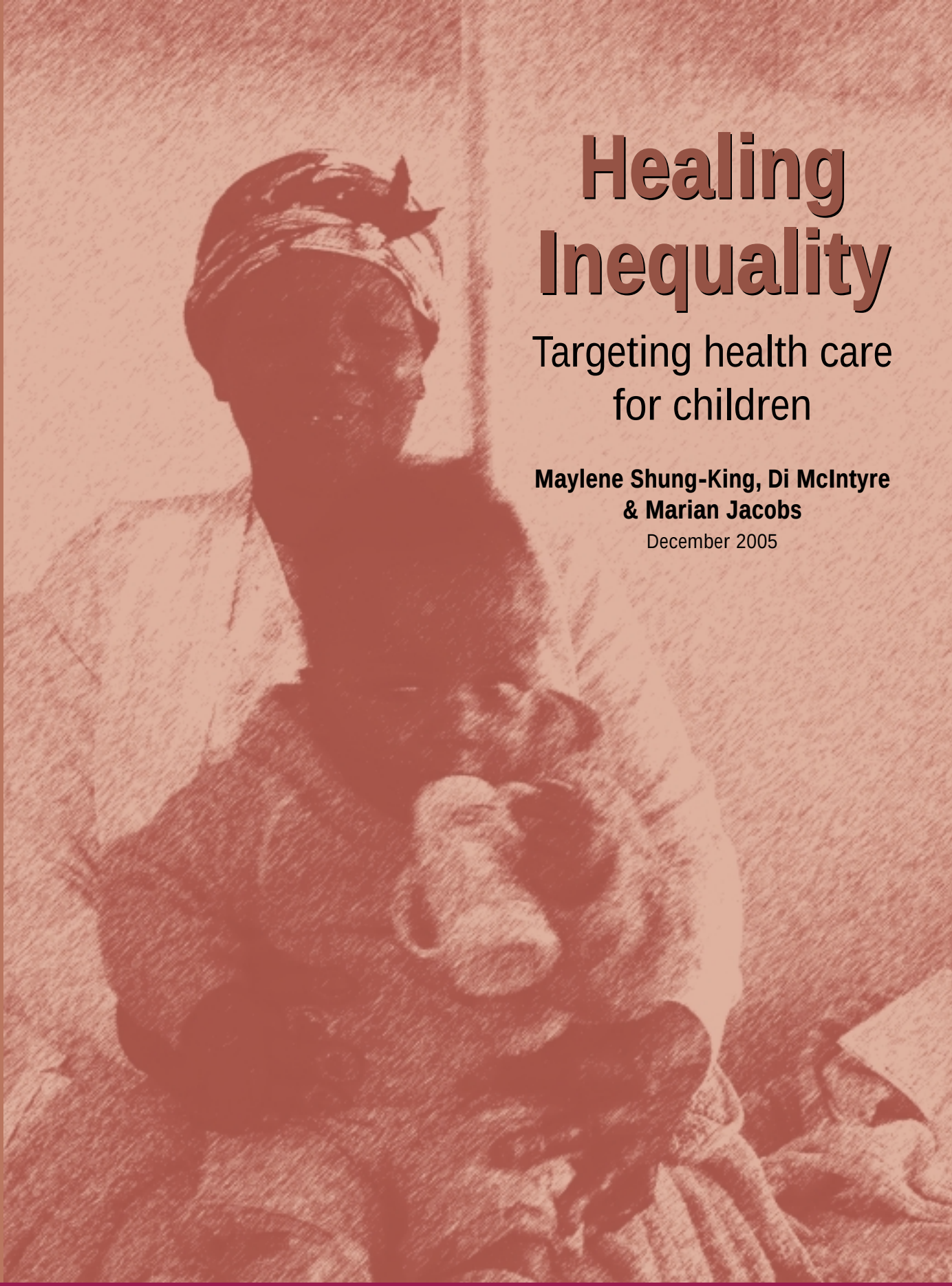
The Means to Live



Healing Inequality

Targeting health care for children

Maylene Shung-King, Di McIntyre & Marian Jacobs

December 2005

children's institute
child rights in focus
Research • Advocacy • Education

UNIVERSITY OF CAPE TOWN

Healing Inequality

Targeting health care for children

Maylene Shung-King
maylene@rmh.uct.ac.za
Children's Institute, University of Cape Town

&

Di McIntyre
dimac@cormack.uct.ac.za
Health Economics Unit, University of Cape Town

&

Marian Jacobs
marian@rmh.uct.ac.za
Children's Institute, University of Cape Town

December 2005

The *Means to Live* discussion paper series

This paper is one of a series that examine the targeting mechanisms of poverty alleviation programmes across different sectors. The papers form part of the *Means to Live Project*, based at the Children's Institute (CI), University of Cape Town (UCT). This project aims to evaluate the State's targeting mechanisms used to realise the socio-economic rights of poor children and their families.

The project is a collaborative project of the Child Rights and Child Poverty Programmes within the Institute, as well as a number of UCT and external collaborators.

Acknowledgements

The authors would like to thank Lori Michelson for her contribution in describing practices with regard to user fees at a few health facilities, and Mr Poggenpoel at Red Cross Children's Hospital for providing us with further details on the fee system at the hospital. Our thanks also to Save the Children Sweden, the Rockefeller Brothers Fund and Atlantic Philanthropies for their financial support to this project. The views expressed in this publication are those of the authors.

Citation suggestion

Shung-King M, McIntyre D & Jacobs M (2005) Healing Inequality: Targeting health care for children. *In***:** Leatt A & Rosa S (eds) *Towards a Means to Live: Targeting poverty alleviation to make children's rights real*. Cape Town: Children's Institute, University of Cape Town [CD-ROM].

ISBN: 0-7992-2297-6

Editing by Charmaine Smith, formatting by Kevin Erntzen, outstanding reference sourcing by Anthea Arendse.

46 Sawkins Road, Rondebosch, 7700, Cape Town, South Africa
Tel: + 27 21 689 5404 Fax: +27 689 8330
E-mail: ci@rmh.uct.ac.za Web: http://web.uct.ac.za/depts/ci

Contents

Figures, tables and case studies

Abbreviations

ANC	African National Congress
CRC	United Nations Convention on the Rights of the Child
IMR	Infant Mortality Rate
MCWH	Maternal, Child and Women's Health
NGO	Non-Governmental Organisation
PHC	Primary Health Care
PSNP	Primary School Nutrition Programme
RDP	Reconstruction and Development Programme
SAPs	Structural Adjustment Programmes
SWAp	Sector-Wide Approach
TB	Tuberculoses
UPFS	Uniform Patient Fee Schedule

1. Introduction

This discussion paper on children's right to free primary health care in South African is one of a series written for the Children's Institute's *Means to Live Project*. The project's aim is to evaluate the government's targeting mechanisms used to ensure the realisation of the socio-economic rights of poor children and their families. Put more simply, it seeks to establish whether current poverty alleviation initiatives are adequately designed and implemented to reach the poor, including children. By focusing on a number of elements of poverty alleviation with significant consequences for children, it will provide answers to the question of whether the poor are able to realise their socio-economic rights through access to these programmes. The research will be used to advocate for the necessary development or changes to government policies and programmes to ensure the realisation of these socio-economic rights.

Other poverty alleviation policies covered in this series include the:

- School Fee Exemption policy (the right to education)
- National School Nutrition Programme (the right to basic nutrition)
- Free Basic Water policy (the right to water)
- Housing Subsidy Scheme (the right to basic shelter and housing)
- Child Support Grant (the right to social security)

The *Means to Live* is a multi-stage, two-year project. The first phase comprised this series of policy reviews on selected poverty alleviation programmes and their targeting. The second phase will be primary research conducted during the second half of 2005. The final research report will be released in 2006.

This paper focuses on free health care provision to children as an example of a targeted, indirect poverty alleviation mechanism. The paper outlines the history of free health care policy as a component of the transformed post-apartheid health system. The implementation of this policy in South Africa is reviewed, and comparison is drawn with experiences with user fees and the introduction of free health care in a number of African countries. Finally, it comments on free health care as an appropriate health sector targeting mechanism in the context of widespread poverty.

2. Children's right to health

South Africa has one of the most progressive constitutions in the world. In particular, the inclusion of a special section on children in the Bill of Rights not only highlights the country's special consideration for children, but also extends and complements children's entitlements to the range of social, economic, political and cultural rights contained in the Convention on the Rights of the Child (CRC) (Office of the High Commissioner for Human Rights 1989). This international human rights treaty was ratified by South Africa in 1995, and together with the Constitution, provides a foundation for ensuring the realisation of children's health rights.

Child health rights

CRC Article 24: States should accord children, "The right to the highest level of health possible through the duty to ensure the right to access to health services".

South African Constitution, Section 27: "The right to have access to health care services for all South Africans."

***South African Constitution, Section 28 (1) (c)*:** Children's "right to basic health care services".

To comply with both the CRC and the South African Constitution, the State is thus obliged to accord children the right to basic health care services and to put in place mechanisms towards such realisation.

Despite several commitments made to children since attaining political democracy in 1994, the country is still some way from realising children's right to health. The current health status of South African children is not optimal, as reflected by poor overall health indices and wide health disparities between groups.

Child mortality indicators have worsened over the past decade, with the infant mortality rate (IMR) rising from 45 in 1998 to an estimated 59 in 2000, and the under-five mortality rate increasing from 59 in 1998 to an estimated 95 in 2000. This is mainly ascribed to the HIV pandemic, as HIV contributes to almost 40% of child deaths in the under-five age group (Bradshaw, Groenewald, Laubscher, Nannan, Nolijana, Norman, Pieterse & Schneider 2003).

Inequities in health status have been persistent over many decades across different groups within the child population of South Africa. Rich children versus poor, urban dwellers versus rural, and young children versus older children have very different prospects for health and survival. This pattern goes back in time to as early as 1944, when the IMR for White children was recorded at 50, but for African children the IMR was estimated at between 150 and 600 – a three- to 12-fold difference (National Health Services Commission 1944).

More than fifty years later disparities persist, with significant discrepancies between rich and poor. In the city of Cape Town, located in one of the richest regions in the country, the infant mortality rate illustrates the divide: In the wealthier city bowl, the IMR for 1998 was recorded as eight, whilst the figure for a large peri-urban informal settlements on the fringe of the city was 60 – a difference of nearly eight-fold (Shung-King, Abrahams, Giese, Guthrie, Hendricks, Hussey, Irlam, Jacobs & Proudlock 2000).

Differences between regions, or provinces, show a similar pattern. The wealthier Western Cape Province has an IMR of 30, while its poorer neighbour, the Eastern Cape Province, has double that rate, with an IMR of 61.

Similar patterns of inequality between urban and rural areas and between richer and poorer provinces are reflected across other child health indicators and are also evident in health service provision and access to health care. Disparities in immunisation coverage, an internationally accepted index of health service access for children, demonstrate this. In the most recent *South African Health and Demographic Survey* (1998), immunisation coverage

ranged from only 50% in the province with the lowest coverage to a maximum of 81% in the province with the best coverage (Department of Health 1998). Results from a study on how prepared clinics are to respond to basic health service interventions for children with HIV corroborated this pattern of disparity in relation to provision of health care (Giese & Hussey 2002). Their investigation showed that most clinics surveyed were not equipped to provide basic interventions such as micronutrient supplementation with Vitamin A, prevention of tuberculosis and prevention of associated infections through treatment with co-trimoxazole. The unavailability of such basic interventions impacts on the quality of care that child health services can provide.

Given the numerous and varied determinants of health, a multi-dimensional approach is required to ensure that children's rights to health are met, and to ensure their long-term survival and development. Many of the underlying determinants of health relate to the provision of basic social services such as water, sanitation, food and shelter as well as safe environments. This is evidenced by the fact that the major killers of children under five years are still easily preventable diseases such as diarrhoea and respiratory infections, with malnutrition and HIV infections being important contributory causes. For older children, deaths from the major killer – trauma – point to the need for safety for pedestrians, better transport and traffic regulation, firearm control and safer environments in general (Bradshaw et al 2003).

Although the response to children's health needs requires an intersectoral approach, the health sector nevertheless has a critical role to play in providing appropriate health service interventions for children that cover health promotion, prevention, cure and rehabilitation. It also has a duty to ensure that the appropriate services are available, that such services are accessible, and that they are of sufficient quality to address the health needs of children.

The first decade of post-apartheid South Africa focused on improving the provision of and access to social services. To reduce the legacy of inequality, and in the spirit of promoting a "better life for all" [1], a number of social interventions focusing on the poor and marginal groups were instituted under the *Redistribution and Development Programme* (RDP). Children, women and the disabled were key vulnerable groups identified (Republic of South Africa 1994).

In the health sector, an extensive clinic building and upgrading programme targeted the needs of rural communities as a marginal group.

