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**Increasing access to 'free' health services: are health workers not a missing link?**

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PERSPECTIVE – International Journal of Clinical Practice

**TITLE:** Increasing access to ‘free’ health services: are health workers not a missing link?

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2 In September 2009 in front of a global audience in New York, leaders from Burundi, Ghana, Liberia,  
3 Malawi, Nepal and Sierra Leone made public commitments to increase access to free health services  
4 in their respective countries, particularly for pregnant women and children younger than 5 years [1].  
5 The commitments reflected, in part, a desire to: ‘accelerate action towards universal access to  
6 primary health care’ as laid out in the World Health Assembly Resolution of May 2009 [2];  
7 specifically address poor maternal and child health outcomes by focusing on women and children,  
8 and in turn; enhance progress against the health-related Millennium Development Goals.

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14 A common theme within the country commitments is the removal of financial barriers to access  
15 health services: in particular, user-fees at the point of service. This is not a new approach and has  
16 been implemented in both high- and low-income countries; albeit with varying degrees of success.  
17 In a 1945 address to Congress on the health of the Nation, Harry S. Truman recognised that “the  
18 principal reason why people do not receive the care they need is that they cannot afford to pay for it  
19 on an individual basis at the time they need it”. His resulting policy highlighted “that financial  
20 barriers in the way of attaining health shall be removed; that the health of all its citizens deserves  
21 the help of all the Nation” [3]. The logic from 1945 is as relevant today.

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27 Published evidence, including reports from the World Health Organisation (WHO) [4], the WHO  
28 Commission on Social Determinants for Health (CSDH) [5], and articles in *The Lancet* [6] and in the  
29 *Bulletin of the World Health Organisation* [7], indicates that user-fees are one of the most regressive  
30 forms of health financing and a barrier to reducing maternal and child mortality.

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*“The policy imposition of user fees for health care in low- and middle-income countries has led to an overall reduction in utilization and worsening health outcomes. Upwards of 100 million people are pushed into poverty each year through catastrophic household health costs. This is unacceptable” CSDH, 2008.*

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User -fee removal is generally considered a positive policy objective and should enable many individuals in lower-income quintiles to enjoy new and improved access to health services.

With such notable publications and health journals disseminating the case for removal of user-fees it is easy to grasp the political appeal to announce increased access to ‘free’ health services: there are indications that other countries will make similar commitments in 2010. But, whilst demand-side

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2 interventions are logical, and a focus on women and children absolutely essential [4] [8], there  
3 remain some concerns that the supply-side characteristics of a national health system, especially the  
4 dynamics of the health workforce, are a missing link to achieve the policy goals of universal health  
5 care. What is the net benefit of increasing *access* to 'free' health services if there is no qualified  
6 health worker available to provide care, or where you may queue all day only to be afforded an  
7 ineffectual consultation which undermines respect, trust, privacy and confidentiality? Such are the  
8 realities in many low-income countries, particularly in rural and remote areas, where health workers  
9 are in drastically short supply, and often over-burdened and/or under-resourced.  
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15 The potential for trade-off between access to a health facility and access to quality health care raises  
16 a number of issues. 'Access' and 'coverage', with or without a 'universal' prefix, are not meaningful  
17 concepts without some reference to *quality and safety*: increasing access does not necessarily  
18 correlate with improved care. Rather the realities of budget limits in low-income countries, even  
19 after donor resources are taken into account, suggest that universal access to a free public service  
20 may only be achieved at a basic level of quality. Many countries have identified an 'essential' or  
21 'basic' package of care to which universal access is targeted in recognition of this. Yet even these  
22 restricted packages may require additional financial allocations if they are to be genuinely 'free'.  
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27 Where these issues are at play the trade-off between coverage and quality as countries seek to  
28 'scale-up' and achieve universal coverage has critical implications for outcomes across the breadth  
29 of the health system [9].  
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33 Evidence suggests that health service utilisation rates tend to increase dramatically once financial  
34 barriers are removed [4] [10] [11] [12] [13]. The existing stock, competencies and distribution of the  
35 health workforce may not be able to respond to increased demand for services whilst maintaining  
36 and improving the quality of the services it provides. This is particularly relevant in the 6 countries  
37 that made public commitments to free health care: each is faced with critical shortages in their  
38 national health workforce. In a standardised, comparative survey conducted by WHO for the 2006  
39 World health report each country was categorised as a 'crisis' country when benchmarked against  
40 the threshold of a minimum of 2.3 Doctors, Nurses and Midwives per 1,000 population in order to  
41 deliver essential services[14] (see FIGURE 1).  
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48 Whilst the science employed by WHO to arrive at the 2.3/1,000 'crisis' threshold remains open to  
49 debate – for instance some countries with a health workforce density less than this are  
50 demonstrating progress against the health MDGs (i.e. Bhutan, China, El Salvador, Morocco, Peru)  
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2 [15] - it has nonetheless acted as a catalyst to afford Human Resources for Health (HRH) a  
3 prominence in global health discourses. This includes the establishment of the Global Health  
4 Workforce Alliance (GHWA) in 2006 to support a 'Decade of Action on Human Resources for Health  
5 (2006-2015)'. GHWA has the laudable Vision that '*All people everywhere will have access to a skilled,  
6 motivated and supported health worker, within a robust health system*'. WHO hosts the GHWA and  
7 is demonstrating its leadership role; in both the 2006 WHR and its 2010-2015 HRH strategy [16] it  
8 has called for and committed to increasing strategic intelligence on the national health workforce. A  
9 revised vision "*to ensure all people have equitable access to an adequately trained, competent,  
10 motivated and supported health workforce so they attain the highest possible level of health*" is  
11 included in the latest WHO strategy. However, if both GHWA and WHO wish to enhance their  
12 respective performance and accountability frameworks in relation to their vision statements it will  
13 require new thinking that moves away from a workforce density focus to consider skills, distribution  
14 and performance. This will require innovation and action on the metrics and science to measure and  
15 evaluate whether countries are making progress in increasing "equitable access", especially for  
16 women and children, to a "skilled" or "competent" health workforce.

