Long-term effects of the abolition of user fees in Uganda

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Ensuring financial risk protection is one of the goals of a health system. The WHO/AFRO health financing strategy advises countries to develop health financing systems that are sustainable, equitable and can support the provision of good quality health services. The strategy calls for minimizing out-of-pocket payments (OOPs) at the point of use and moving to prepayment mechanisms. OOPs, in the form of user fees, have been shown to impact negatively on access to health services, especially for the poor. Households paying for health services have been reported to incur catastrophic health expenditures and face poverty.

The link between poverty and ill health, where poorer households report more illness episodes compared with richer households, is well documented and poverty eradication objectives will only be attained if access to health services – including financial risk protection – is ensured, especially for poor households.

Xu et al. documented factors that predispose to catastrophic health expenditures. They found that higher percentages of OOPs as a share of total health expenditure (THE) are linked to higher incidence of catastrophic health expenditure. Other factors include percentage of the population below the poverty line, where increases in poverty will increase catastrophic health payments. Increases in THE as a percentage of GDP also increase catastrophic payments. Earlier studies in Uganda documented factors linked to catastrophic health expenditures such as the use of private health services rather than public services, the use of inpatient services for the non-poor, the use of private providers remaining significant. The incidence of catastrophic health expenditure increased following user fee abolition, and although it has decreased in the long term it still remains high. Ensuring financial risk protection calls for health system improvements and exploring ways of harnessing the high OOPs into prepayment. The private sector is a significant player, and its effective regulation will need to be addressed. There is also need for wider government intervention to reduce poverty and control population growth.

SUMMARY—Households have been impoverished and faced catastrophic health expenditure as a result of paying out-of-pocket (OOP) health expenses. Using data collected over ten years, changes in utilization and in catastrophic health expenditures in light of the abolition of user fees in 2001 is examined in this article. In the long term, increase in utilization of health services among the poor remained above the national average but cost as a reason for not seeking care was lower among the poor compared with the national average. Use of private providers remained significant. The incidence of catastrophic health expenditure increased following user fee abolition, and although it has decreased in the long term it still remains high. Ensuring financial risk protection calls for health system improvements and exploring ways of harnessing the high OOPs into prepayment. The private sector is a significant player, and its effective regulation will need to be addressed. There is also need for wider government intervention to reduce poverty and control population growth.

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private outpatient facilities for the poor, having household members over the age of 65 years or a household head with little education.\textsuperscript{7}

The Uganda health sector was for a long time concerned with high OOPs which impacted negatively on access to health services, amidst poor health indicators.\textsuperscript{3} In order to address these challenges, the Government of Uganda abolished user fees in public health units in 2001. It was hoped that the abolition would improve utilization of health services, especially among the poor, reduce household OOP, and subsequently improve health outcomes. Several studies have documented the effects of abolition of user fees on the utilization of health services\textsuperscript{6,7} and on the quality of health care in Uganda\textsuperscript{4} soon after the reform.

Benefiting from data collected since the reform in 2001 until 2010, this article examines changes in utilization and in catastrophic health expenditures in light of the user fees abolition and explores lessons learnt in the process. Specifically, it examines patterns of health care use, the importance of cost as a reason for non-use, household OOP expenditure and patterns of government expenditure on health over time. The medium- to long-term effects of user fee abolition on catastrophic health expenditures are examined to evaluate the extent to which the abolition of user fees ensures financial risk protection in a sustainable manner.

in 2002/03, 7,426 households with 39,322 individuals in 2005/06 and 6,775 households with 36,432 in 2009/10.

Data manipulation
Household members that were reported to have had an illness or been injured in the 30 days prior to the survey date were asked whether anyone was consulted (e.g. a doctor, nurse, pharmacist or traditional healer) for the illness or injury. A patient was considered to have made a consultation only if they had sought help outside the home, family or friends. The responses were recorded according to the following categories: drug shop or pharmacy; private health unit; government health unit; traditional; others. Household members who had an illness but did not seek health care were asked the reasons why. For all surveys, the responses were coded according to the following categories: illness mild; facilities are too far; available facilities are costly; other. Only results where cost was stated as a reason are presented.

Expenditure on health and medical care was also collected. The WHO definition of catastrophic health expenditures was used, which proposes that health expenditure should be called catastrophic whenever it is greater than or equal to 40% of the household’s non subsistence expenditure.\textsuperscript{\textcopyright} Basic tables and cross tabulations of means and sums were used as the main approach to data analysis, with the key categories used for analysis being rural versus urban and poor versus non-poor.

MoFPED expenditure tables
The MoFPED expenditure tables are generated by the Macro Economic Policy Department of the Ministry of Finance, Planning and Economic Development of Uganda. The tables include expenditure on three components: wages, non-wages and development. Health is among the 17 sectors included in the results.

