TAXING THE ILL: HOW USER FEES ARE BLOCKING UNIVERSAL HEALTH COVERAGE

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MEDECINS SANS FRONTIERES
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EXECUTIVE SUMMARY

Direct payments by patients at the point of health care delivery, commonly known as user fees, lead to low utilization or exclusion of health care services on offer, difficult assessment of health needs and epidemic risks, and impoverish entire households. Vulnerable groups are particularly affected. Over the past decade, many countries transitioned away from their user fee policies in favor of free health care initiatives for all or for specific population groups, such as pregnant women, children, and people with certain illnesses.

Considering there is a worldwide commitment to achieve Universal Health Coverage (UHC) by 2030, including "financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all",[1] one would expect free health care to be at the core of UHC policies.

However, the reality witnessed by Médecins Sans Frontières/Doctors Without Borders (MSF) teams starkly contrasts the discourse around UHC.[2] Instead of improved access to care, MSF sees a striking trend towards:

- The reintroduction of user fees and other direct payments by patients within national health financing strategies
- A reduction in the commitment and protection of previously accepted fee exemptions, such as those devised for:
  - populations affected by conflict, epidemics, or other crises
  - patients with the need for (life)long, uninterrupted, or repeated treatment and key priority health services, such as treatment for HIV, tuberculosis (TB), malaria, and maternal and child care
- A lack of commitment and support to implement free care policies that secure financial access and ensure sufficient and impactful coverage for the population's health needs.

1 Target 3.8 of the SDG 3 on Health: http://www.globalgoals.org/global-goals/good-health/

2 Around the SDGs adoption in 2015, MSF already provided a reality check of the gaps between the needs and the SDGs health ambitions: http://www.msf.org/en/topics/sustainable-development-goals

In most cases, the proposed policy changes coincide with the expected or announced reduction of international funds for health and a push for domestic resource mobilization to finance the health sector. This discourse currently dominates global health policies, despite many governments lacking the resources or capacity to deliver services at the pace required without continued international support. Failure to provide this is likely to undermine previous achievements and delay progress towards UHC.

There is overwhelming evidence demonstrating that user fees in low resource and/or conflict and crisis settings exclude and deter people from seeking care, negatively affect quality of services, and exacerbate poverty and the disease burden. Indeed, these findings are mirrored by MSF's experiences in the field and will be exemplified through several case studies. Yet, concrete measures to mitigate the negative effects of user fees are not receiving the attention they deserve in current UHC plans.

If the global health community is serious about making UHC a reality and 'leave no one behind', removal of user fees for essential drugs and services must be tackled as a priority. Without that first and foremost step, patients with the greatest medical needs will continue to lack access to essential health care and suffer financial distress.

WHAT ARE 'USER FEES'?

- 'User fees' are direct payments by patients to get medical services and/or medicines at the point of health care utilization
- Additional financial barriers to health care include costs for transport and food, as well as the costs linked to patients' caretakers
- Together, these costs constitute the 'out-of-pocket' payments or OOP

Despite evidence that OOP, including user fees, are an inefficient and inequitable health financing mechanism, several key stakeholders in the global health policy arena are tolerating or even pushing for their reintroduction.

PART I:

BACKGROUND

Over a decade ago, MSF carried out a series of surveys that highlighted the burden user fees were placing on the lives of vulnerable people in several conflict and crisis-stricken contexts as well as stable, low resource settings.[3] User fees were found to result in low utilization of public health facilities, exclusion from timely health care, and exacerbation of impoverishment, forcing many to forego treatment or to seek less effective alternatives. Financial barriers affected 30–60% of people requiring health care in the six countries studied (Burundi, Sierra Leone, Democratic Republic of Congo, Chad, Haiti, and Mali). Exemption systems based on assessment of means (i.e. indigent or not indigent eligibility criteria) proved ineffective, benefiting only 1–3.5% of populations. Alternative payment systems, requiring 'modest' fees from users (e.g. low flat fees), did not adequately improve coverage of essential health needs, especially for the poorest and most vulnerable. Conversely, user fee abolition for large population groups led to rapid increases in utilization of health services and essential health care coverage.[4]

As other NGOs and research institutions were reaching similar conclusions, 60 key civil society organizations (including MSF) joined forces to ask world leaders to act by making health care free of charge at the point of service in poor countries.[5] These different advocacy endeavors were part of a mounting global effort to garner field-based and academic evidence to challenge the discourse in favor of user fees. In the late 1980s, such direct patient payments had been justified by a lack of financial resources in the public health sector in low-income countries and introduced as part of structural adjustment programs by the World Bank and other actors. Instead of recovering costs and discouraging the 'excessive' use of health services, user fees ended up "punishing the poor".[6]

Free services at the point of use eventually started gathering traction, not only in developing countries, but also in the realm of international development agencies.[7] Key public figures such as the British Prime Minister, the Director General of the WHO, and President of the World Bank publicly endorsed the concept in 2009 at a United Nations General Assembly.[8] Many policy makers in sub-Saharan Africa opted for wide exemption policies to lower financial barriers to health care, including for vulnerable populations and life-saving interventions, as well as investigating alternatives to finance the health sector.[9] More ambitious still, in 2015, the 193 member states of the United Nations committed to achieve UHC without financial hardship by 2030 as part of the Sustainable Development Goals (SDG) on health.[10]

AMBITIONS AND RESOURCES FOR UHC

According to the WHO, achieving 16 SDG health targets in 67 low and middle-income countries (that account for 75% of the world's population) would require new investments increasing over time, from an initial 134 billion USD annually to 371 billion USD (or 58 USD per person) by 2030.[11] A projected 41 million deaths of children under the age of five and 20 million deaths from non-communicable diseases (NCDs) such as cardiovascular disease, diabetes, and cancer could be averted. Life expectancy would increase by between 3.1 and 8.4 years and 535 million years of healthy living would be added across the 67 countries.[12] These projections assume that 85% of these costs could be met with domestic resources. However, as many as 32 of the world's poorest countries would face a gap of up to 54 billion USD annually and therefore still require external assistance.[13]

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3 MSF. No cash, No care –How 'user fees' endanger health, March 2008. http://www.msf.org/sites/msf.org/files/old-cms/source/access/2008/NocashNocareMSFapril2008.pdf

4 Ponsar, F. et al. No cash, no care: how user fees endanger health—lessons learnt regarding financial barriers to health care services in Burundi, Sierra Leone, Democratic Republic of Congo, Chad, Haiti and Mali., *International Health*, Volume 3, Issue 2, 1 June 2011. https://academic.oup.com/inthealth/article-abstract/3/2/91/675868?redirectedFrom=fulltext

5 "Your money or your life –Will leaders act now to save lives and make health care free in poor countries?", 2009. Paper produced under the leadership of Oxfam international, and endorsed by 60 organizations, including MSF. Available at: http://oxfamilibrary.openrepository.com/oxfam/handle/10546/115075

6 Statement made by Dr Margaret Chan on several occasions throughout her tenure as former WHO General Director.

7 Dkhimi, F. et al., User Fee Exemption Policies, *BMC Health Services Research*, 15, 2015, supp. 3: I1. https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-15-S3-I1

