

# Healthcare financing and access in West Africa

## Empirical and satirical!

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# Empirical and satirical!



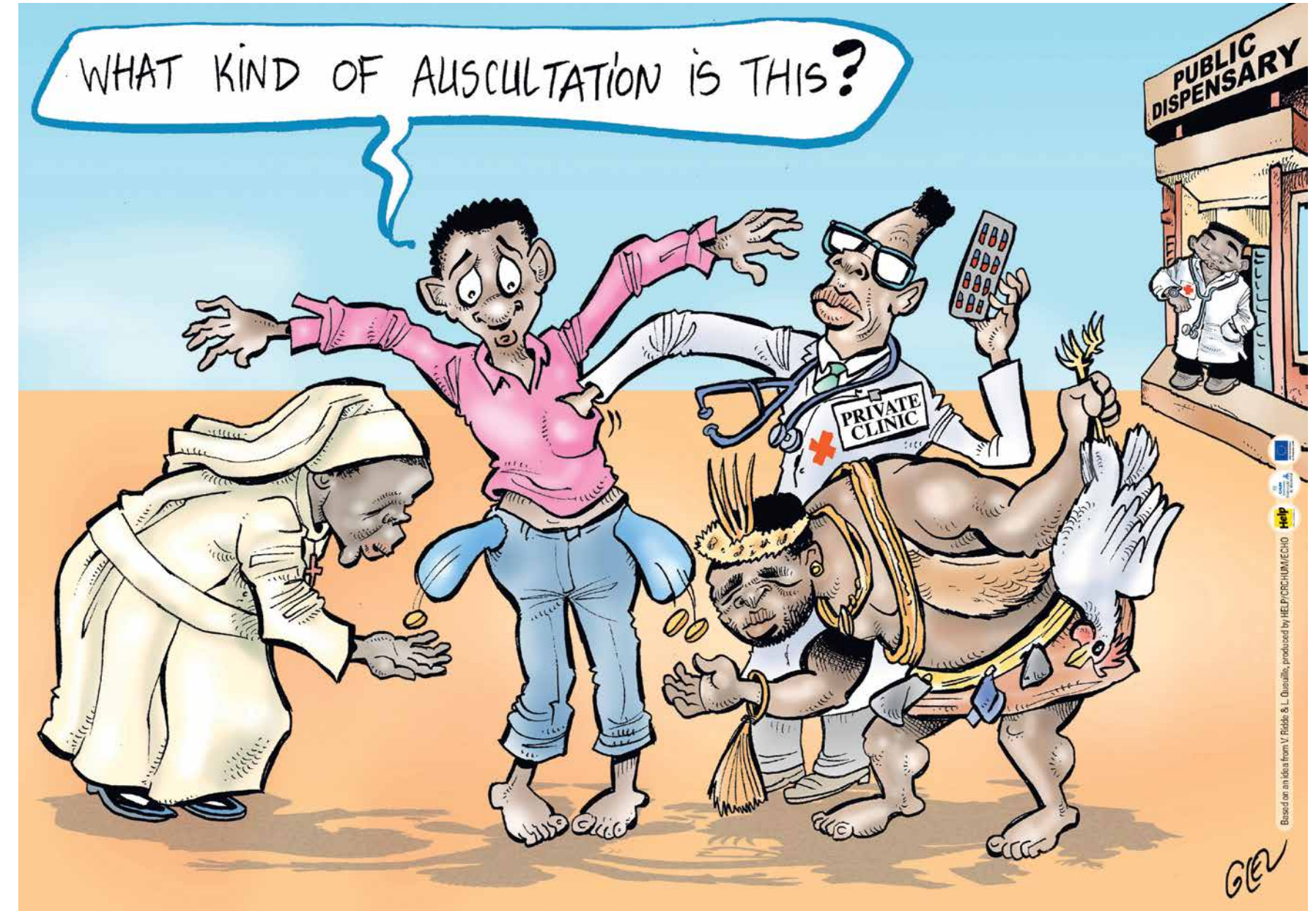
## Preface

Having worked for the past 10 years on producing and applying scientific knowledge about healthcare access and financing in West Africa, we'd like to share a few observations that may sometimes be surprising, by experimenting with using satirical cartoons as a knowledge sharing tool.

