User fees for health care can sometimes help the poor

Mead Over
Center for Global Development
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Making Services Work for Poor People

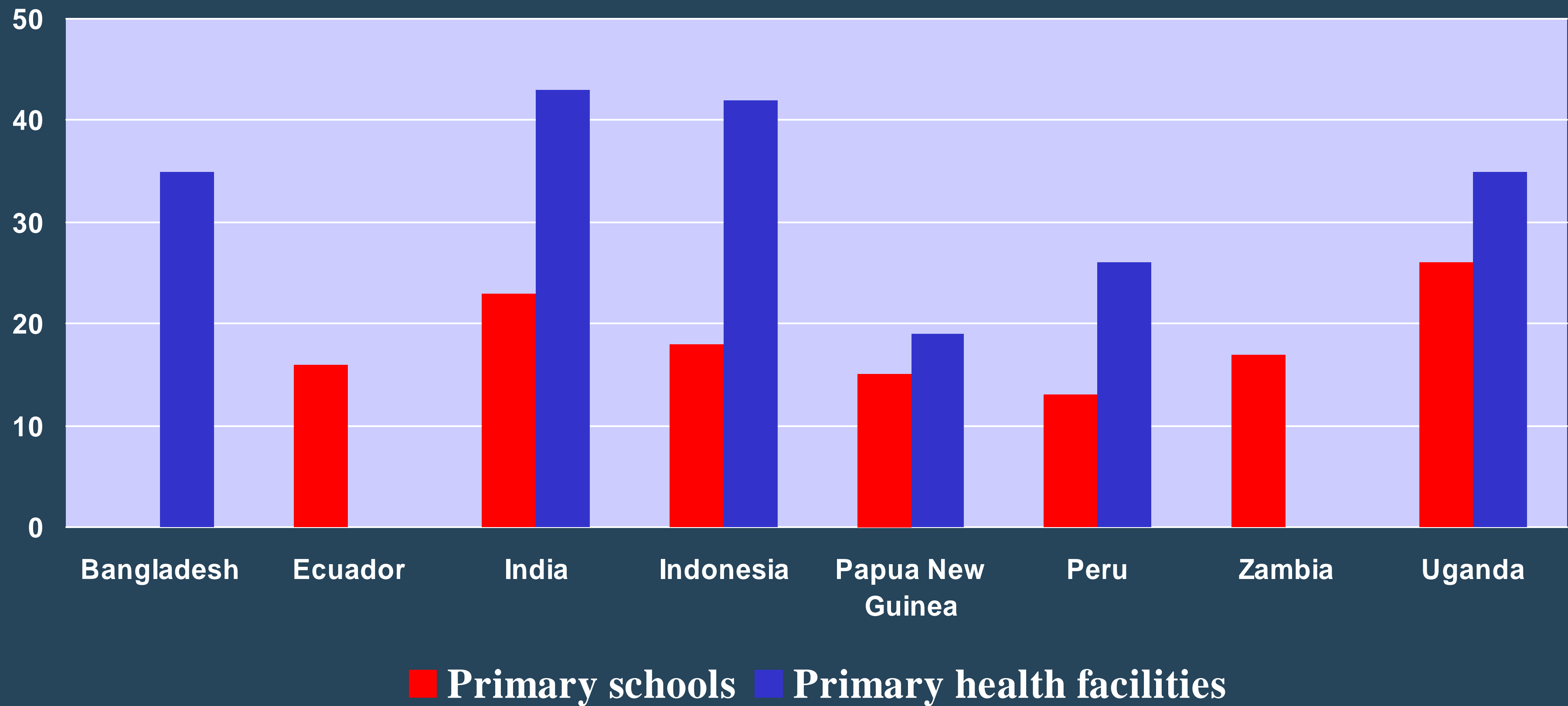
Messages

- Services are failing poor people.
- But governments, citizens, and donors can make them work. How?
- By empowering poor people to
  - Monitor and discipline service providers
  - Raise their voice in policymaking
- By strengthening incentives for service providers to serve the poor

