

REVIEW

# A scoping review of the literature on the abolition of user fees in health care services in Africa

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In Africa, user fees constitute a financial barrier to access to health services. Increasingly, international aid agencies are supporting countries that abolish such fees. However, African decision-makers want to know if eliminating payment for services is effective and how it can be implemented. For this reason, given the increase in experiences and the repeated requests from decision-makers for current knowledge on this subject, we surveyed the literature. Using the scoping study method, 20 studies were selected and analysed. This survey shows that abolition of user fees had generally positive effects on the utilization of services, but at the same time, it highlights the importance of implementation processes and our considerable lack of knowledge on the matter at this time. We draw lessons from these experiences and suggest avenues for future research.

**Keywords** Health sector reform, exemption mechanisms, Bamako Initiative, health financing, scoping review, user fees

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## KEY MESSAGES

- In the literature on the processes of abolishing user fees in Africa and their different effects, there is a scarcity of data on contexts and implementation procedures.
- Political will is important to get decisions made, but it is also needed for implementation; the decision alone is not sufficient to guarantee implementation.
- The literature demonstrates that the abolition of user fees has had generally positive effects on utilization of services, but it highlights the importance of implementation processes and the need for further research in this area.

## Introduction

In the 1980s, after two decades of free but poor quality health services, nearly all African countries introduced user fees for public health care services. This decision, taken by governments with the support of the World Bank, was nevertheless contested by many in civil society and the scientific community (Lancet 1988; UNICEF *et al.* 1989). Many studies in Africa confirmed

their fears and showed that, while increasing access to drugs (Knippenberg *et al.* 1997), user fees reduced access to services for the more vulnerable, resulting in reduced service utilization (James *et al.* 2006; Lagarde and Palmer 2006). In the overall context of poverty, very poor health and commitment to achieving the Millennium Development Goals, health care access is a major issue (Gilson *et al.* 2007). One solution proposed from the beginning has been to lower the financial

barrier to access by exempting from user fees those who cannot afford to pay. However, such exemptions have been rare and generally ineffective in protecting the poorest (Leighton and Diop 1995; Ridde 2008).

To counter these targeting problems, the solution proposed currently is to abolish user fees for everyone, or for easily identified categories of individuals or services. One study estimated that abolishing fees for children under 5 years in 20 sub-Saharan countries could save between 150 000 and 300 000 lives (James *et al.* 2005). Thus, since 2007, the British and Danish aid agencies have committed themselves to support countries that abolish user fees. In its 2008 annual report, the World Health Organization (WHO) declared that we must 'resist the temptation to rely on user fees' (WHO 2008: 26). Still, African decision-makers want to know whether abolishing user fees is relevant and how best to do so. In fact, they are questioning why, after being exhorted to introduce user fees in the first place, they are now being urged to abolish them. A recently published study (Lagarde and Palmer 2008) reviewed five articles evaluating the effect on health service utilization of abolishing user fees. To widen the analysis to include other dimensions of interest to decision-makers, we present in this article a scoping study that reviewed the current literature on the *processes* of abolishing user fees in Africa and their different *effects* (service utilization and others).

## Methods

### Criteria for inclusion

First, to be included, studies had to have the abolition of user fees in sub-Saharan health care services as their main focus. We retained only primary studies dealing with large-scale measures applied nationally to whole groups of populations (all levels of care were included), rather than pilot projects or studies on case-by-case exemptions, because data from pilot projects do not convey the difficulties encountered in nation wide application, being often tightly controlled and sustained by considerable technical support. Secondly, as a criterion of quality, and to respect this review's time and resource constraints, the studies had to be published in peer-reviewed journals. We did not apply methodological inclusion criteria like those of the Cochrane Effective Practice and Organisation of Care Review Group (EPOC), because the abolition of user fees is a complex populational intervention that has been studied using non-experimental designs and both quantitative and qualitative methods. EPOC criteria have not been recommended for synthesizing evidence on any other type of research question than effectiveness, such as the process questions reviewed in the present article. Instead, we adopted the scoping study method, which is recommended for reviewing complex interventions and does not discriminate among studies based on methodological criteria (Arksey and O'Malley 2005).

### Methods for identifying studies

The period under review extends from 1988 (earliest date, corresponding to the generalized introduction of user fees in sub-Saharan Africa) to July 2008, inclusive. First we explored the Ovid MEDLINE, Web of Knowledge and AJOL (African

Journals Online) databases using several key-word combinations (and truncations): ["user fee" or "user charge" or "cost sharing" or "cost recovery"] and ["aboli\*" or "exempt\*" or "waive\*" or "remov\*" or "end\*" or "discontinu\*"]; ["free healthcare" or "free care" or "free health care"]; ["universal access to healthcare" or "universal access to health care"]. Secondly, we systematically explored three websites on health financing (World Health Organization, World Bank, Eldis). Third, we looked at articles in press (end of July 2008) on the websites of three journals (*Health Policy and Planning*; *Bulletin of the World Health Organization*; *Social Science and Medicine*). Fourth, we reviewed the bibliographies of all studies identified in the preceding steps. Using this combination of approaches, we reached a point of saturation. The final list was then validated by two external experts in user fees abolition.