8 Yates, R. Universal health care and the removal of user fees. Lancet 2009;373:2078–81. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)60258-0/fulltext

9 Ridde, V. From institutionalization of user fees to their abolition in West Africa: a story of pilot projects and public policies. *BMC Health Services Research*, 15 (2015), suppl. 3: S6. https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-15-S3-S6

10 The UNGA adopted the SDG in 2015. For more information, see: https://sustainabledevelopment.un.org/post2015/summit

11 WHO. WHO estimates the cost of reaching global health targets by 2030. (accessed 13 Nov,. 2017): http://www.who.int/mediacentre/news/releases/2017/cost-health-targets/en/

12 *Ibid.*

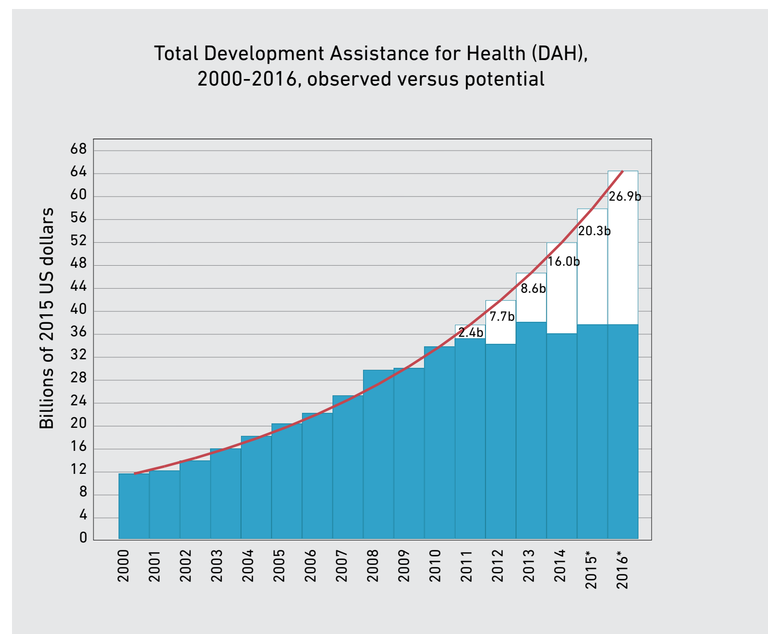
13 *Ibid.*

Yet, recent trends in international aid and health financing diverge from these aims. Towards the end of the 2000-2015 Millennium Development Goals (or MDG) era, international funding for health has leveled off. After a decade of annual growth in Development Assistance for Health (DAH) of 11.4% on average from 2000 to 2010, DAH has increased by only 1.8% annually between 2010 and 2016. If the previous growth rate had continued, an additional 82 billion USD would have been made available to countries between 2010 and 2016.[14]

In recent years, global health initiatives such as the Global Fund to fight AIDS, TB, and Malaria (GF) have faced increasing difficulty in maintaining commitments and the necessary support from their donors. The fund is under pressure to increase value for money and efficiency and is expected to "do more with the same". At the same time, it is expected to contribute more to building 'sustainable health systems', which in some cases may impact its strategic objective to save lives and reduce disease burden in the short term. As a result of stagnating funding from its donors, the GF and other funding mechanisms, such as the Vaccine Alliance (GAVI), have restricted their eligibility criteria and allocation processes, thereby leading to significant cuts in funding for certain countries.

As a country's Gross National Income (GNI) grows, low income countries cross the middle-income threshold, which will impact their eligibility status by international funding agencies. Yet, middle-income countries are home to over 70% of the world's poorest people and the highest number of people living with HIV/AIDS, TB, malaria, and NCDs. Despite improved economic indicators, many countries cannot cope with the financial burden of these diseases, as both prices for commodities increase and international grants reduce. The expectation for countries to become more reliant on domestic resource mobilization is not only placed on middle-income countries, but also on low-income countries like Malawi and Mozambique and countries classified as 'fragile' or 'conflict affected states' such as Afghanistan.

Many countries also face a risk of 'simultaneous transitions', when several donors withdraw within the same timeframe.[15] Premature transition from development assistance to domestic resources for health can lead to a reduction in prepaid, pooled resources and an increase in OOP expenditure.[16] In countries that transitioned to lower middle-income country status, OOP expenses imposed on patients are the main part of expenditure on health.[17] Limitations in fiscal space, health budget allocations, and health worker ceilings mean that vital care is compromised, including to the poorest and most marginalized, as countries are not able to rapidly compensate these shortfalls and in some cases resort to strategies that require patients to pay to access health care.[18]



Source: Financing Global Health Database 2016
*Note: *2015 and 2016 were preliminary estimates.*

USER FEES: THE ALARMING STEP BACKWARDS

Overall, commitments to support progress towards UHC are not backed up by the necessary resources and policies fail to be driven by the current health needs. Countries are expected to do more without a realistic assessment of their financial capacity. Moreover, international aid is increasingly used towards its transformative potential for the security, economic, or political interests of wealthy countries rather than for primary purpose of improving health outcomes. This does not bode well for global health.[19]

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14 IHME. Financing Global Heath 2016. Development Assistance, Public and Private Health Spending for the Pursuit of Universal Health Coverage.2016. http://www.healthdata.org/sites/default/files/files/policy_report/2017/IHME_FGH_2016_Technical-Report.pdf

15 For more information about the consequences of simultaneity, see ACTION's recent report: Progress in Peril? The changing landscape of global health financing, September 2017. http://www.action.org/uploads/documents/Progress_in_Peril_web_updated_103017.pdf

16 Global Burden of Disease Health financing Collaborator Network. Evolution and Patterns of global health financing 1995-2014: development assistance for health, and government, prepaid private, and out-of-pocket health spending in 184 countries, April 2017. Available at: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)30874-7/fulltext

17 *Ibid.*

18 MSF on the Sustainable Development Goals, 2015. *Op.Cit.*

19 For more on this topic, see Dr Mit Philips' piece on the Sustainable Development Goals -Don't Leave People's Health Missing in Action, MSF, 2014: https://msf-analysis.org/sustainable-development-goals-dont-leave-peoples-health-missing-action/

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Despite overwhelming evidence and recognition that OOP, including user fees, are an inefficient and inequitable health financing mechanism, several key institutions in the global health donor arena push for their reintroduction or fail to protect existing free care arrangements. The fact that user fees do not contribute significantly to sustained financing of the health system is conveniently left out of the discussion. Consequently, user fees are either tolerated or incorporated as part of strategies to increase domestic resource mobilization.

One case in point is the World Bank led Global Financing Facility (GFF). Launched in 2015, the GFF aims to improve coverage of maternal, child, and adolescent health care in 16 countries (and will be expanded to 26 since 10 additional countries joined in November 2017). 'Investment case' funding agreements include countries' domestic budgets, donor grants, and loans accessible via the World Bank's International Development Association (IDA) or the International Bank for Reconstruction and Development (IBRD).[20] Yet, as demonstrated in some of the following case studies, revision of national health financing strategies planned within the framework of GFF funding and under the guidance of the World Bank include the (re)introduction or increase of user fees.

