

# Guidelines for Achieving Equity

## Ensuring Access of the Poor to Health Services under User Fee Systems



William Newbrander  
David Collins

 **BASICS**

Office of Sustainable Development  
Bureau for Africa  
U.S. Agency for International Development





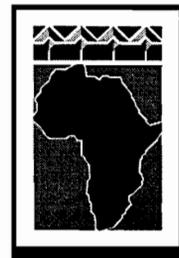
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### **Abstract**

Many developing countries that traditionally provided no-cost health services must now develop and implement user fee schemes to generate needed resources. Before user fees were introduced, it was not known, or was often ignored, what the impact of the fees would have on the access of the poor to health services. Because of concerns for the poor, many countries designed mechanisms to protect the poor from the negative effects of user charges.

This publication presents an overview of issues related to equity and the access of the poor to health services in developing countries where user fee systems have been introduced (Guinea, Kenya, Tanzania, Indonesia, and Ecuador). BASICS carried out five case studies, with the support of the USAID Africa Bureau's Office of Sustainable Development and directed by the Management Sciences for Health (MSH) Health Reform and Financing Program.

A comparison across the different countries determined that the poor have minimal access to health services despite protection mechanisms. In the private sector, few official protection mechanisms exist; yet the facilities usually maintained that everyone had access to necessary services and the fee system was not a barrier for those seeking health services.

The case studies showed the following:

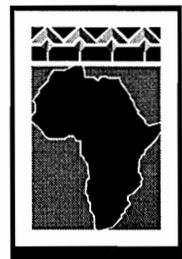
- The poor often pay for care even when the services are supposed to be free.
- Total patient costs are much higher than the fees imposed, creating an additional barrier for the poor.
- The poor and marginally non-poor may not be able to afford user fees.
- The poor lack information and receive misinformation about fee waiver systems.
- The poor are willing to pay for quality health care.

The studies also detailed important policy factors needed in countries that are developing or modifying their user fee systems: guiding principles (have a clear policy and plan), implementation (keep the cost of granting waivers low), fee structures (put patient into a sliding-fee scale category), and acceptability (patients accept fees better when they relate to tangible services).

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# Foreword

The past decade has been a challenging one for the health policy experts and decision makers in developing countries. Increasingly stringent budgets, growing populations, and expanding demands for health services have taxed the government resources just to maintain existing public health systems and services. Government resources are not sufficient to enlarge the health system to meet increased demand or to expand access to health services for the poor. Many countries use cost sharing to fill part of the financial resources gap; their efforts have led to increased resources for the health sector. Kenya, for example, added more than U.S.\$25 million to the public sector financial resources from cost sharing revenues generated during the past five years. Cost sharing, however, has also highlighted an increasing anxiety—how do the poor gain access to public health sector services when user fees are applied to those services?

Because of these concerns, some countries have developed safety nets, such as waivers, to protect the poor from the effects of user charges. In other countries, such as Guinea, the government relies on community-developed safety schemes to maintain access for the poor. Such mechanisms have been discussed and debated and, based on cursory evidence, claims have been made about their effectiveness.

The guidelines in this document are based on a series of studies undertaken by the USAID Africa Bureau's Office of Sustainable Development in collaboration with the Basic Support for Institutionalizing Child Support (BASICS) project. Using a standard methodology, BASICS conducted a systematic study in Guinea, Kenya, Tanzania, Indonesia, and Ecuador to determine the true impact of user fees on the poor's access to health services. Based on the studies, the authors determined the underlying facts about the poor's access in the different health systems, as well as some of the problems in protecting the poor. The authors used the results to develop a set of practical guidelines that can be used by decision makers to design more equitable user fee systems. By basing access to services on need rather than the ability to pay, such systems would promote equitable access to health services by the poor. While there is more to learn about equity of access to health care, these guidelines break new ground by taking lessons learned and demonstrating how they can be applied to prevent inequities in access under user fee systems or to correct problems in health systems where user fees are already implemented. The Africa Bureau hopes this work will encourage further dialogue to ensure that the concerns about equity for the poor are raised and addressed—not just in Africa but around the globe.

Abraham Bekele, Ph.D.  
Office of Sustainable Development  
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The authors also gratefully acknowledge the technical guidance and the contributions of Jean-Jacques Frère, M.D., formerly of BASICS, and Robert Northrup, M.D., of BASICS. Ken Heise of BASICS was instrumental in organizing the administrative aspects and logistics necessary to complete the studies and publish this work. Editorial work was undertaken by Pat Shawkey of BASICS and Barbara Timmons of Management Sciences for Health (MSH).



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# Introduction

## Purpose

The problem of ensuring equity of access to health services when there are user fees has been a concern in many countries, not just in Kenya (see case study 1). This guidebook focuses on how to protect the goal of universal access to health care when the main objective of the user fees is to generate revenue. The tension between these two competing goals is one of the key issues in developing user fee schemes.

This guidebook leads policymakers and health system managers through a discussion of user fee and equity issues; describes mechanisms available for ensuring access of the poor to services; and offers guidance on developing, implementing, and managing such mechanisms. Health policymakers and service managers, in both the public and private sectors, will find the book useful for considering, designing, and implementing mechanisms that protect the poor and ensure equity.

## Background

Most developing countries have a long tradition of providing free public health services. In many countries, however, government resources for the health sector have decreased in recent years, while demand for health services has increased. As a result, the need for additional sources of revenue to operate public health services has become acute. Apart from tax revenues, the main options available have been social insurance and user fees. Social insurance has not been widely implemented, partly due to the absence of significant numbers of formally employed persons in many developing countries. However, user fees have been widely introduced. By 1995, for example, 28 of 37 countries in Africa had some type of user fee system (Nolan and Turbat 1995).

User fee systems represent a significant policy change for many countries. For example, one or two decades ago, in ex-colonial countries, user fees were considered unimaginable because of commitments made at the time of independence to provide free health services. The policy debate has now shifted, however, from the issue of whether the country should introduce cost recovery, to the issue of how the systems should be introduced (Gilson 1997).

In many countries that have adopted user fees, social solidarity and the belief that health care is a basic right support a widespread view that access to health services should be based on need, not on the ability

### **Case Study 1. Failure to Protect the Poor in Kenya**

In Kenya, in October 1989, to generate additional revenue for improving services, user fees were introduced simultaneously at all public hospitals and health centers (Collins et al., 1996). Within one year the fees had been abolished, reportedly because implementation problems resulted in a lack of improvement in quality of care and in hardships for the poor. Evidence indicated that, despite low fees and a broad range of exemptions, many patients had stopped using services. One reason was a continued shortage of drugs and supplies. Beginning in 1992, fees were carefully reintroduced in phases, and they remain in place today. The reintroduction appears to have had little negative impact on the poor, and substantial revenue has been generated and used to improve services.

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to pay. Despite recognition of this viewpoint, the desire to generate revenue to replace decreasing government budgets sometimes takes priority over concerns about how the fees will impact the poor. As such schemes become more widespread, decreased use of services by the poor has caused concern that the poor are being denied access because of fees.

In response, protection mechanisms have been developed to ensure that fees do not create financial barriers. In some cases, however, these mechanisms have been ineffective, and the poor have been denied access to services. In others, the mechanisms have been too generous and not enough revenue has been generated to improve services.

With increasing decentralization, such issues are relevant not only at the national level but also at the provincial, district, and, even, facility levels. These issues concern public *and* private, nonprofit health service providers, such as mission hospitals, which provide significant services to the poor in many countries. In some countries, such as the U.S., even some private, for-profit providers offer free services to the poor. Countries and organizations that want to ensure the poor's access to health services should ask the following questions about appropriate protection mechanisms:

- What are the challenges of charging user fees and ensuring equity?
- When are mechanisms necessary to protect the poor?
- What types of mechanisms are available?
- How effective and costly are the various mechanisms?
- How can a mechanism be selected, implemented, and managed to achieve equity?

## **Basis for the Guidelines**

The questions listed in the Background section on the preceding page prompted the Health and Human Resource Analysis for Africa (HHRAA) project of the USAID Africa Bureau to evaluate the equity implications of user fee schemes to determine what systems work best to maintain equity and, based on the findings, to develop a series of policy options. To do this, BASICS carried out five country case studies, then synthesized and analyzed the findings. Guinea, Kenya, and Tanzania were chosen from the main focus of the study, Africa. The remaining two countries, Ecuador and Indonesia, provided experiences and useful insights from other continents.

The design of the five country studies incorporated elements that allowed the distinctiveness of each system to be apparent while providing similar information across countries, so the lessons from their user fee and protection systems could be compared, contrasted, and synthesized. Basic methodology for the studies was prepared by Management Sciences for Health (MSH) for BASICS and reviewed by a technical advisory group. Detailed background information and the basis for the methodology can be found in *Methodology for Equity and Coverage of Health Care Provision Study* (Newbrander and Collins 1995).

The studies were designed to gather data for two purposes: (1) to provide descriptive information on the waiver and exemption systems, and (2) to enable an assessment of the effectiveness of the waivers and

exemptions mechanisms in place. The descriptive information relates primarily to the operational issues of the system. To complement this information, two types of survey instruments were used: (1) facility-based exit surveys to assess the experiences of patients who used services at the health facilities being studied and (2) household surveys in poor communities near the health facilities to assess experiences for persons who used other services or no services. The information gathered in each country consisted of the following two types of data:

1. Data gathered at health facilities (public and private):
  - patient interviews with administrative and clinical staff
  - exit interviews
  - review of utilization and user fee revenue records
2. Data gathered from household surveys:
  - in surrounding health facilities, interviews of poor households that had experienced recent illness
  - information on health-seeking behavior of the poor
  - information on the poor's access to the public and private health systems

In the study countries, the surveys provided similar information. For example, in Kenya, Tanzania, Guinea, and Ecuador all the studies included household surveys. Most studies included public and private voluntary sector facilities. However, there were some differences in the focus of the samples. The Ecuador study surveyed only private voluntary and municipal health facilities because the public sector Ministry of Public Health staff were on strike at the time of the survey.

