

Nine misconceptions about free healthcare in sub-Saharan Africa

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As universal healthcare gains political momentum, there is a growing international consensus against charging user fees at the point of healthcare delivery. In 1994, South Africa launched the wave of new user fees abolition policies in Africa. In 2010, both the African Union and the UN Secretary General called for free healthcare at the point of service for children under five and pregnant women. However, dismantling a user fees policy that has been in place for over 30 years is no easy task. Not only does expanding free healthcare policies routinely lead to controversy that generally arises when public policies are badly planned, underfunded, and poorly implemented, but certain groups of actors also perceive this move as a threat. However, in most cases, the continued reluctance to make healthcare free in Africa is based not on strong evidence, but rather on misconceptions around the very notion of free care. In this paper, we address nine such misconceptions about free healthcare and provide recent evidence from Africa showing the benefit of eliminating user fees for patients. Our aim is to demonstrate that when free care is properly financed and implemented, which in itself is a major challenge, certain perceptions about the principle of free healthcare turn out to be misconceptions.

Keywords: Africa; user fees; free care; misconceptions; ideas; public policy; equity

Introduction

In 2010, both the African Union and the UN Secretary General called for full exemption from healthcare costs for children under five and pregnant women (African Union 2010; United Nations Secretary-General 2010). Post-apartheid South Africa pioneered this exemption in 1994 (Wilkinson, Sach, and Abdool Karim 1997). Since the early 2000s, a great many African countries have followed suit by instituting user fees exemption policies, or “free healthcare” at the point of service (Meessen et al. 2011). Today, there is a consensus among global health actors against user fees (WHO 2013; Jamison et al. 2013). This far-reaching movement to reform health financing within Africa may have influenced the commitment to work towards universal healthcare undertaken by the General Assembly of the United Nations in December 2012. This radical departure from the widespread implementation of user fees in the 1980s has prompted the Director-General of the World Health Organization (WHO) to confirm that “user fees punish the poor” (Chan 2013). Even the World Bank chief, Jim Yong Kim, said in April 2013 that it makes sense to abolish user fees at the point of service (Elliott 2013) and reaffirmed in May

2013 at the World Health Assembly that healthcare user fees are “unjust and unnecessary”. In December 2013, the Lancet’s Global Health 2035 Commission proposed that universal healthcare should consist of interventions provided with “zero or close to zero out-of-pocket expenses” (Jamison et al. 2013). This debate is thus part of the current universal healthcare movement, which some would like to see become a – if not the only – post-2015 health development goal.

However, dismantling any policy that has been in place for over 30 years is no easy task. In the first place, expanding free healthcare policies routinely leads to controversy, which generally arises when policies are badly planned, underfunded, and poorly implemented (Ridde, Robert, and Meessen 2012; Ridde and Olivier de Sardan 2013). This change in funding methods can also threaten the interests of certain influential actors, whether in the healthcare professions or the private sector, who may feel they are losing certain advantages, as was shown in Mali (Touré 2013). This goes directly to the heart of the political economy of reforms aimed at universal healthcare coverage (Fox and Reich 2013). However, in most cases, the continued reluctance to make healthcare free at the point of service is

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based not so much on evidence, but rather on presuppositions, misconceptions, and particular ideologies around the very notion of free care. Many studies have demonstrated the role of ideas in defining public policies (Béland and Cox 2011). In September 2012, in a series of articles in the *Lancet* highlighting the importance of eliminating user fees, Jeffrey Sachs referred to those ideas as “lazy thinking” based on less-than-rigorous reasoning (Sachs 2012).

In this paper, we address nine misconceptions about free healthcare in Africa and provide recent evidence showing the benefit of eliminating user fees for patients. Our aim is to show that when free care is properly financed and implemented, certain perceptions about the principle of free healthcare turn out to be misconceptions. The data presented in this article are drawn from the most recent studies on the subject. They were selected for heuristic purposes, to show the congruence of evidence from several different countries while not glossing over the difficulties of implementing free care. We also present in Box 1 the specific example of one country, Burkina Faso, to illustrate more clearly the issues addressed in this article.

