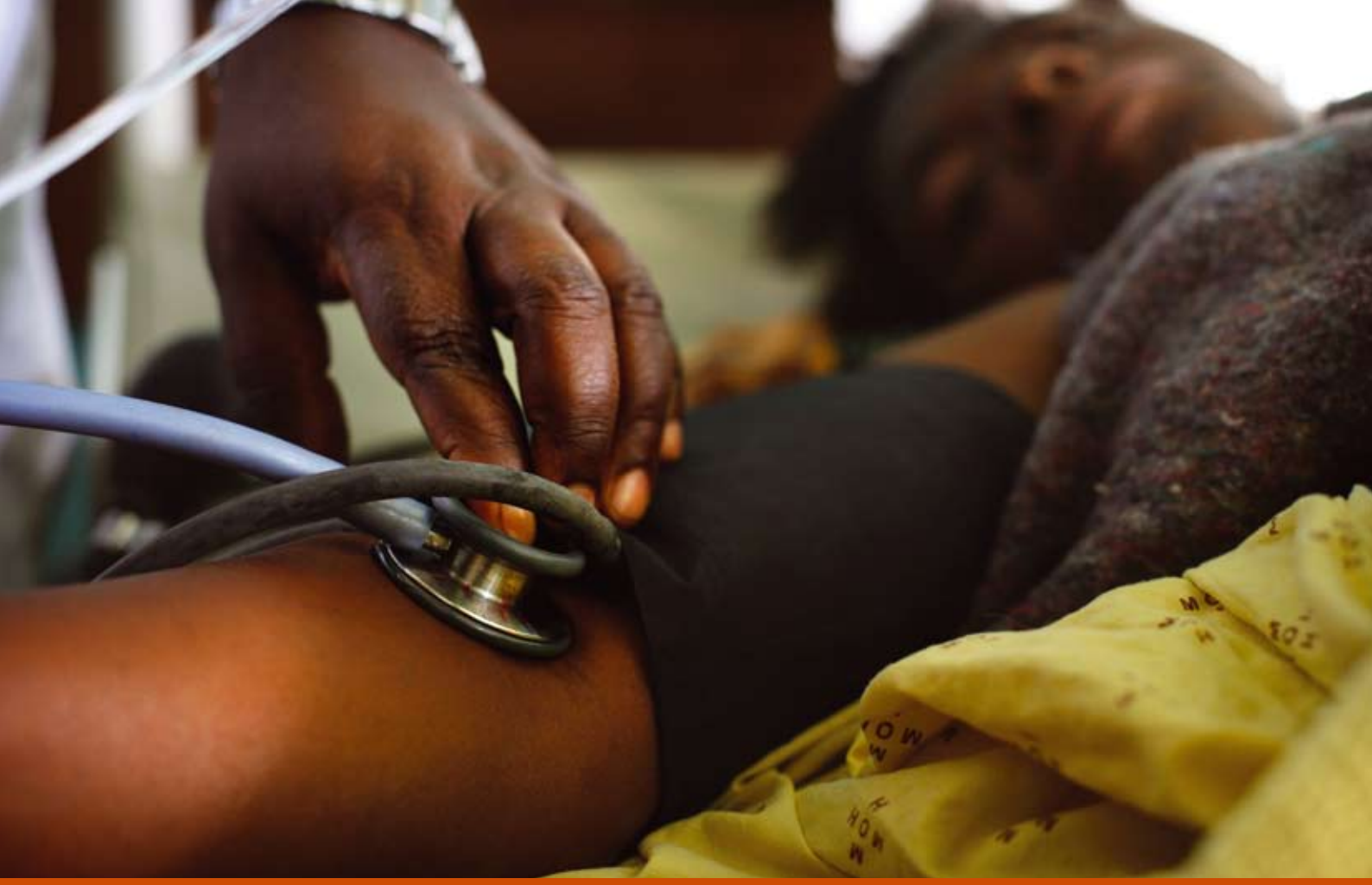

YOUR MONEY OR YOUR LIFE

Will leaders act now to save lives and make health care free in poor countries?

UNISON the public service union
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Health wemos for All
Save the Children UK
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HIV/AIDS ACTION GROUP
interact
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MEDECINS SANS FRONTIERES
Oxfam International
People's Health Movement
PHR
AIDOS
Plan
Sidaction
RESULTS
stop AIDS campaign
TAG Treatment Action Group
TB ALERT
TUC
women and children first (UK)
student stop AIDS campaign
World Vision
International Peoples Health Council (South Asia)
Essential Services Platform of Ghana
RECPHEC
Resource Centre for Primary Health Care
Kathmandu, Nepal.

Your money or your life:
Will leaders act now to save lives and make health care free in poor countries?

User fees for health care are a life or death issue for millions of people in poor countries. Too poor to pay, women and children are paying with their lives. People who can't pay are often imprisoned in hospitals until their families can clear their bills. For those who do pay, over 100 million are pushed into poverty each year.[1] User fees for health care continue to exist in most poor countries despite rarely contributing more than 5% of running costs for health services.[2] This month will witness a global opportunity for world leaders to really make a difference to poor people by backing the expansion of free health care in a number of countries.* The opportunity marks a true test of leaders' commitment to save lives and accelerate progress towards health care for all in our lifetime. The question is, will they pass it?

Progress on health is desperately off track and with the 2015 Millennium Development Goals (MDGs) deadline fast approaching, inaction is not an option. Over nine million children die each year before their fifth birthday, along with more than half a million pregnant women.[3] There is now a global consensus that charging fees for health care is one of the most significant barriers to progress in scaling up access to health care in poor countries and that they should be removed.[4]

On 23rd September 2009 world leaders will meet at the United Nations General Assembly in New York for a high-level event on health. On the table is a proposal to support at least seven developing countries to fully implement free care for women and children or to expand free health services to all. The seven countries are Burundi, Ghana, Liberia, Malawi, Mozambique, Nepal and Sierra Leone. The need to make health care free and expand access in these and other countries is beyond question, but to do so successfully requires high-level political commitment and sustained additional financial and technical support. Leaders in the North and South must back this proposal on 23rd September and announce the additional support they will provide over the coming years to make it a success.

