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Free healthcare is not enough

Evidence from healthcare fee exemptions in Senegal

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Senegal provides exemptions from healthcare fees to children under five and adults aged 60 and above, but the two programmes produce different measured effects at their eligibility thresholds. When children lose eligibility at age five, formal care-seeking does not change, while the probability of making a consultation-related payment rises by about four percentage points. The increase is concentrated in specialist and specialised care. The under-five exemption therefore protects households from charges for care they would have sought anyway. At age 60, gaining eligibility for *Plan Sésame* produces no detectable change in formal consultation or payment. Senegalese survey and programme evidence points to low awareness and implementation difficulties as plausible factors. Policy follow-up should therefore examine how eligible seniors learn about, claim and receive the exemption before considering programme redesign.

Comparing two eligibility thresholds

Out-of-pocket payments can deter timely treatment and expose households to financial hardship. Fee exemptions are therefore intended to protect families from charges and, where cost is a barrier, make formal healthcare easier to use. Yet legal eligibility is not the same as effective free care. A policy succeeds only if the entitlement changes what patients pay when they reach a health facility (Wagstaff et al., 2017; Ridde et al., 2012).

Senegal offers a particularly informative comparison. Under its Universal Health Coverage architecture, children under five and Senegalese adults aged 60 and above are entitled to free or subsidised services within the public health system. The child exemption was introduced in 2013; *Plan Sésame*, which covers Senegalese adults aged 60 and above, was first introduced in 2006. It was later incorporated into the broader coverage framework. Both programmes use a simple age threshold to reduce charges for vulnerable groups, but they do not produce the same effects (ANACMU, 2022; CRES, 2021).

At age five, children move out of free-care eligibility; at age 60, older adults become eligible for *Plan Sésame*. Comparing people immediately on either side of each threshold reveals whether the legal change produces a measurable change in care-seeking or in payments. That simple comparison is the design at the heart of this brief.

Senegal's age-based exemptions

Senegal's public health system is organised as a pyramid. At the base are primary facilities such as health huts and health posts, which are intended to serve as the first point of contact. The secondary level includes health centres and medico-social centres. Hospitals provide specialised and advanced medical services, generally through referral from lower levels of the system.

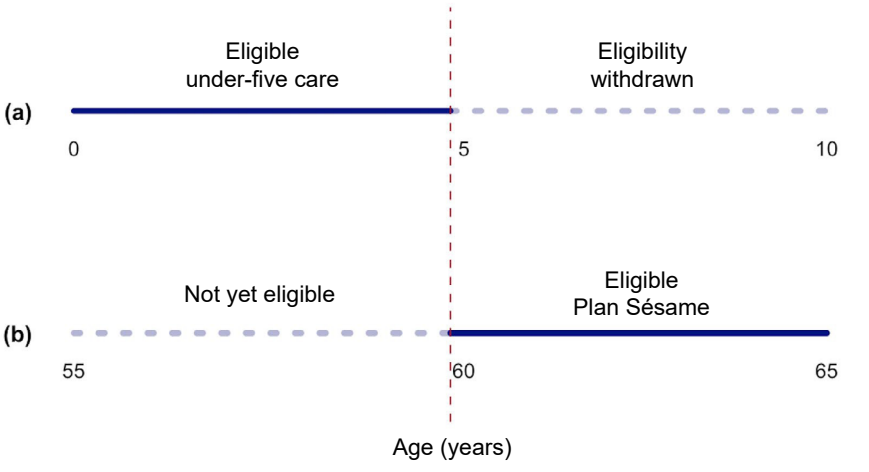
Eligible children can access consultations, vaccinations, generic medicines and selected forms of treatment through the public health system. Eligibility is based on age and can be verified through civil-status or health documents, including a birth certificate, vaccination record or health record. The services available vary across levels of care, with emergency and more complex cases referred to higher levels of care (ANACMU, 2022; MSAS, 2017).

Eligibility to *Plan Sésame* is verified through a digitised national identity card, and beneficiaries are expected to follow the formal referral system. The programme promises free or subsidised access to consultations, generic medicines, diagnostic examinations, medical and surgical procedures, and hospitalisations (CRES, 2021).

