Save the Children
UK

Paying with their Lives

The cost of illness for children in Africa

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Regina Keith and Peter Shackleton

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Save the Children fights for children in the UK and around the world who suffer from poverty, disease, injustice and violence. We work with them to find lifelong answers to the problems they face.

Save the Children UK is a member of the International Save the Children Alliance, the world's leading independent children's rights organisation, with members in 27 countries and operational programmes in more than 100.

Cover photo: Alice Bundor and her three-year-old son, Morie. Morie had cerebral malaria, which left him with brain damage. His parents have spent all their savings and borrowed money in order to pay Morie's hospital fees. ANNA KARI

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Foreword
by Mary Robinson

When many people hear the words 'human rights', they are likely to think first of protection against torture, freedom of religion or equality before the law. As important as these fundamental rights are, they do not cover the whole agenda. Human rights also include the right to education, to adequate food and, importantly, the highest attainable standard of health. These are rights which today most governments in the world have committed themselves to implementing progressively and without discrimination.

Last year, 32 former world leaders and senior figures in international development signed 'The Leaders' Health Statement', which urges countries to fulfil these responsibilities in ensuring the realisation of the fundamental human right to health for all.

Among other things, we called for systemic change to build strong health systems. Countries must confront the global shortage of health workers, implement laws that protect and strengthen health systems, provide predictable, long-term financing for healthcare, and abolish health fees for primary healthcare.

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.

This universal right to health is central to Save the Children's campaign to make healthcare free in the world's poorest countries. It deserves all our support.

Mary Robinson is the chair of Realizing Rights: the Ethical Globalization Initiative, and former UN High Commissioner for Human Rights. She was the first woman President of Ireland.

Summary

The lives of hundreds of thousands of children in Africa could be saved each year by abolishing fees for healthcare. What's more, it would cost relatively little.

Save the Children UK estimates that the lives of 285,000 children in Africa could be saved every year by abolishing healthcare fees. Thousands more children would lead healthier lives without healthcare fees pushing their families into poverty.

Healthcare fees fund less than 5 per cent of what it costs countries in Africa to run public health services.

Fees put basic healthcare treatment out of reach of poor people or force them into debt. In Sierra Leone a course of treatment for a child suffering from malaria costs 18,000 leones, or £4.24. It would take the average Sierra Leonean 14 days to earn this amount. In UK terms, it's the equivalent of a British citizen paying £700 for treatment. Giving birth at a clinic costs around 55,000 leones (£13). That's the equivalent of more than £2,200 in the UK.

For millions of people in countries in Africa, healthcare fees have failed to do the job they were intended to do. African governments have been encouraged by donors such

Satta, from Kailahun district, Sierra Leone, couldn't afford to go to the clinic to have her baby. "When the time came and I had the pain of giving birth I went with my mother to a traditional midwife," said Satta. There were complications with the birth and the midwife said Satta needed to go to the clinic. "It was night and we walked there," said Satta. "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) from friends so she could pay the clinic bill. She earns a subsistence living through casual work and collecting firewood to sell. "We have no idea how we will pay the money back," she says. "I feel bad because we didn't get the baby and we had to pay a lot of money."

as the World Bank to introduce fees for healthcare. It was hoped that charging fees would both help pay for health services and improve access to healthcare.

In reality, however, fees fund less than 5 per cent of what it costs countries in Africa to run public health services and there are high administrative costs. At the same time, when fees have been introduced, take-up of health services has dropped, typically by 40–50 per cent. Inevitably, it's poor families who miss out.

Time to deliver

In 2005, world leaders made a commitment to support free healthcare for the world's poorest countries.

In July 2005, at the G8 summit in Gleneagles hosted by Tony Blair, world leaders made a commitment to support free healthcare for the world's poorest countries. As yet, very little new money has materialised and there have not been significant changes in the lives of poor children in Africa. Now, one year on, it is time to deliver on those promises. As a first step, Save the Children UK calls on world leaders to support countries in Africa to make healthcare free to their citizens.

Abolishing healthcare fees for all and supporting essential healthcare for mothers and young children wouldn't cost much, in relative terms – less than £1 billion a year.[1] That's just £1.38 per person in sub-Saharan Africa – the price of a cup of coffee in the UK.

In calling for health fee abolition, we recognise that this is only a start – a 'quick win' in the words of economist Jeffrey Sachs. The far greater task is to build or rebuild collapsed health systems in order to ensure *all* children and their families in Africa have access to free essential healthcare (see page 14).

The health crisis in Africa 1

Healthcare in Africa is in crisis. Despite having only 11 per cent of the world's population, sub-Saharan Africa bears one quarter of the world's disease burden. Yet it has only 1 per cent of the world's health budget.[2]

Children in Africa are paying for the lack of healthcare with their lives. Globally, each year, 11 million children die from a preventable disease like pneumonia, malaria, diarrhoea or measles – one child every three seconds, as highlighted last year in an advertisement showing celebrities clicking their fingers at three-second intervals. Four million children die before they are a month old and four million are born dead because their mothers did not have access to effective healthcare. Over 40 per cent of these needless deaths occur in Africa.[3]

As well as those children who die, the lives of many millions more are blighted by chronic sickness and injury, leading to reduced life expectancy, lower educational achievement, poverty and, ultimately, replication of these conditions in the next generation.

90 per cent of children who die from malaria are from sub-Saharan Africa.