**Universal free health care must be paid for by a system of progressive and equitable health care financing. The evidence shows that while both taxation financing and social health insurance have the potential to achieve universal access, it is only tax-based financing that has achieved this goal in low-income countries to date.*

Delay costs lives: Save the Children UK estimate that the lives of 285,000 children in Africa alone could be saved every year by abolishing health care fees.[5] That means if free care had been introduced in 2000, when the Millennium Development Goals were agreed, over two and half million children's lives could have been saved by now.

Amnata, from Kailahun district in Sierra Leone, has had seven children but only one has survived. "Some of them we could not take to the clinic because we had no money" she says. "They all died." Now, Amnata's only remaining child is very ill with malaria.
Photo: Anna Kari/Save the Children

Denied care

User fees are the most inequitable way of paying for health care.[6] User fees are a key factor in preventing poor people accessing the health care they need and evidence suggests they lead to higher infant and maternal mortality rates. Surveys conducted in Sierra Leone, Burundi, Mali, Democratic Republic of Congo, Chad and Haiti all reveal a common pattern of exclusion of patients linked to payment for health care.[7]

In Rwanda, when health fees were introduced in 1996, take-up of health services halved.[8] In one Nigerian district, the numbers of women dying in childbirth doubled after fees were introduced for maternity services, and the number of babies delivered in hospitals declined by half.[9] Similar consequences of user fees have been observed in Tanzania and Zimbabwe.[10]

Recent work in Africa has shown how even small payments associated with the social marketing of mosquito nets reduce uptake, and make such investments far less cost-effective than free public distribution.[12] Charging pregnant women only US$0.75 for an insecticide-treated bednet in Kenya for example reduced demand by 75%. In the same country, a small charge introduced for deworming drugs reduced uptake of this highly cost-effective treatment by 80%.[13]

Subsidising costs of drugs not enough: Médicins Sans Frontières implemented malaria treatment pilot projects and programmes in Chad, Sierra Leone and Mali. Their experience showed that having malaria treatment available in health centres, even at a low price, is not enough. In all three countries it was only when completely free care (medicines, consultations and other related costs) was introduced that the number of consultations increased dramatically. [11]

Satta, from Kailahun district, Sierra Leone, suffered complications during the birth of her baby and so went to the local health clinic. "People carried me in their arms. I was hurting so much. At the clinic, I had the baby. It was dead". Satta's mother had to borrow 80,000 leones (£20) to pay the clinic bill. "We have no idea how we will pay the money back". Photo: Anna Kari/Save the Children

Women in Sierra Leone face a higher risk of dying in childbirth than almost anywhere else in the world. Currently one in eight women in the country face dying from pregnancy related causes during their lifetime; that's 1000 times more likely than for women in industrialised countries.[14]

In 2001 the government planned to make health care free for pregnant women and children under five. Sadly, this has not yet been properly implemented. The cost of health care continues to fall heavily on patients who pay amongst the highest out-of-pocket health care costs in Africa.[15] Eighty-eight per cent of people said that "lack of finance" was the main reason they did not use a health facility when they were sick.[16]

Too often health workers do not receive their salaries and have little choice but to charge patients. The problem is exacerbated by a lack of necessary medical supplies, forcing women to pay for drugs, gloves and drips, blood bags and testing.

In facilities that have been able to remove fees, results show a tenfold increase in consultations for under-fives.[17] Elsewhere women and children continue to pay with their lives.

More recent government efforts have potentially begun to improve services for pregnant women, but huge challenges remain. Save the Children have estimated that it may take as little as US$15.6 million annually to make health care free in Sierra Leone.[18]

Adama Turay died in December 2008, several hours after she delivered her first child. Early in her pregnancy, Adama had been attending the local antenatal clinic for check-ups, but she had to stop going because she could not afford the fee for each visit.

"The fear of what it would cost prevented her from seeking the medical attention that she really needed", said Sarah, Adama's sister.

In her eighth month Adama's body became swollen. She delivered a baby girl with a traditional birth attendant, but immediately after the delivery she began to vomit and complain of chills. Adama began to bleed and died before she could get to hospital.

Below: Sarah, Adama's Turay's sister.
Photo: Amnesty International, 2009[19]

In Ethiopia fees charged by public health clinics are a primary reason why people opt for self-care.[20] In Sudan 70% of people in disadvantaged areas who did not seek care when sick reported scarcity of money as the reason for not accessing services.[21] Making households pay for health care excludes women and girls, who are usually last in line for services.[22]

Attempts to target poor people and exempt them from paying fees have failed. In Zambia only 1% of exemptions were granted on the basis of poverty, indicating that either poor people were staying away or being forced to pay.[23]

Now the world faces an unprecedented economic crisis, the full impact of which is still to be felt in poor countries. Lessons from previous crises show that as household incomes decline more people switch from fee-paying private services to seek free services in the public sector.[29] When free services are unavailable in the public sector the number of people denied health care increases dramatically.

Abolishing health care fees for all and supporting essential health care for mothers and young children would not cost much - in relative terms less than £1 billion a year. That's just £1.38 per person in sub-Saharan Africa.[30] For such a small amount there can surely be no justification for governments and aid donors leaving fees in place, blocking access to health care and impoverishing millions of people.

In Burundi poverty is rife with 88% of people living on just US$2 a day. More than half of children under five suffer from moderate or severe stunting and women face a one in 16 risk of maternal death in their lifetime.[24]

Burundi introduced fees for health care in 2002, supported by the World Bank and the International Monetary Fund (IMF). Two years later, a survey found that four out of five patients had gone into debt or had sold some of their harvest to raise the money needed for their treatment. When patients did not pay, clinics imprisoned them or seized their identity papers. It was little surprise that the number of women dying in childbirth rose after the charges were introduced.[25]

Eighteen-year-old Clémentine, from Cibitoke in Burundi, recounted the impact user fees had on her and her newborn baby: *"After the delivery I was presented with a bill for 30,900F [around US$30]. As I didn't have anything to pay with, I was imprisoned in the health centre... I remained there for a week, in detention, without care and without food. I was suffering from anaemia and my baby had respiratory and digestive problems."*[26]

Real progress was made in 2006 when the Government announced free health care for maternal deliveries and children under five. Births in hospitals rose by 61% and the number of caesarean sections went up by 80%.[27] Utilisation of services for under fives increased by 40% within a year.[28] However, despite the Vice President announcing in September 2008 at the UN that free care would be introduced for all pregnant women, this has not yet been implemented. The performance of the existing free health care policy is also compromised by inefficient reimbursement procedures for health facilities and insufficient support from aid agencies. It is critical that the Government of Burundi and aid donors now provide the additional financing and technical expertise to make free health services for pregnant women and children a reality.

