



# Assessing the Case for Abolishing User Fees

## Lessons from the Kenya Experience

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# Areas to be Covered



- Overview of findings from assessment of introduction of Kenya 10/20 policy for cost sharing
- Relevance of findings for debate about abolition of user fees

# Approach



- Facility survey
- Community survey
- Patient Exit survey
- Sample: 60 facilities in 6 districts
  - Kilifi, Meru South, Uasin Gishu, Kakamega, Narok and Isiolo
  - 45 dispensaries, 15 health centres
  - 51 Government, 9 Mission/faith based

# Data Collected on:



- Utilisation
- Revenue collection and use
- Overall financing
- Health seeking behaviour
- Socio economic status
- Current expenditures on health/ability to pay
- Stakeholder perceptions on:
  - Effects of the change in policy
  - Quality of services

Quality of Data variable!



# 10/20 Policy Changed July 1<sup>st</sup> 2004: What Did This Mean?



|                |                 | Pre 10/20  | Post 10/20   |
|----------------|-----------------|--|--|
| Health Centres | Cost Sharing    | <b>Fees set locally.</b> Facility develop plan to spend 75% of revenues – approved at provincial level. 25% retained at district | <b>Standard fee – 20 K Shs.</b> Funds spent as raised – no plans, little reporting |
|                | Community Funds | Unofficial arrangement – fees set, retained and used at facility level   | <b>Abolished</b>   |
| Dispensaries   | Cost Sharing    | None   | <b>Standard fee – 10 K Shs</b>   |
|                | Community Funds | Unofficial arrangement – fees set, retained and used at facility level   | <b>Abolished</b>   |

# Immediate Impact

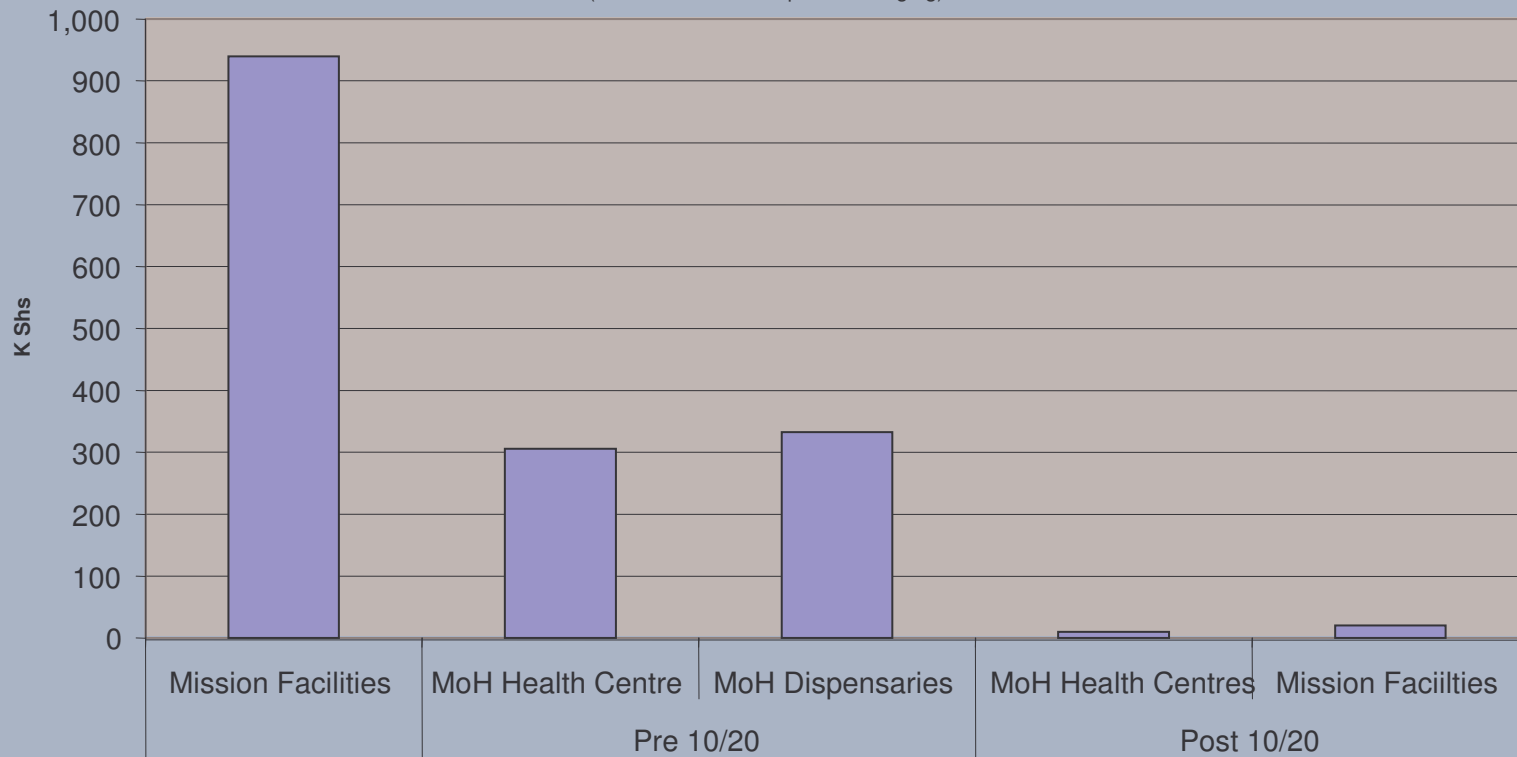
~**reduction in user fees:** large reduction for high cost services such as deliveries.

