Plenary session 4: User fee competition presentations

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The right price for health!

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«There is a whole world of difference between treating people equally and trying to make them equal. If the first is the condition of a free society, the second is but a form of servitude ». (Hayek)

We have the habit of saying that health is priceless. Health however has inherent costs that must be recovered. There is no doubt about this. Hence, if in the beginning, medicine was practised free-of-charge, States and bodies responsible sooner or later found themselves overwhelmed by the huge amounts that went into health, thereby threatening the survival o f health structures. The solution seemed to be outlined through the ideology and principles advocated by the Alma-Ata declaration: priority to the most vulnerable, involvement of the community.

Africa is particularly concerned. Sooner or later however, in view of the slow growth, a weak purchasing power of the population groups, and burdened by the weight of increasingly high operating expenses, a development geared towards self-sufficiency and the self-determination of the health systems became obvious.

Solution: "The population must pay" African ministers decided through the Declaration of intention of the « Bamako Initiative », which advocates cost recovery and community participation. This new direction driven by donor pressure led to the « privatisation of health in Africa», thus further dashing the hope of a possible convergence towards «free universal health coverage».

User fees: a means or finality?

When we recall that apart from households, donors, the State and sometimes companies constitute the main sources of health financing. Whether the State's resources come from direct taxes (income taxes) and indirect taxes ((VAT…); we are tempted to wonder whether « community participation » limited to the economic concept is not becoming a finality other than a means?

Since health financing henceforth « private » [6], comes up in this case to make households pay directly or indirectly either through – contribution – flat rate – for the care and/or drugs, user fees can be applied only for these two.

This measure was initially justified by the need for cost recovery **« complementary financing alternative »** which was to encourage the population groups to contribute by generating constant resources to finance the operations and activities of the health structures. Health services would no longer be threatened with closure; quality of care was expected to improve in view of the very poor and very substantial resources, health coverage extended and the motivation of care providers revitalised; which was proven over time[7].

Both poor and rich could thus attend the hospital and be requested to make a financial contribution. Do they pay: Equally? According to the risk? According to the benefit? According to capabilities?

If social justice claims that the last would be the most equitable, the reality on the ground is totally different. During the international conference on community financing (Sierra Leone, 1989) reservations were expressed about the consequences of the tariff policy on the poorest people. As a matter of fact, direct payment, is practically never calculated according to the financial capability of the population groups. It could also differ very much from one health centre to the other within the same health district. Hence, for the same affordability, some will pay more than others.

Nowadays, it is not surprising to hear people say: *«here people have no money; they prefer to die with their diseases! »*. Has the generalising cost recovery, imposed by donor on public health facilities[8], not transformed these structures into fee-charging care centres: **no money, no care…? …** sometimes to the extent of emptying the structures of them. Consultation fees, far beyond the reach of 59% of the poor population groups, are the first and foremost cause of non-consultation (2).

You could imagine my surprise when during the visit to dentist in a regional hospital in Burkina Faso, I realised that, this dentistry, highly equipped on top of that with 2 dental units, received only between 2 and 4 patient per week: just emergencies! Why? People lack the means of paying the consultation fee (FCFA 300F). What is the fate of all these anonymous people, dying at home or having resorted to unorthodox solutions to reduce their pain, those who die at the entrances of our hospitals for lack of means? *« Only cares are available, medicines also ! »* In spite of the BI, 65.5% of the poor find it difficult paying for the prescriptions[9]. On the whole, the utilisation

[6] SAKHO, CISSE, CODIA: Study of resource mobilisation strategies in the health sector : case of Senegal, 1996 Massachusetts.
[7] SOURA: Impact of tariffing and quality of care on the utilisation of Boromo hospital services / BURKINA FASO.
[8] SARDAN: Neglected health policies, 2004.
[9] INSD, 1997

of the services of (and preventive cares)[10] and fairness of access to cares are adversely affected.

Judicious applicability in Africa

In spite of the growth in the active population (509 million, Africa 2005) 57.7% in sub-saharan Africa live with less than one US dollar per day and 87.1% with less than two dollars,[11] one easily imagines that the lack of management of destitutes increases the financial barrier for the vulnerable stratum, for whom seeking care means to become impoverished which a doctor qualifies as «*iatrogenic poverty* ». Furthermore, social change, has advocated justice that is closest to equality than equity, and reduced solidarity behaviours, widen the the pit which the destitutes find themselves and push them into a *« medical poverty trap »*.

Furthermore, health expenditures in Africa are supported to a large extent by foreign donors. On this account, the countries generally content themselves to following the successful changes in orientations dictated to by the international institutions with the re-tailoring of the related financial flows: primary health care – costs recovery – reorganisation of the health pyramid – hospital reforms today – not to mention the multiple vertical operations regularly driven around pathologies « fashionable» (AIDS, Malaria…). Furthermore, the BI gave the impression that at the end of donor support, the health centres, managed by the population groups – indeed African governments – would become financially independent. Also the relatively low health budget represents less than 10% of national budgets (3.1% Cameroon 1999; 5.32% Côte d'ivoire 1999; 6.5% Senegal 2007) [12]. In addition to this is huge portion of of direct payment in private financing (97.90% Burkina Faso; 68.20 The Gambia, 94.50 Senegal in 2004)[13]. Considering the current priority of governments to resolve the problem of « high cost of living», we qre tempted to think that the chapter on user fees will be delayed.

« Any service » has a price! However, the application of low tariffs would promote an irrational consumption of services and an abuse of the care system in its entirety (1). In view of the high risks of copmletely opposing results of a possible « free care », and those already encouraging but very sensitive, it is proper to find the formula that is most adapted to the African context and realities. As a matter of fact, Africa has this advantage of having imported the experience of other traditional systems even if they are still undergoing reforms. « Pure» private financing of health has largely shown its weaknesses thereby justifying the creation of a parallel health-financing in the USA for the aged and destitutes. However, indirect financing –pre-participation – compulsory (England) or voluntary - contributions (France, Germany) seem most reliable, justifying the fact that Europe, which in the 80s had laid emphasise on the limitation of budgets and direct payment, has for over a decade been considering more refined actions of internal management of the system.

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[10] HADDAD, FOURNIER, 1995
[11] ILO, 2006
[12] WHO
[13] LAFARGE, 2008

Of course the poverty burden, dependence on foreign financial and policy dependence, the sharp disparity among countries or even among regions, the predominance of the informal sector do not foretell a sure future of for direct health payment. Nevertheless, African values being what our mothers do all the time a relative suffers a misfortune or good fortune : family councils, contributions, tontines, etc, African population groups have demonstrated that they are ready to support health; as seen through the membership of micro health or mutual health insurance schemes.

Furthermore, numerous self-financing perspectives such as – pre-financing – income taxes – specific taxes (VAT) – integrated formalisation of traditional medicine- are in the offing. However, importing or applying experiences as wholesale measures without prior prudent adaptation will be « suicide ». Every one could participate according to his/her capabilities. This research-action requires the provision of predictive tools, establishment of a reliable data base for a more specific analysis and the institution of « tailor-made reforms », undeniable result of the joint and multi-disciplinary effort of qualified African leaders who are conscious of their duty and obligation.

The situation of destitute people does not in principle have all the characteristics of a public problem. Nevertheless, it seems urgent, for scientific and solidarity reasons, to <work out> the formula ideally adapted to curb this exclusion. Libya like The Gambia, where there is a high political will not refute this. Only good intentions, poorly oriented, works in a bad way, eventually, “something happen on the way to heaven…”