Misconception #1: a financial contribution, however small, must be required

We often hear that nothing should be provided for free and that every healthcare service should charge a fee, even if only a “token” one. Yet extensive research shows that, however moderate the amount charged, it deters or strongly limits access to health services by people in general and the poor in particular (Lagarde and Palmer 2011). In Kenya, for example, 75% of children received treatment against parasites when it was provided for free, as against 19% when a “token” contribution of USD 0.30 was required. Other studies comparing the sales of “low-cost” health products (water disinfectants for USD 0.25 in Zambia, mosquito nets for USD 0.60 in Kenya) with free distribution show significant differences in the access to these products (Bates et al. 2012). In Mali, free malaria treatments provided by the State made it possible to provide care for an additional 30% of sick patients at a time of high malaria transmission, although consultation fees remained (USD 0.40 and USD 0.60) (Heinmueller and Ridde 2014). In one district in Mali where consultation fees waived as an experiment and free malaria treatments were provided, three times as many patients were could be treated (Heinmüller et al. 2012). In Burkina Faso, the national subsidy cutting the price of birth deliveries to 900 CFA francs (USD 1.75) in health centres increased their number by 40% to 120% depending on the district within only a year. However, when free healthcare was implemented in certain districts, it enabled many more women to give birth in a health centre (Haddad et al. 2013).

Requiring any financial contribution, however small, restricts access to healthcare by the poor and the poorest. While there are other determinants of use (location,

quality of care, etc.), the literature unequivocally shows that the primary reason why patients do not use health services is that they cannot afford them.

Misconception #2: free healthcare does not benefit those who need it most

It is widely assumed, including by public health experts (Victora et al. 2000), that universal coverage policies such as free healthcare for all primarily benefit the most advantaged social groups.

In Burkina Faso, a study found that the national policy of subsidizing childbirth costs led to a decrease in expenses and an increase in the number of deliveries in maternity units for all women, including the poorest (De Allegri et al. 2012; Ridde et al. 2014). In two Burkina Faso districts piloting free healthcare for children under 5, it was proven that the subsidy benefited all children, rich and poor, whether mildly or seriously ill, and regardless of whether they lived near a health centre (Ridde, Haddad, and Heinmueller 2013). For instance, poor and seriously ill children living within 5 km of a health centre benefited twice as much from free healthcare as those who were less poor (Ridde, Haddad, and Heinmueller 2013). In Sierra Leone, three months into State-funded free care, 72% of poor children suspected of having pneumonia consulted a health professional, as compared with 63% of rich children (Statistics Sierra Leone and UNICEF 2011). In Uganda, several studies have shown that the poor benefited fully from free healthcare (Deininger and Mpuga 2005; Nabyonga et al. 2005), more so than others (Nabyonga Orem et al. 2011). Most recently, a study based on data from 35 countries showed that the countries that were fastest in improving coverage for assisted childbirth for all women were also those that were most successful in reducing inequalities between the rich and the poor (Victora et al. 2012).

To date, evidence shows that the most advantaged populations do not monopolize the benefits of free healthcare. The most disadvantaged profit from it just as much, and sometimes even more. Of course, free healthcare at the point of service alone cannot be expected to correct all the existing inequalities in health systems, but it does partly address them.

Misconception #3: free healthcare takes away people’s sense of responsibility and is not valued enough

Many people claim free healthcare would take away people’s sense of responsibility by enabling them, for example, to abuse the use of health services. They also say it would encourage people not to value the services provided to them free of charge and/or to view them as sub-standard. Some economists call this a frivolous demand, but we do not know of any empirical studies on primary care in Africa that would support this hypothesis.

Box 1. History and impacts of user fees abolition in Burkina Faso

Burkina Faso is a West African country of 17 million inhabitants, 43.9% of whom live under the national poverty threshold (2009). It has been estimated that 100,000 children under five years and 2000 women die each year of causes that the health-care system should be able to prevent. Healthcare system use is low. In 2006, only 54% of women gave birth in a maternity unit and only 38% of children with acute respiratory infections went to a health centre. In 2010, 99% of the country's population was not covered by any insurance plan (INSD, Measure DHS, and ICF Macro 2011).

