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**USER FINANCING OF BASIC SOCIAL SERVICES:**

**A review of theoretical arguments and empirical evidence**

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## ABSTRACT

*User financing of basic social services has become common practice in many developing countries. After more than a decade of experimentation, information on performance and impact is disappointingly limited. The available evidence, however, suggests that the conditions in which user financing of basic social services will improve effectiveness, efficiency and equity are more difficult to satisfy than has been thought. User financing has, in many instances, not been able to achieve the dual goal of maximizing quality gains and minimizing equity losses.*

*Although the issues involved are complex and are often country and sector specific, the review leads to the following conclusions: (i) the special features of basic social services associated with positive externalities, public and merit goods, principal-agent interactions and asymmetrical information imply that price signals will not guarantee greater efficiency and effectiveness; (ii) the potential of user financing for resource mobilization should not be exaggerated; (iii) although user financing can promote greater accountability on the part of service providers and more responsibility on the part of users, there is no guarantee that this will be the case; (iv) user financing can result in a sharp reduction in the utilization of services, particularly among the poor; (v) protecting the poor through price discrimination has proved extremely difficult in practice, and exemption schemes can be costly to administer; (vi) gender biases, seasonal variations and regional economic disparities can aggravate the effects of user financing on equity; (vii) user financing requires adequate capacities, effective decentralization and continued government support; (viii) user financing can undermine political support for the goal of universal coverage of basic social services; and finally, (ix) user financing does not empower beneficiaries in the way the recognition of basic social rights does.*

*There are powerful economic and moral grounds on which to avoid user financing for almost all basic social services. Although universal access to free basic social services is the ultimate goal, severe resource constraints may force policy makers to consider user financing as a temporary and pragmatic measure to narrow the gap between supply and demand, especially if budget restructuring and cross-subsidization in favour of basic social services will not be immediately feasible. Under this 'second-best' option, special attention will have to be paid to the following principles of best practice: (i) rely heavily on community participation in the design and management of user financing; (ii) initiate a major programme of community training and social mobilization to build capacity for meaningful co-management, (iii) provide adequate information and incentives to the providers of services; (iv) retain the bulk of the revenue and spending authority at the local level and ensure that user financing does not substitute for existing budgetary allocations ; (v) allow for flexibility in the type and timing of contributions (e.g., cash, in kind or labour); (vi) ensure that users perceive an improvement in the quality of services in the early stage of user financing, e.g., by directing revenue to the procurement of quality enhancing inputs such as essential drugs, textbooks and spare parts of water pumps; (vii) link user fees to the availability of such inputs rather than simply to entry or access (e.g., registration vs. treatment fees, tuition vs. textbook fees); (viii) implement an exemption scheme for the poor that is generous, transparent and equitable, and based on measurable criteria agreed by the community; (ix) exempt selected services - such as immunization - and specific target groups that are more easily identified than the poor; (x) de-emphasize the objective of reducing 'frivolous' consumption; (xi) use graduated fees whenever possible, particularly in the health sector to improve the referral system; (xii) introduce user financing gradually so as to allow for adequate modification to take account of the many cultural, regional and seasonal factors that may inhibit success; and finally, (xiii) set performance targets and conduct regular and comprehensive monitoring, analysis and oversight to adjust and improve the user financing scheme. Experience shows that, in the rush to mobilize additional resources, many of the above points can easily be overlooked.*



## I. INTRODUCTION\*

Until recently, it was common policy for the state to be the quasi-exclusive provider of free basic social services.<sup>1</sup> However, a combination of demographic and economic forces has left an important gap between the demand for and supply of such services. The state provision of services has increasingly come to be seen as either ineffective or prohibitively expensive. Alternative sources of revenue in the form of user charges and cost sharing have been explored in many developing countries since the early 1980s. A recent survey of 37 sub-Saharan African countries showed that only one country (Botswana) did not have — and did not intend to introduce — a policy of user fees in the health sector [Nolan and Turbat, 1995].

The interest in user financing is based on the realization that government budgets for social services have, in many instances, failed to keep pace with population growth and inflation, and that the prospects for growth are constrained by fiscal conservatism and/or anaemic economic recovery and growth. While fiscal austerity has been a major factor in the growing acceptance of user financing, an equally important element has been the rise in the influence of the market-based approach to development. Notable failures of government have fuelled the criticism of state action. As the policy of free services has reportedly failed, public action is being criticized as inefficient, costly, and inequitable.

The private financing of public services<sup>2</sup> is increasingly seen to enhance their efficiency and sustainability. Proponents claim that user financing will lead to an expansion of the coverage and/or an improvement in the quality of basic social services. It will also generate greater allocative efficiency, and create a sense of ‘ownership’ which will lead to greater responsibility on the part of the users and more accountability on the part of the providers of services. All of these factors, it has been argued, will ultimately contribute to better access for all, and hence to greater equity.

Although the case in favour of collecting contributions from users has been made powerfully, some equally powerful criticisms have been raised. In particular, the possible adverse impact of user financing on access to services — especially of the poor — has been highlighted. Empirical evidence on the negative effects of user financing, together with the emerging strength of the development approach which stresses human outcomes over the adherence to market doctrine, have reopened the debate.

User financing involves a complex set of issues that are often country- and sector- specific. The economic and ethical arguments that apply to fees for basic social services are very different from those that apply to non-basic services. This report focuses on the basic level of social services.<sup>3</sup> It reviews the growing body of evidence regarding the implementation of user financing in the social sectors and provides the tools with which to subject the theoretical arguments to critical analysis. The general lesson that will be derived from the review is that the conditions in which user financing

is likely to serve the stated ends regarding effectiveness, efficiency and equity are more complex and difficult to satisfy than has been thought.

Two fundamental questions arise regarding user financing for basic social services. First, can it improve 'value for money' and, second, can it safeguard equity? Indeed, user financing will be successful only if it contributes to the improvement of the quality of basic social services without jeopardizing equitable access. The debate is over whether user financing can serve these two goals simultaneously.

User financing, which represents a radical departure from earlier policy, is part of the wider spectrum of ongoing social-sector reforms in developing countries. User financing plays a pivotal role because the financing method of social services is crucial to the sustainability of the reforms. If user financing fails to improve quality and results in a sharp reduction in service utilization, then it will undermine the prospects for economic growth and human development. Therefore, the role of user financing of basic social services warrants careful attention.

The structure of the report is as follows. Section II clarifies the concepts of user fees, cost recovery, cost sharing and community financing. It also emphasizes the important difference between the willingness and the ability to pay for basic social services. Section III reviews the criteria appropriate for evaluation of user financing, including its potential for resource mobilization; for enhancing efficiency, effectiveness and equity<sup>4</sup>; and for institutional capacity building. Section IV discusses user financing in light of the rights-based approach to development as enshrined in international law and conventions. Section V attempts to summarize the complex issues that are involved in setting the price for basic social services, and highlights the principles of best practice in the design and implementation of user financing mechanisms.



## II. CONCEPTUAL CLARIFICATIONS

### 1. Cost recovery, cost sharing, user fees and community financing

This section attempts to distinguish the terms cost recovery, cost sharing, user fees, and community financing as they are used in the literature. Each of these terms has been used in different and often contradictory ways [e.g., Mwabu, 1990; Creese, 1990; Nigam and Ghosh, 1995; Parker and Knippenberg, 1991; Bennett and Musambo, 1990; Evans and Appleton, 1993; Van Wijk-Sijbesma, 1987]. None appears to have a standard definition. User financing is understood as referring to all direct contributions by users and communities, in a variety of forms, to service providers, but does not refer to indirect costs incurred by individuals in the course of using the service — such as opportunity costs, travel costs and other out-of-pocket costs. Among the many overlapping definitions which can be found in the literature are:

#### *Cost recovery:*

- a) Any form of contribution to costs by users
- b) Contribution to costs by users, undertaken in cash rather than in kind or labour
- c) Contribution to costs by users, whether in cash or in kind or labour, without community management

#### *Cost sharing:*

- a) Any form of contribution to costs by users
- b) Contribution to costs by users, undertaken in kind or labour rather than in cash
- c) Any form of contribution to costs by users, undertaken in the setting of community management and involving community control over the use of these contributions

#### *User fees:*

- a) Any form of contribution to costs by users
- b) Contribution to costs by users in the form of cash
- c) Contribution to costs by users in the form of a charge per unit of service delivered
- d) Any form of contribution to costs by users in which revenues are returned to higher administrative levels

#### *Community financing:*

- a) Any form of contribution to costs by users
- b) Contribution to costs by a community without individual assessments of users
- c) Contribution to costs by users, accompanied by community participation, with local retention and control over revenue

The literature lacks standardization of terminology, and the above definitions are often used inconsistently. Because of the bewildering array of available definitions in the literature across and within sectors, the following definitions are proposed in an attempt to introduce greater consistency:

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Cost recovery:	Contributions to costs by users, in cash rather than in kind or labour, that can be made on an individual basis or by a group of users, and are not necessarily assessed per unit of service delivered.
Cost sharing:	Contributions to costs by users, in kind or labour rather than in cash, that can be made on an individual basis or by a group of users, and are not necessarily assessed per unit of service delivered.
User fees:	Contributions to costs by individual users in the form of a charge per unit of service consumed, typically in the form of cash.
Community financing	Contributions to costs in cash or in kind, made by users and non-users: not based on assessments of individual consumption, and involving community co-management.

Cost recovery is an appropriate term for contributions in cash because the government recovers expenditure by such contributions. Contributions in kind or labour reduce the amount of cash expenditure otherwise undertaken by government. They cannot ordinarily be returned to government coffers, and are appropriately identified with cost sharing rather than the recovery of costs. User fees are charges per unit of use, and apply to individual users. Community financing includes contributions by a community as a whole, both in cash and in kind. Each of the four categories as defined here may be combined with any degree of community co-management. They can be applied to capital or recurrent costs. A fee per unit of service can be used to finance deferred capital costs as well as to pay for recurrent costs. Similarly, a one-time fee might be used to create a fund towards meeting recurrent costs, so there is no necessary relationship between the type of fee collection and the use to which it is put. Table 1 shows how these definitions may be contrasted with one another, although they are not mutually exclusive.

**Table 1: Types of user financing**

<b>Contributions in:</b>	<b>Type</b>
Cash	Cost recovery, user fees
Kind	Cost sharing

<b>Contributions by:</b>	<b>Type</b>
Individual users	User fees, cost recovery and cost sharing
Communities	Community financing

<b>Contributions per:</b>	<b>Type</b>
Unit of service delivered	User fees
Not per-unit-of-service	Prepayment schemes, one-time contributions

<b>Contributions to:</b>	<b>Type</b>
Capital costs	Cost sharing, community financing, any of the above
Recurrent costs	User fees, any of the above

## 2. Ability versus willingness to pay

The distinction between the ability and the willingness to pay is central to the evaluation of user financing. It is often assumed that if individuals are willing to pay for basic social services, they will be able to do so. This assumption must be questioned. In much of the literature, these two terms are treated as if they were identical. In the rare cases where the distinction between ability and willingness to pay is made, it is not made in the most relevant way.<sup>1</sup> The key cases to consider are those in which households are willing but unable to pay for essential services, or both unwilling and unable to pay. An individual or household may express the willingness to pay for an essential service despite the fact that doing so would require cutting back on essential food intake. The necessity to sacrifice one need in order to fulfil another should be taken as an indication of low ability to pay. The degree of duress faced by an individual or household in paying for a basic good or service is a good indicator of the ability to pay.

The difference between the ability and the willingness to pay is related to the distinction, made by the Oxford philosopher G. A. Cohen [1988], between “being free to do something” and “doing something freely”. In Cohen's view, one may choose to do something without it being the case that one was doing it freely. Doing something freely requires the absence of necessity or duress. It is precisely this requirement that is violated when individuals state their willingness to pay for a good or a service despite their lack of ability to pay for it.<sup>2</sup>

The willingness to pay may be higher than the ability to pay if the felt need is sufficiently strong, even if this entails failing to adequately meet other needs. The expressed willingness to pay for water, for example, is widely observed to be high in developing countries, resulting from the urgency of need for water and the high direct and opportunity costs associated with the acquisition of water. However, this does not mean that the ability to pay for water is as high.

Although an individual or a household may express a willingness to pay for a particular service, and may in fact have enough income to do so, this may present an unacceptable strain when placed in the context of other equally pressing needs. Therefore, the argument that even poor households have a high ‘willingness to pay’ for basic social services is based on the subjective expression of the urgency of need for a particular service, rather than on the true ‘ability to pay’ for a service, which stems in contrast from the presence of multiple needs-related claims the limited household budget. The partial assessment that underlies calculations of ‘willingness to pay’ is certainly a major weakness in theory, as well as in practice.

The ability to pay is related to the impact of expenditure on the total household budget, taking into account all other needs. Most evaluations of willingness to pay are based on partial enquiries into the value that individuals place on one particular need. Surveys of willingness to pay, even in the best case, give no indication of ability to pay. Kanji [1989] wrote: “Willingness to pay may be demonstrated by asking the question, ‘How much would you be willing to pay for an x% reduction in the risk of dying?’ If the question is rephrased to, ‘How much can you afford to pay for a particular treatment without getting into debt or cutting down on your food bill?’, the answer

may be very different.” Stanton and Clemens [1989] reported that more than half of the rural households in Bangladesh surveyed in 1986 spent less than 1 per cent of their income on medicine. Despite the households’ expressed willingness to pay more, the authors concluded that “the small percentage spent [on medicine] may well be all that is affordable; to spend more may result in withholding of other subsistence resources which are also essential to health maintenance.”

Evaluations of willingness to pay are based on partial enquiries into the value placed by individuals on fulfilling one particular need. This partial approach may lead to overestimation because it overlooks the presence of other needs in the context of a binding household budget constraint. For example, contingent valuation surveys regarding the willingness to pay for basic social services usually result in overly optimistic results. A survey in Tanzania found that nearly 90 per cent of the people would pay for quality health services [Mujinja and Mabala, 1992]. In the Central African Republic, more than two thirds of the respondents expressed their willingness to pay for the estimated cost of seven quality improvements in public health services [Weaver et al., 1993]. But those results should be interpreted with caution. The case of Zambia illustrates this well. The increase in user fees in 1994 resulted in a massive decline in the utilization of health facilities throughout the country [Booth et al., 1995]. Yet, a survey that took place before the price hike reported that only 4 per cent of the households reported that they would be unable to afford higher fees for health care [Forsberg, 1993]. Whereas willingness to pay measures felt need for a single good, ability to pay is related to the aggregate impact on household resources of a variety of needs (e.g., water, food, shelter, health care). An individual can be desperately hungry, and have a tremendous need for food, and yet not be able to make that demand effective in the market due to lack of purchasing power. Similarly, an individual may express a low willingness to pay for water or health care, due to lack of purchasing power, and yet have a great need for it. Markets by their nature express the level of purchasing power, rather than needs.

Ability to pay is difficult to measure in practice. However, the proportion of household budgets devoted to all necessities, in conjunction with data on the extent to which these necessities are being met, will provide a good indicator of ‘ability to pay’. This more holistic approach to the assessment of household capacities is altogether different from the narrow focus on self-stated ‘willingness to pay’, evaluated in an isolated sectoral context, which has characterized most of the literature. This may require additional information concerning the entire household budget as opposed to only one category of expenditure.<sup>3</sup> The ability to pay is also a far richer instrument to make judgements regarding the equity implications of user financing.

The argument is often made that the ability to pay is far greater than it is generally assumed. The most common example is that patients visit traditional healers who charge more than health facilities.<sup>4</sup> Dunlop and Donaldson [1987, quoted in Shaw and Griffin, 1995] reported that in Ethiopia, one fifth of the households’ average health expenditure was spent on traditional medicine. The corresponding figure for Mali was 13 per cent [Brunet-Jailly, 1990]. When people, including the poor, are prepared to pay for a service which they believe will give them value for money, then, the argument goes, their inability to pay should be considered with suspicion. Hence, the principle that everyone should contribute to the utilization of the basic service should be enforced. However,

anecdotal evidences should be interpreted with caution. Although traditional healers may charge higher fees, they generally request payment only when the patient has been healed, thereby reducing the effective price of health care. Moreover, they allow for flexible payments arrangements, and payments in kind, especially in the form of small livestock and crops, are not uncommon. Poor households can sometimes come up with substantial sums of money overnight to pay for a service, but this often involves severe duress. It would be unrealistic to argue on the basis of these special cases that the poor's inability to pay for basic social services is largely 'make-believe'.

### III. EVALUATION CRITERIA

The case for user financing has been based on two broad types of arguments: that user financing makes possible (i) expansion of the resource base for basic social services, and (ii) a more efficient and effective use of the available resources. This section examines those two types of arguments in detail, using a set of evaluation criteria. Each of these is discussed in relation to sectoral experiences, with a view to drawing policy conclusions on the value and possible limitations of user financing for basic social services.

#### 1. RESOURCE MOBILIZATION

##### *i. Price elasticities of demand*

The price elasticity of demand is the percentage change in the demand which is expected to occur after a one per cent change in price. Because consumers ordinarily choose to consume less of a service when it rises in price (all other things, including quality, remaining unchanged), the price elasticity of a service is typically negative. If the proportionate change in quantity consumed is large as a result of a small change in price, it is said that there is a high elasticity of demand. The elasticity is important because it will determine the amount of revenue that can be raised through the introduction of user fees, and the degree to which they can be expected to reduce demand.

The price elasticity of demand of a good should be distinguished from the willingness to pay for that good, although these two concepts are closely related. The demand elasticity of a good or service is derived from the number of units which individuals are willing to purchase at a given price. In standard economic theory, the number of units consumed is the number of units for which the individual's willingness to pay is greater than or equal to the price at which they are available to the individual. If an individual's willingness to pay for a particular good is less than the price at which it is available, then he or she will not purchase any units of that good. Whereas demand elasticity measures the effect of price changes on the total consumption of a good, willingness to pay measures the highest price which an individual would agree to pay for a unit of a good. The concept of willingness is most appropriately used in the context of hypothetical services which are not as yet available, the consumer's valuation for which is being investigated.<sup>1</sup> Willingness to pay has been in practice most often used in studies of water and sanitation.

A large literature exists on the estimation of price elasticities of demand and willingness to pay for basic social services. The methods rely upon relatively complex econometric techniques, on direct observations of household behaviour in the presence of price changes, and on household questionnaires.<sup>2</sup>

In practice, changes in the quality of a service can greatly affect the demand for it, and can nullify the negative price effect. Moreover, the price elasticity of demand for a particular good differs among various groups of users. Poorer persons, for instance, typically have a higher price elasticity than richer persons. If the elasticity of demand of poorer households for basic services is

substantially higher than that of richer households, then an increase in user fees will cause poorer households to consume comparatively less of the service. On the other hand, small differences in elasticities of demand across social and economic groups will be less inequitable.

A final point regarding the interpretation of price elasticities is that although high price elasticities of demand should be of concern when introducing user financing, low elasticities are not necessarily reassuring either. When considered against a very low initial price (in many cases close to zero), even a low elasticity can entail a very large decline in service utilization for a small absolute (but high proportional) increase in price, since the price elasticity is defined as a percentage change in demand which results from a percentage change in price. Mwabu et al. [1995a] noted a very large decline in health service utilization in Kenya (about 50 per cent) as a result of a small absolute increase in fees, despite a low estimated elasticity of demand.

It is not possible to summarize all of the existing studies in what now amounts to a large literature. However, the following generalizations can be made with regard to each sector:

***Health:***

Studies by Heller [1982] and Akin et al. [1985] concluded that the price elasticity of demand for health services was relatively low (Table 2). They have been extensively used in support of the introduction of user fees because they pointed toward a high willingness and ability to pay for health services [McPake, 1993b].

**Table 2: Early estimates of price elasticity of demand for health care**

Country	Year	Estimate
El Salvador	1980	-0.054
Malaysia (private facilities)	ca. 1975	-0.01 to -0.25
Malaysia (government facilities)	ca. 1975	0.26 to -0.01
Mali	1982	-0.0003
Philippines	ca. 1980	-0.002

*Source:* Jimenez [1987]



More recent studies, however, have raised doubts about the earlier findings. They indicated that the demand for health care is highly price elastic (e.g., de Bethune et al. [1989], Kanji [1989], Yoder [1989], Waddington and Enyimayew [1990], Gertler and Van der Gaag [1989], Lavy and Quigley [1993], Sauerborn et al. [1994], Booth et al. [1995], Haddad and Fournier [1995], and Mwabu and Wang'ombe [1995]). Though higher than in the earlier studies, the estimated price elasticity of demand for health care was relatively low in countries such as Ethiopia, Sudan and Swaziland. For other countries, including Burkina Faso, Côte d'Ivoire, and Peru, the estimates were considerably higher and surprisingly similar. They also indicate that for some socio-economic groups, the price elasticity is larger than unity, suggesting that a 1 per cent increase in price will amount to a decline in consumption of more than 1 per cent. Several studies indicate that the poor appear to be substantially more price sensitive in their demand for medical care than the non-poor. Studies show substantially higher price elasticities of demand for infants and children. As shown in Table 3, Sauerborn et al. [1994] reported that in Burkina Faso, the overall price elasticity of demand was -0.8, but that it was much higher for infants (-3.6) and children (-1.7) and for the poorest (-1.4). Gertler and Van der Gaag [1989] found that in rural Côte d'Ivoire and rural Peru, the poorer households were much more price sensitive than richer ones. Children's demand for hospital care was also found to be considerably more price elastic than adults' demand. Hence, user fees in both countries led to a reduction in utilization rates, particularly among the poor and children.

**Table 3: Recent estimates of price elasticity of demand for health care**

Study	Location/ Year of Data	Results
Jimenez [1989]	Ethiopia (1985)	Overall : -0.05 to -0.50
Jimenez [1989]	Sudan (1986)	Overall : -0.37
Yoder [1989]	Swaziland (1985)	Overall : -0.32
Gertler and Van der Gaag [1989]	Côte d'Ivoire (1985)	Rural Hospitals Income Quartile      Adults      Children Lowest : -0.47 to -1.34   -0.65 to -2.32 Second : -0.44 to -1.27   -0.58 to -1.98 Third : -0.41 to -1.18   -0.49 to -1.60 Highest : -0.29 to -0.71   -0.12 to -0.48
Gertler and Van der Gaag [1989]	Peru (1985)	Rural Hospitals Income Quartile      Adults      Children Lowest : -0.57 to -1.36   -0.67 to -1.72 Second : -0.38 to -0.91   -0.48 to -1.20 Third : -0.16 to -0.37   -0.22 to -0.54 Highest : -0.01 to -0.04   -0.03 to -0.09
Sauerborn et al. [1994]	Burkina Faso (1985)	Overall : -0.79 Age Groups <1 : -3.64 1-14 : -1.73 15+ : -0.27 Income Quartile Lowest : -1.44 Second : -1.21 Third : -1.39 Highest : -0.12

Most studies do not rigorously determine price elasticities but undertake a before/after analysis of the utilization of health facilities following the introduction or change in user fees. Some studies use time series of single providers, while others include multiple providers. Several such studies describe dramatic declines in utilization of medical resources after the introduction of user fees. Yoder [1989], for instance, found a 32 per cent decrease in use of government health facilities after a single increase in user fees in Swaziland. Up to a third of the overall decline was “among

patients who previously had paid the least for health care.” Hongoro and Chandiwana [1994] found that the enforcement of user fees in Zimbabwe was followed by a decline in outpatient attendance of 18 per cent. Another study found that the maternity unit at the Harare Central Hospital registered a 21 per cent increase in the number of babies born before arrival (BBA) in the six months following the stricter enforcement of user charges in 1991, and that the mortality rate among those babies rose by 156 per cent [Lennock, 1994].<sup>3</sup> Condom distribution — which was free until January 1993 — declined dramatically with the introduction of fees. The incidence of sexually transmitted diseases rose as condom demand fell, and cost recovery was soon abandoned [UNICEF, 1996]. Green [1994] reported that the introduction of a consultation fee in Mozambique was followed by a 50 per cent fall in usage of primary health care units. In Lusaka (Zambia), outpatient attendance to 11 clinics dropped by 64 per cent after the introduction of user charges in 1993, with the poorest neighbourhoods showing the sharpest declines [Kahenya and Lake, 1994]. Kenya experienced a decline of about 50 per cent in health service utilization after the introduction of user fees in 1989 [Mwabu et al., 1995a].

However, Shaw and Griffin [1995] have questioned the validity of price elasticity analyses and before/after comparisons because they do not provide information on changes in quality and in the pattern of service use. They pointed out, for instance, that upon closer examination of the Swaziland data, it appeared that 30 to 40 per cent of those who had used public hospitals and clinics switched to private providers of health services.<sup>4</sup> Similarly, Mbugua et al. [1995] showed that attendance at dispensaries in a poor area in Kenya, which continued to provide free services, rose while it fell sharply in all other facilities after the introduction of user fees.<sup>5</sup> If such demand diversion effects are not taken into account, the effect of change in user fees is likely to be overstated.

Evidence of demand diversion is not found in all countries. Booth et al. [1995] reported that the utilization rates of both hospitals and clinics declined precipitously in Zambia.<sup>6</sup> The number of outpatients dropped in all types of health facilities. In one of the children’s hospitals, the monthly average number of outpatients declined by more than 50 per cent over the period 1989-1994. In another hospital, deliveries of babies fell by nearly half between 1991 and 1994, with a reported increase in maternal deaths in home deliveries. Outpatient consultations for malaria plummeted by two thirds between May 1993 and May 1994. In one hospital, total admissions fell by 49 per cent, with the largest declines in the children’s ward (-65 per cent). Simultaneously, the authors observed a dramatic decline in attendance in clinics and rural health centres, suggesting that the decline in hospital use could not be interpreted as an increase in efficiency. On the contrary, if it is assumed that the poor had greater need of health services, efficiency actually declined. Booth et al. concluded that “the available evidence is not consistent with the idea that what we are witnessing is either a short-term response to the ‘shock’ caused by the new charge, or just an adjustment within the formal health care system to a more sensible set of relative prices. Rather, the evidence points to a fairly drastic, uncompensated and prolonged reduction in people’s access to formal health care.”

It is often argued that the utilization response to user fees is only temporary. Waddington and Enyimayew [1990] reported that over a period of two years, utilization rates in urban areas in Ghana gradually returned to their level prior to the increase in user fees in 1983. A similar early

recovery was observed in the Gambia after 1988. But in rural health centres in the Volta region, the drop in utilization had not been reversed three years after the introduction of the charges [Waddington and Enyimayew, 1990]. Lake [1994] reported that monthly attendance in a clinic located in a poor area in Lusaka plummeted immediately after the introduction of user fees, and had not recovered a year later. Longitudinal studies of other health facilities in Zambia did not show any significant recovery either. There is compelling evidence from several countries that fee-induced dropouts are more permanent in nature and more severe than can be justified on the basis of efficiency gains.

Some studies use more sophisticated econometric specifications, using multi-variate analysis that controls for several influences apart from the price of health care, such as distance, travel costs, and changes in the quality of the services. Mwabu et al. [1995a] reported a 52 per cent decrease in outpatient visits at government health centres after the introduction of fees in Kenya in 1989. After suspension of the fees in 1990, the number of outpatients rebounded by 41 per cent. The number of patients using government dispensaries, where the cost did not rise, increased by only 5.9 per cent. They also noted that the number of visits to private and missionary health facilities dropped by some 18 per cent, despite a decrease in the fees they charged.

Such findings strongly suggest that the utilization response to health user fees in most developing countries has been very dramatic indeed. Whether these declines might have been avoided by quality improvements is an open question. In the case of Zambia, the official guidelines made the proviso that “the quality of the [health] service will have to be improved before any of the cost sharing schemes are introduced.” The guidelines neither specified how quality was to be measured nor how it was to be improved. In practice, user fees were introduced without any improvement in the quality of health services.

Lavy and Germain [forthcoming, quoted in Shaw and Griffin, 1995] suggested that the direct effect of user fees on utilization in Ghana — where the number of outpatients declined from over 10 million in 1973 to 5 million in 1987 — was less significant than the effect of distance, travel costs, and quality changes. A similar pattern emerged from the Zambia case study [Booth et al., 1995]: two of the health institutions saw virtually no decline in their utilization rates following the increase in fees in 1994, largely because they served relatively better-off catchment areas and had reputations for delivering quality services. The long distance to reach them meant that the rise in user fees did not deter patients, because the cost represented only a marginal increase over the already high travel expenses.

A major difficulty in measuring the utilization response to user fees is associated with the measurement of the changes in quality. The omission of quality changes may result in misleading conclusions. Quality improvements may cushion or even nullify the negative impact of user fees. The lack of quality improvements may further aggravate the utilization response. Shaw and Griffin [1995] pointed out that a drop in utilization stemming from increased user fees for poor-quality health services can be interpreted as a rational consumer response.<sup>7</sup> However, quality is a subjective variable for which it is extremely difficult to find an acceptable and objective proxy. One study asked

households, pharmacists, physicians and traditional practitioners about the single most important measure of improvements in health services. Only physicians included “more physicians” among their choices [Abu-Zeid and Dann, 1985]. Although this may have been a predictable outcome, it illustrates the degree of subjectivity in this matter. Patients can hold very different ideas about the quality of health care. Both Heller [1982] and Akin et al. [1985] used the availability of physicians as the quality measure. This variable is inadequate. Qualitative assessments and ‘focus group discussion’ techniques have indicated that patients perceive quality in terms of the adequacy of the supply of drugs, the cleanliness of the physical conditions of the health facility, and the availability and attitude of the health personnel. The ‘rudeness’ of the latter is often mentioned as a strong disincentive.

