Direct household payments for health services in Asia and the Pacific

IMPACTS AND POLICY OPTIONS

February 2012

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Direct household payments for health services in Asia and the Pacific: impacts and policy options: policy brief


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Many low- and middle-income countries from Asia and the Pacific rely heavily on user fees and other direct household payments to fund health services. However, empirical evidence has demonstrated that user fees in low- and middle-income countries have, in most cases, reduced access to care, particularly for the poor, and have rarely mobilized sizeable financial resources. Moreover, exemption mechanisms have rarely been effective.

A review of the literature points to some common policy recommendations:

• Abolishing user fees is a useful and politically palatable policy option but it needs to be implemented carefully with adequate alternative funding in place, and should not be seen as an endpoint.

• A more incremental approach, especially in countries where government budgets are particularly tight, could be to start by eliminating user fees for vulnerable population groups that are also easily identifiable and provide adequate subsidies to this group.

• A related but broader policy reform is to expand prepayment mechanisms through general government revenues and/or social health insurance. This requires strong political commitment, as it implies additional funding for health through the government budget and/or through subsidized health insurance premiums.

• Specific attention to the poor and vulnerable is important. Eliminating user fees for mothers and children, while replacing this with adequate budget subsidies, is an important example. Other approaches include the use of vouchers or conditional cash transfers.

• The suitability of adopting more targeted approaches depends on how feasible it is to identify the poorest and most needy households, plus institutional capacity to manage such schemes.
Millions of people in Asia and the Pacific, particularly the poor, still cannot use needed health services because they are unavailable or are too expensive. Millions more suffer financial ruin each year because they must pay for the health services they use at the time they receive them. At the same time, many health systems in low- and middle-income Asia Pacific countries face major government funding shortages which have led to a heavy reliance on user fees and other out-of-pocket payments for funding health services. This policy brief is intended to assist policymakers from the Asia Pacific region in understanding the impact of such funding mechanisms and provide viable policy recommendations based on existing evidence.

Health services can be paid directly by government, through statutory social health insurance funds (with contributions from members, employers and often government), by direct household payments, and from external donor resources. Most developing countries rely substantially on these direct payments from households, also commonly known as out-of-pocket payments.

User fees – a subset of out-of-pocket payments typically referred to as official fees charged by public health facilities – were introduced in government health facilities based on the economic rationales of improved efficiency and a more equitable allocation of public resources in the health sector. The experience with user fees, though, has not generally been a positive one. They have not typically mobilized sizeable additional financial resources. In terms of access to care, a number of literature reviews found that user fees have in most cases reduced utilization of health services, particularly for poorer population groups. The reviews also found that reducing or removing user fees increased the use of certain curative health services. Most of the literature has assessed experiences
in Africa, although there are a few notable studies on countries from Asia and the Pacific. For instance, user fees and other out-of-pocket payments were found to have adverse equity implications in China and Viet Nam, and exemption mechanisms were ineffective in Cambodia and Lao People’s Democratic Republic. More positive experiences were reported in Cambodia, where user fees replaced high unofficial payments, although the evidence here was still mixed. This policy brief includes a number of detailed case studies on the experience with user fees and other out-of-pocket payments from the Asia Pacific region, along with experiences in moving towards universal coverage in China and Thailand.

In recent years, some countries that had introduced user fees have subsequently abolished them. Uganda is the most frequently cited example, but a number of other countries have followed suit. Moreover, the positions of international organizations on user fees have evolved, with organizations such as the World Bank now recognizing that user fee abolition is a viable policy option if carefully implemented.

Nevertheless, many low- and middle-income countries in Asia continue to depend on out-of-pocket payments to finance health services. In 2008, the proportion of out-of-pocket payments as a share of total health expenditure was greater than 50% in Bangladesh, Cambodia, India, Lao People’s Democratic Republic, Myanmar, the Philippines and Viet Nam.

Having reviewed experience with user fees and other out-of-pocket payments, some common policy recommendations emerge. First, abolishing user fees is a useful and politically palatable policy option. But it needs to be implemented carefully with adequate alternative funding in place: abolishing user fees should not be seen as an endpoint. A more incremental approach, especially in countries where government budgets are particularly tight, could be to start by eliminating user fees for vulnerable population groups that are also easily identifiable, such as geographical targeting, or focusing on mothers and children.