These guidelines are based on the findings from the country studies. While each country has unique social, cultural, and economic circumstances, and different health systems, their health financing problems and solutions are similar. There are common issues and experiences in attempting to protect the poor. The guidelines presented here are not prescriptive. They intend to present principles and parameters for making decisions that balance the need to generate revenues from the use of services with the desire to ensure equity of access based on need, as well as possible implications of the various options.<sup>1</sup>

The discussion in this guide is limited to user fee schemes. Other ways of addressing equity, such as improved budget allocation processes or social insurance schemes, are not covered in the guide.<sup>2</sup>

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<sup>1</sup> A full description of the issues, the five country studies, the lessons learned, and the policy and implementation guidelines are provided in the forthcoming book by W. Newbrander, D. Collins, and L. Gilson, *Equity: Ensuring Access to Health Services of the Poor under User Fee Systems*.

<sup>2</sup> An analysis of the other financing options is provided in the WHO publication *Evaluation of Recent Changes in the Financing of Health Services*. WHO Technical Report Series No. 829 (Geneva: World Health Organization, 1993).

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# User Fees and Equity

## What Are User Fees?

User fees are the fees charged to patients for health services. Fees are levied in different ways—an inclusive fee per visit, including all diagnosis and treatment; an inclusive fee for an episode of illness, including all diagnosis and treatment during several visits; or a separate “itemized” fee for each service provided during a visit.

User fees, sometimes called cost sharing or cost recovery, are important because individual patients are responsible for much of the financial burden for their own health care. Paying for services can have a significant impact on care-seeking behavior, especially for the poor. Because of the need to generate revenue, fees can also result in a health care system where priority is given to people who can pay and not to people who have the greatest health needs.

User fees are different from prepaid insurance systems, where the member pays a fixed amount for coverage and the third-party insurer pays the health care bills. User fees are also different from employer-based schemes, where the employer pays the bills. In both cases, the member or employee is guaranteed access to services.<sup>3</sup> Unless social insurance is in place, the poor are usually excluded from such schemes.

## What Is the Purpose of User Fees?

In most cases, the main purpose of user fees is to generate additional revenue, which usually expands geographic or financial access to services or improves the quality of care, or both. Sometimes user fees are introduced for very specific reasons, for example, to provide the cash needed to purchase drugs and medicines for health facilities. User fees can also be used to discourage patients from using less cost-effective services, such as hospitals instead of clinics, thus reinforcing desired referral patterns. Fees can also be used to discourage frivolous care seeking (patients visiting health facilities for free diagnosis and treatment of minor ailments that can be self-treated).

User fees are not new in the health sector. The private sector, including nonprofit providers, has always had to rely on fees to a significant degree unless many patients are insured or there are substantial government subsidies. In the public sector, fees are usually introduced to supplement public sources of funds when those funds fail to keep up with the increasing demands for health care.

If fee revenues are used wisely, they can lead to efficiency and equity improvements. Reduced budgetary funding often results in squeezing non-staff costs because reductions in staff and related costs can be difficult. Using fee revenue to procure non-staff resources that are in short supply can result in impressive efficiency gains. For example, the efficiency of an x-ray department with staff but no film is greatly improved if fee revenue is used to buy x-ray film. The allocation of fee revenues to treatments or programs that are highly cost effective, such as immunization campaigns or cancer screening, may also represent efficiency gains.

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<sup>3</sup> For the purpose of these guidelines, copayments made by patients under such schemes have not been included as user fees.

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Efficiency improvements, that is, providing more services for the same amount of resources or using fewer resources to provide a constant level of services, can also lead to equity improvements. For example, if an x-ray department has no film, patients have to buy film or seek x-ray services in the private sector. If they cannot afford to pay for the film, the tests will not be done and treatment of their conditions will be delayed, perhaps indefinitely, or incorrect treatment may be provided. If fees are high enough to cover the cost of films and provide a small cross-subsidy, the fees will still be lower than private-sector fees, and they will generate funds to cover the cost of film for patients who cannot afford to pay. Patients who can pay and those who cannot will both benefit.

Even if additional revenue can be generated from user fees, the total amount of resources is unlikely to be sufficient to meet the growing need and demand for high-quality health care. The efficient use of both budgetary funds and fee revenues is critically important. For services to improve, improvements in resource allocation, budgeting, financial management, and efficiency must accompany revenue generation (see figure 1).

## What Determines the Revenue Generated from Fees?

The *total amount of revenue* generated from user fees depends on the fee levels, the quantity of paid and free services provided, and the efficiency of collection.

**Figure 1. Key User Fee Issues**

<p>Several questions should be asked before user fees are instituted:</p> <ul style="list-style-type: none"><li>• How can revenue be raised without discouraging the poor from using services?</li><li>• Should some services be free to promote their use?</li><li>• Can the fees collected at a facility be used to improve services at that facility?</li><li>• What quality improvements are needed to justify the fees?</li><li>• How can facilities in poorer areas share in the benefits of revenue generated in better-off areas?</li><li>• Who will be accountable for the collection and spending of fee revenues?</li><li>• How can transparency be ensured in the user fee system?</li><li>• How can the community be effectively involved in setting fee levels?</li></ul>
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The *quantity of services* provided depends on the demand for services and the capacity of the provider to deliver them.

The *demand for services* is affected by the fee level: higher fees result in lower demand.

The *amount of change in demand* depends on the elasticity of demand—the sensitivity of demand to changes in price. If demand is elastic, a small increase in price will result in a large decrease in demand for that service. If a fall in demand is significant, higher fees may result in lower total revenue.

*Provider capacity* depends on all necessary resources being in place and available at the time they are needed. For example, nurses and doctors must be available during working hours, equipment and drugs must be available, and patients must not have a long wait. The efficiency of the fee collection is also important, because a significant amount of fees commonly go uncollected or are

stolen after collection. Efficient systems and trained staff are necessary to ensure that all revenues are collected and remain safe.

The demand for health services also depends on the perceived quality of the services. Where fees are introduced or increased and service quality does not improve, it is likely that demand will fall, particularly when there are alternative sources of care. This has occurred in several countries (Gilson et al. 1995; Creese and Kutzin 1995; Collins et al. 1995). If, however, the patients perceive an improved quality of care, the fall in demand may be reduced or eliminated. For example, improved drug supply as part of a user fee scheme has resulted in increased use (Litvack 1993). As much as possible, the introduction of fees or increase in fees should be accompanied by immediate, perceivable, quality improvements. These can usually be funded from fee revenue, but some initial capital funding may be needed.

## What Is Equity?

Equity can be defined as access to basic, good-quality health care, based on a need for those services. Equitable access should be based on need rather than other factors, such as ability to pay or geographic location. People who are wealthier may have access to services that are not medically necessary—private wards, choice of food, or convenient appointments—but access to health care should be equal when the need is equal (see figure 2).

## Why Is Equity Important?

User fees can become a barrier to utilization of health care because they result in restricted access or they impose a financial disadvantage for people who need care but cannot afford to pay. People may delay seeking care, which can result in their illness becoming more serious and, eventually, more costly to treat. They may be unproductive for longer periods of time because of untreated illness, with a negative effect on family income. They may also go to alternative providers where fees are lower but quality and effectiveness are not as good, thus exacerbating the illness. Patients may sacrifice other immediate basic needs, such as food, to pay user fees. They may also borrow money at high interest rates, perhaps threatening long-term basic needs. Where fee levels are high, patients who are not initially poor may become poor by being forced to sacrifice savings or productive assets (land or animals), or a means of transportation (a bicycle).

**Figure 2. Key Equity Issues**

Equity means that the following requirements are satisfied:

- Everyone must have access to services.
- Services must be provided in accordance with need and not with ability to pay.
- People should not have to sacrifice other basic needs to pay for services.
- Any reduction in utilization must relate to "unnecessary demand" and not to financial barriers.
- The poor should receive the same quality of health care as the non-poor.

### Common Equity Problems

The five country studies indicated a number of common problems related to user fees and access of the poor to services:

- *The poor often delay seeking care.* They often wait longer than the non-poor to seek care; and they often travel greater distances for care, partly because many of the poor live in rural areas where the distance to health facilities is greater.
- *A range of factors influence the choice of care.* Many patients who attended government or NGO facilities did so because they were explicitly referred there by someone, there were no other facilities nearby, or quality and staff responsiveness were perceived to be better—but, not because fees were lower. Some patients chose not to visit health care facilities for a number of reasons: they did not have money, were dissatisfied with staff, treated themselves, bought drugs without a prescription at a shop, or used traditional healers or private providers.
- *The poor often pay fees.* Almost as many poor people paid for services as did the non-poor, and poor patients sometimes paid as much as the non-poor. Many of the poor borrowed money to pay fees, creating a long-term financial burden for themselves and their families.
- *User fees are not the only financial barrier.* The poor often received free services at public facilities, but they had to buy supplies or drugs from the private sector because the public facilities had none. Transportation costs often created additional financial barriers.
- *Managers of facilities have difficulty maintaining a balance between generating revenue and ensuring access.* Facility managers were not able to anticipate the impact of user fees on utilization, revenue, or free care, and they did not know how to balance the competing objectives of generating revenues from fees and ensuring access to the poor. Overemphasis on the former sometimes led to the poor having restricted access to services. Stress on the latter resulted in a shortage of revenues and a related deterioration in quality (e.g., lack shortage of medicine).
- *Facilities lack reporting and monitoring systems.* Few facilities collected data and reported information on the numbers and types of patients that received full or partial exemptions and the value of the fees not collected. Hence, the cost of waivers for the poor was not known.
- *Adequate public information does not exist.* Many patients and community members interviewed did not know that they might be eligible for exemptions. Those who did know found out from family, friends, or informally from staff, not from official sources.
- *Other sectors lack effective mechanisms to protect the poor.* Other sectors that charge fees, such as education and agriculture, also have difficulty balancing the need for revenue with protection of the poor, and they lack the mechanisms to ensure that the poor pay only what they can afford.