The RDP made several additional, explicit commitments towards children's health. These included the provision of free health care to children under six years of age and pregnant and lactating women, and the Primary School Nutrition Programme (PSNP). These programmes were seen to target different vulnerable groups with specific interventions.

The strategy of free health care was conceptualised as key to improving access to health care for young children and pregnant and lactating mothers, whilst the PSNP, on the other hand, was focused on improving the nutritional status of children of school-going age, thus contributing to improving educational outcomes in children. Both these programmes are good examples of the health sector's efforts to direct specific interventions to vulnerable groups of children through targeting.

[1] This was the African National Congress (ANC) election manifesto for the first democratic elections in South Africa in 1994.

3. Free health care for children in South Africa

3.1 South Africa's health system

General

In 1994, South Africa embarked on a process of major political transformation – from an apartheid-driven system of inequity and inequality to a democratic dispensation aimed at redress. Within this process of change, health sector transformation was an important component.

One of the major legacies of apartheid was a health system fragmented into 14 different departments, lacking cohesion and co-ordination, and with spending of close to 70% on expensive hospitals concentrated in large cities. The country had relatively poor primary level care facilities, which were often the only form of health care available to poor rural communities. The challenges of change were further compounded by the existence of an expensive and strong private health care system that served fewer than 20% of South Africans. Health sector reform thus involved changes in the structure, budgeting and functioning of the overall health system.

An important first step was therefore aimed at building a single national health system with the purpose of reducing disparity in access, promoting equity in health and health care and increasing availability, affordability and the quality of care across the country. Such a unitary system would also provide a bridge to collaboration with other development sectors with responsibility for addressing the underlying determinants of health, such as water, sanitation, food and housing.

The main intention of the transformation process was to change the health system from a very curative, hospital-centred system to one underpinned by the primary health care (PHC) philosophy, the principles of which are equity, accessibility, availability and affordability. It prescribes a comprehensive continuum of promotive, preventive, curative, rehabilitative and palliative care, with good communication and referral channels between the different levels and components. The approach also promotes the delivery of integrated health services, rather than fragmented health care delivered in vertical programmes. This facilitates delivery of holistic care, at one site, and at all times.

These changes have resulted in a single national health system, with national and provincial departments co-ordinated through clear policy and budgetary arrangements and a strong commitment to decentralisation to the district in an effort to promote access to health care for all. A strong emphasis was placed on disbanding all vertical services rendered at primary level facilities in favour of a comprehensive integrated service delivered at the primary level facilities.

Previously, vertical health services such as school health services, family planning and mental health services were integrated into the workload of nurses and doctors who staffed primary level facilities and required existing staff to equip themselves to deliver a full range of services to adults and children. This coincided with the advent of free health care. Thus, while the provision of free health services for children was identified for special attention within the overall health system, the challenges facing the broader health system also impacted on the capacity and quality of health services to children.

Child health services

Since 1994, the health sector adopted the spirit of the nation's commitments to children, and implemented the major child health service mandate of the Reconstruction and Development Programme regarding free health care for children under six years. At the same time, through a process of restructuring at both national and provincial levels, directorates for Maternal, Child and Women's Health (MCWH) were established. The purpose of these directorates was to oversee the overall delivery of health services to children; to develop and implement child health policies, programmes and services; and to monitor child health status and health service delivery.

Services for children were and are delivered at all three levels of health care. Primary level services for children, referring to the first level of care, largely include health promotion and preventive and basic curative care. In the public sector, primary level facilities include clinics, community health centres that function either during normal working hours or on a 24-hour basis, and district hospitals. Clinics are the backbone of primary level service provision in the public sector. They exist in various configurations and various proportions across provinces.

Prior to 1994, clinics largely rendered preventive and health promotion services and fell under the jurisdiction of various local authorities across the country. Clinics were either fixed or mobile. Clinic services were nurse-driven and were rendered free of charge, with a nominal fee charged for certain drugs, primarily for adults. Preventive activities for children that included immunisation, growth monitoring and developmental screening were rendered free of charge. Post-1994, clinics were given increasing responsibility for handling curative cases as well and now render a full spectrum of health promotion, preventive and curative care for children and adults. Only serious illnesses requiring attention from doctors, trauma cases and chronic conditions for children are not managed at clinic level.

Community health centres (also known as 'day hospitals' in some areas) and district hospitals focus primarily on first level curative care, meaning curative care that does not require complex or specialist interventions. These facilities are staffed by general practitioners, nurses and allied staff. District hospitals are the first level of hospital care where in-patient facilities, and facilities for surgical procedures that do not require a specialist, exist. The presence of district hospitals varies from province to province. For example, provinces such as Limpopo have a fairly extensive network of district hospitals (pers. comm. Dr. A. Robertson, February 2005), whereas the Western Cape metropolitan area has only two district hospitals with a larger network of regional (second level) hospitals instead. Prior to 1994, both community health centres and district hospitals charged user fees for all children according to a sliding scale based on family income.

More serious or complex conditions requiring specialist care and/or further investigation are referred to secondary level facilities (the next level up from the primary level that handles slightly more complicated cases requiring hospital care or further investigation) or tertiary level facilities (hospitals that offer highly specialised care and investigations, such as the Red Cross Children's Hospital). Secondary and tertiary level hospitals are integral parts of the delivery of health services to children and form a referral continuum with primary level facilities.

Access to, and quality of, secondary and tertiary level hospitals vary, depending on where children live. For example, intensive care is fairly inaccessible to most children living in areas that are far away from the large cities where such care exists. Furthermore, treatment for certain chronic conditions is almost non-existent in the more rural provinces of the country (pers. comm. Dr. A. Robertson, February 2005). Prior to 1994, secondary and tertiary hospitals also charged user fees to all children based on a family income-dependent sliding scale. In addition, referral letters from primary level facilities were required to gain access to hospitals. In the

absence of primary level facilities in a particular area – or sometimes based on client preference – the outpatient departments of hospitals performed primary level functions as patients accessed these departments for fairly minor ailments. This resulted in expensive resources being used to treat minor ailments, and this in itself warranted change (Shung-King 1998).

3.2 The notion of free health care

A key aspect within the health system transformation process that lent itself to immediate attention was that of addressing the accessibility and availability of health care services. Whilst many barriers to accessing health care existed, these two aspects were imminently remediable. The removal of user fees, whilst on the one hand a 'technical' intervention to improve health service access, was also a strong political statement of a changing political, economic and health care philosophy in post-apartheid South Africa.

The provision of free health care to improve access was complemented by an extensive clinic building and upgrading programme through the RDP to address the health care services discrepancies that existed between rural and urban areas.

Debates on the principle of free health care, as part of a health system philosophy emphasising health promotion and improving access to the poor and marginalised majority, have been taking place over a period of five decades in the country. It was first articulated in a ground-breaking report of the *National Health Services Commission of 1944*, headed by the first nationalist Minister of Health, Dr. Henry Gluckmann (National Health Services Commission 1944). Widespread recommendations were made towards improving health care for "native" South Africans in an attempt to reduce the extreme disparities that existed, for example the widely differing infant mortality rates of 50 per 1,000 live births for Whites and "somewhere between 150 and 600 per 1,000 live births" for Africans. Not surprisingly, Gluckmann's progressive report and recommendations were rejected by the government of the day.

The desire to ensure free health care for all as a means of attaining equal health and human rights for all South Africans was further expressed in the *Freedom Charter of 1955*, the blueprint for a politically free South African society. The Freedom Charter stipulated that "free medical care and hospitalisation shall be provided for all, with special care for mothers and young children" and furthermore stated that "a preventive health scheme shall be run by the state" (Congress of the People 1955). These sentiments were much in keeping with those expressed by Gluckmann a decade earlier.

In the 1980s, a groundswell of political activity within the health sector emerged with the establishment of several progressive and alternate health sector unions and non-governmental organisations. Debates on the responsibility of the health sector in terms of child health took on added dimensions as children were detained and physically assaulted by the apartheid regime. Debates on alternatives to the highly inequitable health care at the time raised important issues regarding the 'triple A's' in health care: Availability, Accessibility, Affordability. Debates also focused on quality of care. The formation of the Progressive Primary Health Care network in 1987, founded on the philosophy of the Alma-Ata Primary Health Care declaration of 1978, started providing alternative aspirations for a heath care system that focused on prevention; recognised all levels of care, including community-based health care, as an important continuum; strived towards accessible and affordable health care for all and recognised the need to advance the health rights of the

most vulnerable members of society, such as children and women – especially those living in poverty.

In the early nineties, many progressive health workers and organisations were instrumental in putting together the ANC's *National Health Plan for South Africa*. This plan was to provide the foundation for the *White Paper on the Transformation of the Health System in South Africa,* published as a forerunner to a new *National Health Act*. The ANC's health plan suggested that, "health care be provided free of charge in the public sector for children under 6, pregnant and nursing mothers, the elderly, disabled and certain categories of the chronically ill" (African National Congress 1994). The plan did not indicate the level and type of public sector facilities where such free care would be provided.

There was pressure on the newly-elected democratic government to manifest evidence of delivery as early as possible. A key message in the ANC's election manifesto was the promise to deliver, with immediate effect, certain key interventions through the RDP. The programme intended to redress past imbalances created by apartheid and address the priority needs of the nation. The RDP contained a number of national goals for children to enhance their survival, protection and development. Amongst health priorities for children that appeared in the RDP was the provision of free health care for children under six years and for pregnant women. Coupled with this was the plan to upgrade old and build new clinics extensively, with a special focus on rural areas.

Exactly 50 years after the Gluckmann recommendations, on 24 May 1994, the first democratically-elected president of South Africa, Nelson Mandela, announced his government's top priorities for his first 100 days in office through a series of presidential-led programmes. The announcement included the declaration of free health care, effective from 1 June 1994, for children under six years of age and pregnant and lactating women.

The underlying rationale for the declaration was that children under six years were the most vulnerable in terms of disease and death, as children under five years of age and especially children under one year had the highest death rates. Similarly, by providing free care to pregnant mothers, the health of newborns would improve considerably as there is strong correlation between regular antenatal visits and quality perinatal care and the health status of and mortality and morbidity outcomes for newborns. Improving access to antenatal care for pregnant women is also critical in reducing maternal mortality, which in turn benefits the long-term health of children. In addition, almost one fifth of all pregnancies occur in teenagers; hence such older children would benefit from having improved access to antenatal care, as well as from better access for their babies. This is important given the high risk of pregnancy complications in teenagers. Thus, the removal of user fees as a barrier to accessing health care was seen as an important step towards improving health services for children.

The policy took effect on 1 June 1994 and was announced in the Government Gazette Notice 657 of 1994 (Republic of South Africa 1994). Free health care was literally an overnight institution at public sector health services and was made available to the specified target groups in the specified facilities across the country, regardless of staff and facility capacity.

The policy applies to the following health care facilities:

- State health care facilities, which include hospitals, community health centres, clinics, mobile clinics and satellite clinics.
- State-aided hospitals that receive more than half of their expenditure in subsidies from the State.
- District surgeons (Although there are some full-time 'district surgeons' who provide medico-legal and other services, the majority are private, general practitioners working in rural areas and who also provide mainly curative services to 'state patients' on a part-time basis and are reimbursed by the government for these services.)

The policy however excludes persons (and their dependants) who are members of medical aid schemes and non-South African citizens who visit South Africa specifically for the purpose of obtaining health care.

Pregnant women (of whom approximately one-fifth are teenagers/children) are eligible for free health care at the specified facilities from the time of diagnosing the pregnancy, or if a pregnancy complication has developed, for up to 42 days after the termination of the pregnancy or until such time that the complication has been cured or the condition stabilised.

There are no specific stipulations regarding the type of conditions that render children or pregnant women eligible for free health care, and not any limitations on the level at which such free health care would be provided. Thus, these groups are eligible for free care at primary, secondary and tertiary levels of health care.

The free health care declaration departed somewhat from the original intention, which was to make primary level health care free, to make the treatment of children with referral letters to hospitals free, and that user fees at hospitals were still to apply where children bypassed the system. The rationale of the original intention was that users would seek care at the appropriate level and be discouraged from going straight to a hospital for conditions that could easily be treated at lower levels of care. The downside of this approach was that in the most marginalised and poor areas, primary level facilities were often unavailable and the hospital was, in many instances, the first level of health service.

The second phase following free health care to children under six and pregnant women was announced in April 1996 in a parliamentary budget debate, when health care for all citizens, regardless of their income, was declared free, with similar provisions as above, but only at the primary level of care. This meant that *all* children thus benefited from free health care at primary level facilities, but still had to pay at hospitals.

The third phase was announced on 1 July 2003 by the Minister of Health, Dr. Manto Tshabalala-Msimang. This announcement made provision for free health care for people with moderate and severe disabilities. The conditions for children were similar to those that originally applied to children under six years, where children of any age with moderate to severe disabilities could attend all health services free of charge. There was however a lack of clarity as to whether this included the provision of assistive devices. This provision only refers to children with specific physical and mental disabilities and does not include other chronic conditions such as asthma, diabetes and HIV, for example.

