NO CASH, NO CARE:
HOW "USER FEES" ENDANGER HEALTH

AN MSF BRIEFING PAPER ON FINANCIAL BARRIERS TO HEALTHCARE

March 2008

MEDECINS SANS FRONTIERES

Published by
Médecins Sans Frontières
Brussels operational centre
Rue Dupré 94
1090 Brussels

contact for information: **aau@brussels.msf.org**

Médecins Sans Frontières is a humanitarian medical aid organisation that brings emergency medical assistance to populations in distress in over 60 countries.

INTRODUCTION

As a medical humanitarian organisation, Médecins Sans Frontières (MSF) is concerned with ensuring medical treatment is available to those who need it most. We try to provide health care to the most vulnerable people, regardless of their ability to pay. Over the last five years we have carried out a number of studies into why some people are excluded from health care in the countries where we work. The same factor comes up repeatedly: lack of money.

This document brings together lessons learnt about how financial barriers affect patients' access to public health care in low-income countries. It documents how patient fees – generally referred to as "user fees" - exclude a substantial proportion of those most in need from medical care and exacerbate household poverty.

MSF's research shows that user fees are the most significant obstacle to sick people receiving timely life-saving medical care. Transport costs, having to travel a long distance to health services and the unavailability of medicine are also contributing factors.

In areas where people simply cannot afford to pay user fees, the consequences are disastrous. There are high levels of exclusion and impoverishment, and unregulated forms of medical treatment are readily available through the black market.

Governments and donor agencies have to date shown a lack of urgency and commitment towards changing their policies on user fees. We hope this document will encourage policy makers to consider alternatives to user fees when developing health policies.

The data presented here were collected by MSF between 2003 and 2006 in the Democratic Republic of Congo (DRC), Burundi, Mali, Chad, Sierra Leone and Haiti[1]. By presenting a range of contexts and drawing attention to their differences as well as their similarities, the surveys presented demonstrate the importance of evaluating the specific needs of different populations.

"Financing for essential health services in much of the developing world today can be described in 2 words: insufficient and unfair: user fees are the least equitable method of financing healthcare"

UN taskforce on essential medicines within the Millennium Development Project.

MSF's policy regarding user fees for health

MSF strongly believes that people living in poverty should not be forced to choose between spending scarce resources on health care or going without treatment. We fundamentally refute the idea that asking poor patients to bear most of the financial burden for their ill-health is somehow conducive to better health care and to sustainable health care systems.

MSF's position is supported by our own experiences providing health services in poor countries. When, in the past, we implemented user fee systems ourselves, we experienced significant difficulties ensuring that everyone had access to essential care. We also found that, when MSF projects were taken over by others and user fees introduced, user fees alone failed to ensure the sustainability of the health system.

It is now MSF's policy to provide medical care for free and to cover the cost of patient care. If local or national authorities refuse to let MSF provide free care, patient fees are reduced to the lowest possible level and combined with exemptions for patients who are unable to pay.

MSF's Key Findings on User Fees:

- User fees dissuade people from coming to health centres for treatment;
- The people most excluded from health care are the poor;
- Exemption systems do not work;
- If a user fee system is in place, it is very hard to assess the real health needs of a population. This has important implications for managing public health interventions;
- User fees can impact negatively on the quality of care provided;
- Even modest charges for primary health care risk further increasing the poverty of patients;
- The contributions patients living in poverty can make to financing their own health care are too small to be considered an essential part of health financing;
- Abolishing user fees results in more people seeking health treatment but does not lead to an improper or unnecessary use of services.

[1] For details on the methodology, see annex (page 30). Surveys are avilable on http://www.accesstohealthcare.msf.be

© Carl De Keyzer

BURUNDI

'I was very worried and I brought my little girl to the health centre in my district in the south of Bujumbura. But the nurse wouldn't see us, as I didn't have any money to pay for the consultation. So I had to take my girl back home without having received any care. Then I had no choice but to borrow 2000F (US$1.34) from my neighbours for the consultation. I also bought a few medicines on the black market. Every day I pay back 150F (US$0.17) of the 250F (US$0.29) that I earn carrying bags. I have 100F (US$0.11) left over to feed my family. It's not a lot.'

Woman Bujumbura rural, December 2003

Health situation:

Since the end of the decade-long war in Burundi, the security situation has been slowly improving. However, the national health system is still recovering from the conflict: there are still huge health needs and communicable diseases are a primary cause of illness.

MSF's experience and research in Burundi shows that:

- One million people – 20% of the population - are excluded from the national health system;
- 4 out of 5 excluded patients say it is because they cannot afford to pay for care;
- Even a moderate fee is an obstacle for people living in poor rural areas;
- Exemption systems do not work;
- Mortality rates for malaria are significantly higher amongst patients who have to pay more.

MSF SURVEY

MSF in Burundi

MSF has worked in Burundi since 1992. Today, MSF provides care for female victims of sexual violence in Bujumbura and supports a number of health centres and hospitals across the country. Health services are provided at a very low cost and are free for the most vulnerable.
The objectives of the MSF survey carried out in 2004 were to measure mortality rates; collect information on household incomes; and compare the three payments systems in place in the country in terms of their impact on access to health.

The three payment systems were:
1. **Full cost recovery**, implemented by the government since 2002. The patient pays upfront for all costs: medicines, procedures and overnight stays. Prices are set at national and local level.
2. **Cost sharing systems** piloted by Cordaid in Makamba province. Patients pay for the consultation, medical procedures and half the cost of medicines.
3. **All inclusive flat fee** piloted by MSF and GVC (Gruppo Volontariato Civile) in four provinces: Karuzi, Bujumbura rural, Cankuzo and Ruyigi. Patients pay a low fixed sum of $US0.28 per visit for all treatment costs.
There is an exemption system in the form of an "indigent card" designed to provide free health care for the poorest in all the above systems.

HEALTH AND SOCIO-ECONOMIC RESULTS:

Mortality (deaths/10,000/day)	
Overall population	1.2 – 1.9
Children under five years	3.1 - 4.9
Poverty indicators	
Average income/person/day	US$ 0.3
Population under poverty threshold	99%
Average healthcare cost	
in the national system	12 days work per episode of illness
in alternative system	3 - 6 days work per episode of illness

- Mortality rates at emergency level;
- Mortality rates amongst children at severe emergency level;
- Most deaths are due to infectious diseases;
- Of these, malaria is the biggest killer.