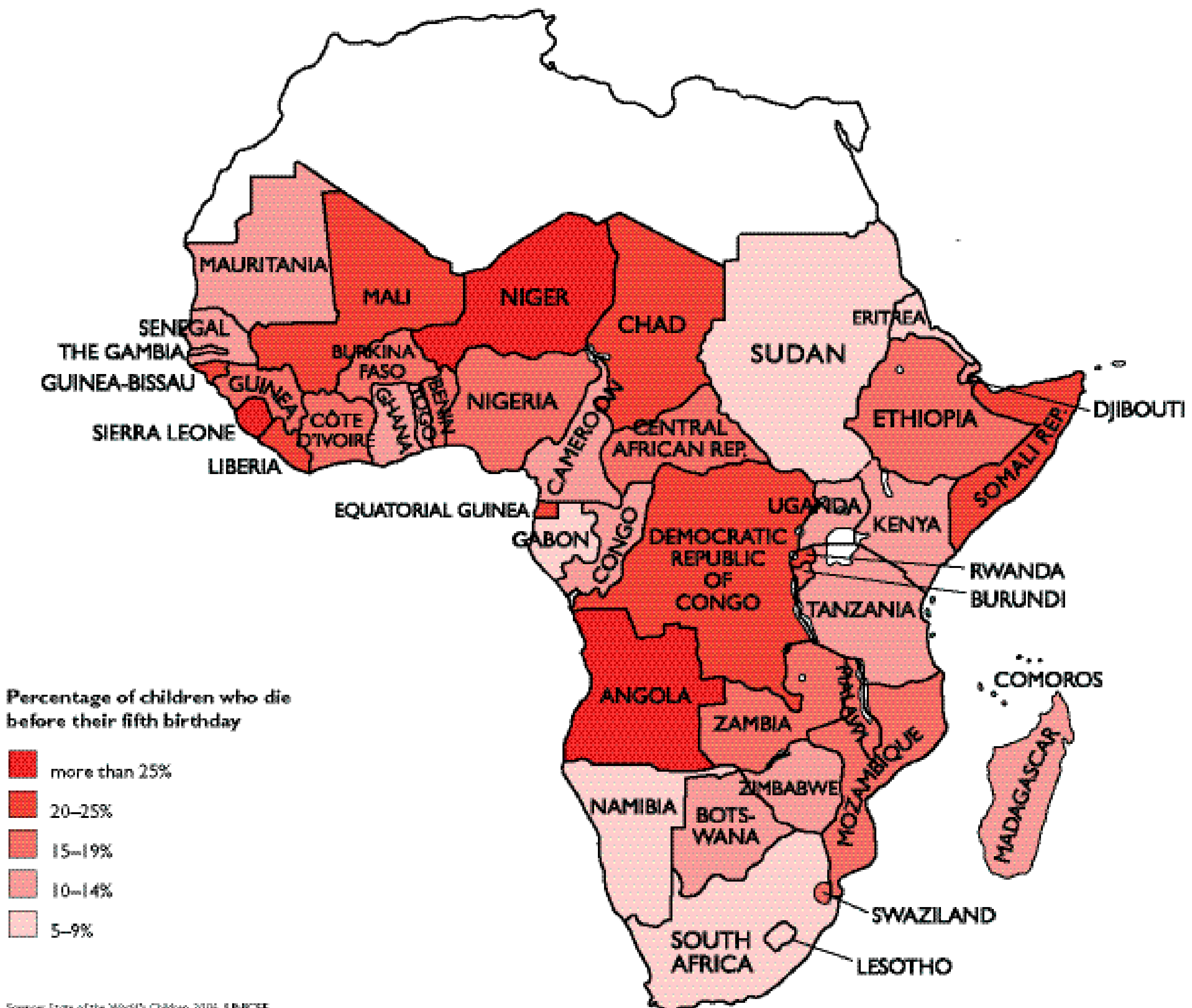
Amnata, from Kailahun district in Sierra Leone, has had seven children, but only one has survived. "They all died as babies," she says. "Some of them we could not take to the clinic because we had no money. I took others to the clinic, but waited to see if they would get better first because we had no money. They all died."

Now, Amnata's only remaining child, seven-month-old Isata, is very ill with malaria. Amnata is very distressed. She had to wait three weeks before bringing Isata to hospital. "My husband was not around and I had no money to take her," she says. "When my husband came he borrowed some money and we came to the clinic."

The toughest places for children to survive

In many countries in sub-Saharan Africa, child death rates – the proportion of children who die before their fifth birthday – are extremely high. The map below shows where these rates are highest. Using child mortality rates, Table 1 ranks the toughest places in the world for children to survive. Of the 20 countries listed, 19 are in sub-Saharan Africa, with Sierra Leone having the highest number of deaths of children under five per 1,000 children born alive. More than a quarter of children there die before their fifth birthday. Almost 30 per cent of these deaths occur within a month of birth.

Figure 1. Child mortality rates in sub-Saharan Africa



What are the main killer diseases for young children in Africa and globally?

The vast majority of children who die before their fifth birthday in Africa are killed by diseases that are preventable and treatable through basic healthcare. The charts below show that the proportion of child deaths that occur as a result of preventable diseases is higher in Africa than it is across the world as a whole. For example, 18 per cent of child deaths in Africa are caused by malaria, whereas globally the proportion is 8 per cent. In fact, 90 per cent of children who die from malaria are from sub-Saharan Africa.[4] Africa also has a higher proportion of child deaths from measles, diarrhoeal disease, acute respiratory disease (eg, pneumonia) and AIDS. More than 50 per cent of deaths from measles and about 40 per cent of deaths from pneumonia and diarrhoea are in the Africa region.[5]