In July 2004, exactly 10 years after health care was first declared free for children under six years and pregnant women, the new National Health Act of 2004 was enacted after several years of deliberations on its provisions. This law legally binds the Department of Health to provide free health care for children under six years and pregnant women at all the facilities as specified in the original declaration, as well as for all citizens using public sector primary level facilities. This will remain until this Act is either amendment to the contrary or repealed.

The waiving of user fees in the public health sector, as a means of improving access to health services for especially the poor, can thus be classified as a universal mechanism at the primary health care level, while targeting at the hospital level of care continue according to targeting criteria such as age and the presence of moderate to severe disabilities. It is also an example of a phased-in mechanism (or progressive realisation) where its original targeting was based on age and condition as indicators of vulnerability (pregnancy being the 'condition'), irrespective of health needs and level of care. This was later extended to include level of care and the presence of specified disabilities. At secondary and tertiary hospital levels, a means test for children six years and older without moderate or severe disabilities and who are not covered by any form of medical aid, is applied. This means test is based on family income, with charges for children based on a pre-determined sliding scale. The current application of free health care is illustrated in Table 1.

Table 1: The current provision of free health care to children by level of care

Level of health care	Children under six years	Children 6 – 18
Primary level facilities (clinics, community health centres, district hospitals)	Free	Free
Secondary hospitals	Free for all children, unless their family's income is more than R100,000 per annum or they are covered by a medical aid	Free for children with moderate to severe disabilities. All other children have to pay according to a means-tested sliding scale based on family income if not covered by medical aid. Children on medical aid have to pay according to specified medical aid rates.
Tertiary hospitals	Free for all children, unless their family's income is more than R100,000 per annum or they are covered by a medical aid.	

3.3 Implementation

Current service practices

The original free health care policy for children under six years and pregnant women, as well as the policy on free primary level care for all citizens, are working well in the sense that none of these groups are required to pay user fees. Thus the policy is implemented appropriately.

However, hospital practices in terms of user fees seem to vary for children older than six years. This was revealed in a snapshot of current user-fee practices at hospitals across three provinces and at different levels of service delivery, undertaken for the purposes of writing this paper. District, regional and tertiary level hospitals in each of the three provinces were asked about their user-fee practices with regard to children.

Some hospitals use a sliding scale based on the income of the caregivers to determine the user fees (pers. comm., fees clerk at Red Cross Children's Hospital, 2005). Other hospitals charge a flat rate that varies from facility to facility.

It was indicated at all the facilities[2] that children under six years who are not covered by a medical aid can access the facility free of charge. Children older than six years are charged according to a fee sliding scale, based on the annual family income. The sliding scale varies between secondary and tertiary hospitals. The minimum amount charged for hospital user fees ranged from R8 to open a patient folder, with everything free thereafter, to R13 for an outpatient visit and R26 in total for an admission of fewer than 30 days. Hospital superintendents appeared uncertain as to whether children with moderate and severe disabilities who require assistive devices will have to pay for those devices. From their responses it seems that a fee is charged for assistive devices. This requires further exploration.

An example of a fee sliding scale used by a large, tertiary children's hospital is displayed in Box 1.

Box 1: Example of a fee sliding scale for children at a tertiary level children's hospital

Children under six years are treated completely free of charge if not covered by a medical aid fund or if the income of the family does not exceed R100,000 per annum.

Four income categories exist, namely categories H0, H1, H2 and H3/private. Income is assessed as combined gross family income of the parent(s) or primary caregiver(s). Proof of income has to be submitted.

H0: Caregivers with children older than six years and who fall into this category do not have to pay. The category includes families where caregivers are formally unemployed and supported by the Unemployment Insurance Fund. Proof of unemployment has to be provided. In addition, caregivers of children that receive social welfare grants such as the Child Support Grant, the Care Dependency Grant, the Single Care Grant and Maintenance Grants are exempt from paying fees. Children who are dependent on adults who get social pensions such as the Old Age Pension are also classified as H0 candidates.

H1: Combined family income of R0 – R50,000. Such children are charged a flat rate fee. Fees, as from 1 January 2005, are R70. This fee thus doubled from R35 in 2004.

H2: Combined family income of R50,000 – 100,000. They are charged a service rate plus 50% of the full uniform patient fee schedule (UPFS) charges that include consultation and all procedures. The service rate for 2005 is R235 per visit, excluding services and procedures.

H3: Combined family income of R100,000 or greater, or if children are covered by medical aid. Service fee per visit, excluding services and procedures, is R338. Full costs of consultation and procedures are charged.

Source: Personal. communication. Mr. Poggenpoel, Fees Office, Red Cross Children's Hospital, Cape Town, February 2005.

All the hospitals denied ever turning away children whose caregivers were unable to pay. Yet, children and caregivers had varying experiences in this regard, as indicated in research

[2] Western Cape facilities included the Red Cross Children's Hospital, Eben Donges Hospital in Worcester and Wesfleur Hospital in Atlantis. Eastern Cape facilities included Frere Hospital in East London and Frontier Hospital in Queenstown. Northern Cape facilities included the Kimberley hospital complex, Gordonia Hospital in Upington and Calvinia Hospital in Calvinia

conducted on the health and social needs of orphans and vulnerable children in the context of HIV/AIDS (Giese, Meintjes, Croke & Chamberlain 2003). A number of children and caregivers reported being turned away from hospitals if they did not have the required fee. A service provider at a large tertiary level hospital confirmed this in his observation that, "despite the emphatic denial of any child being turned away, admission clerks do turn children away if their caregivers or parents are not able to pay" (pers. comm. P. Jeena, 2002). Anecdotally it appears that there are instances where children who are not able to afford the hospital fees sometimes delay attendance at the risk of their condition getting worse. This situation is potentially worse for children living in households where there is a total absence of adult caregivers and when health workers are not prepared to see young children that are not accompanied by an adult.

Despite the fact that user fees have been removed as a barrier to access to health care at the primary level, circumstances and practice suggest that user fees at hospital level may still provide a barrier to access. In addition, other barriers to access remain. Giese et al (2003) found in their research that poor children living with sick and dying caregivers are often unable to access health services for a number of reasons. Some of these include:

- A lack of services in rural and informal settlements.
- Specific health interventions not being available at health facilities. A rapid appraisal of primary health care services (Giese & Hussey 2002) showed that essential health interventions for children infected with HIV were not available in the majority of clinics throughout the country.
- Grandmothers and older caregivers not knowing about mandatory, essential health services for young children, such as the immunisation programme.
- Unaccompanied children, in the context of children living without adult caregivers, being turned away from health services.
- Medicines not being readily available to children who need it.
- Significant transport costs to get to health facilities.

The government's commitment to provide free health care for children remains a step in the right direction, but the follow-through in addressing other barriers to access remains a challenge. This for example includes the provision or subsidisation of transport to and from health facilities in areas where such facilities are situated far from communities; the provision of child-friendly services where children are appropriately prioritised and correctly-trained staff, medication, support services and referral mechanisms exist; and where sufficient budgetary allocations are made to ensure the provision of good quality child health services.

Evaluation of free health care

A year after free health care for children under six years and pregnant women was implemented, the Health Systems Trust commissioned a national evaluation of the implementation. The study was undertaken by the Child Health Unit at the University of Cape Town (McCoy 1996). The evaluation was conducted at numerous facilities across four provinces, with such facilities operating at different levels within the health system. Key findings from this and other evaluations are outlined below.

a. Health service utilisation

The evaluation by McCoy showed that the policy indeed did have an impact on the utilisation of health care services by young children and pregnant women. In this study utilisation data was collected from numerous health facilities (clinics, mobile clinics and hospitals) across four provinces and average monthly attendances compared for the 12 months immediately before and 12 months immediately after the introduction of the policy.

A significant increase in utilisation of public health facilities by pregnant women and children under six years occurred, suggesting that the practice of user fees did act as a deterrent to people accessing public sector services before they were abolished. The attendance figures 12 months before and after the policy was introduced showed a general increase of between 20% and 60%. The increase exceeded 100% in only a few facilities. This increase in attendance was not universal, as a few facilities showed no increase and a few actually experienced a drop in attendance. In most facilities though, both the number and proportion of paediatric patients increased.

The analysis showed that the utilisation of both outpatient and antenatal units increased at most facilities. In facilities where antenatal clinic attendance and booking visits increased, a rise of up to 16% for booking visits and 20% for antenatal clinic visits were recorded. No significant differences were found between utilisation in rural areas compared to urban areas. An interesting finding from the Alexandra health centre in Gauteng Province, where paediatric outpatients continued to be charged R5 for visits for 16 months after the introduction of the policy, was that it showed only a slight rise in patient numbers. In contrast, the clinics surrounding Alexandra showed increases in attendances immediately after the policy was introduced, hence reiterating the impact of user fees on patients' ability to access the service.

A subsequent national evaluation of free maternal care in South Africa suggested that there was a general increase in antenatal attendance in eight out of the 13 sites that were included in the study, and a mean increase of 14.9% across all sites (Schneider & Gilson 1997). A more in-depth study undertaken in the Soweto area for 32 months post-free primary health care showed an initial increase but thereafter a drop in attendance to levels lower than those pre-free health care. The authors further suggest that the provision of free health care seems to have increased the demand for curative care at primary level, which crowds out the ability of nursing staff to engage in preventive health activities. The free health care policy thus comes at a price.

A localised evaluation in the Hlabisa area of KwaZulu-Natal Province was conducted in a similar fashion to the study undertaken by McCoy. This evaluation examined the attendance of under-six-year-olds for a 30-month period before the introduction of free primary level care through to an 18-month period after the introduction of the policy (Wilkinson, Sach & Abdool Karim 1997). This evaluation also compared the proportions of children referred to

hospitals during the two periods. The evaluation showed an increase in the use of curative services by children, but not of preventative services, as the latter have always been free.

The McCoy evaluation showed that the referral rate to hospitals decreased, suggesting that the health problems that children presented with were either of a mild nature or that, due to earlier presentations, fewer complicated cases arose that did not require hospital care. There appears to have been a rise in "inappropriate" presentations at hospital level, but not at clinic level. The hospital statistics were not conclusive. In-patient paediatric admissions as a total proportion of all admissions at all hospitals increased, suggesting that more children that were ill enough to be admitted were identified and referred within the health system.

The evaluation further showed that attendance for curative care at a network of mobile service points reportedly increased by 93%, while antenatal attendance decreased by 20%. This further supports the point made by Schneider & Gilson that preventive activities were being sacrificed in favour of curative care.

An interesting finding of the evaluation was the demonstrated impact of other factors on health service utilisation, such as endemic violence, hospital strikes and the national elections, as concomitant sharp drops in attendances were observed during the months when these activities occurred.

A serious deficiency in available evaluation results is the absence of empirical data on whether the poorest have preferentially benefited in terms of increased utilisation from the free health care policies. On the one hand, it is likely that the lowest income groups have benefited from free health care, given that these groups use public sector services more extensively than higher income groups, who often choose to use private providers. The explicit exclusion of medical scheme members from free health care is also likely to have limited leakage of benefits to the non-poor. On the other hand, the removal of user fees does not remove all obstacles to accessing public health services. Given that the most vulnerable will find it particularly difficult to overcome these obstacles to access, it is possible that the utilisation may have increased disproportionately among the least vulnerable within low-income groups. Thus, the precise benefit incidence of the free care policies should be established.

Furthermore, none of the evaluations addressed the possible impact of free health care on child health outcomes. This is possibly due to the fact that health outcomes are dependent on many other factors and that it would be difficult, at the best of times, to show any direct causal relationship between free health care and health outcomes.

No other national evaluations that examined the possible changes in service utilisation by children beyond the first year of the implementation of the policy were found.

b. Health worker and health service user perceptions of the policy

The McCoy evaluation demonstrated general public support for the policy, but a general negative feeling towards the policy by health workers. Responses from health workers indicated that there were many ambiguous feelings on the free health care policy (McCoy 1996). On the positive side, health workers did feel that the policy promoted the general health of the population, benefited poor and malnourished children and prevented serious illness and death in children and pregnant women.

A more in-depth study of nurses' views on the implementation of various health policies, including the free health care policy, supported many of the points highlighted by McCoy (Walker & Gilson 2004). Nurses felt that the implementation of free health care was rewarding for them personally and that they felt more "professionally fulfilled as a result of the free care policy" due to the knowledge that they were "able to help more people in the community, were able to improve their diagnostic skills and gain professional experience".

McCoy found that users of health services generally supported the policy and felt that access was improved for marginalised groups such as those living in rural areas, informal settlements and workers on White-owned farms. The popularity of the policy with the public was also reiterated in the Hlabisa evaluation.

