

**Improving financial free access to primary health care:  
a rewarding strategy**

**APPEAL TO THE G8**

**April 2008**

## TABLE OF CONTENTS

<b>SUMMARY</b> .....	
<b>LIST OF ABBREVIATIONS AND ACRONYMS</b> .....	
<b>INTRODUCTION</b> .....	
1) <i>Global health, a rising concern and yet insufficient progress made</i>	
2) <i>Removing financial barriers: a first decisive step towards universal access to primary healthcare</i>	
3) <i>The call to the G8</i>	
<b>CHAPTER I: The questioning of user fees and the appearance of policies of free access</b>	
1) <i>Origin of the paradigm of user fees</i>	
2) <i>Health impact and equity</i>	
3) <i>A limited mechanism of funding</i>	
4) <i>Cost recovery among users: a model now questioned</i>	
5) <i>Improving financial accessibility to care: a growing concern in developing countries</i>	
<b>CHAPTER 2: Exemption of payment for pregnant woman and children under five; the case of Niger</b>	
1) <i>The health situation and health system in Niger</i>	
2) <i>Promising results marked by a quantitative and qualitative increase in access to primary health care</i>	
3) <i>The impact of exemptions of the health system</i>	
<b>Chapter 3: Free primary health care, the case of Haiti</b>	
1) <i>The health situation and user fees in Haiti</i>	
2) <i>A positive impact on the attendance rate and the organisation of health centres</i>	
3) <i>Exemption measures and fight against household poverty in Haiti</i>	
4) <i>Future prospects</i>	
<b>RECOMMENDATIONS TO THE ATTENTION OF THE G8</b>	
<b>RECOMMENDATIONS AHEAD OF THE G8</b> .....	
<b>SUMMARY</b>	

## **Abbreviations and acronyms**

IHC: Integrated Health Centre  
ANC: Antenatal Care  
RDPH: Regional Department for Public Health  
SMMUS: Study on Mortality, Morbidity and Utilization of Services  
IMF: International Monetary Fund  
GMR: Global Monitoring Report  
EGD: Essential Generic Drugs  
MDGs: Millennium Development Goals  
PAHO: Pan American Health Organization  
FP: Family Planning  
UNDP: United Nations Development Programme  
NHIS: National Health Information System  
PHC: Primary Health Care  
EU: European Union  
WDR: World Development Report

## ***INTRODUCTION***

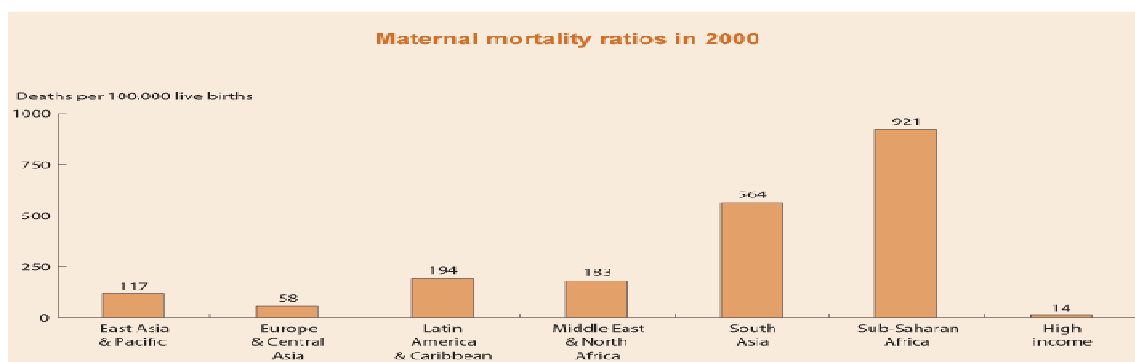
“If you want to reduce poverty, it makes sense to help governments abolish user fees”

#### 4) **Global health, a rising concern and yet insufficient progress made**

For the past few years the issues of world health have reappeared among the major concerns on the international agenda. 2008 is no exception and it is already clear that it will be a decisive year in the sector thanks to the organisation of worldwide events such as the First Global Forum on Human Resources for Health and the Third High Level Forum on Aid Effectiveness which chose health as its pilot sector. In addition 2008 has special meaning since it marks the thirtieth anniversary of the Declaration of Alma Ata. 30 years after this historical international conference, and considering the failure of the objectives that it had fixed itself, it is time that the international community mobilised itself fully in favour of universal access to primary healthcare.

The new commitments made as a result of the Millennium Development Goals (MDGs) have so far not led to any meaningful progress. Today, around 10 million children worldwide – one child every three seconds – die every year from diseases that should normally have been prevented or treated (malaria, pneumonia, diarrhoea, measles...)². Despite promising results in the fight against measles, this disease, for which a jab has existed for more than forty years, still causes the death of around 300,000 children each year³.

Maternal mortality is also a major challenge for which concrete and efficient responses must be found. Around 500,000 women die each year from complications linked to pregnancy, labour or post partum⁴. Moreover the analysis of maternal mortality rates reveals obvious and unacceptable inequalities between rich and poor countries with 99% of these deaths occurring in developing countries.



Source: World Bank staff estimates.

Two regions are in a particularly alarming health situation and show a very high delay in the achievement of the health MDGs: South Asia and Sub-Saharan Africa. With 11% of the world population, the African continent bears alone 24% of the world

<sup>1</sup> « Si l'objectif est de réduire la pauvreté, il est alors sensé d'abolir le paiement direct par les usagers » [http://www.who.int/dg/speeches/2007/050607\\_DFID/en/print.html](http://www.who.int/dg/speeches/2007/050607_DFID/en/print.html)

<sup>2</sup> Global Monitoring Report (GMR), 2007, [www.worldbank.org/gmr2007](http://www.worldbank.org/gmr2007)

<sup>3</sup> WHO, 2007, <http://www.who.int/mediacentre/news/releases/2007/pr02/en/index.html>

<sup>4</sup> GMR 2007, [www.worldbank.org/gmr2007](http://www.worldbank.org/gmr2007)

morbidity and yet it represents only a small 1% of the global budget allocated to health in the world<sup>5</sup>.

### **5) Removing financial barriers: a first decisive step towards universal access to primary healthcare**

Among the numerous barriers which may explain the difficulties and the inequalities in the access to healthcare (long distances to health centres, expensive and difficult transport, necessity to pay for healthcare, insufficient quality of care, dysfunctioning of health centres, cultural factors, sexual discrimination, etc.), **the obligation for the user to pay for healthcare represents a first-line obstacle**<sup>6</sup>. The policy of direct payments by patients, which was introduced at the end of the 80s, has largely removed the populations' capacity to protect themselves efficiently against the risk of disease.

Today the acknowledgment of this situation is increasingly shared and in 2005 it led to a strong and symbolic commitment from the G8 countries towards free primary health care (PHC)<sup>7</sup>. Since then, several governments of the South (mainly in Africa) have committed themselves in this way through the implementation of more or less extensive policies of free access to PHC.

