HEALTH FINANCING POLICY BRIEF NO 2

‘FREE HEALTH CARE’ POLICIES: OPPORTUNITIES AND RISKS FOR MOVING TOWARDS UHC

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Key Messages

- Free health care (FHC) policies remove formal fees at the point of service. FHC applies either to all health services, to the primary care level, to selected population groups, to selected services for everyone, or to selected services for specific population groups.
- This policy brief distinguishes FHC policies from directly targeted user fee exemptions by health workers at the point of patients seeking care, or by local authorities for poor individuals, in that the former does not require income or means assessment to define selected population groups.
- Because FHC policies, as defined here, avoid the challenges of targeting individual capacity to pay, they trade off relative ease of implementation with less focus on equity. Thus, non-poor people will also get access to these free health services. Better-off people may indeed benefit disproportionately, particularly if poorer people have limited geographical access to services. Focusing the FHC reforms on those facilities used predominantly by poorer people, or in poorer regions, is a way to mitigate this impact.
- Evidence on the impact of FHC policies on financial protection and utilization is mixed. Design and implementation deficits have often limited the potential of FHC to contribute to UHC progress. Flaws in FHC design and implementation, particularly a lack of coherence with other health financing reforms within a country, can result in greater fragmentation, damage to service delivery, and a need for users to pay informally for the services that are meant to be provided free.
- At service provider level, critical factors for the success of FHC are i): to increase the level of funding to compensate for the loss of user fees and for the expected increase in utilization and; ii) to establish an alternative set of incentives for service provision and accountability to users. Doing so typically involves creating an explicit link between the promised free services and how the service provider will be paid for those services, as well as strengthening the capacity of providers to deliver the services that are prioritized in the FHC policy. Moreover, there is often a need to increase the autonomy of providers to manage their resources.
- If well designed and implemented, and provided they are formulated as part of a broader and phased strategic vision, FHC policies may constitute a useful starting point for a more comprehensive reform agenda. However, empirical evidence on how to scale up from FHC to wider reforms remains limited and is a priority for future applied research.

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1 WHAT DO WE MEAN BY A 'FREE HEALTH CARE' POLICY?

Many developing countries had promised free services in government health facilities in earlier decades. Yet, funding shortages and governance shortcomings often translated into non-availability of care. A common response was to introduce formal user charges, with retention of the revenues at providers' level. This was based on the Bamako Initiative's rationale of communities participating in health service funding and management (for a summary of the main aspects of this initiative, see UNICEF 2008). It helped to ensure the availability of key inputs, particularly medicines. Some studies showed an increase in utilization, when coupled with supply-side interventions and provider autonomy, whereby retention of user charges at the facility level helped enhance staff motivation, thus improving service quality. But other studies showed a decrease in utilization when fees were introduced, particularly when remitted to higher levels. The poor tended to be excluded from accessing health care. Moreover, instead of user fees co-financing health facilities, public funding sometimes decreased, leading to deteriorating service availability and quality (for a summary see Barroy 2013 and Ridde 2015).

Fee exemption was often granted to poor individuals or other defined population groups; either ad-hoc at the point of use following an assessment by health workers of a person's ability to pay, or beforehand through local government and community authorities that provided poor households with some form of document to be granted fee exemption. However, there were growing concerns that this did not effectively provide a financial protection mechanism as user fees continued to pose an important financial barrier to using healthcare. This is because exemptions mechanisms based on direct targeting often did not work well for a variety of reasons largely related to implementation challenges and feasibility issues (Ridde 2007, Bitran and Giedion 2003). Among other things, these include non-compliance with exemption rules, a lack of clarity in policy of who is eligible or a lack of guidance on how to determine eligibility. Also, health workers would be reluctant to grant fee exemption, as there was usually no compensation of the foregone revenue from user fees. As a result, poor people continued to face severe financial consequences from out-of-pocket (OOP) expenditure or had to forego health care.

'Free health care' policies, or '*politiques de gratuités des soins*' in French, have gained popularity over the past ten years, mostly in West Africa. They are being introduced by a number of low- and middle-income countries as a reaction to the situation where government funded and provided health services are in practice only accessible by paying user charges. FHC policies aim to reduce financial barriers by eliminating formal fees at the point of service; either for all services, mainly at primary level, for selected population groups, for selected services for everyone or for selected services for specific population groups, usually characterized by medical or economic vulnerability. Easy-to-observe socio-demographic (e.g., age, pregnancy) or socio-geographic criteria (e.g., defined geographical areas) are used

to determine whether a person is eligible for free services at the point of use. This is in contrast to relying on individual assessment mechanisms to determine if people are entitled to either exemption from user fees or qualify for subsidized health insurance. So for purposes of this brief, exemptions based on an assessment of an individual's economic vulnerability are not considered as part of FHC policies.

