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How do political factors affect the process of the introduction and removal of health care user fees such that health care utilization changes? A case study of Kenya and Uganda

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How do political factors affect the process of the introduction and removal of health care user fees such that health care utilization changes? A case study of Kenya and Uganda

A thesis submitted in partial satisfaction
of the requirements for the degree Master of Arts
in African Studies

by

Abigail Joanna Newton Enoch

2014

ABSTRACT OF THE THESIS

How do political factors affect the process of the introduction and removal of health care user fees such that health care utilization changes? A case study of Kenya and Uganda

by

Abigail Joanna Newton Enoch

Master of Arts in African Studies

University of California, Los Angeles, 2014

Professor Edmond J. Keller, Chair

Health care utilization dropped following widespread implementation of health care user fees across Africa in the 1980s and 1990s. This thesis investigates the political factors that affected why and how user fees were implemented and removed in Kenya and Uganda, and how and why utilization changed after these policy alterations. Thus we examine the impact of political factors on elements affecting people's utilization choices. Data was collected from the scientific and social science literature, Kenyan and Ugandan newspaper articles, and reports by governments and international organizations. We find that in both countries, care quality and drug supplies generally remained low regardless of user fees, and utilization decreased after user fee

implementation and increased after their removal. User fees did not function as intended, largely due to planning and financing deficiencies. The government-donor relationship, elections' influence on motives, the lack of state bureaucracy accountability, and weak institutions influenced this commitment insufficiency.

The thesis of Abigail Joanna Newton Enoch is approved.

Stephen Commins

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2014

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LIST OF ACRONYMS

DFID	Department for International Development (British)
DHMB	District Health Management Boards (Kenya)
GDP	Gross Domestic Product
HCFD	Health Care Financing Division (Kenya)
HUMCs	Health Unit Management Committees (Uganda)
IMF	International Monetary Fund
KANU	Kenya African National Union (Kenyan political party)
KSh	Kenyan Shillings
NARC	National Alliance of Rainbow Coalition (Kenyan political party)
NGO	Non-governmental organizations
SAPs	Structural adjustment policies
UN	United Nations
UNICEF	The United Nations Children’s Fund
US	United States
USAID	United States Agency for International Development
WHO	World Health Organization

Chapter 1: Introduction

1.1 Aims

Health care user fees were implemented widely across Africa in the 1980s and 1990s as a health financing strategy. Studies later showed that in general, health care utilization dropped following user fee implementation [Lagarde et.al. 2011][Gilson, 1997]. This thesis will investigate what were the political factors that affected why and how user fees were implemented and then removed in Kenya and Uganda, and how and why utilization changed after these policy alterations. Thus the thesis will examine the impact of these political factors on the elements that ultimately influence whether people choose to access health care. Implications of this for future health service reforms in low income African countries will be discussed. Data was collected from the scientific and social science literature, reports by governments, NGOs and international financial and health institutions, and from Kenyan and Ugandan newspaper articles.

Detailed case studies of the history of user fees in each country are provided, including details of the consequences of each policy change and the alterations to health care utilization. Consequences shall be focused on perceptions of affordability, corruption, quality and drug/equipment shortages as these will be assumed to be the primary mechanisms affecting people's choice to access or forgo health care services. We find that in both Kenya and Uganda, health care quality generally remained low before, during and after user fees were implemented, and corruption and drug shortages remained frequent; in addition health care utilization decreased following user fee introduction, and then increased following user fee removal.

The case studies will be followed by analyses of the political factors influencing the user fee introduction and removal processes in each case. The major such political factors include the influence of foreign donors, the level of community and stakeholder involvement in the process, the administrative structures developed for the programs, and the political motives of the leaders.

A discussion comparing the two countries and examining the common political factors follows. Thus we find that the common reason why user fee policies failed in Kenya and Uganda was because the governments did not fully commit to effectively planning or financially investing in the policy changes. We then consider what are the broad political features of the governments and states themselves which are the ultimate reasons for the lack of political commitment and thus ultimately the failure of the user fee policies, and the lack of health care access for the poor. The broad political features that are identified are the governments' reluctance to commit to policies promoted by donors; the lack of motive to invest time, effort, and money in a policy that was only decided upon to raise political support when simply the announcement of the change suffices to raise this desired support; the absence of incentives to improve the quality or equitability of health care when not being held accountable for such goals; and the lack of capacity to set up the administrative structures necessary for an effective user fee policy when strong institutions are not in place. These political features will therefore also have implications for other health reforms and reforms in other sectors.

Finally we consider whether community-based health insurance programs may therefore be a more appropriate policy for low income African countries like these, and we advocate for an increased prioritization of financial investment in health care.

Kenya and Uganda were chosen for the case studies as both countries have introduced and subsequently removed user fees; had fairly stable governments and a lack of extensive conflict over the time period of interest (80s through today); had a political structure of powers distributed across a President, ministers and parliament, all with the capability to influence changes in health care financing policy; and substantial information has been published on both. It is appropriate to compare these two countries because they both implemented and removed user fees within a few years of each other and share many characteristics due to their similar colonial experiences.

The indicators that will be primarily analyzed to determine the consequences of the user fee policy changes on the utilization of health care services will be the perception of affordability, corruption, perception of quality, and the frequency of drug/equipment shortages. This is because these are the main features of health care systems that can be affected by health care user fee implementation or removal, and which then influence whether people decide to access health care services or not. Health care utilization will refer to utilization of government health facilities unless otherwise noted.

Affordability of care is an important driver of whether people decide to access health care or not. Those people who do not have enough income or savings to pay even small levels of user fees, and who are not eligible, or do not know they are eligible, for exemptions, have to decide if they will seek money from some other source or go without care. For those who do seek care, they often have to search for alternative means of payment, which sometimes means sacrificing food or education, or 'distress sales' of assets such as land; the consequences can therefore be debilitating [Russell, 1996].

Corruption, for instance in the form of under-the-table payments or job absenteeism, may be in place when health care is officially free as health workers try to supplement their low salaries. Corruption may still occur when user fees are instated, particularly if wages are still low; or if corruption is so engrained in the system that everyone is used to it and perpetrators are not prosecuted; or official fee structures are complex or non-transparent so patients have difficulty knowing what they should be charged. Corruption is therefore an important factor to consider for this analysis because when it is in place, it increases the cost of the health care and therefore reduces people's ability to afford treatment, and could thereby discourage health care access. Mistrust of the system and lack of transparency over how much to expect to pay for health services are also potential side effects of corruption that can reduce people's willingness to go to health care facilities.

Quality can in turn be affected by user fee policies depending on how health facility operating costs are funded when user fee policies are or are not in place, the level of this funding, and how this funding is allocated. If health care is perceived to be low quality then people will be reluctant to utilize such services, even if they do think they are able to afford them. However, if health care quality is perceived to be high then poor people who may otherwise have felt they did not want to spend their limited resources on care, may be more willing to seek out alternative forms of obtaining enough money to ensure that they can access this good-value-for-money service. Indeed in a letter written to the editor of the Standard newspaper on December 4th 1989, a Kenyan wrote: "the administration in hospitals should see to it that services are worth the money we are going to pay. We wouldn't mind paying full medical fees, provided we receive some human treatment." [Standard, 1989b].

Similarly to quality, whether there are drug and/or equipment shortages in a health system is dependent on the total amount of the health facility budget and what proportion of this is allocated to the provision of drugs and equipment, as well as whether effective administrative structures are in place to ensure timely and consistent means of requests for and provision of supplies of drugs and equipment by and to health facilities. These factors can vary depending on whether there are user fees in place or not and if in place, the specifics of the user fee policy, in terms of total revenues and allocation of this revenue. Drug and equipment shortages can discourage people from accessing health facilities because people can end up paying more for care than anticipated due to having to buy the drugs or supplies from the health workers or from a private health facility or pharmacy. This can also take up more time for people, particularly if they have to travel to another facility or pharmacy to find drugs, which generally means more foregone wages. Thus people may feel that they may as well go straight to a private supplier of drugs, self-medicate, or visit a traditional healer, if they are not going to receive what they perceive as complete care at a health facility.

The literature on the politics of health care reform in Africa is sparse, and where existent, focuses almost entirely on the politics of HIV policies. The literature on the topic of user fees is largely concerned with evaluating whether user fees reduced health care utilization and/or whether utilization increased following user fee removal. Some studies discuss various factors that affect health care utilization, namely health care quality or the frequency of drug shortages, and a few others describe parts of the decision-making and/or implementation process of the user fee policies. However, none make the link in examining which aspects of the political process impact the factors that affect health service utilization. Thus in contrast to other studies this

thesis will be fully discussing why utilization changed, not just stating that it did, and in so doing will also be considering more broadly how political factors can affect health service utilization regardless of the type of health service reform. Moreover, the literature always either considers the introduction of user fees or their removal, rather than considering them together. This thesis will examine both changes together so that factors across health finance policy changes as a whole can be analyzed.

The target audience for this research is governmental policy-makers and others involved in health care provision such as international health organizations and NGOs who want to increase primary health care access in a population. The conclusions from this research will provide valuable information about what aspects of the implementation process of health system changes are likely to positively or detrimentally impact access and why. Some of these implementation process aspects may have similar consequences across countries, while the effects of others may be more context specific, perhaps even varying within the country. Furthermore, the research will point out barriers to health care access that seem to occur regardless of whether user fees are present or not (and therefore which cannot be solved by the introduction or removal of user fees).

1.2 Definition of user fees

One of the roles of governments, although not all embrace it, is ensuring that their population has access to health care. Issues arise however when determining how to assure access for the poorest members of the population and how to finance such systems. Many countries fully or partly fund health care through the collection of taxes from the population, but

in less developed countries, where a large proportion of the population works in the informal sector, it is difficult to raise revenue from taxes [Moat et.al. 2011]. Therefore, governments have tried to resolve these issues in a myriad of other ways, including social insurance, private insurance, community-based insurance, or health care user fees [Bennett et.al 2001].

User fees¹ are a payment for health care and can either be a standard price paid once for any kind of visit to a health facility, or can vary depending on treatment type and quantity [Konde-Lule et.al. 1998]. One of the main purposes of user fees is to raise health care system resources, which can be used for funding running costs, and improving quality through providing more resources for staff salaries, infrastructure, equipment etc. Some argue that user fees can also improve equity of access to health care as revenues can be used to subsidize care for the poor and/or fund services used predominantly by the poor. Some also think that user fees can be useful for discouraging unnecessary use of services [Gilson, 1997][Shaw et.al. 1995].

User fees are also thought to encourage efficiency of resource use, and therefore reduction of costs to the government, by promoting referral systems. Without user fees people tend to go straight to hospitals which have higher operating costs than local health centers but user fees can encourage people to go first to local health centers where user fee prices are lower [Shaw et.al. 1995]. Another suggested purpose of user fees is to create better accountability to the consumer [Bennett et.al. 2001].

A common concern with user fees is that they will reduce utilization of health care and promote inequality in health access by predominantly impacting the poorer members of the

¹ Sometimes also referred to as 'cost sharing'

population who are not able to afford to pay the user fees [Robert et.al. 2013]. Therefore exemption policies have often been introduced in countries using user fees, including in Kenya and Uganda, to ensure that the more vulnerable members of the population can still access health care [Gilson, 1997][Robert et.al. 2013].

1.3 Global history of user fees²

1980s

At the start of independence, many African countries embraced free universal healthcare [Shaw et.al. 1995]. However, the economic downturn starting in the late 1970s/early 1980s, due to increased oil prices and interest rates, and the reduced prices of many primary commodities, led to governments becoming less and less able to fund health care for their populations [Hutton, 2004]. This problem was accentuated by high levels of population growth, and the costs of the growing AIDS epidemic [Shaw et.al. 1995].

In 1987 the WHO and UNICEF sponsored a conference to discuss health care financing in Africa. What resulted was the Bamako Initiative, signed by many African Ministers of Health, and essentially introducing the first international effort to promote health care user fees [UNICEF, Bamako Initiative].

The conference was organized to promote maternal and child health by addressing the growing issues in many African countries of the decreased ability for governments to fund universal health care during the major economic downturn, drug and supply shortages, low

² See Appendix 1 for summarized timeline

quality services, and poor health outcomes [Nickson, 1990][Unicef, Bamako Initiative][Jarrett et.al. 1992][WHO, 1999]. The Initiative proposed at the conference was based on giving patients and communities more responsibility in their health care [Jarrett et.al. 1992][WHO, 1999]. A major component was to be the introduction of a fee for drugs, which would provide the funds necessary to maintain a steady supply of these drugs [Unicef, Bamako Initiative][Nickson, 1990]. It was thought that raising funds through user fees would result in greater health care quality and resource effectiveness and sustainability [Unicef, Bamako Initiative][Jarrett et.al. 1992].

At the time of the Bamako Initiative, there were some NGOs who expressed their views of such policies; for example Oxfam and Health Action International objected to the Initiative [Nickson, 1990]. Health Action International and UNICEF then organized a follow-up conference in 1989 to the Bamako Initiative, where they discussed their criticisms of the Initiative and called to attention factors they wanted to warn countries to take into account if implementing such health financing policies [Nickson, 1990][Jarrett et.al. 1992]. Many African countries then used the Bamako Initiative and the clarifications and alterations accomplished in the follow-up conferences to create their own models of health care financing adjustments [McPake et.al. 1993].

Around this time, as a result of the economic downturn, many African countries were becoming more and more in debt and looked to the International Monetary Fund (IMF) and World Bank for loans to pay off debt and finance domestic programs. The IMF and the World Bank attached conditionalities to these loans, which were based on free market ideology [Hutton, 2004].

These conditionalities generally involved the implementation of structural adjustment programs (SAPS) which were designed to make state spending more sustainable and increase international trade. Therefore policies included for instance extensive deregulation, privatization, currency devaluation and cuts to government spending (including health spending). SAPs were implemented across most developing countries [Hutton, 2004].

Thus the World Bank³ promoted the idea of introducing health care user fees, as an alternative method to solely using government spending, for financing health services. World Bank documents predicted that even modest user fees would enable countries to raise 15-20% of their operating costs and that revenues raised from charging for curative treatments could help fund free preventative treatments [Akin et.al. 1987][de Ferranti, 1985].

These documents did however also caution that charges should be less than 1% of the income of the poor, mechanisms should be created to ensure that those who cannot pay the charges are protected (e.g. through vouchers, lower charges at rural health facilities etc.), and that health services should be of reasonable quality [Akin et.al. 1987][de Ferranti, 1985].

In the late 1980s USAID carried out various studies to investigate the potential implications of user fees, and helped to fund the implementation of such programs in, for example, Kenya and Zaire [Collins et.al. 1996][Bitran, 2002].

1990s

³ The World Bank was more prominent in advocating for health care user fees and working with countries to implement them than was the IMF

By the beginning of the 1990s there was wide support in the international community for user fee implementation, particularly from the World Bank. Many African countries introduced user fees in the early 1990s amidst this support [Collins et.al. 1996].

Throughout the decade, the World Bank continued to advise countries to introduce user fees. It also published numerous documents evaluating the effects of such fees; this was in an effort to determine how to enhance user fee program effectiveness, rather than to question their suitability as a policy [Shaw et.al. 1995][Beattie et.al. 1998].