Second, a related but broader policy reform is to expand prepayment mechanisms through general government revenues and/or social health insurance. That is, whilst user fee removal in government facilities can help improve access, it does not address access problems associated with other
out-of-pocket payments such as on pharmaceuticals in the private health sector. Expanded prepayment requires strong political commitment, as it implies additional funding for health through the government budget and/or through subsidized health insurance premiums; scaling up institutional capacity to manage these prepayment schemes is a real challenge.

Third, specific attention to the poor and vulnerable is important. Eliminating user fees for mothers and children (and replacing this with adequate budget subsidies) is an important example. Other approaches include the use of vouchers or conditional cash transfers. The suitability of adopting more targeted approaches depends on how feasible it is to identify the poorest and most needy households, plus institutional capacity to manage such schemes. In countries with social health insurance, offering subsidized health insurance premiums is a policy option that ensures a specific focus on the poor. As with exemption mechanisms, the challenge is in identification. A compromise between optimal targeting and administrative simplicity is to offer subsidized insurance to specific employment groups, such as farmers or all of the non-salaried sector.

In addition to targeting specific population groups, governments could focus budgets on those health services most used by the poor. Perhaps the most evident example is to invest in primary care.

Efficiency gains are also essential. Though a topic in itself, a couple of cross-cutting policies are worth highlighting. First, a more critical analysis of assessing which health interventions will be (most) subsidized by government is essential, with a need to focus on the most cost-effective interventions. Second, better regulation of both private and public health providers is needed. A key part of this regulation is in moving away from unregulated fee-for-service payment mechanisms. Alternative methods are based on paying providers fixed amounts per population served after adjusting for differences in health needs, with weighted capitation and case payment as the main approaches for cost containment and efficiency gains.

To conclude, the introduction of user fees has in most cases had an adverse impact on the utilization of health services, in particular for the poor. Moreover, fees have rarely raised substantial amounts of revenue. Therefore removing fees, particularly for vulnerable and easily identifiable
population groups such as mothers and children, is a policy option worth considering. Nevertheless, it would be wrong to conclude that abolishing user fees is a panacea. This is because other out-of-pocket payments can also be substantial, such as the purchase of medicines in private pharmacies or consultation fees in private hospitals. Solutions are therefore based on expanding prepayment mechanisms. This will require strong political will matched by sufficient government funds for health and institutional capacities in managing these prepayment schemes.
1 Introduction

Millions of people in Asia and the Pacific, particularly the poor, still cannot use needed health services because they are unavailable or are too expensive. Millions more suffer financial ruin each year because they must pay for the health services they use at the time they receive them. At the same time, many health systems in low- and middle-income Asia Pacific countries face major government funding shortages which have led to a heavy reliance on user fees and other out-of-pocket payments for funding health services. This policy brief is intended to assist policymakers from the Asia Pacific region in understanding the impact of such funding mechanisms and provide viable policy recommendations, based on existing evidence.

After describing the mechanisms by which health services can be financed and clarifying some key definitional issues, the main arguments for and against user fees are outlined in section 2. The evidence on the impact of user fees is then summarized in section 3, with studies from Asia and the Pacific highlighted. Note that this review of the evidence on user fees draws heavily from existing systematic and other reviews, rather than being a new systematic review in itself.

Section 4 moves the discussion from user fees to the broader problem of excessive out-of-pocket payments, and the associated consequences for households. Subsequently, section 5 examines the extent to which countries in Asia and the Pacific rely on user fees and other out-of-pocket payments to fund health services. This section also includes more detailed case studies of country experiences in the Asia Pacific region. Finally, section 6 discusses the main policy options for low- and middle-income countries in Asia and the Pacific to mitigate the adverse effects of excessive out-of-pocket payments.
Who pays for health services?

Health services can be paid directly by government, through statutory social health insurance funds (with contributions from members, employers and often government), by direct household payments, and from external donor resources. Most developing countries rely substantially on direct payments from households, also commonly called out-of-pocket payments. On average, out-of-pocket payments equated to 51% of total health expenditure in low-income countries in 2008, with a corresponding figure of 45% in lower-middle income countries (http://apps.who.int/nha/database/).

