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Article

Answering the Millennium Call for the Right to Maternal Health: The Need to Eliminate User Fees

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Complications during childbirth and pregnancy are a main source of death and disability among women of reproductive age. Approximately 536,000 women die from pregnancy-related complications each year. Developing countries suffer most profoundly, accounting for 99% of deaths. The world's nations, by endorsing U.N. Millennium Development Goals, recognized that most deaths are preventable; they have pledged to reduce maternal mortality by 75% by 2015. This Article assesses the barriers presented by user fees – formal charges for health services still charged by many countries – to the attainment of MDGs. It shows that user fees hamper healthcare access, particularly in emergency-care settings, and fail in meeting their intended purposes of generating funds and improving equity, quality and decentralization of health care. The Article analyzes fees' adverse

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impact through a human rights lens that privileges each woman with an assessment of her health, unlike the MDGs which assess aggregate improvements and benchmarks. Finally, the Article explores alternatives to user fees, including universal health insurance schemes, tax schemes, and debt forgiveness programs and policies. It offers a guiding framework for assessing health financing systems – a framework that is centered on the needs of the poorest and most marginalized community members and that emphasizes accountability.

INTRODUCTION

Complications during childbirth and pregnancy are one of the main sources of death and disability among women of reproductive age in developing countries.¹ Approximately 536,000 women died from pregnancy-related complications in 2005.² For every woman who dies, about twenty others suffer serious injury, infection, or disease.³ The majority of maternal deaths are preventable, even in countries with limited resources.⁴ Behind these startling statistics are the individual stories of persons whose lives are dramatically altered as a result of maternal death – the story, for example, of a young Nigerian woman who went into premature labor as a result of preeclampsia and needed an emergency caesarian section.⁵ Her husband learned that the procedure would cost 20,000 naira (about \$160) and abandoned his wife, leaving her friends and relatives to try to raise the money.⁶ When the doctors refused to perform the required surgery until her family raised 70% of the money, she died.⁷

In the background of the stories are other deeply affected persons –

1. See WORLD HEALTH ORGANIZATION (WHO), *MATERNAL MORTALITY IN 2005: ESTIMATES DEVELOPED BY WHO, UNICEF, UNFPA, AND THE WORLD BANK (2007)* [hereinafter *MATERNAL MORTALITY ESTIMATES 2005*]. For example, the adult lifetime risk of maternal death – the probability that a 15-year-old woman will die from a maternal cause – is one in twenty-six in Africa and one in seven in Niger. *Id.* at 1.

2. *Id.* at 16.

3. See UNITED NATIONS DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS, *PROGRESS TOWARDS THE MILLENNIUM DEVELOPMENT GOALS, 1990-2005, GOAL 5: IMPROVE MATERNAL HEALTH* (2005), http://mdgs.un.org/unsd/mdg/Resources/Attach/Products/Progress2005/goal_5.doc [hereinafter *UNDP GOAL 5 REPORT*].

4. See WHO, *BEYOND THE NUMBERS: REVIEWING MATERNAL DEATHS AND COMPLICATIONS TO MAKE PREGNANCY SAFER* (2004). Maternal death is defined as “[t]he death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.” *MATERNAL MORTALITY ESTIMATES 2005*, *supra* note 1, at 4.

5. Ahmad Salkida, *Nigeria: Maternal Mortality, the Silent Emergency*, DAILY TRUST, Mar. 12, 2008, <http://allafrica.com/stories/200803120391.html>.

6. *Id.*

7. *Id.*

children who suffer from the disappearance of a key caretaker, and spouses, partners, and extended family members who must stretch their resources and assume responsibility for child-rearing and other roles formerly filled by the mother. Maternal deaths do not affect just one person; they impact whole families and communities.

The problem of maternal deaths is experienced most profoundly in developing countries, which account for 99% of the total annual maternal deaths, 533,000 worldwide in 2005.⁸ Africa and South Asia together combined to make up 86% of total worldwide maternal deaths in 2005.⁹ Significant differences also exist within nations, with poor and rural areas frequently experiencing more maternal deaths than their wealthier and urban counterparts.¹⁰

The world's nations, by endorsing the United Nations Millennium Development Goals (MDGs) and other international development consensus documents, have recognized that most of women's deaths and injuries due to pregnancy-related health complications are preventable. They have pledged to take urgent action to ensure that maternal mortality is reduced by 75% by 2015.¹¹ To meet this goal, all women must have access to high-quality health care services during child delivery.¹² The MDGs list three essential elements of these services: a skilled attendant at delivery, access to emergency obstetric care in the event of a complication, and a referral system to ensure that women experiencing complications can reach life-saving care in adequate time.¹³

In its latest report, the World Health Organization noted that the world's nations are not close to attaining this goal.¹⁴ The global maternal mortality rate has declined only 1% each year between 1990 and 2005, far from the 5.5% needed to reach the target goal.¹⁵ Conditions are worse in sub-Saharan Africa, where the annual decline has been about 0.1%.¹⁶

This Article assesses the barriers imposed by formal fees for health care services, more commonly known as user fees. The introduction of user fees in the 1980s arose following the publication of a significant body of literature detailing their efficacy. The World Bank was particularly instrumental in creating the original theoretical consensus for user fees as a viable health financing mechanism.¹⁷ In 1985, the World Bank hailed user

8. MATERNAL MORTALITY ESTIMATES 2005, *supra* note 1, at 15.

9. *Id.*

10. For example, in Ethiopia, the rich are twenty-eight times as likely as the poor to have a medically trained health care provider attend childcare deliveries. In Chad and Niger, the difference is at least fourteen-fold between rich and poor regions. See UNDP GOAL 5 REPORT, *supra* note 3, at 3.

11. See UNDP GOAL 5 REPORT, *supra* note 3, at 1.

12. *Id.* at 6.

13. *Id.*

14. MATERNAL MORTALITY ESTIMATES 2005, *supra* note 1, at 18.

15. *Id.* at 2.

16. *Id.*

17. See, e.g., JOHN AKIN ET AL., WORLD BANK, FINANCING HEALTH SERVICES IN DEVELOPING COUNTRIES: AN AGENDA FOR REFORM 25-48 (1987); DAVID DE FERRANTI, PAYING FOR HEALTH SERVICES IN DEVELOPING COUNTRIES: AN OVERVIEW X (WORLD BANK STAFF WORKING PAPERS, NO. 721, 1985).

fees as “opportunities for greater cost recovery from users,” and one of the four primary ways to improve health care financing in developing countries.¹⁸ Since that time, many studies have more thoroughly examined user fees’ progress in meeting their intended goals.¹⁹ Some studies have emphasized the changes needed to make user fees more successful, including the implementation of better exemption policies.²⁰ Others have highlighted evidence demonstrating that user fees have not improved health service delivery in developing countries.²¹ Selected studies have focused on the gender inequities inherent in health care systems, specifically pointing out the inequity of cost burdens for women.²² Increasingly, studies frame maternal health as a human right.²³

This Article draws on scholarship from the health policy and human rights fields to show that user fees dangerously impede access to urgently needed maternal health care. Such fees create significant roadblocks to the fulfillment of the MDGs in many regions of the world, dramatically altering the trajectory of maternal deaths by hampering access to health care, particularly in emergency care settings. User fees have failed to meet their stated purpose of generating funds for health programs, the rationale for their implementation. Instead, user fees prevent vulnerable individuals from seeking out and receiving necessary health care.

The global community must eliminate user fees for maternal health services to meet the goal of dramatically reducing maternal mortality by 2015. If it fails to do, the world’s nations will not only fall short of attaining the global goal, they will also fail to protect the human rights of a large

18. DE FERRANTI, *supra* note 17, at 5.

19. See GUY HUTTON, DEPARTMENT FOR INTERNATIONAL DEVELOPMENT HEALTH SYSTEMS RESOURCE CENTRE, CHARTING THE PATH TO THE WORLD BANK’S “NO BLANKET POLICY ON USER FEES,” (2004), available at http://www.dfidhealthrc.org/publications/health_sector_financing/04Hut01.pdf.

20. See L. Gilson, *The Lessons of User Fees in Africa*, 12 HEALTH POL’Y PLAN. 273 (1997).

21. See HUTTON, *supra* note 19, § 2.3 (noting, in particular, that “both theoretical and empirical studies were negative towards SAPs [structural adjustment programs] and its effects on health outcomes, mainly through user fees, reduced access to care and deteriorating quality of care”) (emphasis added). See also John Walley et al., *Primary Health Care: Making Alma-Ata a Reality*, 372 LANCET 1001 (2008) (proposing the elimination of user fees and introducing a continuum of care for maternal health services, including community-based care); Chris James et al., *To Retain or Remove User Fees?: Reflections on the Current Debate in Low- and Middle-Income Countries*, 5 APPLIED HEALTH ECON. & HEALTH POL’Y 137 (2006) (offering a more nuanced view of the methods for eliminating user fees).

22. See, e.g., Hilary Standing, *Gender and Equity in Health Sector Reform Programmes: A Review*, 12 HEALTH POL’Y & PLAN. 1, 3 (1997); Priya Nanda, *Gender Dimensions of User Fees: Implications for Women’s Utilization of Health Care*, 10 REPROD. HEALTH MATTERS 127, 128 (2002).

23. See generally L. P. Freedman, *Using Human Rights in Maternal Mortality Programs: From Analysis to Strategy*, 75 INT’L J. OF GYNECOLOGY & OBSTETRICS 51 (2001) (describing a human-rights based approach to reducing maternal mortality that not only denounces maternal death, but also offers ways to integrate human rights into the design and implementation of maternal mortality policies and programs); Paul Hunt et al., United Nations Population Fund (UNFPA), *Reducing Maternal Mortality: The Contribution of the Right to the Highest Attainable Standard of Health* (2007), available at <http://www.unfpa.org/publications/detail.cfm?ID=356> (describing a human rights framework for maternal mortality reduction programs and suggesting potential advocacy and accountability tools).

subset of their citizens.

This Article analyzes user fees' adverse impact on maternal mortality rates through the lens of human rights. It first provides an analysis of user fees, including how they are defined and how they interact with the other costs women confront when accessing key maternal health services. The Article then discusses the history of user fees, from the widespread implementation of user fees by developing countries under pressure from multilateral lenders and aid organizations to the more recent rethinking of user fees in light of their well-recognized harms. Despite the revision of user fee policies, they remain prevalent in developing countries due, in part, to conditional loans from organizations like the World Bank that advocate free-market principles in the provision of social services.

Next, the Article looks at user fees and maternal health. It documents how user fees have detrimentally impacted women across the globe and contributed to high rates of maternal mortality. In light of user fees' harmful impact on women, the Article then examines whether these fees have achieved any of the economic and systemic goals that accompanied their introduction. It shows that user fees have fallen short of their stated goals: exemptions meant to act as a safeguard for the poorest community members have failed to reach their intended recipients; user fees have failed to generate significant revenue for the health sector or increase efficiency; they have made no significant improvements in the quality of care or promoted equity in the provision of health care; and user fees have not decentralized health care provision to increase accountability and community participation.

The Article then applies human rights as a framework to evaluate user fees' impact on maternal health. The framework emphasizes the principle of non-discrimination: all citizens are entitled to human rights, including poor, geographically disadvantaged, and ethnic minority women of child-bearing age. By focusing a lens on these women, one can gauge the global community's success in realizing human rights for all citizens. Notably, the millennium goal regarding maternal health assesses aggregate improvements in women's health status. A human rights framework, in contrast, delves deeper by providing each woman with her own assessment of her health status.²⁴ The Article shows that from a human rights perspective, user fees have failed to secure the rights to non-discrimination, health and life. In order to provide disadvantaged women with the right to health, states must eliminate barriers to service and ensure affordable maternal health services.

Finally, the Article explores several alternatives to user fees, such as, for example, the taxation and insurance provisions employed by Ghana.²⁵

24. International Covenant on Economic, Social and Cultural Rights (ICESCR), art. 12, Dec. 16, 1966, 993 U.N.T.S. 3, 5 ("Certain human rights provide an express foundation for the attainment of maternal health. The most salient of the rights is the right to the enjoyment of the highest attainable standard of physical and mental health.").

25. WOTRO, Integrated Programmes – Reaching the Poor in Ghana's National Health Insurance Scheme, available at http://www.nwo.nl/nwohome.nsf/pages/NWOA_74Y9R3_

It evaluates these alternatives against the backdrop of the great debt burdens confronting many developing countries. The Article offers lessons for international lending institutions and wealthy states that will benefit the poor and ensure accountability. The Article concludes by offering a series of recommendations regarding eliminating user fees and instituting more gender sensitive health care financing schemes. These recommendations draw on human rights principles and offer a feasible path to attaining the millennium consensus goals regarding maternal health.

I. USER FEES: ANALYSIS

Costs associated with maternal health fall into two broad categories: formal fees and informal costs.

A. Formal Fees

Formal fees, those most commonly discussed in the literature, tend to be explicit charges at the point of service for medical treatment provided.²⁶ The fees can be retained at the point of service or aggregated at the national level, and may be used to support capital or recurring costs.²⁷ Formal fees may include consultation fees, rental fees for a hospital bed, registration fees, and fees for medicine, blood or laboratory tests.²⁸ Insurance and other risk-sharing financing schemes tend to address these fees.²⁹

Eng.

26. See WHO, THE IMPACT OF USER FEES ON HEALTH SERVICE UTILIZATION IN LOW- AND MIDDLE-INCOME COUNTRIES: HOW STRONG IS THE EVIDENCE? 839 (2008). The WHO's definition of "user fees" is as follows:

User fees refer to a financing mechanism that has two main characteristics: payment is made at the point of service use and there is no risk sharing. User fees can entail any combination of drug costs, supply and medical material costs, entrance fees or consultation fees. They are typically paid for each visit to a health service provider, although in some cases follow-up visits for the same episode of illness can be covered by the initial payment.

Id.

27. COALITION FOR HEALTH AND EDUCATION RIGHTS (CHER), USER FEES: THE RIGHT TO EDUCATION AND HEALTH DENIED, A POLICY BRIEF FOR THE U.N. SPECIAL SESSION ON CHILDREN 5 (2002), available at http://www.actionaid.org.uk/doc_lib/147_1_user_fees.pdf.

28. *Id.*

29. WHO, *supra* note 26, at 839.

B. Informal Costs

There often are a large number of related costs that households must bear in order to access services related to maternal health, such as transportation costs to reach the hospital.³⁰ In order to travel to receive care, many women must bring family members with them and pay the associated costs for their travel, food, and lodging.³¹ Women also face the opportunity cost of lost work during the time they are away seeking medical care.³² The sum of these costs can be substantial and presents significant barriers to accessing service.³³ This is especially true for women living in remote, rural areas with only intermittently accessible medical service.³⁴

In this Article, we use the term user fees to represent the state-imposed formal fees that are borne by women and their families seeking to obtain maternal health care. We highlight the need for financing mechanisms to minimize formal fees to increase access to maternal health services and decrease maternal mortality. However, the Article also recognizes that governments must address the financial burdens imposed by informal costs such as transportation, food and lodging as part of a comprehensive, long-term solution to maternal health.

II. USER FEES: HISTORY

User fees were first proposed to fill revenue gaps in under-funded public health care services.³⁵ The fees were implemented in the 1980s as part of structural adjustment programs (SAPs) advocated by international lending institutions such as the World Bank.³⁶ These SAPs countered previous high levels of public spending on health services.³⁷

Following their independence from colonial rule, many developing countries, especially those in Africa, adopted progressive policies to provide for free health care services.³⁸ However, in the ensuing decades

30. WORLD BANK, WAIVERS AND EXEMPTIONS FOR HEALTH SERVICES IN DEVELOPING COUNTRIES, SOCIAL SAFETY NET PRIMER NOTES 2 (2003 Vol. 9).

31. *Id.* See also Pablo Enrique Gottret & George Schieber, *Health Financing Revisited: A Practitioner's Guide*, WORLD BANK 232 (2006) (arguing that there are direct and indirect payments associated with accessing health care services).

32. WORLD BANK, *supra* note 30, at 2.

33. *Id.*

34. See, e.g., Monique Hennink & Nyovani Madise, *Appropriateness of User Fees for Reproductive Health in Malawi*, Southampton Statistical Sciences Research Institute Applications and Policy Working Paper (2004) (concluding that those persons in Malawi most likely to be affected by user fees for contraceptives are rural residents).

35. HUTTON, *supra* note 19, § 2.3.

36. *Id.* § 2.4.

