

User Fees in Primary Healthcare in Sub-Saharan Africa:

A Study of the Effects and Legacy of World Bank
Neoliberal Health Policy

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Chapter 1. Introduction

User fees for health care services became a major part of World Bank policy in the 1980s and 1990s in developing nations as part of the World Bank's structural adjustment packages. These policy packages often mandated that countries implement user fees for health care services in order to be eligible to receive World Bank loans. The number of African countries that implemented user fees in health care increased dramatically in the 1980s and 1990s due to these policies imposed by the World Bank. In a 1995 study, 28 out of the 37 countries surveyed had some type of user fee system in place. (Whitehead, 2001)

In this thesis I will look at how user fees policies in healthcare developed in the World Bank and reasons for the World Bank's decision to support those policies. Furthermore, understanding what factors influence World Bank policy is important for critically analyzing future World Bank policies to improve those policies in the best interest of developing countries. In this paper I will look into both internal and external factors that influenced World Bank's policy on health care, in particular factors that led to the implementation of user fees for health services. I will look at key changes in World Bank administration, key events in the global economy and international financial markets, and the influence of the United States on World Bank policy. By examining the progression of the World Bank's ideology in health care policy, both in theory and in practice, I hope to better understand the climate in which user fees were endorsed while also gaining insight into the decision and policy making process of the World Bank. I will demonstrate that user fees were part of a larger package of structural adjustment policies and neoliberal health policy thinking that was heavily influenced by key members of the World Bank administration and the United States government. I will also trace when the World Bank

began to change its attitude toward user fees and stop supporting user fee policies for primary healthcare services, while also looking at the current role of user fees in sub-Saharan Africa and challenges facing the removal of user fees.

Part 1. Development of User Fee Policies in the World Bank

Chapter 2. The Shift in World Bank Thinking

To understand why the World Bank chose to support user fees during the time of structure adjustment it is important to look at user fees not as an isolated policy, but as part of a package of policies that the World Bank designed to develop healthcare systems in developing countries. Looking at the forces that were behind the decision to promote and implement user fees is necessary for understanding the thinking behind World Bank policy-making. In this chapter I will look at the ideological shift in the World Bank's treatment of healthcare that occurred in the 1970s and 1980s that would provide a climate that supported the implementation of user fees in healthcare.

McNamara and Social Development in the 70's

Robert McNamara, the World Bank Group president from 1968-1981 focused on expanding the World Bank's activity to match the need for development in the developing world. Under President McNamara, the number of loans to developing countries issued by the World Bank increased and the bank began to focus its efforts on the developing world, particularly in poor countries (Stein, 2008). McNamara understood the pivotal role good

health plays in good development and opened the discussion for finding ways the World Bank could participate in strengthening health care systems in developing countries (World Bank, 2006a). During McNamara's leadership, publications concerning health treated health care as a public good that should be emphasized in World Bank policy. This followed the sentiment of the Alma-Ata Declaration of 1978, in which the World Health Organization stated that not only is health care a human right, but also that governments should create policies that would make primary health care more accessible and affordable to the general population.

In 1975, the World Bank published its first Health Sector Policy Report, which stressed the importance of improvements in health care for good development and cautioned against relying on traditional cost-benefit analysis of health care due to distortions in the assumptions required for such an analysis. These assumptions include the ability of an individual to make rational, well-informed choices regarding their health care and the ability of the private sector to supply health care. The policy report noted that people are not always able to make sensible choices when it comes to their own health care due to limitations in their understanding and awareness of their health care options. Furthermore, the report states that the private sector would be insufficient in supplying the level of health care needed in many developing countries, especially to the poorest members of society. Since there is little competition in the health care industry in many sub-Saharan African countries, there is little incentive to improve quality or lower cost. In addition, the uneven distribution of income would prevent lowest income households from accessing the health care through a market system.

The 1975 report offered two policy proposals for the World Bank. (Fair, 2008) The first was increasing focus of health care in existing loan packages while the second was creating separate loans specially designed for health care initiatives. The Bank decided to follow the first proposal in which health care projects were treated as subsidiary goals as a part of a larger development package (Stein, 2008). By deciding to keep health care improvements subsidiary to other, more traditional goals like economic growth, the World Bank failed to fully commit itself to improving health care. This attitude of increasing economic growth at the expense of health care programs and projects would become more obvious in the 1980s as structural adjustment packages became the major developmental policy tool of the World Bank. However, the Health Sector Policy Report of 1975 did bring attention to the importance of health in development. The report recognized good health as a key component to success economic development, while also recognizing the ways in which markets fail to provide adequate healthcare coverage (World Bank, 1975).

The World Development Report of 1980 was a product of the new attention to healthcare and reaffirmed the fact that health is a basic human right and that the reduction of morbidity and mortality lies at the core of the development process. It states that people have the right and the duty to be a part of their own healthcare planning and that health interventions are synergistic and intertwined. For example, interventions on infectious diseases are not complete without also addressing problems with malnutrition since rates of infection are higher among the malnourished. The report reiterates the idea that income distribution does not correspond to health care needs since the poorest people are the ones in greatest need of care. Furthermore it states that social benefits that arise from the eradication of disease outweigh private costs. And since private companies are concerned

with economic benefits as opposed to social benefits, the private sector may not be willing to pay the cost for those benefits. The report suggests improvements in the primary care sector should revolve around decreasing the cost of care for the local populous and also using some type of risk sharing or insurance program to provide healthcare. The report also raises concerns about user fees, especially given the importance of accessibility to primary care services and the great need of improved care for the poorest members of a population. The World Development Report of 1980 was revolutionary in the sense that it was an official World Bank Report that encouraged a strong commitment to primary health care and noted the vital role that health, education, food, nutrition, water and sanitation plays in development.

The Berg Report

The World Development Report of 1980 was seen as a great success for social development and social welfare initiatives in the World Bank. However, just one year later the Berg Report was published, drastically changing the World Bank's approach toward health care. After the minimal success in improving the health care sector in developing countries during McNamara's time in office, World Bank began questioning McNamara's approach on health care and development. Many criticized his initiatives as being too broad and unable to acquire necessary funding. The lack of funding was the biggest downfall to McNamara's push for health care improvements and initiated the debate for finding sustainable solutions to the same health care problems. The debate culminated in the Berg Report, which was published in 1981 by Elliot Berg, an economist at the

University of Michigan, and would become one of the most influential publications regarding development in Africa and throughout the developing world.

Ernest Stern, who will be discussed in the next section, commissioned Berg, who was influenced by neo-classical economic theory, to lead a study requested by African Finance ministers on African development. (Stein, 2008) The Berg Report of 1981, titled “Accelerated Development in Sub-Saharan Africa,” concentrated on the lack of economic growth in sub-Saharan Africa. Berg blames slow economic growth in sub-Saharan Africa on government failures and inadequate domestic infrastructure for managing resources and providing public services. Seeing the government as a barrier to development, he states that any growth-oriented program must address, “increased efficiency of resource use in the public sector” (Berg, 5). Berg suggests that giving the private sector and private capital a larger role in providing public services and using decentralized systems to manage the distribution of public services to improve efficiency.

In addition, Berg points out that external debt problems faced by countries in sub-Saharan Africa are the effects of underlying balance of payment problems (Biersteker, 2011). In other words, Berg implies that governments in sub-Saharan Africa are spending beyond their means and thus should cut back expenditures to reduce the burden of foreign debt. Berg suggests exploring alternative sources of funding since the “continuation of low rates of economic growth, coupled with high population growth, would make significant increases in government spending for health on a per capita basis unlikely” (Berg, 87) and that “the only hope of broadly based provision of services in a self-reliant Africa is through greater emphasis on charging beneficiaries for the services they receive” (43). Berg takes a pessimistic view on the future of public services in sub-Saharan Africa, going as far to say

there is no other choice but to implement a user fee like system for public services like health care. This type of thinking would dominate the World Bank's approach to health care for the next 20 years.

Setting the Stage for User Fees and Structural Adjustment: Ernest Stern and Policy Conditionality

The Berg report was extremely influential because it offered the theoretical justification for structural adjustment loans or loans on the premise of policy conditionality (Ali, 2011). Berg gave the World Bank reason to question the ability of governments to instate good domestic policies, which opened the discussion for policy conditionality to ensure that loans were being used for policies approved by the World Bank.