Definitions: user fees versus out-of-pocket payments

The term ‘out-of-pocket payments’ is generally understood as being a broader term than ‘user fees’. Out-of-pocket payments were recently defined in the World Health Report 2010 as comprising:

“charges or fees levied for consultations with health professionals, medical or investigative procedures, medicines and other supplies, and for laboratory tests... levied by government, nongovernmental organizations, faith-based and [other] private health facilities. They are sometimes officially sanctioned charges and sometimes unofficial or so-called ‘under-the-table’ payments.” (WHO 2010)

That is, out-of-pocket payments comprise all health expenditures made directly by households at the point of use, irrespective of the health service utilized or facility type visited. Such out-of-pocket payments include co-insurance, copayment and/or deductibles paid by the insured, as well as payments made by households not covered by insurance or other social health protection mechanisms.

In contrast, user fees have typically been understood to refer to official fees charged by public health facilities (IMF 2007; James et al 2006; Witter 2005; WHO 2010).

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1 The terms ‘direct payments’ and ‘out-of-pocket payments’ are used interchangeably in this policy brief.
2 Taken from the WHO National Health Accounts database: http://apps.who.int/nha/database/. 
2 User fees: rationale and historical context

User fees were introduced in government health facilities based on the economic rationales of improved efficiency and a more equitable allocation of public resources in the health sector.

More specifically, user fees were seen as having four main benefits, three of which relate more to efficiency and one more to equity. A first efficiency rationale was that user fees would generate additional revenue for the health sector, and thereby help improve the quality of health services. Second, fees would increase consumption efficiency by differential charging, in particular by charging patients more if they bypassed primary level health facilities and sought care directly at hospitals. A third efficiency argument was that fees would reduce frivolous demand for unneeded health services.

In terms of equity, the rationale for user fees was that they could actually improve the access of poor and vulnerable households to health services if appropriate exemption mechanisms were put in place. This is because of the implication that public resources would be better targeted at the most needy, with revenues generated from user fees used to cross-subsidize health services for vulnerable population groups.

Based on these expected benefits, the influential 1987 World Bank report recommended that governments in developing countries consider charging patients when they used government health facilities (Akin et al., 1987). The World Bank recommendations at the time coincided with reductions in domestic funding to health care due to squeezed budgets in many developing countries. As a result of these cuts in domestic funding, public health facilities in many low-income countries had (and continued to have) chronic problems of limited supply of medicines and other commodities, low productivity and retention of health care workers, and prevalent unofficial payments.
The Bamako Initiative, adopted by African health ministers in 1987 with subsequent support on implementation from UNICEF, also supported user fees. This was in the context of revolving drug funds either managed by communities or health facilities, with user fees seen as a mechanism to ensure the availability of essential drugs at peripheral levels.
The experience with user fees, though, has not generally been a positive one. That is, the expected benefits have often been smaller than anticipated and at the same time user fees have commonly impeded access to needed care. This section summarizes the available international evidence, highlighting examples from Asia Pacific countries.

**Equity and access to care**

In terms of access to care, a number of reviews found that user fees have in most cases reduced utilization of health services, particularly for poorer population groups (Hutton 2004; James et al 2006; Witter 2005). Moreover, exemption mechanisms have not generally been effective (Sepehri and Chernomas 2001). These studies did note though a few positive experiences, where quality improvements or the formalization of previously unofficial fees have meant the introduction of official fees have not decreased health service utilization.

A more recent systematic review – one which more critically assessed the quality of the evidence, and limited its review to the most methodologically sound studies – provides greater clarity on these findings (Lagarde and Palmer 2011). This review confirmed that when user fees were introduced or increased, the use of health services decreased significantly in most studies. Further, the review concluded that the two studies demonstrating increases in health service use following the introduction of fees (alongside reforms targeting quality improvements) had a high risk of bias. The review also found that reducing or removing user fees increased the use of certain curative health services.

