Equity through Waivers and Exemptions: User Fees in a Municipal Hospital in Mumbai, Maharashtra.

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Governance

- The term *governance* can be used specifically to describe changes in the nature and role of the state following the public-sector reforms of the 1980s and 1990s. Typically, these reforms are said to have led to a shift from a hierarchic bureaucracy toward a greater use of markets, quasi-markets, and networks, especially in the delivery of public services.
- governance can also be used to refer to all patterns of rule, including the kind existed before the public-sector reforms of the 1980s and 1990s. Then, we need to describe the changes in the state since the 1980s using an alternative phrase, such as “the new governance.”

New Public Management

- NPM as part of governance reforms gives a critique of the bureaucratic government of the post-war era, while at the same time attempts to increase the role of markets and of corporate management techniques in the public sector. The state is often advised to withdraw from direct delivery of services. State provision of public services will be replaced with an entrepreneurial system based on competition and markets.

- The NPM advisers often drew on rational choice theory. Rational choice theory extends a type of social explanation found in microeconomics. Typically, rational choice theorists attempt to explain social outcomes by reference to microlevel analyses of individual behaviour. They model individual behaviour on the assumption that people choose the course of action that is most in accord with their preferences.

Marketization

- The most extreme form of marketization is privatization which is the transfer of assets from the state to the private sector.
- Other forms of marketization remain far more common than privatization. These other measures typically introduce incentive structures into public service provision by means of contracting out, user charges, quasi-markets, and consumer choice.

User Fees in Health Care

- User fees are out of pocket charges paid at the time of use of health care in the public sector facilities. User fees in low income countries were imposed as part of the structural adjustment policies, often as a condition of lending from the World Bank and IMF. In its influential study of 1987 the World Bank suggested that to charge patients would have three main benefits.
  - First, fees would generate added revenue.
  - Second, fees would increase efficiency of services delivery by reducing frivolous demand.
  - Third, they would improve access of poor people to health services because user fee revenues could be used to cross-subsidise the disadvantaged.
- They have been in operation in many low income countries including India for more than twenty years.

Three main assumed Benefits of User Fees: 1) Additional Revenue

- A review in 2004 which looked at experiences of 25 countries in Asia and Africa concluded that user fees generally raise very little and do it inefficiently.
- User fees rarely account for more than 10% of recurrent costs and are a far more inefficient revenue raising tool than general taxation due to high administration costs.
- In the case of Mozambique, it was seen that even while the huge costs of administering it were excluded, user fees contributed only a small fraction of overall spending on health - as little as 0.7%. It was noted that scrapping user fees would possibly result in a net increase in resources for health care services if such costs were included.
- The average cost recovery rate in India was observed to be 3.8% of the medical and public health budget.

Three main assumed Benefits of User Fees: 2) Check *Frivolous* Demand

- *Frivolous* use, even theoretically, is a possibility only when the typical 'consumer' faces zero prices at the point of use, by virtue of having insurance coverage or other advantages.

- In many low income countries, low demand for health services is seen to be a major public health challenge and improving it is seen as a pre-condition to reach the health –related MDGs. For example, it was seen that in the Democratic Republic of Congo people visit a health facility only once every 6·7 years. Per capita annual contacts with the health system was noted to be 0.1 in Cambodia and 0.4 in Zaire. In such situations, promotion, rather than rationing would be the correct policy to follow.

- Logically, if this objective (reducing demand) is achieved, then the first (raising revenue) cannot be. Thus, if increasing user charges reduces the utilization of health services, it will not increase aggregate revenue. The argument for raising revenue is based on the assumption that demand for health care is price inelastic; that is, at the level of prices being charged to users, utilization will not fall enough to offset the increased revenue from higher user charges . It is quite a problematic assumption.

Three main assumed Benefits of User Fees: 3) Equity Gains

- There is well established evidence that user fees adversely affect access to health care for the poor.
- The principle of equity also demands that the paying and non-paying patients be treated as equals. In practice, it was observed that the process of accessing systems of waivers and exemptions is often stigmatising and de-humanising.
- Another related issue affecting equity is related to lack of well-defined guidelines and criteria on waiver/exemption policy.
- In all this, from being an entitlement guaranteed as a matter of citizenship, free health care increasingly becomes a charity or a gift from individual staff to the ‘deserving’ among the poor patients.