Yet, despite this first progress, the elimination of the user fees is still resisted, especially on an operational level; this resistance sometimes expresses itself in the very institutions which promote free access. Doubts concerning the reality of the support promised by donor countries, as well as concerns linked to the necessary durability of financing these policies of free access, are among the main reasons given.

### **6) The call to the G8**

This is why, 3 years after the Gleneagles Summit, **it appears essential to us that the G8 States reaffirm with strength and conviction their commitment towards the elimination of user fees, in particular for the most vulnerable populations among which are women and children**. Considering the increasing number of countries who have adopted free access, the members of the G8 have a bigger responsibility to accompany these States in the efficient and durable implementation of this new policy. From this point of view the Hokkaido Summit must be the opportunity to specify the modalities of the support from the G8 countries – and of the main international donors – by bringing the guarantee of a technical and financial support which is **real, adapted and sustainable**.

Based on its field projects in Haiti and in Niger, Médecins du Monde France is today convinced that the questioning of the policies of payment of users and the introduction of mechanisms of more equitable financing can have a positive health impact (significant increase in visits to health centres, earlier, more systematic and

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<sup>5</sup> WHO (2006), The World Health Report 2006, available from <http://www.who.int/whr/2006/fr/index.html>

<sup>6</sup> See for example: WHO (2003), *PRSPs and their significance for health*, available from <http://www.who.int/hdp/en/prsp.pdf> ; SMMUS Report 2006, pp 319-320.

<sup>7</sup> Final declaration at the Gleneagles Summit: « nous soutenons l'engagement de nos partenaires africains de garantir que tous les enfants aient, d'ici 2015, accès [...] aux soins de base, **gratuits là où les pays en auront décidé ainsi** ».

therefore more efficient taking care of patients...) and may in certain cases contribute to the reinforcement of health systems.

## **CHAPTER I: The questioning of user fees and the apparition of policies of free access**

### **7) Origin of the paradigm of user fees**

The idea of recovering part of the costs necessary for the functioning of a health system directly from patients emerged at the end of the 80s both under the impetus of the World Bank<sup>8</sup> and, for the African continent in particular, from the Bamako's initiative initiated by the UNICEF and the WHO. Facilitated by the array of conditionalities imposed by international financial institutions (IFIs), this paradigm generalised itself very quickly. In the middle of the 90s, almost all African countries had implemented the principle of user fees.

Certainly, in the spirit of the Bamako's initiative, user fees were part of a bigger action plan aimed at responding to the dysfunctions of existing health systems; it is however important to remember that this policy at the time also came about in an international context marked by the degradation of the terms of trade and the crisis linked to developing countries' debt. The implementation of plans of structural readjustment, imposed by IFIs in order to facilitate the reimbursement of the Southern countries' debt, will mark the beginning of a period of very strong budget austerity symbolised by radical cuts in the budgets allocated to social sectors. The recovery of costs among users is above all seen as a means to make up for the voluntary reduction in public funds allocated to health.

### **8) Health impact and equity**

Unfortunately one cannot but notice that the obligation to pay to access health care has had and still has important negative consequences on the health situation and the standard of living of populations, especially in countries with a low income. Numerous studies carried out throughout the 1990s have highlighted the fall in attendance rates of health centres following the implementation of user fees<sup>9</sup>. In Kenya for instance, the implementation of measures of payment by users in 1989 resulted in a reduction of visits to district hospitals of 45% on average and 33% to health centres<sup>10</sup>. Likewise, a survey carried out in Burkina Faso in the health district of Kongoussi, revealed a fall of 15% in visits to centres following the introduction of payment by users<sup>11</sup>. The access to health centres is often a key sign of the health state of populations. As the table below shows, one can notice a close correlation between the health centres' attendance rate and the child mortality rate.

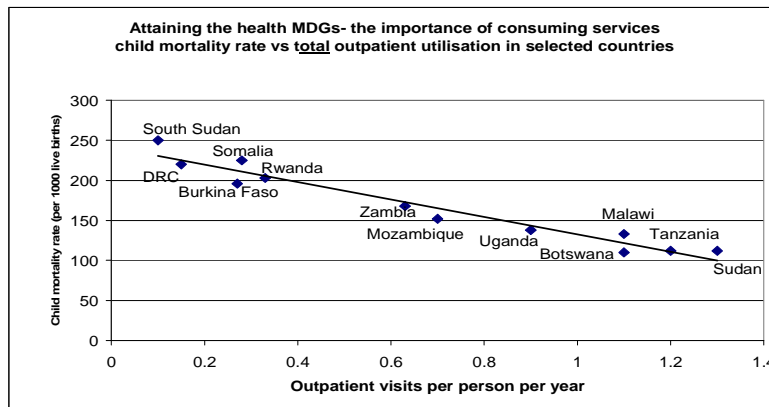
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<sup>8</sup> World Bank (1987), *Financing Health Services in Developing Countries: An Agenda for Reform* ,

<sup>9</sup> See for example CREESE et KUTZIN, J. (1995), *Lessons from Cost-Recovery in Health*, Geneva, WHO/SHS/NHP/95.5

<sup>10</sup> Save the Children (2005), *An Unnecessary Evil? User fees for healthcare in LICs*, p 14, Save the Children, London.

<sup>11</sup> J. E. GIRARD and V. RIDDE (2000), *L'équité d'accès aux services de santé pour les indigents dans un contexte africain de mise en oeuvre de l'Initiative de Bamako*, CNRS/CERDI, Université d'Auvergne, France, available from [http://www.geocities.com/valery\\_ridde/Girard-Ridde\\_final.pdf](http://www.geocities.com/valery_ridde/Girard-Ridde_final.pdf)



The lower the attendance rate, the higher the mortality rate is likely to be.

Rob Yates, DFID, Senior health adviser, IHEA Congress, Copenhagen, 9 July 2007

In an article published in 2005 in *The British Medical Journal*, several researchers also demonstrated a link between having to pay for the access and child mortality. Using a simulation model applied to 20 African countries, these researchers estimated that removing measures of user fees would help prevent more than 230,000 deaths among children under five each year<sup>12</sup>.

Beyond the direct effects on the populations' health, having to pay for care access is a very significant factor of impoverishment for numerous households. In the face of a catastrophic event of disease, the sick and their families very often have to make painful choices, such as taking the children out of school, selling all or part of their belongings or getting into debt with other members of the community. Sometimes renouncing health care becomes the only possible option with no other ways to bear the costs of the disease care plan. According to the World Health Organisation, **almost 100 million individuals fall into poverty each year because of catastrophic health care payments**<sup>13</sup>.

Based on everyone's capacity to pay for primary health care access, the policy of user fees has resulted in the past 20 years in a deeper gap between rich and poor, the sick and the healthy. The principle of solidarity, which was supposed to express itself through exemption schemes for the poor, turned out to be impossible to implement in the field. The policy of cost recovery therefore never managed to meet the concerns of equity in a satisfactory manner, despite being one of the main directing principles from the Bamako Initiative.

