This article originally appeared in:
ARC WM News Blog. 23 Jul 2021; 3(7): 1-2.

Health Financing in Sub-Saharan Africa: the Story of a Bandwagon

Richard Lilford, ARC WM Director

The 1980s, were something of a watershed for healthcare in sub-Saharan Africa. On the demand side, the AIDS epidemic was wreaking havoc. There were also severe problems on the supply side. Many African countries were performing poorly economically under totalitarian and corrupt governments. Investments from the International Monetary Fund and the World Bank were not resulting in the anticipated enhanced economic performance that would enable them to be repaid. It was against this backdrop that the Bamako Initiative was adopted in 1987.

The intellectual basis for this initiative lay in the rising prominence given to community financing. The idea was to harness the productive capacity of communities through initiatives such as micro-finance and loan syndicates. The backdrop also included waxing interest in community self-help,[1] for example through women's groups.

In the particular case of the Bamako Initiative, the idea was to raise funds for primary health care through the sale of drugs at a profit. The initiative was strongly supported by the WHO and UNICEF. In 1989, Paul Garner wrote an article in the BMJ,[2] expressing some doubts about the initiative. Then, in 1993, Barbara McPake and colleagues wrote an influential article describing their evaluation of the initiative based on five case studies.[3] The article was nuanced and fell well short of a ringing endorsement of the initiative. However, in 2003 Knippenberg and colleagues wrote an article concluding that the initiative had led to "improvements in the access, availability, affordability and utilization of professional health services... for the average population and for poorest groups".[4] However, opinion changed and in 2019, Robert Yates, Director of the Global Health Programme and Executive Director of the Centre for Universal Health at Chatham House, wrote an article saying that it is time to bury the Bamako Initiative.[5] What went wrong?

First, a rereading of Knippenberg's article suggests that he and his colleagues likely over-interpreted the data in claiming cause and effect. They documented declining mortality in a number of countries that were part of the initiative, but without controls. This was the era of great improvement in child and infant

mortality, driven by vaccination, malaria prophylaxis, improved detection and correction of malnutrition, improved breast-feeding rates, and improved management of diarrhoea. Mortality was improving all over the world, and in the absence of contemporaneous controls I suspect that Knippenberg was describing a temporal trend. Of course, this does not disprove the initiative, but Mali, the very country where the initiative began, has now scrapped the system. The general climate has also changed, and micro-finance is no longer seen as a magic bullet.[6]

The trend now is, quite rightly, geared towards achieving universal health coverage. In other words, it is no longer believed that communities can be the sole architects of their own salvation. It is important, however, that we do not throw out the baby with the bath water. People were initially hubristic about grassroots and community initiatives. It is also important to avoid hubris regarding universal healthcare; a paper by myself, Celia Brown, and Frances Griffiths in the BMJ Global Health, shows that there simply is not enough money in LMICs to provide adequate state funded care, even at the primary level, and even if the proportion of government spending on health care was to rise.[7]

Meanwhile the Abdul Latif Jameel Poverty Action Lab has shown that a number of micro-initiatives can produce positive impact, earning Nobel prizes for Banerjee, Duflo and Kremer, the architects of the initiative. We are evaluating the effectiveness and sustainability of self-help groups in Nepal, India and Nigeria under funding from an NIHR RIGHT grant (#NIHR200132). We think a combined bottom-up and top-down approach is the best way forward; increase universal health care as fast as possible while not ignoring other sources of finance, such as saving syndicates. Meanwhile, we have made another discovery as part of our work on slum health.[8] Medicines are by far the largest primary health care cost for poor people in cities, greatly exceeding the cost of consultations [*paper forthcoming*]. Is it possible that as countries try to expand universal health care, facilities use public money to cover the costs of consultations, but make up for a shortfall in government funds by a charge on drugs? In that case, the Bamako Initiative is coming back in, but by the back door!

I would very much welcome comments and corrections from people more expert than myself, and continue the debate in these pages.

References:

1. Lilford RJ. Self-Help: A Critical Factor in Healthcare for Many People. *NIHR ARC West Midlands News Blog*. 2021; **3**(4): 1-2.
2. Garner P. The Bamako initiative. *BMJ*. 1989; **299** (6694): 277-8.
3. McPake B, et al. Community financing of health care in Africa: an evaluation of the Bamako initiative. *Soc Sci Med*. 1993; **36**(11):1383-95.
4. Knippenberg R, et al. Increasing clients' power to scale up health services for the poor: THE BAMAKO INITIATIVE IN WEST AFRICA. Background paper to the World Development Report. *World Bank Working Paper No. 26954*. 2003.
5. Yates R. As Mali Scraps Healthcare Fees, It Is Time to Bury The Bamako Initiative. *Chatham House*. 15 March 2019.
6. Lilford RJ. Pre-Payment Systems for Access to Healthcare. *NIHR CLAHRC West Midlands News Blog*. 18 May 2018.
7. Taylor C, et al. Affordability of comprehensive community health worker programmes in rural sub-Saharan Africa. *BMJ Glob Health*. 2017; **2**(3): e000391.
8. Ahmed SAKS, et al. Impact of the societal response to COVID-19 on access to healthcare for non-COVID-19 health issues in slum communities of Bangladesh, Kenya, Nigeria and Pakistan: results of pre-COVID and COVID-19 lockdown stakeholder engagements. *BMJ Glob Health*. 2020; **5**(8): e003042.