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Removing user fees in the health sector: a review of policy processes in six sub-Saharan African countries

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In recent years, governments of several low-income countries have taken decisive action by removing fully or partially user fees in the health sector. In this study, we review recent reforms in six sub-Saharan African countries: Burkina Faso, Burundi, Ghana, Liberia, Senegal and Uganda. The review describes the processes and strategies through which user fee removal reforms have been implemented and tries to assess them by referring to a good practice hypotheses framework. The analysis shows that African leaders are willing to take strong action to remove financial barriers met by vulnerable groups, especially pregnant women and children. However, due to a lack of consultation and the often unexpected timing of the decision taken by the political authorities, there was insufficient preparation for user fee removal in several countries. This lack of preparation resulted in poor design of the reform and weaknesses in the processes of policy formulation and implementation. Our assessment is that there is now a window of opportunity in many African countries for policy action to address barriers to accessing health care. Mobilizing sufficient financial resources and obtaining long-term commitment are obviously crucial requirements, but design details, the formulation process and implementation plan also need careful thought. We contend that national policy-makers and international agencies could better collaborate in this respect.

Keywords User fees, policy process, health financing

KEY MESSAGES

- Twenty years after their imposition, there is a user fee removal 'momentum' at country level across Africa.
- In a number of countries, user fee removal was a top-down decision taken at the highest level, sometimes in a surprise move—a decision-making pattern that is not ideal in terms of design, formulation and implementation. Steps that we identify as 'good practice hypotheses' were not followed by several governments.
- The review identifies several knowledge gaps. Little guidance is available on the best way to compensate health care facilities delivering services for free. There is also a need for greater attention to policy processes, including implementation issues.

Introduction

The political momentum towards the achievement of the Millennium Development Goals (MDGs) has revitalized the debate around sustainable health sector financing and the adequacy of current policies in low-income countries. Against this backdrop, and around 20 years since the initial calls for the introduction of user fees in African countries (Akin *et al*. 1987), a growing coalition of actors is advocating for the removal of user fees in African public health facilities (Save the Children 2005; Yates 2009; African Union 2010). The experience of fee removal in Uganda, in 2001, where an increase in outpatient utilization was observed, with strong indications that the poor benefited the most, has been key in this renewed interest (Nabyonga *et al*. 2005). User fee removal in other countries and the evidence that the policy led to higher utilization of curative services have consolidated the momentum.

While this debate has been raging in the North over the last 7 years, many governments in low-income countries, and in sub-Saharan Africa in particular, have already taken action, often implementing nationwide user fee removal. These different reforms are increasingly being documented in the scientific literature (Ridde and Morestin 2011). This body of literature complements an even larger body of studies documenting the cases of pilot experiments at local level (see for example Ponsar *et al*. 2011, this issue).

Many studies try to assess whether and to what extent user fee removal led to an increase in access to health services. Documenting the situation of the poor is often a primary concern (Nabyonga *et al*. 2005; Penfold *et al*. 2007). Most of the time, an increase in utilization is observed, a finding fully in line with basic economic theory (the law of demand). However, for many observers, the real challenges lie elsewhere. A major question is *how* to remove user fees at national level in low-income countries. Obviously a key issue is whether these reforms can be appropriately formulated, implemented, evaluated and funded by governments (Gilson and McIntyre 2005).

This paper summarizes the findings of a multi-country review carried out in six sub-Saharan African countries which have recently abolished or significantly reduced user fees for a significant package of curative services at national level. The main objective of the multi-country review was to document the process of the user fee removal in order to draw policy lessons for governments considering similar strategies.

Origin, objectives and method of the multi-country review

As explained in the editorial of this supplement, an internal UNICEF policy process sparked the multi-country review. When UNICEF commissioned the Institute of Tropical Medicine in Antwerp, Belgium, to conduct the review, both parties agreed on its main objective. Given the number of countries that had recently implemented nationwide user fee removals in sub-Saharan Africa, knowledge generation should focus on *how* governments implement the decision rather than on the pros and cons of user fees.

The main objective was, thus, operational. The idea was to draw lessons ('dos and don'ts') that could guide the future formulation and implementation of such policies in other countries. Countries were identified for inclusion in the study on the basis of the following criteria: (1) sub-Saharan low-income countries (in order to have enough similarity in terms of contexts and constraints); (2) a significant policy change in terms of benefit package and beneficiaries; (3) only countries with nationwide reforms; (4) a good balance between Francophone and Anglophone countries. The final six countries were: Burkina Faso, Burundi, Ghana, Liberia, Senegal and Uganda. Although the review in each country was mainly descriptive, it was expected that the size of the sample would allow a more detailed examination of the removal of user fees in sub-Saharan Africa, including through cross-country comparison.

In this effort to identify 'dos and don'ts', the multi-country review team faced a major constraint: given the multifaceted nature of user fee reforms, the limited time-frame since the inception of the reforms in most countries and the retrospective approach of the review, we had to opt for a research design that precluded establishing causal links between the reform (its content and its process) and possible effects (on the population, on the health services). In a companion paper (Hercot *et al*. 2011, this issue), we explain our methodological strategy: the adoption of a normative approach to the experiences with a pre-identified set of good policy practices in terms of formulating and implementing a health care financing reform. This approach has limits—discussed in Hercot *et al*.—but has the major advantage of meeting the first objective of the multi-country review: to produce operational lessons for governments and their partners.

