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# Removing user fees for health services in low-income countries: a multi-country review framework for assessing the process of policy change

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Several authors have stressed the fact that many policy reforms fail because of poor formulation or implementation. On the other hand, the health financing literature provides little guidance to policy makers in low-income countries on how to implement a health care financing reform in ways that enhance its chance of achieving policy objectives, even less so for a user fee removal reform.

This paper presents the framework used for a multi-country review of the policy process of removing user fees in six sub-Saharan African countries. The review aimed at developing operational guidance for health managers involved in user fee removal reform. Drawing broadly on Walt and Gilson's 'health policy analysis triangle' (context—actor—process—content), we focused particularly on understanding the process of planning and implementing the reform led by central-level policy actors. Our core analytic strategy was the verification of a list of 'good practice hypotheses' that might be expected in a health financing policy reform against experience.

This framework offers an approach for how to analyse health financing policy reform processes in low-income countries. It allows for an explicit and transparent review of multiple experiences against a set of clear hypotheses. This approach might be a step in the direction of research that supports better formulation and implementation of policies in resource-poor settings.

**Keywords** User fees, health policy, methods, health care reform, low-income countries

## KEY MESSAGES

- More attention should be paid by researchers to the production of knowledge that meets the needs of people managing policy change in low-income countries.
- Good practice hypotheses derived from existing public policy, health policy and health financing policy literature can assist in a review of removing user fees for health services reforms in low-income countries.

## Introduction

Over the last decade, a growing coalition of actors has called for the removal of user fees for primary care in low-income countries (LICs) (e.g. Save the Children UK 2008; Marriott 2009). The 2010 *World Health Report* reiterates the fact that direct payments are a major obstacle to universal health coverage (WHO 2010). Removing user fees was even labelled a 'quick win' for progressing towards the Millennium Development Goals (Sachs and Mc Arthur 2005). Since 2001, at least 17 African countries have removed user fees and the momentum seems to be accelerating.

The removal of user fees usually increases utilization rates of health services (at least in the short term). However, it does not automatically improve health and increase financial protection (Xu *et al*. 2006; Opwora *et al*. 2010). To reach those objectives, the policy must be well-designed and properly implemented. These conditions are not always fulfilled in LICs. One of the reasons could be the lack of guidance. Indeed, despite increased attention in recent years (Walt *et al*. 2008; Ridde and Morestin 2011), there is still little explicit knowledge on how to manage reform processes in such settings (Gilson and Raphaely 2008).

Given the current enthusiasm of African leaders to (selectively) remove user fees, the question today is not anymore whether to retain or remove user fees (James *et al*. 2006), but rather how best to accompany governments pursuing this objective. There is a need to produce more knowledge in this domain. An obvious strategy for doing so is by documenting current and past reform processes and implementation strategies across countries (Gilson and Raphaely 2008). However, to allow cross-country study, an overarching framework is required.

This paper is an attempt to put forward ideas on how to analyse policy reforms in a meaningful way for the community of national policy makers. It shares the rationale and components of the framework developed for a multi-country review (further referred to as 'the review') of user fee reform processes in sub-Saharan African. It is a necessary companion for two other papers included in this supplement (Meessen *et al*. 2011a and Ridde *et al*. 2011).

We have organized the rest of the paper as follows. First we explain how we developed this framework, and then present the framework before discussing its strengths and limits in the context of the review. In our concluding section, we call for more (research) attention to the knowledge needs of people managing policy changes.

## Methodology: developing the framework

The overall objective of the review was to document the processes and strategies recently used for user fee removal in a few sub-Saharan African countries. A key request of the sponsor (UNICEF) was to draw out conclusions and lessons that could guide the future formulation and implementation of such policies in other countries with similar constraints.

When developing the review methodology, the expert team identified several policy analysis approaches offering overarching frameworks to study the policy process (e.g. Walt and Gilson 1994; Sabatier 1999; Nowlin 2011). However, given our operational focus, something more practical was deemed necessary. Drawing on the Walt and Gilson (1994) policy analysis triangle (actors—context—content—process), we included the impact of the reform in our framework, looking at both intended and unintended impact (Figure 1) (Ridde and Diarra 2009). Meanwhile, despite the importance of each element and its relations to the other elements, we decided to pay particular attention to the formulation and implementation phases of the process of user fee removal. This was due to the limited time and resources available to perform the review and to the fact that we were expected to provide operational guidance.

Our approach was to gather a list of good practice hypotheses against which the reforms could be assessed. We defined a practice as the customary way of performing a task or set of tasks to achieve certain ends with accuracy and efficiency. UNICEF (2009) defines a good practice as 'a well-documented and assessed practice that shows evidence of substantial success/impact and which can be replicated, and studied further'. For this review, the good practices were drawn from the literature (in the fields of public policy, health policy and health financing policy) and the professional experience of the reviewers. However, we do not pretend that the way we defined the good practices for this review meets the criteria defined supra. Hence, in this paper, we adopt the suggestion from Patton (2001) to refer to them as 'good practice hypotheses' or simply 'hypotheses'. The study would then strengthen or invalidate the hypotheses and in this way contribute to some extent to the cumulative and collective process of the establishment of good practices.