While the UN did not, and still has not, stated an official stance on the issue of user fees [Robert et.al. 2013], during the 1990s there were various UN conferences dealing with the issue of health care user fees. For instance, the report detailing the decisions made by the UN's Economic and Social Council Commission on Sustainable Development at their Substantive session in May 1994 states that governments and international organizations should prioritize “reassessing health expenditures with a view to more cost-effective health protection and promotion measures, including, where appropriate, the increasing use of economic instruments, such as user fees and insurance systems, in order to generate funds for efficient health systems.” [UN, 1994].

In the 1990s UNICEF continued to promote user fee introduction through discussions of what situations and factors warrant and improve user fee policies. Thus alongside the UN Economic Commission for Africa and the World Bank, UNICEF helped to create The 1997 Addis Ababa Consensus on Principles of Cost Sharing in Education and Health. The 12 principles included for instance that user fees should not be introduced for preventative care and

that resources raised from cost sharing should be supplementary to other funding, rather than replacing it [England et.al. 2001].

It was not until the late 1990s/early 2000s that NGOs became very vocal about their views on user fees [Lee et.al. 2002][Robert et.al. 2013]. From then onwards, NGOs have been prolific in their activities and production of documents promoting their opinions on the matter. Unlike organizations such as the World Bank, UNICEF and the WHO that have at times supported and at times criticized user fees, NGO attitudes have almost always been in opposition to user fees. They were also, unlike other organizations, able to draw on examples from their on-the-ground field experiences to support their arguments [Robert et.al. 2013].

2000s

Various groups attempted to change the practices of the World Bank and IMF in the 2000s. For instance, because of lobbying by American NGOs, in 2000 as part of its foreign aid appropriations bill, the US Congress included language forbidding the US government from funding any World Bank or IMF programs which have conditions that countries must demand user fees for basic social services [Hutton, 2004]. As a result, the World Bank produced statements asserting that it does not support health care user fees, although there were still cases after this date in which the World Bank did promote user fees in providing funding [Hutton, 2004][ActionAid, 2002].

The World Bank's views did change somewhat by the middle of the decade. In its 2004 World Development Report, the World Bank explicitly stated that it does not have a blanket policy on user fees. The report stated that "the wide range of services and country circumstances

discussed in this Report make it impossible to claim that a particular level of user fees or none at all is appropriate in every case. User fees, as with other public policy decisions, must balance protection of the poor, efficiency in allocation, and the ability to guarantee that services can be implemented and sustained”. It then provides a decision tree to be used to determine if user fees are appropriate for a particular context [World Bank, 2003].

UNICEF also underwent a transition in policy during this decade. In 2005 they called “for governments and agencies to work towards the elimination of user fees for primary education and, where appropriate, health-care services” [Corby et.al. 2005]. This indicated that UNICEF had shifted to supporting the removal of user fees, but not unequivocally. This view was further demonstrated: in 2005 UNICEF assembled a consultation of partners and staff from the country and regional level to discuss the issue of user fees, and the resulting paper stated that “removing user fees has the potential to improve access to health services, especially for the poor, but it is not appropriate in all contexts.” [James et.al. 2006].

In 2005, the African Development Bank produced a report entitled Operational Guidelines on User Fees in Health and Education where it explicitly stated that it does not support health care user fees for essential health services (e.g. immunizations, antenatal care etc.) and will help countries who want to abolish such fees, but that its position on other basic health services is on a case-by-case basis, and that it actively supports user fees for higher level services like care at tertiary hospitals [African Development Bank, 2005].

Over this decade, the WHO produced various reports either promoting user fees or at least supporting them in certain situations [Shepard et.al. 2002][Singh, 2003]. However, in their

World Health Report 2008, the WHO stated that “user fees, in particular, are important sources of exclusion from needed care” and that countries, especially the poorest ones, should “resist the temptation to rely on user fees” [WHO, 2008]. This was the first time that the WHO had published a report in which they explicitly stated their opposition to user fees [Robert et.al. 2013].

DFID, the UK’s international development agency, also weighed in on the debate. They produced various reports in the 2000s advocating for the removal of user fees [Pearson, 2004][Bennett et.al. 2001][Robert et.al. 2013].

The UN also made decisions in the 2000s supporting the removal of health care user fees. Thus at the September 2009 UN General Assembly, the conference participants pledged \$5.3 billion to help support new financing methods for maternal and child health, and six countries declared that they were prepared to abolish user fees, if given assistance from the international community [Edwards et.al. 2010].

Furthermore USAID produced various reports during this decade, investigating the impacts of user fees: for instance one found that user fees in Morocco would decrease the poor’s utilization of maternal health services even if quality increased, while another found that women in five countries were largely unaware of user fee exemptions for antenatal services, which reduced their utilization [Hotchkiss et.al. 2003][Sharma et.al. 2005]. However, the organization never officially declared a position either for or against user fees [Robert et.al. 2013].

NGOs were prolific in their production of press releases and reports arguing their views on health care user fees from the start of the 2000s onwards. Almost all of these condemn user

fees and advocate for their removal [Robert et.al. 2013]. Some reports add recommendations to their criticisms, either to be taken by foreign governments, for instance in financial or technical assistance [Partners in Health, 2012][Save the Children UK, 2005] and/or by the countries themselves who have the user fee policies [Save the Children UK, 2009][Edwards et.al. 2010]. Most of the press releases and reports are global in nature, while a few focus on a single country, e.g a Health Poverty Action report that provides recommendations for Sierra Leone's removal of user fees [Edwards et.al. 2010].

Sometimes NGOs have tried to target specific foreign leaders in aiming to increase support for their cause. Save the Children UK criticized Former UK Prime Minister Gordon Brown in a 2005 press release, for not doing enough after he had called for the need for free health care on a trip to Africa. [Save the Children UK, 2005]. Five years later, in Health Poverty Action's report on abolishing user fees, the NGO praises Gordon Brown's efforts at the 2009 UN General Assembly on health that was previously discussed, as he co-hosted the event [Edwards et.al. 2010].

NGOs also continued in the 2000s to attempt to influence major conferences and international gatherings at which health care user fees are discussed. For instance 59 NGOs endorsed a report produced to influence the leaders attending the September 2009 UN General Assembly mentioned above. The report discussed why these NGOs were adamantly opposed to user fees and presented its recommendations for steps to be taken by countries who want to remove their fees, and for foreign leaders who they urged to help provide short and long term financial and technical assistance to accomplish user fee removals [Marriott et.al. 2009].

Thus in the 2000s the international mood had begun to change, particularly in the face of accusations that user fees prevent poor people from accessing health care. Therefore many countries completely or partially removed their user fees during this decade [Robert et.al. 2013].

2010s

NGOs continue to advocate for the removal of user fees in the 2010s. Thus, for example, Oxfam issued a press release after the WHO published its World Health Report 2010, which had, for instance, addressed potential detrimental impacts of user fees on access. The press release said “This report puts the World Health Organization back at center stage”, applauded some of its recommendations: “The WHO support for a tax on the financial sector is fantastic”, and urged others to take note of the findings: “The stakes could not be higher, and this report is a wake-up call for all governments, rich and poor, who need to do more” [Oxfam, 2010].

Oxfam also published a press release supporting a universal coverage resolution that the United Nations General Assembly was voting on in 2012, stating that “Oxfam believes that governments and rich country donors must strengthen state capacities to expand free publicly provided health care, a proven way to save millions of lives worldwide” [Oxfam, 2012a].

Moreover, the International President of MSF spoke at the Economist’s Global Health Care Summit in London in 2012. He criticized user fees: “if people don’t have money, introducing more services will not increase access to health care if those services have to be paid for. [...] The people need a health system that works, not that preys on them as a source of revenue.” [Karunakara, 2012].

The WHO also began to discuss the weaknesses of user fee policies at some of its conferences in the 2010s. For instance, the theme of ‘Towards Universal Health Coverage’ was discussed on the first day of the 65th World Health Assembly in 2012. Some Member States did express their support for universal health coverage at the conference, but this was not explicitly linked to the removal of user fees and no resolutions were passed on the matter [WHO, 2012].

Furthermore, in December 2012, the UN General Assembly passed a resolution supporting universal health coverage, with wide support from member states from both the global north and south [Tran, 2012].

USAID continues to produce reports investigating the impact of user fees or their removal: for instance they found that access and maternal deaths improved when user fees were removed for caesarians in Mali [El-Khoury et.al. 2011]. USAID also produced a report discussing community based health insurance programs in Ghana, some of which it had helped to fund, to help deal with some of the equity issues of affordability that can arise from user fees [Blanchet et.al. 2013].

By 2012, the World Bank had developed an even more nuanced position on user fees whereupon it did not actively support them anymore but was not pushing for their removal either. In October of 2012, 110 NGOs and civil society groups from more than 40 countries met with World Bank President Jim Yong Kim, and presented him with an open letter they had all signed trying to convince Dr. Kim to actively provide support to countries to remove their user fees, for instance by helping countries to develop sustainable financing and national health plans [Oxfam, 2012b].

Subsequently, in December 2013, Jim Yong Kim did pledge the World Bank's support for promoting universal health coverage, at the Global Conference on Universal Health Coverage for Inclusive and Sustainable Growth, co-organized by the World Bank and the government of Japan [Oxfam, 2013]. Oxfam responded to Kim's speech, urging the World Bank to develop a detailed plan of the steps it would take in assisting countries to abolish user fees, including helping them to implement more effective and fair health financing systems, without resorting to making poor people pay for health insurance programs [Oxfam, 2013]. The World Bank reaffirmed this shift in policy when on April 11, 2014, Dr. Kim spoke about his support for universal health coverage in introducing a panel discussion entitled 'Toward Universal Health Coverage for 2030' at the IMF/World Bank Spring Meetings [Kim, 2014].

Currently most NGOs, developed country leaders, and even the World Bank to a certain extent, oppose user fees and advocate for their removal [Robert et.al. 2013].

Chapter 2: A Case Study of Kenya's History of Health Care User Fees⁴

Initial introduction of user fees

Free healthcare was introduced in Kenya shortly after independence. The government decided to do so to provide a distinction from colonial rule when health care was severely restricted, and to raise support from the population for those in power. The US helped to finance this under its Cold War policies [Anangwe, 2008].

⁴ See Appendix 1 for summarized timeline

The economic performance of Kenya decreased in the 1980s in the widespread debt crisis [Collins et.al. 1996]. As in many other African countries at the time, the World Bank demanded the introduction of SAPs in Kenya as a condition of their loans, arguing these were necessary for ensuring economic viability through the reduction in excessive government spending. The six components of SAPs in Kenya were currency devaluation, government spending cuts on social services (e.g. health, education), increased taxes on mass consumption goods, removal of price controls, removal of subsidies (of e.g. food), and improvements in planning and execution of the public sector [Anangwe, 2008].

Therefore the government's expenditure on health decreased, whether measured as percent of GDP or per capita. Kenya had already committed in national plans, such as Health For All by 2000, to providing affordable, accessible and efficient health services for all [Anangwe, 2008]. Health care user fees therefore seemed an attractive alternative form of health care financing to help the country move towards those goals.

The idea of user fees was first suggested in the 1979-1983 Development Plan, which was developed by the Ministries of Planning and Finance, with the assistance of other governmental members, academics, NGOs and private sector representatives. This Plan stated that "in Kenya, where the self-help spirit thrives, groups of private citizens will often take on the task of building their own health clinics. During this plan period the government will assess the level of self-help and other voluntary efforts in each district when determining its own investment proposals" [Mwabu, 1995, p.248]. The 1983-1988 Development Plan was more explicit in these ideas, which were reiterated in the 1989-1993 Development Plan. Nonetheless, in this later document the terminology was changed from 'user charges' to 'cost-sharing' to try to assuage some of the

fear and anger of the population; ‘cost-sharing’ implied that the burden would be shared between the population and the government but in reality the two terms were synonymous [Mwabu, 1995].

The Ministry of Health supported the idea of a health care user fee policy in its 1984-1988 Development Plan [Mwabu, 1995][Anangwe, 2008]. The government subsequently consulted donors such as the World Bank for advice on this matter, and as a result, organizations such as USAID, the World Bank and others funded studies on health system financing options for the government [Anangwe, 2008][Collins et.al. 1996]. The studies returned conflicting evidence: some argued that health care services are price inelastic so user fees would not cause a change in access; other studies suggested that access would decrease for the poor after user fee introduction; some studies argued that quality would increase with the introduction of user fees, and this would be able to compensate for the reduced demand due to cost. A study by Ellis recommended that exemptions be put in place for much of the population and that some of the revenues be available for use by the health facility collecting them [Mwabu 1995].

In 1989 the findings⁵ were brought to the cabinet who agreed to support the implementation of user fees [Anangwe, 2008].

The government eventually decided to implement health care user fees as it was thought that they would improve service quality, increase efficiency of resource use by promoting the referral system, restrain frivolous demand, and promote access for the poor by using the money

⁵ Unfortunately information on the specific findings, who presented and received them, and details about the corresponding discussions are not available in the literature.

from people who could afford the fees to pay for services for the poor. These were all commonly held views at the time of the likely consequences of user fees [Collins et.al. 1996][Mwabu, 1995][Anangwe, 2008].

User fees were abruptly introduced by the government in December 1989 with little administrative preparation. The whole process was supposed to take only six weeks [Mwabu, 1995][Collins et.al. 1996]. Fees were simultaneously implemented at 80 government hospitals and 320 health centers without pilot testing so it would have been difficult to anticipate the problems that arose [Collins et.al. 1996]. These reforms were partially funded by USAID [Collins et.al. 1996]. At the time, the Ministry of Health complained to the World Bank that the suggested user fees were too high [Anangwe, 2008].

The decision to implement user fees was announced through the mass media. The intention was announced before the actual implementation, which Mwabu, 1995 argues is a common tool used when the intended policy is a risky or controversial one [Mwabu, 1995]. The public was ill-informed about the program because the government did not run any informational campaigns on user fees before their introduction, and health workers were not well trained about the user fees [Collins et.al. 1996].

Initial user fee policy

Fees were per visit instead of per treatment; the initial outpatient registration fee was 20 Kenyan shillings (KSh) (the equivalent of US\$1.00) at hospitals, KSh10 (US\$0.50) at health centers, and dispensaries were free. These fees were much lower than those charged at private facilities and mission health centers; for instance surveys in South Nyanza at the time indicated

average private and missionary fees of KSh78 and Ksh56, respectively, while KSh116 was the average fee for such facilities in Nairobi in 1988. Drugs did not incur an additional cost at government health facilities but lab tests, x-rays and some other services did. Patients were given a dated stamp on a health card when they paid the registration fees and then they could attend any health facility of the same or lower level for the following month for free [Huber, 1993].

The Health Care Financing Division (HCFD) was created as a section of the Ministry of Health for the purpose of managing the funds raised from user fees [Anangwe, 2008]. 75% of the revenues raised from user fees were to be kept and used by the health facility that collected them while 25% was to be given to and spent by the districts for primary health care services [Huber, 1993]. The health facilities in Kisumu and Embu districts spent the revenues that they kept in the following proportions: 21% on equipment, 20% on drugs and dressings, 11% on cleaning materials, 3% on transport, 2% on linen and 43% on miscellaneous items such as insecticides, maintenance and utensils [Mwabu et.al. 1995] [see Appendix 2 for map of Kenyan districts].

