

# Mechanisms to Protect the Poor When User Fee Systems Are in Place

The Ghana Case Study

By

Dr Frank Nyonator

PPMED, GHS

# Presentation Layout

- User fee system
- Protection system
- Current Ways Forward

# Ghana at a Glance

- ➔ Gained independence 1957
  - Population (2000 census) – 18,412,529
  - Area (sq. Km) :- 238,833
  - Population density:- 77.1
  - Intercensal growth rate: 2.6%
  - Life expectancy (1998): 60yrs
  - Population below national poverty line: ? 30%
  - Sex ratio: male as % of female: - 96.1
  - GNP per capita(1999): 390 US\$
  - GDP(1999): 7.6billion US\$
    - *Source -World Development Indicators Database*

# Introduction

- ⇒ User fees and cost recovery have been associated with health care delivery in Ghana for many years
- ⇒ Colonial era
  - User charges and cost recovery for drugs – a major part of State Medical Officers' Annual Report!
- ⇒ Independence (1957)
  - Socialist ideology → removal of user fees
- ⇒ Decade of free services → decline in quality

# Attempts to reverse the trend...

- Hospitals Fees Decree 1969 (NLCD 360)
- Hospital Fees Decree 1969 (Amendments)
- Hospitals Fees Act , 1970 (Act 325)
- Hospitals Fees Act, 1971 (Act 387)
- Legislative Instruments
  - Hospitals Fees Regulations 1985: L.I. 1313

# Impetus for Review and Increase in User Fees

- ⇒ Period of economic decline during 1975-1983
  - By 1983 drop in Govt. spending on Health -  $\downarrow < 20\%$  pre 1975 levels
  - Reduction in recurrent budget led to significant reduction in capacity to procure drugs and consumables
  - Dramatic decline in utilization due to poor services
- ⇒ Led to calls for Review of health service delivery from mainly two quarters...

# Impetus for Review and Increase in User Fees (ctd)

- Economic Recovery Programme 1985 (Supported by the Bank)
- Three strategies for the health sector
  - Reduction in wage expenditure
  - Phasing out institutional feeding
  - Increase in revenue through enhanced user charges and full cost recovery for drugs
- Aimed for Govt. to recover 15% ?? of recurrent cost in health

# Impetus for Review and Increase in User Fees (ctd)

- Health professionals concerns (led by GMA)
  - Improving quality and discouraging frivolous use, pilferage and expenditure control
  - Raise extra money into the health sector at the time of financial crisis

# User Fees Legislation -1985

- Official fee levels and exemption categories were established in 1985 (LI. 1313)
  - It specified fees to be charged in various service provision categories
  - It also made provision for drug fees to be 'at cost' and thus to be revised in line with inflation
  - And defined entitlements to full or partial exemption from payment

## User Fees Legislation -1985

- ⇒ Paved way for a nation-wide fee-for-service system
- ⇒ Within the period, fees were raised from token levels to specific charges for services

# Objectives of Legislation?

- ⇒ Objectives of Regulation appear to have been
  - To ensure financial access to care for poor people and persons with communicable diseases
  - Encourage use of preventive services
  - And to provide a benefit to health workers

# Retention and Use of Fees

- ⇒ Initial 25% retention
- ⇒ 100% retention at facilities by 1989
- ⇒ To be used for improving quality...
  - Purchase of Drugs and Consumables
  - Repair of facility
  - Non-salary reimbursements

## Current User Fees Situation

- Whilst the legislation made provision for drug fees to be 'at cost' and thus to be revised in line with inflation, other official fees have not been adjusted since 1985.
- And so the following categories of user fees emerged .....

# Categories of User Fees

- ⇒ 'Cash-and-carry' programme for drugs
  - A revolving drug fund from LI.1313
- ⇒ Other nationally authorized charges
  - As defined in the national fee schedule (LI. 1313), 1985 which cover consultations and services
- ⇒ Locally authorized charges
  - Fees established by individual health facilities – legal but not grounded in the LI, rendering official fees non-operative!
- ⇒ Illegal or unauthorized charges
  - These are the charges levied by individual providers in public facilities

# A Study on Administration of User Fees System in Ghana

➔ Brief highlights

# Pricing Practices

Facility	1985 fee sch.	1996 fee sch.	% increase	1996 value of 1985 fees	% increase (decrease)
Reg. hospital	C75.00	C600.00	700	C1,258.00	-52
District Hospital	C50.00	C400.00	700	C839	-52

