Effects of subsidising maternal and neonatal health care in Burkina Faso: "it's good but still not enough"!

OVERVIEW

The start of the policy to subsidize deliveries and EmOC was fixed by an official note, on 1 October 2006 for EmOC in referral hospitals, and 1 January 2007 for normal deliveries in health centers. However, districts began on different dates.

The policy is a partial exemption of direct healthcare costs (80%), the remaining portion to be borne by patients (20%). The official package is applied in all public health facilities and some private non-profit facilities.

The policy has made two changes in the functioning of health care facilities: firstly, it has made available more financial resources and medicines and resulted in access to care without prepayment by users; secondly, it has revealed constraints that are not linked to the support obtained from care providers, but to the requirements for preserving the continuity and the quality of the services. Since the implementation of the policy, the results of the FEMHealth evaluation, routine data and the DHS (2010), all indicate that deliveries in health facilities have increased significantly, especially in rural areas and among women from poor households. An increase in caesarean sections was also observed much more amongst women from wealthy households, than amongst those from poor households, but, other factors also appear to have also contributed.

The quality of care varies from one hospital to another and, unfortunately, does not seem to increase with the level of care. The absence of comparative data from before the implementation of the policy makes it impossible to assess the effect of the policy on the quality of care. It appears that hospitals that best implemented the policy (through compliance with official rates and guidelines) also had the highest quality of care.

KEY MESSAGES

The evaluation of the FEMHealth programme in Burkina Faso (conducted in a sample of six health districts) identified the following outcomes:

- An increased use of services (assisted deliveries and caesarean sections);
- A reduction in costs borne by households, however these costs still remain well above the amounts estimated by the policy;
- The persistence of problems of equity in access to care;
- Improved quality of care in hospitals applying the best policy;
- The importance of local governance (stewardship) in the success of the policy.

These lead to the following key messages:

- The importance of maintaining the subsidy policy, given the evidence of positive outcomes;
- The need to focus on equity in the provision of quality care, in order to facilitate access to healthcare for the poorest people at all levels of the health system;
- The need for greater attention to good governance in facilities, without which success is not possible, even when inputs and services are available.

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At community level, the amounts paid by households have decreased significantly compared to the results of the studies conducted shortly before the implementation of the policy. Apparently women from less poor households are able to navigate the health pyramid, looking for more skilled care. It therefore seems that a financial barrier persists. Furthermore, some households still face difficulties in meeting the cost of delivery, without benefiting from free care intended for the indigent. It is therefore very important that particular emphasis be placed on the problems of the most vulnerable groups through the operationalization of the 'indigent' component of the policy.

The implementation of the national policy to subsidize deliveries and EmOC has improved the provision of services by health care facilities. It also helped to reduce the costs borne by households, even though they remain higher than expected. However, there are still several shortcomings, the importance of which varies according to districts, and the study identified a number of conditions for the policy to be a sustainable success.

SYNTHESIS OF LEARNING

i) Main problem addressed

The maternal mortality ratio is considered to be the indicator with the greatest disparities between countries in the North and those in the South (1 in 39 deaths in Sub-Saharan Africa compared to 1 in 3,800 in developed countries). In Burkina Faso, emphasis was placed on physical and financial accessibility to health care as part of the subsidization of EmOC (Ministry of Health, 2006).

The entire official policy package was implemented, however there were local disparities (non-functional theatres in some districts, shortage of qualified personnel, inadequate equipment or infrastructure) which caused varied and incomplete adherence to the policy.

Certain services are ineffective, or are adapted without complying with the directives due to a lack of standard definition (e.g. for complicated at the health centre level); a shortage of competent providers; an absence of the required equipment (newborn resuscitation equipment or specialists in anaesthesia for major surgery in operating theatres); and a lack of inputs (shortage of blood products, sue of substandard or non-approved materials/resources).

The unavailability of services at one level resulted in additional costs for users who were then forced to go to the next level, or find more expensive palliatives (purchasing medicines outside conventional channels or use external services for examinations).

In their quest for care, on average 40% of women reported having spent a lot of time obtaining care. In addition to the economic reasons given, the main reason for the delay (72 to 99%) was attending another healthcare service/facility, which may be related to the referral system.

ii) Methods

The practical organization of the programme evaluation included three thematic work packages (health policy and financing of health care, local health systems; quality of care and health indicators) and four country work packages.