Ludovic Queuille & Valéry Ridde



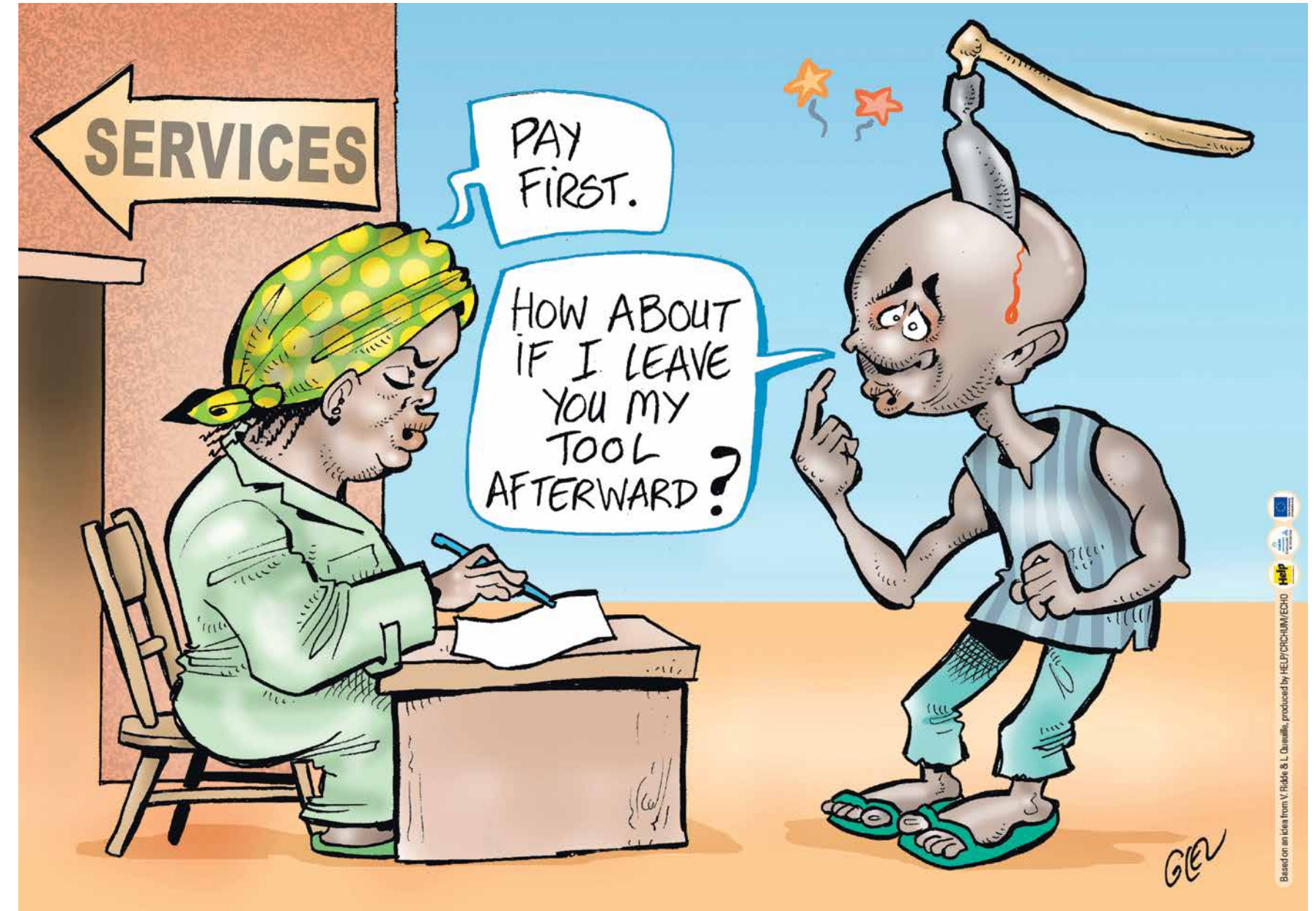
# Universal health coverage and public service



Public healthcare services are often criticized and stigmatized, but most often the care they provide is of better quality than care provided elsewhere and only public funding can guarantee equitable access.



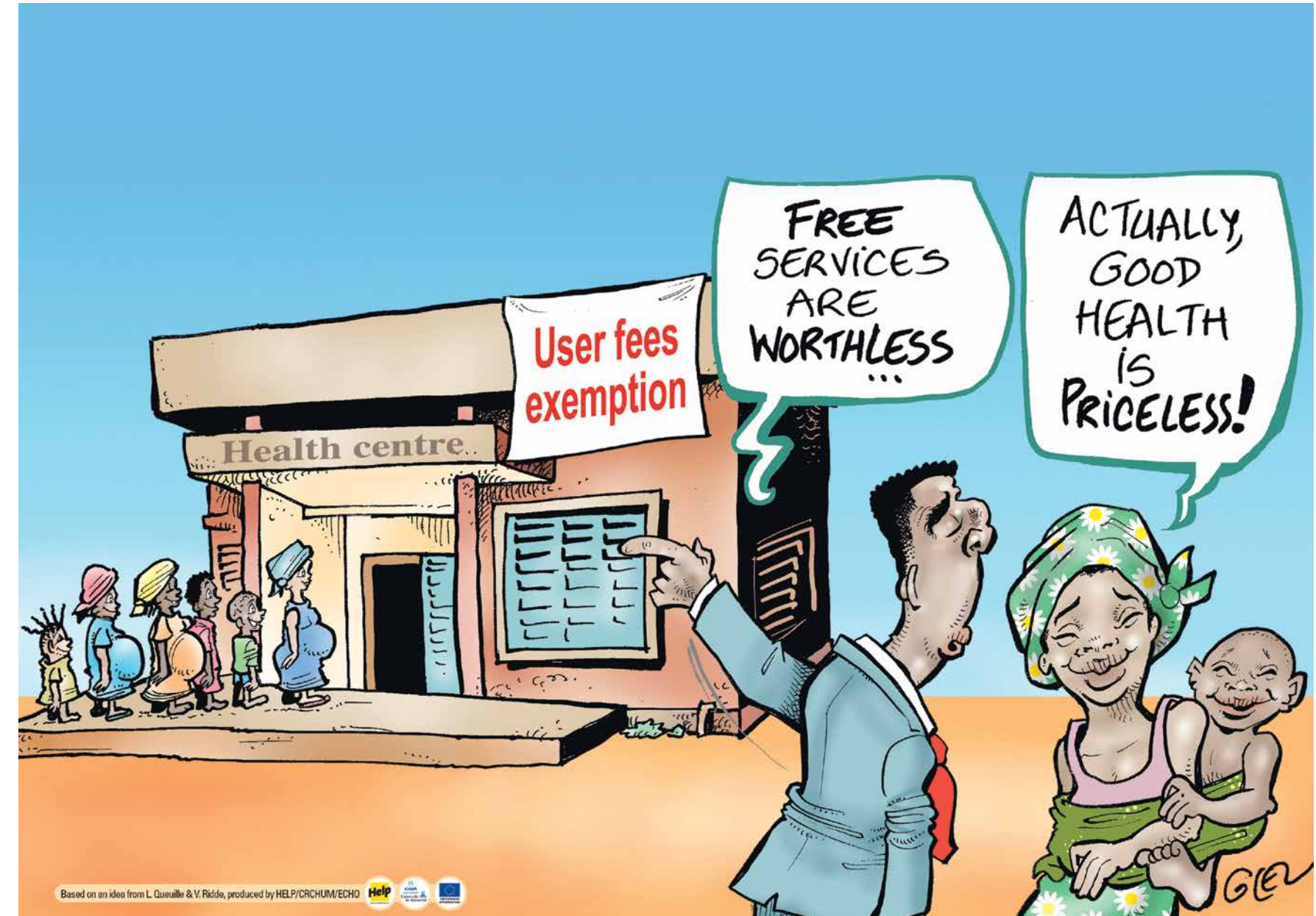
# The consequences of user fees



User fees present a financial barrier to healthcare access for the poor and don't really support healthcare systems financially. Yet even so, they are still very often advocated by some people.