Most of the literature has assessed experiences in Africa, although there are a few notable studies on countries from Asia and the Pacific. For
instance, in Viet Nam user fees and other out-of-pocket payments were found to have increased inequity in health care utilization (Dao et al 2008). Similar equity implications were hypothesized by studies on China (Hu et al 2008; Tang et al 2008). In Papua New Guinea, antenatal clinics on first visits declined by 30% soon after the introduction of user fees. However, the frequency of attendances increased and stabilized 12 months after fees had been introduced (Benjamin et al 2001). In Laos, whilst the 1995 user fee charge policy allowed for exemption of the poor, this did not work well as village leaders verified the poor on an ad hoc basis, with inadequate compensating funds provided by the government (Patcharanarumol et al 2009). Exemption mechanisms were also found to have limited effectiveness in China (Meng et al 2002). More positive experiences were reported in Cambodia, where user fees replaced high unofficial payments, although the evidence here was mixed (discussed in detail in section 5).

Efficiency debates

In terms of raising revenues, official user fees have not typically mobilized sizeable additional financial resources for health. For example, in fifteen Sub-Saharan African countries, experience indicated that official fees generated an average of about 5% of total recurrent health system expenditure, after excluding administrative costs (Gilson 1997). Nonetheless, these relatively small amounts may still represent relatively important sums of money at peripheral levels, especially when central level funds do not effectively permeate down to the lower levels.

There is inconclusive evidence that user fees have led to more or less efficient provision. In China, increased reliance on user fees were found to have improved productivity of public health institutions in terms of the quantity of services per health worker, but led to reduced take up of preventive services (Liu and Mills 2002). In contrast, emerging evidence on the abolition of user fees suggests unintended adverse consequences on the utilization of preventive services and service quality as health workers may become overwhelmed by increased demand and neglect preventative care (Lagarde and Palmer 2008, 2011).
In light of this experience, some countries that had introduced user fees have subsequently abolished user fees. Uganda is the most frequently cited example, but a number of other countries have since followed suit (Yates 2009).

Moreover, the positions of organizations such as the World Bank and UNICEF on user fees have since evolved. The World Bank 2007 Health, Nutrition and Population Strategy, following extensive consultation with country governments and other development partners, supports country-led efforts to minimize the negative consequences of user fees in public facilities (World Bank 2007). Indeed, the World Bank has affirmed its readiness to assist country-led efforts to eliminate user fees, provided that long-term fiscal sustainability and quality of health service issues are addressed, and that the poor benefit.

Similarly, UNICEF has committed to support governments willing to remove user fees for services targeting children and pregnant women (UNICEF 2009). Other development partners are now more ambivalent in their support or indeed more vocal in their opposition to user fees (see, for example, Pearson et al 2004; Save the Children UK 2005).

The World Health Organization recently highlighted the failings of user fees and other direct payments in financing health systems, and strongly advocates to move towards systems based on prepayment and pooling (WHO 2010). However, the WHO has also stressed that the focus of health financing policy reform should not solely rest on removing user fees, but examine the potentially adverse impacts of all out-of-pocket payments. This argument reflects in part findings from the World Health Surveys in 39 low- and middle-income countries. These surveys showed that, on average, only 45% of the total out-of-pocket costs of outpatient care were
for payments at government facilities, and in some countries was less than 15%. The remaining 55% represented payments made to private health facilities, and for medicines and tests bought in pharmacies and other ancillary facilities.

That is, user fees may well be an important financial barrier and cause financial strain for those accessing services, but they are only one part of the wider problem of excessive out-of-pocket payments. Indeed, studies have found a close association between the overall level of out-of-pocket payment and the extent to which households face financial catastrophe and impoverishment because of the costs of health services (Xu et al 2003; van Doorslaer et al 2006).
5 User fees and other out-of-pocket payments in the Asia Pacific region

Regional overview

Many low- and mid-income countries in Asia depend on out-of-pocket payment for health care. In 2008, the proportion of out-of-pocket payments as a share of total health expenditure was greater than 50% in Bangladesh, Cambodia, India, Lao People’s Democratic Republic, Myanmar, Singapore, the Philippines and Viet Nam.

