



Waivers and Exemptions for Health Services in Developing Countries

Background

In response to shrinking budgets and growing demands, many developing countries have adopted formal or informal user fees in government health facilities. While they raise revenue, in the absence of special provisions user fees may hurt equity and efficiency. This paper reviews the success of two such provisions—waivers and exemptions. Waivers enable the poor to obtain free healthcare while exemptions enable all people to receive certain services for free. The dilemma is how to preserve user fees without hurting equity and efficiency.

This paper reviews the international literature and the experience of seven developing countries—Cambodia, Chile, Ghana, Indonesia, Kenya, Thailand, and Zimbabwe—with waivers and exemptions, and draws lessons for countries wishing to introduce such mechanisms.

Assessing Waiver and Exemption Systems

Assessing the relative practical merits of waivers and exemptions in case-study countries was difficult: the evidence was scattered and mixed, and the sources were dispersed and often informal. The review was chiefly concerned with (1) the degree to which waivers reduce out-of-pocket spending by the poor; (2) the increase in utilization resulting from waivers and exemptions; and (3) the enabling factors of successful waiver and exemption systems. Below is a summary of the main findings:

Performance Monitoring and Evaluation. The lack of monitoring and evaluation was a major weakness in all systems reviewed. In their absence, it is not possible to measure performance of waivers and exemptions and to take any required corrective measures.

Success of Targeting. In the low-income countries of the review, coverage of the poor by waiver mechanisms was extremely low, mainly because governments did not adequately compensate providers for the provision of subsidized services. Kenyan government providers, for instance, received no compensation whatsoever. Ghanaian public providers received compensation, but funding was uneven and often delayed. Thus, key to the success of waivers and exemptions systems is the sufficient and timely financial compensation of providers.

Coverage of the Poor and Leakage to the Non-Poor. In middle-income countries—Thailand and Chile—coverage of waivers was high. In these two countries, however, income-eligibility levels were set well above the poverty line, resulting in high levels of ‘leakage’ (where subsidies benefit the non-poor).

Administrative Costs. Virtually no information was available about the administrative cost of waiver systems. This precluded an assessment of the efficiency of targeting mechanisms (i.e., the share of all subsidies devoted to the administration of the system).

National Policies on Waivers and Exemptions. All countries, except Cambodia, had an explicit national waiver policy and all explicitly exempted certain categories of preventative services for all citizens. At the same time, most of these countries have had problems with their eligibility criteria, particularly in terms of distinguishing the poor from the non-poor. For example, in Kenya, a national policy exhorted public providers to exempt the so-called ‘pauper’ patients from user fees, but the lack of guidelines meant each facility adopted its own interpretation of pauper

patients. Formulating a clear definition of target beneficiaries is a necessary condition. It is also crucial that identification criteria be applicable and easily verifiable.

Countering Stigma. In most cases reviewed, the poor were often deterred from claiming waivers as they felt ashamed of their circumstances. Waiver applicants in a large public clinic in Cambodia, for example, were subjected to a public means test in the waiting room. Shame often led prospective applicants to forego their right to request a waiver.

Determining Eligibility. There is no single answer as to who should be responsible for the waiver process. Nevertheless, those determining eligibility should be aware of the selection criteria, be adequately trained, and be fully informed about the constraints governing the waivers process (i.e., how many waivers can be awarded in any given month).

Access costs. Freeing the most vulnerable from out-of-pocket payments may not suffice to promote access to care. The poor often must overcome access costs to healthcare beyond user fees, including transportation, lodging, and food costs as well as the opportunity cost (the cost of being away from work or from home). Cambodia's Health Equity Fund not only waives user fees for the poor but also reimburses their transportation and food costs associated with healthcare.

Updating Fee Levels and Income-Eligibility Thresholds. Fee levels and income-eligibility thresholds need to be adjusted periodically to ensure that they continue to cover those most in need of help. Otherwise, countries may inadvertently hinder access to medical care or induce facilities to adopt their own fee schedules. For example, if eligibility is defined on the basis of income brackets kept nominally constant, inflation may result in fewer people qualifying for assistance.

Institutional Aspects. Providers need clear written guidelines about how waivers and exemptions should work, with enough flexibility to allow for regional or local variation if necessary. Such clarity was generally lacking in case-study countries. Further, the staff responsible for administering waiver systems lacked the necessary training and supplies to carry out their job.

Disseminating the Existence of Waivers and Exemptions. The poor must know they are eligible for free or subsidized care and health facilities must know whom to waive. Likewise, the population should be informed about the existence of certain exempted services. Dissemination mechanisms must be tailored to the special characteristics of the poor, such as the fact that they often live away from major urban centers, have little access to formal media, tend to have little education, and work long hours.

Conclusion

Different countries have tried different approaches with waivers and exemptions. Those that carefully designed and implemented their waiver systems—such as Thailand and Indonesia—have had much greater success in terms of benefits incidence than those countries—such as Ghana, Kenya, and Zimbabwe—that took a more improvised approach. The key to a waiver system's success is adequate financing. Systems—such as those in Thailand, Indonesia, and Cambodia—that compensate providers for the revenue they must forego in granting waivers and exemptions have been more successful than those—i.e., Kenya—which expect providers to absorb the cost of waivers and exemptions.

Other success factors include: the widespread dissemination of information about waivers and exemptions to potential beneficiaries; financial support to poor patients for non-fee costs of obtaining healthcare; and clear criteria for the granting of waivers.

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