### 9) **A limited mechanism of funding**

Not only have user fees proved to be a factor limiting users' access to PHC, but past experiences have also shown that they have never been an efficient means of financing to fill funding gaps within health systems. Most studies carried out on the subject have indeed shown that user fees barely covers 5 to 10% of total spending necessary for the public health system to function. For example, an analysis carried out in 2004 by the DFID revealed that in the 19 surveyed African countries, direct payment had covered on average 6.9% of recurrent costs in health systems<sup>14,15</sup>.

<sup>12</sup> C. JAMES, S. MORRIS, R. KEITH, A. TAYLOR, "Removing user fees for primary care in Africa : the need for careful action", *BMJ* 2005 ; 331, pp 762-765

<sup>13</sup> WHO (2005), *The World Health Report 2005*, p. 158, available from [http://www.who.int/whr/2005/09\\_chap7\\_fr.pdf](http://www.who.int/whr/2005/09_chap7_fr.pdf)

<sup>14</sup> PEARSON (2004), *The case for abolition of User Fees for Primary Health Services*, London, DFID health

Thus, measures of cost recovery by users represent only a fraction of the total necessary financial resources. From this point of view, **the loss of equity in the access to health care seems to outweigh the minimal financial gain.**

**Today, one cannot but notice that policies of cost recovery among users contribute much more to suppressing the demand in health care (by conditioning the access to the capacity to pay) than to reinforce the supply through an increase in additional financial sources.**

### **10) Cost recovery among users: a model now questioned**

For the past several years, the impact of user fees have been increasingly questioned, even by the very institutions which promoted them in the first place. It is notably the case of the **World Bank**, which in 2004, on the occasion of its report on the world development dedicated to the access to essential services, chose to distance itself from the policy of cost recovery. No longer considering this policy as the unique solution, the Bank's report states on the contrary that it represents only a modality of financing among others<sup>16</sup>. In addition, the Bretton Woods institution confirmed this change of mind in its new strategy "health, nutrition and population" adopted in April 2007. Paragraph 205 of this strategy mentions explicitly the World Bank's intention to support beneficiary countries willing to implement free access to care in public health care centres.<sup>17</sup>

**The European Union** and its Member States have also stated on several occasions that they intended to promote free access to primary health care. Thus, in December 2005, Member States adopted a strategic document entitled "EU and Africa: towards a strategic partnership", in which they commit to "provide predictable, multi-year financing for health systems in Africa so that all Africans have access to basic healthcare, **free where governments choose to provide this**"<sup>18</sup>. The action plan 2008-2010, adopted in the Lisbon EU-ACP Summit (December 2007) mentions the elimination of user fees among the actions to undertake in order to reach the health MDGs.

*The Secretary-General of the **United Nations*** also declared himself in favour of free access in his report "In larger freedom", published prior to the Millennium Summit +5 (September 2005)<sup>19</sup>.

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systems resource centre.

<sup>15</sup> See also : GILSON (1997), the lessons of user fees experience in Africa, Health policy and Planning, 12, 273-285

<sup>16</sup> World Bank (2004), *WDR: Making services work for poor people*.

<sup>17</sup> World Bank (2007), *Health, Nutrition and Population Sector Strategy*, avril 2007, § 105 : "Upon client-country demand, the Bank stands ready to support countries that want to remove user fees from public facilities"

<sup>18</sup> Council of the European Union (2005), *EU and Africa : towards a strategic partnership*, 19 décembre 2005, § 8 c) : " Provide predictable, multi-year financing for health systems in Africa so that all Africans have access to basic healthcare, **free where governments choose to provide this**"

<sup>19</sup> Report of the Secretary-General of the United Nations (2005), *In Larger Freedom*, § 44 : « Strong health systems are required to ensure universal access to basic health services, including services to promote child and maternal health, to support reproductive health and to control killer diseases, such as AIDS, tuberculosis and malaria (see box 3). This requires sufficient investments, large numbers of motivated and adequately paid health workers, scaled-up infrastructure and supplies, strong management systems **and the elimination of user fees**".

Likewise, the **United Kingdom** is following this trend and is the bilateral donor most favourable to the implementation of free primary health care access. Therefore it is not surprising that the Commission for Africa, created prior to the G8 Summit in Gleneagles and presided over by the Prime Minister Tony Blair, also advocated the elimination of user fees as a way to finance health systems<sup>20</sup>.

Lastly, the **final declaration of the G8 in Gleneagles** represents without a doubt the strongest and most symbolic commitment insofar as it comes from the eight richest and most influential countries. During the G8, the eight Heads of State and government clearly asserted their intention to support national initiatives aimed at implementing free primary health care access for children<sup>21</sup>.

### **11) Improve financial accessibility to care: an increasing concern in developing countries**

In the past three years and following important declarations of intentions from the main international donors, several countries have decided to start elaborating and implementing policies improving financial accessibility to primary health care. This is especially true for the African continent, for example in countries such as **Kenya, Niger, Burundi** or more recently **Sudan**. All these states have implemented public policies aimed at guaranteeing free access to a minimum bundle of primary health care for children under five and/or pregnant women. As for Zambia, it introduced in 2006 a policy of free primary health care for the population living in rural areas. These policies as a whole are considered as a means to eventually reach the health Millennium objectives in terms of health.

As a field agent, Médecins du Monde is proud of these new national initiatives as part of a system of introduction or extension of free access to primary health care. Concerned about supporting health systems which are functional and accessible in particular to the most underprivileged, Médecins du Monde considers the elimination of financial barriers to be a necessary step towards universal access to primary health care in low income countries.

For almost two years, our association has invested itself on several projects of improvement of financial accessibility to care, notably in Niger and Haiti. The next two chapters present the main lessons learnt from them. As a general rule it appears that questioning policies of user fees represents a positive experience for the improvement of populations' health. Yet, the success of such an enterprise depends largely on the possibility of relying on a strong and real political will of national authorities as well on a advance planning which addresses the technical aspects relating to managing the impact of the free access on populations, on health human resources and on the supply in essential drugs.

## **CHAPTER 2: Exemption of payment for pregnant woman and children under five; the case of Niger**

### **1) The health situation and health system in Niger**

<sup>20</sup> Commission for Africa (2004), *Our Common Interest*, Chapter 6, p. 97

<sup>21</sup> Gleneagles Summit (2005), declaration of the Presidency, p. 5 ; declaration on Africa, § 17,

Ranked by the UNDP 174<sup>th</sup> in the world (out of 177) in terms of human development<sup>22</sup>, Niger faces major challenges on the health level. Today life expectancy is below 56 years old. One child out of four doesn't reach the age of five years old and malnutrition affects about half of the country's children, leading to major delays in growth. One in three pregnant women suffer from anaemia and maternal mortality hits one in seventeen fertile women. In addition this situation is aggravated by a very strong demographic growth which makes extended coverage in basic services very difficult. It has to be noted that the health state of the population shows significant discrepancies between rural areas and urban areas as well as between the various socio-economic groups. According to the latest demographic and health survey carried out in 2006, the presence of modern contraceptives is only 3% in rural areas against 18% in urban areas.