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26 One option for the 6 countries to promote national objectives whilst simultaneously generating  
27 knowledge for other WHO Member States is to include particular emphasis on strategic intelligence  
28 of the health workforce. As the countries implement their 2009 policy commitments it will be  
29 beneficial to conduct prospective evaluation of the risks and supporting measures needed in  
30 removing user-fees, with an understanding of the supply/demand dynamics within the individual  
31 health labour markets and the need to create a baseline from which to monitor trends [17]. This will  
32 include determining the geographical and socio-economic dynamics of 'access to a .... health worker'  
33 as a proxy for 'access to health services'.

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39 'Workforce Surveillance' is an evolving conceptual and scientific approach to support such strategic  
40 intelligence. Its current working definition is: "the routine, dynamic and systematic collection and  
41 analysis of HRH data for the provision of rigorous evidence and information which leads to action"  
42 [18]. Moving beyond an observational nature it seeks to capitalise on existing HRH metrics,  
43 monitoring and evaluation; supplementing this with context-specific real-time intelligence on health  
44 workforce trends from all available sources (including the public sector, professional associations  
45 and communities), and; employing inter-disciplinary and multi-disciplinary research methodologies  
46 to generate new insights. Whilst research and application is primarily in the context of  
47 strengthening HRH in low- and middle-income countries [19] , workforce surveillance is also  
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emerging from the Office of Workforce and Career Development at the Centres for Disease Control and Prevention (CDC) to review the dynamics of the American health workforce [20].

A surveillance exercise in each country could validate a Concentration Index (CI) of the health workforce (by cadre and stratified by sex) to provide additional evidence for data-driven decision-making. The CSDH recommends a CI as a health equity surveillance measure [5]; a WHO Expert Group has encouraged its adoption in the design, implementation and evaluation of initiatives to promote rural deployment and retention [21], and the World Bank has recently adapted CI to review the geographical imbalances in health workforce distribution in seven African countries [22]. This would identify actual and potential gaps in the workforce and its impact on service provision, especially in underserved areas, and enable new policy discussions on the priority engagement, deployment and training of health workers to achieve maximum benefit from the available or planned financial resources.

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*“Documenting and mapping exclusion from various essential services can be a useful tool for planning and can also serve as a baseline against which to measure progress in coverage”*  
WHO, Women’s Health (2009).

Nepal, for instance, has very recent evidence (December 2009) of how staff shortages, gender, knowledge and competencies continue to be contributing factors to maternal mortality and morbidity [23].

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*“The well known issues of staff availability and transfer continue to negatively affect the provision of skilled care, particularly Comprehensive Emergency Obstetric Care, at facilities built and equipped to provide this level of service, highlighting the vulnerability of systems”*  
Nepal – Maternal Mortality and Morbidity Survey.