CONSEQUENCES OF USER FEES:

→ Exclusion from health care:
20% of the country's entire population is completely excluded from basic health care with the national cost recovery system. The main reason that people gave for not going for a consultation was lack of finances (80%). With the alternative system, exclusion was lower but still represented 10% of the population. Lack of finances was also given as the main reason for not seeking a consultation.

→ Failure of the exemption system:
The number of people officially exempted was far too low considering the actual exclusion and poverty levels. In practice, there is no protection for the poor.
In the main national system, only 1% of people have an "indigent card" to exempt them from having to pay. In the 'flat-fee' system 5.9% are exempt and in the 'cost-sharing' system 7.2% are exempt.

→ **Impoverishment as a direct result of needing health care:**
Patients and their families are forced into debt or have to sell their possessions in order to cover health care fees. This leaves them unable to pay for further treatment in the future.
Four out of five households in the cost recovery system had to sell some of their goods or borrow money in order to pay for health care. With the cost-sharing system, three-quarters of households were forced into debt. With the flat fee system, significantly more people managed to pay using their savings. Even so, 59% of the population still found it impossible to pay the flat fee without going into debt or selling capital.

→ **Delay in seeking care:**
Many patients only seek care once their health has seriously deteriorated, by which time it is sometimes too late. 36% of those who didn't seek care for a serious condition stayed at home mainly due to lack of money. This may be a significant factor in the alarmingly high mortality rates.

→ **Imprisonment in hospitals:**
There have been numerous reports of patients being held in health centres and only allowed out after paying the fees owed. This happens more frequently in health facilities offering secondary care (i.e. hospitals), where costs are higher[2].

ALTERNATIVE EXEMPTION SYSTEM IMPLEMENTED BY MSF IN BURUNDI

In light of the inadequate coverage of the existing exemption system, MSF tested an alternative system for identifying the poorest sector of the population. Although this new approach brought some improvements, it still did not fully address the needs of a population with of a high proportion of vulnerable people.

This system, implemented in Karuzi Province, requires members of local "health committees" to identify households in need of exemption according to agreed socio-economic criteria. It is different from the usual systems, which only identify individuals for exemption on a case-by-case basis when they turn up at the health facility. This new system removes the conflict of interest for health staff, who may rely on patient fees to fund the health centre and so be reluctant to grant exemptions. It also helps identify those who can't afford to get to health facilities in the first place, and targets households rather than individuals.
After two years of testing this system, the results were as follows:

- 10% of households qualified for exemptions. This is significantly higher than other areas surveyed, which generally only protect 2 - 3%;
- Those who were entitled to free health care effectively benefited from it;
- More than 10% of households that did not qualify for exemption could not afford the flat fee ($US 0.28), which meant that many were still left without care. The flat fee represented more than the daily expenses of the whole family;
- In practice, only 8% of households had cash available at the time of a family member falling ill.

Conclusions:

In a context in which the majority of the population faces widespread poverty, even a small fee for health care is a major barrier for people trying to access health services. Exemption systems based on individual identification are not very effective and broader exemption policies (for example exempting groups such as children under five and pregnant women from fees) should be considered.

A note: the new policy of free care for children and pregnant women – announced by the President on May 1st 2006 – is a step taken in the right direction and has already proved to have a positive impact on utilisation of health services by the most vulnerable groups (see page 22).

[2] « Detention of insolvent patients in Burundian hospitals », J.Kippenberg, J-B Sahokwasama and J.J.Amon, Health Policy and Planning 2008, vol 23.

© Ake Ericson

SIERRA LEONE

"We normally do not go to the clinics at the time we are supposed to because of the cost of services and we don't have money all the time"

(Focus group discussion with women in Makeni hospital- June 2005)

Health situation:

Sierra Leone has been fairly stable in recent years, but the country is still scarred by war. The general status of the population's health remains very poor: the maternal mortality rate is among the highest in the world and around one in five children die before their first birthday.

MSF's experience and research in Sierra Leone show that:

- Mortality is four times higher than the average for sub-Saharan Africa. A significant number of deaths are due to malaria;
- The national cost recovery system is too expensive for more than half of the population;
- Almost half of all patients seek treatment in the "informal" sector because it is cheaper;
- The poorest are the hardest hit;
- The abolition of fees encourages patients to seek treatment earlier.

MSF SURVEY

MSF in Sierra Leone

MSF has worked in Sierra Leone since 1986. MSF provides basic health services and supports a referral hospital near Bo, the country's second largest city. Until 2007, MSF also provided consultations to Liberian refugees in camps located in the western and southern parts of the country and responds to medical emergencies.

The objectives of the survey carried out in 2005 in four rural districts (Tonkolili, Kambia, Bo and Bombali) were to measure mortality rates, collect information on income and expenditure patterns and compare levels of access to health care with three different payment systems:

1. **A cost recovery system** applied in most public health facilities which requires patients to pay for the majority of services.
2. **An all-inclusive low flat fee system** with a waiver for those who cannot afford it.[3]
3. **Subsidised free health care for all**, except for men aged 20-45 who pay US$0.40. Staff may waive this fee if patients can't pay.[4]

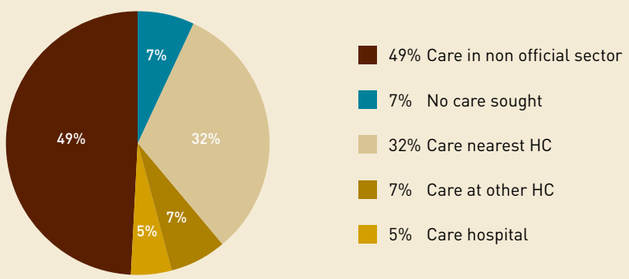
HEALTH AND SOCIO-ECONOMIC RESULTS:

Mortality (deaths/10,000/day)	
Overall population	1.2 – 1.9
Children under five years	2.7 – 3.5
Poverty indicators	
Average income/person/day	US$ 0.11
Population under poverty threshold	97%
Average healthcare cost	
in the national system	50% people pay >US $3.40 (25 days work)
in the flat fee system	US$ 0.08 for children and US$ 0.04 for adults
in the informal sector	US$ 0.09 - US$ 1.30

- Mortality four times higher than expected in a sub-Saharan African country;
- 25%-39% of all deaths due to malaria;
- 63% of child deaths due to malaria.