An exemption policy was introduced which meant that user fees were waived for certain people including children under five, prisoners, those with certain disabilities, and those seeking services for mental health issues, antenatal visits, or treatment for TB or HIV⁶. Civil servants and their families were also excluded from having to pay user fees. Health facilities were responsible for enforcing these exemption policies. Health workers were also responsible for providing waivers to people who could not afford to pay the user fees [Anangwe, 2008]. The facility was meant to provide an exemption stamp to those unable to pay which would be valid for one

⁶ Sources differ on the specific services that were exempted but this list is based on the best available information from the literature.

month. If the person wanted to access health care after this month then they would need to present a written exemption endorsement from the chief or sub-chief of their community to certify that the person could not afford the fees. These endorsements would be valid for 12 months. A certain proportion of stamps provided by the particular facility were allowed to be exempt stamps; this proportion was to be audited and adjusted periodically [Huber, 1993].

Thus there were various aspects of the policy which were in place to aim to ensure that poorer members of the population would be able to get access to health care. These included the exemption fees for many basic health services; the free or reduced fees at dispensaries and lower health facilities which are generally those offering basic health care; the fact that 25% of revenues were to be used for primary health care promotion programs; and the exemption policy for those unable to pay [Huber, 1993].

There were also various other measures that the government aimed to implement at the same time as the introduction of user fees. These were: the decentralization of the health care system, increased focus on preventative services like family planning, development of an insurance program for certain workers, and incorporation of certain areas of traditional medicine into 'modern' medicine [Mwabu, 1995].

Consequences of initial user fee implementation

There was much confusion surrounding the type of fees and fee levels in Kenya, and who needed to pay these fees. In 1991 a resident technical assistance team investigated what were the problems with the original user fee system and found that the exemption system was well-designed but patients and health workers did not understand or use them properly. Also records

were not being kept for waivers so monitoring was not possible [Collins et.al. 1996]. In addition, many health care workers did not agree with the need to grant exemptions [Huber, 1993]. It is thought that less than 1% of patients obtained a user fee exemption because of an inability to pay the fees [Collins et.al. 1996]. This is in contrast to the estimate of 12-34% of people that Huber, 1993 calculated for the proportion of people likely to need an exemption due to an inability to pay user fees. Thus this indicates that the exemption policy was not functioning effectively [Huber, 1993].

There were many other administrative problems which arose soon after user fee introduction. One such issue was that the HCFD which had been created within the Ministry of Health and was responsible for managing the revenues raised from user fees for all health facilities across the country, only had six technical staff and was therefore unable to effectively manage all of its extensive range of tasks [Anangwe, 2008]. Proper administration and accounting systems were also not in place for monitoring the type and amount of health services being utilized, the revenue collected, or the provision of waivers for exemptions [Collins et.al. 1996]. In addition, only 3.4% of the Ministry of Health's budget was being obtained from the user fee revenues [Mwabu et.al. 1995].

In addition, there were often long delays in the expenditure plan approval process, District Treasuries were reluctant to provide funding to health facilities, funds became lost in bureaucracy or bank accounts rather than going towards health service improvement, and revenue which was received was often used in ways that did not impact patients, for instance by painting offices [Collins et.al. 1996][Anangwe, 2008]. Not only did this impact patient

perceptions of care quality, but many health workers therefore also did not approve of the user fees and for this reason sometimes did not charge them [Collins et.al. 1996].

The press heavily criticized the user fee program, reporting that quality had not improved contrary to promises. There were numerous such criticisms including that some corridors and rooms in the Rahemtula wing in Mombasa were not lit, windows were broken, and the roof needed repairs; there was urine and feces on the floor of the latrines at Coast General Hospital; at Nairobi's Special Treatment Clinic for STDs and skin conditions (the only public one serving the 1.5 million people of Nairobi) there was often only one doctor, one medical officer and a small team of nurses to deal with 400 patients per day; patients often had to bring their own sheets, food and water and were only given aspirin or panadol, regardless of their condition; a frustrated citizen who had to take his sick brother out of hospital because all he was being given was aspirin twice a day wrote to the editor of the Standard that "perhaps God is going to heal him together with many others who have been denied treatment in Government hospitals" ["Coast hospital", 1990][“A day”, 1990][“Serious drug shortages”, 1990]. The 1991 resident technical assistance team that was previously mentioned also found that quality had not increased. Furthermore, there were claims that in some situations, health workers were refusing to provide services to the poor [Collins et.al. 1996].

In addition to reporting that quality had not improved after the initial introduction of user fees, the press, and later the resident technical assistance team, also criticized the fact that drug and equipment supply had not improved after implementation, even though this had been one of the goals of the program [Collins et.al. 1996]. 64% of 121 patients interviewed at health facilities in Kisumu and Embu districts said they were not able to obtain drugs even though they paid user

fees [Mwabu et.al. 1995]. Even basic materials were often in short supply: there were reports that health workers in Webuye were prescribing medicines on toilet paper or patients' exercise books because of stationary shortages ["Mang'oli decries", 1990].

The then Minister of Health, Mwai Kibaki, acknowledged the existence of needle shortages early on in the program but said they were only due to "small bottlenecks in the delivery system" and that the Director of Medical Services had resolved the problem swiftly. In addition, he argued that because the government did not put a tax on needles, practitioners should find it easy to buy them and therefore shortages should not be a problem [Standard, 1989a].

Changes in health care utilization following initial user fee implementation

Evidence indicates that health care utilization decreased after the introduction of user fees. One study showed that outpatient utilization at government health centers dropped by 52% while attendance at dispensaries (where fees were not introduced) increased by 6% and, strangely, attendance at private and missionary health centers dropped by 18% as well⁷ [Mwabu et.al. 1995]. Another study found that outpatient attendance dropped by 27% at provincial hospitals, 45% at district hospitals and 33% at health centers [Collins et.al. 1996][See Figure 1].

However, it is important to look at these numbers carefully, as the reduction in attendance at provincial hospitals shown in the Collins et.al. 1996 study followed a significant long term trajectory while the district hospital decrease did not. This could suggest that decreases in

⁷ Data is not available for pharmacies.

attendance at provincial hospitals may have been less due to user fees and more because of the availability of other healthcare sources [Collins et.al. 1996]. Furthermore, in the case of the drop in attendance at private facilities found by Mwabu et.al, 1995, perhaps some of those choosing not to attend private facilities, due to economic or other reasons, instead went to government ones, thereby reducing the impact that otherwise would have been seen; alternatively, perhaps whatever factors that led to a reduction in private facility attendance may also have led to a further decrease in public facility attendance as well.

Initial removal of user fees

As discussed, there was substantial pressure for the government to remove or pause the user fee program. Therefore in September 1990 outpatient user fees were removed to facilitate the re-organization of the administrative system of the policy [Collins et.al. 1996]. The government publically acknowledged that one of the main reasons for removing the fees was “the system was being abused by some medical officers. They did not display a humane attitude towards patients”, which was taken to refer to the low levels of exemption provisions [Huber, 1993].

The removal was announced through mass media [Mwabu, 1995]. Inpatient user fees were still in place but many thought that all user fees had been removed. Some changes were made to inpatient fees, such as that the maternity bed fee was decreased [Collins et.al. 1996].

Changes in health care utilization following initial removal of user fees

After user fees were removed, outpatient attendance increased; by some estimates it increased by 41% and by others it returned to pre-introduction levels [Mwabu et.al. 1995][Burnham et.al. 2004][Collins et.al. 1996].

Second introduction of user fees

While adjustments were being developed, a public discussion was carried out by the media and in workshops. Discussions took place in these meetings on the advantages and disadvantages of user fees [Mwabu, 1995]. Fundamentally, none of the budgetary pressures that had necessitated user fees in 1989 had changed by this point though, so the government felt that user fee re-introduction was necessary [Mwabu et.al. 1995]. Therefore after adjustments were made, outpatient user fees were reintroduced in a much more gradual process, starting in 1992 [Collins et.al. 1996]. No definitive scientific study informed the decision to re-introduce user fees [Mwabu, 1995].

User fees were introduced over a two year period, first at national and provincial facilities and then later at local ones. The new user fees were based on the specific treatment needed or drugs prescribed rather than a generic registration fee [Collins et.al. 1996]. The announcement of the re-implementation was communicated to the general population through mass media [Mwabu, 1995].

Second user fee policy

Those who were exempt from user fees included those receiving family planning or antenatal services, STD services, immunizations, treatment for TB or leprosy, children under 15,

prisoners, civil servants, the unemployed, and people with HIV [Bitran, 2002][Anangwe, 2008]. As of early 1993, 54% of outpatient drug purchases and 42% of outpatient lab tests were exempted and 20% of inpatients were also exempted; roughly half of the total forgone revenue from exemptions for outpatient services in 1993/1994 were for civil servants and children between the ages of six and fifteen. A more organized system for waiver provision was also put in place for those who were not able to pay the fees: patients would have an interview with a health worker based on outlined guidelines and then a designated officer would approve the waiver. Monitoring of waivers also began [Collins et.al. 1996].

In addition, changes were made to the HCFD. Eight more technical staff were hired for the department, and it gained new roles including supporting the National Hospital Insurance Fund⁸ and providing health facility equipment [Collins et.al. 1996][Anangwe, 2008]. District Health Management Boards (DHMBs) of local health facilities were created in May 1992 and they took over responsibility for managing and independently monitoring user fees funds from the HCFD [Collins et.al. 1996]. It was thought that this would increase community participation, empower local decision making, reduce bureaucracy, and lead to better coordination between the efforts of the government, NGOs and private sector [Anangwe, 2008]. Furthermore, the government tried to increase accountability and transparency by making departments have to account for all funds they raised [Collins et.al. 1996].

Allocation of user fee revenue was still supposed to be divided so that 75% would be kept by the facility itself and 25% would go towards district-level primary and preventative services.

⁸ a government insurance program from which one fifth of the population obtained inpatient insurance coverage [Collins et.al. 1996]

Funds were not meant to be used for staff but rather for drugs, maintenance of infrastructure, etc. [Collins et.al. 1996][Shaw et.al. 1995].

Other additional changes were made. Thus training manuals and programs were developed, hospital managers had to undergo training workshops before the reintroduction of the user fees, and follow up visits were supposed to be made by supervisors every month to ensure proper practices were being carried out [Collins et.al. 1996].

The re-introduction of user fees was accompanied by programs aiming to improve efficiency and private sector development. Systems were also put in place to ensure that all inpatient costs were obtained from those involved in the National Hospital Insurance Fund [Collins et.al. 1996].

Consequences of the second implementation of user fees

Even after the administrative changes involved in the implementation process of the second introduction of user fees, the system was still badly coordinated. Budget proposals needed to be sent from the DHMBs to the HCFD to be approved, but this was a lengthy process so DHMBs often implemented their programs without approval. As a result user fee prices rose dramatically and corruption increased [Anangwe, 2008].

The perceived change in health care quality following the 1992 reintroduction of user fees was more variable than after the initial introduction of user fees. Some reports indicated a widespread continued overcrowding and increasingly dilapidated medical equipment and buildings [Anangwe, 2008]. However, a study by Collins et.al, 1996 in which surveys were

conducted with outpatients before and after the reintroduction of user fees, found that perceptions of health care quality varied for different health facilities. Their findings showed that at provincial hospitals, there was an increase in the perceptions of overall quality, staff competency, staff morale, cleanliness and confidentiality. However, at the district hospitals there was a decrease in the views of staff competency and morale, and confidentiality, while increased waiting times were reported at both kinds of hospitals [Collins et.al. 1996].

The actual levels of revenues raised from these fees was still not substantial, and therefore did not make much of a difference to the budgets of the health facilities. Thus for instance, in 1993 user fees at Kenyan government health facilities only recovered 2.1% of the government's expenditure on health services [Gilson, 1997].

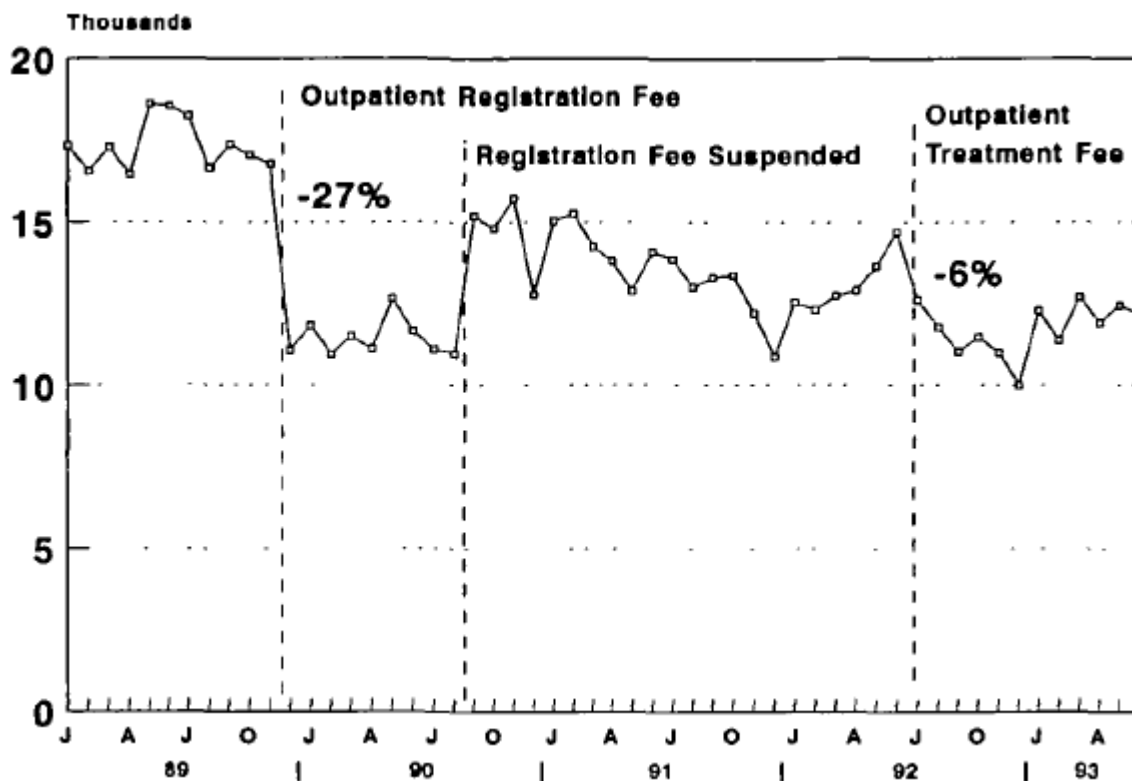
In 1993 a shortage of intravenous fluids, surgical supplies, antiseptics and cleaning products was found in a study of four hospitals. The authors suggested that these shortages were perhaps due to poor management of revenues, or because Treasury funding had not been increasing enough or because the Ministry of Health was saying that drugs should be provided by the Central Medical Stores instead of being bought in bulk at wholesale prices [Collins et.al. 1996].

