the targeting of subsidies.
  - To capture the benefits of user-fees:
    - Services should be accessible and of reasonable quality;
    - Freed revenues should be funneled into under-funded programs providing public benefits such as preventive services (to remain free of charge), and to increase the number and quality of facilities for the poor;
    - The poor must be protected.



## 4. Fees improve targeting

- Griffin (1988):
  - Options for protecting the poor include low or zero fees in local clinics, voucher systems based on the certification of poor households by local community leaders, staff discretion in collecting charges, and means testing.
  - Well designed health insurance programs should be developed to help mobilize resources and protect households from large financial losses.



## 4. Fees improve targeting

- Gilson (1988):
  - Exemption mechanisms have proven difficult to implement and administration costs have been high.
  - The level and type of fee affects both affordability and administrative feasibility:
    - Affordable fees are difficult to establish
    - Systems that are easier to administer can tend to be less equitable.



# The promise of user fees in theory: Summary

- **Horwitz *et al.* (1988):**
  - User charges for government-provided services can help solve efficiency and equity problems.
  - Charges increase resources for the system as a whole and allow government resources to shift to more cost-effective (preventive) programs, which will tend to benefit the poor more than the rich by better addressing their health problems.
  - Channeling revenues into under-funded non-salary expenditures will increase internal efficiency.
  - And careful targeting will improve equity.



# World Bank involvement with user fees for health care

- Bank's main policy papers on health financing in mid 1980s to early 1990s promoted the adoption of user fees.
- In several countries (e.g., Kenya and Zimbabwe), introduction or strengthening of fees were conditions imposed by the Bank in context of adjustment and/or project loans.



# World Bank involvement with user fees for health care

- Major World Bank policy document
  - De Ferranti, D., 1985, Paying for Health Services in Developing Countries, *World Bank Staff Working Papers, No.721*, World Bank, Washington, D. C.
    - Fees are regressive when compared to other means of financing services such as progressive income tax, but fees can be used to benefit the poor by extending and improving basic services; thus the net effect depends upon how the revenues are used.
    - The poor can be protected through discriminatory pricing.
  - Akin, J., M. Ainsworth, D. De Ferranti, 1987, Financing Health Services in Developing Countries, ..., World Bank, Washington, D. C.



# Involvement of other donors with user fees for health care

- World Bank was not the only development agency promoting user fees:
  - UNICEF's implementation of Bamako Initiative in Africa: drug revolving funds.
  - USAID's support of primary health care project designs that relied heavily on user fees (e.g., Zaire's health zones).



# World Bank Current Policy

- 1993 World Development Report: Investing in Health
  - Priority setting
  - Risk sharing
- 1997 Health Strategy Policy Paper
  - Risk sharing
- More recently, Macro Commission on Health
  - Risk sharing



# The problem

- User fees have been in place for decades virtually everywhere.
- They respond mainly to lack of public funding.
- User fees are a “stroke of the pen” policy: easy to adopt.
- World Bank and other donors may have influenced development in fees in some places, but this was only a secondary factor in the history of user fees.
- Given that they exist and are likely to remain in place in LDCs for years to come (irrespective of donor policy), the problem is:

– How to retain their advantages while mitigating the accessibility problem that they pose to the poor?



## **B. Mitigating equity problems of user fees**



# Pricing and equity

- Equity in health:
  - Access to health services in accordance with need;
  - Financing in accordance with ability to pay.



# Basic principles for adoption of efficient, pro-poor user fees

- **Better pricing**
  - Public goods, goods with large externalities, and some essential preventive services should be provided at no direct charge to consumers.
  - Where fees exist, there should be sliding fee scales (fees in proportion to ability to pay) for out-of-pocket payments; also, subsidized coverage of catastrophic health events for the poor should be available.
- **Better management**
  - Administrative cost of user fees should be well below fee revenue.
  - Imposition of fees and quality improvements to occur simultaneously.
  - Fee revenue to be retained locally.



# Pricing principles more formally:

- Governments should use public subsidies for three main purposes:

→ – Subsidize access to medical care for the poor;

– Correct for market failures by financing cost-effective public goods and goods with large externalities;

→ – Correct incomplete markets (a market failure) for health insurance.