~**simplified fees: a single up front payment**



## Comparisons of Charges for Normal Deliveries

(for facilities which reported charging)

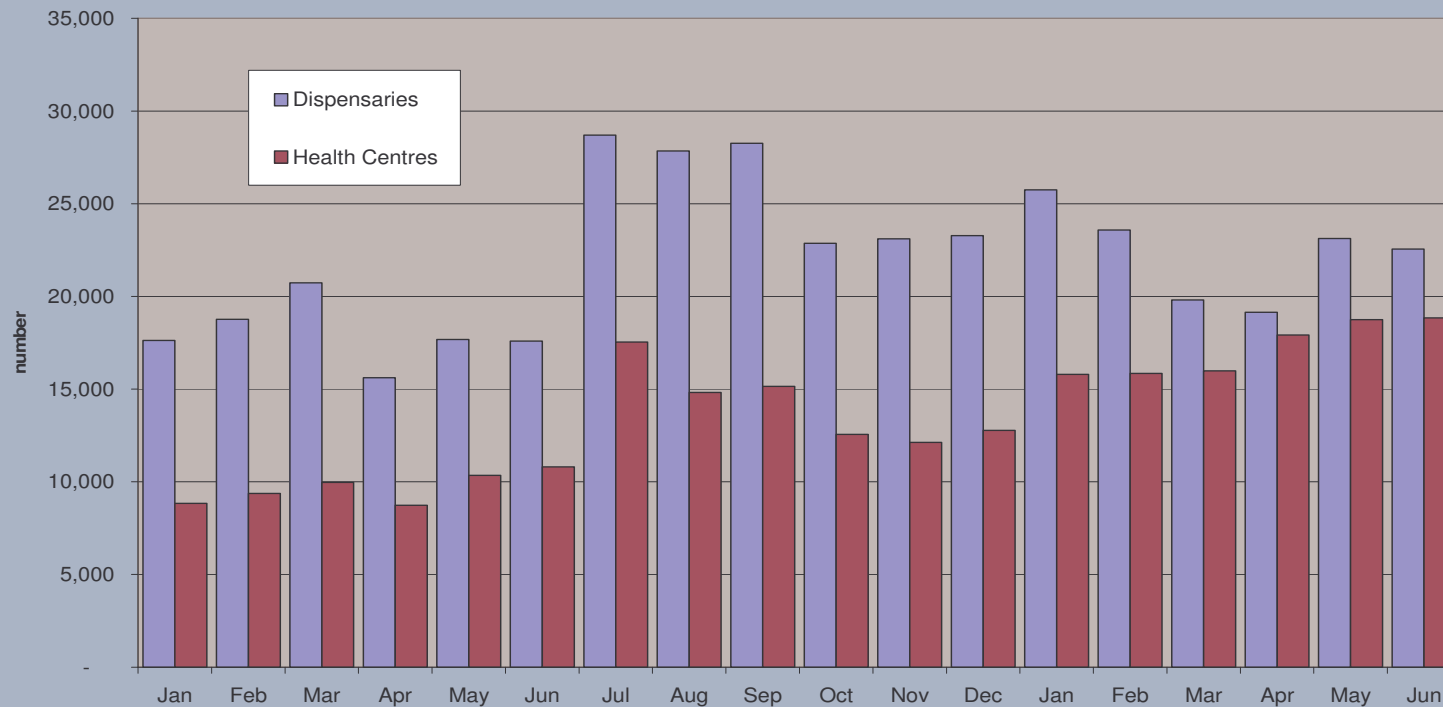


# Effects on Utilisation

- ~initial increase, subsequent decline but remain above original levels
- ~no change for preventive services, NGO facilities
- ~wide variation between districts/facilities