Limited evidence suggests that quality improvements in health care delivery can more than offset the effect of price increases, also among the poor. Litvack and Bodart [1993] used detailed data from five public health facilities in Cameroon that introduced user fees, three of which improved the quality of the service. They found that in those facilities “the probability of the poorest quintile seeking care increases at a rate proportionally greater than the rest of the population.” They interpreted this as an “effective reduction” in the price of care. In order for such an effective price reduction to take place, quality improvements must cross some minimum threshold. A review of the Bamako Initiative<sup>8</sup> in Benin did not reveal any significant difference in the role of financial considerations among various socio-economic groups in deciding to seek medical care [ICC, 1990]. A separate study in Benin found that utilization of all categories of health care increased during a period of significant economic stress, indicating the positive effect of quality improvements on utilization [Jarrett and Ofosu-Amaah, 1992]. More generally, UNICEF/BIMU and Renzi [1990] reported that increases in utilization were observed in Benin, Guinea and Sierra Leone after introducing fees with simultaneous improvement in service quality, whereas studies in Ghana, Mozambique and Swaziland show reduced utilization where fees had little or no impact on quality.

In contrast, Haddad and Fournier [1995] found that user fees led to a fall in attendance in Zaire, although fees improved the supply of drugs and the physical conditions of the buildings. An econometric analysis in Kenya concluded that the number of medical staff or the availability and type of drugs had no significant explanatory power for the demand for health services [Mwabu et al., 1993]. A children’s hospital in Zambia — known by the community as the only establishment in the area with a reliable supply of drugs — saw its number of outpatients and admissions drop by well over 50 per cent following the increase in user fees [Booth et al., 1995]. The staff of a private hospital did not feel that user fees had made any difference to the quality of the service, except negatively because lower-capacity utilization undermined its efficient operation.<sup>9</sup> These examples illustrate the complexities and difficulties in measuring impact of quality on health service demand.

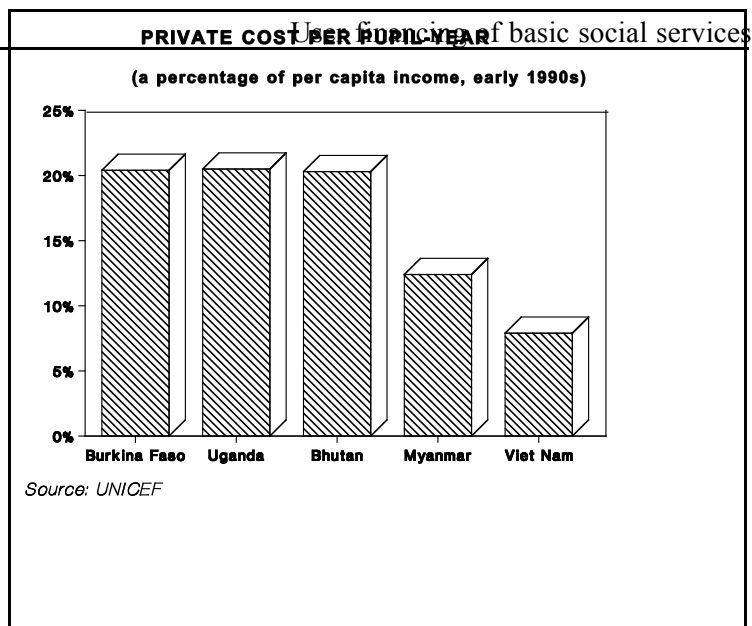
Overall, the evidence supports the proposition that patients base their health demand pattern on a combination of factors, including prices, travel costs and perceived quality. However, the latter two factors are difficult to measure. Therefore, studies on utilization responses seldom lead to firm conclusions, and sometimes yield contradictory results. There is compelling evidence, however, that user fees are associated with drastic declines in utilization rates, and that the poor and the children

are most vulnerable. It is increasingly difficult to dismiss the growing body of evidence of their adverse effects on public health as either anecdotal or based on analyses that are methodologically flawed. This is not to deny that quality improvements can cushion the utilization response, but experience shows that user fees are normally not associated with such changes. Nolan and Turbat concluded that “While it is tempting to assume that utilization fell only where cost recovery was not associated with improved availability of drugs [...], the evidence [...] is so tenuous that it can lend only limited support to that hypothesis.” Many have observed that if user fees were to have an impact on the quality of health service, they would need to be fixed at a much higher level than is commonly the case. This would trigger an even stronger utilization response, inducing lower levels of effectiveness and equity. Moreover, the poor are often the first ones to drop out with increased user fees or high transportation costs, irrespective of the change in quality of health service.

### ***Education:***

Considerably less effort has been taken to estimate the price elasticity of demand for education. This is usually found to be lower than for health. The explanation may be that out-of-pocket costs to households for basic education are generally much higher than for primary health care, so that user fees represent a smaller fraction of total household costs in education. For example, the 1993-1994 household budget survey in Zambia indicated that, on average, households spent five times more on education than on health [Government of Zambia, 1994].<sup>10</sup> A given absolute rise in user fees will, thus, lead to a proportionately smaller increase in the total costs borne by households than in the case of health services. The impact of user fees on the utilization of education services will be less than in health for two reasons: (i) fees represent a proportionately smaller share of total expenditure on education, and (ii) high out-of-pocket costs, particularly at the primary level, have already made many poor children drop out of school before the introduction or rise of user fees.

Recent studies in two African and three Asian countries have confirmed that parents make significant contributions to the cost of primary education. The private costs per pupil — covering uniforms, textbooks, tuition and building fees and PTA contributions, but excluding individual tuition and contributions in kind — were found to be equivalent to between 10 and 20 per cent of per capita income [Mehrotra, Nigam and Thet, 1996], as is shown in Figure 1.



Similarly, a survey in Kenya revealed that households contributed 34 per cent of the total cost of primary education [World Bank, 1995c]. In Uganda, parental financing of primary education was equivalent to 2 per cent of GNP, compared with 0.6 per cent for government expenditure. Similar figures have been reported in other countries and reflect the high value parents place on the education of their children. But increasingly, they perceive that they are getting poor value for money. Households are also discouraged to see that increases in parental contributions are substituting for government support. With the increased incidence of poverty, it is therefore not surprising that the enrolment ratio in several African countries has declined in recent years, and that the decline has been greatest for boys, because their opportunity cost of education is the highest.

As with health, the poor are likely to be more sensitive to the price of education. Jimenez [1987] summarized a number of studies that claimed to show that elasticities of demand for education are often less than unity.<sup>11</sup> In Malawi, the price elasticity was estimated at -0.52, although it was considerably higher in Mali (-0.98). However, the disaggregation of these elasticities by income groups revealed that lower-income groups exhibit higher elasticities [Colclough, 1993a]. Thus, Gertler and Glewwe [1989] found a much higher reduction in secondary school attendance for rural households in Peru belonging to the poorest quartile of the population than for those belonging to the wealthiest 25 per cent, for a given increase in fees. The price elasticity of demand for the poorest quartile was two to three times as large as for the richest quartile. Table 4 indicates that the difference in elasticities between local and distant schools is more significant for the poor, because rich households can more easily afford higher travel costs.

**Table 4: Price elasticity of demand for secondary education in rural Peru**

Price Range (Intis of 1985)	Poorest 25%	Wealthiest 25%	All Income Groups
<b>Local School*</b>			
0-300	-0.14	-0.05	-0.11
300-600	-0.23	-0.09	-0.19
600-900	-0.35	-0.13	-0.28
900-1200	-0.47	-0.18	-0.38
<b>Distant School</b>			
0-300	-0.19	-0.07	-0.15
300-600	-0.32	-0.10	-0.25
600-900	-0.47	-0.14	-0.36
900-1200	-0.61	-0.18	-0.47
<b>Average Household Income</b>	7,236	48,679	20,483

\* A local school is defined as the nearest secondary school to the household.

All other secondary schools are considered to be distant schools.

Source: Gertler and Glewwe [1989]

In Ghana, the introduction of fees for primary school in 1992 led to a decline of over 4 per cent in the intake in the first year of primary education. The affordability of school fees was found to be a major reason for dropping out [World Bank, 1993b]. Similar declines were recorded in Côte d'Ivoire. Indonesia, Kenya and Tanzania all increased their enrolments significantly after abolishing primary school fees [World Bank, 1995a; Lockheed and Verspoor, 1991]. Chisvo and Munro [1994] reported that the introduction of school fees at the primary level was also accompanied by a decline in school attendance in Zimbabwe despite a rise in the catchment population. Several rounds of community-based sentinel site surveillance confirmed that the principal reason why parents did not send their children to school was because they could not afford it. In Malawi, increases in school fees were met with declines in school enrolments [Bray and Lillis, 1988]. In 1994, when the modest



primary school fees were eliminated, school enrolment surged by a staggering 50 per cent.<sup>12</sup> Booth et al. found that the impact of user fees on the access to primary education in Zambia was less acute than in health, mainly because many headmasters did not enforce the new school fees. Nevertheless, school drop-out increased on account of the increased costs, and “showed a clear pattern in terms of both gender and the socio-economic condition of households.” The 1994 poverty assessment in Kenya found that poor communities had serious difficulties keeping children in school mainly due to the cost. Nearly half the households interviewed in seven poor districts had one or more children who had dropped out because of their inability to pay the fees. Girls were found to be twice as likely to be pulled out of school as boys [World Bank, 1995c]. Similar gender biases have been reported for other countries, including Ghana and Zimbabwe.

As in the health sector, some analysts have claimed that fees at the primary level can be increased without decreasing enrolments by bringing about significant increases in quality [Birdsall, 1986; Tan and Mingat, 1992]. However, this claim seems difficult to sustain in view of the observed high price-sensitivity of the poor to the cost of education.<sup>13</sup> Moreover, the gap between school revenue and the level of expenditure required to deliver quality education is so large that it would be unrealistic to assume that parental contributions can close it.

In the education sector, there is much greater incidence of unofficial fees such as ‘parent teacher association’ payments [World Bank, 1988; Mehrotra et al., 1996]. In addition, the proliferation of school fees, cost sharing in the form of community contributions towards school building and maintenance is also common (e.g., harambee in Kenya), but there is little evidence of their effects on demand. Since lump-sum community contributions do not create incremental disincentives for attending school, they should not have any negative impact on individual enrolment behaviour.

At the secondary level, it has often been claimed that there exists significant ‘excess demand’ for education, and that therefore fees can be increased without significantly reducing enrolments. World Bank [1988] provided evidence for this view from Malawi. On the other hand, even if it is true, this does not mean that the composition of enrolment will not change: total school enrolments can remain the same but fewer of the poor, fewer girls, and fewer from a particular region may enrol.<sup>14</sup> The evidence from rural Peru, presented in Table 4, supports this possibility.

### ***Water and sanitation:***

Studies of household economic behaviour in relation to water and sanitation have focused on willingness to pay rather than on demand elasticities. However, demand elasticities are potentially relevant in the water and sanitation sector, because an increase in the cost of water available from a kiosk may lead individuals to make recourse to an unprotected but free source of water — a behaviour which will be exhibited in the price elasticity of demand for kiosk water. Evidence suggests that there is a high elasticity of demand for improved sources in the presence of a traditional source, with respect to both one-time connection fees and monthly tariffs [World Bank Water Demand Research Team, 1991].

The consensus of the literature is that there is generally a substantial willingness to pay for an appropriate level of water service, and to a lesser extent for sanitation, although this must be qualified by the geographical and socio-economic context. This is true for the poor as well as the non-poor although the pattern of preferred expenditures (e.g., public versus yard tap) may vary substantially. There are also important non-income determinants of willingness to pay, e.g., gender, education, occupation, family size and composition, availability and perceived quality of existing sources [Briscoe et al., 1990]. These views are supported by the studies of, among others, Briscoe et al. [1990], Whittington et al. [1990, 1991] and McPhail [1993]. These conclusions have been derived from complex contingent valuation (questionnaire) studies, or in some cases by inference from households' existing levels of expenditures on water. The study by Whittington et al. [1991] of Kumasi (Ghana) and examples such as that of the Orangi Pilot Project in Karachi (Pakistan) [Briscoe and Garn, 1995] can be pointed to in order to demonstrate the willingness to pay of even poor households for at least a low level of sanitation services. The high willingness to pay for water is related to the crucial nature of water as a necessity, as well as to the very high direct and opportunity costs (time in particular) involved in acquiring it.

In many developing countries, households, especially in peri-urban areas, already spend a high proportion of their income on vended water — often between 30 and 40 per cent and as much as 55 per cent [Cairncross and Kinnear, 1991; Katko, 1991; Nigam and Ghosh, 1994]. Cairncross and Kinnear estimated that between 20 and 30 per cent of the urban population of the developing world are served by water vendors. Moreover, the poor are more likely to purchase vended water at higher costs than the rich [Whittington and Choe, 1992]. This fact has often been used as an indication of the willingness of the poor peri-urban households to pay for water, although it is unlikely to be an indicator of their high ability to pay.

Little is known about the willingness to pay for water supply in rural areas, although it is likely that there is considerable variation depending on local context [World Bank Water Demand Research Team, 1991]. For example, the Government of Malawi [1995] decided that the ability to pay for water supply in rural areas was too low to substantially defray costs. One constant is that, in both rural and urban areas, women's time is a prime form of cost incurred due to the unavailability of water, and women usually exhibit a higher willingness to pay for water than men, although they may have a lesser ability to do so.<sup>15</sup>

## *ii. Direct revenue and administrative costs*

An important consideration in the evaluation of user financing is the extent to which it raises additional resources, net of the costs involved in collecting them. This will depend on the demand characteristics of households (elasticities of demand), costs of collection of user fees, as well as related administrative expenses such as the cost of administering a system of exemptions.<sup>16</sup> Although administrative costs always exist, it is necessary to evaluate whether their relative size is merited by the goals for which they are being incurred.

Evidence regarding the relative importance of user financing for government revenue is mostly available for the health sector. Very few estimates of the administrative costs of collecting user contributions exist. This should be a major area of future investigation. Some of the available estimates refer to areas outside basic social services. Rogers [1992] provided an example on irrigation in which “the cost incurred in collecting the fees for water was 117 per cent of the actual amount collected.” On the other hand, Jimenez [1987] estimated the cost of administering student loans in Latin America at between 12 and 23 per cent. Creese [1990] reported that even for many industrial countries with relatively strong administrative systems, “the costs of collecting fees are considered, for many major areas of health care, to outweigh their total yield.” In the arena of basic social services in developing countries, Chisvo and Munro [1994] estimated that the cost of collecting revenue in health user fees in Zimbabwe was more than four times as high as the costs of collecting the same revenue through direct or indirect taxation. In Sudan in 1979, fee administration amounted to 10% of revenue at the primary level and 70% of revenue at the hospital level. In Mali, it was estimated that 50% of health insurance funds were absorbed in administration, as was 14% of the income of the National Hospital Insurance Fund [Gilson and Mills, n.d.]. These figures are suggestive rather than definitive because of the lack of adequate estimates. However, they do indicate that administrative costs can significantly reduce the net direct revenue stemming from user financing.

Because of the price-sensitivity of the poor, an equitable system of user financing will have to include appropriate exemptions. However, this will necessarily require a system of identifying and targeting the poor. These activities are often costly. Since the costs of administering a system of exemptions are directly associated with the introduction of user financing, they should properly be accounted for in a statement of overall costs. However, the costs of administering a system of exemptions are usually not included in estimates of administrative costs. Grosh [1994] found the median costs of administering targeted social welfare programmes in Latin America to be 9 per cent of total costs of the programmes surveyed, reaching as high as 29 per cent in some cases.

### ***Health:***

Although estimates vary, it appears that most African countries, even without taking into account administrative costs, have not been able to raise a substantial proportion of the recurrent budget of their health ministries through cost recovery. The available data are summarized in Table 5. Nolan and Turbat [1995] reported that “A small number of countries are raising 5-10 percent of their recurrent expenditure, but most do not appear to be approaching such levels.” Shaw and Griffin [1995] suggested that the percentages seem to have improved over time. They mention four countries — Côte d’Ivoire, Ethiopia, Lesotho, and Zimbabwe<sup>17</sup> — as examples of increased revenue generation through user fees. The figures, however, need to be interpreted with caution. They certainly do not imply that all countries are moving along an upward trend. Cost recovery in Ethiopia — which had been considered as a success story in the mid-1980s — appears to have declined in recent years. In Ghana, revenue fell from a peak of about 12 per cent after 1987. In Zimbabwe, the importance of cost recovery declined in 1992 when the income limit on exemptions was increased, and fell further in 1995 when the fees for rural clinics were withdrawn.<sup>18</sup> In Senegal, the relative importance of cost recovery in the health sector also seems to have declined in the late 1980s.

Some hospitals, clinics and local projects are reported to recover a higher proportion of their non-salary recurrent expenditure. In 1994, for example, the average cost recovery rate for 168 health centres in Senegal under the Bamako Initiative was 127 per cent of recurrent expenditure, excluding salaries and vaccines [UNICEF/BIMU, 1995]. In Benin, more than 80 per cent of the health centres recovered all their non-salary operating costs. Non-governmental health facilities have also been successful in this regard, often meeting more than 50 per cent of recurrent expenditures including salaries [Mujinja and Mabala, 1992]. There are similar examples of meeting a high proportion of local recurrent costs in government facilities through user charges in Latin America and elsewhere, although such high proportions recovered are not the general pattern [Richardson et al., 1992; Olave et al., 1992; Lewis, 1993]. Salary costs are reported to account for sixty to eighty percent of total recurrent costs at the facility level in the health sector in Africa [Leighton, 1995]. As a result, measures of the proportion of costs covered through user financing which do not account for salary expenditures tend to considerably overstate the successfulness of these measures. Although the significance of high cost recovery at the local level should not be underestimated, some observers have cautioned that the success stories of individual communities “may give a misleading impression of the contribution that cost recovery at the local level can make to financing the public health services” [Nolan and Turbat, 1995].

**Table 5: Magnitude of revenues raised through cost recovery in health in Africa**

Country	Year	Percentage of Recurrent Budget Ministry of Health
Botswana	1979	1.3
	1983	2.8
Burkina Faso	1981	0.5
Burundi	1982	4.0
Côte d'Ivoire	1986	3.1
	1993	7.2
Ethiopia	1982	12.0
	mid-1980s	15.0 - 20.0
Ghana	1984	5.2
	1987	12.1
	1990-1991	5.0 - 6.0
Kenya	1984	2.0
Lesotho	1984	5.7
	1991-1992	9.0
Malawi	1983	3.3
Mali	1986	2.7
Mauritania	1986	12.0
Mozambique	1985	8.0
Rwanda	1984	7.0
Senegal	1986	4.7
	1989-1990	4.0
Swaziland	1984	2.1
Zimbabwe	1986	2.2
	1991-1992	3.5

Source: Vogel [1991], Nolan and Turbat [1995], Shaw and Griffin [1995]

Griffin [1987] pointed out that small fees in hospitals can generate revenues that dwarf those raised at health centres and clinics. Nevertheless, many countries have focused revenue collection on the latter rather than on the former. Concentrating cost recovery on the health centres, the greatest

potential source of revenue has remained unexploited, an approach which could yield adverse efficiency and equity implications.<sup>19</sup> Local cost recovery has, therefore, to be set within the wider framework of the entire health sector financing plan. The recent experience in Kenya has shown that a top-down approach in the implementation of user financing, which starts from the hospitals down to the health posts, was preferable to a bottom-up approach from the perspective of revenue potential, administrative effectiveness, and equity [Government of Kenya, 1995]. If defined in isolation, community-based cost recovery may create “further problems rather than resolve the ones it was designed to address” [Nolan and Turbat, 1995].

### ***Education:***

Direct cost recovery (i.e., in the form of formal fees) in public education is limited or of recent vintage at the primary level, although practiced to a somewhat greater extent at the secondary level. The out-of-pocket costs for parents are very much higher than for health. It is well known that households spend significant amounts of resources on education through all kinds of contributions, in kind, labour or in cash. Although comparative figures on the proportion of public education budgets financed by direct charges such as tuition fees are not readily available, their size may be hypothesized from the proportions of per unit public expenditure shown in Table 6. In 1980, cost-recovery ratios were mostly low for all levels of education services, but they were generally greater at the lower level, particularly in African countries.

More recent data show that cost recovery at the tertiary level of education remains low. Table 7 indicates that the majority of the 46 countries had a cost-recovery ratio of less than 10 per cent of the operating expenditure of public higher education. A survey of 15 African universities found that only half of them charged fees, which generated on the average about 10 per cent of their recurrent budget [Blair, 1992]. A 1992 household budget survey in Kenya showed that households' direct contributions covered 20 per cent of the total cost of higher education, against 34 per cent for primary education. In Lesotho, parents contributed 30 per cent of the total recurrent and capital expenditure on education, and the share was higher for primary than for tertiary education [World Bank, 1988].

**Table 6: Cost-recovery ratios by level of education, 1980**

**(User fees as a percentage of public unit cost)**

<b>Country</b>	<b>Primary</b>	<b>Secondary</b>	<b>Tertiary</b>
Bolivia	0.8	0.4	1.0
Botswana	0.0	2.7	0.0
Brazil	-	-	5.0
Burkina Faso	13.0	0.0	0.0
Burundi	0.0	6.3	14.8
Central African Republic	2.5	2.7	-
Chile	1.6	0.9	25.0
Colombia	-	-	3.4
Costa Rica	0.3	0.5	8.0
Dominican Republic	0.0	0.0	1.0
Ecuador	0.0	0.0	2.0
Guinea	0.0	0.0	0.0
Haiti	6.8	3.4	-
Honduras	0.0	9.6	10.0
India	2.0	18.5	29.1
Indonesia	0.0	9.0	13.0

**Table 6: (continued)**

Country	Primary	Secondary	Tertiary
Kenya	4.0	43.7	0.0
Lesotho	9.0	42.1	5.0
Malawi	37.0	38.0	1.0
Malaysia	5.0	5.0	5.8
Mauritania	0.0	0.0	0.0
Nigeria	30.0	39.0	12.4
Pakistan	1.2	1.8	2.1
Paraguay	4.1	2.0	0.7
Philippines	-	-	3.7
Republic of Korea	3.7	41.2	23.4
Sierra Leone	1.5	20.3	-
Solomon Islands	0.0	25.0	0.0
Swaziland	7.0	26.3	-
Thailand	0.0	12.5	6.9
Togo	13.0	5.0	-
Turkey	0.0	0.0	15.0
Uganda	27.0	24.3	-
Uruguay	0.5	0.4	5.0
Zambia	3.0	11.6	-
Zimbabwe	0.0	5.0	-

Source: Jimenez [1987]

Note: “-” signifies no information available

**Table 7: Fees as a share of unit operating expenditure in public institutions of higher education\* (46 countries, ca. 1990)**



Proportion	0%	1-10%	11-20%	21-30%
Countries	Algeria Argentina Bangladesh Benin Brazil Ghana Madagascar Malawi Mexico Morocco Niger Nigeria Papua New Guinea Peru Senegal Sudan Uganda United Kingdom Venezuela	Bolivia China Colombia Egypt France Guatemala Honduras Hungary India Japan Malaysia Nepal Pakistan Sri Lanka Thailand	Barbados Costa Rica Israel Kenya Philippines Spain United States	Chile Indonesia Jamaica Republic of Korea Viet Nam
Number of Countries	21	15	7	5

\* Excluding expenditure on student accommodation  
Source: World Bank [1995a]

Although these figures do not in themselves tell us anything about the level of educational expenditures which can potentially be borne by the majority of households, they suggest that there are upper limits to raising revenues through fees. The potential difficulty in raising fees without impinging upon the ability to pay is suggested by Colclough [1993b]. He estimated the proportion of household income of the poorest 40 per cent which would be needed to finance two children at primary school on a full cost-recovery basis. As can be seen from Table 8, primary-education costs represent a very significant proportion of poor households' budgets. In the majority of countries, the poor would have to spend over 10 per cent of their meager incomes on primary education. These figures suggest that the proportion of public expenditures which can be shifted to households through user fees without causing a steep decline in enrolments is likely to be small, which is also underlined by the data on elasticities of demand for education cited earlier.

**Table 8: Proportion of household income of the poorest 40% needed to finance two children at primary school on full cost recovery basis (63 countries, 1986)**

Proportion	Less than 5%	5 to 10%	10 to 15%	15 to 20%	20 to 25%	> 25%
Countries	Argentina Bangladesh China Dominican Republic Guatemala Haiti India Mexico Pakistan Paraguay Peru Uganda	Algeria Bolivia Brazil Burkina Faso Colombia Ecuador El Salvador Ghana Israel Lesotho Mauritius Nepal Philippines Tanzania Togo Turkey Uruguay Venezuela	Botswana Burundi Chile Costa Rica Cuba Honduras Iran Jamaica Kenya Madagascar Malawi Morocco Nicaragua Panama Rwanda Syria Trinidad and Tobago Tunisia Zambia Zimbabwe	Côte d'Ivoire Malaysia Mauritania Oman Republic of Korea Singapore Thailand	Central African Republic Liberia	Ethiopia Mali Sudan Yemen Arab Republic
Number of Countries	12	18	20	7	2	4

Source: Colclough [1993a]

Several policy documents on education strongly discourage cost recovery at the primary level. In spite of the emerging consensus, user financing continues to be applied in practice. World Bank [1995a], for instance, recommended that “cost sharing with communities in school construction and maintenance is normally the only exception to free basic education.” Community participation in Malawi has cut the costs of school construction by two thirds and in Senegal by almost one half [Lockheed and Verspoor, 1991; World Bank, 1995a]. In Zambia, it is said to have facilitated expansion in a number of secondary schools [World Bank, 1988]. Zimbabwe more than doubled its primary gross enrolment ratio during the 1980s through community-built classrooms. Bray and Lillis [1988] noted examples from Nepal, Nigeria and other countries of between 15 and 45 per cent of the costs of school construction being borne directly or indirectly by communities.

Cost sharing of this type (contribution towards the cost of school construction) is likely to have fewer (if any) negative effects on school enrolment because it typically takes the form of contributions by the community as a whole, rather than simply by parents of school-goers, and once contributions are made, there are no recurrent costs to parents which might discourage attendance.<sup>20</sup> Because community contributions towards school building and maintenance are in the form of labour and kind rather than cash, they are difficult to estimate. Nevertheless, it is reasonable to conclude that they are unlikely to serve as a disincentive to school attendance, whereas user charges are likely to do so.

It has been argued that costs of collection of user fees in the education sector may be very high [Bray and Lillis, 1988], especially if they are remitted to a central authority. However, estimates on the extent of these costs do not appear to exist.

### ***Water and sanitation:***

There is little direct evidence on revenues or administrative costs associated with user financing in the water and sanitation sector. Accordingly, indirect judgements are necessary. The literature on willingness to pay for water suggests that a high degree of cost recovery may generally be possible. Costs for water systems for peri-urban areas are likely to be fully recoverable, although adequate financing mechanisms might be needed in order to make this practicable [Nigam and Ghosh, 1994-1995; Briscoe and Garn, 1995]. However, the very high level of initial capital costs involved necessitates close attention to the development of financing mechanisms that are accessible to the poor [UNICEF, 1995d]. The bearing of full costs by communities also may be feasible for water systems in rural areas, although the level of technology for which this will be the case will depend on local conditions, including availability of alternative sources [Altaf et al., 1992]. Although users do widely demonstrate a high willingness to pay for water services, it would be wrong to infer from this that they have a high level of ability to pay — the former may simply be an expression of the felt urgency of their need for water.

On the other hand, the willingness to pay for sanitation systems is often lower than the costs [Blackett, 1992; Government of India, 1990; Whittington et al., 1992]. If the policy goal is to achieve widespread usage of safe water and sanitation facilities and not only to shift a high proportion of aggregate costs to users, then some degree of subsidy will be necessary in keeping with the low willingness (in the case of sanitation) and the low ability (in the case of water) to pay of poorer households. The high initial capital cost of establishing both types of services, in both rural and urban areas, underlines the case for subsidy.

Abstracting from administrative costs and other related implementational concerns, the potential for significant direct revenues to be raised in the water and sanitation sector appears to be high, especially in peri-urban centres, but less so in rural areas. The level of administrative costs entailed by user financing for water will depend on the method of assessment of contributions chosen. Some methods are likely to be prohibitively expensive in this respect. For example, the costs of billing and collection for metered taps often exceeds total revenues [Van Wijk-Sijbesma, 1987].

## **2. EFFICIENCY AND EFFECTIVENESS**

Proponents of user financing for basic social services argue that it will promote efficient and effective resource utilization because costs will motivate users to avoid excessive use of the services (i.e., demand-side efficiency) and will create greater accountability on the part of the service providers

(i.e., supply-side efficiency). The quality and sustainability of service delivery will thus be enhanced. Technical efficiency, allocative efficiency, and cost efficiency are all thought to increase. However, there are several reasons why requiring financial contributions from users need not lead to increased efficiency or effectiveness. In some cases, user financing can lead to greater inefficiencies. The principal reasons are discussed below.