In theory, the two programmes are similar in ambition. Both identify a vulnerable group through a simple age rule, aim to reduce direct payments at the point of care, and operate within the same public health pyramid.

Figure 1 – Two age thresholds define free-care eligibility

Children lose eligibility at age five, while adults gain Plan Sésame eligibility at age 60.



How the study compares

The analysis uses data from two rounds of Senegal's Harmonised Survey on Household Living Conditions, conducted in 2018–2019 and 2021–2022. It focuses on people who reported a recent health problem. Formal care excludes self-medication, traditional healers and informal providers. The payment outcome records whether the person paid for a general practitioner consultation, specialised care, or medical examinations.

The comparison uses the age-based eligibility rules themselves. Children immediately below age five remain eligible, while those immediately above have lost eligibility. Adults immediately below age 60 are not yet eligible for *Plan Sésame*, while those immediately above are eligible. The method assumes that people close to each threshold are similar, allowing differences at the cutoff to be attributed to eligibility. The estimates apply locally around ages five and 60 and do not measure total healthcare expenditures. Medicines, transport and hospitalisation costs are excluded from healthcare costs because they were not consistently measured across the two surveys.

The central difference revealed by the evidence is therefore not what the two programmes promise, but whether that promise changes the price households face.

Different effects at the two cutoffs

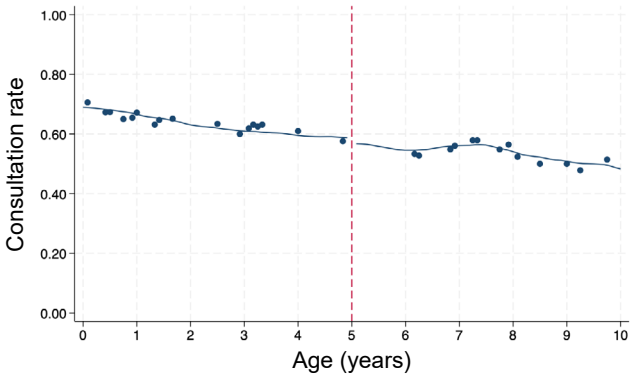
At the age-five threshold, losing eligibility for free care does not reduce formal consultation. Children just above age five are no less likely to consult a formal provider when ill than children just below the threshold. However, losing eligibility does increase payments. The probability of making any formal consultation-related payment rises by about four percentage points after children cross age five. This increase is concentrated in specialist and specialised care, where the probability of payment rises by approximately eight to nine percentage points. Payments for general-practitioner visits and medical examinations do not change detectably.

The exemption therefore does not appear to expand formal care-seeking at this margin. Instead, it reduces the likelihood that households pay for care they would have sought anyway. Caregivers continue to seek formal healthcare after eligibility ends and absorb the resulting cost increase. For children, free care works primarily as financial protection rather than as a mechanism for generating additional formal healthcare use.

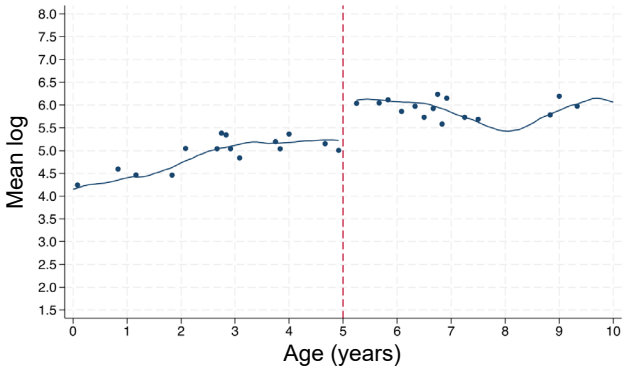
Losing free-care eligibility at age five produces no detectable change in formal consultation, while formal out-of-pocket expenditure is higher above the cutoff.

Figure 2 – Consultation and healthcare expenditure around age 5

A. Formal consultation



B. Log formal out-of-pocket expenditure



Note: Points show average outcomes within age groups, with fitted relationships estimated separately on either side of the age-five threshold. The vertical line marks the eligibility cutoff. Panel B plots the mean of ln (1 + formal out-of-pocket expenditure) among observations with non-missing expenditure for all three components. Formal expenditure comprises general-practitioner, specialist or specialised-care, and medical-examination spending; it excludes medicines, transport and hospitalisation.