This trend is in contradiction with the policies of the World Bank and other institutions that acknowledged the detrimental impact of user fees and had committed to supporting countries to implement care free of charge, at least for key illnesses and population groups.[21] The argument that people are willing and able to pay for care neglects the financial distress placed on households and its role in 'iatrogenic poverty' (or poverty caused by spending on medical treatment), particularly given the burden of additional costs for transport, food, and accommodation of the caretaker.

With at least 400 million people without access to basic health care, 100 million pushed into poverty, and 150 million suffering financial distress because of OOP expenditure on health services,[22] tolerating or reintroducing fees in health financing policies will not help us reach UHC. Instead, it will push people deeper into poverty, increase disease burden, and prevent patients from accessing essential medical care.

20 GFF. Ten Countries Join Global Financing Facility to Save the Lives of Millions of Women, Children and Adolescents. November, 2017. https://www.globalfinancingfacility.org/ten-countries-join-global-financing-facility-save-lives-millions-women-children-and-adolescents

21 The 2015 joint WHO and World Bank Group first global monitoring report tracking UHC states that "The key to protecting people from financial hardship is to ensure prepayment and pooling of resources for health, rather than relying on people paying for health services out-of-pocket (OOP) at the time of use. (WHO/World Bank. Tracking Universal Health Coverage. 2015. http://apps.who.int/iris/bitstream/10665/174536/1/9789241564977_eng.pdf?ua=1

22 WHO. Factsheet on UHC. Updated December 2016. http://www.who.int/mediacentre/factsheets/fs395/en/ (accessed 10 Nov,2015).

PART II:

REALITY CHECK: USER FEES AND THE UHC AMBITIONS

MSF works in over 70 countries.[23] Since 2004, the organization has adopted a policy to remove user fees for its patients, providing health care free of charge. This approach has proved effective in increasing accessibility, affordability, and quality of care for patients.[24]

Many countries have also made efforts to reduce financial barriers to health care, by making services such as child vaccinations, family planning, and preventive and curative care for communicable diseases (including HIV/AIDS, TB or malaria) free of charge. In some cases, free health care policies have been expanded to include other services for vulnerable groups such as the elderly, the poor, and women and children. While the removal of user fees cannot address all the barriers people in resource limited or crisis settings face in accessing care (such as a lack of skilled health workers, essential drugs, and transportation), it is an essential step in improving global health outcomes. Yet, what we witness today is contrary to this:

- Free health care initiatives with positive results are in some instances reduced or discontinued
- Exemptions in crisis situations are reduced or no longer guaranteed
- Patients with communicable and/or non-communicable diseases are not receiving or dropping out of care because of the catastrophic costs linked to (life)long treatment
- Epidemic outbreak monitoring and response frameworks are weakened, since patients unable to afford care die in the community and go unreported in health facilities
- Evidence demonstrating the negative effects of user fees and their limited ability to generate sufficient revenue to finance health systems is disregarded

*Consequently, **user fees end up being a taxation of the ill rather than a contribution to better health,** with severe consequences for the most vulnerable.*

23 For more about MSF activities highlights, go to: http://activityreport2016.msf.org/2016-in-figures/

24 Philips, M. et al – The removal of user fees within MSF supported health services: Lessons learned from an organization-wide policy change. MSF poster at the Barcelona ECTMIH Congress, 2011.

THE REVIVAL OF USER FEES DESPITE COMMITMENTS TO UHC

In **Sierra Leone**, MSF witnessed an immediate increase in service utilization through the introduction of its free health care policy. Consultations for children under five went up by 60% and malaria consultations for the same age group increased tenfold. Furthermore, the improved utilization rates were sustained over the long-term, with frequent use of health services by patients and reduced mortality rates in areas where care was provided free of charge.[25]

The launch of Sierra Leone's Free Health Care Initiative (FHCI) in 2010, which removed user fees for pregnant women, lactating mothers, and children under five, also led to increased utilization of services and was regarded as maintaining value for money.[26] The relative success of the initiative was largely due to the significant political and financial backing it received, including support from the UK's Department for International Development (DFID).

However, the Ebola outbreak brought health gains to an abrupt halt. The virus claimed the lives of around 10% of the country's health workers, wrought havoc on the economy, and disrupted existing health services for an already vulnerable population.[27] Quality, quantity, and distribution of health workers are a core challenge in Sierra Leone's health system. Moreover, researchers have predicted that maternal mortality could increase by a further 74% due to the loss of the health personnel during the epidemic.[28]

25 MSF. Free care: impact on utilization of health structures and health indicators. MSF's experience in Sierra Leone and other countries. MSF roundtable presentation in Freetown. January 29, 2009.

26 HEART Monitoring and Evaluation in Sierra Leone's Health Sector. June 2016 : http://www.heart-resources.org/wp-content/uploads/2016/10/Monitoring-and-evaluation-in-Sierra-Leone-health-sector.pdf?x30250

27 World Bank. 2014-2015 West Africa Ebola Crisis: Impact Update. May 2016. http://pubdocs.worldbank.org/en/297531463677588074/Ebola-Economic-Impact-and-Lessons-Paper-short-version.pdf

28 David K. Evans, Markus Goldstein, Anna Popova: The Next Wave of Deaths from Ebola? The Impact of Health Care Worker Mortality, World Bank Group, Africa Region, Office of the Chief Economist, July 2015

Despite increased donor support to strengthen the health system post-Ebola, a 2016 MSF survey[29] in Tonkolili District found that many of the long-standing issues remain – with chronic shortages of skilled health workers, frequent stock-outs of essential drugs, and a lack of affordable transport severely limiting access to care.[30] A lack of money to pay for a consultation or for transport to reach a health facility was a key impeding factor for 26% of urban women versus 82% of rural women. In addition, informal payments to health workers are common (14% of urban women versus 49% of rural women reported that they paid for services). This also contributes to the mistrust of health workers.

Considering the alarming rates of maternal and child mortality in Sierra Leone, reinforcing the current FHCI as well as expanding access to free, quality health care is urgently required. Despite this, it is unclear whether international donors will continue financing the FHCI beyond January 2018. Without the initiative, women and children will face increased barriers to reaching essential services and progress towards closing the existing UHC-gap will likely be derailed.

In **Afghanistan,** an MSF report published in 2014 documented major barriers that restricted availability of and access to services for the population. This report illustrated the gap between the optimistic rhetoric concerning the health system and the reality of limited access to health services.[31]

Patients were interviewed in four hospitals supported by MSF (Helmand, Kabul, Khost, and Kunduz provinces). One in five people reported a death of a relative or friend due to limited access to health care, with financial barriers as the main reason (32%). Among those who sought care, 44% had been forced to borrow money or sell goods to pay for health services. People paid an average of 40 USD for health services during a recent period of illness in their household, with one in four paid more than 114 USD. Four out of five patients were not using public primary health care due to limited availability or quality of services. Transport costs or the price of drugs, often purchased at private pharmacies when unavailable in public facilities, created additional barriers for patients.

