

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

A Policy Guidance Note for Programme Managers

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Bruno Meessen

September 2009

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1 EXECUTIVE SUMMARY

In recent years, several governments of low-income countries decided to remove user fees in the health sector. A number of factors have led to such policy moves: the evidence that user fees prevent people from accessing health services and hurt the poor in particular, a willingness to remove barriers to the attainment of the health Millennium Development Goals, a greater concern for equity, and aid instruments favoring an increase in public spending in social sectors backed by political support from global actors.

UNICEF is committed to supporting governments willing to remove user fees for services targeting children and pregnant women. In order to expand the knowledge base, it has recently commissioned a study reviewing the experience of nationwide user fee removals in six sub-Saharan African countries. The purpose of the review was to draw lessons that could guide the future formulation and implementation of user fee removal policies in other countries. This multi-country review has helped to identify strengths and weaknesses in the way governments have formulated and implemented the user fee removal policies. A key strength of the six experiences reviewed is the clear leadership displayed by political leaders. In countries where there has been a smooth dialogue between the political leaders and the national programme managers, the formulation of reform benefited greatly. However, the eagerness of the political leaders to move rapidly has also sometimes confronted technicians with the obligation to implement an insufficiently prepared decision.

The purpose of this policy note is to provide programme managers from the Ministry of Health and from bilateral and multi-lateral agencies with the necessary guidance in the formulation and implementation of user fee removal policies. This guidance note is not a blueprint. It identifies issues emerging from country experiences with user fee removal and provides guidance in terms of steps to be made in the policy process. It recalls some basic principles: user fee removal tends to result in an increase in utilization of health services; this utilization brings a real benefit for the users only if health facilities have the capacity to deliver adequate quality care. Ensuring availability of supplies – drugs in particular – and availability and motivation of staff are key challenges facing health systems in low-income settings. Addressing these challenges is key for the successful implementation of these policies. The guidance note also incorporates recent findings from the multi-country review. Among other things, it shows that there are different ways to compensate health care providers delivering health service for free.

The core of the policy guidance note is a list of 18 good practices to follow during the policy process. Nine of them are perceived as crucial for a successful reform: political leadership, a clear understanding of the implication of the reform in terms of resources, consultation of key stakeholders, technical leadership, agreement on the funding of the reform, a clear division of tasks, a robust channeling of funds and finally good monitoring and enforcement of the scheme. Although most of the 18 good practices are not specific to a health care financing, we highlight the importance of each good practice for a successful implementation of a user fee removal policy in the specific context of a low-income country. Here and there, we provide a few tips. A list of useful references is also provided at the end of the document.

2 INTRODUCTION

A growing number of countries are contemplating the removal of user fees in the health sector. This guide has been developed to help national and international technical advisers and programme managers engaged in such a policy process. It is part of a broader effort by UNICEF to improve access to health care for children and mothers. The guide is not a blueprint. It mainly identifies challenges that may be encountered.

2.1 GENERAL BACKGROUND

Your government or the government you are working with might be contemplating the removal of user fees in the health sector. There is indeed a momentum both at global and regional level. The Millennium Development Goals have revitalized the debate on sustainable health sector financing and the adequacy of current financing arrangements in low-resource settings. The recent experience of fee abolition in Uganda where an initial increase in outpatient utilization was observed (with strong indications that the poor benefited the most) has been key in this renewed interest. Furthermore, free health care for HIV/AIDS, tuberculosis and malaria patients shows that user charges are not a prerequisite for the organization of health services, if international or national resources fill the gap. Experiences with the removal of user charges in the education sector show that there is also a momentum in other public sectors.

As illustrated in Table 1, several sub-Saharan African countries have recently taken decisive action in this domain.¹ Their choice to focus on some sub-categories of the population, especially children (MDG 4) and pregnant women (MDG 5) is a new source of inspiration for other countries.

¹ See also Yates (2009).

Table 1: Some recent user fee removal reforms in sub-Saharan Africa

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

Which actions is your government considering? Perhaps it is contemplating a universal free public health care system like in Uganda. Perhaps, it is pondering a more targeted approach; for example, free hospital care for the poorest sub-group like in Cambodia or free health care for children aged under 5 years and free birth deliveries like in Burundi. For some reasons, your government may prefer not to remove user fees; yet, like the government of Burkina Faso, it may still want to take significant action in favor of a sub-group.

In such a situation as a technician you may have real concerns about such a sudden and radical policy shift. This guide has been written to help your country to overcome the many challenges related to such a policy move.

2.2 UNICEF & USER FEES

In recent years, several international organizations have taken a strong stance in favor of abolishing user fees in the health sector. For its part, UNICEF has long wanted to ensure that children have access to quality health care services. Decades ago (cf. the Bamako Initiative in 1987) this concern was in fact the main reason for the agency to support the introduction of user

fees. More recently, UNICEF has begun to pay greater attention to equity. In this respect, UNICEF recognizes that user fees in the health sector often constitute an important barrier to accessing health services, especially for the poor and the marginalized.

In its 2005 Call to Action, UNICEF pledged "for governments and agencies to work towards the elimination of user fees for primary education and, where appropriate, health-care services" (UNICEF 2005). In 2005, UNICEF also convened a consultation of external experts, partner organizations, and country and regional level staff to discuss the specific issue of user fees in the health sector. The consensus that emerged from this consultation has been guiding UNICEF policy since then (James et al. 2006). This was a useful step, yet it was still necessary to equip this policy with more technical content. For example, a major observation of the 2005 consultation meeting was that user fee abolition would improve access to health services only if it was part of a broader package of reforms.

In order to obtain a better view on this complementary package, UNICEF has commissioned the Institute of Tropical Medicine in Antwerp, Belgium, to conduct a study. The study consisted in a review of six recent experiences of user fee reforms in sub-Saharan Africa (Meessen et al. 2009). The findings of the 'multi-country review' have been shared in February 2009 in New-York with UNICEF country and regional level staff, government representatives, external experts and partner organizations. In the same consultation meeting, a consensus emerged that international agencies, including UNICEF, should actively assist governments that decide to remove user fees for children younger than 5 years and pregnant women.

2.3 OBJECTIVES AND NATURE OF THIS DOCUMENT

At this stage, it is important to clarify the perspective of this guidance note to avoid any misunderstanding. This guide is not intended as another piece of science or advocacy in the debate on user fees. As technicians, we all know that there are pros and cons with user fees. One can guess that this debate will not fade away, even if there are some aspects which can no longer be denied (e.g. user fees are a barrier to health care for the poorest households).

As the multi-country review taught us, political leaders often do not wait for scientific evidence. This leadership offers technicians wonderful opportunity to promote health care service reform to remove user fees, yet it also puts technicians in a difficult position: while all their recommendations may not be taken up by the political leaders, technicians can nevertheless find themselves under attack later if the reform fails.

The target readership of this note consists of the technicians who will have the difficult job to design the schemes, and formulate, implement and evaluate the reform. It should be noted that technicians, although often not the main decision-makers, are not just passive recipients of directions set by politicians. A key assumption behind this guidance note is that technicians – especially those situated at the interface between the politicians and the health system – can influence politicians at the different stages of the policy process.²

² Note however that this guidance note takes the political decision to remove user fees for children and pregnant women as a given. This means, among other things, that we do not provide guidance for what policy scientists call the 'agenda setting stage', i.e. putting the removal of user fees on the policy agenda.

The guidance note is not a blueprint. It just identifies some of the main challenges that a government will encounter if it wants to remove user fees. In this respect, it may raise more questions than provide answers. We have tried to be exhaustive in the list of issues to consider during the reform process. This attempt at exhaustiveness may have led to redundant information here and there for some expert readers. We also formulate some recommendations, which hopefully will enhance good technical leadership at country level in terms of policy design, formulation and implementation.

Finally, let us say a few words on the sources used for this guide. This guidance note is the result of a collective work; it has greatly benefited from the review of user fee removal experiences in sub-Saharan African countries mentioned above. The note also builds on the evidence available in the literature (Gilson & McIntyre 2005; Richard, Witter, & De Brouwere 2008) and on the professional experience of the author. Recommendations listed in this guide have been discussed and validated, first by participants to an expert consultation meeting convened by UNICEF, and second by a panel of international experts. Nevertheless, we acknowledge that the document is certainly not perfect. Hence, we will be more than happy to update the guide and improve it further with the comments you may want to share with us. We would especially appreciate feedback from those of you directly involved in user fee removal reforms.