As already noted, high levels of out-of-pocket payment are positively associated with financial catastrophe and impoverishment. Indeed, of the estimated 150 million households annually confronted with financial catastrophe because of the costs of health care, about 105 million are estimated to come from Asia (Xu et al 2007; James et al 2010).

Whilst prepayment schemes can substantially improve financial protection, they are not a guarantee. For example, 15% of those enrolled in the insurance scheme of the Self-Employed Women’s Association in India experienced severe out-of-pocket payments even after reimbursement for hospital admission (Ranson 2002). In China, the Rural Cooperative Medical Scheme covered only 30% of inpatient expenditures in 2007 (Yip et al 2008). In the Philippines, while over half of the population is covered by social health insurance, out-of-pocket payments still account for over 50% of total health expenditure. Appropriate design of the benefit package is therefore essential.

Country case studies

Differing country contexts determine the exact impact of user fees and other out-of-pocket payments. A selection of more detailed country case

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For Singapore, though, this figure includes substantial expenditure on medical savings accounts.
studies from Asia and the Pacific are provided below. Cambodia is an example of a low-income country in the region with high levels of out-of-pocket payments in public and private facilities, limited risk pooling mechanisms, and a large informal sector. China is an example of an emerging economy where there has been strong political commitment to extending prepayment schemes, but where out-of-pocket payments are high and are minimally regulated. Malaysia and Sri Lanka are examples of middle income countries that have been traditionally dominated by health systems that are publicly funded and delivered, but where better-off households are opting to use private services (Tangcharoensathien et al.
Finally, Fiji is an example of the limited application of user fees in the Pacific Islands, with services continuing to be largely financed by general government revenues.

**Cambodia: formalizing unofficial payments and fee exemption mechanisms**

In Cambodia, high unofficial payments for health care were replaced by a formal set of user fees in the late 1990s. This policy aimed to increase the predictability of medical costs for patients, and make fee exemptions more transparent. A national policy framework governed these fees, whereby 50% of revenues from fees were designated for hospital operations, 49% for the compensation of staff, and 1% were transferred to the Ministry of Finance.

Evidence on the impact on health care utilization has been mixed. For example, utilization was found to have increased by more than 50% for inpatient and surgical services in Takeo referral hospital after the implementation of formal user fees (Barber et al 2004). A crucial factor was a transparent exemption process, where fee exemptions were based on a socioeconomic survey that included several indicators of poverty. Further, in the National Maternal and Child Health Center, a tertiary level referral hospital, the number of deliveries, preventive services, bed occupancy rate and overall volume of outpatient services were all found to have significantly increased following the introduction of user fees (Akashi et al 2004). This was hypothesized to reflect a marked reduction in informal payments, as well as improved staff incentives and greater availability of drugs and other essential commodities.

More generally, planning and management of revenues generated from user fees were hypothesized to explain the relatively successful experiences of Takeo referral hospital and the National Maternal and Child Health Center. In both cases, user fee implementation was accompanied by an overall improvement of the resource management systems, including training of staff. At the same time, it should be noted that donor support contributed to the stable financial commitment of the government to these hospitals.
In contrast, in the district referral hospital of Kirivong, the total number of admissions fell in the first few months following the introduction of user fees, though thereafter returned to previous levels (Jacobs and Price 2004). However, the socioeconomic characteristics of the patients changed, with poorer households using the hospital less frequently than before, implying that the fee exemption system had failed. This reflected the fact that the hospital was responsible for identifying patients eligible for fee exemptions, as was the case in other facilities in the country. The financial incentive was to minimize exemptions as foregone fees meant reduced resources for staff compensation and hospital operations. User fees in this hospital also shifted some patients to the private sector, where private providers increased their fees, resulting in an increased financial burden on patients.

To address these problems with fee exemptions, health equity funds were initiated by the Ministry of Health, in collaboration with international donors, in 2001 (Bigdeli and Annear 2009, Hademan et al 2004). The funds were managed by third parties that were independent of hospitals; funds were also responsible for identifying poor patients eligible for fee exemptions. The health equity funds paid health providers for the foregone user fees. Health providers therefore no longer had an incentive to minimize the number of fee exemptions. Donors provided financial support to the programme for designing the health equity funds, as well as for payment of health services, and patient’s food and transportation costs. However, government has recently allocated some domestic funding to the initiative, realizing donor funding is not sustainable in the longer term.

