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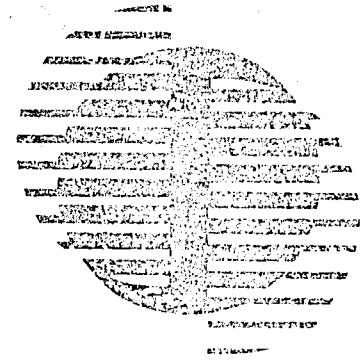
User Fees for Sustainable Family Planning Services

Background Discussion for the Handbook for Program Managers



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and
Technical Support

By Laurence M. Day
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Background

In developing countries all around the world, family planning (FP) programs are increasingly relying on user fee systems to recover public-sector health care costs. Many countries—particularly those which gained independence within the last 30 years—optimistically included universally free health services in their constitutions. Family planning services in particular have long been given a special focus and have been made widely available at little or no charge. However, in response to substantial economic problems and the persistent underfinancing of public health, most of these countries have recently revised their approach: they have begun charging fees for public health services provided. In fact, it has been estimated that about 17% of all family planning costs in developing countries are now covered by user fees.[1]

Even as user fee systems (UFSs) are becoming ever more widely adopted, there is continuing controversy about the effect of these fees on the utilization of FP services. Indeed, user fees have been discussed to such an extent over the past two decades that by now virtually every decision-maker or line manager in health services in developing countries is familiar with the terms and basic concepts involved. What is often lacking is a clarification of these concepts and systematic information on how to design and implement user fees in FP services. It is for these reasons that the SEATS project developed *Designing a Family Planning User Fee System: A Handbook for Program Managers.*

Whenever we consider implementing or expanding a user fee system (UFS) in a particular FP facility or program, there are two fundamental points that should be kept in mind:

- **The objective is to maximize access to and use of high quality FP services.**

  When introducing or updating UFSs, the objective is *not* cost recovery *per se* but rather higher quality services available to more people at prices they can afford.

- **Designing, implementing or updating a UFS need not be a complicated undertaking.**

  Simple systems can be used for setting prices, forecasting costs and revenues, monitoring utilization, managing revenues and determining the best use of those revenues. Moreover, program managers will find that a user fee system becomes a routine part of sound program management.

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If designed and implemented properly, a user fee system can increase the availability of FP and improve its quality, that is, make more services available to more people. Just as important, a system can help increase utilization as users come to value the improved quality and availability of products and services offered.

The Need for Family Planning User Fees

Unfortunately, the current levels of support available to family planning in developing countries are not sufficient to allow programs to expand—or even be sustained—in the long term. There is little doubt that without additional FP financial resources (from governments, donors, and users), it would be impossible to achieve sustainable increases in the use of FP services.

The population of the developing world, excluding China, now stands at over three billion. Of this population there are perhaps 480 million women of reproductive age. To achieve a desired level of population stability over the next two to three decades, contraceptive prevalence (CP) levels need to reach approximately 65%. This means that services have to reach roughly 312 million women a year, a number that increases with each passing year.[2] So far, among the world's 114 or so developing countries, only China and Thailand have succeeded in attaining this level of CP.

Funds Needed

It is possible to develop a rough estimate of the funds needed to achieve 65% CP in the developing world (excluding China). An illustrative one-year cost would be:

Cost of providing coverage for one woman for one year	=	US$20.00
Number of women to be reached with products and services	=	312 million
Total cost to achieve 65% coverage	=	US$6.24 billion

Estimates of current levels of spending range from US$2.2 billion to US$4.5 billion, with donor assistance accounting for US$560 million of this total.[3,4] For the year 2000, some annual cost estimates are as high as US$11.5 billion[5]—several billion dollars over the combined level of funding for FP services currently available from

international donors and governments in developing countries. Appendix 1 provides more detail on projections of costs of FP services.

Since governments' and donors' budgets are already stretched to the maximum, meeting these costs will require informed planning. This multibillion dollar shortfall will have to be met from some combination of donor support, developing country government budgets, and various forms of direct or indirect consumer payments. Additional funds from user fees, which, as was stated earlier, make up perhaps 10-17% of the current costs, will undoubtedly play a continued and increasing role in helping pay for service expansion and improvement.

Considered from another perspective, if 10% of the costs of an FP program can be recovered through user fees, the program can self-finance a 10% expansion of services. If 100% of the costs can be recovered—as occurs in a number of programs in countries around the world—then there are no financial limits to FP service expansion. While these illustrations are simplified, they show how important user fees are to the future of FP programs. As will be seen in the discussion below, our user fee approach is to always balance the importance of applying solid management techniques with the need for expanding the delivery of high-quality services.