# User Fee Policies and Procedures

## Financing Options

There are numerous options for financing a health system:

- increasing the public sector's health budget
- charging user fees
- using social insurance
- improving the allocation and use of resources<sup>4</sup>

User fees are only one option. However, user fees alone cannot be the sole means to finance a health system and ensure its sustainability. Hence, user fees will be a more effective policy tool if the fees are combined with other financing options. For example, additional revenue from user fees will have a limited impact on improving services if all resources are used inefficiently. Relationships between financing options can also affect the access of the poor to services. For example, if funds are used efficiently, the need for fee revenue will be reduced, enabling fees to be lowered or additional free services to be provided without affecting the quality of care. The need for fee revenue may also be reduced if insurance schemes, NGOs, or private providers help fund services for the poor. Health insurance coverage may be extended and expanded to poorer members. Private providers can be required to provide services to the poor as a condition for licensing or receiving government grants. The impact that each component and combination of components has on the access of the poor to services should be analyzed, coordinated, and monitored within each country's situation.

## User Fees Should Not Replace Other Funding Sources

If the purpose of user fees is to raise revenues to provide care for the poor, extend coverage, and improve quality, revenue from fees must supplement government funding and be retained at the collecting facilities. Benefits from user fees are not realized in countries where the fee revenues are transferred from the health facility that collects the fee to the national treasury. Fees must not be used to reduce government budgetary commitments because quality will not improve, and there is no incentive for facilities to collect fees. Revenue should be retained at the facilities where it is collected so that staff are motivated to collect fees and patients are willing to pay for improved quality, especially for the availability of medicines.

## Use of Revenues for Service Improvements

Revenue from fees should be used to improve coverage and quality of care in ways that are appreciated by patients. Improving coverage involves using fee revenues to expand the breadth of services offered to

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<sup>4</sup> See reference in footnote 2.

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the public, as well as providing existing services to more people in the community. To encourage local public support for user fees, funds should be used for quality enhancements that are obvious to the patients, such as improved supply of drugs or bed linen and other basic ward supplies. Patients, including the poor, are more likely to accept fees when they relate to services that are clearly of a high quality. In Kenya, quality was a major reason for both the poor and non-poor seeking care at certain hospitals that charged user fees.

## **Geographic Subsidies**

Facilities in poorer areas will need special additional budgetary allotments to be compensated for their inability to generate as much revenue as health facilities in economically advantaged areas. Otherwise, they will be under pressure to generate revenue, and they may be reluctant to grant waivers to the poor. Central funds should be allocated to subsidize these facilities because they provide a larger volume of services to the poor or charge lower-than-average prices. At the national level, there should be a clear policy and plan detailing the expected levels of free care in different areas of the country. To estimate the likely impact when fee levels are set, the revenue needed should be compared with expected volumes of free and paid care. If substantial free services are expected, it may be necessary to charge higher fees in better-off areas. This process requires a systematic way to identify facilities eligible for the supplementary budget provisions and a policy for setting the level of the increased budget subsidy.

## **Process for Setting User Fees and Waiver Policies**

User fee policies and mechanisms to protect the poor should be established at a national level to ensure that they are applied consistently across the country. A national system is easier for both health program staff and patients to understand and use when the principles are consistent across geographical areas (see case study 2). Such consistency is especially important when a user fee program is new or where services are not decentralized. Where policies are determined at lower levels, such as districts, they should be coordinated to prevent confusing differences. For example, if one district allows waivers for the poor and provides free health care to children under 5, and the neighboring district health facility provides neither, it is likely to confuse providers and users in both districts.

Significant differences may also affect health-seeking behavior; for example, patients may choose to seek care outside their own health district because it is free or cheaper.

### **Case Study 2. User Fees in Kenya**

Since 1993, user fees have been in place at public hospitals and clinics in Kenya. Of the revenue collected, 75 percent is retained at the facility level and 25 percent is transferred to the district for use in district health activities. Revenue has been used for service improvements, such as improving drug supplies and rehabilitating operating rooms. The poor and vulnerable are protected through the low level of fees, a simple waiver process for the poor, and a range of exemptions from paying the fees, such as for children under 5.

The Health Care Financing Secretariat of the Ministry of Health is responsible for monitoring the collection of fees and for granting waivers to the poor, as well as for making recommendations to raise user fees, when warranted.

If fees and exemptions are set centrally, the volume and financial impact of waivers can be modeled and estimated more easily, facilitating the allocation of central resources to compensate for regional inequities (see chapter 3 for a discussion of waivers and exemptions). Even if user fee policies are decentralized, it is more efficient to set waiver and exemption policies centrally. Ensuring access to health care for the poor is a sensitive issue, and the process should include adequate political debate and approval. The process may be lengthy to allow arguments for and against various policy options and mechanisms. It is important to release balanced, objective information to the public during and after this process. Such information programs will be more successful if policies are standardized countrywide. An argument against the centralized approach is that more creative targeting mechanisms are developed when decision making about fees, waivers, and exemptions is decentralized. For example, a wide range of mechanisms were found in private mission and government sectors in Ecuador because managers were allowed to be creative. However, as concluded from the Ecuador experience, the possible negative impact of using multiple policies probably outweighs the benefit of encouraging creativity.

The poor are generally disenfranchised from the political process, and strong political commitment and leadership are necessary to ensure that equity issues are fully addressed when user fee programs are designed. Often, political “champions” are necessary to drive the process.

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# Options for Protection Mechanisms for Priority Populations

“Targeting” designates the concentration of resources on people who need them the most, particularly resources for social programs. In health, this means focusing resources on people for whom health services are a priority, for example, dedicating public funding as a policy priority for immunization programs aimed at protecting children against illness. For user fee programs, targeting refers to mechanisms that ensure vulnerable groups, such as the poor or elderly, are able to access services. These mechanisms may exempt people entirely from fees or charge people an amount they can afford.

## Targeting Options

There are different mechanisms for ensuring that the poor have access to care and for preventing them from suffering financial hardship due to user fees (see figure 3). These mechanisms can be divided into three groups: direct targeting, characteristic targeting, and self-targeting.

*Direct targeting* is the provision of benefits or services to individuals who cannot afford to pay the cost of care. Means testing—assessment of the financial capability of the patient to pay the fee for services—is used to determine how much a person can afford to pay. This mechanism is called “direct” because it seeks to provide benefits only to the poor. Reductions in fees for the poor, based on means testing, are sometimes called *waivers*.

*Characteristic targeting* is the provision of benefits to groups of people with similar characteristics or needs, regardless of their economic situation. Groups receiving benefits include children under 5, pregnant women, and patients with tuberculosis. This may also represent indirect targeting for the poor because, although it is not specifically aimed at them, some poor may benefit. Free services, based on characteristic targeting, are sometimes called *exemptions*.

*Self-targeting* is a person’s choice to receive benefits by willingly subjecting themselves to an inconvenience, such as waiting in line.

These mechanisms can be used individually or in combination, depending on a country’s situation.

The effectiveness of targeting mechanisms can be evaluated by considering how well they perform in three areas: (1) success in granting waivers or exemptions to the poor, (2) success in denying waivers or exemptions to the

**Figure 3. Key Targeting Issues**

<p>Targeting is used to ensure that the poor have access to care:</p> <ul style="list-style-type: none"><li>• Minimize undercoverage—where the poor are denied exemptions from fees.</li><li>• Minimize leakage—where the non-poor receive exemption benefits intended for the poor.</li><li>• Prevent differences in quality of care between the poor and non-poor.</li><li>• Determine whether characteristic or direct targeting is more cost effective.</li></ul>
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non-poor, and (3) success in informing the poor about the mechanisms so utilization of health services by the poor is maintained or increased.

### Direct targeting

In direct targeting, means testing is used to assess a person's ability to pay for health services. While direct targeting should be more accurate than characteristic targeting in discriminating between the poor and non-poor, it is usually more costly to administer because it requires more information and greater effort for the staff to administer.

*Means testing.* Means testing is used to ascertain a person's economic situation or ability to pay based on documentary evidence, such as a pay slip or an interview. Means testing determines if a person should pay all or none of the fees incurred or calculates what percentage of the fees a person should pay.

*Sliding-scale fees or fee categories.* Means testing may be more sensitive in determining the ability to pay than a simple discrete determination using sliding-scale fees or fee categories. Fees and fee categories are used to determine patient categories that can be (1) applied directly to a predetermined sliding-scale fee or (2) used to determine percentages, which are then applied to the full fee. This establishes the differing degrees of ability to pay. In the first case, for a service where the full fee is \$100, there could be five categories: A, B, C, D, and E (see table 1). Each category would have a different fee, for example, A=\$100, B=\$50, C=\$30, D=\$10, and E=\$0. When a patient is assigned a category, the relevant fee would be applied automatically. In the second case, the category would be used to determine a percentage (for example, 40 percent), which would be applied to the full fee.