**China: the challenges in regulating user fees**

Over the past sixty years, user fees have been an important source of financing for public health facilities, alongside revenues from selling medicines and government subsidies. Although there has been no change in financing policy for public hospitals in relation to user fees and medicine sales, the role of direct payments from households to fund hospital operations has become more dominant since the 1980s. This has mirrored the implementation of broader market-oriented economic reforms in the country.
Between 1949 and 1980, the prices of medical services charged to patients were set much lower than costs, with financial deficits of public hospitals balanced by government subsidies. Provincial governments set user fees with guidelines from the central government. To make the prices more affordable, the government further reduced prices charged to patients in 1958, 1960 and 1972 (Liu et al 1996). Fiscal pressure for governments to subsidize hospitals increased in line with increases in medical costs. During this time period, low user fees made most medical care services and drugs affordable. However, because the government did not provide adequate funding for the introduction of necessary technologies and the expansion of health infrastructures, there was a corresponding deterioration in the quality of care.

From the early 1980s, user fees became a more important funding instrument for public hospitals. The driving forces for this change included market-oriented economic reform with hospitals requested to rely more on user fees than government subsidies, drives for greater efficiency in the hospital sector, and increased demand for higher quality health care.

During this period, hospitals were offered increased financial autonomy in generating, retaining and using the revenues generated. This provided incentives for hospitals to generate income through user fees. Moreover, bonus systems for clinical departments or individual health workers also encouraged a greater reliance on user fees: the levels of bonus received by these departments or individuals were usually determined by the volume of services and amount of revenues generated from the provision of health services. At the same time, patients increasingly sought care from hospitals with qualified health professionals, the latest medical technologies, and offering branded drugs. These factors together escalated health expenditures and the reliance on user fees.

The government has periodically adjusted the level of user fees to try and find a balance between the actual costs of health services and the level of government subsidies in order for public hospitals to remain financially viable. Currently, about 4000 fee items are priced for charging patients. Provincial governments are responsible for developing the fee schedules on those fee items and as a consequence fee rates of the same items can be different between provinces. In addition, in some provinces, fee
rates of the same items are differentiated according to levels of hospitals, where higher level hospitals can charge higher prices than lower level hospitals for the same fee item. Criticisms on the fee setting procedure include the distortion of the relative values of medical services, incentives for overprovision of services and over-prescription of medicines because health providers are reimbursed on a fee-for-service payment system, and difficulties in regulating the actual fee rates charged to patients (Liu and Mills 2002; Zheng 2005). The fee structure has tended to under-value the costs of professional services, and over-value the costs of medical technologies. This has encouraged hospitals to purchase and utilize costly medical technologies when simple procedures would be equally effective.

Over the past three decades, the growth rate of out-of-pocket expenditures has generally been much higher than that of the government budget and social health insurance. In 1978, out-of-pocket payments accounted for about 20% of total health expenditure, but reached 59% by 2000. The proportion of out-of-pocket has declined somewhat in recent years, equaling an estimated 43.5% of total health expenditure in 2008. This decline reflects increased investment by government, particularly through social health insurance.

Indeed, one of the key aims in China’s current health system reforms is to reduce reliance on out-of-pocket payments through the expansion of health insurance coverage (see Box 1 for further details), and the removal of incentives for hospitals to provide unnecessary health services. Current health insurance coverage rates have reached more than 95% of the total population in China.

**Malaysia and Sri Lanka: free public sector provision but growing out-of-pocket expenditures**

Historically, Malaysia and Sri Lanka have both provided health services with zero or minimal charges at public health facilities for their entire population. Despite this policy, household out-of-pocket payments have been increasing in both countries. In Malaysia, they reached 41% of total health expenditure in 2008, with a corresponding figure of 48% for Sri Lanka in 2009.
In Malaysia, a perceived lack of responsiveness of public providers has been seen as a key driving factor for greater use of private health facilities (Yu et al 2006, 2008; Chee et al 2008). In Sri Lanka, the country’s National Health Accounts figures indicate that a little over 80% of household out-of-pocket payments were spent on ambulatory care, with only a small proportion spent out-of-pocket on inpatient admissions. This suggests that a significant number of people are paying for consultations, medicines and diagnostics in private outpatient facilities. However, it is not clear whether this result is largely driven by upper income groups bypassing free public services and/or reflects a wider spectrum of income groups choosing to use private health services.

