User Fee in Public Health Institutions
An Experience Across Asian and African Countries

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The introduction of user fee as an alternative source of health financing is widely being questioned across nations mainly because of its inability to generate the required revenue needed for any significant improvements in the quality of care and its implications on equity. This article looks at the experiences of some Asian and African countries for implementation of the fee, which was basically meant to increase the quality, efficiency, sustainability and effectiveness of the government health services and seeks to draw lessons for a country like India. This has been done by the review of relevant national and international studies in the area.

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INTRODUCTION

User fee or user charges is a new method of health financing proposed to most of the low income countries by the World Bank and International Monetary Fund (IMF). It formed an essential component of the health sector reform package and was meant to generate additional resources for the resource-starved government health institutions. Most government health systems across the world have largely been financed by general taxes. Therefore, the principle was that the government will both finance as well as provide health services free of cost. However, the experience of most countries shows that the government could not stick to its commitment of providing free health care and introduced some kind of token payments for registration or for drugs. User charges means much more than token, it means charging for specific services (Green, 1992) and is seen to substitute this tax-based financing of government health services.

USER FEE: MEANING AND OBJECTIVES

The term user fee was first introduced in the *World Development Report* of the World Bank in 1993 and can be defined as

> Any payments made by beneficiary directly to the health care providers at the time of delivery. This includes fee for services or price paid for supplies like drugs and immunization.(Andrews and Mohan, 2002).

In certain situations, the insurance companies may cover only a particular proportion of the total expenses, with the consumer paying the rest. This is called co-payment and can also be considered as a type of user charge.

The fee was introduced with the objective of improving the quality of health care by generating additional resources for the resource-starved government health institutions. The proponents of the fee, the World Bank and the IMF, recommended it as a financing mechanism for achieving the goals of increased efficiency, equity, quality, sustainability and effectiveness of the health sector. However, experience across countries show that the fee was not able to achieve the above-mentioned targets due to which its existence is being questioned in most of these countries. According to Mcpake (1993),

> An experience across countries show that the policy has met far from universal acceptance and has been particularly questioned on the basis of its implication for equity and utilisation of health services and possibly exaggerated potential for revenue generation.

The introduction of the fee has become an area of great public health concern in the countries where it has been introduced, as it defies the public health principles of equity, universality and comprehensiveness and makes health care out of the reach of the poor, which in turn deteriorates the health status. However, supporters of the policy believe that user fee — if implemented properly — can greatly improve the accessibility of health services by improving its other wise poor quality.

This article tries to explore the problems that come in the way of successful implementation of the fee by taking examples from various countries where it was introduced. This is mainly done with a view of drawing lessons for the successful implementation of the fee from these country experiences. This has been done through a review of various empirical studies on the subject, which were published in various national and international journals of public health. For the sake of convenience, I have restricted myself to six African and Asian countries, namely: Zimbabwe, Ghana, and Kenya from Sub-Saharan Africa and China, Cambodia and India from Asia. The article specifically looks into the context in which the fee was introduced in these countries, the revenue generated from it, the effectiveness of the fee in improving the quality of health care, and its implications on equity and health status of the population.

Before going into the cross-country experiences, it would be useful to understand the contextual background in which the fee was introduced in these countries and some issues related to its implementation.

Contextual Background

The policy for levying user fee has arisen in the context of a crisis in health service financing (Mcpake, 1993). Globally, the demands for