37. SOPHIE WITTER, SAVE THE CHILDREN, AN UNNECESSARY EVIL: USER FEES FOR HEALTHCARE IN LOW-INCOME COUNTRIES 5 (2005).

38. *Id.* See also RUDOLPH KNIPPENBERG ET AL., WORLD BANK, INCREASING CLIENTS' POWER TO SCALE UP HEALTH SERVICES FOR THE POOR: THE BAMAKO INITIATIVE IN WEST AFRICA 2 (2003).

many of these countries plunged into debt and economic decline.³⁹ By the 1970s and 1980s, many states suffered from insufficient economic resources to invest in health care systems.⁴⁰ At the same time, confidence in the ability of the public sector to provide effectively for comprehensive health services diminished.⁴¹ Several countries experienced deteriorated working conditions, an inability to pay the salaries of health personnel, and an overall reduced effectiveness of medical systems.⁴²

Thus, the 1980s featured a significant “paradigm shift” with respect to health care provision.⁴³ International institutions including the World Bank, UNICEF, and the World Health Organization began encouraging developing countries to decrease public spending on social services and increase collection of private party payments for services.⁴⁴ User fees were a critical part of a broader neoliberal development trend (now coined the “Washington Consensus”) which pushed a standard reform package for development, advocated to developing countries by the IMF, World Bank, and U.S. Treasury Department.⁴⁵ The Washington Consensus development policy encouraged structural adjustment to a market-oriented economy through, among other actions, the liberalization of trade, decreased public spending, currency devaluation, and increased privatization. With respect to the health sector, the new development policy emphasized reduced public spending on health services, with upfront private payments for health care.⁴⁶

A. The Bamako Initiative’s Push for User Fees

In 1987, African health ministers met in Bamako, Mali to discuss the successes and challenges of the cost recovery approaches that had been recently implemented. Their discussions led to the formation of the Bamako Initiative (BI), which aimed to provide universal accessibility to primary health care through decentralizing services and providing for the self-sustaining payment of health care system recurrent costs.⁴⁷

The BI sought to involve communities in providing health care by challenging these communities to:

- Decentralize management and decision-making in the health sector to transfer control from the national to the local level;

39. WITTER, *supra* note 37, at 5.

40. *Id.*

41. *Id.*

42. *Id.*

43. *Id.*

44. *Id.*

45. See Videotape: John Williamson The Washington Consensus as Policy Prescription for Development (World Bank 2004) (on file with World Bank), available at <http://info.worldbank.org/etools/bspan/PresentationView.asp?PID=1003&EID=328>.

46. *Id.*

47. KNIPPENBERG ET AL., *supra* note 38, at 4-5.

- Create community-based cost-sharing and co-management responsibilities so that local health staff are accountable for access and quality of care; and,
- Minimize the effects of variations in funding from government and donors by generating local revenue to guarantee the availability of medicines.⁴⁸

The BI ultimately led to the implementation of user fees in a variety of forms across many African countries. Cost-recovery via user fees took place through charges at the point of use for such items as medical consultations, medicines, and inpatient stays.⁴⁹ Many view the BI as a strategic initiative that encouraged countries to adopt user fees when their loan agreements did not expressly provide for fee implementation procedures.⁵⁰

International institutions such as the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) initially promoted the BI.⁵¹

An original goal of the BI was to implement user fees in order to increase health sector revenue and the quality and coverage of health services.⁵² One of the BI's salient characteristics was the implementation of user fees on a local rather than national level.⁵³ Indeed, a central principle of the BI was the local retention and management of collected revenue.⁵⁴ This decentralized system was intended to produce higher quality service and accountability in the health sector, increase drug availability, and ensure better implementation of exemptions for the poor.⁵⁵ To this end, user fees were levied at the point of service delivery; they were borne exclusively by the health care consumer.⁵⁶

The BI recognized that fees could pose a barrier to health care access for low-income households.⁵⁷ As such, fees were meant to be levied at a cost proportionate to household income, meaning that the poorest patients would receive free care. User fee advocates thought that community health schemes and the government would be able to subsidize low-income patients.⁵⁸ A subsidy scale existed for different types of materials and treatments, and the poorest members of the community could be entirely subsidized or exempted from payments.⁵⁹ Yet, from the early days

48. *Id.*

49. HUTTON, *supra* note 19, § 2.7.

50. *Id.* § 2.5.

51. *Id.* § 2.4.

52. WITTER, *supra* note 37, at 5-6.

53. *Id.* at 5.

54. *Id.*

55. See HUTTON, *supra* note 19, § 2.6.

56. Alaka Singh, *Building on the User-Fee Experience: The African Case 2* (WHO, Discussion Paper No. 3, 2003).

57. ELDIS, *Background: The Bamako Initiative*, <http://www.eldis.org/go/topics/resource-guides/health-systems/key-issues/user-fees/background> (last visited Jan. 12, 2009).

58. *Id.*

59. *Id.*

of user fees, equity was only a minor goal of the BI.⁶⁰

B. User Fees Prescribed By Multilateral Loans and Aid

The World Bank, the IMF and the Treasury Department began encouraging developing countries to implement user fees by conditioning their international loans upon the BI cost-recovery principles.⁶¹

1. Origins of the World Bank Policy on User Fees⁶²

The World Bank originally introduced user fees as a solution for health sector problems in developing countries in its 1987 “Agenda for Reform.”⁶³ Fees were intended to increase health sector resources, thereby improving the quality and efficiency of existing health programs, allowing more spending on under-funded programs, and expanding the access of the poor to health programs.⁶⁴ The World Bank advanced the theory that the implementation of user fees would:

- Improve efficiency and equity by increasing revenues to the health care system;
- Increase quality and coverage of medical care by reducing frivolous demand; and
- Shift patterns of care away from costly in-patient services to low-cost primary health care services, while protecting the poor through exemptions.⁶⁵

Notably, the World Bank and other lending institutions envisioned that the very poor members of developing countries would be exempted from

60. *Id.*

61. HUTTON, *supra* note 19, § 2.5.

62. The IMF’s policy on user fees is also important to consider, although it is much less transparent than World Bank policy. The IMF advises 184 member countries on policies that promote economic stability, reduce vulnerability to crises, and promote higher living standards. It also makes temporary financing available to member countries to help them address macro-level economic challenges. International Monetary Fund, *What is the IMF*, <http://www.imf.org/external/pubs/ft/exrp/what.htm> (last visited Feb. 26, 2009). The IMF focuses on macroeconomic and financial sector concerns, while the World Bank looks at specific social sector policies; nevertheless these macro-policies can strongly influence social sector developments. It should also be noted that while there is no specific user fee policy promoted by the Inter-American Development Bank (IDB), the Bank does state that countries applying for IDB loans should keep in mind that “[w]herever possible a fee for services rendered principle should be applied In those instances . . . in which services are rendered to income groups capable of payment, ‘user’ fees should be established.” Inter-American Development Bank, *Sectoral Operational Policies, Public Health*, http://www.iadb.org/exr/pic/VII/OP_742.cfm (last visited Feb. 26, 2009).

63. JOHN S. AKIN ET AL., WORLD BANK, FINANCING HEALTH SERVICES IN DEVELOPING COUNTRIES: AN AGENDA FOR REFORM 3-5 (1987).

64. *Id.*

65. See WITTER, *supra* note 37, at 5-6.

certain fees.⁶⁶

User fees soon became an integral component of the World Bank's structural adjustment programs as a means of cost recovery.⁶⁷ Over time, user fees became a condition placed on international finance institutions' (IFIs) loans, namely those of the IMF and World Bank.⁶⁸ SAPs aimed to decrease the role of the state in the provision of goods and services, with the provision of health care shifting from the public to the private sector.

This trend continues today, with public sector funding of health currently accounting for a small share, less than 30%, of the amount spent on health care in low-income countries.⁶⁹ These low levels of public funding of health care are reinforced by the overall strategy of SAPs and neo-liberal development policies.⁷⁰ The low public sector funding is particularly significant in light of the global health spending deficit in developing countries. Although developing countries account for 84% of global population and 90% of the global disease burden, they account for only 12% of global health spending.⁷¹ Furthermore, the poorest countries bear 56% of the global disease burden, yet account for only 2% of all health spending.⁷²

2. Progressive Implementation of User Fees in Developing Countries

SAPs became increasingly pervasive during the 1980s and early 1990s in the majority of developing countries in Africa, Asia, and Latin America.⁷³ A 1993 survey conducted by the World Bank of thirty-seven African countries revealed that thirty-three had cost-recovery policies at the national or local level. Most of these cost-recovery policies had been implemented since 1980.⁷⁴

From early on, exemptions to the user fees advocated by the World Bank were not implemented in a uniform manner. A study of twenty-five African countries in the mid-1990s found that only fifteen countries had user fee exemptions for the poor, and only one country, Zimbabwe, had

66. HUTTON, *supra* note 19, § 2.4 (discussing de Ferranti's 1985 proposed financing scheme).

67. WITTER, *supra* note 37, at 5.

68. CHER, *supra* note 27, at 3.

69. Public spending on health care constitutes only 29% of total health care spending in low-income countries. George Schieber, World Bank, *Health Financing in Developing Countries*, HEALTH SYS. NEWSL. 2 (2006), http://sitesources.worldbank.org/INTAFRHEANUTPOP/Resources/HSD_News_June_2006.pdf (last visited April 15, 2009).

70. See Kasturi Sen & Meri Kolvusal, *Health Care Reforms and Developing Countries: A Critical Overview*, 13 INT'L J. OF HEALTH PLAN. & MGMT. 199, 202 (1998). Structural adjustment programs have also been categorized as simply a form of neo-colonialism. See also Michael Reich, *Reshaping the State From Above, From Within, From Below: Implications for Public Health*, 54 SOC. SCI. & MED. 1669 (2002) (describing how international agencies' policies, such as SAP and neoliberal policies, imposed "from above" affect public health delivery on the ground).

71. Schieber, *supra* note 69, ¶ 1.

72. *Id.*

73. WITTER, *supra* note 37, at 5.

74. *Id.*

clearly delineated income limits that qualified for the exemption.⁷⁵

3. Evolution of the World Bank Policy on User Fees: “No Blanket Rule”

User fees came under attack in the mid-1990s from civil society, particularly non-governmental and human rights organizations, as seen in the Addis Ababa Consensus on Principles on Cost Sharing.⁷⁶ The World Bank’s 1993 Development Report also mentions the growing controversy.⁷⁷ Nevertheless, the Bank maintained that, since even patients at supposedly “free” government clinics faced hidden costs, user fees could increase poor persons’ utilization of health services if they met other intended goals and reduced indirect costs, such as transportation costs.⁷⁸ The Bank did, however, state user fees were not meeting the goal of providing widespread health sector financing and were likely to be more useful improving technical efficiency and drug supply.⁷⁹

By 2000, the World Bank announced that it was retreating from its prior policy of instituting user fees for basic social services. According to one source, while user fees were not uniformly withdrawn from loan conditions, IFIs, which serve as the key architects of health care financing reforms in Africa, began to recognize that commercializing access to health care was contributing to underdevelopment.⁸⁰

In its 2004 World Development Report, “Making Services Work for Poor People,” the World Bank sets forth its current “no blanket policy on user fees”:

There are times when user fees are appropriate – and some when they are not. Based on the primary goal of making services work for poor people, this Report argues against any blanket policy on user fees that encompasses all services in all country circumstances.⁸¹

The Bank uses the following methodology to determine whether to apply user fees:⁸²

75. *Id.* at 7.

76. HUTTON, *supra* note 19, § 3.3.3.

77. DEAN T. JAMISON ET AL., WORLD BANK, WORLD DEVELOPMENT REPORT 1993: INVESTING IN HEALTH 118 (1993) (“User charges for public health services in developing countries have sparked much debate since the World Bank endorsed the concept in 1987 in a policy study on health financing. Critics argue that fees restrict access to care, especially for the poor.”).

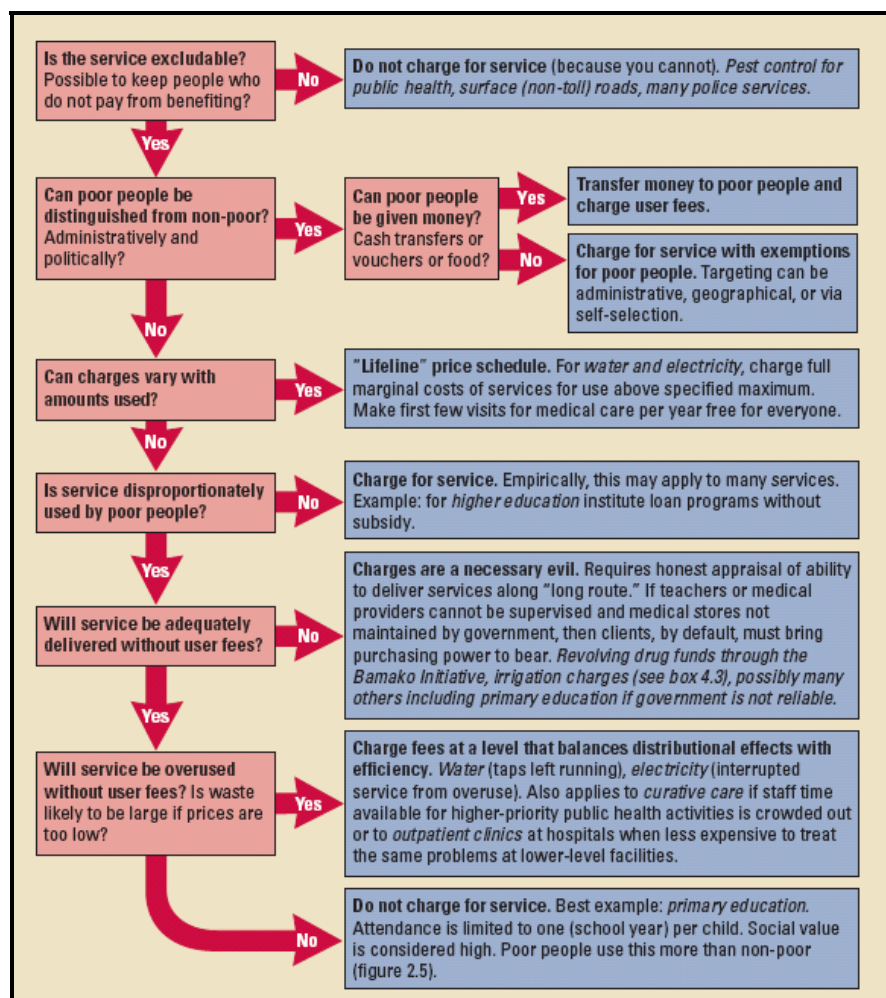
78. *Id.*

79. *Id.* at 11.

80. TAMARA BRAAM, THE IMPACT OF HEALTH SECTOR FINANCING REFORMS ON SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN AFRICA 5, 17 (Sonke Consulting 2005).

81. WORLD BANK, WORLD DEVELOPMENT REPORT 2004: MAKING SERVICES WORK FOR POOR PEOPLE 70 (2004).

82. Chart Originally published in WORLD BANK DEVELOPMENT REPORT 2004, *supra* note 81, at 71. Reprinted with permission from the World Bank. The World Bank holds all copyrights to the data in this chart.



Because various points in the Bank's proposed analysis are susceptible to wide interpretation, the practical implementation of the policy outline on user fees remains fraught with ambiguity. Furthermore, the Bank still strongly adheres to free market principles that create a more rigid framework within which to change policy on social services like health care. Underlying the Bank's approach is a belief that, in addition to generating funding, user fees establish a market relationship between provider and client and empower the client.⁸³ The Bank's free-market orientation with respect to health care transactions is evident:

The most direct way to get service providers to be accountable to the client is to make whatever they get out of the transaction depend on their meeting client needs and desires. That is, money (usually) or other benefits from providing the service should

83. *Id.* at 66.

follow the client – the enforceability of a relationship of accountability.⁸⁴

External donors like the World Bank often use the incentive of future financial rewards, and the threat of imminent aid cessation, as leverage to achieve specific policy changes.⁸⁵ A review of the health programs in sub-Saharan African countries in 2005 found that twenty-eight out of thirty-two countries charged fees for essential healthcare services.⁸⁶ In almost half of the countries, user fees were an integral part of the World Bank project design.⁸⁷ In only two countries did projects actively support free treatment, and these projects were both related to HIV/AIDS.⁸⁸

User fees remain in effect in countries such as Tanzania, where the World Bank helped the government incorporate user fees from 1994 to 1995 as part of an effort to improve the financial sustainability of the health sector and increase access to health services.⁸⁹

The Bank does recognize that restricted access to care during pregnancy contributes to the high maternal mortality rates in developing countries, and that these high rates are exacerbated by poverty.⁹⁰ It recommends focusing on increasing maternal health care access for disadvantaged and high risk groups, such as poor women and women in underserved areas.⁹¹ In its April 2007 Health, Nutrition and Population Strategy, the World Bank noted the importance of “[s]etting the right insurance and/or public financing mechanisms (including donor financing) so that the cost of illness . . . will not throw [a mother] and her family into destitution, forced to sell the few assets they possess.”⁹² Yet the World Bank makes no explicit recommendation that user fees charged at the point of service should be eliminated to achieve this result. None of its recommendations for reducing maternal mortality include abolishing user fees.⁹³

84. *Id.*

85. See EURODAD, WORLD BANK AND IMF CONDITIONALITY: A DEVELOPMENT INJUSTICE (2006), 3-5 (noting that “[o]n average poor countries face as many as 67 conditions per World Bank loan”).

86. See Memorandum submitted by Save the Children UK on ‘The World Bank Africa Action Plan: a missed opportunity’ to the House of Commons (2005), available at <http://www.publications.parliament.uk/pa/cm200506/cmselect/cmintdev/uc569-i/u569m20.htm#note107>.

87. *Id.*

88. *Id.*

89. LEONTIEN LATERVEER ET AL., EQUITY IMPLICATIONS OF HEALTH SECTOR USER FEES IN TANZANIA: DO WE RETAIN THE USER FEE OR SET THE USER F(R)EE? RESEARCH ON POVERTY ALLEVIATION 18 (2004), available at www.repoa.or.tz/documents_storage/Research_and_Analysis/Equity_Implications_User_Fees_Health.pdf.

90. THE WORLD BANK, MATERNAL MORTALITY 1 (2006), available at <http://siteresources.worldbank.org/INTPHAAG/Resources/AAGMatMort06.pdf>.

91. *Id.* at 5.

92. THE WORLD BANK, HEALTHY DEVELOPMENT: THE WORLD BANK STRATEGY FOR HEALTH, NUTRITION, AND POPULATION RESULTS 27 (2007) (emphasis omitted).