*i. Externalities and public goods*

Some goods and services cannot be consumed by an individual without affecting the well-being of other individuals. These effects can in principle be either positive or negative. In either case, externalities exist in consumption. The existence of positive externalities implies that the consumption of a good or a service has benefits not only for the individual consumer but also for others. As a result, setting its price equal to its cost of production would lead to a sub-optimal use from the point of view of the society. The amount consumed will reflect only the direct value of the good or service to the individual consumer and not the benefits to others. In such circumstances, there is a strong argument for subsidy in order to encourage consumption at a socially optimal level. An example of a good or service for which positive externalities exist is immunization against communicable diseases, because an individual's immunization not only protects that person, but also protects others, as the number of possible carriers from whom the disease might be caught is reduced. Increasing the price of a service with positive externalities can lead to the inefficient use of the service. Everyone in the society would be better off if more of those goods, or services, were consumed.

Another type of interdependence among individuals is involved in what is referred to as a public good. A public good is one for which benefits are experienced by all individuals and one which is characterized by two features: (i) there is no rivalry in consumption in the sense that one individual's consumption of the good does not reduce another individual's capacity to enjoy the good; and (ii) it is non-excludable in the sense that there exists no practical mechanism to exclude a member of the community from enjoying the good, if others are already enjoying it. Local pest control and the control of a malarial swamp are examples of a public good. A village handpump is another example of a public good if there is no congestion (through line-ups), and if it is not possible to exclude individual users by coercion. In principle, if individuals are charged according to the degree of benefit they derive from a public good— so that the level of provision of the good is equal to the desired level of consumption— a socially optimal level of that good could be financed.<sup>21</sup> However, it may be difficult to elicit this information from individuals because they may suspect that it will be used to set higher prices that they will eventually have to pay.

Setting the appropriate level of user fees may therefore be difficult if not impossible in the case of public goods. Given the difficulties of determining the appropriate level of contributions and of enforcing them, there is a strong case for their public provision to be financed through general

taxation. If user contributions are required to finance a public good, then the amount of the good demanded will be less than what is in the social interest, because of difficulties in eliciting the full participation of all concerned in proportion to the private benefits realized. In short, where externalities or public goods are associated with basic social services, user financing can reduce both efficiency and effectiveness and lead to a lesser use of the service than would be socially desirable.

### ***Health:***

Positive externalities are quite pervasive in the health sector. This is an issue to which those who implement user financing must be sensitive. The most clear-cut examples of such externalities are communicable diseases. More complex interlinkages are also relevant, such as the fact that the health of a parent can be an important determinant of the health of a child. A number of preventive forms of health services have strong positive externalities. These include immunization and perinatal care, which help to prevent both the communication of disease and the onset of long term disability with its secondary effects upon others. De Ferranti [1985] and Jimenez [1987] have emphasized the comparatively strong association of preventive care with positive externalities. Indeed, de Ferranti argued that, in the case of preventive care, “externalities are likely to be sufficiently large in most cases to justify a no-fee policy” [quoted in McPake, 1993a].

The presumption that positive externalities are not associated with curative care, which has been treated in contrast as being closer to a “pure private good,” has been questioned by, among others, Stanton and Clemens [1989]. They catalogued a variety of external benefits associated with curative care, including the prevention of long-term disability and productivity losses that have significant indirect impacts upon others. The subsidized provision of early curative care can also prevent later and more expensive health care costs which individuals may wish, but not be able, to avoid in the absence of adequately functioning credit markets. The loss of productive potential may be relevant to the health of others, as with the impact on the child if the breadwinner falls ill. Another potentially important type of externality in the context of curative health care can be described as ‘spillovers in diagnosis’: an individual who comes to a health centre for curative care may receive preventive treatment. Stanton and Clemens [1989] cited examples of such spillovers from Bangladesh and Indonesia. In another case, they concluded, “Indeed some of the dramatic improvement in health indicators in Costa Rica has been ascribed to ‘capturing’ traditional non-users of health services by encouraging them to come for simple curative care and providing them with timely patient referrals and health education.”

In Zambia, one side effect of user fees was that hospital deliveries decreased and the number of babies who were not registered and therefore missed (free) vaccination increased. As a result, the country's child immunization coverage reportedly declined from 80 to 50 per cent in just three years. Booth et al. [1995] and Sheng-Lan et al. [1994] reported a similar decline in the immunization coverage in many poor townships in China as a result of increased user charges for other health services.

***Education:***

The positive externalities associated with education, particularly at the primary level, are well known. Literacy, for example, “lowers the transaction costs amongst individuals” [Colclough, 1993b], enhances fertility regulation capacity, and has a beneficial effect on child health and the nutrition status. There is compelling evidence that education has positive effects on the agricultural productivity of all farmers, not only of the literate ones. There is also strong evidence of the significance of education in generating economic growth [Barro, 1990; Levine and Rennelt, 1990]. The new growth theories suggest that countries where the majority of the people remain illiterate are unlikely to experience accelerated and sustained growth. The experience of the East Asian countries underscores the importance of primary education as possibly the single most important contributor to rapid growth [World Bank, 1993c].

Widespread recognition of the positive externalities associated with primary education and with the high price elasticity of demand of low-income groups for educational services underlines the significance of the right to free primary education as stipulated in the Convention on the Rights of the Child.

***Water and sanitation:***

There are significant external benefits associated with safe water and sanitation. These largely take the form of direct health and nutrition benefits, especially in relation to communicable diseases. An individual's use of a safe sanitation system produces health gains for others as well. In addition, it produces indirect external benefits, for example through the effects of time savings on others' conditions of nutrition and health. Although there is considerable controversy about the exact nature and extent of these interlinkages, there seems little doubt that they exist [Rogers, 1992; Whittington and Choe, 1992].

A controversy in the water and sanitation sector is the extent to which both water and sanitation are ‘private’ or ‘public’ goods. This question is difficult if not impossible to settle, because both have private and public good aspects. The degree to which public good aspects and externalities predominate will determine appropriate pricing policies. Judgements about appropriate prices should take into account the value of external benefits, which may not be fully perceived by consumers. This implies that willingness to pay is not a sufficient guide to price setting. Inappropriate price signals may lead to the use of the service at a level which is not commensurate with social benefits.

Aside from the externalities which they may generate in health or other outcomes, shared facilities for water (and less commonly for sanitation) have a specifically public good aspect, which complicates the task of price setting. It would be unclear how to allocate costs amongst individuals

for a shared handpump for example, given the large public good dimension of this technology. Judgements about willingness or ability to pay are likely to be forced to rely upon arbitrary criteria in practice (e.g., amount of land or livestock owned) that do not necessarily bear a reliable relationship to either of these terms in every context. In practice, therefore, a system of assessment of charges against a community as a whole ('community financing') is likely to be the most feasible means of assessing user contributions. This is only a means of shifting the problem of allocation of costs to the local level, which may be better informed about the benefits realized by its individual members.<sup>22</sup>

### *ii. Price signals and efficiency*

User fees are often seen as a means of enhancing efficiency through the provision of appropriate price signals. In particular, they are seen as a way of ensuring that high cost services are allocated to high priority uses rather than used 'frivolously'. A consumer who pays a portion of the cost of a good or service is unlikely to use it unless it corresponds to a real need. This will ensure that services are not overused and that resources are allocated to their most important uses. This argument is often used in the context of health care and water supply. For example, charging higher fees at a district hospital than at a local health post will ensure that individuals do not go to the former for their routine ailments. Similarly, charging for water can ensure that safe water is not used for low priority uses such as irrigation, rather than for a high priority use such as drinking.

Although this is a potentially powerful argument, it must be assessed with caution. It is important to note that the relative importance of uses in this framework is measured in purchasing power and not in terms of need. Thus an important need which cannot be expressed in terms of effective demand due to insufficient purchasing power is not registered as such, whereas a less important need backed up by sufficient purchasing power will be allocated priority in this framework. Price signals do not in themselves ensure thoughtful use of resources from the point of view of other social objectives. Priorities that are determined by effective demand and shaped by price signals are not necessarily the same as those determined by needs. This is an inherent paradox of the market, one which stems from its limited informational basis. Sen [1981] pointed out that famines can occur precisely due to the success of the market mechanism rather than to its failure.

The idea that price signals will serve to allocate resources to their most efficient use relies upon the assumption that consumers are well informed about the characteristics and value of different available types of goods and services. However, there is no reason to believe that this will be the case. A characteristic feature of medical treatment, for example, is the lack of knowledge of patients about their own condition as well as of the merit of alternative treatments [Arrow, 1963]. In this context, it is difficult to conclude that prices alone can guarantee efficient allocation. Sanitation is another example in which individuals' information about its benefits may be low in the absence of a concerted informational campaign [Blackett, 1992; Whittington et al., 1993].

Some examples of the extent to which prices can serve as mechanisms for ensuring efficient resource use are reviewed below.

### ***Health:***

Fees can reinforce a hierarchical referral system in which users are expected first to visit lower level health clinics and only subsequently to seek care at higher level facilities. In Ghana, for example, prices are graduated and directly related to the sophistication and cost of the health care delivered. The price of curative care at the hospital level is a large multiple of curative care at the health centre. Similarly, user fees in Zimbabwe have been set to increase according to the hierarchy of facilities. In Kasongo, Zaire, the system of user fees was structured so as to favour patients living within a well defined immediate catchment area as well as those who had not bypassed the first level within the district health system. An evaluation revealed that this fee structure did affect the behaviour of patients in the manner intended [Criel and Van Balen, 1993]. In Jamaica, it has been proposed to structure fees so as to encourage use of health facilities in afternoons and evenings, when they are comparatively underutilized [Shepard, 1993]. Hospitals in Lesotho charge lower fees for patients who have been referred by a health centre, but the combined fees of the health centre and the hospital are equal to those charged to patients who go directly to the hospital [Nolan and Turbat, 1995]. In that case, there is no incentive to use the low-cost local health centres, apart from possibly reducing the travel and opportunity costs.

However, the idea that user fees are needed to discourage frivolous use has been questioned by a number of authors. It has been argued that most users (i) are unable to tell a priori what is necessary and what is not, and (ii) engage in large expenditure in terms of lost time and extra travel costs to attend health facilities. As a result, it is unlikely that additional charges are necessary to discourage allegedly frivolous use. The private costs of visiting a health centre are already sufficiently high to discourage use which does not correspond to a felt need. Indeed, increased fees in Swaziland did not decrease frivolous use but resulted, on the contrary, in a decline in immunization and preventive services [Abel-Smith and Rawal, 1992]. In Kenya, declines in health service utilization induced by fee increases were found to include a 40 per cent decline in attendance at Nairobi's principal clinic for treatment of sexually transmitted diseases, suggesting that declines in 'frivolous' use were not an especially important dimension of the overall decline. Booth et al. [1995] reported similar results for Zambia. Waddington and Enyimayew [1990] argued further that in circumstances where rural health clinics are far from busy there is little benefit and possibly much harm in trying to discourage 'frivolous' use.

### ***Education:***

Price signals have been less frequent in education. However, some arguments of this type have been made. For example, it has been argued that "to the extent that higher fees would discourage students with lesser academic ability, and hence, lower probability of success, from enrolling in secondary



education, the policy of increasing fees would increase efficiency” [World Bank, 1988, quoted in Lewin and Berstecher, 1989]. This view overlooks the possibility that poorer households may be credit constrained, whatever the academic ability and the expected future returns to education. If academic ability is randomly distributed, then a system which “grants access solely on the basis of willingness to pay” (i.e., without a scheme of scholarships or student loans) will lead to an inefficient selection of students with the degree of inefficiency increasing with the size of the user fees. Another alleged gain in allocative efficiency through price signals involves the role of fees in discouraging students from repeating grades in order to attain improved credentials, which some students might be inclined to do in the absence of user fees [Jimenez, 1987].

User financing schemes may also have perverse allocative effects. Colclough [1993a] argued, for example, that in areas where primary schools no longer deliver access to paid employment or other sources of high private returns, “the perceived probability of gaining entry to secondary schooling has an increasingly important influence on the decision to send children to primary school. Thus, policies which reduce such access (such as the imposition of fees for secondary schooling) may well reduce demand for primary — as well as secondary — schooling.” This claim appears to be substantiated by evidence on determinants of primary school enrolment in Ghana [ibid]. The decline in primary enrolment ratios in sub-Saharan Africa during the 1980s seems to corroborate this proposition. Where such linkages exist, user fees can worsen allocative efficiency rather than enhance it, because children will be discouraged from attending primary schools, which is a prime social goal.

### ***Water and sanitation:***

Among the reasons for advocating user financing in the water and sanitation sector, concern for greater allocative efficiency has not been central, although it has played some role. For example, charging for water has been seen as a way of discouraging frivolous or non-essential use, especially where this may be occurring at the cost of groundwater depletion. Under special circumstances, failure to charge for water has been asserted to lead to a ‘vicious circle’ or ‘low level equilibrium trap’ in which overuse necessitates rationing through reducing reliability of services. This leads in turn to decreases in the household’s willingness to pay for the available service, and the inability to collect sufficient fees to run the system efficiently. Altaf et al. [1992] provided such an example in relation to piped water service in rural Punjab (Pakistan). Charging for water is, in this view, necessary to encourage efficient and sustainable levels of water use [World Bank Water Demand Research Team, 1991]. Similarly, it may be argued that charging the full cost of installation of water taps ensures that yard taps will be installed in preference to community taps only where they are most justified by the additional time or opportunity costs of the users. This claim, however, illustrates the point that price signals can only be used to allocate according to effective demand, but there is no guarantee that they will lead to allocation according to needs.

Although prices may serve as valuable signals with which to encourage rational resource use, the difficulty of determining appropriate prices should not be underestimated. An interesting

example of this is provided by Whittington and Choe [1992], who demonstrated that “increasing block pricing,” in which households are charged increasingly high prices for each additional unit of water they consume— in large part so as to discourage overuse of water — can have perverse effects on equity. In their example, a pricing structure chosen to enhance allocative efficiency may come into direct conflict with equity. The poor, who do not have direct access to water connections, and either purchase water from those who do or share a single water connection, thus pay higher prices for water under this pricing scheme than the non-poor. The non-poor purchase their own household water at the lowest unit rates available. However, the poor who purchase from the rich will do so at higher rates. Similarly, if many poor families share a single tap, they must bear the burden of the higher costs of high total water consumption. Although appropriate pricing structures can improve allocative efficiency, they can also, as in this example, inadvertently undermine other goals, including equity.

### *iii. Principal-agent interactions*

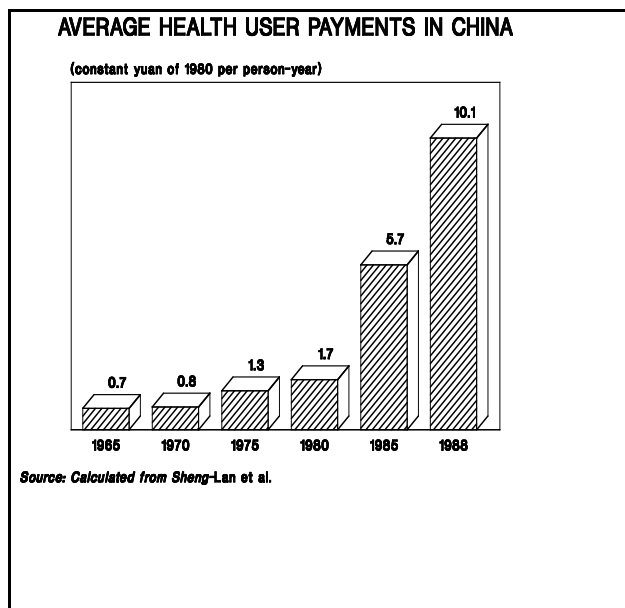
User financing may not be efficient or effective in the presence of strong ‘principal-agent’ interactions. In economic theory, the relation between two parties to a contractual arrangement is often referred to as the relation between a ‘principal’ and an ‘agent’. The principal is an individual who would like a particular objective to be achieved, and ‘contracts’ with another individual (the agent) to help him/her attain that objective. This general formulation may be used to describe a variety of relationships, including those of employer and employee, patient and doctor, and parent and child. Because of divergences in interests, available information, and incentives on the part of the principal and the agent, user fees can lead to outcomes that are not in the best interest of either the principal or the agent, or both. Many of the relevant examples of this set of issues relate to health care [Light, 1992].

#### ***Health:***

A medical practitioner is typically far more knowledgeable about the seriousness of a patient's condition and the relevant treatments than a patient himself/herself. This may create principal-agent problems. For example, under the Bamako Initiative, health workers have been said to have overprescribed drugs so as to increase local revenue. This could result either from administrative pressure to recover costs fully or from incentive schemes that link the health worker's earnings to the amount of costs recovered, which have been introduced in a number of countries [ICC, 1990]. Under this scenario, it is conceivable that extra drugs prescribed could significantly raise overall costs (not to mention their possibly injurious effects on patients), despite the appearance of a high degree of cost recovery at the local level. Some studies on the Bamako Initiative have claimed that there has not been widespread overprescription of this kind.<sup>23</sup> However, another, comprehensive, review of the Initiative cites this as a continuing and at least partially empirically substantiated concern: “There has been widespread concern that cost recovery systems based on drug sales may create incentives for over-prescription and inappropriate use of drugs. The persistence of ‘polypharmacy’ in Nigeria

where charges are based on the drugs prescribed, and of multiple diagnoses in Guinea where the system of cost recovery is based on diagnosis, demonstrate that these fears are not without grounds” [McPake, Hanson and Mills, 1991]. In some cases, due to such causes as the popularity of treatments such as injections that are ineffective for many purposes in sub-Saharan Africa [Kanji, 1989], the incentives of health service personnel to overprescribe and the desire of patients to be overprescribed to may well coincide. Many patients prefer injections because they perceive them as producing more effective and permanent forms of healing than medicine taken orally. A private clinic in Zambia admitted that its popularity was partly due to its willingness to provide chloroquine injections when tablets would be equally effective [Booth et al., 1995] and possibly less expensive. Thus, too much of a demand-driven approach to health services can lead to inefficiencies.

Economic liberalization in China has shifted the financial burden of health care from government and agricultural collectives to individual households. Between 1980 and 1988, the contributions by users in the form of fees and drug sales more than doubled, from 16 to 38 per cent of the total health budget. This was accompanied by an escalation of users' costs. Figure 2 shows that direct user payments by patients followed a slow growth path in the 1960s and 1970s, but skyrocketed in the 1980s, from less than 2 yuan to 10 yuan per person per year (after inflation). Most of the increase in medical costs stemmed from excessive drug prescription. The income of health workers was linked to the revenue generated from service fees and drug sales. Due to this incentive structure and the increased autonomy of health workers, drug prescriptions became the predominant source of income, while preventive care was neglected [Sheng-Lan et al., 1994].<sup>24</sup>



Alternative incentive schemes for health care workers that directly reward workers for providing more desirable forms of treatment (e.g., specific primary health care interventions) could serve to mitigate this problem. Examples from Benin and Guinea are provided in ICC [1990]. However, such schemes are extremely uncommon and only likely to be effectively implemented when accompanied by extensive and ongoing monitoring and supervision.

Different types of pricing schemes can lead to different types of incentive distortion, and misallocations of resources. Thus, if fees are not proportional to drug use but are charged as a single fee per episode of sickness, then health workers may be disinclined to carry patients through a full course of treatment even when this is in the patient's best interest (and society's best interest, in the

case of communicable diseases). A stark example of this is cited in Unger and Yada [1993]. In Kasongo, Zaire, where a fee-for-sickness approach was employed, tuberculosis patients who felt better before completing the full course of treatment were not encouraged to continue despite the resulting social health risks. The possibly high social costs of fee-induced inefficiencies must be taken into account in the design of reforms.

The existence of principal-agent problems in health between parents and children is illustrated by the cases of Burkina Faso and Zambia, where user fees induced declines in utilization rates for infants and children that were disproportionately greater than for parents [Booth et al., 1995; Sauerborn et al., 1994]. These examples demonstrate that principal-agent problems between patients and health workers and between parents and children may interfere with the presumed efficiency gains from introducing user financing in the health sector. Financing reforms by themselves are no panacea. In the longer run, education of communities to lessen the differences between providers and patients in knowledge and information regarding health risks and practices appears to be essential to the rational use of resources [Jarrett and Ofosu-Amaah, 1992]. The possibility that there might be principal-agent problems suggests the need for ongoing monitoring and evaluation. User financing schemes will necessitate significant administrative costs if they are to function well.

### ***Education:***

Although decision makers with respect to schooling are the parents, the principal beneficiaries are the children. A rather cynical — but occasionally realistic — view is that “whereas rates of return to schooling compare the returns to the pupil with the costs to the parents, in fact the important issue is the perceived balance between the costs and benefits to the parents of sending their child to school. Since only some portion of the returns to schooling will accrue to parents, there may be rational (if regrettable) reasons for households appearing to under-invest in schooling, notwithstanding its apparently high economic returns” [Colclough, 1993b]. The possible divergence of interest between parent and child may lead user fees to be far more discouraging to school enrolment than the seeming private benefits would suggest.

Parents contribute considerable resources and efforts to the education of their children. Increasingly, however, they perceive that they are getting poor value for money. Moreover, changing labour-market conditions appear to have reduced the private returns to education. Primary or secondary schooling is no longer a guarantee of obtaining a formal sector job, where real salaries have been in decline for several years. In the context of falling quality and worsening labour-market conditions, the potential significance of principal-agent problems between parents and children seems to be growing rather than declining. The dramatic decline in primary enrolment ratios in many sub-Saharan African countries has been most pronounced for boys. This reverse gender bias may stem from a principal-agent problem generated by the deepening of poverty, which increases the opportunity cost to parents of educating their sons.

Studies of willingness to pay for education are usually based on the perceptions of students regarding the ability of their parents to bear fees [as for example in Tan, Lee and Mingat, 1984, quoted by Jimenez, 1987]. Perceptions of willingness to pay so obtained may well be overstated. They should, instead, be directly based on the perception of the willingness and ability to pay of the parents, not of the students.

***Water and sanitation:***

As in the example of parents and children provided above, gender differences in the perception of needs for water and sanitation can lead to lower than socially desirable investment decisions on the part of households. Women disproportionately bear the cost of water collection within households. It is no surprise then that they have a higher willingness to pay for water than men [Cleaver, 1994]. Women also express a greater interest in sanitation facilities than do men [Government of India, 1990]. However, as men control household resources to a disproportionate degree, it is more than conceivable that their investment in water and sanitation will be inadequate — failing to take into account the private benefits realized by all within the household, let alone the broader social benefits.

***iv. Merit goods and asymmetrical recognition of benefits***

The case that user financing will enhance efficiency (allocative efficiency in particular) relies upon the assumption that individual users of services will be accurate in their judgement of the worth of the services concerned, if not to society as a whole then at least to themselves. This is a problematic assumption for all basic social services. If the assumption proves incorrect, user fees can lead to the allocation of resources according to prevailing perceptions rather than to an accurate estimate of the benefits.

The most obvious case of this kind is that of a ‘merit good’. Musgrave [1959] developed the concept of a merit good to describe a good which should be deemed to be of intrinsic worth and provided regardless of whether or not people demand it. Thus, educational or health services may be deemed to be intrinsically worth providing, regardless of the actual extent of recognition of their worth. In this case, demand based on prices would not be seen as necessarily efficiency enhancing, except insofar as it extends the availability of these merit goods, of which there is no a priori guarantee.

If it is desirable that individuals should consume more of the service in question, two policy alternatives are available: public subsidy, and education/information intended to raise the individual appreciation of the benefits. This problem is known to be of particular relevance in the context of sanitation, the benefits of which are seldom fully recognized. It is also of considerable relevance in the context of education, especially at the primary level, the benefits of which may not be fully appreciated, especially for girls. Requiring user fees for merit goods or where there is an

asymmetrical public and private recognition of benefits may lead to an inefficient allocation of resources from a public point of view.

v. *Accountability and responsibility*

One of the most powerful claims made on behalf of user financing is that it is an essential element in making providers more accountable to users and in making users more responsible for the sustainable use of resources. User financing ensures, it is said, that providers will be responsive to the demand by users for a high level of quality, and that users will take a greater interest in the management of the resources, thereby ensuring greater efficiency and effectiveness. This view is often summarized by the statement that user financing enhances a community's sense of 'ownership'. In some cases this is described as lifting the dependency syndrome which a community may exhibit vis-à-vis the government and/or donors. Arguments of this kind deserve thorough discussion. Although they are often asserted, the conditions under which they hold true have seldom been scrutinized.

There are a number of relevant issues which should be distinguished from one another. User financing is often seen in the literature as intimately linked to community participation and co-management. In the context of health and water supply, the principle that these two should be vitally connected has been articulated forcefully by, among others, Van Wijk-Sijbesma [1987], WHO [1987] and UNICEF/BIMU [1995]. Although user financing is often discussed in conjunction with community co-management, it is important to separate their respective roles, if any, in enhancing accountability and responsibility, and hence efficiency and effectiveness.

The causal links between user financing and community co-management on the one hand and increased effectiveness and efficiency on the other can be viewed in three alternative ways: (i) user financing is sufficient to generate accountability and responsibility, (ii) user financing combined with community co-management will generate greater accountability and responsibility, and (iii) community co-management is sufficient to generate accountability and responsibility without the need for user financing. Each of these arguments is complemented by the assumption that greater accountability and responsibility will lead to higher levels of efficiency and effectiveness.

- (i) User financing is sufficient to generate accountability and responsibility without the need for community co-management.<sup>25</sup>

This view, although less common today, continues to be asserted by some [e.g., Jimenez, 1987; World Bank, 1995a]. The latter, for example, declared, "Charging fees can create accountability between parents/students and school managements," without any attention to mechanisms of participation. If user financing leads to a more careful use of resources through price signals, it might

generate greater individual responsibility. However, from the economic viewpoint, this behavioural change must be triggered by a marginal cost of service use, i.e., the consumption of an additional unit of the service must cost users an additional amount (i.e., through user fees per unit of service consumed). Other types of user financing which do not have this marginal or use-related component, cannot be expected to generate responsibility by this means. For example, a community's contributions to the one-time costs of building a school or a health clinic or drilling a well create no such marginal incentive effects. From the point of view of a community, these are sunk costs. According to standard economic theory, without marginal costs there is no reason to expect that individuals will use these resources any differently than if they had been made available free of charge. Such costs create no ongoing incentive effects. This explains why contributions to school construction are not likely to have the same negative effects on enrolment that tuition or PTA fees are likely to have.<sup>26</sup> If there are reasons that one-time user contributions will provide a sense of ownership, they are not economic but psychological — an early commitment to the project may elicit a continuing concern on the part of users for its success.

The idea that contributions generate a psychological sense of ownership seems plausible. Dworkin [1982, quoted in Evans, 1992] argued, for example, on the basis of studies conducted in Tanzania, Thailand, and elsewhere, that “water systems which provided the most reliable service were those where communities not only contributed to operation and maintenance costs, but met them in full.” On the other hand, a study in Lesotho [Feachem et al., 1978, quoted in Evans, 1992], on the introduction of cash contributions towards the installation of rural water supply, provided an instance of exactly the opposite effect. Villagers' cash contributions amounted to a small share of the total materials cost, but “Rather than instilling a sense of ownership and responsibility, the raising of cash contributions, and provision of labour and local materials for the construction of the schemes, convinced them that they had already paid a fair share of the cost.” This point of view was shared by Cleaver [1991] in her study of Nkayi (Zimbabwe) and by Wood [1988, quoted in Evans, 1992] in a study of the introduction of fees for handpump service in Ghana. These examples suggest that, although there may sometimes be a link between contributions and a sense of ownership, it is by no means the case that such a link should be assumed to be automatic; it may even run in the opposite direction.<sup>27</sup>

In rural communities where there already exists a strong sense that clinics and primary schools are ‘theirs’ on the grounds that community members provided most of the labour and materials to construct or rehabilitate them, additional user fees may actually weaken rather than strengthen the sense of ownership. Indeed, user fees can be counterproductive, as the community members may stop providing their free labour and materials once they know that they will have to pay for the service. Booth et al. [1995] found evidence of this negative reaction in Zambia.

In short, neither economic theory nor empirical evidence provides a guarantee that user fees will start a virtuous circle of greater responsibility and responsibility leading to higher efficiency and

effectiveness. Nor is it the case that there exists some invariant psychological law that assures this. Any assessment of the relationship between contributions towards costs and the sense of ownership must be contextual, contingent, and sensitive to local conditions. This should be an area for considerable future analysis.

- (ii) User financing needs to be complemented by community co-management before it will generate greater accountability and responsibility.

There is no obvious reason why greater accountability on the part of service providers should result from the introduction of user financing. The economist Albert Hirschman [1970] distinguished two ways in which individuals can make their views felt: exit and voice. For example, an unhappy employee can leave a job or, alternatively, voice his/her dissatisfaction explicitly. The two alternatives may not be equally available in all settings. The modern anonymous marketplace as an institution is not likely to offer to consumers the option of 'voice' as much as did the traditional bazaar. The predominant means of expressing dissatisfaction is simply to exit, i.e., to cease to buy a product or a service. In a competitive market, firms are accountable to consumers because 'exit' of too many consumers will drive them out of business, thus forcing them to be attentive to customers' desires. On the other hand, monopolists (e.g., a water utility) may not be similarly forced to be responsive, largely because exit is not possible for most of their clients. In this situation, there is no guarantee that user financing as such will generate accountability. In the context of basic social services in developing countries, given the relatively monopolistic position of public social service providers, it appears that some additional mechanism of representation other than user financing would be required to make service providers accountable to users. The numerous examples of health services in Africa which have introduced user fees on a large scale but have failed to introduce a significant dimension of community management or to improve quality [Mwabu et al., 1995a; Booth et al., 1995; Waddington and Enyimayew, 1990], and have had substantial reductions in service utilization, support this hypothesis. The threat of withdrawal of contributions (or 'exit') is not in itself powerful enough to lead to the improvement of services because of the relatively low magnitude of users' financial contributions compared to the full cost of providing the service.