Figure 2. Causes of death of children aged under five in Africa

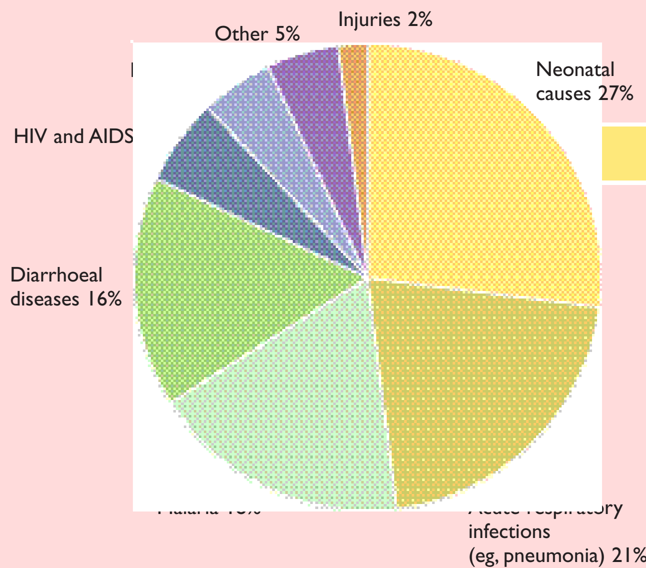


Figure 3. Causes of neonatal death in Africa

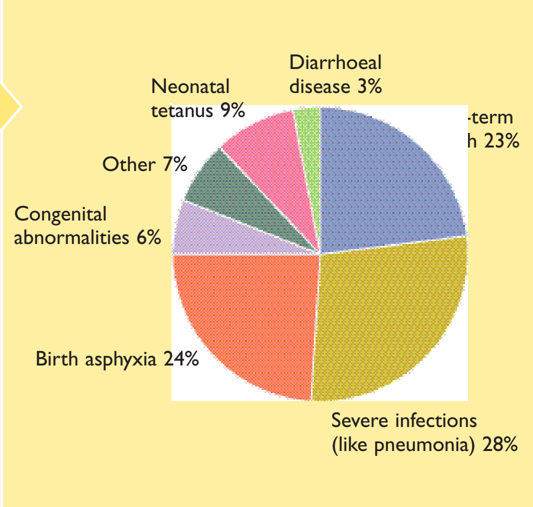
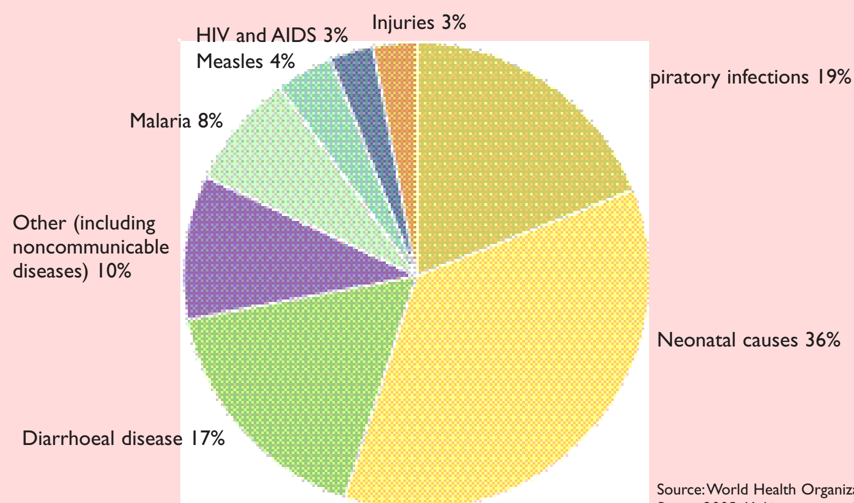


Figure 4. Causes of death of children under five globally, 2000–2003



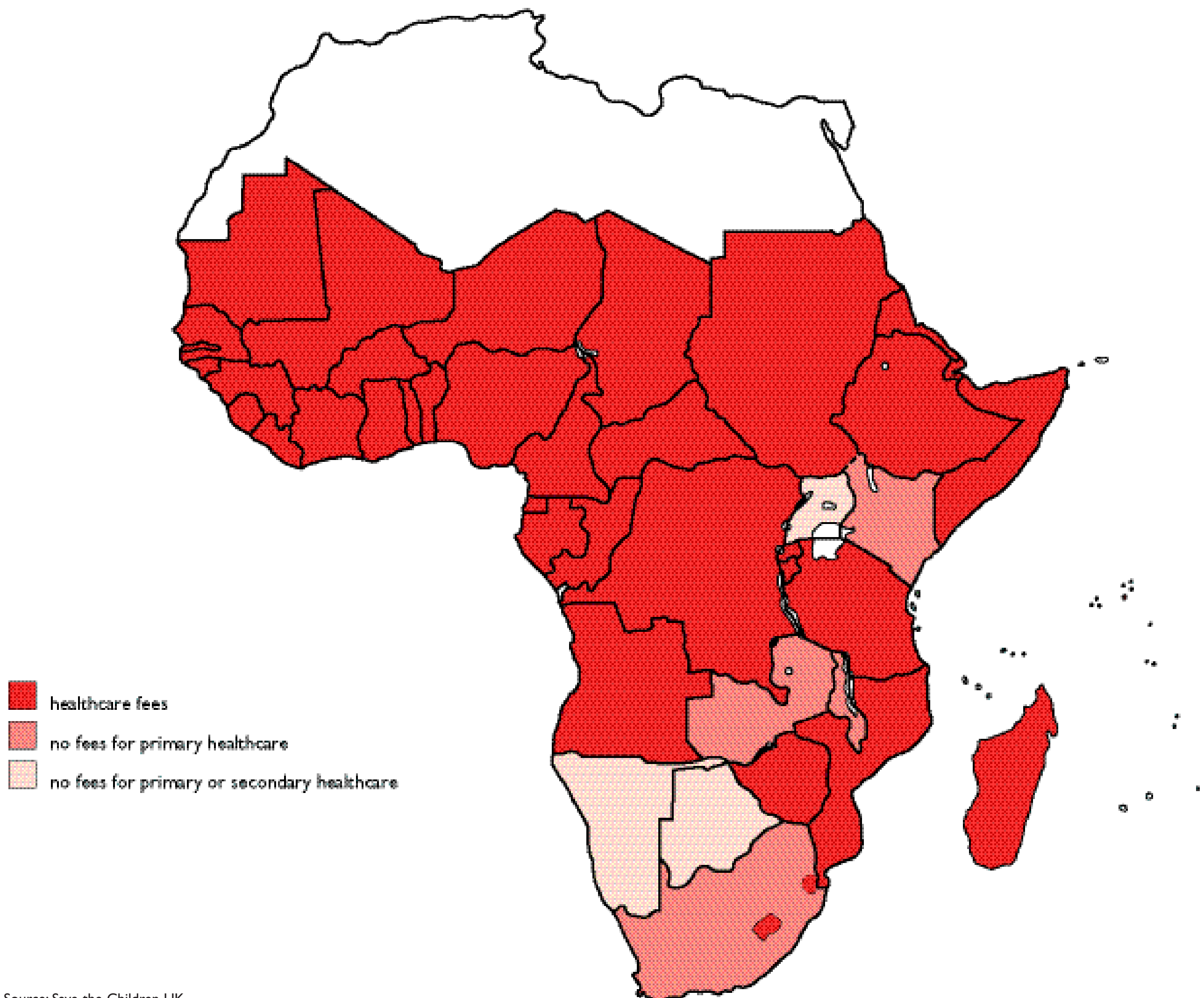
Source: World Health Organization (2005) *World Health Report 2005: Making every mother and child count*

In Ethiopia and Rwanda, 80 per cent or more of children are not taken for treatment when they have diseases like pneumonia.