Syapta, a four-year-old girl, visits Munagano health centre in Northern Burundi with her mother.
Photo: Venerande Murekambaze/World Vision

Ghana is sometimes heralded as the success story of insurance-based schemes to provide medical care. However, the reality is very different. The majority of people continue to pay out-of-pocket for their health care needs[31] and the country is way off track in achieving the health Millennium Development Goals.

By the end of 2008 only 54% of the population was registered under the National Health Insurance Scheme. Even less had actually received their membership card. The vast majority of insurance scheme members are from higher income groups. This leaves those with least money having to pay for their health care or going without.[32]

The government decision to make health care free for all pregnant women in 2008 showed what is possible when fees are removed. Since the policy was implemented at least 433,000 more women have received health care than would have otherwise.[33]

"I heard the news on the television and did not hesitate to register" says Charity Okine, who received free medical care last year when giving birth to her baby at Pram Pram Health Centre in the Greater Accra region. Seven years earlier, Charity had to pay ¢45,000.00 to deliver her first child at the same centre. "Now it feels so easy and better because every one can deliver at no cost at all."[34]

In the run up to the election and in their first budget the new Government of Ghana talked of also ensuring free access for all children, not just those whose parents are registered with the insurance scheme. More recently the Minister of Health has committed to move to a system of one-off registration fees, rather than ongoing insurance premiums.[35] The event planned for the 23rd September gives the government of Ghana an international opportunity to formally commit to these goals and demonstrate its dedication to scaling up to achieve health care for all. They should be enabled to do so with full and additional financial and technical support from rich country governments and aid agencies including the World Bank.

Mother and child take part in community education on malaria in the Volta Region, Ghana
Photo: 2009 Esperanza Ampah/World Vision

Change is possible

User fees were introduced in many poor countries in the 1980s and 1990s, often as a condition of lending from the World Bank and IMF. The evidence is now very clear that, as the Director General of the World Health Organisation recently stated, 'user fees have punished the poor'.[36] In recognition of this, a number of developing countries are leading the way in removing fees. Their experiences show that abolishing fees can have an immediate impact on the uptake of health services when supported by policies to address increased utilisation and loss of revenue.

In Uganda, in the run up to the election in 2001, the President removed all health user fees in public facilities. Service use increased suddenly and dramatically with an 84% increase in attendance at clinics countrywide.[37] Research by the World Bank found the increase in service use was highest for the poorest income groups showing that free health care in Uganda is pro-poor.[38] Importantly, the gains made in Uganda have been sustained. This has been helped by investment in expanding health care delivery and the implementation of quality improvement measures put in place following problems of drug stock-outs in facilities.[39]

Liberia's 14-year civil war killed over 250,000 people and left the majority of the population without access to clean water, sanitation or basic health services. President Ellen Johnson-Sirleaf, Africa's first elected female head of state, has been widely praised for the steps she is taking to rebuild her country's economy and to tackle corruption since fragile peace was declared in 2003.

However, the challenges are huge. Sixty-four percent of Liberia's population live on less than US$1 a day,[40] one in eight children born will not reach their fifth birthday and the country's rate of maternal mortality is the eighth highest in the world.[41]

The decision to introduce fees for health care in 2001 was disastrous. In some facilities attendance dropped by 40%.[42] In 2003 the policy was reversed and health care made free. Evidence from Médecins Sans Frontières shows attendance increased by 60% in the government facilities they were supporting.[43] With funding from the World Bank and other international donors the government was able to increase its health budget from US$6 million in 2006-2007 to US$10 million in 2007-2008.[44]

Unfortunately, in the absence of sufficient resources several public facilities continue to charge patients in order to pay their staff and purchase drugs. Over 50% of women say that lack of money prevented them seeking medical care when sick.[45]

The Government of Liberia has committed to ensuring access to health care for all its citizens but is in urgent need of both financial and technical assistance to successfully implement their free health care policy and scale up overall coverage. Free health care has the potential to play a key role in building trust between citizen and state in this fragile country and the government efforts should be fully supported by bilateral and multilateral aid agencies.

The trend to remove health fees in Africa has been gathering pace. In the past couple of years Zambia, Burundi, Niger, Liberia, Kenya, Senegal, Lesotho, Sudan, and Ghana have abolished fees for key primary health care services for at least some target population groups, most commonly children and pregnant women.[46] The challenge remains to fully implement these policies and extend free care to all. Nevertheless, initial evidence shows promising results.

"Abolishing health fees sits at the heart of the right to health because fees prevent those who can't afford them from accessing their right. Health fees discriminate against the poor. But the right to health is universal and allows no discrimination."

Mary Robinson, 2006[47]

Former United Nations High Commissioner for Human Rights

In Niger, after fees were removed for children and pregnant women in 2006, consultations for under fives quadrupled and antenatal care visits doubled.[48] In Burundi, average monthly births in hospitals rose by 61% and the number of caesarean sections went up by 80% following the abolition of fees for maternity services. When fees were removed in rural areas in Zambia utilisation rates of government facilities increased by 50%. Districts with a greater proportion of poor people recorded the greatest increase in utilisation. Furthermore, while Zambia continues to face severe health worker shortages patients themselves report no deterioration in the quality of care since user fees were removed.[49]

In Mozambique life expectancy at birth is just 42 years.[50] Each day 11 women die in the country as a result of complications during pregnancy and childbirth.[51]

Only half of the population in Mozambique have access to basic health services[52] and lack of money is the number one reason poor people give for not using health services when they are sick.[53] There is only one doctor per 50,000 people; this is 100 times less than the number of doctors in the UK.[54,55]

Despite being a major barrier to access, user fees contribute only a tiny fraction of overall spending on health - as little as 0.7%.[56] And even this does not include the huge costs of administering the user fees. A fee that raises so little for the government yet denies so many people the health care they need makes no sense.

