



TWO SOLITUDES: Learning about Research Systems and Health Systems in Burkina Faso through the History of User Fees

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The experiences and realities of Anglophone, francophone, and lusophone traditions in research and health policy in Africa are seldom shared across linguistic divides. While recent globalized health policy and research funding have begun to blur distinctions between colonial traditions, important differences persist. HRCSGlobal Learning sought to facilitate exchange of experiences across these “solitudes”. This is an extended abstract in English of a working paper produced in French and currently under translation.

Burkina Faso was one of the last African countries to decide (in 2010) to abolish fees for antiretroviral therapy (ART) for patients. Likewise, it is one of the very few countries that continue to charge parents of children under five years (100 F CFA, \$0.20) for a malaria treatment provided at the community level and to expect women to contribute to the cost of a delivery (\$1.80) in public health centres. Those in charge of the health system are thus resisting the current drive toward point-of-service user fees exemption policies upon which 20 or so other African countries have embarked. Rather, they mostly prefer using subsidy policies, seeing this as a means of making patients “take responsibility.” This resistance is surprising on two counts. First, there is a growing body of scientific evidence

that point-of-service user fees exemptions help to improve equity of access to care, and that user fees actually do not contribute to sustainability. Second, exemption from user fees for certain services is not new in Burkina Faso.

It seems, therefore, that developments in the organization of the health system are not taking into account advances in knowledge about point-of-service user fees. It is as if these two systems were operating in parallel, without no reciprocal influence, two solitudes observing each other. To better understand this situation, we diachronously analyzed how the healthcare system context has evolved and the history of different forms of free care, as well as the existence and development of scientific production on healthcare financing.

The health system’s evolution has followed the classic pattern of all West African countries. Today’s organizational structure is pyramidal, with the health district being at the core of its functioning. During the colonial period healthcare was free, to facilitate access to a modern system that was new to the populations (as with colonial schooling...and for colonial purpose). Some forms of free healthcare have since been maintained, particularly for public

health reasons (tuberculosis, leprosy, etc.). For the rest, the health system conformed to the international thinking of the 1980s regarding cost recovery, and the country has not yet committed to following the African Union directives (2010) regarding user fees exemptions for children and pregnant women. Yet there is no lack of production of scientific knowledge about the specific context of Burkina Faso. Our non-exhaustive survey of the social science literature shows that the financial barriers to access to healthcare have been clearly delineated for quite some time. Our bibliometric analysis of published studies on healthcare financing uncovered a significant number of publications (n = 44), even though national researchers were primary authors in only 5% of those cases. The number of such publications has been increasing, especially since 2002, but it is only since 2010 that researchers have begun paying attention to the issue of free healthcare.

This analysis provides a clearer picture of the two systems' parallel development. Two key hypotheses might explain this impermeability, which calls for more in-depth study. First, most of the people currently involved in the health system, especially at the highest level, retain deeply-held beliefs and perceptions about free healthcare. These accepted notions, even when they have been invalidated by scientific evidence, continue to impede decision-making around user fees exemptions. Some researchers even support these notions. Second, the institutions within which these people work do not encourage the questioning of these ideas. The cost of trying to overcome this inertia is too high for individuals, whether decision-makers or researchers. The former work in politicized environments where career advancement depends on not going against the conventional wisdom of the majority, which supports making

patients "responsible". Given the low salaries in public service, and the non-lucrative nature of scientific activity, few are drawn to this world when they can work in more profitable per diem situations. The latter do not have the means to work as researchers, and therefore turn to consultancy work that is often not very critical, or else they depend largely upon their Northern researcher colleagues who struggle to influence decision-making.

How can we attempt to change the situation? Obviously, we could offer suggestions regarding the organization of the research community or of political decision-making. But let's be pragmatic. First, the university system needs to give more weight to the sharing and dissemination of knowledge emanating from studies by early-career researchers, whether from the South or the North. Then, political leaders and high-level bureaucrats need to be better trained to understand the value of taking these studies into account in decision-making, even though political decisions will clearly always be influenced by context and by ... politics. Finally, it is important to implement strategies that would allow these two systems to meet, interact with and influence each other. This is where knowledge application and brokering strategies are most useful, so that solutions can be applied that will respond to the expectations of the third solitude ... those who are most vulnerable.

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