Results
Use of health care services
The use of health care services when ill was fairly high for all the population of Uganda at the time user fees were abolished (see Figure 1). But those in absolute poverty were the least likely to use these services when ill, at 61.3% in 1999. For the same group, 86.0% of those ill in the previous 30 days sought health care in 2009/10. This corresponds to an additional 24.7% points or an increase of 40.3% over the period 1999/2010, which, was much greater than the national average of 27.2% for the same period.

In essence, the abolition of user fees was expected to get non-users to use health services. This was found to be true for those in absolute poverty, as the margin of increase was greatest between the 1999/2000 and the 2002/03 surveys, at 23.2% compared with the national

Methods
This article uses data from two main sources: the Uganda National Household Survey (UNHS data) and the Ministry of Finance Planning and Economic Development expenditure tables (MOFPED tables). The UNHS data were collected in 1999/2000, 2002/03, 2005/06 and 2009/10. In addition, the MOFPED data on actual expenditures from the financial year 1997/98 to 2010/11 were also used.

Sample size
The sample sizes for the surveys were respectively 10,696 households with 57,385 individuals in 1999/2000, 9,711 households with 50,504 individuals

![Figure 1. Percentage of people reporting that they consulted someone during illness](image-url)
Average of 16.1% over the same period. This was sustained from survey to survey over the entire period.

**Cost as a reason for non-use**

Cost as a reason for non-use of health care services continued to decline over the ten years covered by the surveys. This is true for the poor and non-poor, and for those in urban and rural areas (see Figure 2). Over the ten-year period the reduction has been above the national average of 47% only among urban residents, where it was 67%. Those below the national poverty line experienced a reduction of 31%, which was more than the national average of 24% between the 1999/2000 and the 2002/03 surveys. However, this was not sustained over the entire period, and the percentage of reduction was consistently below the national average in subsequent surveys.

**Patient choice**

Looking at the choices patients make in terms of where to seek health care, Figure 3 shows the percentage of patients who chose to use a private or a public provider. The private providers include drug shops or pharmacies, clinics and hospitals, whether for profit or not. The government health care providers included health centres or hospitals. Other than those in absolute poverty, the pattern of choice is similar. Between the 1999/2000 and the 2002/03 surveys, use of government health care providers dropped, except among the poor. At the same time, the percentage of patients choosing private health providers went up, except among the poor. However, in subsequent surveys, the use of government health care facilities rose gain, especially between 2005/06 and 2009/10.
Public expenditure on health

How did public expenditure respond to the policy of removal of user fees? This will be returned to after a discussion on the overall direction of government policy. In light of the 2010 National Development Plan (NDP) emphasizing economic growth, there has been a shift of emphasis from social sectors, e.g. health and education found in its previous strategy – the Poverty Eradication Action Plan (PEAP) – to sectors considered to focus on reducing constraints to growth and investments, e.g. electricity and roads (NPA, 2010).

As a consequence of this shift Figure 4 shows that the share of the budget dedicated to health has stagnated and that for education has declined. It is also important to state at this point that unless there is a reversal in the government’s focus, the share of health is unlikely to increase further. The analysis of the fiscal space for health in Uganda has identified the same fundamental constraint.11

If we now return to the question on public expenditure response, it is reassuring to see that, for access to basic health care services, the health budget for primary health care and essential medicines remains substantial. This is in the true spirit of the user fee abolition because it still allows the poor, especially rural populations, to use publicly provided health services.12 Figure 5 shows that more resources are spent on district health primary health care and on medicines through the national medical stores.

After the abolition of user fees, flexibility in the use of the health budget was allowed and this enabled districts to allocate funds to areas previously supported from user fees.13 Further improvements in service delivery have led to centralization of medicines budgets, and the first time the national medical stores received funds for medicines directly was in 2010. Prior to that, the funds meant for medicines were part of the district health budgets.

Unfortunately though, as Figure 6 shows, a high percentage of district primary health care funds are spent on wages. Close to 80% goes to wages, compared with, for example, district and national referral hospitals which spend about 50% on wages. This implies that the Government
will find it increasingly difficult to finance its district primary health care operations. The other two components of development and recurrent non-wage expenditures constitute a small percentage of the overall budget.

**Out-of-pocket and catastrophic expenditure**

Figure 7 shows that during the period under review, catastrophic health and medical care expenditures increased from 1999 to 2002 and declined subsequently. In the 2009/10 household survey, about 29% of households that spent on health care experienced catastrophic expenditure. In other words, 29% of the Ugandan households who spent on health care saw their expenditure exceed the subsistence level by 40% in 2009/10. Abolition of user fees in 2001 may have put a dent on catastrophic health care expenditure, but the percentage of households affected remains high. Financial protection, again, is a subject that should be on the agenda.

