

Removing User Fees in the Health Sector in Low-Income Countries

A Multi-Country Review

WORKING PAPER



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Removing User Fees in the Health Sector in Low-Income Countries: A Multi-Country Review

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1 EXECUTIVE SUMMARY

The political momentum towards the achievement of the Millennium Development Goals has revitalized the debate around sustainable health sector financing and the adequacy of current arrangements in low-resource settings. Within this wider context, the removal of user fees is being debated once again and is thus back on global and national agendas.

UNICEF has committed to supporting governments willing to remove user fees for services targeting children and pregnant women. In order to expand the knowledge base, it has commissioned a study reviewing the experience of user fee removals in six sub-Saharan African countries.

The ‘multi-country review’ does not re-open the controversy about whether user fees are good or bad. Instead, it focuses on the ‘how’, once a government has decided to abolish user fees. In particular, the review documents the processes and strategies through which user fee removal reforms have recently been implemented in six sub-Saharan African countries: Burkina Faso, Burundi, Ghana, Liberia, Senegal and Uganda. It is therefore mainly a descriptive study. Its main objective is to draw lessons (do’s and don’ts) that could guide the future formulation and implementation of such policies in other countries.¹ The focus of the study is thus operational.

The review is normative to the extent that it tried to check whether countries followed a list of best practices (or plausible good ones) in the reform of health care financing.

The main findings are the following. A momentum is currently building up at national and international levels with respect to user fee removal. African political leaders have shown their willingness to take strong action to remove financial barriers for vulnerable groups, especially pregnant women and children. They are ready to do so by using national resources. Aid mechanisms – and the Highly Indebted Poor Countries Initiative in particular – seem to be supportive of such initiatives. Models adopted by governments vary. The different contexts and traditions in Francophone and Anglophone Africa lead to different orientations and strategies. One of the key issues deserving greater attention in the future, both at the policy and scientific level, is the remuneration model of health care providers (input- versus output-based arrangements).

Another important finding is that the lack of consultation, coupled sometimes with the unexpected character of the decision taken by the political authorities, resulted in insufficient preparation of several user fee removal reforms resulting in weaknesses in the design, formulation and implementation of the reform. The most worrying omissions or mistakes observed are: a lack of attention to other bottlenecks on the supply and demand side; too basic initial estimations of the impact of the reform on the utilization by the population and its consequences in terms of extra burden on frontline health staff and on the public budget; insufficient commitment, allocation or disbursement of resources to finance the increase in utilization; poor understanding of incentive issues; low implication of frontline health workers in the design; poor communication towards them at the launch of the reform; and insufficient effort in monitoring, enforcement and evaluation.

These weaknesses were spread unevenly across countries, which suggests that it might already be possible to improve reform practice in low-income countries by organizing more

¹ These lessons are gathered in: Meessen, B. 2009, *Removing user fees in the health sector in low-income countries: A policy guidance note for program managers*, UNICEF, New-York.

exchanges at regional level. In most countries, we observed program managers doing their utmost to keep the system afloat while taking action to fine-tune the reform.

One must be careful when interpreting limited compliance with plausible good practices. Such a partial compliance is probably more an indicator of lack of preparation and sometimes weak technical capacity than an indication that the reform may fail. We were not able to collect evidence on the outcome of the user fee removal process. Governments with strong leadership and/or committed partners seem able to progressively adapt their policy to maximise the benefits for the target groups.

A primary constraint for successful reform could be the limited availability of technical expertise in health care financing in most countries. International actors have usually not come to the rescue; especially during the formulation and implementation stages of the reform their support was missed. This could be the consequence of a tradition of focusing on one's own aid framework and project. International actors campaigning for user fee removal should also consider shifting their focus from agenda setting to technical support. Possible strategies are: provision of technical expertise, pilot experiments, support to regional networks, better coordination between agencies, technical guidelines and translation of material only available in English. International agencies could help also to develop a firmer consensus on health care financing strategies in post-conflict settings.

The main lesson from the multi-country review is that the current leadership shown by governments in terms of human development offers an exceptional window of opportunity for strategies addressing barriers to access to health care. Mobilizing sufficient financial resources and obtaining a long-term commitment are crucial, but these difficulties should not deter technicians from developing the best institutional solutions, formulation and implementation strategies. Our assessment is that national policy makers and international agencies could better collaborate in this respect, to the greatest benefit of the populations in need.

2 THE STUDY

2.1 BACKGROUND

The political momentum towards achievement of the Millennium Development Goals has revitalized the debate around sustainable health sector financing and the adequacy of current arrangements in low-resource settings. Within this wider context, the removal of user fees is being debated once again and is thus back on global and national agendas. The experience of fee removal in Uganda, in 2001, where an increase in outpatient utilization was observed, with strong indication that the poor benefited the most, has been key in this renewed interest (Nabyonga et al. 2005). Utilization also increased following fee removal in Ghana, Madagascar and South Africa, although concerns about availability of resources and the effects on preventive services have rendered these more qualified successes. Madagascar even reintroduced fees.

Based on these experiences and the adverse effects of user fees on access to basic services in many other countries, many organizations and initiatives have advocated to the removal of user fees under certain conditions. EQUINET (a southern African equity research and advocacy network), Save the Children-UK, the UN Millennium Project and the Commission for Africa, Oxfam, *Médecins du Monde*, *Médecins sans Frontières* and DFID are among the strongest advocates of the removal.

For its part, UNICEF has long wanted to ensure that children, particularly the poor and vulnerable ones, have access to health services and share fully in progress towards the Millennium Development Goals. The organization recognizes that user fees in the health sector often constitute an important barrier to accessing health services, especially for the poor and the marginalized. In its 2005 Call for action, UNICEF appealed "for governments and agencies to work towards the elimination of user fees for primary education and, where appropriate, health-care services" (UNICEF, 2005).

Table 1: Recent initiatives in sub-Saharan Africa in terms of user fees

Country	Description of the policy change	Date of policy implementation
Burkina Faso	Reduction of 80% of fees for C-section and deliveries	October 2006 – April 2007
Burundi	Removal of user fees for deliveries and curative care for children younger than 5 years	May 2006
Republic of the Congo	Free malaria treatment for children younger than 15 years and pregnant women	July 2008
Ghana	Free delivery	April 2005 (nationwide)
Liberia	Suspension of user fees	April 2006
Madagascar	Free delivery Free C-section	June 2008 September 2008
Niger	Removal of user fees for C-section and children younger than 5 years	February 2006 March 2007
Senegal	Removal of user fees for C-section (hospitals) and deliveries (health centres)	January 2006 (nationwide but Dakar)
Sudan	Removal of user fees for C-section and children younger than 5 years	February 2008
Uganda	Removal of user fees in public health care facilities	February 2001
Zambia	Removal of user fees at primary health care level	April 2006 (rural) Jan 2007 (peri-urban)

To inform its policy on this issue, UNICEF convened in 2005 a consultation of external experts, partner organizations, and country and regional level staff to discuss the specific issue of user fees in the health sector. The consensus that emerged from this consultation has been guiding UNICEF policy on this issue (James et al. 2006). Since the 2005 UNICEF consultation, a number of countries have introduced new policies on user fees. A non-exhaustive summary of these initiatives in sub-Saharan African countries is provided in Table 1.²

Knowledge on these experiences is still limited.³ Preliminary evidence suggested that in some cases user fee removal was not supported by other policy measures such as increased national budgets for health care (to protect the quality of care when facing increased utilization), or careful planning and deliberate implementation strategies (Cholet et al. 2008; Ridde 2008). In such instances, fee removal tended to exacerbate the problems facing health systems and weaken their performance. On the other hand, in countries where fee removal was carefully planned and managed, there are signs of increased utilization of services and indications that the poor benefited the most, although this does not guarantee health benefit or sufficient welfare protection (Xu et al. 2006).

2.2 OBJECTIVES AND NATURE OF THE REVIEW

In the UNICEF consensus paper of 2005, participants acknowledged that user fee removal had the potential to improve access to health services, but for this to occur, fee removal needed to be part of a broader package of reforms (James et al 2006).

The multi-country review builds on this starting point. It does not come back to the controversy about whether user fees are good or bad. It focuses on the ‘how’, once a government has decided to abolish user fees. More in particular, the review documents the processes and strategies through which user fee removal reforms have recently been implemented in six sub-Saharan African countries: Burkina Faso, Burundi, Ghana, Liberia, Senegal and Uganda. It is therefore mainly a descriptive study. Yet, due to the size of the sample, the study is informative on what is going on today in sub-Saharan Africa in terms of removal of user fees. Comparison is also insightful.

The main objective of the multi-country review was to draw lessons (do’s and don’ts) that could guide the future formulation and implementation of such policies in other countries.⁴ The focus of the study is therefore operational – it aims neither at advocacy (user fee removal is right or wrong) nor at scientific analysis (for example, we will not study how removal of user fees emerged on the policy agenda or try to measure the impact of the user fee removal on health outcomes).

In order to identify do’s and don’ts we faced a major constraint: given the multifaceted nature of user fee reforms and the limited time-frame since the inception of these reforms, our research design did not allow us to establish causal links between the reform (its content and its process) and possible effects (on the population, on the health services...). We have circumvented this difficulty by adopting a normative approach to the experiences: we have pre-identified a set of what we considered as good practices and checked whether they have been adopted in the six countries.

The whole study was constrained by the amount of time (4 months) and the financial resources available. The general approach was to base the review on peer-reviewed and grey literature (when

² See also (Yates 2009).

³ Two literature reviews are available (Lagarde and Palmer 2008; Ridde and Morestin 2009).

⁴ The companion output of this report is a policy guidance note (Meessen 2009).