The situation is not better today. A recent study by the Dutch Royal Tropical Institute KIT in collaboration with the Ministry of Health (MoPH) found that OOP expenses for patients remain a widespread problem, blocking access to essential health services.[32] Among hospitalized people in the survey cohort, 48.4% need to forego debts, sell possessions, or face financial distress to cover the costs of care. Additionally, 7.5% of those who were ill did not seek care because of cost considerations.

Although the population is still facing a deep crisis, including continued violence and a precarious socio-economic situation, a recent decree (August 2017) plans to reinstate user fees under the guidance of USAID, initially at the secondary and tertiary level. Furthermore, existing NGO contracts to implement the basic health care package are under strain due to reductions in international funding.

In **Mozambique,** a survey by the World Bank in 2002 demonstrated that 51% of people had difficulty to pay the required user fees, 20% had to borrow money, and 17% had to sell goods to pay for care.[33] In 2006, the abolition of the existing user fee scheme was proposed, taking into account the expected increase in coverage and the limited revenue it yielded.[34] Unfortunately, it did not materialize. In 2014-2015, households pay on average 3 USD for health services per month,[35] not including informal fees and other OOP payments.[36] Considering 63% of Mozambique's population live on less than 1.9 USD per day and that inequality indicators have worsened over recent years, financial barriers remain a major concern in improving access to care, with patients requiring regular health visits (such as for HIV) or specialized care worst affected.[37]

Several patients in Tete and Beira reported to MSF that public health facilities charged arbitrarily high fees, up to 1,000 meticais (equivalent of 16.4 USD) for care. Non-nationals also face problems accessing affordable care. One patient described her experience, "*To go to the health center as a foreigner is very hard if you have no money. In some places, they start asking you for money as soon as they realize you don't speak the language well.*"

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29 MSF. Reducing maternal and child morbidity and mortality in Sierra Leone – Key findings and recommendations of a mixed-methods study, August 2017.

30 The study demonstrates unacceptable barriers to healthcare: 90% of pregnant women and children under 5 years experience problems preventing or delaying them accessing health care. The study found that the majority of maternal deaths occurred in the community; and a very high rural child mortality rate: 1.55 per 10,000/day (close to emergency threshold). Other findings of the study such as traditional practitioners being generally more geographically and financially accessible also highlights the problem of economic/financial barriers contributing to the decision to seek care.

31 MSF. Between rhetoric and reality, the ongoing struggle to access health care in Afghanistan. February 2014. http://www.msf.org/en/article/between-rhetoric-and-reality-ongoing-struggle-access-healthcare-afghanistan

32 Jacobs E. et al., Catastrophic health expenditure and care-seeking practices in Afghanistan: a mixed-methods study (ECTMIH presentation), *Tropical Medicine and International Health*, vol. 22 Supp. I P.83, October 2017.

33 Health Financing Consultant Rob Yates presentation for the Health sector (MoH and partners). Moçambique deverá abolir a Cobrança de taxas aos utentes dos serviços de saúde?' 8 June 2006, Maputo; referring to a survey done by World Bank in 2002.

34 Relatorio final Consultoria sobre aboliçao das taxas aos utilizadores do servicio nacionam de saude (SNS) em Moçambique. Universidade de Lisboa, 2006

35 Relatório Final do Inquérito de Orçamento Familiar (IOF), 2014/15, p.26 (quadro 4.3) (final report on the family budget Survey) – Instituto nacional de Estatistica (National Institute of Statistics)

36 Ministry of Health, Health Financing Strategy Draft 4, Maputo. February 2017.

37 World Bank. Country poverty brief. http://databank.worldbank.org/data/download/poverty/B2A3A7F5-706A-4522-AF99-5B1800FA3357/9FE8B43A-5EAE-4F36-8838-E9F58200CF49/60C691C8-EAD0-47BE-9C8A-B56D672A29F7/Global_POV_SP_CPB_MOZ.pdf (accessed Nov 20, 2017).

The discussion on user fee increases is also framed by cuts in international funding. Funding allocations for the existing health pool fund (SWAP, locally called 'ProSaude') shrunk from 85 million USD in 2014 to 25 million USD in 2017, with only 73% disbursed.[38] Commitments by international donors towards the ProSaude pool fund remain uncertain, particularly given the shift by some donors towards the GFF.

Economic problems have hampered mobilization of domestic resources to compensate for the shortfalls in funding. As a result, the health sector at both the national and provincial level suffered major budget cuts in 2016-2017[39] and now faces significant challenges in paying for recurrent costs, such as utilities, running of ambulances, transportation of drugs and staff, and incentives. Stock-outs in essential drugs have been observed throughout the year at health facilities, as well as ruptures in basic items, such as gloves.

Under the framework of the GFF, the World Bank is providing guidance to revise the health financing strategy. This now includes a proposal to significantly increase user fees.[40] Such a measure would further erode access to care and burden patients with additional OOP expenses, particularly for vulnerable groups such as women and children.

The **Malawi** health sector is chronically underfunded. With a per capita health spending of just 40 USD, Malawi spends the least of all the Southern Africa Development Community (SADC) countries on health per person. 70% of Malawi's health budget comes from donor aid. Corruption scandals in 2012 to 2014 saw donors cut direct support for health by up to 50% and the health budget shrank a further 18% from 2015 to 2016.[41]

Despite substantially lower per-capita health expenditure than other countries in the region, most services in public health facilities are free of charge. It is plausible that the provision of free services is a contributory factor to Malawi's good coverage rates for HIV treatment as well as the country's maternal and under-five mortality rates, which are on par or better than their sub-Saharan peers.[42]

The government has explored various options such as sin taxes, a national health insurance scheme and other innovative financing sources as part of the international push for increased domestic resource mobilization and in response to donor withdrawal from direct budget support. It is now considering further expansion of wards where patient payments are required, and specific fees such as bypass fees in public facilities to finance its health services.

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The Universal Health Coverage Coalition (UHCC), a civil society platform which MSF is a member of, recently surveyed patients and health workers across six districts on the possible expansion of these OOP payments in public hospitals. Those interviewed raised concerns on affordability, willingness to pay, inequitable access to care, and financial distress. Respondents were also skeptical that the revenue generated by user fees would be enough to support existing services.

In districts without accessible public health facilities, people rely on CHAM (the Christian Health Association of Malawi) facilities where user fees are required. CHAM is the largest non-government health provider in the country, providing 29% of all health services. As part of the government's health reforms, new Service Level Agreements (SLAs) have been negotiated with CHAM to provide free health services in areas where no public facility is available.[43]

The civil society survey across the six districts found that the SLAs are not successfully implemented yet and patients are still being charged high fees in CHAM facilities. Women interviewed by UHCC complained of exorbitant costs that they incurred to pay off debts, of health passports and property confiscated by the health facility, and of lower quality or no treatment given to them or their children due to an inability to pay for services. In one case, a woman was asked to pay 7,000 MWK (about 9 USD) for malaria treatment for her son. As she failed to pay the full amount, the child was only given partial treatment.[44]

38 Ministerio da Saude. Relatório de Execução Orçamental (REO) Sector Saúde 2017 (Janeiro-Setembro)

39 *Ibid.*

40 Ministry of Health, Health Financing Strategy Draft 4, Maputo. February 2017; World Bank presentation ' Mozambique health user fees analysis: 2014', 23 August 23 2017.