It is important to note that in many countries, free disease-specific or health promotion services have been in place for decades, including: child vaccinations, family planning, and prevention and treatment services for communicable diseases (TB, HIV/AIDS, malaria and other communicable diseases). The rationale for offering these services for free is out of concern for equitable access in particular for poorer population groups as well as being public goods and having strong positive impact on public health. More recently, the focus of FHC policies has expanded to include a wider set of services, particularly those related to Millennium Development Goals 4 and 5 aiming to reduce infant, child and maternal mortality. Examples of free health services include antenatal care, assisted deliveries, caesarean sections, health services for children below a defined age (often five years), or a set of services for the elderly above a certain age (often 65 years). These services are chosen to protect population groups deemed to be especially vulnerable, and particularly the poor. Table 1 provides examples from countries.

Table 1: Overview of recent FHC polices in countries

Services	Population	Country examples
PHC	All	Lesotho, Uganda, Liberia, Zambia
ANC, PNC	Pregnant women	Niger, Benin, Burundi, Sudan, Ghana, Tanzania, Malawi, South Africa
Delivery	Pregnant women	Burkina Faso, Madagascar, Kenya, Senegal, Burundi, Niger
C-Section	Pregnant women	Niger, Benin, Burundi, Senegal, Madagascar, Democratic Republic of Congo
Child care	Children	Niger, Benin, Burundi
Curative child services	Children	Sudan, Ghana, Tanzania, Malawi, South Africa, Ivory Coast, Madagascar
Malaria	All	Burkina Faso

Source: adapted from Barroy 2013

2 WHY IS IT IMPORTANT TO TALK ABOUT FREE HEALTH CARE FINANCING ARRANGEMENTS IN RELATION TO UHC?

By introducing a FHC policy, a government explicitly intends to make progress towards two of the final objectives of UHC:

1. Service utilization in line with people's health needs;
2. Increased financial protection.

Implicitly, the FHC also intends to enhance the quality of health services guaranteed through this policy. Transparency and accountability are also key aspects: people need to know they are entitled to FHC. The aim is therefore to improve UHC in its three dimensions: along the *service* dimension and the *cost* dimension for specific services and for specific *population groups*. Scarcity of budget resources to fund FHC as a way to progress towards UHC however implies trade-offs by prioritizing services and/or population groups. It requires decisions about who should receive access and financial protection and thus implicitly or explicitly who should not.

3 WHERE DOES FHC FIT IN HEALTH FINANCING POLICY?

Health financing consists of the functions of revenue raising, pooling and purchasing, as well as policies relating to service benefits to which some or all of the population is entitled (see WHO 2010). As defined here, an FHC policy entitles some or all of the population to certain services free at the point of use. Therefore, from an overall health financing perspective, it is primarily or initially a policy on benefit package design, i.e. prioritizing services or populations with no co-payments required. At the same time, free health care policies require and trigger decisions around other health financing functions, foremost on revenue raising source mobilization and allocation priorities, as well as on purchasing and provider payments. As such, the benefit package design policy needs to be aligned with the other health financing functions, as well as with service delivery arrangements. Table 2 below lists some crucial policy and alignment questions related to FHC.

Table 2: Free health care arrangements and health financing policy issues

Health financing function	Policy analysis and issues to think about	Potential contribution to health financing system strengthening for progress towards UHC
Revenue raising	Are there funds specified for the FHC policy to replace the foregone user fee income? What are the sources of (additional) funds? Does the specified FHC funding add to or replace existing funding? Are these FHC funds effectively transferred to health facilities? Does the FHC funding take into account the desired increase in utilization?	OOP reduction and increase in publicly-funded prepayment which in turn can improve financial protection and increase service use.
Pooling	Is the incremental funding for the FHC policy pooled and managed separately or with other funding?	Larger pool offers greater potential to redistribute to needed services and populations.
Purchasing	Is a separate purchaser established or used to pay for FHC services, or the same as for other services? Does the FHC reform include changes in provider payment methods that stimulate the production and quality of these services? Are performance incentives that user fees set for health staff replaced by other incentives within the provider payment system? What changes are made to information systems, if any, to link FHC service use to provider payment?	Strengthening of financial management and purchasing capacity for efficient use of resources as well as information management systems for monitoring and provider payment.
Benefit Package	How is the population made aware of the specific entitlements defined in the FHC policy? Are the defined benefits in the FHC policy linked explicitly to purchasing mechanisms? How does a 'new' FHP reform connect to or change existing benefit packages or service guarantees?	Prioritization of public resource allocation to services and population groups identified in the FHP policy, aimed at increasing use of these services with financial protection.
Service provision	Is the supply side 'ready', in terms of the human resources and physical inputs needed to deliver the promised services? Can people get to the 'free services' (physical availability)? Does this policy apply solely to government facilities or to private/NGO facilities as well? What considerations should be factored into a decision on this? Does it give the service providers more managerial capacity, including autonomy over the use of funds?	Availability and quality of service provision is essential for the policy to work, and an FHP policy may stimulate needed investments and other actions (e.g. treatment guidelines, contracting private providers) needed for such improvements.

