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Clinics in Mother and Child Health

Perspective

Characteristics of Family Planning, Maternal, and Child Health Services

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ABOUT THE STUDY

The impact of implementing or increasing health-care user fees in Low-And Middle-Income Countries (LMICs) is debatable. On the one hand, healthcare user fees are viewed as a financial barrier for the poor, reducing their use of health services. Charging user fees, on the other hand, can be an effective way of increasing revenue while also improving the quality of offered health care. Unfortunately, only a few recent researches thoroughly investigated the causal influence of implementing or increasing user fees in LMICs. The majority of studies show a negative impact on health-care utilization, with quality improvements partially compensating for rising rates and, in certain circumstances, sustaining service utilization. In parallel, there are numerous recent studies on the impact of decreasing or eliminating user fees. The bulk of this research shows an increase in healthcare utilization and expense.

This research adds to the body of knowledge on demand-side finance in health by presenting rigorous, causal evidence on the medium-term impacts of implementing user fees in a middle-income country. We assess the impact of implementing user fees in Egypt on the use of family planning, Antenatal Care (ANC), and delivery care services, women's access to health care, and child health status between 2008 and 2014 using a Difference-in-Differences (DiD) identification technique. The unique institutional context in Egypt enables us to identify a causal influence of user fees on a wide range of health outcomes using a longitudinal, comprehensive dataset spanning the years 1992 to 2014. The spatially built longitudinal dataset facilitates the deployment of a causal identification technique. Given the scarcity of causal estimates in the most relevant related literature, one of the main contributions of this work is the robustness of our impact estimates.

In 1997, the Egyptian government began the Health Sector Reform Programme (HSRP) to provide the population with a Basic Benefits Package (BBP) of health services. The programme included both a service delivery and a funding component. The former concentrated on quality enhancement through accreditation of healthcare facilities. Both a supply-side and a demand-side intervention were made by the latter. Funds were transferred from direct to Performance-Based Funding (PBF) of healthcare providers on the supply side. In public Primary Health Care (PHC) institutions taking part in the HSRP's finance component, user fees were introduced to increase supply. Beneficiaries who were previously uninsured had to pay registration fees, renewal fees, and copayments including visit fees, prescription co-payments, and co-payments for other treatments in order to participate in the programme (World Bank, 2004). At the end of 2008, the financial rewards given to contracted facilities taking part in the two halves of the HSRP were stopped.

Therefore, the primary distinction between facilities that are contracted to participate in both components and accredited-only facilities that participate in the service delivery component is that the latter became authorized to charge beneficiaries user fees. By contrasting the health results of contracted facilities with those of accredited-only facilities, we were able to estimate the impact of implementing user fees.

We discover that using family planning, maternal health, and child health services in Egypt during the second half of the 2000s was not always hampered by user fees. We even notice some favorable effects on how often ANC services are used. Given these results, we contend that a greater willingness to pay for a health care that might be, or at least considered to be, of higher quality could have countered the reduction in demand brought on by the imposition of user fees.

Estimating the consequences of user fee imposition is essential since universal health coverage comes at a high cost, especially in environments where resources are scarce. The relevance of this finding is further supported by the depletion or diversion of health system resources caused by subsequent epidemics and pandemics, as well as the detrimental effects of such events on mother and child health. This study is further motivated by the continually high burden of Out-of-Pocket (OOP) health spending in Egypt. The continually high burden of Out-of-Pocket (OOP) health expenditure in Egypt encourages this study even more. As a share of current health expenditure, this burden

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was 62% in 2000, 65% in 2005, 62% in 2008, and 59% in 2014. OOP spending increased per capita from $189 in 2000 to $238, $260, and $289 in 2005, 2008, and 2014, respectively (Global Health Expenditure Database, 2020).

This study adds to the sparse evidence on demand-side financing in health in LMIC settings by presenting rigorous evidence on the medium-term effect of instituting user fees in Egypt on the use of family planning, ANC, and delivery care services, women's access to health care, and child health status. The research fills a gap in the literature by investigating how better perceived quality of health care can buffer the detrimental effect of implementing user fees on demand.