Fee Exemption for Maternal Care in Sub-Saharan Africa: A Review of 11 Countries and Lessons for the Region

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Several countries have recently introduced maternal health care fee exemptions as a quick win approach to reach MDG 5 goals. It has also been argued that these policies were relevant first steps towards universal health coverage (UHC). The scope and contents of the benefits package covered by these policies vary widely. First evaluations raised questions about efficiency and equity. This article offers a more comprehensive view of these maternal health fee exemptions in Africa. We document the contents and the financing of 11 of these policies. Our analysis highlights (1) the importance of balancing different risks when a service is the target of the policy – C-sections address some of the main catastrophic costs, but do not necessarily address the main health risks to women, and (2) the necessity of embedding such exemptions in a national framework to avoid further health financing fragmentation and to reach UHC.

INTRODUCTION

In recent years, African countries have experienced a strong political dynamic to improve financial access to public health service.[1-3] In the early 2000s, user fee exemption policies were initiated for specific pathologies (HIV, malaria, and tuberculosis) or priority groups of people (pregnant women, children under five). There is growing evidence that user fee removal is a strategy that can improve service utilization.[4-5] A large number of countries have put in place maternal health fee exemptions as a quick win approach to reach the Millennium Development Goal (MDG) 5 (maternal mortality reduction).[6] While such initiatives can be seen as real opportunities to accelerate progress towards UHC both at the national and the global level,[7] they also raise specific challenges.[8] The scope and content of the benefits package covered by these policies seems to vary widely, with some countries covering Caesarean sections only, while others aim to cover a more comprehensive set of maternal health services – it is not clear whether selection of services was based on expert maternal health advice. There is also evidence that user fee removals are often driven by political objectives with insufficient consultation of technical experts, i.e. while political ownership at the national level is strong, technical governance is inadequate.[9] Available evidence on the impact of these policies raises some questions about efficiency and equity.[10-13] In the context of limited resources, the financing and sustainability of these policies also poses a challenge.[14] These are matters of concern for technicians and health care providers managing the daily implementation of these exemption policies in the field.[15-16]

This article aims at gathering a more comprehensive view on these maternal health fee exemptions in Africa. We document the contents and the financing of 11 of these policies and discuss the lessons that arise. We identify the

main challenges faced by these policies, a few governance issues and perspectives in terms of their possible contribution to UHC.

Background

In May 2009, some international agencies [i] met in the framework of Harmonization for Health in Africa (HHA) and agreed on better coordination of their efforts in managing knowledge and their support to health systems and health policy. A community of practice (CoP) strategy was adopted.[17] The driving idea behind this strategy is to promote and capitalize on the knowledge and experience of the African experts. In November 2010, HHA agencies, with some 15 African countries, jointly agreed to establish a CoP[ii] on the issue of financial access to health services (FAHSCOP).

The first CoP-organized technical workshop on the topic of maternal fee exemptions was held in Bamako in November 2011. The workshop addressed operational issues and brought together 70 people working on the issue of maternal health and its financing from more than 10 African countries: national experts from Ministries of Health, maternal health care providers, researchers, civil society representatives, and partners working on the topic, as well as members of the CoP. Six Francophone countries (Benin, Burkina Faso, Mali, Morocco, Niger, and Senegal) and four Anglophone countries (Ghana, Kenya, Nigeria, and Sierra Leone) were represented. The selection of countries selection was based on (1) the existence of an on-going national maternal health fee exemption policy, (2) a balance between French and English countries, and (3) available financial support for the participation of technicians, researchers, and civil society representatives. To prepare for the workshop, questionnaires were sent to all the participating countries (11 countries) to compare the benefits package and the funding modalities of these fee exemption policies. The objective of this article is to present a comparative analysis of country policies, based on these questionnaires. While there have been many studies of individual country policies in the past, this analysis provides a more comprehensive understanding of the scale, scope, and approach of current maternal fee exemption policies across the continent.

METHODS

A key principle of CoPs is to favour co-development of knowledge. This study relied on such a participatory approach, as it is practitioners – and more specifically cadres in charge of the policies under study – who provided the data and validated them.

Data Collection

A questionnaire was developed by health economists and maternal health researchers and validated by the workshop organizing committee. The questionnaire had two purposes: to establish the contents of the benefits package covered, as well as its funding modalities. A pre-test was done in Burkina Faso,

working with the person in charge of the national subsidy for deliveries and emergency obstetrical and neonatal care. In September 2011, questionnaires were sent to the key informants in the 11 countries (key informants were people in charge of monitoring the policies). Where information was lacking, researchers who had studied these policies in the countries helped to fill in the questionnaires. Follow-up with key informants was done by telephone and email. Completed questionnaires were reviewed by experts in the field to identify any inconsistencies; if needed, further clarification was sought from the country.

Data Analysis

Country data were entered and analysed with Excel. Benefits packages were compared across the World Health Organization's (WHO) three dimensions of universal coverage: population, services, and costs coverage.[18] Individual country analyses and the comparative tables were reviewed and validated by country key informants during the CoP Bamako workshop.

In order to make the international comparisons easier we have converted local currencies using Purchasing Power Parities (PPPs).[iii]

Study Limitations

The sample was not comprehensive, as we did not include all sub-Saharan African countries that have introduced a maternal health fee exemption policy. Only countries attending the workshop were asked to complete the questionnaire. Eleven countries completed the questionnaire, but only ten attended the Bamako workshop (the Burundi delegation was not able to come).

As researchers were unable to go to the field to collect the data, the questionnaire was sent by email to key informants. Part one of the questionnaire regarding the composition of the benefits package covered by the policy was generally completed, but there were some gaps in the information provided in part two on the policies' financing. All financial information was collected for 2010 with the exception of Mali, Niger, and Nigeria. For Niger, data were provided for 2009, while the data for Nigeria on the policy costs cover the period from November 2008 to June 2010. For Mali, no financial information was obtained via the questionnaire. The data for Mali comes from the 2011 USAID evaluation report.[19] The information on the total cost of the exemption policy was not available in Ghana and Senegal.[iv] It was not possible to obtain data about the total amount of external funding used to support the exemption policy in Sierra Leone. External funding was done via budget support (to the national budget) and thus an estimate of the total amount of development funds used to indirectly support the programme was not possible.

