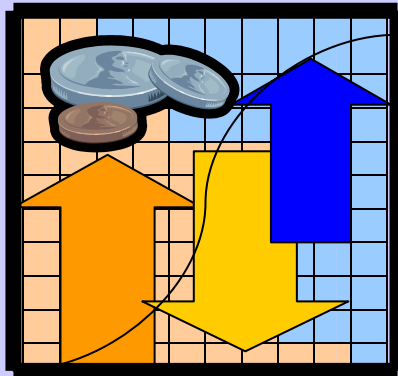




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Building on the user-fee experience:

The African case

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Building on the user-fee experience:

The African case

by

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**WORLD HEALTH ORGANIZATION
GENEVA
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Introduction

This paper reviews the implementation and impact of user fee in Africa in order to inform policy about what works, with respect to utilisation, and why, in terms of institutional requirements. The paper goes beyond the discussion in current literature on one issue or the other by bringing together the extremes - in debate and evidence - and outlines the conditions for next steps in countries that are now considering combining financial contributions with some form of protection and risk pooling through community insurance.

Much of debate on fees at policy level has focused on the efficiency and equity aspects of user charges. Proponents in favour of user charges suggest that fees could make the health system more efficient by guiding demand to cost-effective health care and at the appropriate level. Further, they argue that charges could also improve equity if revenues raised (or freed up) are reallocated to addressing the health needs of the poor¹. The opinion on the other side argues that effective reallocation is in fact administratively and institutionally difficult to implement and therefore, in practice, user charges price the poor out of the market with potentially dire consequences for their health status.²

Since its wide-spread introduction under the Bamako Initiative (BI) in the 1980s, the user fee experience in Africa has been reviewed extensively with respect to actual versus theoretical/planned outcomes.³ This paper starts with a brief contextual background of user charges in Africa. Given the specific goals of the BI, these focused on the demand response to charges, revenues from which were earmarked for improving drug availability as an instrument to promote utilisation of primary health centres (PHCs). Using a basic economic model for household demand for health care, the study then examines the determinants of utilisation response to fees. Under the BI, user fees were levied at the point of service delivery and borne entirely by the consumer, under various institutional setting. Finally, this paper attempts to ascertain policy lessons from the African experience on the necessary 'enabling environment' for a mechanism that could effectively combine charges with financial protection and risk pooling, especially for the poor.

Previous reviews⁴ indicate that predicted levels of resource mobilisation were not realised and that, in fact, revenues raised from implementing user fees fell well short of estimates, being on average about 7% of non-salary costs rather than the anticipated 15%⁵. This has limited both the envisaged increase in utilisation, through an improvement in the availability of drugs, as well as reallocation of resources, through exemptions schemes to protect the poor. The reviews emphasize the importance of establishing an 'enabling environment', especially institutional capacity, as a key first step to ensuring the feasibility of a system of fees: policy directives for fee structures, revenue collection, retention and expenditures; exemption guidelines; and motivated staff with the capacity to enforce these rules with community participation. Exactly how these come together to make a fee-based financing mechanism work effectively is important for future schemes that attempt to move

¹ See for example Griffin, 1988.

² For a recent review see Ahin-Tenkorang, 2001.

³ See for example McPake, 1993; Creese and Kutzin, 1995; Nolan and Turbat, 1995; Gilson, 1997.

⁴ Prominent reviews include McPake, 1993; Creese and Kutzin, 1995; Nolan and Turbat, 1995; Gilson, 1997.

⁵ As predicted by the World Bank when advocating greater use of fees.

from user charges to a system of copayments/prepayments in an community insurance scheme.

User fees in Africa: The context

The wide-spread adoption of user charges as a financing mechanism started in the 1980s under the Bamako Initiative.⁶ The driving force behind BI was a lack of resources to improve a poorly functioning primary health care system. User fee was the policy choice to increase revenue and its use towards improving the availability of drugs the key to increasing utilisation of PHC. On the managerial/administrative aspect, the BI model emphasized that revenue be raised and controlled by the community through activities which were national in scope. Community participation in management was critical for ensuring that resources were used in ways that addressed the persistently poor quality of PHC (especially drug availability); that exemption policies to protect the poor were implemented effectively; and that there was accountability to the users of health care.