The healthcare system is pyramidal and organized into health districts. The first user fees and CR pilot projects started in 1989. The principle was extended nationally in 1992. User fees exemptions for the indigent were envisioned but never implemented. Decision-makers remained prudent, and sometimes inconsistent, on user fees exemption, even though all the public policies affirmed that equity of access was a core objective.

Aside from historical measures related to vertical programmes (e.g. tuberculosis, leprosy), the policy for free emergency obstetric services (2000) was not applied (Bicaba et al. 2003). In 2002 and 2003, the government eliminated fees for prenatal care and infant care, as well as for syringes, iron supplements, and chloroquine. In 2006 and 2007, it launched a policy of subsidizing 80% of the costs of deliveries and caesareans for all women and 100% of those costs for the indigent. In 2008, the Ministry of Health acquiesced to an experimental NGO-supported project that exempted children under five and pregnant women from user fees in four districts. In 2012, the President of the Republic abolished fees for antiretroviral treatments (ARVs) and promised to abolish fees for deliveries. As of 2014, the latter promise had not yet been fulfilled. New malaria treatments artemisinin-based combination therapy (ACTs) have been subsidized by the Global Fund (2010) but the State continues to require a small fee from all patients. In 2011, a third NGO implemented the same exemptions (for women and children) in a fifth district but stopped them in December 2013. In 2012, the national social protection policy adopted user fees exemptions for pregnant women and children under five, and reaffirmed them for the indigent (ministère de l'Action sociale et de la solidarité nationale 2012). In 2014, a project funded by the World Bank in 12 districts plans to exempt the indigent (20% of the population) from user fees following a community-based selection process.

Here are examples of evidence specific to this context regarding the nine misconceptions:

Misconception #1: A financial contribution, however small, must be required

The 80% subsidy for deliveries enabled more women to give birth in maternity units. However, the exemption organized in four districts since 2008 benefited even more women (Ridde, Queuille, Atchessi, et al. 2012). Indeed, requiring any financial contribution, however small, restricts access to healthcare. Fees for ACTs, for example, impede children's access to malaria treatment (Druetz et al. 2013; INSD, Measure DHS, and ICF Macro 2011).

Misconception #2: Free healthcare does not benefit those who need it most

The national subsidy for deliveries increased the use of maternity units and lessened healthcare costs for the poorest women, even if it did not reduce inequities (Ridde et al. 2014).

Misconception #3: Free healthcare takes away people's sense of responsibility and is not valued enough

Families living more than 10 km away bring their children to health centres when care is free, even when they must pay for transportation and indirect costs (Ridde, Haddad, and Heinmueller 2013).

Misconception #4: Free healthcare is substandard care

The quality of medical prescriptions has been maintained in the districts where children's care is now free, thanks to indispensable support measures (Atchessi, Ridde, and Haddad 2012). Free care did not have a negative impact on perceived quality of care, and women's perceptions remained very positive (Philibert et al. 2014).

Misconception #5: Free healthcare is impossible because it creates excessive workloads for health workers

The national human resources policy, the training of male midwives, and the recruitment policy's regionalization have made enough health workers available to deal with the increased demand generated by the exemption (Ly et al. 2013).

Misconception #6: Free healthcare will bankrupt health centres

While reimbursements for the national subsidy for deliveries are sometimes delayed, they do cover the expenses and they are always paid. This creates no ill effects for health centres (Ridde et al. 2011).

(Continued)

Box 1. Continued*Misconception #7: Making deliveries free will lead to more births*

There is no evidence to support the claim that free deliveries lead to more births. Since the delivery subsidy, fertility rates have been decreasing (INSD and ICF International 2012).

