User fees in health services in Nigeria: The health policy implications

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Abstract

There is widespread implementation of formal or informal user fees for health care in Nigeria. Quantitative and qualitative survey was conducted in various parts of eastern Nigeria to assess the impression of the Nigeria general public on the institution or abolition of user fees in health services. Of the total of 910 study participants, 520(57.1%) supported the institution of user fees while 390(42.9%) supported the abolition. Majority of study participants would prefer paying user fees if they are affordable and would guarantee efficient and quality service. The greater percentage of those advocating for abolition of user fees were the non-literate persons, the unemployed and the aged. If user fees are to be instituted, there is need for a mechanism that will provide some concessions such as appropriate systems of waivers and exemptions to these categories of individuals, so that no one is denied assess to basic health care.

INTRODUCTION

In most African countries including Nigeria, government budgets for social sectors have failed to keep up with population growth and demand; consequently, there is widespread implementation of formal or informal user fees for health care in government health systems. Their introduction was justified as a pragmatic solution to severe under-funding, as well as part of a broader ideological shift in health policy that emphasized efficiency [1]. However, international experience suggests that the case for reducing or removing official user fees for primary health services is strong. This is because, evidence from a broad range of developing countries including most parts of sub-Saharan Africa indicates that fees have rarely generated large amounts of revenue, are unlikely to have improved (and might even have worsened) allocative efficiency, and have too often disproportionately affected poor people [2]. Policy debate about user fees has been so contentious with proponents and detractors advancing their arguments often without recourse to the inputs from the general public. The objective of this study therefore was to seek the impression of the Nigeria general public on the institution or abolition of user fees in health services with the view to making the much needed system compatible with the goal of preserving equitable access to services.

METHODS

Quantitative and qualitative survey was conducted in various parts of eastern Nigeria in March 2008 to assess the impression of the Nigeria general public on the institution or abolition of user fees in health services. Structured questionnaire and interview guides designed to reflect the various arguments advanced by proponents and detractors of user fees [3,4], were used for the survey. The survey was conducted at market places, schools, hospitals, along the street, wedding ceremonies, villages, commuter vehicles, homes etc. Consenting participants were of various occupations and educational background and aged 16-72 years old.

RESULTS

Of the total of 910 study participants, 520(57.1%) supported the institution of user fees while 390(42.9%) supported the abolition (Table 1). Analysis based on occupation indicated that 62% of students advocated for user fees while 38% were against user fees. The corresponding figures for other categories were; civil servants: 70.4% vs. 29.6%; business class: 50.4% vs. 49.6%; unemployed: 29.5% vs. 70.5%. Chi-square analysis indicated a significant difference in the trend (χ^2=40.2, P<0.05). Based on educational level, 36.9% of the non-literate persons supported user fees while 63.1% opposed user fees. In other educational categories the corresponding figures were; primary: 44.3% vs. 55.7%;

secondary: 58.7% vs. 38.3%; tertiary: 66.5% vs. 33.5%. There was a significant difference in the trend (χ^2=41.7, P<0.05) (Table 1). Based on age, 54.1% of those aged ≤18 advocated for user fees while 45.9% were against user fees. In other age categories the corresponding figures were; 19-30 years old: 60.9% vs. 39.1%; 31-40 years old: 60.2% vs. 39.8%; >40 years old: 48.3% vs. 51.9%. A statistical significant difference was observed in the trend (χ^2=11.1, P<0.05). Based on gender, 49.0% of the females supported user fees while 51.0% were against user fees; 63.2% of the males advocated for user fees while 36.8% were opposed to user fees. Statistically there was a significant difference in the trend (χ^2=18.4, P<0.05) (Table 1).

Figure 1

Table 1: Assessment of impression of south0eatern Nigerian on user fees in relation to demographic parameters

Parameter	Number(%) for user fees	Number(%) against user fees	Total	Chi-square test
Occupation				
Students	132(62.0)	81(38.0)	213	χ^2=40.2,
P<0.05				
Civil servants	162(70.4)	68(29.6)	230	
Business	213(50.4)	210(49.6)	423	
Unemployed	13(29.5)	31(70.5)	31	
Total	520(57.1)	390(42.9)	910	
Educational level				
Non-literate	41(36.9)	70(63.1)	111	χ^2=41.7, *P*<0.05
Primary	66(44.3)	83(55.7)	149	
Secondary	193(58.7)	126(38.3)	319	
Tertiary	220(25.5)	111(33.5)	331	
Total	520(57.1)	390(42.9)	910	
Age (years)				
≤ 18	20(54.1)	17(45.9)	37	χ^2=11.1,
P<0.05				
19-30	232(60.9)	149(39.1)	381	
31-40	156(60.2)	103(39.8)	259	
>40	112(48.3)	121(51.9)	233	
Total	520(57.1)	390(42.9)	910	
Sex				
Male	331(63.2)	193(36.8)	524	χ^2=18.4, *P*<0.05
Female	189(48.7)	197(50.8)	386	
Total	520(57.1)	390(42.9)	910	

Supporters believed that user fees were necessary especially if people can afford them and if the policy contributes to improving access to appropriate services. However, only 52.3% of the advocates agreed that fees generate additional revenue with which to improve health quality; 42.3% noted that user fees may reduce out-of-pocket and other costs, by substituting public services sold at relatively modest fees for higher-priced and less accessible private services; 47.1% accepted that user fees promote more efficient consumption pattern, by reducing spurious demand and encouraging the use of cost-effective health services; 46.2% agreed that user fees encourage patients to exert their right to obtain good quality services and make health workers more accountable to patients; finally, 44.4% agreed that people can and will pay for quality services but would not pay for poor quality services.