health services were multiplying as a result of population growth, changing preferences and attitudes in many areas, and the appearance of new problems like HIV/AIDS and many other associated conditions. However, the capacity of the developing countries to meet these demands was shrinking due to the ongoing economic crisis. The genesis of this economic crisis can be attributed to the rise in the price of oil declared by the Organisation of Petroleum Exporting Countries, in 1973 and in 1979, forcing countries to take loans at high rates of interest to import. The situation was worsened by the world economic recession (Andrews and Mohan, 2002). It was at this point that the international financial institutions like the World Bank and the IMF stepped in to help these nations come out of the debt trap by offering loans (Rao and Lewenson, 1997) on the condition that they accept the Structural Adjustment Programme (SAP) — a set of policies for restructuring their economy. Under SAP, these countries were suggested to cut their spending on welfare sectors like health and education. This led to a dramatic decline in public health spending, which in turn severely affected the health sector. Health care institutions lacked drugs and necessary equipment and the health workers were underpaid, due to which they were poorly motivated to provide services (Mcpake, 1993). To resolve the ongoing crisis of the health sector and to generate alternative sources of financing, a series of reforms were suggested by the World Bank and the IMF. An immediate solution, which formed a part of the reform package, was the introduction of user fee in public health institutions, which was supposed to be paid by all sectors of the society.

USER FEE: SOME ISSUES IN ITS IMPLEMENTATION

Exemption

When the fee was introduced, all segments of the society were required to pay it. However, soon after its implementation it was realised that the introduction of the fee greatly reduced the accessibility of health services, especially for the poor. Studies done by Creese (1991), Mcpake (1993), and Gilson (1997) strongly support this view. The poor who earlier received services free of cost were not willing to pay for the same. They delayed seeking care and used self-medication and informal sources of care (Booth and others, 1995; Casor and Sans, 1996), as a result of which their health status deteriorated. Several studies done in sub-Saharan Africa support this view.

Hence, the official policy in many countries suggested exempting the poor. However, the planning and implementation of exemption has been very difficult. In practice, exemption mechanisms are often ineffective and fail to protect the poor (Creese, 1991; Gilson, 1997). The major failure that occurs in exemption is targeting which consists of limiting the inclusion and exclusion error (Willis and Leighton, 1995).

However, the exemption mechanism in most developing countries suffers from these errors. The rich are excluded and the poor are included to pay the fee. This happens because, very often, the influential sections use political and social clout to get free treatment even when they can afford to pay (Baru, 2001). As observed by Burgess and Stern (1991):

> targeting of public services to the poor is beset with many problems namely mechanisms of identification and delivery of services to the non needy who have the political power to force the effective and sustained implementation of any given scheme.

Another factor that leads to the inefficient exemption mechanism is the dilemma faced by health workers as to whether they should exclude a patient when including him/her means an addition to their income and strengthening of the otherwise poor health infrastructure (Hardeman, Van Damme, Van Pelt, Por, Kimvan and Meessen, 2004). Besides health workers often do not have the expertise or time to objectively assess the patient's ability to pay (Huber, 1993). A purchasing body or a third party payer which is able to identify the poor and to pay on their behalf may be a good solution to this problem (Nyonatar and Kutzin, 1999). Hence, most of the countries contract a local non-government organisation (NGO) or a private body to identify the poor and collect fee from the non-poor. However, the management cost of these private bodies can consume a substantial chunk of the revenue generated with very little amount left for any improvement in the quality of services (Gilson and Mills, 1995; Wanter, 1995).

Revenue Generation

A major factor that prevents user fee in achieving its objective of equity and quality is the poor revenue generated from the fee. Revenue generation varies over time, sometimes increasing due to improved implementation practices but also failing as a result of inflation or problems such as economic recession (Leightonm, 1995). It also varies across nations; in most of the countries revenue generation is poor and hardly near the expected targets (for example, Zimbabwe and India), while in some other countries sufficient amount of money has been raised from the fee (for example, Ghana and Kenya). The differential in revenue generation across some African countries is depicted in Table 1.