Ernest Stern, who was appointed the Vice President of Operations and Chair of the Loan Committee in 1978, commissioned the Berg report (Stein, 2008). Stern, who worked in the US Department of Aid for International Development before his time in the World Bank (Thompson, 1993) in the 60s, came to the World Bank prepared to push macrostabilization policies that were supported by USAID and the American government. In charge of practically all of the World Bank's lending, Stern became an extremely powerful man in the World Bank and an important advisor to McNamara. In his speech to UNCTAD (the United Nations Conference on Trade and Development), McNamara wanted to emphasize the importance for developed nations to open their markets to exported goods from developing nations. However, knowing that developed countries would look upon this advice unfavorably, Stern advised McNamara to appease developed nations by adding a clause on the importance of macrostabilization policies in developing countries,

allowing the World Bank to also take a stance on the issue of policy conditionality. Knowing that countries like the United States favored macrostabilization and other neoliberal policies, Stern successfully convinced McNamara to state in his speech:

In order to benefit fully from an improved trade environment, developing countries will need to carry out structural adjustments favoring export sectors. I would urge that the international community consider sympathetically the possibility of additional assistance to developing countries that undertake the needed structural adjustment... I am prepared to recommend that the World Bank consider such request for assistance and that it makes available program lending in appropriate cases. (quoted in Kapur et al., 1996, pp 506-507)

McNamara, who was eager to expand the number of loans issued by the World Bank, was willing to add a statement about policy conditionality. By recommending that assistance should be given to “developing countries that undertake the needed structural adjustment,” this speech set the stage for structural adjustment and policy conditionality¹ for loans.

Together with the IMF, a frequent user of policy conditionality, the World Bank worked out a framework in which the World Bank would also be able make loans to developing countries, even though the World Bank’s Articles of Agreement restricted program loans to countries with “exceptional cases”. However, “the senior staff of the Bank successfully argued that exceptionality would simply be defined as countries already having a fund stabilization program.” (Stein, 2004) This allowed to Bank to formally begin making structural adjustment loans to countries that already followed IMF policies and received IMF support. Many of these policies would incorporate the implementation of user fees for health services to offset cost of health clinics in order to reduce government expenditure. In the health care sector, these loans would be part of projects in the Health, Nutrition and Population (HNP) portfolio. In a 1998 internal review of the Bank’s HNP

portfolio, 75% of projects in sub-Saharan Africa promoted user fees (Amin, *et al.*, 2005). By expanding its use of policy conditionality, the World Bank imposed user fees upon developing countries looking for development aid.

User fees were not only used in health care, but also in other social services like education, water and sanitation. (Korte, 1992) The World Bank supported reducing government spending on social services in general, which magnified the impact of each fee on a household. Fees designed based on household incomes do not necessarily take into account the impact of other types of fees a household was subject to pay. In Ghana, the introduction of user fees in 1992 at the primary school level led to a decline of over 4% of enrollment, with affordability being the major reason for dropping out. Similar patterns of decline were seen in other African countries. (Reddy, 1996) In Kenya, Tanzania and Malawi, removal or reduction of fees for education led to drastic increases in enrollment. In Malawi, the reduction of fees in 1994 led to a 50% increase in enrollment. Households in developing countries, especially in urban areas, also spend a significant portion of their incomes on vended water, often between 30 and 40 percent of their income. (Reddy, 1996) Access to education, clean water and proper sanitation is also linked to health. Fees that limit households' use of each of these resources also has a negative impact on health and on households' ability to pay for health services.

Clausen Conservatism in the 1980's

The shift toward neoliberal healthcare thinking was also driven by the appointment of Alden Clausen as the World Bank President by the Reagan administration. US administration under Ronald Reagan believed that foreign aid was just another

disagreeable form of welfare that he thought should not be a part of United States foreign policy, and in turn World Bank policy. Reagan did not want the United States to be responsible for the financial burden of international institutions and threatened that the United States would no longer support government-led and public sector programs of the Bank. Reagan strongly supported Clausen as the next president of the World Bank Group because he believed that Clausen would be able to change the Bank's philosophy toward development loans (World Bank, 2006b). Clausen fit the bill as a believer in the free markets and reducing barriers to trade, an important policy of the Reagan administration and a man well acquainted with neoliberal, conservative economic policy that dominated the field of economics during at the time.

In the same way Robert McNamara was ambitious in his policy goals, Alden Clausen was cautious and conservative in his policy making. And while McNamara mainly used scientists and health care professionals to create health care policy, Clausen relied almost entirely on economists. (Stein, 2008) This new approach emphasized the use of sound macroeconomic policy to spur economic development. A former commercial banker, Clausen preferred to work through the private sector instead of working with governments. (World Bank Archives) In his forward in the Berg Report he states, "African governments should not only examine ways in which the public sector can be operated more efficiently, but should also examine the possibility of placing greater reliance on the private sector." (Berg, 1981) This focus on privatization would also extend to World Bank policies involving health care, reducing the government's role in providing health services and relying more on individuals to pay for health services in the form of user fees.

Clausen also believed in using market-orientated strategies to solve problems in the developing world, focusing on economic growth to instead of the distribution of wealth. (World Bank, 2006b) According to market economics, by allowing the market to dictate prices of health services based on marginal cost and marginal utility, resources will be used in a manner that maximizes efficiency. This market strategy would also be a leading argument for the implementation of user fees in social services. The focus on development shifted to economic development at the cost of discussions of poverty alleviation and social development.

Clausen's commitment to conservative macroeconomic policy and reducing government expenditures can be seen in his "Integrated Plan of Action" to alleviate poverty in the developing world, which he presented in October 1985 at a World Bank meeting in Seoul. According to the report of Clausen's plan, Clausen stated, "the Governments of indebted countries must implement adjustment programmes and after fiscal balance is restored, must ensure that structural changes are made so that they can resume accelerated growth and restore credit-worthiness." (United Nations Publications, 1985). Clausen argues that African governments need to regain credibility in the eyes of foreign banks and investors by paying off their debt. Thus, by regaining credibility, African economies will benefit from increased credit and investment that will improve economic growth, increasing income and thereby increasing standard of living. This was also part of a movement to move away from official aid, as in aid given by the World Bank, toward private aid. By improving their credit, countries in Sub-Saharan Africa would then be able to take loans from private banks and no longer rely on the World Bank or the IMF for loans. This focus on paying off foreign debt and reducing debt by cutting expenditures forced

governments to sacrifice spending on health care to meet the demands of structural adjustment packages. And this sacrifice on health care spending would cause countries to rely on user fees to run health care services.

David de Ferranti

Nineteen eighty-one would also introduce another important player in “neoliberalization” of the World Bank. David de Ferranti, an economist trained at Princeton, came to the World Bank to help reform public health policy in developing country. In 1985 he published an important paper addressing health care in developing countries, a paper that would dominate health care policy for the next 20 years. De Ferranti’s *Paying for Health Services in Developing Countries: An Overview* focused on improving efficiency in health care systems. In this paper de Ferranti emphasizes the need to privatized healthcare and to introduce user fees to reduce waste and unnecessary usage of health services. He also argues that markets are the most efficient way to allocate health care services since price can be set to equal private marginal cost in curative care. De Ferranti views governments as impediments to achieving efficiency through competitive market prices. He proposes user fees as an alternative to distortionary taxes for financing health care spending and presents user fees as a way of generating revenue, efficiency and equity.

Given financial difficulties of many developing countries, de Ferranti argues that user fees are the only feasible way to generate revenue given the growing finance gap in healthcare. Furthermore, user fees would help allocate resources efficiently and prevent price distortion since everything will be based on market prices. Fees would also discourage those who would abuse the health care system if services were free; in other

words, people would only use a service if they really needed it. In terms of equity, fees would improve equity and access to health services since health care providers will have incentive and the resources to improve the supply of services, which will in turn benefit the poor. In this sense, user fees would provide revenue that would allow clinics and health care facilities that would otherwise be unable to operate due to a lack of funding provide services in poorer and more rural communities. He also adds that fees will have little impact on ability to pay because existing fees are small relative to wages and that most people would still be able to afford services and would be willing to pay for such services.