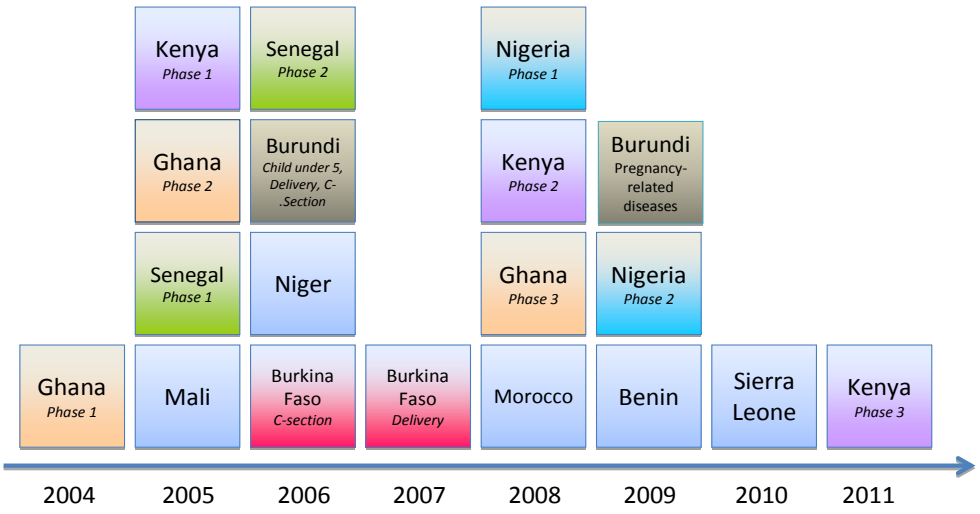
More generally, there are limitations inherent in a one-off cross sectional survey, particularly in describing policies that are dynamic and embedded in changing health systems.

RESULTS

Timing of Introduction

The 11 policies were introduced between 2004 (Ghana) and 2010 (Sierra Leone). As shown in Figure 1, most have gone through a number of iterations (extending the geographical area covered, changing the benefits package and/or changing the delivery mechanisms and co-payments). For example, Senegal's fee exemption policy started in 2005 in five poor regions and was extended one year later to the rest of the country (except Dakar). In Burundi, the policy started in 2006 by covering children under 5, normal deliveries and Caesarean sections. In 2009, pregnancy-related diseases were added to the package of services exempted.

Figure 1: Chronology of the Policies' Introduction (n=11)



Benefits Packages

1. Who is covered?

Coverage involves several elements, including the population sub-group included, whether any income-based targeting is applied, the geographical areas covered, and the sectors included in the policy (see Table 1). The Benin, Mali, and Senegal policies cover only care for pregnant women while other countries also include care for the newborn. In Kenya, Nigeria, and Senegal, the policy covers targeted regions and not the whole country. Five countries apply the policy only in the public sector, while six countries have extended the policy to not-for-profit facilities, and even for-profit facilities with an accreditation process. The majority of policies apply to the entire population of pregnant woman regardless of their income, except for Kenya (whose policy targets poor pregnant women).

Table 1: Target Population of the Policies (n=11)

Country	Target group	Eligibility criteria based on income	Geographical coverage	Type of health facilities
Benin	Pregnant women with complications	NO	National	Public & non-for-profit
Burkina-Faso	Pregnant women (all) + new born with complication	NO	National	Public & non-for-profit
Burundi	Pregnant women + new born	NO	National	Public & non-for-profit
Ghana	Pregnant women + new born	NO	National	Accreditation (all types)
Kenya	Pregnant women + new born	For poor women only	Targeted regions	Accreditation (all types)
Mali	Pregnant women with complications	NO	National	Public
Morocco	Pregnant women + new born	NO	National	Public
Niger	Pregnant women with complications / new Born	NO	National	Public
Nigeria	Pregnant women + new born	NO	Targeted regions	Accreditation (all types)
Senegal	Pregnant women	NO	National (except Dakar)	Public
Sierra Leone	Pregnant women + new born /lactating mother (with children under two)	NO	National	Public

2. Which services are covered?

The only service that is covered by all 11 countries is provision of C-sections (Table 2). Eight of 11 countries cover normal deliveries.[v] Two countries do not cover obstetric complications during pregnancy and labour, and four countries do not cover the complications during the post-partum.

Three categories of countries can be drawn from the table: (1) countries with a very comprehensive package (Burkina Faso, Burundi, Ghana, Morocco); (2) countries with a fairly comprehensive package, but that do not cover the complications related to abortion care (Kenya, Nigeria, Sierra Leone); and the last category: (3) countries with a very limited range of exempted services (Mali, Niger, Benin).

Table 2: Services Covered by the Policies (n=11)

	Morocco	Burundi	Ghana	Burkina-Faso	Kenya	Nigeria	Sierra Leone	Senegal	Mali	Niger	Benin
Antenatal care											
Delivery											
Episiotomy											
Complication during pregnancy				DC	DC				DC		
Complication during labour											
Caesarean section											
Other surgeries								Hyster.		Hyst+Ect.P	Hyst+Ect.P
Postnatal care											
Postnatal complication											
Postnatal family plnning											
Simple post-abortion care											
Complicated post-abortion care											
Newborn care											

Covered by another exemption or subsidy policy

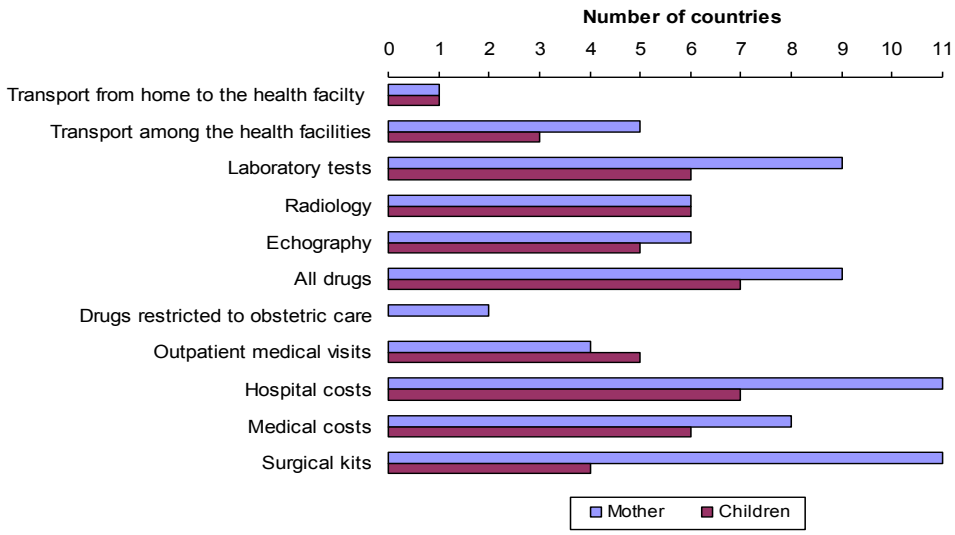
Note: DC=direct obstetric complications, hyster=hysterectomy, ect. p=ectopic pregnancy

3. Which types of cost are covered?

Figure 2 shows the types of costs covered by the policies. Surgical costs and hospitalisation costs are covered by all the policies, but complementary examinations like radiology, ultrasound, and even laboratory tests are not universally covered.