However, many negative feelings towards the policy were expressed by health workers. One of the key reasons for these feelings expressed was that many health workers first heard of the policy through the media. In addition, they were not consulted about their experiences of the initial policy before it was extended to all persons at a primary level, and felt discontented that they were not involved in the planning and implementation of the policy. They also felt that it was imposed on them without a proper assessment of available resources and capacities.

Health workers further questioned the availability of funds for the provision of free health care, with no money apparently available to improve their salaries and conditions of service. They felt that the free health care policy aggravated a number of existing problems within health care facilities such as staff shortages, poor working conditions, poor staff morale and shortage of medicines. In the Walker and Gilson evaluation, health workers expressed strong views on the negative impact of the policy on them as health workers, citing that shortages of resources such as equipment made it difficult to operate in their working environment. The interviewees did not have a problem with the principle of the policy, but certainly with the poor planning and preparation that accompanied its implementation. They also felt that patients do not value services that they don't pay for. The Hlabisa evaluation (Wilkinson et al 1997) reiterated previous findings in other studies, such as that staff in clinics and hospitals are overworked and stressed by the increased workload.

c. Impact of free health care on drugs and other resources

The impact of free health care on drug expenditure was inconsistent and difficult to interpret in the McCoy evaluation. There were no consistent trends between different types of facilities, geographical areas or levels of care. Some facilities showed a real increase in drug expenditure of between 4% and 99%, whilst others showed a real decrease of between 4% and 34%. It was difficult to attribute these changes to free health care provision, as provinces were not able to provide breakdowns of their drug expenditure by level of care. Drug expenditure for selected tracer drugs that are mostly used at primary level showed an increase in expenditure of 17% for micronutrient supplements to 92% for a commonly-used antibiotic. The qualitative responses by nurses in the Walker and Gilson evaluation strongly suggested frequent instances where drugs were not available and equipment unavailable or not working – leaving nurses feeling disempowered and unable to do their jobs properly. They did recognise, however, that these problems were systemic rather than the effect of a single policy.

McCoy demonstrated a small loss of revenue to the public sector to the order of less than 5%, which, in the face of the overall health budget, is relatively insignificant.

Despite the challenges that were highlighted in the various studies, free health care at the primary level was subsequently extended as described earlier, with little visible effort to address the systemic problems of health worker stress primarily due to patient overload and problems with drug and equipment supplies. No subsequent evaluations, aside from Walker and Gilson's evaluation of health worker perceptions, were undertaken after the extension of free health care to all at primary level, and to the disabled.

Despite the significant increase in primary health care budgets/expenditure before and during the first and second phases of the introduction of free health care, the main problem was that the policy was implemented almost with immediate effect during both phases, giving health workers little time to plan adequately for implementation and to stockpile drugs in anticipation of increases in utilisation. Thus, the problem of poor implementation processes, highlighted by McCoy as well as Walker and Gilson, was perpetuated.

Health budget trends of relevance to the introduction of free health care

Without careful planning for the implementation of a health policy, there can be adverse consequences for the health system. Appropriate planning includes adequate consultation with front line health workers and the mobilisation of support from them, as well as the provision of adequate financial and other resources to close any gap arising from declining fee revenue and increased utilisation. It is therefore important to review changes in the allocation of budgetary resources to the South African health system around the time of the introduction of free health care policies to assess the extent to which resource supplementation considerations were taken into account. While it is impossible with existing information systems to consider whether or not additional resources were made available towards health services for young children and pregnant women, it is possible to evaluate trends in primary health care expenditure.

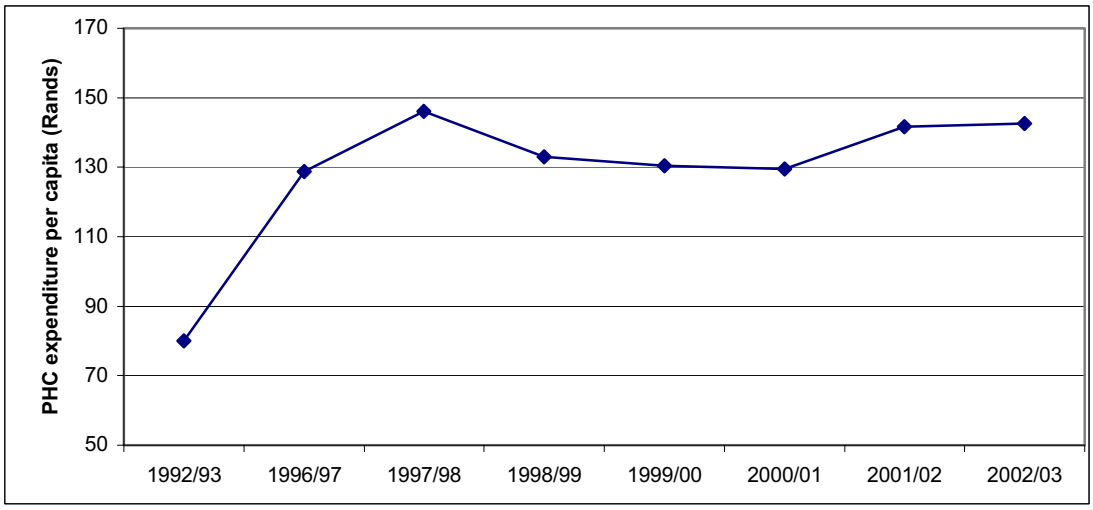
A recent evaluation of trends in publicly-funded primary health care services found that expenditure on these services increased by an average of 15% per annum in real terms (i.e. after inflation has been taken into account) over the period 1992/93[3] to 1996/97 (Okorafor, Thomas & McIntyre 2003). This indicates that there was a dramatic prioritisation of funding for primary health care services after the first democratic elections in 1994, even before free primary care services were introduced for the general population on 1 April 1996 (i.e. at the start of the 1996/97 financial year). There was a further real increase of 16% in primary care spending in 1997/98 compared with that in 1996/97, but there was a 7% decline in real expenditure in 1998/99 and almost no change (0.2% real increase) in 1999/2000. This was largely attributable to stagnation of the overall government health budget during this period.

Thereafter, expenditure began to increase gradually in real terms again, but at a much slower rate that in the mid-1990s. A similar trend is evident (see Figure 1 on the next page) when real expenditure is considered in per capita terms (relative to the population dependent on publicly-financed health services, i.e. after removing those covered by medical schemes). Due to the fact that the population grew over this period, declines in the per capita trend are more pronounced and increases less impressive than when merely focusing on expenditure changes. It is appropriate to consider expenditure trends in relation to the population, excluding those covered by medical schemes, given that this group is

[3] The 1992/93 data are based on the first comprehensive Health Expenditure Review undertaken in South Africa, and care was taken to ensure comparability of these data with those in the late 1990s and early 2000s.

explicitly excluded from eligibility for free health care. In addition, it is well established that medical scheme beneficiaries very seldom use public sector primary care services.

Figure 1: Trends in real per capita expenditure on PHC services, 1992/93 to 2002/03



Sources: Okorafor et al (2003); data for 1992/93 from McIntyre, Bloom, Doherty & Brijlal (1995); data for 1993/94 to 1995/96 not available; data for 1996/97 to 2002/03 from National Treasury (2003).

It is encouraging that significant additional resources were directed towards supporting primary health care services before and during the introduction of the free health care policy. Real per capita expenditure on these services almost doubled over a period of six years. This particularly would have assisted in employing additional staff within existing and new primary care facilities, which would have eased the burden of sudden increases in utilisation after the introduction of free primary care services. However, it is of concern that expenditure levels were not sustained at this level and in fact declined quite significantly in real per capita terms over a three-year period (1997/98 to 2000/01). Although expenditure increased again in the early 2000s, it has not yet returned to the real per capita levels experienced in 1997/98. This likely has adverse implications for sustaining the improvements in access to primary health care services promoted by the free care policy.

It is also important to note that there are considerable disparities in the level of publicly-funded primary health care expenditure between provinces (see Table 2 on the following page). The poorest provinces (Mpumalanga, Limpopo, Eastern Cape, North West and KwaZulu-Natal) have the lowest levels of per capita expenditure. Expenditure in Mpumalanga is almost four times lower than in Gauteng. It is of considerable concern that those provinces where populations face the greatest geographic access constraints – and where they have the greatest need to access free health services given their dramatically lower ability to pay – are those which have the lowest levels of publicly-funded expenditure on these services. A recent modelling of the resource requirements to provide a comprehensive package of primary health care services indicates that about R300 per capita (in 2003/04 terms) would be the 'ideal' expenditure level (Chitha, Cleary, Davauid, Jikwana, Makan, Masilela, McIntyre, Pillay, Sebokedi, Thomas & Wilson 2004). All provinces are below this target, but the poorest provinces would need to experience four- to five-fold increases in primary health care expenditure to meet this target.

Table 2: Primary health care expenditure by province, 2002/03

Province	PHC expenditure per capita (Rands)
Eastern Cape	89
Free State	173
Gauteng	225
KwaZulu-Natal	154
Limpopo	136
Mpumalanga	62
Northern Cape	187
North West	138
Western Cape	202
National	**143**

Source: Okorafor et al (2003); data derived from National Treasury (2003)

In summary: While the growth in real public sector expenditure on primary health care services around the time of the removal of fees for these services would have supported the policy implementation process, this resource prioritisation has not been sustained. Of even greater concern is the continued differential in primary health care expenditure between provinces relative to the need for public sector health services, with the poorest population groups continuing to be faced with the most severely under-resourced primary health care services.

4. The contrasting experience of other African countries charging for health services and free health care provision

Given the South African experiences on free health care, it is useful to reflect on lessons and experiences from other countries to compare and contrast the strengths and challenges of providing free health care as a means of delivering more equitable health services for all. Despite the different political and macro-economic contexts in other African countries, the wealth of experiences from these countries highlight the pros and cons of user fees and their impact on user access, health service utilisation, health service workload and contribution to revenue generation for the health sector.

In addition, very useful lessons on the impact of user fees on households have emerged. This is critical in understanding why there has been a recent surge of interest in the possibility of removing user fees among various African countries. The rationale for the introduction of free health care policies in South Africa was based on similar concerns about the adverse consequences of user fees raised in the following review of African experiences on health care provision. Although South Africa is an upper-middle income country and most other African countries fall in the low income country category, many residents of rural and peri-urban areas in South Africa are as impoverished as their counterparts in other African countries. They hence have similar experiences of the burden of having to pay for health services on an 'out-of-pocket' basis. The following section thus

provides a comparative analysis of user-fee experiences from countries across Africa and sets the scene for briefly reviewing the recent removal of fees in Uganda and Kenya.

4.1 Comparative analysis of user fees and their consequences in selected African countries

History, motivation and objectives of user-fee policies

Some African countries, such as Ethiopia, Namibia and South Africa, have a long history of charging user fees for public sector health services (Gilson 1998). In contrast, many countries had a tradition of providing health services that are fully subsidised by the government, and only implemented user fees in the late 1980s. In the vast majority of African countries, any fees charged were nominal or 'token' and were not seen as a cost recovery mechanism. However, by the mid-1990s, most African countries (28 of the 37 countries surveyed by Nolan & Turbat 1995) had an explicit policy of charging non-token user fees for government health services.

There were two major contributory factors to this rapid growth in user-fee policies in African countries. First, various international organisations vociferously advocated for the introduction of user fees (de Ferranti 1985; Akin, Birdsall & de Ferranti 1987; Jimenez 1987; Vogel 1988). The World Bank was in a particularly strong position to influence policy in African countries as user fees and other cost-recovery mechanisms were often an integral part of World Bank loan conditions and associated Structural Adjustment Programmes (SAPs). Secondly, macro-economic difficulties in many countries (related to low or negative economic growth and increasing indebtedness) limited the resources available to governments for financing and providing health services (Bennett 1992; Gilson & Mills 1995). Government resources were seen as inadequate to meet the growing health needs of populations, and ways of recovering at least some of the costs of health services were seen as necessary.

From the perspective of national governments, two objectives were most frequently used to justify the introduction of, or increase in, user fees. These were the objectives of generating revenue and improving the quality of public sector health services, particularly through the availability of medicines at facilities (Nolan & Turbat 1995). It was anticipated that user fees would generate significant revenue to cover the health care financing gap facing government health services in African countries. While in hindsight this proved to be wholly unrealistic, the generation of revenue was a key motivation and objective of charging user-fee policies.

International institutions that favoured user fees as a cost-recovery mechanism also provided a range of other justifications and intended goals in adhering to this practice. They argued that user fees prevent unnecessary or 'frivolous' health service utilisation and send 'price signals' to patients about the cost of services at different levels of care, thereby promoting appropriate use and adherence to referral mechanisms (de Ferranti 1985; Akin et al 1987; Griffin 1988). Another motivation was that health service providers are more likely to be responsive to patients' needs and concerns and will provide good quality care when patients are paying for services. Finally, it was put forward that fees would promote equity as those who could afford to pay would ease the burden on the government, who in turn could concentrate its resources on the poor. However, as will be shown below, many of these argued 'benefits' of fees were neither realistic nor realisable.