Mozambique needs significant additional financial support to make health care free and to address the severe health worker shortages. Estimates suggest, in the first instance, an additional US$10 million per year is required for user fee removal and to make medicines free,[57] with further increases necessary to fully implement Mozambique's already fully costed health worker strategy. A US$10 million increase constitutes a 25% increase in national government spending on health as compared to an insignificant 2.5% increase in current levels of aid for health in that country. Despite being a signatory to the International Health Partnership,[58] under which aid donors have committed to scale up funding for national plans, no action has been taken to date to fill this identified financing gap.

Photo: Proud Mum and Dad after a routine check-up at Machase District health clinic in Mozambique. Mother and baby are in good health. *Photo: Kate Raworth/ Oxfam*

In Asia too, a UK government-funded study comparing health systems across the continent found that in low-income countries, the most pro-poor health systems were those providing universal coverage of health services that were free or almost free.[59]

In Nepal, one newborn baby dies every 20 minutes, and a woman dies of childbirth-related causes every four hours. Only one third of births are attended by any kind of health worker.[60]

The Government of Nepal has formally recognised access to basic health services as a fundamental human right for every Nepali citizen and since 2006 has been gradually phasing in free care. Emergency and inpatient services are free for the poor, elderly, disabled and female community health volunteers at primary and district level facilities. In 2008 free health services for all citizens at village level facilities were introduced and at the beginning of 2009 all maternal health services were made free.

Initial results produced by the Ministry of Health suggest promising beginnings.[61,62] Research in Surkhet district shows that more than 80% of the beneficiaries of free health services were women and children.[63]

"When user fees were removed by the government in January, the numbers of women coming to give birth here almost doubled. It did not overwhelm our staff, because they no longer had to deal with the red tape of administering the fees." Sister at Kathmandu Hospital, Nepal.[64]

But huge challenges remain. Currently just under half of all doctor posts are unfilled and health worker and drug shortages remain acute in rural areas.[65] Improved governance and transparency in the health sector combined with a significant scale up in financing, workers and medicines are needed to ensure public health care is accessible to all in Nepal.

Below: Mother and newborn at Parbat Hospital, Western Region.
Photo: Options/SSMP/DFID

User fee removal: the need for careful action

Announcements of free health care are not enough to ensure a sustainable increase in access to health care. Any announcements must therefore be accompanied by a broader package of supportive action to ensure that free services are actually available to and used by poor people and that official fees are not merely replaced by informal fees. Countries not immediately able to implement free health care for the entire population could phase it in by initially providing free services for women and children.

Developing countries wishing to remove user fees now, or to improve and extend existing free health care, can benefit from experiences of other countries and from toolkits developed by experienced agencies.[66]

Practical strategies for managing fee removal

- Give a specific government unit the task of coordinating fee removal and the other actions necessary to strengthen the health system
- Communicate clearly with health workers and managers about the policy vision and goals, as well as about what and when actions will be taken—through meetings, supervision visits, newsletters, etc
- Establish new funds at local level, controlled by managers, to allow the managers to make small-scale spending decisions
- Before the policy change, start a wide ranging public information campaign including radio spots, newspaper articles, posters, meetings with village leaders to communicate the policy vision and goals to the general public and to communicate the details of what users can expect to experience at facilities
- Plan for adequate drugs and staff to be available to cope with increased utilisation, and plan how to tackle wider drug and staffing problems in the longer term
- Improve physical access to health services, particularly through "close to client" services
- Establish monitoring systems that cover utilisation trends, including the relative use of preventive versus curative care, and give health workers and managers opportunities to feed back on health facility experiences

Source: Gilson and McIntyre 2005[68]

In every successful case, strong and high-level political leadership and commitment to free health care has preceded the removal of user fees. The evidence is also clear that in any country health spending must increase to offset lost revenue and pay for the increased demand resulting from user fee removal. Failure to increase spending could lead to falling quality of care generated by drug shortages and staff difficulties in managing increased workloads.[67]

> **"It is my aspiration that health will finally be seen not as a blessing to be wished for, but as a human right to be fought for."**
>
> **Kofi Annan**
>
> *Former United Nations Secretary General*

Additional financing for health workers and drugs can be mobilised at the domestic level by increasing spending on health to at least 15% of national spending (as promised in the 2001 Abuja Declaration),[69] through improvements in tax revenue collection systems and more equitable distribution of existing resources. Such action at the national level is essential but on its own cannot raise the level of resources required to achieve health care for all. It must therefore be complimented by additional long-term and predictable financing from rich country governments and multilateral aid agencies, delivered using government budgets and plans. Additional resources for free care should be mobilised through aid, debt relief, innovative financing and measures such as tackling tax havens and tax evasion.

Secondly, free health care policies must be carefully planned and implemented so that health workers and the health system as a whole are fully prepared for the change. Effective communication to staff and the public are particularly essential to avoid confusion and to ensure citizens are fully aware of their rights under the new policy.

Thirdly, efforts should be made by all actors to link the removal of user fees to broader health system improvements to ensure an overall expansion in public health care coverage. This should include support from international donors for: appropriate and equitable health financing mechanisms; strategies to expand and retain the health workforce; improving and expanding drug supply; scaling up the number of health care facilities especially in rural areas; and tackling other significant barriers to access including the low status and lack of empowerment of women, transport costs, poor quality of care, women's education and general knowledge and understanding of health.[74]

'Hands up for Health Workers'[70]

At the heart of every health system is its workforce. There is evidence that worker numbers and quality are positively associated with maternal survival"[71]

Health systems are built of human beings; in poor countries millions of health workers work tirelessly for minimal reward. To achieve MDG 5 - to reduce maternal deaths by three quarters - the World Health Organisation estimates that 700,000 more skilled birth attendants are needed. In the 15 countries with the highest maternal death rates, less than 50% of women have access to a skilled attendant at birth.

