
Facilitating access to healthcare in low-income countries: a contribution to the debate

Martine Audibert and Jacky Mathonnat

**Electronic version**

URL: <https://journals.openedition.org/factsreports/2069>

ISSN: 1867-8521

Publisher

Institut Veolia

Electronic reference

Martine Audibert and Jacky Mathonnat, "Facilitating access to healthcare in low-income countries: a contribution to the debate", *Field Actions Science Reports* [Online], Special Issue 8 | 2013, Online since 12 September 2012, connection on 06 January 2022. URL: <http://journals.openedition.org/factsreports/2069>

This text was automatically generated on 6 January 2022.



Field ACTions Science Reports est mise à disposition selon les termes de la Licence Creative Commons Attribution 4.0 International.

Facilitating access to healthcare in low-income countries: a contribution to the debate

Martine Audibert and Jacky Mathonnat

Introduction

- 1 Despite significant improvements over the last two decades, the health of the population of Sub-Saharan Africa remains well below the global average, or even that of low-income Asian countries.¹ One of the main reasons – along with under-funding² – for this health deficit in Sub-Saharan Africa lies in its dysfunctional and under-performing health systems. A review of the literature shows that since the end of the 1980s, utilization of health services was very low (until the end of the 2000s, the number of consultations per person per year ranged between 0.3 and 0.6 depending on the region: Audibert, de Roodenbeke & Pavy-Letourmy, 2005; Audibert, Dukhan, Grimaldi, Korachais & Mathonnat, 2011). The causes of this fair utilization have been studied (for a review of the literature, see Audibert, de Roodenbeke & Pavy-Letourmy, 2005), and while the financial barrier is certainly a factor (Ridde, Meessen & Kouanda, 2011), they are also strongly correlated with the poor quality of healthcare, notably as perceived by users (Jaffré and de Sardan, 2003), and with the geographical barrier (Audibert, Dukhan, Grimaldi, Korachais & Mathonnat, 2011). It is clear, moreover, that when it comes to public health spending, the efforts made by low-income African countries are very unequal, and the poorest patients tend to see comparatively little of the benefit (Mathonnat, 2010). Several studies have shown that better health outcomes could be achieved in many countries by focusing on the significant room that remains for efficiency gains (see in particular Dukhan, 2010).
- 2 The chronic underutilization of many health facilities, especially in rural areas – often while other structures are overloaded (Audibert et al. 2011), and despite a generally poor population health – is a serious concern for public authorities. For instance, 40%

of deaths among under-fives occur before one month of age (neonatal mortality) whereas they might be avoided by attentive monitoring of mother and child (WHO, 2012). The main causes of postnatal mortality, meanwhile, are diarrheal diseases, respiratory infections, malaria and malnutrition. The treatments are understood, effective, and in theory easy to implement and not necessarily costly (WHO, 2012). But in practice, despite efforts over the last ten years or more to improve coverage of the target population, the monitoring indicators for the recommended treatments show that coverage is still far from universal. In Sub-Saharan Africa, the proportion of under-fives sleeping under insecticide-treated nets is extremely low (17%) and fewer than 50% of children with fever have received any kind of anti-malarial treatment (WHO, 2011). Likewise, the proportion of assisted childbirths and the proportion of women receiving at least four prenatal visits both remain below 50% (WHO, 2010).

- 3 From primary health care strategy (Alma Ata Declaration, 1978) to recent policies of partial exemption or targeted free health care provision, via the Bamako Initiative of 1987 (principle of community involvement) and the stated ambitions of universal coverage, the health policies implemented in the countries of Sub-Saharan Africa have, in many case, achieved significant results, although they fall far short of the Millennium Goals. Following the failure of totally free health care provision, introduced in the early days of independence, and the partial failure of user-fee contributions – which did not succeed in making health care accessible to the poorest, despite the principle of exemption for the very poor, which was made possible by the financial contribution scheme – the question of partial or total exemption is back on the agenda. In addition to prevention policies, some of which require inter-sector cooperation,³ the crucial objective for health policies is to enable those in need to access health facilities in order to receive essential high-quality care.
- 4 The papers in this issue describe projects or experiences that go in that direction. The title “Facilitating access to healthcare in low-income countries: a contribution to the debate” is based on a selection of papers presented to the 3rd international conference on “Health Financing in Developing and Emerging Countries” organized at CERDI (University of Auvergne) on 12 and 13 May 2011. This conference, which brought together more than 200 participants from academic and professional circles (from government, aid and development institutions, health facilities and other service providers from some thirty different countries), was designed to promote discussion about theoretical, conceptual, methodological and applied work on the multiple aspects of the current state of health financing and healthcare access in developing and emerging countries. Adhering to the remit⁴ of the review *FACTS – Field Actions Science*, the selected articles describe experiments that succeeded in improving healthcare access by developing original approaches to financing (such as the “extra centime”) or by helping private doctors to set up practice in rural areas in order to provide local care.
- 5 The first four papers study how the health system financing model affects healthcare provider use and the referral system. The paper of Valéry Ridde, Ludovic Queille et al., “Evaluation of an experiment in healthcare payment exemption for vulnerable groups in Burkina Faso” shows, through a series of assessments of the various expected impacts, that the principle of free health care at the point of service for vulnerable groups (children under five, the poorest, and pregnant women or nursing mothers) increased these target groups’ utilization of health centers, while increasing the

resources available to the health centers and reducing households' expenditures on health. The second paper, by Rolf Heinmüller, Youssouf Dembélé et al., "The impact of free healthcare provision – by an NGO or by the Malian government – on health center use for children under five" also looks at the effect of free provision at point of service on health facility utilization, and asks whether the positive effects of free provision, observed elsewhere, are not due mainly to the intervention of an NGO, which often supports the personnel in implementing such initiatives through frequent supervisory visits and specific training. The authors show that even without the intervention of an NGO, the introduction (by the government) of free healthcare has a significant and positive impact on health center utilization, providing that the health centers' costs are reimbursed within a reasonable period. This presupposes, as the previous article also underlined, a strong commitment from the State.