Almost all countries in Africa have some form of user charges, enforced through national polices, BI or pilot projects. As Table 2 (a,b,c) indicates, the stated objectives of a system of fees were almost uniformly to raise revenues to improve utilisation and quality of PHC, particularly the supply of drugs.⁷

Table 2 (a,b,c) also illustrates the different structure of fees and the arrangements for revenue sharing across countries. In keeping with the objective of improved availability of drugs, almost all countries introduced fees for drugs for both outpatient and inpatient care. However, other charges vary from registration, per visit, and treatment fees or some combination of these. While the expressed aim was to promote PHCs, only a third of the countries implement a system of fee waiver for referrals or fee variations between levels of care that would actually encourage the use of primary facilities. Also, the community focus is diluted too - only half the countries had policy that allowed at least a proportion of revenues raised to be retained at the facility level and fee sharing arrangements ranging from full retention at community/PHC level to 100 per cent remitted to the Ministry of Health. A related financing issue was 'budgetary protection' which safeguarded existing health budgets from dollar-for-dollar reduction against additional revenues raised through user charges. There is very little evidence on this – either on policy stance on the issue or if budgets were actually reduced once revenues were raised through the fee option – though some countries did secure budgets against such cuts.⁸

User fees in Africa: Evidence of impact on utilisation

Quantitative evidence

As an approach to understanding the basic economics of user charges within the context of the financing function and overall health systems goals, this sections discusses how household demand for health care is influenced by fees - if a goal of

⁶ The BI in fact built on previous 'successful' pilots along similar lines, notably, the Pikine Project in Senegal (1975). See Carrin, 1992.

⁷ Raising additional revenues for ensuring drug supplies was in fact a specific aim of the Bamako Initiative and some countries earmarked revenues raised for a drug revolving fund.

⁸ e.g. Kenya.

the health system is to improve health status then demand for care would be a relevant framework in which to discuss policy options to achieve it.

A simple expression of the determinants of consumer demand for care from a particular provider may be stated as:

$$\text{demand} = \text{function} (\text{price}_{\text{provider}}, \text{price}_{\text{alternative}}, \text{income}, \text{quality}, \text{other})$$

i.e. household demand for health care is a function of four main variables: the price of a particular provider; the price of alternatives; household income; and quality of care. These of these four main determinants is examined separately below. Other factors may also have some influence demand e.g. age, sex, severity of illness, but these have been left out of the current analysis as they cannot be influenced by policy directly.

Table 1 tabulates evidence on elasticities of demand.

Price provider

Introducing or raising fees for a service increases prices faced by households and, in terms of the relationship described above, an increase in price causes household to reduce demand or utilisation. This utilisation response may be quantified by the price elasticity of demand which measures the change in demand brought about by a unit change in price.

Evidence on price elasticities of demand indicates a wide range, from -0.10 to -0.79. The evidence on demand response by level of care is mixed: in Ghana, hospital care is more price elastic than lower levels of care - the measure for inpatient care is in fact greater than 1 in absolute value (-1.82) indicating that fees would cause a more than proportionate fall in utilisation of inpatient hospital care; evidence from Cote d'Ivoire on the other hand indicates a higher utilisation response to an increase in charges at health clinics vis-à-vis hospitals. Thus, while an increase in the cost of care results in a fall in utilisation, the magnitude of this impact varies between levels of care and between countries.

Significantly, studies on price elasticities by income group indicate that this measure can be substantially higher for the poor: -1.44 versus -1.12 in Burkina Faso. Evidence from the Cote d'Ivoire suggests this disparity holds between levels of care as well - both groups have higher elasticities for health clinics versus hospital services but, for each level of care, elasticities for the poor are higher than for the rich. Also, in a simulation exercise for rural Cote d'Ivoire, it was found that user fees seemed to have a greater negative effect on the utilisation of children than that of adults. This finding highlights the importance of including strategies to safeguard the utilisation of the poor and other vulnerable groups.

