WANTED:
INCREASED HEALTH COVERAGE

FROM USER FEES TO FREE CARE: MSF'S EXPERIENCE IN LIBERIA

MEDECINS SANS FRONTIERES

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MSF IN LIBERIA

Médecins Sans Frontières (MSF) is an international, medical humanitarian organisation that delivers emergency aid to people affected by armed conflict, epidemics, health care exclusion and natural or man-made disasters.

The organisation works in more than 60 countries throughout the world and has been working in Liberia since 1990, when it began to provide emergency relief to thousands of internally displaced persons and refugees and support medical facilities throughout the country. MSF's priority in the last years has been to particularly address the urgent needs of vulnerable groups, such as women, children and victims of sexual violence.

In the capital, Monrovia, MSF provides free access to healthcare through support to two public health centres (Clara Town and New Kru Town), plus two private hospitals, (Island and Benson). Island Hospital is a 186-bed paediatric hospital in an overcrowded area of the city called Bushrod Island, home to more than 500,000 people. Benson Hospital is a 117-bed facility covering obstetric and paediatric services in the Paynesville area of the city. In fact, in 2008 MSF provided 80% of all the paediatric beds available - thus providing the majority of healthcare for children with serious health conditions.

At the end of 2007, MSF officially announced the start of a progressive handover of its different healthcare activities to the national authorities, to be completed by 2009-2010.

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LIST OF ACRONYMS

BPHS	Basic Package of Health Services
CT	Clara Town Health Centre
DHS	Demographic Health Survey
FBO	Faith Based Organisation
HC	Health Centre
HDI	Human Development Index
HH	Households
HIV	Human immunodeficiency virus
HSS	Health System Strengthening
IPD	Inpatient Department
LD	Liberian Dollar (exchange rate used in the report $1 US= 65 LD)
MCH	Mother and Child Health
MoHSW	Ministry of Health and Social Welfare
NDS	National Drug Service
NGO	Non Governmental Organisation
NKT	New Kru Town Health Centre
PA	Physician Assistant
PMTCT	Prevention of mother to child transmission
PRSP	Poverty Reduction Strategy Paper
SHI	Social Health Insurance
STD	Sexually Transmitted Disease
TB	Tuberculosis
UN	United Nations
UNDP	United Nations Development Programme
WHO	World Health Organisation

EXECUTIVE SUMMARY

Since 1990, MSF has provided primary and hospital care in various parts of Liberia. Our experience clearly shows that the provision of free healthcare is a key factor in ensuring adequate access to care for the most vulnerable groups of the Liberian population.

In Liberia, as elsewhere, MSF has witnessed the negative impact of charging patients for their healthcare. When patients have to pay they are excluded from the essential care they need, delay seeking care when they need it and resort to informal healthcare systems which can be of substandard quality.

Consequently, MSF ensures the provision of completely free quality healthcare in the projects that it runs in the Liberian capital, Monrovia. In its projects, MSF medical teams witness daily the tangible benefits of the provision of free care in terms of patient access and use of healthcare.

In 2006, Liberia's government suspended user fees for patients in its health systems. This was a welcome move.

However, recent assessments carried out by MSF in public health facilities in Montserrado County, reveal that many barriers continue to prevent the full provision of free care in Liberia. Although the Government of Liberia has shown clear commitment to improve access to healthcare for the Liberian population by suspending user fees at the policy level, this is too often not the actual practice in many health facilities. The MSF assessments reveal that free care is simply not a reality for the majority of patients using public health services today. Obstacles preventing patients to benefit from full free care provision include serious drug shortages at health facilities; a lack of staff to run the facilities; irregular payments of staff incentives; plus gaps in both the resources and the funding needed to run health facilities. Thus, even though the Government of Liberia has committed to free care and has increased its health budget, it is abundantly clear that further resources are needed to ensure that free care becomes a reality for patients trying to access health services.

Following almost twenty years of emergency medical interventions in Liberia, MSF will hand over the management of its health activities to the Liberian Ministry of Health and Social Welfare throughout the course of 2009 and 2010.

This report summarises MSF's experience in improving patient access to healthcare in Monrovia, with the objective of:

- contributing to improvements in the provision of free healthcare for the Liberian population today;
- providing additional evidence in favour of a policy decision to permanently suspend patient user fees.

For this to happen, it is essential that Liberia is effectively supported by international donors, UN agencies and NGOs. There is a consensus internationally that patients fees are inappropriate and must be abolished in order to accelerate progresses towards the MDGs. Recent commitments from several development agencies should enable the Government of Liberia to increase health subsidies, so that free healthcare becomes and remains a reality for its people.

INTRODUCTION

In 2003, the war in Liberia finally ended. 13 years of conflict had left behind a country in economic ruin and an extremely vulnerable population. The national health system had collapsed and the health status of the population was a major concern. After a transition period, elections in 2005 saw Ellen Johnson-Sirleaf voted in as the Head of State, bringing with her a new government that committed to improve the health sector and to offer a basic package of health services to its population. At the time, it was also decided that healthcare would be delivered to the population for free[1].

Recovery processes are long and in spite of these important efforts to improve healthcare, Liberia still has some of the world's worst health indices. The United Nations Development Programme (UNDP) Human Development Index (HDI) for 2008 ranks Liberia fourth from the bottom position. Life expectancy at birth is just 35 years; the infant mortality rate is 71 per 1,000 live births and the under-five mortality rate is 110 per 1,000 live births. The maternal mortality is 994 deaths per 100,000 live births, making Liberia one of the most dangerous places on earth for a woman to give birth. Despite a significant decrease since 1992-1996, Liberia's under-five mortality rate still ranks fifth highest in the world: one in every nine children in Liberia will die before his or her fifth birthday[2].

In 2007, MSF committed to maintaining a significant level of support for healthcare in the country until 2009-2010, when it will start handing these activities over to the Ministry of Health and Social Welfare (MoHSW). An important challenge of the handover is the availability of sufficient funding to ensure that patients continue to receive much-needed healthcare for free. MSF currently provides 80% of the total number of beds for children in hospitals in Monrovia. Crucially, 2009 is the year that Liberia's government plans to define its future health financing policy, with one of the options being to make permanent the current measure of suspension of user fees.

With this report, MSF aims at sharing its experience in Liberia and elsewhere to feed into the policy discussions on health financing and their impact on increased health coverage.

[1] Basic Package of Health and Social Welfare Services For Liberia, MOHSW, June 2008.

[2] Reviving health care in Liberia, M. Harris Cheng, the Lancet, April 2009.