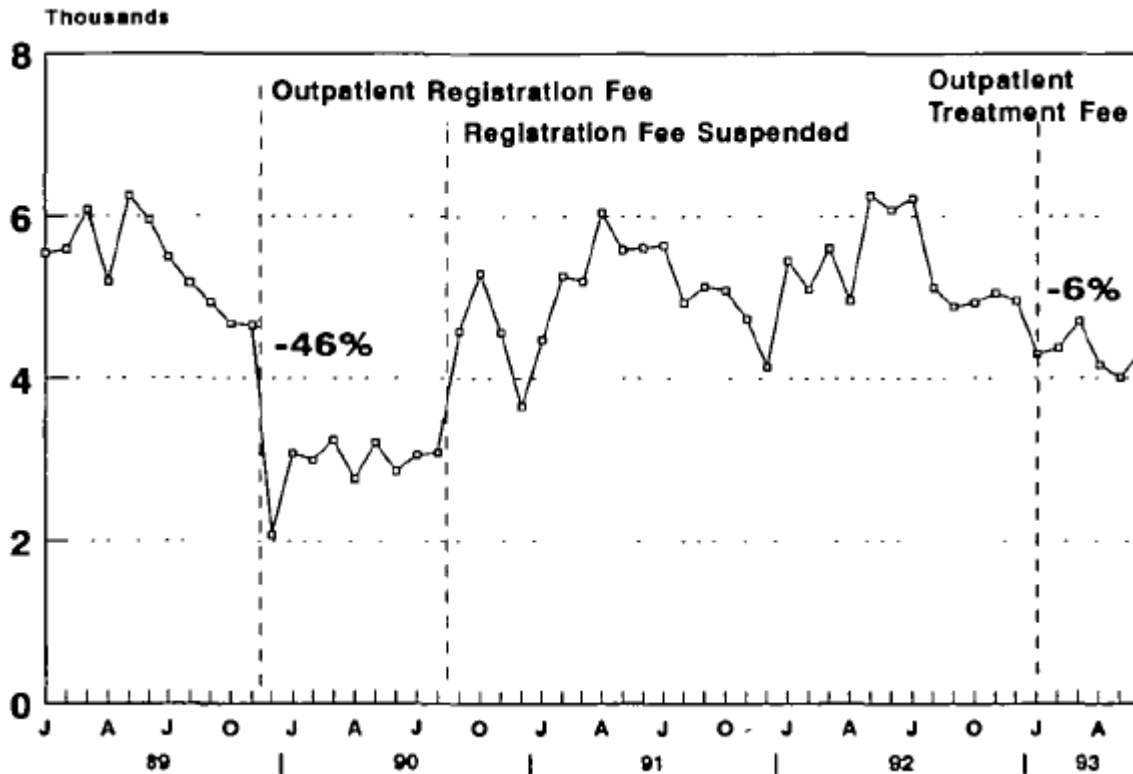
Corruption was inherent within the structure of the health system as a whole: in Transparency International Kenya's bribery index of 2002, the Ministry of Health was one of the ten worst ranked organizations. While it made substantial improvement in its score by 2003, the Ministry of Health still continued to have high levels of reported bribery [Transparency International Kenya, 2004].

Changes in health care utilization following the second introduction of user fees

Evidence suggests that utilization rates decreased again after the second introduction of user fees, however the rates vary by study. Collins et.al. 1996 found that the second access decrease was much less pronounced than the previous drop – only 6% at hospitals [Collins et.al. 1996] [see Figure 1]. Another study found that in one district, outpatient attendance decreased by 40%, and utilization of STD clinics in Nairobi decreased by 60% and 35% for men and women respectively [Mwabu, 1995].

Figure 1a and 1b: Graphs of the average number of general outpatient attendances at three provincial indicator hospitals and four district indicator hospitals, respectively, between January 1989 and June 1993





[Collins et.al. 1996]

Alterations to second user fee policy

User fees had been introduced at the start of the introduction of multi-party politics in Kenya. Therefore, the opposition to KANU, the party in power at the time, continually criticized the government for not being able to provide healthcare to its citizens for free. As a result, the government was always uneasy with the user fee policy and therefore made many alterations over time to the fees, exemptions, and other components of the program [Anangwe, 2008].

The exemption policies were changed many times over the years. For instance, in October 1994, the national exemption policy for children was altered from all children to only those under the age of five, and the exemption for civil servants was removed [Collins et.al.

1996]. In January 2004, user fees were introduced for children under five at Kenyatta National Hospital [Anangwe, 2008].

Changes in health care utilization following alterations to second user fee policy

Utilization levels dropped following the change in exemption for children at Kenyatta National Hospital: there was a reduction from between 300 and 500 children coming for treatment per day to fewer than 200 seen per day [Anangwe, 2008].

Second removal of user fees

By the early 2000s there was evidence showing user fees' detrimental impact on equal access to health care [Chuma et.al. 2009][Collins et.al. 1996][Mwabu, 1995].

After the NARC political party gained power in 2002, members of the cabinet including Charity Ngilu, the Health Minister, began to make promises of health system reform [Ngwiri, 2003]. On the 7th of January 2003, Ms. Ngilu announced she was taking steps to prepare for free health care provision for the population, including investigating setting up a national health insurance program for workers (instead of the National Hospital Insurance Fund that was already in place). She also announced that government facilities could no longer detain people if they could not afford to pay the user fees and that these facilities must provide dead bodies to their relatives even if mortuary bills were not paid [“Kenya: free health”, 2003].

In January of 2003 Ms. Ngilu also stated that “We are aware that fee for service has been a great impediment (to health care access). My ministry and the NARC government will

continue to mobilise resources to put in place an alternative financing mechanism.” [“Kenya: free health”, 2003].

The previous Health Minister, Professor Sam Ogeri, from the KANU party, had sent a group of MPs and health sector supervisors to various European and Asian countries to investigate alternative health care financing mechanisms used elsewhere. A task force was then created, which was assisted by representatives from the German government, to discuss potential financing options; for instance one that was suggested involved using revenues raised from taxes on alcohol and tobacco to help fund a national health financing system. This report was due to be completed in June of 2004, amidst all these announcements by Ms. Ngilu [“Kenya: free health”, 2003].

Ms. Ngilu says she witnessed some of the problems of user fees firsthand when she met a family who were not able to afford to pay for treatment for their daughter. She stated it was because of this experience, which she found unacceptable, that she decided to remove user fees. Thus in June 2004, without prior approval from others in the government, she announced that as of July 1st, 2004 all outpatient treatment user fees would be removed [Real Health News, 2007].

The 10/20 program was implemented in its place. This entailed a single registration fee for dispensaries of KSh10 (the equivalent of US\$0.20) and KSh20 for health centers. In addition, children under five were exempted from this payment, as were those getting treatment for malaria, TB and various other diseases [Chuma et.al. 2009].

The government said this policy change was part of larger health and economic policy changes, and the timing was concurrent with the governmental effort to introduce a National

Health Insurance Fund⁹ [“Kenya: free health”, 2003][Agutu, 2004]. The government declared it would increase the budgetary allocation to health to compensate for the lost revenues: grants would be available to compensate facilities, and KSh4.1 billion of the 2004/2005 budget was going to be used to support the removal process, KSh1.1 billion of which would go towards buying drugs and dressings [Agutu, 2004]. Furthermore, the government announced they were hiring 5,000 additional nurses, as well as more pharmacists, anesthetists and laboratory technicians in anticipation of the increased demand for health care that was predicted to exacerbate the health worker shortage that already existed [Orende, 2004]. Ms. Ngilu also said that the government would set up telephone hotlines for the population to provide feedback on how the removal process was implemented [Agutu, 2004].

Consequences of the second removal of user fees

A study interviewed over 300 patients in Kwale and Makueni districts, three years after the 10/20 policy was implemented in Kenya. They found that: one third and one half of respondents did not know what the fees were for dispensaries and health centers respectively and only 25-40% knew about the exemption policy for children under 5, while only 7-25% of people knew that the poor could be exempted from fees. Health workers were also interviewed in the study and it was found that often the health workers did not know correct information about who could be exempted. Moreover some health workers expressed dissatisfaction with some of the

⁹ It is worth noting that despite all these efforts by the Kenyan government to implement such insurance programs, only a small proportion of the population, particularly of the poor, ever had insurance. Thus as of 2007, 98% of the poorest quintile of the population, 96% of the 2nd poorest and 95% of the third poorest quintile did not have any health insurance [Mathauer et.al. 2008].

exemptions, namely the one for malaria treatment, because of the frequent difficulty in determining if someone is suffering from malaria or something similar [Chuma et.al. 2009].

This same study also found that half of the health facilities in Makueni district and three quarters of the health facilities in Kwale district did not adhere to the 10/20 policy, i.e. they charged higher registration fees than the policy involved. Those working at facilities often argued that the registration fees of the 10/20 policy were too low to meet their operating costs, and the financial allocations from the government did not supplement these revenues sufficiently, hence why so many did not adhere to the 10/20 policy [Chuma et.al. 2009]. Therefore perceptions of affordability would have varied depending on the health facility and its relative adherence to the 10/20 policy.

After the introduction of the 10/20 policy, corruption remained a major issue. Accordingly, Transparency International Kenya conducted a report in 2011 to investigate corruption within the health sector in Kenya. They found that, for instance, health workers commonly took drugs from government facilities and sold them in private facilities; staff hiring was often affected by corruption or nepotism or was influenced by politicians or others with power; and there was a lack of deterrents to corruption due to weak enforcement of rules and laws [Transparency International Kenya, 2011].

It seems that quality did not initially increase after the 10/20 policy was implemented. In one study where health workers, patients and community members were interviewed after the implementation of the 10/20 policy, community members felt that some of the main issues surrounding the policy included reduced care quality and long lines. In addition, health workers

complained that their workload had increased significantly as a result of the increased attendance. Some also said that it was simply not possible to provide high quality services when only charging such low registration fees [Chuma et.al. 2009].

Drug shortages also continued. In the previously mentioned interviews of health workers and patients after the implementation of the 10/20 policy, health workers most often cited drug shortages as the main reason for their facilities not adhering to the 10/20 policy. Also, community members included drug shortages as one of the main issues they raised surrounding the 10/20 policy [Chuma et.al. 2009].

Changes in health care utilization following second removal of user fees

Within the first year after the removal of treatment user fees and the implementation of the 10/20 policy in 2004, health care facility attendance in Kenya increased by 70%. However, attendance then decreased and by 3 years after the removal, rates were only 30% higher than before the removal [Chuma et.al. 2009].

After the second removal of user fees

A pilot program was set up in 2005 in the Coast province, called Direct Facility Funding and supported by the Danish Refugee Council. It provided funding to health centers to compensate for the reduction in revenue received from user fees. Facilities could choose how to spend the funds received but this had to adhere to guidelines such as that only 30% could be used for salary supplementation, and funds could not be used for drugs or lab services; the Kenyan Medical Suppliers Agency was supposed to provide all drugs to facilities [Chuma et.al. 2009].

This was expanded nationally in 2010, was renamed the Health Sector Services Fund, and was supported by the government, the World Bank and DANIDA. Local communities helped to manage the received funds and monitoring was carried out by independent agencies [Ramana et.al. 2013].

Consequences of changes after the second removal of user fees

Within the first couple of years that the Health Sector Services Fund was expanded nationwide in Kenya, there were preliminary results of an increase in certain measures of health care quality. For instance, the increased funding enabled the improvement in the upkeep of facilities and more consumables could be bought . There also appears to have been a significant increase in utilization following this expansion [Ramana et.al. 2013].

Analysis of political factors impacting health care user fee policies in Kenya

The reasons behind Kenya's providing free health care at independence were highly political, namely to demarcate a contrast with the colonial period's health care policies of exclusion, and to garner support from the population.

However, Kenya's eventual implementation of user fees in the late 1980s was highly influenced by foreign groups, particularly the World Bank, which pressured Kenya to implement such a policy as part of its SAPs. Kenya was seeking financial assistance from the World Bank to help cope with its inability to sustain its public expenditures in the economic downturn and therefore the World Bank had a lot of leverage in pushing for its interests. The pressure to implement user fees was further accentuated by the international consensus of the importance of

countries striving to meet high standards of health outcomes, and ensuring that all members of the population are able to access good quality health care.

Nevertheless the Kenyan government did also play a role in considering and developing this policy. The Ministries of Planning and Finance and the Ministry of Health discussed the possibility of health care user fees in their respective Development Plans in the 1980s, while scientific studies and reports were consulted in the government's policy ratiocination process. Ultimately it was the Cabinet who, when presented with all of this evidence, decided that health care user fees would be implemented in Kenya.

However, the extensive donor consultation during this deliberation process, the request of studies to be undertaken by these donors, and the assistance of funding from USAID indicate the influential role of these foreign bodies. This is further exemplified by the fact that once the user fee policy had been developed, the Ministry of Health is reported to have complained to the World Bank that the fees were too high, suggesting the balance of power tilted strongly towards the outsiders.

Perhaps it was therefore because of this jostling for power over the policy decision-making and development that the implementation process fell so far short of effective. The policy was expected to be rolled out in only six weeks (a period not long enough for administrative structures to be set up, health workers or the population to get used to and accept the program, or problems to be detected and resolved); there were no public information

campaigns to explain the policy to the public and no training programs for health workers¹⁰; the HCFD which was meant to manage user fee revenues and allocation nationally had only six technical staff; and the exemption policy was complicated and the systems for its operation and monitoring were not in place. As a result people were confused about the price of the user fees and about exemption eligibility, few exemptions were granted, revenues raised were minimal, drug and equipment shortages were rampant, and the quality of services and infrastructure remained depressed or further dropped. As a result, health care utilization fell substantially.

Perhaps this distinct lack of effective planning and preparation was thus due to a lack of foresight or preparation, either due to a lack of commitment from the political figures with this responsibility (particularly if animosity was felt about the influence of the foreign groups on the policy), or maybe more neutrally simply because there was not sufficient evidence, from academic theoretical arguments, or from examples of policies adopted successfully in other countries, to inform a best-practice course to take for implementation. In addition, the fact that the policy of user fee implementation was largely decided upon due to foreign actors' arguments, which were global in nature, not tailored to Kenya specifically, may have reduced the government's drive to, or ability to, develop effective administrative support, appropriate for the Kenyan context, for the program. Furthermore, the government did not work with stakeholders in program development and therefore was not able to obtain stakeholder input or at least convince them of the governments' reasoning.

¹⁰ Such training could have explained the purpose of user fees to health workers to increase their understanding of and support for the program, taught them about the exemption system (who can be exempted, and how health workers provide exemptions), provided them with skills for explaining the user fee system to patients, etc.

It was the media who played a highly influential role in pressurizing the government to remove this first round of user fees. Many articles were published describing the decrease in access, the drug and equipment shortages, and the abysmal quality of some of the health facilities following the introduction of user fees. The government therefore had an incentive to remove user fees to prevent the embarrassment of the widespread discussion of the policy's failings. Other incentives for the government to make the change were the fact that the policy was clearly reducing health care conditions and access for large proportions of the population who the government was 'supposed' to be helping, and also, perhaps more importantly for the government, that much lower amounts of revenue were being collected than expected.

The government made various administrative changes before the reintroduction of fees, including hiring more staff for the HCFD, making the process for obtaining exemptions easier and changing the user fees from registration to treatment-based. In addition the program implementation process was extended to a two year period. Thus the reduction in affordability, quality and access was smaller than after the initial implementation. The fact that affordability, quality and access did still decrease though after the re-introduction of user fees, despite these administrative changes, might be because, in the short period of time between the first implementation and the second implementation (only two years), it was still the same political actors in power or pressurizing from outside, and all still had the same motives as before. Therefore the political processes behind the changes were much the same as initially.

Exemption policies changed multiple times over the decade or so that user fees were in place, which would have further confused patients who already were not sure of their eligibility and thus their ability to afford care. These changes were often motivated by political factors such

as criticisms from opposition leaders rather than based on scientific evidence or other evidence-based information on economic or access equality reasoning [Anangwe, 2008].

Some argue that Ms. Ngilu abolished treatment user fees in 2004 to fulfill a political pledge and indeed she and the rest of the newly elected government leaders had been making numerous radical announcements since they came to power in 2002 [Chuma et.al. 2009][Ngwiri, 2003]. The change in policy was therefore perhaps also a move to further distance the current administration from the previous one and gain political support from the population. This is supported by the fact that after announcing the removal of fees she said “We must ensure access to basic health care for the majority of poor people in Kenya. This was one of the key elements of memorandum of understanding between the National Rainbow Coalition [the NARC] and the people of Kenya.” [Agutu, 2004].