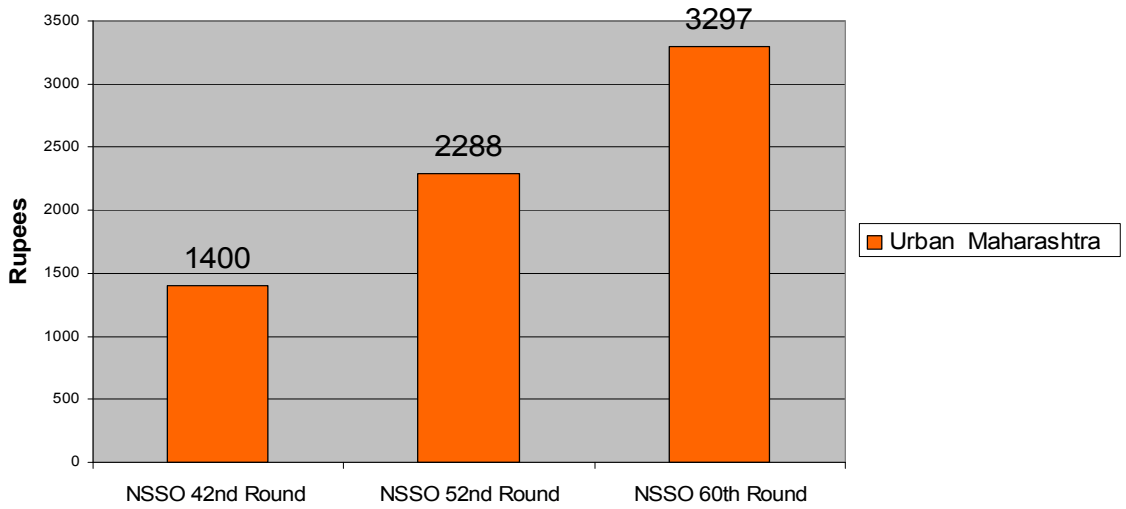
Note: Waivers and Exemptions

- The equity concerns related to user fees were to be addressed through a mechanism of fee waivers and exemptions which would protect the poor and make sure cross subsidisation between better off and poor actually happens.
- Waiver: - A waiver entitles an individual to obtain health services in certain health facilities at no direct charge or at a reduced price.
- Exemption:- Whereas waivers are associated to certain individuals, exemptions are associated to certain services. An exempt service is one that is to be provided at no charge (or at a reduced price) to patients.
- In its broadest form, a waiver entitles its holder to receive all services at no direct charge; in its broadest form, an exemption implies that the exempt service will be provided to all individuals at no charge.

User Fees in Maharashtra

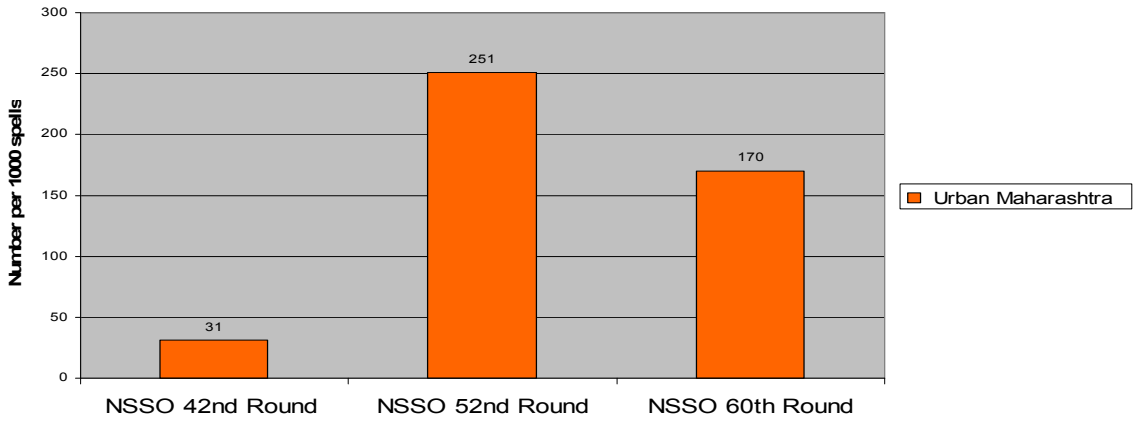
- In Maharashtra, user fees were introduced way back in the eighties along with many other states, and the scope and scale have been steadily increasing with no visible effort of any roll back.
- By 2000, user fees were extended to all rural and women, cottage, districts and non-project hospitals, while clear guidelines on exemptions have been largely absent.
- In 2001, the average user fee paid per patient at government facilities in Maharashtra was raised by a sharp 150%.
- Recently, there have even been fresh proposals to start charging substantially for medical services at Civic hospitals in Mumbai.