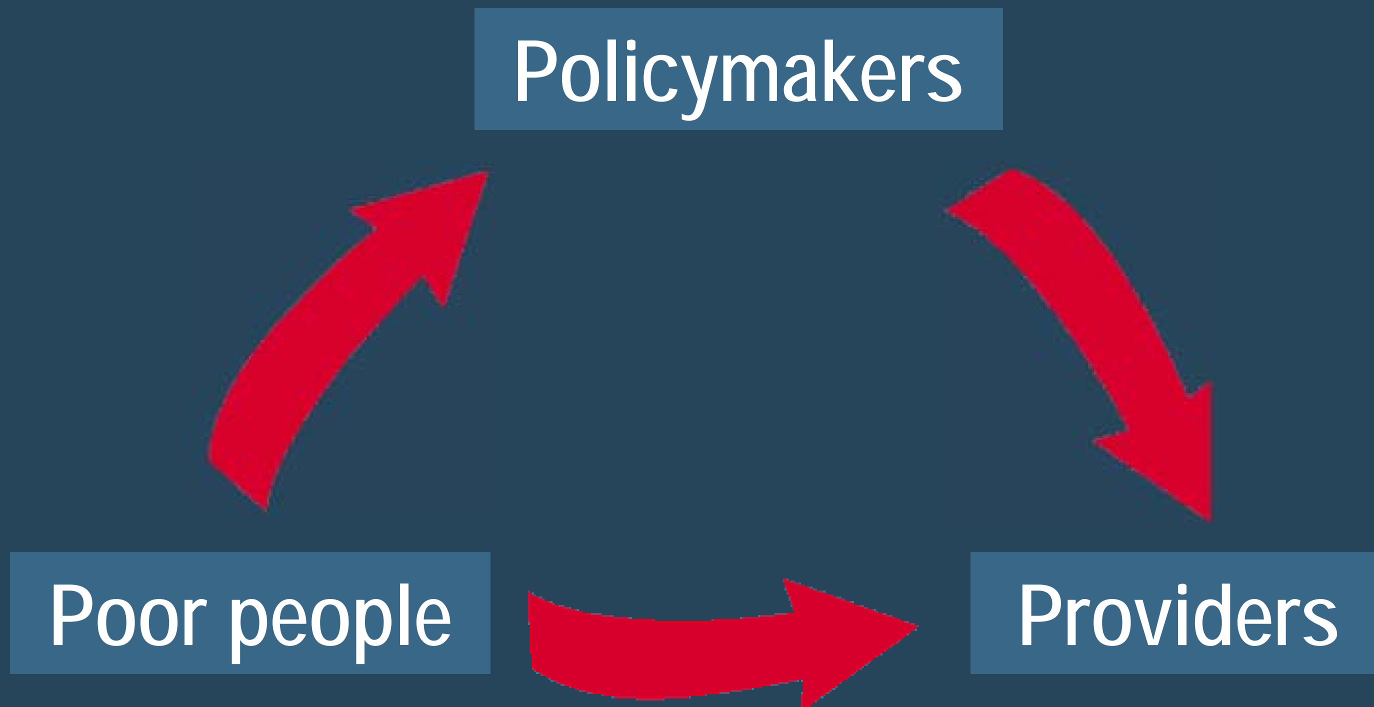
Examples of low service quality

- *Bangladesh:* Absenteeism rates for doctors in primary health care centers: 74 percent
- *Zimbabwe:* 13 percent of respondents gave as a reason for not delivering babies in public facilities that "nurses hit mothers during delivery"
- *Guinea:* 70 percent of government drugs disappeared

Percent of staff absent in primary schools and health facilities



A framework of relationships of accountability



Client-provider

Strengthen accountability by assuring that clients have:

- Information
- Choice
- Participation: clients as monitors
- Financial leverage: User fees, vouchers, etc.

User fees decrease utilization

- First law of economics is that demand rises as price paid by the consumer falls. This is not surprising.
- Among the poor, increased utilization can have substantial health benefits.
- But services can be overused, wasted – e.g. hoarding or resale of free drugs or nets, overuse of specialists w/o referral

User fees increase supply

- Second law of economics is that supply rises as price paid to the provider rises.
  - Providers respond to incentives
  - When government is weak, non-price incentives are harder to wield accurately and efficiently
  - User fees can thus substitute for missing supervision, management incentives, etc..

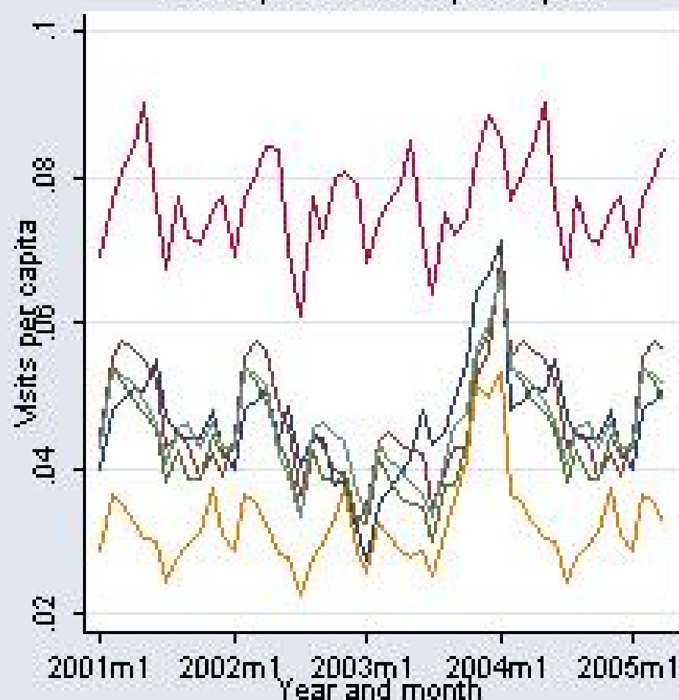
User fees help finance health care

- User fees can be a large percentage of the cost of recurrent inputs – like the cost of restocking bed nets
- Without user fees, there is little incentive to pay a health insurance premium.

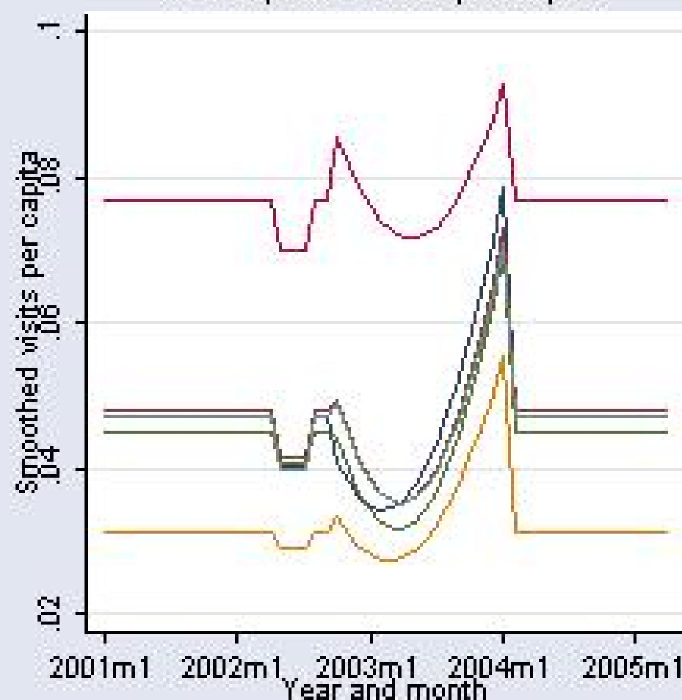
Sub-equilibrium user fees may engender informal fees

- In the absence of strong supervision, when user fees are abolished, informal or “under-the-table” payments may increase so that the patient’s net payment changes little or could even increase.
- Since receipts are not available for informal payments, an insurance company will not be able to insure those risks.