3 BEFORE MOVING FORWARD

The policy process is rarely smooth and linear. Technicians must recognize the value of political leadership and be flexible. A key responsibility for technicians is to clarify what objectives the policy pursues and who should be the main beneficiaries. It is also their responsibility to explain the economics of user fees to the political leaders.

3.1A GOOD UNDERSTANDING OF THE POLICY PROCESS

As technicians, we favor a policy process that takes place in a smooth and rational way. Ideally, there would first be an agenda setting stage; for example, a government realizing, maybe thanks to the evidence collected by scholars, that poor households encounter barriers in their utilization of health services. Then a formulation stage would ensue. For instance, the government would ask some technicians from the Ministry of Health to map all the different barriers and assess to which extent public action can overcome them; to identify strategies for the government to address the barriers; to provide cost estimates and propose a blueprint for action. In this ideal scenario, the government would enthusiastically approve all the bright recommendations made by the technicians and follow their advice in terms of the preferred policy option. Then, still in a perfect world, would come the implementation stage. The Ministry of Health technicians would be entrusted with the mission to roll out the reform step by step all over the country. For example, the technicians would develop management tools, inform the health facilities of the revision in the flows of resources and convey key messages to the general public. Eventually, after the implementation of the reform, the technicians would monitor how the reform works at different levels and swiftly address all the initial problems that may be reported. Obviously, the technicians would be happy to share key findings with the politicians from an evaluation showing that objectives have been reached.

In reality, the policy process is not so comfortable for technicians. Obviously, politicians are the other major players. Their role can sometimes be perceived as disruptive, but the government has the mandate to get things moving to the benefit of the population. The multi-country review has for example shown that in some countries, it is the President who took the lead in the removal of user fees (sometimes in the midst of an electoral campaign).

Such a top-down process can be frustrating for technicians: you may find yourself under intense pressure to get user fees removed quickly, in spite of having a thousand other tasks to fulfill; furthermore, you may quickly realize that you will not be allowed to prepare the reform the way you would like. Problems may also occur later in the policy process. Maybe the Ministry of Finance is quite late in its disbursement of the resources that are needed to implement the free health care model; or the health staff react negatively to what they perceive as a reduction of their discretionary power on resources collected at facility level.

Such situations are sources of frustration, yet, they provide also opportunities. Health care reform might not have previously been so high on the national agenda. If the government is

committed to the reform, you are in an ideal position to promote a package of accompanying measures – those measures without which the reform will fail; you may even get politicians committed to solve problems that have been neglected for years.

This is your world; you know it better than we do. We cannot advise you on the best way to handle all the challenges you will meet in the months to come: they are too specific to your context and situation. However, we can share with you what others have done in similar situations and highlight some key dimensions to keep in mind during the reform process. Even if full control is rarely possible, a vision of what you aim for and the accompanying plan of actions are helpful.

3.2A GOOD UNDERSTANDING OF POSSIBLE OBJECTIVES

Your government may pursue different objectives through the abolition of user fees. Most of these objectives are not exclusive. A clear view of the pursued objectives is crucial to the policy design, as it may determine crucial choices such as the exact content of the benefit package. Clear objectives are also a prerequisite for the evaluation of the reform, as they dictate the indicators on which success will be assessed.

First, let us acknowledge the political impact of the reform: your political leaders are elected; for them, the reform is obviously a way to meet the preferences of their constituency and consolidate their support in the population. Moreover, such a reform is virtually impossible without strong leadership at the highest level: the reform will have high visibility and will require a strong commitment from the whole government, especially the Minister of Finance.

From a more technical perspective, one can try to pursue several objectives through the abolition of user fees. Some are declared objectives and thus obvious: increasing health service utilization (by removing a key barrier) and improving equity in the financial contribution and access to health care services. Yet, one must maintain one's critical public health perspective as well. Service utilization is not a goal per se. What one is trying to maximize is the welfare and health benefits for the user. For instance, if the patient uses the free public health facilities more often, but has to purchase expensive unnecessary drugs in the private sector because of stock-outs in the public health facilities, the outcome might not be that impressive (Xu et al. 2006).

Some objectives may also be more implicit. For example, removing user fees will not solve the whole problem of access; many barriers will remain. Removing user fees could in fact be the first step in a more general effort to improve access to health services; it might be followed by other strategies, sometimes less easy to implement (e.g. vouchers). The highly visible character of this reform could help instill in all the actors a concern for equity and accessibility issues. The abolition of user fees is then an entry point for a broader objective. Similarly, the multi-country review revealed that some countries have decided to remove user fees to also please their stakeholders; if these stakeholders are major contributors in the health system (e.g. humanitarian NGOs in post-conflict situations), this can make a lot of sense. The abolition of user fees can also present an opportunity to improve the overall governance of public finances. Indeed, free care can only materialize if resources really reach health facilities at the peripheral level. Furthermore, through the reform it is also possible to pursue the strengthening of the public health system (versus the private-for-profit sector).

It is useful as well to consider the objectives of the reform for beneficiary groups. Although the poorest are often weak in the political arena, they can gain a lot from the removal of financial barriers. Yet, they will benefit only if public resources focus on the services they need and if other barriers are addressed as well (e.g. information, distance). Some services have more impact than others on mortality and morbidity rates and in terms of contribution to the MDGs. If your government aims to make rapid progress towards MDGs 4 and 5, it makes sense to concentrate resources on activities benefiting (mainly or only) children aged under 5 years and pregnant women (e.g. deliveries). In terms of monitoring and evaluation, such a concern for specific societal segments will require data broken down for different groups (distribution by age, gender, socio-economic groups, by distance to health facility).

3.3A GOOD UNDERSTANDING OF TARGETING

In the early stage of the policy process, it is necessary to clarify who are the main beneficiaries of the reform. Should everyone benefit, or only children, pregnant women or the poor? As experts concerned with public health issues, we hope that this identification will take into account the available information on the respective health status of these different groups and inequities observable at this level. A key question is how targeting – i.e. the policy option of concentrating the benefits of the intervention on the pre-identified group – should be organised (Coady, Grosh, & Hoddinott 2004).

In the targeting literature, four targeting methods are traditionally distinguished. *Self-selection* refers to a targeting resting on choices made by households to make use (or not) of a service. For example, one can offer services which attract only the poorest (e.g. because there is a long waiting queue). *Categorical targeting* refers to a method in which all individuals in a category (e.g. children aged under 5 years, pregnant women) are eligible for the entitlement. With *geographical targeting*, the selection of beneficiaries stems from the implementation of the intervention only in some specific areas. Because of the transportation costs, households living far away will not use the subsidised health facilities or services. *Means testing* refers to a strategy relying on the assessment of individual's resources (e.g. his income).

Most schemes combine one or more of these methods. Targeting is then the outcome of a whole process involving possibly a large set of actors. There is certainly no one-size-fits-all solution and several strategies can probably achieve quite similar results (Meessen et al. 2006). Furthermore, the very way a reform is implemented will often affect its performance in terms of benefits for the poor (Peeters et al. 2009). Even a universal free health care policy can turn out to be regressive if poorly financed.

3.4A GOOD UNDERSTANDING OF THE ECONOMICS OF USER FEES

Before proceeding with our list of recommendations, we would like to remind you of some key dimensions of user fees. Removing user fees without due consideration for these dimensions can have a major detrimental impact on the health system or on the attainment of the pursued objectives.

User fees and health seeking behaviors

A user fee is a monetary price charged to the user of a service.³ In this respect, it follows the standard law of demand in economics: the lower the user fee, the higher the demand by the population. Indeed, if the public health centre decreases the level of the fee (for a service of a given nature), the alternative options (e.g. the private clinic, the drug peddler) become relatively less attractive for people with a health need. This is what economists call the *substitution effect*. The decrease in the fee level also induces an *income effect*: the mere decrease of the price increases the purchasing power of the household's budget. So assuming everything else is held constant, **the removal of user fees will increase the demand for public health care services and their utilization if health care providers have sufficient resources to respond.**⁴

The increase in utilization may vary across groups. Economists say that households have different *price elasticities*. Studies have shown that poor households are more sensitive to price reduction than richer ones (Sauerborn, Nougara, & Latimer 1994). One can therefore expect that the poorest will benefit more from the removal of user fees. Yet, this relationship is not automatic. User fees are just one of the *participation costs* or *barriers* faced by the households to use health services (Ensor & Cooper 2004). Poor households may face more barriers than better-off households to use the (from now on free) health care. This may result in the increase in utilization coming mainly from richer groups. This outcome – an inequitable one given the current pattern of health service utilization in countries throughout the world – is likely for example if the freely accessible benefit packages are being delivered by hospitals (many poor households live in rural areas, i.e. far from hospitals, whereas many better off households live in cities, i.e. close to hospitals). Having said this, better-off households also face participation costs. One factor which may strongly influence their utilization of public services is the opportunity cost of waiting in the queue. If the free health care turns out to be a real success among poor households, the influx of users to the health centers can in fact lead to an increase in the opportunity cost for the better-off. They may then decide to shift towards utilization of private clinics. This situation has for example been observed in Uganda.