Source: Authors' calculations using Senegal's Harmonised Survey on Household Living Conditions, 2018–2019 and 2021–2022.

The result at age 60 is different. Adults who become eligible for *Plan Sésame* show no detectable change in formal consultation uptake or in the probability of making a formal payment. The same pattern applies to payments for general practitioners, specialist and specialised care, and medical examinations.

This contrast is the puzzle the brief sets out to frame. Evidence from Senegalese surveys and programme assessments points to low awareness of *Plan Sésame*. Government reports also indicate recurring implementation difficulties, including verification requirements, referral procedures, interruptions in facility-level benefits and delayed reimbursements (ANSD, 2019, 2023; CRES, 2021; Taverne et al., 2021).

Why implementation may matter

The two programmes offer similar statutory entitlements, but their measured effects differ. Available evidence suggests that implementation may help explain this contrast. Effective free care depends on whether eligible people know about the entitlement, can prove eligibility, navigate referral requirements and receive services without being charged.

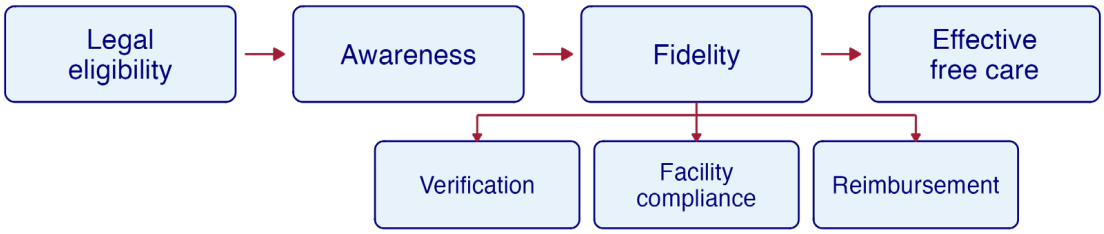
Awareness differs sharply between the two programmes. In 2019, 44.7% of caregivers with children under five knew about the child exemption. Among eligible older adults, only 6.5% reported knowing about *Plan Sésame*, while 2.9% of people aged 60 and above identified it as their health coverage scheme (ANSD, 2019, 2023). These figures show low reported awareness and identification of *Plan Sésame* among eligible seniors.

Programme assessments also document partial medication subsidies, temporary suspension of benefits at some facilities, complex referral procedures and delayed state reimbursements (CRES, 2021; Taverne et al., 2021). Such constraints can weaken the connection between formal eligibility and the prices patients face at the point of care.

The estimated effects do not vary systematically by gender, poverty status, urban residence, distance to facilities or local facility density. In particular, the absence of a clear pattern by measures of physical access suggests that programme awareness, administrative procedures and facility-level delivery warrant further investigation. The analysis, however, does not establish any of these factors as the explanation for the age-60 result.

Successful implementation is a key factor of the policy impact.

Figure 3 – A diagnostic framework for effective free care



Note: The study does not determine whether awareness, verification, facility practices, referrals or reimbursement explain the absence of a detectable effect at age 60.

Source: Authors' conceptual framework, informed by documented implementation constraints.

Insights for further policy action

The evidence supports a narrow but useful conclusion. For children, the exemption already delivers financial protection; for seniors, legal eligibility does not yet translate into any measurable change at the point of care. This study identifies this gap without settling its cause. Policy should therefore begin with diagnosis rather than redesign, along three lines.

- **Track payments among eligible seniors**. Monitoring should record whether eligible patients are charged, which services generate payments and where those charges occur.
- **Measure awareness and use of the entitlement**. Surveys and administrative records should assess whether eligible adults know about *Plan Sésame*, possess the required documentation and attempt to claim the benefit.
- **Review the delivery process**. Facility procedures, referral requirements and reimbursement timelines should be examined to identify where effective coverage may be interrupted.

These steps would not prejudge the explanation for the absence of measurable effect. They would provide the evidence needed to determine whether future changes should focus on communication, administrative procedures, provider reimbursement or another constraint.

Turning a legal entitlement into free care at the point of service, particularly for older adults, is what would make Senegal's health coverage universal in practice.

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