Average total Expenditure per hospitalised case in the government hospitals in Urban Maharashtra



NSSO 42nd Round: 1986-87

Number per 1000 of spells of ailment untreated due to financial reason in Urban Maharashtra



52nd Round: 1995-96

60th Round: 2004

Healthcare Institutions in Mumbai

Public						Private			
Primary	Number	Secondary	Number	Tertiary	Number	Primary	Number	Secondary & Tertiary	Number
1. Health Posts	168	1. Peripheral Hospitals	16	1. Major Teaching Hospitals	4	1. General Practition-ers (GPs)	4663	1. Nursing Homes	1258
2. Dispen saries	162	2. Maternity Homes	5					2. Hospitals	175
3. Post Partum Centres (PPC)	22	3. Speciality Hospitals	26					3. Super Speciality Hospitals	5

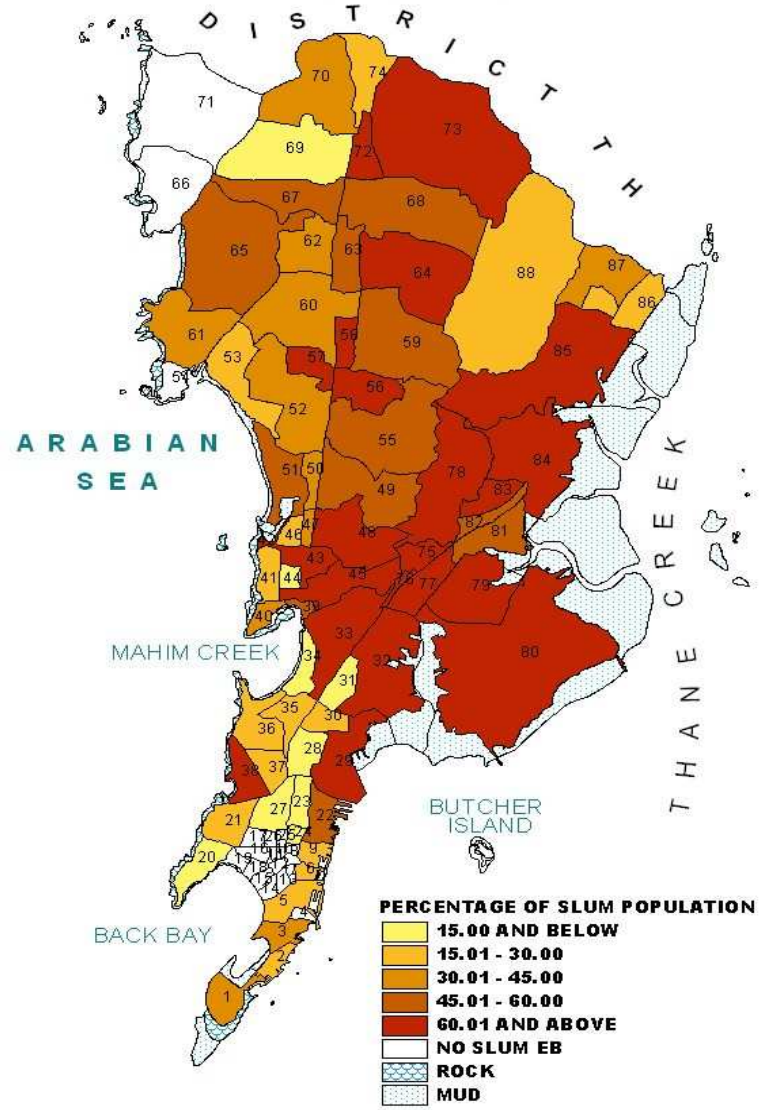
Source: Data obtained from Public Health Department and Epidemiology Cell, MCGM (2008)