Some countries have slashed maternal and infant mortality rates by ensuring universal access to skilled health professionals. Ninety-six per cent of mothers in Sri Lanka now have access to birth attendants and their chances of surviving childbirth complications have more than doubled since 1990.[72]

But today, in poor countries around the world, over four million health workers are simply not in place, and scant plans have been made to train and recruit them. These staff shortages affect poor people disproportionately, particularly poor people in rural areas in low- and middle-income countries and those living in fragile states. In the Democratic Republic of Congo, over 75% of doctors and 65% of nurses live and work in urban areas, leaving too few to cover the remaining population in rural areas.[73]

Redressing the health worker shortages requires urgent and committed action to develop strong and comprehensive health worker strategies in every country. These must be fully funded with increased national spending and long-term predictable aid.

Photo: Abbie Traylor-Smith/Oxfam

Health insurance in low-income countries: Where is the evidence that it works?

Following 20 years of one failed health financing mechanism – user fees – some donor agencies and governments are now proposing that health insurance mechanisms should now be implemented in poor countries instead. But although beneficial to the people able to join, this method of financing health care has so far been unable to sufficiently fill financing gaps in the health systems of developing countries and to improve access to quality health care for the poor.

In low-income countries, private health insurance remains a privilege for the few. Despite years of trying, community-based health insurance today also covers less than 0.2% of the population across Africa and generally fails to protect members from significant out-of-pocket payments for health.

In contrast, both social health insurance (SHI) and taxation financing have the potential to achieve universal coverage, but the global evidence is clear that SHI mechanisms perform badly in terms of covering those outside of formal employment and have proven unable to achieve universal access until economies reach a high level of economic development.[75] In contrast, tax-financed mechanisms have worked even in low-income settings.[76]

It is critical that donor agencies and governments do not replace one inequitable and inefficient health financing policy with another. If we are to avoid another 20 wasted years, advocates of insurance mechanisms need to produce evidence that these can work, before promoting their implementation in poor countries.

Source: Joint NGO Briefing Paper, Oxfam International 2008[77]

The challenges to quality and supply of health care arising from removing fees are real but are certainly not insurmountable. Sadly, these same challenges continue to be used by some senior ranking donor and developing country government officials as a reason to leave user fees in place. Such inaction will continue to deny access to health care for millions of people and is unacceptable in light of increasing evidence and understanding of how to make free health care a success.

In Malawi nearly three-quarters of the population live on less than US$1 a day and life expectancy is just 38 years.[78] One woman in every 100 will die in pregnancy or childbirth.

In recent years, the Government of Malawi, with help from the international community, have made a genuine effort to improve health care. In 2002, the government launched a basic Essential Health Package (EHP), which aims to make the long-standing government commitment to free access a reality. In addition, where possible and appropriate, the government is forming partnerships with mission hospitals to also make health care free in their facilities. Some mission hospitals have seen a tenfold increase in demand for maternal services as a result.

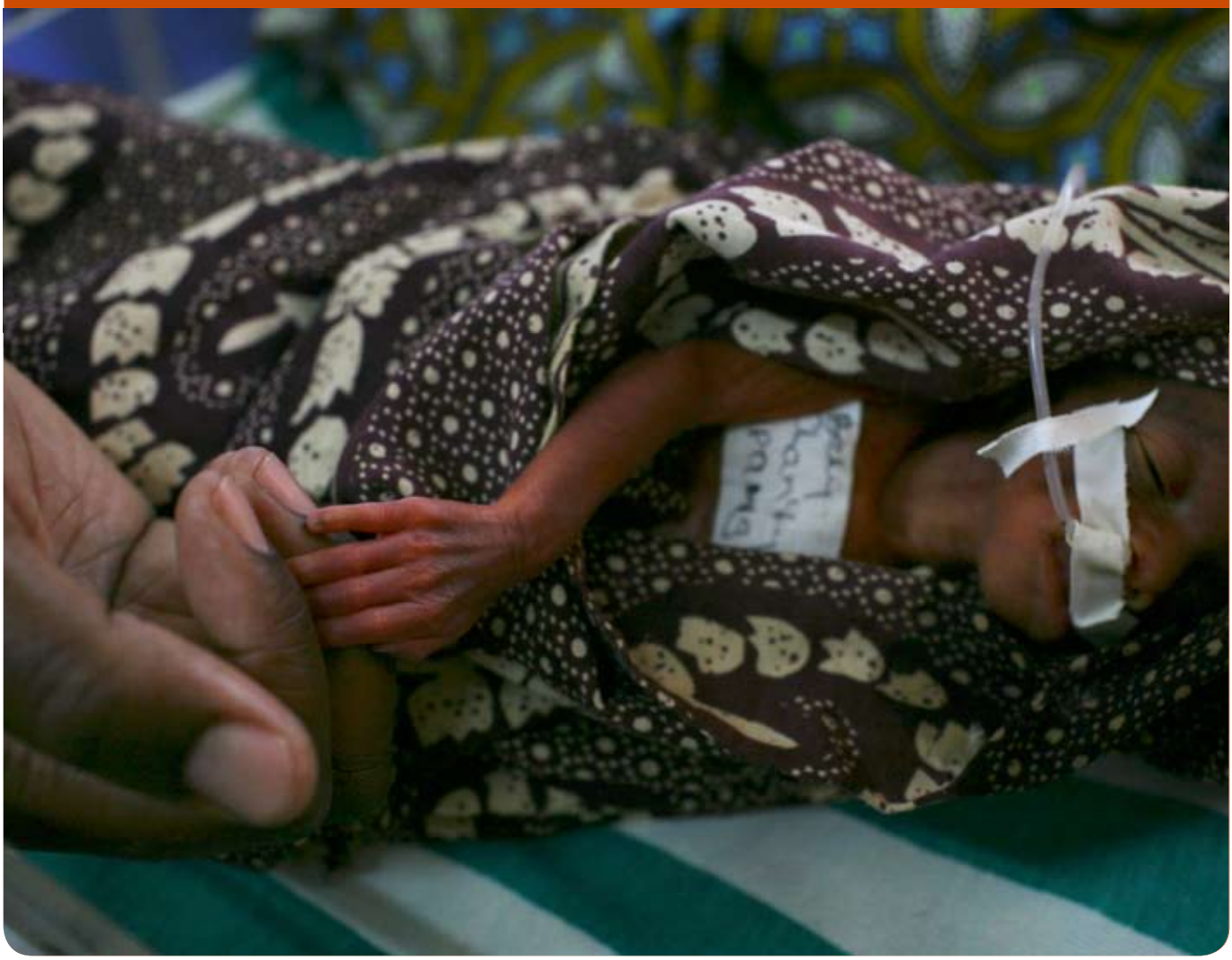
The World Bank has cited the free EHP as one of the key reasons why health provision is more equitable in Malawi than in other African countries.