- 6 The paper by Mamoudou Barro, Hélène Barroy et al., "Solidarity-based financing of medical evacuations to improve access to emergency care, Keita Medical District (Niger)" describes an experiment in which, by levying an additional FCFA 100 on every new consultation at every level of the district's medical pyramid, a (mutual) fund was set up to cover the cost of medical evacuations from the base of the pyramid up to district hospital level. The positive results of this experiment (the number of evacuations rose, the users and general population were satisfied), are of particular interest in that the initiative is based on the idea of pooling resources mobilized by local communities; an initiative that works, in this case, and can be found, in other forms, in the insurance sector. This paper finds echoes in the article by Bruno Galland and Alain Letourmy "Public-private partnerships in micro health insurance" which shows that public-private partnerships (in the case of mutual health funds in Tanzania), by exposing the successes and failings of each partner, and by subsequently uniting their forces, improve the efficiency and effectiveness of the policies put in place, and that these policies then integrate and build on the private sector, instead of being in competition or simple juxtaposition with it.
- 7 Something of the same perspective is taken by Dominique Desplats in "The feasibility of community-based private medical practice in Africa and Madagascar" when he explains that setting up medical facilities in rural areas is no utopia. It improves health care coverage by providing good local – and affordable – care. But to roll this scheme out on a national scale, after promising pilots in Mali, Madagascar and, more recently, Benin, calls for State commitment, notably in the form of a public-private partnership which would treat rural doctors as partners, not competitors. That is the prerequisite for going beyond the sporadic cases of positive local collaboration that have been observed.
- 8 In parallel to measures targeted at demand, which seek to lighten the financial burden of health system users, other policies have been developed that are targeted at supply, and seek to improve the quality of care delivered (which will ultimately help to raise health service utilization). One such measure – the object of a large literature, and of intense debate between its advocates, skeptics and opponents – is performance-based financing. In their paper "The district health system and performance-based financing: Potential synergies and contradictions", Georges Nsengiyumva and Laurent Musango contribute to the debate by illustrating the pitfalls that must be avoided if performance-based financing is not to undermine the way the health system works and

conversely, especially at the decentralized level at a time when reforms are being introduced that are not entirely compatible with performance incentives.

- 9 Finally, Bruno Boidin's paper: "The health community and its failings: a survey in the Kayes Region of Mali", which looks at the workings – and shortcomings – of the user associations (ASACO) that manage the primary level health centers (CSCOM) in Mali, underscores the utility and indeed necessity of a public-private partnership (in this case involving the community) and the role of the State as the health system regulator. He shows that whereas this experiment, now rolled out at national level, has substantially improved primary health care coverage, it has not yet significantly improved the quality of primary health services, partly due to a lack of regulation and rebalancing by the State.

BIBLIOGRAPHY

Audibert M, Dukhan Y, Grimaldi C, Korachais C, Mathonnat J. (2011), *Amélioration de l'accessibilité financière aux soins et orientations pour des stratégies de financement de la gratuité*, Vol. 1, Burkina Faso ; Vol. 2, Mali, Vol. 3, Niger, CERDI, Institut d'Economie de la Santé et de Santé Publique (IESSP), Clermont-Ferrand.

Audibert M, de Roodenbeke E, Pavy-Letourmy A, Traore I. (2005), *Utilisation des centres de santé de premier niveau au Mali : issues et perspectives*, Working Papers Series, 87, World Bank, Africa Region, Department of Human Development.

Dukhan Y. (2010), *Améliorer l'efficience des systèmes de santé et la protection financière contre le risque maladie dans les pays en développement*, doctoral thesis in economics, CERDI, University of Auvergne, 2010

Jaffré Y, de Sardan O (ed.), (2003), *Une médecine inhospitalière*, Paris, APAD, Karthala.

Mathonnat J. (2010), *Disponibilité des ressources financières pour la santé dans les pays d'Afrique subsaharienne*, Notes et Documents, vol. 52, Agence Française de Développement, Paris.

WHO (2012), <http://www.who.int/mediacentre/factsheets/fs178/en/index.html>

WHO (2011), *World Health Statistics*.

WHO (2008), *Trends in maternal mortality: 1990 to 2008*, WHO, UNICEF, UNFPA, World Bank.

NOTES

1. While mortality among under-fives fell from 182 per 1000 live births to 142 per 1000 in the WHO's Africa region between 1990 and 2008, it fell from 113 per 1000 to 63 per 1000 over the same period in the South-East Asia region (WHO, 2011). Maternal mortality in 2008 was in the order of 640 per 100.000 live births in Sub-Saharan Africa (SSA) versus 280 in South Asia (the world's highest level after the SSA region, WHO, 2008).

2. Total per capita health spending for 2008 in \$PPP terms was 146 in the Africa region against 262 in the East Mediterranean region, but only 116 in the South-East Asia region.

3. Reducing the prevalence of diarrheal diseases, for example, depends on providing universal access to a source of drinking water or improved sanitary installations – the role of the hydraulic and sanitation sectors.
 4. Working with front-line actors to collect and disseminate the results of relevant, effective and reproducible experiments.
-

AUTHORS

MARTINE AUDIBERT

CERDI-CNRS University of Auvergne, martine.audibert@udamail.fr

JACKY MATHONNAT

CERDI-CNRS University of Auvergne, jacky.mathonnat@udamail.fr