Table 1 features the key references drawn from the literature we used to develop our hypothesis list. In the table, the letter 'Y' indicates that the cited authors provide evidence in support of the hypothesis. Those marked with a letter 'N' on the other hand provide arguments against the proposed hypothesis, while question mark signs ('?') indicate that the articles tackle the issue but without taking a clear stance. When the field is

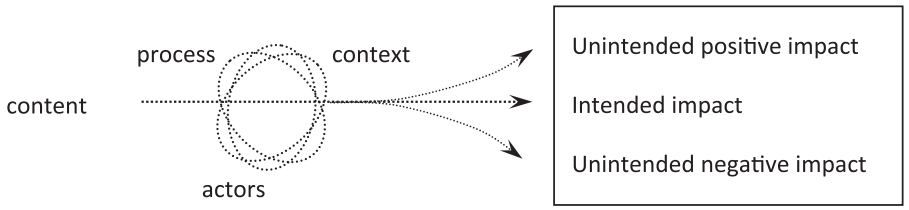


**Figure 1** Five elements of the policy analysis framework

**Table 1** List of good practice hypotheses to succeed in a user fee policy reform and their main references

| | Public policy | | Health policy | | Health financing policy | | |
|---|---|---|---|---|---|---|---|
| | Hogwood Gunn | Patton Sawicki | Green | Saltman | Gilson *et al.* | Save the Children | Witter *et al.* |
| **Situation analysis** | | | | | | | |
| 1. Preliminary situation analysis (H) | Y | Y | Y | | Y | Y | Y |
| **Setting priorities** | | | | | | | |
| 2. Vision, ownership and leadership (C) | | ? | ? | ? | Y | Y | ? |
| 3. Clear policy objectives (I) | Y | ? | Y | Y | Y | Y | |
| **Option appraisal** | | | | | | | |
| 4. International scientific evidence used (H) | Y | | | N | | Y | |
| 5. Contextualized scientific evidence and local knowledge used (C) | Y | | Y | Y | Y | Y | Y |
| 6. Different policy options assessed (H) | | Y | Y | Y | | Y | ? |
| 7. Thorough assessment of the selected option (I) | | Y | Y | Y | | Y | Y |
| 8. Early identification of accompanying measures (I) | | | | | | Y | Y |
| 9. Key implementation stakeholders are involved in the formulation stage (C) | Y | | Y | Y | Y | Y | Y |
| 10. The content of the reform meets preferences of key stakeholders (C) | ? | | Y | Y | Y | | Y |
| **Programming & implementing** | | | | | | | |
| 11. Sequencing reform elements (H) | | Y | | ? | | N | |
| 12. Planning implementation steps (C) | Y | | Y | Y | | | Y |
| 13. Broad communication strategies (C) | Y | | Y | Y | Y | Y | Y |
| 14. Medium-term commitment to budgetary burden (C) | Y | | Y | Y | | Y | Y |
| 15. Clear rules for transferring resources to health facilities (C) | | | | Y | | | Y |
| 16. Technical leadership by the Ministry of Health (C) | Y | | | Y | | | |
| 17. Capacity building (H) | | | | ? | | | |
| 18. Empowered co-ordination unit (C) | | | Y | ? | Y | | |
| 19. New rules are abided by different actors (C) | Y | | | Y | | Y | |
| **Monitoring & evaluation** | | | | | | | |
| 20. Monitoring & evaluation of the reform (C) | Y | Y | Y | Y | Y | | Y |

*Key*: (C): Crucial; (I): Important; (H): Helpful; (Y): Yes, reference supports the hypothesis; (N): No, reference does not support the hypothesis; (?): Maybe, reference discusses aspects of the hypothesis but no clear direction.

empty, the article does not provide a significant contribution to the definition of this hypothesis.

Not all hypotheses could be considered of equal importance, hence, based on the expertise of the authors of the framework, we rated their importance for the policy process. A first set of hypotheses we considered crucial, like the need for a national vision, ownership and leadership; a second group was deemed important, whereas the remaining ones were seen as helpful (as is the case for the sequencing of the reform).

For the sake of clarity we organized our hypotheses according to the rational planning model (see, for instance, Green 2007). However, we know from bottom-up theorists that 'implementation and policy formulation are highly interdependent processes' (Pulzl and Treib 2006). Hence, we considered the hypotheses as an array of possibilities rather than a linear check-list of actions to perform, and we searched for other policy processes that could have occurred concomitantly and influenced the studied policy process (Sabatier 1999). Furthermore, we decided from the start to set aside, as much as possible, our own preferences in terms of health care financing options.