Price alternative

The discussion above refers to 'own' price elasticity of a particular provider but how a fee increase by one provider impacts *net* utilisation will depend on the relative price and price response of alternative providers as well. If households have various health care options to choose from, a price increase by one provider may simply redistribute consumers across providers in which case there may be little impact on net utilisation of services. This concept is measured by the cross price elasticity of demand - the change in demand for alternative provider services when the price of the initial provider changes.

There is very little information on *net* impact on utilisation via an change in user fee. While not calculating cross-price elasticities between specific providers but, rather, substitution between groups of providers, a study in rural Cote d'Ivoire found that households faced with an increase in the price of one provider would more likely turn to other providers than to opt for self-care. For Kenya, measures of price elasticity are available separately for different types of providers with mission and private providers have elasticities much higher than an absolute value of 1, being -1.57 and -1.94 respectively as compared with -0.10 for government providers. Clearly then establishing the 'switch' between providers is crucial to estimating the *net* utilisation response of an increase in public sector fees.

Income

There are no studies explicitly on income effect on demand. Households consume a variety of commodities, one of the being health care, and distribute their income over all of these expenditures. Should income increase, households would spend more on each expenditure item, including health care. Thus, theoretically, income elasticity would be positive for all income groups, though the size of the increase may of course differ across groups depending on the current health status (perceived and actual) and cost of chosen care.

Quality

The final determinant of household demand for health care examined here is quality. Improvement in the quality of services is predicted to increase utilisation as better quality adds additional value to the commodity - the quality elasticity of demand is positive. Thus, should higher fees be accompanied by quality improvements in health services, the negative utilisation response may actually be dampened or even outweighed by the positive impact of quality. i.e. the quality elasticity of demand and price elasticity of demand work in opposite directions and the quality effect may cancel out (all or part of) the price effect on utilisation. However, quality has proved difficult to define and quantify. A comprehensive measure would capture both structural attributes (e.g. drug availability) as well as process indicators (e.g. quality of interaction between providers and patients)⁹ but due to problems of definition and measurement, most studies use drug availability as a proxy for overall quality.

As discussed above, quality is in fact difficult to define and measure and hence there is limited evidence on its impact on utilisation based on a comprehensive measure. Four studies for Africa have modelled quality along with the other determinants of demand using different definitions and hence capturing quality with varying degrees of completeness. The most cited work is a comprehensive 'before and after' study with controls in Cameroon¹⁰. This study found that the probability of using the health centre increased significantly after the introduction of fees and (use of revenue in improving drug availability) - travel time and costs involved in seeking alternative sources of care were high and with the added value of better availability of drugs at PHCs, the relative price of public provision actually fell. Further, this impact was found to be most true for the lowest quintile - care sought increased at a rate proportionately higher than in the rest of the population. Similar conclusions were drawn by a study in Niger¹¹ which also used drug availability as a proxy for quality -

⁹ Mariko, 2002.

¹⁰ Litvack and Bodart, 1993.

¹¹ Chawla and Elis, 2000

even using one of its component quality has a positive impact on utilisation and may even outweigh the negative effect of a fee increase.

A study in Nigeria¹² used three structural quality variables based on facility surveys - expenditure per person in population served, proportion of times drugs were available and evaluation of physical condition of facility - and found that while the price effect on utilisation was important, it was relatively small and public providers could actually increase prices by 87% to private facility levels if they also matched their quality without an adverse impact on utilisation.

Finally, an econometric study highlighted the importance of accounting for both structural - e.g. drugs - as well as process attributes of quality - e.g. 'good' consultations. Its findings for Mali¹³ showed that both these attributes of quality impact utilisation and that omitting the process quality variables from the demand model produces a bias not only in the estimated coefficient of the price variable but also in the estimated coefficient of some structural attributes of quality.