The whole study was constrained by the amount of time (4 months, October 2008–January 2009) and the financial resources available. The general approach was to base the review in each country on peer-reviewed and grey literature (when available) and, for some countries, on qualitative and secondary quantitative data to be gathered through short field visits (~7–10 days per country). Data collection and analysis were based on an analytical framework and templates purposely developed for the review (see Hercot *et al*. 2011, this issue). For the three countries well-documented in the literature (Ghana, Senegal and Uganda), we based our assessment on the available literature plus phone interviews with key informants. For the cases of Ghana and Senegal, we relied on publications by Sophie Witter and colleagues (Witter and Adjei 2007; Witter *et al*. 2007; Witter *et al*. 2008a; Witter *et al*. 2010). Four countries were visited by a co-author of this paper: Burkina Faso (by VR), Burundi (by MN), Liberia (by MN) and Uganda (by DH). For Uganda, the review also benefited from the contribution of a national policy maker (CKT). In those countries, the researchers collected information mainly through key informant interviews.

For the four countries visited, a report was produced by the consultant (Hercot and Morestin 2009; Noirhomme 2009a; Noirhomme 2009b; Ridde and Bicaba 2009). Several key informants were given the opportunity to review the draft versions and made comments. Each final report was then sent to the UNICEF country office, which was responsible for disseminating it at country level. The findings of the reviews were analysed and discussed within the research team in a meeting in December 2008. Comparison allowed the identification of

similarities between countries or clusters of countries (the stable countries vs the post-conflict ones) but also of specificities. Findings were presented to a large audience of international actors at a consultation meeting in New York in February 2009, at a UNICEF regional meeting in Dakar in November 2009 and at a Harmonization for Health in Africa workshop in Dakar in November 2010 (HHA 2010). The multi-country review report was issued in the autumn of 2009 (Meessen *et al*. 2009).

This paper is a shortened version of the multi-country review report. The methodological approach of the review and the good practice hypotheses framework in particular are presented in Hercot *et al*. (this issue). From the findings section, we have dropped the sub-section dedicated to the effects of the reforms in the six countries. This question was not the main focus of the consultation; more fundamentally, the weakness of monitoring systems and the limited attention paid to evaluation in the studied countries (see further) did not allow us to draw obvious impact lessons. The paper focuses on the most original findings of the review: analysis of the content of the user fee removal reforms (with peculiar attention to the institutional arrangements established to remunerate health care facilities) and the process, with a focus on the formulation and implementation stages. For both stages, we report consultants' assessment of the extent to which countries followed the pre-identified list of good practices. In the discussion section of the paper, we confirm the validity of our main findings by referring to relevant international literature.

Results

Context

As mentioned in Hercot *et al*. (2011, this issue), a concern of the multi-country review team was to situate the reforms in their context, as the latter may be a key determinant of the policy process.

Table 1 lists key economic and health sector indicators for each country. The six countries are clearly low-income countries (even very low income in the case of Burundi). Where data are available, more than one-third of the population lives below the national poverty line and is likely to have difficulty paying for health care services. Under-5 mortality rates and maternal mortality ratios are very high. As for health care expenditure, one can observe that external aid contributes significantly to health expenditure in the six countries, with two of these countries—Liberia and Burkina Faso—particularly privileged. In terms of relative share, users are the main contributors to the financing of health services in all but two countries (Burkina Faso and Liberia). Given the poverty of Burundi's population, the level of out-of-pocket payments there is particularly alarming. Comparison with Liberia suggests that the heavy burden on Burundi's population may be due to the fact that Burundi has less access to international aid.

The very high percentage of out-of-pocket expenditure as a percentage of private expenditure in five countries indicates that health insurance schemes still have a very low coverage in these countries. Interestingly, the two countries with the highest coverage are Anglophone. Ghana is currently in the process of rapidly increasing the coverage rate of the national health insurance (Sarpong *et al*. 2009; Witter and Garshong 2009; Agyepong *et al*. 2011).

In terms of basic health system organization, however, the six countries are very similar. Each country is divided into health districts, with health centres delivering a minimum package of activities on an ambulatory basis, and a referral hospital delivering a complementary package of activities, including inpatient care.

Table 1 Key context indicators for study countries

	Burkina Faso	Burundi	Ghana	Liberia	Senegal	Uganda
Population ('000), 2007	13 933	7859	22 535	3442	11 800	31 367
GDP per capita (PPP US$), 2005	1213	699	2481	–	1792	1454
Population living below US$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,[a] 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 a 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 a percentage of total expenditure on health, 2006	56.9	24.6	36.5	63.9	31.5	26.9
Private expenditure on health as a percentage of total expenditure on health, 2006	43.1	75.4	63.5	36.1	68.5	73.1
Out-of-pocket expenditure as a 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

Sources: United Nations Development Programme (UNDP) and the World Health Organization.

[a]These and following data come from WHOSIS on 5 February 2009 (http://www.who.int/whosis/en/). They differ slightly from the national DHS data. Data from Ghana changed following the recent reform introducing the National Health Insurance Scheme. GDP = Gross Domestic Product; PPP = Purchasing Power Parity.

At the political level, all six countries are democracies. This means, among other things, that there may be electoral benefits attached to very visible actions taken by the President or the government. Obviously, free health care belongs to the latter category.

One could also classify the six countries into two main groups on the basis of political stability: four stable low-income countries (Burkina Faso, Ghana, Senegal and Uganda) and two countries coming out of a civil war (Burundi and Liberia). These two groups face different constraints. Worldwide Governance Indicators (WGI) from Kaufmann and colleagues (Kaufmann *et al*. 2008) shows that Burundi and Liberia lag behind the other countries considerably for five (out of the six) governance indicators. The regulatory quality of Liberia and Burundi, for instance, is estimated to be situated around the tenth percentile of countries, as illustrated in Figure 1. Hence, policy options are probably constrained, especially in terms of formulation and implementation processes (managerial skills probably limited). Table 2 summarizes other important contextual differences between these two groups of countries, showing the particular health system and health care financing challenges of post-conflict countries that must be addressed in user-fee removal strategies.

