



REDUCTION OF USER FEES IN THE PRIVATE-NOT-FOR-PROFIT HOSPITALS IN UGANDA: IMPLICATIONS FOR EQUITY AND SUSTAINABILITY

John Mugisha, Lecturer, Uganda Martyrs University

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Abstract

While the reduction of user fees was not seriously contested as a big step towards equity and evidence of faithfulness to their mission, many private-not-for-profit (PNFP) hospitals dragged their feet in implementing these reductions, especially where the fees constituted a big proportion of their income. There were fears of diminishing revenue from fees, increasing expenditure on drugs and sundries, unreliability of government funding, fluctuation of income from other unreliable sources and serious threats to sustainability. With empirical evidence from 4 PNFP hospitals, this article demonstrates that where fees constituted a barrier to access, there is likelihood for the over all revenue from fees to increase after their reduction because of increased patient numbers. It will also be shown that recurrent expenditure on consumables may not increase above the level of revenue from fees where there is prudent management. Henceforth, it will be argued that reduction of user fees does not compromise financial sustainability and health equity but rather promotes them both.

Introduction

The private-not-for-profit (PNFP) health care institutions in Uganda, mainly founded by religious bodies, have been (and still are) charging user fees for their services. At first the fees were very low as majority of these units got significant funding from foreign missionaries and other donor organisations. This situation did not remain the same. By the 1990s, foreign assistance was already reducing in these institutions. As the donations dwindled, the fees increased. A study, which was conducted in 2000, revealed that user fees in the majority of these institutions had escalated so much that the majority of the poor people could no longer access their services (Maciocco et al, 2000).

Since 2001, the Medical Bureaus - religious bodies charged with coordination and supervision of religious health services in Uganda, have embarked on a fee reduction movement code-named "faithfulness to the mission". This initiative consists of reducing and flattening the user fees in order to increase accessibility by the poor to their health services.

The main reason for reducing fees was the need for bureaus and their affiliated units to remain faithful to their missions, which is about providing quality services to all, but preferentially targeting the poor or the underprivileged (Episcopal conference of Uganda, 1999). The services for children and pregnant women are particularly targeted in this initiative, being the least privileged in the society, and a proxy for the poor. The other reason was to demonstrate the fact that government grants to PNFP health facilities were being targeted where they were intended-to the poor.

After a sensitisation workshop organised by the Medical Bureaus, hospital managers pledged to reduce the fees but with a lot of scepticism (UCMB, UPMB, UMMB, 2003). Were the high fees actually the reason for low utilization of their hospitals? There were arguments that hospitals were already serving the poor. Would the reduction of user fees guarantee more equity anyway? If indeed utilization were to increase after fees reduction, would the hospitals cope with the expenditure on required drugs and other medical consumables? How predictable was the flow of delegated funds into the PNFP hospitals? Would the fees reduction not also significantly reduce hospitals' revenue and threaten their sustainability? This article will address itself to the last four questions.

The purpose of this article is to attempt to respond to the afore-said questions (call them fears) voiced by the management boards and teams of the PNFP hospitals. The paper utilises partial results from a study, which is still on-going in the 4 PNFP hospitals of Maracha in Arua district, Angal in Nebbi district, Matany in Moroto district and Naggalama in Mukono district. CUAMM - an Italian non governmental organisation of doctors working with Africa, which partly funds the 4 hospitals, commissioned this study to assess the extent of user fee reduction and flattening and their effect on hospital accessibility, income and expenditure.

Methodology

The data were collected through a descriptive, cross-sectional study that mainly depended on reviewing hospital documents and interviewing core management teams and some patients. The 4 hospitals were selected because of their collaboration with CUAMM. The documents were reviewed from the year 2000/2001 to 2003/2004 to assess the trends.