Notes:

The studies used as evidence above also make two other relevant points:

1. The importance of including all associated cost of accessing care in total costs and these may be context specific - in Uganda for example there are significant 'unofficial costs' which must be taken into account while assessing the impact of increased costs.¹⁴

2. In modelling the impact of quality along with the other determinants of demand the study in Niger observed an increase in the probability of utilisation in districts with indirect payment schemes.

Summing up:

- *price provider*
 - an increase in fee causes utilisation to fall though the size of this response has a wide range across countries and between levels of care.
 - price elasticities of demand for health care higher for the poor emphasising the need for protection of lower income groups.
 - before setting levels of fee, is important to account for all costs, including travel and unofficial costs.

- *price alternative*
 - to estimate the *net* utilisation response of an increase in fee, the relative price of alternative providers needs to be taken into account. The net utilisation impact of user charges may in fact be lower than that predicted by looking at the fee-raising provider alone.

- *income*
 - the theoretical prediction is that higher incomes leads to higher consumption of health care by all income groups, though the size of the increase may vary.

¹² Akin et al, 1995

¹³ Mariko, 2002

¹⁴ McPake, 1993

- *quality*
 - in defining and quantifying quality both structural and process attributes need to be included
 - measuring quality accurately and completely remains a problem and most studies use drug availability as a proxy
 - quality improvements positively impact utilisation and this can outweigh the negative impact of an accompanying price increase, even among the poor.

Qualitative evidence

There is substantial literature, relatively more descriptive in nature, that suggests factors other than those modelled above may be very relevant to the outcome of a system of user charges - specifically, policy and institutional issues. These are further relevant to the current discussion as some of them were stated goals of the BI. Also, this exercise is usefully in identifying factors that could influence the functioning of alternative financing mechanisms that incorporate charges with protection and pooling, namely, copayments/prepayments in insurance schemes. Accordingly, the more descriptive data available is used to draw institutional patterns that emerge from outcomes of increased/decreased utilisation in response to user charges vis-à-vis strategies used to implement them - fee structures and related retention policies, exemption schemes and community participation. Given the importance of quality and in spite of difficulties in measurement, perceptions on quality improvement also included here. Particular country examples are used as illustrations on any additional observations.

Cases from 22 countries have been consolidated to provide as complete a picture possible on each country's fee experience. Tables 2 and 3 (a,b,c) distinguishes these by utilisation outcome and an almost even mix confirms the varied evidence on the strength of the price elasticities discussed above.

Negative utilisation response to user fees

Seven countries reported a fall in utilisation after the introduction of user charges. Only one of these showed an improvement in quality ratings. All but one had exemption policies in place to protect utilisation levels of the poor against the negative impact of user charges, supported by community/local participation in identifying beneficiaries.

The fee structure in these countries where utilisation fell relied on fees for drugs combined with variations of registration, per visit and treatment charges at outpatient facilities and offered waivers for referral and/or variations across levels. For inpatient care, the reliance was more on fees per day with some countries also implementing drug charges. Waivers/variations were less common for this type of care. The retention policy for this set of countries was mixed - some remitted 100% to the MoH while others retained substantial proportions at the facility/local level. Overall revenues raised were limited to less than 5% of recurrent costs in most cases.

Measures of price elasticities of demand for Ghana and Kenya presented earlier were quite low but both countries appear to record a clear fall in utilisation with an increase in user fees and it may be useful to examine the specifics of each country. One study

in Ghana¹⁵ found a 'sustainable inequity' after the introduction of fees. Local staff were active in setting, collecting and using fees to purchase essential inputs and flexibility in expenditure of revenue raised was in fact identified by local medical administrators as crucial for better health service delivery - 2/3 to 4/5 of non-salary operating costs were recovered in the region investigated and for those able to pay for care, quality had improved. However, on the other hand, such a decentralised fee setting and collection practices was difficult to monitor. Official exemptions were largely non-functional, leaving the poor out of the public health care system - less than 1 in 1000 surveyed was granted exemption when as estimated 15-30% lived in poverty¹⁶.