Few policies (five) cover the transport cost between health facilities. Only Morocco covers the transport cost between home and the health facilities (and that only in 24 provinces with poor access over 85 provinces). The range of costs covered is better for the mother than for the newborn. Under all policies, some household costs remain.

Figure 2: Costs Covered by the Fee Exemption or Subsidy Policies (n=11)



The majority of countries cover 100% of the direct costs of targeted services under the policy. Only two countries require some co-payment for the direct costs of targeted services: Burkina Faso (20% of direct costs are paid by the household) and Kenya (which demands a contribution of $1- 2 per voucher. The voucher gives access to maternal health services: facility delivery or management of complications). Some countries have put in place a system of differing reimbursement levels to avoid self-referral to higher levels of the health pyramid. For example, in Burkina Faso, 80% of normal delivery costs are reimbursed in health centres, but only 60% in university hospitals. In Morocco, the exemption policy is applied in university hospitals for referred women only.

How Exemption Policies for Maternal Health are Linked with the Other Initiatives?

Exemption policies for maternal and neonatal care are not unique but one of a growing number of fee exemptions in many countries, which often have parallel policies targeting other disease or population groups (Table 3). Most countries also have a national policy to exempt the indigent from paying direct health care costs, but very often, they are not implemented in practice. Parallel to these initiatives, several countries (e.g. Ghana, Nigeria, and Kenya) have put in place a national health insurance system, while others are in the process of developing one (Mali, Benin).

Table 3: Other Targeted Exemption Policies
(n=11)

Countries	Trageted population group				Targeted diseases or services				
	< 5 years preventive s care	< 5 years curatives care	< 5 ans TB/Malaria /HIV	Ederly	TB	Malaria	HIV	Family planning	Other
Benin			■		■	■	■		Leprosy, Ulcer and Buruli, Onchocerciasis
Burkina-Faso	■		■		■	■	■	■	Surgical emergency
Burundi	■	■	■		■	■	■	■	
Ghana*				■					Psychiatric cases
Kenya			■				■		Séquelae sexual violence
Mali	■		■		■	■	■		NTDs, Leprosy, cervical cancer, Onchocerciasis,...
Morocco	■	■	■		■	■	■	■	Mammography, Iron deficiency Anemia
Niger	■	■	■		■			■	Women's cancer
Nigeria	■	■	■	■	■	■	■	■	
Senegal				■	■	■	■	■	
Sierra Leone	■	■	■		■		■	■	Leprosy
Total	7	4	8	3	9	7	9	7	

* Ghana has exemption for Children under 18 enrolling onto the NHIS.

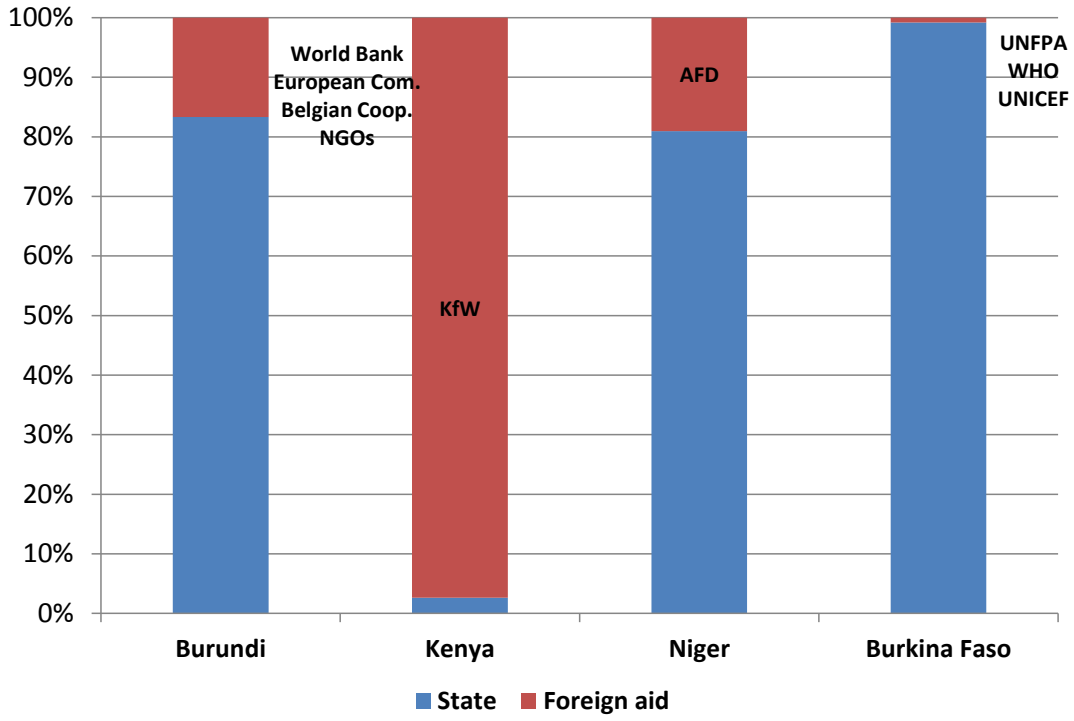
POLICY COSTS AND FUNDING MODALITIES

Revenue Collection

Funding sources for the fee exemption policy vary between countries. Some countries have relied solely on internal resources (Benin, Ghana, Mali, Morocco, Nigeria, Senegal), while others (Burkina Faso, Burundi, Kenya, Niger, Sierra Leone) rely on co-funding (at least to some extent) by development partners (Figure 3). With the exception of Kenya (whose policy - still a pilot project operating only in certain regions and parts of Nairobi - relies almost entirely on external funding from KfW - external funding accounts for a relatively small portion of funding of fee exemption policies (around 20% for Burundi and Niger, and less than 1% for Burkina Faso). Other countries, notably Sierra Leone, rely heavily on budget support funds to support the implementation of the fee exemption policy, even though they are not directly allocated to this programme as such.

Some countries have used resources from the HIPC (Heavily Indebted Poor Countries Initiative) to co-fund their fee exemption policies, as was the case in Nigeria, Ghana (phases 1 and 2), Burundi, and Senegal.

Figure 3: Share of External Funding in the Exemption Policy Funding (n=4)



External assistance is primarily, but not exclusively, monetary. In the case of Niger, for example, external funding is channelled through several mechanisms: provision of funding (AFD), drug supply (AFD, WHO, UNFPA, UNICEF) and contraceptive commodities (UNFPA), and medical transport for referral (NGO HELP). Like Niger, the fee exemption policy in Burundi and Sierra Leone is supported by a multiplicity of donors. In the case of Sierra Leone, the most prominent are DFID (the UK Department for International Development), the World Bank, the African Development Bank, and UNFPA. All of these partners bring substantial technical support, as well as funding.