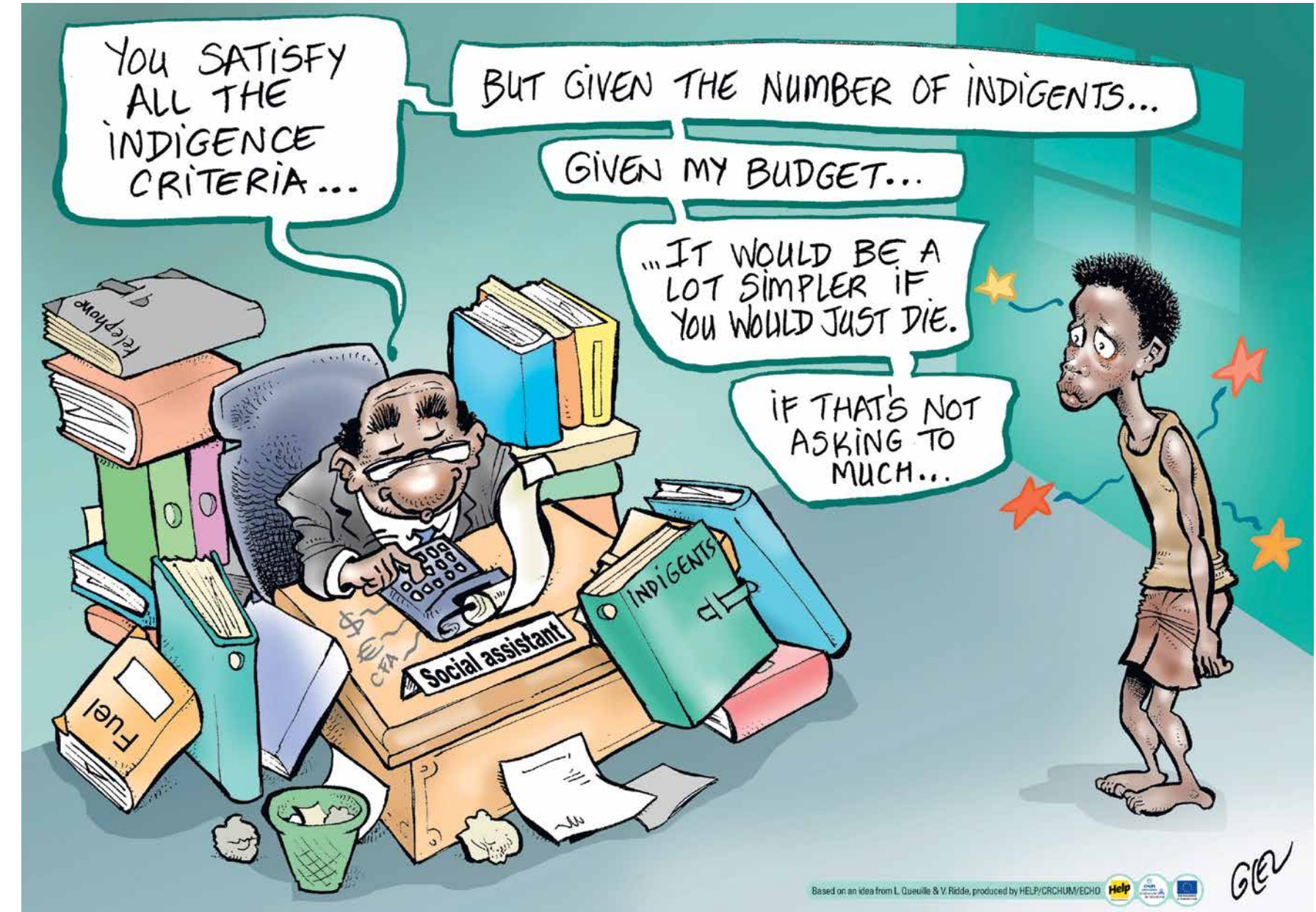
# Health is priceless



The principle of “free care” — or, pardon, “exemption from user fees” (yes, semantics are important, as “free” is a taboo word!) — doesn’t seem to bother anyone but those who have the means to pay for their own access to healthcare services.