User fees as a source of income

The main aim pursued by the Bamako Initiative was to increase resources under control of the health facility in order to help cover its costs, and the cost of essential drugs in particular. When user fees are retained at facility level (versus transferred to the tax department as it was mistakenly organized in some countries), they can represent a major contribution to the financing of the health facility. This is particularly the case in countries where public funding is not reaching health facilities (e.g. because of governance problems or a conflict). Even if user fees are only contributing a limited share of the health facility financing, they have two great qualities in the eyes of the health facility managers: (1) they are a relatively predictable source of cash (contrary to the government budget which can be released very late in the year if the central

³ Note that the monetary nature of the price can be a barrier in itself. In low-income countries, many poor households do not hold much cash and do not have access to credit.

⁴ Let us keep in mind that a higher utilization of public health care facilities does not automatically imply major progress from a public health perspective. This will only be the case for patients needing care who, otherwise, would have foregone treatment or used a sub-standard provider due to the user fee.

government has a treasury constraint); (2) managers have usually discretionary power over the use of this revenue.

User fee removal necessitates the establishment of alternative ways to fund the inputs that used to be financed by the user charges. The compensation must also be predictable and allow enough managerial room for maneuver.

User fees as a rationing mechanism

Economists believe that resources are limited, whereas desires are not. Any society has therefore to design mechanisms to ration the utilization of resources; ideally this rationing makes the best use of rare resources given the objectives pursued by the society.

Public health services are financed with public resources: the public budget. This budget is tight in low-income countries. Purposely or not, by establishing user fees, governments have established a mechanism to ration the utilization of their public resources. Indeed, only those who can afford the fee will consume the public resources (i.e. the time of the doctor, the equipment in the hospital).

An abolition of user fees implies that the government is removing this rationing mechanism. If the costs covered by the fees are now covered by a source different from the users, there will be an increase in utilization which will cause an increase in the consumption of public resources. This implies that **when a government removes user fees, it must foresee a budget superior to what used to be collected through the user fees.**

A consequence of removing user fees is that rationing will occur through other means. If the budget for human resources is too low, the workforce will be the new bottleneck; health staff will for example close the health centre while there are still patients waiting in the queue. If the government budget for drugs is too small, the health facilities will run out of drugs on a regular basis. The key question then is whether the new rationing mechanisms will be more equitable than the previous ones. These are key issues to keep in mind when designing the scheme. One of the most equitable ways to ration public resources is the specification by the government of packages of services that will be free (through the definition of minimum and complementary packages of activities at first and second lines respectively, the establishment of essential drug lists...) and guarantee that these packages are geographically accessible to all.

This reminds us that prices charged to the users are a key mechanism for the government to fix priorities. Indeed, there will be services financed by the government budget and services financed by the users. Economists would recommend that the first group includes the most cost-effective interventions with regard to the objectives pursued by the government (e.g. progressing towards MDGs 4 and 5), including the interventions generating benefits beyond the direct users of the service (activities with so-called *positive externalities*) and/or for which, because of physical characteristics, beneficiaries can not be charged a price easily (e.g. vector control program).

User fees as incentives for the health staff

A rather neglected aspect in the ‘user fee literature’ is that user fees also set incentives to health care providers. In many countries, revenue collected through user fees is retained by the health facility and partly finances health staff income, especially bonuses. User fees are then an incentive for the health staff to adopt behaviors and strategies to increase the utilization of activities charged to the users. For example, health facilities surviving thanks to user fees may focus on curative services and neglect activities that they have to provide for free (e.g. preventive activities). More positively, if minimal competition prevails, the health staff will take the quality of service (i.e. politeness, amenity, cleanliness...) seriously. This problem of incentives also exists in the health committees established at the health centre level in the follow-up of the Bamako Initiative. These community representatives are usually compensated with a part of the user fee revenue for their role in managing the drug stock and the accounts of the health centre.

This means that abolishing user fees can modify the set of incentives faced by the staff or the community representatives. We will show further that there are ways to mitigate some of the related problems.

User fees and transaction costs

Organizing a transaction consumes some resources. Collecting cash from users requires, for example, setting up a cashier position. On the other hand, organizing free health care services also induces some transaction costs. Public resources have to reach the health facility. If the free health care is financed mainly through the donation of inputs to the health facilities (e.g. drug kits), there will be a need to check that drugs are not pilfered by the health staff. If the free health care is financed through outputs (e.g. lump sum fee to reimburse the health facility per service delivered), it will prove necessary to check whether the reported services were indeed provided. Ideally, these transaction costs have to be taken into account in the general efficiency calculus; this is very rarely done in studies.

4 KEY ISSUES TO CARE ABOUT

Champions of the reform must have a sufficient understanding of the context of the policy process and of the attitude of different stakeholders towards the reform. As far as the reform content is concerned, key decisions must also be taken on the accompanying reforms and the remuneration of the health care providers.

4.1 THE IMPORTANCE OF THE CONTEXT

It is well-known that the context is a key determinant of a policy process. For example, it is most likely a change at the context level that has led your government to consider free health care – the problem of financial access for the poor is indeed not a new one. Context will shape the position and influence of various actors. It will influence the content and the implementation of the reform. Having a good understanding of the context is thus crucial.

Hence, our recommendation is straightforward: **if the national leaders give you enough time, try to produce a rapid analysis of the policy context through the lenses of access to care and health care financing.** Among other things, this analysis will be useful to identify opportunities and risks. It will also be conducive to determining which support the country might need, including possible accompanying measures.

Consider at least three levels of the context: the global level, the national level (health excluded) and the national health context.

The global context refers here to all the contextual elements external to the country that may have had an impact on the user fee policy. Examples of factors that could impact the policy content or process are the following ones: the international market, global economic situation and exchange rates; external debt; the Heavily Indebted Poor Countries Initiative status of the country; main sources and channels of aid in the country (e.g. general budget support versus project approaches); and global initiatives in favour of low-income countries.

By ‘national context’, we mean all domestic contextual elements that may have had an influence on the user fee policy. The political stability and security in the country, its economic situation (growth, inflation...), the demography, political system and governance of the country are all factors influencing the capacity of the country to engage in a reform process. If elections are upcoming, this is also a key aspect which should be carefully observed. Socio-cultural aspects matter also. The six country review studies confirmed for example that the attitude towards user fees is quite different in Anglophone and Francophone Africa.

Obviously, the situation of the health system is a key contextual element for a policy on user fees. Information on the **health status** of the population (hopefully broken down into different population groups) is key to deciding the package of services to provide for free and possibly the groups of population who should benefit first (e.g. rural population) or the most (e.g. the

poorest). Information on **the barriers to health care** is necessary to adopt the right design for the scheme. Much information on **the health sector in general** (e.g. 'market share' of the private sector) and more specifically on its **financing** – sources, nature, amounts, channels, beneficiaries – will be required to organise the funding of the reform. The whole spectrum of sources, coordination mechanisms and channels has to be considered; surely, donors and the public budget will be key contributors to the free health care policy. Recent national health accounts are surely helpful; however, the historical perspective (e.g. the history of user fees in the country) and some prospective analyses will be necessary as well. Predictability and a good degree of control over the funds (especially in terms of disbursement) by the Ministry of Health are indispensable for establishing a sound free health care strategy. Note that you must go beyond the financial flows; the way health facilities access **other resources** (e.g. drugs, workforce) matters as well. Obviously, if the drug supply is non-reliable and staff are poorly motivated or unavailable, the free health care policy will require quite significant accompanying measures. In fact, one needs a more or less accurate assessment of the **overall performance of the health system**; any systemic weakness that may affect the reform implementation or monitoring must be identified (e.g. technical capacity at central level, reliability of the health information system and staff motivation). **Institutional arrangements** and the incentives they set must also be well understood; the existence of arrangements such as the health committee, community based health insurance or social health insurance must be taken into account, as the free health care policy may have an impact on them as well. More generally, any aspect that may affect the dynamic of the reform must also be identified (e.g. leadership of the Ministry of Health, turn-over of top managers, decentralisation process, tensions among partners and enthusiasm for community-based health insurance).