# Pricing implications (user fee policy)

1. Low or no fees for “basic” curative services for the poor.
2. Public financing of pure public goods (for all).
3. Low or no fees for goods with large externalities (for poor and near poor)
4. Low or fully subsidized health insurance premium for the poor and near poor.



# Exemptions and waivers

- The problem and the main issue examined here is:
  - How to maximize the equity impact of public subsidies?
  - Or, with existing subsidies, how to maximize the amount of subsidies that reach the poor?
  - Need to “waive” or “exempt” the poor.



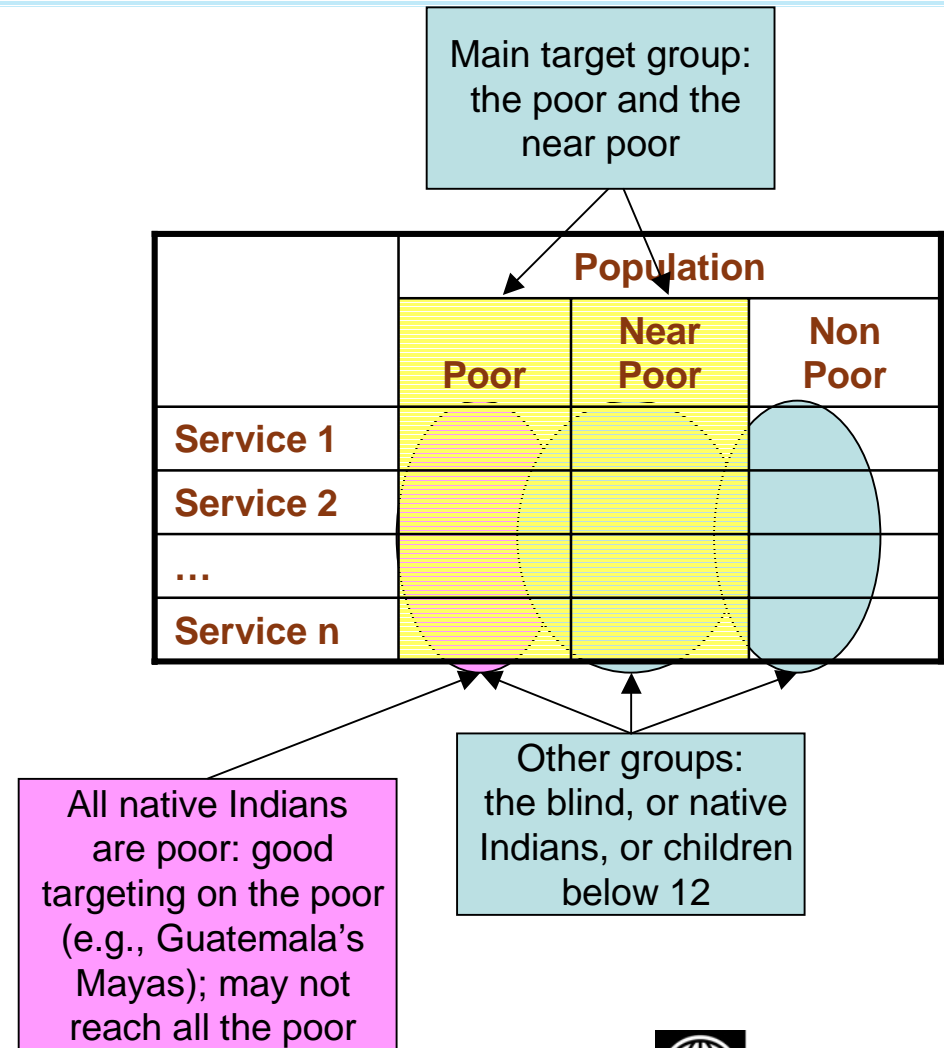
## C. Waivers and exemptions



# Definition: Waivers

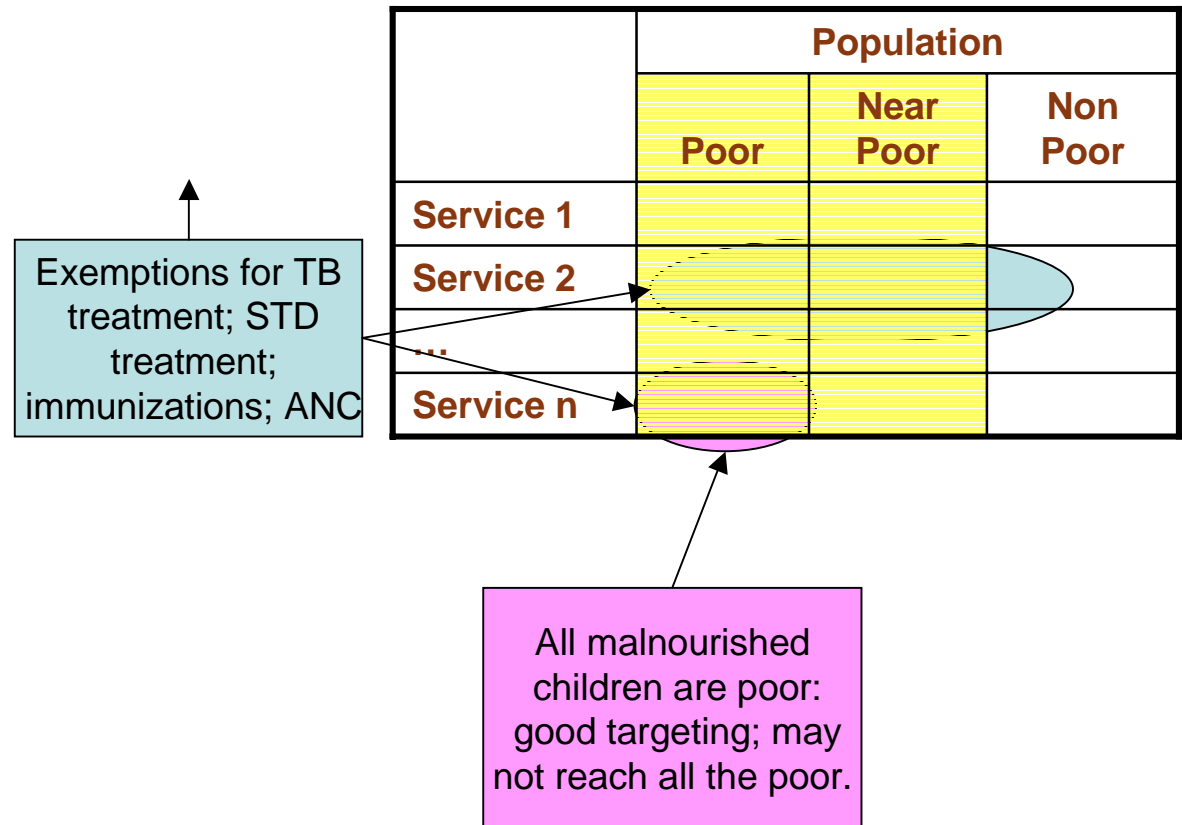
- **Waivers**

- Distribution of rights to the poor or other “target groups” so that they can obtain selected services at reduced or zero prices
- Selection by columns



# Definition: Exemptions

- Exemptions
  - Some services are offered free of direct charge to all consumers
  - Selection by rows



# Exemptions: Kenya's example (1992)

<b>Waiver categories</b>	
Children	0-15 yrs
Prisoners	Yes
Civil servants	Yes
Unmarried children under age 22 (except for inpatient charges)	Yes
Patients from charitable/destitute homes	Yes
Unemployed (certified by their) District Officer	Yes
<b>Exemption categories</b>	
Tuberculosis (TB) patients	Yes
Leprosy patients	Yes
Family Planning	Yes
STD/AIDS	Yes
Internal MOH referrals	Yes
Antenatal and postnatal clinics	Yes