**Discussion**

We see in this study that the utilization of health services increased for both the poor and the non-poor following the abolition of user fees. In the long term, increase in use among the poor still remains above the national average. **Cost** as a reason for not seeking health care was reduced over the medium to long term, although the reduction among the poor is less than the national average. With regard to patient choice, use of private services is still significant for the poor and the non-poor and for rural and urban dwellers. Once user fees were abolished, there was an increase in use of private providers for all categories of the population except the poor. In the long run, we also see an increase in use of public facilities for all population categories. Incidence of catastrophic health expenditure has increased following user fees abolition and still remains high, although it has decreased in the long term.

There are several lessons to be learnt from this process of abolition of user fees in Uganda. Despite the noted reductions in the long term, a significant share of households still incur catastrophic health expenditures. Okwero et al. documented similar results using a slightly different definition of catastrophic health expenditure. They further noted that incidence of catastrophic health expenditures was higher among the poorest quintile (28%) compared with the richest (25%).

The private health sector in Uganda has for a long time been poorly regulated and challenges range from restrictive laws, weak regulatory framework and a very centralized registration system. Recent efforts to address these challenges included development of the Public Private Partnership for Health policy (PPPH), recently finalized after a protracted development period of over ten years. Its implementation is yet to begin. The private not-for-profit sector-facility based (PNFP-FB), under religious umbrellas, has worked more closely with the MoH during the last ten years, contributing close to 40% of health sector outputs. Government has extended subsidies to this subsector since 1997/98, but this contribution has stagnated at only 20% of the cost of providing hospital services and, as a result, user fees as a source of revenue for PNFP-FB health facilities has been increasing. Arguments have been made that effective regulation of the private sector calls for wider governance issues, including freedom of expression and accountability, political stability and absence of violence, government effectiveness, regulatory quality, rule of law and control of corruption. Xu et al. noted that the incidence of catastrophic health expenditure reduces as the population below the poverty line is reduced. In Uganda there was a noted reduction in the incidence of poverty, which dropped from 38.8% of the population in 2002/03 to 31.1% in 2005/06 and 24.5% in 2009/10. However, reductions in absolute numbers were not as dramatic, with a change from 9.81 million in 2002/03 to 8.44 million in 2005/06 and 7.52 million in 2009/10.
This is due to the high population growth rate, estimated at 3.2%.19

The other factor raised by Xu et al. was the OOP expenditure as a proportion of THE. The higher this factor is, the higher the incidence of catastrophic health expenditures.2 According to WHO statistics, it has been consistently over 40% for the last ten years. Similarly, Okwero et al. documented a significant increase in total average OOP expenditure from US$ 7 to US$ 14 per utilization between 2003/04 to 2005/06.1 On the other hand, with government expenditure on health as a percentage of total government expenditure below 10%, government investment in health has remained modest, translating into per capita expenditure ranging from US$ 6 to US$ 14 in the last ten years.17

Concerted efforts have been made to invest in human resources for health, as evidenced by the fact that 80% of the primary health care recurrent budget is going towards wages. However, the non-wage recurrent expenditure has remained constant and very low.17,20

Similar concerns have been raised elsewhere, and it is a challenge that requires attention17 as this low level of investment will not allow for the necessary improvements in quality to sustain high levels of utilization in the public sector. Indeed, this may be one of the reasons that in part explain why the use of the private sector is still significant. For example, drug stock-outs became more common and more pronounced in public health units;21 health workers felt morale had declined after fees were abolished (because the funds were used to supplement their salaries); and many management committees stopped meeting regularly.21 However, we can see that in the long term, use of public facilities is increasing for all categories of the population. This coincides with the creation of a vote within the budget for the national medical stores in the financial year 2009/10, which probably led to improvements in the supply and distribution of medicines. Indeed, the percentage of health facilities which had no stock-outs of essential medicines improved from 26% in 2008/09 to 43% in 2010/11.17

Conclusion

Ensuring financial risk protection will take more than the abolition of user fees. The need for wider health system improvements is already documented, which we also emphasize. In the current Ugandan health financing context, the best way forward is to harness the already high OOP expenditures into some form of prepayment. In addition, we argue that there is a need for wider government intervention, beyond the health sector, in poverty reduction and population growth control. The private sector still plays a significant role in health, and the issue of OOP payments is not an issue in the public sector alone; it has to encompass the private sector as well. The private provider is a preferred choice, even for those that are in absolute poverty, and the removal of fees will not protect the poor without effective mechanisms to work with the private sector in a public-private partnership. There is a need to address wider governance issues and to effectively regulate the private sector, to improve the framework within which the health sector can operate.17

References