As Table 1 (opposite) shows, Sierra Leone is not alone in the parlous state of its health provision. Many children in other African countries have no access to basic healthcare. For example, in Ethiopia and Rwanda, 80 per cent or more of children are not taken for treatment when they have diseases like pneumonia.

Measles can be prevented by a simple injection that costs around 20p, yet it is one of the main killers of children in Africa (see page 5). In four countries in Africa – Liberia, Somalia, Nigeria and the Central African Republic – less than half of all one-year-olds have had the measles vaccine.

Figure 5. Countries in sub-Saharan Africa where healthcare fees are charged



Source: Save the Children UK

Table 1: The toughest places for children to survive

		Under five mortality rate (deaths per 1,000)	Percentage of under-5s with acute respiratory infection (eg, pneumonia) taken to healthcare provider	Percentage of children under one who have had measles vaccine
1	Sierra Leone	283	50%	64%
2	Angola	260	58%	64%
3	Niger	259	27%	74%
4	Afghanistan	257	28%	61%
5	Liberia	235	70%	42%
6	Somalia	225	n/a	40%
7	Mali	219	36%	75%
8	Democratic Republic of Congo	205	36%	64%
9	Equatorial Guinea	204	n/a	51%
10=	Guinea-Bissau	203	64%	80%
10=	Rwanda	203	20%	84%
12	Chad	200	22%	56%
13	Nigeria	197	33%	35%
14	Côte d'Ivoire	194	38%	49%
15	Central African Republic	193	32%	35%
16	Burkina Faso	192	36%	78%
17	Burundi	190	40%	69%
18	Zambia	182	69%	84%
19	Malawi	175	27%	80%
20	Ethiopia	166	16%	71%

Source: *State of the World's Children 2006*, UNICEF

The collapse of health services in Africa

The reasons for the disintegration of health services across Africa are varied. They include poverty, donor and lender-imposed economic policies in the 1980s and 90s that restricted health spending, lack of funding for health systems leading to the collapse of health infrastructure, lack of health workers (with increasing migration to better paying jobs in rich countries), the HIV pandemic, conflict, political uncertainty and geographic and population factors.

However, one thing that unites almost all of the African countries in Table 1 is that patients in these countries have to pay for treatment.[6] The forms these payments take vary (see page 9), but the effect on poor people is the same. They die, get sicker, or take catastrophic financial decisions, making already tenuous existences even harder.

How healthcare fees are hurting children in Africa

2

What are healthcare fees and how much are they?

In most countries in Africa, patients have to pay health fees. These out-of-pocket expenses vary from country to country. At health facilities there may be formal fees for registration, essential medicines, tests and treatment and, in hospitals, for bed occupancy. In addition to these formal fees, patients often pay 'informal' fees that are charged by health workers to supplement clinic costs and their own low incomes.[7] In Tanzania, for example, patients have been charged £1.10 for rubber gloves used by health practitioners.

Poor families in Africa often cannot afford healthcare fees or struggle to pay them. Save the Children found that in Sierra Leone a course of treatment for a child suffering from malaria costs 18,000 leones, or £4.24. It would take the average Sierra Leonean 14 days to earn this amount. In UK terms, it's the equivalent of a British citizen paying £700 for treatment. Giving birth at a clinic costs around 55,000 leones (£13). That's the equivalent of more than £2,200 in the UK.

Table 2: The cost of essential healthcare in Sierra Leone

Condition requiring treatment	Cost of treatment (in sterling)	Cost equivalent in terms of number of days' average earnings	Cost equivalent in the UK
Malaria			
Treatment for adult:	£8.48	28	£1,475
Treatment for child:	£4.24	14	£722
Watery diarrhoea			
Treatment for adult:	£5.65	19	£980
Treatment for child:	£3.77	13	£643
Birth delivery	£12.97	43	£2,217
Caesarean section delivery	£58.96	194	£10,004

Source: Save the Children UK Sierra Leone; World Bank World Development Indicators Database 2006.
Cost examples are from Freetown and Kailahun.

In Sierra Leone, the cost to a patient of a Caesarean section is the UK-equivalent of £10,000.

In addition to the high healthcare charges patients have to pay, they also face other costs in order to get treatment. For example, in rural areas, clinics are often far apart, so that patients have to make a long journey to get treatment. For many poor people in rural areas, travel costs to a health provider are a significant expense. In addition, they have to take time away from their crops, livestock or other small-scale commerce.[8]

What's the impact on people who can't afford to pay?

What happens when poor people in Africa have to pay to receive essential healthcare?[9]

Many people don't seek treatment when they get ill

When poor people have to pay for medical treatment, many simply stay home. In studies in seven countries in East and Central Africa, Save the Children UK found that a third of the population simply didn't go to get medical treatment when they were sick. On average they made only one visit for treatment per person every two to four years, despite the fact that they might be sick more often. In Ethiopia, we found that 80 per cent of households had one or more family members taken ill in the fortnight prior to the study; more than half either didn't seek any treatment or chose to treat themselves

Hawa, from Kailahun district in Sierra Leone, is 12 years old. Both her parents are dead and she is looked after by her aunt. Hawa is almost blind. "At times my eyes get very dark and I can hardly see. They are cloudy," she says.

Hawa's eyesight started to deteriorate a few years ago. "I was not treated – there was no money," says Hawa. "My aunt is poor and she has to look after eight children."

Hawa's aunt borrowed money last year so that Hawa could go to the clinic. "At the clinic they told me that my right eye is very damaged and that I won't be able to see again with it. They also said I need urgent medicine to stop the disease getting worse," said Hawa. But, she adds, they have not been back to the clinic "because there was no more money." Hawa is now worried that she will become completely blind.

with traditional herbs. Across the studies, most cited lack of money as the main reason they did not seek treatment at a clinic.[10]

In Rwanda, when health fees were introduced in 1996, take-up of health services halved.