Content

One aim of the multi-country review was to describe the exact nature of the reform in the six countries. Two main institutional arrangements were documented: that between government and the users (the entitlement to a free benefit package) and that between government and the health facilities (the resource contract). This report deals with the period observable by the time of the consultation.

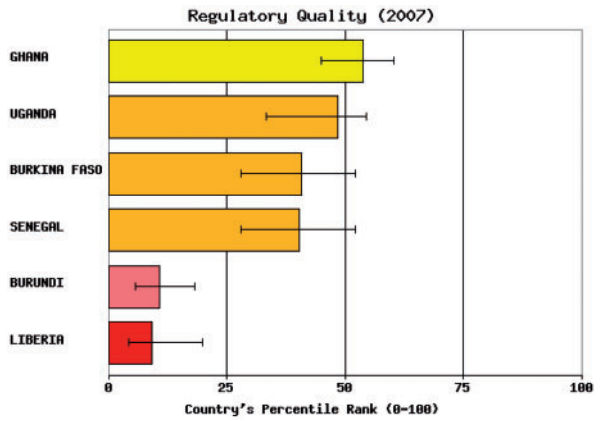

Figure 1 Regulatory quality of countries (*Source*: Kaufmann *et al*. 2008) *Note*: The governance indicators presented here aggregate the views on the quality of governance provided by a large number of enterprise, citizen and expert survey respondents in industrial and developing countries. These data 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. WGI = Worldwide Governance Indicators.

Benefit package

Despite similar aims, the reforms adopted in the six countries varied considerably. We summarize the entitlement offered by each reform in Table 3. Interestingly, universal free health care has only been adopted in Anglophone countries. Francophone countries have opted for what is sometimes referred to as 'categorical targeting' approaches (i.e. only a category of individuals is eligible for assistance). Hereafter this is referred to as 'selective free health care'. Maternal health has received particular attention from governments.

Two countries have also adopted a 'geographical targeting' approach (Coady *et al*. 2004): Ghana and Senegal. Only in Burkina Faso did authorities opt for a subsidy of the selected services (to reduce the prices charged to the mothers by 80%), as decision-makers valued the fact that users have to contribute financially to their health services. All the measures were still in place at the time of our review, except in Ghana, where, in July 2008, the free delivery policy was integrated into a free entitlement to the National Health Insurance for one year (after registration as a pregnant woman).

Funding

Remarkably, in at least four countries, the Highly Indebted Poor Countries Initiative (HIPC) proved to be a key instrument to finance the reform.[1] This has given a strong national budget character to the reform, with obvious advantages (e.g. national ownership) and drawbacks (limited involvement of technical assistants present in the country, see later discussion). More generally, we have observed that all reforms benefit from strong ownership at governmental level. Ownership at parliamentary level is also present in Uganda and Burkina Faso.

In the post-conflict countries, the reforms have also been financed through off-budget humanitarian aid. International aid for free health care was already present in Liberia before the reform (through humanitarian projects in some regions). In Burundi, there were some international non-governmental organizations (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 those organizations that had scaled down their own operations. Some international aid actors [UK Department for International Development (DFID), European Commission Humanitarian Office] responded to the urgent needs created by the unexpected presidential decision, mainly by providing drugs. There is evidence that some health facilities had not yet received such support 7 months after the official removal (see also Nimpagaritse and Bertone 2011, this issue).

Compensating health facilities and accompanying measures

Obviously, if health care is free of charge for the patient, someone else has to cover the costs previously covered by them. The study documented how governments have compensated health care facilities for the revenue loss due to user fee removal and the extra costs generated by the increased utilization (Table 4). We have identified two countries with an input-based approach, i.e. the government provides inputs deemed necessary to produce the free services (Uganda and Liberia); two with an output-based approach, i.e. the government remunerates the health facilities per patient who received

Table 2 A comparison of key features of 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.
Equity issues	Emerging after war times. High expectations.	Major inequities, and for quite a while.
Political power	Newly established → high expectations among the population for concrete actions and symbolic stances ('peace dividend').	Well established; some stakeholders are in the position to defend their vested interests.
Policy agenda	Wide range of political, social and health reforms ongoing (social reconstruction).	A highly visible policy measure can help for re-election.
Health system	Disorganized and weakly regulated. To be rebuilt.	In place, yet performance can be quite low in some countries.
Health information system (HIS), monitoring and evaluation	Weak HIS. Monitoring constrained by the lack of data. No tradition and capacity for evaluation and research.	Stronger HIS. Tradition of research better established. Monitoring normally in place, yet to a different extent.
Health financing	Weak (no tax-based funding, limited support from global health initiatives) and unstable (changes in donor patterns with transition from humanitarian aid to structural aid).	No reliance on humanitarian aid; more stable; sometimes budget support or a sector-wide approach.
Aid partners	Phasing-out of emergency actors; phasing-in of development and global actors.	Bilateral agencies, global health initiatives, development NGOs.
Co-ordination with aid partners	Co-ordination mechanisms to be created (or biased towards humanitarian aid).	Co-ordination mechanisms normally in place, yet to a different extent.