The length of donor commitment to funding fee exemption policies varies from country to country. In Burundi and Kenya, donors have made a financial commitment until 2014 (in Kenya, 344 million Kenyan shillings per year is committed until November 2014). For Niger and Sierra Leone, the period of donors' financial commitment was not provided. In Burkina Faso, donors have made no commitments but their support is marginal compared to the government's financial efforts.

Beyond the question of donors' financial commitments to support these policies lies the critical issue of sustainability. This is certainly the case in Kenya, whose policy is heavily dependent on external funding. In several countries, the policy has a flagship status for the president; in Burundi for instance, the president seems committed to protect his initiative (the country is even about to launch a national scheme to cover other categories of the population). But such political commitment can also encounter the difficult reality of budget

constraints. Niger recently organised a national conference to assess the fee exemption policy: the 160 participants at the conference declared that "*the fee exemption policy was seriously sick and must be saved.*"[vi] The First Minister promised the creation of a fee exemption policy coordination body reporting to the First Minister's cabinet, as well as political commitment to address serious policy failures (underfunding, delays in reimbursement of the health facilities, poor management of the drugs supply chain, etc). Burkina Faso is the only country surveyed with an explicit multi-year commitment to finance the fee exemption policy (till 2015).

Pooling

In the 11 countries, these policies are funded by a single pool funded by tax payers or aid agencies; only Burkina Faso policy still stipulate that households have to cover 20% of the cost.[20] The entitlement is offered to all pregnant women in 8 of the 11 countries (Table 1). The three other countries have tried to implement a targeted approach to enhance the equity of the scheme, either by a focus on the poorest (Kenya) or on less rich regions (Kenya and Senegal). This indicates an overall equitable pooling of resources.

If there is inequity in terms of benefit-incidence, it might have two sources: (1) the barriers encountered by the poorest to access the services and (2) possible transfer of resources from this pool to another pool. It was not the purpose of this rapid study to enter these questions requiring substantial data collection. One can only hypothesise that a country whose policy covers also some of these barriers (e.g. Morocco and its broad assistance for transport) will fare better than a country whose policy leaves a small user fee by the user (e.g. Burkina Faso) or does not cover the transport (e.g. Niger).

Purchasing

Funding Modalities

Most countries pay facilities according to the number of services provided, though some pay in advance and others in arrears, and in some cases kits are an important component of the support to facilities. Benin, Burkina Faso, Burundi, Ghana, Kenya, Niger, and Nigeria pay retrospectively per service. In Mali, the supply of C-section kits is handled on a biannual basis and the reimbursement of health facilities is done on a quarterly basis. In Morocco and Senegal, prepayment of health facilities is done on an annual basis (for regional hospitals only in Senegal) in combination with the provision of delivery kits and medicines (Morocco) and C-section kits at the level of health centres in Senegal.

Different Levels of Reimbursement

Almost all countries have developed fixed reimbursement rates per service exempted, with the exception of Burkina Faso, which reimburses actual costs (retrospective fee for service payment to facilities). Some countries have varying reimbursement rates according to level of care (district/regional/national hospital) and type of facilities (public/non-for-profit/for-profit facilities); cost differences between levels of care are taken into account, with higher level facilities receiving higher funding. In Niger, for example, the reimbursement of a C-section in 2010 was $320.6 PPP in a national hospital, $200 PPP in a regional hospital, and $140.2 PPP in a district hospital.

In another set of countries, the reimbursement rate depends on facility ownership alone. In Kenya, for example, in 2010 a C-section reimbursement was $224 PPP in public health facilities, $579.8 PPP in a faith-based or NGO facility and $1040.5 PPP in accredited private hospitals. In a third set of countries, the reimbursement rate is fixed according to a combination of level of facility and its ownership. In Ghana, the reimbursement of health facilities is calculated using the National Health Insurance Scheme (NHIS) schedule. In five countries (Benin, Mali, Morocco, Nigeria, Senegal), there is a single rate regardless of the level or type of care. In Benin, all facilities performing C-sections are reimbursed $426 PPP per C-section. In Nigeria, there is a mixed reimbursement mechanism: reimbursement based on outputs as well as a fixed amount of financial support per capita (based on the number of persons registered in the Health Management Organisation).

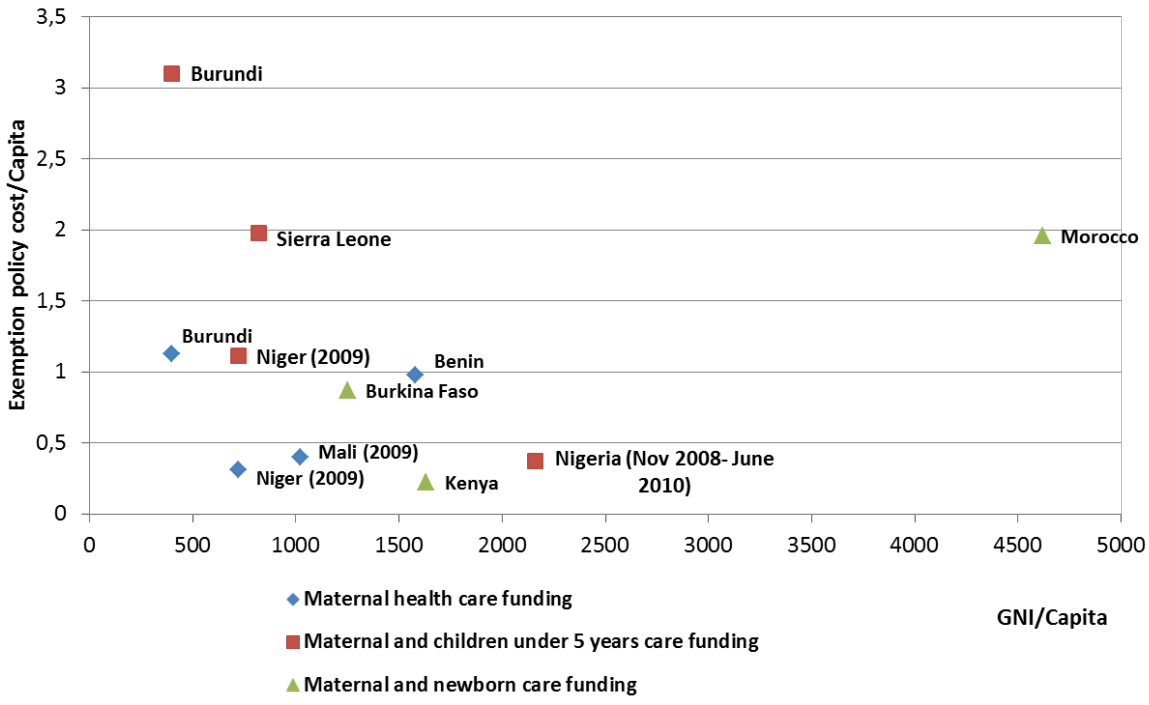
The extent to which the reimbursement rates are based on a real understanding of cost structures or costing studies is unclear. Previous studies have highlighted some differences between the cost of services and reimbursement rates.[21] In Benin, the reimbursement is thought to be over-generous for district hospitals but not sufficient for the university hospitals (situational analysis of FEMHealth project in Benin[vii]).