The report created with assistance from the German government and partly based on experiences of a team sent to Europe and Asia seems likely to have also played a role in user fee removal: it was shortly after the task force’s report was due to be completed that Ms. Ngilu announced the removal of user fees, and it is therefore likely that her opinions and later actions on the matter were influenced by the findings of this report [“Kenya: free health”, 2003].

It is also possible that the extensive consensus among NGOs that user fees are detrimental to health access and should be removed [Robert et.al. 2013], promoted through their work with international conferences, press releases and reports, may have influenced the views of Kenya’s leaders. NGOs’ efforts may have helped to convince the leaders of these views and/or the leaders may have felt a need to conform to international pressures. Furthermore, the World

Bank had by this point altered its stance to instead state that user fees may not be appropriate in certain situations, as shown in the 2004 World Development report [World Bank, 2003]. This new lack of adamant support for user fees may have reduced the pressure to keep user fees in place.

The announcement about the removal of user fees was made only one month before the policy change was to occur, indicating a lack of sufficient planning and organization surrounding the move; therefore, similarly to when user fees were first introduced, there may have not been enough time for patients and health workers to understand the system or to be convinced of its value, or for effective administrative structures to be set up. The resulting confusion surrounding the 10/20 fees and exemptions, and the variable costs of these fees would have meant that, even though total costs for accessing care would have been lower than before the policy change, perceived affordability might not have increased much. In addition insufficient funding was allocated to supporting health facilities and compensating them for lost revenues. This detrimentally impacted the quality of health care after the 10/20 policy was put in place. The low quality levels may also help to explain why health care utilization increased immediately following its implementation, as people hoped that quality would be improved with a policy change, and then when the reality was seen, utilization reduced somewhat.

The fact that the program was implemented too quickly and that the government did not provide sufficient funding seems likely to have been because the policy change was primarily enacted to increase political support, rather than in response to a carefully planned and calculated strategy. Thus the government had neither the evidence nor the motivation to invest the necessary effort and resources to bolster their health care system quality and utilization in the

removal of the treatment user fees. Hence even though there was an initial substantial increase in health utilization after the removal of the treatment fees, this level of access was not sustained, and utilization rates dropped to only slightly elevated levels; it is likely that had the removal process been handled more effectively this high level of utilization might have been maintained.

It seems that drug shortages that occurred while user fees were in place, and afterwards, resulted fundamentally from a lack of funding. People will be reluctant to access a health facility if they think that they will not be able to obtain drugs from there, and will have to either go without the drugs, or go to a private provider to purchase them, thereby increasing their financial and time commitment for accessing care. The fact that drug shortages seemed to have occurred fairly consistently before, during and after treatment user fees were in place, suggests that perhaps drug shortages were not a big factor in explaining the changes in utilization rates over this time period, but rather would have been responsible for a reduced utilization rate at all time-points. The exception is that perhaps some of the initial increase in utilization when the 10/20 policy was instated may have been partly due to people thinking that such a change would reduce the likelihood of shortages, but that when they realized this was not the case, numbers decreased again.

Chapter 3: A Case Study of Uganda's History of Health Care User Fees¹¹

Introduction of user fees

¹¹ See Appendix 1 for summarized timeline

During the 60s, the Ugandan health care system was thought to be one of the best in the continent. However, the political turbulence and reduced health care funding of the Idi Amin and Milton Obote governments of the 1970s and early 1980s led to a large decrease in health care quality: funding for social programs such as health care was not prioritized and thus social programs shifted towards privatization or the informal sector, government health infrastructure was neglected, bureaucracy became over-centralized, many health workers left Uganda, and those that stayed were underpaid and under-trained, and drug shortages were common [De Torrente, 1999].

Similarly to Kenya, SAPs were implemented in Uganda in the 1980s in response to rising economic debt and an inability to sustainably finance the current public expenditures. Health care financing restructuring was a component of these SAPs. In contrast to Kenya, however, governmental health expenditure actually never decreased in Uganda under the SAPs. The policies were designed to rebuild instead of roll back the state, due to the relative collapse of the state in the previous decade and the low levels of state expenditure (8% of GDP compared with a Sub-Saharan average of 25%) [De Torrente, 1999].

User fees were first suggested in Uganda in 1987 by the Health Policy Review Commission. As a result of this suggestion, the Ministry of Health created a National Task Force for Health Financing in 1989 to determine how best to implement such a policy. Based on the resulting guidelines, a bill was prepared in 1990 to be presented to the National Resistance Council (Uganda's Parliament) to create a user fee law [Okuonzi et.al. 1995].

It was thought that user fees would be an appropriate policy to implement because they would provide a source of revenue to fund the operating costs of health facilities. Private and NGO hospitals were already charging user fees for this purpose, and often very effectively: four mission hospitals in Uganda were found to raise 78-95% of their operating costs from user fees [Shaw et.al. 1995]. Furthermore, it was thought that the collection of user fees could address issues such as drug shortages, and would provide communities with more responsibility in the management of their health facilities [Burnham et.al. 2004].

It was also thought that user fees could reduce the incidence of health worker corruption. Inflation in Uganda in the 1970s and 1980s reduced the purchasing power of salaries [Konde-Lule et.al. 1998]. In addition salaries were often irregularly paid, sometimes with a delay of more than six months. There was therefore an incentive for health workers to resort to corruption to supplement wages [Burnham et.al. 2004][Konde-Lule et.al. 1998]. Thus user fee introduction also aimed to increase funding for health worker salaries, and ensure timely payment of these salaries, while thereby improving health worker morale and cutting down on corruption[Burnham et.al. 2004][Kipp et.al. 2001][Konde-Lule et.al. 1998]. Indeed, the Health Policy Review Commission, in suggesting in 1987 that user fees should be implemented in Uganda to increase health facility revenues, reasoned that people were already paying for health services at government health centers, through under-the-table payments, so the system may as well be formalized [Okuonzi et.al. 1995][Konde-Lule et.al. 1998].

However, before the National Resistance Council received the bill, opposition was articulated by the media and various politicians, including even President Museveni. Arguments included that charging fees amounted to charging twice as people were already paying taxes; that

the quality of the health care was not good enough to charge fees; and that user fees might reduce health care access by the poor. The bill did not pass. However, because of all the advantages of user fees outlined above, the Ministry of Health urged districts to implement their own user fee policies instead¹² [Okuonzi et.al. 1995].

The World Bank was also pushing for user fees to be introduced and in 1992 and 1993 they placed conditions on their governmental loans for Uganda to make health reforms such as the introduction of user fees [Okuonzi et.al. 1995][Moat et.al. 2011]. It was even donors, including the World Bank, who largely wrote Uganda's 1992 three year health plan, after they were outraged at the budget presented in Uganda's ten year National Health Plan developed in 1991 [Okuonzi et.al. 1995].

As the Parliament had not passed the bill, it was the responsibility of the districts themselves to choose if and how to implement user fee policies [De Torrente, 1999][Kone-Lule et.al. 1998]. However, there was no clear government policy on user fees; the Ministry of Health initially did not have an official document outlining its policies or recommendations; the guidelines it issued later were not binding anyway; and politicians were making contradictory statements on the subject [Konde-Lule et.al. 1998]. Therefore, implementation was done in a somewhat haphazard and unenforceable way with a distinct lack of transparency, fees varied greatly across facilities, and fee structures were often very complicated [De Torrente, 1999].

Despite this lack of formal national level process for implementation of user fees, by 1993 districts had implemented user fees in essentially all health facilities in the country [Kipp

¹² Recent decentralization allowed them to do so [Konde-Lule et.al. 1998].

et.al. 2001][Konde-Lule et.al. 1998]. Guidelines and training materials were also produced in some areas [Burnham et.al. 2004].

The process of implementation was different in each district. For instance, policy development and implementation in each area of Kabarole district was community led and supported by elected representatives of local village councils [see Appendix 3 for map of Ugandan districts]. First the district health management team and district administrators would hold a public information session, which would often be attended by village and sub-county political representatives, in the catchment area of a health facility. At this session, they told the community about the option of user fees and their potential consequences. Then public meetings were organized by local councils and chiefs for community members to learn about and discuss the user fee option; these were generally well-attended. There were no deadlines or defined processes so each community was left to decide in its own manner and time whether it wanted to implement cost sharing; most communities took four to six months or more to decide [Kipp et.al. 2001].

Health Unit Management Committees (HUMCs) were set up nationwide at the facility level to manage user fees, including to decide how the revenues were used, and to supervise the health facilities [De Torrente, 1999][Galooba-Mutebi, 2005]. In some districts, it was the HUMCs that decided if and how the user fees would be implemented, including whether fees were visit or treatment based [Konde-Lule et.al. 1998]. These HUMCs were made up of members of elected local councils [De Torrente, 1999]. The district councils, which were at the district administration level, had the responsibility of supporting user fee implementation, creating guidelines, and providing services such as auditing (to ensure transparency and

accountability), training and supervision [Konde-Lule et.al. 1998]. In Kabarole district, HUMCs were composed of six to eight people, including political representatives, community members and a health worker. This committee reported on its work and the allocation of user fee revenues during public meetings. HUMCs also proposed the cost of the user fees with help from local councils and then these fees had to be approved at public meetings [Kipp et.al. 2001].

User fee policy

As fees were locally decided, they were variable across areas; some were single registration fees while others were per treatment [Kipp et.al. 2001]. In Kabarole district, fees largely ranged from 50-500 Ugandan shillings, or the equivalent of US\$0.05-0.50, which included one visit and its prescribed drugs [Kipp et.al 2001]. In Mukono, Mpigi and Jinja districts, user fees were sometimes registration fees and sometimes per treatment; the user fee price ranged from 300 to 15,000 Ugandan shillings but in 75% of cases of those interviewed, the price was 500 Ugandan shillings, or the equivalent of \$US0.50 [Konde-Lule et.al. 1998].

The criteria and enforcement of exemptions were also determined locally by the particular community [Shaw et.al. 1995]. In Mukuono, Mpigi and Jinja districts, exemptions existed for those unable to pay the fees, those with chronic diseases, and the staff members of hospitals, HUMCs and local councils, and their relatives [Konde-Lule et.al. 1998].

Ministry of Health guidelines stated that the allocation of payments collected from user fees should have been distributed thus: 30% staff welfare (e.g. increased wages), 10% to maintain health units, 3% for HUMCs, and 57% to buy supplementary drugs. However in reality, generally a larger proportion of the revenues were allocated to staff welfare than suggested in

these Ministry of Health guidelines [De Torrente, 1999]. Some of the local guidelines in Mukuono, Mpigi and Jinja districts recommended that HUMCs allocate up to 50% of the raised revenues to supplementing staff wages [Konde-Lule et.al. 1998], while at Kalisizo Hospital, 90% of funds were used for staff welfare [De Torrente, 1999]. In Kabarole district, most of the user fee revenues were also given to health workers to supplement their salaries. In almost all the facilities these payments were given on the last day of the month which contrasted with the previous irregularity of salary payments. This wage supplementation was substantial; the payments were 50% to 150% of the health workers' normal salaries [Kipp et.al 2001].

Consequences of user fee implementation

Konde-Lule et.al. 1998 interviewed 348 patients in Mukono, Mpigi and Jinja districts about whether they thought user fees were affordable. 70% said that the price was affordable, 26% said they were too high, and 4% did not or could not respond. When asked about whether the user fee policy should change, 22% thought that user fees should continue as currently implemented, 21% thought they should be reduced and 17% thought they should be abolished, although in focus groups nearly everyone said that when user fees were first introduced, they were opposed to them. Many complained that when the fees were introduced neither the government nor the health units explained the reasons for the user fees. In the interviews and focus groups of this same study, it was found that those who opposed user fees thought of these fees as an additional financial burden given that they already paid taxes to the government [Konde-Lule et.al. 1998]. However, as those interviewed were patients, not general community members, the sample would already have filtered out many of those who perceived themselves

as too poor to go to a health facility; therefore these results may not accurately represent the views of those most affected by the introduction of user fees.

These views contrasted with the health workers interviewed in this study. Most of the health workers supported the user fee policy; only 4% wanted prices lowered because they felt that poor people could not afford them, and only 18% of health workers wanted user fee prices to increase. Common recommendations suggested for improving the user fee policy were for better education of the public about user fees and the development of a national policy [Konde-Lule et.al. 1998].

Because there were no official laws in Uganda for user fees, there was no consistency in how user fees were collected or used. Fees therefore varied drastically at different health facilities, fee structures were often very complicated, and the lack of transparency meant it was difficult for patients to determine if they were being charged the right amount [De Torrente, 1999].

There was a lot of misunderstanding surrounding the exemption policies. In the Konde-Lule et.al. 1998 study, only 11% of the 348 patients interviewed thought that there was some kind of exemption policy in place, 53% said that no one could get a user fee exemption, and 36% said they did not know; this was consistent across gender. 67% of patients thought that there should be some sort of exemption policy, 21% said there should not be and 12% did not answer. However, 99% of health workers were aware that there was an exemption policy. Some of the health workers said that they refrain from telling patients about the exemption policy though because they think otherwise many people who were not poor would claim to be so in order to

not have to pay [Konde-Lule et.al. 1998]. Patients often therefore had a lot of confusion over whether they were or were not eligible for health care user fees, a key factor in evaluating the affordability of care.

Perhaps it is not a surprise therefore that the perceived acceptability of paying fees for health care services was highly variable. The results from the interviews and focus groups conducted in the Konde-Lule et.al. 1998 study indicated that: 43% thought user fees were acceptable to the public, 13% disagreed and 44% did not know; 49% supported user fees in government health facilities vs. 51% were opposed. On the other hand, health workers in the three districts studied had very different perceptions. Of those interviewed, 81% thought that user fees were acceptable to their patients, 5% said they were not, and 14% said they were being accepted grudgingly [Konde-Lule et.al. 1998].

Overcharging of fees and other forms of corruption were frequently reported in Uganda. 67% of the 348 patient respondents in the Konde-Lule et.al. 1998 study said they had experienced problems after the introduction of user fees, vs. 37% who said they had not; problems included overcharging, rude staff, drug and supply shortages and poor understanding of the system. 56% said they had to pay additional fees while at a health facility, which in general were under the table fees [Konde-Lule et.al. 1998]. Such bribes were most common for medicines, but also sometimes occurred to see a doctor or for operations or other services. [De Torrente, 1999].

Some patients in the Konde-Lule et.al. 1998 study said that the frequent drug and equipment shortages actually occurred because health workers stole government supplies and

sold them to the patients or at private health clinics. Health workers argued that they only charged patients extra for drugs or equipment such as gloves when these supplies were not provided by the health facility and so they purchased them from a private shop or pharmacy and recouped the costs from the patients [Konde-Lule et.al. 1998].

Corruption also often took the form of health worker absenteeism. Health facilities were often closed when they should have been open: health workers often worked in their fields or treated patients at private clinics in the morning before coming to work at the government health facility, while patients were waiting there for hours to get care. According to a health facility administrative officer in Mwogo sub-county, health workers “have to worry about their own lives before those of the patients” [Galooba-Mutebi, 2005].

Many health workers at government facilities were not paid much, and/or not paid on time, so some argued it was unsurprising that they resorted to ‘survival strategies’ like bribes or seeking other income [De Torrente, 1999]. In the focus groups of the Konde-Lule et.al, 1998 study, many patient participants acknowledged that staff salaries were very low and that this would have contributed to corruption [Konde-Lule et.al. 1998].