4 WHAT DO WE KNOW FROM BOTH THEORY AND PRACTICE?

WHAT DO WE KNOW ABOUT THE IMPACT OF FHC ON UTILIZATION, EQUITY IN UTILIZATION AND FINANCIAL PROTECTION?

While evidence is mixed, one main observed positive impact is increased utilization, at least in the short term (Ridde et al. 2012, Lagarde et al. 2012). This should be anticipated when planning a FHC policy.

Reduced OOP expenditure may or may not be expected as the evidence of this is limited and mixed (Nabyonga et al. 2011 for Uganda for example). Costs for drugs or related (diagnosis) services are often not 'covered' in the free package or not available, and indirect costs such as transportation and food are still substantial (Kruk et al. 2008, Perkins et al. 2009, Hatt et al. 2013). The study of Xu et al. (2005) revealed that catastrophic expenditure did not decrease among the poor in Uganda. In some cases, increased demand is not properly anticipated and backed by increased supplies and medicines, such that patients are forced to pay for these informally or in the private sector. Demotivated staff has also been reported as a result (Ridde et al. 2012). A free health care policy on a specific service or only for some elements of a given intervention (i.e. excluding some drugs and supplies) is therefore insufficient to improve financial protection.

A key policy issue is to ask what best serves the poor in practice: user-fee exemption based on means/income estimation, or an FHC policy using indirect targeting via easy-to-observe socio-demographic or geographic criteria? A free health care policy is in principle a second-best approach because free services are not targeted to the poor only, thus putting less focus on equity: non-poor people will also benefit and some other poor people may not benefit as their health care needs would not fall under the selected interventions that are provided for free.

In practice, the question is this: do FHC arrangements effectively benefit the poorest and most vulnerable people? Are scarce public funds spent in a pro-poor way? The evidence is mixed. In some countries, an increase in utilization was largely attributable to poor and vulnerable people (Ridde et al. 2010). In other cases, it was found that women from higher income groups benefit more from free caesarean section services (El-Khoury et al. 2012, Hatt et al. 2013). There is heterogeneity, but overall on average, public funding tends to be pro-rich (Wagstaff et al. 2014). Benefit-incidence analysis of public spending becomes important here to ensure that it is pro-poor rather than a FHC policy shifting from regressive OOP expenditure to regressive public spending.

Various aspects on the supply- and demand side may cause pro-rich spending. There is a supply-side bias, in that service availability is often better in richer areas. Moreover, there are demand-side barriers that the poor face to a greater extent under any financing arrangements, if no explicit measures are taken. Demand-side barriers can be financial (for instance, informal or private sector payments and indirect costs, as well as transport costs) and non-

financial (for example, limited geographical access to facilities, cultural and language barriers). Poor people are also faced with higher opportunity costs of care seeking (cf. Gabrysch & Campbell 2009).

WHAT DO WE KNOW ABOUT THE IMPACT OF FHC ON SERVICE DELIVERY?

Even when the budget increases at central level, this may not results in improved funding and service provision at lower levels. To avoid 'free health care' being an empty declaration, it is necessary to make these services effectively available by providing sufficient and adequate physical resources and funding and by ensuring that funds are transferred to and reach the facility level. Otherwise, and often in combination with pre-existing underfunding of service provision, there can be a negative impact on the quality of care (Ridde et al. 2013). This is because health providers cannot cope with the increased demand for care, which leads to more shortages in staff and medical supplies, as experienced in Mali and Niger for example (Olivier de Sardan and Ridde, 2013). In Madagascar, the FHC policy was reversed after shortages of medicines became rampant (James et al. 2006).

Moreover, a direct incentive for health workers disappears when user charges that were retained at facility level are abolished. There is a need to recognize that these incentives need to be replaced by other performance incentives. While the overall amount collected from user charges may be small, it is very significant for staff at the facility level. In fact, it was found that staff morale lowered as available funding for staff incentives reduced, and as such had disruptive effects on already dysfunctional health systems (Ridde et al., 2012). As a result, users could be diverted from free-of-charge facilities if medicines are not provided in facilities, thus increasing OOP expenditure and the likelihood of experiencing catastrophic expenditure (Barroy, 2013). Smooth implementation is also critical: delays in reimbursing providers were found to negatively affect the quality of care delivered for free (Ousseini & Kafando 2013).