Misconception #8: African states are incapable of implementing free healthcare

With the potential to serve as a policy of transition towards free healthcare, the national subsidy for deliveries, even if not perfectly planned and implemented, is nevertheless very effective. In some districts without NGO aid, more than 90% of women give birth in a maternity unit (ministère de la santé 2012; Ridde et al. 2014).

Misconception #9: African countries cannot afford free healthcare

The national subsidy for deliveries is financed entirely by the State for the period 2006–2015. The budget is sufficient, but its continuation is not assured (Ridde et al. 2011).

Studies on HIV treatments provided by the Senegalese State have shown that free care helped make patients more responsible about following their treatment, thereby making the fight against HIV much more effective (Laniece et al. 2003). For the same reason, tuberculosis treatment is free in many countries (Ba et al. 2011). Experimental research has shown that paying or not paying for mosquito nets in Uganda and Kenya or for water disinfectant in Zambia in no way affects their levels of utilization by populations. People who pay for these products do not use them more than those who receive them for free (Bates et al. 2012). Furthermore, free care allows more patients to be treated and cured, thereby enabling citizens to play an active part in managing their own health. The aim of making prenatal consultations (PNC) free in most African countries is also to establish links between pregnant women and midwives in order to encourage deliveries in maternity units. In Africa, women who have had three PNCs are nine times more likely to give birth in a health centre than are those who have had none (Guliani, Sephiri, and Serieux 2012). In Burkina Faso, in a region where a majority of the population is poor, a year after free care was introduced 80% of sick children used a health centre vs. 30% when care was not free. Even parents of sick children living more than 10 km away from health centres are flocking in to take advantage of free care (77% more than before) (Ridde, Haddad, and Heinmueller 2013). On the other hand, in Rwanda, where community-based health insurance continues to charge a co-payment at health centres, only 33% of sick children visit health facilities (Lu et al. 2012).

Free healthcare makes people responsible by enabling them to play an active part in managing their own health.

Misconception #4: free healthcare is substandard care

Quality of care is a major issue for healthcare systems. Some people are concerned about the negative effects of free care

on care quality, caused in particular by the increase in the number of consultations for health workers, the excessive “freedom” given to prescribers, stock shortages of medical products, etc. We have not found any research establishing a direct and quantifiable link between free care and a lowering of the quality of care. However, some qualitative research does show, in Niger and Mali, that when free care policies are underfunded and poorly organized, they lead to a lessening of quality in terms of the availability of medications (Olivier de Sardan and Ridde 2012). But this low quality very often predates free care policies, and the deterioration can be explained mostly by poor implementation, rather than by the principle of free care itself. On the contrary, the principle of user fees does not necessarily improve the availability of medications. In Burkina Faso, for example, people must pay for antimalarial medications distributed by community health workers (CHW), unlike in Mali, where they are free of charge. However, in both places, the same implementation and logistical problems arise that make the availability of these products very challenging. In fact, in two rural districts in Burkina Faso, less than 10% of children consult a CHW for malaria treatment (Druetz et al. 2013). The quality of implementation of these policies is therefore central to achieving their intended objectives.

Two studies were carried out in Burkina Faso on quality of care in a situation where free care was well implemented and where use of the services greatly increased. The first study showed that the average durations of medical acts by healthcare workers in a district where care was free were not shorter than those in a neighbouring district where people still had to pay (Ly et al. 2013). The second study showed that medical prescriptions for care to children under five remained, with the introduction of free care, very close to WHO and State standards (Atchessi, Ridde,

and Haddad 2012). The importance of accompanying measures and of the supervision of free care mentioned in that study was confirmed by research conducted in Senegal, where the free distribution of antimalarial treatments by CHWs posed serious problems when no other measures were taken (Faye 2012).

Quality of care is a very complex concept. In the documented cases, the parameters studied do not demonstrate any deterioration in quality of care where free care is well financed and implemented. They do show the importance of accompanying measures when free care is introduced.

Misconception #5: free healthcare is impossible because it creates excessive workloads for health workers

People expected that free healthcare would generate too high a demand for health services, which would create excessive workloads for health workers.