93. *Id.*

4. U.N. Agencies

The U.N. family agencies offer a strong voice countering the World Bank's policies on user fees. The WHO has acknowledged the extremely regressive nature of user fees and advocates a move away from user fees.⁹⁴ A WHO report on reproductive health rights states, "It is uncertain and problematic what effect the imposition of user fees would have on safe motherhood among poor people in developing countries, particularly whether such fees would deter or prevent poor women's resort to necessary maternity care."⁹⁵

U.N. policy also increasingly opposes user fees.⁹⁶ UNICEF's user fee policy states, "There are powerful economic and moral grounds on which to avoid user financing for almost all basic social services."⁹⁷ One of the significant "action messages" of the Safe Motherhood Inter-Agency Group – a partnership made up of a broad constituency of partner countries, U.N. and multilateral agencies, NGOs, health professional associations, bilateral donors, and academic institutions – contains a commitment to increasing access to quality maternal health services and ensuring that social, cultural, and economic factors do not interfere with the attainment of this goal.⁹⁸

C. User Fees: Policies Among Bilateral Donors and NGOs

The World Bank and other IFIs are one major source of user fee policies. However, bilateral donors and NGOs also play an important role. An estimated 3% of donor budgets for aid are dedicated to the combination of maternal and child health programs.⁹⁹ This Article assesses the following agencies, representing some of the larger bilateral donors and NGOs, as examples of broader bilateral donor and NGO policies.

94. WHO, *THE WORLD HEALTH REPORT 2005 – MAKE EVERY MOTHER AND CHILD COUNT* 137-39 (2005), available at <http://www.who.int/whr/2005/en/>.

95. REBECCA J. COOK ET AL., WHO, *ADVANCING SAFE MOTHERHOOD THROUGH HUMAN RIGHTS* 46 (2001), available at http://www.who.int/reproductive-health/publications/RHR_01_5_advancing_safe_motherhood_through_human_rights.pdf.

96. U.N., *Revised Draft Outcome Document of the High-level Plenary Meetings of the General Assembly of September 2005 Submitted by the President of the General Assembly*, ¶ 25, U.N. Doc. A/59/HLPM/CRP.1/Rev.2 (Aug. 5, 2005), available at http://www.un.org/ga/59/hlpm_rev.2.pdf.

97. SARAH ENGLAND ET AL., WHO, *PRACTICE AND POLICIES ON USER FEES FOR IMMUNIZATION IN DEVELOPING COUNTRIES* 29 (2001), available at <http://202.54.104.236/intranet/eip/immunizationmanager/pdf/UserFeesWHOstatement2001.pdf> (citing SANJAY REDDY & JAN VANDEMOORTELE, UNICEF, *USER FINANCING OF BASIC SOCIAL SERVICES, A REVIEW OF THEORETICAL ARGUMENTS AND EMPIRICAL EVIDENCE* 1 (1996)).

98. WORLD BANK, *SAFE MOTHERHOOD AND MATERNAL HEALTH*, <http://go.worldbank.org/V5EPGZUL40>.

99. Anthony Costello & David Osrin, *The Case for a New Global Fund for Maternal, Neonatal, and Child Survival*, LANCET 1 (2005). (estimating a 3% expenditure based on USAID's expenditure of 2.2% of its 2003 overall aid budget on child survival programs and DFID's expenditure of 2.6% of its 2003-04 total aid expenditure on child and maternal health programs).

1. USAID

USAID is the largest bilateral donor in the health sector.¹⁰⁰ USAID has no explicit policy on user fees. Rather, the agency works with individual governments to implement health financing that is efficient, non-wasteful, and equitable.¹⁰¹ Some USAID-sponsored research has opposed the implementation of user fees. For example, a 2005 USAID-sponsored research study concluded, "Throughout the world, health care fees deter the use of lifesaving skilled care at delivery. Poor families typically lack funds to pay for high and often unpredictable maternity care fees."¹⁰²

Other aspects of U.S. policy are more explicitly opposed to user fees. In July 2000, the U.S. House of Representatives approved a measure to put pressure on the World Bank to eliminate user fees from its loan conditions.¹⁰³ NGOs persuaded Congress to create a specific U.S. policy against user fees, and the World Bank retreated from its reliance on user fees.¹⁰⁴ The 2000 U.S. foreign aid bill called for the IMF and World Bank to eliminate the loan condition requiring a blanket policy on user fees.¹⁰⁵ Although the U.S. Treasury found loopholes in this law, they were corrected in 2001. In particular, the original bill allowed a loophole for "exemptions" under which user fees did not technically exist for poor persons, despite the reality that exemptions do not function properly.¹⁰⁶ However, the 2000 language was later modified to forbid approval or endorsement of user fees not only in loans, but also a wide range of World Bank, IMF, and other regional bank agreements. Additional U.S. legal provisions have called for further transparency on the part of IFIs.¹⁰⁷

2. British Department for International Development (DFID)

DFID is the department within the British government that manages and coordinates the delivery of Britain's aid to developing countries. DFID works as a bilateral donor to individual countries and also provides development funding to multilateral agencies.¹⁰⁸ DFID has an explicit

100. See WHITE HOUSE, EXPECT MORE, DETAILED INFORMATION ON THE CHILD SURVIVAL AND HEALTH – POPULATION ASSESSMENT ¶ 2.4, <http://www.whitehouse.gov/omb/expectmore/detail/10000404.2002.html>.

101. See, e.g., Sidney Ruth Schuler et al., *Paying for Reproductive Health Services in Bangladesh: Intersections Between Cost, Quality, and Culture*, 17 HEALTH POL'Y & PLAN. 273, 273-74 (2002) (describing USAID's role in supporting a consortium of NGOs in Bangladesh to provide health services).

102. USAID, REPORT TO CONGRESS: HEALTH-RELATED RESEARCH AND DEVELOPMENT ACTIVITIES AT USAID 26 (2005).

103. Foreign Operations, Export Financing, and Related Programs Appropriations Act, Pub. L. No. 106-429 § 596, 114 Stat. 1900A-1, A-61 (2001).

104. HUTTON, *supra* note 19, Summary.

105. Foreign Operations Act, *supra* note 103.

106. RESULTS, RESULTS SUCCESSES IN 2001: INTERNATIONAL ISSUES, <http://www.results.org/website/article.asp?id=341>.

107. HUTTON, *supra* note 19, § 3.3.3.

108. Department for International Development, About DFID: Who DFID Works With,

policy against official user fees and actively seeks to remove them, at least with respect to African nations. In October 2008, DFID stated that it has:

set out its commitment to help partner governments abolish user fees for basic health services, as part of our wider effort to support quality and equitable healthcare for all. We know that in many countries user fees, and other charges, mean poor people cannot afford to use clinics and hospitals when they get ill. This is slowing progress towards the Millennium Development Goals (MDGs).¹⁰⁹

3. G8 Policy Stance

The G8, an alliance of heads of state of major industrial democracies that has been meeting annually since 1975 to address economic and political issues, has similarly promoted the provision of free health services in those countries that *choose* to provide them. The G8 issued a statement in 2005 regarding fees for health services. It affirmed the core aims for health and education that are outlined in the U.N. Millennium Declaration, including reducing maternal mortality by three quarters by 2015.¹¹⁰ The G8 further noted:

We support our African partners' commitment to ensure that by 2015 all children have access to and complete free and compulsory primary education of good quality, and have access to basic health care (free wherever countries choose to provide this) to reduce mortality among those most at risk from dying from preventable causes, particularly women and children.¹¹¹

The G8's stance can be seen as an implicit recognition that free health care services are a social benefit and should be provided in those circumstances when countries choose to offer them. However, as this Article demonstrates, loan conditionality has made it difficult for developing countries to freely choose to provide health care services free of charge, even if they would like to do so. Indeed, bilateral donors continue to strongly influence the structure of health care financing schemes.

<http://www.dfid.gov.uk/aboutdfid/dfidwork/>.

109. Response on Oxfam's 'Make Free Public Health Care for All a Reality' Campaign, Department for International Development (October 2008), <http://www.dfid.gov.uk/news/files/campaign-responses/oxfam-public-health.asp> (commentary by Gillian Merron, Parliamentary under Secretary of State for International Development).

110. G7/G8 Summit Meetings, Gleneagles Official Documents, Africa Gleneagles, at ¶ 17 (July 8, 2005), available at <http://www.g7.utoronto.ca/summit/2005gleneagles/africa.html>. For a reference to the United Nations Millennium Declaration, see G.A. Res. [without reference to a Main Committee (A/55/L.2)], 55/2 (2000) [hereinafter United Nations Millennium Declaration].

111. *Id.*

4. NGOS

NGOs have largely denounced user fees as a barrier to access and advocate for their removal. In a recent report, Oxfam, Action Global Health, Medecins Du Monde, Save the Children, Plan, Global Health Advocates, Act UP Paris, and Save the Children UK state that user fees represent a failed financing mechanism. The report recommends supporting those countries seeking to abolish user fees to expand universal access.¹¹² A Joint Statement by the Global Health Working Group at the 2008 G8 Summit signed by organizations including SIDACTION, Action Canada for Population and Development, Treatment Action Campaign, the Center for Women's Global Leadership, Global Health Council, Physicians for Human Rights, Family Care International, and the Open Society Institute states that G8 countries should promote maximizing access, affordability, and availability of primary health care services, including the removal of user fees.¹¹³ ActionAid International has called for the end of user fees in a report "What Will it Take?" written as a call to action to governments participating in the United Nations High-Level Meeting on HIV and AIDS in 2006.¹¹⁴

III. USER FEES AND MATERNAL HEALTH

A. The Facts on Maternal Health in the Developing World

The aforementioned statistics on maternal death illustrate the grave challenges that must be met by the international community. The chart below¹¹⁵ presents the WHO's 2005 estimates of maternal mortality in different regions of the world. As the Chart demonstrates, developing countries bear a disproportionate burden of maternal deaths.

112. JOINT NGO BRIEFING PAPER, HEALTH INSURANCE IN LOW-INCOME COUNTRIES. (2008), available at http://www.oxfam.org.uk/resources/policy/health/downloads/bp112_health_insurance.pdf.

113. JOINT STATEMENT OF THE GLOBAL HEALTH WORKING GROUP, WE CAN NO LONGER WAIT JOINT STATEMENT BY THE GLOBAL CIVIL SOCIETY CONCERNING GLOBAL HEALTH (2008), available at <http://www.g8ngoforum.org/english/2008/06/joint-statement-global-health.html>.

114. ADITI SHARMA, ACTIONAID, WHAT WILL IT TAKE? (2006) available at http://www.actionaid.org.uk/doc_lib/236_1_what_will_it_take.pdf.

115. Chart originally printed in MATERNAL MORTALITY IN 2005, *supra* note 1, at 16. Reprinted with permission from the World Health Organization, this chart should not be reproduced for use in association with commercial nor promotional activities.

Table 2. Estimates of MMR, number of maternal deaths, lifetime risk, and range of uncertainty by United Nations MDG regions, 2005

Region	MMR (maternal deaths per 100 000 live births)*	Number of maternal deaths*	Lifetime risk of maternal death*: 1 in:	Range of uncertainty on MMR estimates	
				Lower estimate	Upper estimate
WORLD TOTAL	400	536 000	92	220	650
Developed regions**	9	960	7 300	8	17
Countries of the commonwealth of independent states (CIS)***	51	1 800	1 200	28	140
Developing regions	450	533 000	75	240	730
Africa	820	276 000	26	410	1 400
Northern Africa****	160	5 700	210	85	290
Sub-Saharan Africa	900	270 000	22	450	1 500
Asia	330	241 000	120	190	520
Eastern Asia	50	9 200	1 200	31	80
South Asia	490	188 000	61	290	750
South-Eastern Asia	300	35 000	130	160	550
Western Asia	160	8 300	170	62	340
Latin America and the Caribbean	130	15 000	290	61	230
Oceania	430	890	62	120	1 200

In many developing countries, pregnancy and childbirth health complications are a leading cause of death among women of reproductive age.¹¹⁶ The medical conditions contributing to maternal mortality include hemorrhage, obstructed labor, eclampsia, infection, and abortion.¹¹⁷ Accessible and adequate medical care, particularly in rural regions that have fewer maternal health services, can reduce maternal deaths. An estimated 74% of deaths could be prevented if women had access to the necessary medical interventions to address pregnancy and birth complications.¹¹⁸ In particular, essential obstetric care is one of the most critical interventions needed to save lives.¹¹⁹

User fees may be best understood not in the abstract, but by looking directly at their impact on individual women. Below are a few representative stories from different regions of the world:

116. UNITED NATIONS POPULATION FUND, MATERNAL MORTALITY UPDATE 2002, A FOCUS ON EMERGENCY OBSTETRIC CARE 5, available at http://www.unfpa.org/upload/lib_pub_file/201_filename_mmupdate-2002.pdf.

117. *Id.* at 6.

118. KAREN LASHMAN, CHILDREN'S DEFENSE FUND, ACCELERATING REDUCTIONS IN MATERNAL AND NEWBORN MORTALITY: CHALLENGES AND OPPORTUNITIES 1, available at http://cdf.childrensdefense.org/site/DocServer/Accelerating_Reductions_in_MNM.pdf?docID=2148.

119. A. WAGSTAFF & M. CLAESON, WORLD BANK, THE MILLENNIUM DEVELOPMENT GOALS FOR HEALTH: RISING TO THE CHALLENGES (2004).

- In the case of an obstetric emergency, it is often urgently necessary to transfer a woman to a health facility with more comprehensive medical care. The story of Amancio and his wife Francisca demonstrates the fatal effect of prohibitively costly transportation. Although Amancio took his wife to the local health center when she began experiencing labor pains, Francisca's severe case of eclampsia and subsequent stroke required an immediate transfer to a better-equipped hospital. Since the health center refused to pay for an ambulance, Amancio was forced to search for another form of transportation to take his wife to the hospital. He was unable to find any transport that was not prohibitively expensive, and Francisca passed away before the needed transfer could occur.¹²⁰ The refusal to pay for the ambulance as dictated by Peruvian law effectively constituted a user fee.
- In some cases, the imposition of user fees does not necessarily cause a fatal delay. Instead, women are systematically deprived of their basic rights as a result of failing to pay exorbitant fees for emergency obstetric care. Human Rights Watch has documented the practice of detaining women until they pay medical fees in a variety of health facilities in Burundi. Like many of the women who are detained, Agns I. delivered a baby by caesarean section. She was unable to pay a bill equivalent to \$235 and was effectively imprisoned at the Prince Louis Rwagasore Clinic. Agns was forced to stay in the clinic's lock-up for more than a month. She told human rights researchers, "I have tried to get the money together but I have not managed. I stay here, I cannot get out. I cannot even go out to dry the clothes I have washed." Like the other 20 women in the lock-up, Agns had been fruitlessly searching for a "benefactor" to pay her bill. In the meantime, she was simply locked in a small, dirty room with numerous other women and their infants, manned by security guards contracted privately by the hospital.¹²¹
- In the Indian province of Uttar Pradesh, the imposition of user fees to care for Rama Devi's daughter did not lead to a fatal delay but did impoverish the entire family.

120. ALICIA ELY YAMIN, *DEADLY DELAYS: MATERNAL MORTALITY IN PERU 92-94* (2007).

121. HUMAN RIGHTS WATCH, *A HIGH PRICE TO PAY: DETENTION OF POOR PATIENTS IN BURUNDIAN HOSPITALS* (2006), available at <http://www.hrw.org/en/node/11196/section/8>.

Rama's daughter-in-law had already died in childbirth because she could not access care in a timely manner. She describes how user fees can have a devastating effect on impoverished families even when there is access to health care:

[W]hen it was my daughter's delivery we took her straight away to a government hospital. There they asked us to pay Rupees 700 as something called User Fee before anyone touched her. We told them we were too poor to pay such a large amount, but no one listened to us. We ended up using our life's savings for what we thought would be free. We are so impoverished now there is not even money to buy milk for my grandchild.¹²²

B. User Fees: The Impact on Maternal Death

When women and their families confront user fees, they may delay seeking care or avoid care altogether for fear of the financial burdens these fees may impose.¹²³ User fees are often charged at the time services are rendered and, in certain circumstances, have inflexible payment systems, such as not allowing credit arrangements.¹²⁴ This payment structure leads to lower utilization of health care services and poorer health outcomes.¹²⁵ Certain women seeking reproductive health services are particularly at risk, as their ability to pay is also affected by power relationships in their household and their lower social status compared to men.¹²⁶

The adverse consequences of user fees on women are well-documented. In the Zaria district of Nigeria, hospital records show that in 1983, with obstetric care provided free of charge, hospital staff performed more than 6,000 deliveries, only two of which resulted in mortality.¹²⁷ By 1988, after the introduction and subsequent increases of user fees for obstetric care, general obstetric admissions and deliveries had fallen by more than half, and the incidence of maternal mortality had skyrocketed to sixty-two per year.¹²⁸ As the authors of the report noted, "[e]xempting pregnant women from user fees is *absolutely vital*."¹²⁹

The following examples highlight the detrimental effects that have

122. JAYEETA CHOWDHURY, ANALYSIS OF FACTORS INFLUENCING MATERNAL MORTALITY IN UTTAR PRADESH AND PAVING WAY FORWARD (2008), available at http://www.genevahealthforum.org/ghf08/files/presentations/Free%20Communications/F004-1_Chowdhury,%20J.pdf.

123. See SAVE THE CHILDREN, FREEING UP HEALTHCARE: A GUIDE TO REMOVING USER FEES 1, 2, 16-17, 33-40 (2008).

124. WITTER, *supra* note 37, at 10 (comparing formal user fee payment structure to the more flexible ones offered in Tanzania by traditional healers).