MSF AND FREE HEALTHCARE IN LIBERIA: HIGH NEEDS, HIGH DEMAND

In Monrovia, MSF provides free healthcare to the population of Bushrod Island and Paynesville by supporting primary and hospital facilities and through a referral system. (see box on page 10)

MSF provides free services in line with the current user fee suspension at national level. Effectively this means that MSF provides the necessary financial resources to the two MoHSW supported primary care facilities and directly manages and runs the two private hospitals to guarantee that quality care, with qualified staff and necessary drugs, is delivered to patients free of charge. At both, primary and secondary levels of care, we see massive attendance by patients.

The need for free medical care is clearly illustrated by the activities in MSF projects:

- The supported health facilities (hospitals and health centres) receive large volumes of patients.
- The health facilities provide a high number of patient consultations.
- The number of patients visiting the heath facilities overwhelms existing capacity and as a result some patients are turned away.
- Overcrowding in hospitals means there are often several patients to a bed.

Financial barriers can deter patients from using health services and MSF has learnt from experience that the best way to respond to the health needs of a population is to provide the necessary subsidies to ensure that patient healthcare remains free of charge.

Primary health care

New Kru Town (NKT) and Clara Town (CT) health centres

There is a **high level of medical activities** in both MSF supported health centres. Together, they cover more than 10.000 consultations per month (2007-2008). A quarter of these consultations are for children under the age of five. The main diseases diagnosed in children are: respiratory infections, malaria, skin infections and diarrhoea and, for overall consultations, respiratory infections, malaria and STDs (sexually transmitted diseases).

In addition to serving the populations of NKT and CT areas**, the health centres attract patients from many other surrounding areas** almost halft of patients in 2007 and 2008. This is because quality health care is delivered for free to the population. Recent surveys in both structures confirmed that patients were not asked for money and also revealed good medical practice from the staff.

"I prefer to come to New Kru Town because there are always drugs and doctors here. In the health centre next to my house, doctors don't always come and there are no drugs"
A patient visiting New Kru Town health centre, from Iron Gate, a suburb located one hour from the health centre.

A survey carried out by MSF found that not having to pay was the number one reason for patients to come to MSF facilities[3]. This was confirmed by another recent assessment conducted in health facilities in the surroundings of CT and NKT. The assessment reveals that public health facilities often struggle to provide free care for patients. Although most of the facilities visited did not directly charge patients, a lack of drugs was often cited as the main reason why patients did not benefit from a full free care package. If the drugs are not available at health centres, patients have to buy them elsewhere or go without treatment.

"Patients also come to our facilities because neighbouring health facilities are not always able to provide free healthcare for their patients, as per the national user fee suspension measure. The Government of Liberia has made efforts to subsidise the healthcare system but in practice, what we see is that there are still some gaps in subsidy that prevent patients from fully benefiting from the cost free services. This risks excluding the most vulnerable"

Charles Okoth Menya, Head of Mission for MSF in Monrovia.

In order to offer care to the patients presenting, MSF has doubled the number of staff from initial levels and provides them with incentives. However the patient load still far exceeds this staffing level. With a daily limit of 35 to 40 patients per physician assistant, non urgent patients are sent home daily and asked to come back the following day if necessary. Consultation figures therefore are likely to underestimate the existing demand for healthcare and overall population health needs.

Sufficient subsidies to cover the cost of care are crucial to ensure proper implementation of free quality care. In the facilities it supports, MSF – not the patient – subsidises the cost of care : staff salaries and incentives, drug supply and medical material as well as the logistical costs of running the health centres. A 2008 estimate for required subsidies puts the average cost per curative consultation at $2.8 US[4]. Drugs and medical material account for 50% of the cost, and human resources for 44%.

Based on an average expected utilisation rate of one contact per inhabitant per year in the health facilities[5], a minimum subsidy of $2.8 US per inhabitant per year would be required to meet the costs of curative consultations and deliver it free of charge to the patients.

[3] Access to health care in Monrovia: Who are the patients attending the MSF clinics? Results of an assessment by MSF, November 2005.

[4] This amount was calculated based on National Drug Service (NDS) tariffs and consumption/use of drugs and medical material at CT in 2008. It also covers facility running costs, based on CT's 2008 expenses, and staff salaries and incentives according to the MoHSW salary grid. The figure is specific to costs per curative consultation, and does not include other health centre activities or investment costs. These figures are only indicative as they are calculated based on data from one health facility only.

[5] Based on existing WHO references in urban contexts.

Hospital care

Island and Benson hospitals

In 2007 and 2008, more than 12 600 children were admitted to Island (86% from Montserrado county) and more than 4000 children to Benson in each year. Island hospital admissions in 2007-2008 exceeded 1000 admissions per month. More than 5000 women delivered at Benson hospital in 2007 (22% complicated deliveries[6]) and more than 3000 in 2008 (admission criteria were restricted to targeted complications).

The main reasons for admission amongst the children were malaria (up to 40% of those admitted), lower respiratory tract infections, severe malnutrition, neonatology and anaemia, watery diarrhoea and TB.

Benson hospital seems to be increasingly relied upon as a referral facility for many clinics, both public and private. This can be explained by the fact that there are very few health facilities open on a 24 hour basis and offering free emergency obstetric care.

The number of beds of Island hospital had to be increased several times to meet the continuous increasing demand: from 147 to 167 beds in 2007 and then to 187 in 2008. The bed occupancy rate gives a sense of how busy the hospital is: in 2008, it varied between 90% occupancy, at its lowest level, to 130% at its peak. Benson hospital received a similar high level of admissions in its paediatric department[7].

"Island hospital gives good treatment and for free, while in other hospitals you have to pay and I don't have the money."

A 20 year old caretaker bringing her child to hospital.

The limited free-of-charge paediatric hospital services in Monrovia help explain the high number of admissions in the two MSF hospitals. (see box page 11)

In order to guarantee that free hospital care is available to patients, MSF subsidises staff salaries and incentives, drug supply and medical material as well as the costs of running the hospital. An estimate of the subsidies needed at Island Hospital in 2008 for the inpatient department (IPD) alone amounted to $57 US per patient admitted. This amount includes costs for drugs and medical material, human resources and logistics, but does not include investment costs. Drugs and medical material account for more than 30% of the cost and human resources for 46%[8].

With the expectation that 5% of the population is likely to be hospitalised in any given year, the subsidy needed for a population that includes 500,000 people under the age of 15, as is the case in Montserrado country, would be $2.85 US per inhabitant under the age of 15 per year[9].

