

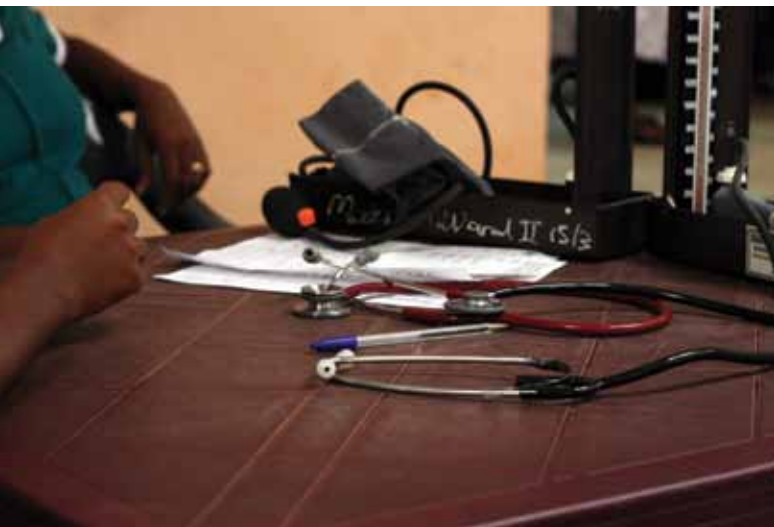


# MISCONCEPTIONS ABOUT FREE HEALTHCARE

# FREE HEALTHCARE IN SUB-SAHARAN AFRICA: CLEARING UP THE MISCONCEPTIONS

*This document introduces a series of nine evidence-based fact sheets showing how certain ideas about free healthcare repeatedly expressed in our knowledge transfer activities actually represent “lazy thinking”<sup>1</sup>.*

## INTRODUCTION



In 2010, the African Union called for full exemption from healthcare costs of children under five and pregnant women [2]. Post-apartheid South Africa pioneered this exemption in 1994. That initiative was founded on strong political will to make healthcare as widely accessible as possible, especially to the poorest. Since the early 2000s, a great many African countries have followed suit by instituting user fees exemption policies, or “free healthcare”, for certain categories of patients [3].

This far-reaching movement to reform health financing in Africa is part of the commitment to work towards universal healthcare undertaken by the General Assembly of the United Nations in December 2012. This radical departure from the widespread implementation of user fees in the 1980s has prompted the Director-General of the World Health Organization (WHO) to call universal health coverage the “single most powerful concept that public health has ever known”.

However, dismantling a user fees policy that has been in place for over thirty years is no easy task. In the first place, expanding free healthcare policies routinely leads to controversy, which generally arises when public policies are badly planned, underfunded, and poorly implemented [4]. However, in most cases, the continued reluctance to make healthcare free is based not on any scientific evidence, but rather on presuppositions, misconceptions and

particular ideologies around the very notion of free care. In September 2012, in a series of articles in which The Lancet highlighted the importance of eliminating user fees, economist Jeffrey Sachs referred to those ideas as “lazy thinking” based on less than rigorous reasoning [1]. The World Bank has also acknowledged that the high cost borne by healthcare users is one of the main causes of poverty [5] and has supported free care for women and young children in Sierra Leone [6].

In these fact sheets we take up the main misconceptions about free healthcare and provide recent evidence showing the benefit of eliminating user fees for patients. Our aim is to demonstrate, with evidence, that when free care is properly implemented, certain perceptions about the principle of free healthcare turn out to be misconceptions. These fact sheets show that this principle, among others, is essential to achieve the universal health coverage called for by the United Nations General Assembly.

Indeed, far from being a panacea, free healthcare makes access to health services not only a right, but a reality, and makes it possible to save lives. In Niger, the free healthcare policy, along with widespread distribution of insecticide-treated bednets and nutritional interventions, helped save 59,000 more lives of children under five in 2009 than were saved in 1998 [7]. In Burkina Faso, if

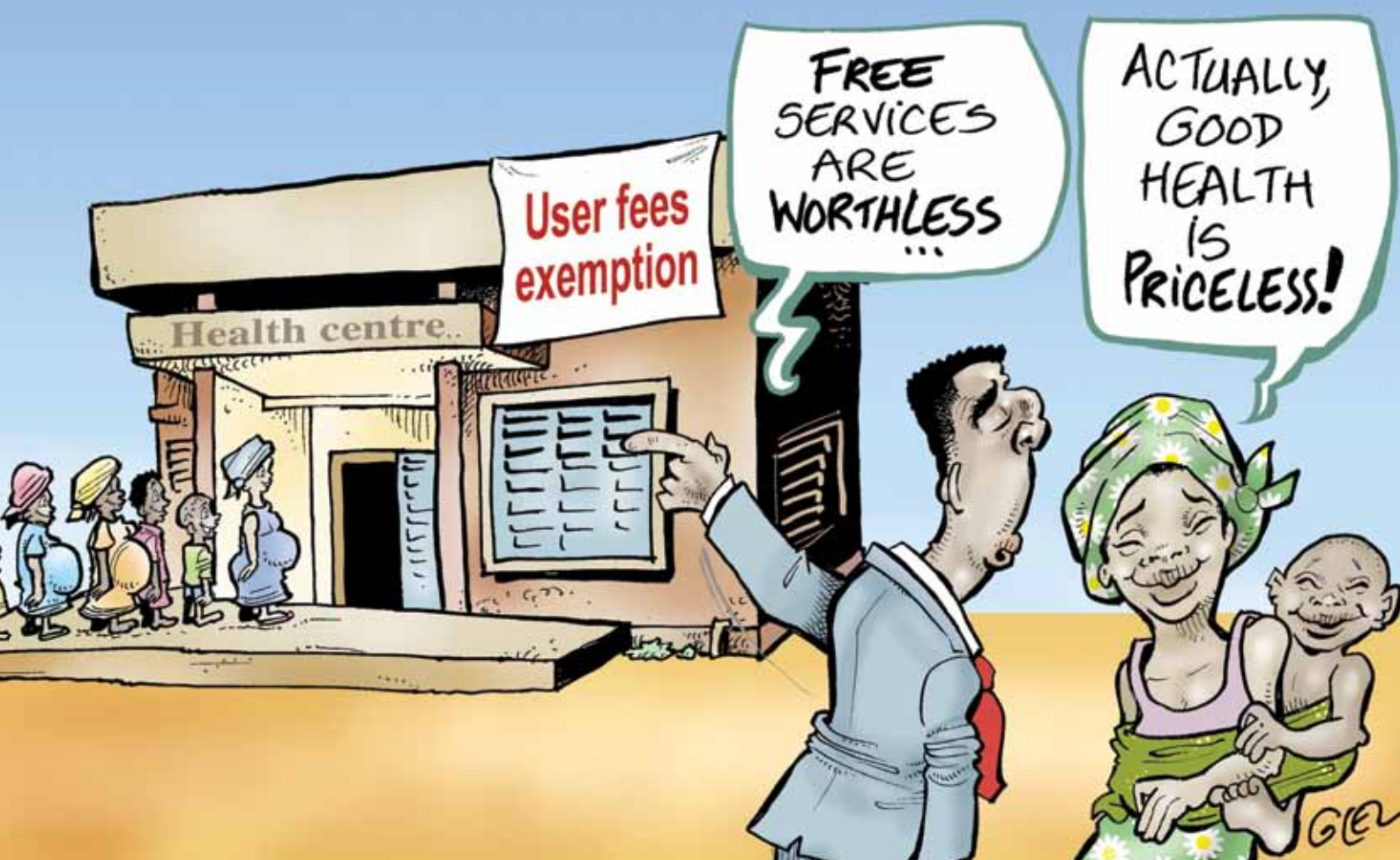
free healthcare were to be implemented nationwide with the same effectiveness as was achieved in two pilot districts, then in just one year it would be possible to save the lives of 14,000 to 19,000 children under five (100,000 children

**Rather than opposing the principle of free healthcare, the aim should be to strive for its effective implementation**

under five die every year in that country) [8]. Free healthcare will not solve all the problems facing populations and health systems, yet because it often serves to uncover malfunctions, it affords a real opportunity for health system improvement [9]. It is time for actors in the health system to consider the numerous studies showing that there is no evidence to support most of the commonly expressed ideas opposing the principle of free healthcare. More often than not, these misconceptions arise in contexts where free care is poorly implemented, underfunded, or not given sufficient political priority. **Rather than opposing this principle, the aim should be to strive for its effective implementation.** Indeed, whenever free healthcare has been properly planned, sufficiently funded, and implemented with targeted support measures, it has proven to be very efficacious and equitable.