The access to the health system in Niger is very limited and marked by deep inequalities which are geographic, structural, financial and cultural. The attendance rate of available health centres has significantly deteriorated since the mid 1990s alongside the implementation of user fees. According to the survey on poverty carried out in 2002, **the average attendance rate per inhabitant has fallen from 0.42 in 1996 to 0.26 in 2003** (NOTE: is this really the survey on poverty 2002 considering the figures mentioned are for 2003?). The bad quality of care and the price of visits have been identified as the main barriers explaining these difficulties to access health centres<sup>23</sup>. In a survey of the population carried out by MDM in 2006 in the district of Keita, 45% of surveyed people declared that they didn't have access to care because of lack of funds.

→ *Cost recovery and implementation of exemptions in Niger*

Following the Bamako initiative, user fees were introduced in Niger in 1994 and extended to the whole territory in 1997 in the form of a Sickness Episode Charge. Unlike other countries of the sub-region where the patient has to pay for the visit and for the price of essential generic drugs (EGD) separately, Niger chose to implement a unique charge per care category (thus covering the visit and the drugs).

Although fairer than the principle of the fees-for-services, the principle of the sickness episode charge had the same results and the same constraints in terms of budget and access to care. On a local scale contributions from users cover 25-50% of expenditures for the functioning of centres, salaries not included. However, as shown by several studies of the World Bank, user fees contribute to only 5% of national health expenditures.

One of Bamako's successes was making EGDs available in health centres efficiently, which was one of the factors limiting service utilisation in prior policies. However **the rate of care utilisation fell by 50% after several years**. The most vulnerable populations were therefore the first excluded from care because of the absence of an efficient policy of taking care of poor people.

Given this observation and following notably the food crisis that the country experienced in 2005, the political decision was made to rethink the modalities of

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<sup>22</sup> PNUD, 2007/2008 Human Development Index rankings, available from <http://hdr.undp.org/en/statistics/>

<sup>23</sup> Survey on beneficiaries, 2<sup>nd</sup> health project of AID, 2003...

financing of the health system to introduce more equality for the benefit of pregnant women and children under five. Thus, between November 2005 and April 2006, three pieces of legislation were adopted providing free care for Caesareans and uterine ruptures, free means of contraception, as well as exemption of payment for antenatal visits (visits/treatments) and care for children aged 0 to 59 months (preventive and curative).

These measures are aimed at populations considered the most fragile and whose health needs are currently the most important but also in light of the problems of the country's development (abnormally high birth rate and child and maternal death rate).

Starting in October 2006 Médecins du Monde intervened in the rural district of Keita, working closely with the district's supervising team, in order to contribute concretely to the technical implementation of the policy of free access for pregnant women and children under five. As a field operator, our association was able to participate in the debate among stakeholders relating to the implementation of the free system (definition of the procedures of care, implementation of uniform charges over the whole territory, rethink of the supply and financing of EGDs, training of the health staff, information for the populations on the existence of this new policy, preparation of reimbursement schemes and involvement of international donors etc).

## **2) Promising results marked by a quantitative and qualitative increase in access to primary health care**

The objective of an improved access to care is reached by exemptions. In the districts of Mayahi, Téra and Keita, an increase in service utilisation of +147% was observed in paying visits as well as exempted ones. Between 2005 and 2007, the volume of care by the health system increased from 253,796 to 628,238 visits.

### a) Exemptions strengthen geographic coverage of health services

Data provided by the National System of Statistic Information make it possible to analyse the impact of exemptions on the geographic spread of the access to care in the district of Keita.

Before the implementation of exemptions, 64% of visits were in the zone of 0-5km from the IHC, 36% in the distance 5-15km and 0% from zones beyond 15km<sup>24</sup>.

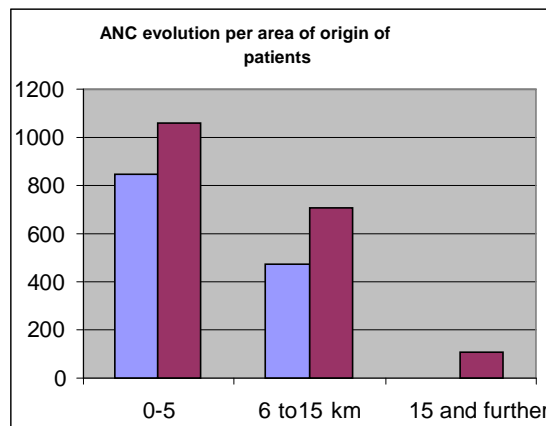
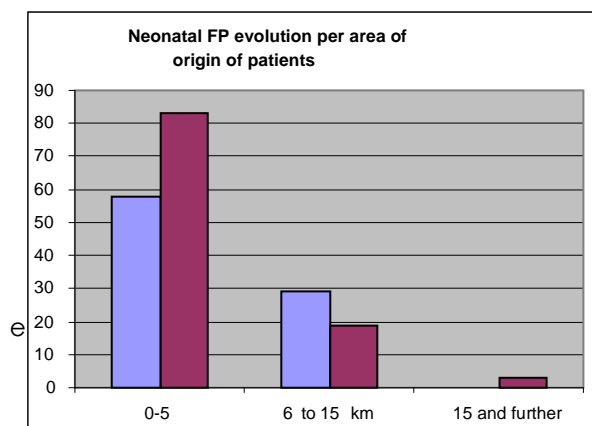
As shown in the tables below, the policy of free access resulted in an extension of the geographic coverage. Exemptions allowed a reduction in the cost of access to the IHC and thus allowed access for populations living beyond 15km of the centre for certain types of care. The example of use of the care for consultations in reproductive health is symptomatic: the attraction of IHC beyond 15km is effective for pathological cases (pregnancies at risk) more than for prevention (ANC and FP),

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<sup>24</sup> The population of the district is divided as follows :

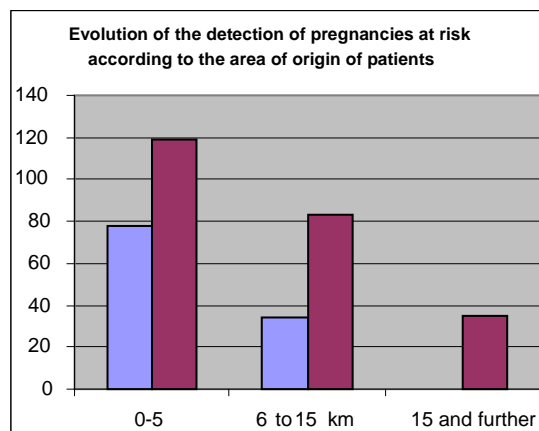
- 37% of the total population from 0 to 5km
- 31% from 5 to 15km
- 32% beyond 15 km

confirming the hypothesis that the exemption policy must continue to focus on supply of service while aiming to improve geographic coverage.