125. *Id.* at 7-17.

126. *Id.* at 11.

127. Kelsey A. Harrison, *Maternal Mortality in Nigeria: The Real Issues*, 1 AFR. J. REPROD. HEALTH 7 (1997), at 12.

128. *Id.*

129. *Id.*

been felt by expectant mothers across the globe as a result of the imposition of user fees:

- A 1996 study of user fees and exemptions in the Volta region of Ghana found that official exemptions from user fees were largely non-functional, with fewer than one in 1,000 patients granted exemptions.¹³⁰ Given the estimated 15 to 30% of the Volta region population that lives in poverty, the study found that the malfunctioning of exemptions effectively denied the poor access to health services.¹³¹ The study further found that a “sustainable inequity” had arisen in the region, in which fees generated some revenue to allow service provision to continue for some community members, while preventing others from accessing these services.¹³²
- Research into the effects of user fees and community-based insurance for health in Tanzania found that user fee revenues were not distributed across the population in a transparent way.¹³³ The revenue was placed in an account that predominantly benefited district hospitals’ supply purchases rather than community-level primary health centers’ supply purchases.¹³⁴ Poor community members failed to receive the user fee exemptions to which they were entitled and were often unable to pay community health insurance premiums.¹³⁵ The researchers concluded that user fees in Tanzania were regressive and contributed to the exclusion of the poor and vulnerable groups from basic health services, including pregnant women from poor households.¹³⁶ The fees may also impact poor households by forcing poor persons to resort to desperate measures, such as taking out loans, decreasing food consumption to save money, and selling necessary productive assets.¹³⁷
- A case study of user fees at a district hospital in Kirivong Operational District in Cambodia concluded that the imposition of user fees created a “medical poverty trap” that, in turn, could lead to greater morbidity, less access to care, unpredictable use of drugs, and impoverishment.

130. Frank Nyonator & Joseph Kutzin, *Health for Some? The Effects of User Fees in the Volta Region of Ghana*, 14 HEALTH POL’Y & PLAN. 329, 329 (1999).

131. *Id.*

132. *Id.*

133. Laterveer et al., *supra* note 89, at v.

134. *Id.* at 36.

135. *Id.* at 37.

136. *Id.* at vi.

137. *Id.* at 23.

Individuals fell prey to the “poverty trap” when, unable to afford public health care, they visited private practitioners. In response to the increased demand, the private practitioners increased their fees over time, with the price per treatment more than tripling from about six to twenty dollars. The private sector’s profiteering, combined with patients’ delay in seeking treatment, created a “trap” in which individuals sought public medical care only when they were really sick and therefore in need of more costly treatments.¹³⁸

In the deprived district of Koppal, India, the government’s failure to appropriately acknowledge and be accountable for gender bias has contributed to high maternal mortality.¹³⁹ Although the government has recommended that women deliver babies in public health facilities with trained health workers, it also charges women for ambulance transport.¹⁴⁰ The researchers in the Koppal, India study argue that the health system suffers from an inequitable structure and financing scheme that does not meet pregnant women’s needs and is in need of reform.¹⁴¹

IV. EFFICACY OF USER FEES: HAVE THEY MET THEIR INTENDED GOALS?

The stated goals of user fees are: 1) revenue generation; 2) increased efficiency; 3) better quality medical services; 4) promotion of equity; and 5) an administrative decentralization to provide a measure of accountability and a vehicle for community participation.¹⁴² Decades of experience with user fees in the field, however, demonstrate that user fees fall short of these intended goals.¹⁴³ Even for smaller, more discrete items like drugs and medical supplies, studies suggest that user fees do not meet their revenue-generating goals.¹⁴⁴

User fees suffer from the following weaknesses:

- Exemptions do not effectively reach those persons most in need;
- Users fees are ineffective as means of health system financing;
- They deter the poorest individuals, often those most in need of care, from accessing health services;

138. Bart Jacobs & Neil Price, *The Impact of the Introduction of User Fees at a District Hospital in Cambodia*, 19 HEALTH POL’Y & PLAN 310, 317 (2004).

139. Asha George et al., *Gendered Health Systems Biased Against Maternal Survival: Preliminary Findings from Koppal, Karnataka, India* 1 (Inst. Dev. Studs, Working Paper No. 253, 2005).

140. *Id.* at 24.

141. *Id.* at 36.

142. See, e.g., HUTTON, *supra* note 19, § 2.6.

143. ELDIS, *Experiences With User Fees for Health: A Quick Guide Through the Key Issues*, <http://www.eldis.org/index.cfm?objectId=23545ABB-F639-5CBF-CDB5E17EF62E5CE6> (last visited Jan. 11, 2009).

144. Brian Abel-Smith & Pankaj Rawall, *Can the Poor Afford “Free” Health Services? A Case Study of Tanzania*, 7 HEALTH POL’Y & PLAN. 329, 334 (1992); Nanda, *supra* note 22, at 129.

- They have not reduced the demand for services; and
- They have failed to galvanize community participation in health care financing.¹⁴⁵

A. Exemptions Have Not Reached Those in Most Critical Need

Many countries that have implemented user fees have tried to reduce their harmful effects on pregnant women by either eliminating fees for reproductive health care, while preserving them for other kinds of health care,¹⁴⁶ or exempting those who cannot afford the fees. These exemptions have largely failed.¹⁴⁷

First, the exemptions are not uniformly applied.¹⁴⁸ Some health care centers and administrators do know when to grant exemptions.¹⁴⁹ Others favor some members of the population over others, so exemptions are not necessarily distributed on the basis of ability to pay.¹⁵⁰ For example, studies have shown that since exemption processes are not routinely monitored, they are issued on a somewhat arbitrary, discretionary basis by healthcare workers.¹⁵¹

Even if exemptions were designed to be uniformly applied with explicit income cutoffs, many individuals would not qualify. This is in part because many developing countries have large informal sectors, with citizens who cannot provide official income documentation.¹⁵² It is difficult and unreliable to identify the very poor in economies with large informal employment sectors and/or a large number of subsistence farmers.¹⁵³ In addition, it can be expensive to collect up-to-date poverty statistics for communities with a small “cash economy” and many members who float in and out of designated poverty thresholds.¹⁵⁴ Means testing has been the most common form of establishing exemption thresholds, but the criteria used are typically vague, leaving an opening for administrative discretion

145. See ELDIS, *supra* note 143; Nanda, *supra* note 22, at 127.

146. See, e.g., SOPHIE WITTER ET AL., *The Experience of Ghana in Implementing a User Fee Exemption Policy to Provide Free Delivery Care*, 15 REPROD. HEALTH MATTERS 61, 62-63 (2007).

147. Nanda, *supra* note 22, at 131-32.

148. *Id.*

149. See Suneeta Sharma et al., *Formal and Informal Fees for Maternal Health Care – Health Care Services in Five Countries: Policies, Practices, and Perspectives* 21-24 (USAID, Policy Working Paper Series No. 16, 2005) (describing variation in health care providers’ knowledge of authorized health care charges).

150. Nanda, *supra* note 22, at 132 (“[T]he evidence suggests that exemptions are vulnerable to subjectivity and distortion.”). Indeed, as mentioned before, in a study of twenty-five African countries in the mid-1990s, only fifteen had user fee exemptions, and only one had clearly delineated income limits that qualified for the exemption. Witter, *supra* note 37, at 7.

151. Nanda, *supra* note 22, at 132.

152. WITTER, *supra* note 37, at 7.

153. ELDIS, Goal 3: Equity, <http://www.eldis.org/go/topics/resource-guides/health-systems/key-issues/user-fees/experiences/goal-3-equity> (last visited Jan. 11, 2009) (noting the challenges involved in identifying the poor).

154. CHER, *supra* note 27, at 8.

and corruption.¹⁵⁵

Governments designing exemptions in such economies are confronted with the choices of either using broad categories, and thereby allowing benefits to “leak” to others, or narrow categories, which are under-inclusive and fail to reach some individuals in critical need of an exemption.¹⁵⁶ If the criteria are too broad, the state’s limited financial resources may be channeled to members of the population who are not the most in need. If too narrow, inequalities in access to health care result, as some of the poorest citizens who are not able to qualify for exemptions do not receive medical care.

Furthermore, women in countries that either have free reproductive health care services or exemptions do not always know that they are eligible.¹⁵⁷ Staff members at health care centers and hospitals are often equally unaware of the fee exemptions. Moreover, women who mistakenly think that they will be charged for reproductive health care might avoid the health care facilities altogether,¹⁵⁸ even though the services there would be free.

In addition, the fear of social stigmatization is high, leading some individuals not to claim exemptions even if eligible.¹⁵⁹ A single mother of four in Tanzania explained, “[I]t was very difficult to get exemption because I had to kneel down before the ten cell leader [a local leader], village council, teachers, guardians in the family, and everybody I felt would sympathize with my problems . . . it cost me my dignity as a mother.”¹⁶⁰ These factors help explain why Ghana’s comprehensive fee exemption system led to fewer than *one in 1,000* patients actually receiving waivers.¹⁶¹

Ghana’s dysfunctional waiver system reflects another detrimental factor: disincentives to staff for granting exemptions. Because central government agencies do not adequately compensate facilities for waivers, health care centers that keep received user fees have a financial incentive to avoid exemptions.¹⁶²

Peru, where recent policy reforms aim to provide maternal health care for free, is a case in point.¹⁶³ According to the local law, districts where more than 65% of the population lives in poverty qualify for universal free coverage under the national insurance plan.¹⁶⁴ The law stipulates that free care includes “prenatal care, normal and high risk deliveries, transfers

155. *Id.* See also Nanda, *supra* note 22, at 132 (“[T]he evidence suggests that exemptions are vulnerable to subjectivity and distortion.”).

156. WITTER, *supra* note 37, at 7.

157. Nanda, *supra* note 22, at 132.

158. Sharma et al., *supra* note 139, at 39 (describing misconceptions among women about health care charges).

159. CHER, *supra* note 27, at 8.

160. *Id.* at 13.

161. Nyonator & Kutzin, *supra* note 130, at 329.

162. Tim Ensor & Jeptekeny Ronoh, *Effective Financing of Maternal Health Services: A Review of the Literature*, 75 HEALTH POL’Y 49, 56 (2005).

163. Sharma et al., *supra* note 149, at 12.

164. YAMIN, *supra* note 120, at 32.

during obstetric emergencies, coverage for costs related to funerals, care for 42 days after delivery, and care for various other health problems related to pregnancy.”¹⁶⁵ Health clinics often lack the resources to provide these services without charging users fees, however, and investigations have found that government reimbursements to health facilities that provide ostensibly free services only partially cover the costs of care.¹⁶⁶

B. User Fees Have Failed to Generate Significant Revenue

When health facilities lack the requisite revenue to operate, they are often constrained to the point that they begin to informally charge patients for care that should technically be free of charge.¹⁶⁷ The failure of user fee waivers to remedy a lack of revenue to support health care infrastructure raises the important question of how well user fees have performed as a means of mobilizing financial resources for medical care in the first place. Based on the evidence, they appear to have fallen well short of the goals set out by the World Bank at the inception of the Bamako Initiative. Save the Children reports that they have generated on average only 5 to 7% of recurrent budgets for health care.¹⁶⁸ Research in Tanzania found that user fee revenues were lower than projected, at around 0.6% of the overall health budget.¹⁶⁹ In Zimbabwe, the revenue generated from user fees from the mid-1980s to the early 1990s equaled only 1 to 2% of the Ministry of Health’s recurrent expenditure.¹⁷⁰ User fees have largely failed to meet set financing targets of 10 to 20% endorsed by the WHO and its counterparts in the 1990s.¹⁷¹ In some cases, user fees have replaced central government funding, resulting in no net gain in health care funding.¹⁷² In countries such as Ethiopia, Namibia, and Zimbabwe, user fee revenues were sent to the central treasury, while in others the central ministry has withdrawn funding under the belief that the decentralized fee collection systems should be sufficient.¹⁷³ There is some evidence that user fees have helped increase revenue for maintaining an adequate stock of drugs¹⁷⁴ or for

165. *Id.*

166. *Id.*

167. See, e.g., Evgenia Delcheva et al., *Under-the-Counter Payments for Health Care: Evidence from Bulgaria*, 42 HEALTH POL’Y 89 (1997) (noting that although informal payments for health services are widely regarded as a negative phenomenon, nearly 43% of patients in Bulgaria paid for services that were officially free).

168. WITTER, *supra* note 37, at 14.

169. LATERVEER ET AL., *supra* note 133, 36.

170. MEREDETH TURSHEN, PRIVATIZING HEALTH SERVICES IN AFRICA 35 (1999).

171. A. CREESE & J. KUTZIN, WHO, CAN USER FEES IMPROVE THE QUALITY OF HEALTH CARE IN DEVELOPING COUNTRIES? 8-12 (1995). *But see* LATERVEER ET AL., *supra* note 89 (noting that although statistics on user fee revenues in Tanzania are hard to generate, user fees comprise an estimated 10.5% of the budget of the district health care system).

172. ELDIS, Goal 6: Quality, <http://www.eldis.org/go/topics/resource-guides/health-systems/key-issues/user-fees/experiences/goal-6-quality> (last visited Jan. 11, 2009).

173. *Id.*

174. Walter Kipp et al., *User Fees, Health Staff Incentives, and Service Utilization in Kabarole District, Uganda*, 79 BULL. WORLD HEALTH ORG. 1032, 1035 (2001).

satisfying non-salary operating costs.¹⁷⁵ However, these costs typically account for less than 30% of total health sector costs.¹⁷⁶ Even where studies indicate that user fees have had a positive effect on expanding basic health care to the poor, the costs of collecting user fees – including staff time and material costs for issuing receipts, accounting, managing money, and banking – have received little attention.¹⁷⁷

C. User Fees Have Failed to Substantially Increase Efficiency

What about efficiency? Even if user fees do not provide significant revenues to health care facilities, they may plausibly affect demand in setting higher prices for higher levels of care. For example, user fees may provide incentives for women to seek treatment at primary care facilities instead of at hospitals, or to opt for natural delivery instead of cesarean section. But in practice, few user fee schemes penalize patients for receiving higher levels of care than necessary.¹⁷⁸

More importantly for the purpose of lowering maternal mortality, the type of frivolous treatment that cost-sharing addresses in health care systems of affluent countries simply does not apply in the context of developing countries. Women who die of pregnancy complications in developing countries face highly limited choices in the type of care, if any, that they will receive. The deterrent effect of user fees more often leads these women to under-utilize health services, which in turn leads to increases in surgical intervention and curative services, as the data from Nigeria and many other countries demonstrate.¹⁷⁹

D. There is No Consensus on Whether User Fees Have Increased Quality

There is some evidence that where services are available, charging modest fees increases quality. For example, after user fees were instituted in Niger, primary care services increased in number and quality, and drug availability increased.¹⁸⁰ In Zambia, user fees appear to have enabled local primary care facilities to offer some services formerly available only at hospitals.¹⁸¹

175. Nyongator, *supra* note 167, at 329.

176. D. Arhin-Tenkorang, *Mobilizing Resources for Health: The Case for User Fees Revisited*, 13 (World Health Org. Commission on Macroeconomics & Health, Working Paper No. WG3, 2000).

177. See CREESE, *supra* note 171, at 20-21 (discussing difficulty of managing user fees).

178. ELDIS, Goal 2: Efficiency, <http://www.eldis.org/go/topics/resource-guides/health-systems/key-issues/user-fees/experiences/goal-2-efficiency> (last visited Jan. 12, 2009).

179. Harrison, *supra* note 127, at ¶ 4.4.

180. ELDIS, Goal 4, <http://www.eldis.org/index.cfm?objectId=E78EBC75-0648-3F4F-AC171C122D244B52> (citing F.D. Dion, *Assessment of Niger's National Cost Recovery Policy Implementation in the Primary Health Care Sector* x-xii (Partnerships for Health Reform, Technical Paper No. 6, 1996).

181. *Id.*

But other evidence contradicts these findings. In Uganda, the *abolition* of user fees for primary care services was found to improve access to quality services for the poor.¹⁸² Indeed, there was increased demand for health services, as outpatient attendances increased by 155% and immunization rates increased from 48 to 89%.¹⁸³ The World Bank found that the abolition of user fees in particular was a benefit to poor persons. For adults, almost half the total benefit accrued to the bottom quintile, and more than two thirds of the benefits benefited those in the bottom two quintiles.¹⁸⁴

Local control of revenues is a significant factor in determining the efficacy of user fees.¹⁸⁵ In some countries, however, user fees simply replace central government funding.¹⁸⁶ As a result, user fees mask the poor performance of states in fulfilling their duty to promote their citizens' right to health "by all appropriate means."¹⁸⁷

E. User Fees Have Not Increased Equity in Access to Health Care

Given the failure of exemptions systems to properly function for the poor, studies have concluded that the overall utilization of health services decreases by up to 40 to 50% where user fees are in place.¹⁸⁸ This decrease is not in "frivolous" services, one of the intended goals of imposing user fees. Rather, the very poor and those in remote areas tend to reduce their consumption of all health services, including those that are critically needed.¹⁸⁹ A Save the Children study in Burundi found that when user fees were the primary health-financing system, the rates of non-consultation were significantly higher in poor groups, at 13%, than they were in wealthier groups, at 6%.¹⁹⁰ Further, in countries such as Tanzania, sick individuals increasingly resorted to traditional healers, who charged for services but often offered cheaper fees and more flexible payment systems, including payment in kind and credit arrangements.¹⁹¹

Those who are poor and live in remote regions will decrease their use of health care more than the wealthy since their demand for health is more

182. Klaus Deininger & Paul Mpuga, *Economic and Welfare Impact of the Abolition of Health User fees: Evidence from Uganda*, 14 J. AFR. ECON. 1, 55-91 (2005) (looking at Uganda household data for the years 1999-2000 and 2002-2003, both before and after user fees were eliminated and concluding that access and health outcomes were better after user fees were eliminated but that these improvements could be overshadowed by declining quality of health care if adequate investments are not made in the health care system).