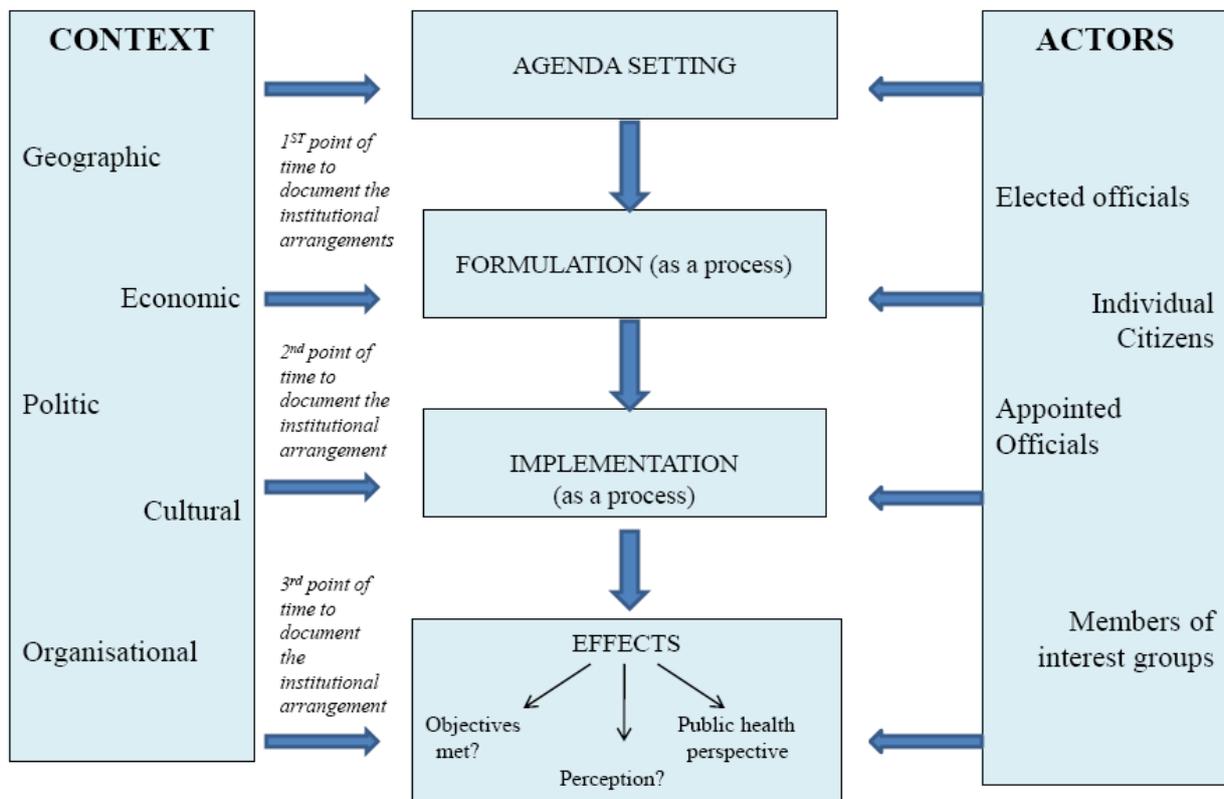
available) and on qualitative and secondary quantitative data to be gathered through short field visits (~ 7-10 days per country).

2.3 FRAMEWORK, DEFINITIONS AND NORMATIVE JUDGMENT

To make data collected across countries comparable, a common framework and definitions were necessary.

Our framework is embodied in the instruments used to collect the data. It follows the triangle model proposed by Walt and Gilson in 1994 (Walt and Gilson 1994) and is organized in four main dimensions: the context of the reform, its content, the actors' involvement and the policy process. We have adapted slightly the original framework based on research from other authors (Gilson et al. 2000; Lemieux 2002; Ridde 2008).

Figure 1 Schematic representation of the framework



It is well-known that the **context** is a key determinant of a policy process. Due to changes at context level, a problem that has already existed for a while might suddenly become an issue for some policy actors. Context may influence the content of the reform. It will also influence the implementation and shape the position and influence of various actors. According to Leichter, context can be divided into four categories: situational factors, structural factors, socio-cultural factors and global factors (Leichter 1979). We have considered three levels: the global context (or more accurately: features relating the country to the external world); the national context outside the health sector; and the national health sector context. For both national contexts, we have looked at structural and organizational characteristics, socio-cultural factors and more situational ones.

Some key statistics describing the context were also gathered; the rest of the information, largely qualitative, came from desk reviews or interviews.

The second part of the framework documents the **content** of the reform. We have adopted an approach focusing on institutional arrangements defined as “the contractual relation or governance structure between economic entities that defines the way in which they cooperate and/or compete” (Williamson 1996). Accordingly, a health care reform is defined as an intentional change of institutional arrangements shaping the provision of health care services. It was not possible to outline extensively the institutional arrangements; in this report, our focus is on the ‘benefit contract’ between the health care providers and the population and the ‘remuneration contract’ between the government and the health care providers (as removing user fees at facility level obviously requires the organisation of alternative financing for the health services).

When designing the multi-country review, we were rather ambitious as far as the documentation of the institutional arrangements was concerned. One objective for example was to compare the institutional arrangements intended by the policy makers (the formulation stage) and the institutional arrangements currently enforced / implemented (the implementation stage). Yet, the truth is that most reforms have been hastily adopted, often with minimal planning. Differences between the formulation and implementation stages - in the literature referred to as the implementation gap - could have indicated a good formulation but poor implementation or conversely a poor formulation and good (corrective) implementation (Pulzl and Treib 2006). Hence this comparison was not possible. Besides the descriptive report of what we observed (or understood, sometimes things are not very clear), we produce a normative appreciation of the design of the reform. This normative appreciation is based on public health and health economics knowledge.

The third part of the framework is dedicated to the **actors**. Ideally, all actors who have played a significant role in the process should have drawn our attention. A list of actors was suggested to the scientist conducting the country studies. Many of these actors were in fact interviewed. For each actor, we tried to document their contribution to the policy process (especially formulation and implementation). In some countries, this information was rather difficult to collect.

The fourth part of the framework aimed at documenting the **policy process**. As already mentioned, agenda setting was not the focus of this study; this is indeed not really the turf of technicians. We have focused on the two other stages: the formulation and the implementation.

For both stages, the framework adopts a normative approach with a list of best practices or plausible good ones (see boxes 1 and 2). These lists were developed after a rapid literature review on user fee removal (Gilson and McIntyre 2005; Richard, Witter and De Brouwere 2008; Ridde and Morestin 2009). We also consulted the general literature on reform and policy process. The list emerging from these reviews was enriched by the personal experience of the experts involved in the design of the protocol; indeed, several of them have been involved in the design and/or implementation of health care financing reforms in low-income countries.

Box 1: Good practices for the formulation of a reform

1. A preliminary situation analysis of the problem is helpful.
2. International scientific evidence and expertise are helpful.
3. Contextualized scientific evidence and local knowledge are crucial.
4. Clarity of the policy objectives is helpful.
5. Considering different policy options is preferable, but optional.
6. A thorough assessment of the option that is picked is helpful.
7. Early identification of accompanying measures is helpful.
8. Vision, ownership and leadership by the national authorities are crucial.
9. Involving stakeholders essential for the implementation stage in the formulation stage is crucial.
10. It is important that the content of the reform meets preferences of stakeholders crucial for the implementation.

The study assessed to what extent the policy process has complied with these recommendations. Furthermore we tried to assess how the reform took into consideration the (un)expected actions of actors in charge of the implementation. During their data collection, researchers remained open to other processes that could have influenced experiences on the ground and could lead to identifying new best practices.

The fifth and last part of the framework covers the possible **effects** - intended or not - of the reform. As a reminder, the purpose of this study was not to demonstrate causal links between the reform and any outcome. However, we understood that our study could help to enrich the list of best practices for technicians. For that purpose, a rough estimate of the effects was thought desirable.

We had initially imagined adopting different definitions for successful user fee removal. Yet, the paucity of data appeared to be a major constraint. For instance, in several countries, we were not able to check whether the objectives listed in the formulation stage had been met because of the lack of a plan or of a reliable monitoring system. The weakness of the monitoring systems (especially in the two post-conflict countries) did not allow us either to check whether mothers and children really benefited from the reform. As a consequence, this review mainly reports evidence already reported by others on the effect of the reform.

Box 2: Good practices for the implementation of a reform

1. The sequencing of the reform is helpful.
2. A process to plan steps to take is crucial.
3. Effective implementation requires wide-ranging communication strategies targeted at different key implementing groups.
4. A clear agreement among partners to share the budgetary burden of the reform is crucial.
5. A clear and robust channelling of resources to health care facilities that compensate the income loss and cover any new cost is crucial.
6. Leadership by national authorities is crucial.
7. A strategy to build capacities and train people is helpful.
8. Having a coordination unit involving capable technicians with relevant decision rights is crucial.
9. Monitoring and evaluation of the reform, including at peripheral level is crucial.
10. Enforcing decisions is crucial.

2.4 STUDY SITES

The basic principle for selecting countries was to secure enough similarities across countries but also enough differences to make the comparison interesting. Several criteria have played a role.

A first rule was to select only sub-Saharan African countries. The rationale behind this choice was to secure enough similarities in terms of contexts (e.g. health needs of the population) and constraints (e.g. level of development). It was understood that this focus would also facilitate the implementation of the study (e.g. selection of the consultants).

A second principle was to focus on countries where the policy change was significant in its effort to remove barriers due to user fees. Different strategies were considered, in order to capture variety in terms of policy options: universal abolition (e.g. Uganda), user fee removal for specific categories (e.g. children younger than five years in Niger) and significant reduction in the fees (e.g. the 80% cut in Burkina Faso). Given the UNICEF mandate, particular attention was given to countries where the policy targeted the children and their mothers.