Vogel explained these differentials in revenue generations across countries by attributing it to excessive exemption and poor administrative machinery (Mcpake, 1993). In his study of four West African countries, Vogel observed striking differences between amounts of revenue generated by a weak administrator and those by a strong one (Mcpake, 1993). He, thus, concluded that revenue generation depends on the administrative mechanism. Other factors

leading to poor revenue generation are lack of motivation of health workers in collecting the revenue and unwillingness of the people to pay the fee. Revenue generation also depends upon the exemption mechanism. If large numbers of people are exempted from paying the fee then it would naturally affect the revenue generated. According to a World Health Organisation report on sub-Saharan Africa, 'low fee and low exemptions can raise more revenue than high fee and high exemption' (Bennett and Ngalande-Banda, 1994).

TABLE 1: Revenue from User **Charges** as **a Percentage of Recurrent Government Expenditures on Health in Selected African Countries**

Country	*Percentage*	*Country*	*Percentage*
Botswana		*Malawi*	
1979	1.3	1983	3.3
1983	2.8		
Burkina Faso		*Mali*	
1981	0.5	1986	2.7
Burundi		*Mauritania*	
1982	4.0	1986	2.7
Cote d'lvorie		*Mozambique*	
1986	3.1	1985	8.0
1993	7.2		
Ethiopia		*Rwanda*	
1982	12.0	1984	7.0
mid-1980s	15.0-20.0		
Ghana		*Senegal*	
1984	5.2	1986	4.7
1987	12.1		
Kenya		*Swaziland*	
1984	2.0	1984	2.1
Lesotho		*Zimbabwe*	
1984	5.7	1986	2.2
1991/92	9.0	1991/92	2.2-3.5

Source: Nolan and Turbat (1993), Vogel (1988), World Bank (1994), Shaw and Griffin (1995): all cited from Quadeer, Sen and Nayar (2001).

Quality

In countries where revenue generation is poor, the fee can hardly contribute any thing towards improvement of the quality of health care (Here quality refers to the infrastructure, drug supply, equipment, motivated and well-paid health staff, and so on). But experience in sub-Saharan countries show that even a small amount of income generated from the revenue can contribute significantly in quality improvements if utilised properly. It's mainly on the basis of the experience of these countries that Creese (1991) made the observation that, 'fee income if appropriately used represents small but significant additional resource

for health care'. In many other countries like India, the revenue generated from the fee has not been utilised properly and thus has hardly made any significant contributions to the quality.

Accessibility

The quality of health care is directly linked to its utilisation. Studies in some South African countries have shown an increase in the utilisation of health care, particularly by those belonging to the low income groups, after the improvement in quality by revenue generated from the fee (Audibert and Mathonat, 2000; Litvack and Bodart, 1993). However, in many cases utilisation decreased significantly after the fee was introduced, which affected the poor in particular (Creese, 1991). Thus, the impact of user fee on equity has been a subject of major debate. While some believe that it is a means of charging the poor for poor services (Prasad, 1998), which makes them avoid seeking health care; some others believe that if implemented properly with proper exemption mechanism, user fee can be a means of improving the quality and accessibility of health care targeted at the poor by collecting revenues from those who can afford to pay (Creese, 1991).

Thus, low revenue generation and poor exemption mechanism which in turn leads to poor quality and reduced accessibility of health services act as major hindrances in the fulfilment of the objectives for which the fee was originally introduced across nations. The rest of the article focuses on exploring the above-mentioned issues in the successful implementation of the fee by specifically looking into the experiences of six countries namely Zimbabwe, Ghana, and Kenya from Africa and China, Cambodia and India from Asia.

USER FEE IN AFRICAN COUNTRIES

Many countries in Africa have a long history of user fees for public health services. Almost all the sub-Saharan countries implemented user fee in the health sector, especially after the launch of Bamako initiative in 1987, to meet the acute shortage of commodities in health care institutions due to decrease in the government spending on health. The strong internal and external pressures to introduce the fee and weak civic opposition led to the easy introduction of the fees in these countries (Andrews and Mohan, 2002). Studies show that the introduction of user fee in these poverty-stricken countries had damaging repercussions for the health of the population. The already poor health of the population further deteriorated due to the reduced accessibility to health services. According to these studies, with the introduction of health sector reform, the incidence of communicable diseases like malaria, diphtheria, tuberculosis, and cholera showed a resurgence and health indicators such as Infant Mortality Rate and Maternal Mortality Rate showed a reverse trend. User fee was an

integral part of the SAP in Zimbabwe, Ghana, Kenya, Zaire and many other sub-Saharan countries.