Source: Médecins du Monde France

■ Before exemptions  
■ After exemptions

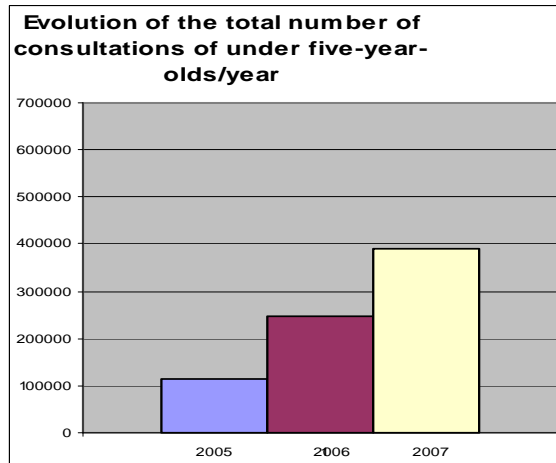
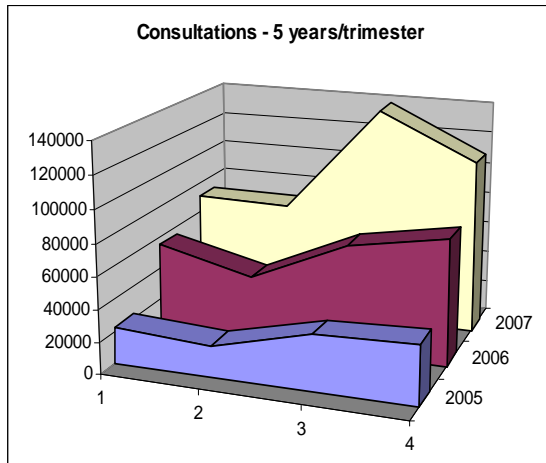


*b) A use of curative care by under five year olds quadrupled*

The implementation of the Bamako Initiative had led to a decrease in the number of consultations by 50%. Conversely the policy of exemption had resulted in the **number of children under five being taken care of as part of curative care services multiplied by four**. In gross figures the health system in the three districts increased the number of people looked after annually from 107,774 in 2005 to 390,819 in 2007.

The WHO's standards for the 0-60 months old are 2 contacts per child and per year. The recorded figures for Niger before 2005 were on the order of 0.5 contact per child and per year (0.47 in the areas of Keita, Mayahi and Téra). The implementation of the policy of exemption allowed this figure to increase to 1.6 contacts per child per year in less than 2 years on sustainable and perennial modalities.

In addition, another consequence of this policy is the return of confidence and of care routines at the level of centres, both by the general population and in particular for the combined mother/child. This attitude perceived in the field is reflected in the increase in consultations, including paying ones.



Source: Médecins du Monde France

#### Testimonial:

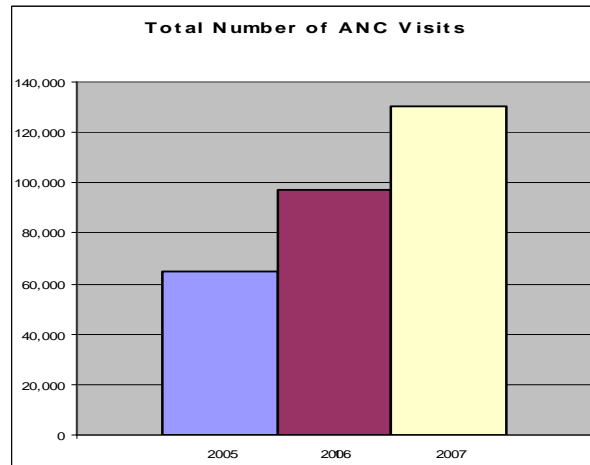
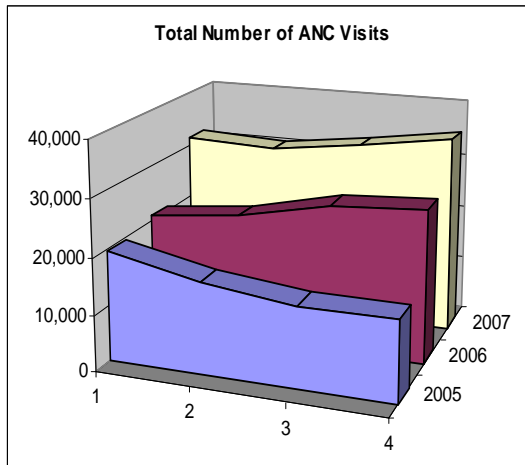


Hamsatou, who can't be more than 16 or 17 years old, has been married for 2 years. She is coming for a visit to have her one-year-old Mahamoud examined, who is suffering from dehydration due to severe diarrhoea. Asked about the impact of free access to care, she answered: "Thanks to free vaccinations and care, I was able to have my little son examined very regularly from his birth".

#### c) Use of preventive services in antenatal care doubled

Even more than curative consultations, preventive activities suffered from the user fees introduced by the Bamako Initiative. Having people pay for preventive activities results in a strong fall in their use. In this respect the example of ANC is a telling one. ANC allow the prevention of malaria attacks, blood pressure checking, anaemia prevention, detection of risky pregnancies, treatment of maternal malnutrition, etc. In Niger the number of ANC visits recommended before childbirth is three. Before the implementation of the policy, there were on average 1.07 visits per pregnancy. After less than two years in the implementation, 2.18 ANC visits per child birth are expected. In the same way in 2005 only 36% of pregnancies were accompanied by antenatal care against 76% today.

In the end the use of ANC services has more than doubled (+117%). It concerns all ANC and has a cumulative effect, as the phenomenon takes longer to get perceived than for curative consultations given the period of time by the first and the third ANC visit. This increasing tendency is continuing with differences between season attendances being smoothed out.



Source: Médecins du Monde France

Care of obstetrical complications has also improved following the implementation of free access. In the maternity hospital Tassigui (reference level), the number of people being looked after has doubled. At the peripheral level one can observe a minimum increase at 5 times, as is the case in Téra for example.

d) Earlier care: an earlier use for potentially invalidating pathologies largely improved

Conjunctivitis is used here as an example to illustrate the direct impact of payment exemptions on health.

As a reminder, conjunctivitis is a frequent and common eye infection preventable through raising hygiene awareness and is treated by hygienic care and antibiotic creams. The level of conjunctivitis going untreated or with poor treatment is linked to the risk of the appearance of the trachoma, the first cause of blindness in Sub-Saharan Africa.

With the implementation of payment exemptions, one observes a strong increase in consultations for conjunctivitis. Out of 100 consultations of children under five, 5.02 are for conjunctivitis with exemptions in comparison to 2.55 before the implementation of this policy. In gross figures **the cases of care for conjunctivitis for children under five increased from 692 in 2005 to 3,559 in 2007 in the district of Keita, that is a variation in +213%.**

At the same time the percentage of paying consultations for conjunctivitis infections went from 1.38 to 1.67% of use, increasing from 302 to 719 consultations.

**Exemptions are therefore a direct factor of prevention of the trachoma.**

e) Care use becoming systematic

Beyond exemptions, a more systematic use of care by the populations can be noted. From 2005 to 2007 in the 3 health districts mentioned in the example, one notices a 28% increase in the use of paying care. This use of paying care can be explained through various factors that would deserve deeper studying. Among main hypotheses, one can mention the following points:

- The development of a **habit of care use** in centres following a first contact through exemptions
- An improvement in the financial availability thanks to the exemptions – e.g. the portion of the income dedicated to the care of children can be reinvested for the care for adults
- A logic of opportunity within a free visit: the time to get there and the linked costs being already supported, a person accompanying another can use the paying service.

