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HEALTH & EDUCATION ADVICE AND RESOURCE TEAM
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The Free Health Care Initiative (FHCI) in Sierra Leone: real gains for mothers and young children

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Overview

In 2010 the Free Health Care Initiative (FHCI) abolished health user fees for pregnant women, lactating mothers and children under five. This was a response to very high mortality and morbidity levels among mothers and children and reports that financial costs were a major barrier to health service uptake and use by these groups. An Oxford Policy Management team conducted an independent review of the FHCI in 2014-2016. The findings are relevant to the future of this important initiative and to inform the rollout of current post-Ebola investments in Sierra Leone.

The FHCI took an ambitious approach to reducing financial barriers by introducing health systems strengthening across all pillars: governance, communications, monitoring and evaluation, drugs and medical supplies, infrastructure, health workforce, and financing. We examined the background to the policy, why it was introduced, how effectively it was implemented, whether it included the right interventions, how it affected other barriers faced by users, its equity effects, any unintended consequences and how to sustain the FHCI in the future. We also assessed whether the FHCI has contributed to saving for the target groups, and extent to which the initiative represented value for money.

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Key messages

1. An independent evaluation of the FHCI found it was very cost-effective, saving an estimated 561,500 – 594,200 life years during 2010-13, at a cost in the region of $420-445 per life year saved (see table).

2. The approach focussed on strengthening the core health system pillars and remains valid now. However, there should be more focus on quality of care (including implementation of the basic package and providing supportive supervision to staff) and engaging communities.

3. There should be a clear forward plan for the FHCI, including its leadership, how the FHCI will evolve, be financed and sustained. The Ministry of Health and Sanitation (MOHS) needs to continue to lead, but also forge stronger intersectoral partnerships. The strengthening of institutions, including the MOHS, is critical to the success of the FHCI.

4. We make recommendations for each of the health system pillars. One crosscutting suggestion is to develop a health financing strategy to provide clarity on future needs and resources, and how best to use them. Our fiscal space analysis can be one input.

5. For future policies, the MoHS and partners should plan evaluations prospectively and invest in stronger routine and periodic health and health system information.

Methods

As the FHCI was complex, dynamic and introduced nationally at one point in time, the study used a theory-based evaluation approach. Firstly, we developed a theory of change and then mapped possible information sources against each domain in an evaluation framework. We drew on mixed methods to populate the framework, triangulating between sources where possible. Analytical approaches included a time series analysis of national survey data to examine mortality and morbidity trends and draw inferences about the contribution of the FHCI to observed trends; modelling of impact using the Lives Saved Tool (LiST); and modelling of future revenues and expenditures for the fiscal space analysis. Other data sources included 137 key informant interviews at national, district and facility level in four districts; 48 focus group discussions at community level in four districts; extensive document review; analysis of routine information systems; and regression analysis.

Main findings

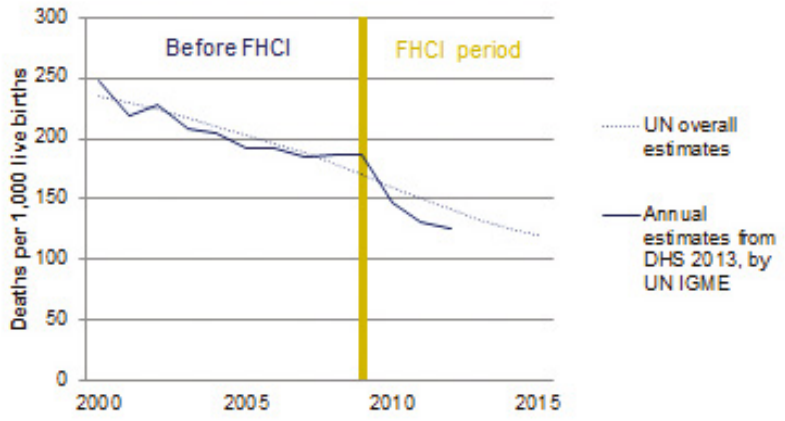
Real gains made in the health system

The FHCI triggered some real gains in the health system such as revitalised structures for sector governance; increased staffing; better systems for staff management and pay and for getting funds to the facilities. New monitoring and evaluation systems were introduced and facility audits conducted; infrastructure improved from very weak starting point; and a communication campaign was initiated with resulting high population awareness.

Increased health financing resources

More financial resources led to a prioritisation of Maternal and Child Health programmes and to some degree a switch from household to donor spending. Household spending as a proportion of total health expenditure went from 83% in 2007 to 62% in 2013. Donor funding went from a low of 12% in 2007 to a high of 32% in 2013.

Under five mortality rate



Source: modelled using data from the UN Inter-Agency Group on Child Mortality Estimation (IGME)

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Barriers to health care use decreased and health gains increased

Awareness of the policy is high and there is evidence that the FHCI contributed to: increased awareness of danger signs by the community; greater willingness to seek health care for children; and to a small extent, greater accountability on the part of services. There is evidence that user fees continue to be charged for a small but significant minority of the targeted population and access is still problematic in remote areas. The government needs to continue to focus on removing these barriers.