Data were collected from a number of variables from each hospital. For the purposes of this article, we shall only refer to the following, all for the same period 2000/01 to 2003/04:

- Extent of user fee reduction and the targeted population
- Exemption mechanisms
- Outpatients utilization
- Inpatient utilization
- Expenditure on drugs and sundries
- Total expenditure
- Income from user fees
- Total income
- Delegated funds to each PNFP hospital
- Government funding per standard unit of output (SUO)
- Expenditure per SUO

The data were analyzed to see the implications of each hospital fee structure and practices on sustainability and equity. The main income and expenditure items are also analyzed in the same way. A standard unit of output (SUO) herein referred to as 'outpatient equivalent' has been used after converting the various hospital outputs - inpatients, deliveries, antenatal care contacts and vaccinations, into outpatient equivalents. The formula that we used was $SUO_{op} = (15 \times no. IP) + (no. OP) + (5 \times no. Deliveries) + (0.2 \times no. immunizations) + (0.5 \times ANC visits)$ which simply equates the cost of treating 1 inpatient to the one for 15 outpatients, 1 delivery to 5 outpatients, 0.2 vaccinations to 1 outpatient and 0.5 antenatal care visits to 1 outpatient. A similar formula is being used by the Uganda Catholic Medical Bureau to calculate a SUO for hospitals when monitoring their performance (Giusti D. in CUAMM Medici con l'Africa, 2002).

Government subsidies to each outpatient equivalent (SUO) rather than absolute figures of money given to the hospitals have been analysed. The same method has also been used to determine how much expenditure on drugs etc, goes for a single outpatient equivalent for efficiency comparison between different hospitals.

Analysis and discussion of facts and figures

User fee reforms and equity

The 4 hospitals have since 2001 revised user fees downwards. They targeted the pregnant women and the children. They also targeted patients with chronic sicknesses. While the trend of utilization has since been increasing in the majority of these hospitals, a correlation has not been done between utilization and fees reduction. Besides, there are other factors such as government funding and quality of care (which have clearly not remained constant) whose possible contribution cannot be overestimated. In fact, government funding has been increasing tremendously over this period, as we shall show later.

Nevertheless there is growing literature in recent times that has criticised, very openly, the adverse equity effects of user fees. Studies have shown that significant proportions of populations are excluded from curative care for financial reasons (Arhin-Tenkorang D, 2000, Bennett S and Gilson L, 2001, Poletti T et al 2004). It has also been articulated that user fees, by their very intrinsic character, discriminate the sickest thereby promoting inequity (Maciocco G et al, 2000). The severe the sickness, the longer the period of hospitalisation, the more the materials consumed in treatment and therefore the bigger the treatment bill. It suffices therefore, on the basis of these studies, to argue that the reduction of user fees in the PNFP hospitals was a vital step in the direction of equity. In the framework of this paper, equity means removing those unfair, unjust and unnecessary factors that create differences in opportunities for individuals to attain good health.

At a hospital level, there are two practical ways of promoting equity under the user fees scheme - through reduction of user fees and through the exemption mechanism. Both are supposed to target the poor. It is practically difficult to identify the very poor, more so among the poor. Hence, it is only practical to focus on the vulnerable groups. Equity in a sense means reaching out to those groups that have widely and historically suffered discrimination. Therefore, targeting the pregnant women and children who have been marginalized socially and are powerless economically is in line with equity requirements. The same applies to people with terminal sicknesses such as HIV/AIDS or diseases like TB who are unable to engage in productive work.

The hospitals have introduced a flat rate system. On one hand, they have flattened fees for some services, on the other, they have flattened for some conditions. Maracha hospital has, for instance, flattened fees for outpatient services, normal deliveries and inpatient children. Matany has flattened for T.B ward with different charges for those from Moroto district and those from outside aimed at enforcing referral discipline. Angal has flattened admission fees for males, females, children, maternity sick wing and deliveries. Naggalama has flattened fees for medical treatment and caesarean section. Flattening of fees is meant to improve utilization by making the cost of treatment more predictable to the service users. Indeed, this has been achieved where fees have been flattened for total outpatient or inpatient services.

However, the so-called 'flattening of fees for conditions' does not augur well for predictability. Many patients will not know if they have simple or complicated malaria or if they will undergo minor surgery, major surgery. They will not know how many days they are going to spend in hospital for a given disease, nor the number and type of drugs nor tests they will be prescribed nor the amount of materials they will consume. They cannot predict what they have to pay.