CONSEQUENCES OF USER FEES:

Health seeking behaviour in last episode of illness



[3] Implemented by MSF in Tonkolili and Kambia.
[4] Fully subsidized care by MSF in Bo.

→ Exclusion from healthcare from government-run health structures:
With the cost recovery system, two-thirds of those surveyed did not seek care at their nearest health facility and 7% didn't seek any care at all.
The main reason for exclusion was financial: a quarter of people said they didn't use official health facilities because they were too expensive. A third of people who chose the unofficial sector did so because of the cheaper cost.
The poorest patients in the survey reported using the public facilities the least.
Pregnant women reported long delays and some said that they were denied care when they could not pay. Mothers told of incidents where they were kept in hospital until the family could settle the bill. Even emergency medical treatment was out of reach, for instance caesarean sections, which can cost up to US$80-$250 in public hospitals.

→ Failure of the exemption system:
The national health policy states that children under five, breastfeeding women and elderly people should be exempt from payment. However, no more than 3.5% of the patients in this category actually received an exemption.

→ Impoverishment:
Half the people paid more than US $3.40 to get treated in the main health system, which represents about 25 days of income. In addition to that, almost 50% of households also incurred other costs such as food and transport which can amount to US $1.8 per episode of illness.

→ High use of the informal sector:
Almost half of all patients sought treatment in the informal sector because it was cheaper and more flexible. 'Pepe doctors' were found to be quite popular in the villages. According to one interviewee, *"they come to people's home, do not ask for consultation fees, sell the same drugs as the health centre for a cheaper price and are flexible in their payment schemes."*

ALTERNATIVE TO COST RECOVERY IMPLEMENTED BY MSF IN SIERRA LEONE

In order to try to overcome the financial barriers to health care, MSF piloted two alternative systems: a flat-fee project in Kambia and a free health care project in Bo. In both areas, access to health care improved. We observed:

- Increased use of services, even by the poorest sector of the population;
- Fewer people reporting financial barriers as being the main obstacle to care;
- Fewer households put at risk of extreme poverty because of health care fees.

In Bo, where flat-fees were abandoned for free care, there was a ten-fold increase in consultations for children under five and the overall attendance rate tripled. Patients with malaria or in need of hospitalisation came to health facilities that they could not previously afford.
In addition, the abolition of fees encouraged sick people to seek treatment sooner. This led to less outpatients having to be hospitalised.
In places where an all-inclusive flat fee was applied the financial burden on the patient also decreased. The average total cost paid was US$ 1.20[5] compared to US$ 3.30 in the cost recovery sample. However, this cost is still high, equivalent to more than a week's average wage. Consequently, 50% of families still had to resort to high-risk methods to raise funds.

Conclusions

In the context of widespread poverty in Sierra Leone, the cost-recovery system is proving to be a huge obstacle in terms of access to care. Implementing a low flat-fee would alleviate the problem, but any amount of money represents a constraint in very poor areas. MSF's experience in Bo showed that moving from a low-fee system to free care produced a sudden and dramatic increase in the number of consultations provided. This clearly illustrates that even very small fees are a significant obstacle to accessing health care.

[5] Average cost found in the survey: it is higher than the expected fee.

© Carl De Keyzer

DEMOCRATIC REPUBLIC OF CONGO (DRC)

"We live in the village of Mbiliona where the health centre is not working, and the nearest MSF-supported centre is over 40km away. Our child got sick in February 2005. He was six weeks old and had a respiratory infection. A man selling medicines came to the village and asked us for 600 francs for three doses of an injectable treatment. My husband and I tried to find all the money we could, which was only 300 francs. The man told us that was only enough for a single dose. Our child died a few days later."

Mrs C., Basankusu health zone 2005

Health situation:

While the international community is working on economic reconstruction in the Democratic Republic of Congo, the humanitarian and health situation of the Congolese population remains worrying even in areas where the conflict has ended.

MSF's experience and research in DRC show that:

- Up to 38% (according to the 'health zone' in which they live) of the population are completely excluded from any type of health care because they cannot afford it;
- Even very low fees exclude some patients;
- In some of the zones surveyed people cannot produce cash to pay as there is none in circulation;
- When treatment is free, attendance at health facilities increases.

MSF SURVEY

MSF in the DRC

MSF has worked in the DRC since 1981 and now provides primary and secondary health care in Ituri, North and South Kivu and Katanga. MSF also addresses the health needs of people affected by specific diseases such as HIV/AIDS in Kinshasa, Bukavu and Kisangani and sleeping sickness in Isangi. MSF runs special programmes focused on sexually transmitted diseases and Sexual and Gender Based Violence In Kisangani. Multiple emergencies including measles, bloody diarrhoea, typhoid fever and cholera are also being addressed throughout the country.

The objectives of the survey undertaken in 2005 in several rural areas in the north, south, east and west of the country[6] done in were to assess mortality, access to health care, vaccination and violence. Another survey compared three payment systems and their impact on access to health[7]:

1. **A cost-recovery system** (the norm in all state-run health facilities);
2. **A free care system** (subsidised), implemented by MSF;
3. **An all-inclusive flat-fee system** (subsidised), implemented by MSF.

HEALTH AND SOCIO-ECONOMIC RESULTS:

Mortality (deaths/10,000/day)	
Overall population	0.8 – 3.4
Children under five years	2.3 – 6.2
Poverty indicators	
Average income/person/day	US$ 0.30[8]
Average healthcare cost	
in the national system	US$ 0.04 - US$ 4.20

- Mortality rates reflect an emergency situation even in areas not directly affected by the conflict;
- In some areas mortality rates have increased since 2001[9];
- Most common causes of death are preventable infectious diseases: malaria, diarrhoea and acute respiratory infections;
- The cost of primary health care is highly variable across different 'health zones'.