183. ROB YATES, DFID HEALTH RESOURCE CENTER, INTERNATIONAL EXPERIENCES IN REMOVING USER FEES FOR HEALTH SERVICES – IMPLICATIONS FOR MOZAMBIQUE 9 (2006) www.dfidhealthrc.org/publications/health_sector_financing/06Yates01.pdf.

184. *Id.* at 11.

185. Kipp, *supra* note 174, at 1033.

186. ELDIS, *supra* note 172.

187. ICESCR, *supra* note 24, art. 2.

188. WITTER, *supra* note 37, at 1.

189. See FREEING UP HEALTHCARE, *supra* note 123, at 1-4.

190. WITTER, *supra* note 37, at 10.

191. *Id.*

elastic than that of the rich.¹⁹² One study on user fees identified the following factors, in addition to poverty and geographic disadvantage, that contribute to this greater elasticity of demand: uncertainty of medical service prices, great indirect costs including costs to access health facilities, and seasonal variation in ability to pay.¹⁹³ Individuals may delay in seeking care, attempt to self-medicate, or resort to alternative methods of care like traditional medicine instead of seeking professional medical care, even in the face of serious illness. The net result is that user fees dissuade the use of health care services by economically and geographically disadvantaged members of the population, thereby failing to promote equity in access to health care.

F. User Fees Have Not Successfully Decentralized Administration of Health Care

While the goals of administrative decentralization, which include increased accountability and community participation in health care decision, are laudable, the experience of user fees points to their failure in meeting this goal in many countries. In Uganda, a decentralized administration has not led to increased accountability because in practice management structures at the local level have been unclear, accounting procedures for collecting and redistributing revenues have been weak, and guidelines for health center operational and financial administration have been largely absent.¹⁹⁴ Furthermore, when management structures are weak, they are often also inefficient. This results in high transaction costs, with funds that could otherwise be directed to health services and goods being spent on administrative costs.¹⁹⁵

V. USER FEES' IMPACT ON MATERNAL HEALTH: A HUMAN RIGHTS ANALYSIS

The prior section highlighted how user fees have fallen far short of the economic and structural goals that served as a basis for their implementation. Despite these failures, they remain in place in many states in the developing world. How can their continued use be reconciled with these states' obligations under international human rights law? What do the relevant treaties and conventions advise regarding governments' health care policy and planning, and user fees more specifically?

192. *Id.* at 11.

193. *Id.* at 9-10.

194. *Id.*

195. MARK PEARSON, DFID HEALTH SYSTEMS RESOURCE CENTRE, ISSUES PAPER: THE CASE FOR ABOLITION OF USER FEES FOR PRIMARY HEALTH SERVICES 16 (2004), <http://www.eldis.org/fulltext/persaon2004.pdf>.

Recognition of maternal death as a human rights issue has grown.¹⁹⁶ Maternal death is not only a “health disadvantage,” it is a “social disadvantage.”¹⁹⁷ Maternal death functions as a powerful sign of the social and economic disparities and inequities between men and women in many societies. Roughly 70% of the world’s poor are women.¹⁹⁸ In many developing countries, women use health care more frequently than men.¹⁹⁹ Reproductive health care services constitute the largest component of that care.²⁰⁰ In comparison to men, many women have reduced access to basic health and nutrition services.²⁰¹ Furthermore, among the overall population of women, maternal death disproportionately affects women who are poor, located in remote regions, or belong to ethnic, cultural, or religious minority groups.²⁰²

Studying user fees from within a human rights framework allows us to more clearly understand how states fail to respect, protect, and fulfill legally binding obligations to women who are pregnant or of reproductive age. This understanding provides a basis for further advocacy to eliminate user fees and bring states into compliance with the Millennium Development Goals. Furthermore, a human rights framework provides the opportunity for increased enforcement of those rights on both an international and domestic level, even though such enforcement currently remains in its early stages.

A. Human Rights: A Legal Basis

Human rights are codified in international conventions and treaties. Relevant international treaties include the International Covenant on Civil and Political Rights (ICCPR),²⁰³ the International Covenant on Economic, Social and Cultural Rights (ICESCR),²⁰⁴ the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW),²⁰⁵ the Convention on the Elimination of All Forms of Racial Discrimination

196. See, e.g., R. COOK ET AL., WHO, ADVANCING SAFE MOTHERHOOD THROUGH HUMAN RIGHTS (2001) (setting out one of the first comprehensive evaluations of maternal mortality within a human rights framework).

197. WHO, REDUCTION OF MATERNAL MORTALITY 2 (1999), http://www.who.int/reproductive-health/publications/reduction_of_maternal_mortality/e_rmm.pdf.

198. See, e.g., Nanda, *supra* note 22, at 128.

199. J. Nabyonga et al., *Abolition of Cost-Sharing is Pro-Poor: Evidence from Uganda*, 20 HEALTH POL’Y & PLAN. 100, 100 (2005).

200. Nanda, *supra* note 22, at 128.

201. *Id.*

202. Tricia McCarter-Joseph, *High Maternal Death Rates Among Minority Women*, 97 J. NAT’L MED. ASS’N 1443, 1443 (2005), available at <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2594695>.

203. International Covenant on Civil and Political Rights (ICCPR), Dec. 16, 1966, 999 U.N.T.S. 171.

204. ICESCR, *supra* note 24.

205. Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Dec. 18, 1979, 1249 U.N.T.S. 13.

(CERD),²⁰⁶ and the Convention on the Rights of the Child (CRC).²⁰⁷ Additionally, regional treaties often reinforce the rights protected in international treaties; for example, both the African Charter on Human and People's Rights²⁰⁸ and the Protocol of San Salvador codify many of the relevant human rights principles.²⁰⁹ Taken together, these treaties represent binding international law which can be used to address the issue of maternal mortality and the impact of user fees.

Because human rights are codified in binding international treaties, governments that ratify them are obligated to ensure that their laws and policies are in conformity with those rights.²¹⁰ By becoming a party or signatory to an international treaty, a state assumes the obligation to respect, protect and fulfill the human rights detailed therein.²¹¹ Governments commit to enact appropriate domestic legislation and take other necessary actions to ensure they fulfill their treaty obligations.²¹² Most developing countries have committed to at least one of the key human rights treaties that provide for the rights to health, life and non-discrimination.²¹³ Overall, there are 153 state parties to the ICESCR, 156 state parties to the ICCPR, 183 state parties to CEDAW, and 192 state parties to the CRC.²¹⁴ In particular, the high number of signatories to CEDAW should be noted, since that convention most specifically codifies the human rights related to maternal mortality.²¹⁵

Within the U.N. treaty system, State parties typically submit periodic reports to a treaty body committee, which reviews the periodic report to ensure that the state is in compliance with the treaty's binding legal

206. Convention on the Elimination of All Forms of Racial Discrimination (CERD), Dec. 21, 1965, 660 U.N.T.S. 195.

207. Convention on the Rights of the Child (CRC), Nov. 20, 1989, 1577 U.N.T.S. 3. It should also be noted that since adolescent pregnancy is prevalent worldwide, many young mothers fall within the scope of CRC.

208. Banjul [African] Charter on Human and Peoples' Rights, *adopted* June 27, 1981, 21 I.L.M. 58 (*entered into force* Oct. 21, 1986).

209. Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, "Protocol of San Salvador," O.A.S.T.S. No. 69 (*entered into force* Nov. 16, 1999).

210. United Nations Office of the High Commissioner for Human Rights, International Human Rights Law, <http://www.ohchr.org/EN/ProfessionalInterest/Pages/InternationalLaw.aspx> ("International human rights law lays down obligations which States are bound to respect.").

211. *Id.* ("The obligation to respect means that States must refrain from interfering with or curtailing the enjoyment of human rights. The obligation to protect requires States to protect individuals and groups against human rights abuses. The obligation to fulfill means that States must take positive action to facilitate the enjoyment of basic human rights.").

212. *Id.*

213. For a full listing of the relevant human rights treaties and their respective ratifications, see U.N. Office of the High Commissioner for Human Rights, Treaty Body Database, <http://www.unhcr.ch/tbs/doc.nsf>.

214. OFFICE OF THE U.N. HIGH COMMISSIONER FOR HUMAN RIGHTS, STATUS OF RATIFICATIONS OF THE PRINCIPAL INTERNATIONAL HUMAN RIGHTS TREATIES 12 (2006), <http://www2.ohchr.org/english/bodies/docs/RatificationStatus.pdf>.

215. The countries which have not signed CEDAW are extremely limited, including only the following: the Cook Islands, the Holy See, Iran, Nauru, Niue, Palau, Qatar, Somalia, Sudan, and Tonga. See *id.* at 2-12.

obligations.²¹⁶ More specifically, CEDAW Committee monitors compliance with CEDAW, the Committee on Economic, Social and Cultural Rights monitors compliance with the ICESCR, and the Human Rights Committee (HRC) monitors compliance with the ICCPR. As discussed below, these committees monitor state efforts to reduce maternal mortality and have voiced concern regarding the prevalence of user fees in developing countries.

When a state party does not adhere to its obligations, most treaty bodies have few concrete enforcement mechanisms with which to mandate compliance; the onus falls on the state to ensure compliance.²¹⁷ Somewhat limited compliance mechanisms do exist, however, in the form of optional protocols to some of the U.N. treaties. Both the ICCPR and CEDAW treaties have optional protocols which have been signed and ratified by numerous states.²¹⁸ Both of these optional protocols set out a complaint process through which individuals who have exhausted domestic judicial remedies may sue to protect their rights under the ICCPR and CEDAW, respectively.²¹⁹ An optional protocol to the ICESCR is also now open for signature, promising the expansion of opportunities for the enforcement of the right to health in the states which ratify the protocol. The CEDAW Committee has heard a variety of cases involving discrimination against women. More specifically, the decision in *A.S. v. Hungary* demonstrates the justiciability of the right to health, ruling that the coercive sterilization of a Roma woman in Hungary violated her right to health as protected under Article 12 of CEDAW.²²⁰ There is also a case currently pending before the CEDAW Committee arguing that Brazil has not met its treaty obligations with respect to reducing cases of preventable maternal mortality.²²¹ The increased focus on international cases designed to enforce the right to health and the right to non-discrimination can lay the groundwork for changes in national public health systems. Furthermore, these international cases can theoretically set the stage for domestic enforcement of international human rights law.

216. Office of the U.N. High Commissioner for Human Rights, Human Rights Bodies, <http://www.ohchr.org/EN/HRBodies/Pages/HumanRightsBodies.aspx>.

217. See, e.g., Terry Collingsworth, *The Key Human Rights Challenge: Developing Enforcement Mechanisms*, 15 HARV. HUM. RTS. J. 2 (2002).

218. Optional Protocol to the Convention on the Elimination of Discrimination Against Women, G.A. Res. A/54/4, U.N. Doc. A/54/59 (Oct. 6, 1999) [hereinafter CEDAW Optional Protocol]. Seventy-nine countries are signatories to the CEDAW Optional Protocol and 105 countries are signatories to the ICCPR Optional Protocol. Office of the U.N. High Commissioner for Human Rights, *supra* note 214.

219. CEDAW Optional Protocol, *supra* note 218.

220. Committee on the Elimination of Discrimination Against Women, *Views of the Committee on the Elimination of Discrimination Against Women under Article 7, Paragraph 3, of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women*, 18, U.N. Doc. CEDAW/C/36/D/4/2004 (Feb. 12, 2004).

221. Center for Reproductive Rights, *Center Challenges Brazil's Record on Maternal Mortality* (Dec. 7, 2007), <http://reproductiverights.org/en/press-room/center-challenges-brazils-record-on-maternal-mortality> (last visited Feb. 26, 2009).

There are also critical, albeit non-binding, international consensus documents related to maternal mortality. The Programme of Action resulting from the International Conference on Population and Development (Cairo Programme of Action) was signed by numerous countries. The Cairo Programme of Action provides a key working definition of reproductive health; it also builds on the principles found in international treaties, stating that “reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to ... the right to attain the highest standard of sexual and reproductive health.”²²² The five-year review document on the Cairo Programme of Action focuses on maternal mortality, stating that governments must:

Ensure that the reduction of maternal morbidity and mortality is a health sector priority and that women have ready access to essential obstetric care, well-equipped and adequately staffed maternal healthcare services, skilled attendance at delivery, emergency obstetric care, effective referral and transport to higher levels of care when necessary, post-partum care and family planning. In health sector reform, the reduction of maternal mortality and morbidity should be prominent and used as an indicator for the success of such reform.²²³

The Millennium Development Goals have also provided a rallying point for the reduction of maternal mortality.²²⁴ Within the U.N. system, the recommendations of the Special Rapporteur on the right to health have recently focused on the issue of maternal mortality, providing more interpretive guidance relating to the right codified in international law.²²⁵

The combination of international law standards and growing international consensus is important not only because it requires states to act in certain ways, but also because it implicates donors and international lending institutions. Under international law, all states are obligated to work toward the full realization of the right to health, including through the provision of international assistance to other states.²²⁶ “Depending on the availability of resources, States should facilitate access to essential

222. International Conference on Population and Development, *Cairo Programme of Action (Cairo Consensus)*, ¶ 7.3, U.N. Doc. A/Conf.171/13/Rev.1 (Oct. 18, 1994), available at <http://www.un.org/popin/icpd/conference/offeng/poa.html>.

223. *Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development*, ¶ 62(b), U.N. Doc. A/RES/S-21/2 (Nov. 8, 1999).

224. See UNDP Goal 5 Report, *supra* note 3.

225. The Special Rapporteur, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶ 7-36, delivered to the General Assembly, U.N. Doc. A/61/338 (Sept. 13, 2006).

226. U.N. Committee on Economic, Social and Cultural Rights, Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights, General Comment No. 14, ¶ 38, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter General Comment 14].

health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required.”²²⁷ Additionally, the U.N. Special Rapporteur on the Right to Health argues that “developed states should ensure that their international development assistance, and other policies, support health systems’ strengthening and other relevant policies in developing countries.”²²⁸

Maternal mortality and maternal health are connected to numerous human rights, including the fundamental rights to health, life, and non-discrimination. The following analysis defines these human rights and then assesses how state parties and international lending institutions that mandate the imposition of user fees fall short of meeting the relevant obligations.

B. The Right to Health

The right to health is protected by numerous international legal instruments. In accordance with Article 12.1 of the ICESCR, state parties recognize “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”²²⁹ Additionally, Article 12.1(d) requires “[t]he creation of conditions which would assure to all medical service and medical attention in the event of sickness.”²³⁰ Article 10(2) specifically adds that “[s]pecial protection should be accorded to mothers during a reasonable period before and after childbirth.”²³¹ CEDAW explicitly provides for the right to certain critical health services for pregnant women, emphasizing that these services shall be “free . . . where necessary.”²³² Under CEDAW Article 12(2), governments must provide access to “appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.”²³³ In addition to this provision touching on user fees, the CEDAW Committee has noted that some women lack the funds to receive care, and hence it becomes the “duty of States parties to ensure women’s right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources.”²³⁴ Beyond these two core treaties, the Universal Declaration of Human Rights (UDHR),²³⁵ the Convention on

227. *Id.* ¶ 39.

228. Report of the Special Rapporteur, *supra* note 225.

229. ICESCR, *supra* note 24, art. 12.

230. *Id.* art. 12(d).

231. *Id.* art. 10(2).

232. CEDAW, *supra* note 205, art. 12.

233. *Id.* art. 12(2).

234. CEDAW Committee, *General Recommendation No. 24: Art. 12 of CEDAW – Women and Health*, ¶ 27, U.N. Doc. A/54/38/Rev.1 (Aug. 20, 1999) [hereinafter *General Recommendation No. 24*].

235. Universal Declaration of Human Rights, art. 25, U.N. Doc. A/810 (Dec. 10, 1948) (noting that “[e]veryone has the right to a standard of living adequate for the health . . . of himself and of his family, including food, clothing, housing and medical care and necessary

the Rights of the Child (CRC),²³⁶ the Protocol of San Salvador,²³⁷ and the African Charter²³⁸ also obligate governments to protect maternal health.²³⁹ All of these treaties are binding on their signatories but, as mentioned before, the treaty bodies that monitor states' compliance with these mandates generally lack efficient enforcement mechanisms.²⁴⁰

It is also important to keep in mind that the right to health fundamentally implicates the attainment of other human rights. When user fees interfere with the fulfillment of the right to health, they necessarily implicate other human rights.

Overall, States must respect, protect and fulfill the right to health.²⁴¹ The U.N. CEDAW Committee stipulates that to fulfill their obligation to respect the right to health, states must refrain from interfering directly or indirectly with the right to health:

For example, States parties should not restrict women's access to health services or to the clinics that provide those services on the ground that women do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried or because they are women. Other barriers to women's access to appropriate health care include laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures.²⁴²

Beyond refraining from interfering with the right to health, states must take appropriate measures to fully realize this right.²⁴³ To this end, states must take positive actions through legislation, policies, and administrative measures.²⁴⁴ However, subsequent interpretive guidelines, such as the Limburg Principles, make clear that "under no circumstances shall [the principle of progressive realization] be interpreted as implying for States the right to defer indefinitely efforts to ensure full realization."²⁴⁵

social services").