Commodity Sustainability

There is yet another issue, commodity sustainability, that makes the financing of FP a more immediate concern. More and more, donors are including provisions in their aid packages for commodity self-sufficiency. In some countries donors require recipients to lay out a schedule for phasing out donations of commodities. Excerpts from a recent document reviewing donor policy in one African country show how important the ability to pay for FP is:

> *". . . contraceptive self-reliance . . . must be an institutionalized long-term priority of the (government) . . . it is developmentally retrogressive for the (government) to depend on donors for provision of a commodity of such critical importance"*

In the coming decades, on both a local and a global level, user fees will prove to be a determining factor in whether FP services can expand to meet the needs of women and thus make possible the sustainable economic development of developing nations.

Issues Surrounding Family Planning User Fees

Outcome orientation versus process orientation

The decision to implement or update a UFS has frequently been viewed as a relatively sure-fire, short-run response to urgent financial needs. This is the typical "outcome orientation," which focuses heavily on macroeconomic considerations. However, it is important to recognize that the motivation for adopting a UFS should be more long-term. Especially in light of trends toward decentralization, planners and managers must be fully aware of the broader implications of a UFS. The process of implementing or updating a UFS may entail substantial changes in the traditional mode of operations—well beyond the more immediately obvious and gratifying revenues which such a system may generate. It is therefore important to approach the implementation or revision of a UFS with a "process orientation."

"Process" issues to be addressed

"Process" issues center around how best to design, implement, and or revise a UFS so that it contributes to the overall viability and effectiveness of FP services. These issues can be expressed in a series of questions:

- How are FP user fee policies defined?
- What are appropriate and equitable pricing structures?
- What total level of revenues can be expected from user fees?
- Where and by whom are fees to be collected, deposited and accounted for?
- What percent of fees will remain at the facility level or local level, and what percent will be sent to the regional office, central office, and to the Central Treasury?
- Are there restrictions on how the revenues can be used?
- How is access to FP services to be ensured for all women and men?
- For what priority activities will revenues from user fees be used (e.g., replacing commodities, establishing new service sites, upgrading equipment, paying salaries)?
- How will these priorities be identified?
- What criteria will be used to establish priorities, and how will the criteria be developed?

- How will the performance of the UFS be monitored and evaluated?
- How, and with what frequency, will the policies and administration of the UFS be revised, for example, to take into account inflation or increases in the prices of commodities?

How these questions are answered will determine the ultimate success of a UFS in terms of its ability to help finance the expanded availability and use of services.

All of these issues must be addressed in the design and implementation of an effective UFS. And program managers should maintain this "process" orientation to ensure that they focus on improving the overall availability, quality and utilization of services. At the same time, this process orientation will also serve as a vehicle for improving management skills and techniques and the overall efficiency of service delivery. These improvements can have an important impact on a range of related characteristics of the FP service delivery system, including:

- Availability of FP services (quantity, method, etc.);
- Access to services;
- Actual utilization of services;
- Quality of services;
- Credibility of the specific facility and, by extension, of the FP service delivery system in general; and
- Financial viability of the specific facility and of the overall service delivery system.

Figure 1 depicts the relationship between key user fee issues and various dimensions of their potential impact on FP programs. These dimensions constitute useful criteria by which to assess the performance and impact of a UFS and, as such, provide important input into the design and fine tuning of FP service delivery policies, in general, and FP user fee policies, in particular.

Figure 1

User Fee Issues and Evaluation Criteria: Potential Impact Areas of User Fee Systems

	Dimensions of Potential UFS Impact-- Some Potential UFS Evaluation Criteria				
User Fee Issues	*Kinds of Services Offered*	*Mix of Services Provided*	*Quality of Services*	*Facility's Financial Viability*	*Access to Services*
User fee policies	•	•		•	•
Pricing structures	•	•	•	•	•
User fee administration	•	•		•	•
Expected total revenues	•	•	•	•	•
Disposition of revenues	•		•	•	•
Spending UF revenues	•		•	•	•
Monitoring UF systems		•		•	•
Revision of UFS	•	•	•	•	•

Fallacies of User Fees

Considerable controversy surrounds FP user fees. This is in large part due to the fact that so much discussion has gone into debating whether fees are appropriate, and so little effort has gone into taking steps toward implementing them in ways that protect utilization levels. To address the concerns of those with doubts, we can consider extreme examples that highlight the nature of user fees. Where these concerns are based on mistaken assumptions, we need to do away with those assumptions. Where there are genuine reservations, we must address them by designing a UFS in such a way that potential problems are avoided.

The fallacy of "free" services

Even when FP services are provided "free," the consumer incurs some cost—often a significant one—to obtain those services. These are mainly indirect costs arising from transportation and the time invested in travelling to a service delivery site and waiting for services. These are known as "opportunity costs." The fact is that *there is no such thing as totally "free" services.* When there is a fee, the total cost, including user fees, transportation and opportunity cost, may be less than the total cost of "free" services if these "free" services involve more transportation and opportunity costs. The demand for FP is a function of all of these costs of access and usage.[1]

The fallacy of user fees as inhibitors of demand

One often hears the argument from line personnel as well as from planners and decision-makers that user fees have the effect of limiting demand. As a result, they are reluctant to implement UFSs. They fear that the introduction of fees (or any increase in cost to the consumer) will leave some people less willing to use services and others unable to obtain commodities and services at all. Since planners and decision-makers realize quite correctly that FP services are highly desirable for the health and economic good of society, they conclude that services should be made universally available free of charge. These concerns must be taken into account when designing a UFS. The system should be designed in such a way that people are *more* willing to use services (because of higher quality, improved convenience, or higher perceived value) and that *more* people have access to services (through subsidization of some services, for example).