41 Ministry of Health. Health Sector Resource Mapping 2014-2015 and 2018-19.

42 GIZ: Concept Note – Policy Dialogue on Malawi's Health Financing Options for the Parliamentary Health Committee, 9-11 November 2017.

43 Ministry of Health. MOH Health Financing Technical Working Group. Minutes of the 26 October 2017 meeting.

44 UHCC policy brief, Securing Access to Health For All through UHC, November 2017.

NO MORE EXEMPTIONS FOR PEOPLE IN NEED OF CARE FOR HIV, TB, AND MALARIA OR FOR CHILDREN AND PREGNANT WOMEN?

In **Guinea,** the national policy stipulates that health care for children under five, and patients with HIV/AIDS, and TB, and emergency obstetric and neonatal care should be free of charge. Despite this, the health system functions largely through user fees, which is used to compensate for low state salaries and shortfalls in recurrent costs for public health facilities (salary top-ups, maintenance, and functioning costs). The financial burden on patients and households is significant, with OOP payments estimated at 45.3% of all health expenditure.[45] In spite of an increase in overall health expenditure, the systematic underfunding of the public health system and its dependence on user fees creates several challenges for optimal care, such as incomplete or interrupted treatment, decreased utilization of existing services, and perverse financial incentives e.g. over-prescription of unnecessary services that generate revenue.

Despite the recurrent crises affecting the country, including the West Africa Ebola outbreak (2014 -2015), interest by international donors to the health plight of Guineans remains weak. To date, next to the government, MSF remains the largest provider of HIV care, with over 10,000 patients receiving antiretroviral therapy (ART) procured by the GF. Despite a national decree to provide HIV testing, ART, viral load and CD4 tests free of charge, people living with HIV (PLHIV) face financial barriers to access HIV treatment services. Many patients must pay for consultation fees (varying between 0.5 USD to 5 USD), laboratory tests, and other medicines associated with HIV care. For example, a creatinine test before switching to another ARV (antiretroviral drug) can be as much as 2.7 USD and a CD4 count and biochemical lab tests required before a patient can be initiated for treatment costs up to 16 USD. Some public health center pharmacies collude with private pharmacies when dispensing medicine against opportunistic infections, forcing patients to pay for their antibiotics (Cotrimoxazole, 30 pills for 0.9 USD) and other medicines that are usually available for free. With a household's average monthly wage of 40 USD,[46] such costs are not affordable.

Similar challenges arise regarding malaria. In the highly endemic zone of Kouroussa, a retrospective MSF survey showed overall mortality was 0.84 deaths per 10,000 inhabitants per day and 1.65 for children under five.[47] Close to half (48%) of the deaths among the general population were caused by malaria, with 8 out of 10 cases of child mortality due to the disease. Among the deaths reported, up to 27% did not seek care for the illness and for 12% of those, a lack of money was the main obstacle. 42% of those who did seek care did not have the necessary funds, 38% had to go into debt or sell goods to raise the money needed, and only 16% received care free of charge. Most patients were required to pay 5,000 GNF (0.5 USD) for a consultation, which is a major financial barrier for most people.

After MSF started its program in the Kouroussa district in July 2017, children under five were cared for free of charge in the five health centers, the reference hospital, and by the 80 community agents supported by MSF. The number of consultations increased tenfold, demonstrating how financial barriers had been a deterrent for people seeking care.

Lesotho has one of the highest maternal mortality rates in the world, with an average life expectancy of 49 years and an adult HIV prevalence of 24%. At the primary health care level, maternal health care (including delivery services) is free of charge to patients. However, they are required to pay fees at the hospital level. While these fees may seem small, they can represent up to a month's salary for some of Lesotho's population.[48] In Lesotho, the national headcount poverty rate indicates that 59.6% of its population lives on less than 1.9 USD per day per inhabitant, with rates of inequality increasing.[49]

In focus group discussions among women of Roma district, one of the most common barriers reported was the difficulty in getting money to pay for care (27%).[50] In addition, women expressed reluctance to give birth in health centers as they feared to be referred to the hospital and be charged fees that they could not afford.

An MSF study examined utilization of obstetric services at Roma district hospital before and after the removal of fees.[51] The introduction of free services in 2014 considerably improved access to quality maternal care and decreased maternal and neonatal mortality. The number of hospital deliveries increased by 49% from 1,547 (from July 2012 to the end of 2013) to 2,308 (from January 2014 to June 2015). Reimbursement of 43.3 USD covered the hospital's cost for a normal delivery and 112.5 USD for a C-section, allowing patients to access care without being charged. Other measures included support for transport and ensuring women waiting to deliver did not have to pay for

45 WHO, Global Health Observatory data repository: Guinea http://apps.who.int/gho/data/view.main.HEALTHEXPRATIOGIN (accessed Nov 17, 2017).

46 https://www.worlddata.info/average-income.php

47 MSF. Rapport d'enquête de mortalité rétrospective dans la préfecture de Kouroussa en Guinée. December 2016

48 MSF. The case for free maternal care in Lesotho hospitals to reduce maternal mortality. Policy brief. March 2015.

49 World Bank. Country poverty brief. http://databank.worldbank.org/data/download/poverty/B2A3A7F5-706A-4522-AF99-5B1800FA3357/9FE8B43A-5EAE-4F36-8838-E9F58200CF49/60C691C8-EAD0-47BE-9C8A-B56D672A29F7/Global_POV_SP_CPB_LSO.pdf (accessed 20 Nov 2017).

50 MSF. The case for free maternal care in Lesotho hospitals to reduce maternal mortality. *Op. Cit.*

51 Shroufi, A. et al. Removal of user fees improved access to quality maternity care and decreased maternal and neonatal mortality in a district hospital, Lesotho, November 2017.

accommodation. Extrapolating these figures for the entire country, it would mean that by adding an extra 1 USD per inhabitant per year to the current public health budget would allow user fees to be eliminated at the hospital level as well as ensure free transport and accommodation for mothers.

