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

This is the first 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"[1] .

MISCONCEPTION 1

WRONG

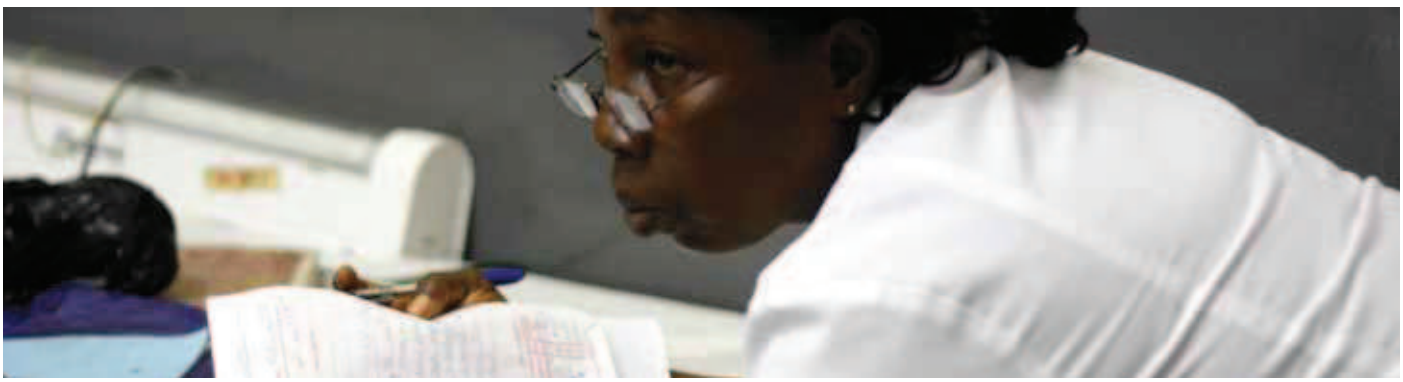
"A financial contribution, however small, must be required!"

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.



References

1) Lagarde, M. and N. Palmer. The impact of user fees on access to health services in low- and middle-income countries. Cochrane Database of Systematic Reviews, 4. Art. No.: CD009094, 2011(DOI: 10.1002/14651858.CD009094).

2) Bates, M.-A., R. Glennerster, K. Gumede, and E. Duflo. Pourquoi Payer ? Field ACTions Science Reports [Online], 2012. Special Issue 4 | 2012, Online since 31 January 2012, Connection on 03 September 2012. URL : http://factsreports.revues.org/1301.

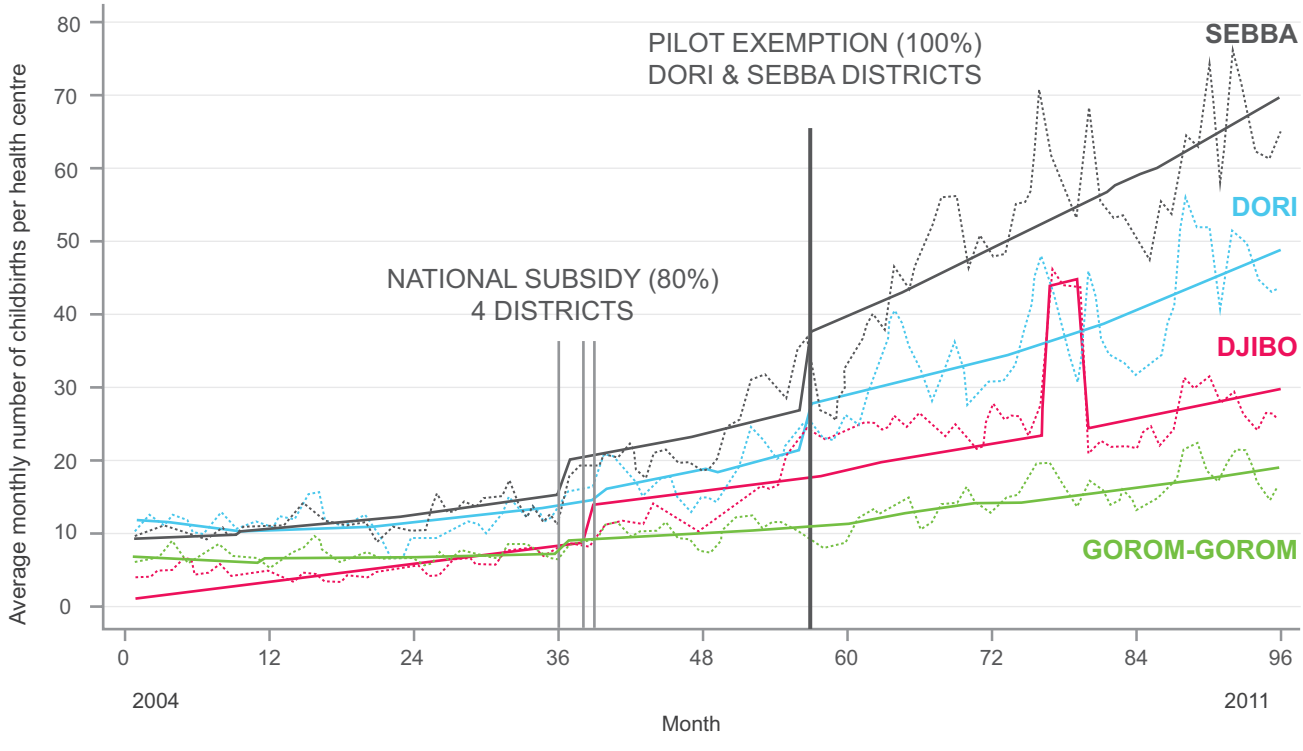
3) Heinmüller, R., Y. A. Dembélé, G. Jouquet, S. Haddad, and V. Ridde. Free healthcare provision with an NGO or by the Malian government – Impact on health center attendance by children under five. Field ACTions Science Reports, 2012. http://factsreports.revues.org/1731

4) 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: Montreal. p. 4.

[1] *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.