Table 3 The new entitlements for the population

Country	Reform	Scope	Date	Funding
Burkina Faso	Deliveries, caesarean sections and neonatal care, 80% subsidy in public facilities	National	Caesareans: 10/2006 Deliveries: 1–4/2007	National budget
Burundi	Free deliveries and free care for children younger than 5 years in public and private not-for-profit	National	5/2006	National budget & Highly Indebted Poor Countries Initiative (HIPC) (+ aid)
Ghana	Free deliveries including in private for profit and not-for-profit sector	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 health centre level), caesareans (at hospital level) in public sector	First in five regions then national for caesareans but Dakar	1/2005, 1/2006	National budget & HIPC
Uganda	Free health care in public facilities	National	3/2001	National budget & HIPC

free services (Burkina Faso and Ghana); and two which adopted a combination of both approaches (Burundi and Senegal).

In Uganda, health facilities have been compensated with a greater provision of inputs by the government (2000–05). A key feature of the user fee removal was its integration within a larger package of reforms addressing some other health system bottlenecks, or possible consequences of the user fee removal (Tashobya *et al*. 2006). The public budget for drugs increased, as well as the budget for other inputs such as human resources and running costs. For example, the problem of deteriorating staff motivation as a result of the withdrawal of incentives funded locally through fee income was tackled with a pay rise. Yet, the increased input levels have not been sustained over time, with drug stock-outs as a particular challenge. User fee removal has also reduced the capacity of health facilities to recruit local staff from outside the public service.

The approach in Liberia is also input-based. It has adopted a 'dual track' model for funding. In counties supported by international NGOs, health facilities rely on resources from the partners; counties not supported by an NGO are funded through government arrangements, which are relatively centralized for some items (e.g. running costs of health facilities are covered by county office budgets).

Senegal also has a dual system. However, in Senegal the approach varies according to the level of health facility. Lower level facilities function under an input-based system, as they are compensated on the basis of a push system of kits for deliveries or caesarean sections (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. Conversely, regional hospitals receive frontload payment for the expected

Table 4 How health facilities are compensated for the cost of free health care

Country	Period of reference	How the cost of drugs is covered at facility level	How the extra burden of work is remunerated to the personnel	Access to cash	Funding at national level
Burkina Faso	2007–11/2008 (visit by the consultant)	Normal deliveries, complicated deliveries and caesarean sections were reimbursed, respectively, at US$7, US$36 and US$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	2006–11/2008 (visit by the consultant)	Provision of drug kits to health centres. Major delays (6–12 months) since the beginning. In addition, the government reimburses health facilities for services and drugs provided (on the basis of a list of fees and drug prices).	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 bonuses (= variable bonus).	Theoretically ensured through fee-for-service arrangement; yet reimbursements were late (6–12 months) and are hoarded at provincial level. In non-supported facilities, a major problem of cash flow has ensued. Situation looks better in areas with performance-based financing.	Drugs in 2006: humanitarian aid (ECHO/UNICEF) Drugs in 2007: DFID Drugs in 2008: HIPC Performance-based financing: International NGOs
Ghana	2003–7/2008 (scheme integrated in another scheme)	The Ministry of Health (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 and HIPC.
Liberia	2006–11/2008 (visit by the consultant)	Supported areas: drugs are provided for free by international NGOs. 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 and national budget.
Senegal	Period covered in studies by Witter et al. (2008a; 2010)	Health centres and district hospitals receive a certain number of drug kits. Rules to distribute kits are not clear. Regional hospitals receive a financial compensation per caesarean 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 and HIPC.
Uganda	2001–12/2008 (visit by the consultant)	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 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 through the national budget and HIPC at the launch of the reform and in the medium term.

cost of C-sections. This lump sum prospective reimbursement is much higher than the actual cost of the service, which can provide a strong financial stimulus for hospitals to perform C-sections (Gouvernement du Senegal *et al*. 2007).

In Burundi, a mix of methods has been used to compensate health facilities as a result of the limited preparation for the reform. User fee removal led to an increase in health facility utilization. In order to cope with the increased consumption of drugs, a few international partners joined forces with the government to support a system of drug kits. These drug kits arrived in the health centres several months after user fee removal. In parallel, health facilities were allowed to claim reimbursement for drugs they prescribe and the services they deliver to exempted patients (see Nimpagaritse and Bertone 2011, this issue). During the first 2 years, both systems have co-existed. The reimbursement system presents a major administrative workload and monitoring is de facto very limited. Delays in reimbursement are substantial. Interestingly, a few provinces were also supported by international NGOs implementing a performance-based financing approach. This means that in these provinces health facilities receive a supplementary and regular income based on their performance in delivering a list of key activities (including preventive ones). Local evidence that there could be substantial synergies between the selective free health care and performance-based financing strategies inspired the government and its partners: they embarked on a reform merging both financing approaches.

In Ghana, the Ministry of Health (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 health facilities according to their needs. In a second phase, the money flowed, as had been normal practice before, 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).

The case of Burkina Faso is extensively described elsewhere in this issue (Ridde *et al*. 2011). It can be interpretated as an illustration of how some countries are 'muddling through' in discovering the best remuneration system. As the experience with input-based financing of free treatment had not been satisfactory in the past, authorities decided that the health facilities would be compensated in cash according to the number of deliveries carried out, i.e. an output-based payment arrangement. The fixed-rate reimbursement would include the cost of the drugs and consumables, but also all other inputs, including a bonus for staff and transportation to hospitals for referrals. This obviously required adopting at national level flat fees for the three 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 and the fee was set at a significantly higher level than the real cost. Furthermore, no clear guidance was issued by the MOH on the exact allocation of the fees collected through the scheme, and more particularly which proportion could be claimed by the staff as bonuses. As a result, health centres adopted different practices in this respect. Some of these practices were probably tantamount to setting strong incentives for the health centre staff to increase the number of deliveries. In a nutshell, the MOH of Burkina Faso seems to have introduced a strong output-based payment mechanism without fully grasping the incentives set and requirements in terms of monitoring the reported activities.