However, a flaw in de Ferranti's argument is his assumption that the change in price would not significantly affect one's willingness to pay. De Ferranti cites a study sponsored by USAID which argues that prices do not appear to affect willingness to pay for health services. (Akin, *et al.*, 1986). The study included a survey of residents of the Bicol region of the Philippines that asked what types of clinics people used for various conditions and illnesses which was conducted in 1978. In 1981 the authors returned to the clinics in the region to look at different variables like the price for services and waiting time, assuming that little changed in three years. Furthermore, they assumed that people went to clinics closest to them, even if they were more expensive. Akin et al. then used this information to predict the probability of attending a clinic for certain illnesses. However, closer analysis of the paper's statistics reveals that there does appear to be a correlation between willingness to pay and user fees in some cases. (Stein, 2008) For example, user fees did negatively affect the probability of seeking prenatal services. In addition, the study evaluated participants from a limited income range, which would not have reflected any effects of income on willingness to pay. (McPake, 1993) It is also important to note the

difference between willingness to pay and ability to pay, which are not always interchangeable. Just because someone is willing to pay does not mean they are able to pay, or have the disposable income available to pay for health services.

De Ferranti does acknowledge certain situations in which some type of exemption system would be necessary to prevent negative effects on equity. (Stein, 2008) However, de Ferranti only acknowledges the need for preventative care services like vaccinations as opposed to curative services since “For most curative services it is doubtful whether any reduction in transmission probabilities is achieved. Available technologies for the treatment of most infectious diseases ... rarely can be made effective before diseased individuals already have had maximal infectious impact on others around them” (De Ferranti, 1985). However, individuals with infectious diseases like HIV/AIDS can spread the disease throughout the duration of their lifetime. For communicable diseases, curing individuals has a positive impact on the welfare of the entire community, a positive externality that should not only be associated with preventative care. Reducing the spread of infection and any productivity losses due to illness are significant external benefits. (Arhin-Tenkorang, 2001)

Additional problems with de Ferranti’s argument lie in the assumption that people will be able to make rational and informed decisions of when to seek care. And when a patient is not sufficiently informed to make decisions himself, the provider will assist the decision making process. (Stein, 2008) However, having fees, however small, for referrals will deter many poor people from seeking care. Additionally, for people who must travel long distances to see a doctor, making a long and costly journey simply for a referral is

hardly practical. However, de Ferranti's proposal fit into Clausen's neoliberal approach as it complemented efforts to privatize health care and reduce government spending.

In 1987, De Ferranti published another paper in collaboration with Nancy Birdsall and John Akin, who authored the study on willingness to pay cited heavily in de Ferranti's earlier work that would be an extension of De Ferranti's earlier work. This new paper, *Financing Health Services in Developing Countries*, would become the cornerstone of World Bank health care policy for the next two decades and serve as theoretical model for implanting user fees in health care systems across sub-Saharan Africa.

Chapter 3. The Role of the United States

Historical Influence of the United States on the World Bank

The United States has historically been a major influence on World Bank policies. Much of this influence is the result of the United States' leadership in the development of the World Bank at the Bretton Woods Conference in 1944. From the view of the United States, a strong organization like the World Bank that would promote stability and growth of a free and open world economy, would ease the burden on the United States of providing economic assistance to developing nations. (Gwin, 1994). An international organization designed to aid in the development and reconstruction of countries would reduce both political and economic pressure on the United States, while also serving United States' foreign policies.

Although the World Bank is an organization with many member countries, the United States has continued to hold significance influence over the institution for reasons not confined to the fact that the United States is largest shareholders in the bank. (Gwin, 1994). For instance, the United States has traditionally appointed the World Bank president, an unofficial but consistent custom. (Faini, 2004) Not surprisingly all Presidents of the World Bank have been US nationals. World Bank President Zoellick, who recently announced his resignation as World Bank president, acknowledged the United States' control over the president selection process. When asked about the appointment of the next World Bank Group president, Zoellick responded, "I think there's a benefit if the United States has a sense of responsibility and ownership of [World Bank] institutions." (Lowrey, NY Times) The longstanding tradition of the United States government selecting the World Bank president has allowed the United States to maintain considerable control over World Bank policies and ideology.

The United States exerts its influence the World Bank in other ways. Managerial positions like vice-president of the World Bank and managing directors of the World Bank are largely linked to nationality, in addition technical skill. (Faini, 2004) The location of the World Bank headquarters in Washington DC favors and the close proximity of the World Bank to the White House also work in favor for the United States as it improves and increases communication between the World Bank and the United States government. "The United States Treasury, moreover, has been able to exert a relatively stronger day to day monitoring and 'control over' both organizations [World Bank and IMF] because of its locational advantage" (Faini, 2004, 8). This advantage allows the United States to have greater input in World Bank decisions and activities.

Furthermore, the United States has the largest share of voters in the Bank with 17% of the share, while Japan, the nation with the second highest share only has 6%. The United States is the only member country with the power to veto on some constitutional issues on its own. The United States also makes the single biggest contribution to the IDA, the International development Association dedicated to offering low interest loans to the poorest countries. Given the importance of the United States in World Bank decision making and funding, the World Bank has pressure to promote United States foreign policy interests (Wade, 2002). This pressure combined with the fact that many of the high level positions in the Bank are held by US nationals has allowed the United States to have a great influence on the World Bank. And that influence extends beyond economic policy, and has played an important role in the World Bank approach toward health care policy, as I will examine in the next sections.

A Change in Attitude: The World Bank and US Relations in 1970's

In the previous decades the United States had, for the most part, supported the World Bank's development efforts, particularly in developing countries. However, in 1973 the US share of world GDP shrunk from 35% in the 1950s to only 26%. Furthermore in 1971 the devaluation of the dollar and overall poor economic performance created concerns about domestic poverty, unemployment and race inequality that left the government less inclined to participate in foreign aid and development efforts. (Gwin, 1994) "Moreover, the Agency for International Development, which had been heavily involved in Vietnam, was seriously discredited... both it and foreign assistance lost their solid constituency" (Gwin, 17). The Vietnam War led to disillusionment in foreign aid and

overall dissent in what role the United States should play in world politics. Support for foreign aid in general decreased during this time, leading to discontent with World Bank's drive to increase lending under the direction of Robert McNamara. Congress in general, had never been a big supporter of the World Bank and was wary of multilateral institutions like the World Bank. After the Vietnam War, Congress increased its role in foreign policy, adding strain to the relationship between the World Bank and United States government. (Gwin, 1994)

William Simon, the US Secretary of the Treasury from 1974-1977, strongly opposed increased World Bank lending. He believed that "the time had come for deficit countries to slow their borrowing and for less developed countries to adjust their economic policies to allow for greater reliance on market forces." (Gwin, 24) Simon's rhetoric on relying on market forces can also be seen in arguments in support of user fees. The World Bank saw user fees as a market-orientated alternative to financing health care systems since they would be subject to market forces and reduce the need for government expenditure and increased borrowing. Not surprisingly, the Treasury was also concerned with the World Bank's support for widening the role of governments in the development process. (Gwin, 1994).

Simon also insisted that loans must also be supplemented with certain policies to reduce the reliance of developing countries on World Bank loans. Structural adjustment, or policy-based loan conditionality, was largely an American idea, which took root at the Washington Consensus (Gwin, 1994). Structural adjustment lending eventually became a staple practice in World Bank lending schemes, undoubtedly influenced by the Washington Consensus and American support. The coincidence of United States Treasury's views and

World Bank views on health care that would develop in the 1980s are not coincidental, especially given the significant role of the United States in World Bank policies.

The Reagan Administration and the World Bank

When Reagan was elected the President in 1981, he brought an administration that was critical of the World Bank to the White House. (Gwin, 1994). The United States government saw poverty alleviation strategies as a form of welfare giveaway (World Bank Archives – Clausen). Reagan did not want to support these World Bank policies, deciding that bilateral assistance programs that bypassed any international financial institution was the only way to insure that aid programs would support US foreign policy. This rift between the United States and the World Bank was resolved by the appointment of Alden Clausen as the president of the World Bank Group. Clausen's first challenge was to appease the United States, which had grown more dissatisfied with World Bank policies. (World Bank Archives, 2006b)

By supporting the appointment of Clausen, the Reagan administration gained an important foothold in the World Bank. Clausen supported policies in the World Bank that mirrored policies in the Reagan administration like using market-orientated strategies and privatization of social services. The Reagan administration also reconciled with the World Bank due to its support for policy-based structural adjustment lending, which the World Bank had begun implementing with increasing frequency. (Gwin, 1994) These policies often included user fees for health care, a policy, which suited Reagan's attitude toward health care and his distrust of government run health care programs.