### Data extraction and analysis

In evaluating the quality of the studies, we adopted an intermediate approach, recommended for reviews associating quantitative with qualitative studies (Mays *et al.* 2005). In accordance with the scoping study method, we did not distinguish between studies in terms of the soundness of their design, nor did we attempt to attribute relative weights to their data (Arksey and O'Malley 2005). However, in Table 1 we present general information on the studies retained that gives a good idea of the robustness of the designs used.

Content was extracted and synthesized using a descriptive-analytical method, by applying an analytical framework drawn from the study of public policy (Sabatier 1999; Ridde 2009). Indeed, health services payment is a public health policy instrument. The public policy process can be understood as comprising several sequential and sometimes concurrent sub-policies: agenda-setting, formulation and implementation. Together, these processes target service utilization and other effects. For five dimensions (agenda-setting, formulation, implementation, effects on utilization, other effects), analysis of the articles' content revealed certain inductive sub-dimensions. For each of these, tables were constructed that present the contents extracted from each article. Because of space limitations, and because the research report was prepared for French-speaking West African decision-makers and respected their need for a survey in that language, the tables are not presented with this article but are available online, in French, at: <http://www.medsp.umontreal.ca/vesa-tc/ressrc.htm>. Finally, for each country, we assessed the quantity of data available on a scale ranging from + (few) to ++++ (many). This assessment is based on an appraisal of all the data extracted. Our assessment is not quantitative; rather, it is simply heuristic, to illustrate how the data availability is distributed according to our analysis framework (shown below in Table 3).

## Results

### Description of the studies

We identified 21 studies that met the criteria for inclusion, one of which could not be obtained (Netshandama *et al.* 2005). Table 2 presents the distribution of the 20 articles we analysed, according to the countries studied, year of publication, year in

**Table 1** Data collection and sample description of articles

Article	Data collection	Sample
<b>UGANDA</b>		
Burnham <i>et al.</i> 2004	<ul style="list-style-type: none"> <li>– Health facilities registers: utilization 8 months before and 12 months after abolition</li> <li>– Structured interviews with health workers and members of the health unit management committees</li> </ul>	<ul style="list-style-type: none"> <li>– In 10 districts (purposive sampling), random sampling of 78 health facilities</li> <li>– 73 health workers and 78 members of the health unit management committees (the most senior available)</li> </ul>
Deininger and Mpuga 2005	<ul style="list-style-type: none"> <li>– Data from the Uganda national household surveys (UNHS) of 1999–2000 (before abolition) and 2002–03 (after)</li> <li>– Administrative data (Health Management Information Services of the Ministry of Health)</li> </ul>	<ul style="list-style-type: none"> <li>– UNHS I = 10 696 households</li> <li>– UNHS II = 9711 households</li> <li>– Administrative data on all the country's health facilities</li> </ul>
Kajula <i>et al.</i> 2004	<ul style="list-style-type: none"> <li>– Focus groups (community members)</li> <li>– Interviews with key informants at local and national levels</li> </ul>	<ul style="list-style-type: none"> <li>– Purposive sampling of 2 districts</li> <li>– 8 focus groups</li> <li>– 28 key informants</li> </ul>
Nabyonga <i>et al.</i> 2005	<ul style="list-style-type: none"> <li>– Health facilities registers and drug stock cards</li> <li>– Focus groups (villagers)</li> <li>– Interviews with key informants at district and health facility levels</li> </ul>	<ul style="list-style-type: none"> <li>– Purposive sampling of 6 districts and random sampling of health facilities and villages</li> <li>– Total 106 facilities: 13 public and 4 private not-for-profit (PNFP) referral centres; 59 public and 30 PNFP health centres</li> <li>– 89 focus groups</li> <li>– 603 key informants</li> </ul>
Xu <i>et al.</i> 2006	<ul style="list-style-type: none"> <li>– Data from the Uganda national household surveys of 1997, 2000 and 2003</li> </ul>	<ul style="list-style-type: none"> <li>– 1997: 6655 households</li> <li>– 2000: 10 691 households</li> <li>– 2003: 9710 households</li> </ul>
Yates <i>et al.</i> 2006	<ul style="list-style-type: none"> <li>– Secondary data: other studies, Ministry of Health administrative data, personal communications</li> </ul>	<ul style="list-style-type: none"> <li>– (Varies according to sources used)</li> </ul>
Nabyonga-Orem <i>et al.</i> 2008	<ul style="list-style-type: none"> <li>– Health facilities drug stocks</li> <li>– Focus groups (villagers)</li> <li>– Interviews with key informants at district and health facility levels</li> </ul>	<ul style="list-style-type: none"> <li>– Purposive sampling of 5 districts and random sampling of health facilities and villages</li> <li>– Total 85 facilities: 11 public and 3 PNFP referral centres; 44 public and 27 PNFP health centres</li> <li>– 71 focus groups</li> <li>– 211 key informants</li> </ul>
<b>GHANA</b>		
Asante <i>et al.</i> 2007	<ul style="list-style-type: none"> <li>– Survey of women having delivered in the 18 months prior to the survey (survey date not specified)</li> </ul>	<ul style="list-style-type: none"> <li>– Purposive sampling of 2 regions and 6 districts within each region</li> <li>– Women identified from vaccination registers</li> <li>– Target sample = 2250 women (final sample obtained and method of sampling not specified)</li> </ul>
Bosu <i>et al.</i> 2007	<ul style="list-style-type: none"> <li>– Public hospital and 'mission' registers</li> <li>– Medical records of deceased female patients aged 15–49 years</li> </ul>	<ul style="list-style-type: none"> <li>– Purposive sampling of 2 regions</li> <li>– Inclusion criteria for hospitals: having reported deaths of &gt;10 women per year aged 15–49 years</li> <li>– 21 hospitals thus identified, with a total of 334 maternal deaths in the period studied, of which 150 were related to childbirth</li> </ul>
Penfold <i>et al.</i> 2007	<ul style="list-style-type: none"> <li>– Household survey</li> </ul>	<ul style="list-style-type: none"> <li>– Purposive sampling of 2 regions and of districts, then random sampling of women on the census rolls</li> <li>– Sample: 2922 women having undergone childbirth</li> </ul>
Witter and Adjei 2007	<ul style="list-style-type: none"> <li>– Interviews with key informants at national, district and health facility levels</li> </ul>	<ul style="list-style-type: none"> <li>– Purposive sampling of 2 regions and 6 districts in each region</li> <li>– 65 key informants</li> </ul>
Witter <i>et al.</i> 2007a	<ul style="list-style-type: none"> <li>– Interviews with health staff and traditional birth attendants</li> </ul>	<ul style="list-style-type: none"> <li>– Purposive sampling of 2 regions and 6 districts in each region</li> <li>– 374 respondents</li> </ul>
Witter <i>et al.</i> 2007b	<ul style="list-style-type: none"> <li>– Interview with key informants at district and health facility level</li> </ul>	<ul style="list-style-type: none"> <li>– Purposive sampling of 2 regions and 6 districts in each region</li> <li>– 65 key informants</li> </ul>