[6] Kilwa, Inongo, Basankusu, Lubutu and Bunkeya.
[7] "User Fees in the Eastern Democratic Republic of Congo: a barrier to Access to Health-Care", MSF-Spain. July – August 2005.
[8] Strategic framework for poverty reduction in DRC, World Bank, March 2002.
[9] http://www.accesstohealthcare.msf.be/DocShareNoFrame/Common/GetFile.asp?ID=56724&mfd=off&LogonName=guest

CONSEQUENCES OF USER FEES:

→ Exclusion from healthcare:

- In four out of five 'health zones', barely half the population was able to reach a health facility and receive treatment.
- 29 - 38% of people (according to the 'health zone') are completely excluded from any kind of healthcare;

Lack of money is the main reason given for exclusion[10], varying from 35% to 85% depending on the zone surveyed.

The other major reasons for being excluded from health care are transport (3% to 13%) and non-availability of drugs (3% to 16%), which is more striking in the remote areas of Basankusu, Inongo and Lubutu.
There is also a severe shortage of physical money in the region with which to pay (money that does not exist in paper form simply cannot circulate).

→ More people use official public health services when alternative fee systems are implemented:
Where the full cost recovery system was in place, more than 50% of those surveyed did not go to the nearest health centre when they were last sick, mostly because they could not afford it. The situation was better under the flat-fee system, but many patients had healthcare-related debt. Under the free care system, patients tended to seek care from the nearest health centre during each episode of illness.

→ High use of the informal sector:
For many households that could not afford to pay for healthcare, the only option was to resort to self-medication, traditional medicine or faith-healing at church. The unregulated drug market potentially puts people's health at risk.

Conclusions

The appalling humanitarian situation in the country calls for the deployment of far-reaching policies focused on the immediate health needs of the Congolese population. In rural areas of DRC where cash is rarely available and subsistence economies are the norm, even small costs place health care out of reach for many patients.

[10] Except for Basankusu where transport is the main reason for non access (40%) before financial barrier (35%).

© Dominick Tyler

CHAD

"During the rainy season we have no money and the food stocks are empty. We don't have any means to pay for care at the health centre and children die..."

Head of Midikil village, Mayo-Kebbi 2006

Health situation:

Chad is one of the poorest countries in the world and the majority of the population lives in poverty. Use of health services is very low. Malaria is the main reason that people seek medical consultation and implementation of the new treatment protocol based on arteminisin combinations (ACT) is urgently needed.

MSF's experience and research in Chad shows that:

- Malaria is the main cause of death: 90% of the households visited said that one of their members had been sick with malaria in the three months prior to the survey;
- Only half of those went to a health centre;
- Subsidising drugs in a system where all other services are charged for has a limited impact on access to health care.

MSF SURVEY

MSF in Chad

MSF has been working in Chad since 1981. The organisation currently works in camps near the Sudanese and Central African Republic borders, where an estimated 200,000 refugees are sheltering after fleeing violence in neighbouring regions. In 2004, MSF started a malaria treatment project in Bongor district in the west of the country, where it also supports the district hospital. MSF frequently responds to emergencies such as cholera, measles and meningitis epidemics.
The objectives of the survey carried out in 2004 were to measure mortality in Bongor District and evaluate patients' access to the new malaria treatment.
In Chad, **a cost recovery system** is in force in the official health facilities but **a subsidised system** was put in place by MSF in Bongor. The new malaria treatment (artemisinin-based - ACT) is subsidised up to the price of the older drug (Chloroquine).

HEALTH AND SOCIO-ECONOMIC RESULTS:

Mortality (deaths/10,000/day)	
Overall population	1
Children under five years	2.9
Main cause of death	Malaria (50% all deaths in under fives)
Poverty indicators	
Average income/person/day	US$ 0.5
Population under poverty threshold	91%
Average healthcare cost	
in the national system	US$ 3.01 (9 days wages) for one malaria episode

- Mortality rates are at emergency levels;
- Mortality for children under the age of five is three times higher than expected;
- In all age groups, the main cause of death is malaria;
- For children under five, malaria is responsible for more than half of all deaths;
- 90% of households visited had someone sick with malaria in the three months prior to the survey.

CONSEQUENCES OF USER FEES:

→ Exclusion from healthcare:
16% of people had had no consultation at all when they were last sick. Only half of sick people surveyed had visited the nearest health centre. The main reason they gave for not seeking health care was lack of money.

→ More people used the alternative health sector:
One patient out of five chose to use the informal health sector. Most of them went directly to drug sellers. The majority of households said they had done so because of financial constraints. The quality of such care is frequently substandard and possibly even unsafe.

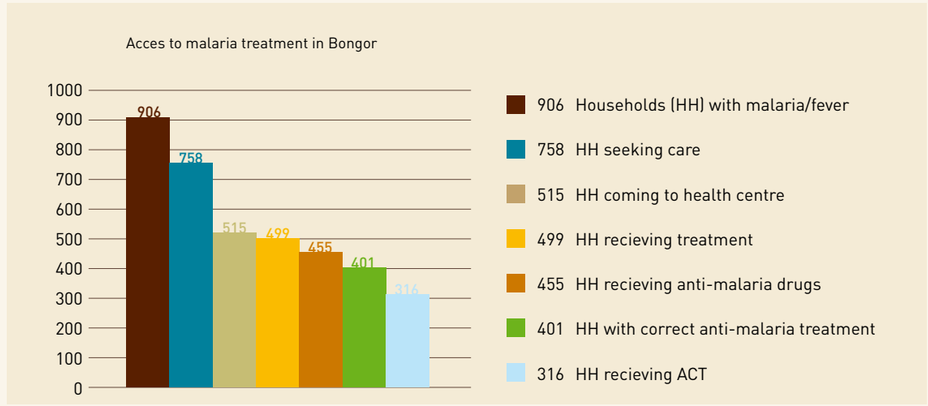
→ Exemptions:
Although a fee exemption system was in place, less than 3% of patients who went to health facilities were actually granted it.
Because people did not know whether or not they would be granted exemption from payment, many chose to stay home.

→ Increased poverty for patients who pay:
Of those who did pay, 50% put themselves at risk by doing so. Some sold parts of their food reserves; others sold their cattle or went into debt. This made them more vulnerable and placed them further at risk.

→ Irrational services:
ACT tariffs were not respected and over-prescription as well as non respect of treatment protocol[11] was found to be common, possibly driven by health personnel trying to bring in extra funds.