Consequences of user fees

The consequences of user fees and free health care are best examined in terms of impact on health status; access to health services as measured by service utilisation; budgetary impacts, both at a micro or household level and at the macro level of government health budgets; and on health services.

Very little, if any, data exists that can demonstrate a direct link between free health care and change in health status. Evaluations primarily concentrate on whether – and to what extent – access has improved, how the policy affected health service workload and health worker morale, and what the health budget implications were. Important work has been undertaken in terms of the consequences of user fees for the poor in general and for households specifically. The following sections reflect on some of the data from selected African countries.

a. Revenue generation from user fees

The reality of user-fee effects is very different from the argued 'benefits'. Various studies indicate that fee revenue in African countries has ranged from less than 1% of recurrent government health care expenditure in Burkina Faso to nearly 15% in Ghana. The Ghanaian experience is exceptional by international standards and this level of revenue generation could not be sustained. As a result, it dropped to approximately 6% of recurrent expenditure in the 1990s (Nolan & Turbat 1995). On average, fees have tended to generate revenue of less than 5% of total operating costs (Creese 1991); although they may cover a sizeable proportion of non-salary operating costs (Creese & Kutzin 1995). However, these studies do not provide an indication of the collection and other fee-related administration costs which translate into even lower net revenue (Creese 1991).

Revenue generating potential is also influenced by whether there are incentives for service providers to collect such fees (Vogel 1988; Shaw & Griffin 1995). If all revenue collected is returned to the Treasury or Ministry of Finance, there is no direct or visible benefit to the health sector; thus there is little incentive for fee collection (Mwabu & Mwangi 1986; Russell & Gilson 1995; Creese & Kutzin 1995). While revenue generation can be increased by the incentive that fees collected at local facilities could be used in improving the quality and/or the quantity of services, this may be in conflict with equity goals (Mwabu & Mwangi 1986; Gertler, Locay & Sanderson 1987). The proportion of fee revenue retained at facilities influences the ability to redistribute resources to facilities that are under-funded, which tend to be those least likely to be able to generate their own revenue. Another adverse equity effect is that health care providers are less likely to exempt eligible patients from fees if health workers and their facility stand to benefit from the revenue generated. These adverse consequences arise when revenue generation goals are given priority over equity goals (Gilson, Kalyalya, Kuchler, Lake, Oranga & Ouendo 2001).

b. Consequences of user fees in terms of efficiency in provision and use

User fees can create perverse incentives for health care providers and lead to supplier-induced demand. For example, certain schemes which prioritise fees on medicines – and which allow some of the fee revenue to be used for the payment of health workers' salaries – provide an incentive to over-prescribe (Kanji 1989).

There is limited evidence to support or refute the assumption that user fees can promote allocative efficiency by encouraging patients to use the correct referral route. This has occurred in some countries, such as Eritrea, which introduced a graduated fee system (i.e.

low fees at primary care facilities and significantly higher fees at referral hospitals). The result was a dramatic drop in outpatient visits to referral hospitals, while health centre visits increased (Asbu 1999). However, in Zimbabwe it was found that the higher fee levels at referral facilities did not offset the tendency of patients to bypass primary care facilities. This is due to the higher perceived quality of care at referral facilities, which tend to have better medicine supplies and are staffed by doctors, and the fact that in some cases a referral hospital is the nearest facility (Hongoro, Musonza, Macq & Anozie 1998). Therefore, in order to achieve location efficiency objectives, an extensive network of high quality primary care facilities is required.

c. Service utilisation consequences of user fees

The consequences of introducing or increasing fees on the utilisation of health services have been extensively documented. Fees obviously tend to reduce utilisation as it places a financial burden on patients at the time of using a health service. Some argue that user fees will mainly prevent unnecessary or frivolous health service utilisation. However, this argument ignores the fact that most patients are not in a position to assess whether symptoms are serious or whether they can be ignored. It also does not recognise that the use of health services is seldom costless. Time, transport and other costs of obtaining health care can be significant and will already deter unnecessary utilisation (Abel-Smith & Rawal 1992). In addition, there is no empirical evidence that fees particularly deter 'frivolous' use. Indeed, a study in Swaziland found that the most substantial decreases in utilisation following a fee increase were for essential health services such as immunisations (which are not necessarily regarded by communities as worthwhile paying for, given that there is no immediate or direct benefit) and care for children suffering from dehydration (Yoder 1989).

The extent of decline in utilisation associated with user fees varies from country to country but there are very few examples of where fee introduction did not result in a decrease in utilisation. Kenya has the most extensive documentation on the development of user-fee policies and their effects, and their experiences are presented in Box 2 on the next page. Some other country-specific findings are summarised below:

- Fees for government health services in Swaziland increased in the mid-1980s from US$0.25 to US$0.90 for curative services, with preventive services changed from being free to charging a fee of US$0.45.This resulted in a 17% decrease in average attendance at health facilities. About 34% of the overall decline in attendance was among patients who previously paid the least for health care (Yoder 1989).
- In South Africa there was a 9.2% decline in average attendances at a Cape Town day hospital (a curative, primary level facility) after a 50% increase in fees (Frankish 1986). Particular concern was expressed about the decline in attendance by hypertensive, diabetic and asthmatic patients, which was accompanied by an increase in hospital admissions among patients who were no longer attending regular chronic care clinics for monitoring and dispensing of medication supplies.
- The move from nominal fees to active cost recovery with ambitious revenue targets in Ghana (mid-1985) resulted in the utilisation of outpatient services declining by almost two-thirds nationally. Surveys in two regions found that, while utilisation returned to pre-fee levels by 1987 in urban areas, utilisation in rural areas did not recover by the end of the same year (Waddington & Enyimayew 1989a, 1989b).
- A district in Uganda that introduced fees (ranging from US$0.05 to US$0.50 at different facilities), with the revenue retained and managed at a community level,

experienced an average of 21% decline in utilisation (Kipp, Kamugisha, Jacobs, Burnham & Rubaale 2001).

- With the introduction of fees in Tanzania, utilisation levels at three government hospitals in Dar es Salaam that were primarily used by the poor dropped by 50% (Hussein & Mujinja 1997).

Box 2: User-fee experiences in Kenya

The Kenyan government at independence from colonial rule (late 1963) indicated its commitment to provide health services free of charge to citizens. This changed, with disastrous consequences, with the introduction of fees in December 1989. This policy was abandoned and then re-implemented within the space of two years. Policy has now come full circle with the reintroduction of free health care.

Prior to the implementation of user fees, a review of fee options and an estimation of the total revenue that could be generated were undertaken (Ellis 1987). Ellis, an international advisor on fees, predicted that revenue would be between 10% and 22% of the government's total recurrent health care costs, even when charging relatively 'modest' fees. Although the fees introduced were similar to the highest fee structure recommended by Ellis (1987), the revenue raised was however approximately 2% to 3% of the recurrent budget (Mwanzia & Mwabu 1993; Mwabu, Mwanzia & Liambila 1995). The major reason for the discrepancy between predicted and actual revenue is that Ellis assumed that there would be a maximum 20% decrease in utilisation at government facilities, whereas utilisation of services at facilities that charged fees actually fell by approximately 52%. The Kenyan government decided to abolish the outpatient registration fee* in September 1990. Utilisation increased by about 41% thereafter (Mwabu et al 1995).

Although children under five years of age and the indigent were officially exempted from the fees, these groups were not entirely protected. During the period when the fees were in force, the use of government health facilities in one district by those living below the absolute poverty line was more than 30% lower than the use by those with incomes of at least twice the poverty line (Mbugua, Bloom & Segall 1995). Outpatient visits of young children to government facilities increased by 26% after the registration fee was abolished, while the utilisation of government facilities for severe illness episodes in children more than doubled.

During the latter part of 1991 and early 1992, a process of gradually reintroducing outpatient fees was initiated. These fees were *treatment* fees, as opposed to the previous *registration* fees. They were first instituted at major hospitals, then at provincial level hospitals and finally at local facility level (Collins, Quick, Musau, Kraushaar & Hussein 1996). The phased-in introduction of fees, combined with broader fee exemptions than in the 1989/90 experiment (still including children under five years), resulted in much smaller decreases in outpatient utilisation (6%) and a steady increase in revenue. There are unfortunately no published studies that evaluated the impact of fees in Kenya in recent years.

**This was a fee paid on arrival at the facility, which only covered the consultation. There were separate charges for other services, such as diagnostic tests and prescribed medicines. The registration fee generated the major portion of user-fee revenue in the late 1980s.*

The evidence on the consequences of user fees highlights the fact that the introduction or increase in fees can lead to dramatic declines in health service utilisation, particularly for the most vulnerable groups (e.g. the poor and household members who have difficulty in accessing household resources, such as women and children). As indicated previously, this decline is not necessarily related to reduced 'frivolous' use. Indeed, a number of studies show that fees at primary care facilities in particular can deter low income households from seeking care until an illness is severe (Heller 1982; Berman, Ormond & Gani 1987; Gilson 1988; Weaver 1995). This is likely to aggravate poverty as more advanced illnesses tend to require more expensive treatment and will have a more significant adverse effect on ill people's ability to work and generate income (these household level impacts are covered in more detail later in this section). Recent research in Ethiopia highlighted that fees

particularly affect the use of government facilities by the poorest, who increasingly turn to self-treatment and/or the use of informal providers such as untrained drug sellers (Asfaw, von Braun & Klasen 2004). There were similar findings in Ghana where the poor were reported to resort to self-medication as a cost-saving strategy (Asenso-Okyere, Anum, Osei-Akoto & Adukonu 1998).

d. User fees and quality of care

Although the majority of the evidence suggests substantial adverse consequences of user fees for the utilisation of health services, some studies suggest that, if some of the revenue was used to improve quality of care (particularly improved availability of medicines at government facilities), the positive effect of quality care may offset the negative effect of price increases. The reason for this is that patients previously chose not to use government facilities because they knew that they anyway would have to purchase the medicines that they needed from a private pharmacy or an informal drug seller. For example, in an experiment in Cameroon, overall utilisation increased in the long term after fee revenue was used to improve quality of care, especially for the poorest (Litvack & Bodart 1993). Another study in Niger found that the introduction of pilot cost-recovery schemes resulted in increased utilisation levels, again particularly among the poor. A specific component of the pilot schemes was the improvement of quality of care through improved availability of pharmaceutical supplies and training of staff in the use of standardised diagnosis and treatment protocols (Diop, Yazbeck & Bitrán 1995).

However, it has been noted that quality of care must improve rapidly after the introduction of fees (Vogel 1988), or possibly even before the introduction of fees (Gilson 1998), and that such quality improvements require a substantial investment in both fixed and variable costs (Wouters 1995). It is also necessary to sustain quality improvements, which require adequate revenue generation and facility level incentives to strive continually to improve and maintain the quality of care (Gilson, Russell & Buse 1995). It should also be noted that all the studies that included a quality of care component were evaluating localised pilot projects. It is thus debatable whether fee revenue generation will be adequate to improve quality of care (and sustain quality improvements) when introduced on a more wide-scale basis (Gilson et al 1995).

In addition, there appears to be little or no explicit targeting of received revenue to extend and improve services for the poor. As noted by Gilson et al (1995: 380) who conducted an extensive literature review, "no study was found which directly assessed whether fee revenue use has disproportionately benefited the poor or the nature and extent of cross-subsidies within user fee systems".

e. Experience of protecting the poor via exemptions from adverse consequences of fees

These African experiences also clearly demonstrate the ineffectiveness of exemption mechanisms, particularly those aimed at protecting the poor (McPake, Hanson & Mills 1992; Gilson et al 1995; Willis & Leighton 1995). To cite but one example from the myriad of studies on exemptions conducted in different African countries – which all reached similar conclusions – a survey of 17 government facilities in Kenya found that on average only two patients per month received fee waivers, despite 42% of the Kenyan population living below the poverty line (Owino & Were 1999). Over 80% of patients were unaware of the exemptions policy.

The example of Ghana's experiences of fee exemptions is particularly informative and is summarised below.

Box 3: Fee exemptions in Ghana

There are a range of official health fee exemptions in Ghana, including for specific services (those for major communicable diseases, immunisations, antenatal and post-natal care) and for certain services aimed at specified demographic and socio-economic groups (children under five years, pregnant women, the elderly/people above 70 years, and paupers). Most importantly, the Ghanaian government has an explicit mechanism for funding exemptions, which stipulates that health care facilities can submit a statement of fee revenue 'lost' through exemptions to request reimbursement. This is a major innovation as exemptions are 'unfunded' in most countries, leaving health care providers with weak incentives to exempt patients from fees.

