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EDITORIAL

User fee removal in low-income countries: sharing knowledge to support managed implementation

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Introduction

User fees have triggered impassioned discussions in international health over the last two decades. Promoted by a number of international organizations since the late 1980s as a strategy to finance struggling public health facilities in many low-income countries, recent years have seen growing criticism of the impact of fees on access to health services, particularly for the poorest groups.

The debate continues and there is evidence for both sides of the argument. User fees are a barrier to users, and the poor in particular, but they also have some valuable characteristics (Meessen *et al*. 2006). Their contribution to generating resources for the benefit of health facilities that are sometimes deprived of any other source of flexible funding is just the most obvious one. Taking the right stance in this debate is far from easy for countries and their aid partners, as different constraints—including country ownership, fiscal space, other pressing development needs and the obligation to ration available resources—have to be taken into account.

In 2005, UNICEF organized an expert consultation to update its position on this controversial strategy. The evidence reviewed at this consultation led to the following consensus: removing user fees has the potential to improve access to health services, especially for the poor. For this to occur, however, fee removal needs to be part of a broader package of reforms that includes increased budgets to offset lost fee revenue, maintain quality and respond to increased demand. It also needs clear communication with a broad stakeholder buy-in, careful monitoring to ensure that official fees are not replaced by informal fees, and appropriate management of the alternative financing mechanisms which are replacing user fees. When the above conditions are not met, fee removal is unlikely to benefit the poor (James *et al*. 2006).

In mid-2008, UNICEF approached a group of researchers with the request to document recent experience with user fee removal. While aid actors in the North were still arguing fiercely about the pros and cons of user fees, a growing number of countries had already decided to remove user fees, at least for some priority services.

A consensus was easily reached between UNICEF and the research team led by the Institute of Tropical Medicine, Antwerp: the multi-country review would not (again) focus on evidence against or in favour of user fees, but would instead try to document how countries formulated and implemented user fee removal. This focus was seen as valuable because it could generate practical lessons for other countries interested in such a step.

The findings of the multi-country review were presented at a meeting of experts convened by UNICEF New York in February 2009. Presentations covered a number of countries as well as comparisons between countries—including a challenging comparison between Rwanda and Uganda. At some point, the 'ghosts' of Bismark and Beveridge entered the room, so there was another episode in the (by now familiar) debate on the relative merits of reducing financial barriers through health insurance or through user fee removal. We do have some country evidence to fuel this broader debate in this supplement; however, its main focus lies elsewhere.

Following the New York meeting, the research team judged that the main question of the multi-country review—the challenges related to design and implementation of user fee removal policies—deserved more visibility than just another report. Indeed, while there is a large consensus among experts familiar with health systems in low-income countries that implementation of new policies and interventions raises major challenges (Peters *et al*. 2009), the formally published knowledge base is still small (Gilson and Raphaely 2008).

Our objectives for this supplement were multiple. From the start we decided we would welcome contributions from different regions and fields of expertise, as the supplement had to be useful for researchers, but also for programme officers and policy makers directly involved in health care financing policies in low-income countries. We acknowledged that contributors would adopt different types of methodological approaches to address different questions. We were also keen to get contributions from the different 'corners' of the user fee debate. Experts familiar with the controversy can see for themselves that this objective has been achieved; a glance at the list of contributors to this supplement suffices.

Content of the supplement

Three papers stem directly from the multi-country review commissioned by UNICEF. In the first paper, *David Hercot et al.* present the review's methodological approach. This approach rested on examining a set of processes the research team considered as good practices in terms of policy formulation and implementation. A key message of the paper is that scientists should try to contribute more to knowledge building around the formulation and implementation of policies. *Hercot et al*. propose one approach; there may be others.

Bruno Meessen et al.'s paper summarizes the main findings of the multi-country review. The key message is that the formulation and implementation of user fee removal policies often turns out to be more complex than thought by most actors involved (including activists in the North and country authorities). Some design and implementation issues—including seemingly trivial ones—can even jeopardize the whole reform.