The poorest are the ones most likely not to come. If the hospitals want to enhance equity through the flat rate system, they have to calculate the average fees for children and adult outpatients, inpatients, maternity services etcetera, and flatten the user fees on that basis. Only then will they be able of making the cost of treatment predictable to the service users.

The exemption system unfortunately is not effective. This is a mechanism that should cater for the poorest and the sickest who cannot afford even the reduced fees. It should work in tandem with targeted reduction of fees to increase access to the services by the poor. Information from the interviews indicated that whereas there are some genuine exemptions such as HIV/AIDS patients in Maracha, the HIV/AIDS and the TB patients in Angal, some investigations for the children and some referrals in Matany, the bulk of the beneficiaries are the members of the boards of governors, the salaried staff, and religious nuns and priests. The latter category of beneficiaries defeats the very purpose of exemption mechanisms and further reduces payment of fees by those who can, threatening even the sustainability of the hospital services. Sustainability here refers to the capacity of a health institution to continue performing its functions of providing services with or without external support.

Reduction of user fees and hospital variable costs

It should be noted that the hospital authorities had dragged their feet in implementing user fee reductions for fear that it would erode their income levels and threaten their sustainability. The concerns raised during a sensitisation workshop of the managers of mission hospitals amounted to a sort of hypothesis that user fee reduction would escalate the expenditure on drugs and sundries while eroding the revenue from fees (UCMB, UPMB, UMMB, op cit, 2003)

At the same afore-mentioned workshop, there was reasoning that while some expenditure such as payment of staff salaries, transport and plant costs, hospital boards costs, administration costs, property costs and expenses on primary health care would possibly stay constant in the short run the costs on variable inputs such as drugs and sundries would rise with the increased patient numbers.

The findings from this study have refuted these hypotheses. The following figure gives a summary of revenue trends and expenditure on drugs and sundries since 2001 when the 4 hospitals began the reduction of user fees.

(Figure 1)

The figure above shows that expenditure on drugs increased less proportionately than revenue from user fees in majority of these hospitals after the fees reduction, namely St. Luke hospital Angal, Maracha hospital and St. Francis Naggalama. These three have been analysed together because they show a general trend that is similar for each individual hospital as well. Logically by reducing fees, more patients accessed the services and paid more in total than

when the fees were high.

But what about expenditure on drugs and sundries? This was expected to increase tremendously with increased patient workload. It did not, for majority of the hospitals. A number of factors could explain this:

- The UCMB had already conducted a training workshop in which the need for prudent management in the wake of user fee reduction was underlined. Issues ranging from reduction of wastage to appropriate prescription of drugs, from monitoring to financial discipline, from cost cutting strategies to maximization of fixed inputs especially the staff were all emphasised.
- CUAMM had already intervened to save Naggalama hospital, which in 2000 was already on its last legs. They had, through what they called "Innovative Cooperation Intervention" taken pragmatic steps to revise book-keeping methods and introduced control mechanisms for handling drugs and consumable items (Santini S. as in CUAMM -Medici con l'Africa, 2002). The 'Naggalama model' became a good to be considered for export by both the UCMB and the government in Uganda, to other hospitals.

Matany hospital which experienced different and unique trends whereby revenue from fees increased less proportionately than expenditure on drugs cannot be left unmentioned.

(Figure 2)

These trends could be a result of their long hospitalisation (they had an average length of stay of 19 days compared to 5 days in Naggalama, 7.4 days in Angal and 12 for Maracha), which is also associated with costly treatment for conditions that take long such as TB, malnutrition and victims of violence (some with bone fractures) that are quite common in the Karamoja region.

It should also be pointed out that success in user fee reduction requires a careful selection of services to target and constant monitoring of the process. Matany hospital implemented a kind of 'omnibus' fee reduction targeting not only children and pregnant women but also all patients from their official health sub-district and surgical services. This could have escalated the cost of treatment.

Government grants to hospitals

One of the arguments for user fees reduction was that government was giving grants to PNFP hospitals in form of delegated funds. In fact this is conditional grant to these hospitals, tied not only to the activities specified in the guidelines, but also to fees reduction to increase service accessibility by the poor.