Hospital Beds and Number of People Per Bed in Mumbai

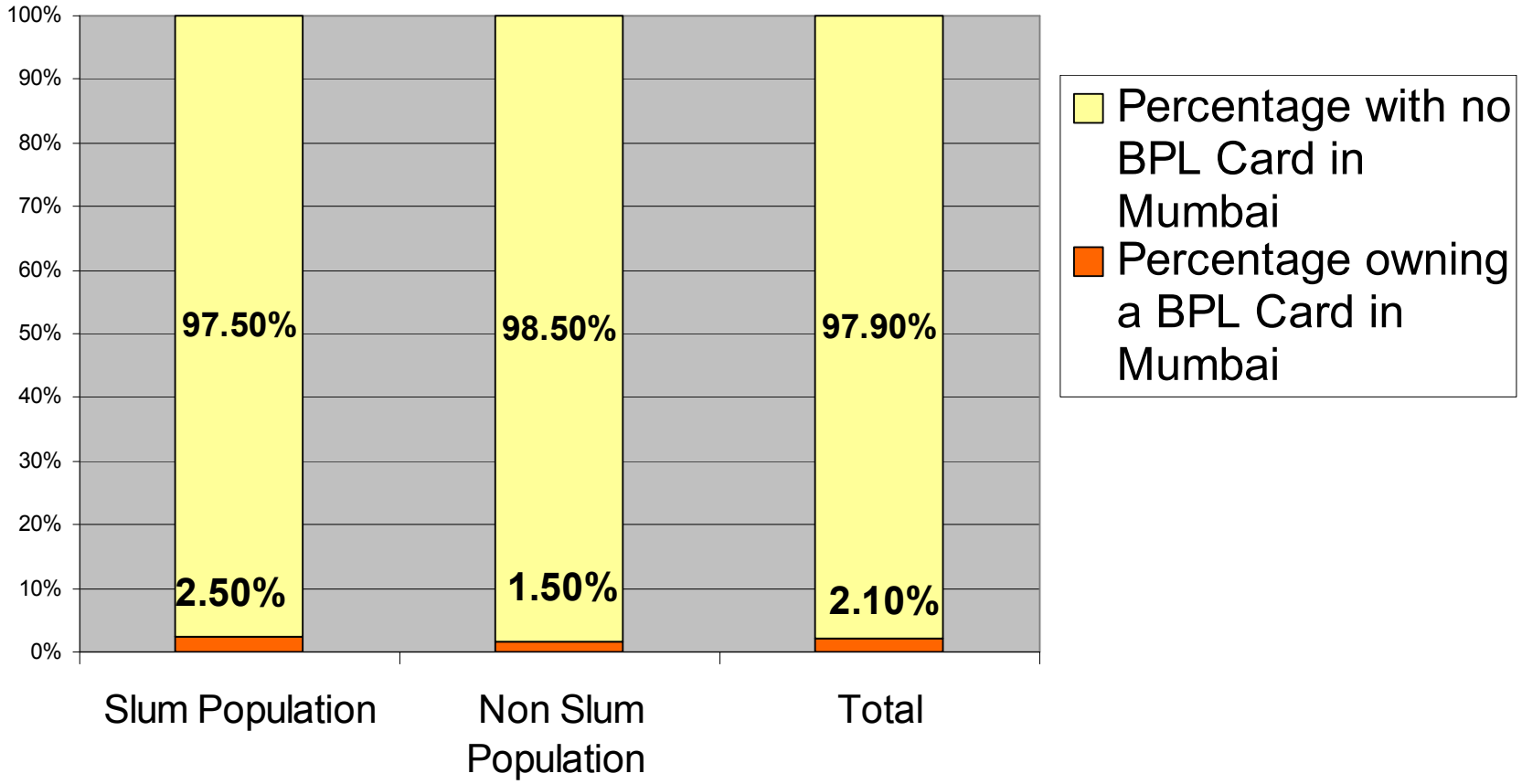
Area	Population (Mid-Year Esti-mates of 2007	Municipal Hospitals		Other Hospitals	
		Number of Beds	Population Per Bed	Number of Beds	Population Per Bed
City	3700098	6386	579	13577	273
Western Suburbs	5689012	2059	2763	8972	634
Eastern Suburbs	3888610	1702	2285	4723	823
Greater Mumbai	**13277720**	**10147**	**1309**	**27272**	**487**

Source: Public Health Department, MCGM (2006)

GREATER MUMBAI MUNICIPAL CORPORATION
PERCENTAGE OF SLUM POPULATION
TO TOTAL POPULATION 2001
(SECTIONS)