The paper by *Valéry Ridde et al.* zooms in on the case of Burkina Faso, one of the six countries documented in the multi-country review. This case study reports on the development of the national subsidy policy for deliveries and obstetric emergency care. Burkina Faso's decision to focus on maternal health care (when reducing financial barriers) is in line with the policy of other countries in Western Africa. However, unlike the others, Burkina maintained a small user fee; this raises specific problems in terms of implementation and communication. With such policies, the devil is in the detail.

Juliet Nabyonga et al. present the Uganda user fee removal experience. This experience—since 2001—played an important role in the advocacy in favour of user fee removal in low-income countries. Today, we have the benefit of hindsight, and perhaps surprisingly to some, the results of the reform are not as positive as initially expected and presented. While the increase in utilization by poorer groups is confirmed, a worrying increase in households' private health care expenditure can be noticed—a paradox, as the policy package just involved a user fee removal. Stock-outs of drugs and consumables at public health facility level seems the first reason for this unsatisfactory situation.

Claude Sekabaraga, François Diop and Agnès Soucat then share the experience of Rwanda, the neighbouring country. The rapid expansion of universal coverage in Rwanda is today well known. In recent years, the Rwandan community health insurance experiences have received even more visibility than Uganda's did in the past. Results confirm that financial access to health services and protection against catastrophic health care expenditure can be dramatically improved in low-income countries. However, this requires a combination of elements—including comprehensive public sector and health financing reforms, as well as political leadership, which are often difficult to build in complex political economy contexts.

Manassé Nimpagaritse and Maria Bertone invite us to cross yet another border. They share with us the experience of a hospital manager confronted with the sudden removal of user fees in 2006, in Burundi. As editors, we obviously welcomed such a stakeholder's account in this supplement. Health staff are well aware of the strengths and weaknesses of policies influencing financial access, as they are the ones who, in the end, have to ration limited collective resources. Their voice deserves to be heard, both at national and at international level.

The supplement focuses on national policies only. In today's world, there is no longer a need to demonstrate the superiority of free treatment in the ideal set-up of a pilot experiment supported by an international NGO, as countries are already engaged in national policies that they have to finance and implement themselves. The key challenges lie elsewhere, we reckoned. We made one exception, however, in this supplement. Indeed, *Frédérique Ponsar et al.* share a challenging finding from a pilot intervention in Mali which indicates that countries and aid agencies concerned with removing financial barriers for curative services for a specific disease (in this case malaria treatment for children under 5) should consider a free entitlement going beyond the drugs only and even beyond the sole disease they care for. Uncertainty about eligibility for the free package probably makes potential beneficiaries forego visiting the health centre, a decision with disastrous consequences for some children in Mali.

Two Asian experiences are included in this supplement. *Sophie Witter et al.* share with us Nepal's promising experiences with free delivery care—currently also a common strategy in Africa, as evidenced by the multi-country review. One of their main messages is that countries need to develop an integrated approach to their health care financing arrangements. Obviously, offering a set of free services each under a different scheme, sometimes limited to access to drugs only, might not be the optimal approach in terms of efficiency, equity and sustainability.

Laura Steinhardt et al. take us to Afghanistan, another mountainous country where geographical access is a major barrier. In a war-torn country like Afghanistan, it goes without saying that doing prospective impact evaluation of different health care financing models is anything but easy. However, their time series data seem to confirm evidence from sub-Saharan Africa: user fee removal is typically followed by an increase in the uptake of curative services. However, they also show that long-term preventive services are not boosted.

The last paper by *Barbara McPake et al.* again dovetails with the concern of our supplement to develop knowledge on the 'how to' of policies. In line with *Hercot et al*., they build on existing evidence to provide policy makers with an approach to support the formulation of effective and sustainable user fee removal policies. One of their concerns is the set of accompanying measures required to accommodate the expected increase in

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utilization after user fee removal. Experience has shown that without appropriate planning, such policies can indeed overwhelm health staff and facilities and rapidly lead to drug stock-outs. Obviously, the care provided for free needs to be quality care.