Kenya¹⁷ introduced phased (top-down) out-patient treatment fee after an initial period of registration fee abandoned due to implementation problems - patient dissatisfaction with quality in spite of higher prices; procedures for waiver were poorly understood; overall revenue collection was low due to unclear claim procedures for those insured and, for cash collections, managers could not/did not control or monitor what was being waived, exempted or collected: overall, the system suffered from poor information - on part of both consumers and providers. Registration fees had caused utilisation to fall by about 1/3 or more at all levels, being particularly high at the district level (where alternative care was limited). The subsequent treatment fee caused a smaller decrease (6%) - the difference from the previous regime being a fee for tangible services; broader exemptions; and general high prices comparatively high prices for all commodities and hence wider acceptance of fees. Also, the establishing of community pharmacies eased the financial burden of drug payments.

Positive response to user fees

Utilisation increased after the introduction of fees in eight countries. Seven of these had marked improvements in availability of drugs. Only half had exemption policies, all with community/local participation.

The main type of fee imposed was for drugs in these countries combined with charges for treatment in some countries - for both out- and in- patient care. Some, though lesser, reliance was placed on registration charges and only one country had an explicit policy of waivers/variation of fees. Evidence available for six countries on retention indicates the bulk of revenues raised were retained at facility level (at least 75%). Revenue collection figures are available for only three countries, in all cases substantial proportions - upto 100% of recurrent costs were recovered.

There are some relevant country illustration here as well. In Cameroon¹⁸ there was considerable success with provincial health funds, built on fees for drugs (and services) and managed by the community. By its third year they raised over 60% of recurrent non-salary costs of public health services and were projected to cover the entire cost by the end of the fourth year. In Mauritania¹⁹ the introduction of cost recovery at the first level of care resulted in improvements in both structural and process aspect of quality - drug availability improved and so did staff motivation as indicated by an increase in preventive activities. However, given the success of pilot

¹⁵ Agyepong, 1999

¹⁶ Nyongator, 1999

¹⁷ Collin, 1996; McPake, 1993; Mgubua, 1995; Mwabu, 1995

¹⁸ Sauberborn, 1995

¹⁹ Audibert, 2000

programmes of user fees, there was a move to substitute the regular health budget with these additional collections and reduce government contributions to the sector.

Mixed utilisation response to user fees

Seven countries reported mixed utilisation responses to user and utilisation in two settled at previous levels after an initial increase/fall. All reported some improvement in the availability of drugs. Four countries protected the poor with explicit exemption policies with participation from the community/local staff in identifying beneficiaries. The exemption and better revenue observations included the two countries that maintained utilisation levels.

The fee structure in these countries varied between the options of registration, per visit and treatment charges with the main focus on fees for drugs in both out- and inpatient facilities and mixed policies on waivers/exceptions. Most countries had a retention policy that allowed revenues raised to be retained at the facility/local level. Of the two countries that experienced an initial decrease/increase in utilisation before previous levels were maintained, one implemented per day charges for in-patient care, else the reliance was on payment for drugs and registration (or per episode)/treatment fees. Also, both countries had provisions for revenue retention at the facility levels or expenditures were earmarked for drugs. Revenue collections were mixed as well, three countries recovered substantial proportions of recurrent but the rest were limited to less than 15%.

One of the few studies that examines the health outcome of user fees reports on the impact of charging for insecticide for treatments of nets in Gambia.²⁰ It found that the overall mortality and prevalence of malaria in children increase with an increase in cost of impregnation.

A comparative survey of NGO and public facilities in Uganda²¹ found that the latter where able to raise up to 40% of recurrent costs from user fee while collection in the latter amounted to at most 7%. The recovery system in public facilities was not standardised, both with respect to collection as well as expenditures of revenues raised and therefore difficult to implement. Notably, also, staff at NGO facilities where better trained and better paid (further, some received in-kind rewards for performance) which, combined with better availability of drugs at NGO facilities, meant higher utilisation of these services particularly at lower levels of care (at higher levels of care public hospitals were favoured). Uganda has in fact the most reported informal charges in the health system and a recent study found that informal activities act as incentives, impacting both quality and utilisation of public health workers - informal charges are associated with better performance regarding hours worked and utilisation rates; drug leakage was associated with poor performance with respect to both these²².