Participants who were against user fees generally argued that fees contribute to an already unaffordable financial burden and reduce the utilization of essential services, especially by poor and vulnerable groups. Up to 60.6% of them noted that user fees are rarely used to achieve significant improvement in quality care; 51.9% disagreed that user fees curtail spurious demand noting rather, that in a poor economy there is a lack not an excess demand; 51.3% agreed that user fees fail to promote cost-effective demand patterns because government health system fails to make cost-effective services available to users; 66.5% accepted that user fees hurt access by the poor and thus harm equity; while 51.3% noted that a country such as Nigeria with a high rate of poverty, cannot implement user fees effectively.

DISCUSSION

The opposing views about the desirability of user fees reflect both a difference in ideology as well as diversity in empirical circumstances. There is however a broad international consensus in favour of universal health coverage that is free at the point of entry. Yet in practice there have been few examples of donors working together with Nigeria government to eliminate user fees, and translate these principles into an everyday reality for poor households. In the present study it is obvious that a great majority of Nigerians would prefer paying user fees if they are affordable and would guarantee efficient and quality service. This was demonstrated in some earlier reports from other parts of Nigeria which indicated that utilization of health services was not deterred in spite of the introduction of user charges [5,6,7]

Despite their potential adverse effect on equity, user fees appear to be relatively easier to implement within Nigeria [6,7] and probably other African countries than other alternative policies which generally are viewed as less viable options than user fees [8,9]. These optional policies include an increase in government health budgets, additional taxation earmarked for health, the reallocation of government health funds from richer to poorer regions, risk sharing arrangements, the reallocation of public funds from urban hospitals to rural primary level facilities, and the targeting of public health subsidies toward the poor [4]. Although some authors have argued in favour of these policy options for eliminating user fees [10], in practice however,

they are harder to adopt policies in Nigeria.

Interestingly, the results of this study show that the greater percentage of those advocating for abolition of user fees were the females, non-literate persons, the unemployed and the aged. Consequently, with the institution of user fees in a developing economy as Nigeria, there is need for a mechanism that will provide some concessions to these categories of individuals, so that no one is denied assess to basic health care in Nigeria simply because the person can not afford the cost [11]. The World Bank recognized that fees could limit access to health services by the poor, and therefore most of its policy papers prescribed that fees should be accompanied by appropriate systems of waivers and exemptions [4].

A waiver is a right conferred to an individual that entitles him or her to obtain health services in certain health facilities at no direct charge or at a reduced price. Whereas waivers are associated to certain individuals, exemptions are associated to certain services. An exempt service is one that is to be provided at no charge (or at a reduced price) to patients. In Nigeria maternal health care services are provided free of charge for pregnant women at antenatal clinics and in recent times free treatment for tuberculosis and HIV patients. In its broadest form, a waiver entitles its holder to receive all services at no direct charge; in its broadest form, an exemption implies that the exempt service will be provided to all individuals at no charge [4]. Exemptions are adopted mainly for efficiency reasons and thus seek to correct some market failures. Their purpose is to promote the consumption of specific health services, including those whose benefits are under-valued by the population, those that have externalities, or those that are pure public goods [4].

User fees, when accompanied by a well-functioning system of waivers or exemptions, can help set up a pricing system with which to improve the targeting of public subsidies to the poor [12]. Thus, appropriate waivers and exemptions mechanisms can boost equity in access and in financing of health services when user fees are in place. Waivers and exemptions may be combined, thus setting a system where certain individuals such as the pregnant women, the unemployed, the handicapped and the aged are entitled to obtain certain health services for free or with a subsidy. Some state governments in Nigeria are already implementing waivers and exemptions in health care services [6]. For the poor, this means that direct payment for basic health services, should be lower than for the non-poor.

Equity in financing holds when those with equal ability to pay make equal payments for basic health care (horizontal equity in financing) and those with greater ability to pay make higher payments (vertical equity in financing) [4,13]. Preserving equitable access to health services under a system of user fees can be accomplished in three steps. First, the poor population to receive preferential treatment must be identified. Second, a protection mechanism must be selected and implemented. Third, to ensure that the protection policy is working adequately, an evaluation of its performance is required. This appears to be most feasible option for the present day Nigeria and worth exploring in other developing countries.

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