## The Framework

The five elements of the framework, presented in Figure 1, were further specified so that they could be used by the researchers in the country evaluations. In Table 2, we describe the 20 hypotheses we retained to analyse the process of the reform and discuss the evidence found in favour of those practices. We describe below how we studied the remaining elements of the framework, namely the context, content, actors and impact.

### Good practice hypotheses for a user fee reform process

In Table 2, the 20 hypotheses are grouped according to the stages of the rational planning model to facilitate reading. For each hypothesis, we rate its importance as crucial, important or

**Table 2** Good practice hypotheses, their description and evidence supporting their definition

| Good practices by stage | Description of the practice | Evidence existing on the importance of this practice |
|---|---|---|
| **Situation analysis** | | |
| 1. A preliminary situation analysis of the problem is helpful | Any decision to develop a policy reform should involve an initial situation analysis that highlights the problem faced, its scope and importance. This should help ensure that the most important problem is tackled. In the context of user fees, the barriers to the utilization of primary health care services should be especially studied. | Most consulted authors consider this stage as highly recommended (Hogwood and Gunn 1984; Patton and Sawicki 1993; Gilson *et al.* 2003; Green 2007; Save the Children UK 2008; Witter *et al.* 2008). According to the available window of opportunity you might need to restrict it to 'an inventory (...) phase, limited in scope and directed at a particular issue' (Patton and Sawicki 1993). |
| **Setting priorities** | | |
| 2. National vision, ownership and leadership are crucial | High-level leadership and vision are key in successful health financing reforms in low-income countries. They are notably required to overcome resistance from some stakeholders and ensure sufficient support to technicians in charge of the reform when bold moves will have to be made. The reform will have more chance of succeeding if entrepreneurs take advantage of a window of opportunity. | Green (2007) argues that the other option—i.e. an implicit consensus among stakeholders—is unlikely in most cases. Gilson *et al*. (2003) emphasize the ability of politicians to support or block the reforms when going from agenda setting or formulation to implementation. Save the Children UK (2008) argues that bold support will ease the process while others merely mention that their opinion should be taken into account just like other stakeholders' opinions (Patton and Sawicki 1993; Saltman 1997; Witter *et al.* 2008). |
| 3. Clear policy objectives are important | Being clear about what the reform wants to achieve is important—providing a vision to drive the reform and allowing assessment of the link between the policy change and the intended results. Define your target in terms of population or financial protection at the level of outcomes. Defining more easily measurable outputs like the number of new attendances expected is also helpful. | Most consulted authors think this is a required step that can foster dialogue between stakeholders, prevent a backlash when implementation starts, help identify additional options and is a prerequisite for sound evaluation (Mazmanian and Sabatier 1983; Hogwood and Gunn 1984; Saltman 1997; Gilson *et al.* 2003; Green 2007; Ridde 2007; Save the Children UK 2008). Patton and Sawicki (1993) suggest that in a policy analysis process, the objective is defined using a problem-oriented approach while in a planning process it is more often a subject-oriented approach. However, Lindblom (1959) argues that due to the existing constraints in real life 'administrators often are reduced to deciding policy without clarifying objectives first'. |
| **Option appraisal** | | |
| 4. International scientific evidence and expertise provide helpful lessons | When engaging in a reform it is helpful to look at the international literature. It is also helpful to look at relevant experiences in other countries or regions that are similar to the one in which the reform is about to be implemented. By keeping in mind caveats and lessons of similar experiences, one can avoid the unnecessary repetition of mistakes and speed up the whole process. Calling in an expert or paying a visit to these countries could also provide insight into the process, and particularly so if data are scarce. | The literature seldom presents this step in the policy process. Notable exceptions are Rose (2005) and Save the Children UK (2008). Some argue that it might be wrongly perceived by some national stakeholders (Saltman 1997; Collins *et al*. 1999). But evidence shows that some mistakes are repeated in many countries (Ridde and Morestin 2011). Addressing this good practice could potentially reduce the knowledge to policy gap (Hogwood and Gunn 1984). |
| 5. Contextualized scientific evidence and use of local knowledge are crucial | A well-designed reform needs to rely on scientific evidence that is adapted to the local context. It should also fit the policy elites' and technical experts' vision of the reform; involve national health care financing experts; use a pilot project before designing the scaling up; use the evaluation of a previous reform to design the current reform. | Most authors strongly recommend policies to be adapted to the local context and the use of local knowledge (for example, Saltman 1997; Gilson *et al.* 2003; Green 2007; Witter *et al.* 2008). Hogwood and Gunn (1984) stress the need to identify insurmountable constraints, and Save the Children UK (2008) suggests studying the effectiveness of past measures to improve financial access. |
| 6. Some assessment of different policy options is helpful | It is helpful to rapidly map the different policy options at hand and consider alternative options. Assess them on different dimensions like easiness to implement, budgetary incidence, expected outcome, etc. Options are, for example, subsidization or free care, selected groups vs the general population, level of care concerned, including the (non-profit) private sector... | Some authors argue for a more or less comprehensive analysis (Patton and Sawicki 1993; Green 2007; Save the Children UK 2008). Others argue that policy making is typically the result of a bargaining process and of windows of opportunity (Lindblom 1959); it is therefore unnecessary to spend too much time on analysing the best option that anyhow will never be implemented (Green 2007). Save the Children UK (2008) recommends that in the case of functioning exemption mechanisms, it might not be necessary to implement free health care. Witter *et al.* (2008) state that targeting only financial barriers might not be the most urgent measure to take in order to improve access. |