A third criterion was to include only countries with nationwide reforms. This criterion excludes the ongoing experiences of user fee removals or free health care taking place in a project or a programme. These experiments or interventions usually benefit from close support, including support by aid partners, and are not very informative on policy challenges existing at national level (ownership, budgetary implications, accountability to constituencies...).

As a fourth criterion, we preferred countries with a recent history of policy change regarding user fees. The main rationale for this choice was to ensure easy access to informants who have been personally close to the policy process. Recent experiences are also probably more representative of the current political environment in favour of user fee removal.

A fifth concern was to get a good balance of countries belonging to different traditions in terms of the organization of the public health system. As the history of user fees is different in

countries that were under French or Anglo-Saxon influence in the past, it was decided that both types of countries should be included.

Participants to the September 2008 workshop at Institute of Tropical Medicine discussed the list of countries pre-identified by the UNICEF New-York office. A list of six countries was finally made: Burkina Faso, Burundi, Ghana, Liberia, Niger and Uganda. Selecting more countries was not an option given the provided time and budget. Participants agreed that these countries required different approaches for data collection. The Ugandan and Ghanaian experiences are quite well documented in the literature; hence it was decided to base the study largely on published material. Phone interviews were organized for the process dimensions insufficiently described in the literature. Experiences in Burkina Faso, Burundi, Liberia and Niger are very recent. Published data are very limited. Therefore field visits would be organized in these countries to collect the information required by the framework.

The framework and the instruments were finalized by the end of October. The missions were slated for the months of November and December 2008. The tight schedule was a challenge for the two field consultants, the UNICEF country offices and the hosting governments. Eventually, it was not feasible to secure an agreement on the study of the Niger case. David Hercot was able to spend a week in Uganda to complete the gaps in the literature review, mainly regarding the process of the reform. In early January, it was decided to replace Niger with a literature review of the experience of Senegal. The latter review of the literature was facilitated by the availability of a very clear report on the reform process (Gouvernement du Sénégal et al. 2007; Witter et al. 2008).

2.5 RESEARCH INSTRUMENTS AND DATA COLLECTION

Research instruments consisted of a set of questions covering the five dimensions of the framework. Researchers used them during their data collection as checklists. For Burundi, Ghana, Liberia and Uganda, data were entered in an electronic format. For Senegal, a short version was produced; whereas for Burkina Faso, the framework provided the structure for the country report. Researchers were invited to think 'out of the box' during the data collection.

The study is to a large extent retrospective (e.g. the documentation of the context or the institutional arrangements before the reform) but to some extent also contemporary (e.g. the reform as it is enforced today). Some researchers used a timeline to follow the sequence of reforms.

For Ghana and Uganda, Florence Morestin and David Hercot (DH) performed the following tasks:

- A review of the national documents and studies on the user fee removal;
- Completion of the framework with this information;
- Identification of gaps in the knowledge;
- Phone interview with key informants based in the country (DH);
- Field visit (Uganda only, DH).

For Burkina Faso, Burundi, Liberia and Uganda, the researchers performed the following tasks and activities:

- A review of the national documents and studies on health financing;
- Interviews at national level with policy-makers, key stakeholders from the government, the civil society, NGOs, technical and financial partners to understand how the policy change was decided and implemented, and their perception of its success;
- Visits to health facilities;
- Interviews at district and facility level with health care workers and district personnel;

- Focus groups with beneficiaries and staff (Burkina Faso: Abel Bicaba and Valéry Ridde; Burundi and Liberia: Mathieu Noirhomme);
- A report in the local language summarizing the objectives, methodology, findings and possible recommendations for improving the existing policy. This report targets a national audience.
- A consultation process to validate the findings (mainly through the dissemination of the ‘national report’).

In Burundi and Burkina Faso, the international researcher worked closely with a national consultant: Abel Bicaba (Burkina Faso) and Sosthène Hicuburundi (Burundi). Where available, the national consultants facilitated the visit and contributed to data collection and analysis. UNICEF country offices facilitated country visits, including briefing and trips to the field.

2.6 DATA COLLECTION, VALIDATION AND ANALYSIS

In terms of data collection, the review rested to a great extent on the instruments, on reports available in countries and on the profile of the consultants.

Consultants were requested not to try to collect primary quantitative data for the study. As far as quantitative data were concerned, they were invited to rely on reports already available in countries. The fact that this report provides limited data is of course a major constraint, but it was inherent to the consultation design.

The consultants collected a lot of qualitative data through their interviews. Validation of this information was done instantaneously through triangulation with existing documents and other informants. Interviews were not taped.

For visited countries, ideally a feedback to key stakeholders should have been organized at the end of the mission. Yet, the very short time of the mission did not allow for this. Another request to consultants was to produce a very short operational report in the language of the country (Hercot & Morestin 2009; Noirhomme 2008a; Noirhomme 2008b; Ridde & Bicaba 2009). Among other things, this report had to include some recommendations to improve the existing national policy. Valéry Ridde and Abel Bicaba, who currently have a research portfolio in Burkina Faso, were able to produce a long report. These national reports have been shared with a few informed stakeholders. Validation has mainly been done through the comments they have made on the reports.

On December 22nd and 23rd, the research team gathered in Antwerp. David Hercot, Mathieu Noirhomme and Valéry Ridde presented their findings to other researchers familiar with the consultation. Main lessons were identified collectively during this workshop. Participants pointed to the fact that the two countries visited by Mathieu Noirhomme were emerging from a civil war. A recommendation to him was to focus his further analysis on the specificity of post-conflict settings for user fee removal reforms.

2.7 QUALITY ASSURANCE

Several mechanisms have contributed to the quality assurance for the multi-country review. First, the researchers who carried out the data collection and the analysis were involved from the time of the development of the study.

Second, the first written version of the protocol was shared with other experts involved in this study and has benefited from their written comments.

The quality of the study rests heavily on the expertise of the consultants who collected data in the field. Valéry Ridde and Mathieu Noirhomme have extensive experience both in the implementation of health care financing strategies and in their study. Mr. Ridde has an in-depth knowledge of Burkina Faso whereas Mr. Noirhomme knows Burundi well. Bruno Meessen supervised the whole study.

We believe that the limited list of experts involved in the study led to more consistency in the data collection. The cross-cutting analysis of the experiences at the Antwerp workshop in December consolidated the consistency in the analysis.

2.8 LIMITS OF THE REVIEW

This review has several limits.

By design, the main ones are the following:

- No possibility to link the process of the reforms with their outcomes.
- If one refers to Walt and Gilson's framework for policy process analysis (Walt & Gilson 1994), one component has received less attention due to time constraints: the actors (their influence, positions, actions...).

Because of data availability, we were not able to provide a good view on the situation today in the six countries. The dearth of data has been particularly an issue for the documentation of Burundi and Liberia experiences. For Ghana and Senegal, our knowledge is very indirect. We mainly report what we have read.

For all countries, the study of the policy process is largely retrospective. Our key informants may have forgotten some actions that took place. More fundamentally, they may not be aware of activities in which they did not participate.

3 FINDINGS

3.1 CONTEXT

We propose to introduce the context on the basis of a few key statistics. Table 2 lists key economic and health sector indicators for each country. The six countries are clearly low-income countries, and even very low-income in the case of Burundi. More than one third of the population lives below the national poverty line. Under-five mortality rates and maternal mortality ratios are very high. As for health care expenditure, one notices that in relative share, users are the main contributors to the financing of the health services. Given the poverty of Burundi's population, the situation there is particularly alarming. The comparison with Liberia indicates that the heavy burden on Burundi's population largely stems from a lower access by Burundi to international aid.

The very high percentage of out-of-pocket expenditure as percentage of private expenditure in five countries indicates that health insurance schemes still have a very low coverage in these countries; interestingly it is two Anglophone countries that achieve the highest coverage. Finally, one can observe that external aid contributes significantly to health expenditure in the six countries; yet, two of them – Liberia and Burkina Faso – seem particularly privileged.

Table 2: Key context indicators (sources: UNDP & WHO)

	Burkina Faso	Burundi	Ghana	Liberia	Senegal	Uganda
Population (1,000), 2007	13,933	7,859	22,535	3,442	11,800	31,367
GDP per capita (PPP US\$), 2005	1,213	699	2,481	..	1,792	1,454
Population living below \$1 a day (%), 1990-2005	27.2	54.6	44.8	..	17	..
Population living below the national poverty line (%), 1990-2004	46.4	36.4	39.5	..	33.4	37.7
Under-5 mortality rate (probability of dying by age 5 per 1000 live births) both sexes ⁵ , 2006	204.0	181.0	120.0	235.0	116.0	134.0
Adjusted Maternal mortality ratio (per 100 000 live births), 2006	700.0	1100.0	560.0	1200.0	980.0	550.0
External resources for health as percentage of total expenditure on health, 2006	32.9	13.7	22.4	42.3	13.5	28.5
General government expenditure on health as percentage of total expenditure on health, 2006	56.9	24.6	36.5	63.9	31.5	26.9
Private expenditure on health as percentage of total expenditure on health, 2006	43.1	75.4	63.5	36.1	68.5	73.1
Out-of-pocket expenditure as percentage of private expenditure on health, 2006	91.5	100.0	78.8	98.9	90.3	51.8
Per capita total expenditure on health (PPP int. \$), 2006	87.0	15.0	100.0	39.0	72.0	143.0

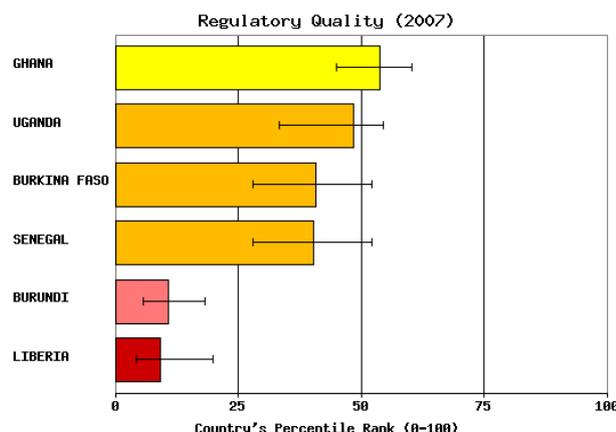
⁵ These and following data come from WHOSIS on February 5th 2009. <http://www.who.int/whosis/en/>; They slightly differ from the national DHS data. Data from Ghana did probably change following the recent reform introducing the National Health Insurance Scheme.