Conclusions

The impact of Malaria on mortality is greater than expected, yet only 35-45% of patients with malaria received adequate and appropriate malaria treatment.
The pilot project in Bongor shows that even when ACT treatment is subsidised, it remains out of reach for too many people. The study shows that if a cost recovery system is in place, it is not sufficient to simply subsidise the drugs. All expenses linked to malaria treatment (consultation costs, drugs and laboratory tests) need to be subsidised. Compensation for the facilities implementing the treatment should also be included. This is a precondition for ensuring that health care services actually answer the health needs of the population, including the most vulnerable.



[11] A fifth of anti-malaria prescriptions were for quinine.

THE BAMAKO INITIATIVE

a 20-year old concept according to which most health systems in developing countries are financed

In 1987, African health ministers met in Bamako, under the leadership of UNICEF, to find new ways of increasing access to primary health care. Most African countries were facing immense external debts, and this was affecting their capacity to fund the health sector. The Bamako Initiative (BI) – as the meeting was subsequently titled – identified a series of ways to increase access to quality health care while guaranteeing the financial viability of health structures. The backbone of the initiative is the increased involvement of the community – including financial participation – and the decentralisation of health decision-making and management, especially in terms of primary health care. Community participation in the financing of health services was also meant to increase efficiency by discouraging unnecessary use of services.

In practice, the setting up of a «drug revolving fund» mechanism is encouraged: communities receive a stock of essential medicines to start a health unit - drugs are then sold to the users with a margin which, added to consultation fees, allows the health centre to buy new drugs and guarantee the quality of services. The resources generated are managed at local level with the participation of the population.

The Bamako Initiative also promotes combining different sources of funding for health, including communities and districts authorities, central government, and individual patients through the introduction of fees. It clearly states that those fees should not replace the health budgets but be a supplement to contribute to local health services development.

From the start, it was recognised that low-income households might find it difficult to pay user fees and that the amount requested should remain easily affordable for families but still generate income for the health services. One of the core principles of the Bamako Initiative was that those who cannot afford to pay the fees should benefit from subsidies or exemptions for the most vulnerable.

In practice, this equity component of the Bamako Initiative has been widely neglected. Many systems rely too much on the financial participation of the users and reduce the responsibility of the state to guarantee accessible public health services. This has led to high levels of exclusion and impoverishment.

© Cristina De Middel

HAITI

"My name is Georges Igomide and I live in Vaudré, in the district of La Chapelle.
I have a daughter who is 15 years old. The last time she had a fever, I went with her to the La Chapelle dispensary.
They asked me to do some tests to find out why she had a fever. The tests cost 100 gourdes. As I could not find 100 gourdes, I gave up and my daughter did not have any treatment."

Habitant de La Chapelle, December 2004

Health situation:

Although Haiti is not usually considered to be a country in humanitarian crisis, basic health indicators remain worrying. In a context of widespread poverty, patients are required to pay for health care according to a cost recovery system.

MSF's experience and research in Haiti show that:

- The use of services in the cost recovery system is very low;
- No exemptions are granted to vulnerable people;
- Use of health services is double in a flat-fee system as opposed to cost-recovery;
- In both systems, half of all people still face financial difficulties accessing health care.

MSF SURVEY

MSF in Haiti

MSF has been working in Haiti since 1991. We have been providing basic health care in Petite Rivière, in the country's centre, since 2001. MSF also supports hospitals and health centres in the capital, Port-au-Prince, where the local population suffers from extreme urban violence and lack of access to services.
The objective of the survey carried out in 2004 was to assess mortality levels and financial access to primary health care in Petite Rivière, Verrette and La Chapelle.
Two payments systems were covered

1. **A cost recovery system**, which is applied across the country. Patients pay for each component of medical care: the consultation, drugs, laboratory tests and medical materials.
2. **A subsidised flat-fee system**, implemented at the Albert Schweitzer Hospital and health centres (HAS) and Interaid health facilities. Patients pay US$ 0.5 for whatever care or treatment they receive.

HEALTH AND SOCIO-ECONOMIC RESULTS:

Mortality (deaths/10,000/day)	
Overall population	0.5-0.7
Children under five years	0.6-1.5
Poverty indicators	
Average income/person/day	US$ 0.9
Population under poverty threshold	80%
Average healthcare cost	
in the cost recovery system	US$ 2.90 per episode per patient
in the flat fee system	US$ 0.50 per episode per patient

CONSEQUENCES OF USER FEES:

→ Exclusion from health care:
8% of the people surveyed were excluded with the flat-fee system and 7% with the cost recovery system. In both systems, lack of money was the main reason for exclusion. This indicates that a certain percentage of the population cannot afford to pay even a small amount.

→ Looking for alternatives:
Huge differences can be observed between the two systems when comparing how often patients sought alternatives to formal health services. With the cost recovery system, 57% of those surveyed sought care in the alternative health sector. With the flat fee system, the proportion was 20%.
More than 10% of people surveyed visited a drug peddler when they got sick. Of these, 65% said it was because that option was cheaper.

→ The exemption system is failing:
MSF's survey suggests that the exemption system exists in theory rather than in practice. 99% of patients

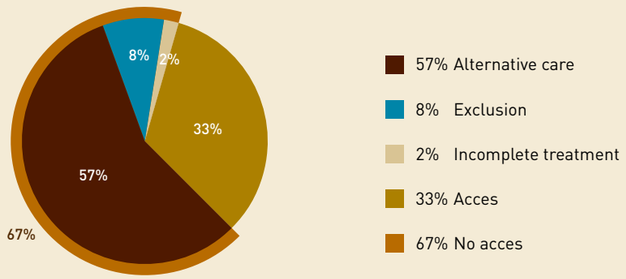
paid for care during their last episode of illness. The only people granted exemptions were health centre employees. No exemptions were granted on grounds of vulnerability (for example, female-headed households and families without land did not qualify).

→ **Impoverishment:**
In both systems around 50% of families who used official health facilities had had to sell land, go into debt, or spend savings in order to pay for health care.

Conclusions

A significant proportion of people cannot access the health care provided in their area because it is too expensive. Where the system is subsidised and the cost to the patient is less, the uptake is better. However, the costs are still too expensive for the most vulnerable segment of society.

Acces to care in the cost recovery system



© Pep Bonet

© Bruno De Cock

MALI

Health situation:

Mali has pioneered the Bamako Initiative principles (see box on p.14) in order to try and achieve high quality, accessible health services. A broad network of community health centres have been set up. The health system is heavily reliant on patient fees to finance services.