Cost of Maternal Exemptions

There is of course wide variation among countries in terms of the overall cost of the fee exemption policy, from $62.8 million PPP in Morocco to $4.8 million PPP in Niger. Size of the population, economic development, scope of the benefit package, and also commitment by the government, are all factors affecting the budget available for the policy. The most interesting comparison is in relative terms.

In Figure 4, the costs of the fee exemption policy per national capita are shown, according to gross national income (GNI) per capita. To facilitate comparison, policies have been presented in three groups according to their target population (pregnant women, pregnant women and newborns, pregnant women and children under 5). It is clear that the spending per capita is not well correlated with national income. These variations reflect a variety of factors, including differing entitlements within the policies, differing degrees of effective implementation, as well as different demographic factors, coverage levels, cost structures, and resource availability. Burundi is making the greatest effort relatively to nation's wealth.

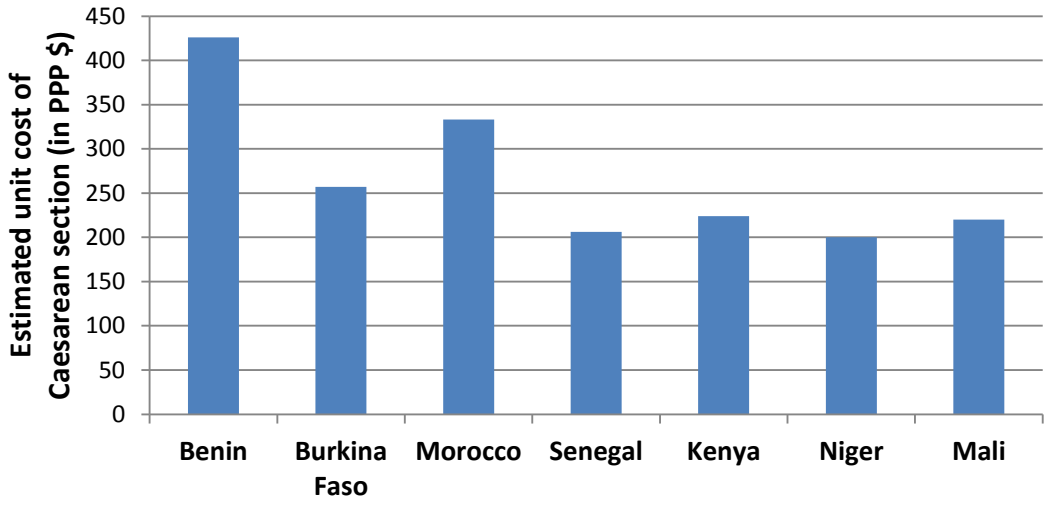
Figure 4: Exemptions Policy Costs per capita, by GNI per capita (n=9)



We were able to obtain cost information for C-sections in seven countries (Figure 5), which varied substantially. In 2010, the direct unit cost of a C-section (surgical kits, drugs, inpatient stay) in Benin was estimated at $426 PPP. This estimate is well above the estimates of Morocco ($333 PPP) and Burkina Faso

($257 PPP). It is double the estimated cost in Niger and Mali - respectively $200 PPP and $220 PPP per Caesarean section (in Niger, the unit cost varies with the level of care). These differences may partly reflect local medical cost structures, but may also reflect the different bargaining power of medical constituencies. Reimbursement systems varied across the policies and were not generally based on a full estimate of the costs of producing these services.

Figure 5: Estimated Unit Direct Costs of a C-section (PPP $) (n=7)



DISCUSSION

Shared Goals, Shared Timing, Shared Learning?

With this review of 11 countries, we can see that there has been a strong movement over the past few years in Africa to prioritising financial access for maternal and child health, especially in the West African region. These shared goals and timing most probably have different drivers, some at global level (MDG 5; HIPC; advocacy by some global actors for free health care), some at national level (national elections).[22-23] There is clearly room for cross-learning between countries and for knowledge strategies such as regional CoPs.

Understanding and Addressing the Real Costs for Households

These fee exemption policies are significant steps towards increasing access to priority services, however it is clear from the table on costs that none of these policies covers all costs relating to maternal and neonatal health care. Patients and their families are still responsible for covering at least part of the direct costs (especially laboratory exams, X-rays, and care of the newborn). Out-of-pocket payments can still be high in case of complementary exams.[24] Transport is also a serious obstacle for households – both financial and practical. Only Morocco covers transport costs from the home to the health centre in rural areas through

an emergency obstetrical and neonatal transport system (SAMU), and only five countries cover transport costs between different health care facilities (in referral cases). In Mali, under the national fee exemption policy for C-sections, transportation is meant to be provided through existing referral systems that are supported by communities via solidarity funds; however since the policy's implementation, community mobilisation has decreased, leaving the emergency transport system very weak.[25]

Even fee exemption policies that appear comprehensive on paper can engender high costs for households due to poor quality, uneven implementation, and lack of monitoring. There are many reports of informal payments to medical staff, prescription of brand-name drugs instead of generic drugs, and/or recurrent shortages of drugs in the public hospital pharmacies that require families to buy drugs from private pharmacies.[26-28] In short, it will be impossible to fully reduce financial barriers and reduce maternal mortality if health care standards remain inadequate or services are simply unavailable.[29] It is essential to invest in building adequate staff capacity and equipment before implementing such policies.[30-31] Increasing the uptake of poorly staffed and low quality health services can also add to, rather than reduce, health risks to women, neonates and children.[32] In a nutshell, fee exemption policies alone are probably not sufficient to provide an effective coverage to targeted priority groups. There is a need for a comprehensive strategy, such as the one, which was developed by Morocco in 2008.[33]

Still Insufficient Understanding of Incentive Issues

The rapid survey approach did not allow us to document the incentive dimensions of the policies. This would clearly require more knowledge on the performance of the country health systems, including efficiency at health facility level. This limit was illustrated during the workshop by an expert discussion about the Benin situation. Is the over-generous reimbursement to district hospitals and the 'insufficient' reimbursement to university hospitals a good thing or a bad thing in terms of the general organization of the health system? In many African countries, misdistribution of qualified staff is a major issue: city hospitals poorly performing because of a plethora of staff coexist with rural hospitals lacking the required expertise. From the perspective of the stewards of the health system, paying the C-section the same price whatever the situation or the level of the hospital could then be a way to improve the overall efficiency. These incentive considerations deserve more in-depth research.