Zimbabwe

In Zimbabwe, user fee was introduced in 1992 as a result of the suggestion of the World Bank and the IMF to cope with the declining government expenditure on health. The government expenditure on health fell by 14 per cent between 1990 and 1992, and by a further 29 per cent in the following year. The Government of Zimbabwe set the fee well below the cost recovery level in view of the sentiments of the people. Revenue generation has been less successful in Zimbabwe with a cost recovery level of a mere 3.5 per cent. This may be due to low fee charges and a weak billing and collection system. Fee revenue was not used to improve the quality, but was only used to sustain the services. As the user fee did not contribute to the quality of services, the utilisation level of public health services decreased by 50 per cent. The worst-affected were the rural poor and other vulnerable sections of the society like tribals, women, children, and so on. This can be best depicted from the fact that the utilisation patterns declined most significantly for ante-natal care and length of stay in the maternity wards. Patients, in many cases, refused certain investigations recommended by physicians in an effort to reduce hospital bills. On many occasions, drug consumption went down. In due course, when the illness became more severe, patients had no choice but to go for more expensive medical care, which led to further impoverishment of the poor households (Andrews and Mohan, 2002). Thus, the introduction of user fee in Zimbabwe at the time of deep financial crisis and human resource constraints failed to achieve its targets of efficiency, sustainability and equity.

Ghana

In Ghana, SAP was introduced in the early 1980s and the user fee policy was included in the mid-1980s. The real government health spending in the early 1980s was only 20 per cent of that in the 1970s. Thus, doctors and managers advocated user fee to maintain professional expectations of service standards. There was also an impetus from the Ministry of Health for a radical revision of fees to overcome the shortage of commodities in the health sector due to the financial crisis. The shortage of foreign exchange was such that no drugs or medical supplies were imported for an entire year. The government succumbed to pressure from the Ministry of Finance and health managers and medical professionals and finally increased the fees in 1985. The policy to introduce user fee was not opposed as people were already paying informal charges at government facilities.

In Ghana, the policy was quite successful in generating additional funds. The country was able to achieve the cost recovery figure well

above the average 5 per cent attested in several African countries. It attained a maximum of 12.4 per cent in 1987 and as high as 20 per cent from two main hospitals. The introduction of cash and carry system where health staff could use the fee revenue to purchase more drugs so as to improve the quality of care, increased the national recovery system, which ensured better drug availability and thus better quality of care. In spite of the improvement in the quality of care, the introduction of the user fee led to a 50 per cent drop in the out patient attendance (Nyonatar and Kutzin, 1999). Thus, Ghana's experience show that the accessibility of care does not depend up on its quality; rather, it is dependent on an individual's ability to pay. A study showed that only 27 per cent of people injured in road crashes used hospital services, the inability to pay user fee was found to be the most apparent reason for this.

Kenya

Kenya's first attempt with user fee was in 1989. Here also, the introduction of fee was driven by harsh economic conditions. It was a hasty process, which lacked a strategy and allowed no time for staff training or testing of systems, as had been the case with Zimbabwe and Ghana. As a result of this, implementation problems and policy failures arose. Cost recovery level was similar to that of Zimbabwe (about 3 per cent) and there was no improvement in the quality of services. In Kenya, too, the number of out patient visits declined by about 40 per cent despite the fact that the user fee was small. It was found that there was a large decline in the demand in treatment for sexually transmitted diseases (Andrews and Mohan, 2002; Huber, 1993).

USER FEE IN ASIAN COUNTRIES

User fee has been introduced in lesser number of Asian countries than African mainly because of the resistances at various levels.