[6] 5288 deliveries in 2007 at Benson hospital, of which 1155 were complicated deliveries.

[7] Benson hospital had a bed occupancy rate ranging between 80% and more than 100% for paediatric activities in 2007 and 2008.

[8] This amount is based on drug and material consumption, NDS tariffs, MoHSW salary grid and logistic expenses at Island hospital in 2008. Figures are calculated based on data from one facility only and therefore can only be considered as an indication.

[9] This calculation was determined as follows: In Montserrado county, out of 500.000 inhabitants under the age of 15, we can expect 25 000 admissions in a year (5% of the population). If the average cost per admission is $57 US, the total cost for admissions in a year would amount $1.425.000 US. This cost, reported to a population of 500.000 people in this age group, corresponds to $2,85 US per inhabitant.

MSF activities in a nutshell

Primary health care

Where:
Clara Town and New Kru Town health centres are located in Bushrod Island, Montserrado county, population over a million inhabitants. There is a total of 73 health facilities in Montserrado county, including 54 clinics, 9 health centres and 10 hospitals. 16 of these health facilities are fully run by MoHSW, 23 are supported by partner organisations (FBO/ NGO) and 35 are private.

Services provided:
Curative consultations; mother and child care (MCH) package including antenatal care, a 24 hour delivery room, postnatal care, family planning and vaccination; prevention of mother to child transmission of HIV (PMTCT); psychological support and medical treatment for survivors of victims of sexual violence.

Staff:
NKT health centre has 82 workers (including 35 medical staff). 39 are on MoHSW contract and the rest are volunteers receiving MSF incentives. CT health centre has 46 workers (including 21 medical staff). Of the 46 workers, 25 are on MoHSW contract and 21 are volunteers receiving MSF incentives. Additional MSF staff support both health centres in a supervisory, administrative and maintenance capacity.

Hospital care

Where:
Island Hospital is located in Bushrod Island, Benson Hospital in Paynesville.

Services provided:
Island hospital is a walk-in emergency paediatric hospital with a 186 bed capacity. It offers general paediatric medical care plus integrated nutritional care for severely malnourished children, psychosocial support and medical treatment for survivors of sexual violence. Counselling and testing are offered to patients with clinical suspicion of HIV infection or TB and positive cases and their care takers are treated.

Benson hospital is a 117 bed hospital performing exclusively secondary health care for children under 15 years old and emergency obstetric care for women. Since July 2008, only complicated and emergency pregnancies are admitted.

Staff:
Today, Island hospital is run by 207 essential medical staff, all under a MSF salary[10]. Benson hospital is run by 139 MSF medical staff members.

[10] This excludes support staff such as laundry and cleaning staff.

MONROVIA : LACK OF BEDS FOR SICK CHILDREN

With 265 paediatric beds in Island and Benson hospitals, the two MSF facilities account for 80% of the paediatric bed capacity in Monrovia. Between them, the two hospitals admit more than 16,000 children per year and ward beds are almost always at capacity, often with more than one child per bed. Apart from these two hospitals, there are about 70 hospital beds for children available for the entire city, of which only a few are located in heath facilities offering free care. This means that sick children have almost no other alternative for hospital care than the two MSF structures. However, during 2009-2010, MSF will progressively hand over its activities to the MoHSW. The only option found up to now has been to expand paediatric facilities at Redemption hospital (public hospital) up to about 100 paediatric beds. Even with this extension of capacity, a gap of at least 165 beds will remain. The MoHSW has planned for a longer term solution to increase the number of paediatric beds in the capital city, however shorter term solutions still need to be found urgently. The Government of Liberia (GoL) needs immediate support from its partners to increase paediatric care capacity and respond to the enormous need for paediatric care in the city right now. Substantial support from partners is also essential to make sure hospitals continue to provide free care. This means securing subsidies for staff, running costs and reliable drug supplies, which is even more challenging for hospital care than for primary care.

MSF'S OVERALL EXPERIENCE: FROM USER FEES TO FREE CARE

Until 2003, MSF implemented a variety of policies on patient financial contributions to health services within its projects. From 2003 onwards, experience in Liberia and elsewhere led MSF to adopt a clear position that in all its projects, healthcare will be delivered free of charge in order to cater to the needs of most vulnerable populations.

When MSF implemented user fees in the past, the organisation failed to ensure everyone had access to care and failed to reach the most vulnerable patients, in spite of the offer of quality care and improved exemption mechanisms. Based on this experience, it is now MSF's policy to provide medical care for free and to cover all patient costs. We are also committed to sharing this evidence to contribute to discussions on access to health and health financing in the countries where we work.

Liberia

When war broke out, MSF started working in Liberia providing free healthcare to population affected by the war. In 2001, when fees for healthcare were officially reintroduced in the public sector, MSF adopted the national recommendations of payment for healthcare in the health facilities it supported in Monrovia. This move saw a dramatic and sustained drop in patient attendance at MSF clinics in 2001-2002. Therefore, in February 2003 MSF moved back to a policy of free care, even before the official government announcement to do the same. This was a key lesson for MSF, and it has maintained a policy of free healthcare in all its projects in Liberia ever since.

The official reintroduction of user fees for healthcare in 2001 saw a fee for services, plus a flat fee of 25 Liberian Dollars (LD) and 10 LD for adults and children respectively to cover the cost of drugs. Although seemingly small amounts, the introduction of these fees saw a 40% drop in consultations at MSF supported health facilities.

Before the new fees were introduced a rapid MoHSW assessment had shown that 38% of households (HH) had said they would not be able to pay higher fees than the fees for services already in place. At the time only 1% of patients benefited from exemption.

When, in February 2003, MSF decided to drop all fees in the health facilities it supported, patient attendance increased to an average of 50 000 additional consultations per quarter. While the utilisation rate was 0.55 contacts per inhabitant in 2002, it increased to 0.78 in 2003 and reached 0.89 contacts per inhabitant per year for curative consultations in 2004. Surveys conducted during the same period by the NDS in some MoHSW structures in Montserrado county showed similar figures[11].

Other NGOs active at the time in the country also contributed to the implementation of the cost-sharing scheme (by introducing patient fees) and observed a similar negative impact in terms of decreased utilisation of services. They reached the conclusion that "cost-sharing in war torn countries can severely limit the access of populations to primary healthcare"[12].