**Table 1. Example of Sliding-Scale and Percentage Methods for Setting Fees**

Sliding Scale		Percentage		
Category	Fee	Category	Percentage	Fee
A (full fee)	\$100	A (full fee)	100%	\$100
B	\$ 50	B	60%	\$ 60
C	\$ 30	C	40%	\$ 40
D	\$ 10	D	20%	\$ 20
E (no fee)	\$ 0	E (no fee)	0%	\$ 0

A sliding scale can be used with bundled fees or itemized fees, but it is easier to use with bundled fees when a fee is set for a package of services or a particular intervention (for example, a primary-level consultation, a normal birth, or an appendix removal). The percentage method can be applied to bundled fees or to itemized fees that are charged on a fee-for-service basis. If a percentage method is used with itemized fees, however, it will not be clear in advance how much a patient will pay because the total fees are not known. When services are costly, this increases the likelihood of having to negotiate, at a later stage, how much the patient will pay. A fixed percentage cannot easily represent how much a person can

## Options for Protection Mechanisms

afford, because a patient may be able to pay 50 percent of a bill for drugs but not 50 percent of a bill for a major operation. The sliding-scale method may be better if the rates are affordable.

The number of sliding-scale fee categories should be determined by administrative capacity and the level and range of services provided at a facility. At a clinic, where lower-cost services are provided and administrative capabilities may be limited, two or three categories may be appropriate. At a tertiary hospital that offers many expensive services, five categories may be necessary. No more than five categories should be used because they make the means testing and administrative processes too complex. The lowest category should have a zero fee (0 percent) and the highest should be the full fee, (100 percent). The other categories should represent a range of rates that are generally affordable to different population groups in the catchment area. This might be 20 percent, for example, for people who have some income but cannot afford to pay much, 40 percent for people who are financially better off, and 60 percent for those who are even better off.

Table 2 shows an example of a sliding scale used in 1997 in one South African province. The private rates represent average full cost and are based on national insurance reimbursement rates for private and public hospitals (less a value-added tax of 14 percent). The public fees cover all services provided; private patients pay additional fees for drugs, use of the operating room, and so on. The average charge to a patient at the highest public rate (H3 category) of R302, in a specialized hospital, is much less than the private rate of R403 per day, because R302 covers up to 30 days (private hospital rate per day). Fees are graduated between levels of the hospital, with the lowest public rate (H1) of R40 at a specialized hospital higher than the R30 charged at a district hospital.

**Table 2. Example of Sliding-Scale Fee Structure for Hospitals**

Tariff Category	Single Person Annual Income	Family Annual Income	Specialized Hospitals— General Ward Fee	District Hospitals— General Ward Fee	Fee Basis
Public H1	\$0–\$16,000	\$0–\$27,000	\$ 40.00	\$ 30.00	Per 30 days or part thereof.
Public H2	\$16,001–\$22,000	\$27,001–\$39,000	\$202.00	\$151.00	Per 30 days or part thereof.
Public H3	\$22,001–\$31,000	\$39,001–\$51,000	\$302.00	\$226.00	Per 30 days or part thereof.
Private	\$31,001 and more	\$51,001 and more	\$403.00	\$301.00	Per day.

Source: Western Cape Province, South Africa, October 1997.

Notes: Fees are in rands. Personal and family assets are to be estimated when a person's income is difficult to determine. For simplicity, the figures are not shown in the example.

*The risk of impoverishing the marginally non-poor.* Mechanisms are needed not only to protect the poor but also to prevent the non-poor from becoming poor. To pay high medical bills, patients may be forced to sell scarce family assets, such as land or cattle. They may also have to borrow money, and the repayment of the money and interest may result in sacrifices of basic needs. The country surveys in Ecuador,

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for example, showed that many patients had to borrow money to pay for higher-priced inpatient and surgical services (Collins 1995). Special care must be taken with means testing for patients that have high-priced bills to ensure that hardship will not result.

*Special fund.* One mechanism for dealing with high fee waivers is to maintain a special fund that collects contributions for the purpose of subsidizing the costs of care for the poor. This fund can be set up and replenished from external sources, for example, donations from local businesses or allocations from government. It may be best to use the fund only for higher-priced services for the poor so a more rigorous approval process can be used and expenditures can be carefully and easily reviewed. A fund can be established at the facility level or it can cover several facilities at the district, provincial, or national level. In Ecuador, a national fund is used for this purpose, while in Kenya funds exist at some mission hospitals. In the U.S., the Commonwealth of Massachusetts has a statewide fund, maintained with compulsory contributions from public and private hospitals, and tax revenue.

*Potential problems with direct targeting, targeting, undercoverage, and leakage.* When means testing is used and applied correctly, the poor will receive free or low-cost care. If the application is too strict, some poor patients may not receive needed care or may have to pay too much. This is called *undercoverage*. If the means testing is too generous, the non-poor may receive waivers to which they are not entitled, which is called *leakage* (see case study 3).

It is probably impossible to completely eliminate undercoverage and leakage, and balancing the two can be difficult. Efforts to eliminate leakage tend to reduce the number of waivers for the poor, which increases undercoverage. Likewise, efforts to reduce undercoverage by applying means tests more generously will probably result in increased leakage. Misclassification of the poor and non-poor may be unintentional (for example, where a clerk is not familiar with the guidelines) or intentional (for example, when a clerk grants a waiver to a relative who can afford to pay the full fee). Unless leakage has a major impact on revenue, it is probably best to err on the side of generosity to ensure that people do not suffer financial hardship.

### **Case Study 3. Reducing Leakage at the Expense of Increasing Undercoverage in Guinea**

In 1994, the Republic of Guinea adopted a direct user payment, fee-for-service policy for hospital facilities. The government policy is that all should pay for care. There are no waivers in this user fee system due to government concerns that waivers result in great leakage of revenues from health facilities. It assumes that since there are no waivers or exemptions to benefit the poor and ensure their access to necessary health services, the poor who cannot pay will receive assistance to pay the fees from within their community. Under the current policy, patients pay a single standardized fee based on the service rendered.

The mechanism developed by the Ministry of Health (MOH) to ensure compliance with payment of fees by all patients was to insist that every patient registering for treatment have a payment recorded for that person in the accounting system register. If a facility attempted to grant a waiver, the accounting books would not balance since there would be patients registered who had received treatment without an entry for a fee paid. Recognizing that this policy requiring all to pay for care might cause a great amount of undercoverage, that is, the poor not seeking care because they could not pay the fee, the decision was that the risk was acceptable because it was important to ensure that no leakage occurred. The hospitals have sufficient autonomy, though they are not required to do so, to allow them to use surplus user fee revenues to create special funds to subsidize the cost of services provided to the poor.

Though there is no direct targeting of the poor, there is some characteristic targeting that benefits some of the poor: chronic disease patients do not have to pay for services. Most preventive services, which do not have a fee, do have an initial token charge for the patient chart or immunization record. To promote the proper use of the referral system, patients referred from another level of health facility pay half the standard hospital fee. Other than the exception for chronic patients, there are no exemptions, as an application of characteristic targeting.

The introduction of fees and the absence of waivers for the poor have had a negative impact on the health seeking behavior of the poor. The poor visit the MOH health facilities less frequently than others in the community. The indigent and poor become ill more frequently and more severely than those in other non-poor economic categories. If there were no financial access barriers, it is assumed that the utilization rates of the poor would be greater than those of the general public. Price was shown to be a deterrent to seeking care. The unofficial waivers that do exist are granted infrequently and are not available on a consistent and equitable basis at all facilities. The funds that hospitals could create to subsidize care for the poor have not been established.

## **Means Testing Procedures**

Means testing procedures must be cost effective and efficient.

### **Use documentary evidence**

If national, local government, or other government department cards indicate poverty, the cards should be accepted as evidence for granting waivers or applying sliding-scale fees. For example, social assistance programs that distribute food and other commodities to the poor can be used to identify and certify the poor. Other documentary evidence can include pay slips, certificates for subsidized electricity service, or letters from a local official. Using existing documentary evidence is easier than interviewing patients.

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### **Means test in the facility**

In the absence of reliable external documentary evidence, means testing is probably best carried out in the facility, rather than in the community. As long as the facility is responsible for funding services to the poor (for example, from a fixed budget), the authority to grant waivers must rest with the institution best able to balance the need to fund services with the need to serve all members of the public. The community can be involved through a hospital board or community health committee.

### **Keep administrative costs low**

When services have low-fee levels because they have a low cost or because—for community health reasons (tuberculosis and others)—their use is encouraged, simple, inexpensive means testing procedures should be used. A straightforward fee or no-fee decision may be sufficient. Expensive staff, such as social workers, should not determine waivers for low-cost services.

### **Discourage waivers**

Means testing should not be applied to all patients, only to patients who request waivers. This also saves administrative costs. The process of requesting a waiver and being means tested will, in itself, be a disincentive to people who can afford the full fee. Even with low-fee services, a simplified means testing process should not be too easy from the patient's perspective, for example, the patient might be required to wait in line.