A large study in Zambia²³ for a 5 year period found a dramatic decrease of 1/3 in general attendance for both hospitals and PHCs over a two-year period followed by continued though slower decrease. Results also showed an increase and shift to health centres of specific care - vaccinations, general admissions and deliveries - though the

²⁰ Chaun, 1999

²¹ Okello, 1998

²² McPake, 1999

²³ Blas 2001

intended overall shift in outpatient care from hospitals to PHCs did not come about. However, a study of referral pattern in Lusaka found that national referral hospitals may indeed be functioning as PHC but as additional *not* substitute facilities. Also, any by-passing lower levels of care has more to do with drug availability than a perception of better overall (technical) quality of care. Importantly, there remains substantial unmet need for health care and equipping health centres to meet this was more urgent than an attempt to decongest hospital outpatients through price (dis)incentives²⁴. The importance of improving PHCs is emphasized by another finding that indicates that inequalities in access costs, especially between rural and urban areas - what seems to contribute to inequality in the cost of access is not the user fee per se but the travel cost and cost of time spent in reaching the health facility²⁵.

Summing up

- Health outcomes
 - may be negatively impacted by an increase in user charges
- The context
 - influences consumer response to user charges: if some form of fee already existed, if the increase in price of health care was in line with prices of other commodities or if fees (and quality changes) meant a relative fall in the price of public services vis a vis accessing alternatives.
- Revenues raised
 - at best a modest portion of recurrent (non-salary) costs
 - this proportion is highest when fees are aimed at specific cost items e.g. drugs.
- Quality
 - important determinant of demand for care, which may, even without other factors maintain or even increase utilisation when user fees are introduced.
- Fee structure and related policies
 - the structure of fees needs to be such that incorporates a clear link between charges and how it benefits the consumer i.e. payment for drugs or treatment rather than fees per day/per visit.
 - revenue retention, at each level of care as well as within the health sector itself, may provide an important incentive to facility staff for both collection as well as appropriate use to improve quality.
 - reducing the health budget in response to additional revenues raised through user fees recreates financial stress on the system.
 - incentives to consumers in form of waivers/variation in fees according to levels have limited value where 'inappropriate use' is not an issue.
 - on the provision side, a structure of fees that specifies its purpose, e.g. charges for drugs gives the necessary instructions for spending revenues raised, else, it is important that the policy spell out expenditure rules for facility staff.
- Exemption
 - exemption policies need to include guidelines to identify beneficiaries that are simple to implement by the community and/or facility staff.
- Community financing and management of resources
 - may have some potential for positively impacting systems performance.

²⁴ Atkinson, 1999

²⁵ Hjortsberg, 2002

IV. Conclusion

This paper reviewed the implementation and impact of user fee in Africa in order to inform policy about what works, with respect to utilisation, and why, in terms of institutional requirements. By identifying the determinants of household demand for health care that underpin utilisation response to charges as well as the prerequisite institutional capacity necessary to successfully implement a system of fees, the paper brought together the set of conditions necessary to create the enabling environment for the next step for these countries - community financing mechanisms that combine contributions with financial protection and risk pooling.

In keeping with the predictions of the analytical framework used, household demand for health care fell with an increase in charges though this measure was very varied in size across countries as well as between levels of care. However, the poor were clearly more vulnerable to a price increase than the relatively better-off though improvements in quality accompanying a fees seemed to reverse this trend, even for lower income groups.

Using a basic economic framework for household demand for health care, the study found that the evidence on the utilisation response to fees is mixed across countries with some countries experiences large falls in demand while the change in others has been more modest. Also, the experience between levels of care has been similarly varied - in some cases lower levels of care were more effected in terms of a utilisation response to fee increases while in others, the impact on demand for hospital care was greater. There is little information on the response of alternative providers to draw any conclusions about the *net* utilisation impact of a price increase by public providers. However, two clear conclusions may be drawn from the available evidence: first, that the poor are more susceptible to an increase in fees than the better off and second, quality improvements that accompany a price increase may balance out the drop in utilisation, even among the poor.