These experiences show that the population's use of existing services is not solely dependent on health needs or the healthcare on offer, rather it is heavily influenced by having to pay for care. Even very small fees were revealed to be an obstacle for patients seeking essential care. Conversely, withdrawal of the fee system had a direct impact on the population's increased use of healthcare services.

[11] NDS monitoring report, 2002.

[12] Lessons learned. Fees for treatment and cost sharing in complex political emergencies: the case of Nimba county, IRC, Liberia.

The current national free healthcare measure could serve as a useful tool in documenting to what extent patients use free services, and the difference between the number of patients accessing healthcare at facilities that provide care for free and those facilities that require some form of financial contribution.

However the lack of reliable data for curative consultations and target populations per health centre is a major obstacle to comprehensive documentation of the benefits and drawbacks of free vs. paid-for healthcare. By reinforcing and validating basic data collection methods, national authorities and their partners could provide crucial evidence to help determine new healthcare policy.

Other contexts

In addition to evidence on user fees in Liberia, MSF has throughout its interventions in many countries gathered critical evidence on the negative impact of user fees and on the positive results obtained when care has been implemented free of charge [13].

MSF's research shows that user fees are the most significant obstacle for sick people to receiving timely lifesaving medical care. Transport costs, having to travel a long distance to health services and the unavailability of medicine in the health facilities are also contributing factors. In areas where people simply cannot afford to pay user fees, the consequences are disastrous. There are high levels of exclusion from healthcare and impoverishment, and patients resort to unregulated forms of medical treatment readily available on the market out of lack of alternatives in the public structures.

MSF's key findings on user fees:

- User fees dissuade people from coming to health centres for treatment.
- The people most excluded from health care are the poor.
- User fee-exemption systems based on individual socio-economic assessment do not work; although exemption systems exist in most locations, they are ineffective in protecting the poor and ensuring access to those in need of care. In contexts where many are too poor to pay, organised general exemptions for all patients or for broad groups like women and children reduce transaction costs, and are easier to organise and control.
- If a user fee system is in place, it is very hard to assess the real health needs of a population as it leads to underreporting of the burden of illness.
- User fees can impact negatively on the quality of care (because of incomplete or inadequate treatment when patients lack money).
- Even modest charges for primary health care risk further increasing the poverty of patients.
- The contributions patients living in poverty can make to financing their own health care are too small to be considered an essential part of health financing.
- MSF's experience shows a significant improvement in access to care when user fees are abolished. Utilisation rates rose significantly, surpassing 1-2 visits to the health centre per inhabitant per year in some contexts.

[13] Results from surveys carried in Mali, Sierra Leone, DRC, Haïti, Burund in: 'No Cash, No Care, How "user fees" endanger health'. MSF briefing paper on financial barriers to health care, March 2008. Available at: http://fieldresearch.msf.org

CHALLENGES TO THE PROVISION OF FREE CARE IN MONROVIA

Recent MSF assessment in Montserrado County (see box page 21) revealed that free care was not a reality for many patients presenting in public facilities: **only 25% of patients interviewed in MoHSW and NGO supported facilities had received a full package of free care in the facilities they visited.**

The majority of the health facilities did not formally report charging patients directly for fees for services or for drugs. However, one of the biggest obstacles to beneficiaries getting full free care in the facilities was the lack of drugs. This forced patients to either go without treatment or to buy drugs outside the facility visited.

Other elements essential to guarantee free quality care - such as sufficient subsidies to pay for essential staff and running costs - were also reported as "inadequate" or "insufficient" in several facilities. These gaps were found to limit free care implementation. Although partner supported facilities were less constrained than others, they also faced drug supply shortages, clearly limiting the availability of a full free care package for patients.

The fable of free care

Assessment results strongly contrasts with what was officially announced by the health facilities. In practice, in most of the cases, free care is not a reality for the patients: for patients coming to MoHSW structures, almost none benefited from a full free care package in the facility they visited, while in partner (NGO) health facilities, two thirds of patients did not get a full free care package on the spot.

- **20 out of 23 patients interviewed in MoHSW facilities did not receive full free care**. This is either because they had to pay directly for healthcare in the facility (6 out of 23 patients – amounts paid range from 10LD for registration to 500LD for deliveries and medication) or, for the majority (14 out of 20 patients), they had to leave the facility without full treatment because drugs were not available.
- **12 out of 19 patients interviewed did not get full free care in the NGO supported facilities they visited**. This is either because they had to pay directly in the facility (3 out of 19 patients) or leave without their full treatment because drugs were not available in the structure (9 out of 19 patients).
- **Patients interviewed in the faith-based organisation facility all paid fees for services and for drugs.**

These findings are in line with results from a recent satisfaction survey carried out by international non-governmental organisation Merlin in the facilities the NGO supports. Merlin reported that: " about a third (31%) of patients paid for the services with almost all clinics charging at least once. This practice severely affects accessibility of the services, and is one of the reasons for poor satisfaction level of clients"[14].

[14] Satisfaction Survey, Monrovia, Merlin, 2008.

Obstacles to full free care provision

Inadequate drug supply

There is a clear lack of drug availability, particularly marked at MoHSW facilities. Currently, the budget seems to be insufficient to support provision of free drugs to all patients visiting MoHSW health facilities. However, the health facilities supported by partners and using the NDS supply, also experience drug shortages. A task force comprising representatives of the MoHSW and partners has been set up to look into these constraints and find solutions.

- All health facilities visited, without exception, were out-of-stock of certain drugs at the time of the assessment.
- For the year 2008, four MoHSW facilities reported 11 months of stock shortages, and two reported five months of stock shortages. Most partner facilities reported no drug shortages during 2008, for the months preceding the assessment.
- In all MoHSW health facilities and in half of the partner supported structures, what was received did not correspond to the most recent drugs order placed in terms of type and amount of drugs.
- For MoHSW health facilities, the time between ordering and receiving drugs varies greatly while those facilities supported by partners receive their order one month after the request or earlier (probably because the payments are made directly and because of partner logistic facilities to collect the orders).
- At the time of the assessment, all the partner structures had received supplies within the last three weeks, while for MoHSW structures, the date of latest drug supply deliveries was much more variable ranging from less than one month to more than three months ago.

  Note: all health facilities assessed get their drug supplies through the NDS. MoHSW facilities benefit from the free drug programme and partners buy drugs at NDS.

There is an urgent need to increase the budget allocated for the supply of free drugs to MoHSW facilities. In addition, the management of the system needs to be reinforced to ensure patients have access to the drugs they need, on time.