- Waivers and exemptions can coexist



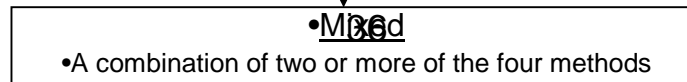
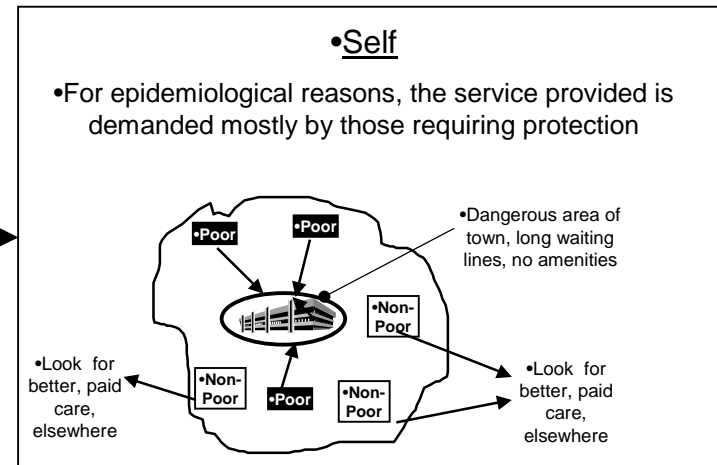
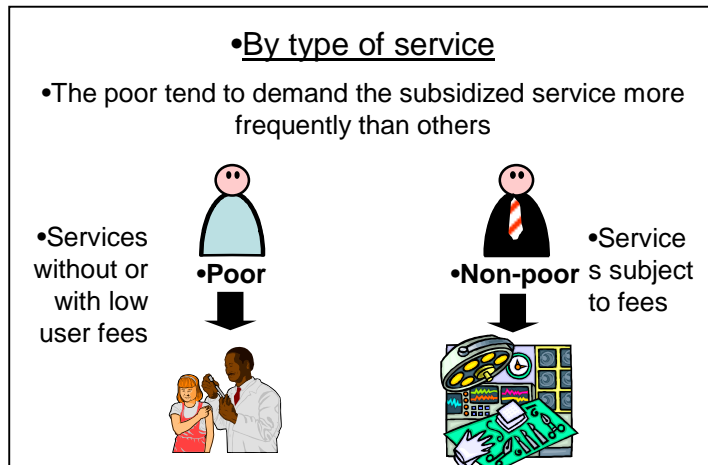
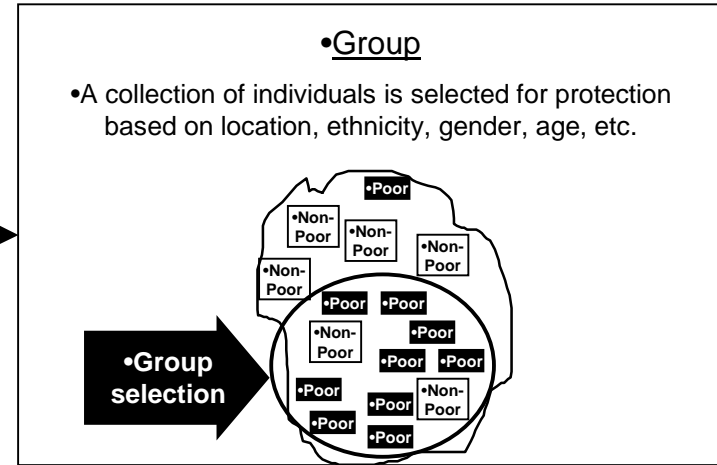
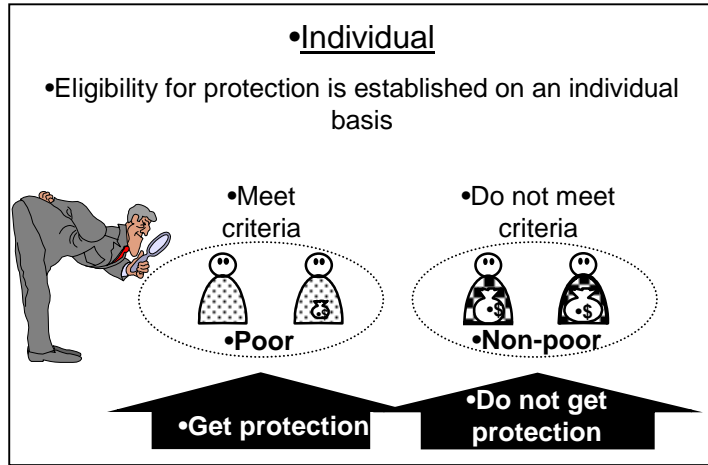
# How to reach the target groups?