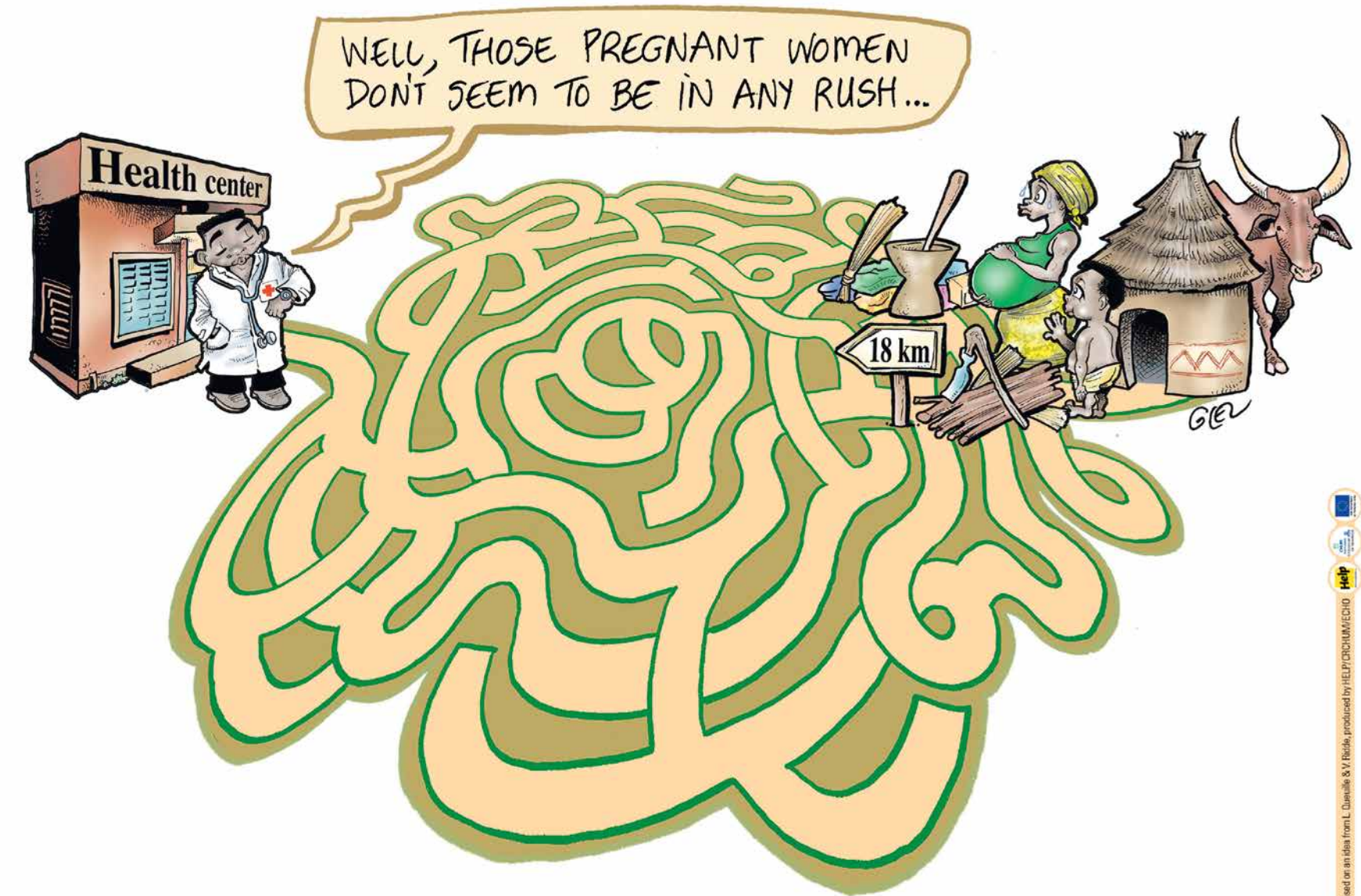
# Providing care to indigents



Exemption of user fees for indigent care has been included in health policies since user fees were introduced. But after 30 years, hundreds of workshops, committee meetings, studies and action research projects to develop criteria and processes for identifying them, the indigent continue to be excluded from the healthcare system. What's really the problem?