The Reagan administration saw the financial crisis that plagued the United States in the 1980s as a result of excessive government spending and high taxes that discouraged economic growth. (Navarro, 1984) This resulted in major cuts in social spending, particularly in health care spending. (Thompson, 1998) In his State of the Union Address, Reagan describes Medicare and Medicaid, the governments largest and most extensive health programs, as programs overrun with corruption.

Back in 1980 Federal investigators testified before one of your committees that “corruption has permeated virtually every area of the Medicare and Medicaid health care industry” ... The time has come to control the uncontrollable... I signed a bill to reduce the growth of these programs by \$44 billion over the next 3 years. (Reagan State of the Union Address, 1982)

Reagan and his administration did not trust government run health programs and would not have supported any World Bank health programs that involved the government as the primary actor. Furthermore, Reagan did not believe that the government should provide social welfare programs and made great efforts to reduce government spending of these programs. (Thompson, 1998) He believed that the market should regulate health services, making individuals themselves and not the government responsible for their own health care. These same ideals can be seen in the World Bank’s treatment of health care in its structural adjustment policies. By pressuring governments to reduce spending on health care and to implement a user fee system in which individuals would be responsible for paying for their own health services, the World Bank mirrored the Reagan administration’s approach to health policy.

Chapter 4. A Closer Analysis of the User Fee Debate

Even though the World Bank pushed user fee policies as conditionalities on loans, user fees were still a contentious issue within the Bank and outside it amongst academics and other development institutions. In this chapter I will look at some of the theoretical arguments and empirical evidence for and against user fees.

Looking at the Case for User Fees

A key motivation behind user fees was creating financial sustainability, especially in countries that do not have the resources to fund a health care system. (Gilson, 1997) The World Bank envisioned user fees as an important source of revenue generation that would create financial sustainability in health care systems in developing countries. Coupled with an exemption policy for the poorest members of society, user fees would, in theory, not discourage use of health services by the poor. Furthermore, de Ferranti argues that user fees would be set so low that they would not act as a barrier to health care access. (de Ferranti, 1985) User fees can also improve health care access by increasing the number of clinics that are able to remain open. Health clinics that would not be able to sustain operations relying strictly on government spending would be able to become fiscally sustainable through the implementation of user fees. In addition the reinvestment of revenues from user fees could also improve health care services and infrastructure. Therefore, user fees would allow a broader range of health services to be offered and would provide improved health services. (Holst, 2006)

User fees were considered more favorable than a tax system as a form of revenue generation. Taxes place a disproportionate burden on the poor, especially taxes on goods

and exports since a large proportion of lowest income households work in export industries like agriculture. (Shaw, 1995) Revenue from these taxes, when used to provide services to the wealthy and the poor, subsidize the wealthy by covering costs that they would be able to afford. In a 1993 Human Resource Development Survey in Tanzania, researchers found that the wealthiest households have the highest attendance rates in both private and public clinics. (Shaw, 1995) This would mean that government resources were mainly being used by the rich, who would be able to afford the services, and not by the poor who are most in need of the free services.

It was also argued that user fees avoid moral hazard and prevent the abuse of health care services. (Gilson, 1997) Moral hazard, a common problem when offering free public services, occurs when those benefitting from a service are not the ones who are taking the risk or bearing the cost of the service. This provides incentives for people to overuse a service or take undue risks since it is at no cost to those receiving the service. An example in terms of health care would be people engaging in risky behavior that would jeopardize their health, risks that they would otherwise not take if they had to pay for their health services. In addition, if services are free, people are more willing to use them, even if they do not really require medical attention, wasting time and resources. User fees can prevent the abuse of health services because people will only seek medical attention when they truly need it. A financial barrier to receiving health care, even if it were small, would then discourage people from using services needlessly. (De Ferranti, 1985). In addition those who are able to pay can take advantage of government subsidized health care. A 1993 Human Resource Development Survey in Tanzania showed that the wealthiest households used both private and public (free) clinics more than the poorest households. (World Bank,

1993) This puts greater financial strain on the government even though the wealthiest households are able to pay for the services.

User fees would also act as price signals to make the referral process more efficient. By having lower fees at primary and lower levels of care, clients would be encouraged to first seek care at lower level facilities like local health clinics. Care is generally less expensive at lower level clinics since “it is more expensive to use high-level medical specialists and technology at the first point of contact” (Shaw, 1995). Furthermore, this prevents higher-level facilities like hospitals from being overrun with cases that could be treated at periphery clinics. However, under universal free health care schemes, there is little incentive to go to lower level facilities, especially since workers at hospitals and higher level facilities are often better trained and have better equipment and resources. However, in a World Bank survey of 38 Sub-Saharan Africa countries revealed that only a minority of countries with user fees has fees structured to promote price signaling. In Senegal, there were no fees at large national hospitals and only fees at the primary level. In Ghana in 1991, eleven government hospitals saw twice as many outpatients as the rest of the government health network combined which consisted of thirty-three health centers, five clinics and seventy-nine maternity health clinics. (Shaw, 1995)

User fees would also have the potential to increase efficiency of health care. By decreasing the unnecessary use of health care services, clinics would be less crowded and waiting times at clinics would be reduced. Using this logic, making the cost of user fees less than the opportunity cost of waiting that would occur under a free health care program, would benefit everyone, especially the poor. Therefore, reducing lines and preventing health care abuses could make health care more efficient and reduce the actual cost

of care for the patient. Studies in Tanzania showed that people would prefer to pay user fees for better health care. (Nanda, 2002). However, ensuring that user fees are used to improve health care is a major challenge on its own.

A major challenge facing health care policy planners is the lack of equity in health services. (Holst, 2006) The access to health care services to the poorest members of the population is very little to nothing at all, especially for those living in rural areas. One goal of user fees is to improve equity, mainly by having exemption programs that will not exclude the most impoverished for services. These exemptions programs assume that those with higher incomes will have higher demands for health care services than those with very low incomes. This difference in demand would allow the fees collected from the services to higher income earners to cover the cost of care for those with lower incomes. Thus the rich would subsidize care for the poor, improving health care equity. Furthermore any additional revenue could be used to improve health care quality and access, which can further improve services provided to the poor. In addition, revenues from user fees that improve regional distribution of services by improve equity by reducing private costs in travel time that the rural poor have to face. (Dor, 1988)

Nancy Birdsall, who collaborated with David de Ferranti on the 1987 World Bank paper *Financing Health Services in Developing Countries*, argues that the supposed equity/efficiency trade off in providing health care does not exist and that inequity is caused by inefficiency. She argues that user fees help “conserve public funds and promote efficiency in the sense of cost-effectiveness and responsiveness to the consumer preferences.” (Birdsall, 1990) This follows the belief that markets will allocate resources in the most efficient way and that prices should be set based on consumer demand and

preferences. This also assumes that governments are inherently inefficient, which Birdsall cites as caused by politicians' desires to get reelected and serve the interest of the most influential, and often wealthiest, members of society. Birdsall argues that this causes goods and services that benefit the less influential individuals to be undersupplied and goods and services that benefit the most influential to be oversupplied. This can lead to governments focusing their resources on hospitals, which are generally in urban areas, which does not aid those living in rural, generally poorer, areas. Furthermore, she notes that the lack of competitive pressure to motivate internal efficiency and additional bureaucratic costs in government programs could lead to greater inefficiency and inflated costs for health services.

Looking at the Case Against User Fees

User fees have produced less than perfect results and have been argued by many to not only be ineffective but also harmful to improving health care. User fees are not a significant source of revenue. (Holst, 2006) Revenue obtained by user fees range from 1-15% of the health budget in African countries, but on average cover only 5% of the budget. For example, user fees only accounted for 4.7% of recurring costs in Senegal, 2.7% in Mali, 3.1% in Côte D'Ivoire, and 7.9% in Ghana in 1986 (12.1% in Ghana in 1987) (McPake, 1993) Furthermore, fees are generally too small to be a significant source of revenue. These fees, which must be small enough so people who have very low incomes can afford them, still can be large enough to discourage the poorest citizens from seeking services without providing any significant financial resources. And even when they are a substantial part of

revenue, as in the case with Ghana, there are inefficiencies in the process of collecting fees due to the cost of management and embezzlement.