Our tip: The policy context analysis should not necessarily require much energy to prepare; it is probably only a matter of brainstorming for a couple of hours. The session can be split up into three exercises with the following assignment: identify opportunities and risks for the policy process (formulation, implementation and monitoring and evaluation stages) at global, national and health sector levels. Try to have participants from different perspectives, including persons familiar with macroeconomic issues. A comparative analysis (e.g. with countries with more or less similar challenges) can also be insightful.

4.2 THE ACTORS

Many actors will be in a position to influence the policy process. For sure, the abolition of user fees will be noticed: this is a very political reform. **If your national leaders permit you enough time, carrying out a rapid stakeholder analysis at the early stage of the formulation will be helpful.**⁵ The exercise will mainly consist of **identifying actors** with a stake in the existing system or actors who could be affected by the reform. This identification will have to include the whole spectrum of actors: national and international; health and non health; central and peripheral level; public and private. A rough categorization into potential supporters and opponents will help to develop the right stakeholder management strategy. The stakeholder analysis should also allow the assessment of their interests, attitude and influence.

⁵ See for example (Varvasovszky & Brugha 2000).

Among the potential opponents, there will be those who are currently benefiting from the user fee policy (e.g. health staff, health committee) or who at least could be negatively affected by the reform (e.g. an international agency that has been supporting another health care financing strategy). The reform will have to adopt a form that protects their stakes (see later in this policy guidance a note on how to do so) or their hostility will have to be countered (e.g. by a large coalition). Resistance may also come from actors who may be put under pressure by the reform. For example, if the drug procurement unit is already weak, the removal of user fees will reveal its low performance even more. This is not necessarily a negative consequence, however policy makers must be aware of the constraint this can create for the reform. They should also anticipate the possible backlash that the weak performance of such actors may generate. Resistance may eventually come from agencies that do not share the analysis backing the reform; they may not agree with the rationale, find the supporting empirical evidence too weak or be concerned about some possible side-effects of the reform.

Poor households are expected to be strong supporters of the reform. Yet, they probably have limited political clout (if they had substantial political power, the reform could have taken place a long time ago). While donors and international agencies have often been ambiguous about user fees, the current momentum at global level should boost support among them. This will probably be the case if the reform targets the poor or other vulnerable groups such as children aged under five years and pregnant women; conversely, if you aim for a national free health care policy, expect much more resistance among the technical and financial partners.

For the supporters, it will be important to identify their potential contribution: will they mainly give political support or also provide resources in kind (e.g. drugs, technical assistance) or in funding (e.g. budget support)? When will this support come into play: during the agenda setting, the formulation, the implementation or the monitoring and evaluation stages? Where will their support be most useful for the reform: at central level or at peripheral level? For the possible opponents, try to assess their power and channels of influence.

The stakeholder analysis is not a goal per se. It is an instrument to inform you on the best actions to take in terms of the content and the process of the reform. It may lead you to consolidate the alliance, to launch a broad participatory process for the formulation stage, to adapt your communication strategy, to adopt some accompanying measures or even to prefer one payment mechanism over another.

Our tip: A rough stakeholder analysis can be done quite quickly. To avoid exacerbating possible tensions among stakeholders, it is preferable that cadres of the Ministry of Health carry out the exercise internally. The exercise should ideally be carried out for each sequence of the policy process.

Table 2: stakeholders of a user fee removal reform (the Ministry of Health perspective)

Some of the actors affected by the reform	Importance to consult/involve them during the formulation process
Governmental bodies: the Presidency, the Prime Minister, the Ministry of Finance, local governments	Crucial, as the success of the reform will depend on their political and financial commitment.
International agencies at central level: WHO, World Bank, IMF, major bilateral cooperation agencies, global health initiatives	Crucial, as the success of the reform will depend on their financial and technical support.
International agencies at peripheral level: international NGOs, some bilateral cooperation agencies	Crucial in post-conflict settings, high in other situations. (support to the implementation process).
Public and non-profit providers: public health facilities (managers/frontline staff), faith-based health care organizations	Crucial, as smooth implementation will depend on their collaboration (consult at least a few health district and hospital managers and the representative of the umbrella organization of the private non-profit health facilities). In some countries, it is important to also consult the health worker unions.
Community health insurance organisation, social health insurance agency	Very high, as the user fee removal will affect their function, yet, they will probably have limited influence on the reform.
Private providers	Low (consult them only if they have an umbrella organization?).
Population and vulnerable groups	They are the main beneficiaries of the reform, yet, their representation goes through the electoral system. Local NGOs can be good proxies. Prefer NGOs active in the countryside.

4.3 THE CONTENT OF THE REFORM

The reform will have a specific content. Some of the key questions are the following ones:

- Coverage: the whole country; only some provinces; only rural sites?
- Scope: all levels of providers; only health centres; also district hospitals; also national hospitals?
- Facilities' eligibility: public facilities only; also private non-profit facilities; also the private for profit providers?
- Individuals' eligibility: universal; some specific groups only (e.g. children under five); some groups with a specific health condition (e.g. pregnant women); means testing (e.g. users below a poverty threshold)?
- Benefit package for the user: full cost or only a subsidy; drugs only; also other inputs such as labour?

There is no rule in this respect. The nature of the health and equity problems in the country will be very influential. Obviously, the broader the coverage, the scope, the facility and the

individual eligibility and benefit packages, the greater will be the budget required to finance the reform. Also keep in mind that the more unclear or complex the rules of entitlement or the benefit package are, the more costly is the administration of the scheme, possibly also for the target group (e.g. cost for mothers to prove that their children are indeed not older than 5 years).

Another crucial content question concerns the **concomitant reforms** or **accompanying measures**. As already mentioned, the removal of user fees will lead to a surge in the utilisation of the health services. This surge will persist in the long-run only if health facilities are able to provide quality services to all their visitors. This requires that they have enough motivated qualified human resources, drugs and consumables in sufficient availability and enough cash to finance their running costs. In fact, the decision to remove user fees is an excellent opportunity to address other problems in the health system. Surely, the user fee removal must be coherent with the government's vision on the development of the health system. User fee removal can for instance clash with a simultaneous effort to develop community-based health insurance. The best approach is probably to develop a comprehensive strategy; user fee removal is then part of a broader set of complementary measures that all aim at strengthening the health system. Uganda took this road in 2001 (Tashobya, Ssenooba, & Cruz 2006).

The last key question in terms of content concerns the contractual arrangement that sets up economic mechanisms to compensate the health care providers delivering the free care. Resources provided for free to the users indeed need to be financed by someone and channeled one way or another to the health facility. The way health care facilities are compensated for the lost revenue is not neutral in terms of incentives. There are different ways to carry out this compensation; key issues are how the compensation is calculated, and more particularly whether the health facility staff may influence, by its behavior, the resources received and whether the staff can benefit from the collected resources (e.g. through bonuses).

Some countries prefer an **input-based approach**. This approach is characterized by two major traits: (1) the health facility receives the resources in kind (drugs, workforce) and there is no direct link with its achievements; (2) the health staff has no earning rights on these resources. This is for example the situation in places with drug kits: the central level determines the composition of the kit and how much kits the health facility should receive (for example, according to covered population or historical achievements). Staff are not allowed to use the drugs outside the public service or to sell them. When the government provides the health facility with a certain quantity of staff and pays their salaries, this also amounts to an input-based arrangement. A supplementary user is not a source of additional reward for the health facility of the individual staff member (yet, this patient induces a supplementary private cost in terms of workload and stress). This may negatively affect the responsiveness of the staff to patients' needs and demands.