<sup>1</sup> Sachs J. : *Achieving universal health coverage in low-income settings. The Lancet 2012, 380:944-947.*

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This series, **Free healthcare in sub-Saharan Africa: clearing up the misconceptions**, consists of nine fact sheets dealing with the following misconceptions:

**Fact Sheet 1:** "A financial contribution, however small, must be required!"

**Fact Sheet 2:** "Free healthcare doesn't benefit those who need it most!"

**Fact Sheet 3:** "Free healthcare takes away people's sense of responsibility and is not valued enough!"

**Fact Sheet 4:** "Free healthcare is substandard care!"

**Fact Sheet 5:** "Free healthcare is impossible because it creates excessive workloads for health workers!"

**Fact Sheet 6:** "Free healthcare will bankrupt health centres!"

**Fact Sheet 7:** "Making deliveries free will lead to more births!"

**Fact Sheet 8:** "African states are incapable of implementing free healthcare!"

**Fact Sheet 9:** "African countries can't afford free healthcare!"

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## MISCONCEPTION 1

**WRONG**

“A financial contribution, however small, must be required!”

We often hear that nothing should be provided for free and that every healthcare service should incur a fee, even if only a “token”. Yet extensive research shows that, however moderate the amount charged, it deters or strongly limits access to health services by people in general and the poor in particular [1]. In Kenya, 75% of children received treatment against parasites when it was provided for free, as against 19% when a “token” contribution of USD 0.30 was required. Other studies comparing the sales of “low-cost” health products (water disinfectants for USD 0.25 in Zambia, mosquito nets for USD 0.60 in Kenya) with free distribution show significant differences in the access to these products [2]. In Mali, free malaria treatments provided by

the State made it possible to provide care for an additional 30% of sick patients at a time of high malaria transmission, although consultation fees remained (€0.30 and €0.45). In one district where consultation fees were waived as an experiment and free malaria treatments were provided, three times as many patients were able to be treated [3]. In Burkina Faso (see figure on the next page), the national subsidy cutting the price of birth deliveries to 900 CFA francs (€1.37) in health centres increased their number by 40% to 120% depending on the districts within only a year. However, when free healthcare was implemented in certain districts, it enabled many more women to give birth in a health centre [4].

*Requiring any financial contribution, however small, restricts access to healthcare by the poorest. While there are other determinants of use (location, quality of care, etc.), the primary reason why patients do not use health services is that they cannot afford them.*



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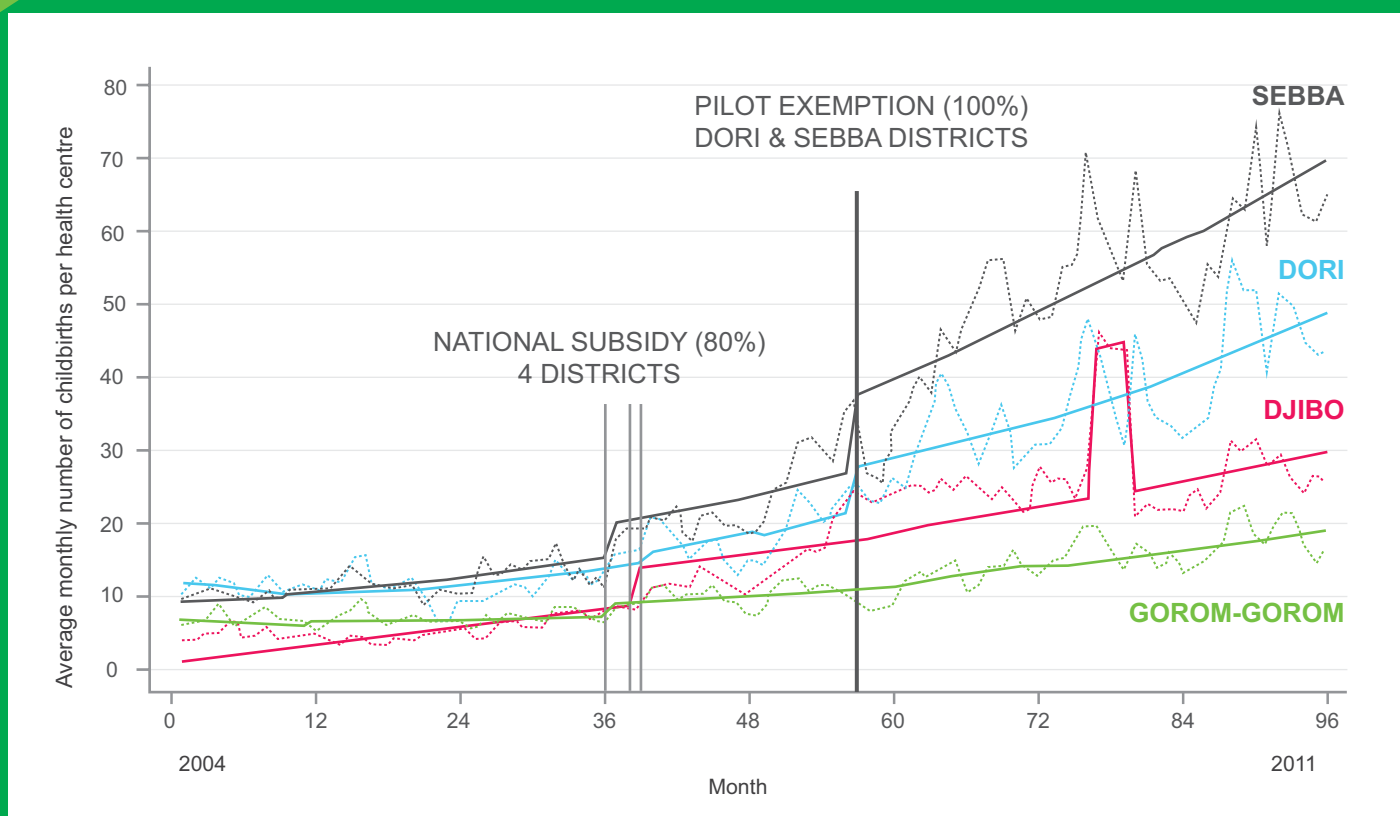
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<sup>1</sup> Sachs J. : *Achieving universal health coverage in low-income settings. The Lancet* 2012, 380:944-947.