In Madagascar, fee suspension increases utilization …



Source : MINSAN/SISG



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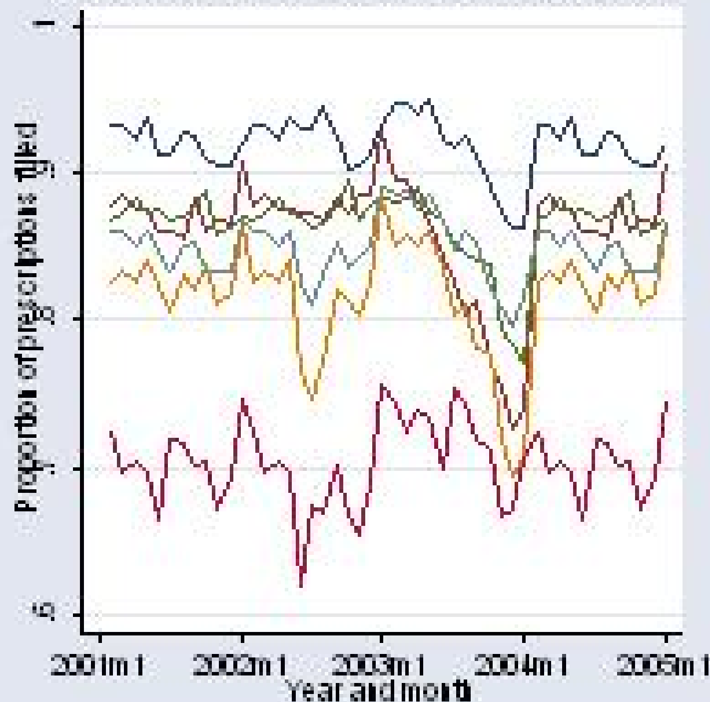
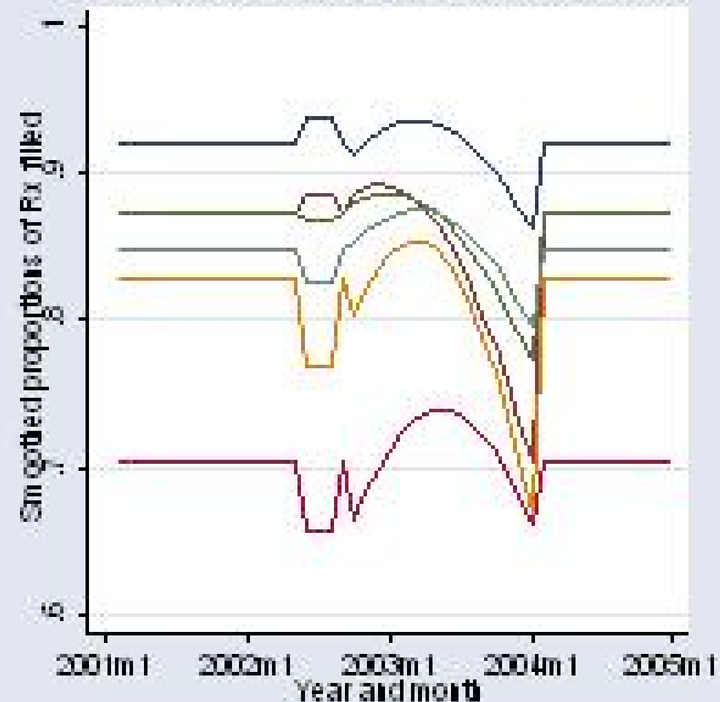
… at the expense of quality