# Fee collection practices

- Multiple payment points
  - ◆ *' They collect bribe from us at the various points ...'*
- Deposit system
  - *... The demand for deposit is too much. Since the money is not there to pay the deposit, I will go out looking for herbs to use'*

# Receipting

– Receipting behaviour and accuracy

Tallies with reported amount spent	All payments
Yes	61.7%
No	38.3%

– ‘..If you pay C14,000, you are given receipt covering C8000 .....’doctor’s money’

# Advertisement of Fee Schedules at Fee Collection Points

- None
- Great deal of uncertainty about what a visit to a health facility is likely to cost

# Exemption Practices

- 5 out of 23 In-Charges of Health Facilities do not give any exemption at all
- In 1995, only 224 exemptions were granted out of 62,755 OPD visits

– ‘...because of poverty some will stay home and die’

# User fees and facility financing

- MOH hospitals on average
  - IGF constitute 82.8% revenue and 82.2% expenditure
- Missions
  - 100%

# Implications of User Fees for Facility Financing

- ➔ Fees are generating more revenues than Govt allocation.
  - Management capacity and systems for making effective use of fee revenues have greatly improved.
  - Revenue-raising through fee collections is dominating other concerns of facility managers and health workers, at the expense of the health and health care needs of the poor.

## Implications (ctd)

- In the face of declining real levels of budget allocations *and decreased supplies of essential consumables from the central medical stores*, facility managers have established their own pricing and fee collection systems.
- This has been allowed by the MOH, but the decentralized nature of fee setting and collection practices has made it very difficult for the ministry to monitor the effects of fees.

# Implications (ctd)

- Facility managers have been very active in setting and collecting fees and using the revenues to purchase essential inputs.
- The level of revenues being mobilized accounts for between two-thirds to four-fifths of the non-salary operating budget of government health facilities, and virtually all of the resources for non-salary operating expenses in mission hospitals.

Health Sector Revenue (Inflows) (1997-2000) (billions of cedis)

	1997	1998	1999	2000
<b>G O G (Budget)</b>	151.9	201.2	238.2	379.9
<b>Financial Credits</b>	101.6	76.9	27.8	31.7
<b>Revenue from user fees</b>	27.6	36.6	50.7	81.7
<b>Donors</b>	56.6	55.2	104.9	230.4
<b>Other</b>	0.4	2.0	6.9	35.6
<b>TOTAL REVENUE</b>	338.1	371.9	428.5	759.3
<b>Revenue as % of total inflow</b>	8.2	9.8	11.8	10.8
<b>Revenue as % of total domestic financing</b>	15.4	11.2	17.5	17.7

Total Spending on Health Sector (1997-2000) (billions of cedis)

	1997	1998	1999	2000
<b>G O G finance</b>	139.5	195.0	232.0	356.3
<b>Revenue from user fees</b>	27.7	33.0	45.0	72.2
<b>Donor finance</b>	56.7	55.3	87.0	183.7
<b>Financial credits</b>	101.6	77.0	27.8	31.7
<b>Total</b>	325.5	360.3	391.8	643.9
<b>Revenue as % of total spending</b>	8.5	9.2	11.5	11.2
<b>Revenue as % of total domestic spending</b>	16.6	14.4	16.2	16.8

# Mechanisms to Protect the Poor - Exemption Practices

Hospital Fees Act, 1971 (Act 387)

Hospital Fees Regulation, LI 1313

⇒ Made provisions for three broad categories of exemptions

- Exemption from ALL fees
- Exemption from all fees except the cost of prescribed drugs
- Exemption from all fees except the cost of hospital accommodation and catering services

# Exemption from ALL fees

- ⇒ Patients suffering from Leprosy and TB
- ⇒ Immunization against any disease (except international travels)
- ⇒ Storage of bodies at the request of any department of state

## Exemption From All Fees Except the Cost of Prescribed Drugs

- ⇒ Meningitis, cholera, malnutrition, typhoid, venereal diseases, rabies and
- ⇒ 18 other conditions usually referred to as diseases of public health importance

# Exemption From All Fees Except the Cost of Hospital Accommodation and Catering Services

- ⇒ Ante-natal and post natal services
- ⇒ Treatment at child welfare clinics

# Other considerations

- ⇒ Regulation did not make explicit provision for paupers and indigents.
- ⇒ Health workers exempted for all services rendered in a hospital (except for special amenities?)