236. CRC, *supra* note 207, art. 24 (recognizing the "right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health").

237. Organization of American States, Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights: Protocol of San Salvador, arts. 10 and 15., Nov. 17, 1988, O.A.S.T.S. No. 69.

238. Banjul [African] Charter on Human and Peoples' Rights, *supra* note 208, art. 16.

239. African Charter on the Rights and Welfare of the Child, art. 14, OAU Doc. CAB/LEG/24.9/49 (1990) ("Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.").

240. *See, e.g.*, Collingsworth, *supra* note 217.

241. General Comment 14, *supra* note 226, ¶ 33.

242. General Recommendation 24, *supra* note 234, ¶ 14.

243. General Comment 14, *supra* note 226, ¶ 33. *See also* General Recommendation No. 24, *supra* note 234, ¶ 14-17.

244. ICESCR, *supra* note 24, art. 2(1).

245. The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, ¶ 21, U.N. Doc. E/CN.4/1987/17/Annex (1987), reprinted in *The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights*, 9 HUM. RTS. Q. 122, 125 (1987). *See also* *The Maastricht*

In meeting their international obligations for the attainment of the right to health, states parties have certain critical obligations which take immediate effect and others that may be progressively realized over time.²⁴⁶ The U.N. Committee on Economic, Social and Cultural Rights (CESCR) has issued General Comment 14 to provide an authoritative interpretation of ICESCR Article 12. Under General Comment 14, states have an immediate obligation to guarantee that the right to health will be exercised in a non-discriminatory manner.²⁴⁷ States also have a core obligation to ensure minimum essential levels of the right to health; this means that states have a duty to guarantee essential primary health care, including maternal health care.²⁴⁸

At the same time, the CESCR recognizes that State parties may not immediately be able to fully meet “the highest attainable standard of physical and mental health.” Hence, the General Comment 14 directs governments to take “deliberate, concrete, and targeted” steps towards the “full realization of the right to health” under Article 12, and that they must do so to maximize the utilization of available resources.²⁴⁹ If resources are limited, states are expected to prioritize key interventions first, including those that will guarantee maternal health.²⁵⁰ Additionally, the obligation “requires States parties to move as expeditiously as possible towards the realization of the rights. . . . [A]ll states parties have the obligation to begin immediately to take steps to fulfill their obligations under the Covenant.”²⁵¹

C. Elements of the Right to Health

The right to health incorporates four interrelated and essential

Guidelines on Violations of Economic, Social and Cultural Rights, ¶¶ 8, 20 HUM. RTS. Q. 691, 694-95 (1998) (echoing this sentiment and establishing that the state bears the burden of proof to demonstrate measurable progress toward the realization of the given right).

246. See General Comment 14, *supra* note 226, ¶ 30.

247. *Id.*

248. *Id.* ¶ 43. Additionally, the Committee on the Elimination of Discrimination against Women emphasizes state obligations “to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care.” *General Recommendation 24*, *supra* note 234, ¶ 17.

249. General Comment 14, *supra* note 226, ¶ 30. “[P]rogressive realization means that States are expected to do better next year than they are doing today, while resource availability acknowledges that what is required of a rich country is of a higher standard than what is required of a low- or middle-income country.” The Special Rapporteur, *Report Of The Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, delivered to the Human Rights Council, A/HRC/4/28 (Jan. 17, 2007).

250. United Nations Population Fund (UNFPA), STATE OF THE WORLD POPULATION 2004: MATERNAL HEALTH, <http://www.unfpa.org/swp/2004/english/ch7/index.htm> (noting that the U.N. Millennium Summit in 2000 “identified maternal health as an urgent priority in the fight against poverty”).

251. The Limburg Principles, *supra* note 245.

elements: availability, accessibility, acceptability, and quality.²⁵²

1. Availability

States must ensure that an adequate supply of goods, services, and facilities are available for maternal health.²⁵³ For example, this includes ensuring an adequate supply of maternity-related health care services and health professionals. The ICESCR has noted that the “precise . . . services will vary depending on numerous factors, including the State party’s development level.”²⁵⁴ However, the services will include basic “determinants of health, such as . . . health related buildings, trained medical personnel...and essential drugs.”²⁵⁵

2. Accessibility

Several components contribute to making health care services “accessible.” First, health services must be physically accessible.²⁵⁶ Physical access to health services is often a key determinant in women’s decisions about whether or not to seek care.²⁵⁷ Significant geographical barriers impede many women’s access to maternal health services.²⁵⁸ Faced with potentially life-threatening medical conditions, these women may not receive care because the time and distance to nearby medical facilities are simply too great.²⁵⁹ Furthermore, the greater the physical distance of health care services from their home, the greater the costs of transportation and food to seek care. Particularly in rural areas, the high cost of transportation acts as an informal cost barrier, thereby discouraging women from seeking necessary obstetric care.²⁶⁰ In many countries, reducing maternal mortality will depend on making relevant services more physically accessible, particularly to women in underserved areas.

Second, health services must be economically accessible and any payments for health services should be equitable. According to the CESCR:

[P]ayment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or

252. General Comment No. 14, *supra* note 226, ¶ 12.

253. *Id.* ¶ 12(a).

254. *Id.*

255. *Id.*

256. *Id.* ¶ 12(b).

257. *See, e.g.,* KIRSTAN HAWKINS ET AL., DFID, DEVELOPING A HUMAN RIGHTS-BASED APPROACH TO ADDRESSING MATERNAL MORTALITY 20 (2005), http://www.hurilink.org/tools/Developing_aHRBA_to_Maternal_Mortality--DFID.pdf.

258. *Id.* at 20. *See also* World Bank, *Maternal Mortality and Morbidity*, <http://go.worldbank.org/6PFOLE29Q0>.

259. HAWKINS, *supra* note 257, at 20.

260. *Id.*

publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.”²⁶¹

Accessibility also implicates other aspects of the right to health, including non-discrimination and equal treatment in access to care. Discriminatory social norms can lead to unequal access.²⁶² In particular, discrimination against women and barriers to accessing health services including limited education and information can impact the realization of the right to health and contribute to greater inequality.²⁶³ In order to remedy inequalities in access to care, governments must address discriminatory laws, policies, and practices in health care and in society that prevent women from accessing maternal health services.²⁶⁴

Article 12 of the ICESCR guarantees information accessibility, which includes “the right to seek, receive and impart information and ideas concerning health issues.”²⁶⁵ Laws or policies that restrict women’s access to appropriate reproductive health services can lead to maternal mortality.²⁶⁶

3. Acceptability

In the context of maternal mortality, acceptability generally addresses issues of cultural sensitivity to maternal health concerns. Preventing maternal mortality and enhancing access to maternal health care is not simply a matter of scaling up technical interventions or making those interventions more affordable. Also important are strategies to ensure that the services, including childbirth practices, are sensitive to the cultures and requirements of all women, including those from indigenous populations and other minority groups.²⁶⁷

261. General Comment 14, *supra* note 226, ¶ 12(b).

262. *Id.* ¶ 18.

263. *Id.* ¶ 21.

264. WHO, MAKING A DIFFERENCE IN COUNTRIES: STRATEGIC APPROACH TO IMPROVING MATERNAL AND NEWBORN SURVIVAL AND HEALTH 21 (2006).

265. General Comment 14, *supra* note 226, ¶ 12(b)(iv).

266. General Recommendation 24, *supra* note 235, ¶ 17 (“Studies such as those which emphasize the high maternal mortality and morbidity rates worldwide and the large numbers of couples who would like to limit their family size but lack access to or do not use any form of contraception provide an important indication for State parties of possible breaches of their duties to ensure women’s access to health care.”). *See also* Kathleen Henry Shears, *Increasing Contraception Reduces Abortion: Complex Relationship Between Contraception and Induced Abortion Grows Clearer*, 21 NETWORK 4 (2002).

267. *See* General Comment 14, *supra* note 226, ¶ 12(c) (“All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.”).

Addressing cultural sensitivity can advance development indicators. In Guatemala, a country with one of the highest maternal mortality ratios in Latin America, the United Nations Population Fund (UNFPA) helped forge a cultural dialogue that included the Catholic Church, evangelical denominations, professional associations, trade unions, and business leaders.²⁶⁸ These parties formed an alliance that urged the enactment of a law promoting better health for women and their families.²⁶⁹

4. Quality

The quality of care influences the outcome of interventions. Without quality care, women who seek medical treatment will still confront great risk of death or disability.²⁷⁰ The right to health includes an entitlement to maternal health care services that are medically appropriate and of good quality.²⁷¹ Quality care requires “skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.”²⁷²

D. User Fees: A Violation of the Right to Health

User fees have not helped to attain the aforementioned components of the right to health. In fact, user fees have clearly hindered the attainment of the right to health in certain situations, particularly in terms of accessibility. First, they have not increased availability of health services for women. User fees were implemented in many countries with the explicit aim of raising money for the health care sector and thereby increasing the amount of health care services available to citizens.²⁷³ Despite being instituted as a form of public-sector health care financing, user fees have fallen far short of their goals of fundraising, bringing in an average of 5 to 10% of funds for health care budgets.²⁷⁴ The imposition of user fees has not substantially contributed to increasing availability via the construction of new health care facilities or the training and hiring of qualified medical professionals.²⁷⁵

Next, user fees have failed to make health care more accessible to

268. Press Release, United Nations Population Fund (UNFPA), Cultural Sensitivity Key to Development, New UNFPA Report Shows, U.N. Doc. POP/904 (May 18, 2004), available at <http://www.un.org/news/Press/docs/2004/pop904.doc.htm>.

269. *Id.*

270. WHO, *Making Pregnancy Safer*, http://www.who.int/making_pregnancy_safer/topics/maternal_mortality/en/index.html (last visited Feb. 26, 2009) (“There are many reasons why women do not receive the care they need before, during and after childbirth. In some remote areas, there may be no availability of professional care. Or, if available, the care may not be good.”).

271. Paul Hunt & Judith Mesquita, *Mental Disabilities and the Human Right to the Highest Attainable Standard of Health*, 28 HUM. RTS. Q. 332, 345 (2006).

272. General Comment 14, *supra* note 226, ¶ 12(d).

273. WITTER, *supra* note 37, at 1.

274. *Id.*

275. See *supra* notes 174-183 and accompanying text.

women. User fees have, in fact, interfered with the right to health by making key interventions less accessible. Exemptions have not increased access, as they are often unevenly or unfairly applied in developing countries, thereby failing to reach the poorest members of the population.²⁷⁶ User fees have also not addressed cultural and physical barriers to minority women's accessing health care. Those who are disadvantaged and in remote regions have the most elastic demand for health services and therefore decrease their use of health care more than the wealthy when user fees are instituted.²⁷⁷ The U.N. CEDAW Committee has expressed its concern over the intersection of user fees and decreased access to care. For example, in the concluding observations regarding China, the Committee expressed its concern regarding the rising costs of health care and user fees which limited the access of rural women to health services.²⁷⁸ Similar statements have been made, for example, in relation to Tanzania,²⁷⁹ Cape Verde,²⁸⁰ Kenya,²⁸¹ and Slovakia.²⁸²

Lastly, user fees have not significantly improved the quality of health care available to women.²⁸³ Where improvements have been made, in some instances the central government has replaced its funding of public health with the user fee revenue,²⁸⁴ resulting in no net improvement in quality of care.

E. The Right to Life

User fees also raise questions implicating the right to life. Under the ICCPR, "[e]very human being has the inherent right to life. . . . No one shall be arbitrarily deprived of his life."²⁸⁵ The right to life can be broadly understood as a government's obligation to ensure that those within its jurisdiction are secure from arbitrary and preventable loss of life. The HRC has explicitly acknowledged that states are not free to restrictively interpret the implementation of the right to life and must adopt positive measures to

276. See *supra* notes 153-171 and accompanying text.

277. WITTER, *supra* note 37, at 1.

278. CEDAW Committee, *Concluding Comments of the Committee on the Elimination of Discrimination Against Women: China*, ¶ 27, U.N. Doc. CEDAW/C/CHN/CO/6 (2006).

279. Committee on the Rights of the Child, *Concluding Comments of the Committee on the Rights of the Child: Tanzania*, ¶ 46, U.N. Doc. CRC/C/15/Add.156 (2001).

280. CEDAW Committee, *Concluding Comments of the Committee on the Elimination of Discrimination Against Women: Cape Verde*, ¶ 29, <https://www1.umn.edu/humanrts/cedaw/cedaw-capeverde2006.html>.

281. CESCR, *Concluding Comments of the Committee on Economic, Social and Cultural Rights: Kenya*, ¶ 33, U.N. Doc. E/C.12/KEN/CO/1 (2008).

282. CEDAW Committee, *Concluding Comments of the Committee on the Elimination of Discrimination Against Women: Slovakia*, ¶ 28, U.N. Doc. CEDAW/C/SVK/CO/4 (2008).

283. WITTER, *supra* note 37, at 2.

284. ELDIS, Goal 4, *supra* note 180.

285. ICCPR, *supra* note 203, art. 6(1). This right is explicitly recognized in numerous other international treaties. UDHR art. 3; European Convention on Human Rights art. 2; African Charter art. 4; American Convention on Human Rights art. 4.

protect the right.²⁸⁶ Furthermore, states must report on pregnancy and childbirth-related maternal deaths.²⁸⁷ In other words, the right to life is not solely implicated in the context of criminal law, but more broadly includes the necessity of state action to protect the right to life in the context of health care services.

F. User Fees: A Violation of the Right to Life

The imposition of user fees constitutes a violation of the right to life when such fees create barriers to accessing life-saving treatment. For example, fees for the use of emergency rooms or for surgical procedures are common. When a woman cannot afford treatment for a life-threatening medical issue, such as a post-partum hemorrhage, the loss of her life can be attributed, at least in part, to the financial barriers to care. User fees, thus, constitute a barrier to governments' guarantee of the right to life with respect to their most poor and vulnerable citizens.

G. The Right to Non-Discrimination

Most governments have made an explicit commitment to protect core human rights; they have pledged to do so in a non-discriminatory fashion.²⁸⁸ CEDAW explicitly requires States parties to provide access to health services in a non-discriminatory manner: "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services."²⁸⁹

The CESCR has similarly interpreted the right to the highest attainable standard as prohibiting "any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement."²⁹⁰ The Committee recommends the integration of a "gender perspective" in the creation and promotion of health related policies.²⁹¹

The denial or neglect of health care interventions that only women need is a form of discrimination against women. Health care interventions necessary for maternal health, such as the provision of emergency obstetric care, must be prioritized in order to "guarantee women's enjoyment of the right to health on the basis of non-discrimination and equality."²⁹² It is

286. Human Rights Committee (HRC), *General Comment 6: The Right to Life*, ¶ 5 (1982); HRC, *General Comment 28, Equality of Rights between Men and Women*, U.N. Doc. CCPR/C.21/Rev.1/Add.10 (2000).

287. *Id.*

288. CEDAW, *supra* note 205, art. 12.

289. *Id.* art. 12(1).

290. General Comment 14, *supra* note 226, ¶ 18.

291. *Id.* ¶ 20.

292. Special Rapporteur, *supra* note 225, ¶ 28(b).

important to keep in mind that, in non-discrimination analysis, discriminatory effect is just as important as discriminatory intent.²⁹³

H. User Fees: A Violation of the Right to Non-Discrimination

User fees for health services disproportionately affect women in developing countries,²⁹⁴ and too often put basic reproductive health care out of their reach.²⁹⁵ Economically disadvantaged women often cannot afford even nominal fees for health care services. The denial of services, particularly at times of emergency, increases the likelihood of injury and death to the woman and her newborn,²⁹⁶ in violation of the rights to life and health. These fees compound the difficulties wrought by inequitable social structures, which take the decision to seek care at all out of these women's hands.²⁹⁷

This social impact is particularly troubling because "dignity in health is not only a question of being free from avoidable disease, but also a function of the way in which individuals, communities, and whole societies engage in the process of obtaining and maintaining a standard of health."²⁹⁸ User fees skew this process away from the recognition of fundamental rights and obscure the state's and other parties' obligations to provide for progressive realization of these rights.

When states or international lending institutions impose user fees on maternal health services, they defy the right to non-discrimination. User fees contravene CEDAW's commitment to providing health services in a non-discriminatory manner because of the often inherently discriminatory nature of their implementation. The imposition of user fees also constitutes an infringement of the rights guaranteed under the ICESCR.

VI. ALTERNATIVES TO USER FEES

Policies aimed at respecting, protecting, and fulfilling women's right to health should be guided by the fact that "as a first principle, programs and policies need to prioritize measures that promote universal access to high quality emergency obstetric care services."²⁹⁹ Because user fees pose a formidable obstacle to access for many women, states must assess and

293. See Alicia Ely Yamin & Deborah P. Maine, *Maternal Mortality as a Human Rights Issue: Measuring Compliance With International Treaty Obligations*, 21 HUM. RTS. Q. 563, 603 (1999); CESCR, *General Comment 16: The Equal Right of Men and Women to the Enjoyment of All Economic, Social and Cultural Rights*, ¶ 7, U.N. Doc. E/C.12/2005/4 (Aug. 11, 2005).

294. See Ensor & Ronoh, *supra* note 162, at 51 (describing a preference for male household members in receiving health care).

295. See, e.g., Nanda, *supra* note 22, at 130-31 (reviewing literature on the relationship between user fees and women's access to health care services).

296. Ensor & Ronoh, *supra* note 162, at 50.

297. *Id.* at 51.

