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"[1] .

MISCONCEPTION 8

WRONG

"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.

References

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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%)
High malaria transmission (Sept. 2010)			
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)	
Low malaria transmission (March 2010)			
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.