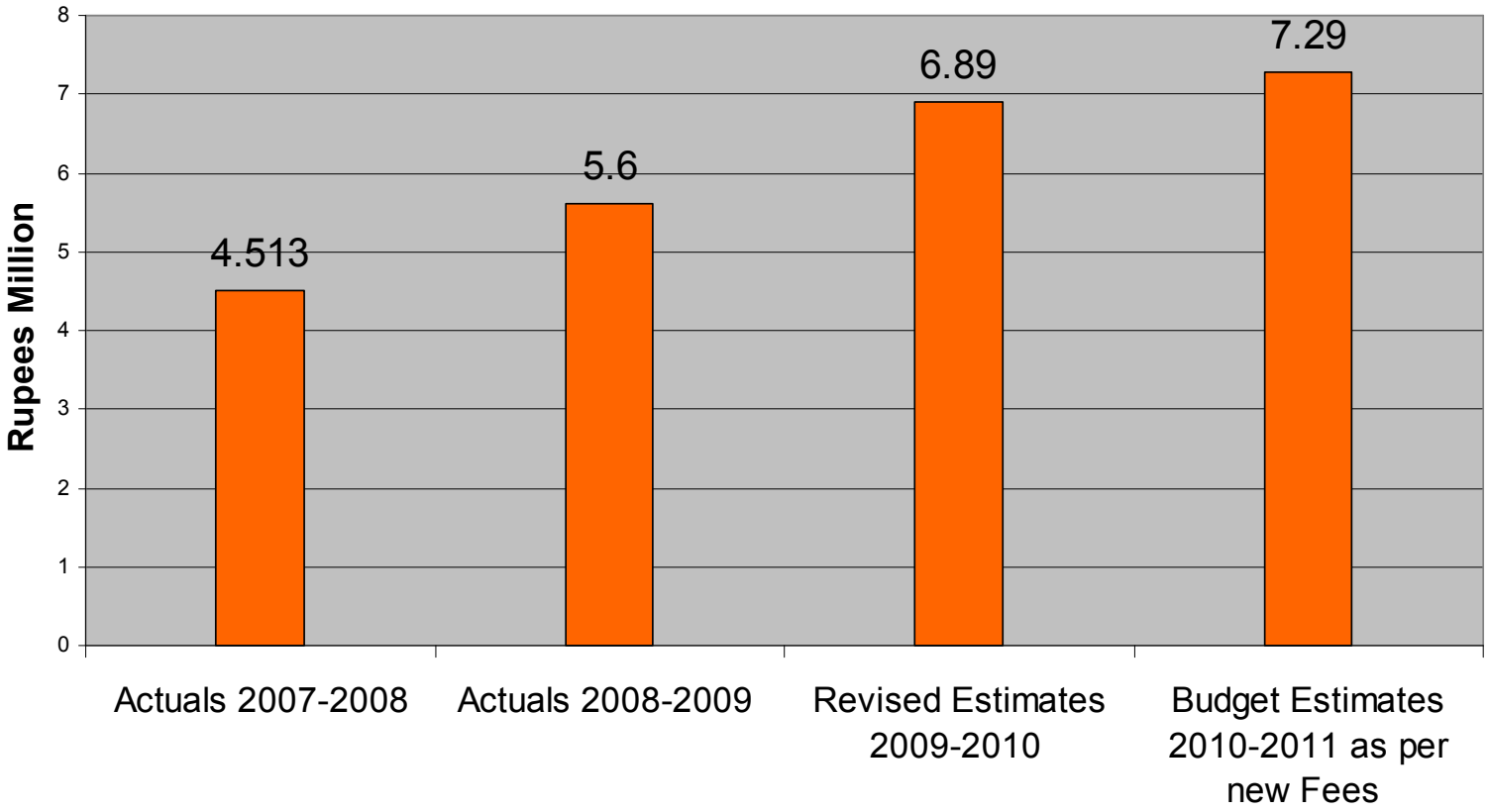
NFHS-3 : Percentage of Families owning a BPL card in Mumbai