Staff shortages :

- None of the health centres assessed had the minimum number of staff required and half of the clinics assessed did not have the minimum staff required[15].
- Many staff complain that incentives to top up health workers salaries were not provided on a regular basis.

MoHSW is currently working on securing funds for staff incentives. Partners should support these efforts. This is crucial to ensure the presence of motivated staff and guarantee that they do not charge patients to make a living.

[15] There is an official list describing the minimum staff required to deliver the BPHS at the various levels of the national health services.

Running costs :

> Facilities reported a lack of basic material and stationery and difficulties coping with fuel and transportation costs. This was particularly marked for facilities without partner support.

There is clearly a lack of funds to cover the running costs of health facilities. Sufficient support to the structures - financial or non-financial - is key. Additional budgets and logistics support should be available to cover these costs.

Conclusions and actions needed for full provision of free care

Although the government has already taken measures to improve healthcare access, important gaps still exist in terms of subsidy and other measures to guarantee that the Basic Package of Health Services (BPHS) can be delivered without cost to the patient. Gaps exist in essential staffing, drug supply and running costs for facilities.

Partners and donors must step in to fill these gaps, in line with the commitments they have made towards improved access to care and better health results.

For MoHSW structures, it means that :

> Additional funds are needed to guarantee adequate drug supply, to cover running costs of the structures and to recruit and ensure sufficient staff in each facility as well as regular payment of incentives.
> Mechanisms are needed to ensure that these additional funds will reach the structures and contribute to replacing all patient's payments.
> Complementary measures to improve drug supply should be looked into.
> Verification measures should be set up to make sure free care is correctly implemented in all public facilities.
> Monitoring of results should be reinforced.
> Management capacities at HC and county level should be reinforced.

For partner supported structures, it means that :

> Partners (and their donors) who support MoHSW structures should make sure they give sufficient subsidy to replace all patient's payments (covering drugs, staff and other running costs).
> Reliable drug supply should be improved.
> Verification measures of implementation of free care should be taken.
> Monitoring of results of structures should be reinforced.

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MSF assessment in Montserrado County

As part of the preparations to hand over its activities to the MoHSW, at the end of 2008, MSF carried out an assessment of 12 health centres in CT and NKT areas where MSF supported HCs are located. Its aim was to look into the way health centres were organised, and to identify the potential gaps and challenges to user fee suspension[16]. Although findings may not be representative of all health facilities in Montserrado county, they give an indication as to the current challenges to full implementation of the user fee suspension policy.

Out of the 12 structures assessed, half were MoHSW and half had "partner" support (five received support from an NGO, one from a faith-based organisation (FBO)). Six were clinics and six were health centres.

The assessment focused on services offered (range of services, staff, pharmacy and procurement), support provided (financial and non financial) and official cost of care.

In addition, in 10 health facilities patients were interviewed as they left the facility, to get information on drugs received and payment for care. Patients' records could only be collected in nine of the ten health facilities (four MoHSW, four NGO and one FBO) because one had no patients at all at the time of the visit, as they had run out of drugs several months previously. As both MoHSW and "partner" structures were included in the survey, results were analysed in order to differentiate between these two.

Considering the scarcity of medical data available in the health centres it has been very difficult to provide some basic outcome indicators like utilisation rates in the primary care facilities visited. This is a clear weakness in the current reporting system. There are ongoing efforts to reinforce data collection and monitoring. These efforts should be pursued because these data are key to the evaluation of current coverage of health services and for evidence-based policy.

[16] MSF decided to visit these health facilities to determine why a large number of patients were coming to MSF health centres at NKT and CT from outside of the direct target area. Other health facilities in Montserrado county were also assessed in order to have a relevant sample size: they included facilities in Central Monrovia and Careysburg areas and health centres previously supported by MSF such as Duport Road, Sonniwein and New Georgia Clinic.

USER FEES: AN UPDATE ON INTERNATIONAL POLICIES AND OPPORTUNITIES

Since the late 1980s health financing in many African countries has been largely inspired by the Bamako Initiative, which includes financial contribution of patients as one of its core principles. However, a review of health financing in low-income countries over the last 20 years has shown very negative results related to the introduction of user fees: they have demonstrated to be an ineffective, inefficient and inequitable health financing mechanism. There is a clear consensus today in the medical community that user fees and other out-of-pocket expenses have harmful effects on healthcare use, especially for the poorest households, and are therefore not an appropriate financing mechanism for health services in developing countries[17].

In addition to the risk of pushing already vulnerable people into poverty, user fees deter people with serious illness from seeking care. As a result public health services have been unable to respond adequately to the health needs of the population they are supposed to serve.

The Millennium Development Goals (MDGs) brought health onto the international agenda with ambitious mortality reduction objectives. These objectives will not be reached if millions of people remain excluded from essential health services. For many countries in Sub-Saharan Africa, where vulnerable people bear the burden of high morbidity and mortality rates, reaching the MDGs remains a pipe dream.

"User fees for healthcare were put forward as a way to recover costs and discourage the excessive use of health services and the over-consumption of care. This did not happen. Instead, user fees punished the poor. WHO estimates that, each year, the costs of health care push around 100 million people below the poverty line. This is a bitter irony at a time when the international community is committed to poverty reduction. It is all the more bitter at a time of financial crisis."

WHO General Director, Margaret Chan, April 2009.

In this context and in an attempt to accelerate progress towards the MDGs, several African countries are taking the lead on implementing policies of removal of user fees for their population. Today, essential health services are free in many of these countries and the trend to remove patient fees in Africa has been gathering pace with a positive impact on population use of key primary care services[18].

While the introduction of user fees was strongly donor-driven, the initiative to remove them is being led by developing countries. The international community is slowly catching up with the movement launched by African states, with leading development agencies adopting a clear position to support governments wanting to remove user fees. These include the UK Department for International Development (DFID), the government of Denmark, the World Bank and WHO[19], and several others have adopted this position recently as well. During a recent expert meeting organised by UNICEF it was agreed that the organisation should recommend and support governments in developing countries to provide basic quality health services, free at the point of delivery for women and children[20]. A 2009 meeting organised by the European Commission on social protection for health reached similar conclusions on the need to eliminate out of pocket payments for children and pregnant women[21]. The action plan for the implementation of the Africa-EU strategic partnership also states that in order to reach health MDGs, basic fees for health care should be eliminated[22]

[17] James C, Hanson K, McPake B, Balabanova D, Gwatkin D, et al. To retain or to remove user fees? Reflections in the current debate in low and middle income countries, Applied Health Econ Health Policy 5:137-153, 2006. Ridde V, L'initiative de Bamako, 15 ans après, un agenda inachevé, HNP discussion paper 2004.

