Contribution of Nouna HDSS in breaking the barriers to access to health care in Nouna health district, Burkina Faso

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Background (1)

- Nouna HDSS is established
  - Since 1992
  - Current pop size = 90 000

- Data collected on socio economic, morbidity, mortality and health-seeking behaviour allow:
  - Low levels of health care utilization
  - Quantifying the extent of catastrophic household health care expenditure and determining the responsible factors
  - 6–15% of total HH in Nouna District incurred catastrophic health expenditure.
The key determinants = economic status, modern medical care utilization, chronic illness

Solution = CBI & key of success are:

- Formative research
- Follow up studies of the implementation

HDSS as ideal tool for monitoring & Evaluation
Objective

- To set up based on evidence a community-based insurance schemes as a perspective of breaking the financial barrier as bottleneck of access to the health care in the Nouna health district
Group 1 studies: Formative researches

- Exploration of:
  - risk perceptions and traditional risk-sharing arrangements
  - community preferences for a benefit package

- Calculation of cost of benefit package

- Informed scenarios used to explore households willingness to pay (WTP) for CBI
  - Median WTP for average household of 8 (4 adults, 4 children) = 11.45€
  - Actuarial projections ⇒ 12.20€

- Study results were fed back to the newly created CBI scheme
Organisational structure

Local community

Access to services free of charge

Premium payment

CBI

Contracting

Healthcare providers
Group 2 studies: impact analysis research

- Main tool to measure impact: HH survey from HDSS
  
  Socio-economic information, morbidity and health care utilization, perceived quality of health care services, enrolment in CBI & relevant reasons

- Others quantitative methods:
  
  Health facilities registers analyses, discrete choice experiment, questionnaire

- Qualitative methods: FG discussion, observation and indepth interviews

- Step-wedge cluster randomized community-based trial

33 clusters: 24 rural + 9 urban clusters

An additional 11 clusters received intervention every year
Lesson(1)

- **Financial:** running cost exceed revenues (30%)

- There is a deficit every year
Lessons (2)

- Enrolment of children was the same as adults
- No difference between Children and adult for health care demand
- Outpatient visits in the insured group is 40% higher
- No significant difference found for inpatient care utilization
- With CWR subsidies poor enrolment rate increase by 6 fold
- The very poor are less likely to enrol in CBI and to utilize health services (because of others barriers)
Children subsidies can absorb the deficit by completing the premium as per adult.
Conclusion

- CBI improve **access to health care** specially for outpatient visits
- There is a need to **subsidize children** premium as per adult
- **Public policies must support** CBI initiatives in order to improve health care demand
- **Subsidies for the very poor** can improve **equity** to health care
Thank You!

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