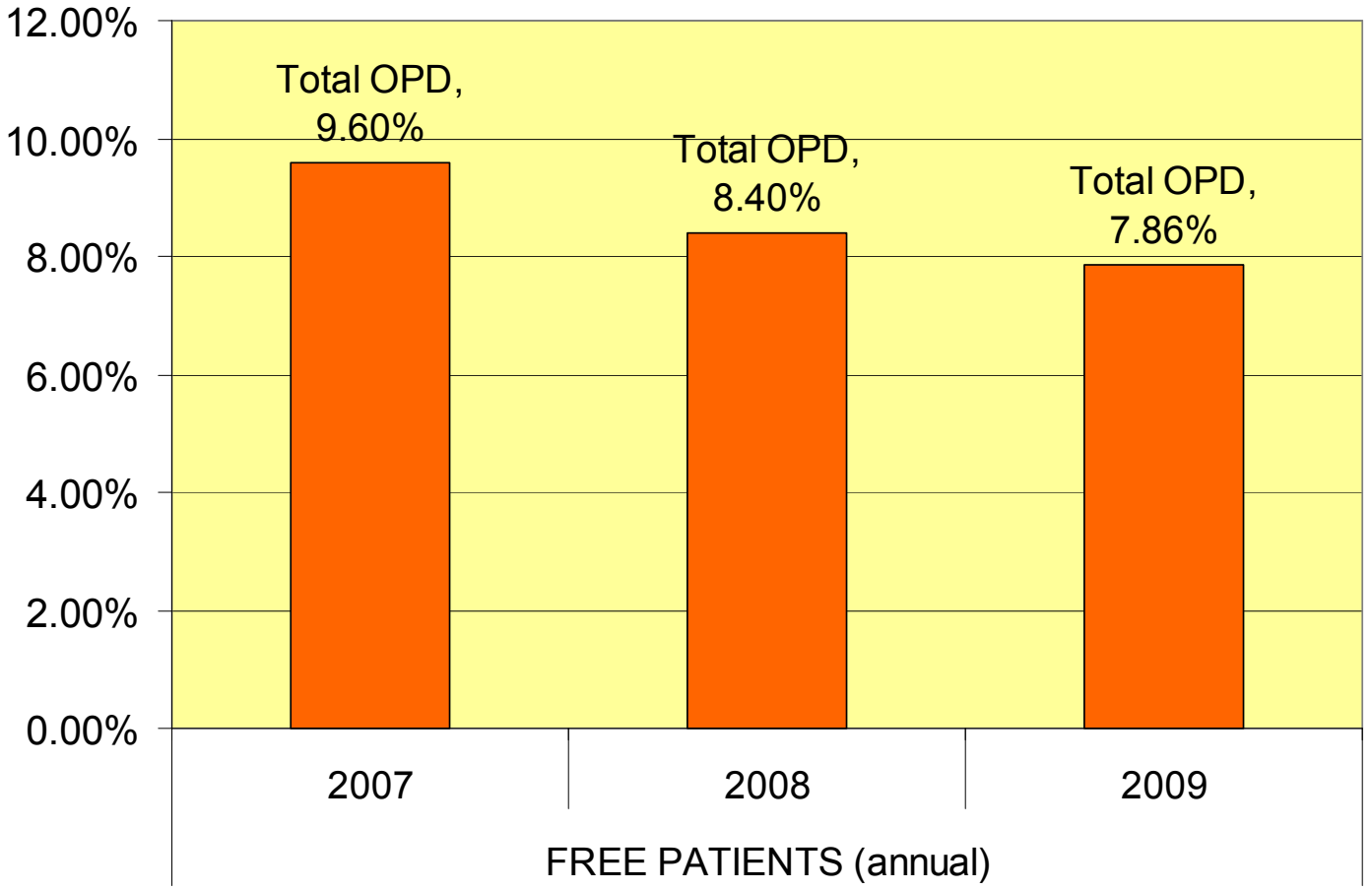
The Study

- CEHAT is conducting a study titled **Implementation of User fee in a Municipal Hospital in Mumbai: a Study mapping the flow of User Fees.**
- In Mumbai the collected user fees is deposited into the Municipal Treasury, and not retained at the facility.
- In this presentation we share some interesting data regarding access to the needy and some preliminary observations.

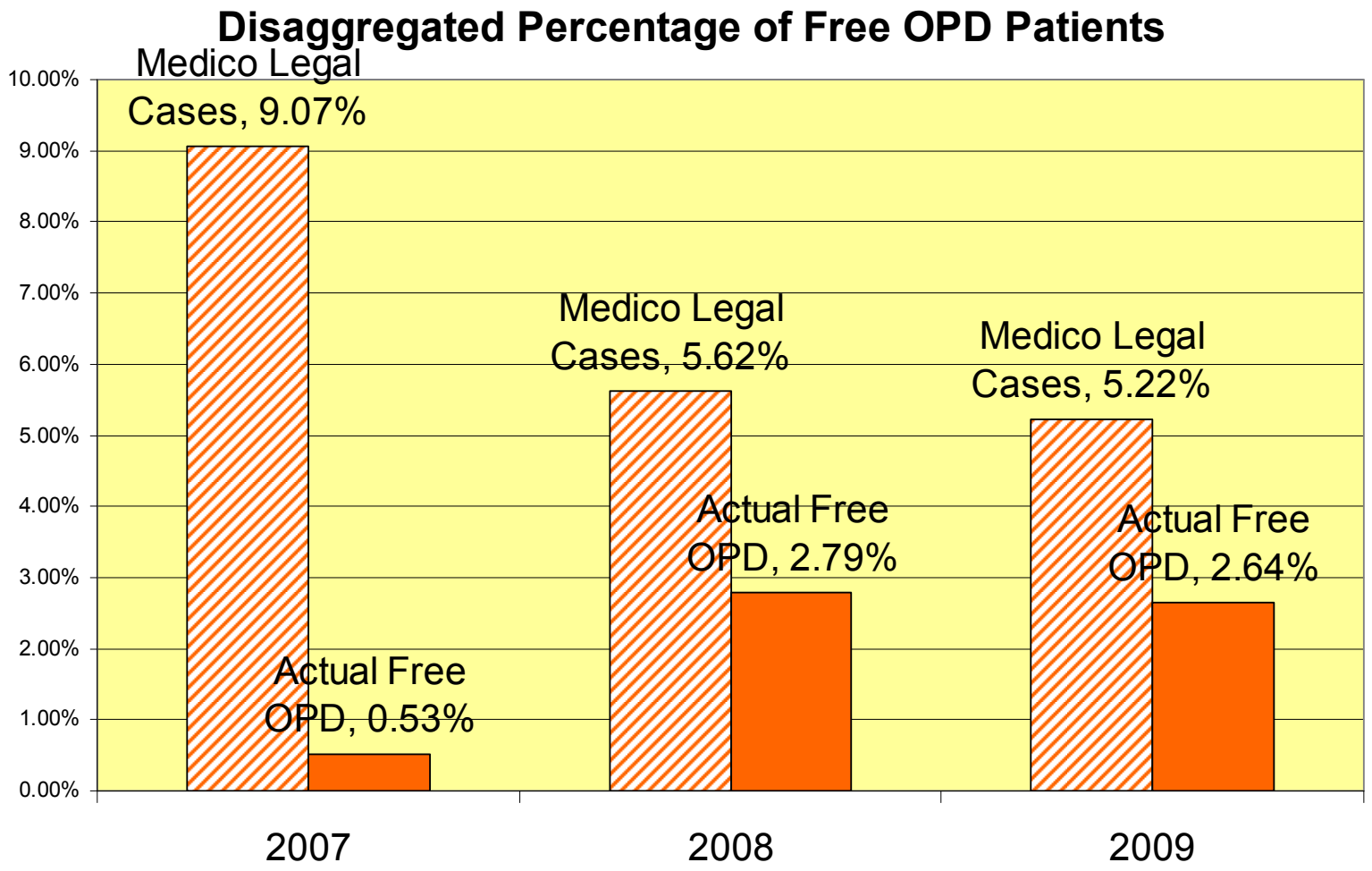
Total User Fee Collections from the periphery hospital (Rs Million)