### **3) The impact of exemptions of the health system**

If results on health indicators are very encouraging and the fact that the policy is becoming national tends to confirm these data, it is essential to analyse the possible impact of the exemptions policy on the health system itself.

In the case of Niger it seems that the targeted free access to children under five and pregnant women didn't have any destabilising effect on the health system as a whole. For example one can note in terms of impact on the health staff that the access has become free while human resources have remained constant, at least in the district of Keita. The low level of use prior to the implementation of exemptions meant that there wasn't a need to recruit additional staff.

In addition it seems that the implementation of free PHC has a positive structural effect on the health system in Niger. Indeed the fact that the State is back to being a "paying third party" leads the government to seek greater efficiency in the system management and especially in the cost control. Thus the management modes as a whole are being questioned, from the standards of allocation and allowance, whether it be the implementation of the care centres, the allocation and the management of the health staff, the modes of prescribing, patient welcoming or management of the EGD. **Responsibility for reimbursing the health centres is fine,** the State is directly interested in the improvement of the health centres which expresses itself not only through a better quality of services but also and above all by reductions in costs of care.

One can also consider that the exemption policy implemented by the government contributes to the improvement of the productivity of health centres not only thanks to earlier use but also because of the increase in the number of consultations.

The data for visits mentioned above illustrates a phenomenon of an early use of care leading to less complicated care of pathologies. Thanks to these pathologies being simpler to care for by the staff of peripheral centres, the volume in evacuation and care at the superior level are decreasing. Care is therefore less expensive for patients as for centres in a direct way (inputs, staff costs) as well as indirectly (evacuation costs, lost activity days...).

Lastly, from a financial point of view, the policy of exemption for pregnant women and children under five is today financed via a new free budget line integrated in the Niger national budget. This line doesn't represent a huge spending since it amounts to 4 million euros, of which two million are granted by the French Development Agency. Still, if the starting of this new policy is today assured by this

financing, it is essential to assure that the “free” line will be approached in a perennial way with a reduction, in time, in international aid.

### Chapter 3: Free primary health care, the experience of MDM in Haiti

#### 1) The health situation and fees-for-services in Haiti

In Haiti life expectancy at birth is around 54 years old against 73 for the rest of countries in Latin America and the Caribbean's (LAC)<sup>25</sup>. The synthetic index of fertility for women of childbearing age (15 – 49 years old) is 4.0 (SMMUS IV, 2007) compared with 2.0 in LAC (PAHO/WHO, 2006). The latest Study on Mortality, Morbidity and Utilization of Services of 2005- 2006 (SMMUS IV) showed an increase in maternal mortality, with the rate going from 523 in 100,000 living births (for the period 1995-2000) to 630 in 100,000. One must note that 80% of births take place at home with the help of traditional midwives, most of them having little training. The child mortality rate, although decreasing since 2001, is still the highest in the region of the Americas and one of the highest in the world. It amounts to around 57 in 1,000 (SMMUS IV).

The reasons for this situation are numerous but one cannot but notice that the main one is the difficulty of the access to basic care, especially in rural areas. The financial difficulties for the access to care represent a barrier particularly pressing over the whole territory. According to the SMMUS III survey, 41% of people seriously injured or sick couldn't be taken to institutions because of the very high costs. 40% of sick people also declared that the choice of the health centre had been determined by the cost of care.

This situation is consistent with the fact that in Haiti, the income per inhabitant barely amounts to 450 US dollars per year (IMF, 2006) and that 76% of Haitians live on less than 2 dollars US per day (UNDP, 2005) in a context where health spending in relation to gross domestic product only amounts to 2.7% (PAHO/WHO, 2006).

##### a) *Cost recovery among users*

The measures of cost recovery among users, that is the fees-for-services for the consultation and drugs prescribed during the medical visit, were implemented from...? In the absence of national policy setting the exact cost of a consultation, prices vary depending on locations from 0.2 and 0.5 euros. In addition the patient must then pay for the drugs, which most often correspond to the bulk price marked up by a cumulated margin at each level (central deposit, peripheral deposit, health centre). The poorest don't benefit from any exemption system except in individual cases and for a few known poor.

Today after more than... years of implementation, numerous development agents <sup>26</sup> intervening in Haiti acknowledge the failure of this policy. In addition to noting that it has favoured a disengagement from the State in the taking care of the care system, several critics underline the fact that the initial objectives of the policy haven't been

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<sup>25</sup> PAHO/WHO (2006), report of the PAHO /WHO 2006, (exact source?)

<sup>26</sup> Médecins sans Frontières, Initiative and Development, Save the Children, WHO/ PAHO...

reached<sup>27</sup> and that the financial participation of users appear as the main obstacle to the access to basic care.

b) *The introduction of the free access by Médecins du Monde in the department of the Grande Anse*

MDM has intervened *in the department of the Grande Anse* in a continuous way since 1989. This department is very remote from the rest of the country as a result of its location beyond several mountain chains: it takes 11 to 12 hours to drive the 285km that separate Jérémie, the main town in the Grande Anse to Port-au-Prince, the capital city. MDM has led several projects consistent with the philosophy and the objectives of the association: community health actions; latrine projects; health education; direct support to health centres, etc. Since 2002 MDM has involved itself in development projects to support the implementation of the Health National Plan in the department of the Grande Anse: elaboration of a socio-health diagnostic in the Communal Health Unit No 2 (CHU 2); a support project implementing an integrated and centralised health system (CHU 2); a project of "Rehabilitation and redynamisation of the CHU 2 of the Grande Anse" in support of six health centres. Following the assessment of the latter project, MDM has decided, together with the departmental health authority of the Grande Anse, to reorientate its action by refocusing on two health centres (Carrefour Charles et Lopineau) and by **implementing a programme of financial accessibility to basic care, focused on two concrete measures: implementation of free access for pregnant women and children under five<sup>28</sup> and a charge of 25 gourdes** (1/2 euro) for the rest of the population. Located in the town of Roseaux (16000 to 18000 people), this project consists mainly of providing free access to the three antenatal consultations and consultations of children under five as well as free essential drugs delivered in the medical consultations.

This reorientation followed the publication in July 2005 of a decree in the official Haitian journal announcing exemption measures in favour of pregnant women. However, as it was issued by the transitory government and because of a lack of financial means to apply it, this political decision was never put into action. MDM's project is therefore part of an effort to implement effectively this decree and aims to obtain the extension of exemption measures to the benefit of children under five.