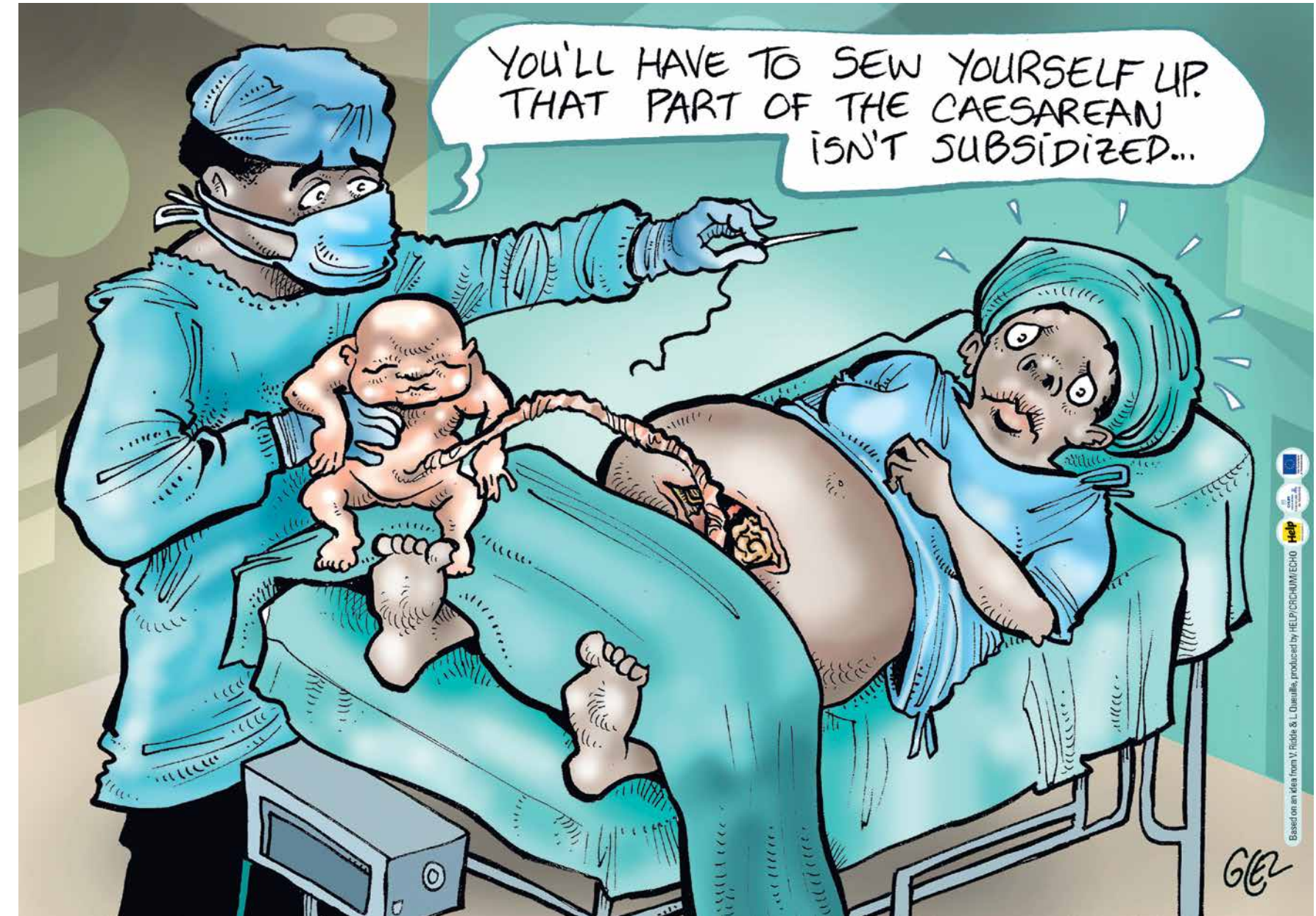
# Maternity without risk



Sometimes people say that it will never be possible to get “those women” to deliver in a health centre, usually because of cultural reasons. But why should we assume that some people would never go to a health centre, when it’s been shown that when financial and geographic barriers are removed, that’s no longer true for most people?



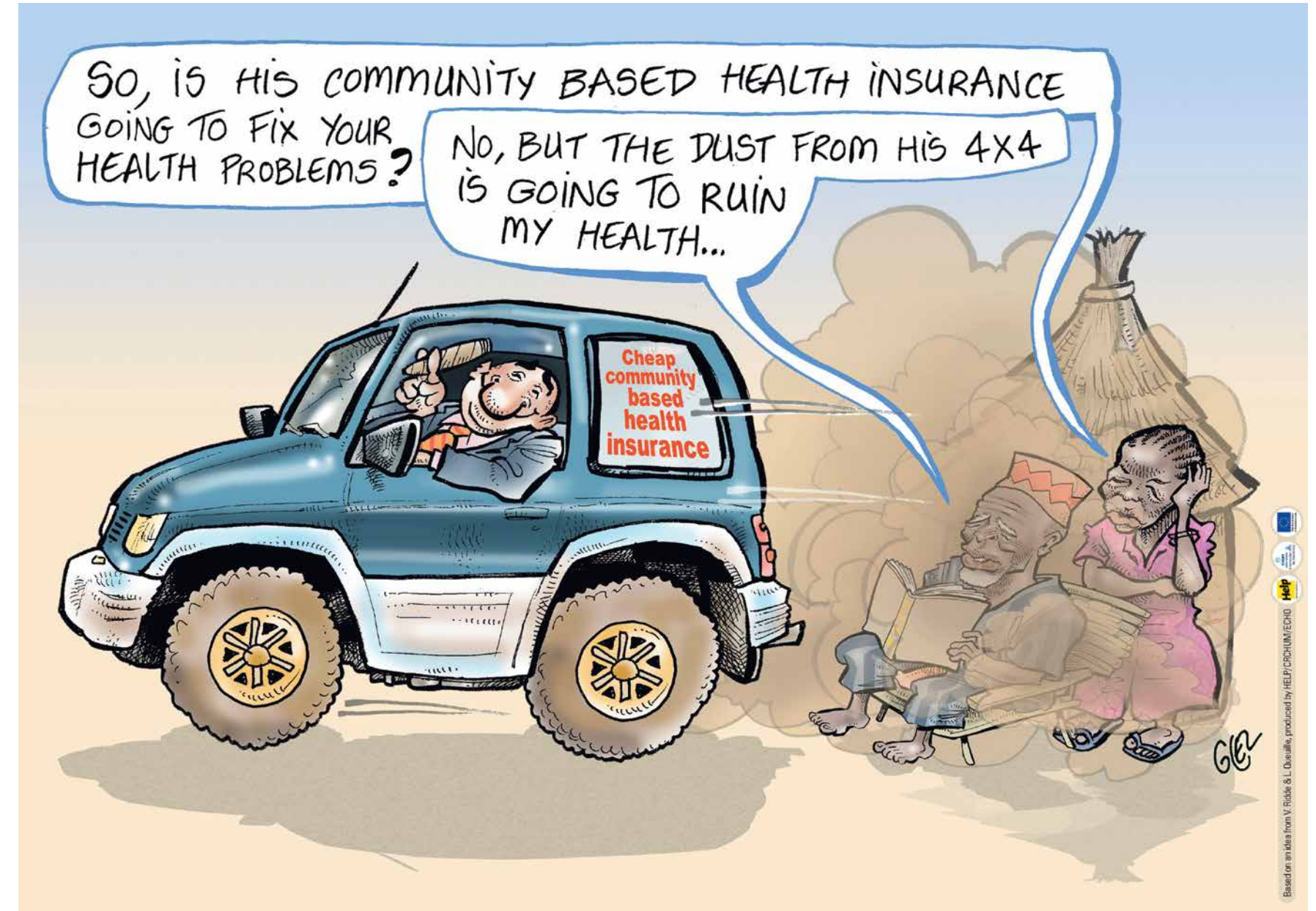
# Planning and funding subsidy policies



Some healthcare subsidy programs offer partial coverage and have “holes” in the package of services provided. Often they’re complex, making them difficult to understand, for the population and sometimes even for health workers. As such, they go against the principle of continuity of care and become less effective.