In terms of political systems, the six countries are democracies. This means, among other things, that there are potentially electoral benefits attached to very visible actions by the President or the government. Free health care belongs to the latter category.

In terms of health system organization, the six countries are very similar. Each country is divided in health districts, with health centres delivering a minimum package of activities and a referral hospital delivering a complementary package of activities.

One could classify the six countries into two main groups: the four stable low-income countries (Burkina Faso, Ghana, Senegal and Uganda) and the two countries coming out of a civil war (Burundi and Liberia). These two groups face different constraints. The data from Kaufmann and colleagues shows that Burundi and Liberia are markedly lagging behind for five out of the six governance indicators. The regulatory quality for example of Liberia and Burundi is estimated around the tenth percentile of countries as illustrated in Figure 2 (Kaufmann et al. 2008). In Table 3, we summarize some of the key differences between the two groups of countries.

Figure 2: Regulatory quality of countries (Kaufmann 2008)



Source: Kaufmann D., A. Kraay, and M. Mastruzzi 2008: Governance Matters VII: Governance Indicators for 1996-2007
 Note: The governance indicators presented here aggregate the views on the quality of governance provided by a large number of enterprise, citizen and expert survey respondents in industrial and developing countries. These data are gathered from a number of survey institutes, think tanks, non-governmental organizations, and international organizations. The aggregate indicators do not reflect the official views of the World Bank, its Executive Directors, or the countries they represent. The WGI are not used by the World Bank Group to allocate resources or for any other official purpose.

Table 3: A comparison of the context between stable and post-conflict countries

	Post-conflict countries: Burundi and Liberia	Stable countries: Burkina Faso, Ghana, Senegal and Uganda
Population	Huge health needs and widespread severe poverty.	Health needs are high, poverty is not general.
Political power	New → high expectations for concrete & symbolic stances.	Well established.
Political agenda	Wide range of political, social & health reforms ongoing (social reconstruction).	A highly visible policy measure can help for re-election.
Health system	Disorganized & weakly regulated. To be rebuilt	In place, yet performance can be quite low in some countries.
Health financing	Weak and jeopardized (no tax-based funding, no global financing, changes in donor patterns...).	Not relying on humanitarian aid; more stable.
Aid partners	Phasing-out of emergency actors; phasing-in of development & global actors.	Bilateral agencies, Global Health Initiatives, development NGOs.
Coordination	Coordination mechanisms to be created.	Coordination mechanisms normally in place, yet to a different extent.
Equity issues	Emerging after war times. High expectations.	Major inequities, but for quite a while.
Information system	Non-existent. No studies. Weak Health Information System (HIS). Weak monitoring & evaluation.	Stronger HIS. Tradition of research better established.

3.2 CONTENT

Benefit package

Although concomitant, the reforms adopted in the six countries varied to a fair extent. We summarize the entitlement offered by each reform in Table 4. Of interest to note is that universal free health care has been adopted only in Anglophone countries.⁶ Francophone countries have opted for what is sometimes referred to as ‘categorical targeting’ approaches (i.e. only a category of individuals is eligible to the assistance). Maternal health has received particular attention from governments; this indicates that the efforts made at global level to establish maternal mortality as a top priority is bringing some results.

Two countries have also adopted a ‘geographical targeting’ approach: Ghana and Senegal. Burkina Faso authorities value the fact that users have to contribute financially to their health services; they have opted for a subsidy of the services (i.e. an attempt to reduce the prices charged to the mothers).

All the measures are still in place, except in Ghana, where the free delivery policy was replaced in July 2008 by a free entitlement to the National Health Insurance for one year (after registration as a pregnant woman).

Table 4: The new entitlements for the population

Countries	Reform	Scope	Date	Funding
Burkina Faso	Deliveries, C-sections and neonatal care, 80% subsidy in public facilities	National	C-sections: 10/2006 Deliveries: 1-4/2007	National budget
Burundi	Free deliveries and free care for children younger than 5 years in public and PNFP	National	5/2006	National budget & HIPC (+ aid)
Ghana	Free deliveries including in private sector FP and NFP	First in the four poorest provinces, then in the whole country	9/2003, 4/2005 Integration in another scheme: July 2008	National budget & HIPC
Liberia	Suspension of user fees in public health facilities	National	4/2006	Aid & national budget
Senegal	Free deliveries (at HC level), Caesarean-section (at hospital level) in public sector	First in five regions then national for Caesarean-section but Dakar	1/2005, 1/2006	National budget & HIPC
Uganda	Free health care in public facilities	National	3/2001	National budget & HIPC

⁶ The two other sub-Saharan countries which adopted some kind of universal free health care strategy are also Anglophone countries: South Africa and Zambia.

Funding

Remarkably in four countries the Highly Indebted Poor Countries Initiative (HIPC)⁷ proved a key instrument to finance the reform. This was an unexpected finding for us; we are still unclear about the exact contribution of the arrangement in favouring the reform (as by principle, it is part of the national budget). We could not confirm this information for Burkina while Liberia is not yet eligible.

Plausible explanations could be: (1) the HIPC arrangement sets clear incentives for governments to allocate resources to the health sector; (2) governments have to decide which intervention to finance; (3) universal abolition of user fees (or ‘categorical exemption’) is an interesting option for governments. We hypothesize that removal of user fees is appreciated by governments for four main reasons: it is perceived as a policy option addressing a major barrier to access; it complies with the health policy vision of the country and of the donors (e.g. MDG 5); it is perceived as easy to implement in a top-down and rapid way with public resources (if one compares for example to developing community-based health insurance or universal mandatory health insurance like in Rwanda or Ghana); the measure is often popular with the population. This hypothesis deserves to be tested through a more systematic review of the interventions carried out by governments through the HIPC since its introduction.

As a matter of fact, we have observed that the different reforms benefit from strong ownership at governmental level. Ownership at parliamentary level is present in Uganda and Burkina Faso.

In the post-conflict countries, the reforms have also been financed through humanitarian aid. International aid for free health care was already present in Liberia before the reform (through humanitarian projects in place in some regions). In Burundi, there were some international NGOs active in the countryside before the reform; some of these were providing highly subsidized health care. Yet, their contribution to the financing of the reform has been limited, especially for the ones that had scaled down their own operations. Some international aid actors (DFID, ECHO) responded to the urgent needs created by the unexpected presidential decision, mainly by providing drugs. Such a “damage control” approach is clearly not optimal. There is evidence that some health facilities had not yet received any support seven months after the official removal.

Compensating health facilities and accompanying measures

Beside the entitlements, which can be seen as the formal contract between the government and the population, we have tried to understand the contract between the government and the health facilities (Table 5). Obviously, if health care is free of charge for the patient, someone else has to cover the costs. The study documented how governments have compensated health care facilities for the revenue loss due to the user fee removal and the extra costs generated by the increased utilisation. We have identified two countries with an input-based approach (Uganda and Liberia), two countries with an output-based approach (Burkina Faso and Ghana) and two which have adopted a combination of both approaches (Burundi and Senegal).

In Uganda, health facilities have been compensated through a greater provision of inputs by the government (2000-2005). A key trait of the user fee removal was its integration in a larger

⁷ The HIPC Initiative is a global debt cancellation scheme that stipulates as a condition the allocation by the government of a substantial share of the debt relief to social sectors.

package of reforms addressing some other bottlenecks or possible consequences of the user fee removal. There was an increase of the public budget for drugs, but also for other inputs such as human resources and running costs. For example, the issue of staff motivation was dealt with by an increase of the salaries. Yet, the increase of inputs has not been sustained over time leading to inadequacies, with drug stock-outs as a particular challenge. The user fee removal has also reduced the capacity of health facilities to recruit staff outside of the public service.

Liberia is also under an input-based approach. As far as the funding is concerned, it has adopted some kind of a 'dual track' model: in counties supported by international NGOs, health facilities rely on resources from the partners; counties not supported by a NGO are under a governmental arrangement, which is relatively centralized for some items (e.g. running costs of health facilities are covered by county office budgets).

Senegal has a dual system by level of health facilities. Lower level facilities are under a partial input-based system and are compensated on the basis of a push system of kits for deliveries or C-sections. These kits merely cover drugs and consumables for normal deliveries at health centres. The planned additional cash payment to cover other inputs (e.g. staff) has not been implemented so far. On the other end, regional hospitals receive frontload payment for the expected cost of C-sections. The lump sum reimbursement is much higher than the actual cost of the service. This frontloaded output-based payment generates strong financial stimuli for hospitals to perform C-sections (Gouvernement du Senegal, UNFPA, IMMEDIATE, & CEFOP 2007).

In Burundi, a mix of methods has been used to compensate health facilities. This mixed approach was not a deliberate choice but rather a result of the unprepared character of the reform. The user fee removal led to an increase in health facility utilisation. In order to cope with the increased consumption of drugs, a few international partners organised together with the government to support a system of drug kits. These drug kits arrived in the health facilities several months after the user fee removal. In parallel, health facilities have been compensated according to the quantity of drugs they prescribe and the quantity of services they deliver to patients, which amounts to a fee-for-service arrangement. During the first two years, both systems have co-existed. The reimbursement system presents a major administrative workload and monitoring is limited. There is a consensus that this is not a good solution. Interestingly, in provinces practicing Performance-Based Financing (PBF), beside the reimbursement of exemptions on the fee-for-service basis by the government, the health facilities received a lump sum payment from the local international partner. The PBF brings significant income to the health facilities and establishes strong incentives to increase production. The national plan is to merge the free health care policy with the PBF approach. The lump sum fees for the different free services would cover the costs of the drugs and the staff motivation.