Despite the successes, there is still a long way to go – due to poor procurement and distribution there has been stock-outs of basic antibiotics, HIV-test kits, and insecticide-treated nets across the country. Vaccines have also run dangerously low. Despite progress Malawi also still faces a chronic shortage of health workers.

To compound these two problems, health facilities are often too far away from patients – over half of the population live further than 5km from their nearest formal health facility.

There is an urgent need for the Government of Malawi and its aid donors to commit to a rapid expansion of free public health care coverage so that all citizens live within 5km of decent quality health care.

Adapted from: Oxfam International Research Report 2008 [79]
Below: A premature baby in Bwalia Hospital in Lilongwe, Malawi. Photo: Abbie Traylor-Smith/Oxfam



Agenda for action

User fees block access to health care and contribute to stalled progress on the health Millennium Development Goals. On 23rd September 2009 leaders will meet at the United Nations General Assembly in New York for a high-level event on health. We want this event to represent a global turning point in the fight to make health care free for all. On the table is a proposal to support at least seven developing countries to fully implement free care for women and children or to expand free health services to all. The seven countries are Burundi, Ghana, Liberia, Malawi, Mozambique, Nepal and Sierra Leone. The need to make health care free and to expand access in these and other countries is beyond question, but to do so successfully requires high-level political commitment and sustained additional financial and technical support.

"User fees for health care were put forward as a way to recover costs and discourage the excessive use of health services... This did not happen. Instead user fees punished the poor... This is a bitter irony at a time when the international community is committed to poverty reduction."

Margaret Chan[80]

Director General of World Health Organisation

If world leaders are serious about improving access to health care and making real progress on the health MDGs, we call on them to back this free health care proposal on 23rd September and to announce the additional support they will provide over the coming years in each country to make it a success.
More specifically we call for:

High-level commitment from the governments of Burundi, Ghana, Liberia, Malawi, Mozambique, Nepal and Sierra Leone to:

- Introduce free health care for women and children and/or fully implement and expand free health care for all
- Rapidly expand coverage of government health care to ensure all have access to the health care they need
- Increase government spending on health to at least 15% of the national budget to pay for increased demand, especially for health workers and medicines
- Make sure official fees are not replaced with informal fees by providing additional funding at facility level
- Improve the transparency and accountability of public spending on health
- Address other significant barriers to health care access including bringing services closer to citizens, improving quality of care, tackling income insecurity and improving women's education

High-level commitment from rich country donors and multilateral aid agencies to:

- On 23rd September officially extend the offer of financial and technical support for free health care to all poor countries who wish to remove fees and to make this event a global turning point in the fight to make health care free for all
- Provide the additional long-term and predictable funding necessary to successfully implement free health care in all seven countries
- Immediately deliver a minimum of US$10 billion additional financing per year for health systems from government sources[81] and commit to ensure no good national health plan will fail due to lack of funding
- Provide the urgently needed technical assistance to all seven countries to fully implement existing and newly announced free health care commitments
- Invest in increasing their own capacity to respond to requests from poor countries for technical assistance to remove fees, raise additional resources from general tax revenues and improve the equity of health spending

1 Xu, K., Evan, D. B., Carrin, G., Aguilar-Rivera, A. M., Musgrove, P. and T. Evans (2007) 'Protecting households from catastrophic health expenditures', Health Affairs, 6: 972–983.

2 Gilson, L. (1997) 'The lessons of user fees experience in Africa', Health Policy and Planning, 12: 273-285.

3 Loaiza, E., Wardlaw, T., and P. Salama (2008) 'Child mortality 30 years after the Alma Ata Declaration', Lancet, 372: 874-876.

4 This consensus is articulated in a recent report from the Global Campaign for the Health Millennium Development Goals endorsed by 15 Presidents or Prime Ministers from the North and South including Australia, France, Germany, Japan, the Netherlands, Norway, the UK, Liberia, Mozambique and Senegal as well as the World Bank, the WHO, the EC and UNICEF. http://norad.no/en/Thematic+areas/Health+and+aids/Maternal%2C+child+and+women%27s+health/Media+advisory Last accessed 2nd September

5 Keith, R. and P. Shackleton (2006) Paying with their Lives – The Cost of Illness for Children in Africa', Save the Children UK.

6 Gilson, L. and D. McIntyre (2005) 'Removing user fees for primary care in Africa: the need for careful action' British Medical Journal, 331:762-765.

7 Médecins Sans Frontières (2008) '"No cash, no care", How user fees endanger health', Brussels: Médecins Sans Frontières.

8 Save the Children UK (2005) 'Mind the Gap: The Cost of Coping with Illness: Rwanda', London: Save the Children.

9 Maternal deaths in the Zaria region of Nigeria rose by 56%, while there was a decline of 46% in the number of deliveries in the main hospital. Nanda, P. (2002) 'Gender dimensions of user fees: implications for women's utilisation of health care', Reproductive Health Matters, 10: 127-134.

10 Nair, S., and P. Kirbat, with Sexton, S. (2004) 'A Decade after Cairo – Women's Health in a Free Market Economy', Cornerhouse Briefing 31, June 2004, http://www.thecornerhouse.org.uk/item.shtml?x=62140 Last accessed 3rd September 2009.

11 Médicins Sans Frontières (2008) 'Full Prescription: Better Malaria Treatment for More People, MSF's Experience', Brussels: Médicins Sans Frontières.

12 Cohen, J. and P. Dupas (2008) 'Free Distribution or Cost-Sharing? Evidence from a Randomized Malaria Prevention Experiment', Cambridge, MA, USA: Poverty Action Lab, Massachusetts Institute of Technology.