- The literature recognizes 4 “targeting methods” (Targeting: *act by which public subsidies are directed toward target groups*):
  - Individual targeting
  - Group targeting
  - Targeting by type of service
  - Self-targeting



# Targeting methods: Which to choose?

-Methods



# Waivers and exemptions: Performance indicators

- Ultimate goal of waiver and exemption systems is to improve equity in access and financing.
- Thus, performance indicators should be based on improvements in:
  - equity in access
  - equity in financing

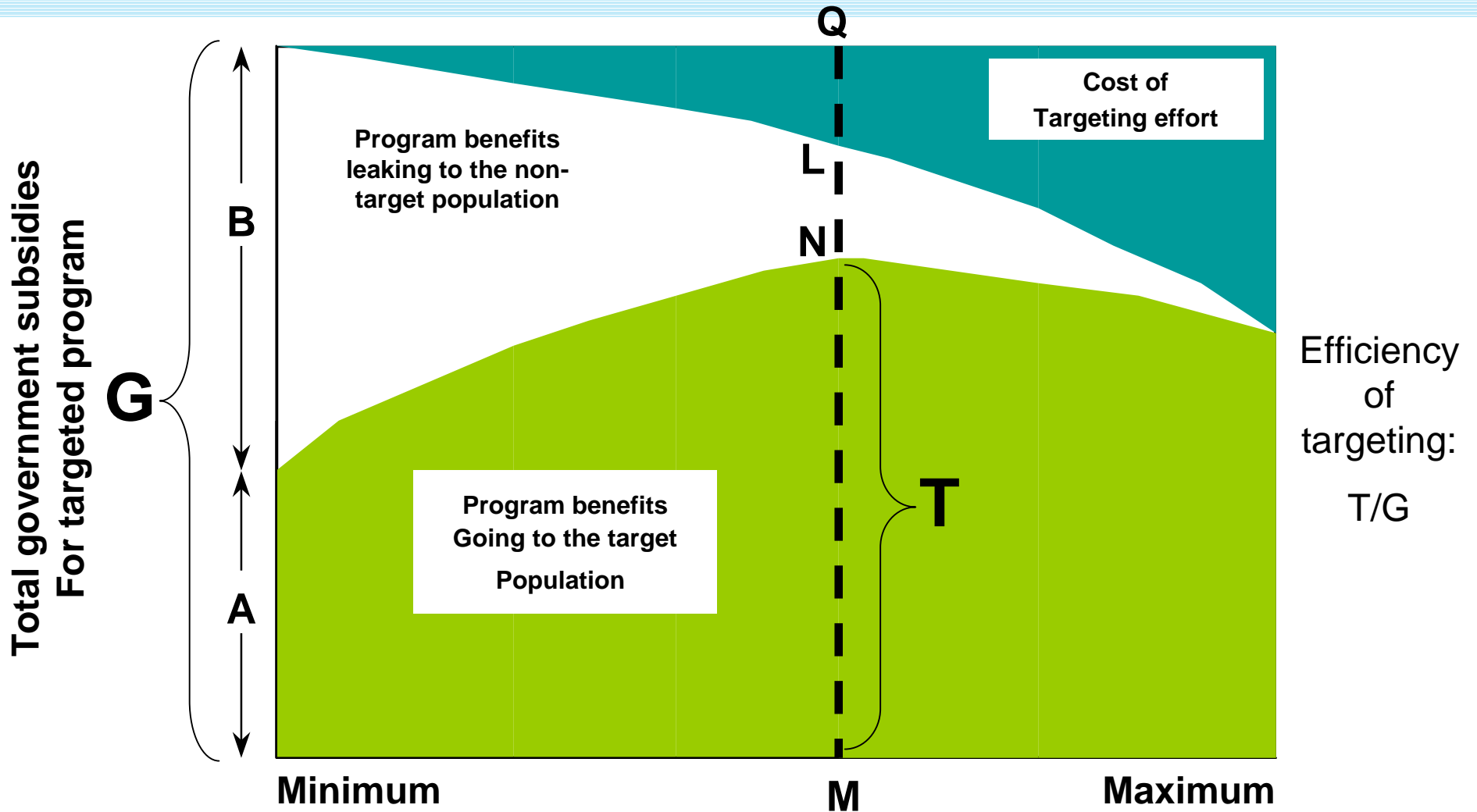


# Coverage and leakage: Errors in targeting

		Actual status	
		Poor	Non-poor
Classified As	Poor	Good targeting	Leakage Incorrectly given benefits
	Non -Poor	Under- coverage Incorrectly denied benefits	Denied benefits