## **2) A positive impact on the attendance rate and the organisation of health centres**

a) *A significant increase in the attendance rate of the target populations*

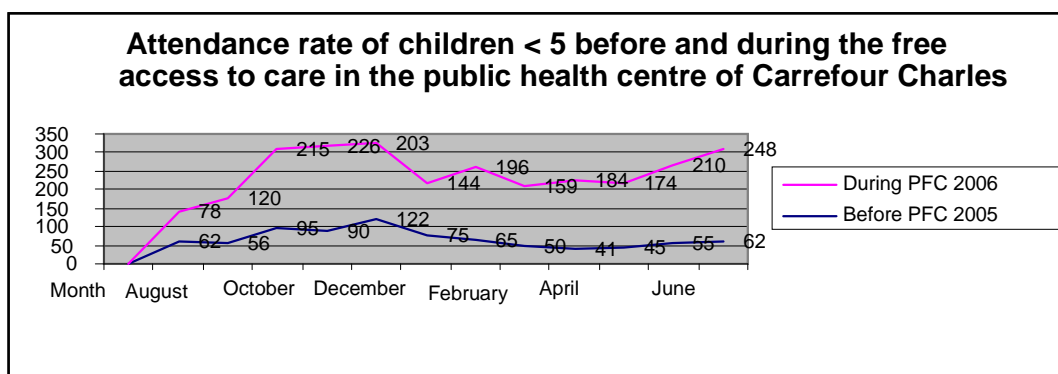
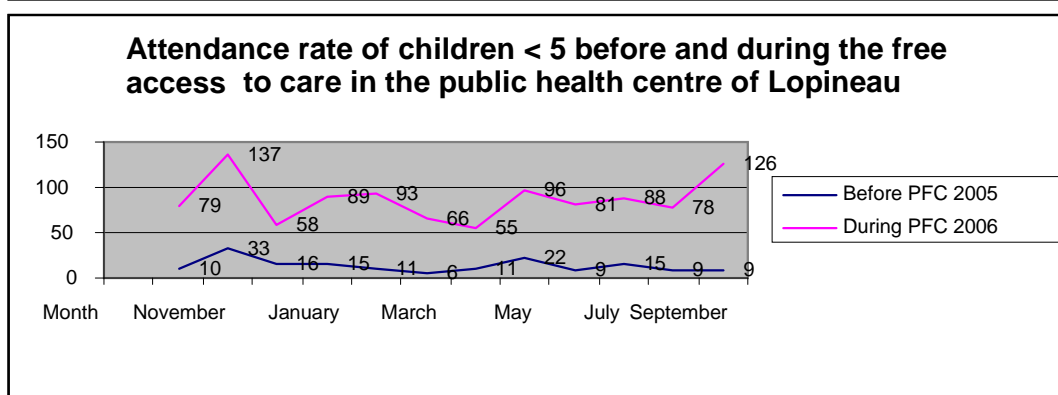
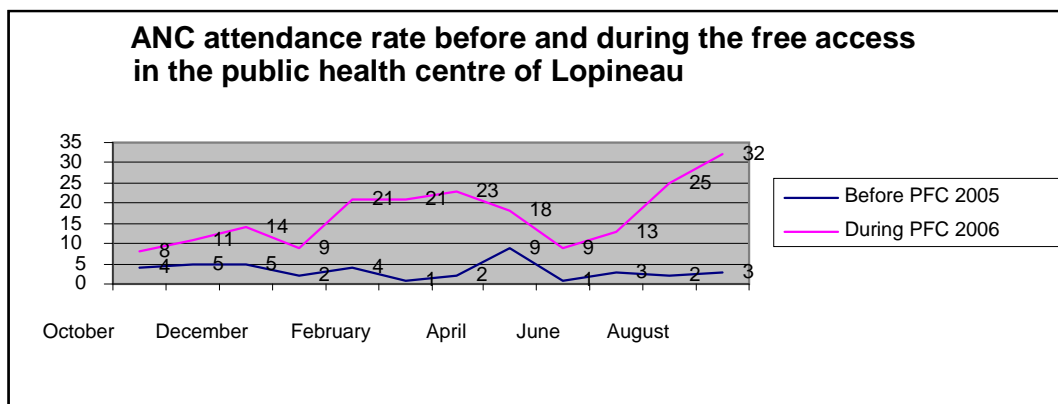
Since the implementation of the free access in the two affected dispensaries, one can observe a significant increase in the attendance rate of pregnant women and children under five. In the Lopineau centre, the number of antenatal consultations per month has been multiplied by five while the attendance rate of children under

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<sup>27</sup> Mobilize additional income, improve the efficiency of the health system, develop the equity in care access, support decentralization and sustainability of the system, promote the development of the private sector, develop the quality of care and develop the participation and the responsibility of communities.

<sup>28</sup> This programme of free access is based on the following three points: free access for the first 3 antenatal consultations and for consultations for children under five; free essential drugs delivered during these medical consultations.

five went from 13 consultations per month to 87 monthly consultations. The charts below show the evolution of the monthly attendance rate in both dispensaries:



**PFC**= Programme of Free Care  
**ANC**= Antenatal Consultation

Sources: Médecins du Monde France

**Testimony of a pregnant woman, Wesh Elodie, filler**, 24 years old, mother of 2 children, is pregnant for the third time:

"I walked for more than 6 hours to get to the dispensary. I left home in the town of Miya, at noon and arrived at the Carrefour Charles at 6pm where I spent the night. Before I had difficulties with my pregnancies; I was told that antenatal consultation visit was very important, so I came. I admit that if I had to pay for it, I wouldn't have come. In my first two pregnancies I only went to 1 ANC visit. I paid 200 gourdes (4 euros) which I saved up for in 2 and a half months while waiting for the bean crop.

*Now with this programme this is the third ANC visit I have attended. This programme is to be encouraged for it saves people's lives. Unfortunately all pregnant women in the town are not as brave as me. Some of them at the end of their pregnancy have never had an ANC visit because of the distance to walk to get to the Carrefour Charles dispensary. If the other health centres had this programme too, we would be more than happy!"*

Today the demand for treatment at the two pilot dispensaries is so high that the health staff is currently experiencing difficulties in coping with the numbers. According to Miss Marie Odie Jean Félix, ancillary nurse for three years at the health centre of Carrefour Charles, *the number of people visiting was so high that the staff had to ask a dozen patients with less serious problems, and who don't live very far, to come back to the health centre the following day. This situation is partly due to the high proportion of patients coming from areas which are not linked to the concerned dispensaries. In Carrefour Charles for example, the proportion of « out-zone » patients represents more than a third of pregnant women and children under five coming for a consultation. This underlines the need to extend this programme of improvement of the financial accessibility to care to the other health centres so that the entire district's population can benefit from an equitable and fair health service.*

*b) The improvement of the organisation of dispensaries, a direct effect of the free access*

As indicated in the previous paragraph, the implementation of the programme of free access in both health centres resulted in an increase of the attendance rate, which presented challenges to the management of the dispensaries. The acceptance of new *medical* staff (the health department management accepted the allocation of nurses in social care), the organisation of an additional consultation room or the implementation of a planning tool to carry out daily tasks, are all necessary accompanying measures which contributed to the improvement of the internal organisation of health centres.

Today, MDM observes that the programme of implementation of the free access to primary health care for children under five and pregnant women allowed a qualitative jump in the management and internal planning. Thus patient recording or filing has improved a great deal. Before the free access, certain patients had 2 or 3 files attached to them. Since, the archivist could be trained, supervised and could benefit from a follow-up. From now all patients have one file and research is carried out more easily.