The Risks of Focusing Too Exclusively on C-sections

The content of the package also needs reflection. The one service covered by the fee exemption policy in all of the 11 countries surveyed is the cost of C-sections. Other obstetric complications during labour are omitted in two countries: Niger and Benin. Post-abortion care is not covered in seven countries. There is a need to align benefits packages with current global evidence on maternal health.

While C-sections, as surgical procedures, are expensive to families, other direct obstetric complications, such as treating infection and eclampsia, are also expensive because of the costs of drugs.[34] Therefore, a policy focusing narrowly on making C-sections "free" does not eliminate the possibility of catastrophic expenses for families. It is also important to highlight that the major cause of maternal mortality in Africa is postpartum haemorrhage (33,9%) which cannot be treated by a C-section.[35] Indirect causes of maternal mortality (HIV infection, tuberculosis, malaria, severe anaemia, others infection) represent also a significant part (26,6% all causes confounded – 6,2% related to HIV) and do not required surgery but rather good primary and secondary prevention during antenatal care.[36-37] To dramatically reduce maternal mortality, it is essential to move beyond C-sections and support more comprehensive emergency obstetric care measures, as well as to assure qualified assistance during delivery.[38]

Studies carried out by WHO in Africa, Asia, and Latin America on modes of delivery and short-term outcomes for mother and newborn also show that C-sections actually increase the risk of mortality and severe complications for the mother (admission to intensive care, blood transfusion, hysterectomy).[39] C-sections carried out for non-medical reasons, either before or during labour, place women at greater risk of mortality or severe complications, particularly in Africa where health care standards tend to be poor.[40-41] During subsequent pregnancies, women who have undergone a C-section are at greater risk of uterine rupture or of implantation abnormalities (placenta praevia or accreta).[42-44] Implemented as an isolated measure, without other accompanying measures and strategies to reduce maternal mortality, a narrow "free C-section" policy may lead to an increase of unnecessary C-sections. It is therefore important to monitor the evolution of the number of C-sections and their indications.[45-46] The risk of supply-induced demand, particularly when C-sections are well reimbursed for providers, is non-negligible.

A general lesson for countries trying to move towards UHC by starting with schemes targeting priority groups (see below) is that it is crucial to involve specialised public health experts in the design of the policy.[47-49]

Fee Exemption as a Step Toward Universal Health Coverage

Whereas one can wonder whether these fee exemption policies will be enough to make rapid progress towards the MDG 5, there is no doubt that they are part of the national response to the political momentum created by the MDG agenda. As evidenced in the review, several countries have in fact adopted a fee exemption policy covering children under 5, which can be interpreted as an effort to accelerate progress towards MDG 4 as well.

As clearly stated by the WHO report[50] there is no single model to progress towards UHC. Yates has argued that fee exemptions for children and women would be a major step in the right direction.[51] In terms of content of the policy, there is no doubt that removing user fees can – if the policy is well-funded and implemented – significantly improve access to the health services for substantial groups of users. It can also improve financial protection, especially when the benefit package includes services, which are very costly. In terms of process, one

can also consider that focusing first on a vulnerable group such as pregnant women is an equitable route to UHC. The policy extends potential benefits to all parts of society, which also favouring the poor, who tend to have larger families and are also more likely to seek care in the public sector.

However, physical access to facilities is a major constraint, which discriminates against rural households. A priority is to ensure that barriers met by the rural poor are really addressed – to avoid that the policy mainly finances the privileges of the better-off living in the cities. Some countries in our review have been more attentive to others to this aspect. The second one is to handle the articulation of the exemption fee policy with the rest of the UHC agenda. This aspect seems to have been less well-handled in most of the reviewed countries.

Governance at the Country Level: Reducing Fragmentation and Complexity

We have seen that in many countries there is a panoply of fee exemption policies in operation: for communicable diseases, the poor, medical staff, etc.[52] These different initiatives lead to a complex architecture, with many actors and rules for eligibility. This complexity and lack of clarity make it difficult for the clients and for civil society to understand, and thus claim their rights. Even health staff can be confused by the plethora of policies, which are often poorly communicated and coordinated, leading to poor implementation and waste. Simultaneously, many countries are developing national health insurance schemes, and the relationship between insurance and exemption is rarely clearly defined.[53] In Sudan, for example, one study found a cross-subsidy of insured patients by the exemption policy for pregnant women and under-fives, but this appeared to vary by locality.[54] A similar problem has been identified in Burundi, where the civil servant insurance fund may have made big savings since the introduction of the free health care policy (as it is now the public budget which reimburses the facilities). The participants at the Bamako workshop reiterated the importance of having a coherent strategic vision for health financing, and the need to coordinate all health financing mechanisms to achieve the ultimate goal of universal coverage, through a sustainable system that develops over time to extend equitable access to health care for all.[55]

Priorities for Further Research

The rapid growth in exemption policies focused on these target groups opens up a number of important research questions (Table 4). In particular, there are outstanding questions on the cost-effectiveness of this strategy, compared to alternative approaches, and a need for further research on their sustainability and how they can be linked into broader health financing plans.

Table 5: Outstanding Research Questions

Policy drivers
• Why were these particular policies developed?

- What were the drivers?
- What informed the different choices which countries made (situation analysis, research, priorities etc.)?
- What was the balance of internal/external factors?
- For international transfers, what were the mechanisms?
- Are we now shifting towards a more juridical approach to health (human rights, recent constitutional changes etc.)?

Impact on households

- What impact have they had on household payments?
    - Formal and informal
    - In public and private sectors
- What are the short and longer term economic and social impacts on the households?
    - Spending on other goods
    - Intra-household dynamics and allocation
    - Social relations

Impact on health

- How have the exemption schemes affected the quality of care?
- How have they affected utilisation (taking into account secular trends, and any changes to reporting)?
- What is their contribution to addressing the burden of mortality & morbidity?
    - Depends on services covered
    - Reaching right group
    - Delivered with appropriate care
- To what extent have they had adverse effects (e.g. over-medicalisation with C-sections)?

Impact on equity and access

- How have the benefits of the policy been distributed, in terms of poorer women, women in more remote areas, and other marginalised groups?
- Have they addressed the most significant access barriers?

- Are the policies based on a consensus about priority groups?
- How have they affected social solidarity?
- How have they changed community perceptions and care seeking?

Impact on staff

- How well were staff working before?
  What margin was there for additional effort?
- How has the removal of fees affected their financial rewards?
- How has removal of fees affected their non-financial (and intrinsic) rewards and their motivation?