### **Determine who recommends a waiver**

A two-step process is often used to grant waivers: first the initial staff person does a simple assessment or means test and recommends granting or denying a waiver. If the waiver is for a substantial fee, the second step is required: a supervisor or administrative staff member confirms or denies the recommendation of the first staff member. The level of person authorized to recommend a waiver should depend on the level of service. In a small clinic, this could be the receptionist; in a medium clinic, it could be a nurse or counselor; in a large clinic, it could be a social worker; and in a hospital, it would be one of several social workers. Where existing staff have time to carry out this task, the marginal cost will be low.

### **Determine who approves a waiver**

The level of person authorized to approve a waiver should depend on the financial value of the waiver. At the small clinic level, it can be approved by the person in charge. At medium and large clinics, it can be approved by the director or the administrator. At hospitals (or large clinics), a two-tier approval system can be used, where an approval for a waiver up to a certain value is given by the social worker, perhaps with countersignature by another social worker, but approval for a waiver over a certain amount is approved by the head of the social work department or the hospital administrator or both. This procedure can be simplified by having all outpatient waivers approved at the lower level and all inpatient waivers at the higher level.

### **Use standard questionnaires**

Standard questionnaires should be used at all levels to determine the patient's ability to pay as part of means testing. This will reduce undercharging and make patients aware of a more formal structure. The use of a standard form avoids confusing patients who may attend different facilities, and it assists in the comparison of data within and across facilities. For a simple waiver decision, short direct or indirect

questions can be used. A direct question could be, “How much do you earn?” and an indirect question could be, “Where do you live?” or “Do you own a television?” More complex means testing will usually require a longer set of questions aimed at obtaining information on assets, liabilities, income, and expenditure. The process should allow the interviewer to ask other related questions and to use some subjectivity in making the final determination, provided the information is recorded on the form.

### **Use means testing for high-priced services**

For high-priced services (e.g., inpatient or surgery), patients should be categorized, but there should be no more than five categories. A sliding fee scale is preferable to categories that only set percentages; it helps avoid negotiating with patients. So the patient knows the likely price in advance, the means testing process should occur upon admission or before the outpatient procedure is performed. An involved and complicated system for determining who is eligible for waivers of fees is expensive to administer. If the fee for the waiver is small, it may be more cost-effective to provide the service free to everyone rather than incur the expense of determining who can or cannot pay the fee (see figure 4).

### **Set policies about partial payment and negotiate fees in advance**

When fees are high, the process of determining the amount to be paid may require some negotiation. For example, the interviewer may determine that a patient should be able to pay \$30 for a service. If, however, the patient only has \$20, a decision must be made—to accept the \$20 as payment, to refuse to provide the service (assuming that it has not already been provided), to ask the patient to bring the balance later, or to grant formal credit. This is a difficult decision, and it is important for the facility to set a clear policy to avoid confusion and inconsistency for both staff and patients. To avoid negotiating when a patient is ready to be discharged, it is best to establish the probable fee on or soon after admission and to negotiate at that time.

### **Determine the duration of waiver certification**

After a patient has been interviewed and given a category, that category should be valid for a predetermined period of time—one or two years. During that time the patient will not need to be re-interviewed, and the category can be automatically applied to other members of the immediate family. Certification works best with sliding-fee scales because the patient does not need to be re-interviewed for subsequent treatments with different prices. A patient’s income or fee category should be written on the patient card or record, or on a separate card. The card can be valid for a family for the predetermined period and be transferable within a network of facilities. It is important to limit the certification to the immediate family, as economic status of more distant relatives may vary widely and extending waiver certification to a wider family circle may result in leakage.

### **Figure 4. Guidelines for Administering Means Tests**

Means testing will be more effective if simple guidelines are followed:

- Administer the means test once (note on card or with letter).
- Do not use tests for low-cost services (too expensive to determine who is or is not poor).
- Use detailed means testing for expensive services (surgery, inpatient care).
- Do not have too many categories for sliding-scale fees.
- Involve high-level managers in decisions for waivers of higher-priced services.

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### **Consider referral waivers**

Consideration should be given to the applicability of categories within a network of facilities. In other words, if a waiver level is determined at a health center, then it may be possible to take this determination into account at a hospital. However, the hospital must monitor such referral waivers closely, as they can be abused.

### **Control credit**

It may be appropriate to grant credit if it is determined that patients can pay for services but they cannot pay at the time the service is rendered. For example, in farming areas, a patient's income may be seasonal, and the health facility may decide to grant credit until the patient receives payment from the sale of crops. The credit approval process should be separate from the means testing or waiver process, and the process should involve the administrative staff of the facility. The facility staff should carefully assess the cost-effectiveness of trying to collect a debt; they may decide to write off the unpaid debt. The use of credit should be tightly controlled to make sure that credit is more cost effective than granting a waiver. The negative aspects of credit include the time spent trying to collect the amounts due and the risk that some patients will not return because they would have to pay the debt. It may be preferable to waive the fee and ask the patient to pay the full fee on the next visit than to risk causing the patient hardship (see case study 4).

#### **Case Study 4. A Mission Hospital in Kenya**

##### **Kendu Adventist Hospital**

Many private NGO mission facilities in Kenya had no formal targeting mechanisms for the poor, yet the poor always had access and received care even when they could not pay. For example, at one mission facility, when patients could not pay upon discharge, they were released and their bill was listed as an account receivable. Over time, when the amount of the accounts receivable became too large to meet the financial obligations of the hospital, the medical superintendent went to the community leaders. He explained that the hospital was a resource for their community, but if it could not pay its bills it would have to reduce services or close. He then gave them the list of accounts receivable and said that the hospital did not expect the truly poor to pay but that others who were not poor and had not paid should pay. He then left it to the community to determine who should pay.

Within a day, there began a stream of former patients coming to make partial or full payment on their accounts. This was repeated two to three times a year. So while there was no formal waiver system for the poor, no one was turned away from receiving care for lack of money. The nongovernmental facilities with their various mechanisms still found that the revenue generated by the fee systems of mission facilities was adequate to maintain their operational expenses.

## Characteristic Targeting

There are three basic types of characteristic targeting:

- *Public health*, which are health services with significant public benefits, such as immunizations, or groups that are particularly vulnerable, such as pregnant women.
- *Poverty proxy*, which are groups of people most of whom are poor, such as people who live in a low-income community.
- *Political*, which are politically important groups, such as the military, police, or health workers.

Relating to user fees, characteristic targeting involves declaring a service to be free of charge (exempt) or with a reduced fee for patients with a particular characteristic.

### Public health targeting

Aims to provide free or reduced-fee services to promote the use of certain services or to encourage particular groups of people to seek treatment, including—

- services to the vulnerable, such as children under 5 years of age
- treatment for contagious illnesses, such as tuberculosis, sexually transmitted diseases (STD), or HIV/AIDS
- preventive services, such as immunizations for children, prenatal visits for pregnant women, or family planning for women of childbearing age and men
- cost-effective treatment, such as primary health care (PHC)

This type of characteristic targeting promotes services that benefit the wider community or services that are cost effective because they prevent illness or treat illness at an early stage. When user fees are first introduced, it is especially important to protect people who are both poor *and* vulnerable, such as young children from poor families. It may, therefore, be prudent to start with a wide range of characteristic targeting (for example, free services for all children under 5 years old regardless of family income), to ensure that they all have access. After the public and providers become accustomed to the fees, means testing procedures can be put into place and free services for all children can be dropped.

In a general clinic, if patients with certain diseases (e.g., tuberculosis) are exempt and fees are routinely charged before consultation, it may be best to charge for consultation and tests provided before the disease is diagnosed. If they are positively diagnosed as having the disease, further tests and treatment can then be provided free. It may be easier to provide services in a special clinic because all the services will be free instead of mixing nonpaying patients with other patients who are paying fees. Preventive services are also frequently provided in special clinics because they are easier to administer. Special clinics may not, however, be very efficient from the providers' or patients' perspective compared to integrated or "one-stop" services.

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### Poverty proxies

Used for groups of people who are perceived to be poorer than the general population and are delineated by the following:

- geographic origin, such as patients living in poorer areas
- age group, such as senior population
- occupation, such as students or prisoners

With a *geographic proxy*, all people from a poor community are served free or at low cost. It is recognized that some people in the community may be able to pay higher fees and some leakage may occur, but because the majority are poor, it is more cost effective to exempt everybody. A geographic exemption is easy to administer if the facility serves only the poor community. It is harder if the facility serves both poor and better-off communities, because staff must identify where the patients live to see if they qualify. To solve this problem, cards may be issued to all people from the poor communities. Indonesia has used this form of targeting extensively (see case study 5).

The *age proxy* is generally used for old people because they have low incomes and greater health needs.

The *occupation proxy* can be used for groups of patients who have a low income by virtue of their occupation, including—

- *Students*: While sometimes exempt from fees, it is questionable if this group should be because there may be few students. In a low-income country, exempting students may be a form of political targeting (see *Political targeting* in the next section), because the government may see the students as a potential source of opposition. Exemption should be easy to administer if the students possess dated identification cards.
- *Prisoners*: Usually easy to identify and probably poor. Instead of the health department providing free care, it may be more appropriate for the government department responsible for the prisoners to pay their health care costs.

### Case Study 5. Geographic Targeting: Poverty Proxies in Indonesia

The Indonesian health system charges fees for services at public facilities. The fees have generally been low, but because there are many low income individuals, they created the Surat Miskin (poor letter) program. This letter waves fees for the poor. To obtain such a letter requires the poor person to get a letter from the village head. The signed letter must be taken to the subdistrict head for another signature. With both signatures it may be used at a hospital or health center to receive a total or partial waiver of fees. However, the letter must be obtained for each episode of illness. Thus, it is difficult, costly, and time consuming for the poor to use this waiver system and few do. Due to fee increases and concerns about their impact on the poor, a new program, Kartu Sehat, was developed for the poor to receive waivers.