## SUPPORTING EVIDENCE



**Figure:** Number of births in the health centres of the health districts of the Sahel region in Burkina Faso, from 2004 to 2011 (chronological baseline)



**Source:** Haddad, S., V. Ridde, Y. Bekele, and L. Queuille. *Increased subsidies for delivery costs translate into more women giving birth in health centres. Policy brief, 2011. UdeM/CRCHUM/HELP/ECHO: Montreal. p. 4.*

This figure shows the evolution in the average monthly number of births per health centre in the four health districts of the Sahel region in Burkina Faso from 2004 to 2011. The dotted lines show the average number of births registered. The solid lines show the average number of births predicted by regression models (i.e., after correcting for fluctuations over time and taking into account modifying factors). When the State implemented its national subsidy bringing the cost of deliveries down to 900 CFA francs (vertical coloured lines between the 36th and 40th months), the

effect on the number of births was immediate and dramatic in all four districts (visible “jump” in the curves of the following months). However, the effects of the switch to free healthcare implemented by a pilot project two years later (vertical black line at the 57th month) in the Dori and Sebba districts also produced immediate and significant effects. Free healthcare made it possible to lift barriers to healthcare access even further by effectively and equitably complementing the national subsidy.

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## MISCONCEPTION 2

**WRONG**

“Free healthcare doesn’t benefit those who need it most!”

It is widely assumed, including by public health experts, that universal coverage policies such as free healthcare for all primarily benefit the most advantaged social groups [1].

In Burkina Faso, a study found that the national policy of subsidising childbirth costs led to an increase in the number of deliveries in maternity units for all women, including the poorest [2]. Moreover, this subsidy reduced health expenditure in maternity units more markedly for the poorest women than for others [3]. In two Burkina Faso districts piloting free healthcare for children under five, it was proven that the subsidy benefited all children, rich and poor, whether mildly or seriously ill, and regardless of whether they lived near a health centre. For instance, poor and seriously ill children

living within 5 km of a health centre benefited twice as much from free healthcare as those who were less poor [4]. In Sierra Leone, three months into State-funded free care, 72% of poor children suspected of having pneumonia consulted a health professional, as compared with 63% of rich children [5]. In Uganda, several studies have shown that the poor benefited fully from free healthcare [6, 7], and even more than others [8] (see figure on the next page). Most recently, a study based on data from 35 countries showed that those that moved most quickly to improve coverage for assisted childbirth for all women were also those that were successful in reducing inequalities between the rich and the poor [9].

*The most advantaged populations (the least poor, urban populations, etc.) do not monopolize the benefits of free healthcare. The most disadvantaged profit from it just as much, and sometimes even more. Of course, free healthcare alone cannot be expected to correct all the existing inequalities in health systems.*

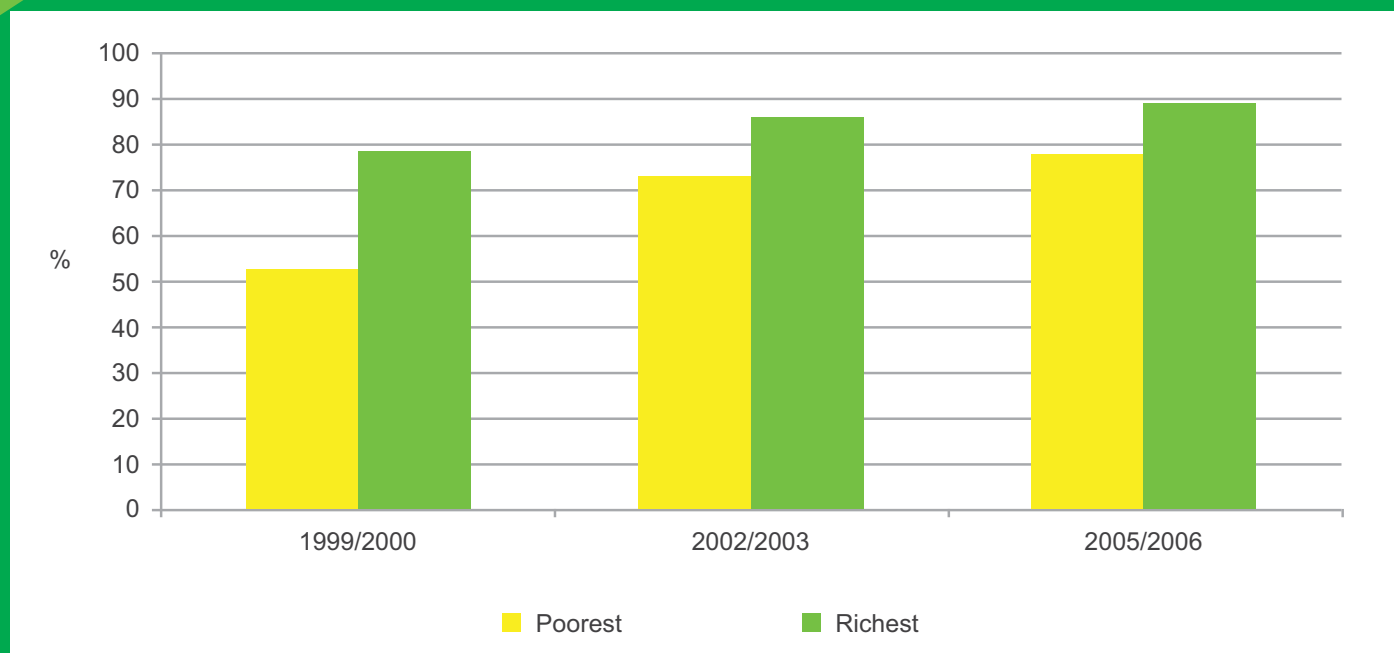


<sup>1</sup> Sachs J. : Achieving universal health coverage in low-income settings. *The Lancet* 2012, 380:944-947.

## SUPPORTING EVIDENCE



**Figure:** Proportions of the population having sought medical attention for an episode of illness in Uganda between 1999 and 2006, divided into socio-economic quintiles



*Source:* Uganda national Household surveys 1999/2000, 2002/2003, 2005/2006, adapted from [8].

This figure is adapted from an article [8] exploring the effects of free healthcare introduced in Uganda in 2001. It shows the proportions of the population that sought medical attention for an episode of illness, divided into socio-economic quintiles, based on data from three national population surveys conducted in 1999/2000 (prior to free care), 2002/2003 and 2005/2006 (after free care was implemented). The data show a reduction in inequalities of access

to health services over the studied period. The poorest population quintile benefited far more from free care than did the others. For example, among the poorest patients, the proportion who sought medical attention went from about 50% in 1999/2000 to nearly 80% in 2005/2006 (a multiple of about 1.6), whereas over the same period, the proportion of the richest patients only increased from under 80% to nearly 90% (a multiple of about 1.12).

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## MISCONCEPTION 3

**“Free healthcare takes away people’s sense of responsibility and is not valued enough!”**

Many people claim that free health care would take away people’s sense of responsibility by enabling them, for example, to abuse services. They also say it would encourage people not to value the services and products provided to them free of charge and/or to view them as substandard. Yet there is much scientific data proving otherwise.

Studies on HIV treatments provided by the Senegalese State have shown that free care helped make patients more responsible about following their treatment, thereby making the fight against HIV much more effective [1, 2]. For the same reason, tuberculosis treatment is free in many countries, including Senegal and Cameroon [3]. Experimental research has shown that paying or not paying for mosquito nets in Uganda and Kenya or for water disinfectant in Zambia in no way affects their levels of utilisation by populations [4] [see figure 1 on the next page]. People who pay for these products do not use them more than do those who receive them for free.

What is more, free care allows more patients to be treated and cured, thereby enabling citizens to play an active part in managing their own health. The aim of making prenatal consultations (PNC) free in most African countries is to establish links between pregnant women and midwives in order to encourage deliveries in maternity units [5]. In Africa, women who have had three PNCs are nine times more likely to give birth in a health centre than are those who have had none [6]. In Burkina Faso, in a region where a majority of the population is poor, a year after free care was introduced 80%

of sick children used a health centre vs. 30% when care was not free [7]. Even parents of sick children living more than 10 km away from health centres are flocking in to take advantage of free care (77% more than before) [7]. On the other hand, in Rwanda, where mutual health insurers continue to charge a fee at health centres, only 33% of sick children visit health facilities [8].