MSF's experience and research in Mali show that:

- Mortality rates are abnormally high for a stable country;
- Malaria is the main killer but the average cost of treatment is equivalent to two months worth of wages (US$8)
- During the three months of the survey, 20,000 people in the catchment area stayed home when sick because they couldn't afford care.

MSF SURVEY

MSF in Mali

MSF has been working in Mali since 1983, focusing on primary health care, maternal health and nutrition. MSF also has a project focusing on vesico-vaginal fistulas in Tombouctou and responds to emergencies. The current MSF project began in July 2005 and focuses on introducing the new malaria treatment protocol (ACT) in the health zone of Kangaba.

The objective of the survey done in 2005 was to measure mortality, analyse the health seeking behaviour of patients and collect quantitative data on access to health care – with specific focus on financial barriers – in the Circle of Bougouni (Sikasso region).
User fees are the most common payment system used in community health facilities across the country.

HEALTH AND SOCIO-ECONOMIC RESULTS:

Mortality (deaths/10,000/day)	
Overall population	0.8
Children under five years	1.9
Poverty indicators	
Average income/person/day	US$ 0.12
Population under poverty threshold	98%
Average healthcare cost	
in the national system	US$ 8 per episode of illness (= 2 months income)

- Mortality rates are abnormally high for a stable country, especially for children under 5 years of age;
- The main reported cause of death is infectious disease – especially malaria;
- Primary health care costs are exorbitant.

CONSEQUENCES OF USER FEES:

→ Exclusion from healthcare:
A fifth of sick people surveyed did not seek any medical assistance, even when their condition was serious. The vast majority said they did not seek care because they could not afford to pay for it.
Applied to the total population of the Circle of Bougouni (roughly 352,900) this means that in the three months before the survey, 20,000 stayed at home when they needed care.
In contrast to the great need for health care and improved geographic spread of health facilities, utilisation of services remains poor, with an average of 0.2 contacts per person per year[12] in health centres.
This contrast with the fact that, on average, a person reported suffering from 1.8 episodes of illness every year and clearly shows that the needs of the population are not met.

→ Failure of the exemption system:
Mechanisms supposed to help the poorest families do not work effectively. They only reach about 2% of the population and not always the most vulnerable.

→ Impoverishment:
17% of the families surveyed said they had a debt related to paying for health care. We estimate 40,000 people in the three months prior to the survey had financial difficulties associated with health care. Either they could not afford it or they had to sell cattle or land to pay for it, thereby leaving them more vulnerable to further impoverishment.

→ Use of the alternative health sector:
17% of the people who had been sick declared having used the informal sector (traditional "doctors", drug sellers, etc.). The main reason for doing this was financial.

Conclusions

New, effective treatments (such as ACT for malaria) need to be accessible to all if they are to have a real impact on health. Even in a stable country such as Mali, the vast majority of the population lives in poverty and health facilities are under-used. It is vital that the existing financial barriers to accessing health care are properly addressed.

[12] WHO reference is 0.6 contacts per inhabitant per year in rural areas.

POSITIVE OUTCOMES OF ABOLISHING USER FEES

MSF'S EXPERIENCE IN BURUNDI AND SIERRA LEONE

Burundi

"Removing user fees can dramatically increase access to health services. in Uganda, abolishing fees doubled the number of people going to the clinics and doubled immunisation rates for children. More than 230.000 lives could be saved each year if fees were abolished in 20 African countries"

Eliminating World Poverty, Making Governance Work for the poor, UK department for international development, 2006.

MSF has supported 10 health centres and a referral hospital in Karuzi province since 2003. Until April 2006, patients had to pay an all-inclusive low flat fee. This system was complemented by an exemption scheme covering the most vulnerable. On 1 May 2006, the new national policy was implemented to provide free care for pregnant women and children under five.

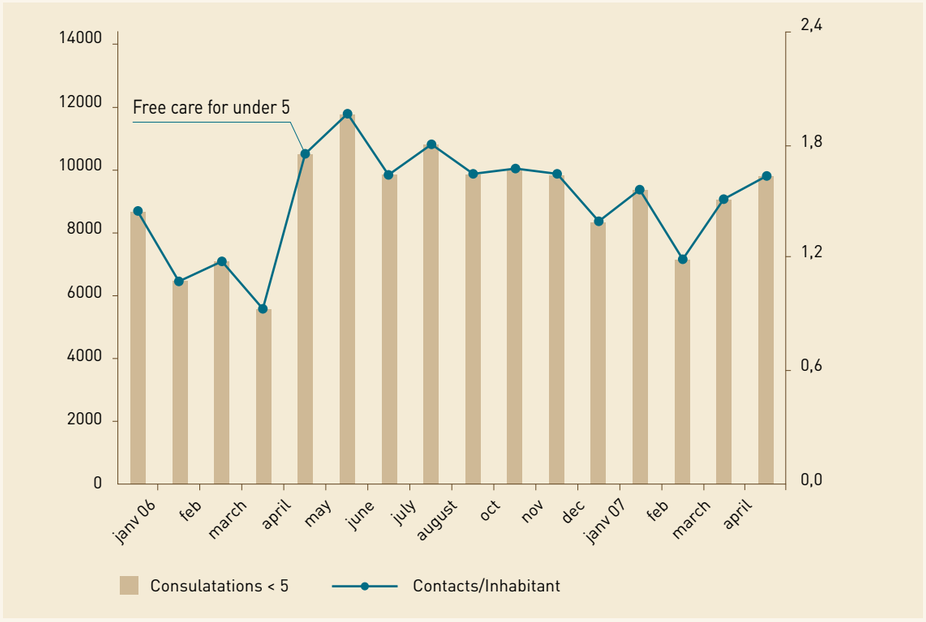
The all-inclusive flat fee in place prior to 1 May 2006 was supposedly affordable for the general population. However, the switch to free care for large groups of the population led to a sharp increase in the number of people using health services.

For the under fives, utilisation of services increased by 40 % compared to the previous year. The number of consultations increased from 9,000 per month to 13,000 per month in the province. Attendance rate for this specific group increased from 1.6 to 2.2 contacts per patient per year.