Whilst there is expectation that Nepal’s Aama programme to remove user-fees will reduce barriers to access there is recognition that it will not immediately alter health workforce dynamics. Active workforce surveillance to routinely capture stock, competencies and distribution, including a regularly updated CI, combined with improved time-to-event analyses of workforce trends (i.e. on stability and retention rates and their underlying causes) would add new insights to address this. If these insights were subsequently correlated with findings from the maternal mortality survey, it

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would offer a clearer pathway on implementing part 4 of the Consensus on Maternal, Newborn and Child Health (MNCH) – ‘to deploy skilled and motivated health workers in the right place at the right time’ [24].

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As the 6 countries implement their respective programmes of ‘free’ health care, with support from various international development partners [\(including a new Centre for Progressive Health Financing launched in March 2010 by the UK Department for International Development \[25\]\)](#), we return again to Harry S. Truman when he spoke 65 years ago. One of the key elements he recognised was that access to care, irrespective of financial barriers, was multi-faceted. He argued that health workers - doctors, dentists, public health and hospital administrators, nurses and other experts – are ‘one of the most important requirements for adequate health services’. At the time Truman spoke some rural districts in America had zero Doctors per 1,000 population. His commentary recognised this failing: “It is not enough, however, that we have them....They should be located where their services are needed” [3]. Like many since, he recognised that promoting free health care through the removal of user-fees without addressing health workforce distribution is unlikely to improve access to quality care services.

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If we follow the premise that demand for health services is in part related to their perceived quality, then actions must be taken to strengthen the supply-side elements. And if removal of user-fees is targeted to those individuals who have been economically disadvantaged in the past, especially women and children, then the priority must be to strengthen the health workforce in the areas in which they live. This requires new strategic intelligence to prioritise HRH interventions, especially in rural and remote areas: workforce surveillance to enable prospective evaluation, evidence and action is one suggested approach.

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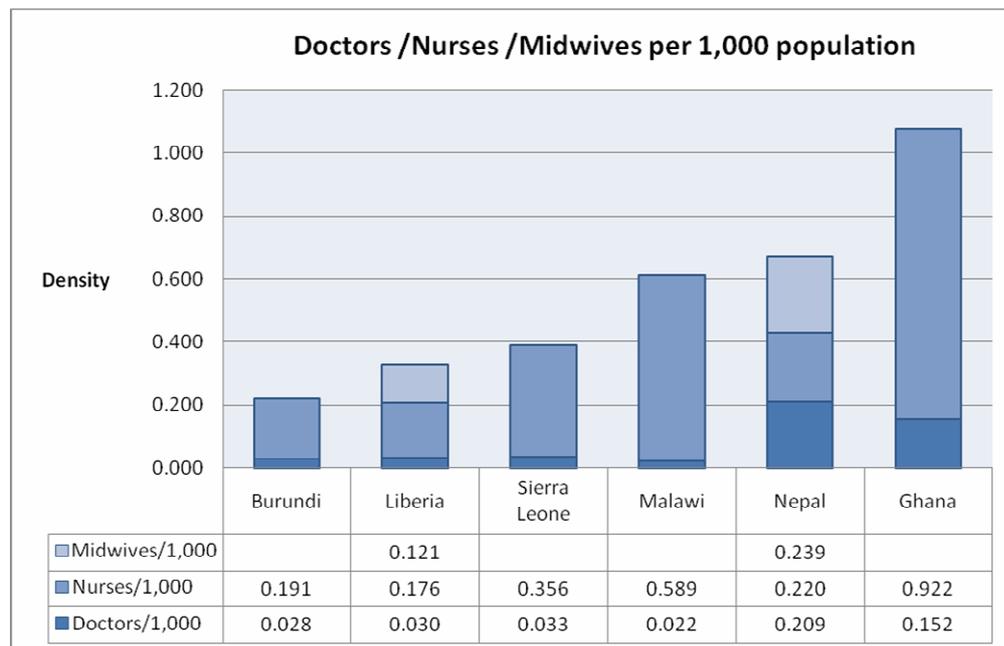
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[25] Further information available at: <http://www.progressivehealthfinancing.org/>

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Figures:

Figure 1. Density of Doctors, Nurses and Midwives per 1,000 population.



Source: adapted from WHO, 2006.