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

This is the second 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 2

WRONG

"Free healthcare doesn't benefit those who need it most!"

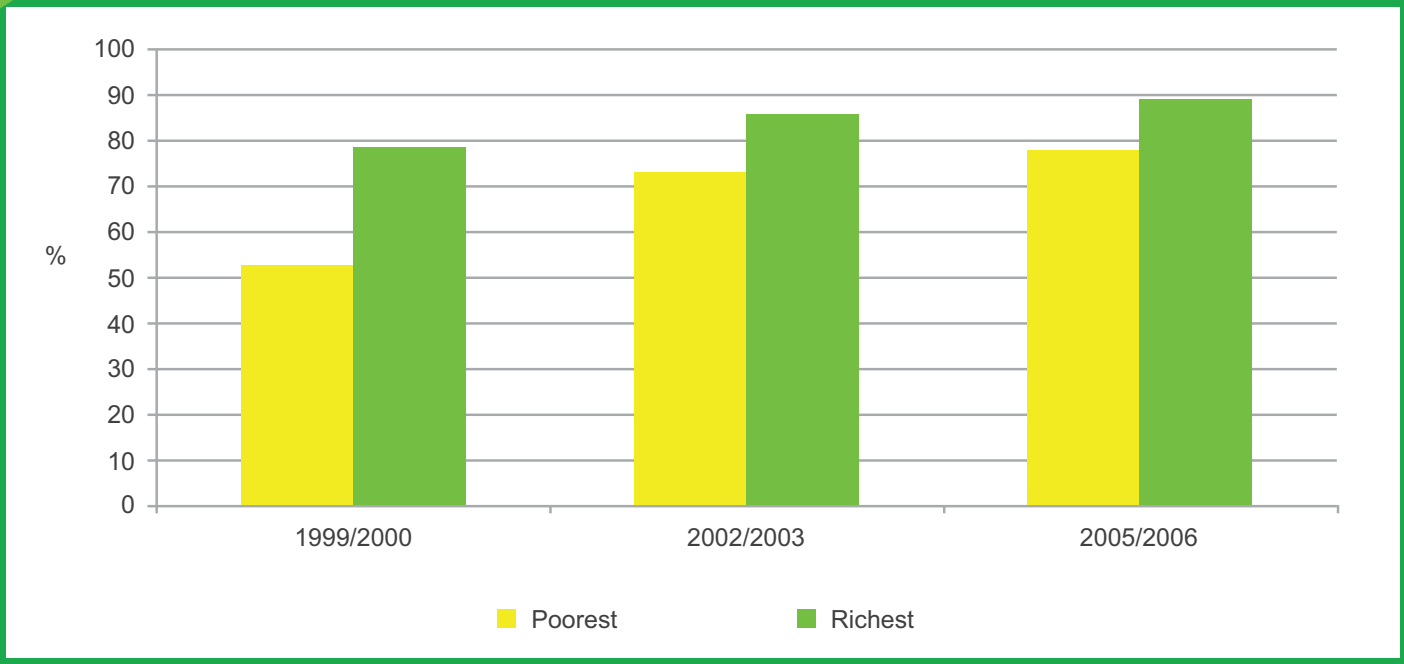
It is widely assumed, including by public health experts, that universal coverage policies such as free healthcare for all primarily benefit the most advantaged social groups [1].
In Burkina Faso, a study found that the national policy of subsidising childbirth costs led to an increase in the number 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.

[1] *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).

References

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