Another strategy, sometimes called the **output-based approach**, compensates the health facility in cash according to the activities it has actually produced (e.g. per unit of service delivered) and allows the health staff to use part of this revenue as a remuneration. The compensation to the health facility is paid by the public budget or a so-called third party payer (e.g. a fund holding agency). The great quality of this model is that it may set an incentive to the staff to treat more patients. Indeed, if the fee paid to the health facility by the third-party is superior to the unit cost, any supplementary patient is lucrative. Interestingly enough, several

countries documented in the multi-country review have adopted such an output-based payment model. Unfortunately, their adoption was only partial. For example, all of them have neglected to establish the very strict verification system required by such an approach. Indeed, whereas checking whether data reported by health facilities correspond to utilization registers is necessary, this is not enough to prevent dishonest health facility managers from reporting ghost patients. In order to avoid this over-reporting, the golden rule is to regularly sample a few users, trace them in their community and interview them in order to verify their actual use of the services. Besides fraud, the other risks associated with the output-based approach are that health care providers have an incentive to deliver services they are technically not able to provide and they tend to overlook services which are not remunerated or prescribe services which are not appropriate, given the health status of the user (Meessen, Kashala, & Musango 2007). For example, the risk to induce doctors to perform unnecessary caesarian sections is well documented in the literature. It is unclear whether governments which recently decided to abolish user fees for caesarian sections and adopted an output based system approach have fully taken into account these risks.

In Table 3, we summarize the pros and cons of the two approaches. The analysis is based on theoretical thinking (economic models) and recent observations in different countries. There is not enough evidence currently available to be more authoritative in this respect.

Our tip: Try to combine two kinds of expertise when you discuss the reform content: public health and health economics. Recruit consultants if necessary.

Table 3: Pros and Cons of Different Payment Mechanisms

Area of Interest	Input-based approach	Output-based approach
Application	Very effective in systems where accountability and ethical standards are high (e.g. humanitarian NGOs).	Interesting potential in settings where accountability to the users is low.
Risk of drug stock-outs	Very high	Low, if the fee also covers the cost of the drugs.
Risk of staff de-motivation	High if no accompanying measure	Low, if the fee also covers the cost of the staff effort.
Influence on drug and service prescription	Low	Risk of over-prescription if the payment is piece-rate; under-prescription if the payment is lump sum.
Vulnerability to late disbursement	Only for drugs	High
Implementation	Easy to start	Requires to set up a body for verification
Transaction costs	Required for following the management of drugs and the efforts to serve the population	Needed to verify the output reality.

5 THE POLICY PROCESS

From a planner perspective, the policy process can be divided into three main stages: the formulation, the implementation and the monitoring, enforcement and evaluation. While the whole process will rarely be fully under control of the policy makers, following some good practices can increase the chances of success. We list here the major ones for each stage; most of them are standard for a reform process. We mark each practice in terms of importance (“crucial” or “helpful”).

5.1 THE FORMULATION STAGE

Each reform is a challenge and requires good preparation. Our experience is that ministries of health in low-income countries do not always have the necessary in-house technical expertise to formulate a health care financing reform. A possible solution for the Ministry of Health is to rely on technical assistance from its technical and financial partners or to contract consultants. Yet, it is well-known that aid agencies do not always share the same view and that their coordination can be a supplementary challenge for the health authorities. Reform also often affects the stakes of some actors. The Ministry of Health will have to develop the appropriate leadership, tap knowledge, involve stakeholders and take into account some of their preferences. By *formulation*, we refer to all the steps taken to design the reform package. Here is a list of good practices in terms of formulation.

Good practice #1: Vision, ownership and leadership by the national authorities are crucial.

The multi-country review has shown that in a user fee removal reform leadership usually comes from a political authority, often the president himself. On the one hand, this is great as one can expect a strong commitment from the whole government; among other things, this might consolidate the buy-in by the Ministry of Finance. The downside is that your president has probably limited expertise in health care financing and has a time horizon different from yours: speed is essential for him, things should move fast. These different priorities can lead to real policy hazards.

In fact, one can anticipate two different scenarios. Under the first one, you are the passive recipients of a decision suddenly taken by a higher authority. As technicians, you have the unenviable job of sorting out the trouble generated by the new decision. If this higher authority is responsible, it will display the required leadership which, among other things, entails that it allows you to formulate and implement the policy simultaneously. Your own leadership will have to focus on buying time through actor management, learning rapidly and correcting big mistakes.

The second scenario is more comfortable: as technicians, you are already involved in the policy formulation. The challenge is that you may be the one who has to display the required leadership. In such a situation, your key concern will be to make sure that a large coalition of

actors, both at the top of the government and at the lower levels of the health system, supports the reform. If you are in this situation, maintain a critical attitude towards your usual partners and yourself: are you powerful enough to ensure long-term commitment to the reform? If not, engage with powerful players. In any case, do not rely too much on the financial assistance you get from donors traditionally supporting the health sector. Free health care will quickly have to be financed from the budget. The current aid architecture – especially the Highly Indebted Poor Country Initiative – sets strong incentives for your government to commit part of its budget to free health care, nevertheless, the Ministry of Finance must be convinced that the reform is one to finance consistently in the long run.

Our tip: An option is to establish a multi-sector national committee, ideally chaired by the Minister of Health and comprising the Minister of Finance and heads of donor agencies. This mechanism is particularly helpful for building ownership at every level. One of the responsibilities of the committee could be to commission periodic reviews of the implementation of the reform process.

Good practice #2: A preliminary situation analysis of the barrier problem is helpful.

The better one knows the problem one claims to address, the better the chance of solving it. Hopefully, at the stage of formulating the policy, you already have quite extensive documentation of the barriers to the utilization of primary health care services. Your **preliminary situation analysis** will then mainly consist of reviewing the existing evidence on barriers. This evidence may have been published in scientific peer-reviewed journals, but most of the time it will be part of the so-called ‘grey literature’: reports and studies produced by the government or its technical partners in order to guide their operations. Population surveys (like the Demographic and Health Surveys) are also very useful to identify where the main problems and the possible top priorities lie, especially with respect to MDGs 4 and 5 (in terms of interventions, target groups and geographical areas). Some NGOs produce very interesting case studies full of insights, and lots of documents are also produced by other sectors. In many countries, the Ministry of Planning and its partners produce very useful studies of the poverty at national level.

Our tip: Make use of this stage to already engage with key actors. You can, for example, organise a consultation workshop where you invite different actors to share evidence and knowledge on barriers for accessing services to reach MDGs 4 and 5. You can try to conclude the workshop by preparing a consensus note synthesising the findings. Your review will then largely consist of the set of slides and reports presented during the workshop and the consensus note. If some ‘unknowns’ remain, choose a pilot project over pure research: your learning will be much quicker!

Good practice #3: International and national knowledge to developing the policy solution is helpful.

Developing a solution to a problem is not as straightforward as one might think. If one is serious about addressing barriers to health care service utilization, the solution will include much more than just the ‘abolition’ of user fees. The word ‘abolition’ is in fact rather unfortunate: one

cannot 'abolish' rationing, instead, one replaces one mechanism by another. One of the challenges you face may lie in reminding your national leaders of such economic realities.

There is a wealth of knowledge to tap into to design the policy solution. This could be knowledge on the scheme to address the problem (what?) or on the way to implement the reform (how?). Let us keep three things in mind three things.

First, be aware that any policy rests on some underlying views on human beings (how they behave), theories and values. Making them more explicit is helpful (also see our tip).

Second, you have to draw lessons from experiences elsewhere. Knowing what others have done in the face of similar problems can only enrich your decisions. There are three main ways to access international knowledge: literature, brokers of knowledge and study tours. International scientific evidence on user fee removal, alternatives (e.g. health equity fund, community-based health insurance) or complementary schemes (e.g. vouchers) is growing. This evidence is shared in conferences and in scientific journals. Many references are available online. If you do not have easy access to scientific journals, you may also call on an international agency to assist you in this literature search. Be aware however that most publications are in English. This is a barrier in many non-Anglophone countries. Another way to tap international knowledge and expertise is to engage some international brokers of knowledge. Scholars are usually well-informed about the international scientific evidence. However, most of them are not very familiar with operational issues. Private consultants have more hands-on expertise; their experience in different countries makes for good advice. Your last option is to undertake (or organise) a study tour in a country which has recently introduced a policy similar to the one you are considering. This can be an excellent opportunity to learn about the challenges and mistakes to avoid.

Third, you must also draw lessons from experiences in your country. Admittedly, the solution developed in country A cannot be implemented as such in country B. There is a need to consider local constraints in terms of context and actors (see respective sections) and find some local adaptations. For a start, you can analyse all the financing schemes in place (e.g. social health insurance, community based health insurance...). What are their limits? Is there a problem only in terms of coverage (e.g. the entitlement is limited to the civil servants) or is the problem mainly situated at the level of the enforcement (e.g. decree establishing free health care for the indigents)? How is the performance of these existing schemes? Think also of the different vertical programs which usually provide free services to their target groups.