High level of out-of-pocket payment in Sri Lanka is partly a result of low level of government spending in health. Between 1995 and 2008, general government health expenditure ranged from 5.5% to 8.5% of general government expenditure. In Malaysia, the corresponding share of general government expenditure was in the range of 5.3% to 8.6%. In both countries, there has been some discussion of mobilizing payroll tax contributions from formal sector employees.

Fiji: an example of the low reliance on user fees in the Pacific

Although user fees have been adopted in Fiji and some other Pacific Islands, they have played only a minor role in financing public facilities in Fiji and throughout the Pacific. Indeed, government expenditures continue to be the principal source of health care financing in all Pacific Islands, accounting for 75.3% (Fiji) to 99.8% (Tuvalu) of total health expenditure in 2008.

Nevertheless, user fees have become more widely practiced across the Pacific in recent years. The application of user fees has a long history in Fiji, starting from the Public Hospitals and Dispensaries Act 1955, although fees were not actually introduced until the 1960s (Roberts et al, 2011). The user fee system in Fiji has three characteristics. First, fees are only charged for a limited set of services. Minimal fees are charged for inpatient care,

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4 Note that government expenditures on health can include external as well as domestic funding sources.
some laboratory diagnoses, dental care, circumcisions, and quarantine services [Panda 2003]. Second, prices charged have been mainly set based on the operational costs in the 1940s. Until recently, those prices have not been adjusted, other than for some minor changes in the early 1980s. Therefore user fees are much lower than the full costs of these health services. Indeed, revenues generated from fees were equal to an average of only 0.83% of general government health expenditure for the period 2003 to 2008 [Roberts et al, 2011]. Finally, revenues received from fees are not retained by health providers, but instead contribute to the government’s general consolidated fund.

To reflect the real costs of services, a revision of the fees has been suggested for many years, and in 2010 the fee schedule was revised. But because affordability is seen as a critical policy issue by Fijian policymakers, these revisions have also been modest. In addition, a number of population groups have been exempted from user charges, including the military and police, as well as children aged under-fifteen years. Nevertheless, in Fiji out-of-pocket expenditures accounted for approximately 15% of total health expenditure in 2008, largely reflecting over-the-counter drug purchases and expenditures in private health facilities.
6 Policy recommendations

Having reviewed the experience with user fees and other out-of-pocket payments in a range of different country contexts, including examination of recent positions from development partners and the WHO World Health Report 2010, some common policy recommendations emerge. These are discussed below, with two additional boxed texts summarizing the experiences in moving towards universal coverage in China and Thailand.

First, **abolishing user fees** is a useful and politically palatable policy option. But it needs to be implemented carefully and should not be seen as an endpoint. That is, if user fees are to be abolished, they must be replaced by alternative funding sources to make up funding shortfalls. Evidence has shown that removing fees has typically increased health care utilization, particularly for curative services at the primary care level, but without careful implementation there can be unintended consequences such as reduced use of preventive services (Lagarde and Palmer 2011). Decisions to abolish user fees have often been sudden and in a highly politicized context (Ridde and Morestin 2010). But for the policy to be sustainable requires careful planning, particularly in terms of ensuring adequate alternative sources of funding.

Most fundamentally, user fees should only be removed if government has identified alternative funding sources to replace lost fee revenues and meet increased demand. Without such alternative funding, there is the risk of shortages of medicines and other essential commodities, and health workers being overwhelmed by demand, leading to reduced quality of care. Good communication with health providers as well as the general population is also a prerequisite to success, since health providers are the ultimate implementers of such a policy (Gilson and McIntyre 2005).