Most studies on free healthcare show that it produces an immediate, substantial and, above all, sustained increase in use of services, if properly implemented [9]. If people did not value free healthcare, attendance at health centres would decline over time. However, the situation is quite the reverse; free healthcare enables an increasing number of patients to be treated and cured, thereby restoring citizens’ confidence in the health system. Considering the high costs generated by illness, in addition to those incurred in health centres, it is both illogical and inappropriate to assume that people would devalue the care they obtain simply because it is free. All this was confirmed by a study on the perceived quality of deliveries, which compared the perceptions of women who gave birth in a Burkina Faso district where they had to pay with those of women in the neighbouring district where free care was being tested [10]. There was no difference in any of the three dimensions of quality studied: interpersonal relationships, care provided, and environment. In other words, the fact that the services were free did not negatively affect the women’s perceptions of the quality of the deliveries (see figure 2 on the next page).

*Free healthcare makes people responsible by enabling them to play an active part in managing their own health. People’s perceptions of the value of healthcare are not affected by whether the services are free. On the contrary, making healthcare free may serve as a strategy to bolster people’s confidence in health services and professionals.*

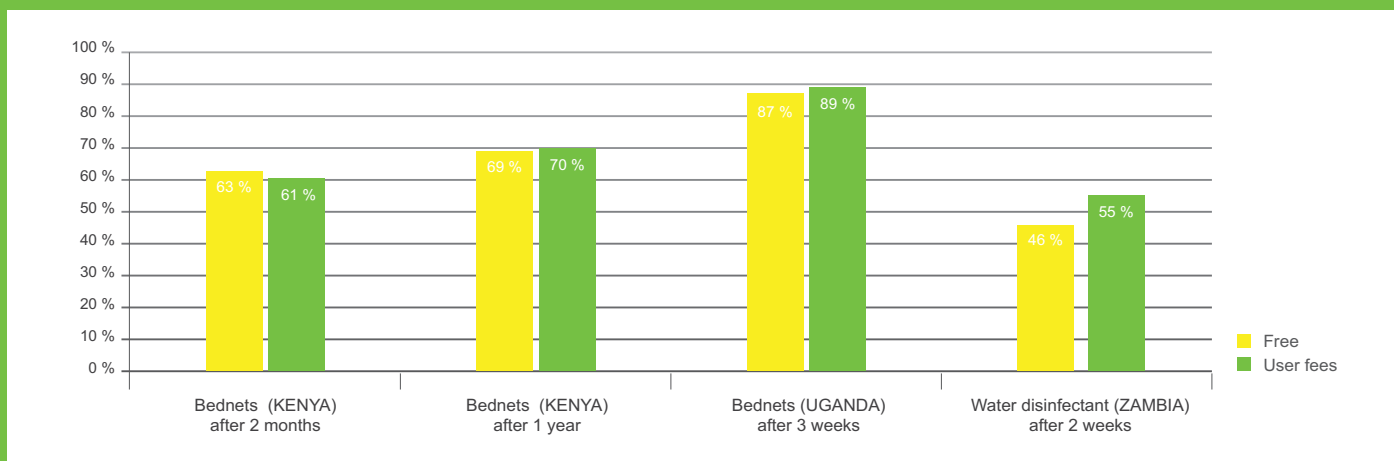
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<sup>1</sup> Sachs J. : *Achieving universal health coverage in low-income settings. The Lancet* 2012, 380:944-947.

# SUPPORTING EVIDENCE

**Figure 1:** Utilisation rates of recipients of free products vs. those who paid for them (effect of payment on use)

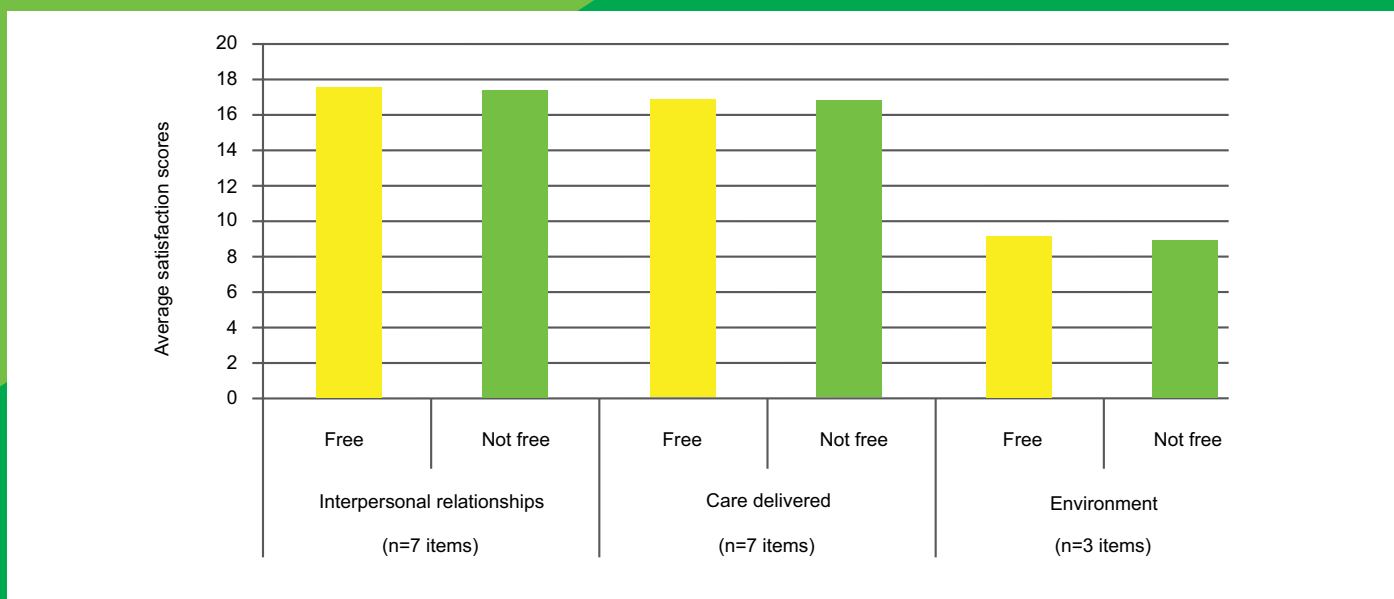


Source: <http://factsreports.revues.org/1301>

This figure is drawn from an article analysing the relevance of charging for health products and services in certain contexts [4]. The article reports there is “no evidence showing that someone who must pay for a product will use it more” (abstract, p. 28). Figure 1 presents the results from analysing the overall effect of price on product use (verification done by surveyors at beneficiaries’

homes). For instance, in Kenya, there was no significant difference between the 63% utilisation rate within two months for those who received a free mosquito net and the 61% rate for those who paid for it, just as there is no major discrepancy between the 69% and 70% rates after a year. This study showed that charging fees did not encourage product use.

**Figure 2:** Breakdown of average satisfaction scores into the three dimensions of quality under study in two districts (free deliveries vs. not free) in Burkina Faso



Source: Ridde V., A. Philibert, A. Bado and P. Fournier. *Les accouchements gratuits sont perçus de très bonne qualité par les femmes au Burkina Faso. Note d’information, 2012. CRCHUM/HELP/ECHO : Montréal. p. 4.*

This figure summarises the results of a quantitative study carried out in Burkina Faso, which compared the perceptions of quality of care among women who gave birth in a district where deliveries had been made free to those of women in a district that continued to charge fees [10]. The comparison of average scores between the two districts (free vs. not free) shows that there was no significant

difference for any of the three dimensions of perceived quality (interpersonal relationships, care provided and environment). Scores in the “environment” category are lower because they are based on only three questions versus seven in the two other dimensions.

