# User fees or equity funds in low-income countries

See Viewpoint *Lancet* 2006; **368:** 2253–57

In last week's *Lancet*, Bruno Meessen and colleagues[1] compared fundamentally different approaches to redress the unfairness towards poor individuals that characterises health systems in low-income countries: equity funds and abolition of user fees. In Cambodia, an equity fund was established to enable the poorest patients in hospitals to be exempted from health-care and transport fees. By contrast, user fees in Uganda were abolished at all levels of the health system for all patients.

Both experiments sharply increased attendance by poor patients. Two crucial differences merit discussion. First, the Cambodian system recognised that financial barriers in health-care access include indirect costs such as transport or opportunity costs. By only abolishing user fees, the Ugandan experiment neglected this point. Transport as a proportion of total patients' costs can be high,[2] especially in developing countries (28% in Burkina Faso, 25% in northeast Brazil). In Tanzania, costs of transport were so high that "the substantial costs in time and effort and the money spent on travel make it unjustifiable to introduce charges on the grounds that it would discourage frivolous use of services".[3] Thus the abolition of user fees does not resolve all financial barriers for poor patients. However, user fees are a major part of the reason why the poorest groups are excluded from health care, and alternatives need to be found.

The printed journal includes an image merely for illustration

Still Pictures

Field hospital in Burkina Faso

Second, use of performance-based payment in Cambodia is increasingly advocated by donors such as the World Bank to improve health-care delivery. Performance-based payment has been praised for overcoming the limitations of per-capita fees (leading to under-provision of services) and fees for services (leading to over-provision of services). Meessen and colleagues point out that the removal of user fees in Uganda removed the incentive for providers to aim for quality care. This observation assumes that patients can influence quality of providers through payment. The fundamental question is why such financial incentives should come from patients, especially from those least able to pay. Since Meessen and colleagues, among many others, accept that user fees are regressive, discussion of other funding mechanisms to support incentives, such as capitation, would be useful.

Meessen and colleagues' article sits at a crucial moment in the debate about access to health care for poor people in low-income countries. Donors and health economists have advocated user fees since the 1980s as a sustainable and cost-effective health-financing mechanism able to constrain health-care demand in resource-scarce countries.[4] Individual studies claiming to show benefits of user fees, such as curtailing frivolous demand for health care,[5] encouraging individuals to take responsibility for their health (including preventive behaviour),[6] and reducing inappropriate use of referrals,[7] have been repeatedly contradicted. Rice and Morrison[8] and Sepehri and Chermonas,[9] among others, have shown that problems with efficiency and equity persist with user fees. User fees are not always cost effective: national systems have generated an average of only 5% of total recurrent health-system expenditure,[10] and necessary as well as unnecessary demand for care is constrained. The RAND Health Experiment—a large

randomised study in the 1970s in the USA—showed that health-service use fell as cost-sharing increased. However, there were reductions in both ineffective and effective services, and poorer health outcomes overall.[11] Also, supply-side incentives (ie, for health workers) might be more efficient at constraining demand than demand-side incentives (ie, for patients).[12] For equity, because health care has been argued to be an essential good, the demand for it will not fall with price (ie, price inelasticity), and people in the lowest income quintile have shown to be highly responsive to even small changes in price.[13] Hence, even very small fees can reduce their access, and exemption mechanisms for these groups have repeatedly failed.[9] Médecins Sans Frontières studied prices paid in several sub-Saharan African countries at public-health centres that applied user fees for primary care,[14–16] and found that the fees represented a substantial share of household expenditure (equivalent to 12–30 days of expenses), forcing many families to borrow money or sell goods.

All this information begs the question of why we still need to argue about user fees. The discussion is an old one,[17] but unfortunately still relevant. The debate has regained intensity in view of the international agenda for poverty alleviation and the Millennium Development Goals, and Meessen and colleagues' article is a useful addition. Several donors have acknowledged the failings of user fees, some at least rhetorically (World Bank), and others are adapting their aid-policy implementation (UK Department for International Development). Some countries have recently abolished user fees fully (Uganda, Zambia) or partly (Burundi, Niger). Yet, user fees remain in most of sub-Saharan Africa, often publicly denounced by donors but privately accepted as the only viable option if poor countries are not to spend more than their domestic resources allow.

Health economists and donors are now focusing on community-based health insurance, which is defined as any scheme with voluntary membership that uses prepayment for health care by community members.[18] However, the fundamental question remains—who will pay for those unable to afford it?

Meessen and colleagues rightly conclude that no one solution can improve access for poor individuals worldwide. However, they point out that context-specific solutions are attainable. It is time to learn from the accumulated evidence from the past two decades and follow up with action to effectively overcome financial barriers for the world's poorest populations.

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