But underlying these concerns is a significant assumption that should be addressed: the demand for FP is highly sensitive to both income and prices. To borrow a term from the economists, FP planners are assuming that there is *a high price elasticity of demand* and that there is *a high income elasticity of demand*. Studies of health service utilization in some countries have shown that there were significant drops in utilization when prices were increased. Studies from other countries have shown that utilization rose when prices were increased and quality improvements made. Indeed, empirical evidence from many countries shows that demand for family planning services is relatively *price inelastic*. That is, moderate changes in price tend not to result in changes in utilization. Studies in Thailand, Jamaica, Colombia,[illegible] and Sri Lanka[illegible] have shown that long-term demand did not change after modest price increases were introduced. Additional studies in Colombia,[illegible] Egypt,[illegible] and Korea[illegible] have shown that when similar, known facilities provided either moderately priced or free contraception, demand tended to remain about the same. Furthermore, it appears that when prices are set too *low*, consumer confidence in the market for FP is undermined. Indirect marketing evidence from Egypt and India[illegible] and post-price-rise increases in demand in Jamaica[illegible] and Sri Lanka[illegible] support the supposition that a "too low" price will inhibit demand. Apparently, consumers of FP services conclude that the reason services are offered for free is that they are not worth much. Hence, severely underpricing in an attempt to make FP affordable to all can have adverse consequences.

It has been suggested that most types of health care that are publicly provided in developing countries are relatively *income inelastic*. As a result, both rich and poor purchase similar quantities—albeit in substantially different qualities—of health care.[illegible] The narrower categorization of family planning might, however, lead to a different conclusion. Because family planning is considered by some to be a luxury and/or unnecessary purchase (given very limited household budgets), the income elasticity may actually be quite high[illegible]—especially in comparison to the income elasticity of health care as a whole.[illegible]

The demand for FP appears to vary greatly from one locale and culture to another. Yet, once adequate information and education about means for limiting family size, improving maternal, infant, and child health, as well as improving the quality of life, become available, FP becomes a desired economic good. With FP information and appropriate and equitable pricing, the demand for FP becomes more inelastic, despite geographic location.

In summary, the fear that user fees will necessarily decrease demand does not appear to be supported by available experience, even though there are certainly instances of utilization dropping after significant price increases were introduced. Demand can be maintained when prices are increased within certain limits, even among lower income groups. On the other hand, demand may *decrease* when services are provided free of charge. Of course, user fees may not be the most important factor in determining whether people use FP services. Other factors, such as convenience and quality, may be more important. **Therefore, planners and program managers must design UFSs in such a way that user fees increase availability, lower indirect and opportunity costs, and increase value (real and perceived) to the consumer.**

The fallacy of windfall revenues

Another fallacy that must be addressed relates to the belief that user fees will solve a host of recurrent cost-financing problems—problems that are universally experienced in public-sector health-delivery systems in developing countries. Unfortunately, managers often anticipate an end to problems of shortages of supplies, of needed repairs, and of transportation as a result of these new revenues generated by user fees. Of course, they realize that a poor population will not supply high levels of revenues, but they hope that the unknown amounts to be generated will be a significant increase over the funds normally available. The reality is that in most circumstances, user fees will generate at most 100% of the recurrent costs of service delivery, and oftentimes much less. Put plainly, no gold mine can be found in FP user fees. However, small amounts of revenues can defray program costs. Marginal cost recovery can go a long way to expanding service delivery. And a well-managed UFS can begin an important long-term trend toward recovering significant proportions of the cost of providing services.

The fallacy of bureaucratic burden

One often hears the argument in the field that a UFS is a complicated and cumbersome affair and that the cost of training people and administering a UFS exceeds the revenues that can be expected. Experience shows, however, that if a UFS is well designed, it should cost very little to implement and can be expected to generate enough to justify its presence. Without a doubt, considering how difficult it is to account for commodities and the potential loss of clients, the cost of *not* implementing a UFS is more than the cost of implementing one.