In the **Democratic Republic of Congo (DRC),** maternal mortality rates remain one of the highest in the world, with 846 deaths per 100,000 live births, while the under-five mortality rates are at 104 deaths per 1,000 live births. Malnutrition affects 43% of the children, with 8% suffering from severe acute malnutrition.[52] Recurring epidemic outbreaks of measles, cholera, malaria, and other diseases negatively impact the population's health status.[53]

Various country and donor policies stipulate that 'free access to care' should be available for a range of patients, such as for those affected by HIV/AIDS, TB, and malaria, pregnant women and children under five, as well as during health crises, and for vulnerable populations. However, these policies are rarely applied. At present, the Parliament is working on a national bill which would enforce these exemptions and expand the current free policy to a broader range of health issues faced by pregnant women and children under five, and would be financed by a specific health solidarity fund. [54]

Overall health expenditure is estimated at about 21 USD per capita, with 42% paid by households' OOP expenses and 14% by government resources.[55] Poverty is pervasive throughout the country, with 73.6% of the population living below the poverty line in 2016.[56] Lack of public funding for health, disbursement problems, and low nursing wages mean that user fees are the main source of revenue. In 2017, the World Bank reported that 98% of health structures in the country demand fees, which for consultation vary between 2,200 CDF (1.4 USD) and 4,299 CDF (2.7 USD). Half of the health posts, two thirds of the referral health centers, and close to 70% of the hospitals ask patients to pay for each medical act performed, while the other structures ask a flat fee per case managed.[57]

A 2014 study on the financing of treatment for children with severe malaria in Kinshasa referral hospital showed that households with lower socio-economic status were six times more likely to be forced to borrow money.[58] The results of a 2017 MSF population survey in the health zone of Bili, Northern Ubangi, where malaria is highly endemic, also demonstrated how financial barriers block access to care.[59] Among households reporting a death, 49% had died at home and 11% on the road. In a quarter of cases of illness preceding death, no care was sought, for which 27% was attributed to a lack of money. Of those consulting, only 62% had the funds available, while 15% had to borrow money. Of 596 children with a bout of fever, only 15% had been tested for malaria, 27% had received treatment, and only 4% received artemisinin-based combination therapy (ACT). The latter can be explained by frequent stock outs of ACT or by preferential prescription of quinine by health workers, as observed by MSF teams. While ACT should be provided free of charge, quinine can be sold and thus is preferred by health workers, despite not being the recommended first line treatment.

Care for HIV/AIDS patients provides another striking example of how financial barriers contribute to the delay or discontinuation of ART. Before 'free' ART is provided, patients must pay for a clinical consultation, laboratory testing, and for drugs for opportunistic infections. A consultation card costs between 3-5 USD and a CD4 test between 15-20 USD, which is unaffordable to most patients. In a Lubumbashi study, direct costs incurred by hospitalized HIV patients were on average found to be just over 200 USD, exceeding patients' monthly income in 63% of cases. Patients with opportunistic infections incurred additional costs as high as 31 USD. [60] Close to one in four HIV-patients hospitalized in the MSF-supported ward in Roi Baudouin hospital in Kinshasa die because of HIV/AIDS, as the illness is too advanced by the time patients seek care. A third of these deaths (34%) occur within 48 hours of admission. Over half of these patients were previously on ART but interrupted their treatment, with a lack of money as one of the main reasons.[61]

Without a dedicated subsidy to ensure free services, patients will continue to arrive too late in health facilities to be tested and treated, dying out of sight.

52 Ministère de la Santé Publique de RDC, Cadre d'investissement pour la santé reproductive, maternelle, du nouveau-né, de l'enfant et de l'adolescent en vue de l'atteinte de la couverture sanitaire universelle en République démocratique du Congo. October 2017.

53 For more information about MSF in the DRC, go to : http://www.msf.org/en/where-we-work/democratic-republic-congo

54 Ministère de la Santé. Proposition de loi fixant les principes fondamentaux et règles relatifs à l'organisation de la santé publique en RDC. March 2017.

55 Ministère de la Santé Publique de la RDC. Rapport sur les comptes de la Santé RDC. 2014.

56 Department for International Development, Understanding poverty and social exclusion in DRC, 2017.

57 Enquête de base pour le programme de financement basé sur la performance en République Démocratique du Congo (PDSS & PVSBG), Banque Mondiale, 2017.

58 Félicien Ilunga-Ilunga et al, (2016) ; « Financement de la prise en charge du paludisme grave de l'enfant par les ménages à Kinshasa, République Démocratique du Congo », Santé Publique 2015/6, (Vol. 27), p. 863-869.

59 MSF. Enquête quantitative réalisée sur la Zone de santé de Bili, Nord Ubangui, RDC. April 2017.

60 Mundongo, T. et al. (2013); Cost of hospital care for HIV/AIDS infected patients in three general reference hospitals in Lubumbashi, DR Congo: prospective cohort study Henri Mundongo Tshamba1. *Pan African Medical Journal*. 2013; 15:76. http://www.panafrican-med-journal.com/content/article/15/76/full/

61 For more information about advanced HIV, see MSF's report " Waiting isn't an option: Preventing and Surviving Advanced HIV", July 2017, available at: http://www.msf.org/sites/msf.org/files/17109_msf_aids_rapport_a4_v9.pdf

Effective supervision to ensure care is provided free of charge and adequate remuneration of health workers to compensate for lost revenue is required. Failing this, health workers will continue to charge patients and/or misuse drugs and medical supplies. This applies to other killer diseases such as malaria, Hepatitis C, or TB and for the provision of care to vulnerable groups, such as women and children.

Under the GFF, the Ministry of Health with guidance from the World Bank, foresees a five-year health financing framework to tackle maternal and child health in 14 selected provinces, as part of DRC's UHC goal. [62] Unfortunately, the GFF investment case presently only speaks about a lump sum payment by patients, without detailing what the latter will entail. Also, it does not include specific measures to allocate funding to ensure provision of key services free of charge for children under five and pregnant women, as proposed by the Ministry of Health bill. Similarly, elsewhere in the country performance based schemes supported by the World Bank, do not include instructions to provide free care; pricing of health services is left to the health facilities to determine. Recently the Minister of Health stated that in order to make free care policies a reality, the overall allocation to health must increase drastically.[63]

TOWARDS THE END OF FREE CARE FOR PEOPLE AFFECTED BY CONFLICT, EPIDEMICS AND CRISES?

In **Jordan,** barriers faced by Syrian refugees in accessing health care are commonplace, especially since the reintroduction of user fees.

In order to access public services, including health care, Syrian refugees in urban areas are required to have a UNHCR Asylum Seekers Certificate and a Ministry of Interior (MoI) service card. This used to give them access to free public services through the Ministry of Health's facilities. However, at the end of 2014, the government changed its policy and required those holding the Certificates and MoI cards to pay the same rate as uninsured Jordanians.[64] These fees, while still a subsidized rate, prove unaffordable to many. A delivery in a public hospital at the uninsured rate varies between 70-80 USD while a C-section can reach up to 420 USD. These costs are even higher for those who are undocumented. These financial barriers have led to a decrease in preventative and curative health services.[65]

62 Ministère de la Santé Publique de RDC, Op.Cit.

63 Discours du Dr Oly Ilunga au VIe congrès de l'AFMED, 13 novembre 2017, https://drolyilunga.cd/news/2017/11/13/discours-du-dr-oly-ilunga-au-vie-congres-de-lafmed/

64 With some exceptions on immunization (EPI) vaccinations are provided free of charge to children and pregnant women. Furthermore, treatment for communicable diseases such as Leishmaniosis, TB, and HIV are also provided free of charge to Syrians (as well as uninsured Jordanians).