Policy change process

The agenda-setting stage

As mentioned in Hercot *et al*. (2011, this issue), the multi-country review paid limited attention to the agenda-setting stage of the policy process. However, some insights were derived from the work.

In all countries, the removal of user fees has been a highly visible policy measure. The policy measure often followed reports of major problems of access to health services. Electoral considerations have played a role. For instance, in Uganda, the decision was taken during the presidential election campaign under pressure of opposition candidates. In Burundi, Liberia and Uganda, the decision to remove user fees was taken by the President, sometimes in a sudden and top-down manner (see for instance Nimpagaritse and Bertone 2011, this issue). In Liberia however, our informants insisted that the policy decision just aimed to 'suspend' the user fee policy, as the government is still developing its long-term policy. In Burkina Faso, the decision-making process was more participatory, as the Council of Ministers took the decision in this country.

In Ghana, the free delivery policy looks somewhat like an interim measure. We were not able to find out whether the policy was undertaken to respond to donor pressure and/or to seize the opportunity offered by conditions under the HIPC's arrangement without undermining the major scheduled policy: the roll out of the National Health Insurance. We were not able to collect information on the agenda-setting stage in Senegal, but it is noticeable that the decision followed shortly after the approval of debt relief by the 'Paris Club' and shortly before the approval of the Poverty Reduction Strategic Paper.

The role of donors was quite limited in most countries. The strongest influence was perhaps in Liberia, where international humanitarian NGOs, in particular, were clearly influential. They expressed their preference for maintaining the strategy of free health care in their own projects, and 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. International NGOs also had some influence in Burundi (mainly through two international reports pointing out the incoherence in the national user fee policy). In Burkina Faso, the World Bank played a facilitation role (see Ridde *et al*. 2011, this issue). We were not able to identify a major influence by international agencies in the three other countries.

The policy formulation stage

One of the main foci of the multi-country review was to assess the extent to which governments have followed good practices in terms of policy formulation (Hercot *et al*. 2011, this issue). Researchers extensively reviewed the peer-reviewed and grey literature, and carefully explored this question with their key

Table 5 Good practice in the formulation stage, comparison of six countries

	Burkina Faso	Burundi	Liberia	Uganda	Ghana	Senegal
1. Preliminary situation analysis conducted	Yes	+/−	No	Yes	No	+/−
2. & 3. International and national scientific evidence used	+/−	No	No	No	Yes	?
4. Clear policy objectives	Yes	+/−	+/−	Yes	Yes	Yes
5. Different policy options assessed	Yes	No	Yes	Yes	No	No
6. Thorough assessment of the selected option	Yes[a]	No	No	No	No	No
7. Early identification of accompanying measures to support reform	No	No	No	Yes	No	No
8. National vision, ownership and leadership	Yes	+/−	Yes	Yes	+/−	+/−
9. Key implementation stakeholders involved in the formulation stage	+/−	No	No	No	No	No
10. The content of the reform meets preferences of key stakeholders	Yes	Yes	Yes	+/−	Yes	Yes

[a]But there has been a major overestimation in cost per delivery.
+/−: good practice partially followed; ?: the review could not find any positive or negative evidence on this good practice.

informants in each country. Table 5 summarizes the main observations across all the six countries.

Our analysis is that Burkina Faso did rather well in terms of policy formulation (see Ridde *et al*. 2011 for a detailed account). However, the identification of the accompanying measures was hindered by an unexpectedly rapid decision by the Council of Ministers on the budget allocation. Technicians at the MOH were not fully ready. The other countries did not perform well according to our best practice propositions. Our analysis is that the process was inadequate in Burundi; this is largely due to the fact that the decision by the President took the MOH and its partners by surprise (see Nimpagaritse and Bertone). Liberia obtains a better assessment mainly because of the pragmatic approach adopted by the government, especially in terms of managing partners. 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 was only an intermediate step in an ongoing process of developing a sound health financing policy.

The policy process in Uganda is a good example of strong presidential leadership. Several studies had reported how user fees were a barrier for the population. The problem was highlighted by all opponents (of the incumbent President) during the presidential election campaign; they promised to remove user fees if elected. The President, running for a second term, reacted swiftly: he checked with the MOH how much the removal of user fees would cost, and with the Ministry of Finance on the room for manoeuvre in the public budget. The weakest steps were those carried out by the Ugandan technicians (e.g. the thorough assessment of the option); this is largely due to the narrow window of opportunity. Although user fee removal had been under consideration for some years prior to the decision, no consensus had been reached on the best way to reform user fees. In 2001, MOH technicians were favouring less radical options of reform than eventually implemented.

Health workers and district managers can be expected to resist user fee removal where they fear a loss of advantages (such as incentive payments for health workers made from user fee revenue). Yet despite that (or because of that?), in all countries frontline actors were not involved in policy formulation. As is more common (e.g. Walker and Gilson 2004), user fee removal policies seem to be in line with the professional commitment of many health staff, as they acknowledged that fees are a heavy burden for the target population (Witter *et al*. 2007; Nimpagaritse and Bertone 2011, this issue). Still, dissatisfaction about increased workload and insufficient compensation were also reported in several countries of the study.