Furthermore, HUMCs had been created during the introduction of user fees, partly to supervise health facilities and workers, one of the purposes of which was to discourage under-the-table payments. This accountability system was intended to be particularly effective because it was community led as committee members were from elected local councils. However, the HUMC system did not function properly as meetings rarely actually occurred, mainly due to lack of pay. Moreover those few members who tried to object to health worker corruption mostly

ended up giving up as they generally failed to make a difference, due to the lack of support from other committee members. Moreover, some health workers who were well known for corruption were related to or friends with local politicians whom committee members did not want to antagonize [Galooba-Mutebi, 2005].

Of those patients who were interviewed in the Konde-Lule et.al. 1998 study and supported user fees, many said that the reason for their support was that user fees were needed for improving care quality [Konde-Lule et.al. 1998]. Did user fees achieve this goal? Evidence seems to suggest that it did. In the Konde-Lule et.al, 1998 study 63% of patient respondents thought that services had improved considerably following user fee implementation while 21% said they had remained the same and 16% did not know. One of the main positive changes in services that were mentioned was that health workers now worked longer. When discussed in focus groups, many said that building renovation and construction were positive consequences of user fees. 89% of health worker respondents thought that user fees had led to an improvement in quality [Konde-Lule et.al. 1998].

90% of health workers in the study conducted in Kabarole district said that receiving regular supplements to their salary had improved their motivation, led to them spending more time working, and had improved the quality of their care [Kipp et.al 2001]. Health workers in Mukono, Mpigi and Jinja districts also generally felt that user fees improved their morale [Konde-Lule et.al. 1998].

It seems that generally drug supply was not increased as a result of user fee implementation. In the aforementioned study where 67% of 348 patient respondents reported that

they had experienced problems after the introduction of user fees, vs. 37% who said they had not, drug and supply shortages was a commonly cited problem. This was especially problematic given that people often had to pay the user fee upon arrival and were not refunded if the drug was not available. In fact, most respondents had experienced this for essential drugs, such as anti-malarials. Patients were often also asked to pay for supplies such as gloves, paraffin etc. [Konde-Lule et.al. 1998]. There was also the perception by some in the focus groups of the Konde-Lule et.al. 1998 study that health workers sometimes gave diluted medicines [Konde-Lule et.al. 1998].

A Ministry of Health report showed that in 2000/2001, only US\$18 per capita was spent on health in Uganda, and only US\$3.2 of this was from government sources, including budget support from donors. From 1998-2001, the total amount that the government spent on health care increased but because of the rate of population growth this actually amounted to stagnating spending [Uganda Ministry of Health, 2004].

Changes in health care utilization following user fee implementation

Health care utilization in Uganda before user fees were introduced was as low as 0.1 to 0.3 visits per person yearly [Kipp et.al 2001]. After the introduction of user fees, access changes appeared to be variable in different areas. For instance, in Kabarole district, utilization of health services decreased by 21.3% on average. However this differed by area of health facility: utilization increased in rural areas by 20.7% and decreased in urban/semi-urban areas by 40.6%;

utilization decreased in all four urban/semi-urban facilities investigated while it only decreased in one rural area facility¹³ [Kipp et.al 2001].

There is some evidence that attendance increased again after the initial decrease following introduction. Thus by 1998 district policy-makers stated that attendance figures were rising again. They attributed this increase to the improvement in quality of care [Konde-Lule et.al. 1998].

Removal of user fees

President Museveni announced the removal of health care user fees ten days before the presidential election in 2001 [Moat et.al. 2011]. There was strong political support for this decision from the Parliament [Meessen et.al. 2009]. Other political candidates had also announced during the campaign that they would remove user fees if elected [Matsamura, 2001][Meessen et.al. 2009]. A report that the government sent to the IMF the week of the announcement has no mention of this major policy change, indicating that the Ugandan government did not discuss the issue beforehand with the IMF [Moat et.al. 2011].

Despite being announced during the political campaign, the policy formulation process, while not extensive, was not as rushed as it may have seemed. Before announcing the removal, President Museveni consulted with the Ministry of Health to determine the cost of abolishing user fees and discussed with the Ministry of Finance how to fund such a policy change from the

¹³ There are indications that the reason why health care utilization actually increased in rural areas of Kabarole district after user fee implementation was because of an increase in drug supply at these facilities due to the policy change [Kipp et.al. 2001].

public budget. In fact for the previous few years various options for user fee policy reform were in the process of being discussed. However, because of the political pressure, the decision was made earlier than had been planned and was a more drastic measure than most of the options that the government had been considering [Meessen et.al. 2009].

Evidence from a report which outlined the detrimental impact of user fees on the disadvantaged in Uganda may also have played a role in swaying the decision [Moat et.al. 2011]. Moreover, much lower levels of revenue were being collected than anticipated: collected user fees accounted for 1% of health facilities' operating budgets but the target had been 15% [De Torrente, 1999]. This therefore indicated a lack of effectiveness of user fees, thereby reducing their perceived benefits, and providing another reason to remove them.

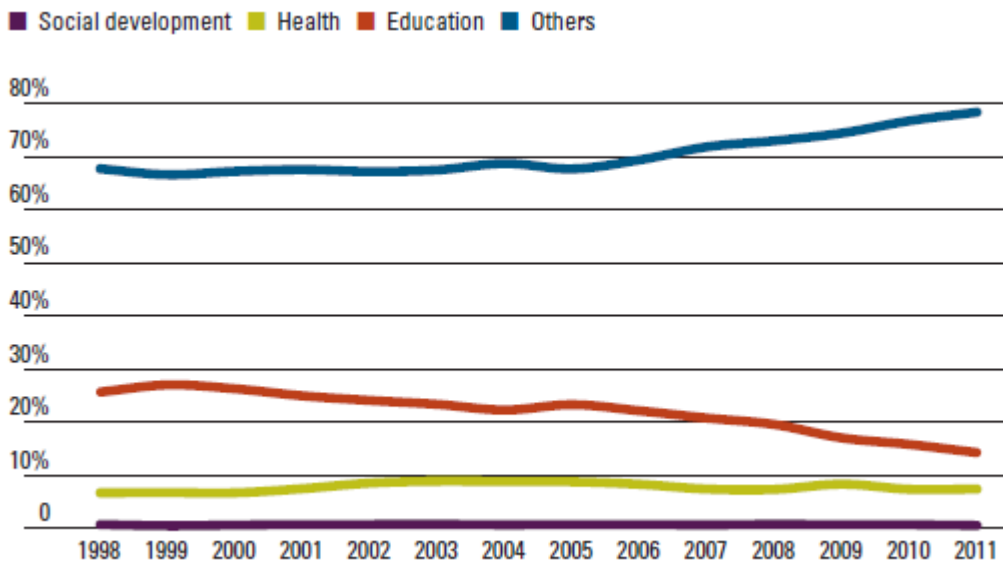
The views of health workers did not seem to influence decisions over user fee implementation or removal. On April 12th, 2001 after the removal of user fees, the Uganda Medical Workers' Union released a statement calling for user fees to be re-introduced. Mr. Apollo Nyangasi, the chairman, said that "though the money contributed by each patient was little, it enabled the patients to get adequate attention as morale of the workers remained high". He added that removing user fees was "unrealistic and shows lack of understanding on the part of government of the needs of the people" [Eremu, 2001]. No changes however were subsequently made to the new health financing policies.

The removal of health care user fees in 2001 was done very publically. The abolishment was a national program, funded by the national government and by the Highly Indebted Poor

Countries Initiative. Radio broadcasts were used to tell the public about the removal of the fees [Meessen et.al. 2009].

To compensate facilities for lost revenues, and to pay for increased use of the facilities as a result of the removal of fees, the Ministry of Health allocated 7 billion Ugandan shillings, or the equivalent of US\$5.5 million, into health facility financing [Burnham et.al. 2004][Meessen et.al. 2009]. This increased funding was from the district health services project, which was supported by the World Bank [Burnham et.al. 2004]. The drug budget thereby increased by 22% [Burnham et.al. 2004][Chuma et.al. 2009]. While the proportion of the budget spent on health care did increase following user fee removal, this was a small increase and was not sustained, as shown in Figure 2 [Nabyonga et.al. 2013][Meessen et.al. 2009].

Figure 2: Graph of the percentage of government expenditure on various sectors



[Nabyonga et.al. 2013]

Allocation of additional funding for facilities was performed through an input-based approach, and facilities were able to obtain drugs from the government free of charge [Meessen et.al. 2009]. An additional 1,387 nursing assistants were also trained by the Ministry of Health to help handle the increased workload of the facilities [“Uganda: Sh8B lost”, 2001].

Meessen et.al. 2009 rated how well Uganda performed in developing its policy for user fee removal. Uganda received high ratings for preliminary situation analysis; clarity of the policy objectives; considering different policy options; early identification of accompanying measures; and vision, ownership and leadership. It received low ratings for international and national scientific evidence; thorough assessment of the option; and involving in the formulation stage stakeholders crucial for the implementation; and received neutral ratings for the content of the reform meeting preferences of stakeholders [Meessen et.al. 2009].

They also rated Uganda’s performance in carrying out the implementation process. Uganda received three points (the maximum) for leadership by the government; and monitoring and evaluation. It received two points for communication strategies with users; medium term commitment on budgetary burden; empowered coordination unit; and enforcing the reform. However, it only received one point for the planning process and the communication strategy with stakeholders; and it received a negative score for sequencing of the reform and capacity building [Meessen et.al. 2009].

Consequences of user fee removal

Data from the Uganda National Household Survey and the Ministry of Finance Planning and Economic Development expenditure tables, shows that cost as a reason for non-use of health

services was already decreasing before user fees were removed. Perhaps this was because people grew to understand the prices and/or exemption policies, thereby enabling them to better calculate their perceived affordability of care; alternatively, perhaps people were getting more frustrated with other factors such as quality or drug shortages. This reduction trajectory continued when fees were abolished. The rate leveled off somewhat a couple of years after user fee removal, and then continued to decrease [Nabyonga et.al. 2013].

Cost as a reason for non-use of health services would still have remained even once user fees were removed because many demand-side barriers to access were still present which could have limited the affordability of even supposedly free health care. Such barriers would have included transportation costs, lost earnings from taking time off work, food while at/going to the health facility, time, etc. [Meessen et.al. 2009][Shaw et.al. 1995][Meessen et.al. 2006].

Health managers became accustomed to user fees providing funding for them to run their health facilities, and health workers got used to user fees ensuring they would have regular and higher salaries. Thus they all relied on this funding and thought of it as essential [Moat et.al. 2011].

Perhaps it was therefore not a surprise that health worker morale decreased after the removal of user fees, as did other measures of quality. A study interviewed a senior health worker and a senior member of the HUMC at 80 primary health care facilities in Uganda. They found that health workers were concerned that there was not enough funding to provide adequate salaries to all of their staff. In addition, 67% of the health workers had a more negative view of their work after the removal of user fees; more than a third thought that maintenance and

cleanliness were worse after the removal; it was perceived that HUMCs were only meeting rarely if at all after the removal of user fees; and there were apprehensions that management of health facilities was shifting away from local communities to the central government. 30% of HUMC members said that health worker morale had decreased, and in general they agreed with health workers that cleaning and maintenance had worsened since the removal of user fees [Burnham et.al. 2004].

Nabyonga-Orem et.al. 2008 conducted a study in which they carried out focus groups and interviewed district and health facility officials from five districts at 3 month intervals from April 2001 through June 2004. While most of the government health facility staff in the focus group discussions complimented the demeanor of health workers in their facilities, some complained that “the health workers don’t care. [...] You can go there at 9:00 am and leave at 2:00 pm [when] you end up giving up and go back home” or that “they are also very rude, there is also segregation among the nurses, those who are known are treated properly and first, but those who are not known may end up mourning for the children”. When asked what were the common problems in undertaking their jobs at government facilities, 68% of responses included either lack of transport, staff shortages, or a lack of services such as water, electricity and inadequate allowances [Nabyonga-Orem et.al. 2008].

This decrease in morale, the concerns over salary payments and the perceptions of problems such as a lack of facility cleanliness were despite the fact that the Ugandan government had increased their health care funding with the aim of compensating for the loss in user fee revenues. This shows that this increase was not sufficient [Meessen et.al. 2009]. In fact this funding discrepancy issue was even acknowledged by the Director General of Health Services

who, at a conference in Kampala in February 2002, said that it was necessary to increase the Ministry of Health's budget three-fold to ensure adequate funding for health care [Nakazibwe, 2002].

In a speech at the unveiling of an equipment donation to a health center in October 2001, the State Minister for Energy acknowledged the reduced quality of care but instead of suggesting ways that the government could help alleviate this situation, he solely blamed the health workers themselves. He said that after user fees were removed, the professional ethics of health workers had collapsed, leading them to no longer take as much care as they did before. He said "I urge all health workers to ensure the spirit of team work and always have a zeal to see that the health conditions of the people improve, despite the harsh conditions in which you work". Instead of calling for more governmental funding, he asked for more support from Basoga living in America, some of whom had just donated equipment through the Twegaite Association, and he further said that local people should invest in their local health facilities [Mukyala, 2001]. The Health Minister on the other hand saw reduced quality as a necessary evil; he argued that "scrapping cost sharing reduced on quality, but that is better. It is better for people to get low quality than some getting high quality while others get nothing at all." [Nakazibwe, 2002].

After the removal of user fees it was still common for patients to have to buy pharmaceuticals from private drug stores [Meessen et.al. 2009]. The Burnham et.al. 2004 study found that only 24% of the 80 interviewed health workers thought that there was an increase in the supply of drugs after user fee removal, and there was concern that there was not enough funding to buy more essential drugs; 51% thought that there were fewer syringes and needles. Of

the 80 interviewed HUMC members, 60% thought that drug supply had decreased [Burnham et.al. 2004].

In their study with district and health facility officials from 2001 to 2004, Nabyonga-Orem et.al. 2008 found that the average number of drug stock out days (i.e. days when drugs were not available) increased in government health facilities after the removal of user fees, but that this number then decreased somewhat by 2004. A member of a focus group in 2001 stated that “we get drugs when they are available and this has been rare since the abolition of user fee charges. We [now] normally purchase them from clinics or nearby drug shops. The poor of course go without drugs.” A member of an HUMC noted in 2004 that “drugs are brought here but not very frequently, the quantity delivered is inadequate, the patients are too many and so these drugs cannot sustain them, especially the injectable drugs”. 80% of the staff at government health facilities who were interviewed said they had not received drugs and supplies on time at some point both before and after user fees were removed, while only 12-16% of staff at private not-for-profit health facilities said this was the case at their health centers over this period [Nabyonga-Orem et.al. 2008].