(continued)

Table 1 Continued

Article	Data collection	Sample
<b>SOUTH AFRICA</b>		
Bhayat and Cleaton-Jones 2003	– Health facilities registers	– 9 community clinics and 1 hospital
Walker and Gilson 2004	– Structured questionnaire self-administered to nurses in community health centres – In-depth interviews	– Questionnaires completed by 113 nurses in 7 community health centres – Interviews with 10 nurses in the 3 centres where the questionnaires elicited the most positive perceptions of free services
Wilkinson <i>et al.</i> 1997	– Registers of a mobile clinic	– One mobile clinic (purposive sampling)
Wilkinson <i>et al.</i> 2001	– Registers of a mobile clinic	– One mobile clinic (purposive sampling)
<b>KENYA</b>		
Mwabu <i>et al.</i> 1995	– Health facility registers – Household interviews – Exit interviews with patients	– Purposive sampling of 2 districts – 32 public and non-public health facilities – Random sampling of 128 households and 121 patients
Mwabu and Wang'ombe 1997	– Health facility registers	– Purposive sampling of 1 district hospital and 3 public health centres in 1 district
<b>MADAGASCAR</b>		
Fafchamps and Minten 2007	– Interviews with key informants and focus groups in the communes – Surveys in the health centres (methods not specified)	– For each province, purposive sampling of 6 districts, and in each district, random sampling of 4 communes – Sample: 138 health centres in 138 rural communes.

which abolition of fees was implemented and field of application.

### Agenda-setting

#### Decision-makers

Abolition is decided at the highest levels of government—in certain cases (Uganda, South Africa, Madagascar) by the President. The role of the Ministry of Health is mentioned only for Uganda, where it had envisaged abolition for many months (Yates *et al.* 2006) but lacked political power to impose the decision (Kajula *et al.* 2004). Funding agencies are sometimes mentioned as having an interest in abolition (Ghana) (Witter and Adjei 2007), or indirectly in the fight against poverty (Uganda) (Nabyonga *et al.* 2005).

#### Context

Often, abolition was decided suddenly and in a highly politicized context (pre- or post-election). In South Africa, it was one of the first decisions of the first post-apartheid government (Wilkinson *et al.* 1997; Walker and Gilson 2004). In Uganda, the president took the decision in the middle of the electoral campaign (Kajula *et al.* 2004). In Madagascar, abolition was aimed at repairing the consequences of political and economic crises subsequent to the contested presidential elections of December 2001 (Fafchamps and Minten 2007).

#### Justifications

Many reasons are mentioned for abolishing user fees: (i) negative effects of fees on service utilization and population health (Uganda, Kenya, Ghana); (ii) inability to generate substantial revenues and improve service quality (Uganda,

Kenya); and (iii) the fight against poverty (Madagascar, Ghana, Uganda).