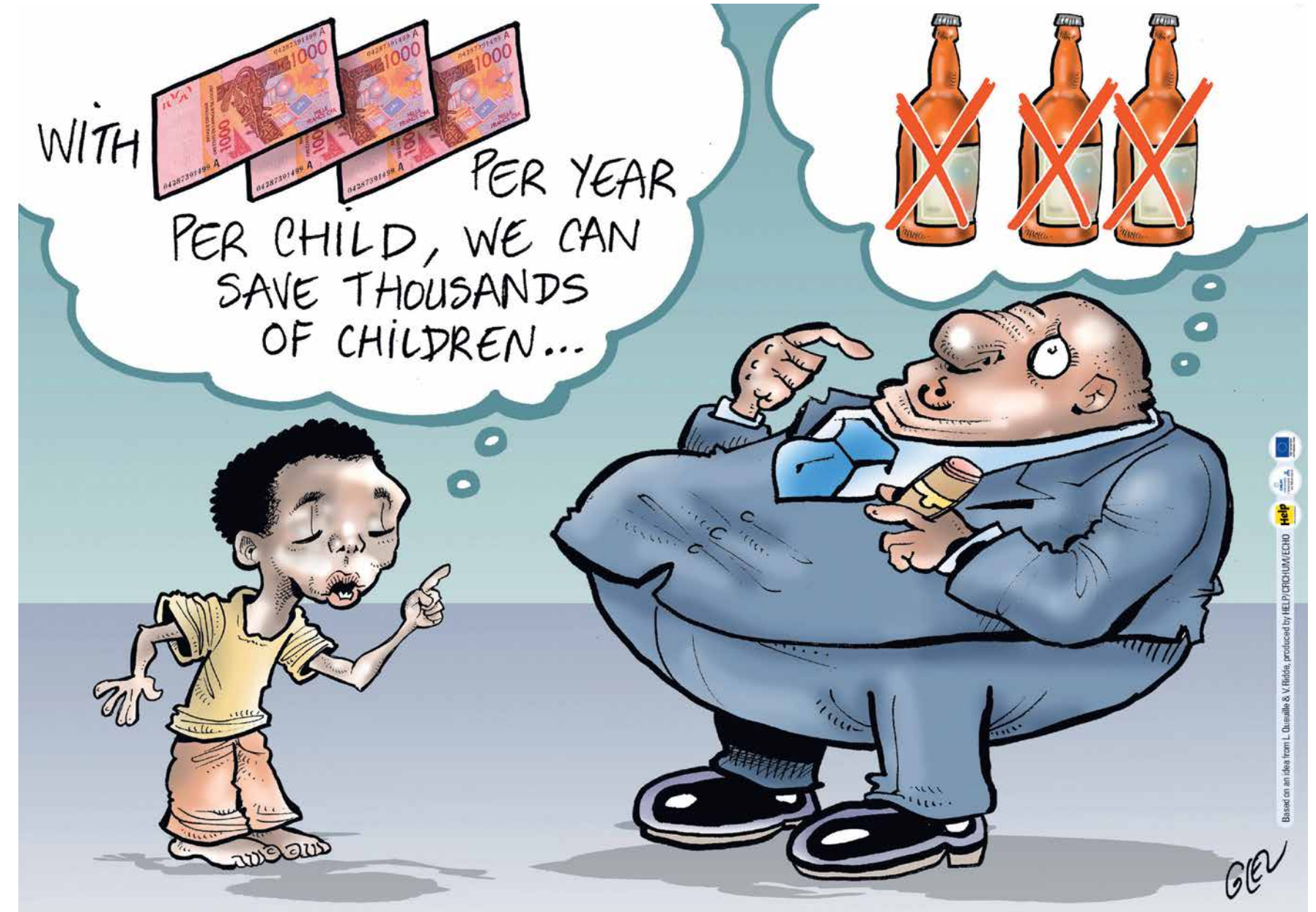
# The myth of community-based health insurance



In 30 years of attempts in West Africa, the most successful community-based health insurance have never gotten above 10% coverage. Nevertheless, they continue to be a staple feature of any reflection on improving financial access to care for the worst-off.



# Vision and political will



In West Africa, children can access healthcare services because they are exempted from point-of-service user fees. This costs less than \$5 US per child per year, and is funded thanks to the political will of decision-makers.