# Performance of Exemptions Practices

- ⇒ Over the years, exemption facility (like managing the user fees) has undergone changes
- ⇒ Most, even though not backed by law, have been accepted within the health sector
- ⇒ The different interpretations of the provisions of the policy have also been modified by circulars and accepted norms

# Major Review

- ➔ January 1997 Presidential Sessional Address to Parliament made a major review...
  - Aged over 70 – free treatment for acute illness only
  - ANC Visits (4X) at Public Health Facilities up to District Hospital level only
  - To continue the free services of Under fives at the CWC's

# Concerns

## ⇒ Concerns of most managers

- To many health managers, this was simply an extension of L.I. 1313
- That this came out without any evaluation of how well the L.I. was being implemented
- That directive was given at a time when there was no budgetary provision

# Current Scope of Exemptions

- ⇒ Exemption for disease deemed to be of public health importance (in principle include all 24 conditions outlined in the LI. 1313)
- ⇒ Exemption for ANC
- ⇒ Exemption for children under five years
- ⇒ Exemption for the elderly (over 70yrs)
- ⇒ Exemptions for paupers and indigents
- ⇒ Exemptions for snake bites and bites by dogs suspected or confirmed to be rabid

# Implementation

- ➔ These services are expected to be provided by the health facility to all eligible patients and be reimbursed upon the presentation of a bill