Hopefully, you will also be able to build the new national policy on evidence collected in certain pilot schemes. The great benefit of pilot projects is that they provide contextualised evidence; this is helpful if the policy reform is instigated or influenced by external actors (foreigners may underestimate certain constraints and opportunities in your country). Pilot projects are not very popular among politicians: they want policy developments to be rapid and visible. Perhaps, they will be sensitive to the argument that a failure will eventually hurt their reputation. If you outline for them the different challenges reported in this document, they may go for the safer route of pilot experiments. This is particularly feasible in vast countries.

In terms of user fee removal, the standard pilot is a project run by an international NGO. Usually such experience powerfully demonstrates that user fee removal will induce a major increase in health service utilisation. Unfortunately, many NGOs opt for schemes that suit their operational and fiduciary constraints, but much less so the government's constraints. In other words, a health district in which a rich and very reactive international NGO operates with its own drug supply and staff does not provide perfectly replicable lessons for a whole country. The ideal situation, if you have enough time, would be that your partner organisation adopts in the pilot project the system that will apply at country level (e.g. procure from the central medical store, use an output-based system of reimbursement). Pilot projects are then very useful, as they identify weaknesses in the system and provide the national level with a full set of management tools and procedures. This greatly facilitates a smooth reform (which to some extent may consist in scaling up the pilot scheme at national level).

The last advantage of pilot projects is that they generate national operational expertise. Several of these new experts will be the managers of the public health system at the peripheral level. These persons will be vital resources for you in the preparation and implementation of the reform.

Our tip: A useful exercise could be to formulate the links between the causes of the problem, the intervention you are considering and the outcomes you want to achieve. Once your framework is ready, try to identify national and international scientific evidence supporting it. Then share the framework with experts with different backgrounds, among others, public health specialists, health economists and public finance experts. You may realise that things may be more complex than you imagined at first. If you do not have the time to do this analysis yourself, you may want to subcontract the analysis to a consultant.

Good practice #4: Clarity of the policy objectives is helpful.

Earlier in this document, we have explained that several objectives could be pursued by a user fee removal. Our recommendation to the government is to put on paper exactly what it exactly is pursuing through the reform. The multi-country review has revealed that this obvious step is sometimes skipped by leaders. If the national leadership has omitted to clarify the objectives, it is probably the responsibility of the Minister of Health to prepare such a note and share it with other ministers.

Clear objectives are useful for at least two reasons. First, they explicitly state what one is trying to achieve. This can facilitate policy dialogue between political leaders and technicians thereby, for example, permitting, the technicians to propose better strategies to achieve the same goal. It may also put the policy proposition into a broader perspective. For example, if the goals are to reduce infant and maternal mortality rates, the free health care policy must embrace much more than just curative services: what about preventive services such as immunisation and family planning? In a nutshell, clear objectives allow constructive criticism.⁶ Second, without clear objectives, it is impossible to identify how the reform will be monitored and assessed. Clear objectives are quantifiable and can be synthesised in a few indicators.

⁶ However, be aware that there is a downside to explicit objectives: it facilitates also destructive criticism, as it allows different actors to see what they want to object to.

Our tip: Writing short memos is probably one of the best ways for a technician to share his concerns in terms of mismatch between a policy and its declared objectives.

Good practice #5: Considering different policy and design options is helpful.

Policies are instruments to reach goals; they always have pros and cons. One can imagine more than one policy to improve access to health care. Before adopting a strategy or a design option, it is preferable to assess it against alternatives. This step requires that the policy makers are very clear on the content of the different policy options they are considering (cf. section 3.3.). Obviously the yardstick to assess each option is the attainment of objectives pursued by the reform. One might wonder whether sometimes persons are indeed too hasty to form a solution.

As technicians, you probably want to compare options from a public health and equity perspective (impact on the target group). Keep in mind however that for politicians the anticipated political pay-offs are not equal across solutions. If the beneficiary target group is too narrow (e.g. the poorest), you can undermine the political support at national level for the reform. Remember also that someone (most probably you!) will have to implement the reform. Try to compare the options in terms of necessary conditions for success, easiness of implementing and enforcing, budgetary incidence (see next recommendation), support from stakeholders, possible conflict with other policies and risks more generally.

Tip: The dialectical method - an oppositional discussion - is probably the best way to identify the pros and cons of different strategies. If you have actors who champion different strategies, you can always invite them to present their arguments. Keep in mind however that you may have to use bits of everyone's ideas eventually, as you do not want anybody to lose face.

Good practice #6: An economic assessment of the chosen option is crucial (especially if there are few resources to respond to unexpected consequences).

Policies aim at affecting human behaviour. Hence some uncertainty is unavoidable: how will different actors – and more particularly the population and the health staff – react to the user fee removal?

There are methods to explore different response patterns and their consequences. A key requirement will be to carefully forecast the resource implications of the free health care policy. Again, as was the case for the previous good practice, this good practice requires a clear formulation of the content of the reform (scope, benefit package, contractual model...). Obviously, if utilisation increases (probably the main goal of the reform), there will be a surge in the consumption of some resources (e.g. drugs, time of personnel, cash flow). How much will the utilisation increase?⁷ Will the health facilities be able to respond to this increase?⁸

⁷ Consider that some users will switch from one provider to the other. For example, people in neighboring areas or countries not implementing free health care may flock towards the facilities providing treatment for free.

⁸ In terms of human resources, constraints can be very different between rural and urban health facilities.

Do you have the budget to meet this increase? If you have opted for an output-based model, how much will you reimburse the health care providers for the different services? If the room for manoeuvre is limited, small mistakes could result in serious problems.

When you carry out the forecasting exercise, keep in mind the role that rationing mechanisms and incentives will play. This will require you to have a good understanding of the economics of the new scheme (including how it will interact with existing schemes). From a more administrative perspective, do not forget to carry out a fiduciary analysis of the scheme, including a careful look at possible fraud.

For this thorough assessment, the best approach is probably the dialectic within a small technical group: a few persons tend to know more than one person; initially conflicting views will eventually culminate in a more thorough assessment. Involving critical or even sceptical individuals may help to disclose the possible weaknesses of the option you are considering.

Our tip: The forecast analysis is a key step in the formulation stage. Our experience is that it is quite demanding in terms of expertise (a lot of data analysis involved). If there is no technical assistant familiar with the technique, it is probably better to hire a health economist consultant. His main assignment will be to carry out simulations to assess different scenarios of user response to the user fee removal. This analysis will facilitate an assessment of the impact on the budget. A useful reference is the guide recently produced by Save the Children UK (Save the Children 2008).

Good practice #7: An early identification of accompanying measures is helpful.

As already mentioned, the removal of user fees will trigger a surge in the utilisation of health services. An adequate package of ‘accompanying measures’ must be identified at the formulation stage, especially if there will be limited room for adaptation during the implementation stage.

These accompanying measures will be very context specific. In country A, it may be that the drug supply needs to be fixed, whereas in country B staff motivation may need a boost. If accompanying measures are not sufficient, the reform will create a lot of frustration and tension within the health system. Hence, policy makers should expect a backlash.

Some measures may have to be identified as pre-requisites for a health facility to be eligible for the scheme. Do not under-estimate the harm that your reform could generate.

Our tip: Involve main stakeholders in the formulation of the policy. Allow them to raise concerns and advocate for some actions to be taken. Technical and financial partners are usually keen on helping governments to address different bottlenecks.

Good practice #8: Collecting information on the preferences of key stakeholders is crucial.

Experience across sectors has shown that there can be a gap between the plan and the action – the so-called *implementation gap*. This gap can be due to the resistance of some stakeholders who mark their disagreement with the reform by impeding its implementation (cf. section 5.2.

and the stakeholder analysis). Policy makers can pre-empt such problems by trying to meet the preferences of key stakeholders. Obviously, it will not be possible to please everyone. Stakeholders are aware of that, but they know also that they (or their representatives) are the best to defend their perspective. They certainly expect to be consulted. Hostility is often due to ignorance or misunderstanding.

It will therefore be crucial to involve key stakeholders in the formulation process of the user fee removal policy. Co-production will create a sense of co-ownership and consolidate the commitment of all to make the reform a success. Your commitment to involve others must be sincere; you will be respected as a policy maker only if you take into account their comments and criticisms. Moreover, if there is plenty of evidence that user fees hurt the poor, there is much less evidence of the impact of user fee removal on the health system. Be humble and recognize that other stakeholders may be as concerned as you to develop the best health system for your country.