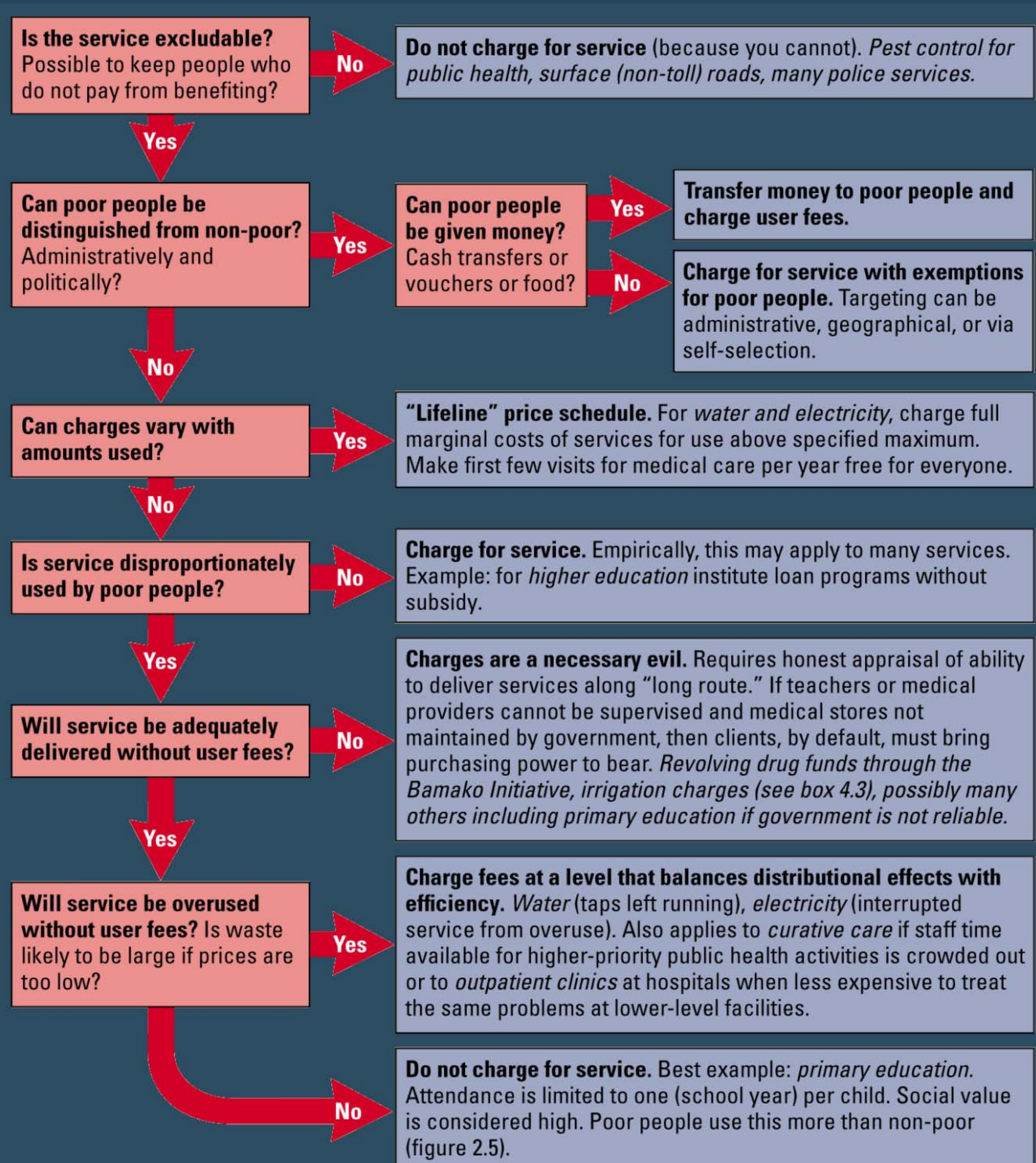


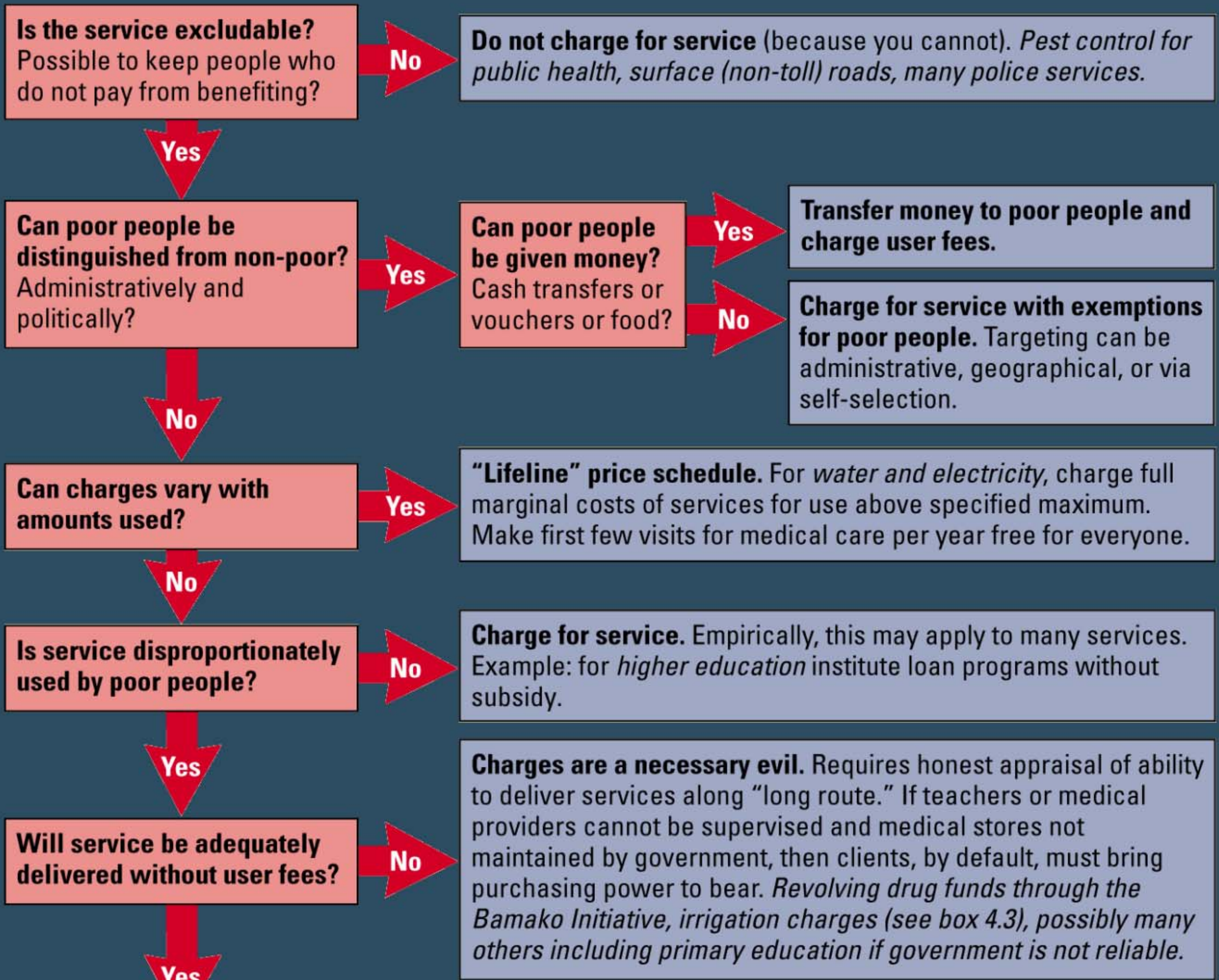


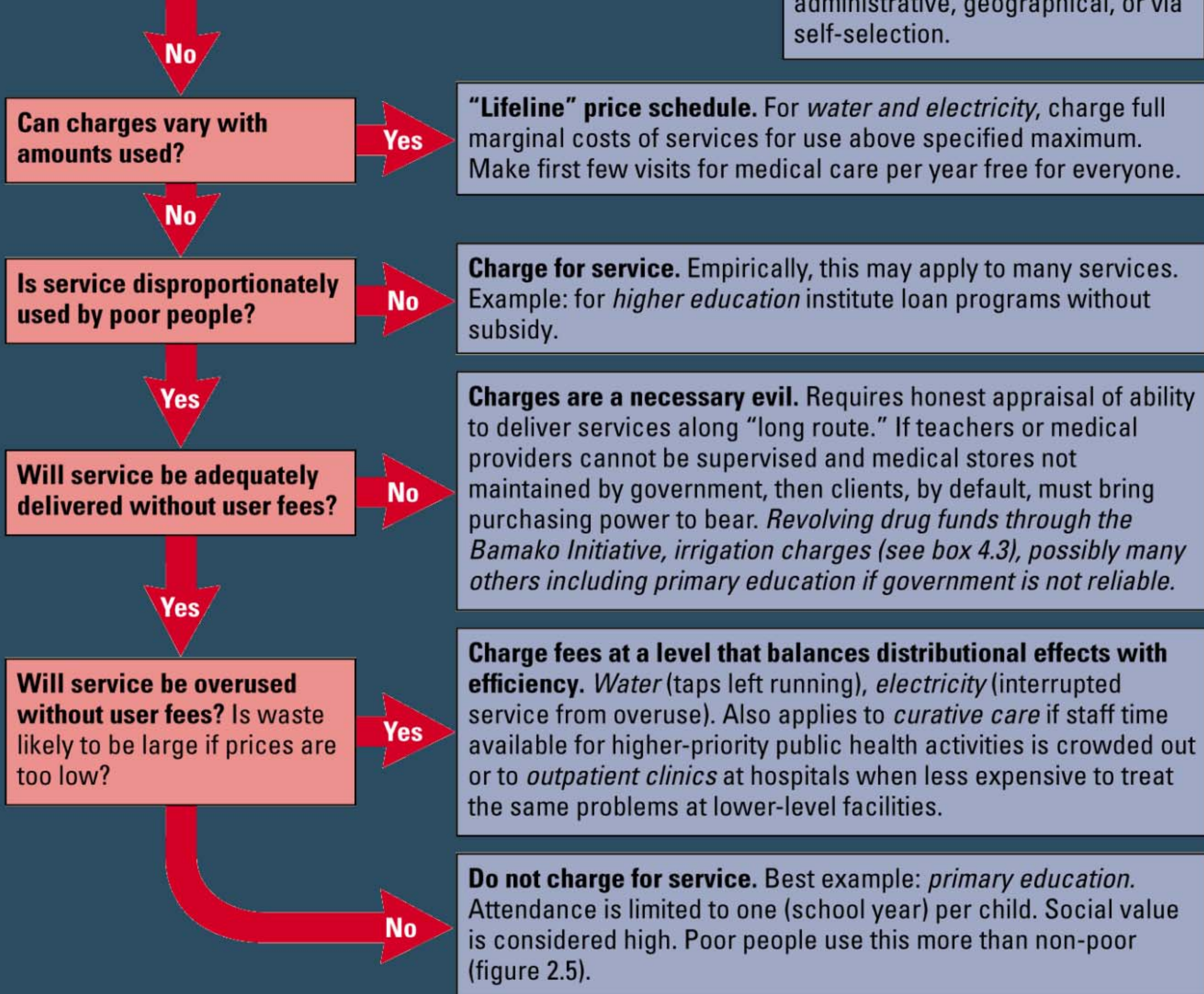
User fees are a policy instrument

- Government has only a small number of instruments, should not discard any.
- The citizen/patient has even fewer instruments, of which user fees are one.
- User fees can be negative for some services, positive for others.