(continued)

**Table 2** Continued

| Good practices by stage | Description of the practice | Evidence existing on the importance of this practice |
|---|---|---|
| 7. A thorough assessment of the selected option is important | Once an option is selected it is useful to develop the practicalities of the option, like the budgetary burden or the political risks. Entrepreneurs of a reform should assess likely or potential consequences, benefits and difficulties of implementing the selected option. In particular, a stakeholder analysis is helpful. Technical issues must also be identified. A simulation exercise could prove helpful. For instance, in the case of removal of user fees, one can expect a surge in activity for curative services with all the consequences in terms of running costs, drug supplies and workload. | Careful assessment can help the reform succeed (Patton and Sawicki 1993; Saltman 1997; Green 2007; Save the Children UK 2008). In particular, resistance by some actors should be anticipated (Gilson *et al*. 2003; Walker and Gilson 2004). Assessing the option also helps when planning the reform or could serve more directly to draft required legislative changes (Patton and Sawicki 1993; Witter *et al*. 2008). |
| 8. Early identification of accompanying measures is important | It is important to map out the required fixes to the system to mitigate identified adverse consequences and optimize benefits. Building on the example developed in previous good practice, it is crucial to plan additional drug procurement and staff deployment. This should be planned well in advance if the given time and budget allow. | Removing user fees in low-income countries will generate increased demand for health care. Therefore, depending on the context, some accompanying measures like increasing health workforce numbers and motivation, and fixing broken supply chain management, can contribute to the success (Gilson and McIntyre 2005; Save the Children UK 2008; Witter *et al.* 2008). |
| 9. Involving key implementation actors in the formulation stage is crucial | Actors whose co-operation will be required in the implementation stage should already be involved when designing the policy. Their early-stage participation can help to design policies that are realistic and workable. Co-production will create a sense of co-ownership and consolidate the commitment of all actors involved to make the reform a success. | Most authors present the importance of having actors contributing to the formulation of the reform as a key element of success (Hogwood and Gunn 1984; Saltman 1997; Gilson *et al.* 2003; Walker and Gilson 2004; Green 2007; Save the Children UK 2008; Witter *et al.* 2008). |
| 10. It is crucial that the content of the reform meets preferences of key actors | To increase the likelihood of success, the reform has to be largely endorsed or at least accepted by the persons who will be responsible for its implementation. In the case of user fee removal one should look at incentives for the health staff and community participation bodies on the ground, as in many countries they draw benefits from locally collected user fees. | There is now plenty of evidence that implementers play a major role in the successful implementation, or failure, of a particular reform (Lipsky 1980). In order to succeed, a broad consensus on the reform is required, among all actors able to influence the implementation process (Saltman 1997; Gilson *et al.* 2001; Gilson *et al.* 2003; Walker and Gilson 2004; Green 2007; Kamuzora and Gilson 2007; Witter *et al.* 2008). Hogwood and Gunn (1984) argue that compliance from implementers is required. |
| **Programming and implementation** | | |
| 11. Sequencing reform elements is helpful | The sequencing of the reform is helpful, especially if top-down approaches are difficult to be implemented in the country. In a context where the implementation capacity is limited in terms of human, administrative and financial resources, it makes sense to test the reform first at a small scale to fine-tune it, before scaling it up. | Consulted authors are not unanimous on the idea of sequencing. Some, like Brinkerhoff and Crosby (2002), Gilson *et al*. (2003), argue that it can help fine-tune the reform. Patton and Sawicki (1993) mitigate this stance by adding that the time horizon is often compromised by elections. Others think that less distortion and resistance will be observed if there is a fast implementation process (Saltman 1997). Save the Children UK (2008) argues that the benefits of free care for all will outweigh the difficulties of an immediate large-scale implementation. |
| 12. Careful planning of implementation steps is crucial | If the reform process is to unfold smoothly, it is crucial that all tasks are specified in an appropriate sequence. In other words, the tasks required to guarantee reform success need to be clearly identified, the proper sequence of the tasks has to be set, and the responsibility for them should be clearly assigned to relevant actors. Ideally a plan should be drawn up. For example, an increased amount of drugs should be ordered 6 months in advance of the removal of user fees, and financial procedures should be explained to the implementers before the reform is enforced. | Many authors agree (Green 2007; Hogwood and Gunn 1984; Witter *et al*. 2008) that for a reform to succeed, there is a need to plan the implementation carefully in a series of logical steps. Saltman (1997) argues that 'the way the implementation process itself – i.e. the stage required to introduce the change – is conducted is a key element in achieving change'. |
| 13. Broad communication strategies targeted at different groups are crucial | A clear communication strategy should be put in place targeting different groups of stakeholders such as local authorities, health staff in charge of implementation, users and social workers. Various channels of communication should be used to inform and collect feedback on the proposed policy change. This feedback is an opportunity to fine-tune the reform or reinforce communication strategies to improve knowledge. | Many argue that both the public and health workers should be well aware of the policy vision, goals and practicalities of the reform before it is implemented (Hogwood and Gunn 1984; Saltman 1997; Gilson *et al.* 2003; Walker and Gilson 2004; Gilson and McIntyre 2005; Green 2007; Save the Children UK 2008; Witter *et al.* 2008). |