Despite Ghana having a relatively comprehensive health care policy, there is considerable evidence that the fee exemption policy is poorly implemented. For example, one study in the Volta region of Ghana found that 84% of patients who were eligible for exemptions did not receive them (Nyonator & Kutzin 1999). A more recent national study found that almost half of the clients interviewed and who were eligible for exemptions had in fact paid for services (Garshong, Ansah, Dakpallah, Huijts & Adjei 2002). Research has also highlighted that the poor very seldom receive exemptions, while the demographic categories (under-five-year old children, the elderly and pregnant women) are more frequently exempted (Adams, Darko, Accorsi, Tetteh, Anemana, Agongo & Banka 2002). Although this is 'good news' from the perspective of improving access for young children and their mothers during pregnancy, it highlights the plight of those who do not fall into these demographic categories and yet are extremely vulnerable as they have very limited financial resources.

Several factors contribute to the 'lower than desirable' effectiveness of exemption implementation practice (Garshong et al 2002). One factor is the lack of clarity among health service providers about the exemption policy (who is exempted and for which specific services). Another factor is that certain patient categories, such as pregnant women, are easier to identify than others. While it is sometimes difficult to establish the exemption eligibility of patients on the basis of age, the most serious problem relates to identifying 'paupers'. There are also obstacles on the health service user side. A national survey of patients found that, while most patients know of the policy, the level of awareness of specific exemption categories is poor. Of even greater concern is that many patients who are aware of their eligibility for exemption sometimes do not exercise their rights due to fear of confrontations with providers. Barriers to seeking and obtaining exemptions are likely to be particularly severe for the poor given the stigma attached to applying for pauper status in a crowded health facility. Finally, funds set aside for exemption reimbursements are insufficient, and there are often lengthy delays in disbursing these funds to care facilities.

Exemption mechanisms for the poor tend to be the least effective. But looking at it from a children's perspective as the primary focus of this paper, it is encouraging that exemption systems targeting specific demographic groups such as young children are generally reported to be considerably more effective, largely because such groups are easier to identify. Nevertheless, if health care facilities are not committed to implementing exemptions, even easily-identifiable groups such as young children will not receive the exemptions to which they are entitled. A very recent study in the Lindi district of Tanzania reports that, although children under five years are eligible for a fee exemption from all health services, only 20% of such children were exempted from fees when admitted to hospital, and 49% were exempted from fees for outpatient care of acute illnesses (Save the Children 2005).

f. Household level consequences of user fees

The mounting evidence on the adverse service utilisation consequences and the inability of exemption mechanisms to protect some of the most vulnerable groups has resulted in questions being raised about the wisdom of imposing fees on users of public sector health services. There are particular concerns about the household level consequences of fees, both in terms of treatment-seeking decision-making (whether or not one seeks care when ill and which providers are used) and their effect on household livelihoods. Unfortunately, the household level studies that have been undertaken do not specifically focus on the impact on children. Nevertheless, deteriorating livelihoods due to the burden of paying for health care have an impact on all members of the household, including children (e.g. reduced food consumption in a household will have adverse consequences for children).

In South Africa, a national household survey of health needs and health care affordability was conducted just after the introduction of free care services for young children and pregnant women. The study showed that 22% of African interviewees reported being refused treatment on the grounds of being unable to pay. Approximately 54% of unemployed Africans and 18% of white-collar workers reported not seeking treatment as they felt unable to pay for it (Hirschowitz & Orkin 1995).

A Tanzanian survey among individuals who had used health services in the preceding four weeks indicated that 84% of rural dwellers found it either difficult or very difficult to find money for health service utilisation, while 81% of urban dwellers experienced similar problems (Abel-Smith & Rawal 1992). The 1994 Demographic and Health Survey in Zimbabwe indicated that 42% of the urban poor and 14% of the rural poor cited inability to afford health care fees when indicating why they had not sought care for an illness that they experienced in the previous month (Bitrán & Giedion 2002). Similar results were found in many other African country studies.

The direct costs of obtaining health care can account for a substantial proportion of households' income. Payments for health services and medicines accounted for an average of 4% – 5% of household incomes in the African countries surveyed by Makinen, Waters, Rauch, Almagambetova, Bitran, Gilson, McIntyre, Pannarunothai, Prieto, Ubilla & Ram (2000). When other direct costs associated with obtaining care (such as transport costs) are included, some studies have found that total direct costs can be as high as 10% of household income (Lucas & Nuwagaba 1999). The direct costs of long-term potentially fatal illness, particularly AIDS, have the most devastating effects on households. A study in Tanzania has estimated that the direct costs of treatment for a person living with AIDS during a six-month period is about 64% of per capita household income for the same period (Tibaijuka 1997). There is consistent evidence that the heaviest burden of health care costs, particularly those that are considered catastrophic, falls on the poorest households (Xu, Evans, Kawabata, Zeramdini, Klavus & Murray 2003). For example, a study in Malawi found that the cost of malaria to households was over 7% of their income on average; but for the poorest households, these costs were as much as a third of their income (Ettling, McFarland, Schultz & Chitsulo 1994).

There is growing international evidence that health care costs can plunge households into poverty and that the likelihood of a poor household ever being able to move out of poverty diminishes when confronted with illness-related costs (Whitehead, Dahlgren & Evans 2001). While this particularly relates to catastrophic illness, even routine ambulatory care with so-called nominal fees can worsen the situation of extremely poor households. In

order to cope with the costs of ill-health, households use strategies such as reducing consumption (including of basic necessities), selling assets and borrowing (McIntyre, Thiede, Dahlgren & Whitehead 2005). A recent study in Ethiopia found that households which had used available cash to pay for health care had intended to use the money for basic consumption needs including food, fuel, clothes and education (Russell & Abdella 2002). Assets sold may include those that are essential to the household's future livelihood, such as livestock and land. A study in Asia indicated that 60% of forced land sales were due to illness (Corbett 1989).

Borrowing to cover health care expenses is extremely widespread in Africa. A survey in Tanzania found that 40% of respondents had borrowed money to pay for health services used in the preceding four weeks (Abel-Smith & Rawal 1992). Another study found that between 25% and 49% of respondents in surveys in Kenya, Uganda, Nigeria, Guinea and Burundi borrowed money from family and friends to pay for health services (McPake, Hanson & Mills 1993). They have noted (1993:1391-1392) that, "the evidence suggests that when ill, most people seem to find amounts of money which appear large in relation to their regular incomes. This is probably a tribute to the informal risk sharing mechanism of the extended family and other community support mechanisms. Nevertheless, it highlights the plight of those who fall through this safety net for whom even charges for very basic care may be prohibitive".

Although the above experiences refer to households in general, they have direct relevance for children. Given that young children more frequently need health services than adults, the coping strategies adopted (e.g. selling assets and borrowing) often relate to obtaining cash to access health services for children. The impact on livelihood also affects children, for example when funds are no longer available to cover school fees.

The evidence about the adverse consequences of user fees for household livelihoods is so overwhelming that even the arch-protagonist of user fees in the 1980s and 1990s, the World Bank, has acknowledged that, "Out-of-pocket payments for health services – especially hospital care – can make the difference between a household being poor or not" (Claeson, Griffin, Johnston, McLachlan, Soucat, Wagstaff & Yazbeck 2001:1). This indicates that alternative financing mechanisms such as insurance may be preferable. Another institution that has historically supported user fees, the US government, took a bold step when in its 2001 foreign appropriations bill reports that it required the US Congress to oppose any World Bank, International Monetary Fund or other multilateral development bank loan which includes user fees for basic health or education services, and to report to Congress within 10 days if any loan or other agreement is approved which includes such fees (US Network for Global Economic Justice 2003).

There is increasing international advocacy for the removal of fees, particularly at the primary health care level, which would benefit all people (including children) who are dependent on publicly-funded health services. For example, the British government's foreign aid organisation, the Department for International Development (DfID) commissioned research to explore the feasibility of abolishing fees for primary health care. It is of particular importance from the perspective of this study that Save the Children are embarking on an advocacy initiative calling for free access to quality basic health services for all, as they believe that this is the most effective strategy for ensuring that children access services when needed. Some African countries, most notably South Africa, Uganda and Kenya, have already abolished all or some user fees, while others such as Tanzania are currently considering such a policy decision (Laterveer, Munga & Schwerzel 2004).

4.2 Recent initiatives to introduce free health care provision

Earlier sections clearly indicated that there were substantial adverse consequences from the introduction of user fees, particularly in relation to reduced utilisation of health services, and the greatest impact on household livelihoods for low income and poor households. It was also shown that exemption mechanisms are ineffective at protecting the poor due to difficulties in identifying the poor. It could be argued that the most effective way of protecting poor households from the potentially catastrophic costs of health care is to provide free care at public sector facilities (and if government subsidies are available, potentially also at mission facilities)[4] for all users, although this will result in 'leakage' of benefits of free care to the non-poor. It is beneficial to review the experience of those countries that have introduced free health care to assess whether the adverse consequences of user fees are reversed (e.g. by evidence of increased utilisation and particular benefits for the poor) as a result of a free care policy.

Uganda introduced user fees on a universal basis in 1993 in order to meet a World Bank loan conditionality (Okuonzi 2004). Although revenue generation was relatively low (generally less than 5% of expenditure) it was an important source of funds for supplementing health worker salaries, maintaining facilities and purchasing additional drugs (Burnham, Pariyo, Galiwango & Wabwire-Mangen 2004). However, there were growing concerns about the consequences of user fees, particularly for the poor (Burnham et al 2004). In 1999, a participatory poverty assessment highlighted the extent of the impact on the poor and the level of grassroots dissatisfaction with the policy (Okuonzi 2004; Yates 2004).

User fees at public sector facilities were abolished in March 2001, with the exception of private wards (Yates 2004). Various studies have shown that utilisation of health services increased immediately and dramatically. One study of 78 health facilities in 10 districts, using data for eight months before and 12 months after the removal of fees, found that the mean monthly number of new visits increased by 53%, although in the case of children <5 years of age the increase was only 27%, while repeat visits increased by 24% overall but by 81% for children <5. The researchers were not able to postulate as to the reason for this pattern of utilisation increases in young children. Although immunisations, antenatal services and family planning had always been free, utilisation of these services also increased (by 17%, 25% and 32% respectively) after the removal of fees (Burnham et al 2004). Two years after the abolition of fees, sustained utilisation increases of 77% were recorded (Yates 2004).

An extensive study using the first and second Ugandan National Household Surveys (conducted in 1999/2000 and 2002/03 respectively) and data from the Health Management Information System highlighted that the poor had particularly benefited from the removal of fees (Deininger & Mpuga 2004). Although the incidence of reported illness in the previous 30 days was similar in the two surveys (of slightly less than 30%), the percentage of those who were sick and who sought professional care increased from 69% to 79%, while the number of days when the sick person was unable to work declined from 8.3 to 7 days on average. In addition, 30% of those who did not seek care cited inability to afford health care as the reason in 2002/03, compared to 50% in 1999/2000. The poor benefited most from the

[4] This will clearly not solve access problems fully as the distribution of public health care facilities is poor and many rural communities have no option but to use private providers. Mission and other NGO facilities are an important source of care in rural areas in many African countries, but often the primary source of care for poor rural communities is that of informal drug sellers.

abolition of fees, utilisation of health services when the ill increased from 58% to 70% in the case of the poorest quintile, and from 80% to 85% for those in the richest quintile.

A key finding of this study was that, although there were substantial differences between the rich and the poor in their use of health services when ill and while fees were in place, these differences were completely eliminated in the case of children (but not in the case of adults) after the removal of fees. Once again, the researchers did not explore the underlying reasons for this difference, but it could feasibly be related to children receiving priority within households in relation to health care use. Given that the removal of fees does not eliminate all costs of illness and treatment seeking, such as transport to a facility and time lost to productive activities, the above finding suggests that, in the poorest households, children will be taken to a health care facility when ill, whereas adults will avoid seeking treatment if possible to avoid non-user-fee direct costs and losing productive work time to seek care.

A number of the studies have highlighted that the sustained utilisation increases and related positive outcomes, such as national immunisation coverage increases from 41% in 1999/2000 to 84% in 2002/03 (Yates 2004), could not have been achieved without an increase in the resources available for public sector health services. Of particular importance was the pro-active provision of a $5.5 million buffer fund by the Ministry of Health to offset the potential impact on availability of drugs arising from the loss of fee revenue and utilisation increases (Burnham et al. 2004). In addition, the move away from project donor funds to the provision of general budget support to the Ministry of Health by donors under a Sector-Wide Approach (SWAp) initiative resulted in the Ministry budget doubling in real terms between 1999/2000 and 2002/03. The Ministry has control over the allocation of these SWAp resources and has directed the additional resources preferentially to primary health care services. District budgets have increased seven-fold since 1999/2000 (Yates 2004). This implies that previously, donor funds allocated via specific projects (often vertical programs) were not consistently supporting primary level services.