Several quantitative and qualitative tools were applied, in order to:

- assess the financial flows generated by the policy from the central level to the peripheral level (adequacy, delays and possible bottlenecks);
- determine the cost of production of targeted services at maternity hospitals;
- understand the behaviour of users in seeking maternal care, and their opinions on motivating factors (costs incurred, quality of services received);
- assess the motivation of health workers based on the changes introduced by the policy;
- evaluate effects on local health system (adequacy and level of implementation, reasons for the adoption of the policy and conditions for success);
- understand how the policy was introduced and transferred, from the central to the peripheral level;
- analyze the quality of care in hospitals (relationship between the performance in complying with policy guidelines, and care quality indicators) and trends in obstetrical and neonatal near misses in the population; and
- analyse changes to utilisation of delivery and caesarean services over the period of policy introduction.

Six health districts were selected based on eligibility criteria. Based on the expected number of pregnancies, eligible districts must (i) have at least 150,000 inhabitants and (ii) have performed at least 50 c-sections/year prior to the subsidization policy. Thereafter a hierarchical classification of the districts was carried out with the following indicators:

- the average area covered by facilities as an indicator of the difficulty in accessing a basic healthcare structure;
- the poverty index;
- the level of service uptake prior to the implementation of the policy (% assisted deliveries, caesarean section rates).

iii) Main findings

Some key results provide information on the current situation:

- the increase in deliveries recorded after 2006 has been maintained since the implementation of the subsidy. Stratification according to criteria (level of well-being and area of residence) shows that the increase is related primarily to rural women or from very poor or moderately poor households.

- for caesarean sections, the observed increase began before the implementation of the policy. Women from wealthier households take most advantage of caesarean deliveries.
- a reduction in the financial barriers to accessing delivery care, from the policy in addition to other local cost reduction initiatives, was observed. However, the average costs incurred by households remain high compared to the expected theoretical amounts (inability to meet delivery expenses was reported by 19% of respondents in one district and 11% in the other).
- satisfaction was reported by respondents with reference to the waiting time, the quality of the treatment received, the cost of care, and the availability of medicines. However, the quality of care (which varied between facilities) did not seem to increase with the level of care.
- although women expressed some financial difficulties in accessing care, and indeed some had cut short their care for economic reasons (dropouts or early discharge), no women reported receiving a total exemption from payment of fees.
- the calculation of availability scores (services, human resources, equipment and medicines) and omission scores for clinical procedures, revealed various difficulties experienced by the structures, and the importance of good governance for the success of the policy.

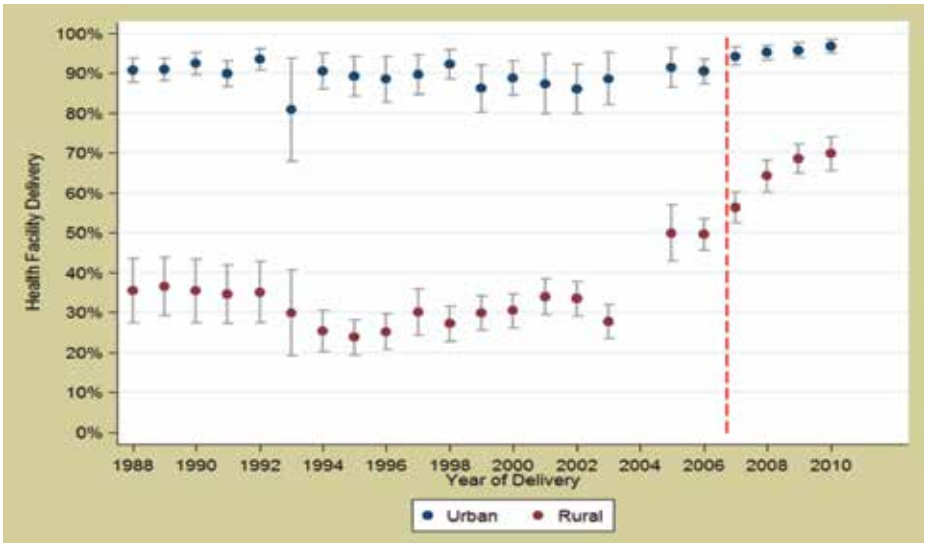

Figure 1: Annual trends of deliveries in health facilities in Burkina Faso, stratified by area of residence

iv) Analysis of the findings

The evaluation (in-line with routine reporting and the DHS) found significant increases in deliveries in health services from 2007, with the biggest increase occurring in rural and disadvantaged populations. The same trend was observed for caesarean sections, but this was prior to the implementation of the policy, and was observed most often amongst more affluent women.