The Importance of Quality in a UFS

While many men and women in developing countries are willing to pay for desired goods and services, these must be perceived to be of high quality.[7] The perception of quality is an attraction. The quality of care elements have been shown to correlate with users' knowledge, satisfaction, contraceptive acceptance, fertility, and health.[8] Program quality and sustainability are interdependent. In fact, income-generating services have the potential for improving quality and thereby attracting more paying users.[9]

One law of the market is that services which are perceived as "better" and which are priced at the right level will draw more patrons. For example, the Indonesian private nonprofit organization Yayasan Kusuma Buana (YKB) increased client visits 75% per month between 1987 and 1988 by moving clinics to more accessible sites, promoting services through community education, extending hours of service, and improving the appearance of the clinics.[10] In Egypt, since 1988, the Egyptian Family Planning Association has managed the Clinical Services Improvement (CSI) project. Over 100 well-equipped, clean, fee-for-service FP clinics with well-trained staff emphasize "quality and caring service at an affordable price." Between 1988 and 1990 CSI attracted over 58,000 FP clients and plans to cover 66% of its costs by 1995 through gradual fee increases.[11] Further empirical information documents that a larger, more committed clientele of satisfied contraceptive users stems directly from the quality improvements in service delivery.[12] Increased acceptance and sustained usage will eventually translate into increased contraceptive prevalence and a decreased rate of fertility, financed largely by user fees.

Additional Arguments in Favor of User Fees

Signalling:

Another ethical issue which is addressed by user fees involves informed choice. Even a modest payment for a method (especially sterilization) signals that it is valued by the client and that the decision to use FP services was made of free will.

Accounting and tracking:

In addition to increasing revenues and indicating value, collecting fees offers the advantage of facilitating the accounting and tracking of the contraceptives. For example, in Ghana, public clinics were able to monitor their stock of contraceptives and maintain adequate supplies because small fees were instituted. It is not unusual for drugs, contraceptives, and other supplies to be stolen from public clinics and later sold in private facilities or on the street.[13] With the monitoring of supplies, theft or loss is reduced.

Efficiency:

Ultimately the inefficiencies encouraged on the production side due to lack of accountability and inadequate supplies are borne by FP program clients in time and travel costs.[9] Waiting time and visits to unstocked, understocked or closed facilities entail real costs. When available resources are used with greater efficiency, more is achieved with a given amount of financial resources.[9]

Effectiveness through variety:

The effectiveness of almost any FP program can also be increased when a choice of methods is available at a clinic or center. And a stronger financial base makes choice of method possible. This proposition has been explained based on three factors:[9]

- First, individuals and couples pass through different stages in their reproductive lives and thus, over time, their needs and values change; this often results in a change in their preferred FP method.
- Second, when there is a choice of methods offered, those who find the initial method unacceptable and or unhealthful have options.
- And third, given the erratic nature of supplying contraception, when there is a variety of methods available, it is more likely that at least one acceptable method will always be available to clients.

Placing User Fees in Perspective

The evidence from both research and field experience is clear: appropriate user fees are a very positive and useful component of any FP service-delivery system. They should not have a major negative impact on demand, nor should they generate windfall revenues. They should help to improve management and quality without creating a serious administrative burden. It is important, though, that (1) the UFS be well-designed and well-managed, charging fees at an affordable and equitable level, and (2) fees be used for the most essential purposes of resupplying contraceptives and maintaining and or improving the quality of service delivery.

Experience with Family Planning User Fees in Developing Countries

As mentioned in the introduction to this paper, many countries offer free services: it is often those countries which can least afford to do so. In fact, an analysis of those countries offering public sector services for free shows that the poorer the country, the greater the tendency to offer free services.[7] It may seem obvious that governments in poorer countries would have even more reasons to offer services for free than governments in richer countries. But the fact is that using only public resources makes it more difficult for these poorer countries to provide quality services and reliable supplies of contraceptives.

Where UFSs are in place and operational, a range of cost recovery has been achieved. Table 1 on the following page summarizes some of the current experience with FP user fees in various developing countries. Though these are only a few examples, they do show that the amount of costs recovered can range from 30% to 100%, and even higher.

This table also shows some of the dimensions of a UFS that will be discussed in the following sections. One is the presence of a sliding-scale fee structure (as mentioned in the Brazil PROPATER program). Another is the importance of phasing in fees; in the Egypt CSI program, the projections are that two-thirds of costs will be recovered in the fourth year of user fees. A third dimension which appears on this table is the presence of cross-subsidization, by which some of the costs of providing FP services are covered by revenues raised from other services. The last example of the Table, the Indonesian program, shows that within a FP UFS, fees from wealthier clients were used to subsidize services for poorer clients.

Each of these cases shows an essential characteristic of a UFS: its success lies in adaptation to local circumstances and needs. Each has developed payment and financing mechanisms which apply revenues from user fees to enhance services. And each has worked on gradual improvement over time to pay for expansion and quality improvements.