Main messages

We believe that this supplement conveys at least four general messages. First, policies aiming to reduce financial barriers can be very effective in improving health service utilization, provided they are well designed, funded and implemented. Evidence from *Ponsar et al*., *Nabyonga et al*., *Sekabaraga et al*., and *Witter et al*., among others, confirms this again. *Sekabaraga et al*. add two important points for those who seek to support policy change through evaluation: (1) in assessing impact, we have to move away from using time series data based on routine information systems, as the latter do not capture variations of utilization at the level of providers which do not report to the routine information system (e.g. the private sector); and (2) we have to document the impact on services with obvious benefits for the population, such as preventive services.

The second main message conveyed by the supplement is that user fees cannot be removed with the stroke of a pen: the removal needs careful preparation, requires accompanying measures (especially in terms of drug supply and staff motivation) and deserves close monitoring and appropriate evaluation. Challenges are multiple. They include, as identified in the papers, getting the design right (e.g. importance of considering incentives and unintended consequences of the policy, identifying the correct level of reimbursement of health providers), securing sufficient budget, and good policy implementation (e.g. securing the resources needed to communicate the policy to front-line health workers and to the population). It is the effectiveness of the policies which is at stake, and in the medium term, their mere sustainability.

A key strength of the experiences reviewed is the clear leadership displayed by political leaders. When such leadership was coupled with smooth dialogue with programme managers, the formulation of the reform benefited greatly. However, the eagerness of the political leaders to move rapidly has also sometimes confronted programme managers with the obligation to implement an insufficiently prepared decision. In this respect the user fee removal debate only echoes the user fee implementation debate (Gilson 1997): policy change needs to be deliberately thought through to stand a chance of protecting, at least, as well as promoting equity goals.

A third (and perhaps equally familiar) message is that there are different ways to mobilize, pool and allocate collective resources to finance improved financial access for vulnerable population groups. Obviously, one supplement cannot cover all design options. Nevertheless, we believe that evidence gathered in this supplement can feed the ongoing policy discussions.

Currently, political momentum is growing for the mobilization and pooling of resources in many low-income countries: governments commit public resources to health services, with a marked preference for targeting vulnerable groups (e.g. children under 5, pregnant women) or the services these groups need (e.g. deliveries). In some countries, this governmental commitment has been consolidated by donors, but not everywhere. More worryingly, in 2011, some donors pulled out of countries after having encouraged them to remove user fees in the first place.

An often neglected dimension in the user fee debate is how a government should compensate health facilities when it decides to ban user fees; in addition, there is a question about the incentives established by the chosen compensation 'formula'. Findings from the multi-country review allow a better understanding of challenges on these issues, but many questions remain. Obviously, the current approach adopted in several countries of bringing selective free health care policies and performance-based financing together—with Burundi the most advanced in this respect, having merged its policies since April 2010—will offer a variety of lessons (Basenya *et al*. 2011). Our assessment is that user fee removal could in fact lead some countries to quite radically rethink their health system or at least catalyse greater attention to issues such as drug supply, staff motivation or other barriers to access (Ridde *et al*. 2011).

A fourth message is that development partners have played varying roles in the country experiences gathered in this supplement. In some cases they were present and stepped up to provide financial resources and technical assistance, while in others they did not. There is an urgent need for them to play a more active role in this process. They could contribute financial and technical resources where these are requested by national authorities and required for effective implementation. They could also help countries in monitoring and evaluating these policies. Major questions—insufficiently documented in many countries—are the benefit-incidence of these free care policies (are the poorest the main beneficiaries?) and their impact on the performance of the health system as a whole.

As international organizations, development partners have also a major responsibility in terms of knowledge management. It is our firm belief that real efforts must be made at regional level to bring together relevant knowledge—not just formal evidence—to support fee removal and improvements in financial access. A top priority should be to remove the walls between the different 'niches' of knowledge: policy makers, scientists, operational actors and aid agencies must learn to develop knowledge together (Meessen *et al*. 2011). Countries should also better share lessons of experience and good practices. There is, therefore, a need for much better collective learning.

In sub-Saharan Africa, this is the knowledge agenda that agencies gathering under the banner of 'Harmonization for Health in Africa' have assigned to the *Financial Access Community of Practice* (Harmonization for Health in Africa 2010).[1] This is a vital path to better policies for improved and equitable health outcomes.

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Conflict of interest

None declared.

Endnote

[1]http://groups.google.com/group/CoP-Financial_Access_Health_Services.

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