In addition, there are significant problems in implementing a user fee system. In a study of the effects of user fees in Tanzania, it was shown that while revenue from user fees can help a decentralized health care system, revenue cannot be effectively used without a strong, centralized management system. (Gilson, 1997) This is a paradox to the World Bank model of health care in developing nations. Ensuring fees are being reinvested in health care and are invested in projects that will improve care and health care infrastructure requires a strong centralized system to monitor and enforce the proper use of user fees. However, with the World Bank's push toward privatized health care, there is no program in place to develop a centralized system to ensure user fees will be reinvested in beneficial projects. Furthermore there is no compelling evidence that revenues from fees have led to improvements in quality of care and health care infrastructure (Holst, 2006; James, *et al.*, 2005). Revenues from user fees can only improve health care if they are reinvested properly. However, in a review of user fee policies in sub-Saharan Africa, Gilson notes that because of the lack of enforcement of good revenue handling and the general lack of infrastructure investment in African countries, revenues are used inefficiently (Gilson, 1997).

The concept of user fees stems from the idea that the poor should only pay for health care when they need it. However, by implementing a pay-as-you-need system, people will not go to health care services until they are seriously ill at which point treatment is most expensive. (Whitehead, 2001) Treatment for diseases at later stages are often more expensive and have lower success rates than treatment at an earlier stage.

Delaying seeking care can be very costly both in terms of the health of the patient and in terms of monetary cost.

While many proponents of user fees recognize that time and travel costs are the greatest costs that the poor face when seeking medical assistance (Nanda, 2002), they still argue that free health services are at risk of being abused. According to Margaret Whitehead, given such high costs non-fee related costs associated with seeking health care like travel and time costs, the added costs of user fees are unnecessary when trying to prevent the abuse of medical care, since the cost of seeking care is already so high. It can, however, prevent people from using medical services just because the additional cost serves as another barrier to care (Whitehead, 2001). Additionally, opponents of user fees argue that the cost of user fees should not be measured only in terms of opportunity cost of waiting in line, but also as forgone income that might have otherwise been spent on food or other goods essential to good health (Arhin-Tenkorang, 2001). For example, forgoing food in order to pay fees can lead to poor nutrition, which leads to increased susceptibility to disease and weaker overall health. Understanding what a household must give up in order to pay for user fees is important in calculating the actual cost of user fees. Even when a small user fee is added, this can make a huge difference for someone with an extremely low or unstable income.

In addition, differentiating fees based on income levels is complicated and difficult to enforce. (Whitehead, 2001) However, many user fee policies base their commitment to improving health care equity on their ability to charge higher fees for those who can afford to pay more and lower or even no fees to the poorer members of society. Many exemption policies are considered unclear and not user-friendly (Holst, 2006). And even in cases when

they are well defined, many people who would qualify may not even know they are. In a case study of the Volta region of Ghana, only 1 out of 1000 patients received an exemption before 1995 even though the researchers estimated that 15-30% of the population lives in poverty and would qualify for an exemption (Nyonator, 1999). According to the study, there are little incentives for administrators to treat patients who are exempted since user fees are often tied with the salaries of the health care employees. This discourages health care workers from informing those who would qualify for exemptions of their eligibility. This problem is exacerbated since the poorest members of society are often the ones who have the least access to information regarding health care services. The difficulty of implementing a successful exemption schemes also prevents user fee policies from improving health care access to the poorest members of society, who tragically are the ones in greatest need of medical care. Furthermore opponents argue user fees may be impractical because a large proportion of the population will likely need exemptions (Whitehead, 2001). With high poverty levels in Sub-Saharan Africa, many people will qualify for exemptions, which will put a heavy financial burden on health care systems if they rely on user fees. (Mbugua, Bloom, & Segall, 1995)

Willingness to Pay vs. Ability to Pay

Another problem with user fees is deciding what services require a fee and how much that fee should be. Generalized consultation fees have generally been discarded because different medical services require different amounts of resources and therefore should not be charged equally. However, deciding what the cost of a user fee is difficult because it requires knowing what the poor are willing to pay. (Gilson, 1997) Proponents of

a user fee system have misestimated what the poor can afford to pay and the barrier user fees pose to receiving health care. In a study done on the willingness to pay for social services in Côte D'Ivoire, user fees discourage the poor from purchasing health care services significantly more than they discourage the rich. (Gertler, 1988) In the study, Gertler found that user fees would "increase the welfare and medical care utilization of individuals in the top half of the income distribution, while reducing the welfare and medical care utilization of individuals in the bottom half of the income distribution" (Gertler, 1988) Unlike other models that found that price had little effect on demand, Gertler based his model on the assumption that price effect is dependent on income; in other words, price differences among providers will have more of an effect on those with a lower income than those with higher incomes.

However, supporters of user fees argue that people are willing to pay higher fees for better health care services. Even in low-income countries, there is relative high health expenditure per capita. In Côte D'Ivoire with a GNP per capita of \$900 in 1985, private health expenditure per capita was \$19 compared to \$8.20 government health expenditure per capita. Similarly high private expenditures relative to public expenditures can be seen in Ghana and Nigeria. (Shaw, 1995). Much of this high private expenditure is attributed to payments to traditional healers, private pharmacists, and private practitioners. Given this willingness to pay other sources of health service, it can be argued that people would also be willing to pay higher fees for health services in clinics and hospitals. However, many traditional healers, who are often members of the same community as the patient, use flexible payment methods based on the family's ability to pay. These payments are not necessarily paid at one time or immediately, and may not include traditional monetary

payment. (Korte, 1992; Arhin-Tenkorang, 2001) Additionally, fees may force people to go to traditional healers, since payment methods are more flexible, even when they may have preferred to go to a medical doctor.

It is also important to note the difference between health services and traditional market goods. (Korte, 1992) Health services are not subject to the same market forces as other consumer goods since they are literally a matter of life and death, especially in a region plagued with epidemics and disease like Sub-Saharan Africa. Deciding whether or not to seek health services is often not a question of choice but of survival. (Korte, 1992) Even though people willing pay for drugs and health services, it does not necessarily mean that they can afford it. According to Korte, the primary cause of landlessness in some Asian and African countries is the cost of treatment for a family member. Giving up land in exchange for health services is not something most households are willing to do, but rather is an act of desperation.

While cost of health services play a large role in decisions of whether or not individuals choose to seek treatment, it is dangerous to assume that individuals will be able to pay for health services simply because they appear to be willing to pay. Differentiating ability to pay and willingness to pay is incredible complex and unclear. Basing the provision of a good like healthcare on the assumption that individuals are both willing and able to pay for services ignores possible consequences and poor health outcomes that can results in having to allocate income to paying for services.

Lessons From Medical Anthropology

There is much that can be learned from medical anthropology in analyzing limitations of biomedical health care models, particularly in areas where biomedicine is not the dominant medical system. Biomedicine may not be the preferred source of medical care, especially in Sub-Saharan Africa where there is a culture of traditional medicine. Although households spend significant portions of their income on traditional healing methods, they are not necessarily willing to pay for services by a biomedical doctor. Households may prefer to be seen by a traditional doctor for a multitude of cultural reasons.

Arthur Kleinman refers to the idea of explanatory models of sickness and disease. In other words, each culture has its own explanations for illness and its own definitions of illness and when a person is considered sick. (Kleinman, 2006) Biomedicine is one example of an explanatory model. Understanding that different cultures will have different ways to define illness is important when looking at De Ferranti's assumption that people will have the information to know when they should seek medical care and what services they should use. Cultures with different explanatory models will have different interpretations of the same sickness. For instance, in parts of Egypt where schistosomiasis is extremely widespread, "the passing of blood by boys was considered as a normal and even necessary part of growing up, a form of male menstruation linked with male fertility." (Kloos, 2002). A doctor trained in biomedicine would have a very different reaction to the peeing of blood and a very different explanation for the cause of schistosomiasis. Assuming that people who do not come from a culture of biomedicine to recognize symptoms in the same way as

physicians fails to take into account the ways that culture shapes our perceptions and understanding of illness and disease.

Furthermore, asking the poor to seek service when they need it assumes they will know when to seek medical care. This assumes that the poor are aware that paying for treatment early will be less costly in the long run given forgone income due to illness and expensive future treatments. (Arhin-Tenkorang, 2001; Stein, 2008) This also assumes that the poor can differentiate between symptoms caused by poor living conditions or dangerous diseases. But the poor often do not have the knowledge or resources to know when they should seek medical help. Thus asking the poor to seek medical attention only when they think it is necessary will be more expensive for them in the long run. In addition, it can lead to people seeking cheaper alternatives to treatment like self-medication. In a study of three districts in Ghana, there was a significant increase in those who used self-medication after the introduction of user fees (Aseno-Okyere, *et al.*, 2000). Self-medication can be extremely dangerous, especially when sales of different drugs in markets are unregulated and part of the black market.