The implementation stage

The other major focus of the multi-country review was the implementation stage of the reform (Table 6).

Our analysis led to mixed findings. The most interesting reading of Table 6 is perhaps a horizontal reading. We see that three countries adopted a 'big bang' approach of nationwide implementation, while the other three carried out reforms more gradually. Yet we have not found significant evidence that countries which proceeded gradually really benefited from the opportunity to learn from the early steps of implementation (perhaps this gradualism reduced the pressure on the technicians in charge of the implementation?). In all countries, the measure was communicated to the population, but communication remained fairly basic: a radio broadcast of the decision. For Burkina Faso and Senegal, we know that the communication campaign was hampered due to a lack of financial resources. Yet a communication strategy is surely a major mechanism to enforce the reform in health facilities, as users then claim free treatment. Communication of universal user fee removal is relatively easy, but informing people of the Burkina Faso subsidy approach is clearly more complex. Unsurprisingly, areas and places in Burkina (and stakeholders for that matter) have interpreted the reform in very different ways. And even in Ghana and Senegal, where the majority of the population had heard about the reform, the understanding of the package varied widely.

The medium-term funding commitment was a weakness in the Ghanaian and Senegalese experiences. As for the transfer of resources to health facilities, several countries showed weaknesses. 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

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

	Burkina Faso	Burundi	Liberia	Uganda	Ghana	Senegal
1. Sequencing reform elements	No	No	+	No	+	+
2. A process of planning implementation steps	+	No	+	+	No	+
3. Communication strategies – policy implementers (not users)	++	No	No	+	+	+
4. Communication strategies – users	+	+	+	++	+	+
5. Medium-term commitment to budgetary burden	++	+	++	++	No	No
6. Clear rules for transferring resources to health facilities	Same	New	Adapt	Same	New[a]	New
7. Technical leadership by the Ministry of Health	++	+	++	+++	+	+
8. Capacity building	+	No	No	No	No	No
9. Empowered co-ordination unit	+	+	++	++	No	+
10. Monitoring & evaluation of the reform	+	+	+	+++	No	No
11. New rules are abided by different actors	++	+	+	++	+	+

Key: +++: Very good implementation; ++: Good implementation; +: partial or weak implementation; No: no evidence of implementation.
[a]Ultimately the new system was dropped and replaced by the old mechanism bypassing the local authorities and thus the decentralization efforts.

facilities has not been constant; there is still a serious administrative burden to be overcome, owing to the cumbersome reimbursement system; and furthermore, money disbursed by the central level has been withheld by the provinces. In Liberia, counties supported by aid agencies still benefit from much better funding than those compensated by the government.

Across countries, the technical leadership role has mainly been taken on by MOH technicians with little involvement of technical assistants. 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 Burundi, the set of problems generated by the sudden decision to remove fees has contributed to the setting up of better co-ordination mechanisms between the Ministry of Health and its technical and financial partners.

A major finding of the study was the weak monitoring and evaluation procedures of 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 first putting in place a basic system to monitor progress. While this is understandable in post-conflict countries like Burundi and Liberia, it is rather surprising in more stable contexts. This weakness, of course, greatly hampers the general piloting of the reforms and their adaptation, if necessary, to maximize outcomes and rapidly correct problems.

In all six countries, the reform was initially 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, perhaps, perverse incentives, are now undermining the policy (e.g. households are obliged to purchase drugs from private drug outlets). In Ghana, the health facilities started implementing the reform but some resumed charging when reimbursements were exhausted and debt was piling up at regional drug stores (Witter and Adjei 2007). In Senegal, there is evidence that even at the start of the reform some facilities failed to provide free deliveries or only removed part of the user fee charges (Gouvernement du Sénégal *et al*. 2007). Insufficient funding seems to be the main cause of imperfect compliance at facility level.

Discussion

Context: a momentum at national and international level

The review confirms that 20 years after their imposition, there is a user fee removal 'momentum' at country level across Africa. Several African governments are willing to take decisive action to remove financial barriers met by priority groups. Two clusters of policies seem to emerge: universal free health care in the public sector and selective free health care focusing on pregnant women and sometimes children. Respective policies seem to follow a geographical dichotomy: Anglophone countries—Liberia and Uganda, but also South Africa (Gilson *et al*. 2003) and Zambia (Carasso *et al*. 2011; Cheelo *et al*. 2011)—prefer the first option, whereas Francophone countries—Burundi, Burkina Faso and Senegal, but also Madagascar, Mali and Niger—opt for the latter (Ridde *et al*. 2010). In all countries, governments are ready to fund their policies with national resources. Again, this shows their commitment.

What is fuelling this momentum? Our interviews have confirmed that governments perceive user fees as a major barrier to access and, more importantly, as one of the easiest to address. The multi-country review shows that governments and presidents, in particular, have understood the political value of decisive action in this respect (Gilson *et al*. 2003). The fact that a growing number of governments are only opting for the removal of fees for specific vulnerable groups, such as children under 5 or pregnant women, could indicate an increasing awareness of the greater needs of these groups, but budget constraints also play a role. There are also indications that 'free delivery' is today a strategy considered or adopted by many of the African countries lagging behind in terms of progress

towards MDG 5 (African Union 2010). Our study also confirms the influence of some international actors (at least in the two post-conflict countries) in raising awareness of the accessibility problem generated by user fees and lobbying in favour of user fee removal.