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## MISCONCEPTION 4

**WRONG**

“Free healthcare is substandard care!”

Quality of care is a major issue for healthcare systems [1]. Some people are concerned about the negative effects of free care on care quality, caused in particular by the increase in the number of consultations for health workers, the excessive ‘freedom’ given to prescribers, stock shortages of medical products, etc. We have not found any research establishing a direct and quantifiable link between free care and a lowering of the quality of care. However some qualitative research does show, in Niger and Mali, for example, that when free care policies are underfunded and poorly organized, they lead to a lessening of quality in terms of the availability of medications [2]. But this low quality very often predates free care policies, and the deterioration can be explained mostly by poor implementation, rather than by the principle of free care itself. On the contrary, the principle of user fees does not necessarily improve the availability of medications. In Burkina Faso, for example, people must pay for antimalarial medications distributed by community healthcare workers, unlike in Mali, where they are free of charge. But in both places the same implementation and logistical problems arise that make the availability of these products very challenging and worrying. The quality of implementation of these policies is therefore central to achieving their intended objectives.

Thus, two studies were carried out in Burkina Faso on quality of care in a situation where free care was well implemented and where use of the services very greatly increased. The first study showed, contrary to this misconception, that the average durations of medical acts by healthcare workers in a district where care was free were not shorter than those in a neighbouring district where people still had to pay (12 minutes compared to 9 minutes respectively for curative consultations; 63 minutes compared to 62 minutes for deliveries; 15 minutes compared to 11 minutes for ANC (antenatal consultations)) [3]. The second study showed that medical prescriptions for care to children under five remained, with the introduction of free care, very close to WHO and State standards [4] (see table on the next page). The importance of accompanying measures and of the supervision of free care mentioned in that study was confirmed by research conducted in Senegal, where the free distribution of antimalarial treatments by community healthcare workers posed serious problems when no other measures were taken [5].

*Quality of care is a very complex concept. In the documented cases, the parameters studied do not demonstrate any deterioration in quality of care where free care is well implemented. They do show the importance of accompanying measures when free care is introduced.*



<sup>1</sup> Sachs J. : Achieving universal health coverage in low-income settings. *The Lancet* 2012, 380:944-947.

## SUPPORTING EVIDENCE



**Table:** Comparison of medical prescriptions for children in Burkina Faso before/after and with/without free care

Indicator	WHO standard	Prescriptions for children 0 to 4		Prescriptions for children 5 to 10	
		Before free care	After free care	Before free care	After free care
Use of antibiotics (%) (i)	< 50%	54%	53%	61%	71%
Use of injections (%) (ii)	< 17%	7%	8%	10%	10%
Average number of medications (iii)	< 2	2,26	2,19	2,3	2,2

*Source:* Atchessi N., V. Ridde, and S. Haddad, *Combining user fees exemption with training and supervision helps to maintain the quality of drug prescriptions in Burkina Faso. Health Policy & Planning, 2012. In press.*

This table shows the effects of free care on medical prescriptions for children under five [6]. This quantitative study with control groups (before/after and with/without intervention) showed that free care (intervention) did not lead to prescribers' deviating from quality standards set by the World Health Organization (WHO) and the Ministry of Health. The results for three of the indicators evaluated—i) use of antibiotics, ii) use of injections and iii) the average number of medications—showed no significant difference

before and after the intervention for prescriptions to children under five, and that this situation was no different in the control group of children from five to 10 years old (with the same prescribers). The average number of medications per prescription for children under five, for example, went from 2.26 before the intervention to 2.19 after the intervention (WHO and national standards: <2), whereas the average for children ages five to 10 years (control group) went from 2.2 to 2.3.

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# FREE HEALTHCARE IN SUB-SAHARAN AFRICA: CLEARING UP THE MISCONCEPTIONS

*This is the fifth in a series of nine evidence-based fact sheets showing how certain ideas about free healthcare repeatedly expressed in our knowledge transfer activities actually represent “lazy thinking”.*

## MISCONCEPTION 5

**WRONG**

“Free healthcare is impossible because it creates excessive workloads for health workers!”

Many of the people we spoke with expected that free healthcare would generate too high a demand for health services, which would create excessive workloads for health workers.

There is no denying that the substantial increase in patients’ use of services brought about by free healthcare increases workloads in health centres. Here, before going any further, we should celebrate, because this is in fact the primary outcome sought by this type of strategy, namely satisfying population needs by making healthcare accessible to the greatest number of people by removing the financial barrier at the point of service. More specifically, there have been very few studies producing objective information on the workload question. Health workers do, in fact, complain about this increase, which is real, and which they describe as “work overload” in several countries [1]. However, health workers’ reports of the average time spent providing free services in Burkina Faso and Niger systematically exceed the time measured by researchers [2, 3]. In

Niger, with only 1.4 nurse and midwife for every 10,000 inhabitants [4], there was a limited number of health workers to cope with the increased attendance generated by free care when funded by an NGO [3]. However, in a district where free care was organised only by the State, with many problems and therefore lower use, the number of health workers was sufficient [3]. In Burkina Faso, the State has invested in more health human resources: there are 7.3 nurses and midwives for every 10,000 inhabitants [4], i.e., five times as many as in Niger. Thus, in 2011, there were enough health workers to accommodate the demand, both in a district where fees were charged and where services were therefore less often used (less than one consultation per year, per child), and in a district where care for children under five and for pregnant and nursing women was free (almost three consultations per year, per child, for example) [2] (see figure on the next page).

*Measuring healthcare workloads produces varying results, which are closely dependent on context. Measurement makes it possible to distinguish between health workers’ perceptions of increases in workload and actual overloads. Most often, health human resources exceed the need. Therefore, the increased use of health centres generated by free healthcare makes the system much more efficient by using resources more effectively. If demand does grow to exceed supply, it is up to the health system to adjust to meet the needs that up to then were not recognized because of the constraints imposed by user fees.*