298. Freedman, *supra* note 23, at 51.

299. *Id.*

implement alternatives to these fees. States must use all available resources and take all appropriate measures in order to work towards the realization of the right to health.³⁰⁰

Eliminating user fees requires more than the removal of formal fees. Substantial funding increases are necessary. Indirect costs, such as transportation and food, serve as barriers to care and compound the effects of formal fees. In addition, if formal user fees are used to finance facility operations or reduce the demand for services at a facility, then dismantling fees without making a commitment to having a compensating increase in funding from tax revenue or another source may lead to health care providers to charge additional fees in order to cover their expenses. Governments must provide supplementary funding to replace the lost revenue or they risk adversely affecting the supply of essentials like drugs and medical supplies, and the corresponding quality of care.³⁰¹

The following analysis will first address the issue of debt repayment, a critical factor that constrains governments' effort to finance health care, particularly in the developing world. Our analysis then focuses on three health care financing policies that have received considerable attention in the health care debate: taxation, debt relief, and insurance/mutual aid schemes. We then apply a human rights framework to assess these alternatives.

A. Debt Repayment

Health care financing alternatives must be considered within the context of debt repayment to IFIs. In 2000, in Sierra Leone, the government spent 280% more on debt service than it did on its health care budget.³⁰² These statistics are not unusual. That same year, the Kenyan government spent about 250% more on debt service than it did on its health care budget, and the Ghanaian government spent over 400% more on debt service than it did on its health care budget.³⁰³ A study examining ten African countries found that these countries were spending four times more on debt servicing per year than on health and education.³⁰⁴ In Africa, the average government expenditure on health is less than \$50 per person.³⁰⁵ A survey by UNICEF found that in thirty developing countries, governments consistently under-invest in social services, in part because of the fiscal

300. *Id.* at 55.

301. See, e.g., Josephine Borghi et al., *Mobilising Financial Resources for Maternal Health*, 368 LANCET 1457, 1459 (2006).

302. See International Debt Observatory, *Debt Service/Health Care Budget (DS/HB)*, http://www.oid-ido.org/en.ratio.php?id_article=96 (using World Bank debt service figures and WHO health care budget figures to analyze the ratio between debt service, "DS," and health care budget, "HB"). "DS/HB measures the burden of the debt service in relation to the country's expenditure in healthcare. It shows to what extent debt service can prevent health expenditure." *Id.*

303. See *id.*

304. Ann Pettifor & Romilly Greenhill, *Debt Relief and the Millennium Development Goals* 18 (U.N. Development Programme, Occasional Paper, 2002).

305. BRAAM, *supra* note 80, at 9.

burden imposed by servicing debt.³⁰⁶

WHO literature points to the same problem. For example, in 2001, a WHO commission called for governments to increase health sector spending as a long-term development strategy.³⁰⁷ However, it is difficult for countries to meet these new health sector spending standards. Dr. Sergio Spinaci, Executive Secretary of the Coordination of Macroeconomics and Health Support Unit of WHO, stated, "It is not easy within present budgetary constraints to invest more in health, especially if you have a large proportion of the budget invested in debt repayments and a macroeconomic policy focused on containing even minor inflation and setting rigid spending ceilings for the social sectors."³⁰⁸ Making changes in national health policy requires a major reallocation of resources, which can be daunting for many governments.

While the World Bank and IMF's more recent debt relief programs for Heavily Indebted Poor Countries (HIPC) have alleviated some of the harsh effects of debt services on developing countries, they have not been a comprehensive solution. First, not all countries have qualified for HIPC debt relief.³⁰⁹ Furthermore, at least one study has found that debt relief for HIPC countries has, at the margin, little or no effect on health expenditures, perhaps due to lingering debt overhang or different spending priorities of HIPC countries.³¹⁰

Loan repayment compounds difficulties in financing health services because repayment draws off a disproportionate percentage of public money for interest payments. In addition, eligibility for loans is often conditioned on the reduction of public services.³¹¹ In effect, debt repayment imposes a double burden, with particularly deleterious consequences for the poorest members of the population.

B. Taxation

Financing tools can be separated into direct and indirect methods. User fees constitute direct methods, and have resulted in the inequities and deficiencies in health care service discussed previously. Instead of charging directly at the point of service to the person receiving care, some policy makers have suggested that countries use indirect methods of

306. HUTTON, *supra* note 19, § 5.1.

307. Clare Nullis Kapp, *Macroeconomics and Health Commission Findings Become Reality*, 82 BULL. WHO 957 (2004), available at <http://www.scielosp.org/pdf/bwho/v82n12/v82n12a18.pdf>.

308. *Id.*

309. Ralf Hepp, *Health Expenditures Under the HIPC Debt Initiative 1* (U. Cal. Davis Working Paper Series, Paper No. 12, 2005).

310. *Id.* at 17-18.

311. Jubilee USA Network, *Background Briefing and Frequently Asked Questions: Debt Cancellation and the Jubilee Act for Responsible Lending and Expanded Debt Cancellation* (2004), http://www.jubileeusa.org/fileadmin/user_upload/Resources/JUBILEE_Act/m408_hearing/042408JubileeUSA_BackgroundMemo.pdf (noting the IMF's HIPC debt forgiveness condition that countries restrict public sector salaries for doctors and teachers).

financing that “pool across time (prepayment) and across different risk and wealth groups (insurance and general taxation).”³¹²

Funding through general taxation has inherent limits in poor countries, but states do have the obligation to work towards universal access to health services “by all appropriate means.”³¹³ This includes addressing the obstacles facing the most disadvantaged groups, such as the poor, residents of rural areas, racial and ethnic minorities, and women.³¹⁴

Taxation presents options for states to pool tax funds and redistribute them to marginalized segments of the population. Marginalized women may enjoy increased access to health care and coverage of medical treatment, paid for by the taxes of wealthier citizens. Of course, the taxation model moves away from the decentralized management goals that accompanied the institution of user fees, and typically calls for more central government control over collection and allocation of resources.

However, taxation, like other financing options that rely on more centralized control, could positively interplay with national governments’ growing commitment to devote significant portions of the national budget to health care. Indeed, in the Abuja Declaration of 2001, the heads of state of the Organisation of African Unity committed to “take all necessary measures to ensure that the needed resources [for the health care sector] are made available from all sources and that they are efficiently and effectively utilized. . . . We pledge to set a target of allocating at least 15% of our annual budget to the improvement of the health sector.”³¹⁵

The central governments’ allocation of at least 15% of funds, if combined with progressive taxation schemes, could provide a robust pool of money to build health care infrastructure to target a range of national health priorities, including maternal health care services. Ultimately, the policy choice between centralized and decentralized control of funding and distribution of health care services is one that must be made by the governments and members of civil society in developing countries, perhaps in consultation with development scholars.

C. Debt Forgiveness

While increased aid would make abolishing user fees more feasible, the risks of adding to countries’ already sizeable debt burdens are substantial if aid is provided in the form of additional loans. Donor funding can prove unreliable over time making it difficult to plan annual health budgets around fluctuating streams of cash.³¹⁶

312. Ensor & Ronoh, *supra* note 162, at 49.

313. ICESCR, *supra* note 24, art. 2.

314. General Comment 14, *supra* note 226, ¶ 12(b).

315. *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*, para. 26, U.N. Doc. OAU/SPS/ABUJA/3 (Apr. 24-27, 2001), http://www.un.org/ga/aids/pdf/abuja_declaration.pdf.

316. For example, the United States has been an unreliable source of funding for the United Nations Population Fund (UNFPA), which in turn has affected UNFPA’s ability to do important reproductive health work in developing countries. See POPULATION ACTION

An alternative has been proposed via debt-forgiveness programs, in which donors agree to forgive portions of debt under certain conditions, such as, for example, a governmental commitment to channel money that would otherwise be dedicated to debt service to particular sectors. In 1996, the World Bank and IMF launched a debt relief program under the HIPC Initiative to assist the poorest countries with unsustainable debt burdens.³¹⁷ Since 1996, more than 30 countries have received some debt relief under the HIPC Initiative. These countries must submit to funding conditions; savings must be channeled to social sectors such as health and education.³¹⁸ Some commentators have criticized these conditions as being too inflexible to allow countries to design and sequence innovative solutions to their country-specific development challenges.³¹⁹ Nevertheless, country data collected over the past 10 years have shown that many countries are experiencing clear gains as a result of debt forgiveness, particularly in the fields of health and education. The IMF reports:

Before the HIPC Initiative, eligible countries were, on average, spending slightly more on debt service than on health and education combined. Now, they have increased markedly their expenditures on health, education and other social services and, on average, such spending is now about six times the amount of debt-service payments.³²⁰

The combination of the HIPC Initiative and the United States' Multilateral Debt Relief Initiative (MDRI) is expected to reduce the debt stock of 31 HIPCs by \$96 billion.³²¹ Debt AIDS Trade Africa reports that for every dollar freed from debt service payments, African governments have been able to increase social spending by two dollars.³²² Further, debt relief has helped to "create a more attractive environment for private investment and improve the long-term chances for sustainable development" and poverty eradication.³²³

The experience of Honduras under the HIPC Initiative demonstrates the potential for channeling these funds into demonstrable improvements in the quality and coverage of health care. Honduras began receiving HIPC debt forgiveness in 2000, and it devised a poverty strategy reduction program that aimed, in part, to address concerns about quality and

INTERNATIONAL, WHY THE UNITED STATES SHOULD RESTORE FUNDING FOR UNFPA (2008), http://www.populationaction.org/Publications/Fact_Sheets/FS3/Summary.shtml.

317. IMF, DEBT RELIEF UNDER THE HEAVILY INDEBTED POOR COUNTRIES (HIPC) INITIATIVE (2008), <http://www.imf.org/external/np/exr/facts/hipc.htm> (last visited Feb. 26, 2009).

318. *Id.*

319. HIPC DEBT RELIEF: MYTHS AND REALITY 6-7 (Jan Joost Teunissen & Age Akkerman, eds., 2004).

320. IMF, *supra* note 317.

321. Jubilee USA Network, *supra* note 311, at 2.

322. *Id.*

323. *Id.*

coverage in the health sector, particularly regarding women.³²⁴ The government's strategy sought to decentralize health services and improve the provision of basic health services.³²⁵

Honduras sought to institute reform of the social security system, crucial to coverage and quality of health services. This included strengthening the regulatory capacity of the Ministry of Health and improving coverage, efficiency, and quality of health service provision.³²⁶ As of 2005, 121 health facilities had been rehabilitated and licensed under the health ministry's new certification program that helps set health standards.³²⁷

Honduras also aimed to strengthen basic health services for the poor. In particular, it sought to deliver basic health care to at least 100,000 beneficiaries in poor communities,³²⁸ with emphasis on primary and maternal/child health.³²⁹ During 2004, coverage of the basic package of primary health care services was extended to cover more than 285,000 persons in poor communities.³³⁰ Since the institution of the HIPC Initiative, therefore, measurable improvements have been seen in the health sector, particularly with respect to the poor and disadvantaged citizens of Honduras.³³¹

Other international lending institutions have experimented with debt forgiveness as a type of targeted funding to particular sectors. In March 2007, the Inter-American Development Bank (IDB) agreed to cancel \$4.4 billion in debt and interest owed by five of the poorest Latin American and Caribbean countries: Bolivia, Guyana, Haiti, Honduras, and Nicaragua.³³² Savings will be channeled to health care, education, and infrastructure development.³³³

Progress has been made in HIPC-qualifying countries. Yet there is much more room for action. Of the world's sixty-six poorest countries, the majority are beholden to debtors and in the midst of a "debt crisis."³³⁴ A January 2007 study evaluating forty-one countries that had not yet completed the HIPC Initiative found "that a majority of these countries were paying more now on debt service than they were in 1996."³³⁵

324. IMF, Decision Point Document for the Enhanced Heavily Indebted Poor Countries (HIPC) Initiative 8 (June 20, 2000), <http://www.imf.org/external/NP/hipc/2000/hnd.pdf> (last visited Apr. 13, 2009).

325. *Id.*

326. IMF, 2005 Article IV Consultation, Second Review Under the Three-Year Arrangement Under the Poverty Reduction and Growth Facility, 40, IMF Country Report No. 06/35 (Feb. 2, 2006), <http://www.imf.org/external/pubs/ft/scr/2006/cr0635.pdf> (last visited Apr. 13, 2009).

327. *Id.*

328. *Id.*

329. *Id.* at 43.

330. *Id.*

331. *Id.*

332. Press Release, Inter-American Development Bank, IDB Governors Approval \$4.4 Billion in Debt Relief for Bolivia, Guyana, Haiti, Honduras and Nicaragua (March 16, 2007).

333. *Id.*

334. Jubilee USA Network, *supra* note 311, at 2.

335. *Id.*

The success of debt forgiveness programs will depend on governments working with international lending institutions like the World Bank to identify shortfalls in their health care systems, as well as specific strategies for remedying these shortfalls. International donors like the World Bank and IMF face increasing pressure to eliminate the restrictive conditions that have made debt relief less effective. The Center for Global Development and Jubilee USA Network criticized the IMF's stringent requirements imposed on poor countries that include paying down the domestic debt and restricting public sector salaries for doctors and teachers.³³⁶

Debt forgiveness policies should be sensitive to emerging needs in the wake of user fee elimination, particularly the needs of women and the poor. Loan forgiveness programs should work towards implementing long-term, sustainable systems of support for health care funding.

D. Health Insurance/Mutual Aid

Government funded, tax-based health insurance is a prevalent feature in many countries' health care policies. In theory, a nationwide insurance policy should allow the government to pool risk and transfer resources to those most in need. In practice, however, a number of factors may frustrate these objectives. Many studies of state spending that focus on maternal health have found that the provision of government health services tends to be "only weakly pro-poor."³³⁷

The following sections articulate some of the common challenges facing policy makers as they design and implement national health insurance policies. The final section analyzes Ghana's recently-enacted National Health Insurance Scheme (NHIS) as an example of how even well-intentioned health insurance schemes will be ineffective at meeting the health needs of the poor unless they are designed through an anti-poverty, "pro-poor" lens.

1. Remedying Regressive Funding of Health Services

Studies have shown that some governments allocate health care funding regressively.³³⁸ The reasons for this failure are illustrative. They included the location of better-financed health facilities in urban, wealthier areas, greater awareness of available services among more affluent populations, and the exclusionary effects of informal costs.³³⁹ Regressive funding exacerbates inequalities between rural, typically poor, residents and their urban, wealthier counterparts. In order to meet the greater health needs of the entire population, governments must focus resources on

336. *Id.* at 3.

337. See *infra*, note 352 (providing an example of the "only weakly pro-poor" nature of Ghana's recently enacted National Health Insurance Scheme).

338. Ensor & Ronoh, *supra* note 162, at 52.

339. *Id.*

poorer areas to ensure that all members of society attain the right to health.

2. Addressing Socioeconomic Inequities

Insurance programs rely on voluntary, flat-rate premiums from community members, which help to finance local care facilities that provide free or discounted care. However, they also produce marked inequalities in many communities. For example, community insurance members in the Democratic Republic of Congo were seven times more likely to receive assisted delivery care than non-members.³⁴⁰ Screening patients and exempting poor people from paying premiums produce many of the same difficulties as user fees.

A possible solution to minimize premiums is to differentiate between services deemed necessary and those deemed not necessary. For example, one community insurance scheme in the Kasongo District of the Democratic Republic of Congo separated medical services into “needs” and “demands.”³⁴¹ In this scheme, while a caesarean section might be considered necessary, the request for a private hospital room might be treated as a demand.³⁴²

3. Remediating Coverage Gaps

Community health insurance schemes often fail to provide women with access to adequate reproductive care. In Kenya, insurance schemes excluded normal delivery altogether, restricting coverage to complicated deliveries and other treatments for conditions that were not “pre-existing or self-determined.”³⁴³ In Gujarat, India, a community-based scheme excluded the costs of normal delivery care, although it included costs of pregnancy complications if they resulted in a hospital stay of more than 24 hours.³⁴⁴ Coverage exclusions were justified on the grounds that the burden of higher risk patients demanding complicated deliveries would make the health care scheme financially unsustainable.³⁴⁵ These coverage gaps are troubling if community health insurance is expected to replace user fees in poor areas.

4. Meeting the Needs of Community Members Who Are Unable to Pay the Premiums

Perhaps an even more difficult obstacle facing community health

340. See, e.g., Josephine Borghi et al., *Mobilising Financial Resources for Maternal Health*, 368 LANCET 1460 (2006).

341. Bart Criel, *District-Based Health Insurance in Sub-Saharan Africa*, STUD. IN HEALTH SERVICES ORG. & POL'Y (1998), at 16-17.

342. *Id.* at 7.

343. Ensor & Ronoh, *supra* note 162, at 53.

344. Borghi et al., *supra* note 301, at 1460.

345. *Id.*

insurance programs is community members' ability to pay for health insurance. Community insurance programs may prove to be unsustainable in the face of economic downturns, poor agricultural yields, or other contingencies. "Acknowledging that the financial objectives may not, and probably should not, be full cost recovery, many [community-based health insurance programs] will appropriately aim initially to match the revenues from user-fees rather than substitute for government funds to the district health services."³⁴⁶

Unlike user fees, community health insurance has been shown at least in some cases to increase demand for maternal health care and thus improve access.³⁴⁷ Notwithstanding these advantages and the potential of at least a supplemental role for community health insurance, an inherent problem with these programs is the fact that the poorest clients, regardless of how the market is structured, lack disposable income to dedicate to premiums. Moreover, the redistributive capacity of moving resources from the poor to the poorest has obvious limitations.

5. Case Study: Ghana's National Health Insurance Scheme

Ghana's National Health Insurance Scheme (NHIS) provides an example of how even well-intentioned health insurance schemes are often only weakly pro-poor.