We have insufficient data to make conclusions about changes in maternal mortality. However, we found that the FHCI contributed to gains in under-five mortality reduction; increased coverage of MCH services; and improved equity of MCH service coverage, which were significant in absolute terms.

Support for the policy is widespread. However, focus group discussions highlight concerns about the state of the health care infrastructure, staffing levels, skills and attitudes, and medicine shortages.

Costs of the FHCI

The costs equated to an increase of an additional US$4 (2010) to US$ 6.2 (2013) per capita in government and donor funding for core items such as additions to payroll, drugs and performance-based financing. Broader indirect reproductive and child health expenditure added US$ 2.5 (2010) to US$ 8 (2013) per capita per year.

Recommendations

Our main recommendation is that the government and donors renew and strengthen their commitments in this area by deepening the reforms that were started in 2010.

Overall recommendations are:

Bring a relentless focus to bear on quality of care

Clear standards and protocols for the basic package should be developed and incorporated into training and supportive supervision.

Indicators to monitor technical quality of care are lacking and should be built into routine systems.

Indicators of responsiveness and respectful treatment should also be incorporated into surveys.

It would also be useful to repeat the Emergency Obstetric and Newborn Care needs assessment carried out in 2008 (UNFPA, 2008) in order to assess progress in key domains.

Address wider barriers to access and deepen decentralisation

Engage with communities, support transport to facilities, spread information about entitlements and the benefits of health services, and raise awareness of danger signs for women and children.

Build stronger intersectoral collaboration between the MoHS and other ministries such as the Ministry of Education, Social Welfare, and Gender and Children's Affairs.

Specific recommendations are:

On governance:

Invest in institutional development of the MoHS to steward the policy and health system, avoiding parallel systems and boosting planning and staffing capacity.

Develop a health financing strategy to provide coherence between the FHCI and other policy strands.

Institute better communication and planning between the Cabinet, MoFED and the MoHS in relation to the FHCI. This should include clear leadership on the policy and an agreed plan, based on projected needs and resources.

Introduce greater accountability and greater transparency to monitor performance.

Strengthen community engagement beyond civil society monitors and learn lessons from the Ebola experience.

On health financing:

Provide additional funds to the health sector to reduce out of pocket (OOP) spending, addressing the systemic problems with human resources and provisions of drugs and supplies.

Tax revenue collection is a priority and continues to require reform over the next 10 years.

There is some evidence that earmarked taxes could be supported.

There are not enough domestic resources to pay for the requirements of the FHCI, or universal health coverage, in the next 10 years so continued and increased donor support is needed. However, there is also a strong argument for improving public financial management to encourage on-budget external funding.

Provide more flexible financing to the local level, including revisiting the potential for strengthening of the public-based financing system.

There is a need for investment in improving data on health financing in particular, improved monitoring and evaluation for capturing the true costs of the FHCI; and improved methods for measuring OOP payments.

On monitoring and evaluation:
Develop and implement a robust and comprehensive monitoring and evaluation strategy for health. This should include the monitoring of the whole results chain (inputs, outputs, outcomes) and those areas where data have been weak such as quality of care, staffing, drugs and financing.

Increase the demand for and use of health information, particularly through health sector reviews and accountability processes.

On human resources:
Improve the management of the payroll, including decentralisation of human resource functions to the district level, to ensure greater responsiveness to district needs and a greater ability to performance manage staff effectively.

Human resource management capacity at central level should be strengthened.

Given the inequalities in distribution of staff and staff shortfalls in some key cadres, the MoHS should develop integrated and sustainable packages to retain qualified staff in remote areas and where there are shortages of particular workforce cadres.

Clarify the roles and funding of different types of staff and close-to-community providers, such as Traditional Birth Attendants and Community Health Workers.

Strengthen training institutions, revise training curricula, and assess staff competences to support continuous professional development among human resources for health.

Supportive supervision should be promoted and resourced.

On infrastructure, drugs and supplies:
Urgent investment is needed to bring key health infrastructure up to acceptable standards and maintain it.

Connect rural health posts with district hospitals and improve the referral system by reconditioning Ebola ambulances donated by aid agencies, and continuing to explore the feasibility of a national ambulance service.

Implement a 'pull' system for drugs across all hospitals and Primary Health Units.

Support the simplification of forms to be filled in by hospitals and Primary Health Units.

Build adequate storage facilities and ensure the Standard Operating Procedure Manual is implemented.

Allocate a fixed budget for the supply chain.

On communications:
A communications budget should be allocated at the very start of any future reform.

Communications need to be integrated across all initiatives and a longer-term approach to information, education and communication developed. Engaging the implementers and addressing their concerns should always precede communication with the public.

Resources

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Contact information: FHCI evaluation project manager: Nouria Brikci (nouria.brikci@opml.co.uk) or team leader: Sophie Witter (switter@qmu.ac.uk).