### Formulation

#### Abolition focused on services

The most widely applied decision was to abolish fees for certain services for all users. In Uganda, all services are free; in Kenya, the abolition applied to all services except for laboratory tests; in South Africa (second abolition measure, in 1996) primary care services are free; and in Ghana, all services related to childbirth.

#### Abolition focused on population groups

Only South Africa, in 1994, made all services free to specific groups (children under 6 and pregnant or nursing women). It should be noted that, in Ghana, only services related to childbirth are free, not all services provided to pregnant women; for example, the treatment of complications of pregnancy is still charged for.

#### Health facilities

Abolition may involve only certain health facilities. In Uganda, hospitals continue to charge 'those who could afford it' (Nabyonga *et al.* 2005). In Ghana, delivery in regional hospitals is free only if the woman is referred; this is true even in private facilities, whereas other countries' abolition policies apply only to the public sector.

#### Duration of the abolition

In Madagascar, abolition was intended to be a temporary measure, for the time it took to overcome the political and

**Table 2** Distribution of the articles reviewed

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	Total
<b>Field of application</b>																				
Uganda												X			2	2	2	1	1	7
Ghana														X		X		6		6
South Africa					X			1			1		1	1	1					4
Kenya						1		1												2
Madagascar	X												X							1
<b>Total</b>					1	1	2	1			1	1	1	1	3	2	2	7	1	20

X = date of abolition.

economic crises subsequent to the contested presidential elections of December 2001. In Kenya, user fees were suspended only for 18 months, apparently the result of the government's inability to fund this policy, rather than because of any deliberate decision (Mwabu and Wang'ombe 1997). In the other countries, the duration of the abolition is, in principle, unlimited—although Ghana has experienced funding difficulties that threaten its sustainability (Witter and Adjei 2007).

**Implementation**

Of the 20 articles, only three focus significantly on planning and implementation—in Ghana (Witter and Adjei 2007; Witter *et al.* 2007b) and South Africa (Walker and Gilson 2004). The other articles give these factors only sparse mention, mainly in describing study contexts or interpreting results.

**Application**

Most articles provide only the official date of abolition. Some, however, provide indications of the measure's actual time of application. These reveal frequent disparities [up to 6 months in some Ghanaian districts (Asante *et al.* 2007) and 10 months in certain provinces of Madagascar (Fafchamps and Minten 2007)]. They also reveal that in some cases, such as Ghana, application was intermittent; when funding was unavailable, some health facilities temporarily reinstated user fees (Penfold *et al.* 2007; Witter and Adjei 2007). Other articles describe precipitous application. Uganda's plan for gradual implementation was set aside when immediate abolition became a major electoral issue (Yates *et al.* 2006). In South Africa, care providers deplored the lack of planning for abolition (Walker and Gilson 2004). In Ghana, abolition was implemented in two waves—first in half the regions, then 18 months later in the rest—but the second wave occurred without the first having been evaluated and without adequate funding (Witter *et al.* 2007b).

**Funding**

Funding is the aspect of operationalization most often mentioned (14 articles out of 20). In Uganda, US\$526 000 was immediately made available to purchase drugs for free distribution, and the health sector budget increased by US\$12.5 million in the year following abolition, with continued growth in subsequent years (Yates *et al.* 2006; Nabyonga-Orem *et al.* 2008). Conversely, in Madagascar, many months elapsed between the announcement of abolition and the provision of US\$3 million in free drugs (Fafchamps and Minten 2007). In Ghana, US\$2 million was allocated to the regions in the first wave of abolition (Bosu *et al.* 2007), but the additional funding was stopped several months after abolition was extended to the other regions (Witter and Adjei 2007).

Only the articles on Ghana offer information on the calculation of funds allocated to abolition measures. There, the central government calculated allocations to regions according to population, with a higher per capita rate for poorer regions, rather than according to the number of deliveries—though this had been the criterion for funding allocation at the local level (see *Management system*, below). These centrally provided payments proved grossly inadequate to cover the health facilities' activity levels (Witter *et al.* 2007b). In fact, no plan had been

established to set the duration and total cost of the abolition programme (Witter and Adjei 2007).

Finally, with respect to funding, two players are mentioned with whom the health ministries have little room to manoeuvre: (i) external funding sources (World Bank in Uganda; debt relief funds in Ghana); and (ii) ministries of finance, which have the primary role in budget allocation decisions. In Uganda, these decisions primarily benefited the health sector; but in Ghana, the Ministry of Finance ultimately withdrew the programme of free deliveries, apparently due in part to 'competition' from another emergent programme, national health insurance (Witter and Adjei 2007; Witter *et al.* 2007b).

#### **Management system**

Management of funds allocated to abolition remained centralized in Madagascar, but was decentralized in Uganda and Ghana. The Ugandan government even relaxed the rules, allowing health districts to redirect the funds to expenditure items previously supported by user fees (Nabyonga *et al.* 2005). In Ghana, the central government transferred the funds to the health districts, which then reimbursed health facilities retroactively according to the number of deliveries carried out. Ministry of Health guidelines set a fixed price for each type of delivery (degree of complication) and type of health facility (public/private). However, at least in certain cases, health facilities were reimbursed at different prices (Witter *et al.* 2007b).