While there is overwhelming evidence of the substantial positive consequences of fee removal in Uganda, particularly for the poorest, there have been some negative consequences. Of particular concern is the decline in staff morale (Burnham et al 2004). This is related to the loss of fee revenue which had previously been used to supplement staff salaries, as well as the fact that workload had increased by about 47%. Health workers and members of the health facility management committees also indicated that maintenance of health facilities and cleanliness had declined. It should be noted, however, that these findings were obtained in the 12 months after the fee removal. The more recent substantial increases in primary care facility budgets may have improved staff workload ratios.

It is too early to evaluate the consequences of fee removal in Kenya, given that it was only announced on 20 June 2004[5]. This policy arose from an election promise to provide free health care and free primary education in the 2002 general elections. Free primary education was introduced in January 2003, but limited funds and overcrowded schools resulted in the government deciding to address these problems before introducing free health care. As from 1 July 2004, most fees were removed at primary care facilities. Children under five years of age were exempted from all fees for primary care services, but all other patients were expected to pay a nominal registration fee. Although the stated

[5] All information on the Kenyan experience provided by Jane Chuma, Kilifi, KEMRI (Kenya Medical Research Institute).

intention is to remove fees from public hospital services as well, it is envisaged that this will only be feasible once social health insurance has been introduced.

As with Uganda, the Kenyan government did make additional resources available to support the implementation of the free care policy. However, the additional $51.5 million appears to have been inadequate; it simply returned Kenyan government health spending levels to the pre-fee levels in the late 1980s. Unpublished results of an early evaluation of the Kenyan policy indicate that major difficulties have been encountered, particularly in terms of declining availability of drugs at primary care facilities, but also overcrowding problems, although the latter finding suggests substantial increases in utilisation.

5. Conclusions to the analysis of the free health care for children programme

The overall objective of the *Means to Live Project* is to assess whether government policies or programmes that target individuals or groups of beneficiaries at whom the intended intervention is aimed, do indeed reach the intended beneficiaries – in this instance children living in poverty.

The provision of free health care is indeed an internationally accepted and appropriate mechanism to alleviate the burden of health care costs for the poor. As reflected in the experiences from a number of African countries, the removal of user fees does increase utilisation and frees up scarce household income for other uses. It also shows that the poor do enjoy proportionally greater benefit from the removal of user fees. Unfortunately most of the evaluations from the African countries did not indicate the specific effect of user fees, or the removal thereof, on children. It thus has to be assumed that the demonstrated overall benefit to poorer households of health service fee removal also benefits the children living in those households.

Although the exact beneficiaries of fee removal policies have not been established in the South African context, it is most likely that it has benefited the lowest income groups, given that they are the primary users of public sector health services – particularly at the primary care level – and that medical scheme members (mainly from the highest income groups) are explicitly excluded from the benefits of the free care policies.

The South African policy of free health care is indeed a politically desirable and economically appropriate one, where the initial emphasis on young children and pregnant women was an appropriate start for the more universal policy that followed. The current application of free health care in South Africa is a mixture of a targeted and a universal intervention, where it progressed from a narrower policy targeted initially at children under six years and pregnant women, and then expanded to universal free health care at a primary level for all non-medical scheme members using public sector facilities. The current policy for children is still targeted, where younger children and children with moderate to severe disabilities benefit from free health care at all levels of care, whilst children older than six and with no or mild disabilities have to pay for hospital access according to a sliding scale based on a means test.

It is fair to conclude in principle that free primary health care does cater for all children in need. In the analysis of programme implementation it seems as if practices regarding user fees are being appropriately applied at the primary level at least. However, of concern is the anecdotal evidence that children older than six that are unable to pay are still being turned away at hospitals. This is clearly contradictory to the spirit of the policy and indeed to the commitment of ensuring children's right to health and health care. Based on recent Burden of Disease estimates (Bradshaw et al 2003), children older than five years primarily suffer from health conditions relating to trauma, HIV and chronic health conditions, amongst others. These are all conditions that are likely to require some degree of hospital treatment on a once-off or ongoing basis. Children in this age group also have to expend scarce household resources on school fees and other educational requirements; yet if 14 years or older they are not able to access the Child Support Grant. Such children would therefore not, for example, benefit from hospital fee exemptions as per the H0 exemption criteria in the example provided in Box 1 on page 10. The exact nature of hospital practices for older children requires more in-depth investigation.

Aside from the potential increased access by removing user fees for children, many barriers to health care other than user fees still exist. Addressing these barriers is particularly important in ensuring that the poorest and most vulnerable children benefit from free care. These need to be addressed concomitantly as part of ensuring children's right to basic health care services – transport to and from health services being one of the key considerations. It is clear that the removal of user fees as a means to improve access for children living in poverty is not enough. Unless there is sustained budgetary commitment to ensure the continued availability of good quality health services, children will not necessarily have access to the required health interventions. The South African health budgetary analysis reflects a worrying trend in this regard given that the health budget, including that for primary health care, has stagnated since the late 1990s in real terms. This is especially of concern in the face of the growing HIV pandemic that brings with it an increase need for more complex health interventions at all levels of care, as well as significantly increasing numbers of patients that present with HIV- and AIDS-related illnesses.

The provision of free health care practically coincided with the rise of the HIV pandemic in the country. The need to introduce new health service interventions thus became necessary. Interventions that specifically relate to children include the provision of counselling and voluntary testing for HIV to their parents/caregivers and to older children (although these do not exist in real terms as most health workers are not trained to council children); the prevention of mother-to-child transmission programme; specific prophylactic interventions for children with HIV such as Cotrimoxazole prophylaxis; and nutritional support (in some areas this includes the provision of free milk formula). Antiretroviral therapy for children has recently commenced and requires input from health facilities at all levels of care. Currently almost 40% of child deaths are due to HIV (Bradshaw et al 2004) and many hospitals report that at least 40% of their in-patient admissions are for HIV-related conditions (Shung-King 1998). One might thus extrapolate that at least 40% of children at all levels of care will require support for HIV.

Whilst there has not yet been a formal evaluation to assess the impact of HIV in children on health service utilisation at all levels of care, many reports (including anecdotal ones) point to a health service that is ill-prepared to cater adequately for children in this regard. Given that children with HIV require health services on a long-term basis, require more complex care and treatment and require health workers to have additional skills and expertise to

address the needs of children with HIV adequately, the potential impact on health service provision at all levels is significant. The impact of the HIV pandemic, in relation to the impact of free health care provision, requires further analysis.

Whilst the evaluations on the potentially differential impact of free health care provision focus on urban versus rural and facilities in rich versus poor areas, one might deduce that the reported unmanageable increases in workload and resultant decrease in quality of care would impact much more on health facilities in rural and poorer areas. These most likely started out with a below-baseline level of staffing and quality of care, and are likely to have felt the impact of the increased workload and the subsequent demands of the HIV pandemic much more – possibly widening the inequity in relation to their urban and richer counterparts. This again poses a further challenge for health systems research.

Given the current non-coverage of children older than six with no or mild disabilities by the free health care policy, the application of user fees at hospitals for older children where such user fees might prevent children from accessing these levels of care must be re-examined in the context of potential negative impact on access. Previous research in South Africa has shown that user fees for patients in the H0 – H2 categories generate extremely little revenue and the costs of administering the means test and collecting fees from low-income patients (who frequently need to be sent repeated accounts before payment) translate into very low net revenue levels (Dangschat & McIntyre 1996). It would be valuable to evaluate whether this is still the case, given that the introduction of the new UPFS may have increased revenue levels.

As medical schemes are actively negotiating with public facilities to become preferred providers for hospital care for their members – and that these scheme members would be treated in 'differentiated amenities' – there would be a great incentive for medical scheme members to declare their membership status, thereby obviating the need for costly means testing procedures. Submission of accounts to medical schemes would be streamlined and less costly than the current billing administration. While there may be concerns about utilisation increases, this will be minimised by only providing free care to those who have followed the appropriate referral channels. In this context, any increase in utilisation will be addressing currently unmet need rather than related to 'frivolous' use.

A further concern is the point highlighted by Schneider & Gilson (1997), that "free health care for curative conditions is compromising the delivery of preventive care". This is of particular concern for children as many childhood conditions rely on the execution of good preventative services such as immunisation, growth monitoring, nutrition programmes and health promotion outside of health facilities such as school health promotion activities. This is yet another issue requiring further exploration.

Finally, the application of free health care to improve access of poor children to health services, although desirable and appropriate, is insufficient as an isolated policy commitment. It needs to be backed up with sustainable commitment to ensure that health services remain accessible in all respects. Further consideration must be given to some of the unintended consequences of such a policy decision and strong commitment to strengthening the primary health care system in general is required.

6. Recommendations

The following recommendations emerge from this analysis of free health care for children.

1. A *national evaluation* to re-examine the impact of free health care is required in South Africa, given the expansion of this policy to a much wider group than children under six years and pregnant women. This is especially necessary in light of the HIV pandemic and its impact on all levels of health service provision. Specific issues that must be looked at include:
    - Hospital practices regarding user fees for older children.
    - The impact of free health care on the ability of primary level services to deliver quality preventative services.
    - The benefit incidence of the free care policies (i.e. who is benefiting most from these policies and why). This would include the impact of free health care on the most marginalised groups in poor rural and peri-urban settlements, as the impact of increased workloads and lack of resources might be affecting facilities primarily accessed by the poor more adversely.
    - How user fees at hospitals are applied in the case of children older than six years, what the potential impact on older children's access to hospital care is and what the best mechanisms are to minimise/abolish the need for mean-tested access to older children.

2. *Sustained budgetary commitment* is required to strengthen the primary level of care, including the provision of adequate staff, drugs and related resources.

3. Specific attention must be given to *sustaining quality preventative services*.

4. Attention should to be given to *other barriers to access*, so as to maximise the potential of free health care. This requires fully exploring what factors are adversely affecting access to health care for the most vulnerable children and what policy options are most appropriate to address these obstacles.

References

Abel-Smith B & Rawal P (1992) Can the poor afford "free" health services? A case study of Tanzania. *Health Policy and Planning,* 7(4):329-341.

Adams I, Darko D, Accorsi S, Tetteh I, Anemana S, Agongo E & Banka F (2002) Effects of the exemption policy on utilization of hospital services in the three northern regions of Ghana (1998 – 2000). *Bulletin of Health Information,* 1(2&3):14-18.

African National Congress (1994) *A National Health Plan for South Africa.* Johannesburg: African National Congress.

Akin J, Birdsall N & de Ferranti (1987) *Financing health services in developing countries: An agenda for reform. A World Bank Policy Study*. Washington, D.C.: The World Bank.

Asbu EZ (1999) Analysis of user fee for health care policy in Eritrea. *Central African Journal of Medicine,* 45:86-87.

Asenso-Okyere W, Anum A, Osei-Akoto I & Adukonu A (1998) Cost recovery in Ghana: Are there any changes in health care seeking behaviour? *Health Policy and Planning,* 13:181-188.

Asfaw A, von Braun J & Klasen S (2004) How big is the crowding-out effect of user fees in the rural areas of Ethiopia? Implications for equity and resources mobilization. *World Development*, 32(12):2065-2081.

Bennett S (1992) Promoting the private sector: A review of developing country trends. *Health Policy and Planning,* 7(2):97-110.

Berman P, Ormond BA & Gani A (1987) Treatment use and expenditure on curative care in rural Indonesia. *Health Policy and Planning,* 2(4):289-300.

Bitrán R & Giedion U (2002) *Waivers and exemptions for health services in developing countries.* Washington, D.C.: The World Bank.

Bradshaw D, Groenewald P, Laubscher R, Nannan N, Nolijana B, Norman R, Pieterse D & Schneider M (2003) *Initial Burden of Disease Estimates for South Africa, 2000.* Cape Town: Medical Research Council of South Africa.

Burnham GM, Pariyo G, Galiwango E & Wabwire-Mangen F (2004) Discontinuation of cost sharing in Uganda. *Bulletin of the World Health Organization,* 82: 187-195.

Chitha W, Cleary S, Davauid E, Jikwana S, Makan B, Masilela T, McIntyre D, Pillay Y, Sebokedi L, Thomas S & Wilson T (2004) *Financial resource requirements for a package of primary health care services in the South African public health sector.* Cape Town: Health Economics Unit, University of Cape Town, & national Department of Health.

Claeson M, Griffin C, Johnston T, McLachlan M, Soucat A, Wagstaff A & Yazbeck A (2001) Health, nutrition and population. *In*: World Bank (2001) *Poverty Reduction Strategy Papers' Sourcebook.* Washington: The World Bank.

Collins D, Quick JD, Musau SN, Kraushaar D & Hussein IM (1996) The fall and rise of cost sharing in Kenya: the impact of phased implementation. *Health Policy and Planning,* 11(1):52-63.

Congress of the People (1955) *The Freedom Charter*. Kliptown, Johannesburg: Congress of the People.

Corbett J (1989) Poverty and sickness: the high costs of ill-health. *IDS Bulletin,* 20:58-62.

Creese AL (1991) User charges for health care: A review of recent experience. *Health Policy and Planning,* 6(4):309-319.

