Voucher Systems Can't Replace Public Healthcare, Doing So Would Leave the Poor Behind.

By Allana Kembabazi *[Published 17th June 2020 in The Observer newspaper]*

I read with interest an article in the Observer last week entitled, "**USAID Maternal Health Project Exposes Flaws In Free Health Care"** where it states that the "**United States Agency for International Development (USAID) has recommended that the government drops the public free healthcare system in favor of mechanisms that allow the low-income earners and the informal sector pool resources to service their health bills**."

It is unsurprising that USAID would back something like this. One only needs to look at the United States to realise the disastrous effect privatizing health care poses especially when pandemics like COVID arise. Who loses when out of pocket costs are promoted? The poor. In the USA it was black people, who were already disproportionately poor and therefore delayed seeking healthcare because of the cost, which led to them dying in large numbers.

The Initiative for Social and Economic Rights (ISER) released a report last year on public private partnerships in health, featuring voucher programs including USAID Voucher Plus and the World Bank's Uganda Reproductive Health Voucher Project (URHVP). It has since done further research that will be released soon. The two programs purported to increase access to maternal reproductive health for the poor by enabling women to access a voucher that provided them with antenatal care, safe delivery and some post partum care. The USAID project eschewed government providers from the onset, focusing on private. The UHRVP did predominantly focus on private with some government facilities.

In both, despite overwhelming evidence that user fees, regardless of how nominal, pose a barrier to healthcare for the poor, the funders insisted on charging people to get the vouchers. Their argument was people would not value what they do not pay for. To understand why this is problematic, we have to look at the broader context of user fees. Healthcare user fees were introduced through structural adjustment programs of the World Bank and IMF in the 1980s. In 2001, President Museveni abolished user fees due to concerns that they excluded poor people from accessing healthcare. A national participatory poverty assessment brought this issue to the fore. World Bank research found the poor benefited disproportionately when he did so and demand for health services doubled. The World Health Organization has now explicitly tasked countries with removing user fees and co payments given that they inhibit access to healthcare, an issue brought to the fore by the ongoing COVID 19 pandemic.

Pay for voucher systems like the ones USAID and the World Bank promote are another market based reform, basically an incarnation of user fees. ISER's research and the recent Office of the Auditor General Report on the similar UHRVP found that the poorest were

excluded due to cost. ISER found that in projects like these aside from the cost of the voucher, attendant costs like transport, feeding and other costs hindered women from accessing services.

A critical shortfall of these programs is the lack of sustainability of this and similar voucher initiatives since they depend on ongoing donor aid, subject to the interests of the donor and with limited government or community ownership. When the vouchers were concluded, demand for the private services fell. **In the concluded World Bank funded Uganda Reproductive Maternal Health Voucher Project, once the voucher project was done communities resorted to trekking the long distances to the government health facilities because they could not afford the private ones.**

When asked repeatedly, the community requested for government to invest in its health facilities to ensure they provide quality healthcare. Rather than address the community's need to have a public health system that is closer to them, funding piecemeal and adhoc projects like these further weakens the public health system, which is already underfunded.

It is ironic that USAID is calling on government to drop the free public health system in the COVID 19 era. COVID 19 should have reinforced our sense of interdependence. If anyone is unable to access healthcare, the security of the country's health system and the economy are all at risk. An obvious place to start is removing financial barriers.

Wouldn't it make more sense to focus on coming up with a resilient public health system that works for everyone? The more relevant discussion should be why is the public health system not delivering? We have seen it can deliver when given resources and backed by political will. As we are in budget season, we should talk about higher levels of public financing for health, funded by public revenue and through progressive tax systems. Financing that should trickle down to those who need it the most—the poor. While organisations like ISER have backed national health insurance, it should be clear that the scheme passed should not leave out the poorest. In fact earlier versions of the bill tasked government to pay for those that were truly vulnerable.

The COVID-19 pandemic has exposed structural weaknesses. We have an opportunity to build a healthcare system that works for all. We should not squander it with cheap rhetoric that perpetuates patchwork, fragmented systems that will ultimately hurt the poor. **The poor, the low-income earners can't perpetually be ignored to line the pockets of a few. We will not reach universal health coverage--healthcare for all regardless of ability to pay--by continuously implementing policies that leave the most vulnerable behind. Make no mistake; the poorest always turn to the public health system. Calling for low investments in public health systems will only undermine equity, public health and ultimately economic progress.**

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