No blanket policy on user fees




Is the service excludable? Possible to keep people who do not pay from benefiting?
No
Do not charge for service (because you cannot). Pest control for public health, surface (non-toll) roads, many police services.
Yes
Can poor people be distinguished from non-poor? Administratively and politically?
Yes
Can poor people be given money? Cash transfers or vouchers or food?
Yes
Transfer money to poor people and charge user fees.
No
Charge for service with exemptions for poor people. Targeting can be administrative, geographical, or via self-selection.
No
Can charges vary with amounts used?
Yes
"Lifeline" price schedule. For water and electricity, charge full marginal costs of services for use above specified maximum. Make first few visits for medical care per year free for everyone.
No
Is service disproportionately used by poor people?
No
Charge for service. Empirically, this may apply to many services. Example: for higher education institute loan programs without subsidy.
Yes
Will service be adequately delivered without user fees?
No
Charges are a necessary evil. Requires honest appraisal of ability to deliver services along "long route." If teachers or medical providers cannot be supervised and medical stores not maintained by government, then clients, by default, must bring purchasing power to bear. Revolving drug funds through the Bamako Initiative, irrigation charges (see box 4.3), possibly many others including primary education if government is not reliable.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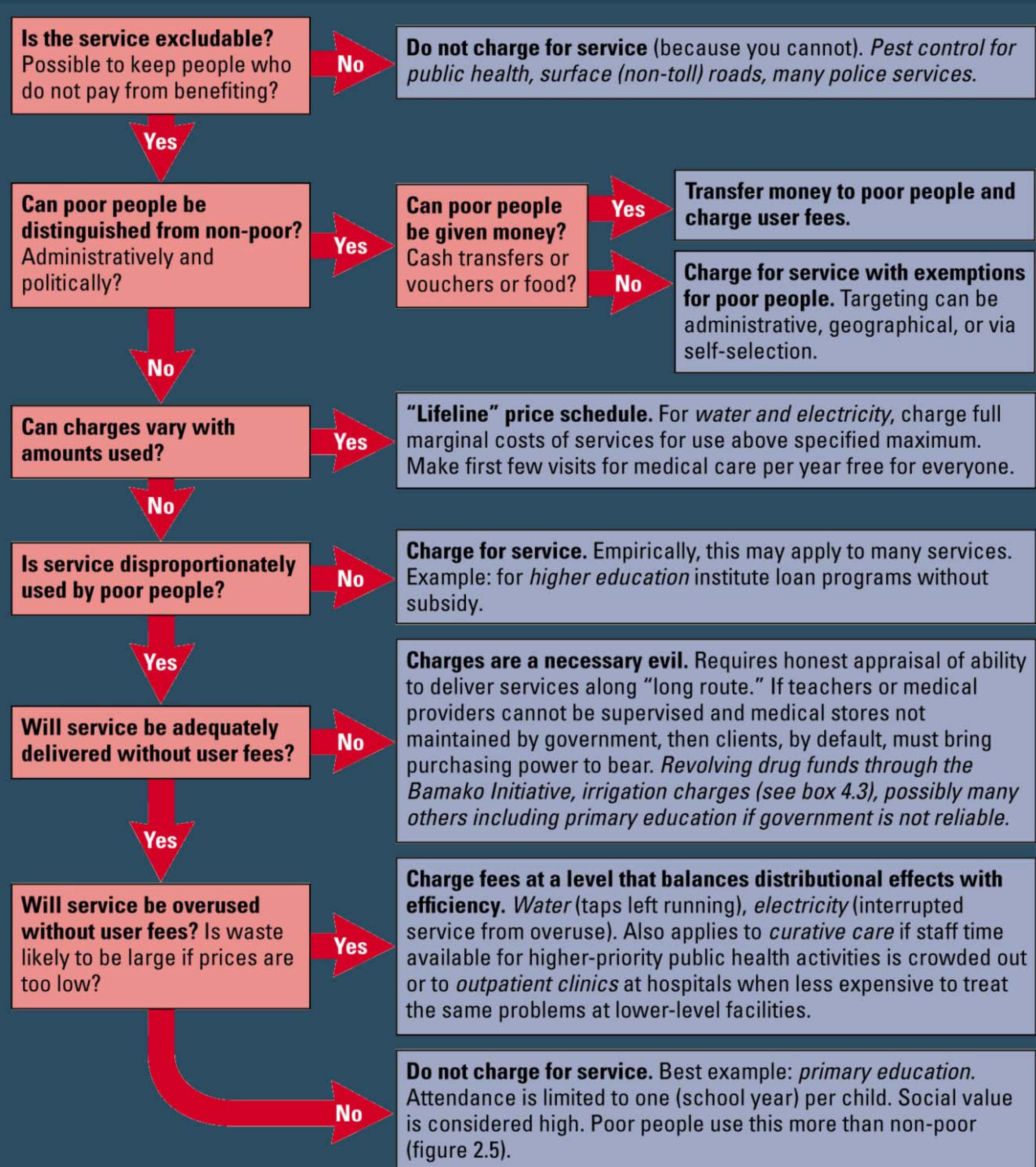
Yes
Will service be overused without user fees? Is waste likely to be large if prices are too low?
Yes
Charge fees at a level that balances distributional effects with efficiency. Water (taps left running), electricity (interrupted service from overuse). Also applies to curative care if staff time available for higher-priority public health activities is crowded out or to outpatient clinics at hospitals when less expensive to treat the same problems at lower-level facilities.
No
Do not charge for service. Best example: primary education. Attendance is limited to one (school year) per child. Social value is considered high. Poor people use this more than non-poor (figure 2.5).

No blanket policy on user fees



How about bed nets?

- Are bed nets a public good or do the externalities outweigh the private benefits?
- Will nets be “adequately” delivered w/o fees?
- And what about that estimate at 10 KSh?