The case of Burkina Faso is particularly interesting. As the experience with input-based financing of free treatment had not been satisfactory in the past, it was decided that the health facilities would be compensated in cash according to their activities, i.e. an output-based payment arrangement. This payment would include the cost of the drugs and consumables, but also all other inputs, including a bonus for the staff and transportation to hospitals in case of referrals. This obviously required adopting (at national level) some lump sum fees for the different activities covered by the scheme. For the cost of the C-section, Burkina Faso benefited from costing analyses done in different hospitals; the fee adopted was a fair approximation of the real costs. For normal deliveries, the decision was purely administrative (according to an existing fee list for hospital acts) and fixed a fee significantly superior to the real cost. Furthermore, no clear guidance was issued by the Ministry of Health on the exact allocation of the fees collected through the scheme. The key question was: How are the 20% the staff is entitled to calculated? 20% of the subsidy,

20% of the full price (the fee + the co-payment), 20% of the difference between the subsidy and the real cost or 20% of the difference between the full price and the real cost? As long as there was no clear rule issued by the MoH, health centres adopted different practices in this respect. Obviously, some of these practices were very powerful incentives for the health centre staff to increase the number of deliveries. Of particular interest in this story is that the MoH of Burkina Faso has introduced a very strong output-based payment mechanism without a full understanding of the incentives it was establishing. This arrangement could explain the high increase in utilization observed in Burkina Faso.

In Ghana the MoH chose to reimburse the facilities according to the average cost per delivery. The average cost was calculated at national level and the money was sent to the regions for distribution to health facilities. During the first wave of funding, the money flowed through the local governments who allocated money to the health facilities according to their needs. In a second phase, the money flowed as previously through the channels of the Ghana Health Services. Each studied region developed its own mechanism to manage the grant received from the central level (Witter and Adjei 2007).

Table 5: How health facilities are compensated for the cost of free health care

Countries	How the cost of drugs is covered at facility level	How the extra burden is remunerated to the personnel	Access to cash	Funding at national level
Burkina Faso	Normal deliveries, complicated deliveries and C-sections are reimbursed respectively at \$7, \$36 and \$88.	According to older rules, the personnel can retain 20% of the total fees as bonuses (= variable bonus).	Ensured through the fee paid by the national budget.	National budget
Burundi	Provision of drug kits to health facilities. Major delays (6-12 months) since the beginning. Last drug orders have been delivered in late 2008. In addition, the government reimburses health facilities for all services and drugs provided. This second mechanism will be the only one in the future.	In areas non-supported by international NGOs, no measure. Several provinces are under performance-based financing. Personnel retain a high proportion of the fees paid by the third-party (NGO) as bonus (=variable bonus).	Theoretically ensured through the fee-for-service arrangement; yet, reimbursements were late (6 to 12 month) and are hoarded up at provincial level. In non-supported facilities, it has generated a major problem of cash flow. Situation looks better in PBF areas.	Drugs in 2006: humanitarian aid (ECHO/UNICEF) Drugs in 2007: DFID Drugs in 2008: HIPC PBF: International NGOs
Ghana	The MoH defined an average cost that allowed defining regional budgets. The budget was used differently across regions (tariffs set by the MoH not respected).	No explicit remuneration described.	Claims were to be submitted to the Region that reimbursed the health facility according to availability of funds and regionally defined procedure and amounts.	National budget & HIPC

Countries	How the cost of drugs is covered at facility level	How the extra burden is remunerated to the personnel	Access to cash	Funding at national level
Liberia	In supported areas: drugs are provided for free by international NGOs In non-supported areas: drug grant at the national medical store is under government funding.	An incentive system has been designed to fill the gap between official and actual salaries. Complementary incomes are paid by international NGOs in supported areas, by the government in non-supported areas (= fixed bonus).	Non-Supported areas: No cash anymore at peripheral level (county takes care of everything).	Aid & national budget.
Senegal	Health centres and district hospitals receive a certain amount of kits. Rules to distribute kits are not clear. Regional hospitals receive a financial compensation per C-section they provide (fee-for-service).	None in health centres and district hospitals although it was planned. Included in the fee for regional hospitals.	Not ensured in health centres and district hospitals. Ensured in regional hospitals via the front loading (justifications are to be subsequently submitted)	National budget & HIPC
Uganda	Health facilities receive drugs for free from the government, first under a push system and later on (2004) through a credit line at the central medical store and by using part of their "primary health care funds". Quantities were and remain insufficient.	Increase of the governmental salaries in 2002. Because of the user fee removal, health facilities cannot recruit non-civil servant staff anymore.	Recurrent costs are covered through the decentralized public budget.	Significant and rapid effort by the national budget & HIPC at the launch of the reform and in the medium term

3.3 ACTORS

During data collection, limited attention was paid to the agenda setting stage. In a nutshell, one can say that international NGOs have been influential in Liberia – they expressed clearly their preference for maintaining the strategy of free health care in their projects. Suspending user fees was perceived by the government as the best way to retain these financial and technical partners in a period of serious financial uncertainty. They also had some influence in Burundi (mainly through two international reports stigmatizing the incoherencies in the national user fee policy). Some international agencies have played a role in Ghana, Senegal and Burkina Faso mainly during the dialogue process. In general, the role of donors was apparently rather limited in the six countries.

In Burundi, Liberia and Uganda, the decision to abolish user fees was a decision by the President; in Burkina Faso, the decision was taken by the Council of Ministers. In Burundi it was a top-down and sudden decision while in Uganda, the decisions was taken during the campaign for the presidential election. In the three other countries more actors have been involved in the decision.

In all countries, the removal of user fees has been a highly visible action taken by the government in the health sector (from a citizen perspective). In Ghana, the free delivery policy looks more like an interim measure, either to respond to donor pressure and/or to seize the opportunity offered by the conditions under the HIPC Initiative's arrangement without undermining the major policy under development: the roll out of the National Health Insurance. In

Senegal it came at the same time as the discussion around the “*Plan Sesame*” to provide free care for the elderly.

In all countries, frontline actors have only been involved during the implementation of the reform. Obviously this late involvement has not eased the implementation (see further).

3.4 FORMULATION STAGE

One of the main focuses of our study was to assess the extent to which governments have followed good practices in terms of policy formulation. Researchers have extensively reviewed the peer-reviewed and grey literature and carefully explored this question with their key informants. Information on each country is reported in country reports.

Table 6 summarizes our observations for the six countries.

Table 6: Good practice in the formulation stage, comparison of six countries

	Burkina Faso	Burundi	Liberia	Uganda	Ghana	Senegal
1. Preliminary situation analysis	Yes	+/-	No	Yes	No	+/-
2. &3 International and National Scientific evidence	+/-	No	No	No	Yes	
4. Clarity of the policy objectives	Yes	+/-	+/-	Yes	Yes	Yes
5. Considering different policy options	Yes	No	Yes	Yes	No	No
6. Thorough assessment of the option	Yes ⁸	No	No	No	No	No
7. Early identification of accompanying measures	No	No	No	Yes	No	No
8. Vision, ownership and leadership	Yes	+/-	Yes	Yes	+/-	+/-
9. Involving in the formulation stage stakeholders crucial for the implementation	+/-	No	No	No	No	No
10. The content of the reform meets preferences of stakeholders	Yes	Yes	Yes	+/-	Yes	Yes

Our analysis is that Burkina Faso did rather well in terms of policy formulation. The identification of the accompanying measures has been hindered by an unexpectedly rapid decision by the Council of Ministers on the budget allocation. Technicians at the Ministry of Health were not fully ready. The other countries did not perform well according to our standards. The poor score obtained by Burundi is largely due to the fact that the decision by the President took the MoH and its partners by surprise. Liberia obtains a better score largely because of the pragmatic approach adopted by the government. Suspending user fees was in fact a challenge only in places where health facilities were not supported by international NGOs (as the latter were already providing health care for free to their beneficiaries). This reform is only a first step in a large ongoing process of developing a sound health financing policy that should be ready by mid 2009.

⁸ But there has been a major overestimation in cost per delivery.

The score of Uganda reflects well the policy process in the country. Several studies had reported how user fees were a barrier for the population. The problem was highlighted during the presidential election campaign by all opponents to the incumbent President who promised to remove user fees if elected. The incumbent President, who was running for a second mandate, reacted swiftly: he checked with the Ministry of Health how much it would cost to remove user fees and with the Ministry of Finance the room for manoeuvre in the public budget. Due to the narrow window of opportunity, the weakest steps were those carried out by the technicians (e.g. the thorough assessment of the option). A process had been ongoing for a few years prior to the decision but no consensus had been reached on the way to reform user fees. In 2001, the MoH technicians were indeed favouring less radical options of reform. The reform was designed to replace all lost revenues.

One could fear that health workers and district managers in many countries would resist reforms with a user fees removal component, fearing a loss of advantages; but surprisingly enough, an important percentage of health workers in Ghana and Senegal did support the removal of user fees for deliveries as they acknowledged user fees were a heavy burden for the population (Witter et al. 2007). Still dissatisfaction about increased workload and insufficient compensations are often reported off the record in all countries of the study.

3.5 IMPLEMENTATION STAGE

The other major focus of our study was the implementation stage of the reform. It is well-known that several reforms in sub-Saharan Africa have failed because of poor implementation.