Cambodia

User fee was officially introduced in Cambodia in 1997 under the National Charter of Health Financing to generate extra finances for the health sector, which was under crisis. The revenue generated from the fee was used to improve the quality of care and to raise the salary of the health workers. Though the revenue generated from the fee was used to improve the quality of care, it severely reduced the accessibility by the poor. To help the poor meet the expenditure of health care, a health equity fund was created by the Ministry of Health and UNICEF. The management of the fund was done by local NGOs working in different districts. These NGOs identified the poor and paid on their behalf. Out of the total cost for running a hospital in Sotnikum district of Cambodia, 62 per cent was funded by the state, 21 per cent through

user fee, and 17 per cent by external parties (Hardeman and others, 2004).

China

User fee existed in China prior to the formation of the People's Republic of China in 1949. Afterwards, cooperative medical system prevailed until the advent of economic transformation (market socialism) in the 1980s. The collective payment system gave way to individual user fee. In China, the government pays only a small proportion (10-20 per cent) of the actual expenses of the health care system. The rest comes from private pockets. User fee is high in China and recovery is around 30 per cent. It is levied for both curative and preventive care. Tuberculosis is the leading cause of mortality in China and the introduction of user fee has had an adverse impact for tuberculosis control programme. It has prevented patients from being diagnosed early and getting treatment. The introduction of user fee has undermined China's achievement of controlling tuberculosis during the 1960s and 1970s (Andrews and Mohan, 2002).

India

The history of user fee in India predates the SAPs. Due to the severe opposition from various lobbies, the fee was introduced in some selective states like Andhra Pradesh, Karnataka, Punjab, West Bengal, Rajasthan and Haryana in the 1980s. With the introduction of SAP, the budgetary allocation on health dropped to 0.9 per cent of the Gross Domestic Product (GDP) in 1991 after an increase of 1.3 per cent in 1986. To cope with the shrinking budget on health, the state health development project of the 1990s proposed to implement the existing legal charges more rigorously (Baru, 2001). Hence, states like Maharashtra, Assam, Kerala, Madhya Pradesh, Orissa and Uttar Pradesh also introduced the fee in the 1990s.

In Andhra Pradesh user fee was introduced in 1998. With the introduction of the fee, patients were required to pay for medical services in public hospitals, and also purchase drugs from outside. Recent attempt to hike the fee has met with opposition from various quarters (Prasad, 1998).

Maharashtra began the World Bank-funded health sector reform in 1999 and increased the user fee substantially in 2000. However, revenue generated from the fee is not being used and is merely adding to the state's resources. Despite paying user fee, patients did not get the required drugs, equipment were malfunctioning and diagnostic tests were prescribed to be done privately. Besides, the maintenance of hospitals was also very poor (Duggal, 2003).

In Kerala, which has some of the best health outcomes, user fee was introduced in the end of 1980s. Money was collected at the health facility level for various services but it accumulated in a local account

without being used. So the Government of Kerala banned the fee in 1992, as it felt that the fee was charging the poor for poor services (Duggal, 2003). Recently, an attempt was made to roll back the fee but it has met with serious resistances from various quarters (Andrews and Mohan, 2002).

Rajasthan is the only state in India where the experience of user fee has been a positive one. According to a report by the Ministry of Health and Family Welfare (India: 2000), user fee which was introduced in the state in the 1980s has been successful in generating an average of 10-15 per cent of the hospital budget. Rajasthan's success of user fee. can mainly be attributed to a systematic administrative mechanism (Mangal, 2002).

However, a strong administrative mechanism doesn't ensure effective cost recovery in all the cases. In Maharashtra, in spite of the strong administrative mechanism, a number of social groups were exempted from being charged for the fee mainly due to the political and social clout used by them. This included those with monthly income of less than Rupees 180, civil servants and their families, medical and nursing staff, and medical students. Despite detailed administrative guidelines, hospitals collected less than 1 per cent of its running costs in 1984-1985 (Griffin, 1992). So Mcpakes' assumption that effective administration ensures better revenue collection does not hold true for Maharashtra.