It is promising to note that the delegated funds from government have been increasing over time. They are, in fact, another stable and relatively reliable source of funding at least in the foreseeable future. Clearly, even in the case of Matany hospital, which lost some income after UFR, the delegated funds have increased more than proportionately to cover the loss. The following figure shows increasing trends in the government funding to the PNFP hospitals.

It is clear, therefore, that government grants have been increasing tremendously. In Naggalama, they have increased more than four times from a paltry Shs. 43 million in 2000/01 to Shs. 193 millions in 2003/04. In Angal, they increased from Shs. 137 millions in 2000/01 to Shs 362 million in 2003/04. In Maracha, they have risen from Shs 155 millions in 2000/01 to Shs 295 million in 2003/04 and in Matany, from Sh. 230 millions in 2000/01 to Sh. 602 million in 2003/04.

On the basis of absolute figures, one could argue (in fact many have argued) that sustainability of PNFP hospitals is certain given the persistent increase in government funding and the sure policy of the Public-Private-Partnership in Health (PPPH).

The survival of the public-private-partnership is an issue that will not be discussed here and now. It was there in the 1960s and crumbled later on although this is not a basis for pessimism. What is more sufficing to note is that even the government funding under the PPPH arrangement is itself donor funded, or at least most of it. It will survive in so far as the donors keep funding the government budget, which also will depend on several factors - political, social, economic, diplomatic etcetera.

(Figure 3)

Predicting the sustainability of hospital services basing on increasing government funding requires analysis of more than just the absolute figures. How much does government fund one outpatient equivalent in each hospital? Has this funding also been increasing in the same way as absolute figures? What is the proportion of government funding to the total hospital income? These (and other) questions need answering before we could base on government funding to talk about sustainability of the PNFP hospital services.

The following figure shows trends in government funding as subsidies for outpatient equivalent; how much government is giving to a single outpatient equivalent per hospital.

(Figure 4)

The figure below simply shows that government grants to the PNFP hospitals are still peanuts even if the figures may appear too high in absolute terms. For instance, while Matany received Sh 600,000,000 in the last Financial Year, the same subsidy per outpatient equivalent is only Sh 3000. Again if considered as subsidies for the outpatients equivalent, the delegated funds have not increased tremendously since 2000/ 2001. Actually for some hospitals, the trend is tending to move downwards. This is in spite of the tremendous increase in amount of funds. In this approach, absolute figures are simply divided by workload after getting a standard unit of output of 'outpatient equivalent'.

From the FY 2000/01, government subsidies for each outpatient equivalent only increased from Shs 1,000 to 1,000 in Naggala hospital, from Shs 2,000 to 2,400 in Maracha, and from Shs 1,800 to 3,000 in Matany. Only in Angal was there a significant increase from Shs 700 to 2,000. Even for this case, the unique trend is more a result of gross under-funding in 2000/01 than improved funding in 2003/ 04. It could not have been less expensive then to treat one patient in Angal than it was in Naggalama. Neither is it more now in Maracha.

It needs to be pointed out, however, that all funding of private health facilities by government is a step towards equity. This is true more especially of those facilities that are facing challenges of coping with the demands of a huge workload, or which exist in areas not served by the public health facilities. Equity in health means obviously directing health resources where there is need. It also means providing equal opportunities for all to be as health as possible.

Hospital revenue and sustainability

The hospitals have limited sources of revenue, mainly three - government delegated funds, user fees and donations. Some hospitals also have income generating projects, which we shall refer to as 'other' sources. Are these sources sustainable? Are they in line with equity principles? The different revenue sources for 2003/04 are summarised in the figure below.

(Figure 5)

It is interesting to note that PHC funds from government have been increasing over time. They are a stable and relatively reliable source of funding. Clearly, even in the case of Matany hospital, which suffered revenue decline after user fees reduction, the delegated funds have increased more than proportionately to cover the gap. It is therefore clear that if government funding continues to increase, two birds will have been killed with one stone - fostering equity and helping in the sustainability of the PNFP health services.

There is also ample evidence to show that user fees are still an important source of revenue for the PNFP hospitals. For Naggalama, Angal and Maracha, they are currently the next major source of funding to the delegated funds. As such, they are not likely to be done away with unless another substitute revenue source is identified.