Changes in health care utilization following user fee removal

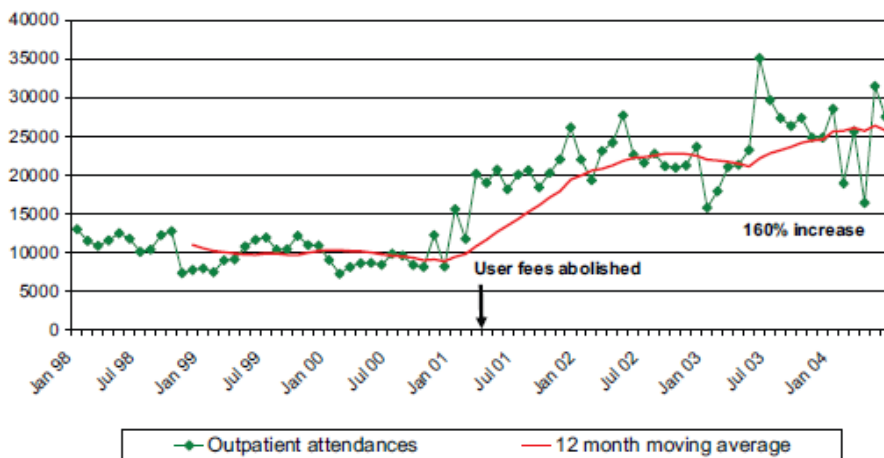
There is extensive evidence that access increased after the removal of user fees. In fact some estimates suggest that outpatient attendance doubled in the five years after user fees were removed [Meessen et.al. 2006]. Figure 3 shows the significant increase in utilization reported by Tashobya et.al. 2006 that occurred in Kisoro district after the removal of user fees [Tashobya et.al. 2006]. Burnham et.al. 2004 found that the utilization increase that they observed was

different for children than the general population: they compared attendance 8 months before user fees were removed vs. 12 months after and found that new visits per month increased by 53% on average, and increased by 27% for children under five; average monthly re-attendance increased by 24% on average, and increased by 81% for children under five [Burnham et.al.2004].

These researchers also found that there was a large drop in utilization after October 2011. Health workers attributed this drop to the drug supplies running out by then after initially being augmented in coordination with the removal of user fees [Burnham et.al.2004]. This was because the increased funding from the government was not sustained [Meessen et.al. 2009].

The investigators of this study also interviewed senior health workers at 80 primary health care facilities in Uganda: 74% of these health workers agreed that after the removal of user fees there was better access to health care, particularly for the poor [Burnham et.al. 2004].

Figure 3: Graph of monthly new out-patient attendances for all the health units (government and not-for-profits) in Kisoro district 1998-2004



[Tashobya et.al. 2006]

According to data from the Uganda National Household Survey and the Ministry of Finance Planning and Economic Development expenditure tables, shortly before user fees were removed, 61% of those who were poor accessed health care if they became ill; this was a lower proportion than for those who were not poor. Between 1999/2000 and 2002/2003 (i.e. from pre to post removal of user fees), there was a 23% increase in the number of poor people who accessed care when ill, which was higher than the 16% national average of increase. This pattern continued: between 1999/2000 and 2009/2010, the proportion of poor people who accessed health care when ill increased by 40% to a total of 86%, which contrasts with those who were more wealthy, whose utilization increased by roughly 27% [Nabyonga et.al. 2013].

However, the data on increasing health care utilization needs to be carefully considered as it seems that the removal of user fees may not have been the only factor at play at the time in increasing utilization. For instance, utilization increased, albeit to different extents, in both public facilities (where fees were removed) and private health facilities (where fees were not removed) [Meessen et.al. 2009]. In addition, the study that found the differences in utilization changes between adults and children also found that, comparing attendance 8 months before user fees were removed vs. 12 months after, attendance also increased for antenatal visits (25% increase), family planning (32% increase) and immunizations (17% increase for those under five), even though user fees had never been introduced for these services [Burnham et.al. 2004].

Analysis of political factors impacting health care user fee policies in Uganda

It therefore seems that health care utilization in general decreased following health care user fee implementation but this was variable as access increased or remained constant in some areas. Then utilization increased substantially after user fee removal. What were the political factors that shaped the user fee implementation and removal policies, which led to these changes in utilization?

There were various political decision-makers, motives and strategies that influenced the implementation of user fees in Uganda. There was a substantial external influence, particularly from the World Bank. It was the World Bank who pushed for the SAPs during the 1980s as a method to deal with the effects of the economic downturn in Uganda on public expenditures, and health care user fees were a suggested component of these SAPs. In addition, at the start of the 1990s, the World Bank explicitly made user fees a condition of some of its loans to the government and was integral in developing Uganda's 1992 three year health plan. Pressure to conform to the World Bank's wishes would have been substantial given that the World Bank was a major donor of funds that the country needed for public expenditures across a range of sectors. Not conforming to these common views of the international aid community could have jeopardized other funding or political support sources as well. Implementing a policy at least partly due to foreign pressure may have reduced the support for this program (and therefore the effort and/or financial investment in it), and also may have meant the program was not ideally tailored to the Ugandan context rather than to a generic model.

However national politics also played a major role in this policy change. It was the political turbulence and reduced health care funding of the Idi Amin and Milton Obote governments of the 1970s and early 1980s that initially reduced the quality of the health care

system from its stable and fairly high level in the previous decade, and that thus increased the need for additional sources of health care funding [De Torrente, 1999].

The national government did make some efforts to investigate the viability of a health care user fee policy with its Health Policy Review Commission and the Ministry of Health's National Task Force for Health Financing. However the policy became highly politically controversial, as shown by the opposition that the suggested bill received from a range of politicians and even from President Museveni. Arguments from the opposition included concerns for the poor, perceptions of low quality care, and opposition to what was seen as another tax. Various suggestions have been made to explain this high level of opposition: perhaps it was largely due to a lack of lobbying of the politicians who therefore did not have sufficient knowledge about the possible benefits of such a program; maybe this opposition was simply a reflection of the views felt by the general population who did not want to pay user fees but rather wanted improvements in quality and reductions in corruption; alternatively, it is possible that it was known that the Ministry of Health did not have sufficient funds to support an effective national implementation of such a program; it is likely that considerations for the next parliamentary elections would have discouraged politicians from supporting a policy that they feared would appear to be essentially an additional tax [Okuonzi et.al. 1995].

Not only was there no national program but there were not even any national enforceable guidelines for health care user fee implementation. Perhaps neither the government nor the Ministry of Health undertook this because they were not particularly invested in the idea of the policy, as they prioritized other political concerns such as elections and/or because of a lack of a feeling of ownership for a program primarily advocated by foreigners. Alternatively, perhaps

these governmental bodies, intentionally or not, suffered from a lack of precedence and scientific evidence on what has worked in other countries. Whatever the reason, the Districts therefore gained the responsibility to choose whether and how to implement health care user fees in their respective areas.

This lack of parliamentary support for a potential national program, coupled with the lack of national enforceable guidelines, had profound ramifications for the health care user fee policies that would come to be implemented. Thus as a result, the price of user fees and who was eligible for exemptions varied greatly across districts. This meant it was harder for people to understand how much they were supposed to pay or whether they could obtain an exemption. This was accentuated by the fact that, because of the lack of a national policy, there were no national communication campaigns to educate the population about what user fees are, why they were implemented, and the details of the policies. If people perceive that they are unable to afford health care, or if they are confused about its affordability, due to incomplete, inaccurate or variable information, then they are likely to either just obtain drugs themselves from a pharmacy, visit a traditional healer, self-treat or forego care altogether. This may therefore partly explain the general decrease in health care utilization after the introduction of user fees.

Not only was the public confused about exemptions but health workers often felt antagonism towards the exemption policies; this was perhaps partly because, again due to the lack of national policy, in many cases there were no training programs for health workers who therefore may not have understood how or why to provide exemptions, and yet they were the ones responsible for doing so.

The implementation of user fees was often carried out in each district by a council consisting of community members and/or individuals from other local elected councils, with at least some community involvement. This could have been beneficial in situations where the views of the community were genuinely taken into account in the local political decisions for the local policies, as the program could be tailored to local needs, perspectives, and wishes. However, in others, local politics and local political dynamics may have gotten in the way of any real community involvement, leading to top-down decisions based on preferences and incentives of local political leaders. The potential problems associated with local political maneuvering getting in the way of an effective user fee policy was exemplified by the failure of the HUMC system, where there was often a disincentive to object to health worker corruption as prominent health workers known for corruption were sometimes related to or friends with local politicians whom committee members did not want to antagonize [Galooba-Mutebi, 2005]. Such variability in local political dynamics may help to explain the variability in the types of user fee policies that were eventually implemented and their varying consequences in terms of affordability, transparency, revenue collection and allocation, and service quality.

The issue of under-the-table payments was not tackled, probably as a result of its perpetuation within the higher political levels as well. This led to further inflated costs of health care, and therefore a reduced perception of affordability of care. Political leaders also did not allocate sufficient funding to health facilities, relying too heavily on user fee revenues to raise operating costs, when in reality, user fees only provided a very small portion of these costs. This led to the quality of services only being improved at some facilities and not others; HUMC members refusing to have meetings due to lack of pay; the persisting high frequency of drug

shortages; and an insufficient health worker salary increase resulting in continued incentives for under-the-table payments and staff absenteeism. People are often less inclined to pay for low quality services even if they believe they can afford them, and conversely may try to obtain extra funds for the care if it is perceived as high quality. Drug shortages are a disincentive to access care; when people think they will not receive drugs from a visit to a health facility they will often go straight to a pharmacy, or will self-treat, instead of paying at a health facility for incomplete care. Similarly people will be less likely to go to a health facility if they have heard or experienced that there are long lines because the health workers are often not there.

It seems likely that the removal of user fees was a campaign strategy given that Museveni removed user fees shortly before a presidential election. This hypothesis is supported by the fact that the decision was only made after other candidates had already pledged to remove user fees, which would have put pressure on President Museveni to remove the fees immediately, and by the fact that it seems that the government did not consult with major donors before making the decision¹⁴ [Matsamura, 2001][Meessen et.al. 2009][Moat et.al. 2011].

However, some of the actions of donors had, in a way, facilitated this change: in 2000 a Memorandum of Understanding for a Sector Wide Approach was signed between Uganda and donors which meant that donor funds contained less conditionalities and became pooled, instead of going to specific sectors. This made it easier for President Museveni to remove user fees [Moat et.al. 2011].

¹⁴ The World Bank and IMF said they were shocked by the announcement of the policy change [Moat et.al. 2011]

President Museveni had consulted with the Ministry of Health and Ministry of Finance prior to the election campaign to discuss potential health financing changes. However, because of these campaign pressures, President Museveni's decision was made before conclusions had been drawn from these discussions, and the resulting policy of complete removal of fees was a more drastic policy than those debated in the previous meetings with the Ministries [Meessen et.al. 2009].

Some argue that it was strange that no one tried to counter Museveni's quick removal of fees, particularly because there should have been many mechanisms by which to veto the decision; for instance because local governments largely had responsibility for their own health systems, the Parliament's power was distinct from the executive, and there was a lack of political parties and hence party allegiance. The reason why this vetoing did not occur may be because of the "Big Man" concept and the "economy of affection" where the President is the one with access to the resources so it is in everyone's best interest to agree with his policies because this might result in reciprocal support from him [Moat et.al. 2011].

Making such a policy change as an election campaign strategy rather than basing it on scientific evidence or in depth discussions and calculations with a range of stakeholders had far-reaching implications for the user fee policy. A major consequence was that although the government increased its health care spending to help compensate for the removal of user fee revenues, this funding increase was clearly not sufficient and was also not sustained. Thus health worker morale dropped with the fall in their salaries, with probable further effects on the quality of the care they provided; drug shortages continued or even increased; and issues such as the lack of cleanliness of facilities became widely noted. This lack of funding was probably partly

because, as user fee removal was largely a political move, the policy may not have been planned properly; commitment may have been more concerned with being able to say that the fees were removed, rather than actually investing the necessary significant resources into the policy.

Some governmental leaders refused to accept that there was a lack of funding, resorting to blaming health workers for their decrease in morale, instead of bearing any of the responsibility themselves, while others resigned themselves to the fact that quality would decrease after the removal of user fees but that this was unavoidable, and still a better solution than poor people not being able to afford care. Such public statements could have been due to a lack of understanding about the significance of the funding gap or the consequences of such a discrepancy, but it is more likely that these politicians simply wanted to prevent any of the blame for the new or continuing problems being placed on them.

A positive factor of the removal process was how publically communicated the policy change was, including through radio broadcasts. This is likely to have contributed to the increased perception of affordability after the removal as people became quickly aware of the policy change.

Overall health care utilization increased after the removal of user fees, despite the lack of sufficient funding or extensive planning of the removal of the policy, which resulted in the decrease in perceived quality of health services, and the continued frequent drug shortages and corruption. This indicates that the perception of the affordability of care was probably the most important factor influencing people's decision of whether to access care. However, it is unclear whether, had the policy been better planned and funded, by politicians wanting to create as

effective a policy change as possible, rather than a quick political move, if this increase in utilization might have been even higher and more sustained.

Finally, it is interesting to note that the removal of user fees seems to have been entirely driven by national level politics rather than foreign influences. It is unclear how this may have influenced later impacts on health care utilization.

Chapter 4: Comparing Health Care Financing Reform in Kenya and Uganda

The foremost similarity between Kenya and Uganda's health care user fee policies was that neither was successful in its goals of increasing access, increasing quality or reducing drug/equipment shortages. While both tried to create user fee policies that were pro-poor, particularly with the incorporation of exemption systems, neither program worked as it was supposed to.

There are many similarities between the two countries in some of the political factors which led to the flawed implementation of user fees that resulted in such a disproportionately detrimental impact on the poor. For instance, the introduction of user fees by the government in both contexts was significantly driven by donor pressure. This conflict over decision-making power in both cases resulted in only limited planning, support and commitment of the governments to their policies. Many of the problems associated with how the programs were developed, implemented and run stemmed from this lack of political commitment, and resulted in less efficient programs and reduced health care utilization.

One such example included the lack of administrative structures developed in Kenya and the lack of national guidelines in Uganda, both of which contributed to reducing access. Furthermore, neither country involved stakeholders (e.g. health workers, health system managers) or civil society in the policy development process; doing so may have allowed for more effective tailoring of the program and an increase in support for the policy. Both countries also utilized only a small amount of scientific evidence to inform their decisions; perhaps a more thorough analysis of scientific studies may have led to more effective practices. Moreover, neither quality nor corruption was targeted directly for improvement in either case. Both countries were unable to effectively collect substantial revenues or run functioning exemption systems, which was partly due, in both cases, to insufficient administrative structures, a lack of health worker training on the user fee policies, and a lack of public information campaigns to educate the public on which fees and exemptions they may be eligible for.

User fees were removed in both Kenya and Uganda for what seems like mostly or perhaps entirely political maneuvering in both countries, i.e. to raise popular support for a political leader (President Museveni in Uganda) or political party (NARC in Kenya), rather than simply as a means to improve health care access for the poor members of the population. As the goal of user fee removal was therefore to be able to say that user fees were removed, rather than to plan and carry out an effective removal process, it is perhaps unsurprising that these policy changes were rushed and underfunded in both countries. Thus patients were confused about the change, health worker morale dropped and health care quality fell. While health care utilization increased in both countries after the removal of user fees, it seems likely that if the policy changes had been based on scientific literature, stakeholder deliberations and careful planning,

the proportion of the population choosing to access health care due to its affordability, high quality, low corruption and adequate drug and equipment supplies, would have been even higher.

A lack of prioritization in funding health care services was a consistent issue in both Kenya and Uganda. Drug shortages were an endemic problem throughout the time period, regardless of which health system funding program was in place. This was largely driven by the fact that neither country invested enough public funding into the health care system. Both governments relied too heavily on user fees contributing substantially to the operating costs of health facilities, which in both countries they did not. When user fees were removed, both governments announced that they would increase funding for the health system to compensate for lost revenues but in both situations this funding increase was too low and was not sustained. In addition to its impact on the frequency of drug shortages, the lack of funding in both countries probably led to a decrease in health care quality and a decrease in health care utilization as a result.