Table 1 - Examples of Family Planning User Fee Systems

Country	*Program*	*Year*	*Range of Cost Recovery*	*Impact on Utilization*	*Source*
Barbados	Unidentified Social Marketing Program		100%		Lande and Geller, 1991
Brazil	PROPATER (Vasectomies Only)	1980-1990	52% cost-recovery with sliding-scale fee schedule	Tenfold increase in number of vasectomies per month	Haws, et al., 1992
Colombia	PROFAMILIA	1990	Raised 50% of income from sales and fees for family planning	Raised prices 3-4 times yr with no clientele loss	Lande and Geller, 1991
Dominican Republic	Unidentified social marketing program		100%		Lande and Geller, 1991
Egypt	Clinical Services Improvement (CSI)	1988-1990	Plans to cover 2/3 of costs by 1995 by gradually increasing fees	Over 100 fee-for-service FP clinics attracted 58,000 clients	Lande and Geller, 1991
Ghana	Ghana Social Marketing Program		95% program costs financed by subsidies		Lande and Geller, 1991
Indonesia	YKB SOMAR K (social marketing program)		83% program costs financed by subsidies		Lande and Geller, 1991
	Cross Subsidization				
Brazil	Sofia Feldman Hospital	1989	45% of FP costs covered by lab revenue		Lande and Geller, 1991
Colombia	PROFAMILIA	1990	30% of FP costs from OBGYN, Urological services, infertility treatment, STD's, prenatal care, general med. care		Lande and Geller, 1991
Indonesia	Yayasan Kusuma Buana (YKB)	1989	Clinics in wealthy Jakarta neighborhoods recovered 150% of costs & excess helped clinics in poorer areas		Lande and Geller, 1991

Determining the Context of User Fees In Family Planning Programs

When FP user fees are introduced, it is done within a larger context of health services. Therefore, program managers must, from the beginning of the process, have a basic understanding of that larger context: what is currently happening within the system, what policies are in force, and so forth. Once managers understand the context, they are better able to articulate a set of objectives that are consistent with other parts of the system.

Since a thorough "systems analysis" is a complicated process, we are only interested in undertaking a quick review of some important aspects of the FP service delivery system to help ensure that the UFS will work the way it is intended to work and will not be counterproductive. We can think of this as sketching out a road map to determine where the UFS fits in relation to policies and services in other parts of the system.

By addressing a number of relatively simple questions, managers can develop an adequate understanding of the context of user fees. By reviewing each of these questions, they will have a better idea of where a newly designed or updated UFS fits in. This process also helps to organize information before tackling important issues, such as how much will be charged, how much will be raised, or what will be done with revenues.

All of the steps in the design and implemention of a UFS require some understanding of the external factors which may limit options or affect the design in a number of ways. There are eleven questions which can serve as a starting point:

1. What is the national policy on health financing and user fees?
2. Are user fees charged for services other than FP?
3. Who makes decisions about changing fee schedules and fee policies?
4. What level of revenues are currently generated by the existing UFS?
5. What is the disposition of revenues generated?
6. How do fees affect where people currently go for services?
7. What other kinds of co-financing (through communities, insurance, employers, etc.) exist?
8. What is the current mix of public and private services, how big is each sector, and have there been changes or trends in this mix?

9. Who tends to use private services and who tends to use public services?

10. What is currently being charged in each sector?

11. How was the existing user fee schedule determined?

Question # 1: What is the national policy on health financing and user fees?

To the extent that there is a specifically defined policy or guidelines on charging for health services, FP services will normally be subject to those policies and any restrictions they entail. For example, a program planner or manager must determine (1) what the FP and financing goals of the public health sector are, (2) if there have been any formal decisions, policies, or rules on the part of the central government which place restrictions on provision of health services, or (3) if policies apply to FP services at all, or just to other health services such as ambulatory care or child health care. Many times, there will be inconsistent policies or policies that have become obsolete, such that managers make changes without regard to any "policies" that may exist.

Question # 2: Are user fees charged for services other than FP?

Many West African countries participating in the "Bamako Initiative" have recently begun charging fees in a program where previously fees were charged only in an irregular fashion. They have thus created an infrastructure for charging and managing fees. In other countries, there is a fee schedule on paper, but it is not enforced, collected, or reported in any way. Existence of a functional UFS can facilitate the task, since it is generally easier to modify or raise fees than to introduce them where there were none before. Clients are already familiar with paying for services, and administrative systems—even if they are rudimentary—are generally easier to adapt or update than to implement from scratch. At times it may be more difficult to modify an existing system, however, since peculiarities of that system, once entrenched, may be difficult to modify. The important step to take at this point is to identify the fees being charged and the characteristics of the existing UFS (e.g., are fees actually charged or do they merely exist on paper?).

Question # 3: Who makes decisions about changing fee schedules and fee policies?

There are potentially many people with the authority to change a user fee policy, whether that change involves introducing new fees or modifying existing ones. In some countries the authority is very decentralized, while in others it lies with the Minister of Health. In many instances, no official will have a ready answer to this question because it may never have been raised before. The manager needs to determine where authority lies. If authority exists under a "reserve decision-mak-

ing" process such that modifications can be made on a decentralized basis as long as they do not conflict with formal policies and regulations, a manager will have a great deal of flexibility and can carry out the steps in the user fee Handbook with some degree of independence. If decision-making is based on specific pre-authorization, a manager will have to identify the individual who holds authority and to gain his or her support. In either case, it is important to have general support among the people who are directly or indirectly involved with decisions about the FP system.

Question # 4: What level of revenues are currently generated by the existing UFS?