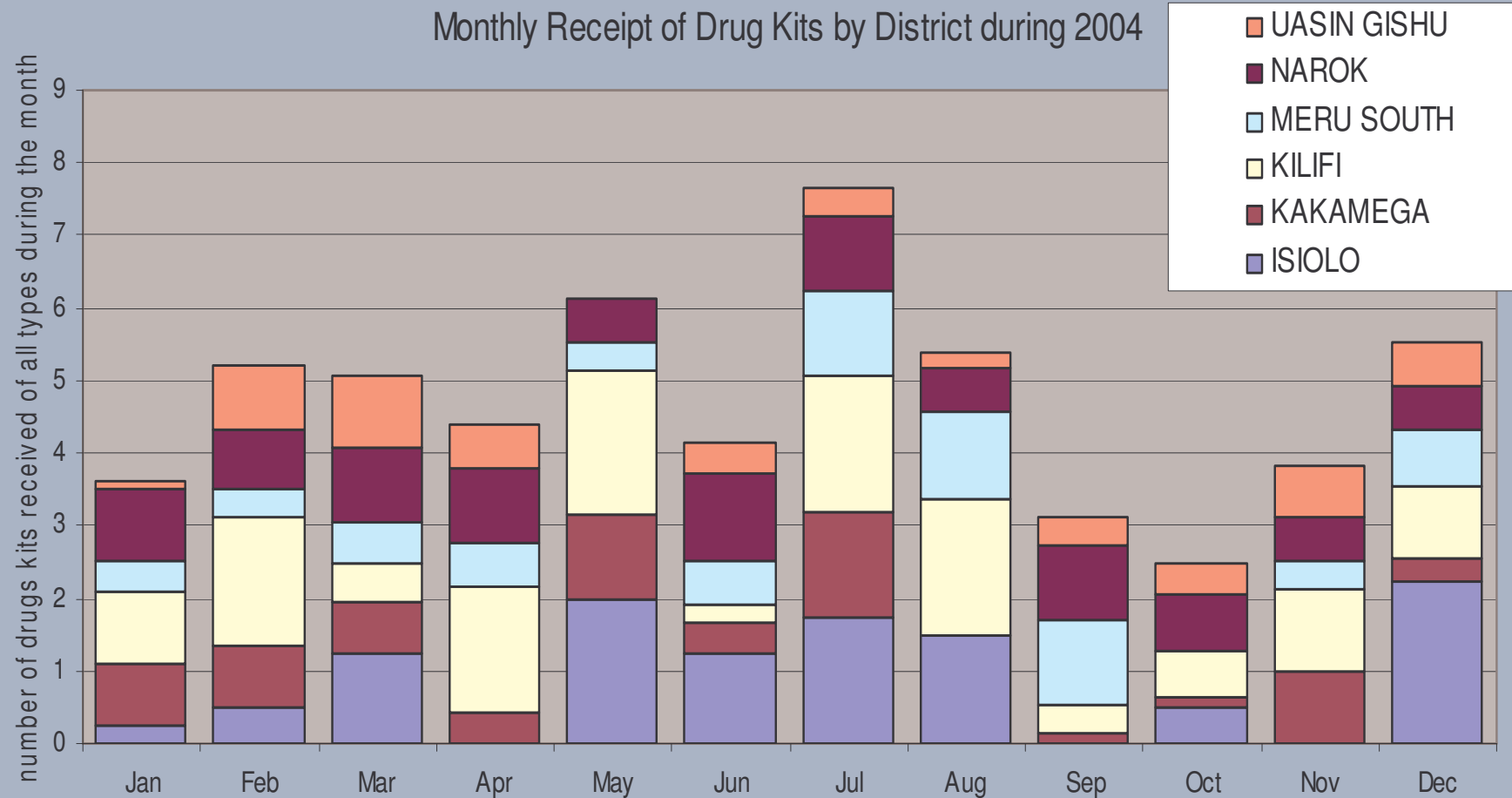


Total Number of New Visits and Re-Attendances in Study Facilities  
January 2004 - June 2005