There were also differences between the two countries' political processes and their consequences. The health care user fee policy in Kenya was a national program supported by the government whereas in Uganda the implementation was more locally driven by communities and local leaders. The advantage of the Kenyan system was that there was a consistent policy across the country with equal fees in all equivalent health facilities for the same services, and transparent levels of these fees. Unfortunately people were still confused by this system due to a lack of public awareness about the program. The advantage of the Ugandan system was that in some districts the policy development and implementation process was more bottom-up in that the communities themselves had a say in when and how to implement user fees, which seems to

have increased perceptions of affordability and quality in some cases. However, in other districts, it is likely that the local power dynamics and power struggles of district and lower level political leaders took over the decision-making, resulting in top-down approaches. There was no community involvement in the policy decisions in Kenya though. The only exception is possibly the influence of the media on pushing for the initial removal of the fees. Another difference between the two countries was that administrative institutions were somewhat more effective in Uganda than in Kenya, and this may have contributed to the fact that some in Uganda did report an increase in quality after user fee introduction, while in Kenya such reports did not occur.

Finally, while foreign donors did not have a role in the decision to remove user fees in Uganda, in Kenya it is quite likely that the mounting international consensus on the detrimental effects of user fees played a role in pressurizing the Health Minister to make the policy change.

So far we have discussed what were the specific political factors associated with the implementation and removal of these specific user fee policies, and how these affected health care quality, frequency of drug shortages, access to care, etc. However it is also worth considering the broader political features of these countries that were not just associated with user fee decisions and policies but rather with the overall characteristics of the state and the government; thus these features influence everything that the government does, including but not limited to health care financing reform. It is important to consider these broader political features because they are the more fundamental causes of why user fee policies were not successful, and also because they therefore have implications for other health reforms and reforms in other sectors. It seems that the main broad political features thus impacting health finance reform were the influence of foreign donors on policy-making, the influence of elections on motives, the lack

of accountability in the state bureaucracy, and the presence of weak institutions, all of which shall be discussed below.

Thus one such broad political feature of both Kenya and Uganda that seems likely to have influenced these countries' policies was that neither government was in complete control of their own policies, due to the pressure from international donors to make particular decisions or take particular actions. Such situations can lead to a reluctance by governments to fully commit to policies pushed by international organizations, and a choice to instead do as little as possible to appease these organizations.

Hence during the economic downturn in the 80s, Kenya and Uganda had very little choice but to accept loans from the World Bank and IMF to maintain or at least stabilize their funding for their prioritized programs and policies. Therefore when these organizations pressurized the Kenyan and Ugandan governments to introduce user fees, particularly as conditionalities for their loans, the governments had little power to refuse. However it is likely that these governments felt an antagonism towards these user fee programs because of being pressured into undertaking them; the governments may have felt that they should have had ultimate sovereignty over their populations with the power to decide their own policies, and instead this foreign pressure was undermining the perception of their authority and legitimacy. Hence perhaps the reluctance of both governments to properly plan or finance the user fee programs that were eventually implemented in their countries was partially due to the governments being unwilling to fully commit to programs over which they did not have full ownership.

Another element to consider is that even when decisions are made within and by the countries themselves, elections can skew motives and actions. This is the second broad political feature affecting health reform in Kenya and Uganda. Leaders decided to remove user fees in both Kenya and Uganda based largely on political strategy i.e. to maximize votes or support for themselves or their party, rather than to maximize the quality of life of the population. Thus the political gains were made simply through the announcement of the policy change and therefore there was little incentive for either government to invest the necessary time, energy and resources to develop an effective program. Such electoral strategy motives do not only drive health financing reform decisions, but are often a major driver of leaders' decisions on policies across all governmental sectors, in not only Kenya and Uganda but in most if not all countries that have elections; it is thus a side effect of democracy.

The fact that the Kenyan and Ugandan governments were able to decide not to invest the necessary effort and resources into these policies, without fear of repercussions, suggests that Kenya and Uganda were not being held accountable to their population for their actions, which is the third broad political factor to be discussed. In terms of health care user fees, the governments were specifically not being held accountable for ensuring that high quality health care was available to all members of the population, including the poor.

Thus in both countries, whether user fees were in place or not, health care quality was generally low. However there were seemingly no repercussions for this, except for perhaps the media reporting on the low quality services after the initial introduction of user fees in Kenya. Virtually no civil society organizations spoke out against the barriers that the poor faced in accessing health facilities under user fees, the lack of drug supplies, or the dilapidated

infrastructure. Two rare exceptions were the Uganda Medical Workers' Union which called for the re-introduction of user fees to increase health worker morale, and various Kenyan and Ugandan NGOs who contributed to the open letter opposing user fees that was presented to the President of the World Bank in 2012.

Furthermore, the government did not include any stakeholders (e.g. health workers) or civil society organizations in the development, implementation or evaluation stage of the programs, despite the fact that doing so could have helped tailor the policies to the needs and context of the population, and raised support for the policy. Political leaders assumed they knew best, did not want their authority undermined by such collaborations, and knew that the population would not hold them accountable for involving them in the decision-making process.

There are many potential possibilities for why Kenya and Uganda were not held accountable for not providing high quality and equitable health care. For instance perhaps this was not seen as a responsibility of the government. Alternatively maybe there was a perception, by the government, the public or both, that the government does not need to be accountable to the people to such an extent. Alternatively these states may not have been particularly open at the time to such criticisms by civil society, particularly of government programs. There may also have been the influence of the Big Man concept discussed earlier where people felt it is more advantageous to support those in power and their policies rather than critique them as support may lead to favors through patronage. Whatever, the reason, this lack of accountability would have reduced the incentive for the governments to properly plan or invest the necessary funding into these policies, because there were little if any repercussions for not doing so.

On a more micro level, health workers were also not accountable to their patients. There were frequent reports of sub-optimal care from health workers in both countries (which could be caused by a plethora of factors including lack of training, low morale, high workload etc.) but the performance of these health workers was not assessed and there was no way for patients to hold these health workers or the health facilities to account for this low quality care. Corruption, including under-the-table payments and staff absenteeism, also occurred in both countries before, during and after user fees were in place. However, similarly there were no mechanisms by which patients could hold these health workers accountable for such actions; health workers were not monitored; and there were no repercussions for health workers carrying out corruption. Perhaps this was because corruption was so common in all levels of the state bureaucracy and therefore there was no incentive for the government to try to tackle the issue. Whatever the reason, there was therefore a reduced incentive for health workers to provide high quality and equitable care.

Finally, even if the governments had the political incentives to try to implement effective health finance reform programs that would maximize health care quality and health care access, the fourth broad political feature to be discussed, the lack of strong institutions, would have reduced their ability to do so successfully. For user fee policies to be effective and thus to not detrimentally impact the poor, the country needs to have the capacity to implement administrative structures to support the necessary national systems. This would enable the provision of exemptions in a fair, clear, simple and efficient manner, and the monitoring of this process. Such administrative structures are also necessary to accumulate the user fee revenues and to allocate such funds efficiently and transparently to a range of previously determined and defined functions or groups. However, such a national system is difficult if not completely

unfeasible to set up when strong institutions are not already in place, which is the case in both Kenya and Uganda, and most other low income African countries.

Hence, there were various broad political features of the Kenya and Ugandan governments which would have impacted health finance reform given that they influence many aspects of the governments' policy-making. Thus the governments of both countries did not have an incentive to extensively plan their user fee policies or removal, or to invest enough funding in these changes, because they felt an animosity towards the programs given that they were pushed to implement them by foreign donors; and/or they had made the changes for political strategy, and the political gains resulted from the announcement rather than the effectiveness of the policy itself; and/or they were not being held accountable for providing good quality and equitable care. The governments also perhaps did not have the capacity to implement the administrative structures necessary for an effective national user fee program, due to a lack of strong institutions.

Chapter 5: Conclusion

Based on the present study, it is evident that user fees did not work as intended in Kenya and Uganda. In both countries, in general health care quality remained low whether user fees were in place or not, and corruption and drug shortages were frequent before, during and after user fees existed. As a result, health care utilization decreased in both countries after user fees were implemented, and even though utilization subsequently increased after user fee removal, it seems likely that this increase could have been larger if the removal process had been carried out

differently. The poor are most likely to have been affected by this low quality care and reductions in utilization.

Importantly, it seems that it was not necessarily the case that it was the user fees themselves which led to these detrimental effects on health care and its utilization, but rather that the user fee policies did not function properly. It seems that this is mainly because the Kenyan and Ugandan governments did not adequately plan the health care user fee policies or their removals and did not invest enough financially into the programs or in health care in general. This was because of fundamental broader political features of these countries: the pressure from foreign donors to implement particular policies resulted in a reluctance to fully commit to these policies; making decisions based on strategies to increase political support for elections led to flawed policies when simply announcing the change provided the desired political support; there was little incentive to invest extensively in the creation of effective policies when the state bureaucracy was not being held accountable for whether the population had high quality and equitable health care; and the lack of strong institutions meant there was little capacity to set up the necessary administrative structures to support an effective user fee policy. These broad political features are likely to also be characteristics of other low income African countries.

Given that user fee policies did not work as they were supposed to in Kenya and Uganda, it seems that perhaps other health financing solutions may be more appropriate within the context of these countries, and similar low income African countries. For instance, community-based insurance could be a good solution [Chankova et.al. 2008][Atim, 1998][Bennett et.al. 2001]. Such community-based insurance groups are often small groups centered around a particular geographic area, a specific industry, women's associations etc., so their specifics can be tailored

to the economic, social and cultural characteristics of the particular group, increasing their acceptance, enrollment and effectiveness. Such systems are particularly appropriate in contexts such as Kenya and Uganda where only a small proportion of the population is employed in the formal sector. There are already some community-based health insurance programs in both Kenya and Uganda, but these only cover small proportions of the population [USAID, 2006a][USAID, 2006b][Mathauer et.al. 2008]. It thus seems that access to health care, particularly for the poor, could be maximized by a national expansion of such groups, with the governments working with the World Bank, bilateral and multilateral aid donors and NGOs, to educate the public about such programs, help to set up and fund initial programs and provide necessary training.

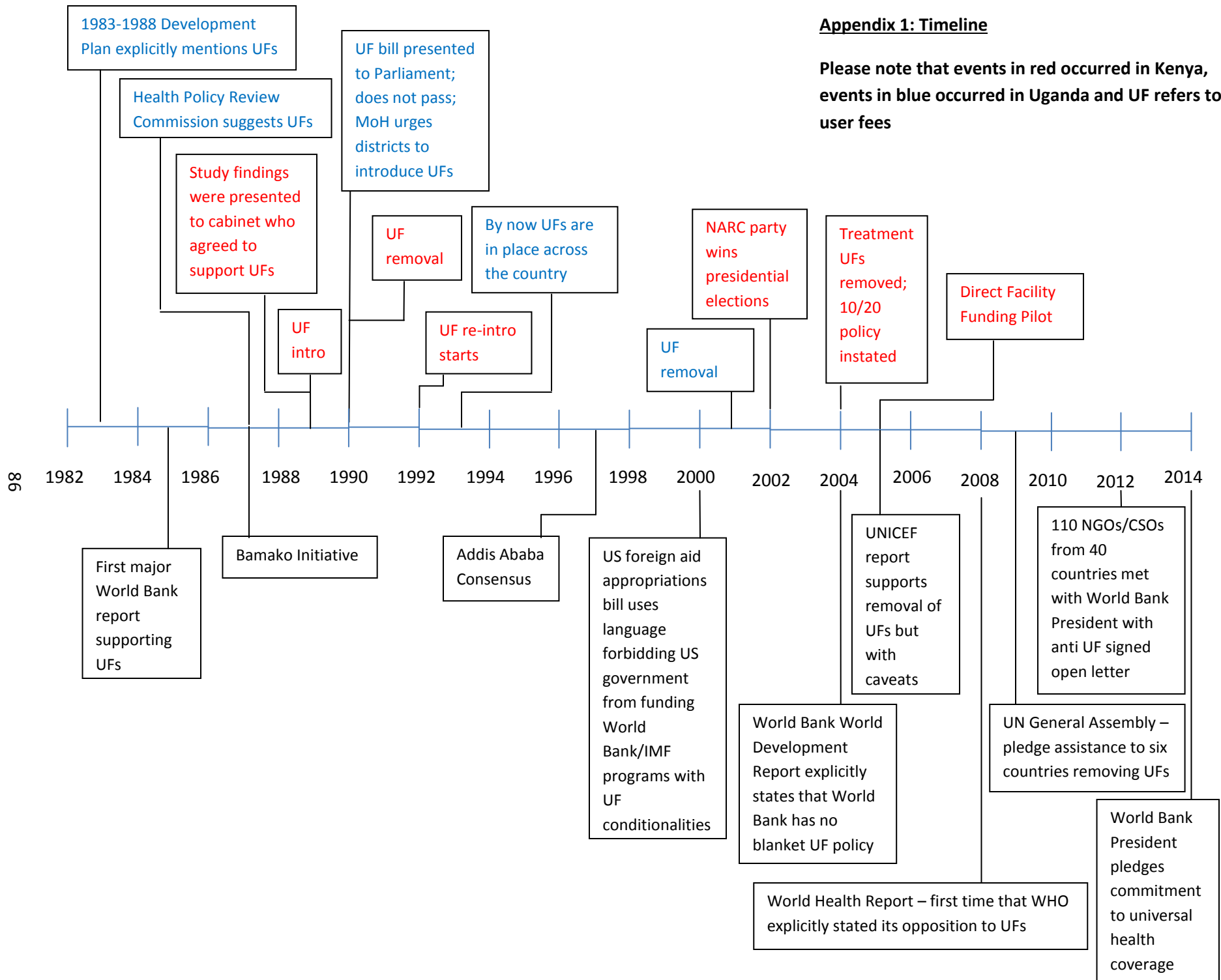
The governments of these countries do also need to prioritize funding for health care. Health facilities should not be left to fund their operating costs from health service fees; there should be a substantial investment from the government in health facilities. This will ensure that health services can be of a high quality, because if they are not then people will still not access the facilities even if community-based health insurance programs are promoted (not to mention, health outcomes for those who do access the facilities will not be optimal). As part of the Abuja Declaration in 2001, African countries agreed to allocating 15% of their budget to their health systems but neither Kenya nor Uganda have done so: in 2013 Kenya spent less than 6% (with a trend of decreasing proportion) and Uganda spent 8-9% [WHO, 2011][Wafula, 2013][Butagira, 2013]. Thus health needs to be prioritized by these governments. These countries could also endeavor to raise more public revenues for investing in health care by, for instance, increasing

taxes on e.g. tobacco and alcohol sales, and cutting down on foreign/multinational corporation tax evasion [Okonjo-Iweala, 2014].

The findings of this thesis demonstrate that political factors always need to be considered when deciding on, planning and implementing any health reform, as such political factors impact this process extensively, leading to changes in health care utilization. Because of such political factors and features in Kenya and Uganda, user fee policies were not effective and thus health care quality and access were not maximized. Perhaps if these countries, and similar low income African countries, increased their investment in their health care system, and also promoted community-based insurance programs then high quality and equitable health care could be achieved.

Appendix 1: Timeline

Please note that events in red occurred in Kenya, events in blue occurred in Uganda and UF refers to user fees



Appendix 2: map of Kenyan districts



[Kenyan Ministry of Health, 2014]

Appendix 3: map of Ugandan districts



[Ugandan Ministry of Health, 2004]

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