What is the total amount generated? How do these compare to the cost of contraceptives? To the total operating cost?

Question # 5: What is the disposition of revenues generated?

Do they remain at the facility or are they sent to a more central administrative level?

Question # 6: How do fees affect where people currently go for services?

Are clients using services for which they have to pay fees, or do they tend to use free services only? What changes can be expected if fees were to change slightly?

Question # 7: What other kinds of financing and co-financing (through communities, insurance, employers, etc.) exist?

What forms of payment can be identified for health services? There will generally be a combination of payments from employers, insurance companies, coverage under a social security plan, or under a union or association plan, revolving funds, or other funds for paying for health services set up by communities. Individuals may participate in these funds automatically or by choice. For those who participate, they may pay into the scheme on a monthly basis, or they may pay at certain times of the year, such as at harvest time. These are all parts of an overall system that can be used to pay for FP services. Each is of great interest to us for that reason. For the purpose of designing an effective UFS, however, a manager needs to know, at a minimum, what exists for health services generally and for FP services specifically, and to have some idea of who participates in these schemes and in what numbers.

Question # 8: What is the current mix of public and private services, how big is each sector, and have there been changes or trends in this mix?

Generally, FP services will be available from some mix of public facilities and private facilities such as private doctors and midwives, or mission hospitals. Knowing who is providing services and what recent trends have been (such as growth in one or both sectors) will help to anticipate how changes in user fees may result in changes in utilization.

Question # 9: Who tends to use private services and who tends to use public services?

It is important to determine who is using the services provided by the facility or program for which the new UFS is intended, and how they may differ from other users or potential users in the area (i.e., what is the "market share"?). Are they more able to pay or less able to pay? How will they respond to quality changes, such as a decreased waiting time?

Question #10: What is currently being charged in each sector?

At a minimum, a manager should know what is being charged by other providers in the area or the region. If clients have access to a variety of public and private FP providers, then we would expect many clients to go to those providers if we were to introduce higher fees. If we introduced fees which are comparable to other services, then we would expect people to go where the services are most convenient or of the highest quality. Losing some clients may even be a desirable development if they were people who decided not to use other services simply because they did not want to pay (though they were able to pay) and have now returned to those other sources of FP services. If there are others providing free services, then we can be more confident that we can restrict eligibility for our system.

Question #11: How was the existing user fee schedule determined?

On what basis were fees set? Based on actual costs? Or are they more arbitrary?

In Conclusion

At this point, you, the manager, should have a better sense of those factors or circumstances that affect your user fee options. You should have a sense of what makes certain decisions easier and others more difficult. And you should have some sense of how changes in the UFS might be affected by other parts of the delivery system outside your control. When you have made the decision to design or update a UFS, the Handbook will assist you in following some simple steps toward a workable system.

Endnotes

[1]Population Crisis Committee (1990). The United Nations Development Program has made a lower estimate of the proportion of costs borne by users, at 10% (cited in Lande and Geller, 1991).

[2]Projections of users of modern family planning methods for the year 2000 range from 229 million (Destler *et al.* 1990) to 510 million (Mauldin and Ross, 1991). A more complete discussion of projections is provided in Lande and Geller (1991).

[3]*ibid;* Bulatao (1985) estimates current spending at about $2.5 billion.

[4]Janowitz, Bratt and Fried (1990).

[5]Lande and Geller (1991).

[6]USAID cable *Harare 09165.*

[7]Lewis (1984).

[8]In economic terms, this touches upon the discussion of whether FP goods and services are "public goods" or whether they are "private goods." We will not address this issue here; for a discussion of this topic, the reader can refer to Akin *et al* (1987).

[9]At this juncture we apologize for introducing economic jargon, but it is important to understand the nature of these issues and the available FP service delivery evidence from around the world.

[10]Mwancia and Mwabu (1992) discuss findings from Kenya; Yoder (1989) discusses findings from Swaziland.

[11]A recently completed study in Cameroon (Livak, 1992) demonstrated that when prices increased for integrated family health services through public sector facilities, along with improvements in the quality of those services and related medicines and supplies, demand actually increased. This was true for all socio-economic levels of users, even the poorest quintum.

[12]Baldwin (1978); Family Health Division (1983).

[13]Howell and Seims (1979).

[14]Ojeda, *et al.* (1983).

[15]Abeywickrama (1983).

[16]Traitongyoo (1985) attributed some of the success of Thailand's largest private health and FP project to the effect that user fees had on individual spending patterns: "The fees that are charged are important to the success of the program as these reinforce the importance of the services to the recipients as well as generate the necessary funds for the program's existence...we try to instill in the people a lifetime commitment to health and family planning practices, and part of the commitment involves altering spending patterns" (p. 32).

[17]Bailey and Umana (1978).

[18]Gadalla, *et al.* (1980).

[19]Chen and Worth (1982).

[20]ICSMP (1983).

[21]Howell and Seims (1979).

[22]Abeywickrama (1983).