A Look at Empirical Studies

There have been numerous empirical studies looking at the effects of user fees in sub-Saharan Africa. According to a study done by Litvack and Bodart (2002) in the Adamaoua province of Cameroon, user fees have caused an increase in the use of health services due to the better quality of care and less waiting time for care. (Mbugua, 1995) A greater proportion of the population living in the community studied by Litvack and Bodart (1993) had access to medical care after the introduction of user fees and was using more

medical services than before, providing evidence that user fees with proper management and implementation can improve health care quality and increase health service usage. However, it is important to note that the specific community they studied was relatively better off than most of the poor communities in Cameroon, making the findings not a universal representation of most sub-Saharan African communities (Gilson, 1995). The main source of income in the region came from trading cattle and not from farming. Cattle trade based society generally have higher incomes and more liquidity compared to farming based society, which is significant when considering user fees require upfront payment. (Litvack, 1993)

While the study in Cameroon shows positive effects of user fees for the Abamaoua province, it does not paint a representative picture of the effects of user fees on the accessibility and utilization of health services. The most significant consequence of user fees has been decreasing attendance rates at health care facilities, particularly among the lowest income group. In Swaziland, there was a 34% decline in attendance of all health services among patients with the lowest incomes. (McPake, 1993). In Kenya, a similar decline in attendance rates was among the lowest income group in Kibwezi, a poor rural area. (Mbugua, Bloom, & Segall, 1995). In the Ashanti-Akim region of Ghana, the clinics in rural, poorer areas showed a decreased in attendance rates after the implementation of user fees.(Waddington & Enyimayew, 1989) In a study of the impact of user fees at sexually transmitted disease clinics in Kenya, male attendance rates decreased to 40% of the attendance rate before fees, while female attendance rate decreased to 62% of the attendance rate before fees. After removal of fees, male attendance rates increased but were still less than pre-user fee rates, while female attendance rates increased beyond pre-

user fee rates. (Moses, *et al.*, 1992) In South Africa, after user fees for primary health care clinics were abolished in 1997, there were also increases in attendance rates for curative care. (Wilkinson, *et al.*, 2001)

Part 2. User Fees as a Dominant World Bank Health Policy

Chapter 5. The Persistence of User Fees

While many studies in the 1980's and 1990's (as previously noted) suggested that user fees were having adverse effects in terms of healthcare access, the persistence of user fees and World Bank insistence on user fees still continued until the beginning of the new millennium. The persistence of user fees manifested in a new trend in researching ways to improve user fees, since user fees were generally considered the only viable option for health care financing in sub-Saharan Africa. The debate on user fees within the World Bank changed to how user fees should be implemented as opposed to whether or not they should be implemented.

World Development Report 1993: Investing In Health

The World Development Report of 1993 was dedicated to health and offered policy recommendations for the World Bank. It emphasized the need to invest in health care

infrastructure, particularly in terms of preventative care and noted that the World Bank should return to supporting health infrastructure policies. However, the report did not remove user fees from World Bank strategy, and still held onto some of the neoliberal ideas of the bank's healthcare policy from the previous decade. Nonetheless, the report did mark a return to the discussion of health care as fundamental right in the World Bank.

The report outlines three key messages regarding health care delivery. The first is creating an environment that allows households to improve health care conditions by pursuing "economic growth policies that will benefit the poor including, where necessary, adjustment policies that preserve cost-effective practices." (World Bank, 1993, 6). The World Bank's commitment to looking at health care primarily through neo-classical economics is still present in this development report. However, the Bank also acknowledges in the report the importance of other factors like improving education and promoting rights and status of women in improving the health status of the entire population. The second key point outlined in the report is improving government spending on health care by increasing effectiveness of government spending in improving health care. The report recommends reducing government expenditure on tertiary facilities (like hospitals), specialist training, and interventions that are not cost-effective. By focusing more on primary care and primary clinics that are generally less expensive to run and more effective in reaching poorer, rural areas, the development report aims to channel health care initiatives to the most vulnerable. The last key point is promoting diversity and competition amongst health care providers and in health care delivery schemes. In this respect, the World Bank has moved away from the idea that user fees alone should be used as the financing mechanism in health care clinics.

However, also linked with the idea of producing more competition is the notion of the privatization of health care and moving away from government provided health services to private health care providers. This follows the World Bank's general distrust of government run health care services. The report notes the danger of having government subsidized or free health services at public clinics because it would discourage competition from private health care providers. User fees at public health centers would allow other private health care providers to compete and succeed in the health services market.

While the development report acknowledges the importance of government investment in health care, which is a change from the previous decade's stringent commitment to reducing government expenditures, the World Bank still outlines specific policies that it believes governments should follow when investing. These include what types of services and projects to invest in. As stated earlier, the World Bank wanted governments to move away from health measures that were considered not cost-effective. Measures deemed cost effective in the report are largely preventative care measures like immunization, family planning and AIDS prevention. The report also addresses limitations in how much governments should address and discuss the importance of integrating structural adjustment policies into health care policy, particularly macrostabilization. "In the 1980s many countries undertook macroeconomic stabilization and adjustment programs designed to deal with severe economic imbalances and move the countries onto sustainable growth paths. Such adjustment is clearly needed for long-run health paths." (World Bank, 1993, 21-22) Again, the World Bank is looking at increasing economic growth as the key to improving health care, focusing on economic policies like macrostabilization

designed to improve the economic health of a country with policies at user fees, at the expense of the health of its people.

In regards to user fees, the World Development Report acknowledges some of the inequities caused by user fees and argues that other financial policies like social and private insurance plans should also be used to cover costs of health care. However, the report does not back away from user fees entirely and notes that they are still an important source of revenue and necessary for efficient allocation of resources. “Households can buy health care with their own money and, when well informed, may do this better than governments can do it for them.” (WDR 1993, 5) This argument, again, relies on the assumptions that people know when they should seek health care and understand the benefits related to different health care services. Furthermore, it makes reference to free market and market-orientated health care strategies in assuming that supply and demand for a service will generate a price that promotes the most efficient allocation of resources.

In addition the report states, “Since patients are already paying supposedly free or low-cost health care, new user fees, when accompanied by a reduction in indirect costs and improvements of service, may increase utilization.” (WDR 1993, 172) It cites the study done in Cameroon by Litvack *et al.* which notes that user fees combined with improved health care quality leads to increased utilization of health care services. However, this study is biased in that it was conducted in a relatively well-off region in Cameroon where income is largely tied to cattle and not agricultural, and cannot be seen as representative of most poor villages in sub-Saharan Africa.

While the World Development Report does note that user fees do not raise substantial revenues on a nationwide basis (WDR 1993, 25), it defends user fees based on their importance in improving technical efficiency by allowing consumers to self-target and prioritize services and how to spend their resources. The overall conclusion of the report on user fees is that user fees are a necessary part of cost recovery in countries with limited resources, like in sub-Saharan Africa, but need to be improved on to avoid any losses in equity and to improve efficiency.

Focus on Improving User Fees

The World Bank dealt with critics on user fee policies by acknowledging their faults and extending their research on ways to improve user fee systems. Recognizing that user fees tend not to generate any significant source of revenue, proponents of user fees still believed that user fees could contribute to improving health care status in other ways. For example, fees would reduce the burden on Ministry's of Health of supplying health care services, which would allow them to invest in other important health care infrastructure. (Hecth, 1993) This would allow governments to focus on investing in health care projects and infrastructure, which would be beneficial to the entire population. There are also arguments made on the ground of equity, citing that those wealthy enough to pay should pay for health care services and not use limited public resources (Shaw, 1995). In his book Shaw argues that the rich are using a disproportionate percentage of public shares compared to the poor who need it most, using data from a survey in Tanzania showing the rich use public clinics more frequently than the poor.

In addition, it was believed that user fees could be used as effective price signals. Failure of user fees to improve the (Arhin-Tenkorang, 2001) referral system was largely blamed on inadequate or non-existing price differentiation that did not encourage first seeking care at lower level facilities. (Shaw, 1995). This failure was largely seen as a result of poor policy planning and inconsistencies within the health care system (i.e. lower fees at higher level facilities) and not as a cause of perceptions of the quality of care. However, since doctors with the most training often work at large hospitals, it is important to recognize that people may wish to use higher levels facilities, not only because of inconsistencies in cost, but also because of perceived higher quality of care.