Community effects of high bed-net coverage were demonstrated in Kenya

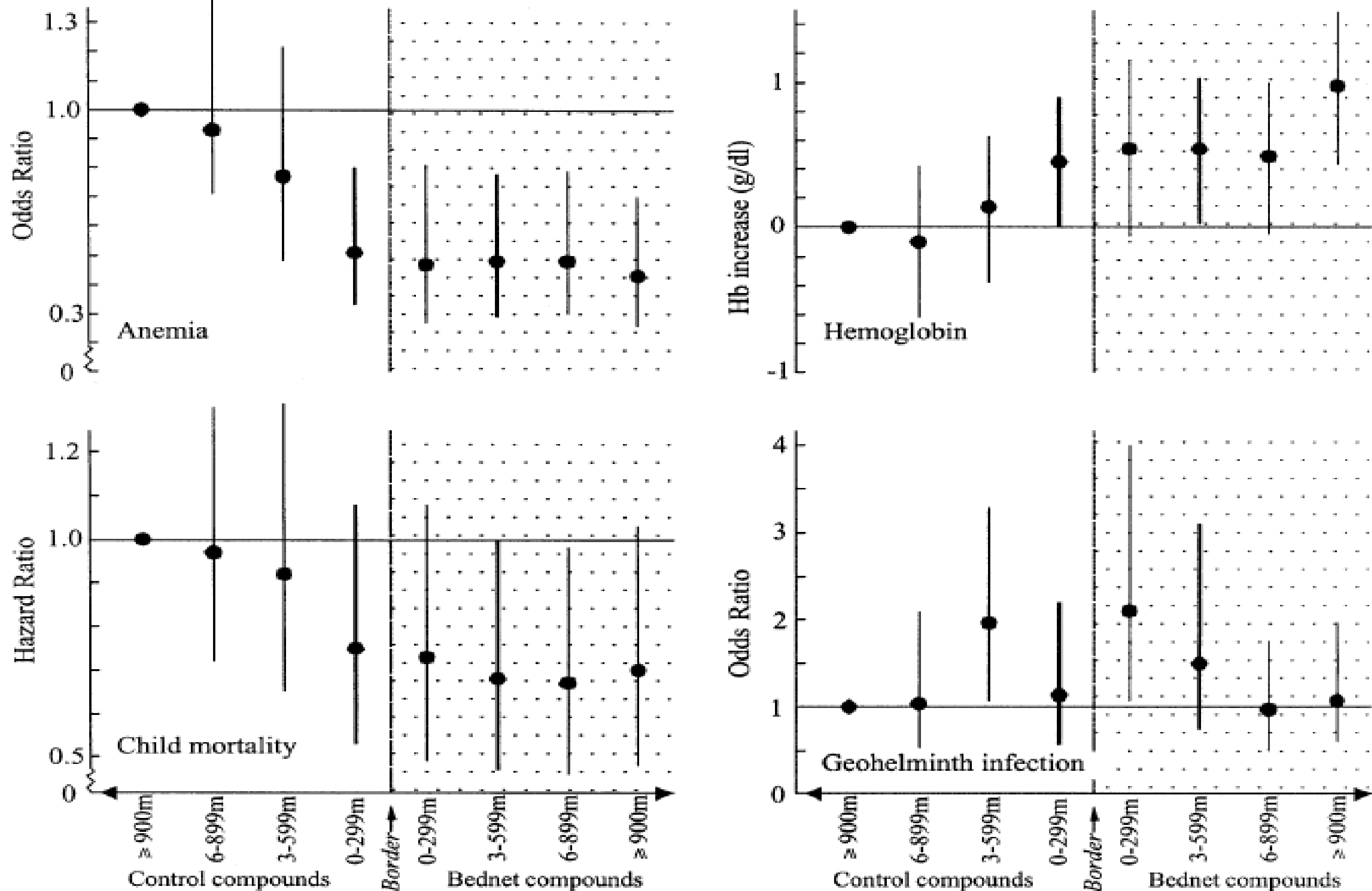


FIGURE 2. Effect of distance to nearest compound of differing intervention status on six health outcomes. Point estimates and 95% confidence

Source: Hawley, W. A. et al. 2003, Fig. 2, p. 125

External benefits of bed nets

- Part of the benefits of bed nets accrue to neighbors
  - Therefore they are NOT "excludable"
  - Bed nets are NOT a "purely private" good
- Furthermore a substantial part of INDIVIDUAL benefits are the result of GROUP coverage
  - People are susceptible before they go to bed

Will nets be adequately delivered w/o fees?

“Clinics were provided with **financial incentives** to carry out the program as designed.

“For each month of implementation, clinics received a **cash bonus** (or a piece of equipment of their choice) worth Ksh 5,000 (approximately US$ 75) if no evidence of “leakage” or mismanagement of the ITNs or funds was observed.

“Clinics were informed that **random spot checks** of their record books would be conducted, as well as visits to a random subsample of beneficiaries to confirm the price at which the ITNs had been sold and to confirm that they had indeed purchased an ITN (if the clinic’s records indicated so).”

(Cohen & Dupas, p. 6)

Will nets be "adequately" delivered w/o fees?