Unfortunately, the system of user fees has been criticised for exacerbating health inequities between individuals and families. In virtually all cases where user fees were increased or introduced, there has been a concurrent decline in service utilization (Bennett S and Gilson L, 2001). However, most user fee schemes have also been poorly designed, planned and implemented. This study already suggests that user fees schemes with targeted low charges and flat rates can increase access by the poor while increasing revenue that is essential for sustainability.

The donor funds have been another important source of revenue to the 4 hospitals. Unfortunately, donations can be erratic and in most cases not flexible to the hospital priorities. Many of them are given in-kind, hence they can only be put to particular uses. They may not help in financing recurrent expenditure, which is where sometimes there is greatest need. However, they are very important since other forms of domestic funding seem inadequate. There have been arguments that donor funds are not sustainable. On the contrary, nothing is sustainable. Countries and big organisations have sustained their activities on donor funds for many years. But attraction of donor funding requires prudent management, effective control mechanisms, timely accountability and reporting. Fortunately, these competencies can be attained through training and technical assistance.

Hospital expenditure and sustainability

The hospitals have almost similar expenditure items. In this study, they were categorized into six employment costs, medical goods and supplies, property and plant costs, administrative costs, supplies and services and expenditure on primary health care. To address sustainability from the expenditure side, one has to take efficiency measures. All expenses that could be reduced should. Below is a summary of hospital expenditure for the financial year 2003/04.

(Figure 6)

For the 4 hospitals, employee costs constitute the biggest cost. This is mainly staff salaries, allowances and staff training expenses. Employee costs have actually been growing in the last 4 years in all the hospitals mainly due to increment in staff salaries in the government hospitals, which forced the PNFP units also to adjust salaries upwards. This was necessary to prevent an exodus of health staff from PNFP to government hospitals.

There have been arguments in favour of cutting staff costs by increasing staff productivity. Indeed, there cannot be sustainability without efficiency. However, staff productivity cannot be stretched beyond certain levels. This of course is not a plea for inefficiency. But increased productivity is itself likely to cause agitation for increased pay consequently raising the employee costs. Given that employee costs in the PNFP hospitals are likely to further increase in the face of impending increment of health workers' salaries in public health institutions, a combination of measures, including lobbying government for more seconded staff, will be necessary.

The other significant hospitals' expenditure is on drugs and supplies. Of course, utilization has increased following user fees reduction, which also means consumption of more drugs and sundries. However, analysis of the drugs expenditure per outpatient equivalent shows wide variations between Maracha and Angal (Ush. 565 and Ush 880 respectively) and Naggalama and Matany (at Ush Ush 918 and 1,177 respectively). Some of these variations are not justifiable. For instance, there is reason to believe that Naggalama could spend the same or even less of what Maracha spends on drugs and sundries owing to their geographical location. Even if there were specific reasons for the variation, it would not be so wide. It is therefore possible to ensure continuity of the services by exploiting more efficiency gains and reducing on some of the expenses. This analysis could mask issues such as stock out durations but the interviews that were carried out showed no significant variability in drugs availability between hospitals.

Conclusions

In the view of the foregoing, a number of conclusions can be made:

- That user fees schemes could be re-designed and reformed to focus more on equity by targeting the poor and vulnerable people while raising enough revenue to contribute to sustaining various hospital activities.
- That the reduction of user fees does not necessarily lead to reduction in income and therefore may not threaten sustainability of PNFP hospitals.
- That the system of exemption is not effective in enhancing equity but is instead effectively working against both equity and sustainability.
- That while government funding to the PNFP hospitals has been increasing tremendously in absolute terms over the past 4 years, they have increased less when considered as subsidies for every outpatient equivalent. Therefore, there is need to consider the changing utilization patterns to appreciate the increase and use this as a basis for lobbying if delegated funds are to be relied on for sustainability.
- That user fees are still an important source of funding to the PNFP hospitals and therefore they will have to stay but be managed in a way that caters for the poor and the less privileged.
- That given the variations in expenditure per outpatient equivalent, there is room for some hospitals to exploit further efficiency gains and therefore reduce on their over all expenditure, save some money and enhance sustainability of their activities.

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