In Zimbabwe, a study done by Hecht *et al.* concluded that people were willing to pay more for curative services if quality of care improved. Hecht interpreted this as a sign that people were willing to pay for fees and that fees could be used effectively if fees were linked to quality of care. Thus, recommendations for Zimbabwe were to connect the collecting of fees with retention of fees in the facilities. Allowing clinics to retain any fees they collect would encourage facilities to improve their fee collecting capacity and improve service quality. (Hecht, 1993) However, this might also discourage facilities to grant exemptions to those who would qualify.

Overall, conclusions from past mishaps in the implementation of user fees and healthcare were blamed on poor fee design, management, and collection. User fees were still seen as the only viable option in low-income countries for financing health care systems. (Arhin-Tenkorang, 2001) Policy recommendations to improving health care access while maintaining health care financial sustainability was presented in terms of a

user fee system with effective exemption policies, pricing that encouraged cost-effective referral practices, improved collection of fees and use of fees for quality improvement.

Part 3. The Removal of User Fees

Chapter 6. The World Bank's Changing Perspective

User fees have always been a contentious policy in the World Bank, but with the turn of the new millennium and the World Bank's refocused commitment to poverty reduction in the Millennium Development Goals, the debate of whether or not to implement fees for basic social services was renewed. However, this time the World Bank was facing pressures to remove user fee policies in its loans. In 2001, the United States government required Congress to oppose any World Bank loan that included user fees in primary health care or education as conditions for loans, citing the negative effects of user fees on the utilization of social services. (James, *et al.*, 2006) As I have discussed earlier, the United States has traditionally held a very influential role in World Bank policies. Ensuring the United States support in its development programs has always been an important factor in World Bank policy and decision-making. By withholding support for user fee policies, the United States government exerted considerable pressure on the World Bank to change its policies. This pressure was compounded by other countries, like the UK and the members of the G8, also publically supporting the elimination of user fees. (James, *et al.*, 2006) Other international institutions also encouraged the World Bank to remove user fee policies. The United Nations Research Institute for Social Development Report in 2000 stated, "Of all

measures proposed for raising revenue from local people this [user fees] is the most ill advised.” (UNRISD, 39)

The Millennium Development Goals also ushered in a new era of the World Bank, focused on combating poverty as opposed to structural adjustment. The 2000-2001 World Development Report, *Attacking Poverty*, and 2004 World Development Report, *Making Services Work For Poor People*, are examples of the World Bank's new focus on poverty alleviation. The World Bank has moved to results-based financing (RBF) strategies that focus on linking financing to results. “RBF focuses on paying for outputs and outcomes – for example, increasing the percentage of women receiving antenatal care or having a trained health worker deliver their baby – rather than for simply inputs or processes (e.g. training, salaries, and medicines)” (World Bank, 2011). With this strategy, improvements in health care are measured by quality and access to care, not by traditional cost analysis. With more emphasis on access to care, the World Bank has been forced to reassess user fees in health care and their consequences in developing countries.

In the past decade, the World Bank's opinion of user fees has changed drastically. In the 2004 World Development Report, *Making Services Work for Poor People*, the World Bank stated that there should be no blanket policy for the implementation of user fees, admitting that in some situations, user fees have significantly lowered access of health care for the poor. In 2009 World Bank President Robert Zoellick and UK Prime Minister Gordon Brown co-chaired the Taskforce on Innovative International Financing for Health Care Systems, which focused on removing financial barriers of health care access, like user fees. (Campbell, Oulton, McPake, & Buchan, 2009). However, translating this change in attitude to changes in policy and practice has been slow and difficult.

Change, A Slow Process

Even with the Millennium Development Goals and pressure from the United States, removing user fees from World Bank policy has been slow. In the program descriptions of health policy loans distributed by the Bank from 1995-2008 there is a clear change in approach of health care financing.² Projects before 2003 focus largely on revising user fees systems in place, emphasizing that fees are the only feasible cost-recovery system, while also having potential to generate new resources and act as a price signals to improve referral systems. In program proposals after 2003, user fees were no longer a standard condition for loans and instead encouraged countries to find other innovative, risk-pooling alternatives to financing health care. However, the World Bank rarely addresses user fees (or their removal) directly in their policy recommendations, instead emphasizing the importance of finding other financing mechanisms

However, the Ghana Health Sector Program Support Project II (World Bank, 2003) does discuss user fees and notes that the government of Ghana is “committed to not increase out of limits private payments, to progressively abolish the ‘cash and carry’ which is a front payment system and to replace it with health insurance and community based payment schemes” (13) However, the report also acknowledges that user fees will be one of the four main sources of cost-recovery and that the government and that the exemption policy should be revised to account for this. This pattern can be seen in many of the health

² Health System Performance loans: 1994 Guinea Health/Nutrition Sector Project, 1995 Uganda District Health Project, 1995 Mozambique Health Sector Recovery, 1998 Mali Health Sector Development, 2000 Tanzania Health Sector Development Credit, 2003 Ghana Health Sector Program Support Project II, 2005 Niger Second Public Expenditure Adjustment Credit, 2005 Niger Public Expenditure Reform Credit, 2006 Mauritania Health and Nutrition Support Project. 2007 Madagascar Sustainable Health System Development Project

and nutrition support projects that focus on increasing demand and accessibility of health services by improving healthcare infrastructure, investing in human capital, and improving health education and awareness in the general population. While all these factors are important for improving healthcare systems, these initiatives do not address the harmful nature of user fees on healthcare access and affordability. In addition, these projects continue emphasize the importance of macrostabilization and improving public expenditure management. While using resources efficiently and effectively is important, continuing to focus on macrostabilization limits the ability for developing countries to invest in healthcare and provide healthcare services. The talk of macrostabilization is reminiscent of earlier World Bank policy that lead to the push for user fee policies. Overall, after analyzing World Bank health policy loans it appears that the focus of the World Bank seems to have shifted from actively supporting user fees to avoiding talking about them.

In a 2010 study of 49 low income, high mortality countries in Asia and Africa (with 38 of the countries in Africa), 88% of the countries surveyed continue to apply user fees. (Witter, 2010) The 6 countries that did not have any sort of user fee system did not appear to be linked by income since they consisted of relatively wealthier countries like Angola (GDP/capita of \$3,890) and much poorer countries like Liberia (GDP/capita of \$260).³ All of the countries with user fees but two (Central African Republic and Mauritania) have some sort of exemption policy, the most common exemptions for the poor and those with tuberculosis. Other patterns noted in the study are similar to studies done in the 1990's that noted low revenue from user fees (almost half of the countries reported fees cover 0-

³ Average GDP/capita of all countries surveyed was \$1,800

9% of costs) and heavy reliance of out-of-pocket expenditure of healthcare services (50% of total expenditure overall). With so many countries still implementing user fees, little progress has been made so far on the removal of user fees in developing countries, particularly in Sub-Saharan Africa.

What now? Community Health Insurance

Moving away from user fees, the World Bank has turned to health insurance as the new system of healthcare financing in sub-Saharan Africa. While there are several variations of health insurance schemes, community based health insurance programs are the more widespread and researched. These voluntary, non-profit based schemes are “formed on the basis of an ethic of mutual aid, solidarity and collective pooling of health risks” (Allegri, *et al.*, 2009, 286). They favor pooling community resources and risk sharing, in order to protect individual members against the cost of illness. However, community health insurance schemes face many challenges in sub-Saharan Africa that limit their effectiveness.

In a 2009 survey of different community health insurance plans in sub-Saharan Africa, Allegri, *et al.* found that most schemes suffer from the lack of clear legislative framework, low enrollment rates, high overhead costs and cultural barriers that reduce enrollment. Only four countries in sub-Saharan Africa had legislative policies that supported community health insurance plans on national, universal level. Lack of legislative and regulatory consistency has negative effects on enrollment rates and excluded individuals that find themselves in the gaps for these programs. Low enrollment rates were a consistent problem in the countries surveyed, with rates between 1% and

10%. Low enrollment limits risk sharing by reducing the size of the pool that risk is spread over. High overhead costs due to administrative costs and high start-ups costs also pose big challenges to community health insurance. In addition, the concept of risk aversion is culturally constructed and culturally bound. In communities where the idea of insurance is new and unfamiliar, people are unaware of the benefits of health insurance and have little incentive to join an insurance program.