[18] Universal healthcare and the removal of user fees, viewpoint by Rob Yates in the Lancet, April 2009.

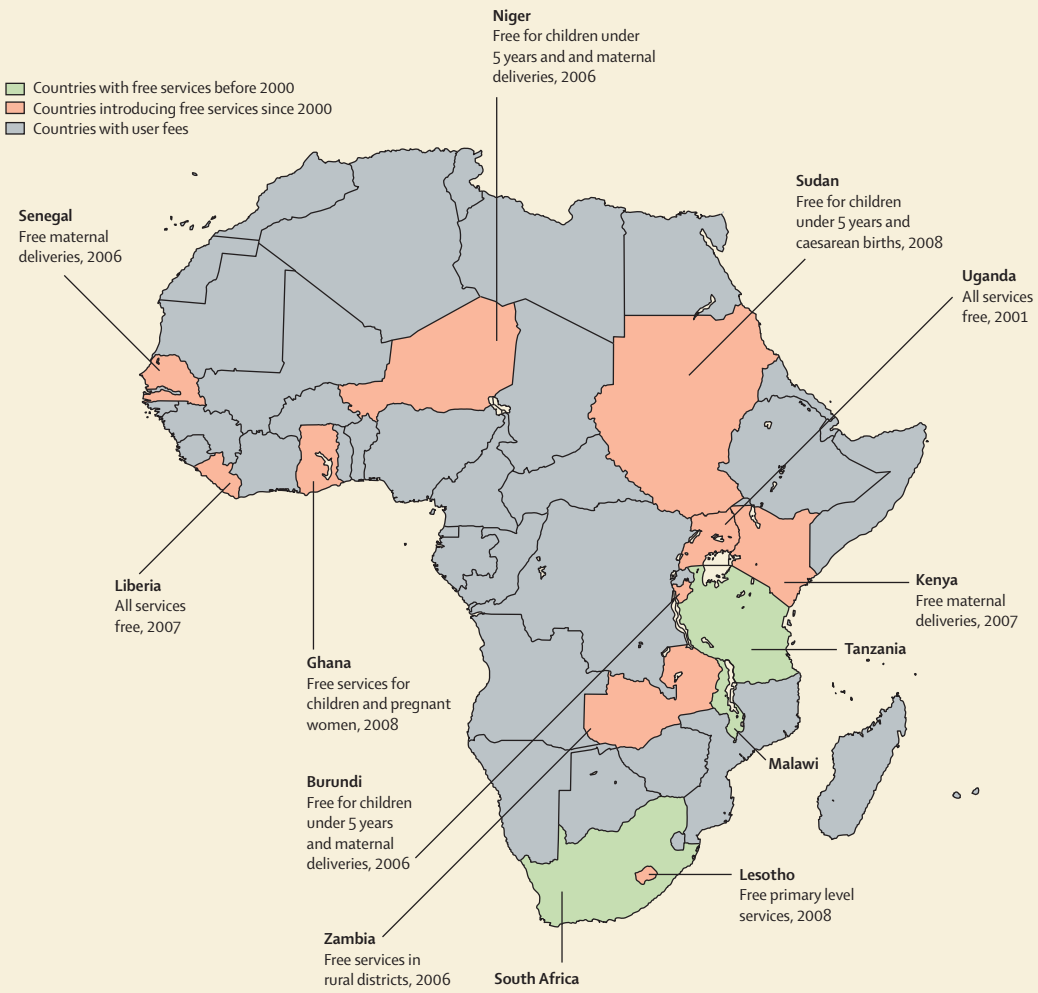
[19] Ibidem

[20] Health slips as the financial crisis grips, Lancet editorial, April 2009.

[21] Final report of Consultation workshop on financing of health systems and social protection in health in developing countries, Brussels, 23 – 24 March, 2009

[22] First action plan (2008-2010) for the implementation of the Africa-EU strategic partnership. Available at: http://ec.europa.eu/development/icenter/repository/EAS2007_action_plan_2008_2010_en.pdf

Map : African countries with and without user fees[23]



Recently several initiatives committed to the achievement of the health MDGs have also emerged. It is increasingly clear that the wider population, and vulnerable groups in particular, must start using essential health services if public health services are to contribute to reaching the health MDGs.

Free quality services for women and children at the point of use and other barriers removed

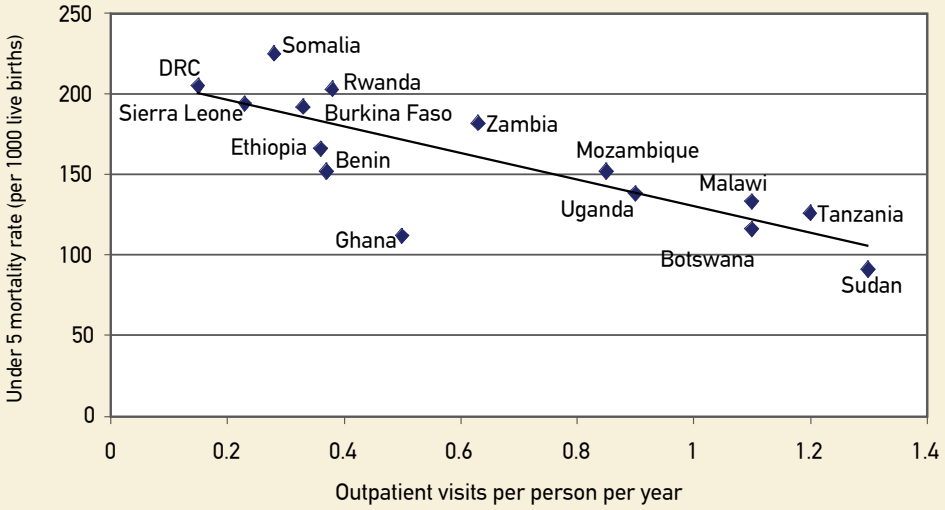
"In many high-burden countries, women face many barriers to accessing health care, including financial, geographical, social and cultural barriers. Key barriers include the distance from the household to the health facility and the costs involved, both in terms of transport and using services. Fees may be formal or informal[...] Evidence is now mounting for the efficacy of a package of free quality services at the point of care to overcome the inequity that fee-for service inevitably breeds. This is one effective, evidence-based and equitable way to expand access to services to a greater proportion of the population"

The Global Campaign for the Health Millenium Development Goals 2009[24]

[23] Universal Healthcare and the removal of user fees, viewpoint by Rob Yates in the Lancet, April 2009.