The multi-country review is also informative with respect to the support offered by aid mechanisms to national leadership. In some countries, the Poverty Reduction Strategic Paper process has probably raised awareness at high level and outside the MOH. The MDGs give clear directions. An important finding of the review was the role played by the HIPC Initiative in terms of funding. The HIPC arrangement sets clear incentives for governments to allocate resources to the health sector. Given these experiences we hypothesize that the removal of user fees (and even more so, the implementation of selective free health care) 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 relatively easy to implement in a top-down and rapid way with public resources (if one compares it, for example, with developing community-based health insurance or universal mandatory health insurance as 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 (for a similar recommendation, see Kaddar and Furrer 2008).

There was no evidence of financial and technical partners actively opposing user fee removal in countries where there was national leadership. However, the multi-country review did reveal that financial and technical partners were often not very involved in the formulation and implementation of the reforms, because of the strong national ownership, but perhaps also due to the fact that these policy initiatives occurred outside project frameworks. This is probably a missed opportunity, as many aid agencies have some expertise to share and alignment between government and donors has been shown to support financing reform (Gilson *et al*. 2000).

Actors: politicians–technicians relationships

The multi-country review also sheds some light on the relationship between politicians and technicians, a reality which tends to be overlooked by public health analysts and health care financing experts (Gilson *et al*. 2003). The reforms adopted in the six countries differ greatly. Our analysis is that this diversity attests to strong ownership, including different preferences (cf. the different approaches in Francophone and Anglophone Africa), and the pursuit of different objectives under different sets of constraints. Post-conflict and stable countries face very different constraints; this also has an influence on the policy process.

In several countries, user fee removal was a top-down decision taken by the highest level, sometimes in a surprise move. This is a scenario also observed elsewhere, for instance in Niger or Mali (Olivier de Sardan *et al*. 2010). Some informants interpreted this leadership and the lack of technical preparation characterizing it as political opportunism. It is unclear whether this pattern—which is not ideal in terms of careful design, formulation and implementation—can be influenced. Ideally, ownership and vision should be shared by both politicians and Ministry of Health technicians (Gilson *et al*. 2001; Gilson *et al*. 2003). This was the case in Burkina Faso, for instance. While these characteristics are not a guarantee of success, they should help. In Ghana and Liberia, we saw that decision-makers can be pragmatic and seize funding opportunities without undermining their long-term health care financing vision.

A drawback of our review was its focus on recent experiences. The case of Uganda, where the reform is older, shows another potential risk at the level of the politician–technician relationship. The Uganda experience—with a recent decline in terms of financial support by the government (see Nabyonga *et al*. 2011, this issue)—shows that a free health care policy necessitates long-term commitment and a sustained advocacy effort.

Thanks to the inclusion of two post-conflict countries, the multi-country review also provides some insights on the politician–technician relationship in an (unfortunately) rather familiar context in sub-Saharan Africa. In post-conflict settings, free health care is just one issue out of a wider set of political, health and social pressing demands. Stakeholders are usually less rigid; this creates room for more radical change in the organization of the health system (Bornemisza *et al*. 2010). In Liberia, the suspension of user fees was a first step in the development of a wider health financing policy and plan. In Burundi, the removal eventually triggered more co-ordination among partners and led to a very ambitious reform of the way to remunerate health care providers (performance-based financing).

The fact that politicians and technicians have different patterns of action influences the reform process. It creates major risks. Our assessment is that political leaders tend to underestimate the technical challenges related to user fee removal reforms. In several countries, informants have reported insufficient consultation of stakeholders and technicians. In countries where the decision to remove user fees was unexpected, the reform was characterized by a lack of preparation. This lack of preparation generates what we perceive as weaknesses in the design, formulation and implementation of the reform (Gilson *et al*. 2003).

Content of the reform: some matters for concern

In most countries, we did not observe a comprehensive approach in addressing the barriers households encounter in their utilization of health services. The top-down character of the reforms initiated by a political level above the MOH probably partly explains that (Gilson *et al*. 2001). This is worrying, as persistent bottlenecks on the supply side 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 (Witter *et al*. 2008b). Similarly, bottlenecks on the demand side—and the geographical barrier in particular—do not seem sufficiently addressed by the reforms. This could both limit their overall impact and be a major source of inequity; for example, as those living close to the health facilities become the main beneficiaries of the free health care (see also Gilson *et al*. 2008).

There are different ways to remunerate and incentivize health care providers who provide health services for free. The six countries under study have opted for different approaches. Our assessment is that the six countries were relatively ignorant of the incentive implications and managerial requirements of the remuneration strategy they adopted. This is noticeable for instance in the ill-advised monitoring efforts put in place by countries with an output-based approach: a centralized bureaucratic review of invoices instead of the required independent random home visits to verify whether reported activities really took place. Countries should certainly not be blamed for this error. Provider incentives have received very little attention over the last two decades in the discussion on user fees (or their removal).

As for free health care services, pros and cons of input- and output-based approaches are not sufficiently clear yet (Meessen 2009). The future may even show that this categorization is too crude. With this review, we lack the hindsight to give an unequivocal recommendation. Input-based financing apparently makes sense in post-conflict settings: actors are familiar with the strategy (e.g. humanitarian agencies traditionally provide support in kind) and it is an easy strategy to implement if aid is sufficient. Yet public resources may also be very limited and their utilization hampered by constraints specific to the public sector (e.g. weak governance). More positively, governments and their partners may also want to seize the window of opportunity offered by the user fee removal and the post-conflict period to innovate in terms of health care financing. Recent experiences with performance-based financing (an advanced form of output-based payment) have shown, for instance, that the redistribution of roles required by the strategy could be easier to implement in post-conflict countries than in stable ones (Toonen *et al*. 2009). The case of Burundi, which has embarked on an ambitious reform combining selective free health care and performance-based financing, will certainly deserve our full attention.