Therefore, the view that user financing needs to be complemented by community management enjoys greater support today. It is supported by the empirical success of projects which have combined these two elements, e.g., the Bamako Initiative [UNICEF/BIMU, 1995; Jarrett and Ofori-Amaah, 1992; Litvack and Bodart, 1993; McPake et al., 1991]. Similarly, a wide range of examples from the water sector serve as seemingly successful instances of combining community participation with cost recovery or cost sharing arrangements, such as the Tegucigalpa water project in Guatemala [UNICEF Guatemala, n.d.; Evans and Appleton, 1993]. It is clear that genuine



community co-management can enhance the sense of responsibility on the part of users and accountability on the part of service providers.

Community co-management and user financing can be mutually supportive. If service providers are likely to be influenced by the amount of resources raised, either through financial incentives or because of their professional interest in the strength of service delivery, then they will be more likely to be attentive to the views of communities than in the absence of user financing. These are among the reasons that policy practitioners have been drawn to these two measures in conjunction with one another. Shaw and Griffin [1995] stated that “Perhaps the ultimate goal of cost sharing should be to ensure that households and communities have a say in the design and delivery of basic, cost-effective services.”

(iii) Community co-management is sufficient to generate accountability and responsibility.

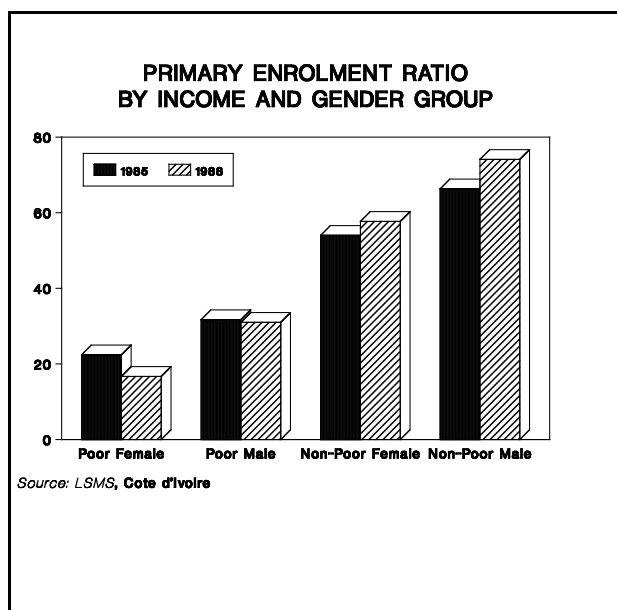
Although the linkages between successful community participation and user financing are potentially strong, they may not always be important. In practice, communities are likely to gain their power to influence service providers more from administrative mechanisms than from financial ones. Local committees do not routinely gain their authority from their capacity to generate resources, but rather from formal administrative subordination. For example, local health workers can be administratively subordinated to a local health committee. In Hirschman's terms, the power of local committees may result more from their capacity for voice rather than from their powers of exit through the withdrawal of funds. With a high degree of political and administrative commitment to decentralization, many of the earlier-cited advantages of accountability to local committees through community co-management could very possibly have been achieved without user financing.

The view that community co-management should not per se be linked to user financing is not common today because user fees have come to be so widely viewed as a cornerstone of social sector reforms. However, communities should not be requested to buy their management rights. It is perfectly possible that under appropriate conditions — in particular, genuine decentralization — the accountability of providers and the responsibility of users can be enhanced solely through a higher level of community management and participation. This does not deny that user financing can be necessary for other reasons such as net resource generation, but it argues that user financing is not essential to generate accountability and responsibility. Cleaver [1991] showed in the context of rural water supply in Zimbabwe that a significant degree of responsibility can be mobilized through community management without user financing, in particular for preventive maintenance. This alternative view remains largely untested, but it is useful to keep community co-management separate from community financing, especially in view of the difficulties faced by user financing schemes in effectively safeguarding equity.

### 3. EQUITY

User financing for basic social services must be judged in relation to whether it furthers three central goals: efficiency, effectiveness, and equity. These goals need not be mutually inconsistent. As argued in the Convention on the Rights of the Child, safeguarding the access to basic social services for all — which is an equity-related goal — must be the guiding principle of social policy in relation to user financing. Equity is concerned with the safeguarding of the effective access of the poor to basic social services. Concern for equity is distinct from concern for equality, which is a more demanding concept.

Although average national indicators are known to hide important disparities among the various socio-economic groups, social indicators are seldom disaggregated because of the lack of integrated data bases. The World Bank-sponsored Living Standard Measurement Surveys (LSMS) are one of the few data sources that allow cross-tabulation of social indicators by economic characteristics. In Côte d'Ivoire, for instance, an LSMS series, conducted in the second half of the 1980s, showed that primary enrolment was determined by two major factors: the socio-economic status of the household and the gender of the child, as is depicted in Figure 3. The disparity between the poor and the non-poor was found to be greater than between the gender groups (the average ratios were about 2.5 and 1.5 respectively). Furthermore, Figure 3 indicates that the socio-economic and gender gaps widened under the conditions of economic stagnation, fiscal austerity and structural adjustment which prevailed in that period. The enrolment ratio among poor girls and boys declined between 1985 and 1988, while it increased among the children of non-poor households. Indeed, user financing is likely to be associated with widening socio-economic disparities if it is not accompanied by exemptions or differential prices for the vulnerable groups.



Given the evidence regarding high price elasticities of demand of the poor, as well as the distinction between ability and willingness to pay, safeguarding equity must be a crucial concern if the case for user financing is to be sustained. This section will review the (i) evidence on the effectiveness of exemption schemes for the poor; (ii) implications of user financing for gender equity; (iii) implications of alternative forms of contributions for equity; (iv) equity implications of prepayment schemes; (v) equity implications of seasonal variations in income and needs; (vi) regional inequality and cross-subsidization and; (vii) possible conflict between 'ownership' and equity.

How should the effect of user financing on equity be measured? One way to approach this question is to compare the situation against an initial baseline. This comparison is between the profile of users before and after the introduction of user financing. Thus, a particular policy measure might represent an improvement in terms of equity, even if the measure in itself is not equitable. To take the example of water, many poor households in peri-urban areas pay extraordinarily large sums to water vendors because of their lack of direct access to water sources [Cairncross and Kinnear, 1991; Katko, 1990; Ghosh and Nigam, 1995]. These households could be supplied with safe water through piped water systems for a fraction of the costs they are paying, but are not being serviced due to institutional, legal, or credit-related obstacles.<sup>28</sup> A water delivery system that charges poor households anything less than they are already paying will improve equity.<sup>29</sup> That system may not in itself be equitable as it may still charge poorer households more than wealthier households, or poorer localities as a whole may be charged whereas wealthier localities may not be. In these situations, there would be scope for further equity improvements. Nonetheless the policy measure would improve equity with respect to the baseline.

Charging households for health or educational services could also in principle lead to similar equity improvements given the high amounts which household already pay for allegedly ‘free’ services [Abel-Smith and Rawal, 1992]. Thus, a critical first test of user financing is whether it improves the situation of the poor, and not whether it makes them as well off as they could be. However, although this test is important, it is not the only one which should be applied. It is equally important to ask whether a proposed policy leads to a situation which is as equitable as it could be, and whether even more equitable arrangements could be achieved. Indeed, if access to basic social services is seen as a social right, then the level of equity measured against the initial baseline must be seen as unacceptable. Moreover, the concern goes beyond that of social justice. Communities may “refuse to pay, knowing that more favoured persons receive government services without charge” [Stinson, 1982]. There is at least one reported project in the health sector in Ghana which has failed for that reason.

Proponents of user financing hold that fees can protect and enhance equity through two possible mechanisms. The first mechanism is that if the poor can be accurately identified and exempted from payment or assessed lower fees, then they can be protected from being any worse off than before. A second possible mechanism by which user financing can enhance equity is that even if the poor cannot be accurately identified and made the subjects of exemptions or contribution reductions, the resources generated through user fees will expand the coverage or enhance the quality of service. Under certain conditions, this type of service extension may directly benefit the poor. For example, if unmet demand exists, then service extension can benefit the poor, whether or not exemptions are in place. Similarly, if resources raised through user financing enable remote areas to be served by basic social services, even without a system of exemptions, the result can be an improvement in equity.

In both cases, it is argued by the advocates of user financing that the position of the poor with respect to their baseline can be maintained, if not improved. The second of these arguments relies upon the capacity of user financing to generate a considerable amount of net resources, and that these resources will be used to extend basic social services. The amount of net resources likely to be generated has been touched upon earlier (section III.1). Experience does not support the view that they will make a significant impact on either the coverage or the quality of service delivery. The likelihood that resources will be actually used to enhance basic social services given prevailing configurations of political and economic interests will be examined subsequently (section III.5). The first argument, which rests upon the possibility of specifically identifying and exempting the poor from user financing, is analysed below.

*i. Exemption schemes*

The performance of exemption schemes is poorly documented. Given their significance for the ultimate sustainability of social policy reforms, they should be documented much better in the future. The limited documentation indicates, however, that the experience with exemption or reduced contributions for the poor has not been encouraging, although there have been some cases of success.

User financing can make use of graduated fees or sliding scales by type of service, by region, by gender of the head of the household, by socio-economic characteristics, or by other more complicated criteria to enhance equity. In practice, these have been rarely applied, primarily because of their administrative difficulty. Straightforward ‘all or none’ exemption schemes have typically been used instead.

Schemes intended to protect the poor have often used income criteria for exemption. However, poverty cannot be reduced solely to an income measure, even though income is an important indicator of poverty. Estimates of the incidence of poverty and the identity of the poor depend very much on definition. In Colombia, an integrated survey allowed comparison of the estimates of income poverty with those of basic needs poverty [World Bank, 1994b]. Apart from leading to very different levels of poverty, the results also showed that about half of the income poor were not basic needs poor and vice versa. Hence, targeting social services or subsidies on the basis of income poverty alone would have led to a substantial misallocation of resources and possibly greater inequities. Because income is notoriously difficult to measure, more visible and monitorable criteria are often used in practice, e.g., proxies or means testing. Proxy criteria such as land and livestock ownership are mostly used. Other, highly approximative criteria such as physical appearance or self-declaration of the poor, have also been applied.

In practice, many exemption schemes do not even seek to identify the poor, but focus on easily recognizable groups for political or other reasons (e.g., the aged, residents of a particular area, civil servants, or members of the military). In this case, exemptions are fairly easy to administer, although they are often very inequitable. Vogel [1988] identified a range of health facility payment

exemptions in West Africa which benefited specific occupational groups, especially state employees, in a highly regressive fashion.<sup>30</sup> Ensor and San [1995] reported that the exempted categories in Viet Nam include “families that lost a son in war” regardless of their income characteristics. Weaver et al. [1994], observed that in Niger civil servants and students were targeted for exemption.

Exemption systems directed towards equity, in contrast, face the difficulty of accurately assessing the ability to pay. In general, exemption schemes can be based on the direct identification of the poor, or upon the targeting of larger groups (e.g., residents of a particular region or female-headed households). In the first case, the costs of identification are potentially very high, while the second can err significantly in the identification of the poor.

Targeting schemes have been less effective than is generally accepted. Grosh [1994], in an examination of a wide variety of targeted social programmes in Latin America, found that the share of benefits of the poorest 40 per cent ranged from 59 to 83 per cent. These programmes faced median administrative costs of 9 per cent of total programme resources, with a maximum of 29 per cent. Although she concluded that this affirms the success of targeted social programmes, these figures might be read otherwise. First, the proportion of benefits captured by the poor is a measure of efficiency, not of effectiveness. Although a reasonable proportion of the benefits might have reached the poor, a high proportion of the poor might not have been reached. Empirical evidence from other regions has shown that targeted programmes often reach less than 5 per cent of the target population. Second, when administrative costs are included, targeted programmes appear even less efficient. A universal entitlement would, if private costs do not dissuade poor users from using a service, lead to 40 per cent of programme benefits being captured by the poorest 40 per cent. In this light, a low of 59 per cent of benefits being captured by the poorest 40 per cent is not an exceptionally good result for a targeted scheme. Untargeted schemes also have administrative costs, but they are normally lower than those of targeted schemes.<sup>31</sup> The benefits of targeting may not be high enough to justify the additional costs. Far too little information exists about the administrative costs of targeted programmes with which to justify firm conclusions regarding their efficiency and effectiveness. This should be the subject of further analysis.

Of different varieties of targeting schemes, Grosh found that there is no single best method, although she indicated that targeting by gender of the head of the household is particularly inaccurate for identifying the poor. In general, the inaccuracy of targeting diminishes when the size of the targeted unit becomes smaller. For example, if districts are the unit of targeting, poor districts can be targeted within rich provinces, and rich districts can be excluded within poor provinces, whereas with units the size of provinces, the former type of districts will be excluded from the benefits but the latter included.<sup>32</sup>

Remarkably little evidence exists on the effectiveness of exemption systems. Some authors draw upon non-governmental organization (NGO) experience and emphasize the necessity to engage in ongoing monitoring of exemption schemes to ensure that they are effective and sustainable

[Diskett and Nickson, 1991]. In the absence of monitoring and evaluation by higher levels of administration, service providers may have little incentive to apply means tests, and there can be a significant reduction in both the number and accuracy of exemptions offered. Nolan and Turbat [1995] found that exemption schemes for health in sub-Saharan Africa are not only rare, but they are also implemented in informal and ad hoc ways. Their survey showed that exemptions based on the ability to pay are extremely uncommon in practice. The decision to exempt is often left to the discretion of local service providers, while the characteristics of the poor are generally not defined in a clear fashion.

In the absence of well-defined guidelines and criteria, lower levels of administration may receive conflicting signals from higher levels regarding the exemption policy. Indeed, there is an inherent conflict between attempting to recover costs and seeking to protect the poor. Exemptions will reduce the amount of costs recovered. If financial incentives or performance appraisals are linked to the criterion of cost recovery, as they have been in many countries, including those implementing the Bamako Initiative, then there can be a direct trade-off between the goal of revenue collection and that of reducing the negative equity impact of user financing. An appropriate policy response is to include in the incentives for service providers criteria that reward the full and effective use of available exemptions. Individuals may also be insufficiently aware of exemption schemes. Authorities do not always undertake sufficient efforts to inform individuals of their existence. Moreover, even where individuals are informed of them, they may face large costs in terms of time and effort to go through the exemption process.

Finally, exemption schemes can be stigmatizing and dehumanizing. Individuals who satisfy the exemption criteria may not wish to identify themselves publicly. There may be dishonour or a sense of shame involved in accepting an exemption, which may appear as a form of public 'charity'. Individuals may, therefore, fail to make use of exemption criteria even where available. There is widespread evidence of this. Whether any of these concerns are justified can only be uncovered by a review of experience. There has been much more experience, monitoring and analysis in this area in the health sector than in the other sectors. Nevertheless, information on exemption schemes in the social sectors is nowhere available to a satisfactory degree.

### ***Health:***

Stinson [1982] listed exemption schemes which have been used in the health sector throughout the world. These include exemptions for children, for specific categories of patients (e.g., tuberculosis), for repeat visitors, for residents of a particular area, or for those simply judged to be poor. Such schemes are also recounted in Richardson et al. [1992]. It has been pointed out by Vogel [1988] that in four West African countries, existing systems of exemption have tended to offer blanket exemptions to some privileged groups, such as government employees and the military.

Often, systems of exemptions have relied upon arbitrary methods of designating beneficiaries in practice. For example, the Ford Foundation [1990] reported an exemption system in Gujarat (India) based on the casual judgment of the health practitioners, and on ‘bargaining’ between doctors and patients, suggesting that the former are not necessarily seeking to identify the poor correctly. Huber [1993] presented important results from Kenya on the accuracy of the criteria employed to identify those unable to pay. Based on statistical estimations, she found that measured socio-economic characteristics predicted only 10 per cent of the variability in income — which suggests that it is very difficult to identify the poor based on readily observable characteristics.

A widely held view is that community-based systems are far better at identifying the poor than higher levels of administration, because they are closer to users and more likely to be informed about their individual circumstances [Parker and Knippenberg, 1991]. Thus it is appropriate to determine exemptions at the lowest level of a referral system, where knowledge about personal circumstances is thought to be higher, and to carry these exemptions through to higher levels of care. The view — community-based health systems are likely to be more accurate in identifying the poor — may not be entirely justified, however. Where large populations are served by a community health centre, as is typically the case in Africa in South Asia, it is not certain that such identification can be carried out better. For example, McPake et al. [1991], reported that the typical number of persons served by a local health post in Africa is eight to ten thousand. Moreover, local managers and service providers often face the perverse incentive to maximize revenue.

The Progress Report on the Bamako Initiative to the UNICEF Executive Board in 1992 noted that “even with a considerable increase in the amount of data available, there is still little concrete evidence as to the number of exemptions being made to payment at health centres, often because there is a reluctance on the part of both the providers and the consumers to acknowledge such action.” However, it is suggested that community observation has indicated that community solidarity does exist with respect to the poor. The provision of credit guaranteed by the community to patients in Mauritania, including to members of nomadic groups visiting desert villages (which is not likely to be recovered), is provided as an example. On the other hand, McPake et al. [1991] wrote in their review of the Initiative, “Exemption mechanisms in case study countries generally have a very limited scope (as in Nigeria, Burundi, and Kenya), appear ineffective in practice (Uganda) or do not exist (Guinea).” Where systems of exemption exist, communities have been relied upon to provide the criteria by which individuals will be exempted. However, they may have tended to rely too much on pre-existing categories of classification (for example, in Benin, “indigents” have been considered “victims of natural disasters”, and “abandoned women with their families” [ICC, 1990]), or worse still, to fail to provide criteria of classification at all. Thus, UNICEF/BIMU [1995] concluded that “In many countries, fees are waived for patients who cannot afford to pay for health care, but clearer guidelines concerning the use of waivers and exemptions are needed.” In Benin, a poverty assessment found that local community management committees failed to exempt the poor [World Bank, 1995d].

In their recent survey, Nolan and Turbat [1995] found that the frequency of exemptions ranged between “very few” and “not many”. Of the 37 countries examined, only one (Zimbabwe) had a national exemption policy for the poor with uniform procedures and formal guidelines.<sup>33</sup> Ad hoc exemption schemes that left their application to the discretion of local managers and providers of service. They stated that: “Surprisingly, in many countries exemptions granted because of poverty or the inability to pay appeared to be rare rather than common occurrences.” Booth et al. [1995] reported that Zambia's guidelines referred to exemptions and stipulated that the treatment of infectious diseases and immunizations should be free of charge. The guidelines also required that patients suffering from acute and life-threatening conditions should be treated first and payment discussed later. In practice, however, they found that the entire health sector was under severe pressure to collect revenue and minimize exemptions.<sup>34</sup> One of the researchers reportedly witnessed the arrival of a 14-year-old boy at a hospital suffering from acute malaria. His parents were unable to pay the registration fee of ZK300 (equivalent to US\$ 0.33), and the boy was turned away. The report added that “within two hours the boy was brought back dead.” Mbugua et al. [1995] analyzed the impact of health user charges on children in a poor rural area in Kenya. Their longitudinal survey revealed that, although children under five years of age were exempted from fees, the pattern of utilization by young children mirrored the decline among the rest of the population, suggesting that they were not protected from the adverse effects of fees.

Mwabu et al. [1995] reported that health facility managers had no uniform way of dealing with patients who could not afford the fees charged because there was no formal system of exempting the poor. The ministry left fee exemption to the discretion of the managers. As a result, “some of the facilities treated patients on credit, others treated them free of charge and others turned them away.”<sup>35</sup> Xing-Yuan et al. [1995] found that the increased reliance on health user fees in China resulted in a situation whereby the level of hospital utilization was clearly related to the level of income. They report that “45 per cent of people referred by a doctor in the moderately poor counties did not get hospital care, compared with only 9 per cent in the rich counties.” Nearly two thirds of those who were not admitted said it was because of costs. In a study on exemptions in Viet Nam, Ensor and San [1995] reported no significant relationship between exemptions actually granted and economic status. This was because exemptions were largely based on non-economic criteria which bear little or no relationship to economic status, such as disability, invalidity, or families who lost a son in war. Exemptions were determined by the communes to which individuals belonged and which run health centres.<sup>36</sup>

A further disturbing phenomenon is that when exemptions are available, they have seldom been utilized. This is related to the inadequate information, education and communication between policy makers and the staff on the ground who implement the policy. In Zambia, for instance, the guidelines included the principle of not charging fees until exemption mechanisms had been established [Booth et al., 1995], but the pressure to raise revenue overruled that principle. Moreover, local staff and patients often ignored the existence of exemption schemes. Some clinics and hospitals reportedly treated the poor for free but did so on a case-by-case basis. They did not advertise the



availability of free services, so that most of the eligible patients were deterred and never visited these health centres.

Other reasons why full use is not made of exemption mechanisms are the social stigma on the part of beneficiaries, a lack of self-recognition of poverty or eligibility for exemptions and the reluctance of health providers or managers to bestow exemptions which are within their power. Chaulaghai [1995] reported, for example, that exemptions were seldom requested although they were available for a fee-for-drug scheme in Nepal. Waddington and Enyimayew [1990] reported some reluctance on the part of the authorities to use an exemption clause available to them. On the other hand, Mujinja and Mabala [1992] found an extensive level and variety of exemptions for the poor, disabled, sick, chronically ill and retired offered by many NGO hospitals and dispensaries in Tanzania that operate on the basis of user financing.

Cumbersome procedures appear in some instances to have dissuaded those who would otherwise be eligible from applying for exemptions. In Zimbabwe, the burden of proof of eligibility was placed on the shoulders of the poor. They had to produce a daunting set of documents (e.g., identity card, marriage certificate, birth certificates of children, proof of earnings or retrenchment, proof of residence), adding to the cost and time for obtaining a fee waiver. Moreover, the absence of clear eligibility criteria led to arbitrary decisions by the social welfare officers, and hence uncertainty on the part of the applicants. Many clinics and hospitals did not accept the free medical treatment order because of the long delays in reimbursement [UNICEF, 1996]. In spite of all the shortcomings and the high opportunity and out-of-pocket costs, the number of applicants for free medical treatment continued to rise, suggesting that user fees represented a real obstacle to access for a large portion of the population.<sup>37</sup>

### ***Education:***

In the absence of formal exemption mechanisms in Zambia, there was a de facto non-implementation of the cost recovery measures, as headmasters did not enforce their power of barring children from school for the non-payment of fees and uniforms [Booth et al., 1995]. However, children felt stigmatized when they were allowed to attend classes without uniforms or without shoes. In general, stigma effects of exemptions in education are greater than in health, because of the sustained and social character of school attendance.

In Zimbabwe, exemptions for school fees were not applied as widely as expected, largely because of the cumbersome character of exemption procedures. The International Labour Organization [1993] reported that “the complex procedures mean that many who would be entitled to assistance do not get it. Delays in processing have also led to drop-outs, and failure to enter examinations.” The long delays in reimbursing urban primary schools that enrolled exempted students seriously undermined their cash flow position. As many of them were being sued by their creditors, they became less willing to accept students from poor households. Furthermore, lack of

clarity of the eligibility criteria among headmasters and social welfare officers led to unnecessary exclusions. In many cases, the child's academic performance was used as a selection criterion. In others, parents had to pay a levy to the school before the headmaster would refer their case to the Department of Social Welfare. Because of their heavy workload and limited budget, social welfare workers seldom conducted home visits so that referrals by headmasters led to automatic approval, and hence mistargeting [UNICEF, 1996]. Despite all the problems, the population applying for exemption rose every year, indicating that user fees were limiting access.<sup>38</sup>

There is some experience with targeted stipend and scholarship schemes to offset direct school fees at the secondary level. However, these do not appear to have been studied in detail, for their effectiveness, efficiency, or contribution to equity. In Bangladesh, girls pay lower tuition rates than boys at the secondary level. A policy of full tuition waivers for girls has been established in northern Nigeria [World Bank, 1995a]. Grosh [1994] surveyed three university-level tuition waiver programmes in Colombia, Costa Rica and Jamaica. Although it appears that these programmes were unsuccessful at excluding the better off, it is unclear to what extent they succeeded in reaching the poor.

In sub-Saharan Africa, fees to the PTA, building funds and other out-of-pocket costs have been large, and primary education has never been 'free'. Although there may be systems of adjustment of these fees according to ability to pay in many settings, little concrete evidence in this regard is available. It is not possible from the evidence available to draw conclusions regarding the effectiveness of targeted exemption or contribution-reduction schemes in the education sector.

### ***Water and sanitation:***

There has been much discussion of possible exemption schemes based on the ability to pay in the water sector. However, there is almost no concrete evidence on the operation of such schemes in practice and it is therefore difficult to evaluate the role and performance of exemption systems in the sector. In practice, there has been greater experience with systems of reduced contributions on the basis of group characteristics (e.g., locality) than with individual exemption schemes. An exception is an unmetered piped water supply scheme in Indonesia, where 19 of a total of 650 families (otherwise paying a flat fee) were exempted from water payments. In other cases, the elderly- and female-headed households with children have been exempted from payments. In southern Colombia, a system of graduated rates for four different user groups was established, corresponding to criteria including housing type, household assets, and size and type of farm. The assessment was based on individual visits by representatives of the water agency and on existing property-tax data. The water rates were then accepted by vote of an assembly of the users [Van Wijk-Sijbesma, 1987].

Separate rates for private and shared taps have also been suggested as a way to adjust payments according to ability to pay. Richer households pay for the convenience of a private tap and their higher fees are used to cross-subsidize other households. Other criteria by which

assessments can be targeted include the family size or structure, or the amount of a particular cash crop produced, especially where agricultural marketing boards can readily collect this data. Evans [1992] provided an example of such a scheme in Sindh (Pakistan). Where metered systems existed, “increasing block tariffs” — i.e., progressively higher rates charged for subsequent blocks of water use — have been thought of as an instrument for cross-subsidization of the poor by the rich. However, as mentioned earlier, such schemes can have the opposite impact on equity when poor households share a single tap, or purchase water from rich households. By explicitly providing lower rates on taps shared by several households, this effect could be partially counteracted. However, this would require a large effort in information collection. An example of cross-subsidization of poorer or rural regions by richer and urban ones is that of Umgeni Water in Natal (South Africa) which has established local water committees for community co-management and cost recovery [Nigam and Ghosh, 1995].

The examples above are all of contribution towards recurrent costs. However, the large initial capital costs involved in the water and sanitation sector make exemptions from or reductions to initial contributions towards capital costs of special importance for equity. A piped water scheme in Salto de Barones (Colombia) serves as such an example. Households in the community were asked to pay a fixed and uniform amount in cash. However, the cash contribution could be reduced according to the amount of labour and materials contributed. This provided an opportunity for poor households to select the form of contribution so as to reduce the resulting burden, although it may still have been difficult for some households to contribute in view of the opportunity cost of labour [Van Wijk-Sijbesma, 1987].

There appears to be little recorded experience with variable contributions according to ability to pay in the sanitation sector. The many examples of adjustable fees and contributions in water schemes do, however, suggest that they are possible. A systematic study of the effectiveness at reaching the poor of any one of these schemes does not seem to exist. The available schemes seem to use ‘broad brush’ indicators of ability to pay or else to require great informational resources. Designing an effective system of exemptions is a challenging task. More careful studies of the effectiveness at safeguarding equity (as opposed to mere description of the operational mechanics) of such schemes should be a major subject of future work, and a prerequisite to advocacy of more user financing.

## *ii. Gender equity*

Gender differences are likely to be of considerable relevance to the analysis of user financing where men usually control a large proportion of cash income. In general, the household's willingness to pay is not a well-defined concept. Women may express a high willingness to pay for services but may not in practice control the necessary cash resources to pay for them. Expenditures related to basic social services are often considered women's responsibility. As such, women bear the burden of the contributions towards such costs within the households. They may therefore demonstrate a high

willingness to pay for services while having a low ability to do so. In Zimbabwe, women were found willing to pay 40 per cent more than men for an improved domestic water supply [Briscoe and de Ferranti, 1989, quoted in Cleaver, 1994].

Alternatively, although women's willingness and ability to pay may be low, those of men may in practice be used to set contributions that will be paid in the final analysis by women, with resulting gender inequities. For example, in a water project in western Kenya, low cost recovery rates despite seemingly high household ability to pay were traced to the fact that women, with much lower incomes than men, were generally held responsible for this expense. Evans [1992] concluded that "Affordability studies had been targeted at the wrong group, and had produced quite misleading results." Moreover, the assessed levels of contribution were much higher than was affordable for those who would ultimately bear the costs — women.

The high willingness to pay for water on the part of women stems, at least in part, from the large extent to which the burden of water collection is borne by women. Men are likely to place a lower value on saving women's time and effort than women themselves [Cleaver, 1994]. Unless there are net resource transfers to women, gender inequity in contributions is likely to result from user fees that are calculated on the basis of 'household' — read 'male' — willingness to pay.