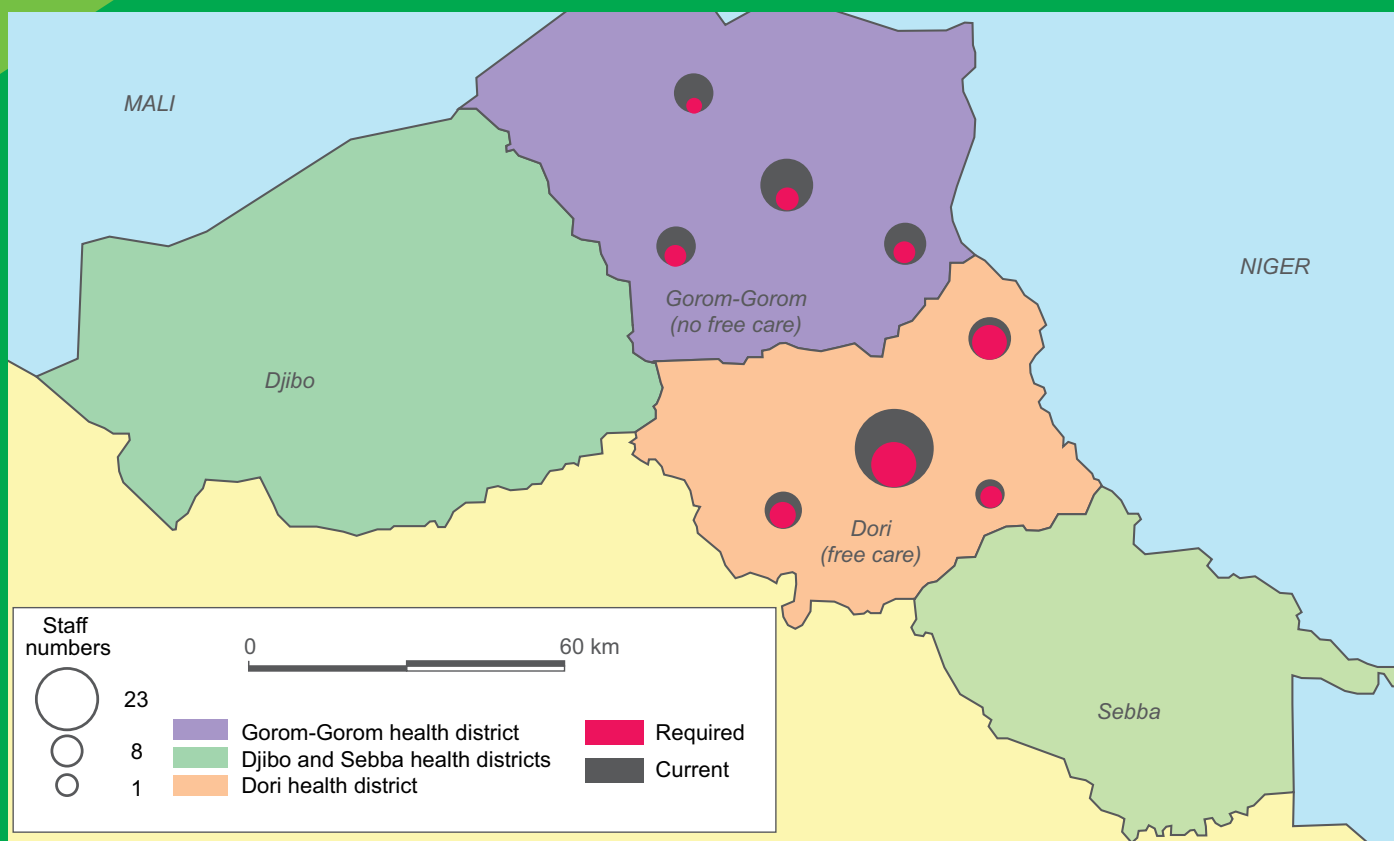


<sup>1</sup> Sachs J. : Achieving universal health coverage in low-income settings. *The Lancet* 2012, 380:944-947.

## SUPPORTING EVIDENCE



Figure: Current and required staff numbers in the surveyed CSPSs of two districts (free care vs. not free) in Burkina Faso



Source: Bonnet E., V. Ridde, S. Kouanda and A. Ly (BNDOT, 2009, IRSS).

This figure is taken from a policy brief [2] on the effects on health workers' workload of providing free healthcare for children under five and for pregnant and nursing women, as tested in a Burkina Faso district. The results of this study, based on qualitative and quantitative data (using the World Health Organization's Workload Indicators of Staffing Need method), show that the increase in workload brought about by free care is manageable by existing

health staff. As the map suggests, current health worker numbers in the Dori district (free care, black circles) exceed staff numbers needed to handle the substantially increased use of health services (red circles). In the Gorom-Gorom district (without free care), the gap between current and required staff numbers are more than sufficient to accommodate the low demand for health services.

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# FREE HEALTHCARE IN SUB-SAHARAN AFRICA: CLEARING UP THE MISCONCEPTIONS

*This is the sixth in a series of nine evidence-based fact sheets showing how certain ideas about free healthcare repeatedly expressed in our knowledge transfer activities actually represent “lazy thinking”<sup>1</sup>.*

## MISCONCEPTION 6

**WRONG**

“Free healthcare will bankrupt health centres!”

Health officials regularly contrast the principle of free health care against the major advantages of the Bamako Initiative, a health systems reform undertaken in the late 1980s [1]. Two of that reform’s strategic pillars were the implementation of a cost recovery (CR) system based on point-of-service user fees and community involvement in managing health centres and the newly generated funds. The revenues generated by CR were intended to renew stocks of essential generic drugs and cover certain operating costs (facility maintenance and repairs, community staff payroll, bonuses for health workers, etc.). CR also generated revenues that should normally have been used to improve healthcare quality and access, but which instead were most often simply hoarded. Community involvement took the form of local health centre management committees. Thus, free care is criticized as going against the cost recovery system and as putting health centre management committees at risk of bankruptcy and of being dismantled. From a theoretical perspective, the assumption that free care does not comply with the cost recovery system shows a poor understanding of the principle of free care. Of course, “free” health care does not mean nobody pays. It just means the service provided is not paid for by users, but by a third party (say, the State or an insurer) whose resources come from various sources (State, international aid, taxpayers). Therefore, free care is perfectly

compatible with the cost recovery system thanks to third-party payment. In fact, free care even produces a substantial revenue increase and generates additional resources for health centre management committees because of the marked increase in attendance. Obviously, if such a policy is underfunded and/or the third party fails to pay, cost recovery ceases to function, with disastrous effects on the financial situation of management committees. But this would be true, whatever the funding mechanism. This is in fact the situation in Senegal and Niger [2], but a principle cannot be assessed based on examples that failed to meet the most basic prerequisites. In Mali, a study has demonstrated that the national policy of free malaria treatment has had no negative effect on community finances [3]. Health centres’ financial assets remain substantial, averaging 2 million CFA francs (over €3,000). In Burkina Faso, while reimbursement based on the national subsidy is not flawless, it certainly has not made health facilities bankrupt. Health facilities receive the required amounts, sometimes late, but in sufficient quantities [4]. That said, the potential beneficial effects of free care at the community level are not only financial. Studies carried out in Burkina Faso have shown that free care also contributed to the empowerment of members of management committees, women, and indigents [5] (see film excerpts on the next page).

*Free healthcare is perfectly compatible with the cost recovery system. It helps financial centres expand their financial capacities, provided it is sufficiently funded and properly implemented with a third-party payer. It can also further empower members of health centre management committees and the general population.*



<sup>1</sup> Sachs J. : Achieving universal health coverage in low-income settings. *The Lancet* 2012, 380:944-947.

## SUPPORTING EVIDENCE



Watch on YouTube the documentary film: Payment exemption: a step towards universal healthcare - Pilot experiment in Burkina Faso: Equity - Frisque, J.C., K. Ametepe, L. Queuille, V. Ridde, and N. Marcellin. 4-minute film, 2011, Manivelle Productions/HELP/CRCHUM/ECHO: Ouagadougou.

### EXCERPTS



"Before free access to healthcare, sick children stayed at home, but now that it's free, everyone does benefit from the healthcare needed and it helps all the population".  
Adjaratou Diallo, recipient of health and social services



"If your five-year-old child gets ill, you think all night long : what could you sell to cure him?".  
Mamadou Dicko, COGES vice-president of Seytenga health centre

Source: <http://www.youtube.com/watch?v=GJH41jULht4&list=ULI9MTaaoFDeg>

For a deeper understanding, we recommend watching the film in its entirety. This 4-minute film summarises some results of evaluative research into a pilot program undertaken by the Sahel regional health department in Burkina Faso, with the support of an NGO, to provide free healthcare to children under five and to pregnant and nursing women. In this documentary, health workers, members

of health centre management committees, household heads and mothers explain the positive effects of free care at the community level: empowerment of women and households, strengthening of health centre management committees, and increased financial resources.