65 Amnesty International. Living on the margins – Syrian refugees in Jordan struggle to access health care. 2016. https://www.amnesty.be/IMG/pdf/living_on_the_margins_-_syrian_refugees_struggle_to_access_health_care_in_jordan.pdf

In northern Jordan, MSF currently provides NCD care for more than 3,300 patients, and approximately 70% are Syrian refugees. In 2016, the organization conducted a survey[66] on access to health services among non-camp Syrian refugees in Irbid Governorate, including for NCDs. The burden of NCDs in this population (21.1% of adults suffering from at least one NCD) has stretched the country's health care system to its limits. Almost a quarter (22.9%) of surveyed NCD patients did not seek care when needed. Financial limitations to pay for provider costs were the main barriers (for over 60%), which also impact retention in care. Close to a quarter of adult NCD patients needing regular medication experienced an interruption of more than two weeks in the previous six months because of affordability issues. The average cost of an NCD consultation was 23 USD per visit (6.9% of average monthly household income). Patients from the poorest income quintile were less likely to seek NCD care.

Results of the same survey for general care access followed suit: two thirds (68%) of adults needed health care in the 6 months prior to the survey, but close to a third (30.2%) did not seek care, and a quarter (24.9%) did not bring their sick child to the health structure, primarily for reasons of unaffordability in both cases. The average household burden for direct health care costs for adults represented 17% of the mean monthly household income and 9.5% for child care.

A comparison of the service provision across the different health sectors (general care, vaccination, NCD care, and antenatal care) revealed that sections with widely accessible free-of-charge or low cost services, such as antenatal care and vaccination services, showed remarkably higher utilization rates. Continued external support to cover the needs of this vulnerable population is therefore essential.

In the **Central African Republic (CAR),** renewed violence in 2017 has forced hundreds of thousands of people to flee their homes, either displacing them elsewhere within the country (over 600,000 which is the highest number since April 2014), or forcing them to flee to neighboring countries.[67] During peaks of violence, people have sought protection in hospitals, churches and mosques, or fled to the bush.

More than half of the population requires assistance but needs continue to exceed available resources. In fact, aid delivery is expected to continue to decline because funding remains low and humanitarian access is restricted in large parts of the country.[68] Only 30% of pledges made at the November 2016 Brussels Conference on CAR have been fulfilled to date.

66 Rehr, M. et al. Access to non-communicable disease health care among non-camp Syrian refugees in northern Jordan. 2017. https://f1000research.com/slides/6-716

67 ACAPS, CAR country overview: https://www.acaps.org/country/car (accessed November 15th 2017).

68 *Ibid.*

Maryse is 29. She delivered her baby in the MSF supported Castors hospital in Bangui, where care is provided for free. But prenatal care fees in her local health center got her into debt. She explains, *"I did six prenatal consultations and I had to pay for them all. In addition, I did some prenatal exams, but not all of them, because I did not have the money to pay for them. I was asked to pay 1,500 CFA [approximately 2.7 USD] for an HIV test but I could not afford it. When I was 6 months' pregnant, I began to have water flowing from my lower belly. At the health center, I was prescribed a treatment of a perfusion twice daily. This cost me 1,000 CFA per day. I had to ask my neighbors for money to cover these expenses. I repay them little by little, but I'm still in debt."*

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Likewise, the Humanitarian Response Plan, which was revised upwards in August 2017 to reflect increased needs has only been funded by 34%.[69]

The last few years of violence have exacerbated an already fragile health system, with health facilities looted, limited presence of medical staff due to security reasons, and a lack of essential medicines and supplies.[70] Life expectancy at birth is just over 50 years of age, HIV/AIDS has been the leading cause of death among the general population since 2000, and malaria is the main killer for children under five.[71] In addition to war wounded, MSF teams across the country see the direct consequences of violence on the health of civilian populations; children are unable to reach medical facilities during malaria season, vaccination coverage remains low, HIV and TB treatment is interrupted, and pregnant women are left without assistance when they deliver.[72]

In addition, OOP payments have negatively impacted the ability of the population to access care. In Bangassou, a retrospective mortality survey in 2014 showed a third of the people interviewed had been through a bout of fever in the preceding two weeks, but only 20% had sought medical care at a health structure. The main reason was the cost of care (58% in urban areas and 82% in rural areas). [73]

Forcing patients to pay is particularly problematic in a conflict-affected country where over 65% of the population lives below the poverty line (less than 1.9 USD per day). In August 2014, a government decree sought to mitigate financial barriers to care by exempting patients from payment during the crisis.[74] However, due to a lack of resources, the decree limited free care to certain patient groups (primarily women and children) and to international NGO-supported health facilities as part of the Humanitarian Cluster's strategic plan, although this was poorly implemented in practice.

Today, financial barriers remain a major issue throughout the country. A delivery in a hospital in the capital, Bangui, can cost up to 21,000 FCA francs (the equivalent of 37.6 USD) and a C-section up to 60,000 FCA francs (107 USD), which amounts to one month's worth of food for a family of four.[75]

69 UNSC. The situation in the Central African Republic. November 2017 Doc. S/PV.8084:http://www.un.org/en/ga/search/view_doc.asp?symbol=S/PV.8084 (accessed 28 November 2017).

70 MSF, Out of Focus, *Op.Cit.*

71 WHO : Statistical profile of the Central African Republic. http://www.who.int/countries/caf/en/

72 For more information on MSF's response, see : http://www.msf.org/en/article/central-african-republic-crisis-update-september-2017

73 MSF, Epicentre, OMS. Enquête de mortalité rétrospective et de couverture vaccinale dans la Sous-Préfecture de Bangassou, February 2015.

74 This comes on top of regular exemptions for the main killer diseases, malnutrition, family planning, etc.

75 MSF data collected in Bangui in November 2017.

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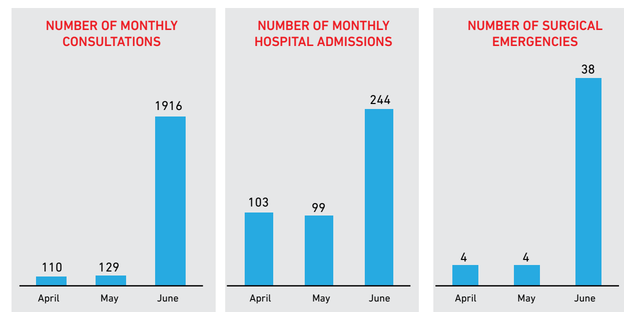
As touched upon earlier, **DRC** is prone to epidemics and crises. A review of MSF's experience during several measles outbreaks in 2017 confirmed that payment by patients is the rule rather than the exception. For malaria, only 2 in 10 health facilities assessed provided treatment free of charge; elsewhere children under five paid between 0.4 and 1.2 USD, with up to 6.7 USD as outpatients. In hospitals, patients had to pay between 1.2 and 3.18 USD per day. The cost of a C-section was reported to be between 28 and 38 USD. Despite high morbidity and mortality rates in the country, the number of daily consultations in these health facilities was low (typically less than 10 patients) as many patients cannot afford to pay.



Evolution of health care utilization in the referral hospital. Figures from the report on the Ebola outbreak in the Likati Health Zone. MOH, WHO and JICA, 2017.