How do we know that it is fees – rather than the cost of travel or time away from their crops – that deter people from seeking medical help? Because when countries that once had free healthcare start to charge, people who used to go to a clinic or hospital simply stop going.

In Rwanda, when health fees were introduced in 1996, take-up of health services halved. Research shows a clear link between people's ability to pay and whether they seek treatment. In one survey, 100 per cent of people in the wealthiest group sought treatment from a formal healthcare facility when ill. Among the poorest group, 75–90 per cent of people either sought no treatment or treated themselves with herbs.[11]

In Zambia, after the introduction of registration fees at health centres and treatment fees in hospitals in the mid-1990s, overall attendance dropped by a third over two years and continued to decline slowly in subsequent years.[12] In April 2006, the Zambian government announced the abolition of fees for healthcare in rural districts, supported by a £14.5m grant from the UK's Department for International Development (DFID). At the time of writing, no statistical evidence for an increase in patient numbers was yet available, but early media reports indicate that people are coming back in significant numbers.[13]

People look for treatment that is cheaper – but less effective

Evidence from Ethiopia shows that poor people think modern medicine is more effective, but take-up is reduced because they have difficulty accessing it, partly because of fees.[14] The relative cost of modern medicine leads many people to turn to traditional medicine, which tends to allow more flexible forms of payment and to be more local, therefore involving lower travel costs and less loss of earnings than going to a health clinic. Save the Children UK research in Tanzania has shown that women in particular – having generally less access to money than men – are more likely to use traditional medicine.[15] Fees for healthcare, therefore, particularly restrict the choices of women seeking healthcare for themselves and their children.

Making effective medicine free encourages its use. The day after Zambia abolished health fees in rural areas in April 2006, 67-year-old patient Peter Chibize said, "We normally take our children to traditional medicine men who give them herbs, some of which are fatal. I will announce at the village that the fees [at the nearby hospital] have now been scrapped."[16]

People are forced into catastrophic financial decisions

When a medical problem worsens, poor people will use any means available to raise treatment money. Cash savings are rare, so responses to health emergencies usually involve borrowing money from friends, relatives or money-lenders. Where that fails, possessions are sold or mortgaged. Most possessions or assets, like cattle, crops,

Fees for healthcare particularly restrict the choices of women.

The World Health Organization estimates that 100 million people are forced into poverty each year by catastrophic payments for healthcare.

K was working in Dar es Salaam in Tanzania when she fell sick. She used all the money she had saved in order to pay for treatment. When she didn't get better, her belongings had to be sold to pay health charges. Then, when she still failed to recover, her father mortgaged his coconut plantation to pay for treatment, but to no avail. "Finally, we just took her home and waited for her days to finish, as there was nothing left to sell to help her," K's sister recounts. "In the end, she died and my father lost his plantation as he couldn't afford to reclaim it within the agreed time."

bicycles or pots and pans, are also used to generate income, food or housing, either through mortgaging and pawning them or through selling them.

So-called 'catastrophic' financial decisions can set in motion a vicious cycle where a family's increased poverty typically leads to a deterioration in nutrition and living conditions, poorer health, and an even greater inability to pay for sudden and unexpected costs like health fees.[17] The World Health Organization estimates that 100 million people are forced into poverty each year by catastrophic payments for healthcare.[18]

Knock-on effects of healthcare costs on children

Health fees have a wide range of consequences for families. For example, families who are poor may take their children out of school so they can earn money to help support the family. Missing out on education can have a long-term and damaging impact. Children who receive an education live longer than those who miss out on school, they have children of their own later (rather than as children themselves) and are less poor. All of this is jeopardised by health fees.

Sherifa lives in Lindi district in Tanzania with four of her daughters. Her husband died in 2004.

Sherifa's daughter, Rehema, has had to stop going to school because her mother can't afford the uniform. "It's just a skirt and a shirt," says Rehema. "I would really like to go back to school but my mum doesn't have the money for the clothes."

Rehema understands how important it is for her future that she finishes school. "If I finish standard seven, I'd like to be a farmer or maybe a business lady in the village."

The case for scrapping healthcare fees 3

Healthcare fees don't do the job they were intended for

Donors like the World Bank recommended healthcare fees in many African countries as a way to help pay for health services. However, healthcare fees have failed to provide significant funds for health services. On average, health fees in Africa account for less than 5 per cent of what it costs countries to run national public health services.[19] Health fee systems are costly to manage, with 40–60 per cent of the funds raised lost through administration costs.[20]

Healthcare fees were also intended to improve access for all to quality healthcare by raising extra funds. Some research, especially at district level, has found that funds raised through fees have proved invaluable to health workers, particularly in districts most in need that rarely receive adequate resources from government. Fees can help to motivate health workers and provide small amounts of ready cash, which they can choose how to spend.

However, where healthcare fees have been abolished, research shows that fees reduce take-up of health services by 40–50 per cent, on average. In addition, there is conclusive evidence from research undertaken in the last 30 years that health fees are inequitable. They place the burden of care upon those least able to shoulder it – the poor and the sick.[21]

In recognition of the fact that healthcare fees hurt those who are poorest, economic planners recommended initiatives to soften the impact. Various exemption and waiver systems were introduced for vulnerable groups, such as children under five years old, pregnant women and those suffering from poverty or chronic illness. However, these initiatives have been piecemeal. A review of 25 African countries operating health fees revealed that only 15 had exemption policies, and only one had clear guidelines. Where exemption systems are in place, research has found that they often fail to benefit poor people. Health workers are often reluctant to grant exemptions since they rely on fees for flexible income. In addition, exemptions are often hijacked by those who can pay for health, while those who are most in need are often unaware of their entitlement to exemptions or how to claim them.[22]

In Rwanda, healthcare fees reduced take-up of health services by 50 per cent.

Scrapping fees would be relatively cheap

As described above, healthcare in Africa is in crisis. The fundamental reason for this is that healthcare in Africa is massively underfunded (see Table 3 opposite) – and has been for decades.