13 Cohen, J. and P. Dupas (2007) and Kremer, M. and E. Miguel (2007) cited in Yates, R. (2009) 'Universal health care and the removal of user fees', Lancet, 373: 2078-2081.

14 Amnesty International (2009)'Lives Cut Short', London: Amnesty International.

15 Patients pay about 70% of health care costs. Ibid.

16 Sierra Leone: Service Delivery Perception Survey (2008), UK Government, Department for International Development.

17 Médecins Sans Frontières (2008) 'No Cash, No Care: How 'user fees' endanger health, An MSF briefing paper on financial barriers to healthcare', Brussels: Médicins Sans Frontières.

18 Keith, R. and Shackleton, P, op. cit., p.14.

19 Adama's story is sourced from Amnesty International, op. cit.

20 Asfaw, A., Von Braun, J. and S. Klasen (2004) 'How big is the crowding-out effect of user fees in the rural areas of Ethiopia? Implications for equity and resource mobilization', World Development, 32: 2065-2081.

21 Witter, S. and M. Babiker (2005) 'Ability to pay for health care in Khartoum State: results of a household survey', London: Save the Children.

22 The willingness of households to pay for services is differentiated on the basis of income, gender, and other factors. Where women and girls have a low status in society, making households pay often means that women and girls are much less likely to access services. See De Vogli, R. and G. L. Birbeck (2005) 'Potential impact of adjustment policies on vulnerability of women and children to HIV/AIDS in sub-Saharan Africa', Journal of Health and Population Nutrition, 23: 105-120.

23 Yates, R. (2009) 'Universal health care and the removal of user fees', Lancet, 373: 2078-2081

24 Economist Intelligence Unit (2008) 'Country Report Burundi' referenced in UNICEF (2009) 'The State of the World's Children 2009: Maternal and Newborn Health', New York: UNICEF.

25 Médecins Sans Frontières (2004) 'Burundi: vulnerable population deprived of access to healthcare', Brussels: Médecins Sans Frontières.

26 Ibid.

27 Batungwanayo, C. and L. Reyntjens (2006) 'Impact of the presidential decree for free care on the qf health care in Burundi'. Burundi: Ministry of Public Health, Government of Burundi.

28 Médecins Sans Frontières (2008) '"No cash, no care", How user fees endanger health', Brussels: Médecins Sans Frontières.

29 The Global Campaign for the Health Millennium Development Goals (2009) 'Leading by example – protecting the vulnerable during the economic crisis', Oslo: Office of the Prime Minister of Norway. http://norad.no/en/Thematic+areas/Health+and+aids/Maternal%2C+child+and+women%27s+health/Media+advisory Last accessed 2nd September.

30 Keith, R. and Shackleton, P, op. cit., p.2.

31 McIntyre D., Garshong B., Mtei G., Meheus F., Thiede M., Akazili J., Ally M., Aikins M., Mulligan and J. Goudge (2008) 'Beyond fragmentation and towards universal coverage: insights from Ghana, South Africa and the United Republic of Tanzania', Bulletin of the World Health Organisation, 86:871-876.

32 Ibid

33 Stewart, H (2009) 'Gordon Brown backs free healthcare for world's poor', http://www.guardian.co.uk/business/2009/aug/03/brown-free-healthcare-poor Last accessed 5th September 2009.

34 Osabutey, P. (2008) 'Ghana: Achieving MDG5 Through Free Medical Care for Pregnant Women', http://allafrica.com/stories/200807251080.html Last accessed 5th September 2009.

35 Ghanaian Times (2009) 'One Time NHIS Premium Next Year', 16 June 2009, http://news.myjoyonline.com/health/200906/31488.asp Last accessed September 2nd 2009.

36 Dr. Margarat Chan (2009) 'Address at the 23rd Forum on Global Issues –The impact of global crises on health: money, weather and microbes' http://www.who.int/dg/speeches/2009/financial_crisis_20090318/en/index.html Last accessed August 26th 2009.

37 Yates, J., Cooper, R. and J. Holland (2006) 'Social protection and health: experiences in Uganda',Development Policy Review, 2006, 24(3): 339–56.

38 Deininger K. and P. Mpuga (2004) 'Economic and Welfare Effects of the Abolition of Health User Fees: Evidence from Uganda', World Bank Policy Research Working Paper 3276. http://ssrn.com/abstract=610321 Last accessed August 27th 2009.

39 Save the Children UK (2008) 'Freeing up Healthcare: A Guide to removing user fees', London: Save the Children Fund.

40 Liberia: Poverty Reduction Strategy Paper (2008) Washington DC: Republic of Liberia and Washington DC.

41 World Health Organisation (2009) 'World Health Statistics 2009 – Part 1 Health-related Millennium Development Goals' Geneva: World Health Organization.

42 Médecins Sans Frontières (2007) 'From emergency relief to development: No cheap solution for health care in Liberia', http://www.msf.org.uk/reports.aspx Last accessed August 27th 2009.

43 Ibid.

44 IRIN (2007) 'Post-conflict dilemma – should health care be free?', 12 October 2007 http://www.irinnews.org/Report.aspx?ReportId=74776 Last accessed August 27th 2009.

45 Liberia Demographic and Health Survey (2007) http://pdf.usaid.gov/pdf_docs/PNADM580.pdf Last accessed August 27th 2009.

46 Yates, R. op. cit.

47 Keith, R. and Shackleton, P, op. cit

48 Médecins du Monde (2008) 'Free Access to Primary Care: A rewarding strategy – Appeal to the G8', Paris: Médecins du Monde.

49 Masiye, F., Chitah, B. M., Chanda, P. and F. Simeo (2008) 'Removal of user fees at Primary Health Care facilities in Zambia: A study of the effects on utilisation and quality of care', EQUINET Discussion Paper Series 57. Harare: EQUINET, UCT HEU. www.equinetafrica.org/bibl/docs/Dis57FINchitah.pdf Last accessed August 26th 2009.

50 Data for 2007, World Bank (2008) 'Mozambique at a glance',. http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS/0,,contentMDK:20485916~menuPK:1297819~pagePK:64133150~piPK:64133175~theSitePK:239419,00.html Last accessed July 2009.