Percentage of Free* Patients



***This just means that they did not pay the mandatory Rs 10 to register.**


Disaggregated Percentage of Free OPD Patients
10.00%
9.00%
8.00%
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
Medico Legal Cases, 9.07%
Actual Free OPD, 0.53%
Medico Legal Cases, 5.62%
Actual Free OPD, 2.79%
Medico Legal Cases, 5.22%
Actual Free OPD, 2.64%
2007
2008
2009

An indicative case: ECG Charges @ 20 for the month of October 2010

Total	Free because they have already paid Rs 200 for the ICU	Family Planning cases	Rest of the Free patients (Municipal Employees and their dependents + Medico-Legal cases + Senior Citizens +School Children+ unknown patients+ the Poor)
660	122	38	72
	18.48%	5.76%	10.91%

An indicative case: X-Ray Charges @ 30 for a week (1-7 October 2010)

Total	Family Planning Programme	Senior Citizens	Municipal Employees	Unknown Patients	Rest of the Free Patients (Dependents of the employees+ Medico-legal cases+ School Children+ The Poor)
937	6	2	17	4	72
	0.64%	0.21%	1.81%	0.43%	7.68%

The number of Free Patients Jan-Oct 2010

Sevices	Rate (Rs)	IPD Attendance (Jan-June 2010)	OPD Attendance (Jan-June 2010)	IPD + OPD (Jan-Jun 2010)	Free Patients (Jan- Oct 2010)	Percentage of free patients in (OPD Jan-Jun 2010) *	Percentage of free patients in (OPD+IPD Jan-Jun 2010) *
Medical ICU	@200				89		
Surgical ICU	@200				100		
X-Ray	@30				39		
Colour Doppler	@500				8		
USG Abdomen	@100				38		
Major Surgeries	@500				45		
Minor Surgeries	@100				12		
Total		10056	152833	162889	331	0.22%	0.20%

*This is an overestimate given free patients numbers are for Jan- Oct 2010, while IPD and OPD figures are for Jan-Jun 2010.

Poor Box Charity Funds

- A Poor Box Charity Fund is available at every municipal hospital, which reimburses -partially, or sometimes fully- the expenses of selected poor patients.
- PBCF is primarily funded by money from donations from individuals and private and charitable trusts. Some money collected from the patients as blood bank and morgue charges(just over 1% of total collections), go into PBCF. There are 11 Fixed Deposits which have been instituted in 2004, whose interest income flows into PBCF.
- There are no notices put anywhere in the hospital about exemptions, waivers or reimbursements.
- There is a tendency among municipal and hospital administration as well as staff to present PBCF as the equity addressing component of the user fees system. But actually PBCF is an semi formal charity arrangement which has been in place for many years. PBCF in Mumbai municipal hospitals predate user fees by at least 40 years.
- Lastly, PBCFs in Mumbai have not been free from corruption.