The number of deliveries doubled in the health centres of the province after the change. Health centres now register an average of 380 deliveries per month since free care was introduced, compared to 160 previously.

In the hospital, the **number of caesarean sections** also increased sharply from 24 to 32 per month, which indicates a better coverage of emergency obstetric interventions.

These results - based on the first year of the change being implemented - clearly reflect the positive impact of abolishing the fees on the coverage of these vulnerable groups.



Sierra Leone

Since 2001, MSF has been providing health services in Bo under a low flat fee payment system. At the end of 2004, the decision was taken to provide free care for children, women and the elderly[13] in the MSF-supported clinics.

The effect of the abolition of user fees (for the majority of patients) on utilisation rates was rapid and consistent. The average number of consultations for curative care increased from **1** per person per year in September 2004 to **4.5** in June 2005[14].

The concern that the increase in patient numbers did not necessarily correspond to serious illnesses was investigated through an analysis of the data for children under five with confirmed malaria and hospitalised patients. The results are indisputable:

- There was a ten-fold increase in the number of consultations for children under the age of five;
- Ten times more children under five were diagnosed with malaria and therefore confirmed to be in need of effective malaria treatment. This need was clearly not covered before the abolition of fees;
- There was a clear increase in the number of patients needing hospitalisation (although the medical criteria for referring patients to secondary care did not change).

These results show the positive impact of providing free health services. It also reveals that even a modest flat fee had previously been a significant barrier for many patients in need of medical care.

© Renzo Fricke

[13] This categorisation corresponds to a declaration made by the President in which children under five, pregnant and breastfeeding women and the elderly are exempt from payment. See also 'National Health Policy, October 2002'.
[14] Including patients coming from outside the target area.

ANALYSIS OF KEY RESULTS

Health centres applying user fees are not being used by patients

Wherever user fees are in force, a significant proportion of the population is excluded from health care and the use of public health services is low. People who are sick – even those living in close proximity to services – will forgo treatment and search for cheaper alternatives, usually in the informal/unofficial health sector.
People do not know exactly what price they will be asked to pay so many choose not to go at all. Others need time to sell belongings to raise the cash, and therefore often delay getting urgently needed care. The uncertainty about the amount of money that will be charged only adds to the difficulties of using public services.
As a consequence, the alternatives to the official health sector are being used intensively. The benefits the informal sector brings to patients are lower costs, flexible payment systems, and care to your doorstep. The disadvantages are that drugs can be unsafe or wrongly prescribed and those selling them may not be adequately qualified. This exposes patients to potentially ineffective treatment, adverse effects or intoxication and the development of drug resistance.
The fact that many patients do not utilise official health services has serious implications for public health. Most health data is collected at official health facilities. If patients do not attend these facilities, it is difficult to ascertain the real demands and health needs of a population. This has important implications for detecting illnesses and responding to public health problems.

- Between 5 - 20% of sick people stayed at home and received no medical treatment whatsoever because they could not afford any;
- Approximately half the families we surveyed were prevented from visiting their nearest health facility when last sick because of the cost;
- People in the areas surveyed had an average contact with public health facilities of 0.2-0.4 per inhabitant per year – far too low given the high mortality/morbidity rates.
- Drug peddlers are one of the most popular alternatives to health centres simply because they are cheaper. 30-60% of households stated that price was the incentive for using them.

User fees can impact negatively on quality of care

MSF's experience shows that far from improving the quality of care, user fees can actually have a negative effect.
It is argued that fees prevent unnecessary and improper use of health services and that the funds they raise can be used to improve the quality of health provision. But excluding people in need of care is not a 'rational' use of a health facility. Furthermore, the problem today is one of under-use rather than over-use of health services. If some patients need to be prioritised over others, the decision should be made on medical grounds alone, and certainly not on a patient's financial situation.
We have also witnessed the over-consumption of drugs and tests, and the promotion of some procedures over others, because of the revenue they bring in. Facilities or staff can try to earn more by promoting more expensive treatment, thereby distorting the care provided.
Fees can also alter the quality of care offered, especially for the most vulnerable patients. MSF has seen how patients with little money have been given sub-standard care. For example, we have witnessed situations in which diagnostic tests have not been carried out because the patient couldn't afford the fee. We have also seen poorer patients being prescribed lower quality drugs or given incomplete treatment.

- The treatment of malaria demonstrates how fees can lead to irrational service delivery. In Burundi, many health care workers preferred to prescribe quinine (even though more effective ACT is available) because this tripled financial revenue;
- In Chad, it was common to make unnecessary prescriptions disregarding standard protocols because these were more lucrative;
- We have seen many hospitals withhold nursing care from patients who can not pay.

Paying for health care can lead to a cycle of impoverishment

The surveys revealed poverty to be far more significant and widespread in rural areas than country averages would suggest, with the majority of households living below the poverty line.
For those who did pay for health care, it took on average 5-30 days of work to cover the cost of one visit to a primary health care facility. The cost of secondary health care such as hospitalisation or surgery was significantly more.
Very few households have this kind of money available when illness strikes, particularly in subsistence economies where cash is scarce. Valuable time is lost selling possessions and raising funds. Households get deeper into debt.

- 50% of households risked getting poorer by paying for health care, even at a primary care level;
- In some locations, 50% of household debt was due to health expenditure.

Raising the necessary funds to cover fees also leads to delays in seeking care. The delay may lead to the worsening of a patient's condition. In some cases, the treatment patients need by the time they get to the health facility is far more intensive, and possibly more expensive.

Exemption systems do not work

Although exemptions systems exist in most locations, they proved to be ineffective. Despite the extreme poverty of many of the households surveyed, only 1% to 3.5% had benefited from exemptions in cost recovery systems. In addition, those that did benefit were not necessarily the most in need.
Few exemption systems are properly subsidised, which leads health facilities to rely on patients for their income. Consequently facilities and staff have few incentives to grant exemptions.
Also, poverty is not static. Someone who might not qualify for an exemption today may do so tomorrow. A patient who was initially able to pay for treatment may go bankrupt because of the costs half way through. The constant re-assessment required and the associated administrative costs are unworkable.
In areas such as those surveyed, where most people live below the poverty line, deciding the cut off line for exemptions is difficult and somewhat arbitrary. MSF's experience confirmed that whatever the exemption system introduced, unacceptable numbers remained excluded from essential care.