There is no denying that the substantial increase in patients' use of services brought about by free healthcare adds to workloads in health centres. This, in fact, should be cause for celebration, as increased use is the primary outcome sought by this type of strategy. After all, in countries with very high mortality rates, increasing individuals' contacts with health services is desirable. In Niger, for example, only 18% of births were assisted by qualified personnel in the period 2005–2011 (WHO 2011). With regard to the issue of health workers' pressure, there have been very few studies producing objective information on the workload question. Health workers do, in fact, complain about this increase, which is real, and which they describe as "work overload" in several countries like in Mali (Touré 2013). However, health workers' reports of their average time spent providing free services in Burkina Faso and Niger systematically exceed the time measured by researchers (Ly et al. 2013). In Niger, with only 1.4 nurse and midwife for every 10,000 inhabitants (WHO 2011), there was a limited number of health workers to cope with the increased attendance generated by free care when funded by a non-governmental organization (NGO). However, in a district where free care was organized only by the State, with many problems and therefore lower use, the number of health workers was sufficient (Ly et al. 2013). In Burkina Faso, the State has invested in more health human resources: there are 7.3 nurses and midwives for every 10,000 inhabitants (WHO 2011), i.e. five times as many as in Niger. Thus, in 2010, there were enough health workers to accommodate the demand, both in a district where fees were charged and where services were therefore less often used, and in a district where care for children under five and for pregnant and nursing women was free (Ly et al. 2013).

Most often with user fees demand is low and health human resources are underused. Therefore, the increased

use of health centres – and subsequently of human resources, infrastructure and equipment – generated by free healthcare makes the system much more efficient by using those resources more effectively. As previously highlighted, the removal of user fees does need to be accompanied by supporting measures to enable the health system, and in particular health workers, to cope with the increase in demand.

Misconception #6: free healthcare will bankrupt health centres

Health officials regularly contrast the principle of free healthcare with the major advantages of the Bamako Initiative, a health systems reform undertaken in the late 1980s mostly in West Africa (UNICEF 1995). Two of that reform's strategic pillars were the implementation of a cost recovery (CR) system based on point-of-service user fees and community involvement in managing health centres and the newly generated funds. The revenues generated by CR were intended to renew stocks of essential generic drugs and cover certain operating costs. CR also generated revenues that should normally have been used to improve healthcare quality and access, but which instead were most often simply hoarded (Kafando and Ridde 2010). Community involvement took the form of local health centre management committees (Foley 2010). Thus, free care is criticized as going against the CR system and as putting health centre management committees at risk of bankruptcy.

From a theoretical perspective, the assumption that free care does not comply with the CR system shows a poor understanding of the principle of free care at the point of service. Of course, "free" healthcare does not mean nobody pays. It just means the service provided is not paid for by patients at the point of service, but rather by a third party whose resources come from various sources. For this funding system to be efficient and equitable, private funding through fees must be replaced by a publicly financed system, as suggested for universal healthcare by both WHO and the Lancet Commission (WHO 2010; Jamison et al. 2013). Therefore, free care is compatible with the CR system thanks to third-party payment. Obviously, if such a policy is underfunded and/or the third party fails to pay, CR ceases to function, with disastrous effects on the financial situation of management committees. But this would be true, whatever the funding mechanism. This is, in fact, the situation in Senegal and Niger (Ridde, Queuille, Kafando, et al. 2012), but a principle cannot be assessed based on examples that failed to meet the most basic prerequisites. In Mali, a study has demonstrated that the national policy of free malaria treatment has had no negative effect on community finances (Kafando and Ridde, *Forthcoming*). Health centres' financial assets remain substantial, averaging over USD 3850. In Burkina Faso, while reimbursement based on the national subsidy is not flawless,

it certainly has not made health facilities bankrupt. Health facilities receive the required payments, sometimes late, but in sufficient amounts (Ridde et al. 2011). Furthermore, numerous studies in Africa have shown that CR covers only a very small portion of health centres' operating needs (Nolan and Turbat 1995; Gilson 1997).