In general, there is an urgent need for experimentation, documentation and technical guidance on how health care facilities should be remunerated when they provide services for free. In the meantime, for those opting for an output-based approach, some lessons can already be drawn from countries which pioneered performance-based financing, especially in terms of managerial requirements (Meessen *et al*. 2006; Soeters *et al*. 2006).

Process: formulation and implementation

In the formulation and implementation of their reform, several governments have not followed steps identified as 'good practices' in our framework.

In formulation, the most frequent divergences between country practices and our framework were: a lack of, or too basic, estimations of the impact of the reform on the utilization by the population, no proper assessment of the 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 involvement or consideration of the needs of frontline health workers in the design.

As for implementation, the most frequent divergences between country practices and our framework were: no pilot project to test certain strategies, poor communication towards district managers and frontline health staff, low level of public information activities, insufficient monitoring effort (effort focused on accounting), insufficient enforcement effort, lack of interest in evaluation (or the adoption of sub-standard approaches), inadequate feedback loop (adjusting the scheme after observation of problems).

These divergences may have their sources in different factors. First, as a reminder, we acknowledged from the start that some of 'our' good practices were probably more compelling than others. For instance, if suddenly a window of opportunity opens, it makes a lot of sense to seize it and go for a major national reform: pilot projects are not always possible and even appropriate. Second, among our good practices, some were beyond the control of technicians. A sudden top-down decision by the President obviously does not allow an intense consultation of stakeholders. Similarly, in post-conflict settings, time, knowledge and resources are often lacking for a careful formulation process.

Still, most of the good practices identified in the review framework are relatively common knowledge; they are addressable by technicians. One possible explanation for the gap between the 'good' and the 'actual' practices could be the limited technical expertise in health care financing in most of the six countries (and elsewhere, Gilson *et al*. 2003).

In most of these countries, 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) (Ir *et al*. 2010), 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.

The current inability to develop or tap national and international knowledge for improving the policy process shows that there is still massive room for improvement in terms of knowledge management and co-ordination (Meessen *et al*. 2011). The current process in Liberia is worth monitoring as it seems to show that applying recommendations drawn from the international literature in the development of one's future health financing policy and planning is feasible, even in a fragile state.

Limits and further research

This review has obvious limits. The weaknesses related to the 'hypothetical good practice approach' and the normative judgements they require are discussed in Hercot *et al*. (2011, this issue). A second limitation is related to the data collection process. As noted before, the multi-country review was not designed as a research study; the timeframe and the data collection procedure did not always allow the collection of similar evidence in the six countries. A third weakness is the inevitability of subjective assessment when assessing some components of the framework and the compliance with the good practices in particular. The small size of the sample was not a problem: six countries

proved enough to demonstrate both common patterns and interesting variations.

Future research should certainly dig deeper into country realities. Possible directions are: (1) apply the framework to user fee removal reforms in other countries; (2) apply the framework to more than one health policy in a same country—some of the weaknesses identified in this review may be quite generic and reflect general tensions in the political economy of health system reforms; (3) expand data collection, especially on how and to what extent these policies are funded, with a particular attention to funding sources, disbursement procedures and provider payment methods; (4) better scrutinize causal links between formulation and implementation on the one hand and impact of the policy on the other.

Conclusion

Several governments of sub-Saharan African countries are demonstrating new leadership in trying to develop strategies addressing barriers to access to health care. Removing user fees is politically feasible and even attractive. From a technical perspective, however, these reform processes have not always been optimal. In some countries, because of design defects, poor implementation and persistent bottlenecks on demand and supply sides, final impacts could still turn out disappointing. As there is a momentum now, failed reforms would be a major missed opportunity.

Recommendations can be formulated at three levels. In donor countries, it is probably time to move from the agenda-setting stage (discussing whether or not to abolish user fees) to technical support. International actors who have forcefully advocated for user fee removal should now pay attention to technical issues as well. There are operational problems to solve and everyone should get on board. Their financial resources would also be useful, especially in post-conflict settings.

The regional level is probably the most appropriate level to develop the knowledge management strategy required by the problems identified in this review. A key priority is to improve sharing of experience and lessons learned. Regional workshops, study tours, a common research agenda and a community of practice gathering experts working on user fee removal are possible options. Much is expected from the last strategy—launched in late 2010—as it could become an important platform to enhance interaction between different knowledge holders (Meessen *et al*. 2011). If a government launches a bold initiative, its first concern is normally not the production of knowledge for other countries. Hence, the success of such collaborative knowledge strategies will largely rest on international agencies.

At country level, greater attention should be paid to the formulation, implementation, funding, monitoring and evaluation of user fee removal policies—and how they contribute to strengthening the health system as a whole (Gilson and McIntyre 2005). In health care financing and health system strengthening, the perfect solution is never reached. Reformers have to establish a dynamic of change and a capacity to correct policy as it unfolds. Furthermore, they must keep in mind that to guarantee access, user fee removal will not be enough. It can only be a first step. Time will tell whether the recent initiatives will succeed in leading countries to establish sustainable equitable health financing policies.

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Conflict of interest

None declared.

Endnote

[1] The HPIC initiative is a global debt cancellation scheme launched by the International Monetary Fund and the World Bank. In order to obtain the debt cancellation, countries must meet certain criteria, one of which is the allocation by the government of a substantial share of public budget resources freed by the debt relief to poverty reduction strategy, such as social sector spending (see: http://www.imf.org/external/np/exr/facts/hipc.htm).

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