(continued)

**Table 2** Continued

| Good practices by stage | Description of the practice | Evidence existing on the importance of this practice |
|---|---|---|
| 14. Medium-term commitment to the budgetary burden is crucial along with a clear agreement among government and international partners | A clear agreement is needed among government and international partners on how to share the budgetary burden of the reform. Removing user fees means that someone other than the patient needs to pay the cost; furthermore, costs directly linked to the implementation process should be anticipated. | Most authors agree on this crucial step. Without (sufficient) funding, the reform will most likely come to nothing (Hogwood and Gunn 1984; Saltman 1997; Gilson and McIntyre 2005; Green 2007; Ridde 2008; Save the Children UK 2008; Witter *et al.* 2008). This is particularly important when the funding is expected to come from different sources, including from external donors as is often the case in low-income settings. |
| 15. Clear rules for transferring resources to health facilities to compensate for any income loss and to cover any new cost are crucial | Transparent and robust channelling of resources to health care facilities that compensate the income loss and cover any new cost is crucial. The allocated resources need to reach the facilities where the services are provided within a reasonable timeframe. Existing channels should be preferred over the introduction of new mechanisms. This includes defining appropriate pricing of services, channels for the transfer of funds and/or drugs, definition of decision rights . . . | The authors of this article are firmly convinced of the importance of this practice. Saltman (1997) and Opwora *et al*. (2010) insist on the use of existing mechanisms when developing a reform. Witter *et al*. (2008) recommend that 'average production costs are reimbursed for each provider type'. |
| 16. Technical leadership by the Ministry of Health is crucial | Political leaders should allow enough space for technical leadership by relevant officials in the line ministry. The different levels of management, i.e. the national and the district level, should have clear roles in the implementation of the reform. | A lack of technical leadership would leave plenty of room for inaction and the possibility of a reform tailored to the implementers' own preferences (Hogwood and Gunn 1984; Saltman 1997), possibly at the expense of the target beneficiaries. |
| 17. Capacity building is helpful | A strategy to build capacity and train people who have to abide by the new rules is helpful. If capacity building is needed, this should be carefully planned to ensure that sufficient capacity is built before the reform is enforced. | Although there may be a preference for implementing reforms that do not require additional skills (Saltman 1997), the introduction of a change in user fee rules might require some training and well-thought-out instructions. Yet, this has not been confirmed by the literature we consulted. |
| 18. A co-ordination unit of capable technicians with relevant decision rights is crucial | A co-ordination unit of capable technicians with relevant decision rights and the opportunity to meet regularly is a crucial asset for championing the implementation. One of the key tasks of the co-ordination unit could be to build consensus among stakeholders. In donor-dependent countries, this co-ordination unit could involve international technical assistants. | Gilson and McIntyre (2005) support this idea. The unit should have sufficient decision rights and expertise in order to have sufficient legitimacy (Saltman 1997). It should be able 'to adapt and revise the strategies used to maintain its direction towards its objectives' (Gilson *et al*. 2003) and act as a bridge between various stakeholders (Green 2007). |
| 19. It is crucial that the different actors abide by new rules | Many experiences have shown that a rational decision taken at policy level does not necessarily materialize. Policy managers should pay attention to enabling more effective implementation of the reform. Contracting parties have to comply with the contracts. In this context, timely supply of drugs by the central level, free provision of drugs to users, timely reimbursement of invoices, recruitment of new staff are among the items needed.<br><br>This may seem obvious, but, for user fee removal, questions such as 'Have problems like fraud, malpractice or weak commitment been observed, and if so, what actions were taken?' are not trivial ones in many low- and high-income countries. | Once a reform has been put on the agenda, the next stage is ensuring that it is implemented according to the original intentions (Saltman 1997). Stakeholders have to comply with the new rules (Hogwood and Gunn 1984). The policy needs to be implemented successfully to have a real impact on people's health (Save the Children UK 2008). For instance, user fee removal can be compromised by tardy delivery of drugs or irregular disbursement of funds by the Ministry of Finance (Witter *et al*. 2008). |
| **Monitoring and evaluation** | | |
| 20. Monitoring and evaluation of the reform across levels is crucial | Monitoring and evaluation of the reform across levels is crucial to follow up implementation problems and to check whether and how managers follow instructions. Implementers on the ground should also have access to the feedback loop to inform them on their performance and the overall progress of the reform.<br><br>Key output indicators for short-term monitoring could be the utilization rate, the disbursement rate, drug stock-outs . . . Longer-term evaluation is also required and could include patient satisfaction, the financial procedures, the quality of care provided . . . | Weak monitoring of policy reform is a frequent problem in low-income countries. However, as Lipsky (1980) has shown, reforms implemented in a top-down manner will often be transformed by street-level bureaucrats. Furthermore, unforeseen issues can arise that impede the enforcement of the policy. Therefore, reform managers must monitor progress and propose additional adjustment steps when necessary (Saltman 1997; Gilson and McIntyre 2005). If implementers are not kept informed of the progress, their commitment to the reform might falter (Gilson *et al*. 2003). Funders also need to be encouraged to sustain their commitments. Providing process and outcome results could play a role in this (Witter *et al*. 2008). |