In the context of health care, user fees are likely to compound the effect of gender bias. Stanton and Clemens [1989] reported, for example, that "in rural Bangladesh the gender of the patient may be an important determinant of a family's willingness to pay for health care" — with an observed preference for males. Thus, user fees may exacerbate gender inequalities in treatment. The same is sure to be true in education, if parental preference for sons is expressed in the form of a higher willingness to pay for sons' education.<sup>39</sup> Recent experience in Zambia confirms the differential impact of education fees on the schooling of boys and girls [Booth et al., 1995]. In Kenya, parents were found to be twice as likely to withdraw their daughters from school than their sons if they had to make a choice about who would stay in school. Odaga and Heneveld [1995] confirmed that girls are more likely to be withdrawn from school when households are faced with financial constraints.

### *iii. Cost sharing versus cost recovery*

Cost-recovery schemes, which prefer payment in cash, are likely to be more inequitable than cost-sharing schemes, which allow payment in labour or in kind. This is because the poor and the less advantaged are less likely to have equal access to cash resources but are comparatively more likely to be able to contribute in labour or, to a lesser extent, in kind. In the absence of a perfectly functioning labour market, individuals will be imperfectly able to trade their available time for cash resources. As a result, contributions in labour time can be easier for the poor to provide than the cash equivalent of this labour time calculated at the 'going' wage. Similarly, contributions in kind may be easier for poor households to provide, although this is not likely to be true to the same extent as for labour time.<sup>40</sup>

In general, the most equitable mix of contributions towards costs is likely to involve different forms of contributions (in cash, in kind and in labour) and preferably a choice for the individuals concerned, which will have the advantage that those for whom a particular type of contributions are most advantageous will identify themselves through self-selection. There is no empirical evidence on differences in price elasticities of demand with respect to payments in cash or in kind. However, it can be assumed that cash contributions are likely to be more burdensome because of more limited household opportunities to generate cash income.

Although contributions in the form of labour can be less burdensome for many individuals to provide than contributions in cash, the former can also be difficult to organize in practice. For example, in the context of school construction, poor leadership and intra-village strife has led to difficulties in organizing labour contributions [Bray and Lillis, 1988]. Moreover, it is particularly hard to contribute labour if parents live far from the schools. The possible difficulty of organizing contributions in labour must be balanced against its equity advantages. The same applies to payments in kind. In Zambia, patients were offered the option to pay health fees in cash or in kind, but the so-called Mwase-Mphangwe initiative lacked realism. For practical reasons, payments in kind were strongly discouraged because the valuation, storing and resale of agricultural produce or small livestock created enormous logistical and managerial problems for the managers of the health facilities [Booth et al., 1995].

*iv. Prepayment schemes*

Prepayment schemes are usually discussed in relation to the health sector because the unpredictable nature of events (illnesses) requires a significant element of insurance against risk. A prepayment scheme in the health sector is one in which individuals make contributions to a health service for the right of future use. In a hybrid prepayment scheme, this right may however be qualified by a partial service charge, referred to as a deductible or a co-payment in insurance markets.

Equity advantages of a prepayment scheme are that it reduces the impact of charges upon the poor — who are more likely to be sick. The cost of treating the sick is spread across all the insured.<sup>41</sup> Diskett and Nickson [1991] observed that prepayment schemes prevent situations in which “patients are penalized at their most vulnerable time, when they are sick and perhaps unable to work.” Moreover, “annual payment of fees can take into account seasonal variations in members’ ability to pay.” A further administrative advantage of such schemes is that they facilitate the budgeting and planning of otherwise unforeseeable health expenditure.

However, the advantages of prepayment schemes can be undermined in practice because those who are healthier are often unwilling to make payments for a service which they are less likely to use and which may benefit the sicker disproportionately — among whom the poor are overrepresented. This phenomenon is called ‘adverse selection’. In addition, households may be unwilling and unable to release resources for a purely prudential expenditure because of extreme

poverty. Poverty may force them to take a gamble, hoping that ill health will not occur even though if it does the expenditures may be much higher than the insurance fee. It is also possible that those who are insured and face little or no marginal cost of service use will make wasteful use of the service beyond the level merited by their ill health. This phenomenon is known as 'moral hazard'. All of these problems threaten the financial sustainability of prepayment schemes. Diskett and Nickson [1991] reported, for example, a low level of membership of a prepayment scheme in Bangladesh.

Although prepayment schemes can in principle be a valuable tool for the promotion of equity within the context of user financing, the conditions under which they are viable appear to be limited. They are unlikely to be self-sustaining if the better off do not join them, and they are not likely to join unless there are other benefits of doing so. Stinson [1982] listed a wide array of examples of prepayment plans in the health sector, involving contributions in both cash and kind. The most successful of these involved large-scale memberships tied to cooperative production or marketing associations. Because individuals also gain benefits from these affiliated economic arrangements and not only from the health plan, such insurance schemes are less likely to suffer from problems of adverse selection.

**v. *Seasonal variation in income and needs***

Poor households are characteristically subject to significant seasonal variations in their ability to pay, but user financing schemes are not always sensitive to those variations. User contributions towards costs should be adjusted seasonally rather than require individuals to make equal contributions throughout the year. Similarly, contributions in labour should not be required in peak employment seasons when opportunity costs are high. Seasonal variations in the ability to pay are often compounded by seasonal differences in the need for services. For example, the need for water is highest during the dry season, when the ability to pay of the poor is generally at a low ebb.

A study done in Anambra state in rural Nigeria found reluctance on the part of users to pay fixed monthly sums for water supply due to widely fluctuating seasonal demand [Whittington et al., 1990, quoted in Gopalakrishnan, 1993]. Similarly, Fabricant and Kamara [1991] reported measurable seasonal variation in the ability as well as the willingness to pay for health services in Sierra Leone. School fees charged at the end of the dry season before the harvest can cause notorious hardship among the poor [Government of Malawi/UN, 1993]. In Côte d'Ivoire, school fees are payable in September while most farmers obtain the money for their cash crops only in November/December, which often delays enrolment by three months.

**vi. *Local financing and regional inequality***

User financing can lead to the emergence or deepening of regional inequality in the coverage and quality of basic social services because of differences in resource bases. Richer regions will characteristically collect more than poor regions in absolute terms under similar user financing schemes, and fewer individuals will be eligible for exemptions or reduced contributions. Matching funds provided by governments might also aggravate regional disparities. Since economic growth is in part determined by human resources development, regional disparities in terms of the coverage and quality of basic social services may perpetuate economic differences and can potentially worsen regional inequalities.

Although it is possible to diminish the negative consequences of user financing on interregional inequalities through resource transfers, the latter are unlikely to eradicate regional disparities because large transfers would act as strong disincentives for the administrators to collect resources in wealthy regions. Moreover, redistribution of the magnitude required may be politically infeasible. McPake et al. [1993] observed that it is unlikely that losing regions would agree to the process in many countries.”

An important example of cross-subsidization to reduce interregional inequality is that of Umgeni water in Natal, which subsidized rural water consumers through the fees paid by urban dwellers. It was made feasible not only by appealing to concern for equity, but to the need to reduce negative externalities related to upstream pollution [Nigam and Ghosh, 1995]. It seems unlikely that this cross-subsidization would have been feasible and acceptable otherwise. Lewin and Berstecher [1989] provided an example from Sri Lanka of user fees resulting in unequal levels of provision. Schools with wealthier catchment areas were comparatively better endowed. They concluded that “This increases the differences between schools in ways which favour the already advantaged and which may be counter to the broad objectives of social policy.” Mali saw the number of “écoles spontanées” expand rapidly in the late 1980s, but 70 per cent of this type of community schools were set up in Bamako, without a single one emerging in the far-away regions of Tombouctou and Gao. They developed much faster in the richer than in poorer regions, leading to the question “as to whether the basic school has not helped to worsen inequalities in the access to education” [Tounkara, 1993, quoted in UNESCO, 1995]. In Papua New Guinea, it was reported that health system decentralization “not merely perpetuated previous inequalities [across regions] in resource distribution but actually widened them.” This was reported to have occurred both in terms of the distribution of expenditures and of personnel [Gilson and Mills, n.d.].

In the health sector, concern has been expressed under the Bamako Initiative that mechanisms of exemption should not overburden a system. A response to this has been that “if the community determines the [level of] exemptions and deferred payments, this might minimize the problem” [UNICEF/BIMU, 1990]. Although this is true, it is also clear that setting the level of exemptions according to the level of locally available resources will lead to poorer communities granting fewer exemptions than richer communities. This is anything but equitable. In China, for example, a 1987 survey reported that the percentage of patients that were referred to the hospital but not admitted varied by the income level of the region. In addition, the position of the poor was made more vulnerable because village welfare funds virtually collapsed in poor counties, whereas they continued

to provide about a quarter of the financing of health stations in richer counties [Xing-Yuan et al., 1995].

Regional inequalities can result from user financing not only as a consequence of differences in available resources, but also as a result of differences in the degree of social value attached to a particular service. Areas in which there is already some value attached to a particular service (e.g., primary education or sanitation) are more likely to direct the resources generated to effective service extension and improvement. Thus, in Anambra State of Nigeria, parts of the state where primary education was already well established showed far greater interest in a secondary school construction scheme [Bray and Lillis, 1988].

**vii. *Ownership versus equity***

Although the goal of creating a sense of ownership may be valuable from the vantage point of sustainability, it is not evident that it is always as valuable from the equity point of view. This is made very clear in a fascinating example provided in Cleaver [1994]. In Nkayi, Zimbabwe, users who had contributed to communal hand-dug wells were told that by contributing to implementation they had 'paid' for the well, which they now 'owned'. The regular user community consisted of the 10 or 15 families living in the immediate vicinity of the well who had participated in the project. However, there were also occasional users, living further away, who were allowed to use the well by virtue of a "strong traditional principle that no one should be excluded from using a water source." However, when wells began to dry, the regular user community began to impose extensive restrictions on occasional users, who were generally from poor households. "Regular users felt justified in doing this by their having been told that they 'owned' the water source, which they had not previously felt." In this case, the avowed goal of ownership led to results which were quite contrary to the equally avowed goal of equitable access.



#### 4. INSTITUTIONAL CAPACITY AND POLITICAL ECONOMY

The consequences of user financing for basic social services will not only be determined by features such as the presence of positive externalities, the magnitude of price elasticities of demand and the effectiveness of systems of exemption, but also by factors relating to the political and economic interests. This set of issues may be placed under the rubric of ‘political economy’. In addition, the consequences of user financing are also dependent upon institutional structure and managerial capacities.

##### *i. The danger of budgetary displacement*

The case for user financing for basic social services is based in part on the conception that it will increase the aggregate level of resources available. This supposition has been widely questioned. If public resources are directed away from basic social services in equivalent amounts to the resources contributed by users, then there will have been a shift of the burden to recipients without any increase in resources. That this is not unlikely is suggested by some evidence that social sector spending in developing countries has been particularly vulnerable to budget cuts, both in absolute and relative terms, particularly in sub-Saharan Africa and Latin America [Ebel, 1991; Jespersen, 1992; ECLAC, 1994; World Bank, 1994a]. Given the past low level of political commitment to maintaining basic social expenditures in periods of austerity, it is doubtful that all newly generated resources will be turned towards this end, even if they come from the social sectors. In any event, this question is difficult to test because of the range of simultaneous changes involved. Leighton [1995] cites a number of instances in which governments have reduced Ministry of Health budgets once fee revenues have materialized, including Cambodia, Chile, China, Iran, Jordan, Nepal, and Thailand, “sometimes by explicit agreement between ministries of health and finance.” In Kenya and the Central African Republic, in contrast, health officials explicitly sought and received assurances that fee revenues would supplement rather than reduce existing allocations to the health sector.

The increase in net resources available for basic social services, if any, will depend on the degree of substitution between these resources and previously available government resources. One way of ensuring that such substitution does not occur is to clearly separate categories of expenditure. Thus, revenues raised through user financing might be specifically applied to one area of expenditure (e.g., quality-related inputs such as essential drugs, textbooks and spare parts for water pumps), whereas government responsibility for financing other expenditures (e.g., salaries) would continue. This seems in part to be the rationale under the Bamako Initiative for distinguishing between recurrent non-salary expenditure (as a category to be financed by users) and capital and salary expenditure to be financed by the state. This type of compartmentalization is helpful but will also require a level of sustained political commitment.

*ii. Revenue retention at the local level*

It has been widely pointed out that local providers, users and communities will have an incentive to collect or pay user fees only if they are permitted to retain them — in full or in part. If revenues are simply directed to higher-level authorities, there may be little or no incentive to engage in the effort of collection. Transfers to higher administrative levels constitute an effective tax on earnings at the local level with all of the attendant disincentive effects. Moreover, the capacity of user financing to generate a sense of ownership will also be correspondingly undermined. If contributions towards costs cannot be spent as desired at the local level, then there is no reason why they should generate greater local responsibility. The connection between community co-management of resources raised and improvements in services is demonstrated by Table 9, which suggests that increases in health service utilization under the Bamako Initiative have generally occurred where there has been local revenue retention and local management of the resources raised.

**Table 9: Country experiences with user financing under the Bamako Initiative**

Country	Local Management of Resources	Availability of Essential Inputs	Utilization of Services
Benin	Increase	Increase	Large Increase
Ghana (Govt. Hospitals)	Decrease	Decrease	Decrease
Ghana (Mission Hospitals)	Decrease	Increase	Increase
Guinea	Increase	Increase	Large Increase
Guinea Bissau	Increase	Increase	Large Increase
Liberia	Increase	Increase	Large Increase
Mali (Bankas)	Increase	Decrease	Decrease
Mali (Djenne)	Increase	Increase	Large Increase
Mozambique	Decrease	Decrease	Decrease
Rwanda	Increase	Increase	Increase
Sierra Leone	Increase	Increase	Large Increase
Swaziland	Decrease	Decrease	Decrease
Uganda	Increase	Ambiguous	Same
Zaire (Kindu Boma)	Increase	Decrease	Decrease
Zaire (Vako Boma)	Increase	Decrease	Same

Source: Parker and Knippenberg [1991]

In Zimbabwe, fees collected in the health sector initially went straight to the central treasury, not even to the Ministry of Health. It was not surprising that the level of fee collections was low, at about 4 per cent of the recurrent budget of the Ministry of Health and Child Welfare [Chisvo and Munro, 1994]. The same occurred in Côte d'Ivoire, Mali and Senegal [Vogel, 1988] and most

Anglophone countries in Africa [Nolan and Turbat, 1995]. From 1989 to 1992, user fees in health centres in Kenya were largely locally retained (up to three quarters), but the central treasury retained authority over spending decisions. As a result, “About 40% of health facilities did not spend the revenue they retained because their expenditure plans were not approved by the Ministry” [Mwabu et al., 1995].

Some contrary evidence does exist, however. A recent survey of cost recovery schemes in the health sector in sub-Saharan African countries revealed that “retention at the local level is neither a necessary nor a sufficient condition for success in covering a significant proportion of costs” [Nolan and Turbat, 1995]. They referred to community projects in Guinea Bissau and Uganda that raised little revenue despite local revenue retention and to Lesotho’s national schemes of user fees without local retention that generate a respectable 9 per cent of the recurrent budget of the Ministry of Health.

Local revenue retention is also often presumed to minimize administrative costs. However, local retention will require substantial training of local staff to develop adequate capacity and appropriate safeguards and accountability, as well as a comprehensive system of accounting and financial control. This will involve considerable costs of its own Bennett and Musambo [1990], ICC [1990] and Booth et al. [1995] reported serious reservations about the linkage between user fees and greater accountability. Communities that expressed willingness to pay for health care and primary education disagreed with the idea that community-based staff should handle cash, because they had experienced several instances of financial irresponsibility by health workers and teachers in the past.

It should not be assumed that even where revenues are retained at the local level they are necessarily easily or effectively spent. Bennett and Musambo [1990] documented the tendency of local health committees in Zambia to spend resources on construction and facility upgrading projects rather than on measures with much more direct health impacts. Indeed, Waddington and Enyimayew [1990] questioned whether resources raised will be spent at all. They reported in their study of the Volta region of Ghana: “It is perhaps a foible of human nature to assume that spending money will not normally be a problem! Yet there was a considerable reluctance at health centres and health posts to spend their percentage of the fees revenue.” In Burkina Faso, the retained fees were spent by the local communities on services other than health care, thereby undermining the motivation of health workers to raise them [Nolan and Turbat, 1995]. In Tanzania, decentralization was reported to have led to “insufficient emphasis” on preventive services and drug supply, which led to a return to centralized and “vertical” programmes [Gilson and Mills, n.d.].

### *iii. Participation and its discontents*

Successful user financing has usually been accompanied by a significant element of community participation, decision making or co-management. Indeed, community participation has been seen widely as a kind of panacea, likely to enhance immeasurably the likelihood of project success. There

is certainly considerable evidence of the value — if not the necessity — of community participation in project design and implementation. Community involvement should be seen, moreover, as a central goal in itself, and not only as of instrumental relevance. Nevertheless, there has been a tendency to considerably underestimate the difficulties involved in bringing about successful (and, in particular, equitable) community involvement. In this light, it may not be appropriate to regard participation as a cure-all. In the extreme, there is a danger that, “In a society of pervasive inequality and unmet needs, greater participation can [...] act as a figleaf to cover the powerlessness of the poor” [Doyal and Gough, 1991, quoted in Vivian, 1994].

In the first place, the foundations for successful community co-management can take years to establish. Although it is desirable, it may require considerable energy and resources. Evans and Appleton [1993] provided an example from Cameroon of a successful community management system for water supply that took more than 10 years and several attempts to establish.

The homogeneity and cohesiveness of local communities are often overestimated, and deepening poverty usually reduces the capacity and willingness of community members to maintain traditional safety nets and community solidarity. In urban areas, the insecurity related to squatting seldom motivates poor residents for engaging in community work. As a result, the ease as well as equity with which participatory approaches can be implemented are often exaggerated. In the water sector, Feachem et al. [1978] found that attempts to manage community contributions for water supply in rural Lesotho gave rise to “factionalism and hostility.” The term community itself may not be clearly defined, in view of the many ethnic, gender, religious and other differences which typically divide individuals. In view of these challenging differences, project organizers may rely upon traditional leaders or existing structures of power to sustain community management. Evans and Appleton [1993] provided an example of this in Yemen. However, this carries corresponding risks of reproducing inequality and perpetuating power hierarchies in the context of service provision. Indeed, worries about the potential for such consequences can be so significant that households may prefer that “management should remain with an external agency, accepting the defects of such a system as a better option than perceived unfairness or ineffectiveness in existing village political structures.” Indeed, Altaf et al. [1992] found that nearly two thirds of households surveyed in rural Punjab voiced such a preference for exactly these reasons.

Gender biases over the use of resources can lead to sharp conflicts over resource use. In the case of water, these can center over the use of water for domestic as opposed to productive purposes. Where specific regulations are imposed to try to ensure the representativeness of committees, they may fail to support their goals given the actual dynamics of local life. Cleaver [1991] reported, in a large scale study of water supply in Zimbabwe, that guidelines required that there should be at least two women on a waterpoint committee. Such prescriptions were adhered to only in form. In many villages, the woman was the official member of the committee but her husband undertook all her duties. Men predominated not only in numbers but in terms of holding the posts of committee chairmen. An evaluation of a UNICEF-supported community-based water project in

Chivi district found that the committee members were in majority female but the chair was always male — and he had veto power [Government of Zimbabwe, 1993]. Obura [1993] reported that in a department of the Burkinabe province of Sissili, only one out of 270 PTA members was a woman.

The formal structure of a basic social service committee may also not be one in which women feel comfortable or are able to articulate their views. “In many contexts it is regarded as inappropriate for women to speak out or take the lead in public and women find it difficult to break through the barriers of their own diffidence and the indifference or hostility of men in the meeting” [Clever and Elson, 1995].

Much of the literature on participation tends to equate the concept of a service-using community with that of a decision-making community [Clever and Elson, 1995]. However, the gender, ethnic and geographical profile of the two may be different. Patterns of service use may not fall conveniently into simple administrative boundaries, traditional or modern. As a result there is a danger of mistakenly assuming that a formally established committee is representative and “socially embedded” when it is in fact quite “socially disembodied” and hence ineffectual. Unger and Yada [1993] provided an example in relation to health services which illustrates this point in Burkina Faso: “The lack of community control over ‘its’ health committee and pharmacy has been confirmed by the World Bank evaluation team. Although they know of the existence of health committees, people interviewed did not know their functions or the objectives of cost recovery.” Similarly, parent-teacher associations are usually dominated by the teachers because of their social and economic status in the community. Moreover, parents typically fear that their children will be victimized if they voice any grievances. Booth et al. [1995] reported that many rural primary schools engage in income-generating projects in Zambia since they receive little or no funding from the central government apart from teachers’ salaries and allowances. Parents complain that their children are spending too much time on manual work instead of learning. Moreover, teachers seldom report to the PTA on the allocation of the proceeds of this type of ‘child labour’. Nevertheless, parents were reluctant to raise the matter at PTA meetings. Formal committees cannot, this evidence suggests, be relied upon to enhance community management in primary schools.

It may be difficult, even impossible, to ensure that committee members are also socially representative in the manner programme designers may desire. Bray and Lillis [1988] noted that only a small proportion of leaders and organizers on ‘harambee’ (self-help) school construction projects in Kenya were women: “This may be disappointing to advocates of greater female participation, but a major feature of harambee is its grass-roots nature, and the composition of committees is not generally amenable to manipulation from above.”

Finally, communities may be unable to absorb all of the responsibilities which some advocates of community management would like to thrust upon them. Indeed, responsibilities are sometimes transferred to communities precisely because they have proved beyond the capacity of governments. These responsibilities include the choice of appropriate technologies, identification of

needs, provision of funding, maintaining and sustaining facilities, and determining the level of contributions [Cleaver and Elson, 1995]. These are formidable tasks indeed, and it should not be assumed that communities will be capable of undertaking them without sustained capacity development, and certainly not without adequate support and clarity of role definition [McPake et al., 1991]. Even if such capacity development were possible, it is not clear that the transfer of all of these responsibilities would be equitable. It is important to ensure that community management does not serve simply as a foil for the shedding of responsibility by the better off and by the state. Nor must it be seen as a means of gaining the cooperation and acquiescence of the poor, but as genuine decentralization and devolution of authority, capacity and responsibility, and not only of responsibility without authority or capacity. It is of vital importance that calls for participation in conjunction with user financing should not simply become a form of rationalization for the incapacities of higher levels of government or for their lack of social concern.

In 1990, Papua New Guinea devolved the administration of health services to the district level, only to discover later that the medical care had become less efficient, that decisions were being made by people with little health training and that there was a generalized lack of financial resources for supplies [*The Economist*, October 1995]. Ghana's education-sector reform strongly emphasized community-based primary education. Not surprisingly, several rounds of the Ghana Living Standard Measurement Survey showed a substantial increase in household expenditure on education. However, parents and education officials alike admitted that the quality of education had declined [UNESCO, 1995]. Prud'homme [1995] showed how the centralization — not decentralization — of the water and sewerage functions in Tunisia's municipalities led to a remarkable improvement in services, suggesting that it is administrative and technical capacities that are key factors, not solely the method of financing and the level at which control is exercised.

#### *iv. Universal entitlements and political sustainability*

An often overlooked consideration in the design of social service financing schemes is their political sustainability. Spreading the costs of social service provision may not always be conducive to maintaining political support for it. It is useful in this regard to consider the historical development of universal entitlements to social services in the industrial countries. One of the arguments in favour of universality of social entitlements was the need to have a strong base of political support, in addition to arguments concerning positive externalities and equity. A social benefit to which all individuals are entitled is more likely to maintain political support for its continuation. In contrast, a targeted benefit for which eligibility is restricted will be politically easier to whittle away at, both because of the relative political weakness of the poor and because of the ease with which political considerations can lead to modifications of the technical criteria of eligibility. When the opportunity for the extension of services to the poor exists, it should be seized without assuming, however, that such services will continue to be supported unless appropriate incentives are provided to the diverse interest groups concerned. The universality of these programmes was — and remains — an essential component of making them possible and politically sustainable.

Where social benefits accrue only to the poor, the non-poor have less of a stake in protecting these benefits and the poor alone are often too weak to prevent political attacks on the programmes. Dreze and Sen [1989], quoting Richard Titmuss on the rapid expansion of public services in Britain during the Second World War, provided a further example in this regard: “That all were engaged in war whereas only some were affected with poverty and disease [...] had much to do with the [...] scope and quality of the war-time social services. [...] It was the universal character of these welfare policies which ensured their acceptance and success. They were free of social discrimination and the indignities of the poor law.” Universality of social benefits has been very effective at furthering goals of full coverage and equity, even if these may not have been achieved in the most efficient ways.

At present, it is the concern with efficiency that seems to dominate the policy debate. Still in Britain, it was “the strength of popular objection to any kind of means test” [Lord Beveridge, quoted in Jimenez, 1987] that led to the introduction of an untargeted social security system during the 1940s. To some extent, this was reversed in the 1980s, when targeted programmes started to reappear. It has been widely argued that universal access to particular goods and services can be achieved without necessarily making recourse to public action. Social rights can, in theory, be satisfied through a variety of institutional mechanisms, and not only through the free and exclusive provision by the state. However, the historical evolution of the recognition of social rights in the industrialized countries raises the question whether in practice universal access to basic social services is ultimately separable from the institutional form in which they are provided and financed. The strong historical link between the extension of social rights and the gradual extension of universal and free social services in the industrialized countries seems difficult to deny [Marshall, 1950]. Similarly, the high achievers among the developing countries in terms of social development have one point in common, namely a strong commitment to invest in the education and health of their children through affirmative public action [UNICEF, 1995a].

Where the better-off are required to pay fees for services while the poor are exempted, there may be little support from the former to ensure that this system of exemptions is effective and sustained. The better-off may have little interest in expending the effort necessary to monitor a system of exemptions for the fulfilment of its goals, and the poor alone may have little or no voice in its administration. As a result, attempts to reduce the extent of exemptions may not be strongly resisted, as long as quality of service delivery for the better-off is maintained. In contrast, a system offering universal entitlements to service is more likely to generate political support for quality improvement from the more politically powerful sections of society, especially where large-scale private alternatives do not exist. These improvements are likely to benefit all, including the poor. If the better-off come themselves to rely upon well-run publicly provided services, it is likely that the poor will be provided for on a politically sustainable basis. The Swedish middle classes, for instance, strongly supported welfare provisions, and lobbied for improvements in their quality, partly because they were among their prime beneficiaries [Esping-Andersen, 1991], apart from other considerations of social solidarity.



This story may seem to be just a fable, inapplicable to the desperate circumstances of many developing countries where there are often neither high quality publicly provided services nor a lack of outside alternatives to public services for the rich. There are however a number of examples from developing countries of greater targeting of programmes making it increasingly difficult to sustain them politically. For example, after Sri Lanka replaced its universal food subsidy programme with a less costly targeted food stamp programme, benefits delivered under the programme declined over time as it lost middle-class support. Similarly, a food subsidy directed to poor consumers in Colombia was “so tightly targeted that it lacked an effective political constituency, and it was dropped at a change of administration,” according to World Bank (1990). These examples suggest that the political challenges of introducing policies of user financing should be taken seriously. Exemption systems are essential if these policies are to be equitable. However, it is not certain that they will be strongly supported politically.









#### IV. SOCIAL RIGHTS AND USER FINANCING

One of the fundamental questions surrounding the application of user financing for basic social services is whether it is compatible with treating access to basic social service as a right. Article 28 of the Convention on the Rights of the Child reads: “States Parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equality of opportunity, they shall, in particular: Make primary education compulsory and available free to all.” Similarly, Article 24 of the Convention reads: “States Parties recognize the right of the child to the enjoyment of the highest available standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.” The Programme of Action of the World Summit for Social Development includes the following objective: “Ensuring that people living in poverty and low-income communities have access to quality health care [...] free of charge or at affordable rates.”

Admittedly, the Convention does not identify the specific mechanisms by which the social rights are to be fulfilled.<sup>1</sup> Thus, user charges for health care may arguably be consistent with the right of the child to have access to health services, so long as the ability to pay or other factors do not serve as impediments to use of these facilities. It does not seem difficult to argue that the Convention — like other international agreements on social and economic rights — requires, as a minimum, that states parties should ensure that no child is deprived of his or her right of access to relevant social services as a result of inability to pay or other involuntary factors. The Convention directs that a pre-eminent emphasis should be placed on equity, which does not seem, in principle, to preclude user financing as long as it is consistent with this minimum standard. In practice, however, user financing is unlikely to be consistent with the attainment of this minimum standard. The Convention on the Rights of the Child enjoins the duty of fulfilling basic social and economic rights upon “States Parties,” implying a central role for public action in the attainment of the goal of universal availability of basic social services to all.

Rights are an absolute concept. By their nature, they demand priority over non-rights considerations [Rawls, 1971]. This entails that if social and economic rights are taken seriously, they should take priority over other goals such as greater efficiency or more revenue generation, except where the pursuit of these other goals is instrumentally important in furthering the fulfilment of the basic rights. Therefore, if user financing diminishes the access of the already least served, it must be avoided. Creese [1990] and Brunet-Jailly [1990] have argued, for example, that where there is scope for savings through greater cost efficiency within the public sector, it should be the focus of the policy reforms. Similarly, the World Bank [1995d] recommended that cost sharing for basic social services should be considered only after the options of budget restructuring, efficiency gains in public spending, cross-subsidization and the possibilities of multiple providers have been exhausted. Only if and when these are exhausted would it be fully legitimate to turn to contributions from the poor. This stance is justified not only on ethical grounds but also on economic ones — it is inefficient to pass on unnecessarily bloated costs to users.