The study also used the more descriptive information to ascertain an enabling environment with respect to policy and institution issues for better implementation of fees. This literature indicates that overall revenue collection from user fees has been limited to a proportion of recurrent (non-salary) costs. It reiterates the importance of quality improvement in maintaining or increasing utilisation levels and suggests that both a clear link between increased contributions and better quality (e.g. drug availability) in the fee structure as well promoting staff motivation through revenue retention and expenditure at the facility level may contribute toward improving quality. While there is evidence to indicate that a negative utilisation response to fees may be reversed through quality improvements even among the poor, viable exemption polices need to be in place to ensure their protection. Also, community participation in administration/management and financing may have some potential for positively impacting systems performance.

Table1: Estimates of price elasticity of demand for health care

Country	Service type	Data type	Overall	Low income	High income	Source
Burkina Faso	Public provider	All ages	-0.79	-1.44	-0.12	Sauberborn et al (1994)
		Age 0-1	-3.64			
		Age 1-14	-1.73			
		Age 15+	-0.27			
Cote d'Ivoire	Health clinic			-0.61	-0.38	Gertler and van der Gaag (1990)
	Hospital outpatient			-0.47	-0.29	
Cote d'Ivoire	Health clinic		-0.37			Dow (1996)
	Hospital outpatient		-0.15			
Ethiopia			(-)0.5 - (-)0.50			Jimenez (1985)
Ghana	Hospital inpatient		-1.82			Lavy and Quigley (1993)
			-0.25			
			-0.34			
			-0.20			
			-0.22			
Kenya	Government provider		-0.10			Mwabu et al (1993)
	Mission provider		-1.57			
	Private provider		-1.94			
Sudan			-0.37			Jimenez (1986)
Swaziland			-0.32			Yoder (1989)

Table 2a: Objectives, structure and retention plans of user charge systems (Countries where utilisation fell)

	Country	Objectives	Fee Structure										Retention
			Outpatient					Inpatient					
			Registration	Per visit	Care	Drugs	Waiver/ Variation	Registration	Per day	Care	Drugs	Waiver/ Variation	
1	Burkina Faso	Improve PHC, ensure drug supplies			Yes	Yes				Yes	Yes	Yes	40% at hospitals
2	Ghana	Raise revenue, improve services, ensure drug supplies		Yes		Yes	Yes						Distributed between district, MoH and treasury
3	Kenya	Raise revenue to improve services, promote appropriate use			Yes	Yes	Yes		Yes			No	75% at facility and 25% at district
4	Lesotho	Raise revenue, promote appropriate use	Yes			Yes	Yes	Yes	Yes	Yes	Yes	No	100% to MoH
5	Mozambique	Raise revenue, improve services, ensure drug supplies	Yes			Yes	No		Yes		Yes	Yes	Not known
6	Swaziland	Equalize public and NGO fees		Yes					Yes			No	Revenue to MoH/Treasury
7	Zimbabwe	Raise revenue, strengthen position of MoH, improve equity		Yes		Yes	Yes		Yes	Yes	Yes	Yes	Full retention by nation hospital; all other revenue remitted to Treasury

Table 2b: Objectives, structure and retention plans of user charge systems (Countries where utilisation rose)

	Country	Objectives	Fee Structure										Retention	
			Outpatient					Inpatient						
			Registration	Per visit	Care	Drugs	Variation	Registration	Per day	Care	Drugs	Variation		
8	Benin	Improve PHC	Yes		Yes	Yes	Yes				Yes	Yes	Yes	75% at facility, 25%
9	Burundi	Not stated	Yes			Yes	Yes		Yes					100% in community
10	Cameroun	Improve PHC, ensure drug supplies			Yes	Yes					Yes	Yes		100% at health centres; 50% at hospitals
11	Guinea	Improve PHC, ensure drug supplies	Yes			Yes			Varies				100% at facility	
12	Mauritania	Improve PHC, ensure drug supplies				Yes						Yes		
13	Senegal	Improve PHC, ensure drug supplies			Yes				Yes					
14	Sierra Leone	Improve PHC, ensure drug supplies				Yes	No					Yes	No	Most goes to DRF, rest retained at facility
15	Togo	Ensure drug supplies				Yes					Yes	Yes		100% at facility