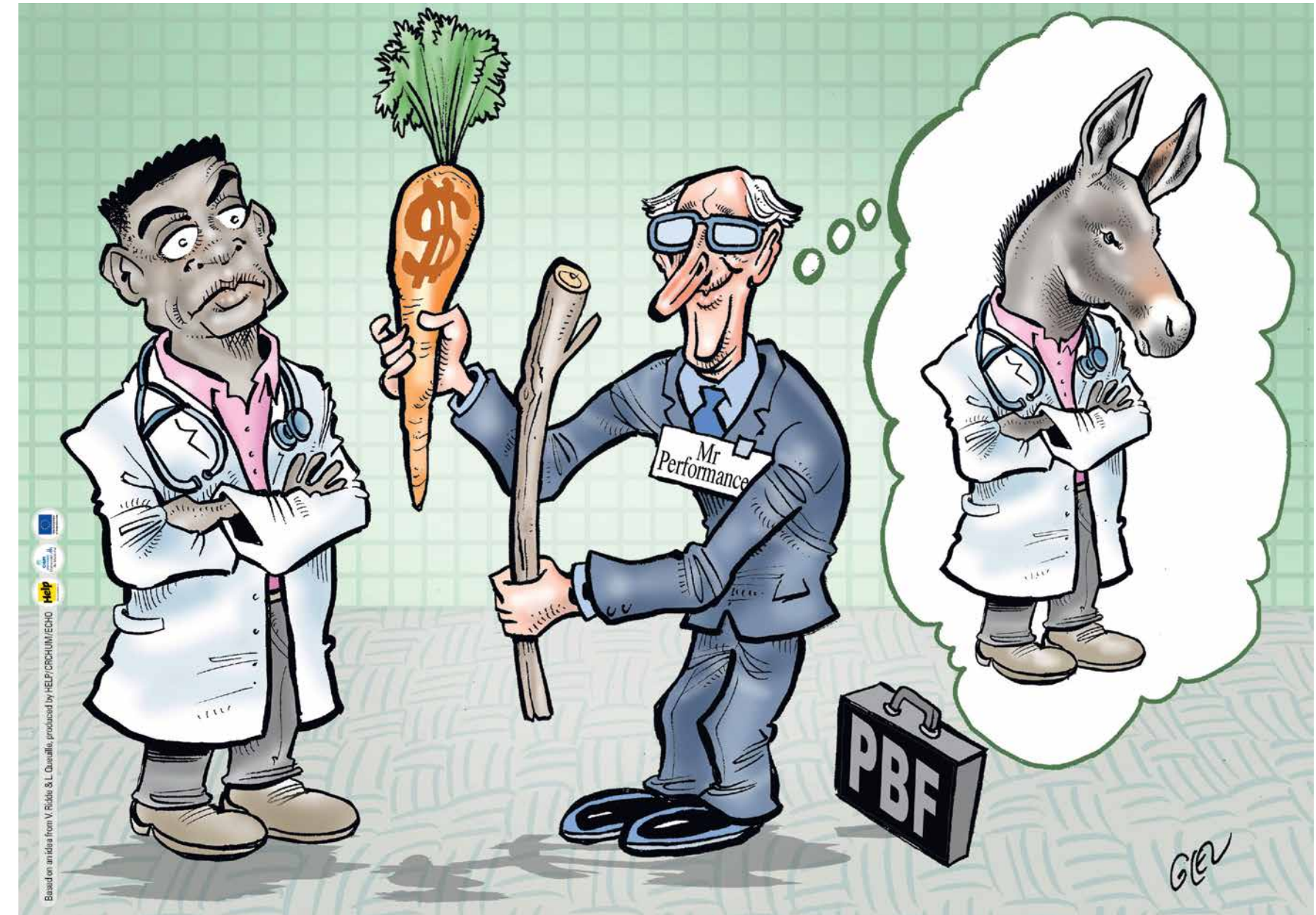
# Health insurance and national solidarity



Recently in Burkina Faso, as in Mali, during the phase of sectoral and regional consultations on the strategic orientations of national health insurance, several key sectors of the Nation were opposed to the principle of national solidarity.



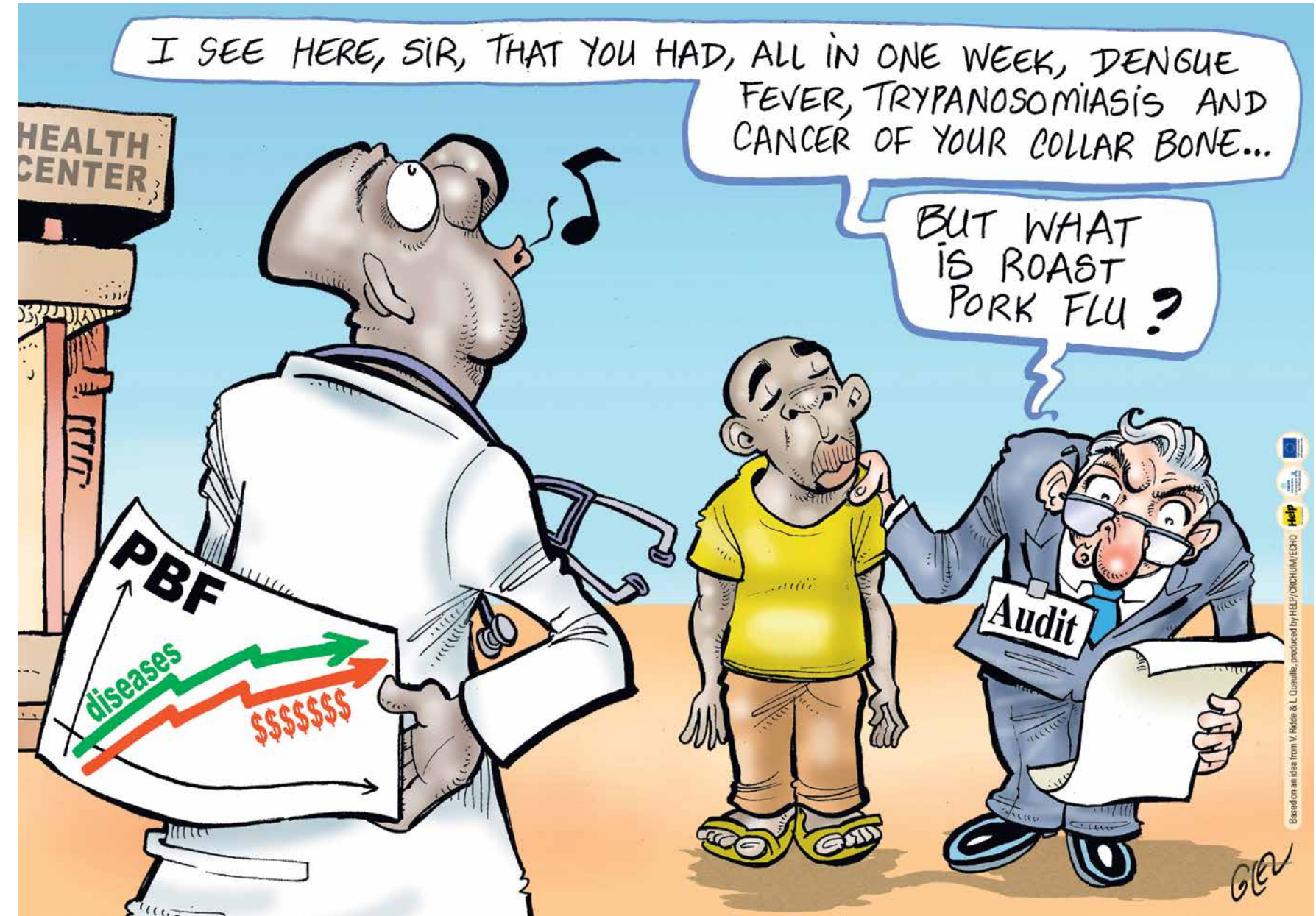
# Performance-based financing (PBF) and motivation