A card is issued to families and is valid for up to eight family members. They are entitled to receive no cost care at the nearest health facility. Services include consultations, immunizations, laboratory work, prenatal care, delivery, family planning, and necessary surgery. The targeting of this card is geographical in that the government has issued the Kartu Sehat cards to villages that have been deemed the poorest. All members of that community received the cards. The government's intends to later issue the card to individuals who are poor and reside in villages and geographical areas that have not been designated as poor. Hence, much undercoverage exists as the poor who do not reside in poor villages have not been issued such cards.

### Political targeting

Political targeting relates to free services for politically important occupation groups, such as the military, civil servants, and health workers. The poor receive little benefit because members of these groups are usually not poor, even though many of them in the poorer developing countries have low salaries. While it may be appropriate to exempt these occupation groups from fees to reduce opposition to a new fee program, the exemptions should be removed as soon as possible. Whenever possible, the cost of health care should be reimbursed by the government department where the patient is employed.

### Self-targeting

Another mechanism for improving access for the poor is self-targeting. This mechanism encourages poor and non-poor patients to use separate services. It entails having separate consultation rooms or times for non-paying and paying patients on the grounds that many patients who can afford to pay the fees will choose to be treated separately from those who cannot afford the fees. Both the special room and special time mechanisms appear to discriminate against the poor, which may discourage them from using the service. A variation of this mechanism is to have a time set aside for appointments, when higher fees are charged. Many patients who can afford to pay will make appointments to reduce waiting time. Free patients will be seen at separate times on a first-come, first-serve basis.

## Comparison of Targeting Mechanisms

Direct targeting provides waivers to individual poor people based on their income levels while characteristic targeting provides exemptions to groups based on criteria, such as health, location, or age. The two types of targeting have important cost-efficiency differences. Determining if someone qualifies for an exemption based on characteristic targeting is straightforward because the qualifying criteria are easy to apply (see case study 6).

### Case Study 6. Exemption Categories in Kenya

The following exemptions were in place in government facilities in Kenya in October 1994:

- *Patients:* children under 5 years old; medical training college students; inpatients re-admitted for the same episode of illness within 14 days of discharge; patients from charitable, destitute, and mentally handicapped homes; prisoners; and unemployed persons with certificates.
- *Outpatient services:* family planning, antenatal and postnatal, child welfare, and STDs.
- *Illnesses:* complications during pregnancy, tuberculosis, and AIDS.
- *Inpatient services:* ward fees after 14 days, and downward referrals.

When fees were introduced in 1990, civil servants, their spouses, and dependents under age 22 were exempted. When fees were extended to health centers in 1992, the child exemption age was raised from 5 to 15 years. In 1994, the civil servant exemption was removed and the eligibility for the child exemption age was reduced to 5 years.

Source: Collins et al., 1996

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Patients are generally easy to identify as part of a health, geographical, or age group. Unlike means testing, which often requires a judgment on the part of the health worker, it is easy to tell if a woman is pregnant or if the patient is under 5 years old. With age groups, it will not matter too much if the age is mistaken, for example, if a six-year-old is included in an under 5-year-old group. Determining income levels, however, is generally more complex, requiring the application of means testing procedures that take time and judgment.

The numbers of poor people that benefit under public health targeting depends on the proportion of poor among the people who use the service. Some people qualify under both mechanisms. For example, a child from a poor family who qualifies for a waiver may also be exempt if she is under 5 years old, if she is getting an immunization, or if she has HIV/AIDS. The poor tend to benefit more from characteristic targeting in areas where the majority of the people are poor, or where there are alternative private providers that middle-income and wealthy patients can use. Free immunizations in public health centers often benefit primarily the poor because the poor are the most frequent users of those facilities. Better-off people who use the free service represent a form of leakage because they receive a free benefit intended to help the poor. However, there is a public health benefit if those people would not otherwise be immunized.<sup>5</sup>

It may be more cost effective to provide services free of charge if fees are low, if means testing or fee collection costs are high, or if a large number of users are poor. This may be appropriate for specific PHC services for vulnerable groups or for all PHC services in areas used mostly by the poor. As a rule of thumb, if more than half the people who use a free or subsidized public health service are poor, there is likely to be a positive impact from an equity viewpoint, as well as a public health benefit.

Targeting mechanisms have multiple costs: costs of administering the system, the clerical or nursing staff who perform the assessment or means test, as well as any senior staff who must be consulted for approval of waivers. There are supply costs, such as receipt books for the collected fees and supplies for issuing waivers or cards to identify the poor who are eligible for treatment. The system loses the uncollected revenues from patients not paying fees due to characteristic targeting and, also, intangible patient costs, such as a loss of dignity when a request for a waiver by the poor must be processed publicly or is known by other patients. Loss of time and additional transport costs may be incurred by the poor if they must seek letters or documentation entitling them to a waiver. Hence, the multiple costs—direct and indirect—must be considered in assessing the cost-effectiveness of the different protection mechanisms.

The following example (see table 3) shows some of the considerations and trade-offs when deciding on targeting mechanisms. It represents a hypothetical community of 10,000 people: 10 percent are wealthy, 60 percent are middle-income, and 30 percent are poor. They all use the public health services.

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<sup>5</sup> In this case, a self-targeting mechanism may be appropriate; a patient can wait in line for a free service or pay for faster service (e.g., receive a service by appointment).

**Table 3. Example of Utilization and Service Costs in a Hypothetical Community**

	PHC Visits	PHC Costs	Hospital Visits	Hospital Costs	Total Cost	Total Population
Rich	2,000	\$10,000	200	\$20,000	\$30,000	1,000
Middle-income	15,000	75,000	1,500	150,000	225,000	6,000
Poor	9,000	45,000	900	90,000	135,000	3,000
<b>Total</b>	<b>26,000</b>	<b>\$130,000</b>	<b>2,600</b>	<b>\$260,000</b>	<b>\$390,000</b>	<b>10,000</b>

In addition to the information in table 3, assume that 80 percent of the budget comes from a subsidy and the rest must be generated from fees. The net revenue objective is \$78,000 (20 percent of total cost). The marginal cost of means testing is \$1 at the PHC level and \$10 at the hospital level; and the marginal cost of billing and collecting fees is \$0.50 at the PHC level and \$5 at the hospital level. The average costs are \$5 per PHC visit and \$100 per hospital visit. Of total PHC and hospital services, 30 percent are used by children and 10 percent are used by old people.

Based on this information, the revenue objective can be achieved in several ways (see the following examples—1, 2, and 3).

1. Exempt all PHC services, provide waivers for the poor who use the hospital, and charge fees to the wealthy and middle-income hospital patients. Based on the calculation shown below, the average fee per hospital visit would need to be \$56.17. Services to 17,000 wealthy and middle-income PHC patients would represent leakage. If means testing is properly applied, there would be no undercoverage.

Hospital means testing costs (900 × \$10)	\$ 9,000.00
Hospital billing costs (1,700 × \$5)	8,500.00
Net revenue objective	<u>78,000.00</u>
Total additional revenue needed	<u>95,500.00</u>
Cost of billable services	\$170,000.00
Cost recovery proportion	56.17%
Average fee per hospital visit (\$100 cost × 6.17 percent)	\$ 56.17

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2. Charge all wealthy and middle-income patients for PHC and hospital services, and provide waivers for the poor. Based on the following calculation, the average fee would need to be \$44.31 per hospital visit and \$2.21 per PHC visit. There would be no leakage and no undercoverage if means testing is properly applied.

PHC means testing costs (9,000 × \$1)	\$ 9,000.00
Hospital means testing costs (900 × \$10)	9,000.00
PHC billing costs (17,000 × \$0.50)	8,500.00
Hospital billing costs (1,700 × \$5)	8,500.00
Net revenue objective	<u>78,000.00</u>
Total additional revenue needed	<u>\$113,000.00</u>
Cost of billable services	\$255,000.00
Cost recovery proportion	44.31%
Average fee per hospital visit (\$100 cost × 44.31%)	\$ 44.31
Average fee per PHC visit (\$5 × 44.31%)	\$ 2.21

3. Exempt all children at PHC level (to encourage use of services) and old people at PHC and hospital (as a poverty proxy). Charge everyone else. Based on the following calculation, the average fee would need to be \$31.25 per hospital visit and \$1.56 per PHC visit. Services to wealthy and middle-income PHC children and old people at the PHC level, and old people at the hospital level, would represent leakage. Services to poor patients who are not children or old people would represent undercoverage. Some of the poor people would not use the services because they could not afford the fees. Anticipated revenue would not be realized and the health of the poor people would probably deteriorate. Others might sacrifice necessities to pay the fees.

PHC billing costs (60 percent of 26,000 × \$0.50)	\$ 7,800.00
Hospital billing costs (90 percent of 2,600 × \$5)	11,700.00
Net revenue objective	<u>78,000.00</u>
Total additional revenue needed	<u>\$ 97,500.00</u>
Cost of billable services	\$312,000.00
Cost recovery proportion	31.25%
Average fee per hospital visit (\$100 cost × 31.25%)	\$ 31.25
Average fee per PHC visit (\$5 × 31.25%)	\$ 1.56

These are simplified calculations. For example, the calculations assume that none of the wealthy and middle-income patients request waivers and that they are means tested.