In reviewing healthcare fees, it is crucial to consider the overall context of underfunding of health services in Africa. In 2001, the Commission on Macroeconomics and Health calculated that to cover the cost of a comprehensive package of essential healthcare each country would need to spend between $30–$40 per person per year on health.[23] In that report, national governments in developing countries were called upon to increase health funding by $33bn annually, while donors were asked to deliver on their 30-year-old promises of 0.7 per cent of their national budget dedicated to aid and come up with an extra $27bn just for healthcare.[24] To reach this level of investment, sub-Saharan Africa would need to increase health spending by $18.6bn annually.[25] Little progress has occurred in this area since 2001, with most new money targeting adult diseases rather than building health systems to improve health for all.

Abolition of healthcare fees is a 'quick win' in the fight to improve healthcare in the world's poorest countries.

In 2001, African governments agreed in Abuja, Nigeria, that they would ensure their health spending reached 15 per cent of national expenditure in order to achieve the health-related Millennium Development Goals[26] and win the war against deadly diseases like HIV and AIDS, malaria and tuberculosis. They reconfirmed this commitment in Maputo, Mozambique, in 2005. Yet Table 3 shows how few nations have met this target.

Against this backdrop of large-scale underfunding, it becomes clear that, despite the widespread use of healthcare fees throughout Africa (see Figure 5, page 6), they contribute very little to funding healthcare – less than 5 per cent of year-to-year costs, as noted on page 13. The abolition of fees for the whole of sub-Saharan Africa would cost around £1bn, allowing for the provision of an essential healthcare package of cost-effective treatments for mothers and children. That is £1.38 per person in sub-Saharan Africa, which is more than some countries – Burundi and the Democratic Republic of Congo – spend on healthcare per person per year (see Table 3).

In international development terms, this is a very small sum, making it a worthwhile and simple first step. In the words of economist Jeffrey Sachs, abolition of healthcare fees is a 'quick win' in the fight to improve healthcare in the world's poorest countries, an area where quick wins are few and far between.[27] For a country like Sierra Leone it might cost as little as $15.6m annually.[28]

Table 3. Funding for healthcare in the toughest places for children to survive

Countries with the worst record on child health	Are fees charged for healthcare?	Percentage of health fees borne by patients†	Proportion of government expenditure on health	Per capita government expenditure on health (US$)
Sierra Leone	yes	100%	10%	$4
Angola	yes***	100%	6%	$22
Niger	yes	95%	n/a	$5
Afghanistan	yes	80%	n/a	$4
Liberia	yes***	96%	5%	$4
Somalia	yes	100%	1%	n/a
Mali	yes	89%	2%	$9
Democratic Republic of Congo	yes	100%	0%	$1
Equatorial Guinea	yes	80%	21%	$65
Guinea-Bissau	yes	100%	1%	$4
Rwanda	yes	65%	5%	$3
Chad	yes	96%	8%	$7
Nigeria	yes	90%	1%	$6
Côte d'Ivoire	yes	95%	4%	$8
Central African Republic	yes	95%	n/a	$5
Burkina Faso	yes	99%	7%	$9
Burundi	yes	100%	2%	$1
Zambia	yes*	75%	13%	$11
Malawi	yes**	43%	7%	$5
Ethiopia	yes	66%	6%	$3

Sources: *World Health Report 2006*, World Health Organization, 2006 and Save the Children UK

† Out-of-pocket expenditure as a percentage of private expenditure on health (2003). In some countries exemptions exist for vulnerable groups, but research by Save the Children UK shows they often fail to benefit poor people (see page 13).

* Fees were abolished in rural districts on 1 April 2006 and there are signs this might soon be extended to the rest of the country.

** Primary healthcare is free, but there are charges for NGO and faith-based providers, which make up 50 per cent of services.

*** Fees abolished during war. In Luanda, fees are in use again and non-state providers also charge fees. In Liberia, no official fees exist but private (NGO) providers still charge, and they provide the majority of healthcare at present.

James (not his real name) works in a health clinic in Sierra Leone. His clinic is the main health access point for 41,000 people.

"Twenty tablets of paracetamol is just 500 leones (12 pence), but even that most people cannot afford," says James. "I would say a quarter of the population cannot afford to buy even the cheapest drugs. That's why we have such a high death rate. These people don't even come to ask for treatment or a diagnosis. Since they have no money they just stay at home."

James described the case of a boy with a broken leg who came to his clinic. "This boy's leg is not straight and he is in pain. He also has an infection. The family has no money, they can't even pay me for some painkillers. But there is nothing I can do for him, he needs to go to the hospital. If the boy's leg is not treated the bone marrow could get infected – then we would have to amputate his leg. Neither the government, me or his parents can take responsibility for this boy. All we have for him is suffering."

Aid and donor support

Aid and donor support remain important sources of financing for health in developing countries. Even if developing countries meet their 15 per cent target of national expenditure on health, they will still need predictable, sustained donor aid for a number of years until they are able to support their own health financing from taxation and other revenue streams, in order to fund a package of essential

'Disease burden and economic growth are intimately related.'

International support for abolishing fees

Save the Children UK stepped up campaigning for abolition of healthcare fees last year in the run-up to Gleneagles and the Millennium Summit review. Since then, we have seen significant changes in attitudes, with increasing recognition in the international community that fees, rather than helping to provide health services, are actually preventing people from using them:

- **The G8** declared support in July 2005 for African governments to provide 'basic healthcare (free wherever countries choose to provide this) to reduce mortality among those most at risk from dying from preventable causes, particularly women and children.'[31]
- **The World Health Assembly** in 2005 urged its member states to move away from user fees towards other payment mechanisms like tax-based and insurance systems 'in order to achieve the goal of universal access and financial and social protection.'[32]
- **The Africa Commission** recommended that African governments 'remove fees for basic healthcare' and that 'donors should make a long-term commitment to fill the financing gap'.[33]
- **Gordon Brown**, UK Chancellor of the Exchequer, said last year that 'there must be universal and free schooling and health care as the beginning of justice for the poorest countries of the world.'