Impact on facilities

- What are the financial implications of selective removal of fees for the facilities?
- How do they affect their accountability?
- How have they adapted to it (threats and opportunities)?

Impact on the health system

- What impact has the free care had on the system as a whole?
- Has it helped to integrate services or to fragment them?
- Has it added to or diverted finance, staff time, and resources for other services?
- Has it managed to catalyse wider health system strengthening?
- How have different sectors and provider types been affected?

How to set priorities

- How can different criteria be traded off (e.g. greater coverage versus broader package of services)?
- If you have limited funds, which services provide the best return?

Cost-effectiveness of policies

- What are the costs (total and marginal) of these policies?
- What are their transaction costs?
- What is the cost effectiveness of these policies?
  - These are financing policies, so often we are assessing not new services but changed incidence of costs, and/or improved distribution and/or improved quality

- How do their marginal costs and benefits compare to alternative possible use of the funds?
    - Costs localised; effectiveness varies; also need to think about funding source and how transferable it might be

Sustainability

- Can the cost be sustained, now and as utilisation/coverage increases?
- What support is likely to be forthcoming, especially after 2015?
- What is the fit between exemption policies and overall health financing strategies? (Are they pulling together or pulling apart?)
- Are there synergies with other strategies (e.g. performance-based funding, decentralisation etc)?

Source: S. Witter, "Summary Presentation for Bamako Workshop," 2011

CONCLUSION

Selective user fee removal was developed by governments to address the urgent needs of priority groups in a resource-constrained context. However, the thinking behind these policies needs to be re-examined, as well as their potential integration into the system as a whole. The basis for selecting particular services would benefit from a discussion of the balance of risks – C-sections address potentially catastrophic costs, for example, but do not necessarily address the main health risks to women. They also present iatrogenic risks and a distinct risk of unnecessary medicalization. Ideally, packages of care should integrate care of mother and the newborn to a higher degree than happens at present. Preventive elements, such as family planning and antenatal care should also be part of the package, if possible, as they are highly cost-effective.[56-57] For households, some costs which are very important barriers, such as transport, have been neglected.

Each context will be different and it is not appropriate to prescribe specific packages here. However, it is important that all policies have clear objectives and are based on an inclusive dialogue about local priorities, risks and resources.[58] They should also learn from evidence and from one another – an important objective for the CoP and also for this article. Finally, the policies should fit into a clear national health-financing framework, not operate as stand-alone programmes with limited reflection about how they interact with other initiatives. Reducing fragmentation is the best way to reach UHC.

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[1] B. Meessen et al., *Removing User Fees in the Health Sector in Low-income Countries: A Multi-country Review*, (New York, United Nations Children's Fund, 2009).
[2] F. Richard, S. Witter, and V De Brouwere, "Innovative Approaches to Reducing Financial Barriers to Obstetric Care in Low-Income Countries," *American Journal of Public Health* 100, no. 10 (2010): 1845-1852.
[3] V. Ridde and F. Morestin, "A Scoping Review of the Literature on the Abolition of User Fees in Health Care Services in Africa," *Health Policy and Planning* 26, no. 1 (2011): 1-11.
[4] *Ibid*.
[5] S. Witter, "Mapping User Fees for Health Care in High-mortality Countries: Evidence from a Recent Survey," (London, HLSP Institute, 2010).
[6] F. Richard et al., "Sub-Saharan Africa and the Health MDGs: the Need to Move Beyond the "Quick Impact" Model," *Reproductive Health Matters* 19, no. 38 (2011): 42-55.
[7] R. Yates, "Women and Children First: an Appropriate First Step Towards Universal Coverage," *Bulletin of the World Health Organization* 88, no. 6 (2010): 474-475.
[8] D. R. Gwatkin and A. Ergo, "Universal Health Coverage: Friend or Foe of Health Equity?," *The Lancet* 377, no. 9784 (2011): 2160-2161.
[9] B. Meessen et al., "Removing User Fees in the Health Sector: a Review of Policy Processes in Six Sub-Saharan African Countries," *Health Policy and Planning* 26 Suppl 2 (2011): ii16-ii29.
[10] Witter, "Mapping User Fees."
[11] C. D. James et al., "To Retain or Remove User Fees?: Reflections on the Current Debate in Low- and Middle-Income Countries," *Applied Health Econonimcs and Health Policy* 5, no. 3 (2006): 137-153.
[12] B. Meessen, L. Gilson, and A. Tibouti, "User Fee Removal in Low-Income Countries: Sharing Knowledge to Support Managed Implementation," *Health Policy and Planning* 26 Suppl 2 (2011): ii1-ii4.
[13] S. Witter, "Service- and Population-based Exemptions: Are These the Way Forward for Equity and Efficiency in Health Financing in Low-income Countries?" in *Innovations in Health Systems Finance in Developing and Transitional Economies*, ed. D. Chernichovsky and K. Hanson., vol. 21 *Advances in Health Economics and Health Services Research*, (Bingley: JAI Press, 2009), 249-286.
[14] B. McPake et al., "Removing User Fees: Learning From International Experience to Support the Process," *Health Policy and Planning* 26 Suppl 2 (2011): ii104-ii117.
[15] J. Campbell et al., "Increasing Access to 'Free' Health Services: Are Health Workers Not a Missing Link?," *Internaional Journal of Clinical Practice* 65, no. 1 (2011): 12-15.
[16] M. Nimpagaritse and M. P. Bertone, "The Sudden Removal of User Fees: the Perspective of a Frontline Manager in Burundi," *Health Policy and Planning* 26 Suppl 2 (2011): ii63-ii71.
[17] B. Meessen et al., "Communities of Practice: the Missing Link for Knowledge Management on Implementation Issues in Low-Income Countries?," *Tropical Medicine and International Health* (2011).
[18] WHO, The World Health Report 2008: Primary Health Care Now More Than Ever (Geneva, Switzerland: World Health Organization, 2008).
[19] M. El-Khoury et al., *Improving Access to Life-saving Maternal Health Services: The Effects of Removing User Fees for Caesareans in Mali*, ed. Health Systems 20/20, (Bethesda, MD: Abt Associates Inc., 2011).
[20] V. Ridde et al., "The National Subsidy for Deliveries and Emergency Obstetric Care in Burkina Faso," *Health Policy and Planning* 26 Suppl 2 (2011): ii30-ii40.
[21] Witter, "Mapping User Fees."
[22] M. Pearson, *Issues Paper: The Case for Abolition of User Fees for Primary Health Services*. ed. DFID Health Systems Resources Centre, (2004), 1-44.