#### **Communication**

This dimension is mentioned only in one article on Uganda (Kajula *et al.* 2004), one on South Africa (Walker and Gilson 2004) and three on Ghana (Witter and Adjei 2007; Witter *et al.* 2007a; Witter *et al.* 2007b). All report the complaints of care providers and local managers about not having been consulted in the process of deciding and planning for the abolition of user fees. Another problem mentioned is the lack of information. In Ghana, communities apparently did not properly understand the abolition measure, despite various types of publicity effort (Witter *et al.* 2007b). Communication in the opposite direction was also problematic in Ghana. Local health facilities and officials did not render accounts to the central government of the utilization of funds received (Witter and Adjei 2007; Witter *et al.* 2007b).

#### **Ancillary measures**

In Ghana, all health professionals' salaries were increased and certain regions introduced incentive bonuses for each delivery carried out (Witter *et al.* 2007a; Witter *et al.* 2007b). In Uganda, salaries rose by between 14% and 63% depending on the professions (Nabyonga-Orem *et al.* 2008), the drug supply system was reorganized (Nabyonga *et al.* 2005) and health sector funding became more effective thanks to the evolution of international aid from project-based to sector-based funding (Deininger and Mpuga 2004; Yates *et al.* 2006). One article mentions, without details, an exercise to accelerate staff recruitment (Nabyonga-Orem *et al.* 2008).

#### **Effects on utilization**

The effects of abolition on health services utilization were the main focus of the studies, discussed by 17 of the 20 articles.

##### ***Curative visits in primary care***

All the studies report increases in visits after abolition compared with before. These range from 17% in Madagascar (Fafchamps and Minten 2007) to over 80% in Uganda (Burnham *et al.* 2004; Yates *et al.* 2006). Nevertheless, limitations were noted. In Kenya, the increase was not enough to bring utilization back to pre-user fees levels (Mwabu and Wang'ombe 1997). In South Africa, the number of visits among children and pregnant women grew rapidly after the first abolition measure, but extending abolition to the whole population in 1996 had little effect on the pre-existing trends (Wilkinson *et al.* 2001). In Uganda, the increase in visits affected children less than other patients (Burnham *et al.* 2004; Deininger and Mpuga 2004; Nabyonga *et al.* 2005), because, according to some, children's visits were already charged at reduced rates prior to abolition (Nabyonga *et al.* 2005).

##### ***Hospitalizations and deliveries***

The number of hospitalizations remained stable in Uganda after abolition (Nabyonga *et al.* 2005; Yates *et al.* 2006), despite a 26% increase in referrals to hospitals (Deininger and Mpuga 2004). This might reflect hospitals' capacity limits, or it may be that people declined hospital services because of cost-related uncertainties, since hospitals continued to charge 'those who could afford to pay' (Nabyonga *et al.* 2005). In Uganda, results related to deliveries are contradictory. One article mentions a 28% increase in the number of facility-based deliveries after abolition (Deininger and Mpuga 2004), while another reports that the proportion of facility-based deliveries (in relation to all deliveries) decreased by three percentage points (Yates *et al.* 2006). All studies on Ghana report increases in facility-based deliveries, ranging from 10% to 36%, depending on the studies. Complex (and costly) interventions such as Caesareans were also on the rise (Witter *et al.* 2007b). Conversely, when fees for deliveries were temporarily reinstated, the number of facility-based deliveries went down (Witter *et al.* 2007b).

##### ***Services already free before abolition***

In Ghana, health professionals considered that postnatal follow-up—a free service—improved after deliveries became free (Witter and Adjei 2007). In Uganda, many articles report increases in utilization of preventive services (Burnham *et al.* 2004; Deininger and Mpuga 2004; Yates *et al.* 2006), while another reports no change in prenatal visits (Nabyonga *et al.* 2005). In South Africa, utilization of free services (vaccination and child development follow-up) was decreasing before the first abolition measure, increased immediately afterwards and then began again to decrease (Wilkinson *et al.* 2001).

##### ***Services for which charges continued after abolition***

In Kenya, private sector visits decreased by 32% during the period of free public services (Mwabu *et al.* 1995). Traditional birth attendants in Ghana have experienced reductions in clientele (Penfold *et al.* 2007; Witter *et al.* 2007a). However, in Uganda, utilization of private health services was on the rise

before abolition and continued thereafter (Nabyonga *et al.* 2005; Xu *et al.* 2006; Yates *et al.* 2006). In South Africa, in one public hospital (not involved in abolition), dental visits increased by 58% after abolition, compared with only 9% in primary care dental clinics offering free services—where, on the other hand, the number of *emergency* visits increased significantly (Bhayat and Cleaton-Jones 2003). Many authors suggest that newly free services had difficulty responding to increased utilization, such that patients with means turned to paid services (Deininger and Mpuga 2004; Xu *et al.* 2006).