A more incremental approach could be also considered, especially in countries where government budgets are particularly tight. For example,
governments could start by eliminating user fees for vulnerable population groups that are also easily identifiable (for example, mothers and children, or for specific illnesses more prevalent amongst the poor). This has the advantage of focusing first on some of the most vulnerable groups, whilst at the same time avoiding the problems associated with more complex exemption criteria. Again, it is essential that sufficient funds are available from government budgets, insurance, and/or donors to pay for such a policy.

Second, a related but broader policy reform is to **expand prepayment mechanisms through general government revenues and/or social health insurance**. That is, whilst a policy of user fee removal in government health facilities can help improve access, it does not address access problems associated with other out-of-pocket payments. Expanded prepayment requires strong political commitment, as it implies additional funding for health through the government budget and/or through subsidized health insurance premiums (depending on the institutional nature of the country’s health financing system). Fiscal capacity is therefore a major policy issue.

Some countries provide full subsidies for the poor and partial subsidies for the informal sector, such as in China and Viet Nam. The Philippines, though providing subsidies for the poor, faces challenges to ensure sufficient financial commitment from government. Further, a lack of subsidies has made enrolment of the informal sector into their individual contributory scheme difficult (Tangcharoensathien et al 2011). Furthermore, voluntary community-based health insurance schemes can be a useful first step in extending prepayment. At the same time, it is important to recognize that such schemes have only limited ability to extend coverage and are likely to face financial viability issues without government investment, particularly because of adverse selection (WHO 2010).

Third, **specific attention to the poor and vulnerable** is important. Eliminating user fees for mothers and children (and replacing this with adequate budget subsidies) is an important example, particularly in view of commitments towards the Millennium Development Goals 4 and 5. Other approaches targeting the poor and vulnerable include the use of vouchers or conditional cash transfers. The suitability of adopting more targeted approaches depends on how feasible it is to identify the poorest and most
needy households, plus institutional capacity to manage such schemes. While previous experiences with exemption mechanisms for user fees offer a salutary lesson, more precise exemption mechanisms may be more feasible in countries with adequate and transparent identification systems already in place. Indeed, the experience with health equity funds in Cambodia, and more recently in Laos, show that more precise targeting is possible, though these funds have had high administrative costs and are heavily dependent on external donor resources.

In countries with social health insurance, offering subsidized health insurance is another policy option that ensures a specific focus on the poor. As with exemption mechanisms, the challenge is in identification. A
compromise between optimal targeting and administrative simplicity is to offer subsidized insurance to specific employment groups, such as farmers or all of the non-salaried sector.

In addition to targeting specific population groups, governments could focus budgets on those health services most used by the poorer segments of the population. Perhaps the most evident example is to invest in primary care. Indeed, this focus on primary care was a central policy in Thailand’s rapid movement to universal coverage of health services (see Box 2).

Finally, efficiency gains are also essential. Although a separate topic in itself, a couple of cross-cutting policies are worth highlighting here. These relate to the purchasing function of government. First, a more critical analysis of which health interventions should be (most) subsidized by
government is essential, with a need to focus on the most cost-effective interventions. Second, better regulation of both private and public health providers is needed. A key part of this regulation is in moving away from unregulated fee-for-service payment mechanisms, since fee-for-service systems create perverse incentives for health providers to increase the volume and intensity of care. Alternative payment methods are based on paying providers fixed amounts per population served after adjusting for differences in health needs, with weighted capitation and case payment as the main approaches (see Langenbrunner et al 2009 for an in-depth discussion). Indeed, Thailand successfully applied capitation and case-based payment for their universal coverage scheme since 2002.

To conclude, the introduction of user fees has in most cases had an adverse impact on the utilization of health services, in particular for the poor. Moreover, fees have rarely raised substantial amounts of revenue. Therefore, removing fees, particularly for vulnerable and easily identifiable population groups such as mothers and children, is a policy option worth considering. Nevertheless, it would be wrong to conclude that abolishing user fees is a panacea. This is because other out-of-pocket payments can also be substantial, such as the purchase of medicines in private pharmacies or consultation fees in private hospitals. Solutions should therefore be based on expanding prepayment mechanisms such that out-of-pocket payments are not so high to cause financial catastrophe or act as a barrier to seeking care. This will require strong political will matched by sufficient government funds for health.
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