TABLE 2: **Implementation of** Cost **Recovery in Various States.**

State	*Structure*	*Services Charged*	*Excess Funds*
Andhra Pradesh	Quasi-Official Advisory committees attached to health institutions and hospital development societies in tertiary hospitals		Funds deposited in Government treasury
Orissa	District Societies	Diagnostic services; Private wards	Retained by the Health institutions
Rajasthan	Hospital-based Societies	Out-patient department (OPD); in-patient, Registration; Diagnostic services; Private wards	Retained by the health institutions
Madhya Pradesh	Roji Kalyan Samiti	-	Retained by the Health institutions

States	*Structure*	*Services Charged*	*Excess Funds*
Assam		Out-patient department; in-patient, Curative, and diagnostic services	Deposited in government Treasury
Haryana		_ . . .	Deposited in government Treasury
Kerala		Diagnostic; surgery; In-patient	Retained by the Health Institutions
Maharashtra		Out-patient department; in-patient Registration; diagnostic; surgery; meals	Retained by the Health institutions
Uttar Pradesh		Out-patient department; in-patient Registration; diagnostic; surgery; meals	Retained by the Health institutions

Source: Mangal (2002).

State-wise implementation of the user fee is clearly depicted in Table 2. The average revenue generated from various states, which has implemented the fee, is 3.8 per cent of the gross budget for running the health services. However, marked difference occurs in the revenue collection from different states. This, according to Baru (2001), is mainly dependent on the degree of dominance of the private and public sectors in the states.

In states where the public sector is dominant like Madhya Pradesh, Karnataka, Orissa and West Bengal, the revenue generated from the user fee is high. While in states where private sector is dominant like Kerala, Andhra Pradesh and Gujarat, the rich and the middle class were charged user fee by the public hospitals prefer to pay the same money or little more and go to private hospitals and only the poor who are exempted from paying the fee are left to utilise the public hospitals. As a result the revenue generated from these states is very low (Baru, 2001). Table 3 below shows the revenue generated from each of the 15 states in which user fee was implemented during the period 1975 to 1989.

SUGGESTIONS FOR EFFECTIVE IMPLEMENTATION OF THE USER FEE

Thus, experience across Asian and sub-Saharan African countries shows that the user fee was hardly able to achieve its targets of

improving the quality of health services and thus its accessibility. Instead, it further made health care out of reach for the poor. While many public health practitioners are fully convinced by this view and oppose its existence, there is a lobby that strongly supports the fee and believes that it can become an effective devise of health financing and can help the poor get better quality health care, provided its implementation is proper. Experience from the state of Rajasthan where the fee has been highly successful in fulfilling its targets also suggests the same.

These proponents of the fee have outlined suggestions for effective implementation of the fee. According to them, in order to enable the consumers pay the fee, the fee amount should be set by assessing the consumer's willingness and ability to pay. The fee structure should be simple and in accordance to the treatment received, for example, prescription fee (Bennet and Ngalande-Banda, 1994; Gilson and Mills, 1995).

TABLE 3: Cost Recovery **in Medical and Public Health Services (Non-ESIS) in Percentage**