Creese A & Kutzin J (1995) *Lessons from cost-recovery in health*. Geneva: World Health Organisation Forum on Health Sector Reform Discussion Paper No. 2.

Dangschat J & McIntyre D (1996) *Patient fee collection: Is it worth it? A case study of Groote Schuur hospital.* Cape Town: University of Cape Town, Health Economics Unit Working Paper No. 22.

de Ferranti D (1985) *Paying for health services in developing countries: An overview.* World Bank Staff Working Papers No. 721. Washington, D.C.: The World Bank.

Deininger K & Mpuga P (2004) *Economic and Welfare effects of the abolition of health user fees: Evidence from Uganda*. Washington, D.C.: World Bank Policy Research Working Paper No. 3276.

Department of Health (1998) *South African Health and Demographic Survey*. Pretoria: Department of Health.

Department of Health (1997) *White paper for the transformation of the health system in South Africa.* Pretoria: Government Printer.

Diop F, Yazbeck A & Bitrán R (1995) The impact of alternative cost recovery schemes on access and equity in Niger. *Health Policy and Planning,* 10(3):223-240.

Ellis RP (1987) The revenue generating potential of user fees in Kenyan government health facilities. *Social Science and Medicine,* 25(9):995-1002.

Ettling M, McFarland DA, Schultz LJ & Chitsulo L (1994) Economic impact of malaria in Malawian households. *Tropical Medicine and Parasitology*, 45(1):74-79.

Frankish JG (1986) Day hospital fees and accessibility of essential health services. *South African Medical Journal,* 70:285-288.

Garshong B, Ansah E, Dakpallah G, Huijts I & Adjei S (2002) A study on factors affecting the implementation of the exemption policy in Ghana. *Bulletin of Health Information,* 1(2&3):22-31.

Gertler P, Locay L & Sanderson W (1987) Are user fees regressive? The welfare implications of health care financing proposals in Peru. *Journal of Econometrics,* 36:67-88.

Giese S & Hussey G (2002) *Rapid appraisal of primary level health care services for HIV-positive children at public sector clinics in South Africa.* Cape Town: Children's Institute, University of Cape Town.

Giese S, Meintjes H, Croke R, Chamberlain R (2003) *Health and social services to address the needs of orphans and other vulnerable children in the context of HIV/AIDS – research report and recommendations.* Cape Town: Children's Institute, University of Cape Town, & national Department of Health.

Gilson L (1988) *Government health care charges: Is equity being abandoned?* London: London School of Hygiene and Tropical Medicine, Evaluation and Planning Centre for Health Care Publication No. 15.

Gilson L (1998) The lessons of user fee experience in Africa. *In*: Beattie A, Doherty J, Gilson L, Lambo E, Shaw P (eds) *Sustainable health care financing in Southern Africa*. Washington DC: Economic Development Institute of the World Bank.

Gilson L, Doherty J, McIntyre D, Thomas S, Brijal V, Bowa C & Mbatsha S (1999) *The dynamics of policy change – health care financing in South Africa 1994 – 1999*. Durban: Health Systems Trust.

Gilson L & Mills A (1995) Health sector reforms in sub-Saharan Africa: Lessons of the last 10 years. *In*: Berman P (ed) *Health sector reform in developing countries: Making health development sustainable.* Boston: Harvard University Press.

Gilson L, Kalyalya D, Kuchler F, Lake S, Oranga H & Ouendo M (2001) Strategies for promoting equity: experience with community financing in three African countries. *Health Policy,* 58:37-67.

Gilson L, Russell S & Buse K (1995) The political economy of user fees with targeting: Developing equitable health financing policy. *Journal of International Development,* 7(3):369-401.

Heller PS (1982) A model of the demand for medical and health services in Peninsular Malaysia. *Social Science and Medicine,* 16:267-284.

Hirschowitz R & Orkin M (1995) *A national household survey of health inequalities in South Africa.* Johannesburg: Community Agency for Social Enquiry for the Henry J. Kaiser Family Foundation.

Hongoro C, Musonza TG, Macq J & Anozie A (1998) A qualitative assessment of the referral system at district level in Zimbabwe: Implications on efficiency and effective delivery of health services. *Central African Journal of Medicine,* 44:93-97.

Hussein AK & Mujinja PG (1997) Impact of user charges on government health facilities in Tanzania. *East African Medical Journal,* 74:751-757.

Jimenez E (1987) *Pricing policy in the social sectors: Cost recovery for education and health in developing countries.* Baltimore: Johns Hopkins University Press for the World Bank.

Kanji N (1989) Charging for drugs in Africa: UNICEF's Bamako Initiative. *Health Policy and Planning,* 4(2):110-120.

Kipp W, Kamugisha J, Jacobs P, Burnham G & Rubaale T (2001) User fees, health staff incentives and service utilization in Kabarole District, Uganda. *Bulletin of the World Health Organization,* 79(1):1032-1037.

Laterveer L, Munga M & Schwerzel P (2004) *Equity implications of health sector user fees in Tanzania: Do we retain the user fee or do we set the user f(r)ee?* Report commissioned by Tanzanian Research for Poverty Alleviation. Leusden: ETC Crystal. Accessed on: http://www.repoa.or.tz/rawg/reports.

Litvack J & Bodart C (1993) User fees plus quality equals improved access to health care: Results of a field experiment in Cameroon. *Social Science and Medicine,* 37(3):369-383.

Lucas H & Nuwagaba A (1999) *Household coping strategies in response to the introduction of user charges for social service: a case study on health in Uganda*. Sussex: Institute of Development Studies Working Paper No. 86.

Makinen M, Waters H, Rauch M, Almagambetova N, Bitran R, Gilson L, McIntyre D, Pannarunothai S, Prieto A, Ubilla G & Ram S (2000) Inequalities in health care use and expenditures: empirical data from eight developing countries and countries in transition. *Bulletin of the World Health Organisation,* 78(1):55-65.

Mbugua JK, Bloom GH & Segall MM (1995) Impact of user charges on vulnerable groups: The case of Kibwezie in rural Kenya. *Social Science and Medicine,* 41(6):829-835.

McCoy D (1996) *Free health care for pregnant women and children under six in South Africa. An impact assessment.* Durban: Health Systems Trust.

McIntyre D, Bloom G, Doherty J & Brijlal P (1995) *Health expenditure and finance in South Africa.* Durban: Health Systems Trust & the World Bank.

McIntyre D, Thiede M, Dahlgren G & Whitehead M (2005) What are the economic consequences for households of illness and of paying for health care in low- and middle-income country contexts? *Social Science and Medicine* (in press).

McPake B, Hanson K & Mills A (1992) *Implementing the Bamako Initiative in Africa: A review and five case studies*. London: London School of Hygiene and Tropical Medicine, Department of Public Health and Policy Publication No. 8.

McPake B, Hanson K & Mills A (1993) Community financing of health care in Africa: An evaluation of the Bamako initiative. *Social Science and Medicine,* 36(11):1383-1395.

Mwabu GM & Mwangi WM (1986) Health care financing in Kenya: A simulation of welfare effects of user fees. *Social Science and Medicine,* 22(7):763-767.

Mwabu G, Mwanzia J & Liambila W (1995) User charges in government health facilities in Kenya: effect on attendance and revenue. *Health Policy and Planning,* 10(2):164-170.

Mwanzia J & Mwabu G (1993) *User charges in government health facilities in Kenya: Effect on revenue and attendance without improvement in medical care quality.* Unpublished report on study undertaken by the Kenyan Ministry of Health in conjunction with the World Health Organisation.

National Health Services Commission (1944) *Report of the National Health Services Commission, 1942 – 1944*. Pretoria: Government Printer.

National Treasury (2003) *Intergovernmental Fiscal Review*. Pretoria: National Treasury.

Nolan B & Turbat V (1995) *Cost recovery in public health services in Sub-Saharan Africa*. Washington, D.C.: Economic Development Institute, the World Bank.

Nyonator F & Kutzin J (1999) Health for some? The effects of user fees in the Volta Region of Ghana. *Health Policy and Planning,* 14(4):329-341.

Office of the High Commissioner for Human Rights (1989) *Convention on the Rights of the Child, General Assembly resolution 44/25.* Geneva: United Nations.

Okorafor O, Thomas S & McIntyre D (2003) *An evaluation of public PHC financing: 1992/93 – 2002/03. Report prepared for Valley Trust*. Cape Town: Health Economics Unit, University of Cape Town.

Okuonzi SA (2004) Learning from failed health reform in Uganda. *British Medical Journal* 329:1173-1176.

Owino W & Were M (1999) *Enhancing access to health care among vulnerable groups: The questions of waivers and exemptions*. Nairobi: Institute of Policy Analysis and Research Discussion Paper No. 14/99. Accessed on: http://www.ipar.or.ke

Republic of South Africa (1994) *White paper on Reconstruction and Development: Government's strategy for Fundamental Transformation*. Pretoria: Government Printer.

Republic of South Africa (1994) *Free health services for pregnant women and children under the age of 6 years. Notice 657 of 1994.* Pretoria: Government Printer.

Republic of South Africa. (1996) *The Constitution of the Republic of South Africa. Act 108 of 1996.* Pretoria: Government Printer.

Russell S & Gilson L (1995) *User fees at government health services: Is equity being considered?* London: Health Policy Unit, London School of Hygiene and Tropical Medicine.

Russell S & Abdella K (2002) *Too poor to be sick: Coping with the costs of illness in East Hrarghe, Ethiopia.* London: Save the Children UK.

Save the Children (2005) *The unbearable cost of illness: Poverty, ill-health and access to healthcare – evidence from Lindi Rural District, Tanzania*. London: Save the Children UK.

Schneider H & Gilson L (1999) The impact of free maternal health care in South Africa. *In*: Berer M & Sundari Ravindran TK (eds) *Safe motherhood initiatives: critical issues.* London: Blackwell Science.

Shaw RP & Griffin CC (1995) *Financing health care in Sub-Saharan Africa through user fees and insurance.* Washington, D.C.: The World Bank.

Shung-King M (1998) *An evaluation of the down-scaling of Red Cross Children's Hospital medical outpatient department in the Western Cape metropolitan region*. Cape Town: Child Health Policy Institute, University of Cape Town.

Shung-King M, Abrahams E, Giese S, Guthrie T, Hendricks M, Hussey G, Irlam J, Jacobs M & Proudlock P (2000) Child Health. *In:* Ntuli A (ed) *South African Health Review 2000*. Durban: Health Systems Trust.

Tibaijuka AK (1997) AIDS and economic welfare in peasant agriculture: case studies from Kagabiro Village, Kagera Region, Tanzania. *World Development,* 25(6):963-975.

US Network for Global Economic Justice (2003) *Elimination of user fees brings bid increase in clinic utilization rates in Uganda*. Accessed on: http://www.50years.org/cms/updates/story/15.

Vogel RJ (1988) *Cost recovery in the health care sector: Selected country studies in West Africa.* Washington, D.C.: World Bank Technical Paper No. 82.

Waddington CJ & Enyimayew KA (1989a). A price to pay: The impact of user charges in Ashanti-Akim district, Ghana. *International Journal of Health Planning and Management,* 4:17-47.

Waddington CJ & Enyimayew KA (1989b). A price to pay, Part 2: The impact of user charges In the Volta Region of Ghana. *International Journal of Health Planning and Management,* 5:287-312.

Walker L & Gilson L (2004*)* We are bitter but we are satisfied: nurses as street-level bureaucrats in South Africa*. Social Science and Medicine,* 59(6):1251-1261.

Weaver M (1995) User fees and patient behaviour: Evidence from Niamey National Hospital. *Health Policy and Planning,* 10(4):350-361.

Whitehead M, Dahlgren G & Evans T (2001) Equity and health sector reforms: Can low-income countries escape the medical poverty trap? *Lancet*, 358(9284):833-836.

Wilkinson D, Sach ME & Abdool Karim SS (1997) Examination of attendance patterns before and after the introduction of South Africa's policy of free health care for children under 6 years and pregnant women. *British Medical Journal,* 314(7085):940-941.

Willis CY & Leighton C (1995) Protecting the poor: The role of means testing. *Health Policy and Planning,* 10(3):241-256.

World Health Organisation & United Nations Children's Fund (1978) *Declaration of Alma-Ata.* International Conference on Primary Health Care, 6 – 12 September 1978, Alma-Ata, USSR.

Wouters A (1995) Improving quality through cost recovery. *Health Policy and Planning,* 10(3): 257-270.

Xu K, Evans DB, Kawabata K, Zeramdini R, Klavus J & Murray CJL (2003) Household catastrophic health expenditure: A multicountry analysis. *Lancet,* 362(9378):111-117.

Yates R (2004) Voting with their feet: What lessons can be learnt from increased consumption of public services in Uganda? *Health Policy and Development*; 2(1):48-51.

Yoder RA (1989) Are people willing and able to pay for health services? *Social Science and Medicine,* 29:35-42.