Difficulties implementing and expanding insurance plans may be one of the reasons why user fees are still so prominent in sub-Saharan Africa, particularly among low-income households. 80% of community health insurance schemes still rely on fees or some type of out-of-pocket payment for services (Allegri, *et al.*, 2009). In Burkina Faso, health insurance appeared to increase health-seeking behavior but had no discernable effect on out-of-pocket expenditures, due to fees that are still in place (Gnawali, *et al.*, 2009). Furthermore, benefits from insurance schemes are not equally distributed to all members of society. The rich are more likely to enroll in health insurance programs than the poor. And even if they are insured, the poor are less likely to utilize health services compared to their wealthier counterparts (Gnawali, *et al.*, 2009).

Nonetheless, moving from a fee based financing system to an insurance-based system has had positive effects. In a study done in Burkina Faso, those with insurance recorded 40% higher outpatient visits given illness, compared to those without insurance (Gnawali, *et al.*, 2009). Similar studies have shown that removing user fees and implementing insurance policies has had a positive effect on health-seeking behavior (Ansah, *et al.*, 2009; Brugiavini & Pace, 2011; Ridde & Morestin, 2011). In Ghana, the

National Health Insurance Scheme that was fully implemented in late 2005, has led to increased utilization of formal antenatal care, increased probability of having a delivery in an institution, and increased probability of being assisted by a trained healthcare provider during delivery (Brugiavini & Pace, 2011).

However, while there is evidence for positive effects on health-seeking behavior, there is still limited research done on how removing user fees and health insurance plans affect health outcomes. In a study looking at health outcomes in Ghanaian children, although the removal of user fees resulted in increased health-seeking activity, there was no noticeable difference in health outcomes before and after the removal of fees (Ansah, *et al.*, 2009). This underlines the importance of understanding the complexity of the problems that face healthcare systems in sub-Saharan Africa that extend beyond reducing financial barriers. Finding ways to improve health and well being in sub-Saharan Africa will require a comprehensive approach that works to not only improve access to care but also improve the quality of care given and improve health outcomes for the entire population.

Chapter 7. Conclusion

The World Bank has long been regarded as a leading institution in international development and a key player in providing financial assistance to developing countries. However, this assistance has come at a cost for many developing countries, in particular in the countries of sub-Saharan Africa. Through its structural adjustment policies, the World Bank has weakened health care systems across sub-Saharan Africa by pressuring

governments to reduce spending in health care and replacing that funding with a user fee system that places the burden of the cost of health care on the sick, a disproportionate amount of whom live in extreme poverty.

The implementation of user fees in healthcare has existed long before the World Bank. However, in the 1980's and 1990's the World Bank institutionalized user fees in their loan packages in a way that completely changed healthcare systems in developing countries around the world, particularly in countries in Sub-Saharan Africa. The World Bank's practice of policy conditionality on its loan gave the World Bank leverage to pressure developing countries to follow its policy recommendations. Low-income countries with high debt and few alternatives for loans turned to the World Bank for help and in doing so were forced to implement user fees for primary healthcare services.

User fees were part of a structural adjustment package that looked at government expenditure as the major cause of debt. The World Bank encouraged countries to implement macrostabilization policies that would reduce government expenditure and debt. User fees would allow governments to reduce expenditure, without necessarily decreasing funding toward health centers. David de Ferranti championed the notion of market-efficiency in healthcare and the policy of user fees as a means to efficiently allocate healthcare resources and services. De Ferranti's policy suggestions were supported by important members of the World Bank staff, including the World Bank President Alden Clausen. President Clausen's focus on market-orientated health strategies and reducing the role of the public sector brought a neoliberal mindset to the Bank at the same time policy conditionality was becoming a staple in Bank policy.

At the same time the United States government, after a costly war in Vietnam, began to question its role in foreign aid. Reluctance to commit more foreign aid and wariness of government run healthcare programs prompted the United States government to oppose World Bank efforts to increase lending, particularly lending in the public sector. Pressure from the Reagan administration to include conditions for loans like reducing government expenditure on healthcare and reducing the role of the government in providing healthcare also drove support for user fee policies. As the largest shareholder in the World Bank, the United States was able to influence World Bank health policy to suit American interest.

The World Bank rapidly added user fee policies as conditions in lending to developing countries and user fees for primary health services became widespread in 1980's and 1990's. Backed by neoliberal economics and health theory, user fees were thought to be the solution to providing developing countries with sustainable healthcare systems. However, in practice user fees did not have the positive results that the World Bank had hoped for. Declining attendance rates in health clinics, particularly among the poor, failure to improve quality of care and failure to increase equity can be contributed both to theoretical and practical problems in World Bank reasoning. The theory behind user fees is based on many assumptions that are difficult and dangerous to make. For instance, the assumption that efficiency would necessarily lead to equity due to improved quality of care and investment in healthcare infrastructure (Birdsall & James, 1990) requires a strong management system that ensures revenue generated from user fees are used for investing and improving quality of care. The World Bank, which was concurrently aggressively decentralizing healthcare management, in some ways undermined efforts to improve user fee management. Furthermore, believing that people know when they should

spend money on services assumes that everyone have full access to healthcare information. However, the reality is that information is distributed unequally, with the poorest most likely to have the least access to information and the least knowledge of when to seek care. Separating symptoms from disease and symptoms from poverty cannot be assumed to be naturally understood by everyone. Exemption policies often fail for similar reasons. Assuming that everyone who would qualify for exemptions knows that they would qualify does not take into account the reality of imperfect information and barriers in access to information. It is also important to note that willingness to pay and ability to pay are not interchangeable or easily measured. One's willingness to pay can far exceed one's ability to pay, especially when looking at opportunity cost as lost income that cannot be spent on other goods like food (or healthier food), clean water or another goods essential to health needs.

By pressuring countries in sub-Saharan Africa to implement user fees, the World Bank prioritized economic goals, like macrostabilization and debt reduction, over social development goals, like increasing health care access. In prioritizing economic goals, the World Bank essentially treated healthcare policy as subsidiary to economic policy. However, with increasing evidence of the poor performance of user fees and the negative impact user fees have on the poor, the World Bank was forced to reevaluate user fees policies in social services. The push toward removing user fees came largely from the United States government, which had ironically played an important role in their implementation. The changing focus of the World Bank toward poverty reduction also brought a reevaluation of user fee policies and reports from within the Bank encouraging

their removal. However, the removal process has been slow as the transition to other forms of health financing like health insurance schemes faces its own set of challenges.

User fees still remain an important part of many healthcare systems in sub-Saharan Africa. A major reason for this is the difficulty in implementing health insurance schemes or other forms of community financing and general disagreement of how to implement these policies. Countries are also facing consequence of long-term underfunding of healthcare infrastructure, in part due to World Bank policies. (Gilson & McIntyre, 2005) The challenge of balancing investing in infrastructure and human capital and providing more affordable healthcare services can be extremely difficult. However, as Gilson and McIntyre note, international actors like the World Bank must be willing to support the efforts of governments to remove user fees for primary care. It is important for the World Bank to take an active role in reinvesting in healthcare and in supporting financial initiatives that will improve healthcare access to all members of a population.

Important lessons can be learned from the World Bank's experience with user fees, especially in looking at the key factors that decide World Bank policy. In the 1980's, World Bank health policy was a product of its key administrators and their views on development. The neoliberal attitude of the World Bank and its highest-ranked officials brought user fees from publications to policy conditionalities. The development and later support for user fees in the World Bank demonstrates how quickly shifts in ideology can take place due to key changes in administration and pressures from outside sources, like the United States. Pressures from the United States government and within the World Bank pushed the World Bank to favor conservative economic and health policies at a time when sub-Saharan

Africa needed progressive policies focused on social issues like increasing access to healthcare.

Understanding reasons why the World Bank supports certain policies is especially important in light of policy conditionality. If the World Bank chooses to impose policies on other countries, it must take full responsibility when those policies do not work, especially in cases like user fees which had negative results in most developing countries. However, the World Bank has learned, though slowly, of the dangers of user fees and is working to develop alternative financing models that focus on risk sharing and reducing individual burden of cost of disease. In order to make informed policy decisions, the World Bank must design policies that are country specific and are influenced by those who they are designed for and not by other, external factors.

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