#### *Service utilization by socio-economic status*

In Uganda (Burnham *et al.* 2004), Ghana (Witter *et al.* 2007a) and South Africa (Walker and Gilson 2004), care providers considered that the abolition of user fees had primarily benefited the poor. In Ghana, the proportion of facility-based deliveries increased in every socio-economic quintile, but the greatest increases were in the two poorest (Penfold *et al.* 2007). In Uganda, the greatest increases in health services utilization after abolition were among the poor (Deininger and Mpuga 2004; Nabyonga *et al.* 2005); however, the poor also greatly increased their utilization of private health services (Xu *et al.* 2006). After abolition, Ugandans who were not poor tended to avoid public health facilities in favour of private services (Xu *et al.* 2006; Yates *et al.* 2006).

#### **Other effects of user fees abolition**

Fifteen of the 20 studies, touching upon all the countries except Kenya, presented data on other effects, intended or not, of the fee abolition policies.

#### *Quality of services*

All the countries experienced problems of drug availability. In South Africa the distribution received little planning effort (Walker and Gilson 2004) and in Madagascar it was late and poorly organized (Fafchamps and Minten 2007). Those involved in the Ghanaian health system consider that increased funding for drugs *at the start* of the exercise helped improve the quality of services, but this situation did not last (Witter and Adjei 2007; Witter *et al.* 2007b). Uganda seems to have fared better. While stock shortages were more frequent in the year following abolition, the situation improved thereafter (Burnham *et al.* 2004; Deininger and Mpuga 2004; Kajula *et al.* 2004; Nabyonga *et al.* 2005; Nabyonga-Orem *et al.* 2008). In South Africa, higher numbers of visits meant lower quality: less time for each patient, lack of privacy (Walker and Gilson 2004). Ugandan studies draw contradictory conclusions, with some reporting deteriorating cleanliness of facilities (Burnham *et al.* 2004), long waiting times and unfriendly staff (Kajula *et al.* 2004), while others report no change in cleanliness or workers' attitudes (Nabyonga *et al.* 2005; Nabyonga-Orem *et al.* 2008).

#### *Health system revenues*

Eight articles, devoted to Uganda and Ghana, report on this impact. The loss of revenues to the Ugandan health system was estimated to be US\$3.4 million annually, but this was largely compensated by economic gains generated by fees abolition—an estimated US\$9 million annually in revenues that, without abolition, would have been lost due to illness (Deininger and

Mpuga 2004). When user fees were abolished in Uganda, health facilities lost revenues and had difficulty meeting recurrent expenses until compensatory funds were released (Kajula *et al.* 2004; Yates *et al.* 2006). In Ghana, when funds were still available to reimburse facilities for deliveries performed, health facility managers preferred them to user fees, which required facilities to recover costs from postpartum women who had trouble paying. However, this compensation was inadequate and health facilities went into debt, to the point where some had to reinstate user fees (Witter and Adjei 2007; Witter *et al.* 2007b). In Uganda, incentive bonuses paid from user fees disappeared and staff quickly 'forgot' the salary increases received from the government (Burnham *et al.* 2004; Nabyonga-Orem *et al.* 2008). In Ghana, eliminating fees for deliveries ended the practice of charging women (unofficially) for small supplies (Witter *et al.* 2007b), and only certain regions introduced bonuses related to numbers of deliveries, but the staff seemed to appreciate the salary increases they received (Witter *et al.* 2007a).

#### *Health care expenses*

Seven articles report on expenses still assumed by patients in Uganda and Ghana. On one hand, some health workers started or continued to charge unofficial fees (Kajula *et al.* 2004; Witter *et al.* 2007b); 9% of Ugandan respondents encountered such fees (Yates *et al.* 2006). On the other hand, when resources (e.g. drugs) are unavailable in the public sector, those who can, turn to paid services (Kajula *et al.* 2004; Nabyonga-Orem *et al.* 2008). Finally, some charges (e.g. transport) are excluded from abolition policies. These factors help explain unforeseen situations.

Ugandan households' health expenses have increased slightly since abolition (Deininger and Mpuga 2004). Birthing expenses decreased but did not disappear in Ghana, dragging more households under the poverty line; on the other hand, the *extreme poverty* situation has improved (Asante *et al.* 2007). If we break down expenses by socio-economic category, some effects are as expected: lower health expenditure in the two poorest quintiles in Uganda (Deininger and Mpuga 2004) and fewer catastrophic expenses for deliveries in the poorest quintiles in Ghana (Asante *et al.* 2007). Other effects are surprising. In Ghana, the proportion of birthing expenses in households' total budget decreased for the poor quintiles after abolition, but the decrease was even more marked in the richest quintile (Asante *et al.* 2007). In Uganda, the greatest reduction in health expenditure after abolition was seen in the second-richest quintile (Deininger and Mpuga 2004). Catastrophic expenses decreased for the non-poor after abolition, but not for the poor (Xu *et al.* 2006).