If it is determined that the PHC exemption is unnecessary to encourage the wealthy and middle-income people to use PHC services, option 2 may be preferable because the fees are distributed among the users

in an equitable manner. In all cases, the rich pay much less than the total cost of services, because the net revenue target is low (20 percent) and the number of poor people in the community is relatively low.

If the number of PHC services to the poor is a much higher proportion of total PHC visits, or if the cost of means testing or fee collection is much higher at the PHC level, it would be more cost effective to exempt all PHC services, as shown in option 1.

If the wealthy and middle-income people all use private services, there would be no leakage, but there would still be undercoverage if the public facilities tried to collect fees from the poor. In these circumstances, it would be more cost effective to make all public facility services free. There would, however, be no fee revenue for service improvement.

## Measuring the Effectiveness of the System

The examples in the previous section are simplified comparisons of the costs and benefits of using alternative mechanisms. A major problem, however, of comparing the cost-effectiveness of different protection mechanisms is deciding how to measure their effectiveness. If the cost of the mechanism is compared with the revenue collected, facilities that grant fewer waivers appear to be more cost effective. However, if the cost of the mechanism is compared with the number or value of waivers granted, facilities that grant more waivers (as a proportion of patients interviewed for waivers) seem to be more cost effective. Neither measure is appropriate by itself.

To develop appropriate measures, we must define the purposes of user fees, including the role of protection mechanisms. If we use the definition *collecting enough revenue from users, in accordance with their individual ability to pay, to provide good-quality, efficient services to the target population*, we are saying that an effective waiver mechanism ensures that everyone pays what they can afford. This combines the two “conflicting” objectives of generating revenue and protecting the poor (see case study 7).

### Case Study 7. Local Government Services in Ecuador

A busy municipal hospital in Quito has to raise all its non-staff costs from fees, which represent 30 to 40 percent of its total budget. Fees are charged for all services—there are no exemptions. Patients are mostly from the lower-middle-income economic group. A social worker, using a standard questionnaire, interviews all patients before admission. Patients are given one of three categories: “A,” full fee, less than full cost; “B,” full fee less 10 percent; and “C,” free. Outpatients are interviewed only if they request waivers; most do not because fees are low and patients expect to pay. Waivers are not granted for medicines or tests. The social worker interviews one patient per day on average, mostly for inpatient services. Less than 0.5 percent of patients receive waivers. When a patient is ready to leave, the social worker prepares a waiver request, which is submitted with the bill to the director for approval. A few patients are granted credit, and about 80 percent of them repay the loans. When patients have large bills that they cannot pay, the hospital sends a claim to a special government fund.

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To measure the effectiveness of means testing and other components, it is necessary to look at the user fee system as a whole. If target goals are set for service volume and revenue, and waiver volume and value, based on the characteristics of the catchment population, the most cost-effective system is the system that achieves those targets for the least cost (see figure 5). Because this measurement is complex, the best solution may be to use a series of indicators to measure cost-effectiveness, with each indicator providing a different perspective. For the waiver system, the indicators could include system cost compared to the number of waiver interviews, number of waivers granted, and value of waivers granted. For the user fee system, the indicators could include user fee system cost compared to total gross revenue earned and net revenue received after waivers. The comparison of facility-based waiver systems with other mechanisms (exemptions or differential subsidies) is more complicated.

Table 4 shows the advantages and disadvantages of four protective mechanisms: subsidized fees, characteristic targeting, direct targeting, and welfare funds.

### **Figure 5. Example of Target Indicators for Fee Collection and Waivers**

If a facility charges \$5 for outpatient visits and there are 1,000 visits in a month, the total revenues that could be generated are \$5,000. If 20 percent of the clinic's catchment population is poor, then the targets should be 800 paying patient visits and revenues of \$4,000 (800 × \$5), and 200 nonpaying patient visits, with a waived value of \$1,000.

Table 4. Features of Several Protection Mechanisms

Option	Advantages	Disadvantages
<b>1. Subsidized Fees</b>		
Fee levels below cost to generate revenue and avoid exemptions or waivers.	<ul style="list-style-type: none"> <li>No administration costs.</li> <li>Most people can pay fee if set at low levels.</li> </ul>	<ul style="list-style-type: none"> <li>Revenue less than optimal.</li> <li>Collection costs may be high percentage of revenue.</li> <li>High leakage if fees too low.</li> <li>High undercoverage if fees too high.</li> </ul>
Reduced fees or public health exemptions to encourage use (e.g., TB).	<ul style="list-style-type: none"> <li>Low administration costs.</li> <li>Encourages treatment.</li> <li>Efficient if most users are poor.</li> </ul>	<ul style="list-style-type: none"> <li>Low revenue if disease widespread.</li> <li>High leakage if many users can pay.</li> </ul>
<b>2. Exemptions: Characteristic Targeting</b>		
Age exemption to encourage use (e.g., infants).	<ul style="list-style-type: none"> <li>Low administration costs.</li> <li>Encourages use.</li> <li>Efficient if most users are poor.</li> </ul>	<ul style="list-style-type: none"> <li>Low revenue if many infants use services.</li> <li>High leakage if many users can pay.</li> </ul>
Age exemption as poverty proxy (e.g., old people).	<ul style="list-style-type: none"> <li>Low administration costs.</li> <li>Efficient if most users are poor.</li> </ul>	<ul style="list-style-type: none"> <li>Low revenue if many infants use services.</li> <li>High leakage if many users can pay.</li> </ul>
Service-level exemption to encourage use (e.g., PHC, hospital OP consultations, preventive care).	<ul style="list-style-type: none"> <li>No administration costs.</li> <li>Efficient if non-poor use private providers.</li> <li>Saves collection costs on lower fee services.</li> <li>Encourages cost-effective use of referral system.</li> </ul>	<ul style="list-style-type: none"> <li>Low revenue.</li> <li>High leakage if non-poor use services.</li> <li>May encourage frivolous care seeking.</li> </ul>
Occupation exemption (poverty proxy).	<ul style="list-style-type: none"> <li>Low administration costs.</li> </ul>	<ul style="list-style-type: none"> <li>High leakage potential because employed are unlikely to be very poor.</li> <li>Requires proof of low salaried employees.</li> </ul>
Unemployed exemption (poverty proxy).	<ul style="list-style-type: none"> <li>Low administration costs.</li> </ul>	<ul style="list-style-type: none"> <li>Identification only possible if certified.</li> </ul>
Self-exemption (e.g., special hours).	<ul style="list-style-type: none"> <li>No administration costs.</li> <li>Saves collection costs.</li> </ul>	<ul style="list-style-type: none"> <li>Two-tier services may be socially unacceptable.</li> <li>May be inefficient use of resources (staff and space).</li> </ul>
Fees exempt in poorer areas (poverty proxy).	<ul style="list-style-type: none"> <li>No administration costs.</li> <li>Low leakage if majority are poor.</li> </ul>	<ul style="list-style-type: none"> <li>Requires extra budgetary funding or cross-subsidy from revenue generators.</li> </ul>
<b>3. Direct Targeting of the Poor</b>		
Means testing.	<ul style="list-style-type: none"> <li>Complex to administer.</li> <li>Low administration costs if used only for high-fee services.</li> <li>Maximizes revenue.</li> </ul>	<ul style="list-style-type: none"> <li>High administration costs if used for low-fee services.</li> </ul>
<b>4. Welfare Funds</b>		
External welfare fund (for high-value waivers).	<ul style="list-style-type: none"> <li>No cost to facility.</li> <li>Low total administration costs if used sparingly.</li> </ul>	<ul style="list-style-type: none"> <li>Needs government or local donors to establish and replenish fund.</li> <li>High administration costs.</li> </ul>

Note: Reduced fees may be used instead of exemptions in the examples above but, in that case, fee collection costs are not saved.



# Designing, Implementing, and Managing Fee and Targeting Systems

## Choosing a Fee Structure and Targeting Mechanisms

Choosing user fee systems that successfully generate revenue and protect the poor involves deciding on fee levels and types, as well as targeting mechanisms. The choice of fees and targeting mechanisms depends on the situation in the individual country. National priorities, issues of social solidarity, and the structure of the health system must be taken into account, in addition to the revenue goals, the administration costs, and the circumstances of the catchment population and target groups.

Revenue targets should be based on how much additional funding is needed to achieve the objectives of improving coverage and quality. If staff costs are covered through the government budget, fees might be set to recover non-staff costs. Fee levels would have to be set higher for better-off patients to cover revenue foregone because of exemptions and waivers. Fee levels should be compared with private-sector fees to ensure that they are more affordable. This is likely to be the case if staff costs are covered from the government budget; public-sector inefficiency, however, may be a factor. Administrative costs will depend on the complexity of the system, particularly the degree to which means testing is used.

While the choice of fees and targeting mechanisms will vary according to the local situation, some general principles should be considered:

*Low or no fees for public health services:* Automatic exemptions, or very low fees, should be used for services that are desirable from a public health viewpoint, especially at primary care levels. Highest priority should be given to those services that primarily benefit the poor. Examples might be curative services to children under 5, treatment of malnutrition, vaccinations, and prenatal and postnatal checkups.

*Fees related to costs:* Fees should be graduated among service levels, with higher fees at secondary and tertiary levels. The higher fees would reflect the higher cost of those services and the need to recover the costs. This would also encourage more cost-effective use of services through proper use of the referral system.

*Ability to pay:* Fees may vary according to the general ability to pay in a certain area. For example, services may be free or cheaper at a clinic in a poor area.

*Medical necessity:* Consultation may be free or inexpensive to ensure that all patients see a doctor if it is medically necessary. Outpatient charges for drugs, tests, and medical supplies should be set as close to full cost as possible.