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# FREE HEALTHCARE IN SUB-SAHARAN AFRICA: CLEARING UP THE MISCONCEPTIONS

*This is the seventh in a series of nine evidence-based fact sheets showing how certain ideas about free healthcare repeatedly expressed in our knowledge transfer activities actually represent “lazy thinking”<sup>1</sup>.*

## MISCONCEPTION 7

**WRONG**

“*Making deliveries free will lead to more births!*”

Some people maintain that free deliveries will encourage more births and, as such, that this measure runs counter to the promotion of family planning. There is no evidence to support this notion, whereas a vast body of knowledge has shown quite the reverse. In Africa, deliveries are most expensive in urban areas, where birth rates are also the lowest. In Mali and Burkina Faso, women living in rural environments have an average of 7.2 and 6.7 children respectively, whereas those in the capital have only 4.8 and 3.4 [1, 2]. In Burkina Faso, Ghana, Senegal, and other countries, the downward trend in fertility continued even when deliveries were heavily subsidized or made free over the 2005-2010 period. Furthermore, it has long been known that education is among the most important factors influencing fertility, and that poverty slows down any decline in fertility [3]. Childbirth expenditures, and especially caesareans, can plunge the least well-off households

into extreme poverty [4]. We have already mentioned in this series of fact sheets (sheet 2) the lowering of health expenditures for the poorest thanks to the national subsidy of deliveries in Burkina Faso [5]. From a human rights perspective (see figure on the next page), but also on a strategic level, the concept of “risk-free maternity” is aimed at saving women’s lives through assisted deliveries by qualified personnel that facilitate the detection of complications, which occur in 15% of childbirths, and rapid referral to hospital for treatment. As explained in fact sheet 1, charging user fees for deliveries encourages home births, thereby limiting access to care that should be available to all pregnant women. Generally speaking, it is paramount to improve people’s access to information and sexual health services so that women may be in a position to freely choose to use contraception.

*Free healthcare increases the number of assisted deliveries by qualified personnel and ultimately saves lives. Free deliveries and family planning are complementary. Both deal with reproductive health, respond to health needs, are aimed at reducing poverty, and promote the enforcement of sexual and reproductive rights.*

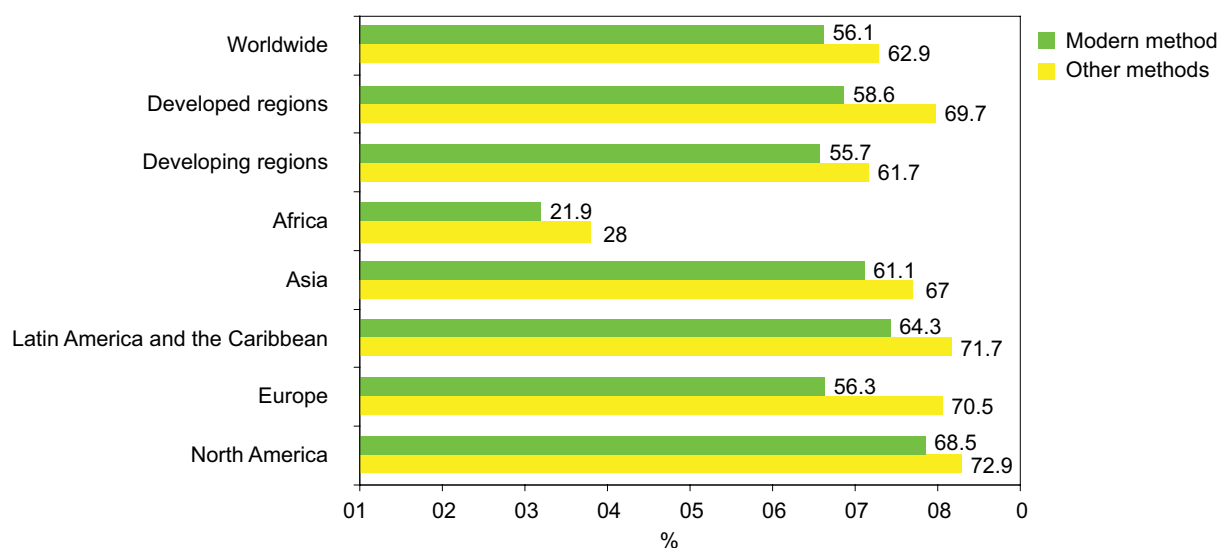


<sup>1</sup> Sachs J. : Achieving universal health coverage in low-income settings. The Lancet 2012, 380:944-947.

## SUPPORTING EVIDENCE



**Figure:** Percentage of women who are married or in common-law relationships using either modern contraception or any other method. 2007.



**Source:** World Health Organization. 2012. *Safe abortion: technical and policy guidance for health systems (2nd ed.)*.

This figure shows that the percentage of women using contraception in Africa is very low compared with other continents. Women's reproductive rights are not respected when contraceptive products

are not accessible and available free of charge, as is the case for deliveries. In developing countries, 200 million women have unmet needs for contraception, and 130 million of these are in Africa.

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# FREE HEALTHCARE IN SUB-SAHARAN AFRICA: CLEARING UP THE MISCONCEPTIONS

*This is the eighth in a series of nine evidence-based fact sheets showing how certain ideas about free healthcare repeatedly expressed in our knowledge transfer activities actually represent “lazy thinking”<sup>1</sup>.*

## MISCONCEPTION 8



### “African states are incapable of implementing free healthcare!”

Many people, including in Africa, question the capacity of African states to implement free healthcare policies. Indeed, several countries, such as Niger and Senegal, are encountering serious difficulties in organizing these policies [1, 2]. But when these policies do not work well, it is primarily because they are poorly planned and/or underfunded. As with the principle of free healthcare, the States’ capacities in this regard should not be called into question based on a few bad examples, as several African states have achieved encouraging results. The efficiency of the policy promoting healthcare access for the poorest in Uganda demonstrates that States are in a position to implement such policies successfully [3]. The Malian government, without any NGO support, has made both malaria treatment and caesareans free. Although implementation is not flawless [1], these public policies effectively help to increase health centre attendance [4, 5]. A thorough statistical study conducted in 98

health centres across four Malian districts with no NGO involvement revealed that four years after the introduction of the national policy of free malaria treatment (2010), the use of health services went up by 30% during the period of high malaria transmission (see table on the next page) [5]. Again in Mali, four years after the introduction of the free caesarean policy, the rate of caesareans performed on women living in towns with district hospitals was 5%, which bodes well for maternal mortality reduction. The free caesareans policy also substantially diminished the joint likelihood of mother and newborn death, which dropped from 4.6% before to 2.4% after its introduction (see figure on the next page) [6]. In Burkina Faso, the national subsidy of deliveries has been very effective, including for the poorest women [7, 8], and there may be a move toward totally free deliveries. In Senegal, free antiretroviral treatments made it possible to care for a greater number of patients while maintaining their immunological status and stabilizing costs [9].

*There are many examples to show that, given sufficient political will and proper adherence to the various stages of planning and financing, African states are in a position to implement effective free healthcare policies.*

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<sup>1</sup> Sachs J. : Achieving universal health coverage in low-income settings. The Lancet 2012, 380:944-947.