MSF's introduction of free health care services during emergency interventions leads to significant increase in utilization of services. This was once again illustrated during the recent Ebola outbreak in Likati (August 2017). Free health services, set-up by the Minister of Health, led to an increase in outpatient consultations, hospital admissions, and emergency surgical interventions (see graph), which in turn enabled better detection of suspected cases. The removal of user fees also significantly reduced the number of people dying as a result of waiting too long before seeking care. The number of transfusions and duration of hospital stays for children also reduced, indicating the benefits of early intervention and effective, quality care.[76]

Another example of this is MSF's intervention in 2017 to address one of the most severe cholera epidemics in recent years. MSF treated more than 22,000 cases, while 46,000 cases were registered nationwide. According to the Ministry of Health regulations, the treatment of cholera should be free, but without supplies and funding, hospitals must buy the materials and medicines themselves. This often results in patients being charged sums that they cannot afford. As one patient explained, "Before MSF arrived, they did not let you leave [the hospital] if you did not have the money to pay. A friend had to act as a guarantor or the head of the village had to be held liable and say that you would pay the bill. Only then did the hospital agree to discharge you".[77]

76 MOH, WHO and JICA. Report on the Ebola outbreak in the Likati Health Zone, DRC. 2017.

77 MSF, Democratic Republic of Congo: One of the most severe cholera epidemics in years continues, October 2017. Available at: http://www.msf.org/en/article/democratic-republic-congo-one-most-severe-cholera-epidemics-years-continues

PART III:

WHAT DOES THIS MEAN FOR PATIENTS AND UHC, AND WHAT CAN BE DONE?

International agencies such as the World Bank, WHO and other UN agencies, donors, and national governments play an active role in health financing policy processes, and in some cases, in ways that not only contradict previous commitments regarding user fees, but also negatively affect all three dimensions of the 'UHC-cube': the overall utilization rates of services; the range and quality of services provided; and protection against financial hardship.[78]

It is time to stop presenting user fees as an acceptable health financing option to achieve UHC.

The reality is that, **because of** user fees:

- Patients are excluded, deterred, and delayed from seeking care, in particular, vulnerable groups or those with lower social status (such as women)
- Households are impoverished and forced into financial distress
- Patients are more vulnerable to abuse and misuse, such as withholding care or holding them captive until they pay for the cost of treatment
- Health workers that are poorly remunerated are prone to sacrifice quality of care by opting for treatments or services that generate the most profit
- Health facilities are underutilized and service provision is rendered less efficient, both in terms of optimal use of health workers and avoiding expiry of drugs
- Frameworks for the detection of and timely response to outbreaks is weakened, as patients that cannot afford treatment tend to delay seeking care
- Health facilities are ineffective at providing coverage for preventive services (such as vaccination) and priority treatments (e.g. HIV, TB, and malaria)
- The main effect of user fees is reduced demand rather than mobilization of additional resources
- Exemption systems based on assessment of means (i.e. indigent or not indigent eligibility criteria) are ineffective in protecting vulnerable people and imply transaction costs that may exceed revenue collection[79]
- Without independent verification by civil society organizations or community monitoring for the implementation of free care policies, it is unlikely that subsidies will translate into increased financial access or utilization of care

TO IMPROVE THE IMPLEMENTATION OF FREE HEALTH CARE AND MAKE RAPID PROGRESS TOWARDS UHC:

The WHO should update and remind health actors of the existing evidence regarding the detrimental impact of user fees and clarify the recommended policy guidance on the issue.

Key stakeholders such as the World Bank, the GF, UNAIDS, and other health agencies should make it clear that they are in favor of protecting access to free care at the point of service and should guard against the negative impact of OOP expenditures.

78 For more information about the three dimensions of UHC, see: http://www.who.int/health_financing/strategy/dimensions/en/

79 Mathauer, I. Free health care' policies: Opportunities and risks for moving towards UHC (Health Financing Policy Brief No 2), WHO, Geneva. 2017. WHO/HIS/HGF/Policy brief/17.2

The most urgent action point is ensuring that countries at risk of curtailing their existing free care policies receive the necessary support to prevent them from choosing 'regressive' options that put progress towards UHC at risk.

To prepare and implement free care schemes, countries need to take leadership, backed up by sufficient technical and financial support. We suggest that a specific work stream is dedicated to supporting user fee abolition, which could be within the UHC 2030 process for example.

As part of the various health system strengthening initiatives, specific measures and resources should be allocated to reinforce services so that they have the capacity to cope with increased utilization and loss of revenues linked to the abolition of user fees.

In order to ensure access to free, quality healthcare, specific efforts are required to ensure medicines are affordable and that both medicines and services are adequately subsidized. For instance, the purchase of commodities by the GF (at optimal prices) should be complemented with the necessary resources and measures to make sure effective utilization of services is guaranteed. This includes adequate remuneration of frontline public health workers to prevent charging of patients. The reluctance of international donors to contribute funding to human resources for health remuneration also needs to be tackled. Specific funding should also be allocated to independently verify that free care policies are being applied at the point of delivery, for example through community or civil society organizations.

In the short term, there are specific **opportunities** to move away from user fees and to reduce OOP expenses. The GFF should provide funding and technical assistance (globally and at country level) to eliminate these barriers. Attention should be given to the revision of countries' health financing strategies, which could in turn provide less regressive alternatives to user fees. These pool funds provide leverage potential to achieve UHC. Similarly, additional subsidies within the growing performance based financing schemes could be made conditional on the provision of free health services.

In view of the different international initiatives and fora related to UHC, an unequivocal statement by the UHC movement on the detrimental impact of user fees is required to prevent further suffering and death. This statement should also push for the abolition of user fees and state that the drive to increased domestic resources mobilization for health should not result in increased user fees and other health-related OOP expenses.

CONCLUSION

There is overwhelming evidence that user fees are not only an inefficient and inequitable health financing mechanism, but also lead to barriers in accessing health services as well as increased morbidity and mortality. The (re)introduction of user fees is therefore contrary to the pursued goal of UHC.

In 2005, user fees were called "an unnecessary evil"[80] and by 2009, all stakeholders were called upon to "learn the lessons of the past 20 years and not advocate [for] the roll out of inappropriate financing mechanisms in the world's poorest countries"[81] in order to "make health care free in poor countries".[82] Almost a decade later, we can only remind people of the intolerable consequences of user fees, such as exclusion of care and further impoverishment.

If the global health community is serious about making UHC a reality and its promise to 'leave no one behind', removal of direct payment by patients, and in particular user fees for essential drugs and services, must be tackled.

MSF therefore calls on policy makers, national governments, key health donors, and global health stakeholders to actively discourage policies that have proven to be harmful to patients, and to mobilize resources and technical support to remove user fees from health financing strategies and health system reforms as a matter of priority.

80 Sophie Witter. An unnecessary evil? User fees for health care in low-income countries January 2005, Save the Children. http://www.eldis.org/document/A20422

81 Yates, R. Universal health care and the removal of user fees. *Op.Cit.*

82 "Your money or your life –Will leaders act now to save lives and make health care free in poor countries?", 2009. Paper produced under the leadership of Oxfam international, and endorsed by 60 organizations, including MSF. Available at: http://oxfamilibrary.openrepository.com/oxfam/handle/10546/115075

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