51 United Nations Development Program (UNDP) press release (February 2009) 'Mozambique: Country in Danger of Missing Millennium Goals', http://www.undp.org.mz/en/newsroom/news/news_2009/mozambique_country_in_danger_of_missing_millennium_goals Last accessed August 27th 2009.

52 Action for Global Health (2008) 'Healthy Aid - Why Europe must deliver more aid, better spent to save the health Millennium Development Goals', Action for Global Health.

53 Chao, S. and K. Kostermans (2002) 'Improving Health for the Poor in Mozambique - The Fight Continues' , Washington: World Bank.

54 Data for Mozambique for 2002, World Health Organisation (2006) 'Country Health System Fact Sheet 2006 - Mozambique', www.afro.who.int/home/countries/fact_sheets/mozambique.pdf Last accessed September 2nd 2009.

55 Data for UK for 2002, OECD Stat Extracts website, http://stats.oecd.org/index.aspx Last accessed September 2nd 2009.

56 Yates, R. (2006) 'International Experiences in Removing User Fees for Health Services – Implications for Mozambique', London: DFID Health Resource Centre.

57 Cabral, A. and A. Convidado (2007) 'Consultancy on the abolition of user fees in the national health service in Mozambique', Instituto de Higiene e Medicina, Universidade Nova de Lisboa for the UK Government Department of International Development, London.

58 The International Health Partnership was signed in September 2007 between aid donor countries and agencies and a number of developing countries. It aims to improve aid effectiveness for health and scale up funding for health systems strengthening, www.internationalhealthpartnership.net

59 Rannan-Eliya, R. and A. Somanathan (2005) 'Health Systems, Not Local Projects, Provide the Key to Social Protection for the Poor in Asia', London, DFID Health Systems Resource Centre.

60 DFID (press release), (2009) 'Free Childbirth Comes to Nepal - 14 January 2009', http://www.dfid.gov.uk/Media-Room/News-Stories/2009/Free-childbirth-comes-to-Nepal/ Last accessed August 28th 2009.

61 Health Sector Reform Support Programme, Ministry of Health and Population (2009) 'Examining the Impact of Nepal's Free Health Care Policy - First Facility Survey Report, April 2009' Kathmandu: Health Sector Reform Support Programme, Ministry of Health and Population, Government of Nepal.

62 Health Sector Reform Support Programme, Ministry of Health and Population (2009) 'Examining the Impact of Nepal's Free Health Care Policy - Second Facility Survey Report, June 2009' Kathmandu: Health Sector Reform Support Programme, Ministry of Health and Population, Government of Nepal.

63 Resource Centre for Primary Health Care (Forthcoming) 'Free Health Service: Rhetoric or Reality? A Case Study on the Effectiveness of Free Health Services in Nepal (February – March 2009)'.

64 Interview with the White Ribbon Alliance for Safe Motherhood http://www.whiteribbonalliance.org/

65 Ibid.

66 See for example Save the Children UK, 2008, op. cit.

67 McCoy, D. (1996) 'Free health care for pregnant women and children under six in South Africa: an impact assessment'. Durban: Health Systems Trust.

68 Gilson, L. and D. McIntyre, op.cit

69 The Abuja Declaration on HIV/AIDS, TB and other related diseases in 2001 committed African governments to spend at least 15% of their annual budgets on health, http://www.uneca.org/ADF2000/Abuja%20Declaration.htm Last accessed 9th September 2009.

70 Merlin's 'Hands up for Health Workers' campaign aims to raise the profile of human resources for health at international and national levels and to promote action on improved workforce planning, http://www.handsupforhealthworkers.org/

71 World Health Organisation (2006) 'World Health Report: Working together for health - April 2006', Geneva: World Health Organisation.

72 Oxfam (2006) 'In the Public Interest: Health, Education and Water and Sanitation for All', Oxford: Oxfam International.

73 Merlin (2007) 'Human resources for health: A Merlin study', London: Merlin.

74 Save the Children UK (2008) op. cit.

75 Wagstaff, A. (2007) Social Health Insurance Reexamined, World Bank Policy Research Paper 4111, January 2007 http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2007/01/09/000016406_20070109161148/Rendered/PDF/wps4111.pdf Last accessed 4th September 2009.

76 Task Force on Global Action for Health System Strengthening (2009) 'G8 Hokkaido Toyako Summit Follow-Up. Global Action for Health System Strengthening. Policy Recommendations to the G8', Japan Centre for International Exchange, http://www.jcie.org/researchpdfs/takemi/full.pdf Last accessed September 1st 2009.

77 Joint NGO Briefing Paper (2008) 'Health insurance in low-income countries: where is the evidence that it works?' Oxford: Oxfam International.

78 Ministry of Health (2007) 'Malawi National Health Accounts 2002/3-2004/5' Lilongwe: Ministry of Health

79 Oxfam International (2008) 'Malawi Essential Health Services Campaign, For All Campaign: Country Case Study'. Available online at: www.oxfam.org.uk/resources/policy/healthOxfam

80 Dr. Margarat Chan (2009) 'Address at the 23rd Forum on Global Issues –The impact of global crises on health: money, weather and microbes' http://www.who.int/dg/speeches/2009/financial_crisis_20090318/en/index.html Last accessed August 26th 2009.

81 Under the Taskforce on Innovative International Financing for Health Systems Strengthening, some of the financing options under consideration include raising money from voluntary contributions from the private sector and the general public. It is the responsibility of governments to raise and redistribute their own resources to fulfil the right to health and deliver health care for all, and therefore private financing should not be counted towards filling the financing gap for national health plans in developing countries.

This paper has been endorsed by the following organisations:

Action for Global Health
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Oxfam International
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Plan
Public Services International (PSI)
Regional Network on Equity in Health in Southern Africa (EQUINET)
Resource Centre for Primary Health Care (RECPHEC), Nepal
RESULTS UK
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The International HIV/AIDS Alliance
The International Women's Health Coalition
The Liberia Democratic Institute
Trades Union Congress (TUC)
UK Student Stop AIDS Campaign
UNISON
Voluntary Service Overseas (VSO)
Wemos
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