The Ghanaian Parliament approved the Health Insurance Act 650 in 2003, and two years later the NHIS was launched.³⁴⁸ The goal of the initiative was to replace user fees, which the government realized had limited poor persons' access to health care, and "improve access to health care for the poor and improve financial sustainability of the health system."³⁴⁹ The NHIS collects a large portion of its the revenue through a 2.5% consumption tax, as well as mandatory payroll deductions and a graduated premium payment scheme.³⁵⁰ As of January 2007, more than seven million people had enrolled in the program, constituting more than 35% of the population but still below the program's goal of complete national coverage.³⁵¹

A range of key policy issues have emerged in the first years of the NHIS implementation. First, under the scheme, certain categories of individuals who are unable to pay the minimum premium are intended to be registered for the scheme, but made "exempt" from paying the premium payment. In particular, "indigents," elderly persons over

346. Dyna C. Arhin-Tenkorang, *District Based Health Insurance in Sub-Saharan Africa*, 4 TROPICAL MED. & INT'L HEALTH 629, 629 (1999) (book review).

347. Ensor & Ronoh, *supra* note 162, at 52.

348. WORLD BANK, PROJECT INFORMATION DOCUMENT, HEALTH INSURANCE PROJECT: NATIONAL HEALTH INSURANCE COUNCIL, REPUBLIC OF GHANA, World Bank Report No. AB3035 (April 9, 2007).

349. *Id.*

350. *Id.*

351. WOTRO, *supra* note 25.

seventy, and children under eighteen whose parents are registered are intended to belong to an “exempt” group.³⁵²

However, the NHIS has identified a threshold of 0.5% participation by indigents, a percentage far below the country’s rate of poverty, after which point a review is triggered.³⁵³ “Indigents” are defined restrictively under the scheme’s implementing regulations, so that poor persons living in compound facilities with family members, a frequent form of social support, are often unable to qualify if they have any visible source of income or live with a person providing “identifiable consistent support.”³⁵⁴ Further, district scheme managers are encouraged to stay within the 0.5% indigent target because when they exceed it, they trigger a review of their registration “by whatever means the [National Health Insurance] Council determines.”³⁵⁵ Unregistered persons, in turn, may confront increased costs of treatment as the pool of persons seeking health care becomes fragmented and costs spiral for those making out-of-pocket payments.³⁵⁶

The World Bank has noted the difficulties in providing effective coverage under the scheme for the poor and “exempt” indigents:

Although the purpose of the NHIS is to provide a pro-poor alternative to the Cash and Carry system, there are still problems with identifying and registering indigents who are “exempt” from coverage; registering poor informal sector workers who may still find the income-based premium levels too high; [and] finding a financially sustainable solution for subsidizing the “exempt” groups . . .³⁵⁷

The World Bank has responded by supporting policy developments that aim to improve the governance of the NHIS implementation, including “maintaining a pro-poor focus.”³⁵⁸ It has noted that in order for Ghana and other developing countries to realize the goals set out by the United Nations MDGs, including dramatically reducing maternal mortality, they must increase spending on health care.³⁵⁹ To meet the goal of reducing maternal mortality, health care spending must target certain critical programs, including the provision of antenatal and emergency obstetric care. Health insurance schemes like NHIS will have to be designed to effectively spread risk and target the poor through selective premium

352. Ghana National Health Insurance Regulations (2004) (LI 1809), at Regulation 56 (discussing exemption for dependents and elderly); Ghana National Health Insurance Act 650 (2003), at Section 77(2)(c) (explaining that the health insurance fund should “set aside some monies from the Fund to provide for the Health care cost of indigents”).

353. Ghana National Health Insurance Regulations (2004) LI 1809), at Regulation 58(5).

354. Ghana National Health Insurance Regulations (2004) (LI 1809), at Regulation 58(1).

355. Ghana National Health Insurance Regulations (2004) (LI 1809), at Regulation 58(5).

356. Diane McIntyre et al., *Beyond Fragmentation and Towards Universal Coverage: Insights from Ghana, South Africa and the United Republic of Tanzania*, 86 BULL. WORLD HEALTH ORG. 817 (2008), available at <http://www.who.int/bulletin/volumes/86/11/08-053413/en/index.html>.

357. World Bank, *supra* note 346, at 3.

358. *Id.* at 5.

359. *Id.* at 3-4.

subsidies.

VII. DESIGNING EFFECTIVE HEALTH CARE FINANCING

Overall, the trend appears to be moving away from user fees, with a large number of international lenders and intergovernmental alliances advocating free health services. Yet, international criticism may not be sufficient to eliminate the harmful effects of user fees. User fees are often still imposed because of the belief that they can improve health sector financing and quality, or are still in place because of bureaucratic inertia.³⁶⁰ The challenge of loan repayments, coupled with countries' desires to expand and improve health services, contribute to the maintenance of user fees. Misplaced spending priorities and a small tax base exacerbate the financial pressures that help to justify user fees. This is true despite user fees' proven ineffectiveness at raising substantial revenue.³⁶¹

Yet, when the international development policy debate is viewed through the lens of human rights, it becomes clear that the policy of imposing user fees for access to basic reproductive health care cannot be reconciled with states' obligations under international human rights law. In the long term, fees channel limited resources away from the individuals who most critically need health services. The poor, vulnerable and marginalized members of the population are excluded from the health system. In the specific context of maternal health, researchers in Benin and Ghana looking at 'near-miss' obstetric events noted that the total cost of delivery, including drugs and medical supplies, creates a large financial burden for households and contributes to high rates of maternal mortality.³⁶² This has been confirmed by the work of international NGOs such as Save the Children, which has calculated that the elimination of user fees would save the lives of 285,000 children each year.³⁶³

User fees present impediments to accessible and affordable health care, and they thereby contribute to the startling maternal mortality statistics confronting the developing world today. Their continued use is incompatible with minimum obligations under international human rights law.

A. Lessons for the World Bank and Large International Lenders

The World Bank, as one of the major international lenders to developing countries, plays a significant role in the continued existence of user fees. The World Bank views itself as having a comparative advantage

360. WITTER, *supra* note 37, at 25.

361. *Id.*

362. Josephine Borghi et al., *Costs of Near-Miss Obstetric Complications for Women and Their Families in Benin and Ghana*, 18 HEALTH POL'Y PLAN 383, 386-87 (2003).

363. SAVE THE CHILDREN, STILL PAYING WITH THEIR LIVES: THE COST OF ILL FOR CHILDREN IN AFRICA 1 (2006).

in the following area: “health financing, insurance, demand-side interventions, regulation, and systemic arrangements for fiduciary and financial management.”³⁶⁴ The World Bank has said it intends to further develop its advantages as it works with other agencies, like WHO, that have an advantage in designing technical programs such as disease control.³⁶⁵

The World Bank’s “no blanket rule” discouraging user fees will likely have a substantial impact on the health care financing policies of developing nations in the coming decades. But the Bank should do more. In accordance with a human rights framework, the World Bank and other key international actors should rethink, rescind and remove user fees.

B. Lessons for Wealthy States

Wealthy states continue to play a key role in setting health care financing schemes in developing countries, through their role in World Bank and international lender decisions, through their individual donor efforts, and through debt forgiveness. The implementation of user fees represents a failure of the obligations demanded by the right to health and by Article 2 of the ICESCR for rich states to assist poor states in achieving economic, social, and cultural rights, including the right to health. This obligation consists of two elements. First, rich states should not impede the provision of necessary health care services.³⁶⁶ Second, rich countries should assist poor countries in progressively realizing the right to health.³⁶⁷ This second element extends to the encouragement and subsidization of the delivery of critical health services, such as maternal health care.

CONCLUSION

The majority of maternal deaths are preventable, even in countries with limited resources.³⁶⁸ User fees continue to serve as a barrier to the services necessary for improving maternal health. Over the past twenty years user fees have failed to accomplish their stated goals, including improvement of efficiency and equity through increase in healthcare revenue and an increase in quality and coverage of medical care.³⁶⁹ To the contrary, the implementation of user fees has worsened the situation of access to healthcare by creating barriers to care for those citizens who are most in need of care, particularly women and the poor. In light of these

364. World Bank, *supra* note 92, at 18.

365. *Id.*

366. ICESCR, *supra* note 24, art. 2.

367. *See id.*

368. *See* WHO, *supra* note 4. Maternal death is defined as “[t]he death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.” MATERNAL MORTALITY IN 2005, *supra* note 1, at 4.

369. WITTER, *supra* note 37, at 5-6.

failures, this Article argues that if countries do not abolish user fees, they will not respect, protect, and fulfill expectant women's rights to health, life, and non-discrimination.

The following recommendations pertaining to health sector reform and user fees should be considered by countries to better enable the realization of human rights with particular regard to pregnant women.

A. Abolish User Fees for Basic Care, Including Emergency Obstetric Care

As argued in this Article, user fees are "perhaps the most regressive form of health care financing."³⁷⁰ Overwhelming evidence demonstrates that user fees hurt the poor, impose a barrier to access, reinforce inequitable social structures, and lower transparency in allowing governments to shirk their responsibility to respect, protect, and fulfill the human rights of all their citizens. They fail to yield any appreciable efficiency, revenue generation, or accountability gains. Countries must recognize that exemption and waiver schemes have failed to adequately protect the poor and must abolish user fees for health, including emergency obstetric care.

B. Increase Funding

In phasing out user fees, governments and donors must provide adequate resources to meet the increased demand and to offset the limited revenue that user fees generate for local facilities. Without an accompanying increase in funding, the elimination of user fees threatens quality of care and may actually lower access. External donor funding should support increases in a consistent and reliable manner, with the goal of making health care programs in developing countries self-sustaining in the long term.

C. Decentralize Funding

Decentralization has the benefits that were originally identified, yet not attained, in the Bamako Initiative. There is the potential for decision-making on a local level that is sensitive to the needs of the community. Community-based co-management of health services can target care to a particular community's needs and establish a clearer system of accountability for providing accessible and quality care. For example, in the event of a health sector shortfall, it is oftentimes easier to identify a local health center's weaknesses in management or its need for additional

370. Lucy Gilson & Di McIntyre, *Removing User Fees for Primary Care in Africa: the Need for Careful Action*, 331 BRIT MED. J. 762 (2005).

financial assistance to address a community's unique need for gender-sensitive than it is to identify systemic breakdowns and failures in the health sector. Nationwide funding schemes such as taxation and general insurance, which pool resources, would have to reallocate them to local control in order to achieve such decentralization.

Evidence suggests that decentralization is an effective model. For example, decentralization partially explains the successful elimination of user fees in Uganda.³⁷¹ There, management committees had been established to co-administer user fee revenues from local health facilities.³⁷² In eliminating user fees, the government of Uganda not only increased overall health funding but also retained the decentralized user fee administrative structure, allocating a portion of the (tax-generated) budget to the management committees for them to use according to their preferences.³⁷³

Economic feasibility and political acceptability have constrained the development and effectiveness of decentralized schemes. Yet, it may be possible to realize effective decentralized schemes by combining economic reforms with increased foreign aid commitments. Donors have already made commitments to issue aid more reliably,³⁷⁴ and development policies are increasingly helping governments raise revenue by establishing an effective tax base and a progressive taxation scheme. The IMF and World Bank can offer technical assistance to help countries design solid economic foundations that can sustain functioning health care systems.

D. Raise Awareness While Increasing Monitoring and Accountability

Increased monitoring and accountability mechanisms can also help ensure that public spending makes its way to the poor. On a country-wide basis, monitoring systems should be established to document the provision of geographically accessible emergency obstetric care. One commentator advocates a minimum of four basic care facilities – giving women access to essential drugs like antibiotics and oxytocics and assistance for uncomplicated deliveries – and one comprehensive care facility that offers blood transfusions and cesarean sections per 500,000 inhabitants.³⁷⁵

371. See HUTTON, *supra* note 19, § 5.2.

372. *Id.*

373. *Id.*

374. See, e.g., Paris Declaration on Aid Effectiveness (2005), <http://www.oecd.org/dataoecd/11/41/34428351.pdf> (representing an international agreement to which more than 100 ministers, heads of agencies, and other senior officials adhered, committing their countries and organizations to continue increasing efforts in harmonization, alignment, and managing aid through a monitoring system).

375. Angela Sawyerr-Kamara, *Maternal Mortality: A Public Health Perspective*, in LEARNING TO DANCE 131 (Alicia Ely Yamin ed., 2005).

To ensure that women have access to appropriate treatment once they reach individual facilities, public health care workers, and governments should gather critical information on factors such as the distribution of emergency obstetric care facilities, the number of complicated procedures performed, fatality statistics, the availability of essential drugs, and the community's view of the facility.³⁷⁶ To address sites with existing user fees, public officials should determine which facilities charge fees and identify priorities for increased funding to these facilities.

Awareness campaigns can also help to ensure that end-users know what health services they are entitled to, and what fees they can expect. Members of civil society and health care workers should play a role in these conversations. Patients must understand their rights under the law to be able to demand them. If user fees are abolished without an adequate public information campaign, health workers may continue to charge informal costs. Policy makers should also increase their own awareness of implementation challenges by consulting with the staff at local facilities and gathering ideas on how to move forward.

E. Focus on the Poor

Perhaps most importantly, states must work to address the often widespread inequalities in health care provision. They must ensure that all citizens, irrespective of their economic status, receive adequate health care services. Targeting health spending towards the poor offers a means for states to fulfill their treaty obligations as well. The pitfalls of targeting the poor through exemptions are well-documented. Nevertheless, as part of a strategy for phasing out user fees, public funding may be creatively targeted to address the cases of those most in need and thus complement an otherwise comprehensive community health insurance program.

Vouchers³⁷⁷ or refunds³⁷⁸ for medical services are two such innovative methods that have been piloted to attempt to increase poor women's access to maternal health care.³⁷⁹ Vouchers have the disadvantage of being

376. *Id.* at 135.

377. Vouchers are coupons that entitle the bearer to a predefined package of "best practice" health services free of charge. *See, e.g.*, Peter Sandiford et al., *Vouchers for Health: Using Voucher Schemes for Output-based Aid*, PUB. POL'Y FOR THE PRIVATE SECTOR (April 2002), available at <http://www.gpoba.org/docs/OBAHealthNicaragua.pdf> (describing a voucher system in Nicaragua that has created incentives for health care providers to lower prices or raise quality).

378. Under a refund scheme, patients pay for their health care services and later receive a refund for the costs that they bear. *See, e.g.*, BRAC, http://www.brac.net/usa/bw_health.php (describing a TB treatment regime where a fixed dose of treatments are given and the recipient often pays deposit money for the treatment in advance and has this deposit money refunded upon the completion of the treatment regime).

379. *See, e.g.*, Josephine Borghi et al., *supra* note 301, at 1462 (noting that although the World Bank has piloted the use of vouchers in several Asian countries, the results of the evaluation of the scheme are not yet available).

susceptible to diversion from their intended use into the black market.³⁸⁰ Refunds, on the other hand, may not provide relief to those most in need, i.e. those who lack cash in advance for services. Again, exemptions and targeting programs run the risk of becoming so complex that potential beneficiaries cannot easily understand the services to which they are entitled. Complexity also reduces transparency and results in more barriers to access.

Geographic price discrimination, such as reducing or eliminating user fees in rural areas, presents a targeting strategy for minimizing this complexity. Peru's national insurance scheme, cited above to illustrate the deficiencies of user fee exemptions, takes this approach.³⁸¹ In Peru, the law provides that in districts where greater than 65% of the population lives in poverty, residents qualify for universal free coverage under the national insurance plan.³⁸² Despite the problems in implementing this scheme, it avoids much of the difficulty of exemptions based on individual assessments of ability to pay and presents fewer transparency problems.

Another targeting strategy for avoiding this assessment is to exempt certain treatments, such as obstetric care. In Bolivia, a subprogram of the social insurance system specifically targeted maternal and child health services by making key services free of charge.³⁸³ The program led to a 50% increase in the use of public facilities for antenatal and delivery care, primarily by the poor.³⁸⁴ Lack of funding resulted in a curtailment of the Bolivian plan, however.³⁸⁵ In addition to adequate financing, monitoring and accountability measures (such as reviewing the indicators discussed above) play an important role in assuring that targeting strategies achieve their desired objectives.

By adhering to this Article's concluding lessons – specifically abolish user fees, decentralize and increase funding, place a greater focus on the poor, and increase participation and accountability – developing countries can move closer to fulfilling their international and domestic obligations to reduce maternal mortality. Further, as large international lenders and donors continue to play a formative role in designing health care financing schemes, they too should consider their policy choices from within a human rights framework. It is important to keep in mind the U.N. MDG regarding reducing maternal mortality by 75% by the year 2015. Yet, in reaching for this aggregate reduction in maternal mortality, the international community must remain cognizant of the inherently human, individual nature of this work. A central question is: how does this health care financing scheme advance and secure the right to health for *each* woman, including those most marginalized by race, ethnicity, geography,

380. *Id.* at 1463.

381. Sharma et al., *supra* note 149, at 10, 21.

382. YAMIN, *supra* note 120, at 32.

383. TANIA DMYTRACZENKO ET AL., EVALUACIÓN DEL SEGURO NACIONAL DE MATERNIDAD Y NIÑEZ EN BOLIVIA [EVALUATION OF NATIONAL MATERNAL AND CHILD HEALTH INSURANCE IN BOLIVIA] xvii (1998), http://www.abtassociates.com/reports/1998230338609_37030.pdf.

384. *Id.*

385. *Id.*

poverty, or other factors? Without a concerted effort to advance the right to health for *these* marginalized women by allowing their voices and concerns to resonate in the policy debate, many will continue to die preventable deaths.