*Means testing:* When services have low fees, simple means testing processes should be used. Patients should be encouraged to pay the full fee, so means testing is carried out only on request. More complex, accurate means testing processes can be used for higher fees, particularly at secondary and tertiary levels.

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Sliding scales can be used for higher-fee services if there is a wide range of ability to pay. The sliding scale should have no more than five categories, with the highest fee equivalent to the full cost of the service.

*Informing patients about fees:* An estimate of the fee should be made on admission or shortly after so patients know roughly how much they will have to pay. Patients can then make arrangements to pay the fee upon discharge.

*All-inclusive (bundled) fees:* Bundled fees should not be used unless all the services covered by the fee are available. Itemized billing, where each service element (e.g., consultation, x-ray, drugs) is billed separately, when it is provided, is preferable when all services are not available, even though it requires more administrative effort.

*Emergency services:* Fees should not be obligatory for emergency services at public or private providers. Fees may be collected after a patient is stabilized but only if the patient can afford to pay. Once a patient's condition is stable, he or she can be moved to an appropriate facility.

## **Implementing New Fees and Targeting Mechanisms**

To ensure success, special consideration must be given to the introduction of new fees and targeting mechanisms. The main priority is to gain *acceptance*, to overcome any initial opposition, not to generate immediate revenue. The user fee program must be acceptable to all parties—public, politicians, providers, trade unions, employers, and patients. Implementation should be phased so that policy options and mechanisms can be tested and the reaction of patients and providers can be evaluated. To gain acceptance, fees should be set on the low side, exemptions should be broad, and waivers should be granted generously. After the principle of fees is accepted and initial reactions are assessed, fees can be raised, exemptions narrowed, and waivers applied more strictly. Some key aspects of implementation follow:

*Acceptable fee types:* Fees should be first put in place for diagnosis and treatment. They are less likely to discourage utilization than a general consultation fee; patients perceive those services as more tangible, and the services are more expensive in the private sector. Consultations can remain free until later on the grounds that staff salaries are covered by budgetary funds and the poor can have free medical advice.

*Low fee levels.* Fee levels should be initially low; they can be raised slowly, over time, to the desired level. To maintain quality, an automatic annual process should be established to adjust fees to reflect cost increases.

Reduce exemptions over time. Initially, automatic exemptions should be broad to protect people who are both poor and vulnerable, such as young children from poor families or malnourished children. To achieve this, all children can be exempted initially. Exemptions can gradually be narrowed and replaced with means testing procedures.

*More stringent means testing over time.* The means testing system should be liberal initially to guard against undercoverage. Over time, as the system operates more smoothly and people understand how to use it, the system can be tightened.

*Introduce fees gradually, beginning with the highest-level facilities.* Fees and protection mechanisms should be introduced first at higher-up national and regional hospitals. Implementation problems can be solved before proceeding to the larger number of lower-level facilities. The larger, tertiary hospitals are also likely to have the greatest potential to generate revenue.

## Management

Poor management can cause user fee programs and protection mechanisms to fail. Well-trained, capable staff and effective information and accounting systems are essential to ensure that revenue is properly collected and the poor are protected. Following are some of the management and system requirements necessary for a user fee and exemption system (see figure 6).

*Setting targets:* Forecasts of revenue to be generated *and* waivers to be granted to the poor should be used to set targets (e.g., if 20 percent of the population served by a health facility is poor, 20 percent of services should be provided free through waivers for the poor). The targets should be used to compare the actual volume and value of waivers delivered. The standardization of such forecasting and target-setting procedures will facilitate regional and national policymaking and monitoring.

### Figure 6. Facility Recording, Reporting, and Monitoring Systems

When management and system requirements are followed, the user fee and exemption system will be successful.

- Estimate fees, exemptions, and expected waivers to forecast budgetary impact (e.g., on computer spreadsheets) by preparing a model of fee collections, exemptions, and waivers using spreadsheet programs to assess the impact of the actions to be taken on income of the health facility.
- Set targets for individual departments and for people who grant waivers (for example, social workers).
- Conduct rapid patient and household surveys at least once a year to determine the impact of fee, exemption, and waiver policies.
- Put monitoring systems in place to record and report the volume, type of patients, and revenue not collected because of waivers and exemptions.
- Enter revenue not collected in the accounting system to track the financial impact of the policies. Compare actual volumes of waivers and revenue foregone with targets. If there are large variations, investigate why too many or not enough waivers were granted.
- Monitor systems to assess the impact of user fees on utilization, especially by the poor, to ensure the system is working as planned and is consistent with the user fee objectives.

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*Continuous monitoring:* Monitoring is required to assess whether the poor are benefiting, as intended, from the direct targeting mechanisms. Characteristic targeting must also be assessed to ascertain if the benefits being received are accruing to those intended. Some of the monitoring can be done through a routine reporting and information system. Other, more involved and costly monitoring mechanisms, such as household surveys, should be done periodically to determine whether the poor not presenting at the health facilities are receiving the care they need. Mechanisms will need to be adjusted, over time, as the environment changes. Revenue and waiver performance should be monitored monthly through the accounting records. The cost-effectiveness of targeting mechanisms should be monitored in the context of the overall cost-effectiveness of both the user fee system and the work of social workers because means testing is closely integrated with both.

*Accounting for exemptions and waivers:* The financial impact of exemptions and waivers should be recorded in the financial information system. To do this, the gross fee for each service must be shown on the bill (or receipt) and the value of the exemption or waiver should be shown separately as a deduction from the bill. The gross fees must be entered in accounting records, also by service or department, and the value of waivers should be entered as an expense and posted to a special “waivers” expense account. For accounting control (i.e., reconciling revenue with services), it is better and easier to enter gross fees and waivers than to enter fees according to categories, which requires extra coding. Private fees should be recorded separately, also to facilitate control.

*Review of patient characteristics:* The characteristics of patients who receive waivers and patients who do not receive waivers should be regularly reviewed to monitor the effectiveness of the waiver system for appropriate selection and to monitor the impact of fee and system changes. Particular attention should be paid to patients who borrow money to pay the bill because of the risk of causing them financial hardship.

## Public Information

Information must be provided to the public and patients about the fee structure, automatic exemptions, and the availability of waivers for the poor. A public information campaign is important to advise the public, patients, and providers about how the new system will work. Changes to the system must be announced in advance. Information must be provided at the national, local, and facility levels. Posters showing fees and exemptions, and describing how waivers can be obtained, should be prominently displayed in all facilities. Information should, however, aim to dissuade people from seeking to pay less than they can afford. To encourage payment of fees, information on revenue collections and use of funds should be displayed prominently in the facilities. It is important to educate health staff so they understand what the fees are, who is charged and when, how people are exempted from fees, and how the poor can obtain waivers. To prevent revenue collection from being seen as the first priority, facility managers must emphasize the importance of ensuring access of the poor to services.

# Conclusion

Health financing generates the resources needed to achieve national health objectives. User fees are one health financing strategy. They also represent a means to the end—to provide health services—rather than an end in themselves.

User fees are not a panacea that will solve a government's health financing problems. Other concurrent actions are required, including reallocating government resources to the most cost-effective services, improving efficiency to make existing funds go further, and risk-sharing through social insurance.

The fundamental principle is that access to health care should be determined by need, not ability to pay. Policymakers and managers must find creative ways to generate the revenue needed to deliver high-quality services while they protect the poor. This must be done within their local environment, following the principle that each should pay only what they can afford.

Some guiding principles for introducing equitable user fees systems are—

- Combine mechanisms because one mechanism alone is not cost effective.
- Combine low fees, age exemptions, and limited waivers for primary and consultation services with means testing for higher-cost inpatient services.
- Allocate central funds to compensate facilities in poorer areas.
- Focus on granting exemptions for the poor and vulnerable, such as the children of the poor.
- Protect the poor *and* prevent others from becoming poor.

To make user fee systems effective in raising revenues while ensuring equity, the basic preconditions for success include—

- leaders committed to the principle of equity
- accountability to communities for the use of revenues raised
- clear guidelines on implementing the user fee system and applying exemption systems
- public knowledge about the user fee system, use of fees collected, and eligibility for exemptions
- capacity to administer the system, exempt the poor, and correctly use the collected fees to benefit the community and the poor

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# Glossary

*Characteristic targeting:* The provision of free or reduced-price services to groups of people with certain attributes, regardless of income level (e.g., children, patients with tuberculosis, pregnant women).

*Direct targeting:* The provision of free or reduced-price services to the poor, often using some form of means testing to determine how much people can afford to pay.

*Exemption:* A form of characteristic targeting where a free service is automatically provided based on medical condition, age, or other evidence. No means testing is required.

*Leakage:* Occurs when the non-poor receive benefits, such as a reduced fee or no fee, that were intended for the poor (charging users less than they can afford to pay).

*Means testing:* A process of determining a person's ability to pay for the purpose of providing free or reduced price services to those who cannot pay the full price of the services.

*Self-targeting:* A mechanism that encourages people who can pay to choose a more convenient service (e.g., consultation by appointment), leaving the people who cannot pay to take the less convenient service (e.g., waiting in line).

*Undercoverage:* Occurs when the poor do not receive benefits intended for them because the rules covering waivers for user fees or the means testing procedures were too strictly applied or applied incorrectly.

*Waiver:* A form of direct targeting when a fee is eliminated or reduced for a person who cannot afford to pay a user fee for a service. Usually determined by the health facility or in the community using means testing.

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