#### *Workload*

Six articles report heavier workloads in Uganda (Burnham *et al.* 2004; Kajula *et al.* 2004), Ghana (Witter *et al.* 2007a; Witter *et al.* 2007b) and South Africa (Bhayat and Cleaton-Jones 2003; Walker and Gilson 2004), one of which reports a 47% average increase per worker (Burnham *et al.* 2004). Health promotion activities were sacrificed in Uganda and South Africa (Kajula *et al.* 2004; Walker and Gilson 2004). In Ghana, health officials believed workers had managed to assume the additional load

**Table 3** Amount of data available concerning the abolition of user fees in Africa

	Agenda-setting	Formulation	Implementation	Effects on utilization	Other effects
Uganda	++	+	++	+++	+++
Ghana	+	++	+++	+++	+++
South Africa	+	+	++	++	++
Kenya	+	+	+	+	-
Madagascar	++	+	++	+	+

No data = -.

Amount of data available = + (few) to ++++ (many).

(Witter *et al.* 2007b), but the majority of workers disagreed (Witter *et al.* 2007a). Managers complained of additional work created by abolition, with new channels of funding and reporting (Witter *et al.* 2007b). Conversely, other actors in the system have seen their tasks disappear, such as Uganda's management committees, which had been responsible for managing revenues from user fees (Burnham *et al.* 2004), and health cooperatives associated with public health facilities (Nabyonga-Orem *et al.* 2008).

### Satisfaction

Six articles mention satisfaction. As expected, users of health services were satisfied with the abolition policies (Kajula *et al.* 2004), and became angry when these were suspended or non-functioning, creating tensions with health personnel (Walker and Gilson 2004; Witter and Adjei 2007; Witter *et al.* 2007b). The picture is different for staff. Two articles on Uganda mention professional demoralization (Burnham *et al.* 2004; Kajula *et al.* 2004). Ghanaian health workers appreciate fees abolition for deliveries, particularly because they eliminate cost-recovery difficulties (Witter *et al.* 2007b); however, impacts on professional satisfaction vary widely (Witter *et al.* 2007a). In South Africa, nurses interviewed were ambivalent (Walker and Gilson 2004). While they felt they accomplished more professionally because free care meant they were able to help more patients, they also deplored having been neglected by decision-makers during the implementation of abolition, and having to deal with patients who, according to them, abuse the free system. This has serious consequences, since 70–80% of these nurses attribute to the abolition of user fees their sense of being exploited, overworked and demotivated to the point of considering resignation.

## Discussion

### Limitations of the study and of the literature analysed

As far as we know, this is the first comprehensive review of the literature on the abolition of user fees. Our aim was not to uncover new information, but rather to produce a first synthesis of what is available. The results of this literature survey should be analysed with caution, given the methodological constraints. The number of articles was limited because of our inclusion criterion requiring peer review in scientific journals. The number would have been even smaller if we had retained only the articles that respected EPOC criteria, which would have excluded in particular articles on the abolition process. Clearly the articles

retained do not cover all cases of experience with user fees abolition. The small number can be explained by the fact that national policies on this matter are recent.

For publication, researchers are compelled to limit descriptions of contexts and processes. Sometimes they also 'parcel' their studies into several articles, which can limit the overall vision of the policy being studied. All these factors combine to explain the scarcity of data on contexts and implementation procedures (Table 3). In terms of methodology, as others have observed (Lagarde and Palmer 2008), this survey reveals the low quality of available evidence (Table 1). Very few studies use population data, and those that analysed service utilization data were constrained to short timeframes and a limited number of facilities. There is a scarcity of robust studies on health outcomes that use mixed methods or provide time-series analyses over a long period with comparison groups, which would offset the shortcomings encountered in a context of 'Real World Evaluation' in low-income countries (Bamberger *et al.* 2006). Finally, some articles are missing certain methodological information. That being said, our literature survey provides some indicative data for decision-making, and policy-makers seeking more specific data for implementation can also refer to two very recent policy guidance documents (Save The Children UK 2008; Meessen and UNICEF 2009).

### Lessons learned

Box 1 provides a summary of the lessons learned. While we know political will is important in this type of decision, this review shows the extent to which political leaders at the highest levels often assumed the role of political entrepreneur in decision-making. We see that political entrepreneurs seized upon windows of opportunity (elections, poverty-reduction strategic frameworks) to make abolition emerge as a solution to exclusion from services. In some cases, funding agencies definitely acted as policy brokers in favour of this measure, although the articles do not convey that as clearly as our own field experience. The fact that abolition involves readily identifiable services or populations (i.e. childbirth, children's services), and not individuals identified case-by-case (e.g. the indigent), has definitely facilitated these decisions. Moreover, in some cases, the creation of strategic alliances and the role of ministries of finance seem to have been essential success factors.

However, political will is not enough. Often, the preparation stage was missing, even when the time between decision and implementation was quite long. Decision-makers seemed to consider the decision sufficient to guarantee implementation.

**Box 1** Lessons learned

- Generate political will that is not just asserted, but is committed to implementation.
- Create alliances between ministries of health and finance.
- Develop customized information and consultation processes with all stakeholders.
- Plan the whole process in detail.
- Provide all resources required (human and financial resources, drugs) to meet increased demand.
- Organize measures to control utilization of these resources.
- Provide incentives to enlist health workers' support.
- Monitor utilization of health services targeted by abolition and other services.