Poor Box Charity Fund payments Vs Available Funds

Poor Box Charity Fund Receipts (Rs)							Payment to Poor Patients as Reimbursement	Reimbursement as percentage of total PBCF	(Total User Fee Collection)-	Total PBCF if all user fees are added	Reimbursement as percentage of total PBCF +User Fees
YEAR	Blood Services Charges	Morgues Charges	Cash Donation	Total Receipts	Interest Income	Total PBCF = Receipts + Interest Income					
2007	58125	57400	43745	154420	1454661	1609081	179305	**11.14%**	4513000	6122081	**2.93%**
2008	47150	59875	22361	137589	376591	514180	176849	**34.39%**	5600000	6114180	**2.89%**
2009	38525	98900	46000	184850	1776419	1961269	282877	**14.42%**	6890001	8851270	**3.20%**

Concerns

- A policy of user fees is being pushed forward in health care despite obvious equity concerns. That there are no clear guidelines is a matter of great concern.
- The implementation of whatever rudimentary guidelines that exist is done in a very arbitrary manner. Virtually no accountability systems exist.
- Free health care is consciously being shifted from the realm of citizens right to that of individual charity. Access to free government health care, instead of being a right to the needy, has become more of a benevolent gift from some 'kind' individual who is part of the system. But a health system cannot depend for its success on *kindness* of some individuals. Instead, the system itself has to become more equitable and sensitive to the needs of the three-fourths of the population which it is supposed to serve.
- When we talk about right to health, we shall be particularly concerned with the danger of "exclusion errors", i.e. of leaving poor households out.
- In policy circles, the focus seems to be on "inclusion errors" since the primary concern is the "cost-effectiveness" of public expenditure.
- Of course, ultimately both exclusion and inclusion errors may be important, but when the focus on the latter is at the cost of the former, the access will always suffer.
- Exemptions and waivers as a policy mechanism in the context of user fees will have equity enhancing effects only if the population that is unable to pay are a small proportion of the total. When the poor population is large like in India , such mechanisms inevitably fail and user fees as a policy must be rejected.

Impact of Removal of User Fees on Access

- After user fees was removed in South Africa in 1994, outpatient attendances increased by 77%.
- In Madagaskar, after a temporary abolition of user fees, monthly visits to public rural health centers almost doubled compared to the previous year.
- In the case of Kenya, reduction of user fees resulted in an increase in utilisation averaging about 30% more than the pre-removal period.
- In Uganda, since user fees were scrapped in Government health units in 2001, outpatient attendances have increased by 155% (an extra 14.9 million visits). In Uganda, results of research undertaken by WHO and the World Bank demonstrated that the removal of user fees was very favourable for poor people.
- Uganda's experience has lead to some kind of a Domino effect across Africa and over the last three years countries like Zambia, Burundi, Niger, Liberia, Kenya, Senegal, Lesotho, Sudan, Malawi, Sierra Leone and Ghana have abolished fees for key primary health-care services as shown on the following figure.
- In Niger, after user fees were removed for children under five and pregnant mothers in 2006, consultations for children under five quadrupled and antenatal care visits doubled.
- In Burundi, utilisation for children under five increased by 40% within a year of user fees being removed.
- In Bo, Sierra Leone, removal of user fees led to a tenfold increase in consultations for children under five.

NRHM Experience

- It is a fact that many states and population groups in our country have health indicators worse than that of Sub-Saharan Africa. This has not, unfortunately, prevented our policy makers from pursuing user-fees enthusiastically. In fact, the only condition for release of central grants to the States for the Hospital Development Societies (RKS) was that the Samiti would levy the charges.
- In NRHM, the situation is such that the Common Review Mission observed that RKS are seen by the patients as merely a vehicle for collection of user fees. It further notes; “since evidence from various parts of the world has shown that user fees act as barriers to access health care by the poor, women and girls as well as other marginalized groups, its effectiveness needs to be assessed to ensure equity. Almost every state mission has observed this problem in the persistent user fees and the impact on access it has”.

Future Directions (Concerns?)

- “The analysis from the field visits has also demonstrated that judicious exercise of user fee, based on the exclusion of the BPL category, can be an effective mechanism for mobilization of resources for facility improvement, quality care and patient welfare. States/ Cities would be facilitated to develop mechanisms for income generation through realization of service charges by cross subsidizing the beneficiaries (urban poor) and by levying service charges to non-beneficiaries which could be utilized for sustenance of the project during the post mission period”.

  - National Urban Health Mission, Draft Mission Document (2009)

Thank You.