Yet, there are also positive examples of countries that tried to address these challenges. In Jigawa State of Nigeria, an explicit budget line was dedicated to the Free Maternal and Child Health Programme (Baruwa et al. 2011). Moreover, a performance-based financing (PBF) mechanism linked to a free-at-point-of-use policy turns into a funded and effective FHC policy with funds reaching the providers. This has been the case in Burundi (Fritsche et al. 2014), where health workers had clear financial incentives for performance.

WHAT DO WE KNOW ABOUT THE EFFECTS OF FHC ON FRAGMENTATION?

Setting up separate funding and remuneration mechanisms for FHC (not linked with other health financing mechanisms) may contribute to health financing system fragmentation. Moreover, several of the countries launching a FHC policy equally start implementing health insurance schemes that seek to collect contributions from certain population groups. When there are several FHC policies in place for a variety of services, they also may create disincentives to enroll in health insurance schemes with more comprehensive benefit packages and cross-subsidization.

5 WHO's PERSPECTIVE

An FHC policy can be an effective way to expand coverage in a context of resource constraints and can therefore be part of a strategy and a catalyst to move towards UHC. But it needs to be well designed and implemented, including strong monitoring mechanisms to enable both equity and implementation problems to be quickly detected and addressed. It is, in effect, a benefit package policy that puts priority on specific services and/or population groups, but can also serve as a way to advocate for and focus on increasing revenues and aligning provider payment mechanisms with allocation priorities. As FHC policies intend to reduce OOP, their aim is to lower financial barriers to access and improve financial protection. Applying FHC policies to poor regions or to certain types of facilities only (for example, health centres but not hospitals) enhances their pro-poor orientation.

Nonetheless, impacts of FHC policies have so far been rather mixed, especially for the poor, who may not benefit or to a lesser extent compared to the better-off. Hence, successful implementation requires preparatory and complementary measures for FHC policies to live up to their promises. First, sufficient financial resources need to be provided and effectively transferred to the facility level, in order to compensate for the loss of revenue induced by FHC. Second, provider payment methods should be in place – before the policy is implemented – through which the promised free services are effectively purchased and through which health workers are incentivized to ensure the desired increase in utilization and promote accountability to users. Third, efforts are needed to improve and make health services available and bring them closer to the most distant and vulnerable population groups. Related measures include increasing the autonomy of providers over the management of their resources while concurrently holding them accountable for the delivery of the free services. Finally, other measures to address demand-side barriers (such as cash transfers) will be required to ensure that a FHC policy is pro-poor. This includes diagnosing all of the factors (i.e. not just user fees) that constrain the use of priority health services by the poor and monitoring trends over time.

However, FHC policies may remain an intermediary strategy only on the path towards UHC. To date, very few countries have managed to expand the range of services provided for free towards a broader package of essential services. Empirical evidence on how to scale up from FHC to wider reforms remains limited and is a priority for future applied research. In the medium term, one option is to transform the arrangements used to implement FHC policies into a more explicit purchasing arrangement in which budget transfers are managed by an independent agency to purchase services on behalf of all or part of the population. If, for example, there is an existing health insurance scheme in place, this could lead to integrating responsibility for purchasing the FHC services within that scheme, while ensuring that entitlement to those services is universal rather than limited to specific contributors to the scheme.

Another policy concern is the potential lack of alignment with other health financing mechanisms and health financing reforms, which may easily result in fragmentation. It is therefore crucial to ensure coherence in legal provisions and alignment in health financing functions when introducing such a policy, foremost with respect to service delivery, benefit package design and purchasing mechanisms. Likewise, effective financial and information management systems are required. Policy makers need to look for synergies in implementation and ensure that specific reform initiatives, such as FHC, can leverage related changes (e.g. improved provider payment methods relying on a unified patient information system) that can lead towards a coherent architecture and more effective mechanisms to strengthen national health financing systems.

In conclusion, an FHC design that focuses on specific services or easily identified population groups (for example pregnant women and children under five) may be less pro-poor than a targeted user fee exemption or cash transfers based on income assessment or means testing, but in practice a FHC policy may be more feasible to implement. In policy design, the trade-offs need to be considered between what might be ideal and what is implementable, and the implications of alternative designs for improving equity in service use and financial protection. A particular attention needs to be given to replacing incentives for health workers when direct user charges are abolished. Provided they are formulated as part of a wider and phased strategic vision, FHC policies can be an effective instrument to broader UHC-oriented reforms.

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