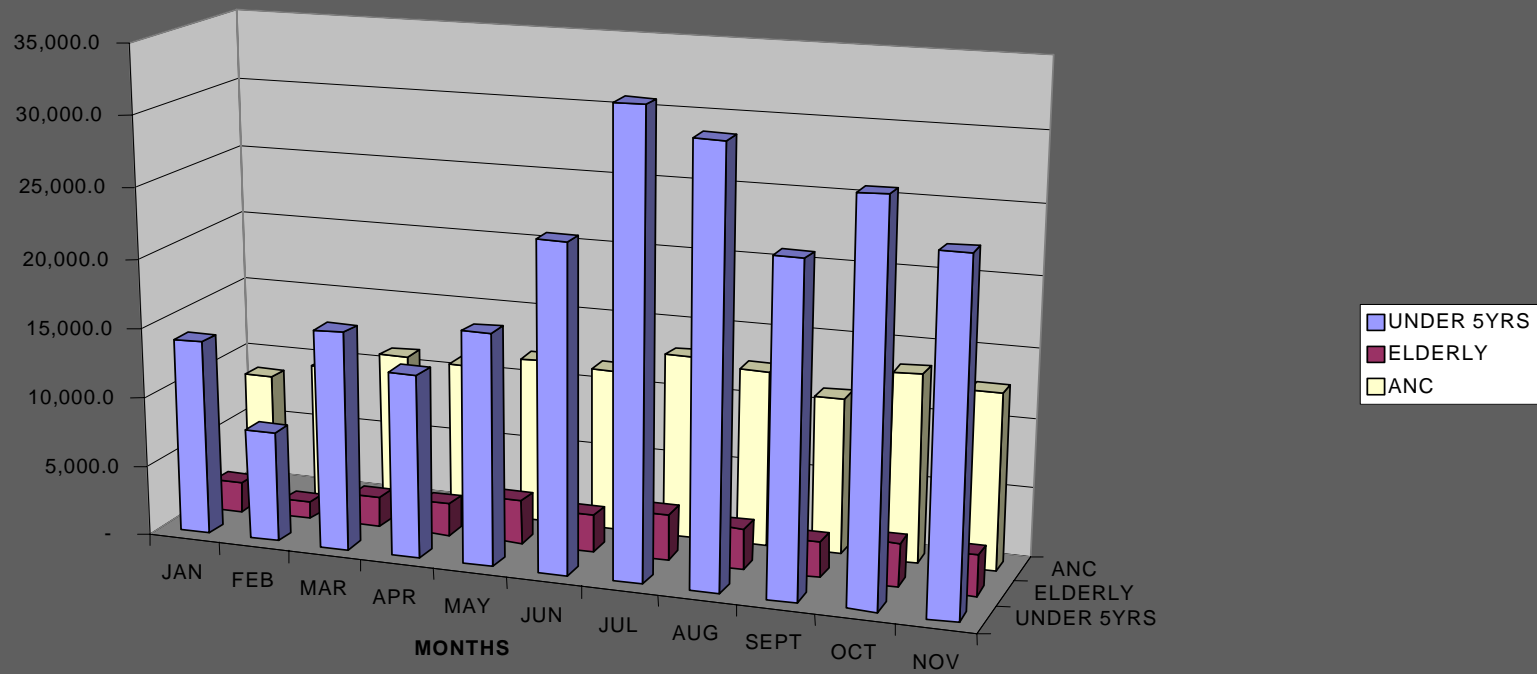
# Difficulties

- ➔ No clear interpretation of the provision of the policy
  - Regions gave own interpretation e.g. the three Northern Regions
- ➔ Modalities for reimbursement not clear
- ➔ Claims have outstripped the exemption budget

# Decentralised and Regional Variations

- ⇒ *Northern Region* exempted more services that the government circular specified
- ⇒ People under 5 years of age and over 60 years of age were entitled to free medical care and
- ⇒ pregnant women were entitled to free institutional delivery

## Utilization of Facilities by Exempted Groups in the Northern Region 2000



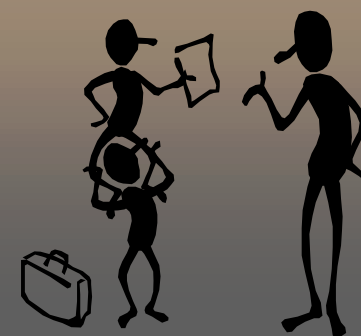
# Current State of Exemption Practices

- ➔ Recent Review of the implementation of the exemption policy found the following problems:
  - Guidelines were unclear and there were wide regional, district and facility variations in implementation.

# Current State of Exemption Practices(ctd)

- Exemptions for treatment of TB and other specific diseases were implemented consistently, but other groups (such as paupers and children under 5 years) were often expected to pay for drugs.

# Current State of Exemption Practices(ctd)



- Most health workers knew who was entitled to exemptions but there was little agreement about the services that should be provided free of charge.
- Many facilities had not established efficient procedures to put together claims for reimbursement of services for exempted patients.

# Current State of Exemption Practices(ctd)

- There were long delays in reimbursement and some most facilities' drug revolving funds were decapitalised
- Some institutions, especially the mission institutions, have opted out and imposing user charges on all patients

# Current State of Exemption Practices(ctd)

- It is clear that official exemptions are largely non-functional.
- With estimates that between 15 - 30 percent of the population lives in poverty, the failure of exemptions to function means that fees are preventing access for the poor, or are posing significant financial hardships on this part of the population.

# Way Forward

- ⇒ Some changes in the way the system operates are clearly needed
  - to simplify fee collection practices
  - promote access and income protection for the poor
  - and make the system more transparent to the population

## Way Forward (Ctd)

- ➔ There is a case to be made for increasing public funding of the health facilities, so long as this is done in a targeted way that promotes access and income protection for the poor
- ➔ The GPRS has outlined some strategies to address this

## Way Forward (ctd)

- While exemption mechanisms in Ghana could clearly function *less badly*, there is no reason to think that they could function *well*, especially if the requirement to grant exemptions is an 'unfunded mandate' placed on facility managers.
  - Exemptions according to the guidelines estimated to cost 44bn cedis/year, but Govt. allocated total of 10bn cedis in 1999 and in 2000

## Way Forward (ctd)

- New approaches are needed to promote active 'purchasing' of services on behalf of poorer persons.
  - Govt's pledge to abolish 'Cash and Carry' and establish 'zero-cost-at-the-point of need' system
- The possibility of establishing small scale risk pooling mechanisms are being explored, with the hope that government funds will be used to subsidize the participation of poor persons.

# Conclusion

- ⇒ Health facilities in Ghana have achieved a kind of 'sustainable inequity', with fees enabling service provision to continue, while concurrently preventing part of the population from using these services
- ⇒ With 30% of population below poverty levels - Need to design effective protective and waiver mechanisms for the poor is paramount
- ⇒ Or Else ...



➡ ....at 11.00am on a Monday Morning!!!!





Thank You