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