[23]In effect, the demand curve for FP is backward bending below some price (Lewis, 1986).

[24]Griffin (1988).

[25]Given that population under consideration does not have a truly measurable income, and that all proxies for income are second-best approximations, it is not surprising that demand studies to date have focused on the price elasticity of demand for family planning rather than the income elasticity. There is, however, a relationship between changes in income and the demand for family planning. With respect to health and medicine, optional (i.e., elective) goods and service purchases are classified as income elastic (they change with income), while essential health purchases are income inelastic (they tend not to change with income).

[26]To return to the issue of public goods *versus* private goods, if family planning was considered by all to be a necessary good, education and marketing would be redundant.

[57]Akin *et al.* (1987); Ashford and Haws (1992).

[58]Lewis (1986).

[59]Lande and Geller (1991).

[60]*ibid.*

[61]*ibid.*

[62]Lipton, *et al.* (1987); Jain and Bruce (1989); Lande and Geller (1991).

[63]Lande and Geller (1991).

[64]Lewis, 1986.

[65]Efficiency is two-dimensional. The allocative dimension involves raising capital and allocating resources in order to maximize the net benefit to society. The operational dimension involves devising financing mechanisms as well as the least costly methods of producing and delivering the given health services to achieve required improvements in health status (see Mills, 1984).

[66]Jain and Bruce (1989).

[67]This is based on a survey of some 20 countries carried out by SEATS.

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Appendix 1 - Projected Expenditures on Family Planning in Developing Countries in the Year 2000

Author & Date (Ref. No.)	Population Projection Used	Contraceptive Prevalence in 2000	No. of Contraceptive Users (Total Modern)	Method Mix	Indirect Costs Included	Year 2000 Cost in 1988 US$: Per Modern Method User	Year 2000 Cost in 1988 US$: Total	% Increase of Year 2000 Cost Over Est. 1988 Expenditure
Bulatao 1985 (World Bank) (37)	World Bank "standard" fertility decline (includes China)	58%	425 million NA	Varies by country	Training, institutional development, data collection, and others	$19.55[a]	$8,310,000,000	57[b]
Destler et al. 1990 (63)	UN high variant (excludes China)	56%	280 million 229 million	Female sterilization 32%, Vasectomy 5%, OCs 20%, IUD 10%, Injectables/Implant 4%, Vaginal methods 1%, Condom 8%, Traditional 20%	Training, institutional development, data collection, and others	$21.83[a]	$5,000,000,000	117[b]
Gillespie et al. 1988 (US AID) (84)	UN medium variant (excludes China)	52%[c]	349 million 265 million	Sterilization 28%, OCs 24%, IUD 11%, Condom 6%, Other supply 7%, Traditional 24%	Some training and information activities	$19.72	$5,226,000,000	74[b]
	UN medium variant (excludes China)	52%	349 million 265 million	Sterilization 27%, Injectables 15%, OCs 23%, IUD 10%, Norplant 15%, Condom 6%, Other supply 7%, Traditional 24%	As above	$20.00	$5,301,000,000	79[b]
	UN medium variant (excludes China)	52%	349 million 265 million	Sterilization 26%, Injectables 5%, OCs 22%, IUD 9%, Norplant 5%, Condom 6%, Other supply 6%, Traditional 24%	As above	$20.25	$5,365,000,000	79[b]
Janowitz et al. 1990 (100)	UN medium variant (excludes China)	48.4–49.5%[c]	320 million 257 million	Varies by region	Donor funding of biomedical and demographic research, evaluation, training, and information activities (= $715 million in 2000)	$14.10	$3,623,000,000	67
Kocher & Buckner 1991 (127)	UN medium variant (excludes China)	Africa: 23%; Asia: 57%; LA: 55%	474 million 422 million	Female sterilization 55%, Vasectomy 11%, Injectables 2%, OCs 13%, IUD 24%, Vaginal methods 1%, Condom 7%, Other 9%	Information activities, data collection, research, policy development, and training and institutional development (= $2.9 billion in 2000)	Af: $15[a]; As: $10[a]; LA: $10[a]	$7,812,000,000	47
Mauldin & Ross 1991 (156)	UN medium variant (excludes China)	50%	567 million 510 million	Female sterilization 36%, Vasectomy 8%, Injectables 4%, OCs 13%, IUD 22%, Condom 6%, Other 10%	None	$1.23 (commodities only)	$627,000,000 (commodities only)	57
Population Crisis Committee 1990 (179,239)	Stable world population by 2095 (includes China)[d]	75%	720 million NA	NA	Information, training, and research	$16.00[a]	$11,500,000,000	250
van Arendonk 1990 (United Nations) (215)	UN medium variant (excludes China)	50%	567 million 510 million	Female sterilization 36%, Vasectomy 8%, OCs 13%, Injectables 4%, IUD 22%, Condom 6%, Other 10%	Research, information and promotion activities to policy-makers, evaluation, institutional development, training	$17.65	$9,000,000,000	100