Table 7: Good practice in the implementation stage, comparison of six countries

	Burkina Faso	Burundi	Liberia	Uganda	Ghana	Senegal
1. Sequencing of the reform	No	No	+	No	+	+
2. Planning process	+	No	+	+	No	+
3. Communication strategies – Stakeholders (not users)	++	No	No	+	+	+
4. Communication strategies – Users	+	+	+	++	+	+
5. Medium term commitment on budgetary burden	++	+	++	++	No	No
6. Channelling of resources	Same	New	Adapt	Same	New ⁹	New
7. Leadership by the government	++	+	++	+++	+	+
8. Capacity building	+	No	No	No	No	No
9. Empowered coordination unit	+	+	++	++	No	+
10. M&E of the reform	+	+	+	+++	No	No
11. Enforcing the reform	++	+	+	++	+	+

Key for symbols: +++: Very good implementation; ++: Good implementation; +: partial or weak implementation; No: No evidence of implementation.

⁹ Ultimately the new system was dropped and replaced by the old mechanism bypassing the local authorities and thus the decentralization efforts.

Our analysis brings mixed findings. The most interesting reading of Table 7 is perhaps a horizontal reading. We say that three countries adopted the ‘big bang’ approach, while the three others carried out reforms more gradually. Yet, we have not found significant evidence that countries which proceeded gradually really took benefit from the possibility to learn from the early steps (perhaps this gradualism reduced the pressure on the technicians in charge of the implementation?). Across countries, the measure was communicated to the population, but communication remained fairly basic: a radio broadcast of the decision. This communication strategy is surely a major mechanism to enforce the reform in health facilities (as users claim for free treatment). The communication campaign in Burkina Faso and Senegal was hampered due to a lack of financial resources. Communication of universal user fee removal is relatively easy, but informing on the kind of approach adopted in Burkina Faso is clearly more complex. As a matter of fact, the reform over there has been interpreted in very different ways across places in the country (and stakeholders). In Ghana and Senegal, although the majority of the population had heard about the reform, the understanding of the package varied widely.

The medium term commitment in terms of funding was a major weakness in the Ghanaian and Senegalese experiences. As far as channelling of resources is concerned, there have been weaknesses in several countries. In Senegal the new model designed to channel funds to health facilities to make up for lost revenue could not be implemented. In Burundi, the flow of funds and drugs to the facilities has been confused and still has to overcome a serious administrative burden; furthermore, money disbursed by the central level is withheld by the provinces. In Liberia, counties supported by donors still benefit from much better conditions than those compensated by the government.

Across countries, the technical leadership, which did not always take the form of a coordination unit, has mainly been taken by Ministry of Health technicians. The fact that the reform was a decision taken by the political leaders and was funded by national resources has probably contributed to the adoption of such an approach. In countries with limited capacity, a greater involvement of some partners – possibly too accustomed to interaction only within project frameworks – would probably have benefited the implementation. In Burundi, the mass of problems generated by the sudden decision has contributed to the set-up of better coordination mechanisms between the Ministry of Health and its partners.

A major finding of the study was the appalling situation of monitoring and evaluation in five countries. Furthermore, most of the monitoring effort is of an administrative nature (e.g. accounting, control of the invoices in Burundi). In Burkina Faso, Burundi, Liberia and Senegal, even basic indicators such as health facility utilization or coverage rates are not routinely followed up by the health authorities in charge of the implementation of free health care. In a nutshell, these reforms have been launched without the prior establishment of a basic system to monitor their progress and their impact. While this is understandable in post-conflict countries like Burundi and Liberia, it is rather surprising in more stable contexts. This of course greatly hampers the general piloting of the reforms and possibly their adaptation to maximize the outcomes and rapidly correct problems.

In all six countries, the reform has initially been enforced in most facilities. In Uganda, there is evidence that this happened on a large scale and lasted for years. However, there are indications that insufficient funding and maybe perverse incentives are undermining the policy (e.g. households are obliged to purchase drugs from private drug outlets). In Ghana the health facilities started enforcing the reform but some resumed charging when reimbursements were exhausted and debt was piling up at regional stores (Witter & Adjei 2007). In Senegal, there is evidence that some

facilities did not even start to provide free deliveries or only removed some parts of the bill (Gouvernement du Sénégal, UNFPA, IMMPACT, & CEFORP 2007). Insufficient funding seems to be the main cause of imperfect compliance at facility level.

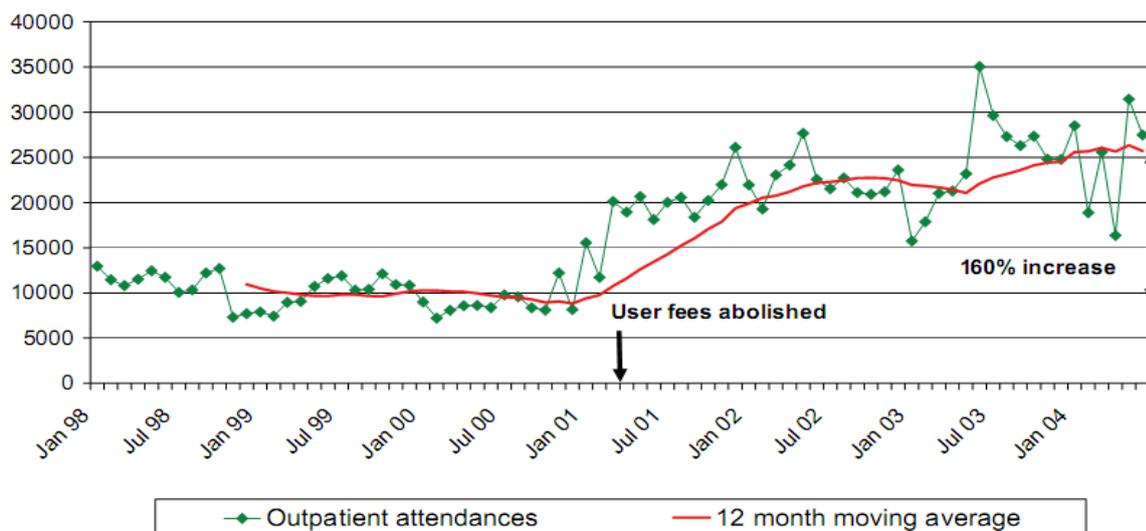
3.6 EFFECTS

As already mentioned, effects were not the main focus of this consultation. We still tried to develop a general view on the basis of existing studies and documents. In none of the studied countries was a sound monitoring process put in place; the poor situation of health information systems was particularly constraining. No country performed a baseline study nor set up a control group. This greatly limits all findings on the effects (and more particularly, raises the issue of controlling for confounding factors). Another constraint was that hindsight was lacking for four of the six reforms. By far, Uganda is the best documented experience in terms of effects. Most accessible publications on Uganda analyse data covering the period before 2005. This section must be read with these limits in mind.

Health service utilization

As expected, an increase in utilization of the free or subsidized services was observed in the different countries. However, because of weaknesses in monitoring and our own incapacity to access data, we cannot provide national figures for the six countries. There are some data describing the increase in utilization in Uganda and Ghana. In Uganda, according to the national health information system, new OPD contacts per capita did not change from 0.42 in 1999/00 to 2000/01, but rose to 0.56 in 2001/02, and further to 0.72 in 2002/03, and to 0.79 in 2003/04 (see also Figure 3). However there was a limited increase or no increase at all for key services such as deliveries (Nabyonga et al 2005). Household surveys have confirmed this increase in the utilisation of public services (in total and by the poor), but they also show a major increase in the utilisation of private services, possibly to address the limitation of public services, especially drug shortages.

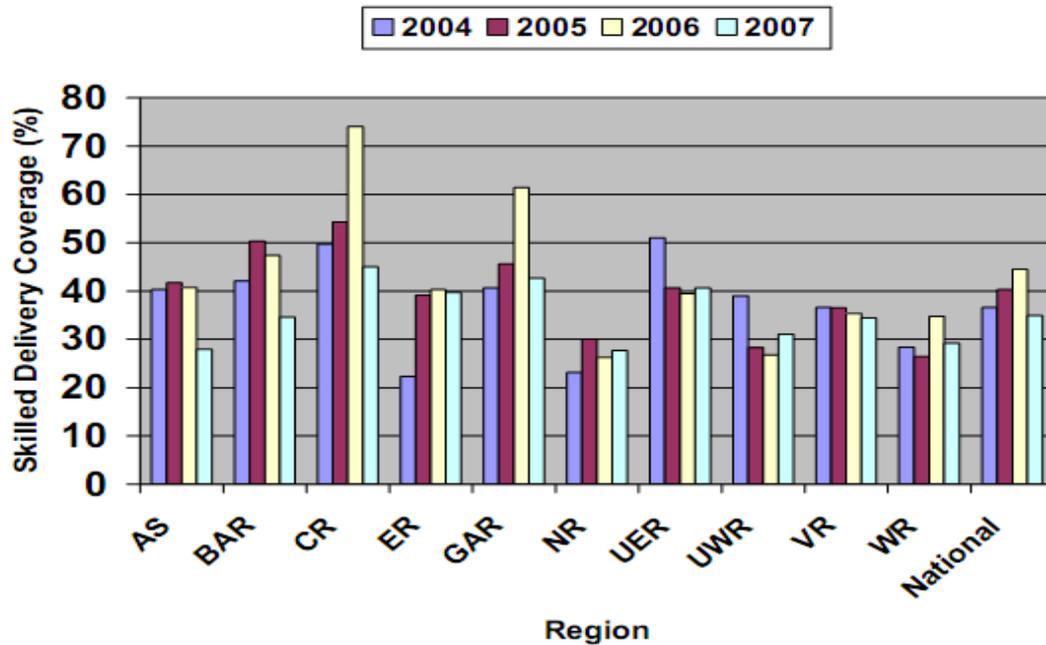
Figure 3: Outpatient attendances in Uganda between 1998 and 2004 (Tashobya et al. 2006)



Source: MoH (Selected years).