# Accuracy-cost tradeoff



# Waivers and exemptions: Measures of success

- Coverage
- Leakage
- Changes in utilization/access
- Changes in effective financial protection
- Efficiency of targeting (cost of administering system of waivers and exemptions and incidence)



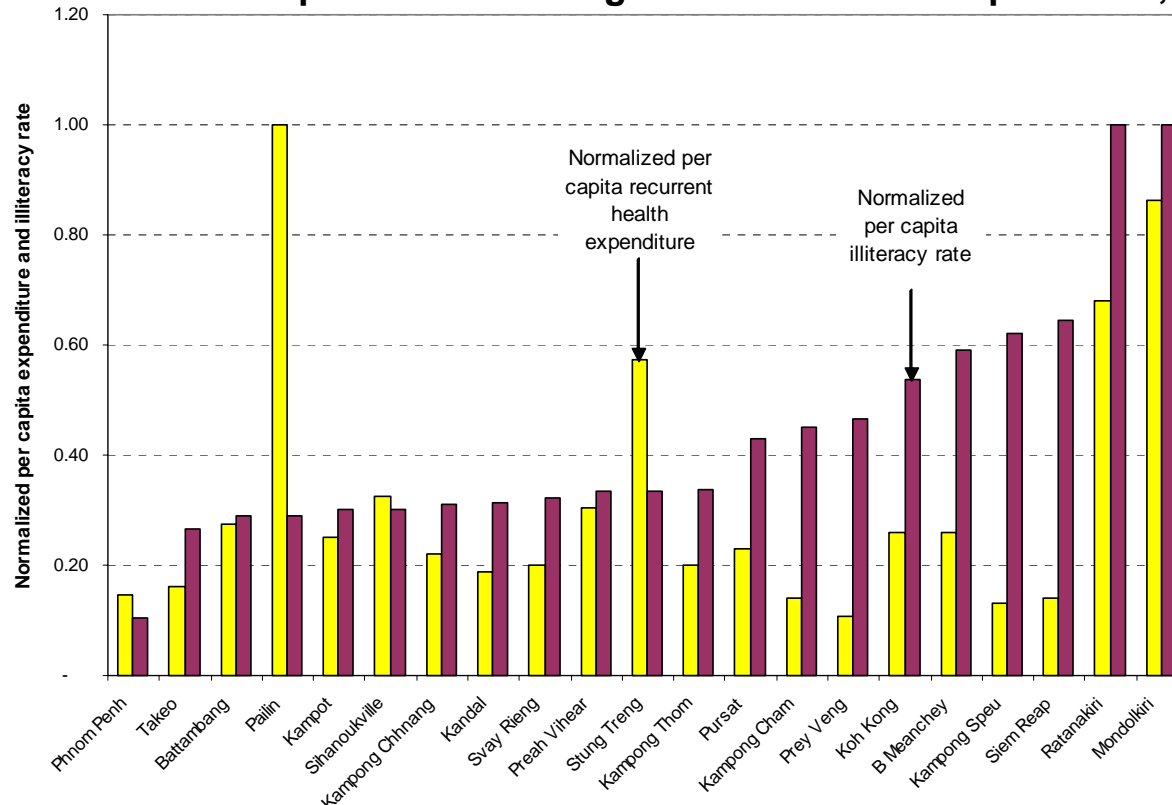
# How to improve equity through public subsidies?

- Through waivers and exemptions.
- Sufficient public subsidies must be available to finance waivers and exemptions.
  - Geographic reallocation of public subsidies is often required.



# Pro-poor reallocation of government budgets

Cambodia: Per capita allocation of government health expenditure, 1999



- Current allocation does not seem to be pro-poor.
- Should it be made more pro-poor?
- Can it be made more pro-poor?



# Major issues in waivers and exemptions

- Beneficiary identification
- Information dissemination
- Aligning of incentives
  - Do agents responsible for identifying those eligible for waivers/exemptions have an incentive to do their job?
  - Do providers have an incentive to honor system of waivers/exemptions (See case studies)
- Performance monitoring



# To follow

- Case studies
  - Thailand (Giedion)
  - Ghana (Nyonator)
  - Cambodia (participative, Bitran)
- Best practice
- Panel