You will have to make your own list of stakeholders to involve. There will be actors at central level (different Ministry of Health departments, the Ministry of Finance, the major donors, some agencies active at peripheral level), but also representatives of peripheral actors (e.g. hospital managers, the health committees, the health staff...). Their involvement does not mean of course that you should lose the leadership. This leadership will be necessary to arbitrate conflicts between consulted stakeholders. You should also clearly define the core of your reform and the areas that are negotiable.

Our tip: Establish a coordination body (e.g. a task force) during the formulation stage; invite all the stakeholders important for the reform to join. Try to engage individuals who will champion the reform within their own organizations and will help you later during the implementation. In order to elicit the preferences of decentralised actors (e.g. households, health committees), you can adopt strategies such as focus groups, surveys and opinion polling.

5.2 THE IMPLEMENTATION STAGE

Introducing change into a system raises a lot of operational challenges. Our experience is that ministries of health in low-income countries have a relatively good understanding of the steps needed for routine changes (e.g. introducing a new protocol), but less experience with radical and nationwide transformation. A possible solution for the Ministry of Health is to get assistance from its technical and financial partners, especially those working at the peripheral level. Yet, aid agencies have their own planning; this may create tensions. By *implementation* we understand all steps taken to make the reform real in the daily activities of the health care facilities. The end-result of the implementation is what comes out of the mix of original plans and the actions or non actions taken by the actors to enforce or limit the changes. Here is a list of good practices in terms of implementation.

Good practice #9: Technical and managerial leadership by the Ministry of Health and its technical partners is crucial.

Although user fee removal is often a decision made at the highest political level, its implementation will require technical leadership. This technical authority must rest with the

Ministry of Health (or its equivalent in highly decentralised countries). The best strategy is for the Ministry of Health to set up a technical task-force with a clear leader. This task-force must be inclusive enough to involve all the expertise required to let the reform succeed. Some of this expertise may be located in the international agencies. A first role of the coordination unit will be to build consensus; experience has shown that partners may have different views; those who piloted a health care financing scheme will expect that their 'model' is a major source of inspiration. The main role of the task-force will be to steer the reform and its implementation. Experience in several countries has shown that there will be challenges and areas to improve. It will be therefore essential to set up a very effective monitoring mechanism (see further) and to retain sufficient decision-making ability to adjust the process when required. This means, among other things, that the coordination role of this unit will be acknowledged and respected by everyone.

Another function of the task-force and its members is to become the champions of the reform. They must work out a strategy so that the reform produces optimal results. This may even include the development of mechanisms to keep politicians accountable for their commitments and declarations.

Good practice #10: A good plan of action is helpful.

This advice is obviously not specific to user fee removal reform. Once a planning exercise is completed, one realises how problematic a sudden 'abolition' of user fees can be, especially if package and scope are broad. Indeed key actions to take for a correct implementation will be: anticipative drug purchasing and positioning – something which can take several months if drugs are imported, staff redistribution, development of the communication strategy, development of a procedure manual and management tools and training of staff in the new procedures.

The multi-country review has shown that in several countries user fee removal occurred in a rather unplanned way. This generated a major shock in the health systems, often characterised by a massive influx of patients (the objective!), rapid and frequent drug stock-outs, a rise in tensions between the users and the health personnel and eventually staff de-motivation. In one country, the reform was much better prepared, yet, the health technicians were still taken by surprise by the sudden release of funds by the Ministry of Finance.

Our tip: Try to buy time from the politicians. The need to have enough drugs available is a constraint that they should understand. Once you have this time, define a realistic plan of action and hold regular meetings to follow up on issues arising during implementation. Identify bottlenecks; be logical in your priorities; assign tasks and responsibilities; introduce deadlines and milestones.

Good practice #11: Sequencing of the reform is helpful in some settings

A reform can take the shape of a big-bang model (many or major universal changes, occurring on the same date) or it can be much more incremental. Both models have advantages and drawbacks. Big-bang approaches are sometimes unavoidable (e.g. a change in a currency, a new law); their strength is that they are, from a communication point of view, very powerful approaches (one message applying to everyone) and keep the system unified in terms of rules

and procedures (at least formally). The main advantage of incremental reforms is that they allow learning by doing and are more reversible (if for example, it appears that the reform does not bring the expected outcome). Sequencing the reform in several steps is a way to keep control over the process. As for user fee removal, sequencing can be organised by geographical areas (first some regions or the rural areas), by categories of providers, by categories of users, or by services. There is no real rule in this respect, apart from the obvious need to avoid a big failure. A good recommendation is surely to take into account possible prerequisites; it does indeed not make much sense to remove financial barriers to a service of a very low quality. For example, free delivery will have an impact in terms of maternal mortality only if there are ambulances and referral hospitals with a capacity to perform major obstetrical interventions. Another way to sequence the reform is to follow an equity concern, i.e. start by targeting the poorest. Finally, the sequencing of the reform can also be dictated by the need to ensure smooth implementation and enforcement. It may help for example if the reform requires intensive training and communication at the peripheral level. Sequencing the reform (or even better, a pilot project) can also help to identify the unforeseen limitations of some solutions (e.g. bugs in computer software used to organise payments).

Good practice #12: A clear agreement between the government and partners on how the budgetary burden of the reform is shared is crucial.

Someone has to bear the cost of the reform, i.e. its development process but also the resources to ensure real ‘free health care’. Once the budgetary simulation is done (cf. formulation stage), you will have to share the results with stakeholders who have a funding capacity, including the office of the Prime Minister, the Ministry of Finance and financial partners. The goal is to reach a clear understanding of who will finance what and for how long. The implications of medium and long term financing must be well understood by the government. Use the different tools developed by the international aid actors to consolidate this financial commitment to the reform (e.g. mid-term expenditure framework and the ‘compact’). Pay attention to the disbursement constraints specific to the different sources of funding. Distinguish the funding of the free health care from the funding of measures required to prepare the reform (e.g. development of information tools, training) or that need to accompany it (e.g. the strengthening of obstetrical capacities in certain referral hospitals).

Good practice #13: A clear and robust channelling of resources to health care facilities is crucial.

The objective of user fee abolition is to increase utilization of health services by the population. This triggers new costs for health facilities: more drugs to deliver, more time to spend with patients, more running costs to operate the services. The multi-country review has shown that in all six countries there have been problems for the health care facilities to access the budget, the drugs or the reimbursements of the outputs. Under input-based systems, drug shortages are frequent. Under output-based systems, the rationing often materialises into late or even incomplete disbursements.

One reason for this poor performance can of course be that the policy makers underestimated the resources required for funding the reform. Other potential reasons are the

weaknesses in the drug supply system. The accounting reporting – if ill-conceived it can be very bureaucratic - can also introduce major delays.

We have observed that in some countries, the flows of resources and information required to decide on the allocation of resources were laid down often relatively late in the reform process. Some reforms started in a slightly chaotic or, at least, confused way. It was observed that if criteria for disbursement or utilisation of the funds are unclear, peripheral levels will implement the reform the way they deem appropriate (and often to their advantage). Revisiting such misunderstanding can be a source of frustration at the health facility level.

Our tip: Develop a procedure manual on how to get reimbursement or access to resources required to deliver free health care services and the adequate management tools; take into account the different situations that may exist in the countries, even sometimes within the public sector; clearly define the rights of health facility managers concerning resources; teach the new procedures to the managers; communicate with them about the changes.

Good practice #14: Wide-ranging communication strategies are useful.

The more stakeholders know about the upcoming changes, the better they can prepare for them. The multi-country review has shown that governments often communicated the reform well to the population (e.g. in a radio announcement), but paid much less attention to other stakeholders. Sometimes health staff learned about the reform only a few days before its official application. This obviously does not help to pave the way for acceptance. Any actor with a role in the reform must have a full understanding of how he or she has to fulfil that role.

Ideally, a communication officer should be appointed at an early stage of the reform process. His or her role would be to develop an overall communication strategy. This strategy would involve approaching different stakeholders through different media and tools. It should identify and train actors in charge of communication at the peripheral level.

In terms of targeted audience, key attention should be paid to all the actors who have not been involved in the formulation process: the population, health staff, local officials, health committees... The communication strategy should cover the information needs during the reform preparation, at its launch, but also in the aftermath of the reform. The communication officer will for example have to provide reports to journalists about the rationale and the benefits of the reform.