In addition, several management tools had to be designed to collect accurately certain data such as the number of patients registered per day, the number of pregnant women, the number of children under five, the number of poor people benefiting from exemptions, or the number of consultations actually charged for. These tools are still functional and allow a better tracking of the evolution and of the main characteristics of the consultations delivered in both dispensaries.

Lastly the management of the drugs and the inputs was also found to have improved following the implementation of the free access. Orders of drugs went, on average, from 15,000 gourdes before the free access to 80,000 gourdes after the implementation of the free access, with the difference being due to the increase in

the attendance rate and the storage of drugs that didn't exist before the implementation of this measure. It was therefore a necessity to train the health staff in filing and storing drugs, in stock management and inventory.

### 3) Exemption measures and fight against household poverty in Haiti

In 2006, a survey <sup>29</sup> supported by MDM that aimed at understanding the mechanisms of care access of the populations in the Grande Anse and identifying needs perceived as a priority, revealed the following results:

- **Medical consultations and drugs make households poorer :**

In prevision of the cost of the consultation and the drugs, surveyed people declared planned spending of:

- |                              |       |
|------------------------------|-------|
| • Less than 50 gourdes       | 9.7%  |
| • Between 50 and 100 gourdes | 45.2% |
| • More than 100 gourdes      | 41.9% |
| • Didn't give an answer      | 3.2%  |

Regarding the time necessary to gather the consultation fee, 71% of surveyed people admitted it took them more than four days.

When an emergency consultation is necessary:

- 32.3% use their savings,
- 45.2 % borrow this money from people around them
- And 35% find themselves forced to sell a belonging.  
(the total is higher than 100% because most people using their savings also have to resort to another means of financing.

- **The lack of money is a major obstacle to attending a medical consultation:**

83.7% of surveyed people declare that they do not systematically visit the dispensary in the event of sickness;

80% mentioned they didn't have the money available necessary for the consultation during the event of sickness.

These results illustrate perfectly the mechanisms of spending that characterise the policy of cost recovery which results in vulnerable people either being forced to find a difficult solution (often the source of impoverishment) in order to receive care, or for reasons for which cost recovery is an obstacle to reaching the MDGs, in particularly those relating to the fight against extreme poverty and reduction in maternal-child mortality.

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<sup>29</sup> External survey carried out among 41 households selected in 2 villages located in the town of Roseaux (UCS2, GA). This survey has no statistical value for the sample is not representative of the population of de Roseaux and the mode of selection of households was not random but targeted on families presenting external signs of vulnerability.

In these conditions, one can consider that the programme of financial accessibility with free access for pregnant women and children under five is an alternative to cost recovery and an important means at a large scale to make reaching the MDGs more likely, for it allows a removal of the financial barrier, which is the main obstacle to the care access in Haiti. On an individual or family level the free care promotes saving or use of money for other purposes, in particular for food. On a larger scale it allows the inhabitants of the Grande Anse, mainly farmers and fishermen to be in good health thus to participate in the economic growth of the country through their work.

#### **4) Future prospects**

Currently the measure of free access for pregnant women and children under five, implemented by MDM in the last trimester 2006 is a real success and attracts populations from all neighbouring towns. It is frequent to see pregnant women and children walk for more than three hours to go to a consultation. Certain towns are located more than six hours walk away.

However if this measure is not extended to the whole country, the geographic organisation of the whole country will be completely destabilised due to non compliance of the populations with the health district allocation. In fact we will witness a two-tier health system, with on the one hand, free services for target groups living in the towns close to the health centres where free access is implemented, in general implemented by NGOs, while on the other hand paid care for towns located around health centres which do not benefit from free services. In the latter case, the sick will have to either to find the money to receive care (often itself linked to impoverishment: e.g. borrowing, sale of cattle, etc.), or walk several hours to reach health centres implementing free access, which is currently the case in our two dispensaries where 30% of our consultations of pregnant women and children under five are "outside zones".

Within its contribution to the strategy of reduction in poverty, the Ministry of Public Health and Population (MPHP) has reasserted its will to implement in a progressive way a scheme of social protection in health by beginning with the most vulnerable groups, in particular women and children under five. All through the year 2007 the Ministry for Health mobilised itself in an important process of construction of a social dialog to replace the health sector at the centre of the strategy of growth and reduction in poverty, carry out an assessment of the state of advancement of the reform of the health sector. This process is based on the Forum for the Realignment of the Reform of the Health Sector (FRRHS), an area of national dialog initiated in December 2007 and that will carry on all through the year of 2008.

#### **RECOMMENDATIONS TO THE ATTENTION OF THE G8**

At the current speed of development, Millennium objectives relating to health (MDG 4, 5, 6), will not be reached by 2015. In Sub-Saharan Africa, a region of the world that shows the biggest delay in the area, more than a century would still be needed to fulfil these international commitments. To avoid this failure, it is now necessary to implement a real emergency plan towards world health. 30 years after the declaration of Alma Ata on universal access to primary health care, we hope that

the year 2008 will provide the opportunity for the international community to mobilise itself fully around the issues of global health.

Under the impetus of the Japanese presidency, we are inviting the G8 to make the strengthening of the health systems a priority of the Hokkaido Summit. In this respect, we are specifically expecting the countries of the G8 to adopt concrete and ambitious measures aimed at strengthening human resources in the sector of health and to support the emergence of fair mechanisms of financing of health systems.

More precisely, we recommend that the G8 Members States:

- *Immediately apply (as from 2008) the commitment that they made in the d'Heiligendamm Summit to mobilise 60 billion dollars to reinforce health systems and the fight against the three big pandemics; and that they apportion as soon as possible 0.7% of their NDP to the public aid of development.*
- *Commit to invest in the long term in all aspects of strengthening of health systems, beginning with adopting the 50/50 principle recommended by the WHO (world health report 2006).\**
- *Ensure a better coordination of their APD and commit on the long term within budget constraints to help efficiently partner States to cover the recurrent costs which health centres face (payment of salaries, supply in essential drugs etc.)*

In addition, MDM considers that the implementation of systems of fair and efficient financing constitutes one of the pillars of the reinforcement of the health systems. From this point of view, the elimination of the system of cost recovery among users constitutes a first decisive step.

Thus, considering the increasing number of low income countries that have recently started to implement total or partial free access, G8 governments today have the responsibility to accompany these countries in the implementation of this efficient and perennial new policy. In this respect we are asking the G8 countries to:

- *Reassert without any ambiguity their commitment taken in the Gleneagles Summit to promote free access to primary health care (in countries that wish to) and mention explicitly their will to obtain the removal of user fees, in particular for the most vulnerable users such as pregnant women and children.*
- *Provide sustained financial support to aid implementation of the policy of free access and help to make up for the loss in resources brought about by the elimination of user fees.*
- *Specify that current debates around the cover of the risk of disease (compulsory/voluntary health insurance, supplementary health insurance....) must not be an obstacle to the implementation of policies of free access in the poorest countries.*