[24] The recently released report "Leading by example- Protecting the most vulnerable during the economic crisis" provides an update on the efforts being made by countries and institutions in protecting women and children duriung the global economic crisis. It includes contributions from Ban Ki-moon, Secretary-General of the United States; José Manuel Barroso, President of the European Commission; Ellen Johnson-Sirleaf, President of Liberia; Margaret Chan, Director General,WHO; Robert B Zoellick, President of the World Bank Group.

MDGs- the importance of consuming services Under 5 Mortality Rate
VS Total Outpatient Utilisation In Selected African Countries[25]



One approach to increase general utilisation of health services is to make health systems more equitable and effective. Putting more money into health system strengthening (HSS), could be an excellent opportunity to eliminate the financial barriers related to user fees. In particular:

- Increased subsidies to health systems should, as a first priority, replace revenues from patient user fees in order to open up access to available essential health services. If this does not happen, healthcare will remain financially inaccessible to many and therefore overall health status will not improve. If increased subsidies do not ensure access to healthcare, their impact will be limited and poor value for money.
- Subsidies that increase the availability of free-of-charge essential drugs in public health facilities will cause a major increase in the number of patients seeking care and will reduce out-of-pocket expenses for patients.
- Subsidies to motivate and expand the health workforce eliminate the need for health staff to supplement low salaries with patient user fees.

Governments need to take responsibility for financing health systems in low-income countries. Complementary international funding will be necessary to strengthen health systems. Both Global Health Initiatives (such as the Global Alliance for Vaccines and Immunization GAVI, the Global Fund to fight AIDS, TB and Malaria and Providing For Health P4H) and bilateral donors (Pepfar, PMI, USAID, EU and others) have expressed their willingness to increase their support to health systems in order to strengthen and improve access to care.

Liberia – where the government continues to demonstrate its commitment to healthcare by increasing its domestic funding - could be an excellent case to put these fine principles into practice and move from rhetoric to action.

As international actors revise their positions on user fees, African countries like Liberia, which have already taken the lead in removing them, should receive the sustained support they need to improve implementation of these policies and consolidate them over time. The Liberian government has taken steps to turn commitment into action to improve population access to healthcare and increase health budgets and it deserves concrete support from partner donors and international agencies for implementation of its health policy.

[25] Graph presented by DFID, Sierra Leone round table on free care, Freetown, 2009

USER FEES AND HEALTH FINANCING IN LIBERIA

A quick history of user fees in Liberia[26]

Economic crisis and a government coup in the 1980s brought an end to a decade of free healthcare subsidised by the Liberian government. Although official government health financing policy did not change, health services started to unofficially charge patients to keep services running. When war broke out, many health facilities worked directly with donors and NGOs to provide free healthcare but by 1992, the European Union had reintroduced user fees in Monrovia. However, this user fee system failed to provide resources for the city's healthcare service because the population abandoned it in favour of the free health services that were offered in the camps in the city's outskirts.

A reduction in external funding in 2000 put pressure on the government to introduce fees for treatment. After a quick population assessment and intensive community mobilisation, fees for treatment were introduced in the country in 2001. However, in practice, 80% of the public health system was supported by international organisations, some of whom continued to deliver health care for free. As a result, Liberia thus had a hybrid healthcare system with marked discrepancies between donor-supported and unsupported government facilities.

As stability slowly returned to Liberia in 2003, the transition government officially decided that patient fees would be suspended until a newly elected government was formed. When the new government was elected in January 2006, health financing policy was a pressing issue. Soon after her election, President Ellen Johnson-Sirleaf made the pragmatic decision that healthcare would be free of charge for the still vulnerable population. That decision remains in place today. The entire population is eligible for free health care throughout the public healthcare system, within the limits defined by the Basic Package of Health Services. Only non-public health facilities are not affected by the decision.

At the same time, subsidy measures were adopted for health structures not supported by partners to cover the costs of drug procurement and incentives for healthcare personnel. In practice, the MoHSW allocates a grant through the "free drug programme" to the National Drug Service (NDS). This grant is used to finance drug procurement for the structures which do not receive external donor support. An additional budget is also supposed to cover the cost of incentives to complement MoHSW staff salaries.

[26] Primary data in this report are sourced from UNICEF multi-country study on abolition of user fees in the health sector. Noirhomme, M. Liberia country report, November 2008. MSF reports on its activities in Liberia are a source of additional data.

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THE LIBERIAN POPULATION TODAY: WILLING AND ABLE TO PAY?

Today, in Liberia, 76% of people live on less than $1 US/day and 90% of people live on less than $2 US/day[27]. "Poverty is pervasive [...] takes many forms, including low levels of income and consumption, poor nutrition and food security, low health and education indicators"[28].

Many households have a very low income, experience difficulties in coping with the cost of healthcare and risk falling into poverty as a result of paying for healthcare:

> At the end of 2005, MSF carried out a quick assessment of patients attending our supported primary health facilities[29]. MSF structures attracted a highly vulnerable population such as single mothers, displaced people, families with handicapped or chronic sick patients, and families with very low income. 36% of patients interviewed stated that they had no direct form of income, while the average income for the remaining patients was found to be very low (the average income was 0.30 US$ per person per day). The majority of patients had only eaten one meal the day prior to the interview. A third of the patients interviewed had debts, with 40% of them having health related debts. At the time, reintroduction of a 20 LD ($0.30 US) fee for service, just for registration, would in fact mean the need to spend an entire day's income. For the majority of the interviewed patients, free care was an important reason why they choose to come to the clinics.

[27] Interagency Health evaluation report, Liberia, 2005.

[28] PRSP report, 2008.

[29] 'Access to health care in Monrovia: Who are the patients attending the MSF clinics?' Results of an assessment by MSF, November 2005.

> Another recent survey was conducted in 2008 on health seeking behaviour and health financing in Liberia[30]. It reached similar conclusions, confirming that the population remains highly vulnerable.

The few people employed earned very low income of approximately 500 LD per month. 76% of households interviewed reported having food and income constraints. Households reported depleting savings, selling assets and borrowing to pay for basic necessities. The main coping mechanism reported if facing food shortages was to reduce the number of meals per day.