Yet the public policy literature is clear on the need for good preparation of the execution of the decisions and the planning of the implementation (Pülzi and Treib 2006). Stakeholder information also appeared to be lacking in many cases. Those furthest away from the centres of decision-making were least likely to be informed. Also striking is the extent to which implementation was top-down and never bottom-up. It appeared that decisions emanating from the highest political levels could only follow a process that was technocratic and administrative, not participative and community-based. Yet, in many countries the discourse around community participation in health care services persists. From the articles we reviewed, health workers did not appreciate this rigid process (there are no data on the population's assessment of the process).

While we had little information on financial and human resources, we observed they were often lacking. Hence the importance of adequate planning for implementation. Not only must revenues previously generated by user fees be replaced, but increased service utilization must be anticipated and more resources mobilized in response. The role of drugs as a tangible source of access to service among populations is central to the fees abolition policy. Inadequate resources produce definite frustrations. People turn away from the public sector—free, but without the resources needed to meet the demands—and ultimately purchase services in the private sector. Health workers, faced with insufficient resources, sometimes reinstate fees or begin/continue unofficial practices. Still, the experiences of Ghana and South Africa show that street-level workers respect the abolition measures, as long as they are given the resources to make them work. The issue of resources is even more critical in francophone African countries, where user fees (retained locally) are an even more important source of operating revenues for health centres than in Anglophone Africa. The success of abolition will depend very much on the effectiveness of the process of reimbursing health centres for services for which user fees have been abolished. Our recent field experiences would indicate that the effectiveness of these processes is variable, going well in Burkina Faso (Ridde and Bicaba 2009), but less well in Niger (Ridde and Diarra 2009) or Senegal (Witter *et al.* 2008).

Regarding effects, the data show, beyond any doubt, that abolition promotes service utilization. Nevertheless, this increase is not unequivocal. Effects are sometimes quite heterogeneous (part of this heterogeneity may be explained by methodological differences between studies, as in Uganda), and even negative effects have been observed, particularly among preventive services.

**What we do not yet know: avenues for further research**

Decision-makers are now reassured on the effects of abolition, but want to know how it should be done. In this, the literature still falls short. What management procedures should be implemented? Should health facilities be pre-financed or reimbursed for services used? Should funding be centralized or decentralized? The influx of many patients, some going to health facilities for the first time (previously unmet demand) has consequences for professional practice and patient-care-giver relations. We might wonder what the general population and the users of health services think about the abolition of user fees and the quality of services. Yet these subjects have hardly been explored. On the other hand, political leaders who have not yet decided to abolish user fees seek information on how much this will cost the state and the cost-benefit ratios of abolition. We must acknowledge that the real cost of this measure is as yet unknown. On the population side, we need to study the health expenses still carried by households. As noted in some of the articles surveyed, these expenses can be high and continue to discourage service utilization. Despite the abolition of direct fees, financial barriers have still not been entirely broken down.

In the West African context, where the Bamako Initiative and local management committees allow health facilities to retain revenues generated by user fees and use them locally, the issue of fees abolition raises additional issues (Ridde and Diarra 2009). This is also the case in countries that have promoted community-based health insurance for the past 15 years. The case of Uganda shows the urgent need to study the effects of abolition on community financing systems, particularly in West Africa, where abolition has just begun (Basaza *et al.* 2007).

Regarding the effects of abolition, the inadequacy of most of the methodological designs calls for other, more controlled studies that will also take into consideration longer-term effects (Bamberger *et al.* 2006; Ridde and Haddad 2009). We must also verify whether abolition favours those who are less poor [the famous inverse equity hypothesis (Victora *et al.* 2000)]. Available data on differences in utilization among population sub-groups are not clear. Finally, to the extent possible in the intervention environments, effects on population health should be examined.

Box 2 provides a summary of the avenues for further research.

**Conclusion**

Fifteen years ago, South Africa began abolishing payment for certain services. Many countries in East Africa and Southern Africa followed suit. Several funding agencies and global

**Box 2** Avenues of research

- Analyse implementation processes.
- Describe and compare different modalities for managing the abolition.
- Understand the effects on professional practices and patient–caregiver relations.
- Calculate the real costs and cost–benefit ratios of fees abolition policies.
- Study health expenses still carried by households.
- Describe effects and linkages between fees abolition and community financing systems (Bamako Initiative and community-based health insurance).
- Verify whether it is really the poorest who benefit from abolition of user fees.
- Verify the longer-term effects.

leaders are ready to support countries interested in taking the same decision (Meessen *et al.* 2009; Global Campaign for the Health Millennium Development Goals 2009). This review of the literature should be helpful to West African decision-makers as they now consider the relevance of such a measure and, in particular, how it should be organized. The literature demonstrates that the abolition of user fees has had generally positive effects on utilization of services but, at the same time, it highlights the importance of implementation processes and our considerable lack of knowledge in published literature on the matter at this time. The study of processes therefore merits particular attention, since ‘if implementation fails, everything fails’ (Chen 2004).

## Competing interests

The authors declare they have no competing interests.

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