# Lack of Complementary Inputs

A Key Factor: mismatch between drug needs and utilisation

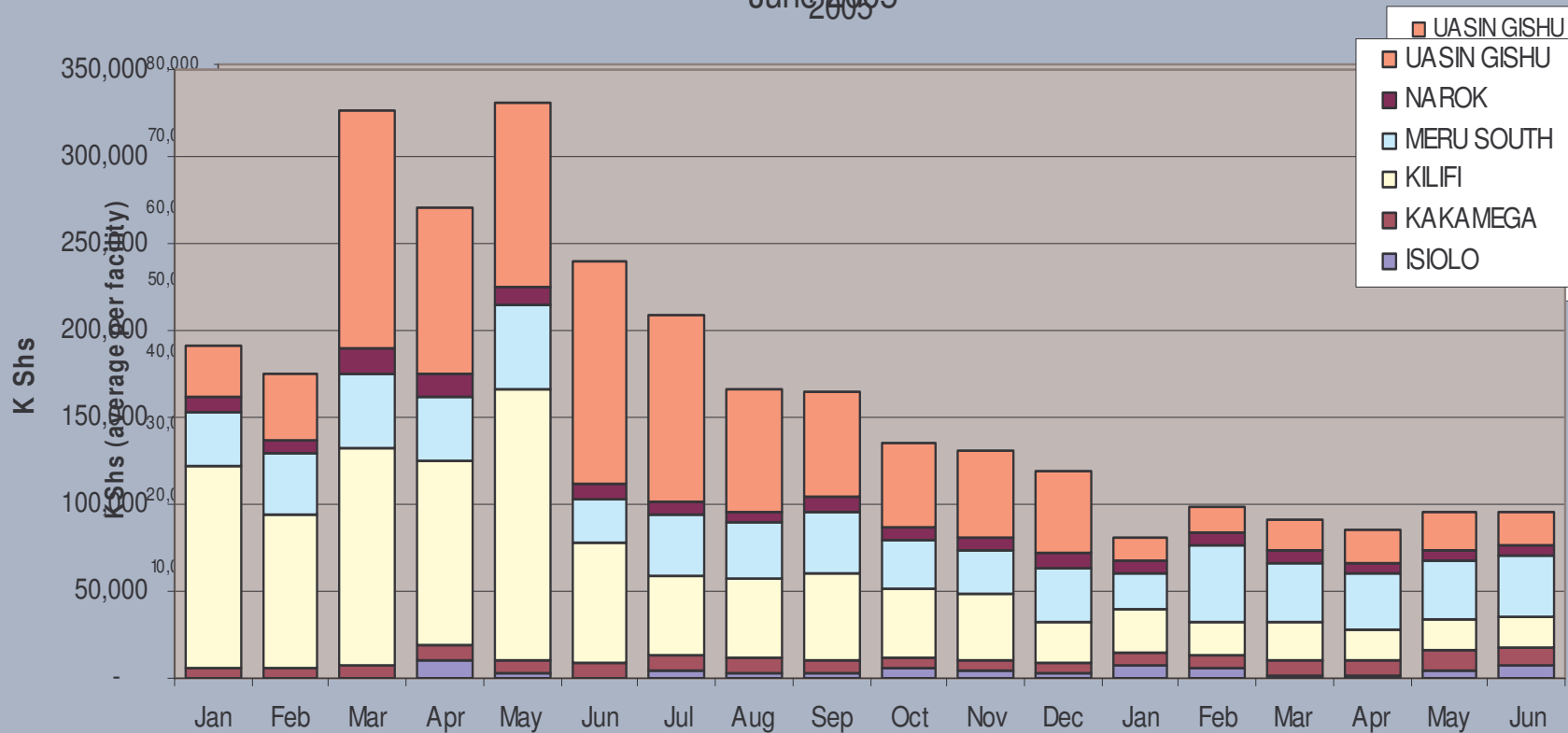


# Effects on Revenue

~50% decline – esp in high revenue districts



Revenues from Cost Sharing and Community Financing in Health Centres: January 2004 to June 2005



# Impact on Employment and Range of Services

~support staff laid off, services discontinued, services privatised



Number of Facilities staff laid off by District and Cadre

| DISTRICT     | CLEANER  | WATCHMAN  | LAB TECH | OTHERS    | TOTAL     |
|--------------|----------|-----------|----------|-----------|-----------|
| Isiolo       | -        | 1         | 3        | 1         | 5         |
| Narok        | 2        | -         | -        | -         | 2         |
| Kilifi       | 2        | 3         | -        | 6         | 11        |
| Kakamega     | 3        | 3         | -        | 1         | 7         |
| Meru South   | -        | 1         | -        | -         | 1         |
| Uasin Gishu  | 1        | 2         | -        | 3         | 6         |
| <b>TOTAL</b> | <b>8</b> | <b>10</b> | <b>3</b> | <b>11</b> | <b>32</b> |

5 facilities – 3 in Uasin Gishu and one each in Kilifi and Isiolo - had discontinued lab services.

# Summary of Findings



- **mixed impact on utilisation emphasising the need for complementary inputs and actions:**
  - the failure of resources to trickle down to the facility level the disparity in funding levels at facility level
  - the importance of adequate and timely supplies of drugs
  - the need to relate drug supplies more closely to need at the facility level
  - numbers and distribution of staff
- **reduced revenue** has had **serious knock on effects with possibly more to come**. *Net* revenues may have declined by even more. Other revenue sources did not compensate.
- **polarised views:** the approach is popular with communities but not with health workers
- **reduced community participation:** reinforces perception that MOH is responsible
- cost sharing even before 10/20 was **not the major barrier** to access
  - other barriers important: distance, staff attitudes, quality of services/lack of drugs
  - probably **not even the major financial barrier**. People would be willing to pay more

# International Experience with User Fees:



Generally User Fees are a pretty lousy idea.....

- they are an inequitable and inefficient means of raising revenue
- if there are no alternatives - good design helps - negative effects (on access) can be reduced if resources are retained and used locally to improve quality... but this rarely happens
- importance of political commitment plus complementary measures (provision of extra drugs, addressing financial management issues)

# Conclusions



- Financial support for abolishing user fees may make sense *as part of a well planned and coordinated set of reforms....*
- Done in isolation it may just make things worse!
- If donors simply replaced user fees this would not be enough .... and is easier said than done. User fees are a symptom rather than a cause of the problem
- Why turn user fee abolition into a “project” – better to focus on overall financing with the caveat that it may provide an “early quick win” or play a catalytic role in promoting wider reforms



Thank  
you!



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