Some experts explain that the success of performance-based financing (PBF) is guaranteed by the fact that it is based primarily on the “carrot-and-stick” principle. But isn’t health worker motivation a little more complex than that?



# Performance-based financing (PBF) and population health



Some experiments have already shown that quantity-based healthcare financing can have pernicious effects. If we put too much pressure on health workers by focusing on the quantity of illnesses, is there a risk of making people even sicker?



# Advocacy or proselytizing...?



The constant proselytizing from most technical and financial partners (including certain researchers...) trying to sell their “agenda” to governments has turned into pandemonium for the national decision-makers who set policy.



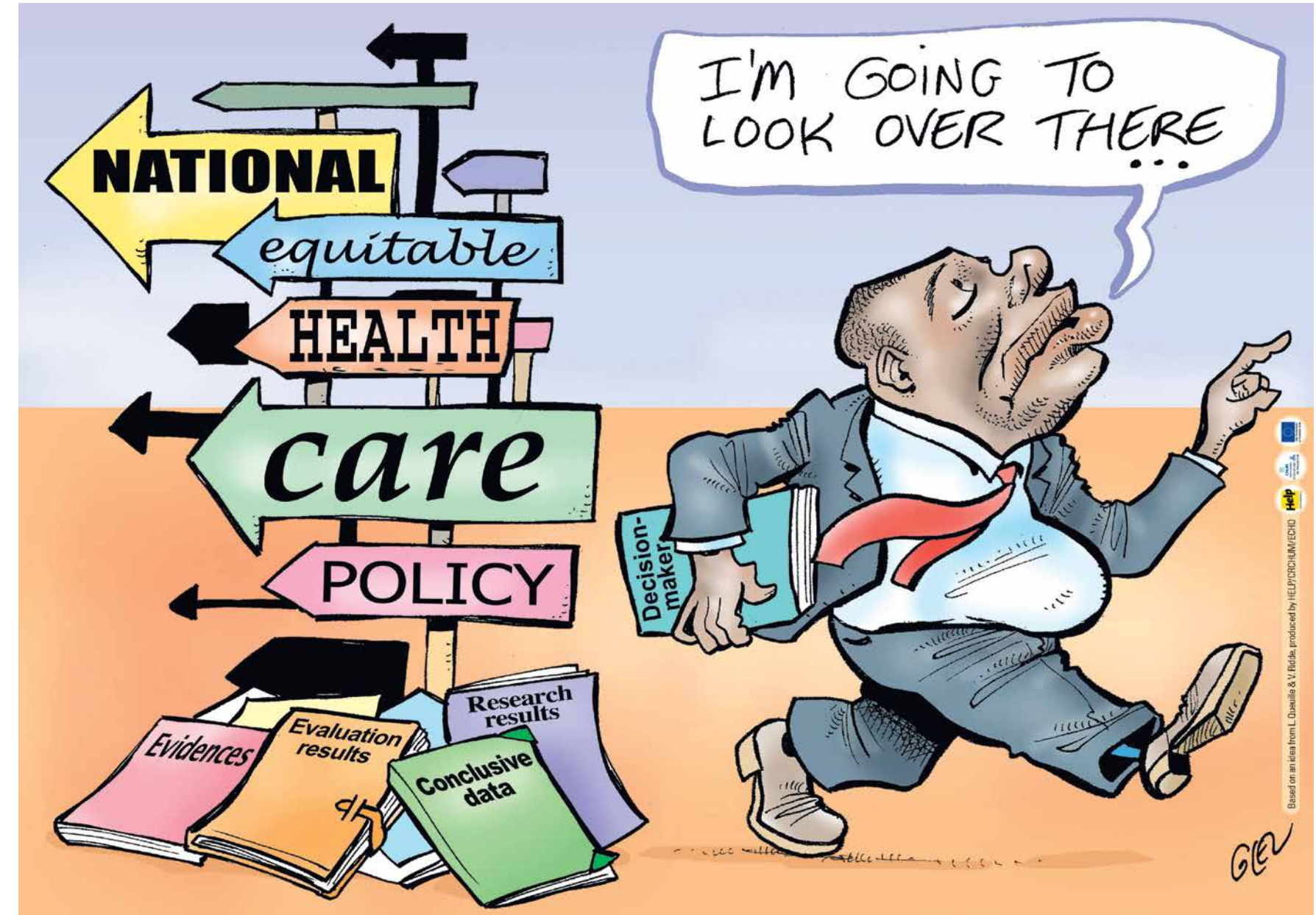
# Vertical organization and bureaucracy



Because of the vertical organization and bureaucracy of many health programs, health centre managers have to manage their team, their inputs, the infrastructure, financial resources, the epidemiological situation, and keep up with training, submit countless numbers of reports every month, etc., and, oh, by the way,.... look after patients.



# Equity and the use of evidence



Even though it is never easy to formulate and implement public policies, there is a great deal of scientific evidence that could make them effective and equitable. Yet in the past 30 years decision-makers have most often forgotten about equity in their policies.



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