Good practice #15: A clear and coherent division of tasks is crucial

The success of the reform will largely rest on how it is implemented and enforced by key bodies, both at the central and peripheral levels. This implies that tasks are clearly divided. The central level will have a key responsibility in setting the main directions of the reform, determining its exact content and steering its implementation. However, the real implementation (i.e. providing free treatment) will be carried out by frontline actors. A key issue will be that these frontline actors face the appropriate incentives to implement the reform in line with the central level plan. Intermediary levels (e.g. the health district office) also have a role to play; for instance, through their monitoring, they will be key to ensuring that procedures are interpreted and enforced in a

consistent way across the country. A clear division of tasks greatly enhances the monitoring of the performance at each level, and therefore the general accountability of the health system.

The division of tasks must be coherent in that it should limit conflicts of interest. A good instance of the implication of such a principle is the verification of activity data under an output-based remuneration system. Under such a system, health care providers have a strong incentive to inflate their records with ghost patients. The function of verification then becomes key. This includes checking reports produced by health facilities (against their registers) and cross-checking whether utilisation was real by comparing home visits to a sample of reported users. The multi-country review has shown that countries that opted for an output-based financing of the free health care services have so far overlooked the establishment of this new function. Their approach to verification and reimbursement is very bureaucratic and vulnerable to fraud.

Recent experiences with performance-based financing have revealed that a good practice in this domain is to entrust the verification function to a body fully independent from the health pyramid. In Rwanda, the verification task is shared between the local government and an NGO; in Burundi, the plan is to establish provincial health committees that gather representatives both from the government and the civil society; in both countries, home visits are carried out by grassroots organisations.

If your country adopts an output-based strategy, this means that new bodies may have to be established. These persons will have to be trained and assisted to succeed in their mission. Establishing these verification bodies at an early stage of the reform is highly recommended.

Our tip: These are issues that greatly benefit from pilot projects.

5.3 THE MONITORING, ENFORCEMENT AND EVALUATION STAGES

Good practice #16: Monitoring of the reform is crucial.

As the reform is being implemented, it will become clear that some corrective measures are required. A reform is indeed a very dynamic process, involving a lot of learning by doing. Local managers will try to find solutions at their level, yet, as the reform is largely top-down, most of the responsibility will fall on the shoulders of the coordination unit at the Ministry of Health. They will have to identify the problems and propose the solutions. Such identification will be possible only if enough information is flowing back to the coordination unit. The multi-country review has revealed that many governments tend to overlook the importance of information flows in user fee removal reform. We have observed that in several countries, the central level had limited access to relevant, even sometimes very basic, information such as the increase in the utilisation of preventive and curative services. Having a minimally functional health information system appears to be a prerequisite for monitoring the reform. The only acceptable exception could be post-conflict countries, where everything has to be rebuilt.⁹ Monitoring should also

⁹ Yet, even in these countries, there is a need to have some information on the outputs, in order to be able to decide on the exact quantity of inputs that are needed (especially drugs).

cover other dimensions such as: drug availability, rational drug use, disbursement of the budget, cash arriving at health facilities and staff satisfaction. Ideally information produced by the monitoring mechanism must also be accessible to actors at the decentralised level (at least all those who could take action to solve the problems). Regular financial audits may also be required.

Good practice #17: Enforcing the reform is crucial.

User fee removal will be effective only if the new arrangements are universally enforced. Enforcement here must be understood in the broad sense of behaviours that comply with the policy plan. This compliance may result from pressure from the hierarchy, but also because of positive incentives, a sense of co-ownership or shared values.

A prerequisite is that everyone knows and understands his role and obligations. In this respect, a manual of procedures is crucial. Standardised management tools will also help in the enforcement process. In addition, it is clear that recent developments in information technology (spreadsheets, database, internet) can greatly enhance the enforcement of the reform. In Rwanda for example, the performance-based payment to health facilities is conditioned on the timely completion of their monthly report. Late submission is financially sanctioned.

Whatever the compensation system adopted, there will be a need to check whether health facilities deserve the resources they receive (see also above ‘monitoring’). Under an input-based system, the focus should be on the correct use of the drugs (e.g. no pilfering) and the actual efforts made by the staff to serve the population. Under an output-based system, whether services were really delivered should be the focus, sometimes also their appropriateness (e.g. caesarean sections). Our observation is that governments under-invest in collecting information to enforce the schemes. In several countries, we have observed also that governments do not always fulfil their own share of the contract: they provide drugs in insufficient quantities; there are delays in reimbursement of health facilities, and so on. Enforcing also means that fraud, malpractice or disrespect of commitment when observed are sanctioned. This may require that the authority to penalize and the types of sanction are well identified. Contractual agreements may help to clarify such aspects.

Good practice #18: Evaluation and research are helpful.

Evaluation can be understood in different ways. Some evaluation models are simpler than others. The key question is which dimension of the reform you want to evaluate: the compliance of the implementation with the plan and the reasons for any deviation from it; the effectiveness of the reform in achieving to the declared objectives; the impact of the reform; its efficiency; the reason for its success? The nature of the evaluation approach will depend on the objective pursued by the evaluator. We believe that your government may value at least three kinds of evaluation.

First, it will be useful after a while (e.g. 9-12 months) to make a preliminary assessment of the reform. The main objective will be to spot problems and areas to improve. This evaluation can be entrusted to a consultant with a very operational profile. He or she will have to be able to

analyse the appropriate quantitative and qualitative data and propose solutions. An alternative is to rely on the analytical capacity at the decentralised level.

A second type of evaluation concerns the impact of the reform. The goal is to attribute causality of a change in an outcome variable to the reform itself. This raises major challenges from a scientific perspective; a huge challenge is the need to control the different confounding factors which could also have influenced the outcome variables. The issue is to have a counterfactual which will isolate the exact contribution of the reform. This requires having two different groups: households/health facilities included in the reform and households/health facilities not covered by the reform. Obviously such a situation is not possible if the reform was implemented throughout the entire country on the same day. Impact evaluations are also very demanding in terms of data to collect (one needs at least two ‘pictures’: one of the situation before the reform and one afterwards) and analysis. Such an evaluation is only possible if you have teamed up with scientists, if you give them the appropriate budget and enough time to carry out their study. The key advantage of a conclusive impact evaluation is that it provides sound evidence; this enhances the visibility of the reform and may enhance fundraising for new initiatives (e.g. a scale up of a pilot project).

A less ambitious objective can be to check whether desirable effects are taking place (without striving for attributing these effects to the reform in particular). For such more modest evaluations, interesting variables could be: whether the poor use the services more than before (benefit-incidence analysis at facility level or on the basis of household surveys); whether the quality of services has improved (from a technical but also a user perspective); whether households have reduced their out-of-pocket expenditure; whether resources reach frontline providers better; whether staff productivity has increased; and whether there is any perverse effect on another group. Medias and operational agencies will appreciate having access to such information. It can indeed contribute to consolidating the political support to the reform.

A third type of evaluation focuses on the reasons for success or failure of the reform. The main idea is to try to answer the ‘why?’ question. Such evaluations are particularly precious (1) for those of you whose responsibility is to support the permanent effort of improving the health system performance; (2) for countries that could be interested in duplicating or taking inspiration from the strategy adopted in your country. UNICEF and other international agencies could be interested in conducting such studies, as their role is also to help countries succeed in their reform.

Our tip: Ideally, you should develop your evaluation and research program before the launch of the reform. Involve scientists at an early stage of the discussion. Foresee an adequate budget.

6 CONCLUSION

Removing user fees in the health sector is very appealing to political leaders. In the past, a few of these leaders thought that they could abolish user fees with the stroke of a pen; they rapidly discovered that they were wrong. One does not abolish user fees: one replaces them with another way to fund the health services. Establishing this alternative financing option requires its quantification, the identification of its source, the long-term commitment of the sponsor, the institutionalization of the arrangement and the channeling of resources. These are things never secured with the stroke of a pen. Consultation, analysis, argumentation, communication and training sessions are some of the actions required to move forward. Technicians have a key role to play at this level.

In this policy guidance note, we have first identified a list of issues that policy makers willing to remove user fees should be aware of. We have then put forward a set of good practices to maximize the chances of a successful implementation of the reform. Any reform has its share of annoyances, unexpected situations and errors to correct. However, the better the reform is prepared and implemented, the greater the chances that benefits are maximized for the target group.

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