## SUPPORTING EVIDENCE



**Table:** Effects of free malaria treatment (ACT) for children under 5 in 4 Malian districts in an average centre

	Quarterly number of consultations (CI 95%)	Annualized rate of consultations per person (CI 95%)	Multiplier effect (CI 95%)
<b>High malaria transmission (Sept. 2010)</b>			
With free care	443 (389 - 503)	0.66 (0.58 - 0.75)	1.30 (1.07 - 1.59)
Expected without free care	340 (275 - 421)	0.51 (0.41 - 0.63)	
<b>Low malaria transmission (March 2010)</b>			
With free care	258 (229 - 290)	0.39 (0.35 - 0.44)	1.15 (0.97 - 1.36)
Expected without free care	224 (187 - 270)	0.34 (0.28 - 0.41)	

**Source:** Heinmueller R., V. Ridde, I. Traore and L. Toure. *Évaluation de l'effet de la gratuité des CTA et TDR dans quatre districts sanitaires du Mali. 2012, CRCHUM, MISELI: Montréal*

This table is taken from a statistical study conducted in 98 health centres across four districts in four different regions of Mali. This study sought to evaluate the effects of the policy providing free new malaria treatments (artemisinin-based combinations) implemented in Mali in July 2007. In this case, however, consultation fees continued. The quantitative analysis made it possible to estimate, after adjusting for various confounding factors, the multiplier effect (that is, the factor by which use was multiplied) on

the use of services attributable only to State-sanctioned free care without NGO support. The table shows an estimated net multiplier effect of 1.30 (CI 95%: 1.07; 1.59), or 30%, during the high malaria transmission period, i.e., when children's needs were most critical, three years into the free malaria treatment policy. Nevertheless, a few differences in effects between the four districts remain unexplained.

**Figure:** Predicted probability of survival of mother and newborn before and after free caesareans in the Kayes region of Mali



**Source:** Fournier P., A. Philibert, C. Tourigny, A. Coulibaly, M. Traoré and A. Dumont. *La gratuité de la césarienne sauve des vies surtout dans les villes. 2012, CRCHUM, Université de Montréal. p. 2.*

This figure presents the statistical results of a study carried out in the Kayes region of Mali. It shows that the predicted probability of survival of the mother and her newborn child increased dramatically after free caesareans were introduced. These data take into account factors that may affect this probability, such as the woman's age, the district, clinical indications, history of caesareans, and the presence of a referral and evacuation system. There has been

improvement in all three zones studied: zone 1 (towns with district hospitals), zone 2 (village with community health centre) and zone 3 (village with no health facility). The study also showed that these positive effects were more marked for women living in towns. Thus, further efforts are required to promote access to caesareans for women living in rural areas.

# FREE HEALTHCARE IN SUB-SAHARAN AFRICA: CLEARING UP THE MISCONCEPTIONS

*This is the ninth in a series of nine evidence-based fact sheets showing how certain ideas about free healthcare repeatedly expressed in our knowledge transfer activities actually represent “lazy thinking”<sup>1</sup>.*

## MISCONCEPTION 9

**WRONG**

“African countries can’t afford free healthcare!”

There is a cost to free healthcare for the State and its partners. Just like any other public policy, it needs funding. However, many people think African states are in no position to finance free health care. In most cases, though, free healthcare for children or pregnant women in Africa is funded by the State, with external partners playing a very limited role (Burkina Faso, Mali, Senegal, etc.) [1, 2, 3]. A recent study showed that health funding by public rather than private entities benefits the poor more than the rich (Ghana, Tanzania, and South Africa) [4]. However, nearly all African states still do not ascribe enough importance to the health sector. The goal of devoting 15% of the State’s budget to this sector (Abuja Declaration of 2001) is rarely attained (3.3% in Chad, 8.1% in Burundi, 9.2% in Benin, etc.) [5]. Yet national resources are often available. Moreover, certain national resources normally allocated to the poor are sometimes misused. A study by the International Monetary Fund (IMF) showed that 120 billion CFA francs released by the Burkina Faso government during the 2008 crisis to help the poorest actually

benefited the wealthy [6]. If we compare this 120 billion CFA francs against the annual budget of two billion CFA francs allocated to the national child delivery subsidy, whose benefits are not appropriated by the richest [7], we see that it’s a question of setting priorities and using resources wisely. Over the past few years, Ghana has had the political intent to increase its VAT (still progressive [8]) to fund two-thirds of its national health insurance [9]. Meanwhile, Niger and Gabon spent two billion CFA francs to help their football team make it to the Africa Cup of Nations. Finally, there are resources available at the international level. Donor countries just need to honour their commitment to allocate 0.7% of their gross national product to official development assistance (ODA) [10]<sup>2</sup> and to write off Africa’s external debt by promoting investments in the social sector. As to free healthcare, the main international funders have expressed their willingness to help African states in implementing such policies [11], but have not yet done so.

*In most cases, free healthcare policies for children and pregnant women already in place in Africa are funded by national budgets, of which the share devoted to health remains woefully insufficient. National and international resources are available to finance free healthcare policies, provided African governments and their partners give them the required priority.*



<sup>1</sup> Sachs J. : Achieving universal health coverage in low-income settings. *The Lancet* 2012, 380:944-947.

<sup>2</sup> According to the OECD, net ODA in 2011 was just 0.31% of the cumulated gross national income of donor countries. It is estimated that these statistics include 95% of world ODA expenditure.

# SUPPORTING EVIDENCE

## The road to universal coverage and WHO proposals for funding health systems



The World Health Report 2010 of the World Health Organization [12] looks at how user fees constitute a major hindrance to universal health care coverage and highlights the need to find other resources to finance health systems. This report exposes both African heads of states' failure to fulfil their health commitments and donor countries' failure to honour their ODA commitments. However, it also recommends improving the efficiency of health systems and developing the principle of risk sharing.

### More health for the money

The WHO report proposes nine measures aimed at addressing the principal causes of health system inefficiency for a more judicious use of resources. According to this report, an estimated 20% to 40% of resources spent fail to improve people's health but have the potential to yield "enormous" health benefits if better invested.

### More money for health

The report also suggests a series of innovative ways of funding national health (see table below). It cites the example of Gabon, which in 2009 introduced a tax on money transfers to raise funds to finance medical care for low-income groups. The tax of 1.5% on net after-tax profits imposed on money transfer companies and 10% of mobile telephone operators brought the equivalent of 30 million US dollars into the health sector.

**Table:** National options for innovative funding

Options	Fundraising potential*
Special levy on large and profitable companies	\$\$-\$\$\$
Levy on currency transactions	\$\$-\$\$\$
Diaspora bonds – government bonds for sale to nationals living abroad	\$\$
Financial transaction tax	\$\$
Mobile phone voluntary solidarity contribution	\$\$
Tobacco excise tax/Alcohol excise tax	\$\$
Excise tax on unhealthy food (sugar, salt, etc.)	\$-\$-\$
Selling franchised products or services	\$
Tourism tax	\$

\* \$, low potential; \$\$, moderate potential; \$\$\$, high potential

Source: WHO, *The World Health Report 2010*.

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### OXFAM France

Oxfam France is a member of the international confederation Oxfam, a network of 17 organisations working together in more than 90 countries, as part of a global movement for change, to build a future free from the injustice of poverty. In France, Oxfam has been campaigning for 25 years, strengthening the power of people to press decision makers to change policy and practice that cause poverty. It also supports emergencies and long-term development program in collaboration with partners and allies around the world.  
[www.oxfamfrance.org](http://www.oxfamfrance.org)

### NGO HELP

Help is a non governmental organisation for humanitarian aid. Aid is given to people in need regardless of race, creed or nationality of the recipients and without adverse distinction of any kind. The most important pillars of Help's work are emergency aid, development aid and rehabilitation. Thanks to public funds and private donations Help implements various projects in many countries worldwide. [www.help-ev.de](http://www.help-ev.de)

### CRCHUM

The University of Montreal Hospital Research Centre (CRCHUM) seeks to improve populations' health care thanks to a continuum of high level university research. The CRCHUM is home to more than 360 researchers and 450 students. Its various projects are focused on research questions related to the evaluation of changes to health systems (service delivery and mechanisms that facilitate access) and to world public health programs aimed at examining the links between poverty and health and at reducing disease burden (HIV/AIDS, maternal mortality).  
[www.chumtl.qc.ca](http://www.chumtl.qc.ca)