The principles of social rights that are embedded in international law and standards empower the beneficiaries whereas market transactions — and user financing — determine access to basic social services on the basis of purchasing power. Moreover, the emphasis on individual choice in health and education on the basis of the principle of caveat emptor — which is promoted by user financing — can reduce the collective control of the community over the consequences of these choices, as well as over the distribution of service delivery to different segments of the population. Private choices made by consumers based on price signals are not the same as those made by citizens. Leaving decision making in the health and education sectors solely to individuals on the basis of market signals would deprive citizens of their chances to make collective choices in line with social values and in pursuit of agreed priorities and set targets.

## V. CONCLUSIONS

User financing is now commonly applied in developing countries in an effort to narrow the gap between the demand for and supply of basic social services. Proponents argue that the policy of providing nominally free social services has failed to meet efficiency, effectiveness and equity targets. This paper has examined whether user financing has been better able to meet these objectives.

The arguments in favour of user financing for basic social services are well known. They include the possibility of heightened resource mobilization, expanded coverage, improved quality, a greater sense of ownership, enhanced accountability on the part of service providers, and more responsibility on the part of the users. These are powerful arguments indeed. But some equally powerful criticisms have been raised. The negative impact of user charges on access to basic social services — especially among the poor and children — is now well documented. Moreover, the weak linkage between user financing on the one hand and quality improvements on the other is cause for concern. The growing attention to social rights and to the human development approach have reopened the debate on user financing.

The review has shown that user financing for basic social services raises an array of complex issues. It confirms that the goals of maximizing quality gains and minimizing equity losses represent a major challenge to policy makers. This is not to deny that there is scope for introducing user financing in the name of effectiveness, efficiency and equity. The areas where those stated objectives can be met most easily, however, are not in basic social services. Services that generate strong positive externalities and whose beneficiaries are primarily the poor are not well suited for user financing. Tertiary education, central hospital care and urban piped water supply are examples of areas in which user financing is better suited for achieving the goals of effectiveness, efficiency and equity.

Although a pricing policy that differentiates between the level of services and the type of consumers may be more effective, efficient and equitable than a policy of free services across the board, there are also many reasons why this may not be the case. Taken in sum, the case for user financing of basic social services seems to have been overdrawn in recent years.<sup>1</sup> Its advocates would do well to exercise greater caution, in view of the range of circumstances in which user financing is unlikely to further the goals of efficiency and effectiveness, let alone of equity. It can detract from the understanding of the ultimate social objectives and from the political viability of pro-poor policies. Far from being secondary issues, such broader implications of social sector reforms will determine their ultimate successfulness in furthering the fulfillment of fundamental social rights.



The review of the economic, social and ethical arguments and empirical evidence regarding user financing of basic social services leads to ten principal conclusions:

- i) **Basic social services are associated with positive externalities, have the characteristics of public and merit goods, and are subject to principal-agent interactions and asymmetrical information. For those reasons, user financing will not guarantee greater efficiency and effectiveness, either in theory or in practice.**

The conditions under which user financing increases efficiency and effectiveness are difficult to satisfy because many basic social services have important positive externalities (e.g., immunization reduces the risk of contagion and illness for the entire community, not only the individuals who have been immunized; primary education increases agricultural productivity of all farmers, not only the literate ones; education reduces the fertility rate); or belong to the category of public or merit goods (e.g., the control of a malaria swamp; literacy should be provided regardless of the demand for it). Increasing the price of such services will typically lead to their sub-optimal utilization. The special features justify subsidies to encourage their use to the socially optimal level.

Furthermore, basic social services are characterized by the presence of principal-agent interactions (i.e., the relationship between decision makers and recipients of basic social services, such as between parents and students, and between doctors and patients) and by imperfect information (e.g., patients are seldom able to evaluate or compare different medical treatments). In Burkina Faso, for instance, the decline in the utilization of health services which resulted from a price rise was sharpest among infants (evidence of a principal-agent problem involving parents and children). In China, user fees led to an escalation in medical costs, mainly because health workers overprescribed drugs to maximize their personal income, which was related to the revenue generated by the health centre (the result of a principal-agent problem between doctor and patient). In Zambia, clinics that administered chloroquine injections instead of tablets witnessed heightened demand (the consequence of informational asymmetry between providers and users).

These special features of basic social services imply that price signals will not automatically guarantee a more efficient allocation of resources, because individual users are not able to appraise the correct value of the service to themselves, let alone that to the community.

- ii) **The potential of user financing for resource mobilization should not be exaggerated.**

The resources raised through user financing are relatively low. In health, they typically represent less than 10 per cent of the ministry's recurrent budget. In education, the share is often lower. Some local projects and health facilities reportedly recover a higher proportion of their non-salary recurrent expenditure. However, it would be incorrect to interpret such success stories as evidence that local cost recovery can finance public health care or primary education. In many instances, the fact that budget allocations to basic social services are small implies that the same level of resources, raised

painstakingly at the local level, could just as easily have been raised through small shifts in the pattern of aggregate budget allocations. Furthermore, the evidence indicates that the administrative costs can be very high. Collecting one dollar in Zimbabwe through user fees reportedly costs four times more than through direct or indirect taxation. Hence, the justification for user financing as an instrument of net resource mobilization is not strong. User financing is unlikely by itself to close the wide resource gap that prevents substantial improvements in the quality and coverage of basic social services.

**iii) Although user financing can promote greater accountability on the part of the providers and more responsibility on the part of the users, there is no guarantee that this will be the case.**

The argument in favour of user financing is also based on the claim that user financing enhances 'ownership'. Participation has been widely identified as a necessary ingredient for the success of user financing. However, the assumption that community participation can be readily implemented deserves careful scrutiny. Experience shows that not too much can be expected from the community, particularly in terms of purchased inputs and cash. Moreover, it takes time to develop successful community involvement, because local communities are seldom homogeneous and cohesive. Ethnic, gender, religious, age and other differences typically divide their members on economic and social matters. Traditional values and local power hierarchies are sometimes real obstacles to genuine participation by community members. In addition, deepening poverty can undermine the capacity and willingness of community members to maintain traditional safety nets and exercise community solidarity. Genuine participation is an important goal but cannot be taken for granted in the context of weak capacities, endemic poverty and pervasive inequalities.

User financing can also be counterproductive. Households and local communities already contribute substantial resources and efforts to basic social services, and additional payments will not necessarily strengthen their sense of ownership, especially where communities already feel that they 'own' the clinic or primary school. Communities may actually question why they should continue to provide free labour and materials for the construction and maintenance of schools, clinics or water facilities, if they will have to make additional payments for their use. 'Frivolous' consumption of basic social services should not be overestimated either, because private out-of-pocket and opportunity costs associated with visiting a health centre or attending primary school are often sufficiently high to discourage use which does not correspond to a strongly felt need.

**iv) User financing is likely to result in a reduction in the utilization of services, particularly among the poor.**

It is increasingly difficult to dismiss the growing body of evidence on the adverse effects of user financing on service utilization as either anecdotal or based on flawed analyses. In the wake of changes in the pricing policy for health services, utilization rates have declined sharply in many

countries. The impact on education is less well documented. Elasticities of demand or utilization responses for education are usually lower than for health because higher out-of-pocket and opportunity costs imply that cost-sensitive pupils drop out before the introduction of or increase in school fees. Evidence indicates that primary school attendance dropped in Côte d'Ivoire, Ghana, Indonesia, Zambia and Zimbabwe after the introduction of school fees in recent years. Suggestively, in Malawi, the elimination of primary school fees in 1994 resulted in an overnight increase in enrolment of over 50 per cent. In Zimbabwe, the lifting of tuition fees in 1980 also contributed to the rapid increase in enrolment in subsequent years. In most countries, the decline was not temporary, and quick recoveries in utilization rates were rare. The decline often occurred across all varieties of facilities, indicating that demand diversion to lower levels or to private facilities was not important.

The response to social sector pricing varies by level of service and by socio-economic and age groups. The highest elasticities have been observed amongst the poor. In Burkina Faso, for instance, a 10 per cent increase in the price of health services led to a decline in demand of 14 per cent among the poor, compared with a decrease of only 1 per cent among rich households. The price elasticity of demand for health care of infants dropped by more than 30 per cent.

The validity of the results based on demand elasticities and before/after comparisons has been questioned because they seldom provide information on changes in the quality of the service — an omission which may exaggerate the utilization response to user fees. Although important, it is very difficult to take quality changes into account. Because of the complexities and difficulties in measuring quality and other relevant changes, studies of utilization responses seldom lead to firm conclusions, and sometimes yield contradictory results. However, experience shows that user fees are normally not associated with quality improvements. It has also been observed that if user fees were to have a significant impact on quality, they would need to be fixed at a higher level, which might trigger even stronger utilization responses and result in lower levels of effectiveness and equity.

**v) Protecting the poor has proved difficult: exemption schemes do not appear to have performed well and can be costly to administer.**

User financing without adequate provision for exemptions will in almost all cases worsen the well-being of the poor. An effective system of identifying and supporting the poor is indispensable for reasons of equity and sustainability. However, exempting the poor has proved to be extremely difficult. Exemptions have not been implemented systematically. Informal and ad hoc schemes seem to predominate, and the decision to exempt an individual or a household is often left to the discretion of local managers and headmasters. The limited evidence indicates that exemption schemes have not worked well because of (i) difficulties in accurately identifying the poor; (ii) limited awareness of exemption schemes among the poor; (iii) lack of transparent exemption criteria and procedures which create high transaction costs and uncertainty for those seeking exemptions; (iv) reluctance on the part

of providers to grant exemptions in part because of the lack of incentive for them to do so; and (v) reluctance on the part of the poor to seek exemptions because of social stigma. Stigma effects associated with exemptions are likely to be greater in education than with health and water.

Moreover, exemption schemes can involve high administrative costs, absorbing up to a quarter of total programme resources. Untargeted schemes are less costly to administer. Services that generate considerable positive externalities should not be targeted, because leakages to the non-poor are likely to be less costly to society than paying for the consequences of excluding important segments of the poor.

Information on the design and effectiveness of exemption schemes is woefully inadequate. As a precondition for further user financing of basic social services, considerably more efforts must be directed towards the appraisal and monitoring of exemption schemes.

**vi) Gender biases, seasonal variations and regional economic disparities can aggravate the negative impact of user financing on equity.**

The equitable design of a system of user financing requires careful attention to a variety of cultural, social, economic and environmental issues. These include gender biases and seasonal variations in income and needs. Where a household's willingness to pay for health care or education is biased against the girl child, the introduction of user financing can further aggravate the gender bias. Contributions in kind and in labour are often more equitable than contributions in cash, although evidence shows that problems of valuing, storing and disposing in-kind contributions can reduce efficiency. A prepayment health insurance scheme is inherently progressive, but problems of extreme poverty, adverse selection and moral hazard can undermine its practical utility and sustainability. Seasonal variations often reduce the household's ability to pay when needs are most urgent (e.g., water in the dry season). User financing may also contribute to the worsening of regional disparities in access to basic social services.

**vii) Capacity building, decentralization and continued government support are of critical importance.**

The success of user financing will depend on a range of institutional and political economy factors. The degree to which governments reduce budgetary resources allocated to basic social services in proportion to the contributions generated from users is a real concern. There is little information but also little room for optimism on this score. User financing must supplement existing budget allocations, and cannot be allowed to replace them. For user financing to be effective, revenues and the authority over their expenditure must be retained at a local level. However, genuine decentralization and devolution to the local level require human and institutional capacity and constant monitoring. The need for strong administrative, managerial and technical capacities to implement user financing cannot be overemphasized. In the context of chronic fiscal austerity and

growing inequalities, decentralization and privatization of basic services should not become a euphemism for shedding the responsibilities of the state to deliver basic social services. The role of the state in the delivery of basic social services should remain that of facilitator, policy maker, principal financier and, where necessary, provider .

**viii) User financing can undermine the political support for the goal of universal coverage of basic social services.**

The provision of basic social services without user financing has the advantage of generating broad-based political support. The historical experience of the industrialized countries confirms that the universality of social services can be effective at furthering the goal of equity, even though it may not always be optimal in terms of efficiency. Recent experience shows that targeted schemes are extremely vulnerable in times of fiscal austerity, when eligibility can be made exceedingly restrictive. When social benefits accrue only to the poor, the non-poor will have a lesser stake in protecting the service. The poor alone are generally too weak to prevent the gradual erosion of the political and budgetary support for that service. A strong emphasis on user financing for basic social services can, therefore, undermine the political momentum towards universal coverage in times of scarcity and austerity. High achieving countries in terms of social development have had one point in common, namely a strong political commitment to invest in the education and health of all children through affirmative public action.

**ix) User financing does not empower beneficiaries in the way the recognition of basic social rights does.**

Social policy has to be consistent with the principles of social rights embedded in international law and standards such as the Convention on the Rights of the Child. If social and economic rights are to be taken seriously, they must take precedence over other goals such as greater efficiency or more revenue generation, except where the pursuit of these goals is instrumentally important in furthering the fulfillment of basic rights. The Convention directs that a pre-eminent emphasis should be placed on equity. If user financing diminishes the access of the already least served, it must be avoided. The normative or rights-based approach is important, because it entitles individuals to a basic level of social services. Rights empower the beneficiaries, whereas market transactions — and user financing — determine access on the basis of purchasing power. The fulfillment of basic social rights requires strong political support for sustaining the momentum towards universal access to basic social services.

**x) Principles of best practice under the second-best option:**

In spite of the above economic and moral arguments, which caution against introducing user financing for almost all basic social services, severe resources constraints may force policy makers to consider

user financing as a pragmatic instrument in the interim period to narrow the gap between the supply of and demand for basic social services or to rehabilitate service delivery, especially if budget restructuring and cross-subsidization in favour of the poor will not be immediately feasible. Although the principle of free basic social services should remain the ultimate goal, the second-best option of sharing the cost of basic social services with the users and communities may have to be contemplated. In such cases, particular attention will have to be paid to the following practical guidelines based on best practice:<sup>2</sup>

- rely heavily on community participation in the design and management of the user financing scheme;
- initiate a major programme of community training and social mobilization to build capacity for meaningful co-management;
- provide adequate information and incentives to service providers, with adequate checks and balances to avoid excessive zeal and potential abuse;
- retain the bulk of the revenue and spending authority at the local level;
- ensure that user financing does not substitute for existing budgetary allocations;
- apply flexibility in the type and timing of contributions (e.g., in cash, in kind or in labour);
- ensure that users will perceive an improvement in the quality of services in the early stage of user financing, e.g., by directing revenue to the procurement of quality-enhancing inputs such as essential drugs, textbooks and spare parts of water pumps;
- link user fees to the availability of this type of inputs rather than simply to entry or access (e.g., registration vs. treatment fees, tuition vs. textbook fees);
- implement an effective exemption scheme for the poor that is generous, transparent, equitable, and based on measurable criteria agreed by the community;
- exempt selected services — such as immunization and sexually transmitted diseases — and specific target groups that are more easily identified than the poor;
- de-emphasize the objective of reducing ‘frivolous’ consumption;
- use graduated fees whenever possible, particularly in the health sector, to improve the referral system;
- introduce user financing gradually so as to allow for adequate modification at the local level to take account of the many cultural, regional and seasonal factors that may inhibit success; and
- set performance targets and conduct regular and comprehensive monitoring, analysis and oversight to adjust and improve the user financing scheme.

Experience shows that, in the rush to mobilize additional resources, many of the above points can easily be overlooked in the design and implementation of cost-recovery schemes. User financing of basic social services cannot be seen in isolation from the entire sectoral financing framework, which will include budget and aid restructuring as well as reforms to enhance efficient utilization of the resources available.



**APPENDIX I:****EFFICIENCY, EFFECTIVENESS, AND EQUITY**

User financing for basic social services should be judged in relation to whether it furthers three central goals — efficiency, effectiveness and equity. These goals need not be mutually inconsistent, and can be mutually supportive. Reforms that are perceived as inequitable are less likely to be efficient and effective. As argued in the Convention on the Rights of the Child, safeguarding the access to basic social services for all — which is an equity-related objective — must be the guiding principle of social policy in relation to user financing.<sup>1</sup> One cannot speak of efficiency, effectiveness or equity except in the context of particular objectives. Equity is concerned with the safeguarding of the access of the poor to basic social services. Concern for equity is distinct from concern for equality, which is a more demanding concept.

At least three concepts of efficiency can be distinguished:

- (a) *Allocative efficiency*: The allocation of resources to the most socially valuable uses. Ordinarily, the term is used in relation to end products or services delivered.<sup>2</sup> For example, using a unit of clean water for drinking may be more allocatively efficient than using it for irrigation, given the limitations on the supply of potable water and the greater availability of other ‘unimproved’ water sources that may be used for irrigation.
- (b) *Technical efficiency*: The best use of resources to attain a given end. A technically efficient production or delivery process is one which delivers a given output with the least inputs or which delivers the most output with given inputs. Technical efficiency is related to the idea that there is some maximum amount of output that can be produced with any given level of inputs. Technical efficiency is what is required to produce this maximal amount. In the health sector, for instance, a well-organized cold chain can ensure that spoilage of vaccines is kept to a minimum. Technically efficient organization of a cold chain can ensure a minimum loss of vaccines, given the available resources of refrigeration, transportation, and other facilities.
- (c) *Cost efficiency*: The delivery of a given amount of goods or services at least cost, as measured at market prices.<sup>3</sup> Technical efficiency is a necessary but not a sufficient condition for cost efficiency. For example, it may be more cost efficient for rural schools to be built with local materials than with imported ones. However, both methods of construction may be equally technically efficient in the sense that they both use a similar mix of inputs to produce the most possible output.<sup>4</sup>

*Effectiveness* is the attainment of a given end to the greatest extent possible, irrespective of the means. Technical efficiency is a necessary condition for effectiveness. On the other hand, neither



allocative efficiency nor cost efficiency is necessarily required for effectiveness. An example involving effectiveness is that of a general food subsidy scheme, where the objective is to reach as many of the poor as possible. Such a scheme that reaches all the poor may involve large amounts of leakage to the non-poor, in which case it will also be allocatively inefficient. It may also be more expensive than a targeted scheme, in which case it is cost inefficient. However, it may still reach a larger number of the non-poor than any targeted scheme. If so, given the chosen objective—reaching as large a number of the poor as possible—the food subsidy scheme is more effective than other options, although it is neither allocatively efficient nor cost efficient. Targeted schemes, by contrast, can be more efficient without being necessarily more effective.

**APPENDIX II:****SOME QUESTIONS TO BE ADDRESSED PRIOR TO INTRODUCING  
USER FINANCING FOR BASIC SOCIAL SERVICES****1. EQUITY**

- i) Have all other avenues of raising resources been exhausted, such as inter- and intra-sectoral budget restructuring in favour of basic social services, additional and targeted taxation and/or improvements in cost efficiency?
- ii) Is there scope for introducing equity-enhancing mechanisms other than exemptions, such as the cross-subsidization from richer to poorer areas or from non-basic to basic services? Are existing political and economic interests likely to support such arrangements?
- iii) What is a reasonable estimate of the price elasticity of demand? Is it different for the poor compared with the non-poor? Will it depend upon the type of contribution (e.g., cash, labour or kind)?
- iv) Does the ability to pay for the service exist? How large an ability is it?
- v) If ability to pay is fully taken into account, how many exemptions or reduced contributions are likely to be necessary? Can the poor be accurately identified? What criteria will be used to identify them? Who will ultimately decide on their exemption?
- vi) How will these exemptions be administered? Can they effectively and reliably be administered by the providers of the service? What is the role of the community? Who will ensure that exemptions are effectively implemented?
- vii) Will the poor be able and ready to take advantage of exemptions? Will there be a mechanism to monitor the performance of the exemption system? Are the non-exempted likely to maintain an interest in the system of exemptions?
- viii) What are the implications of user financing for gender equity and for interregional equity? Have the equity implications of seasonal fluctuations in income and needs and of different types of contributions been taken into account?

## 2. EFFECTIVENESS

- i) Are local committees or other participatory institutions likely to be genuinely representative and socially embedded? If not, will effectiveness in promoting the range of programme goals be impaired? Can training improve the situation?
- ii) Is there a willingness to pay for the service? How large a willingness is there?
- iii) Is the overall elasticity of demand less than unity? Is revenue likely to increase or decrease as a result of user financing? What are likely to be the costs of collection?
- iv) Is the expected revenue integrated in the budgeting process? Will user fees supplement or substitute for central government expenditure?
- v) What are the likely costs of granting and administering exemptions? By how much are these costs expected to reduce projected revenues?
- vi) Are the net resources likely to be retained within the sector? Are they likely to be used for the improvement or extension of the service? Or is it likely that there will be a high degree of central government substitution away from the sector as a result of the resources generated through user financing?
- vii) Will revenues be retained locally? Will there be an institutional arrangement in place to ensure that these resources are used effectively? What will be the continuing role of higher level authorities in monitoring or overseeing the expenditure of resources? How is such a role likely to affect local level incentives?
- viii) Is special attention being paid to the improvement in service quality? Are user fees being linked to the availability of specific inputs or are they solely linked to access?
- ix) Will the introduction of user financing increase or decrease the political momentum for the extension of basic social services?

**3. EFFICIENCY**

- i) Are there externalities or public-good aspects associated with the service? How significant are these? Are principal-agent interactions likely to occur? Is user financing likely to improve or worsen allocative efficiency?
- ii) Is user financing likely to increase the degree of responsibility with which individuals use services? Are there other ways to enhance their responsibility without user financing?
- iii) Is user financing likely to increase the degree of accountability which service providers have towards users? Could accountability be enhanced without user financing?
- iv) Is there a strong tradition of community participation in the provision of social services? Or is community participation solely motivated by the introduction of user financing? What are the capacities of the local communities to participate in meaningful co-management?
- v) How will user financing empower communities and users?
- vi) Is the proposed system of user financing being tested before it is introduced nationwide? What are the steps of the gradual approach that will be followed?



## REFERENCES

- Abel-Smith, B. (1986), "Funding Health for All - Is Insurance the Answer?", *World Health Forum*: 7: 3-32.
- \_\_\_\_\_ (1991), "Financing Health for All", *World Health Forum*: 12: 191-200.
- \_\_\_\_\_ and Rawal, P. (1992), "Can the Poor Afford 'Free' Health Services? A Case Study of Tanzania", *Health Policy & Planning*: 7(4): 329-341.
- Abu-Zeid, H.A., and Dann, W.M. (1985), "Health Utilization in Ismaila, Egypt", *Social Science and Medicine*: 21: 451-461.
- Ahmad, S. (1994), " 'The Rhetoric of Participation Re-Examined': The State, NGOs and Water Users at Varanasi Uttar Pradesh, India", *The Environmentalist*: 14 (1): 3-16.
- Akin, J.S., Griffin C.C., Guilbey, D.K. and Popkin, B.M. (1985), *The Demand for Primary Health Service in the Third World*. (Totowa, NJ: Rowan and Allenheld).
- Altaf, A., Jamal, H. and Whittington, D. (1992), *Willingness to Pay for Water in Rural Punjab, Pakistan*. Water and Sanitation Report No. 4. Program Report Series. UNDP-World Bank Water and Sanitation Program. (Washington, D.C.: The World Bank).
- Arrow, J. (1963), "Uncertainty and the Welfare Economics of Medical Care", *American Economic Review*: 53: 941-973.
- Bardhan, P. (1995), "Research on Poverty and Development Twenty Years after Redistribution with Growth". Annual Bank Conference on Development Economics, 1-2 May. (Washington, D.C.: The World Bank).
- Barro, R.J. (1991), "Economic Growth in a Cross-Section of Countries", *Quarterly Journal of Economics*: 106(2): 407-444.
- \_\_\_\_\_ and Lee, J-W. (1994), "Sources of Economic Growth", *Carnegie-Rochester Conference Series on Public Policy*: 40: 1-46.
- Bennett, S. and Musambo, M. (1990), "Report on Community Financing and District Management Strengthening in Zambia". Bamako Initiative Technical Report. Report prepared for the Ministry of Health (Zambia) and UNICEF (New York: Bamako Initiative Management Unit, UNICEF).
- Bennett, L., Goldberg, M. and Hunte, P. (1996), *Participation Sourcebook: Group-Based Financial Systems and Participation*. (Washington, D.C.: The World Bank).
- Berhane, S., Kabirizi, A. and Geria, I. (1994), "Direction of Drilling Operations in Uganda". Draft Final Report. (Kampala: Directorate of Water Development).
- Berman, P. And Rannan-Eliya, R.P. (1994), "Framework for Selection of Priority Research and Analysis Topics in Private Sector Health Development in Africa". Technical Paper No.1. (Washington, D.C.: Human Resources and Democracy Division, Office of Sustainable Development, Bureau for Africa, USAID).
- Birdsall, N. (1986), "Cost Recovery in Health and Education: Bank Policy and Operations in Uganda". Draft final report.
- Biswas, A. (1986), "Water Development Policies", *Comment. Resources Policy*: 12(4): 290-292.
- \_\_\_\_\_ and Sewell, W. (1986), "Implementing Environmentally Sound Management of Inland Waters". *Resources Policy*: 12(4): 293-306.
- Blackett, I. (1992), *Low-Cost Urban Sanitation in Lesotho*. Water and Sanitation Discussion Paper Series. Discussion Paper No. 10. (New York: UNDP/Washington D.C.: The World Bank).
- Blair, R. (1992), *Financial Diversification and Income Generation at African Universities*. AFTED Technical Note No.2, (Washington, D.C.: The World Bank).

- Blakney, R., Litvack, J. and Quick, J. (1989), "Financing Primary Health Care: Experiences in Pharmaceutical Cost Recovery". Technologies for Primary Health Care (PRITECH) Project. (Arlington, VA: Management Sciences for Health).
- Booth, D., et al. (1995), "Coping with Cost Recovery". Report to SDA. Commissioned through the Development Studies Unit, Department of Social Anthropology, Stockholm University. (Stockholm: Stockholm University).
- Bossert, T. and Galloway, J. (1992), "Jamaica Health Sector Initiatives Strategic Plan". Prepared for the Health Sector Initiatives Project/Ministry of Health. Latin America and Caribbean Health and Nutrition Sustainability: Technical Support for Policy, Financing and Management. (Washington, D.C.: Health and Nutrition Sustainability Project).
- Bossert, T., Phillips, T., Vargas, V. and Bongiovanni, A. (1991), "Primary Health Care Recurrent Cost Study — Belize". Latin America and Caribbean Health and Nutrition Sustainability: Technical Support for Policy, Financing and Management. (Washington, D.C.: International Science and Technology Institution University Research Corporation).
- Bray, M. (1995) "The Costs and Financing of Primary Schooling in Bhutan". (Thimpu: UNICEF/Government of Bhutan Division of Education, Ministry of Health and Education).
- \_\_\_\_\_ and Lillis, K. (eds.) (1988), *Community Financing of Education: Issues and Policy Implications in LDCs*. (New York: Pergamon Press).
- Briscoe, J., de Castro, P., Griffin, C., North, J. and Olsen, O. (1990), "Toward Equitable and Sustainable Rural Water Supplies: A Contingent Valuation Study in Brazil", *The World Bank Economic Review*: 4(2): 115-134.
- Briscoe, J. and de Ferranti, D. (1989), *Water for Rural Communities*. (Washington, D.C.: The World Bank).
- Briscoe, J. and Garn, H. (1995), "Financing Water Supply and Sanitation under Agenda 21", *Natural Resources Forum*: 19(1): 59-70.
- Brunet-Jailly, J. (1990), "Le financement de la santé dans les pays pauvres: recouvrer les coûts ou les réduire?" Background Paper for *African Health Policy*. Mimeographed. (Washington, D.C.: The World Bank).
- Cairncross, S. and Cliff, J. (1987), "Water Use and Health in Mueda, Mozambique", *Transactions of the Royal Society of Tropical Medicine and Hygiene*: 81: 51-54.
- Cairncross, S. and Kinnear, J. (1991), "Water Vending in Urban Sudan", *Water Resources Development*: 7(4).
- Carlsson, J. and Geria, I. (1994), "Cost-Effectiveness of Water and Sanitation in Uganda". Final Draft. Andante AB. (Stockholm: SIDA).
- Carrin, G. (1988), "Community Financing of Health Care", *World Health Forum*: 9: 601-610.
- \_\_\_\_\_ Perrot, J. and Sergent, F. (1994), *The Influence of Financial Participation by the Population on the Demand for Health Care: An Analytical Tool for Countries in Greatest Need. Guiding Principles*. Macroeconomics, Health and Development Series, No. 6. WHO/ICO/MESD.6. (Geneva: World Health Organization).
- Chaulagai, C.N. (1995), "Community Financing for Essential Drugs in Nepal", *World Health Forum*: 16: 92-94.
- Chisvo, M. and Munro, L. (1994), "A Review of Social Dimensions of Adjustment in Zimbabwe, 1990-94". (Harare: UNICEF).
- Cleaver, F. (1991), "Maintenance of Rural Water Supplies in Zimbabwe", *Waterlines*.



