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

This is the fourth 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 4

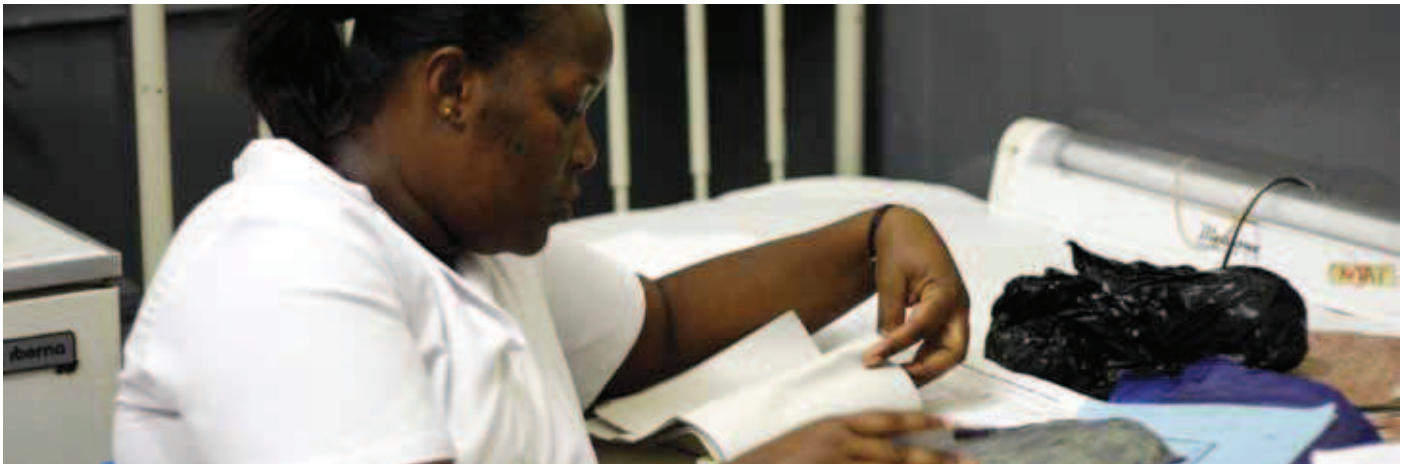
WRONG

"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 ANCs (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.



[1] *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.

References

1) WHO, World Health Report 2000: Health systems – Improving performance. Geneva: World Health Organization; 2000.

2) Olivier de Sardan, J.-P. and V. Ridde. Les contradictions des politiques publiques. Un bilan des mesures d'exemption de paiement des soins au Burkina Faso, au Mali et au Niger. Contemporary Africa, 2012. 243(3):11-32.

3) Ly A., L. Queuille, S. Kouanda, and V. Ridde. The user fees exemption pilot project in the Sahel region did not lead to work overloads for health workers. Policy brief, 2012. CRCHUM/HELP/ECHO: Montreal. p. 4.

4) 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. Published online Oct. 16.

5) Faye, S.L. Améliorer la prise en charge du paludisme par les tests de diagnostic rapide (TDR) : appropriation par les prestataires et bénéficiaires de soins au Sénégal. Bulletin de la Société de pathologie éxotique, 2012. 105(3):237-44.

6) Atchessi N., V. Ridde, S. Haddad, R. Heinmueller, and L. Queuille. The user fees exemption pilot project in Burkina Faso did not lead to a waste of medicines by health workers. Policy brief, 2011. CRCHUM/HELP/ECHO: Montreal. p. 4.