Table 2c: Objectives, structure and retention plans of user charge systems (Countries where the utilisation response was mixed)

	Country	Objectives	Fee Structure										Retention	
			Outpatient					Inpatient						
			Registration	Per visit	Care	Drugs	Variation	Registration	Per day	Care	Drugs	Variation		
16	Gambia	Ensure drug supplies	Yes			Yes	No			Yes		Yes	No	Earmarked at MoH or DRF
17	Guinea Bissau	Improve services, ensure drug supply		Yes		Yes	Yes				Yes	Yes	Yes	National goes to MoH; BI retained for community, facility and region
18	Mali	Improve PHC, ensure drug supplies			Yes	Yes	Yes				Yes	Yes		National policy
19	Nigeria	Improve PHC, ensure drug supplies	Varies				No	Varies				No	Varies from facility to state level	
20	Uganda	Improve community services	Varies				No	No official fee					Retained at community level	
21	Zaire	Improve PHC	Yes			Yes			Yes	Yes				100% at health zones
22	Zambia	Raise revenue, improve community services	Yes				No	No information					Full retention of project revenue at community level	

Table 3 (a): Countries where utilisation fell after introduction of user charges

	Country	Revenue raised	Quality	Exemption	Community/ local participation
1	Burkina Faso	Low proportion of facility costs	No improvement reported	No	
2	Ghana	5% of recurrent expenditure	Drug shortages persisted	Yes	Facility staff
3	Kenya	Upto 7% of recurrent costs at provincial hospitals; lower (1%) at PHC	Improved rating provincial hospitals	Yes	Both
4	Lesotho	Upto 9% of recurrent costs	No clear pattern	Yes	Both
5	Mozambique	Below target'	Not clear	Yes	
6	Swaziland	Less than 5% of recurrent cost	No obvious change in quality	Yes	Facility staff
7	Zimbabwe	Less than 5% of recurrent cost	No evidence	Yes	Facility staff

Table 3 (b): Countries where utilisation rose after introduction of user charges

	Country	Revenue raised	Quality	Exemption	Community/ Local participation
1	Benin	Upto 40% of costs in BI districts	Improved drug availability in PHC	Yes	Facility staff
2	Burundi	Not known	Improved drug availability in PHC	Yes	Community
3	Cameeron	Not known	Improved drug availability in PHC	No	
4	Guinea	Upto 100% of non-salary costs in some projects	Improved public perception	No	
5	Mauritania		Improved drug availability in PHC	Yes	Both
6	Senegal		No evidence	Yes	Facility staff
7	Sierra Leone	Varies, some district covering most of drugs cost	Improved drugs availability	No	Community
8	Togo	Not known	Improved drug availability in pilot PHC	No	

Table 3 (c): Countries with mixed utilisation response to introduction of user charges

	Country	Revenue raised	Quality	Exemption	Community/ local participation
1	Gambia	Upto 40% of drug costs	Drugs availability improved	Yes	Facility staff
2	Guinea Bissau	Minimal (less than 1% of recurrent); bit higher in BI pilots	Improvement in drugs supply in some facilities	No	Local management committee
3	Mali	100% of drug costs; 30% of other costs at pilot PHCs (less than 2% of recurrent MoH costs)	Improved drug availability	Yes	Health committee
4	Nigeria	Low	Improvement in drugs supply in	No	Community/facility staff
5	Uganda	Low	Improvements varied	No	Community
6	Zaire	Varies across zones - upto 80% of operating costs	Facilities improved	Yes	Community/facility staff
7	Zambia	Limited revenue nationally, community projects raising 10-15% of costs	Improvements varied in community projects	Yes	

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