- \_\_\_\_\_ (1994) "Gendered Priorities for Water Resource Management in Nkayi District, Zimbabwe". Presented at Edinburgh Conference, 1994. *'Gender and Environment in Africa' Perspectives on the Politics of Environmental Sustainability*. Centre of African Studies. (Bradford: Development and Project Planning Centre, University of Bradford).
- \_\_\_\_\_ and Elson, D. (1995) *Women and Water Resources: Continued Marginalization and New Policies*. Gatekeeper Series, No.49. (London: The International Institute for Environment and Development).
- Cohen, G.A. (1988), *History, Labour and Freedom*. (Oxford: Clarendon Press).
- Colclough, C. with Lewin, K.M. (1993a), *Educating All the Children: Strategies for Primary Schooling in the South* (Oxford: Clarendon Press).
- \_\_\_\_\_ (1993b), "Education and the Market: Which Parts of the Neo-Liberal Solution are Correct?" Innocenti Occasional Papers. Economic Policy Series, No. 37. Special Subseries: Fiscal Policy and the Poor. (Florence: UNICEF International Child Development Centre, Spedale degli Innocenti).
- Collins, C. and Green, A. (1994), "Decentralization and Primary Health Care: Some Negative Implications in Developing Countries", *International Journal of Health Services*, 24(3):459-475.
- Commonwealth Secretariat (1985), "Community Financing of Schools: Commonwealth Regional Workshop with Special Reference to Southern Africa. Gaborone, Botswana. 12-19 June 1985." Report. (London: Commonwealth Secretariat).
- Cornia, G. A. and Stewart, F. (1993), *Two Errors of Targeting*. Innocenti Occasional Papers. Economic Policy Series, No.36. Special Subseries: Fiscal Policy and the Poor. (Florence: UNICEF International Child Development Centre, Spedale degli Innocenti).
- Creese, A. (1990) "User Charges for Health Care: A Review of Recent Experience." *Current Concerns*. SHS Paper No.1. WHO/SHS/CC/90.1. (Geneva: World Health Organization).
- \_\_\_\_\_ (1994), "Global Trends in Health Care Reform: Health Systems", *World Health Forum*:15: 317-322.
- Criel, B. and Van Balen, H. (1993), "Paying for the Kasongo Hospital in Zaire: A Conceptual Framework", *Health Policy & Planning*: 8(1): 61-71.
- Dávid, L. (1986), "Environmentally Sound Management of Freshwater Resources". *Resources Policy*: 12(4): 307-316.
- de Bethume, X., Alfani, S. and Lahaye, J.P. (1989), "The Influence of an Abrupt Price Increase on Health Service Utilisation: Evidence from Zaire." *Health Policy & Planning*: 4(1): 76-81.
- de Ferranti, D. (1985), *Paying for Health Services in Developing Countries*. (Washington, D.C.: The World Bank).
- de Geyndt, W. (1991), *Managing Health Expenditures under National Health Insurance: The Case of Korea*. World Bank Technical Paper No.156. Asia Technical Department Series. (Washington, D.C.: The World Bank).
- Diskett, P. and Nickson, P. (1991), "Financing Primary Health Care: An NGO Perspective", *Development in Practice: An Oxfam Journal*: 1(1): 43-51.
- Dow, G. (1995), "Welfare Impacts of Health Care User Fees: A Health Valuation Approach to Analysis with Imperfect Markets". Paper presented at the North-East Universities Development Economics Conference, Harvard University. October 1995. (mimeograph).

- Doyal, L. and Gough, I. (1991), *A Theory of Human Need* (New York: Guilford Press).
- Dreze, J. and Sen. A. (1989), *Hunger and Public Action* (Oxford: Clarendon Press).
- Dujardin, B. (1992), Book Review of *Implementing the Bamako Initiative in Africa*, by B. McPake, K. Hanson and A. Mills. Health Policy Unit, Department of Public Health & Policy, London School of Hygiene and Tropical Medicine, Publication No. 8.
- Dunlop, D. and Donaldson, D. (1987), "Sector Review, Ethiopia: A Study of Health Financing Issues and Options". Report 6624-ET Eastern African Department. (Washington, D.C.: The World Bank).
- Dworkin, D. (1980a), *Rural Water Projects in Tanzania: Technical, Social and Administrative Issues*. AID Evaluation Special Study No.3. (Washington, D.C.: USAID).
- \_\_\_\_\_ (1980b), *The Potable Water Project in Rural Thailand*. AID Project Impact Evaluation Report No.3. (Washington, D.C.: USAID).
- \_\_\_\_\_ (1982), *Community Water Supply Evaluation Summary: Conference Working Paper*. (Washington, D.C.: USAID).
- Ebel, B. (1991), *Patterns of Government Expenditure in Developing Countries During the 1980s: The Impact on Social Services*. Innocenti Occasional Papers. Economic Policy Series, No.18. Special subseries: Fiscal Policy and the Poor. (Florence: UNICEF International Child Development Centre, Spedale degli Innocenti).
- ECLAC (1994), *Social Panorama of Latin America*. LC/G.1844. (Santiago: United Nations Economic Commission for Latin America and the Caribbean).
- Eicher, J. (1984), *Education Costing and Financing in Developing Countries: Focus on Sub-Saharan Africa*. World Bank Staff Working Papers, No.655. (Washington, D.C.: The World Bank).
- Ensor, T. and San, P. B. (1995), "Health Charges and Exemptions in North Viet Nam". Bamako Initiative Research Programme. Final Report. (New York: Bamako Initiative Management Unit, UNICEF/York: The University of York).
- Esping-Andersen, G. (1990), *The Three Worlds of Welfare Capitalism*. (Princeton, NJ: Princeton University Press).
- Evans, P. (1992), *Paying the Piper: An Overview of Community Financing of Water and Sanitation*. Occasional Paper No.18. (The Hague: International Reference Centre [IRC] for Community Water and Sanitation).
- \_\_\_\_\_ and Appleton, B. (1993), "Community Management Today: The Role of Communities in the Management of Improved Water Supply Systems." (The Hague: International Reference Centre [IRC] for Community Water and Sanitation).
- Fabricant, S. and Kamara, C. (1991), "The Financing of Community Health Services in Sierra Leone: Seasonality, Socio-Economic Status, Gender, and Location Factors Affecting Access to Services". Bamako Initiative Technical Report Series, No.8. (New York: Bamako Initiative Management Unit, UNICEF).
- Feachem, R. et al. (1978), *Water, Health and Development: An Interdisciplinary Evaluation*. (London: Tri-Med.).
- Fiedler, J. (1991), "The PROSALUD Model: A Private, Non-profit Organization Providing Primary Health Care for a Fee." Prepared for the U.S. Agency for International Development Latin America and Caribbean Health and Nutrition Sustainability: Technical Support for Policy, Financing and Management. (Washington, D.C.: International Science and Technology Institution University Research Corporation).
- Fielden, R. (1991), "Use of Cost-Effectiveness Analysis in Three Countries in Eastern and Southern Africa Region." Report of a Consultancy for UNICEF Eastern and Southern

- Africa Regional Office, 24th November—15th December 1990. Reviewed and Edited by Anne Mills/London School of Hygiene and Tropical Medicine. (Nairobi: UNICEF).
- Ford Foundation. (1990), *The Costs and Financing of Health Care: Experiences in the Voluntary Sector. Case Study 2: SEWA-Rural, Jhagadia; Bharuch District, Gujarat* (New Delhi: Ford Foundation).
- Forsberg, B.C. (1990), "Household Health Expenditure Survey: Western Province, Zambia". (Stockholm: Department of Social Medicine, Karolinska Institute).
- \_\_\_\_\_(1993), "Paying for Health Care: The Household Perspective". *Sweden Journal of Health Economics*: 7: 26-28.
- Frederick, K. (n.d.), *Balancing Water Demands with Supplies: The Role of Management in a World of Increasing Scarcity*. World Bank Technical Paper No.189. (Washington, D.C.: The World Bank).
- Freyens, P., Mbakuliyemo, N. and Martin, M. (1993), "How Do Health Workers See Community Participation?", *World Health Forum*: 14: 253-257.
- Fryatt, R., Rai, P., Crowley, S. and Gurung, Y. (1994), "Community Financing of Drug Supplies in Rural Nepal: Evaluating a 'Fee Per Item' Drug Scheme", *Health Policy & Planning*: 9(2): 193-203.
- Fuller, B. and Habte, A. (eds.) (1992), *Adjusting Educational Policies: Conserving Resources While Raising School Quality*. World Bank Discussion Papers. Africa Technical Department Series No.132. (Washington, D.C.: The World Bank).
- Gertler, P. and Glewwe, P. (1989), "The Willingness to Pay for Education in Developing Countries: Evidence from Rural Peru". Living Standards Measurement Study. Working Paper No.54. Policy, Planning, Research. (Washington, D.C.: The World Bank).
- Gertler, P. and Van der Gaag, J. (1989), "The Willingness to Pay for Medical Care: Evidence from Two Developing Countries". (Baltimore: The Johns Hopkins University Press).
- Ghai, D. (1989), "Participatory Development: Some Perspectives From Grass-Roots Experiences", *Journal of Development Planning: Human Development in the 1980s and Beyond*: No.19.ST/ESA/209.
- Ghazala, A. (1990), "Cost Analysis Standardization Study of UNICEF WATSAN Interventions." Mission Report. (New York: UNICEF).
- Gilson, L. and Mills, A. (1995), "Health Sector Reforms in sub-Saharan Africa: Lessons of the Last 10 Years", In: *Health Sector Reform in Developing Countries: Making Health Development Sustainable*. P. Berman, Ed. Harvard Series on Population and International Health. (Boston: Harvard University Press).
- Gopalakrishnan, R. (1993), "Willingness to Pay: Affordability, and Alternate Financing Mechanisms for Rural and Peri-Urban Water Supply and Sanitation". A Report for the Office of Social Policy and Economic Analysis, and the Water and Environmental Sanitation Sections. (New York: UNICEF).
- Government of India (1990), (National Drinking Water Mission), *People, Water and Sanitation: What They Know, Believe and Do in Rural India*. Based upon information contained in the report, "Water, Environment and Sanitation: A Knowledge, Attitudes and Practices Study in Rural India, 1988-1989". A study undertaken by the Indian Market Research Bureau for UNICEF.
- Government of Kenya (1995), "Impact of Cost-Sharing in Kenya: Health Care User Fees and Social Insurance 1989-1994. (Nairobi: Ministry of Health).

- Government of Malawi/United Nations (1993), *Malawi Situation Analysis of Poverty* (Lilongwe: United Nations in Malawi, Government of Malawi).
- Government of Malawi (1995), "Rural Water Supply and Sanitation in Malawi: Sustainability through Community-Based Management." UNICEF Co-ordinated Inter-agency WES Sector Mission. (Lilongwe: United Nations in Malawi, Government of Malawi).
- Government of Sierra Leone/Ministry of Health and UNICEF (1989), "Assessment of the Impact of the Essential Drugs' Cost Recovery Programme on the Utilization Levels of Peripheral Health Units".
- Government of Zambia (1994), "Zambia Household Budget Survey", *Quarterly Bulletin*: 2. (Lusaka: Central Statistical Office).
- Government of Zimbabwe (1993), "Evaluation of the Pilot Community-Based Handpump Maintenance Project in Chivi District, Zimbabwe". (Harare: Government of Zimbabwe District Development Fund/UNICEF).
- Green, R. (1994), "Health for All, Participation, Cost Sharing and Poverty". (Sussex: Institute for Development Studies).
- Griffin, C. (1987), *User Charges for Health Care in Principle and Practice*. Economic Development Institute. Seminar Paper No.37. (Washington, D.C.: The World Bank).
- \_\_\_\_\_(1989), *Strengthening Health Services in Developing Countries through the Private Sector*. Discussion Paper No.4. (Washington, D.C.: International Finance Corporation, The World Bank).
- Grosh, M.E. (1994), *Administering Targeted Social Programs in Latin America* (Washington, D.C.: The World Bank).
- Gujja, B. (1993), "Towards Environmentally Sound Rural Domestic Water and Sanitation in South Asia: A Comparative Review of Problems and Opportunities". (Kathmandu: UNICEF Regional Office for South Asia).
- Haddad, S. and Fournier, P. (1995), "Quality, Cost and Utilization of Health Services in Developing Countries. A Longitudinal Study in Zaire", *Social Science and Medicine*: 40(6): 743-753.
- Hanson, K. and Chindele, F. (1992), "Cost, Resource Use and Financing: A Study of Monze District, Zambia". Bamako Initiative Technical Report Series, No.12. (New York: Bamako Initiative Management Unit, UNICEF).
- Hanson, K. and Gilson, L. (1993), "Cost, Resource Use and Financing Methodology for Basic Health Services: A Practical Manual". Bamako Initiative Technical Report Series, No.16. (New York: Bamako Initiative Management Unit, UNICEF).
- Heller, P.S. (1982), "A Model of the Demand for Medical Health Services in Peninsular Malaysia", *Social Science and Medicine*: 16: 267-289.
- Hinchliffe, K. (1993), "Neo-Liberal Prescriptions for Education Finance: Unfortunately Necessary or Inherently Desirable?" Review Article. *International Journal of Educational Development*: 13(2): 183-187.
- Hirschman, A.O. (1970), *Exit, Voice and Loyalty*. (Cambridge, MA: Harvard University Press).
- Hiscock, J. (1993), *Sustainability in the Health Sector*, Part 1: Ghana Case Study. (London: Save the Children UK).
- Hongoro, C. and Chandiwana, S.K. (1994), "The Effects of the Enforcement of User Fees on the Health Care Delivery System in Zimbabwe". A study financed by UNICEF

- Harare. (Harare: Blair Research Laboratory and Ministry of Health and Child Welfare).
- Huber, J. (1993), "Ensuring Access to Health Care with the Introduction of User Fees: A Kenyan Example", *Social Science and Medicine*: 36(4): 485-494.
- ICC (1990), *Children in the Tropics: The Bamako Initiative: Primary Health Care Experience*. No.184/185. (Paris: International Children's Centre).
- IHPP (1995), "User Charges in Kenya: Health Service Pricing Reforms, 1989-93". International Health Policy Program Policy Brief (Washington, D.C.: The World Bank/Geneva: World Health Organization).
- ILO (1993), *Structural Change and Adjustment in Zimbabwe*. Occasional Paper 16. Interdepartmental Project on Structural Adjustment. (Geneva: International Labour Organisation).
- Jarrett, S. and Ofosu-Amaah, S. (1992), "Strengthening Health Services for MCH in Africa: the First Four Years of the 'Bamako Initiative'", *Health Policy & Planning*: 7(2): 164-176.
- Jespersen, E. (1992), "External Shocks, Adjustment Policies and Economic and Social Performance". In: Cornia, G.S., Van der Hoeven, R., and Mkandawire, T., *Africa's Recovery in the 1990s. From Stagnation and Adjustment to Human Development. A UNICEF Study*. (New York: MacMillan).
- Jimenez, E. (1987), *Pricing Policy in the Social Sectors: Cost Recovery for Education and Health in Developing Countries*. (Baltimore, MD: The Johns Hopkins University Press).
- Johnson, R. (1992), *Guidelines for Cost Management in Water and Sanitation Institutions*. WASH Technical Report No.54. Prepared for the Office of Health, Bureau for Research and Development, U.S. Agency for International Development. (Washington, D.C.: Water and Sanitation for Health Project).
- Jones, C.W. and Kiguel, M.A. (1994), *Adjustment in Africa: Reforms, Results and the Road Ahead*. (New York: Oxford University Press).
- Jordan, J. and Wyatt, A. (1989), "Estimating Operations and Maintenance Costs for Water Supply Systems in Developing Countries". WASH Technical Report No.48. Prepared for the Office of Health, Bureau for Science and Technology, U.S. Agency for International Development. (Arlington, VA: Water and Sanitation for Health Project).
- Kabirizi, A., Etima, A., Geria, I. and Nyakuni, Z. (n.d.), "Cost Study of Water and Environmental Sanitation (WES) Sectors - Uganda".
- Kahenya, G. and Lake, S. (1994), "User Fees and Their Impact on Utilisation of Key Health Services". Summary report of a study carried out in Lusaka Urban District, January/February 1994. (Lusaka: Government of Zambia, Ministry of Health and UNICEF Lusaka).
- Kalyalya, D.H. (1995), "User Fees in the Health Sector: Policy, Practice, and Perceptions". Study commissioned by the Ministry of Health with financial support from The Study Fund. (Malawi).
- Kanji, N. (1989), "Charging for Drugs in Africa: UNICEF's 'Bamako Initiative'", *Health Policy & Planning*: 4(2): 110-120.
- Katko, T. (1990), "Cost Recovery in Water Supply in Developing Countries", *Water Resources Development*: 6(2):86-94.
- \_\_\_\_\_(1991), "Reselling and Vending Water". Paying for Water in Developing Countries. Management and Operations, *Journal AWWA*.
- Lake, S. (1994), *User Charges in the Health Sector: Some Observations on the Zambian Experience*. (Lusaka: UNICEF).

- Lal, D. (1994), *The Role of the Public and Private Sectors in Health Financing*. Human Resources Development and Operations Policy Working Papers, No. 33. (Washington, D.C.: The World Bank).
- Lavy, V. and Germain, J. (forthcoming), "Tradeoffs in Cost, Quality and Accessibility in Utilization of Health Facilities: Insights from Ghana." In: Shaw, R.P. and Ainsworth, M., eds. (date) *Financing Health Services through User Fees and Insurance: Country Case Studies from Sub-Saharan Africa*. (Washington, D.C.: Population and Human Resources Department, The World Bank).
- Lavy, V. and Quigley, J. (1993), *The Willingness to Pay for the Quality and Intensity of Medical Care*. LSMS Working Paper 94. (Washington, D.C.: The World Bank).
- Leighton, C. (1995), "Twenty-Two Policy Questions About Health Care Financing in Africa". (Washington, D.C.: USAID).
- Lennox, J. (1994), "Paying for Health: Poverty and Structural Adjustment in Zimbabwe". (Oxfam UK and Ireland).
- Levine and Rennelt (1990). "A Sensitivity Analysis of Cross-Country Growth Regressions", *American Economic Review*: 82(4): 942-963.
- Lewin, K. (1993), Review of *World Bank Financing of Education: Lending, Learning and Development*: Phillip W. Jones. Routledge, London, 1992, 285 pp. Book Reviews. *International Journal of Educational Development*: 13(4):387-392.
- \_\_\_\_\_ and Berstecher, D. (1989), "The Costs of Recovery: Are User Fees the Answer?", *IDS Bulletin*: 20(1). (Sussex: Institute of Development Studies).
- Lewis, M. (1987), "The AID Experience in Health Care Financing, 1978-1986". (Arlington, VA: Resources for Child Health Project - REACH).
- \_\_\_\_\_ (1993), "User Fees in Public Hospitals: Comparison of Three Country Case Studies", *Economic Development and Cultural Change*: 41(3): 513-532.
- Light, D. (1992), "Equity and Efficiency in Health Care", *Social Science and Medicine*: 35(4): 465-469.
- Litvack, J. and Bodart, C. (1993), "User Fees Plus Quality Equals Improved Access to Health Care: Results of a Field Experiment in Cameroon", *Social Science and Medicine*: 37(3): 369-383.
- Lockheed, M., Vespoor, A., et al. (1991), *Improving Primary Education in Developing Countries*. A World Bank Publication. (Washington, D.C.: Oxford University Press).
- Lovei, L. (1992), "Approach to the Economic Analysis of Water Supply Projects". Policy Research Working Papers: Water and Sanitation. (Washington, D.C.: Infrastructure and Urban Development Department, The World Bank).
- Makinen, M. and Block, S. (1986), *Pricing for Cost Recovery in Primary Health Care in Guinea*. CCCD/ Guinea. (Arlington, VA: The Resources for Child Health Project- REACH).
- \_\_\_\_\_ Graybill, D. and Percy, A. with assistance from Mpese, M., N'Diaye, B., and Jeanée, E. (1989), *Proceedings from the Workshop on Health Care Financing in the Central Africa Republic, April 24-28, 1989*. Bangui, Central African Republic. (Arlington, VA: Resources for Child Health Project - REACH).
- Mandl, P.-E. (1988), *Annotated Bibliography on Community Financing for Local Health Services*. Staff Working Paper No.3. (New York: UNICEF).
- \_\_\_\_\_ and Ofosu-Amaah, S. with Knippenberg, R., Niimi, R. Sarr, R. and Topping, M. (1988), *Community Financing Experiences for Local Health Services in Africa*. Staff Working Paper No.2. (New York: UNICEF).

- Marshall, T.H. (1950), *Citizenship and Social Rights*. (Cambridge, U.K.: Cambridge University Press).
- Mbugua, J.K., Bloom, G. and Segall, M. (1995), "Impact of User Charges on Vulnerable Groups: The Case of Kibwezi in Rural Kenya", *Social Science and Medicine*: 41(6): 829-835.
- McGowan, R., Hodgkin, J., and Kaplan, P. (1992), "Water Supply Issues in the Peri-Urban (Informal) Sector". WASH Field Report No.355. Prepared for the Office of Health, Bureau for Research and Development, U.S. Agency for International Development. (Arlington, VA: Water and Sanitation for Health Project).
- McPake, B. (1993a), "Community Financing of Health Care in Africa: An Evaluation of the Bamako Initiative", *Social and Science Medicine*: 36(11): 1383-1395.
- \_\_\_\_\_ (1993b), "User Charges for Health Services in Developing Countries: A Review of the Economic Literature", *Social Science and Medicine*: 36(11): 1397-1405.
- \_\_\_\_\_ Hanson, K. and Mills, A. (1991), "Experience to Date of Implementing the Bamako Initiative: A Review and Five Country Case Studies". (London: Health Economics and Financing Programme, Health Policy Unit, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine).
- McPhail, A. (1993), "The 'Five Percent Rule' for Improved Water Service: Can Households Afford More?", *World Development*: 21(6): 963-973.
- Mehrotra, S., Nigam, A. and Thet, A.T. (1996), *Public and Private Costs of Primary Education: Evidence from Selected Countries in Asia and Africa*. Staff Working Paper No.14. (New York: UNICEF).
- Moens, F. (1990), "Design, Implementation, and Evaluation of a Community Financing Scheme for Hospital Care in Developing Countries: A Pre-Paid Health Plan in the Bwamanda Health Zone, Zaire", *Social Science and Medicine*: 30(12): 1319-1327.
- Mujinja, P. and Mabala, R. (1992), "Charging for Service in Non-Governmental Health Facilities in Tanzania". Bamako Initiative Technical Report Series, No.7. (New York: Bamako Initiative Management Unit, UNICEF).
- Musgrave, R. (1959), *The Theory of Public Finance* (New York: McGraw Hill).
- Mwabu, G. (1990), *Financing Health Services in Africa: An Assessment of Alternative Approaches. Policy, Research, and External Affairs*. Population, Health and Nutrition Working Papers Series, No. 457. (Washington, D.C.: Population and Human Resources Department, The World Bank).
- \_\_\_\_\_ Mwanzia, J. and Liambila, W. (1995a), "User Charges in Government Health Facilities in Kenya: Effect on Attendance and Revenue," *Health Policy & Planning*: 10(2): 164-70.
- \_\_\_\_\_ and Wangombe, J. (1995b), "User Charges in Kenya". IHPP Report on Work in Progress. (Washington, D.C.: International Health Policy Program).
- Nepal National Planning Commission and UNICEF Kathmandu. (1994), "Budget Restructuring to Achieve Human Development Goals in Nepal" (Kathmandu: Institute for Sustainable Development).
- Nigam, A. (1995a), "Umgeni Water: 'Basin Management' Approach in the Provision of Rural and Urban Services in South Africa", *Waterfront: Water Supply, Environmental Sanitation and Hygiene News*, Issue 7, May. (New York: UNICEF).
- \_\_\_\_\_ (1995b), "How to Improve Cost-Effectiveness of WES Programmes: Brief Findings of Case Studies in Benin and Uganda", *Waterfront: Water Supply, Environmental Sanitation and Hygiene News*, Issue 7, May. (New York: UNICEF).

- \_\_\_\_\_. (1995c), "Getting Children into Primary School in Malawi", *Exchange: Newsletter of UNICEF's Economic and Social Policy Analysts*. Winter. (New York: UNICEF).
- \_\_\_\_\_. and Ghosh, G. (1994), "Financing Rural and Peri-Urban Water Supply and Sanitation or Financial Empowerment — Water Supply and Sanitation as Entry Points". (New York: UNICEF).
- \_\_\_\_\_. (1995), "A Model of Costs and Resources for Rural and Peri-Urban Water Supply and Sanitation in the 1990s," *Natural Resource Forum*, 19(3):193-202.
- \_\_\_\_\_. and Heyward, D. (1993), "Improving Cost-Effectiveness of Rural Water Supply and Sanitation Programmes." Prepared for UNICEF Workshop on Planning for Health and Socio-Economic Benefits in the Water and Sanitation Sector, 21-22 April 1993. (New York: UNICEF).
- Nolan, B. and Turbat, V. (1995), *Cost Recovery in Public Health Services in Sub-Saharan Africa*. EDI Technical Series. (Washington, D.C.: Economic Development Institute of the World Bank).
- Nwe, Y.Y. (1995a), "Synthesis of Some Thematic Evaluations in West and Central Africa: Lessons Learnt from Strengthening and Revitalization of Health Systems." (Abidjan: UNICEF West and Central Africa Regional Office).
- \_\_\_\_\_. (1995b), "Synthesis of Some Thematic Evaluation in West and Central Africa: Lessons Learnt from Water, Sanitation and Guinea Worm Interventions." (Abidjan: UNICEF West and Central Africa Regional Office).
- Obura, A.P. (1993), "Issues of Dissemination and Impulse in Research in Africa", In: Muyanda- Mutebi, P. and Matovu, M.Y. (eds.) *Education Research for Development in Africa*, UNESCO-BREDA/ASESP, pp.43-48.
- Odoga, A. and Heneveld, W. (1995), "Girls and Schools in Sub-Saharan Africa: From Analysis to Action." World Bank Technical Paper No.298. (Washington, D.C.: The World Bank).
- Okun, A. and Lauria, D. (1992), "Capacity Building for Water Resources Management: An International Initiative for the 1990s", *Development and Management Issues*. Reprinted by permission from Water Technology International 1992. (Century Press).
- Okyere, A. and Kwadwo, W. (1995), "Financing Health Care in Ghana", *World Health Forum*: 16:86-91.
- Olave, M., Gimenez, D., Meerhoff, R. et al. (1992), "Study of the Recurrent Unit Costs of Primary Health Care Services in a Sample of Bolivian Ministry of Health Facilities, 1990-1991." Prepared for the Ministry of Public Health and Social Welfare and USAID/Bolivia. (Washington, D.C.: University Research Corporation/International Science and Technology Institute).
- OECD (1987), *Managing and Financing Urban Services*. (Paris: Organisation for Economic Cooperation and Development).
- OXFAM (1995), *The OXFAM Poverty Report*, Kevin Watkins. (Oxford: OXFAM).
- Parker, D. and Knippenberg, R. (1991), "Community Cost-Sharing and Participation: A Review of the Issues". Bamako Initiative Technical Report Series, No. 9. (New York: Bamako Initiative Management Unit, UNICEF).
- Patel, M. (1989) *Elimination of Social Distance Between North and South. Cost-Effective Goals for the 1990s*. Staff Working Paper No.5. (New York: UNICEF).
- Pereira, S. (1992), "Guidelines for Financial Planning of Water Utilities". WASH Field Report No.370. Prepared for the Office of Health, Bureau for Research and Development,



- U.S. Agency for International Development. (Washington, D.C.: Water and Sanitation for Health Project).
- PRICOR (1987), "Community Financing of Primary Health Care: The PRICOR Experience. A Comparative Analysis". (Baltimore, MD: Primary Health Care Operations Research, Center for Human Services).
- Prud'homme, R. (1995), "The Dangers of Decentralization", *World Bank Research Observer*: 10(2).
- Ransom, A., Khoo, S.M., and Selvaratnam, V. (1993), *Improving Higher Education in Developing Countries*. Economic Developing Institute of the World Bank. EDI Seminar Series. (Washington, D.C.: The World Bank).
- Rawls, J. (1971), *A Theory of Justice* (Cambridge, MA: Harvard University Press).
- Reynolds, J. (1991), "Handpumps: Toward a Sustainable Technology. Research and Development During the Water Supply and Sanitation Decade". Water and Sanitation Report No.5. (New York: UNDP-World Bank Water and Sanitation Program).
- \_\_\_\_\_ and Gaspari, K. (1988), *Operations Research Methods: Cost-Effectiveness Analysis*. (Bethesda, Maryland: Primary Health Care operations Research Center Human Services).
- Richardson, P., Galloway, J., Olave, M., et al. (1992), "Quality, Costs and Cost Recovery: A Comparative Study of the Unidad Sanitaria of the Ministry of Health (MOH) and Prosalud in Santa Cruz, Bolivia". Latin America and Caribbean Health and Nutrition Sustainability: Technical Support for Policy, Financing and Management. Prepared for the Ministry of Public Health and Social Welfare and USAID/Bolivia. (Washington, D.C.: University Research Corporation/International Science and Technology Institute).
- Riddell, A. (1993), "The Evidence on Public/Private Educational Trade-Offs in Developing Countries", *International Journal of Educational Development*: 13(4): 373-383.
- Rogers, P. (1992), *Comprehensive Water Resources Management: A Concept Paper*. Policy Research Working Papers: Water and Sanitation. WPS 879. (Washington, D.C.: Infrastructure and Urban Development Department, The World Bank).
- RUWASA (1993), "Inspection Report on the Use of Latrines: Bukooma & Nsinze Sub-Counties. Iganga District". (Uganda: Rural Water and Sanitation East Uganda Project).
- Sauerborn, R., Nougbara, A. and Latimer, E. (1994), "The Elasticity of Demand for Health Care in Burkina Faso: Differences Across Age and Income Groups", *Health Policy & Planning*: 9(2):185-192.
- Save the Children UK. (1992), "Health Financing and Sustainability in Vietnam". Working Draft, 20th October. (London: Save the Children UK).
- \_\_\_\_\_ (1993), "Sustainability in the Health Sector". Report on a Save the Children Workshop, Nutfield Institute, Leeds. 26th-28th May 1993. (London: Overseas Information and Research Department, Save the Children UK).
- Sen, A. (1980), "Equality of What". Tanner Lectures on Human Values. (Salt Lake City, UT: University of Utah Press).
- \_\_\_\_\_ (1981), *Poverty and Famines*. (Oxford: Oxford University Press).
- \_\_\_\_\_ (1992), "The Political Economy of Targeting". Draft for Discussion. World Bank Conference on Public Expenditures and the Poor: Incidence and Targeting. June 17-19, 1992. (Washington, D.C.: The World Bank).