helpful; then we describe the practice; and finally we discuss the current evidence on its importance based on our review of the literature.

## Context

For the purpose of this review we studied the context at three levels: the global context (or more accurately, features linking the country to the external world); the national context outside the health sector; and the national health sector context. When analysing the global context, we tried to pinpoint any contextual element external to the country that may have had some influence on the user fees policy. Some factors are obviously shared by many LICs in sub-Saharan Africa (e.g. the drive to achieve the Millennium Development Goals, the Abuja Declaration, the significant influence of donors in public health policies . . .). At the national level outside the health sector, we looked at macro-economic, developmental and governance indicators as well as at the political system and socio-cultural aspects. At the health sector level, we studied the actual architecture and constraints of the health system by analysing governance, human resources, health financing, medical supplies, infrastructure and information management (WHO 2007). We also tried to identify recent or current reforms, including decentralization processes and their outcome, to examine to what extent they interacted with the proposed user fee reform. Several findings of the review confirmed the importance of the context, for example, the role of the Highly Indebted Poor Country Initiative or the influence of political elections (Meessen *et al*. 2011a, this issue).

## Content

We found it important to pay attention to the content of the user fee removal policy package and its objectives. We adopted an approach that focused on institutional arrangements, here defined as 'the contractual relation or governance structure between economic entities that defines the way in which they cooperate and/or compete' (Williamson 1996). The underlying view, drawing on New Institutional Economics, is that contracts set incentives which determine the behaviour of the actors. Accordingly, a health care reform was defined as an intentional change of institutional arrangements shaping the provision of health care services. Our aim was to observe the institutional arrangements at three different points of the reform process: before the reform, when conceived by the policy makers (the formulation stage) and after implementation.

The content was summarized in two main institutional arrangements: the implicit contract between the government and the users (the entitlement to a free benefit package) and the contract between the government and the health facilities (the 'resource contract'). For the contract between the state and the users, we looked at the population and services covered (WHO 2008) and the funding sources. This was particularly useful at the cross-country comparison stage (see Meessen *et al*. 2011a, this issue). For the contract between the state and the providers, we looked at how the health facilities could access key resources (drugs, human resources, items required for general functioning and cash), but also at the actual discretion that health facility managers had to allocate these resources. For each arrangement, we paid attention to differences in contracts for different providers and settings (like rural and urban settings). We also examined how changes in the contracts affected the behaviour of the actors. In several countries we collected information on health staff coping mechanisms; for instance, in some settings, vagueness in the definition of the benefit package (e.g. when does the delivery actually start?) offered staff some room for manoeuvre to claim payment from the users (Ridde *et al*. 2011, this issue) or conversely allowed managers to widen the eligibility criteria (Nimpagaritse and Bertone 2011; Ridde *et al*. 2011, this issue).

In terms of data analysis, it was expected that comparison between the 'before' stage and the formulation stage would allow assessment of the relevance of the reform package. Scrutiny of changes to different contracts between formulation and implementation would provide evidence on adaptations of the policy and provide insight into the capacity of the actors to correct errors in the policy design. It was understood that such normative appreciation would have to be based on public health and health economics knowledge. Such analyses inspired some of the feedback to countries (see, for instance, Noirhomme 2009).