Respondents expressed a preference for seeking care from a formal health system mainly due to the availability of free services. Those who failed to seek care when ill reported that lack of money was the major barrier. The mean amount paid for care in urban areas was 552 LD. Households had to use coping mechanisms to cover healthcare costs. Such mechanisms (other than savings) accounted for 66% of sources used to meet medical costs. Respondents cited various constraints to accessing healthcare including loss of working time, reduced household funds and food and income shortages. These household level constraints were alleviated by the availability of free services. Interviewees suggested that the government should ensure free provision of healthcare for the population.

The report concluded that in the current context of Liberia, (re)introducing user fees was not an option given the level of poverty. Health insurance was not found to be a valid option due to the low capacity of the population to contribute to the cost of their healthcare.

Overall, the surveys revealed a very vulnerable population, extremely low levels of income representing a significant barrier to accessing healthcare, and those who do pay for healthcare running a serious risk of falling into a poverty trap.

Previous assessments have concluded that since some patients had paid for healthcare, their households had the capacity to do so. This conclusion is misleading for two reasons:

Firstly, these results are based only on those patients who were using the health facilities, and do not take into account households who do not visit facilities. The results therefore do not represent the entire population and are likely biased towards less vulnerable households.

Secondly, the results do not consider coping mechanisms adopted by the households to produce the necessary funds to pay for their healthcare. Assessments both in Liberia[31] and in other contexts[32] reveal that more than half of the households who pay for their healthcare risk further impoverishment by doing so. They go into debt, have to sell assets or reduce other basic expenses.

Such results should not be used without considering other elements including population data rather than health centre data only, existing levels of exclusion from care and their reasons, socio-economic indicators and risks of further impoverishment linked to payment of care.

[30] Community survey for health seeking behaviour and health financing in Liberia, June 2008.

[31] Ibidem.

[32] 'No Cash, No Care, How "user fees" endanger health'. MSF briefing paper on financial barriers to health care, March 2008. Available at: http://fieldresearch.msf.org

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State of the debate today in Liberia

A Zambian health expert recently suggested that, given the evidence of the negative impact of user fees on health systems and population health, we could now put this issue to rest and instead shift the debate to more substantive approaches to resource mobilisation[33].

In Liberia, a country with years of experience without user fees, this is certainly what the debate on health financing should focus on: how to make sure additional resources are available to avoid reintroduction of direct out-of-pocket payments by patients?

Two main options are currently under debate: maintain free care at point of use with additional government and donor resources to subsidise the system; or opt for indirect patient payments through membership fees towards health insurance schemes to create extra funding.

The first option – free care at the point of use – has been experienced in several African states and its positive effects have been documented[34]. The example of Uganda, where fees were abolished as part of a set of reforms to strengthen the health system, shows that the outcome of fee removal has been particularly beneficial for the poor.

[33] Putting the debate on user fees to rest: a call for focus on what needs to be done for equitable financing for health, Bona Chitah on Equinet: www.equinetafrica.org.

[34] Nyabonga et al, abolition of cost-sharing is pro-poor, evidence from Uganda, Health Policy and planning 2005.
Deininger and Mpuga, economic and welfare effects of the abolition of health user fees: evidence from Uganda 2004, World Bank policy research working paper.
Batungwanayo and Reyntjens, Impact of the presidential decree for free care on the health care in Burundi, Ministry of Public Health, Government of Burundi, 2006.

Regarding the latter option, to date, there is no evidence of the efficiency of such systems in Sub-Saharan Africa[35]. "In practice, although social health insurance is often raised as an equitable option for financing universal healthcare coverage, there is in fact limited or zero revenue from social security schemes in the African region. In countries such as Ghana, Tanzania and Rwanda, these social health insurance schemes are substantially financed through taxation or support from external resources. They therefore appear to be more hybrid tax-based systems with additional transaction costs that may be generating inefficiencies in resource use and allocation"[36].

In contexts of widespread poverty, where formal employment is very low and where general governance and management issues remain a challenge, implementing a new system of social health insurance would require enormous efforts, would probably lead to very low coverage and bring very limited additional resources for health financing.

Based on previous health financing failures, experts recommend today that when defining new approaches for health financing, governments and donors should primarily refer to evidence-based information: "All stakeholders should learn the lessons of the last 20 years and not advocate the roll out of inappropriate financing mechanisms in the world's poorest countries. As policy makers ponder how they are going to finance their health sectors to achieve universal coverage, they should ensure that important decisions are evidence-based. We need to see which countries made the fastest progress towards universal coverage and how they finance their health systems. All potential financing mechanisms should be rigorously assessed to ensure that they are effective, efficient and equitable"[37].

It is crucial that Liberian policy makers base their decisions on the existing evidence to choose the model that is best suited to the country. In the case of Liberia, we trust that the authorities will use all international evidence as well as its own country experience to strongly support the case for continuation of free care for its population, subsidised through increased national and international funding. Partner donors and agencies should not miss the opportunity to make their recent commitments of support a reality.

[35] Health insurances in low-income countries: where is the evidence that it works ? Joint NGO briefing paper, May 2008.

[36] Putting the debate on user fees to rest : a call for focus on what needs to be done for equitable financing for health, Bona Chitah on equinet : www.equinetafrica.org

[37] Universal Healthcare and the removal of user fees, viewpoint by Rob Yates in the Lancet, April 2009.

CONCLUSIONS

After years of war that led to the collapse of its health system, the Liberian government has, laudably, made health a priority over the past years, striving to increase the availability of basic health services and to ensure their free delivery to the population. These efforts have been followed by improvements both in terms of availability of services and access. However, the task remains huge and there are still important challenges to address in order to improve the health of the population.

With 90% of Liberians living on less than $2 US a day, the people are not in a position to pay for their healthcare. In Liberia, as well as in many other African countries, a free health service at primary and hospital level has proved to be key to ensuring patients are using health services when they need them. This coverage of essential health needs is crucial to reducing mortality rates - and in Liberia one child in nine dies before his or her fifth birthday.

Increased use of health services would lead to improvement of health throughout the country, but there are still important challenges ahead to make sure that patients are not deterred from using the services because of financial problems.

The government has increased its domestic funding of health care, and is maintaining its efforts in 2009. But inadequate drug supplies, poor staffing levels and insufficient salaries mean that there are still a number of obstacles preventing patients receiving a free basic package of health services. It is therefore crucial that:

- The current user fee suspension measure receives increased support from the MoHSW and its partners.
- The user fee suspension measure is confirmed into a health financing policy, with sustained support from partners.

As discussions will be held this year on the health financing policy, MSF urges the Liberian government to take stock of all the evidence and convert its free health care measure for patients into policy. For this to happen, it will be necessary for the government to be guaranteed full support from all its health partners.

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