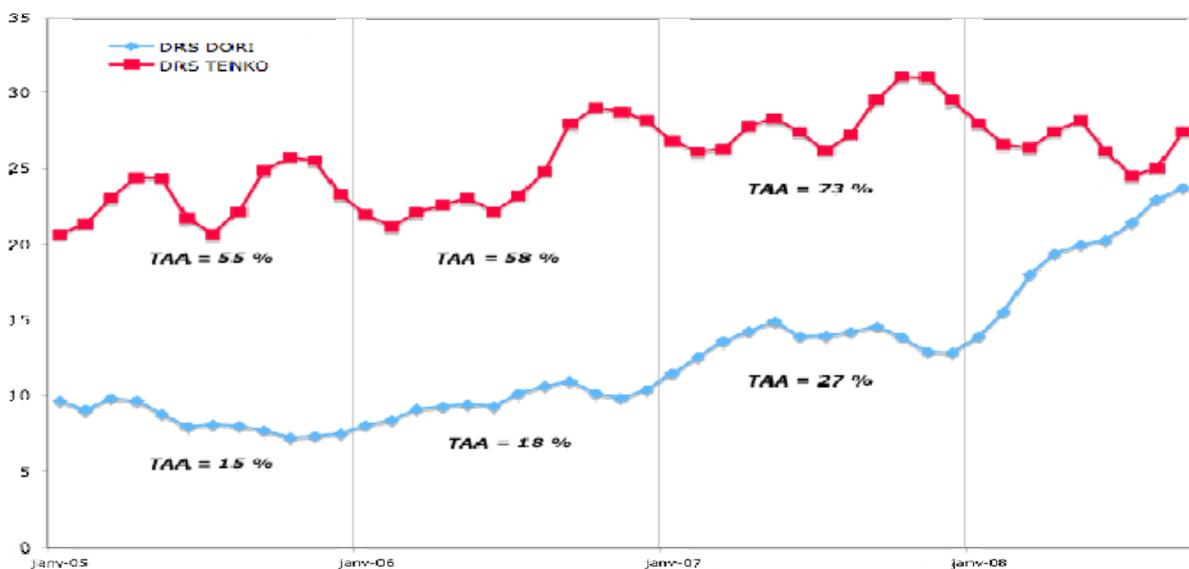
In Ghana, after an initial increase between 2003 and 2004, the subsequent years have seen a decrease in coverage rate of assisted deliveries. This could be explained by the interruption of payment for performed deliveries (Figure 4)

Figure 4: Skilled delivery per region in Ghana between 2004 and 2007 (Ghana Health Service 2008)



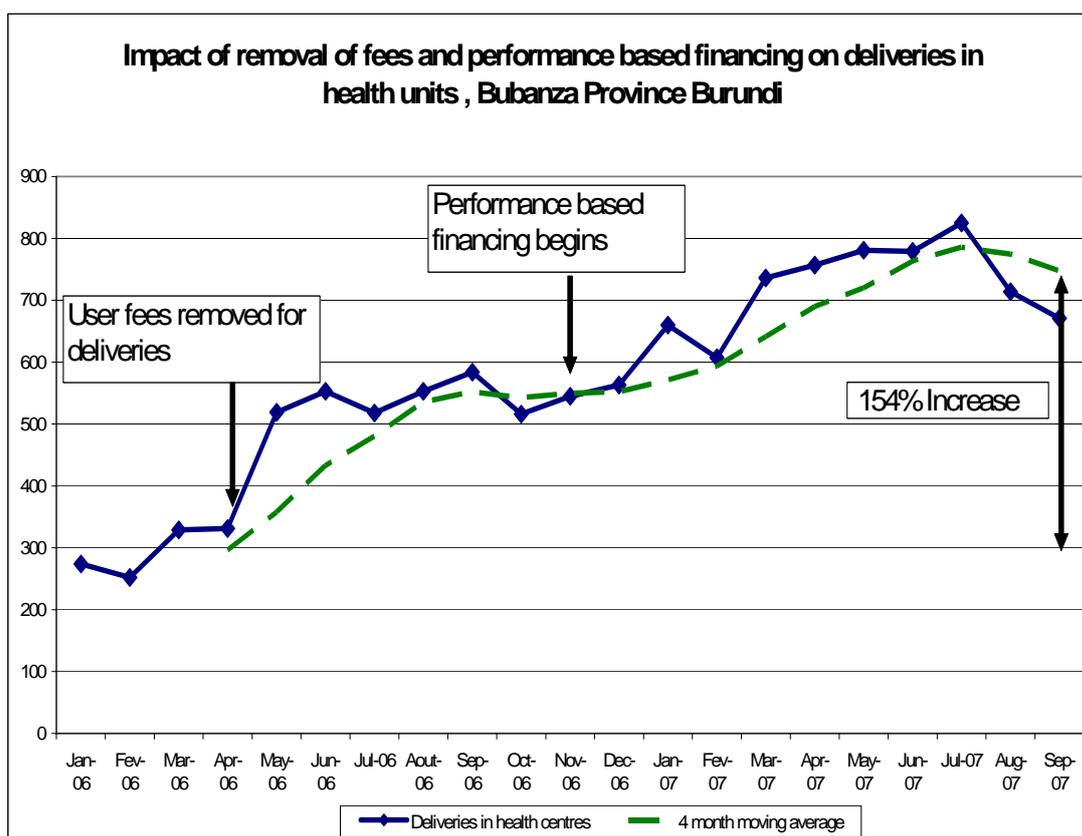
In terms of utilization of services, there may be important variations across regions and health facilities. An increase at national level can hide large variations inside the country. The data collected from the national health information system in Burkina Faso show that in regions with an initial low coverage of assisted deliveries (the Northern districts) the removal of a financial barrier has had a major impact on utilisation while in Southern districts it has had almost no impact on utilisation.

Figure 5: Monthly mean numbers of assisted deliveries in health centres in two regions in Burkina Faso (Ridde & Bicaba 2009)



The extent to which the region or the health facility is assisted through other means (e.g. assistance by an international NGO active in the district) and the way this complementary assistance is channelled to health facilities may have an impact. Noteworthy, the case of Burundi seems to indicate that there could be a synergy of effects between the user fee removal and performance-based projects.

Figure 6: Impact of removal of user fees and performance based financing on deliveries in health units, Bubanza Province, Burundi (Source: R. Yates, Bubanza, health information system)



For most countries, the experiences are too recent to assess the sustainability of the increase. The Ugandan experience proves that an increased utilization can be maintained on the long-term. There is evidence from Uganda and Ghana that the increase in utilization by poor households can be higher than the increase in utilisation by other socio-economic groups (Nabyonga et al. 2005; Penfold et al. 2007).

This higher utilization indicates that households appreciate free health care. The satisfaction among the population about the reform was reported in the different countries although the implementation was diversely appreciated.

Health outcomes

It is difficult to establish the proof of the impact of the reforms in terms of health outcomes (e.g. infant mortality rate or maternal mortality ratio). It is doubtful there will be any evidence, given the limited attention paid to evaluation.

As a matter of fact, none of the six reforms lifts all the barriers faced by poor rural households in the utilization of health services. Many barriers on the demand side, especially the cost of transport remain. More thorough analysis in the future could show that in some countries, the higher utilization is more marked in certain population groups for example by individuals living close to the health facilities.

The status of the barriers on the supply side is unclear. We have not identified many accompanying measures that attempt to address them. Little effort for example has been made in terms of staff motivation. In a separate but related reform, Uganda increased salaries in the months following the user fee removal. In Burkina Faso, Ghana and in some regional hospitals from Senegal, the output-based financing approach has probably contributed to lifting supply side barriers but not necessarily on purpose. We could not find evidence that technical barriers on the supply side – e.g. availability of an ambulance for the referrals in each health district or 24 hour service for C-section - have been addressed before the reform. However, in Burkina Faso there were activities included in the national plan for emergency obstetric care that contributed to improving the supply side (Gouvernement du Burkina Faso 2006). It was beyond the scope of this study to try to map these more systemic efforts in the six countries. Such a complementary study would be interesting in countries where deliveries are now free of charge. Indeed, if many barriers remain, impact of the user fees removal on maternal mortality will probably be disappointing.

Health care expenditure

As just mentioned, removing user fees does not lift all financial costs for the households. The purpose of this study was not to collect evidence on this dimension. The studies in Uganda provide mixed results (Xu et al. 2006). This can be attributed to the fact that drug shortages are recurrent in public health services. This obliges households to buy their drugs in the private pharmacies

Impact on the health system

Many experts are concerned by the possible negative effects of user fee removal on the health facilities. The main expected negative effect is a significant decrease in the health facilities' revenue (if the government does not compensate enough), which could undermine their financial viability. User fees are indeed usually a key mechanism to finance running costs, drugs, but also bonuses for the personnel. The fact that we were not able to access evidence in this respect (e.g. balance sheets) is another testimony of the weakness of the monitoring system in place.

Another risk, overlooked by most experts, is the possible consequences of the change in incentives brought about by the way health facilities are compensated for the free health care. Our analysis is that this issue would deserve to be documented in the six countries.

The input-based approach adopted in Uganda seems to show some limits: the reform has not positively affected staff morale; drug shortages are persistent – the latter are partly due to the unavoidable rationing of limited resources, but could also be a possible consequence of the incentives in place (Meessen et al. 2006); and accountability of health staff to the population remains weak. Two tracks seem possible: (1) to establish new voice mechanisms to empower the communities (Björkman and Svensson 2009) or (2) output-based financing. Burundi, Burkina Faso and Ghana have opted for an output-based remuneration for the health services delivered free (or at low price) to their users.