Abolishing user fees improves access to care

MSF's experience shows a significant improvement in access to care when user fees are abolished. Utilisation rates rose significantly, surpassing 1-2 visits to the health centre per inhabitant per year. This positive impact was reflected in an increased number of consultations which were medically justified: confirmed malaria cases, increased number of patients hospitalised, increased number of supervised deliveries and of caesarian sections, contributing to a higher coverage of these essential services. In some places it also led to higher coverage for preventative services such as children's immunisation.
In our experience, free primary health care led to lower rates of exclusion, less reliance on the informal sector and fewer debts. When free care was limited to children, user rates increased significantly among this age group.

© Julie Remy

MYTHS AND REALITY ABOUT USER FEES AND EXEMPTION SYSTEMS

User fees are an important source of funding to develop a sustainable health system.

- NO: Income brought in by fees only cover a fraction of the actual cost of health care[15] [16] while field experience shows that fees exclude a large proportion of the population.

User fees encourage patient empowerment: if services are not good, patients will not pay or will go elsewhere.

- NO: When people have no money to pay at all, they do not have the freedom to look for services elsewhere. In any case, there are often no alternatives.

Exemption systems allow all those who cannot afford to pay to receive treatment.

- NO: In areas of extreme poverty surveyed only 1 to 3.5% of people had benefited from exemptions. These were not necessarily the people most in need.

User fees promote rational use of services by restricting over-consumption by patients.

- Excluding people in need of care because they cannot afford it is not a 'rational' use of a health facility. Fees can lead to over-prescription by health staff as a way of increasing income for the health facility.

Free access leads to irrational use by attracting many people with non-serious conditions.

- NO: MSF's experience show that after switching to free care, the increase in the number of consultations corresponds to an increase in the number of confirmed malaria cases, hospitalised patients and supervised deliveries.

[15] ARHIN-TENKORANG D., *Mobilizing resources for health care: The case for user fees revisited,* Working Group of the Commission for Macro-Economics and Health (WG 3 paper 6), Nov 2000, Geneva.
[16] PREKER and CARRIN, *Roles of communities in resource mobilization and risk sharing: A synthesis report,* 2001, HPN.

CONCLUSION

Across the range of countries surveyed by MSF, one thing stands out: making patients pay fees for health care has a negative impact on access to health services and people's health suffers as a result.
Many of the countries studied are in a period of transition, emerging from crises and moving towards a "development phase". However, despite being in a 'post-conflict' period, countries such as Burundi, Sierra Leone and certain regions of DRC still have mortality rates that exceed international emergency thresholds. Even though the conflicts in these places officially ended several years ago, many people are extremely vulnerable. To ask them to pay for their health care when they can barely feed their families is unrealistic.
Even some countries that are considered stable, such as Mali, have unacceptably high mortality rates. In many cases this is due to the prevalence of infectious diseases, notably malaria, highlighting the urgent need for affordable care.
Despite alarming levels of morbidity and mortality, health authorities, some NGOs and international donors remain disturbingly reluctant to suspend user fees.
Countries such as Uganda, Zambia, Liberia, Burundi and Niger have all taken steps to abolish user fees for large groups such as women and children, yet the support of donor agencies to make these initiatives possible and effective remains timid to say the least. National authorities and donor agencies should mobilise around this crucial issue and act quickly to reduce financial barriers for patients.

- MSF cannot accept the argument that people in need of life saving medical treatment must be sacrificed for the sake of longer term objectives such as political transition or economic development. As user fees only cover a small fraction of the funding needed for health, alternative methods for health financing must be found.
- National health authorities in low-income countries must be informed about the negative consequences of user fees and need to look into alternative ways to ensure their people have genuine access to public health care.
- International donors and technical support agencies need to measure the impact of financial barriers on access to health in the programmes they fund. They urgently need to integrate the documented negative impact of user fees into their policies and ensure coherence with their political commitment on improved health in developing countries. The UN taskforce on essential medicines within the Millennium Development Goals project stated that: *"Financing for essential health services in much of the developing world today can be described in 2 words : insufficient and unfair: user fees are the least equitable method of financing healthcare".*
- Local representatives of donor countries and UN agencies in low-income countries need to be more supportive of measures aimed at improving financial access and help provide the necessary additional funds to make it happen.

© Dominick Tyler

ANNEX

SURVEY METHODOLOGY AND ANALYSIS

The data presented in this document originates from population-based surveys of 900 households, using the **two-stage cluster sampling method** (30 clusters of 30 families). This method is commonly used to assess the health status of populations[17]. Household members were interviewed in areas surrounding health centres where the same payment system applied.

Questions focused on mortality, health-seeking behaviour during the last episode of illness and methods of payment. Specific causes of morbidity and mortality correspond to those reported by the household member interviewed. No verbal autopsy was carried out. Basic socio-economic data were also collected.
The general objective of these surveys was to measure people's access to health care and evaluate financial barriers to health service use. To do so, households within one payment system were chosen within a 5 km radius of clinics (maximum 1 hour walk). This was done to minimise the role distance might play and to focus on financial barriers. It does mean, however, that for families living further away, distance may present a more significant obstacle than these findings suggest.

Mortality data are expressed in number of deaths per 10,000 people per day.
For the analysis of mortality data, the same references and thresholds are used throughout the document :
The Crude Mortality Rate (CMR) in a stable population in developing countries is estimated at 0.5/10,000/day (for industrialized countries, this rate is around 0.3). A CMR equal or above 1/10,000/day indicates a state of emergency.
For under-fives (MR←5): the assumed baseline is 1/10,000/day and a state of emergency is reached when the rate equals or exceeds 2/10,000/day.[18]
The full surveys are available at www.accesstohealthcare.msf.be

"If you want to reduce poverty, it makes sense to help governments abolish user fees."

Dr Margaret Chan, WHO General Director, Launch of the UK Department for International Development's new health strategy, June 2007.

© Carl De Keyzer

[17] See World Health Organization, The Management of Nutrition in Major Emergencies, 2000,Geneva, Switzerland
[18] Interpreting and using mortality data in humanitarian emergencies, F. Checci and L. Roberts, Humanitarian practice network, Number 52, September 2005.

MEDECINS SANS FRONTIERES

Rue Dupré 94
1090 Brussels
Belgium
aau@brussels.msf.org