Fine words. We now need to see them followed up with action. Of major donors and international institutions, only the UK government has both formulated and is implementing a policy against healthcare fees. In 2006, DFID committed £14.5m in aid over five years to Zambia to help it make rural healthcare free.

It's a start, but no more. Zambia needs help to make healthcare free in urban areas. And care must be taken to ensure that healthcare fees are abolished carefully and with quality monitoring. DFID has set a target of 12 'first wave' countries working towards scaling up health and education and abolishing fees, by the end of 2006.[34] It is vital that these milestones are met, and that other donors follow this lead in assisting poor countries to make healthcare free.

healthcare and strengthen their health systems. Developed countries must fulfil their promises urgently.

As the Africa Commission has stated, 'disease burden and economic growth are intimately related'. People who are healthy are more productive and more likely to be able to care for their children and benefit from education. Income levels of countries with severe malaria are a third of equivalent countries without malaria, and grow 1.3 per cent less per person annually.[29]

Yet only 3 per cent of overseas development assistance in 2002 was allocated to basic health programmes.[30] Debt repayments have also hampered progress for Africa. Countries have become crippled by the burden of high interest and repayment rates levied upon them following large loans taken out in the 1980s. Meeting these repayment costs has prevented many countries from investing more in health and education. Promises made by the G8 to abolish debt in 19 heavily indebted countries must be delivered.

What happens when fees are scrapped? 4

A handful of countries have led the way in abolishing health fees. It has often been done hurriedly, however, and consequently there are lessons to be learned for countries that wish to remove their own health fees in the future.

South Africa's experience

Following South Africa's abolition of health fees for pregnant and lactating women in 1994, there was a 77 per cent increase in the use of curative services over 18 months. When fee abolition was extended to all primary health centres in 1997, curative consultations almost doubled.

Although fee abolition was welcomed, the change had been implemented without sufficiently consulting, supporting or preparing health workers for the enormous increase in demand for health services. This left them overworked and demoralised. It is essential to learn lessons from South Africa's experience and ensure that health fee abolition is effectively and inclusively planned and resourced to ensure that staff have the capacity, skills and resources to deal effectively with the increased demand for services.[35]

Uganda's experience

Like South Africa, the Ugandan decision to abolish health fees was political. Without any planning with health workers and other stakeholders, Uganda saw the first, immediate increases in take-up of health services begin to dip after six months as the system struggled to cope and patients and staff became frustrated. Although take-up had initially increased by over 100 per cent, staff had not been prepared or given the resources to deal with the increased demand. However, due to other health sector reforms and newly released debt relief money, the government was able to increase funding for primary healthcare (from 33 to 54 per cent) and for non-governmental health service providers so they too could abolish fees, as well as increasing the drug budget by 50 per cent and health worker pay by between 15 and 65 per cent. This led to an overall increase of 120 per cent in use of health services in some districts and a national increase in use of out patient care facilities of 90 per cent. Even services like immunisations for children (previously free) saw an increase in uptake by 105 per cent, as patients enjoyed their new universal right to free treatment.

On average, health spending per family dropped from $3.50 per month to $2.20 per month. But research demonstrates that the poorest households reduced their monthly spending on health by 47 per cent. The same research also demonstrates that 70 per cent of the increase in take-up of services was attributable to women and children. All of these changes only cost an extra 15 per cent of national expenditure on health over five years, but ensured more equitable distribution of resources, with the most needy communities being given 51 per cent more per person per year.[36]

Practical strategies for managing fee removal: lessons learned

Gilson and McIntyre[37] point out that although fees are the least effective way to resource health services, abolishing fees will require context-specific planning and extra resources to meet the increase in demand and consumption of health services. They suggest that each country planning to abolish fees should establish a government-led working group ensuring that all stakeholders have a voice in the planning. Some countries in sub-Saharan Africa have already held such meetings to decide which health-financing option will work for them, setting clear national visions, strategies and milestones with timelines. Countries with proven ability to implement effective health policies have ensured that district-level health resources (financial, technical and human) are available to meet increased demand for health services. These countries have also established effective communication strategies to ensure that communities know what policy changes to expect by when, so they can take full advantage of them. Some countries will need to gather more health information, train more staff and build more health posts before they can successfully implement health policy changes. Once the new policy is agreed, resourced and implemented, regular review will ensure problems can be detected and managed quickly.

Recommendations 5

- G8 countries, as a first step, must publicly acknowledge that healthcare fees are damaging and kill vulnerable people while delaying economic development.

- All donors and lenders, including the UK government, G8 countries and the World Bank, should assist poor countries that want to make healthcare free to their citizens to do so.

- Developed countries must keep their current commitments to increase aid and write off debt. Last year's G8 summit at Gleneagles promised to abolish debt in 19 of the poorest countries. Release of this money is essential if those countries are to invest adequately in health and education. Other severely indebted countries need similar debt relief.[38]

- Having shown international leadership by assisting Zambia to make its rural health system free, the UK government should do the same with at least one more country by the end of 2006, and support a total of 12 countries by 2010.

- More aid must be channelled through governments' health budgets to promote health systems strengthening. In 2002, only 3 per cent of overseas development assistance was allocated to basic health programmes.[39] This must increase to $1.7bn for sub-Saharan Africa in 2006 as a matter of urgency and to $18.6bn by 2010.

- Developing country governments must ensure that adequate resources (financial, technical and human) reach the districts in most need. For example, one district in Tanzania reduced child deaths by two-thirds in six years with only an extra $2 per person per year, by realigning its health spending to target the problems most affecting local children.[40]

Endnotes

[1] Save the Children analysis, carried out using World Health Organization *World Health Report 2005: Making every mother and child count* along with Save the Children research, published in the *British Medical Journal*, October 2005 and World Bank (2005) *African Development Indicators*.

[2] World Health Organization (2006) *World Health Report 2006: Working Together for Health*, WHO, Geneva p. xix

[3] World Health Organization (2005) *World Health Report 2005: Making every mother and child count*, WHO, Geneva

[4] *ibid*

[5] *ibid*

[6] The sole exception is Zambia, which abolished fees for patients in rural health centres in April 2006.