- \_\_\_\_\_. (1993), *Markets and Freedoms: Achievement and Limitation of the Market Mechanism in Promoting Individual Freedoms*. Oxford Economic Papers, No.45., pp. 519-541. (Oxford: Oxford University Press).
- Shaw, P., and Griffin, C.C. (1995), *Financing Health Care in Sub-Saharan Africa through User Fees and Insurance*. (Washington, D.C.: The World Bank).
- Sheng-Lan, T., et al. (1994), "Financing Health Services in China: Adapting to Economic Reform". Research Report No. 26. (Sussex, UK: Institute of Development Studies).
- Shepard, D. (1993), "Cost Recovery in Jamaican Health Facilities". Final Report. Latin America and Caribbean. Health and Nutrition Sustainability: Technical Support for Policy, Financing and Management. (Washington, D.C.: University Research Corporation/International Science and Technology Institute).
- Sow, B. (1994), "Survey on Willingness and Ability of Households to Pay for Health Care in Three Provinces of Burkina Faso". Technical Note No.34. Health Financing and Sustainability (HFS) Project. (Bethesda, MD: ABT Associates Inc.).
- Stanton, B. and Clemens, J. (1989), "User Fees for Health Care in Developing Countries: A Case Study of Bangladesh", *Social Science and Medicine*: 29(10): 1199-1205.
- Stevens, C. (1984), "Cost Recovery by Government Hospitals in LDCs: A Key Element in Strategy to Increase the Commitment of Resources to Primary Health Care (PHC)." *Primary Health Care Issues*. (Washington, D.C.: American Public Health Association/International Health Programs).
- \_\_\_\_\_. (1987), "Creating Sustainable Community Health projects: The PRICOR Experience." (Chevy Chase, MD: Primary Health Care Operations Research, Center for Human Services).
- Tan, J.-P., Lee, K.H. and Mingat, A. (1984), *User Charges for Education: The Ability and Willingness to Pay in Malawi*. World Bank Staff Working Paper No. 661. (Washington, D.C.: The World Bank).
- Tan, J.-P. and Mingat, A. (1992), *Education in Asia*. (Washington, D.C.: The World Bank).
- Tanzi, V. (1995), "Fiscal Federalism and Decentralization". Annual Bank Conference on Development Economics, May 1-2. (Washington, D.C.: The World Bank).
- The Economist*, February 25, 1995. "A Lesson from Malawi". p.43. International Section.
- \_\_\_\_\_. October 7, 1995, "Good intentions, road to hell?". p.107. Science and Technology.
- Tounkara, A. (1993), "The Cooperative School in Mali". In: Neida, *Innovations in the Cause of Basic Education*, UNESCO-Dakar.
- UNDP, UNESCO, UNFPA, UNICEF and WHO (1994), *The 20/20 Initiative: Achieving Universal Access to Basic Social Services for Sustainable Human Development* (New York: Division of Information, UNICEF).
- UNDP/UNICEF/WHO/UNDP-World Bank Water and Sanitation Program. (1993), *Community Management Today: The Role of Communities in the Management of Improved Water Supply Systems*. (The Hague: International Reference Centre [IRC] on Community Water and Sanitation).
- UNDP-World Bank (1993), *Water and Sanitation Publications*. March. (Washington, D.C.: Water & Urban Development Department, The World Bank).
- UNESCO (1995a), "Audience Africa. Social Development: Africa's Priorities". Final Report. UNESCO Paris, 6-10 February. (Paris:UNESCO).
- \_\_\_\_\_. (1995b), *Report on the State of Education in Africa, 1995: Education Strategies for the 1990s: Orientations and Achievements*. (Paris:UNESCO).

- Unger, J.-P. and Yada, A. (1993), "Should Medicines be Distributed by Health Services or Pharmacies? A Preliminary Evaluation of the Boulgou Project in Burkina Faso", *Health Policy & Planning*: 8(3): 240-246.
- UNICEF (1991), *First Call for Children: World Declaration and Plan of Action from the World Summit for Children: Convention on the Rights of the Child*. (New York: UNICEF).
- \_\_\_\_\_ and SANAA. (1992a), *The Water and Sanitation Sector of Honduras: Coverage and Investment Needs for the Decade*. (Tegucigalpa: UNICEF).
- \_\_\_\_\_ WHO-DAP. (1992b), "Operational Research Relation to Rational Use of Drugs". Paris, 25-26 March 1991. (Paris).
- \_\_\_\_\_ (1993), "Planning for Health and Socio-Economic Benefits From Water and Environmental Sanitation Programmes: A Workshop Summary. April 21-22". (New York: Water and Environmental Sanitation Section: Evaluation and Research Office, UNICEF).
- \_\_\_\_\_ (1994a), "Eau Potable et Assainissement en Milieux Rural et Periurbain, Benin: Vue d'ensemble et analyse des coûts." Tomes I (Vue d'ensemble) et II (Analyse des coûts et note bibliographique). Revision mai 1994. (Cotonou: UNICEF).
- \_\_\_\_\_ (1994b) *The Progress of Nations 1994*. (New York: UNICEF).
- \_\_\_\_\_ (1995a), *Profiles in Success. People's Progress in Africa, Asia and Latin America*. (New York: UNICEF).
- \_\_\_\_\_ (1995b), *The Progress of Nations 1995*. (New York: UNICEF).
- \_\_\_\_\_ (1995c), *The State of the World's Children 1995* (Oxford: Oxford University Press).
- \_\_\_\_\_ (1996), "Influencing Policies in Favour of Children: An Evaluation of UNICEF's Experience in Zimbabwe". An internal evaluation of UNICEF's economic and social policy work. (New York: UNICEF).
- UNICEF/BIMU (1992), "The Bamako Initiative: Progress Report. UNICEF Executive Board 1992 Session". Presented at Board as E/ICEF/1992/L.6, 3 February 1992 and Annex 1 (E/ICEF/1992/L.20) (New York: Bamako Initiative Management Unit, UNICEF).
- \_\_\_\_\_ (1995), *The Bamako Initiative: Rebuilding Health Systems* (New York: Programme Publications, UNICEF).
- \_\_\_\_\_ and Renzi, M. (1990), "Economic Crisis, Adjustment, and the Bamako Initiative: Health Care Financing in the Economic Context of Sub-Saharan Africa". Background Document for the Pan-African Conference on Community Financing in PHC, Kinshasa, Zaire, 25-27 June. (New York: Bamako Initiative Management Unit, UNICEF).
- UNICEF Guatemala (n.d.), "Water Supply and Sanitation to Urban Marginal Areas of Tegucigalpa, Honduras". Urban Example - Prospective for the Future. (Guatemala: UNICEF).
- United Nations/Economic and Social Council (1995), "UNICEF Strategies in Basic Education". Policy Review. E/ICEF/1995/16. Prepared for United Nations Children's Fund. Executive Board. Annual Session. 22-26 May 1995. (New York: United Nations).
- United Nations/Economic and Social Council (1995), "UNICEF Strategies in Water and Environmental Sanitation". Policy Review. E/ICEF/1995/17. Prepared for United Nations Children's Fund, Executive Board. Annual Session 1995, 22-26 May 1995. (New York: United Nations).
- Van Lerberghe, W., Tellier, V. and Van Dormael, M. (1992), "Quality of Health Care Provision in Africa Through the Bamako Initiative: Problems and Strategies". Workshop Report. Prince Leopold Institute of Tropical Medicine/UNICEF, 3-4

- December 1992. Antwerp, Belgium. (New York: Bamako Initiative Management Unit, UNICEF).
- Van Wijk-Sijbesma, C. (1987), "What Price Water? User Participation in Paying for Community-Based Water Supply, with Particular Emphasis on Piped Systems." Occasional Paper Series. IRC Water and Sanitation Centre. (The Hague: International Reference Centre [IRC] for Community Water Supply and Sanitation).
- Verspoor, A. (1993), "More Than Business-as-Usual: Reflections on the New Modalities of Education Aid", *International Journal of Educational Development*: 13(2): 103-112.
- Vesth-Hansen, K. and Engberg-Pedersen, P. (1992), *Evaluation of UNICEF. Sector Report, Water and Environmental Sanitation. Working Paper.* (New York: UNICEF).
- Vivian, J. (1994), *Social Safety Nets and Adjustment in Developing Countries.* Occasional Paper No.1. UNRISD. (Geneva: United Nations Research Institute for Social Development).
- Vogel, R. (1988), *Cost Recovery in the Health Care Sector: Selected Country Studies in West Africa.* World Bank Technical Paper No.82. (Washington, D.C.: The World Bank).
- \_\_\_\_\_(1991), "Cost Recovery in the Health-Care Sector in Sub-Saharan Africa", *International Journal of Health Planning and Management*: 6: 167-191.
- \_\_\_\_\_(1994), "Health Care Cost-Recovery Simulations From Parametric Estimates: Methodology and Results for Ogun State, Nigeria", *International Journal of Health Planning and Management*: 9: 183-198.
- Waddington, C. and Enyimayew, K.A. (1990), "A Price to Pay, Part 2: The Impact of User Charges in the Volta Region of Ghana", *International Journal of Health Planning and Management*: 5(4): 287-312.
- WASH (1986), "Economic and Affordability Analysis of Sanitation Alternatives for Self-Help Housing Areas in Botswana". WASH Field Report No.148. Prepared for the USAID Mission in Botswana. (Arlington, VA: Water and Sanitation for Health Project).
- \_\_\_\_\_(1992), "A Primer on Comparing and Using Cost Data in Water and Sanitation Reports". Technical Note. (Arlington, VA: Water and Sanitation for Health Project).
- Watson, G and Jagannathan, N. (1995), *Participation in Water and Sanitation.* Environment Department Paper No.2. (Washington, D.C.: The World Bank).
- Weaver, M., et al. (1993), "Willingness to Pay for Child Survival: Results of a national survey in Central African Republic." (Washington, D.C.: USAID).
- \_\_\_\_\_(1994), "Prospects for Reform of Hospital Fees in sub-Saharan Africa: A Case Study of Niamey National Hospital in Niger", *Social Science and Medicine*: 38(4): 565-574.
- White, J. (1991), "Quantification of the Benefits of Rural Potable Water Supply Projects." Draft. ODA Guidance Note. (London: ODA).
- Whittington, D. (1992), "Possible Adverse Effects of Increasing Block Water Tariffs in Developing Countries", *Economic Development and Cultural Change*, 41(1): 75-87.
- \_\_\_\_\_, Briscoe, J. and Mu, X. (1987), With the assistance in the Haiti case study of Barron, W., Duval, J.-M., and Bourgeois, T. "Willingness to pay for Water in Rural Areas: Methodological Approaches and an Application in Haiti". WASH Field Report No.213. Prepared for the Office of Health, Bureau for Science and Technology, U.S. Agency for International Development. (Arlington, VA: Water and Sanitation for Health Project).
- \_\_\_\_\_(1990), "Estimating the Willingness to Pay for Water Services in Developing Countries: A Case Study of the Use of Contingent Valuation Surveys in Southern Haiti", *Economic Development and Cultural Change*: 38(2): 293-312.

- Whittington, D. and Choe, K. (1992), "Economic Benefits Available from the Provision of Improved Potable Water Supplies: A Review of the Existing Evidence". WASH Technical Report No.77. Prepared for the Office of Health, Bureau for Research and Development, U.S. Agency for International Development. (Arlington, VA: Water and Sanitation for Health Project).
- Whittington, D. Lauria, D., Choe K., Hughes, J. and Wright, A. (1993), "Household Sanitation in Kumasi, Ghana: A Description of Current Practices, Attitudes and Perceptions", *World Development*: 21(5): 733-748.
- Whittington, D., Lauria, D. and Mu, X. (1991), "A Study of Water Vending and Willingness to Pay for Water in Onitsha, Nigeria", *World Development*: 19(2/3): 179-198.
- Whittington, D., Lauria, D., Wright, A., Choe, K., Hughes, J. and Swarna, V. (1992). "Household Demand for Improved Sanitation Services: A Case Study of Kumasi, Ghana". Water and Sanitation Report No.3. UNDP-World Bank Water and Sanitation Program. (Washington, D.C.: The World Bank).
- Whittington, D. and Lovei, L. (1991), *Rent Seeking in Water Supply*. The World Bank: Sector Policy and Research. Infrastructure and Urban Development Department. Discussion Paper. Report INU 85. (Washington, D.C.: The World Bank).
- Whittington, D., Mu, X. and Roche, R. (1990), "Calculating the Value of Time Spent Collecting Water: Some Estimates for Ukunda, Kenya", *World Development*: 18(2): 269-280.
- Whittington, D., Mujwahuzi, M., McMahon, G. and Choe, K. (1988), "Willingness to Pay for Water in Newala District, Tanzania: Strategies for Cost Recovery". WASH Field Report No. 246. Prepared for the USAID Mission to the Government of Tanzania and the UNICEF Tanzania Mission. (Arlington, VA: Water and Sanitation for Health Project).
- Wood, M. (1988), "Ghana's tariffs have mixed effects", *World Water*: 11(7): 32-35.
- World Bank (1988), *Education in Sub-Saharan Africa: Policies for Adjustment, Revitalization and Expansion*. (Washington, D.C.: The World Bank).
- \_\_\_\_\_ (1990), *World Development Report*. (New York, Oxford University Press).
- \_\_\_\_\_ (1991), *Federal Republic of Nigeria: Health Care Cost, Financing and Utilisation*. Report 8382-UNI. (Washington, D.C.: West Africa Department, The World Bank).
- \_\_\_\_\_ (1993a), *Better Health in Africa*. (Washington, D.C.: Africa Technical Department, Human Resources and Poverty Division, The World Bank).
- \_\_\_\_\_ (1993b), *Ghana: Primary School Development Project*. Staff Appraisal Report. (Washington, D.C.: The World Bank).
- \_\_\_\_\_ (1993c), *The East Asian Miracle*. (Washington, D.C.: The World Bank).
- \_\_\_\_\_ (1993d), *Water Resources Management*. (Washington, D.C.: The World Bank).
- \_\_\_\_\_ (1994a), *Adjustment in Africa: Reforms, Results and the Road Ahead*. A World Bank Policy Research Report. (New York: Oxford University Press).
- \_\_\_\_\_ (1994b), *Colombia Poverty Assessment Report*, Volumes 1 and 2. (Washington, D.C.: Country Operations Division I, Latin America and the Caribbean Region, The World Bank).
- \_\_\_\_\_ (1995a), *Priorities and Strategies for Education*. (Washington, D.C.: Education and Social Policy Department, The World Bank).
- \_\_\_\_\_ (1995b), *Ghana: Growth, Private Sector, and Poverty Reduction*. A Country Economic Memorandum. Report no. 14111-GH. (Washington, D.C.: Country Operations Division, West Central Africa Department, The World Bank).

- \_\_\_\_\_(1995c), *Kenya Poverty Assessment*. (Washington, D.C.: The World Bank).
- \_\_\_\_\_(1995d), *The Poor and Cost Sharing in the Social Sectors of Sub-Saharan Africa*. (Washington, D.C.: Human Resources and Poverty Division, Africa Technical Department, The World Bank).
- \_\_\_\_\_(1995e), *World Bank Participation Source Book*. (Washington, D.C.: The World Bank).
- World Bank Water Demand Research Team (1991), "Towards a New Rural Water Supply Paradigm: Implications of a Multi-Country Study of Households' Willingness to Pay for Improved Water Services." A Paper Submitted to *The World Bank Research Observer*.
- WHO (1987), "Cost Recovery in Community Water Supply and Sanitation." Report of the Second Informal Consultation on Institutional Development, Geneva, 5-9 October 1987. WHO/CWS/87.5. (Geneva: WHO).
- \_\_\_\_\_(1988), *Estimating Costs for Cost-Effectiveness Analysis: Guidelines for Managers of Diarrhoeal Diseases Control Programmes* (Geneva: Programme for Control of Diarrhoeal Diseases, WHO).
- \_\_\_\_\_(1989), "Managerial and Financial Principles for Water Supply and Sanitation Agencies: Report of the Fourth Consultation on Institutional Development Working Group on Cost Recovery, Geneva, 21-25 November 1988." *Community Water Supply and Sanitation*. Volume 1. WHO/CWS/89.5. (Geneva: WHO).
- WHO Study Group (Contandriopoulos, A.P., Evlo, K., Hongvivitana, T., et al.) (1991), *The Evaluation of Recent Changes in the Financing of Health Services*. (Geneva: WHO).
- WHO Task Force on Health Economics (Kinnon, C., Velasquez, G., and Flori, Y.-A.) (1994), *Health Economics: A Guide to Selected WHO Literature*. WHO/TFHE/94.1. (Geneva: WHO).
- WHO/UNICEF (1991), "Report of the Pan-African Conference on the Financing of Community Health Activities." Volume I: Conference Report. Kinshasa, Zaire: 25-27 June, 1990. (New York: Bamako Initiative Management Unit, UNICEF).
- Yoder, R. (1989), "Are People Willing and Able to Pay for Health Services?", *Social Science and Medicine*: 29(1): 35-42.
- Xing-Yuan, G., Bloom, G., Sheng-Lan, T. and Lucas, H. (1995), *Financing Health Strategies in Poor Rural China: A Strategy for Health Sector Reform*. Institute of Development Studies Working Paper No. 17. (Shanghai: Shanghai Medical University/ Sussex, UK: Institute of Development Studies Collaborative Research Programme).







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1. Free services refer to those that are financed through general taxation, although they often carry a price tag in terms of out-of-pocket and/or opportunity costs (e.g. free tuition does not necessarily mean free education).

2. It is important to distinguish between the private and public financing and delivery of services. This report is essentially concerned with the private financing of publicly delivered basic social services.

3. Basic social services cover basic education, primary health care and nutrition, low-cost water and sanitation, and reproductive health and family planning, as described in the 20/20 initiative [UNDP et al., 1994b].

4. The appendix attempts to clarify the concepts of effectiveness, efficiency and equity.

1. Gertler and Van der Gaag [1989], for example, examined the case where an individual is able but not willing to pay. They provide the example of an individual who is able to pay for a health service without reducing consumption of other necessities but who is unwilling to do so because of addiction to alcohol. Another example is that of the non-poor who are able to pay for basic social services but are unwilling to do so because they expect that these services should be provided free of charge by the state.

2. Although standard economic theory does not distinguish between ability and willingness to pay, a distinction between these two concepts can be made. Willingness to pay may be represented within the standard model of consumer behaviour as the ratio of the marginal utility of a good or service over the marginal utility of money. It represents the rate at which an individual would be willing to trade money for an extra unit of the good. In contrast, the marginal utility of money may itself be taken as an indication of the ability to pay. A high marginal utility of money, which is the characteristic of the poor, may be taken as a good proxy for their ability to pay.

3. Another example is that venality among health workers means that patients often face illicit payments for so-called free services. Under those circumstances, a policy reform in health sector pricing would merely formalize an existing practice of cost-recovery.

4. For example, although willingness to pay for water may be inferred from the actual high expenses of households on vended water [Katko, 1990], this can in no way be seen as in itself an indication of ability to pay, since high expenditure on vended water may be simply the consequence of the lack of other alternatives, even in the presence of very low purchasing power and other unfulfilled needs.

1. Value to consumers is understood here in terms of effective demand, rather than in terms of the fulfilment of need or any other criterion.

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2. Although households typically bear substantial costs even when using officially 'free' social services, the focus here is on increases in the 'official' prices of the services concerned.

3. In addition, the perinatal mortality of mothers who did not register for antenatal care was found to be five times higher than for those who registered. Such evidence on the adverse impact on public health eventually motivated the government to withdraw user fees in rural clinics in 1995.

4. They also pointed out that by using the opportunity cost of the patient's travel time as a proxy for the cost of obtaining health care, Gertler and Van der Gaag [1989] actually confirmed that distance, not user fees, can be a barrier to health service utilization.

5. The study also revealed that the relative importance of mission and private clinics was negatively correlated with the level of household income. The fact that the very poor made less use of government hospitals and health centres was explained by their inability to pay for transportation to government referral facilities, their perception about quality, and their greater likelihood of being exempted at mission clinics. However, it should be added that the consumption of health services by the core poor per episode of illness was only half that of the moderately poor.

6. Modest charges for curative services to outpatients at government and mission hospitals were introduced in 1989, and utilization dropped by about half [Forsberg, 1990].

7. This does not answer the question, however, why the utilization response for some basic health services has been disproportionately larger than for non-basic services.

8. The Bamako Initiative, launched under the aegis of a WHO/UNICEF meeting of African Ministers of Health in 1987, has been referred to as an example of "user fees that work." However, it would be incorrect to see the initiative primarily as a model centred on user fees. Strategic elements in its approach to revitalizing health systems in low-income countries are decentralization and community co-management, combined with a better supply of generic drugs. The involvement of communities is "a fundamental feature in that it changes the balance of power between service providers and users and brings about a 'new' form of governance of public health systems" [UNICEF/BIMU, 1995].

9. This contradicts the argument that reduced attendance that results from the user fees automatically contributes to the improvement of the quality of the service by reducing waiting time and overcrowding, an argument which entails a strong trade-off between quality and equity.

10. Zambian households reportedly allocate 3.2 and 0.6 per cent of their expenditure to education and health, respectively.

11. This implies that an increase in fees would lead to an increase in government revenues.

12. The elimination of the fees was accompanied by the lifting of the requirement of school uniforms. However, the wearing of uniforms had not been enforced for several years.

13. Another issue is that it may be necessary to further disaggregate educational expenditures in order to obtain an accurate picture of the elasticity of demand for education: "Parents may be less willing to pay for basic tuition than for institutional materials" [World Bank, 1988]. In other words, direct tuition fees

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may be more discouraging of schooling than fees towards instructional materials. However, there exists little concrete evidence on this score.

14. This will depend on the system by which available places were 'rationed' prior to the price change.

15. This issue is discussed further in section 3 (ii).

16. Although there are other costs and benefits in terms of resource use and welfare, these are excluded here so as to focus on the direct significance of revenues and administrative costs defined narrowly.

17. It is not clear why Botswana and Ghana, which are reported to have increased their percentages as well, are not mentioned together with those four countries.

18. The Policy Framework Paper of 1990 projected that revenue from school and health fees would quadruple in real terms in four years, to a level equivalent to 0.5 and 0.2 per cent of GDP, respectively. Needless to say, Zimbabwe failed to meet these ambitious targets.

19. Increased or full cost recovery for hospital care will not be possible without the full coverage through health insurance and/or an effective scheme for protecting the poor.

20. Put in economic terms, there are no individual disincentives to enrolment (or private marginal costs) created by these one-time community contributions (which can be viewed as equivalent to lump-sum taxes).

21. The literature on willingness to pay, especially in the context of water systems, attempts to do precisely this.

22. However, there does not appear to be any guarantee that the resulting intra-community distribution of costs will be equitable, as will be discussed in section III.3.

23. UNICEF/BIMU and Renzi [1990] suggested that user charges for drugs would discourage rather than encourage overprescription because health workers would be aware that patients would have to pay for drugs and seek to save them this expense. Although this motivation is plausible it should be contrasted with the motivation to meet cost recovery targets and raise the health workers' own benefits.

24. As a result, the immunization coverage in many poor townships reportedly dropped from 85 per cent in 1988 to less than 50 per cent in 1992.

25. Each of the three alternative causal mechanisms will be discussed for the three sectors simultaneously because the issues are cross-sectoral.

26. There is, however, one exception. If individuals believe that they may have to engage in capital expenditure again if the facilities are not adequately maintained, then there is a direct incentive for individuals to pay greater attention to ongoing operations and maintenance in order to avoid premature renewal of capital costs. In this case, there is a sense in which contribution to capital costs may have an effect on the 'responsibility' exercised by users. However, from the point of view of standard economics,

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this is only because there is a marginal (or incremental) disincentive to inadequate maintenance. It seems hardly convincing that this could be the sole reason why community contributions to capital costs could produce a sense of 'ownership', and it is certainly not the reason which is stressed in the literature.

27. In any case, the concept of responsibility should be further disaggregated in order to be used effectively. For example, Cleaver [1991] demonstrated that rural communities in Zimbabwe felt a strong sense of responsibility for some dimensions of preventive maintenance of handpumps and communal management of water use, while at the same time feeling little or no sense of responsibility for corrective maintenance, which was seen as the role of government.

28. For example, Evans [1992] reported that in Tegucigalpa (Honduras) people in peri-urban areas paid vendors on average \$14 to \$21 per month (8% to 12% of their average income). In contrast, higher-income households connected to the municipal water system paid only \$3 to \$4 per month for a much higher level of service and a much larger quantity of water.

29. If we neglect the incomes of the water vendors.

30. On a narrow basis of justice, it could be argued that such exemptions are not necessarily inequitable when they are part of an implicit contract to compensate civil servants for low nominal wages. Nevertheless, if the objective is to serve the poorest, then such targeted exemptions cannot be viewed as equitable.

31. Cornia and Stewart [1993] reported that the administrative costs of untargeted social programmes in the UK averaged 3.5 per cent whereas they amounted to between 5 and 15 per cent for means-tested programmes. In the US, the administrative costs of universal programmes were found to be 2.5 per cent, compared with 12 per cent in two means-tested programmes.

32. For a discussion of possible E-mistakes (excessive coverage) and F-mistakes (failure of full coverage), see Cornia and Stewart [1993].

33. Nevertheless, UNICEF [1996] concluded that it "proved to be a costly and ineffective mechanism of protecting the poor."

34. Hospitals and clinics did not expect to forgo the fees for treating exempted patients. The understanding was that they would recover the costs from the Ministry of Community Development. The latter, however, had no budget for that purpose. Social workers were therefore reluctant to register people for fee exemption.

35. They conclude that "cost-sharing forced some 20-26% of the patients out of the modern health care system altogether" [ibid].

36. In response to the lack of concrete information on equity issues under the Bamako Initiative, five country studies are in progress, the first of which to be available is Ensor and San [1995].

37. In 1995, all fees in rural health centres were cancelled.

38. Community-based sentinel site surveillance confirmed that high costs was the principal reason why parents did not enrol their children in school.

39. Consider a simple example. Suppose that a family's willingness to pay for treatment for a girl child is  $A$ , and that for a boy child is  $B$ , with  $B > A$ . If user fees are set at zero, both boys and girls will receive treatment, but if they are set at  $C$ , with  $A < C < B$ , then only boys will receive treatment.

40. This general principle should be qualified in the case of large one-time contributions. In cases where very large initial contributions are required (e.g., some water projects), it may be easier for individuals to make cash contributions rather than to contribute in labour or in kind if the former can be spread out over a longer period through an appropriate financing scheme. It is not typically possible to spread out contributions in the form of labour or in kind to initial construction. Over the lifetime of such a financing scheme, small but regular cash contributions can be less burdensome to a household than large initial contributions in labour or in kind, although this will depend on specific circumstances.

41. As such, prepayment schemes inherently carry a progressive element, provided that the poor make adequate use of services, which they may not if large private out-of-pocket costs are involved.

1. Article 4 of the Convention states that "With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international cooperation." The stress on available resources seems to leave open a wide range of possible financing mechanisms and levels of provision consistent with satisfactory progress towards the fulfilment of this right. The Programme of Action of the World Summit for Social Development, on the other hand, recommends that "Governments should give greater focus to *public* efforts to eradicate absolute poverty [*italics added*]."

1. An internal review of the World Bank [1995d] of the impact of cost sharing in the social sectors on the poor in sub-Saharan Africa concluded that "there are many questions to ask *before* focusing on user fees."

2. Appendix 2 below lists some of the questions that policy makers should address when considering the introduction of user financing for basic social services.

1. Amartya Sen's question "Equality of What?" [Tanner Lectures on Human Values, 1980] might be answered here as "equality of access to basic social services."

2. Value judgements about what constitutes a socially valuable use of a resource are inescapable in the discussion of allocative efficiency.

3. If 'shadow' prices are used, then cost efficiency can be conceptually identical to other forms of efficiency, depending on the nature of the objective to which the 'shadow' prices correspond.

4. In the terms of standard economics, technically efficient production corresponds to production anywhere on the production 'frontier', whereas at given prices (and standard 'convexity' assumptions) there is only one point on this 'frontier' which is cost efficient.