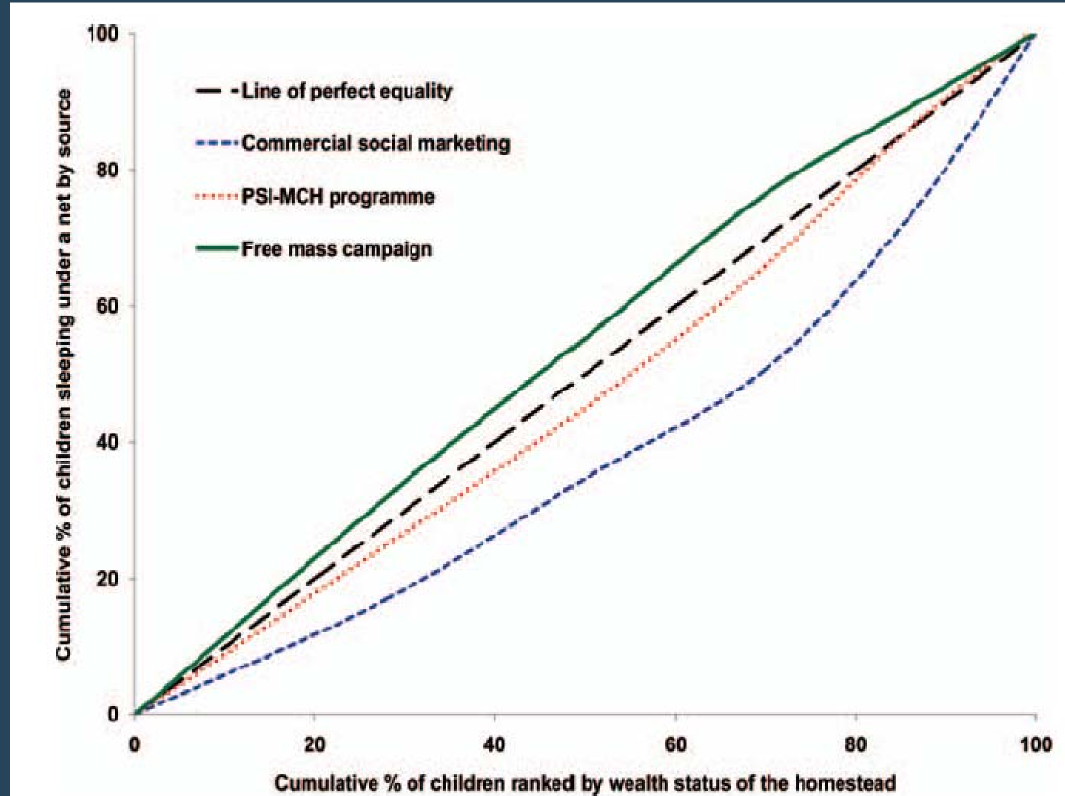
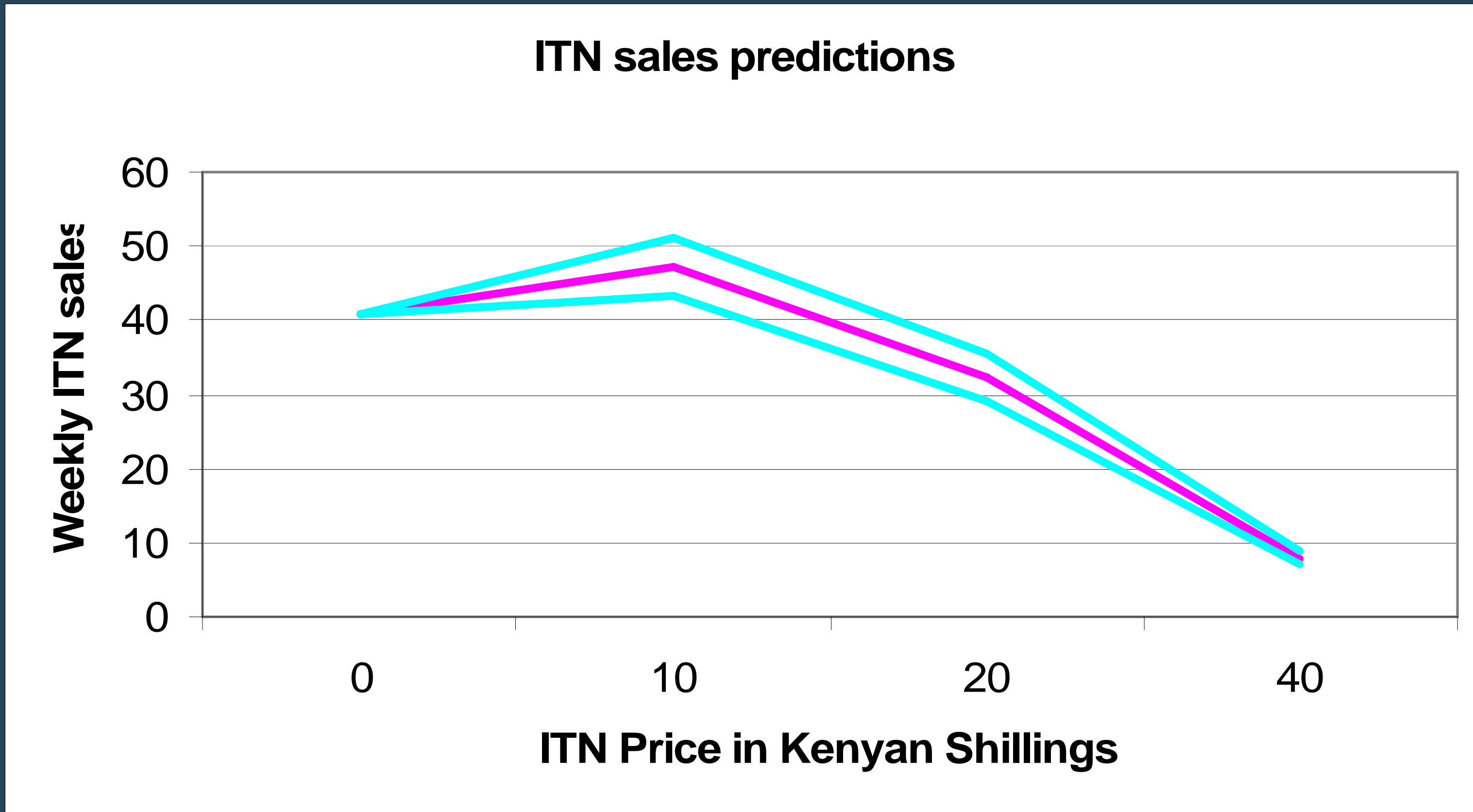


Figure 3. Degree of Inequality in Socioeconomic Targeting by the Three Principal Net Delivery Mechanisms in Four Districts in Kenya by 2006/7
Delivery mechanisms included commercial social marketing, the PSI-MCH programme, and a free mass campaign.

Source: Noor, Abdinasir, Akhwale, Snow, 2007, Fig. 3, p. 255

What's going on at a price of 10 Ksh ?



Source: Cohen & Dupas, Table 2, Col. 6

We need experiments on the supply side

- Under what condition would public providers succeed in sustaining a free delivery system?
  - Information
  - Choice
  - Participation: clients as monitors
  - Financial leverage: User fees, vouchers, etc.
- What is the optimal mix of various distribution policies?