[7] Formally abolishing health fees can lead to the abolition of informal fees too, since patients know and understand their new right to free treatment. Where fees are used to supplement incomes and pay for running charges and equipment and drug purchasing, the abolition of fees will need to be accompanied by adequate decentralised funding for health workers and facilities. See Save the Children UK (2005) *An Unnecessary Evil? User fees for healthcare in low-income countries*.

[8] Key to ensuring increased health provision in the world's poorest countries will be improving access, particularly in rural areas, through making health clinics available, and incentivising staff to work in these remote locations. See Save the Children (2005) *The Cost of Coping with Illness: East and Central Africa*.

[9] In health development theory, 'basic' healthcare usually means care of common skin conditions, infectious diseases (like malaria and pneumonia) and preventive care (like immunisations). Save the Children UK calls for an 'essential' package to be delivered to the poorest people. The essential package adds to the basic one by also providing life-saving interventions such as skilled midwives to deliver babies, and treatment of severe infections and complications during pregnancy.

[10] Save the Children UK (2005) *The Cost of Coping with Illness: East and Central Africa*, Save the Children, London, p. 3; Russell, Dr S and Abdella, Dr K (2002) *Too Poor to be Sick: Coping with the Costs of Illness in East Hararghe, Ethiopia*, Save the Children, London, p. 37

[11] Save the Children UK (2005), *Mind the Gap: The Cost of Coping with Illness: Rwanda*, Save the Children, London

[12] Blas E, and Limbambala, M (2001) 'User Payment, Decentralisation and Health Service Utilisation in Zambia', *Health Policy and Planning* 16, pp 19–28

[13] For instance, BBC News Online, http://news.bbc.co.uk/1/hi/world/africa/4883062.stm

[14] Russell, Dr S and Abdella, Dr K (2002) *see above*, p.37

[15] For instance, see Save the Children and Ifakara Health Research and Development Centre (2003) *Health Seeking Behaviour, Illness Costs and their Implications for the Poor*, Save the Children UK, Dar es Salaam

[16] Interviewed by Shapi Shacinda, *Zambia Introduces Free Health Care After Debt Relief*, Reuters, 2 April 2006

[17] Witter, S (2004) *The Unbearable Cost of Illness: Poverty, ill-health and access to healthcare – Evidence from Lindi Rural District, Tanzania*, Save the Children, London

[18] World Health Organization (2005) *World Health Report 2005: Making every mother and child count*, WHO, Geneva

[19] Save the Children UK (2005) *An Unnecessary Evil? User fees for healthcare in low-income countries*, Save the Children UK, London

[20] *ibid*

[21] *ibid*

[22] *ibid* p. 7, 8, 9

[23] Commission for Macroeconomics and Health (2001) *Macroeconomics and Health: Investing in health for economic development*, WHO, Geneva

[24] *ibid*

[25] This calculation is based on data from World Bank (2005) *African Development Indicators* and World Health Organization (2006) *World Health Report 2006: Working together for health*.

[26] Three Millenium Development Goals (MDGs) relate to health: MDG 4 aims to reduce child deaths rates by two-thirds by 2015; MDG 5 aims to reduce mothers dying from pregnancy related causes by three-quarters by 2015; and MDG 6 aims to halt the spread and reduce the prevalence of HIV and AIDS, TB and malaria by 2015.

[27] Jeffrey Sachs *et al* (2005) *Investing in Development: A practical plan to achieve the Millennium Development Goals*, Millennium Project

[28] Using data from James, C, Morris, S, Keith, R and Taylor, A (2005) 'Impact on child mortality of removing user fees: simulation model', *British Medical Journal*, 2005, 331:747–9

[29] Commission for Africa (2005) *Our Common Interest: Report of the Commission for Africa*

[30] People's Health Movement Medact and Global Equity Gauge Alliance (2005) *The Global Health Watch: An alternative World Health Report*, page 324–5 Unisa Press Pretoria and Zed Books London/New York

[31] G8 Communique, Gleneagles, July 2005, paragraph 17

[32] World Health Assembly Resolution 58.31, 2005, Agenda item 13.2, 'Working towards universal coverage of maternal, newborn and child health interventions'

[33] Commission for Africa (2005) *Our Common Interest: Report of the Commission for Africa*, p. 196

[34] DFID website: www.dfid.gov.uk/g8/milestones.asp

[35] Gilson, L and McIntyre D (2005) 'Removing user fees for primary care in Africa: the need for careful action', *British Medical Journal*, 331:762–5, No 7519 1 October 2005

[36] Save the Children UK (2005) *An Unnecessary Evil? User fees for healthcare in low-income countries*, Save the Children UK, London; Yates, R (2004) *The Ugandan Health SWAP: Improving efficiency and equity*.

[37] Gilson, L and McIntyre D (2005) *op cit.*

[38] G8 Communique, Gleneagles, July 2005

[39] People's Health Movement Medact and Global Equity Gauge Alliance (2005) *The Global Health Watch: An alternative World Health Report*, page 324–5, Unisa Press Pretoria and Zed Books London/New York

[40] Grow Up Free from Poverty coalition (2003) *80 Million Lives: Meeting the Millennium Development Goals in child and maternal survival*, p. 89

Save the Children
UK

Anna Kari

Paying with their Lives

The cost of illness for children in Africa

Save the Children UK estimates that the lives of 285,000 children in Africa could be saved each year by abolishing fees for healthcare. What's more, it would cost relatively little.

For millions of people in countries in Africa, healthcare fees have failed to do the job they were intended to do. Fees fund less than 5 per cent of what it costs countries in Africa to run public health services. When fees have been introduced, take-up of health services has dropped by 40–50 per cent on average. Inevitably, it's poor families who miss out.

In July 2005, at the G8 summit hosted by Tony Blair, world leaders made a commitment to support free healthcare for the world's poorest countries. As yet, very little new money has materialised.

One year on, Save the Children UK is calling on world leaders to deliver on those promises by supporting countries in Africa to make healthcare free for their citizens.

Save the Children's OUCH campaign is calling for free healthcare for the world's poorest children.

Join us – text OUCH to 88600 and show the politicians you care.

OUCH

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