[23] S. Witter, *An Unnecessary Evil? User Fees for Healthcare in Low-income Countries,* (London, UK: Save the Children Fund, 2005), 1-41.
[24] J. Borghi, K. T. Storeng, and V. Filippi, "Overview of the Costs of Obstetric Care and the Economic and Social Consequences for Households," in *Reducing Financial Barriers to Obstetric Care in Low-Incomes Countries*, ed. F. Richard, S. Witter, and V. De Brouwere., vol. 24, Studies in Health Services Organisation and Policy (Antwerp: ITG Press, 2008), 23-46.
[25] El-Khoury et al., "Improving Access to Life-saving Maternal Health Services."
[26] Amnesty International, *Giving Birth, Risking Death: Maternal Mortality in Burkina Faso*, (London, UK: Amnersty International, 2009) 1-126.
[27] E. M. Mbaye, et al., "'Doing More to Earn More': Caesarean Sections Based on Three Cases of Exemption From Payment in Senegal," *Sante Publique* 23, no. 3 (2011): 207-219.
[28] S. Witter, M. Armar-Klemesu, and T. Dieng, "National Fee Exemption Schemes for Deliveries: Comparing the Recent Experiences of Ghana and Senegal," in *Reducing Financial Barriers to Obstetric Care in Low-Income Countries*, ed. F. Richard, S. Witter, and V. De Brouwere., Studies in Health Services Organisation and Policy 24 (Antwerp: ITG Press, 2008).
[29] Campbell, et al., "Increasing Access to 'Free' Health Services," 12-15.
[30] Richard, et al., "Innovative Approaches to Reducing Financial Barriers to Obstetric Care," 1845-1852.
[31] McPake et al., "Removing User Fees," ii104-ii117.
[32] Nimpagaritse and Bertone, "The Sudden Removal of User Fees," ii63-ii71.
[33] Kingdom of Morocco, *Reducing Maternal Mortality in Morocco: Sharing Experience and Sustaining Progress,* ed. Ministry of Health, (Rabat, Morocco: Direction des hôpitaux et des soins ambulatoires, 2011), 1-23.
[34] Borghi, et al., "Overview of the Costs of Obstetric Care," 23-46.
[35] K. S. Khan et al., "WHO Analysis of Causes of Maternal Death: a Systematic Review," *The Lancet* 367, no. 9516 (2006): 1066-1074.
[36] *Ibid.*
[37] C. Ronsmans and W. J. Graham, "Maternal Mortality: Who, When, Where, and Why," *The Lancet* 368, no. 9542 (2006): 1189-1200.
[38] O. M. Campbell and W. J. Graham, "Strategies for Reducing Maternal Mortality: Getting on With What Works," *The Lancet* 368, no. 9543 (2006): 1284-1299.
[39] J. P. Souza et al., "Caesarean Section Without Medical Indications is Associated with an Increased Risk of Adverse Short-Term Maternal Outcomes: the 2004-2008 WHO Global Survey on Maternal and Perinatal Health," *BMC Med.* 8 (2010): 71.
[40] A. Shah et al., "Cesarean Delivery Outcomes From the WHO Global Survey on Maternal and Perinatal Health in Africa," *International Journal of Gynaecology and Obstetrics* 107, no. 3 (2009): 191-197.
[41] J.P. Souza, "Caesarean Section without Medical Indication Increases Risk of Short-term Adverse Outcomes for Mothers," (Geneva, Switzerland: World Health Organization, 2010).
[42] M. Lydon-Rochelle, "First-Birth Cesarean and Placental Abruption or Previa at Second Birth(1)," (2001).
[43] S. Rasmussen, L. M. Irgens, and K. Dalaker, "A History of Placental Dysfunction and Risk of Placental Abruption," *Paediatric and Perinatal Epidemiology* 13, no. 1 (1999): 9-21.
[44] R. M. Silver et al., "Maternal Morbidity Associated With Multiple Repeat Cesarean Deliveries," *Obstetrics & Gynecology* 107, no. 6 (2006): 1226-1232.
[45] C. Ronsmans et al., "Measuring the Need for Life-Saving Obstetric Surgery in Developing Countries," *BJOG* 111, no. 10 (2004): 1027-1030.
[46] L. Gibbons et al., "Inequities in the Use of Cesarean Section Deliveries in the World," *American Journal of Obstetrics and Gynecology* 206, no. 4 (2012): 331.
[47] Richard, et al., "Innovative Approaches to Reducing Financial Barriers," 1845-1852.
[48] Meessen et al., "Removing User Fees in the Health Sector," ii16-ii29.
[49] McPake et al., "Removing User Fees," ii104-ii117.
[50] World Health Organization, *The World Health Report: Health Systems Financing - the Path towards Universal Coverage*, (Geneva, Switzerland: World Health Organization, 2010), 1-106.
[51] Yates, "Women and Children First," 474-475.
[52] Witter, "Mapping User Fees."

[53] D. McIntyre et al., "Beyond Fragmentation and Towards Universal Coverage: Insights From Ghana, South Africa and the United Republic of Tanzania," *Bulletin of the World Health Organization* 86, no. 11 (2008): 871-876.
[54] Witter, "Mapping User Fees."
[55] Y. Kafando, et al., ."Maternal Health Fee Exemptions - Policy Brief," (Bamako, Community of Practice on Financial Access to Health Services, 2012).
[56] J. Stover and J. Ross, "How Increased Contraceptive Use Has Reduced Maternal Mortality," *Maternal and Child Health Journal* 14, no. 5 (2010): 687-695.
[57] T. Adam et al., "Cost Effectiveness Analysis of Strategies for Maternal and Neonatal Health in Developing Countries," *British Medical Journal* 331, no. 7525 (2005): 1107.
[58] G. Carrin, K. Xu, and D. B. Evans, "Exploring the Features of Universal Coverage," *Bulletin of the World Health Organization* 86, no. 11 (2008): 818.

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[i] The African Development Bank (AfDB), UNAIDS, UNFPA, UNICEF, WHO, and World Bank

[ii] This Community of Practice is supported by UNICEF, UNFPA, USAID, ECHO, EU (FP7 FEM health) website: http://www.hha-online.org/hso/financing/subpillar/financial-access-cop

[iii] PPPs can be defined as exchange rates that equalize the purchasing power of different currencies. Website: http://www.economywatch.com/economic-statistics/economic-indicators/Implied_PPP_Conversion_Rate/

[iv] In Ghana this can be explained by the fact that there is no separate budgeting or funding for this policy within the NHIS (National Health Insurance Program). In Senegal only data on the cost of Caesarean sections performed in regional hospitals could be given to us: PPP $ 1.8 million in 2010.

[v] Spontaneous vaginal delivery

[vi] Declaration of the National Conference on Free Health Care in Niger. Accessed on 6 May 2012: <http://www.santemondiale.org/ihpfr/2012/pis-159-declaration-conference-nationale-gratuite-soins-niger/>

[vii] http://www.abdn.ac.uk/femhealth/