This part of the framework was particularly useful at the stage of the cross-country comparison. A major finding of the review was the observation that different approaches, i.e. 'resource contracts', were adopted by governments of the six countries to remunerate health care facilities accepting patients for free (input- vs output-based payment; cash vs resources in kind, see Meessen *et al*. 2011a, this issue). These different resource contracts have very different implications in terms of incentives for providers.

## Actors

Interactions between policy actors and the other elements of the policy analysis triangle have already been identified in some of the hypotheses described in Table 2, see for example the

**Box 1** Example of actors in each group

**Individual citizens**
- **Users**
- Rural/urban
- Men/women

**Elected Officials**
- **State**
- President
- Members of Government
- **Local Government officials**

**Appointed Officials**
- Ministry of Health and other Ministry officials
- Ministry of Health's first-line staff

**Members of Interest Groups**
- Health personnel in any facility (public, private for-profit or private not-for-profit)
- **Donors and United Nations**
- **Civil society**
- Community participatory bodies
- Community health insurance
- International and national NGO
- Unions
- Religious co-ordinating body
- **Academic**
- **Media**

implication of stakeholders in the formulation or the need for broad communication strategies. A stakeholder analysis is an important part of effective actor management in a policy process because it allows pro-active consideration of actors' positions and power, which can influence policy processes to a great extent. In this study we did not have time to perform a state-of-the-art stakeholder analysis. Nevertheless we assessed who the key actors were, and broadly tried to map their positions and influence over the course of the process.

Actors were divided into four groups following Kingdon and Lemieux (as illustrated in Box 1) (Kingdon 1995; Lemieux 2002 in Ridde 2007): elected officials, appointed officials, members of interest groups and individuals. All actors who played a significant role in the process had to be studied. We tried to document their general influence in the policy arena, their stance on user fees removal, the role they played in this process and their possible response to it. Links with the context, content and process were explored to identify why these actors had that particular position at a given moment in time and how much it influenced the process.

### Impact

It was not the aim of this review to demonstrate causal links between the reform and certain outcomes. Nevertheless, we sought to provide some information on the impact of the reform at national, district and facility level, in order to link policy process aspects to outcomes whenever possible.

The framework listed a series of indicators to measure achievement of the stated objectives of the reform. We intended to monitor indicators of utilization, drug availability, quality of provided care, staff morale, user's satisfaction, household patterns of health care and health expenditure, budget allocation in the public sector, impact on existing community participation schemes and insurance schemes, and leadership of stakeholders and politicians. However, our hope to get access to evaluation reports or surveys clashed with the paucity of available documentation in several countries. With the exception of utilization rates, the indicators we initially listed for review were often not available or would have required specific study methodologies which were beyond the purpose of this review.

## Discussion

The current policy trend is towards the removal of user fees in the health sector in LICs to improve health outcomes and financial protection of the population. Researchers surely have a role to play in assessing the impact of these changes, and they have indeed done so to some extent (Ridde and Morestin 2011). Yet, they can also contribute to a better implementation of those policy changes by providing answers to the 'how' question.

This paper presents the framework developed for the UNICEF multi-country review. The framework was built on the existing policy literature and the professional experience of the researchers involved in the review. Its use in the field proved relatively easy and contributed to the production of new evidence on how to remove user fees in the health sector in resource-poor settings (see Meessen *et al*. 2011a and Ridde *et al*. 2011 in this issue). The framework finds a balance between putting good practice hypotheses to the test and more analytical descriptions. It was particularly helpful in identifying the strengths and weaknesses of the processes of policy formulation and implementation. It has since inspired a policy guidance note (Meessen 2009).

Now that we have used the framework successfully in the review, we are even more convinced that the use of good practice hypotheses is an effective way of strengthening knowledge on the policy process. It is useful to zoom in on a set of crucial aspects amid a sea of parameters that could have an influence on a policy process. As Patton (2001) rightly describes, good practices are only as good as the evidence that supports them, and their definition and applicability typically evolve in time and space. Out of the 20 hypotheses we developed, some are less supported by the literature, like the sequencing of the implementation in phases. Other hypotheses are supported by most authors, like the involvement of key implementation stakeholders in the formulation stage, the need for broad communication strategies and the importance of monitoring the reform. Still, other hypotheses could be reformulated. For example, the distinction between the two hypotheses on international and national evidence could be merged in one more comprehensive hypothesis. Another example is the relevance of separating 'the process of planning implementation steps' and 'the need to sequence the reform' in two distinct hypotheses. Obviously, the latter could be seen as a part of the former. Although these discussions are valid and should take place each time the framework is used, we suggest that delineating a (sub-)practice helps to draw attention to this practice.

