R
tected in market oriented approaches to
health financing, user fees have been
recommended for two decades by interna-
tional agencies and aid donors as a mech-
anism for mobilising new resources and rationalising service delivery. Many
developing countries are still relying on user
fees. No credit was permitted in a health
centre in Haiti (January 2005, in French and
Creole: “no credit for you today, perhaps
tomorrow, thank you”). In contrast with the
claims of user fee proponents, such finan-
cing methods have excluded vulnerable
populations from basic health service, with
damaging implications for equity.1 Even the
World Bank is stating now that they “did not
support user fees for basic health services for
poor people”.2 Removing user fees for pri-
mary care is necessary but it’s not enough3
even if the case of Uganda seems interesting
in terms of equity.4 Prepayment and volun-
tary insurance schemes are not able to
protect the worst off and most of the
exemption systems have failed to protect
the poorest. We still know so little about
health financing to promote access in low
income settings.5 In the context of user fees
and cost recovery schemes, some pilot
projects are emerging in Cambodia (Equity
Fund), Mali (Medical Assistance Fund), and
Burkina Faso (Community exemptions
schemes), but more research is needed to
provide evidence to decision makers to
implement more health equity policies.

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