Free healthcare helps health centres expand their financial capacities, provided it is sufficiently funded and properly implemented.

Misconception #7: making deliveries free will lead to more births

Some people maintain that free deliveries will encourage more births and, as such, that this measure runs counter to the promotion of family planning. There is no evidence to support this notion, whereas a vast body of knowledge has shown quite the reverse.

In Africa, deliveries are most expensive in urban areas, where birth rates are also the lowest. In Mali and Burkina Faso, women living in rural environments have an average of 7.2 and 6.7 children, respectively, whereas those in the capital have only 4.8 and 3.4 (CPS/DNSI and Macro International Inc. 2007; INSD and ICF International 2012). In Burkina Faso, Ghana, Senegal, and other countries, the downward trend in fertility continued even when deliveries were heavily subsidized or made free over the 2005–2010 period. Furthermore, it has long been known that education is one of the most important factors influencing fertility, and that poverty slows down any decline in fertility (Schoumaker 2004). Childbirth expenditures, and especially for caesareans, can plunge the least well-off households into extreme poverty (Xu et al. 2007). We have already mentioned the lowering of health expenditures for the poorest thanks to the national subsidy of deliveries in Burkina Faso (Ridde, Kouanda, et al. 2012). Seven of the 11 articles identified in a systematic review studying the impact of eliminating user fees for deliveries on the use of healthcare facilities surveyed between 1999 and 2011 demonstrated a positive impact (Dzakpasu, Powell-Jackson, and Campbell 2013). The “safe motherhood” concept is aimed at saving women's lives through assisted deliveries by qualified personnel that facilitate the detection of complications, which occur in 15% of childbirths, and rapid referral to hospital for treatment. Charging user fees for deliveries encourages home births, thereby limiting access to care that should be available to all pregnant women.

Free healthcare increases the number of assisted deliveries by qualified personnel (who must be trained and made available by the States) and ultimately has the potential to save lives. Free deliveries and family planning are complementary. Both deal with reproductive health, respond to health needs, are aimed at reducing poverty, and promote the enforcement of sexual and reproductive rights. It is urgent that these

actions be undertaken to improve women's health and advance universal healthcare (Quick, Jay, and Langer 2014).

Misconception #8: African states are incapable of implementing free healthcare

Many people question the capacity of African states to implement free healthcare policies. Indeed, several countries are encountering serious difficulties in organizing these policies (Ridde, Robert, and Meessen 2012). But when these policies do not work well, it is primarily because they are poorly planned and/or underfunded. 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, at least at the beginning, demonstrated that States are in a position to implement such policies successfully (Nabyonga Orem et al. 2011). The Malian government has made both malaria treatment and caesareans free. Although implementation is not flawless, these public policies effectively help to increase health centre attendance (Heinmüller et al. 2012). 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, the use of health services went up by 30% during the period of high malaria transmission (Heinmueller and Ridde 2014). 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 (Fournier et al. 2012). The free caesareans policy also substantially diminished the joint likelihood of mother and newborn death, which dropped from 4.6% before its introduction to 2.4% after (Fournier et al. 2012). In Burkina Faso, the national subsidy for deliveries has been very effective, including for the poorest women (De Allegri et al. 2012; Ridde, Kouanda, et al. 2012; Ridde et al. 2014), and there may be a move towards 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 (Taverne et al. 2012).

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.

Misconception #9: African countries cannot afford free healthcare

There is a cost to free healthcare for the State and its partners. Just like any other public policy, it needs funding.

However, many people think African states are in no position to finance free healthcare.

