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"[1] .

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.

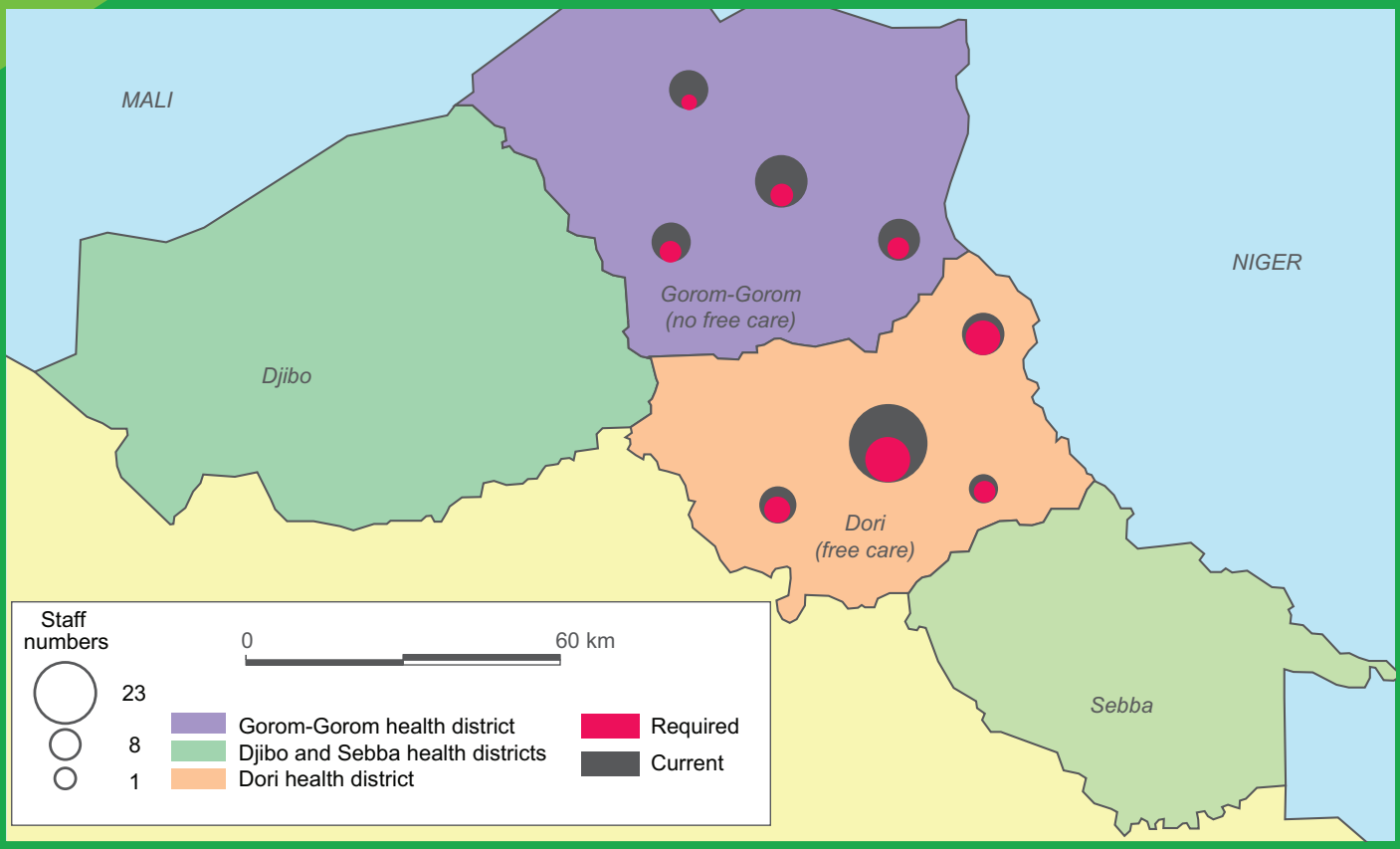
There is no denying that the substantial increase in patients' use of services brought about by free healthcare increases workloads in health centres. Here, before going any further, we should celebrate, because this is in fact the primary outcome sought by this type of strategy, namely satisfying population 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.

[1] 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 is far bigger and staff numbers are more than sufficient to accommodate the low demand for health services.

References

1) 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):13-32.

2) 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/IRSS/ECHO: Montreal. p. 4.

3) Ly A., V. Ridde, and S. Kouanda. Au Niger, l'exemption du paiement des soins a entrainé une charge de travail très élevée pour les agents de santé d'un district soutenu par une ONG. Policy brief, 2012. CRCHUM/HELP/IRSS/ECHO: Montreal. p. 4.

4) WHO. World Health Statistics 2011. 2011, World Health Organization: Geneva. p. 149.