REDUCING USER FEES

Implementation challenges and a possible solution

CREHS

POLICY BRIEF
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THE PROBLEMS WITH USER FEES

During the 1980s and 1990s user fees were introduced in many African countries as a way of financing health systems. They generate income when people pay for health services (including drugs, medical supplies, and consultation or registration fees) at the point of use.

Over twenty years since their implementation, it is now widely recognised that:

- Fees present a major barrier to accessing health services.
- Money raised through fees covers only a small proportion of running costs for health facilities (usually less than 5%).
- Many households are significantly impoverished by their efforts to meet user fee bills.
- The poor and vulnerable suffer the worst consequences of user fees.

Health user fees damage children's health

The Guardian Newspaper reports that the British government is right to highlight the highly damaging consequences of health user fees.

Although these fees are not the only barrier to accessing healthcare, a wealth of research evidence shows that, when they are introduced, poor people's demand for primary health services falls, and when they are abolished, it

• Photo courtesy of Joanna Schellenberg

Gordon Brown leads push to bring free healthcare to tens of millions

world will be given access to free healthcare for the first time under plans to be launched by Britain this

Killer bills - Make child poverty history - abolish user fees

The reduction and removal of user fees is currently one of the top policy priorities in Africa today and several countries have reduced or abolished user fees. However, there is concern that without due attention to the process of fee removal, the expected utilization and affordability benefits may not be achieved. This policy brief examines the challenges of implementing fee reduction in the Kenyan context, and assesses an innovative approach to alleviate these challenges through direct funding of health facilities.

IMPLEMENTING USER FEE REDUCTION: THE KENYAN EXPERIENCE

In Kenya, affordability problems with the high and variable user fees introduced in the late 1980s led to their replacement in 2004 with a flat registration fee of KES 10 (US$0.15) at dispensaries, and KES 20 (US$O.30) at health centres. In addition, complete exemptions were granted for all children under five, and for specific conditions such as malaria and TB. An early evaluation found that this '10/20 policy' was widely implemented, and that levels of health facility utilization increased.

Researchers from the KEMRI - Wellcome Trust Research Programme have investigated whether these early positive findings were sustained after the policy change. The findings are based on research in Kwale, Makueni and Kilifi Districts between 2004 and 2007, including household surveys, patient exit interviews, and focus group discussions with community members.

Many health facilities did not reduce user fees in line with the 10/20 policy

Although user charges were reportedly lower in 2006 than pre 10/20, between half and three-quarters of facilities did not reduce fees to the 10/20 policy level. In some facilities, even children under five were charged. The most common reasons given for poor adherence to the policy were declining revenue and drug shortages. Non-adherence was reportedly often sanctioned by district level managers and health facility committees (HFCs). HFCs consist of local community members and the health worker in charge of the facility. They are responsible for oversight of facility management and representation of community concerns.

> " *Committee members increased registration fees to KES 20 per person including children following discussions with the community because it became impossible to continue providing services under the 10/20 policy* "
>
> *Facility in-charge*

The user fee policy content was not clear even to health staff and managers. Many health workers unknowingly charged registration fees for certain illnesses and services that ought to be provided for free.

Users of health services lacked knowledge about the 10/20 policy

Communities had very limited understanding of the 10/20 policy. Approximately one third of survey respondents could not correctly state the recommended charges for dispensaries, and half did not know the recommended charges for health centres. Community members were more concerned about having to pay for registration than for drugs, particularly given frequently reported drug shortages. Many asked for greater clarity and

communication from authorities regarding charging levels.

Relations between community members, health facility committees and health facility staff

Perceived resource constraints and a lack of clarity around the registration fee appeared to undermine the relationship between HFC members and communities. Committees had little money to work with to ameliorate facilities.

DIRECT FACILITY FUNDS - AN INNOVATIVE APPROACH TO SUPPORT USER FEE REDUCTION

In response to the challenges in implementing the 10/20 policy, the Kenyan Government and the Danish International Development Agency (DANIDA) piloted an innovative scheme of direct facility funding (DFF) in Coast Province. In DFF, health facilities receive money directly into their bank account, and the funds are managed by the HFC. We explored the implementation and perceived impact of DFF at 30 health centres and dispensaries in two districts in Coast Province (Kwale and Tana River), using a structured survey, record reviews, exit interviews, and in depth interviews with health workers, managers and other stakeholders. Key research findings include:

- DFF accounted for an average of 56% of the facilities' annual cash income, but represented only a small fraction of the total running costs (2% and 13% of recurrent costs at health centres and dispensaries respectively).
- DFF was perceived to have had a highly positive impact through funding support staff; outreach activities for immunisation and antenatal care; building renovations; patient referrals and increasing the activities of HFCs.
- Employment of extra support staff and payment of staff incentives in the form of allowances, has reportedly improved health worker motivation, the safety and cleanliness of facilities, and led to reduced waiting time.
- Remaining concerns are that training of HFC members needs strengthening, as does awareness of the broader community of DFF funds and of HFC representatives. Crucially, many facilities were still not adhering to the user fee policy.

POLICY RECOMMENDATIONS

- The policy on user fees should be clarified with a document from the Ministry of Health that lists all applicable fees, displayed at all health facilities. This should be preceded by careful consideration of whether a flat drug fee might be preferable to a flat registration fee.
- Facilities should be compensated for lost revenue associated with fee removal and additional resources (both human and financial) should be provided to cater for increasing demand. DFF is a promising channel for this. National scale up is warranted and planned in Kenya, and should be supported with government and donor funding.
- Performance based financing mechanisms are being increasingly discussed, but have potential disadvantages including administrative burden, fraud and perverse incentives. This study indicates that even without performance targets, an increase in funding at peripheral level may have a positive impact on utilization and quality.
- DFF implementation and operations should be strengthened through comprehensive training for HFC members and health workers, and a clear manual which covers HFC elections and roles, and key elements of DFF operations.
- Adherence to the user fee policy should be a key part of DFF training, and the receipt of DFF money should be conditional on user fee adherence.
- Policies aimed at removing or reducing user fees should be based on early consultation with health workers, facility committees and district health management teams, to ensure that their views are incorporated and any implementation problems addressed promptly.

This policy brief is based on the following publications:

• Chuma J, Musimbi J, Okungu V, et al. (2009) Reducing user fees for primary health care in Kenya: Policy on paper or policy in practice? *International Journal for Equity in Health* 8:15 doi:10.1186/1475-9276-8-15.

• Chuma J, Gilson L, Molyneux CS (2007). Treatment-seeking behaviour, cost burdens and coping strategies among low-income rural and urban households in Coastal Kenya: an equity analysis. *Tropical Medicine and International Health*, 12, 673-686.

• Molyneux CS, Huchkins B, Chuma J, Gilson L (2007). The role of community-based organizations in household ability to pay for health care in Kilifi District, Kenya, *Health Policy and Planning*, 22:6: 381-392

• Opwora A, Kabare M, Molyneux C, Goodman C. Direct facility funding as a response to user fee reduction: Implementation and perceived impact among Kenyan health centres and dispensaries. Submitted to *Health Policy and Planning*.

• Opwora A, Kabare M, Molyneux C, Goodman C. (2009) The Implementation and Effects of Direct Facility Funding in Kenya's Health Centres and Dispensaries. CREHS research report.

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