In most cases, though, free healthcare for children or pregnant women in Africa is funded by the State, with external partners playing a very limited role (Burkina Faso, Ghana, Senegal, Uganda, etc.) (Meessen et al. 2011). A study showed that health funding by public rather than private entities benefits the poor more than the rich in Ghana, Tanzania, and South Africa (Mills et al. 2012). We also know that community-based health insurance plans, being voluntary, are not the solution for achieving universal healthcare coverage (WHO 2013). However, nearly all African states still do not ascribe enough importance to the health sector. The goal of devoting 15% of the State's budget to this sector (Abuja Declaration of 2001) is rarely attained (3.3% in Chad, 8.1% in Burundi, 9.2% in Benin, etc.) (WHO 2011, 2010). Yet national resources are often available (innovative financing) and health systems could be more efficient (WHO 2010; Marchall and Flessa 2011). Moreover, certain national resources normally allocated to the poor are sometimes not used or misused. In Niger, where user fees for children under five years and caesareans were eliminated in 2005–2006, the additional four billion F CFA (\$8 million) allocated by the government in 2008 to finance all the needs (8 billion FCFA, \$16 million) was not fully used by the Ministry of Health. Thus, the Council of Ministers decided to repatriate the funds and instead to build regional centres for maternal and child services (Ousseini 2014). A study by the International Monetary Fund showed that 120 billion CFA francs (USD 240 million) released by the Burkina Faso government during the 2008 crisis to help the poorest actually benefited the wealthy (Arze del Granado and Adenauer 2011). If we compare this 120 billion CFA francs against the annual budget of two billion CFA francs (USD four million) allocated to the national subsidy for deliveries, whose benefits are not appropriated by the richest (Ridde, Kouanda, et al. 2012; Ridde et al. 2014), we see it is a question of setting priorities and using resources wisely. Over the past few years, Ghana has had the political intent to increase its VAT (still progressive (Mills et al. 2012)) to fund two-thirds of its national health insurance (Seddoh and Akor 2012). Meanwhile, Niger and Gabon each spent two billion CFA francs to help their football teams make it to the Africa Cup of Nations. Finally, there are resources available at the international level. Donor countries just need to honour their commitment to allocate 0.7% of their gross national product to official development assistance (OECD 2011) and to write off Africa's external debt by promoting investments in the social sector in African countries.

In most cases, free healthcare policies for children and pregnant women already in place in Africa are funded by national budgets, of which the share devoted to health remains woefully insufficient. National and international resources are available to finance free healthcare policies,

provided African governments and their partners give them the required priority.

Box 1 presents, in the form of a case study, one example of these various points, placing them in the socio-historical and political context of Burkina Faso. This example illustrates, within the context of one country, what we have shared in this article regarding many other countries in Africa.

Conclusion

Far from being a panacea for universal health coverage, free healthcare makes access to health services not only a right, but a reality, and makes it possible to save lives, as shown by historical experiences such as that of Thailand (Gruber, Hendren, and Townsend 2014). In Niger, the free healthcare policy, along with widespread distribution of insecticide-treated bednets and nutritional interventions, helped save 59,000 more lives of children under five in 2009 than were saved in 1998 (Amouzou et al. 2012). In Ghana, an evaluation suggests that the free maternal health care initiative saved more than 3000 maternal lives from 2008 to 2011 (HERA and HPG 2013). In Burkina Faso, if free healthcare were to be implemented nationwide with the same effectiveness as was achieved in two pilot districts, in just one year it would reduce under five mortality by 16% (95% CI: 4–26%), saving an anticipated 14,000–19,000 children's lives annually (Johri et al., *Forthcoming*).

Free healthcare will not solve all the problems facing populations and health systems, yet because it often serves to uncover malfunctions, it affords a real opportunity for health system improvement. It is time for actors in the health system to consider the numerous studies showing, to date, that there is no strong evidence to support most of the commonly expressed ideas opposing the principle of free healthcare. More often than not, these misconceptions arise in contexts where free care is poorly implemented, underfunded, or not given sufficient political priority (Ridde, Robert, and Meessen 2012; Ridde and Olivier de Sardan 2013).

Rather than opposing this principle, the aim should be to strive for its effective implementation when the African government decide to abolish user fees. Indeed, whenever free healthcare at the point of service has been properly planned, sufficiently funded, and implemented with targeted support measures, it has proven to be very efficacious and equitable.

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