IUD = intrauterine device
LA = Latin America
NA = not available
OCs = oral contraceptives

[a] Cost per user of modern and traditional methods
[b] % increase over projection for 1990 rather than for 1988
[c] Assumes decreasing cost per user as prevalence increases
[d] % increase over 1985 expenditure

[e] Gillespie and colleagues based prevalence on the 1986 UN assessment of world population. Janowitz and colleagues used the 1988 assessment, which reported higher fertility rates than the 1986 assessment

[f] Projects prevalence needed to stabilize world population at 9.5 billion by 2095

See explanatory note on following page

Reprinted from Lande and Geller (1991)

Note to Appendix: Projecting Family Planning Costs

To estimate future costs of family planning services, researchers:

(1) Adopt a set of projected population growth rates and then calculate the contraceptive prevalence and the number of users or other measure of service output necessary to achieve those rates; and

(2) Calculate a unit of cost: the cost per user, per visit, or per couple-year of protection (CYP, or the equivalent of one year of contraceptive protection for one couple).

Total costs are then the number of users or visits multiplied by the appropriate unit cost.

Projecting Numbers of Users

Most estimates have focused on the year 2000. To project the number of users in 2000, researchers begin with projections of national fertility rates in that year. Most use the United Nations medium variant projection of population growth. This projection forecasts the 5-year period between 1995 and 2015 in which each developing country will reach replacement-level fertility. According to the 1990 projection, all developing countries will reach replacement-level fertility by 2015.

To calculate the prevalence and the number of contraceptive users needed to achieve these rates, most researchers use the Target-Setting Model developed by John Bongaarts. The model relates fertility rates to a variety of factors, including the proportion of women who are married, contraceptive use, and the level of induced and spontaneous abortion. Typically, researchers assume that any changes in factors except for contraceptive use will offset one another. Thus, future fertility rates will depend entirely on increases in contraceptive use, taking into account both contraceptive prevalence and the effectiveness of the methods used. Projected numbers of users are then calculated by multiplying the prevalence rate by the projected number of married women of reproductive age.

Estimating Costs

Researchers' estimates of family planning costs in the year 2000 depend partly on the mix of contraceptive methods that they project and how they estimate commodity and service delivery costs. Most use the current method mix as reported in standard sources such as the Demographic and Health Surveys or UN estimates. They then assign costs to each method. For example, Duff Gillespie and colleagues assigned commodity costs to each method and added an average service delivery cost of $18 per CYP for all methods. In contrast, Barbara Janowitz and colleagues calculated the cost of the different modes of service delivery (clinics, community-based distribution, and social marketing, for example), rather than cost per user, using data on service costs and surveys in three countries. Rodolfo Bulatao of the World Bank calculated costs from population program expenditures in 40 countries, thus implicitly assuming the current method mix in those programs. Whatever the method mix, in all projections the cost of service delivery exceeds the cost of supplies and commodities.

Most studies assume that cost per user will remain constant as use of family planning expands. This may not be the case, but data on costs are not reliable enough to project costs per user confidently. As programs expand into rural areas, the cost of reaching each user might be higher than in urban areas. In fact, however, a comparison of cost data from national surveys shows that family planning costs per user decline from about US$11 per user at 20% prevalence to about $6 at 50% prevalence. Also, as developing countries become more urbanized, more users may have more access to services at lower cost per user. The one projection that assumed declining cost per user, by Harriett Destler and colleagues, nevertheless estimates that costs of family planning will more than double by the year 2000.

Glossary

Commodity Sustainability - the ability to generate sufficient funds to purchase all needed contraceptives.

Contraceptive Prevalence - percentage of women of reproductive age practicing contraception.

Cost Recovery - process of recovering some or all of the costs of providing products and services; synonymous with user fees.

Cross Subsidization - using funds generated from one service (e.g., laboratory services) to cover part of the cost of another service (e.g., vasectomies). Cross subsidization can also occur based on geography (urban subsidizing rural) or based on income. Subsidies may be intentional and explicit, or they may be unintentional and implicit.

Disposition of Revenues - percentage of locally generated revenues which are distributed to the local, regional, or central level.

Income Elasticity - amount to which a change in income levels will bring about a change in demand. If income elasticity is low, rich and poor people will purchase comparable amounts despite the differences in their income. Goods which are seen as necessities (eg. Health Care) generally have low income elasticity.

Marginal Cost Recovery - all the additional non-fixed costs directly associated with providing an additional unit of this particular product service are recovered, but not operating or other ongoing expenses.

Price Elasticity - amount to which a change in price will bring about a change in demand. If price elasticity is low, moderate changes in price will not result in a significant change in utilization.

Revenues - funds which are available from user fees, government allocation, or other sources, that enable activities to take place.

Sliding-Scale Fees - fees which are adjusted according to user's ability to pay

User Fees - payments made by the patient, client, or user for products and services received.

User Fee Systems - the set of managerial, administrative or financial structures which govern the setting of prices, collection and management of fees, and spending of revenues.