Whilst the amount paid by households was considerably reduced for the services covered by the policy (theoretically 20% of direct costs are still to be paid by households), these costs are still significantly above the rates fixed by the policy, even with local initiatives to reduce costs (cost-sharing systems). This poses a potential barrier to access to care amongst very poor households that incur lasting consequences from catastrophic expenditure.

The lack of data on expenditure on healthcare for the indigent may reflect difficulties in the implementation of this component of the policy. This is probably due to the lack of harmonized criteria for selection amongst the poorest groups.

The quality of care varied from one hospital to another and did not seem to increase with the level of care. Neonatal care was not fully taken into account during policy implementation. In the facilities, maternal and child health care is the main focus, with neonatal care equipment and skills often lacking. The absence of comparative data from before policy implementation makes it impossible to assess the effect of the policy on the quality of care.

Seven key clinical indicators for the management and monitoring of mothers and newborns were used to establish an omission score (low for good quality of care and high for the contrary). The results showed that the quality of care was higher in hospitals best applying the policy, which shows that policy implementation was not linked to worse quality of care.

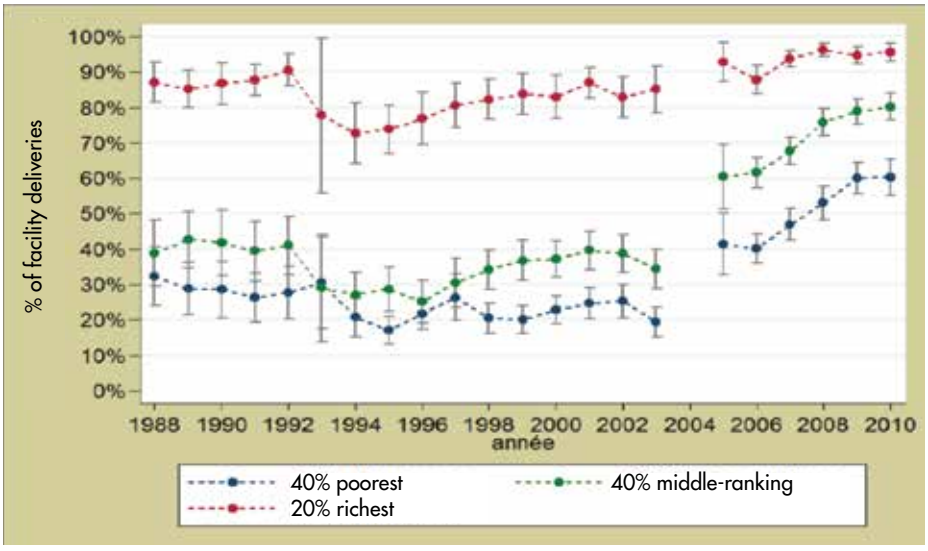

Figure 2: Annual trends of deliveries in health facilities in Burkina Faso, stratified by level of economic well-being

Specifically, hospitals with the lowest costs borne by households (where the costs were nearest to those outlined in the policy), had the lowest omission scores, and vice versa. In addition, hospitals with a high omission score had a high frequency of re-admission to the delivery room for retained placenta, and also had a high mortality rate amongst women with severe obstetric complications.

The low budget requirement of the policy, compared to public health expenditures, is an positive factor in its sustainability. But success in its sustainability requires clearer guidelines, rigorous management of inputs with a control mechanism, and a vision of stewardship taking into account the public interest.

v) Recommendations

There remain several challenges in the implementation of the policy, which are addressed by the following recommendations made from the evaluation's key findings:

1. strengthen the knowledge/skills of the health personnel and improve equipment, for better quality of care of newborns in accordance with the guidelines of the subsidy policy;
2. operationalize the indigent component of the subsidization to overcome the persistent barriers to access to care faced by the poorest groups;
3. introduce a control mechanism in the subsidization procedures to stop non-compliant practices and avoid negative additional costs for users;
4. evaluate best practices in the management of kits, and disseminate these best practices to rationalize the use of drugs;
5. find a solution to the workload created by reporting on the procedures covered by the subsidization policy;
6. clarify guidelines, rigorously manage inputs and ensure good governance in care facilities, to promote the sustainability of the policy and services.

Contact information:
Dr Maurice Yaogo
AFRICSanté – 01 BP 298 Bobo-Dioulasso 01 – Burkina Faso
Phone : (226) 20 98 63 68 (Office)
Fax: (226) 20 98 63 69
E-mail: africsante@gmail.com
Web site: www.africsante.org

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