The framework and its five elements were designed to be as comprehensive as possible in studying aspects of the policy process that are relevant for the user fee removal. During the review, it became apparent we did not collect everything we had planned in our framework. While keeping the framework in mind, researchers obviously tried to focus on aspects that were more relevant in the studied context. Conversely, they left some parts of the framework out or elaborated them to a lesser extent if they seemed less relevant. In our overarching analysis of the data from the six countries, we applied a flexible approach that acknowledged the diversity of experiences, but also revealed cross-cutting trends in the countries' political processes. Multi-country reviews can, by their very nature, reveal patterns across countries. For example, the review highlighted how different the compensation schemes for providers were across studied countries, and that governments often did not have a full understanding of the implications of their choices in this respect. Our recommendation that more attention be given to the contracts between the government and the providers during formulation, implementation or evaluation, capitalized on evidence on this particular dimension for six countries (see Meessen *et al*. 2011a, this issue).

A limit of this framework is the fact that it does not pay enough attention to the interaction between actors. The study design of the review did not allow for a state-of-the-art stakeholder analysis. However, the segmentation of stakeholders according to Kingdon and Lemieux, utilized in this framework, was useful as it allowed us to group key actors around potential similar interests or ways to influence the process

(Kingdon 1995 and Lemieux 2002, in Ridde 2007). In other words, it simplified the analysis of actors.

The research design and the limited time allowed for data collection did not help to identify causal links between compliance with a hypothesis and the final outcome of a reform. Another major constraint in the data collection process resulted from the weak monitoring and evaluation systems in place in study countries. For instance, very few data were available for assessing the impact of the user fee removal reforms. This reinforces our opinion about the need to complement quantitative data with qualitative data on policy process research in LICs.

Drawing on the literature and on the expertise of the authors, this framework contributes to building evidence in the field of user fee removal policy processes. It can probably be reused and adapted in similar or in slightly different contexts by consultants and researchers. Actors currently involved in the process of removing user fees in a LIC might also find some inspiration in it.

In an ex-post analysis of a policy process like this review, it is often difficult to document fully the process of policy change and the influences exerted on it. There may be little documentary evidence available, whereas interview data tend to be influenced by respondents' memory filters. Simply triangulating data in a country review can help to develop an understanding of the experience. However, multi-country studies of similar experiences allow for superior validation and knowledge-building, as they can test hypotheses on these processes.

## Conclusions

A policy reform in one country will never mirror a policy reform in another country. The institutional arrangements and the balance of power in any given environment will invariably shape both the process and the outcome of the reform. Nevertheless, reformers, policy makers and programme managers do follow some (implicit) rules or guidelines when they embark on reform. Some (health) policy practices seem to be relevant in all settings. We find them across sectors, across reforms and across countries.

Use of 'good practice hypotheses' is not a common approach to study the reform process in health policy, unlike in the field of management science for example. There, authors try to carefully formulate good practice hypotheses they have identified and then try to confirm them. Clinical medicine, too, tends to rely increasingly on evidence-based medicine to improve practice (Flores-Mateo and Argimon 2007). Even in public health, some past publications did identify key steps or good practices that increase the probability of success for a health financing reform (see for example Gilson *et al*. 2003;Witter *et al*. 2008). Without falling into the trap of making too normative judgments—each policy process unfolds in its own way—the study of 'good' policy practices can be a useful approach to link evaluation, and potentially research as well, to practice. The evidence collected through research and evaluation can then be translated into policy options and good practices which policy managers in the field should keep in mind. As we have seen in this study and in many others, good ideas are not always implemented fully and expected impact thus is not always achieved. However, LICs can ill afford reform failure in the domain of human development. Moreover, the Millennium Development Goals have also created a new dynamic where just about everybody expects swift results (Richard *et al*. in press). As shown by the current user fee removal momentum, countries move swiftly and they need assistance in the formulation and implementation of their bold decisions.

The urgency of the need questions the habits of many of us: empirical researchers, international agencies, editors of journals . . . National health experts in Ministries of Health in LICs engaged in a reform are often left to their own devices. Many years often pass by before scientific evidence is produced. Furthermore, when theories do exist in the literature, they are seldom accessible for the implementers. Language barriers and resource constraints evidently play a role in many LICs. More researchers should try to come up with readily usable and no-nonsense recommendations to improve the policy process even if these recommendations cannot be carved in stone for the time being. We may have to look for new collective models of generating and sharing knowledge to reduce the gap between researchers and other actors. In our opinion, more interactive models like communities of practice are a way forward (Meessen *et al*. 2011b). As researchers, one of our responsibilities will certainly be to guarantee enough scientific rigour when producing operational knowledge. Empirical validation and accumulation of case studies is a key approach in generating such knowledge. By using sound methodologies and being transparent and flexible about their use, the strength of the findings can be improved. Cross-country analysis is an underused strategy to generate knowledge and test specific findings across contexts.

The approach of this framework, combining the use of recommendations derived from the literature, expert opinions and multiple case studies to validate the proposed good practice hypotheses, seems a promising way to bridge the gap between scientists and implementers. In spite of obvious limits, this paper should be seen as a step towards research better suited to support strategic management in public health.

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None declared.

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