States	*1975-76*	*1980-81*	*1984-85*	*1988-89*	*Average*
15 major states	6.4	4.1	3.04	1.6	3.8
Andhra Pradesh	2.9	3.4	3.8	0.8	2.7
Assam	3.9	3.5	_	1.6	2.2
Bihar	17.0	8.5	3.3	_	7.2
Gujarat	3.7	5.0	1.9	2.6	3.3
Haryana	6.4	3.9	7.7	1.5	4.9
Karnataka	11.0	3.2	2.7	6.6	5.9
Kerala	3.8	4.1	3.7	1.6	3.3
Madhya Pradesh	4.9	2.4	6.4	2.4	4.0
Maharashtra	12.9	3.5	1.7	1.7	5.0
Orissa	2.6	3.0	4.3	1.1	2.8
Punjab	15.6	5.6	4.3	5.4	7.7
Rajasthan	**4.0**	3.9	2.5	0.8	2.8
Tamil Nadu	**4.0**	3.9	2.5	0.8	2.8
Uttar Pradesh	5.3	1.9	1.3	0.5	2.3
West Bengal	2.2	2.1	2.1	0.8	1.4

Source: Tulsidhar (1992), cited in Quadeer and others (2001).

As mentioned in the earlier sections, one of the frequently faced problems in the successful implementation of the fee is that of exemption. Exemption mechanisms are often faulty and are even costlier than the revenue generated from the fee which prevents generation of any surplus. This can be overcome by setting simple and

efficient exemption mechanism, the administrative cost of which should be low. The cost of administration of the exemption mechanism should always be less than the funds generated from the fee. Another problem which prevents successful utilisation of the fee is the lack of set guidelines for using the fee revenue. Hence, fixed guidelines and procedures for effective utilisation of fee revenue for quality improvements should be set. Also, institutions collecting the fee should be authorised to use the funds without referring them to the state government. This would motivate the local health staff to collect the funds. Revenue generated from the fee can be enhanced by giving incentives to the health workers. This again would motivate them for fund collection. Hence, in order to enhance the effectiveness of user fee, all systems for setting the fee, accounting and auditing procedures, purchase procedures, exemption mechanism and the decision-making process should be well stated. As Mangal (2002) says, 'Accountability and transparency in collection and utilization of user fee for improving the quality of care are hallmarks of any successful interventions'.

CONCLUSION

Thus, the review of literature shows that the experience of user fee across countries has not been a positive one. The theoretical benefits of the fee were not realised because of the problems in implementation. The above mentioned suggestions for effective implementation of the fee were hardly put into practice in any of the countries mentioned in the paper. An experience across the six countries clearly shows that the fee was hardly successful in achieving its objectives of equity, efficiency, effectiveness and sustainability and thus defied the principles of public health as well.

Revenue generated from the fee was very low in most of the countries (Zimbabwe, Ghana, and India) which prevented any marked improvement in the quality of care. This, in turn, deteriorated the accessibility of care by people in general and poor in particular. Even in countries where the revenue generation was good and there was improvement in the quality of services, accessibility remained poor (Kenya and Cambodia). This shows that accessibility of services has very little to do with quality and is totally guided by affordability. Therefore, the assumption that user fee will improve the quality of care and thus improve the accessibility was proved wrong from the experience of these two countries. It was found in almost all the countries that the introduction of fee further deteriorated the health status of population as it affected the accessibility to health services. Thus user fee, which was actually meant to benefit public health by improving financial sustainability and shared the similar objectives as that of public health, resulted in becoming a threat to it in practice.

An experience of the fee across the above-mentioned nations raises some question on the very existence of the fee. If the revenue generated

from the fee is so low and if it has such damaging repercussions for the accessibility of health care — especially for the poor — then why does the fee still exist in these countries? Why does the state rely on such faulty mechanisms of financing for health, which is further deteriorating the health of the population? Is it actually lacking funds or is it running away from its responsibility of providing free, basic health care for which it had earlier committed to?

In the Indian context, when the government can spend one-fourth of it's GDP on projects like linking of rivers then why can't it increase the budgetary allocation on health? Why does health still comes last in the list of priorities for the government? Has it forgotten the earlier commitments made in the constitution and the Alma Atta Conference? Is it merely because of the pressures of the international agencies like the World Bank and the IMF or is it something else? Why are we still talking about implementing the fee in a better fashion and not removing it? Isn't the experience of the above-mentioned countries enough for us to draw lessons from?

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