The experiences of Burundi and Burkina Faso with the output-based approach are interesting. Burkina Faso has discovered the approach somewhat by accident. Some minor corrections have been made during implementation. The experience of output-based payment with the user fee abolition has been quite disappointing so far in Burundi, largely because of the many constraints prevailing in a post-conflict setting. Yet, this country brought out an interesting lesson in terms of impact on the (governance of the) health system: whereas a brutal removal of user fees is clearly regrettable in the short term, it can nevertheless boost the awareness at country level of the need of better coordination between the government and its financial partners. In this respect, Burundi has made significant steps, even if perfect coordination is still not in place. The progressive integration of free health care and performance based financing on a national scale will be the real test for government and donor coordination. Ghana has also set up an interesting mechanism that reimburses facilities on their output. Unfortunately the impact cannot be assessed as the reform has only been in place for four years but was poorly funded from the onset.

More generally, we believe that for each country, the key indicator to measure the impact of user fee removal on the health system should be whether the removal triggered a real dynamic of sustained effort to address problems of accessibility to effective health care. In this respect, the experience of Uganda is slightly disappointing in recent years. The current dynamic in Burkina Faso and Liberia is interesting. In Burkina, a key issue will be whether the government manages to implement a system of entitlement for the indigents.

4 CONCLUSIONS AND LESSONS LEARNED

There is a momentum at national and international level.

- (1) There are African governments willing to take strong action to remove financial barriers met by vulnerable groups, especially pregnant women and children. They are ready to do so using national resources.
- (2) The fact that several governments have opted for removing fees only for children younger than five years and pregnant women indicates that MDGs 4 and 5 mobilize governments. Some international actors have also contributed to raising awareness of the accessibility problem generated by user fees. One may suspect that removal of user charges in other sectors (e.g. education) or by some vertical programs (e.g., artemisinin combination therapies, antiretroviral treatments) has had an influence as well: user fee removal is perceived today as a possible option.
- (3) Governments perceive user fees as a major barrier to access or at least as one of the easiest to address; they have understood the political value of decisive action in this respect.
- (4) Aid mechanisms seem to be supportive to such national leaderships. In some countries, the PRSP process has probably raised awareness at high level and outside the Ministry of Health. The MDGs give clear directions. The HIPC Initiative is a key aid instrument encouraging such reforms. A cross-country review of its impact on the health sector would be a useful study.
- (5) Financial and technical partners are not actively opposing user fee removal when there is national leadership.

Politician-technicians relationships: different patterns of actions

- (6) Reforms adopted by governments differ greatly. Our analysis is that this diversity attests to strong ownership, including different preferences, the pursuit of different objectives under different sets of constraints. The different contexts and traditions in Francophone and Anglophone Africa lead to different reforms. Post-conflict and stable countries face very different constraints; this has also an influence on the policy process.
- (7) In several countries, the user fee removal has been a top-down decision taken by the highest level, sometimes by surprise; it is unclear whether this pattern – which is not ideal in terms of careful design, formulation and implementation – can be influenced.
- (8) It is better when ownership and vision are shared by both politicians and MoH technicians, as it is for instance the case in Burkina Faso. While these characteristics are not a guarantee of success, they should help.
- (9) The pragmatic approach adopted by policy makers in Ghana and Liberia is positive. They were right to seize the opportunities in terms of funding without undermining their long term vision in terms of health care financing.
- (10) The experience of Uganda – where there has recently been a decline in terms of financial support by the government – recalls that a free health care policy necessitates a long-term commitment and a sustained effort in advocacy.

- (11) In post conflict contexts, free health care is just one issue out of a wider set of political, health and social issues. Stakeholders are usually less rigid; this creates space for bringing more radical changes to the organisation of the health system. In Liberia, suspending user fees was a first step before development of a wider health financing policy and plan. In Burundi, the removal eventually triggered more coordination among partners.

But also major risks on the reforms

- (12) Political leaders may underestimate the technical challenges related to such health care financing reforms.
- (13) Due to lack of consultation and the unexpected character of the decision, most user fee removal reforms have been poorly prepared. This lack of preparation generates serious weaknesses in the design, formulation and implementation of the reform.

Design

- (14) If some bottlenecks on the supply side are not addressed, the user fee removal could lead to a limited increase in utilization or it could have a rather limited impact in terms of MDGs 1, 4 and 5 (if effectiveness of the care is low). This looks particularly crucial for interventions targeting pregnant women.
- (15) Similarly, bottlenecks on the demand side – and the geographical barrier in particular – are not always sufficiently addressed by the reforms. The final impact in terms of MDGs 1, 4 and 5 could be disappointing. Moreover, this will be a major source of inequity.
- (16) There are different ways to remunerate and incentivize health care providers that provide health services for free. The six countries under study have opted for different approaches. We lack the hindsight to give a univocal recommendation. Input-based financing could make sense in post-conflict settings: actors are familiar with the strategy (e.g. it is the one practiced by humanitarian agencies) and it is a strategy easy to implement. Yet, governments may also want to seize the opportunity of user fee removal to innovate in terms of health care financing. Output-based financing is receiving growing attention by governments and their partners. As far as output-based financing is concerned, lump sum payment (lump sum payment including drugs, consumables but also a revenue to motivate staff) looks more promising than piece rate reimbursement (like in Burundi). Yet the related managerial requirement (e.g. creation of the verification function) and the risks of the strategy are not well understood by the community of actors. There is an urgent need for experimentation, documentation and technical guidance in this respect.

Formulation and implementation

- (17) Several governments have skipped very elementary and fundamental steps in the formulation and implementation of their reform. These practices could possibly

undermine the success of the reform. It is also a missed opportunity in terms of taking lessons on reform management.

- (18) The most frequent omissions or mistakes in terms of formulation are: lacking or too basic estimations of the impact of the reform on the utilization by the population, no proper assessment of the consequences in terms of extra burden on frontline health staff, insufficient allocation of resources to finance the increase in utilization, incorrect prices to compensate health facilities, poor understanding of incentive issues (e.g. the intensity of the incentives, how to organize monitoring under an output-based system), insufficient commitment in terms of public budget funding, weak planning forecast (e.g. drugs quantity required) and low implication of frontline health workers in the design.
- (19) The most frequent omissions or mistakes in terms of implementation are: no pilot project to test certain strategies, poor communication towards district managers and frontline health staff, low level of public information activities, insufficient effort in monitoring (the effort focuses on accounting), insufficient effort in enforcement, lack of interest for evaluation (or the adoption of sub-standard approaches), inadequate feedback loop (adjusting the scheme after observation of problems).
- (20) Having enough time to prepare the reform can contribute to a better design and formulation and a better implementation processes, but the link is not automatic.
- (21) There is a lack of technical expertise in health care financing in most countries. In most countries under review, international actors have not filled this gap, especially during the formulation and implementation stages of the reform. This is indicated by the lack of pilot projects (partners have a role to play in this respect, as they have more flexible frameworks of action), the lack of technical assistance in the design of the reform, the lack of commitment in terms of funding the implementation of the reform and the insufficient investment in rigorous evaluation. In this regard the actual process in Liberia is worth monitoring as it is applying most of the recommendations drawn from the international literature in the development of their future health financing policy and planning.
- (22) In post-conflict settings time, knowledge and resources are lacking for a careful formulation process. Our recommendation is that international partners contribute to the process of formulation and support the implementation with their resources nationwide.

About seizing opportunities

- (23) Agenda setting: some countries might be interested in adopting similar strategies, if they prove successful. There is an issue of documenting rigorously what works and what does not work, of sharing experiences among countries and of translating knowledge for rapid use by policy-makers.
- (24) In health care financing, the perfect solution is never reached. What we have to establish is dynamics of change. As for access, other measures (e.g. vouchers, health equity funds) are needed. Removal of user fees should only be a first step; it will be interesting to see whether Burkina Faso will be able to build on what has been done so far (e.g. implementing the solution identified for the indigents). The Ugandan experience is a bit disappointing in this respect. Time will tell whether Liberia manages to develop its health financing policy and plan.

- (25) The study indicates that there could be powerful synergies between user fee removal and performance-based financing; this must be explored further. Burundi and Burkina Faso would be the best cases to follow, but lessons can be drawn also from countries like Rwanda.

General assessment and action steps

We should welcome the new leadership shown by governments in terms of developing strategies addressing barriers to access to health care. Yet, because of (1) persisting bottlenecks both on the demand and supply side, and sometimes (2) insufficient preparation of the reform and (3) a poor implementation, final results could still turn out disappointing. As there is a momentum now, failed reforms would be a major missed opportunity. We recommend international actors to shift their focus from agenda setting to technical support (or at least to extend their attention to technical issues as well). There are operational problems to solve. However, strategies should not focus only on the Ministry of Health; the right way to involve the highest authorities is still unclear.

Some actions could already be undertaken in 2009: (1) a workshop in Africa gathering policy makers, civil society representatives and technicians involved in the recent reforms (assignment: to exchange experiences and to produce recommendations to their governments); (2) dissemination of the upcoming results of this study and other available guidelines. e.g. the Freeing up Health care Report by Save The Children (The Save the Children Fund 2008).

Other actions could be developed in the years to come. Among others, (1) an international consultation for reaching a consensus on health care financing strategies in post-conflict settings; (2) a network of technical experts; this community of practice should facilitate the exchange of experiences and the access to international expertise when required; (3) better coordination among international agencies in order to seize synergies with other efforts (e.g. health system strengthening) and favour a clear distribution of roles with respect to possible assistance to countries willing to remove user fees; (4) translation in French and Portuguese of some key technical documents, including this report; (5) study tours and other strategies to reduce the gap between national politicians and the national health technicians; (6) development of research agenda, including an effort to measure impact of reforms.

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