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

Adama Traoré, Germain Sawadogo, Maurice Yé, Louis Niamba, Ali Sié

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.

Background (2)

- 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

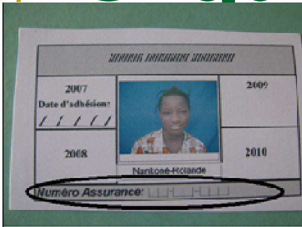
Objective

- 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

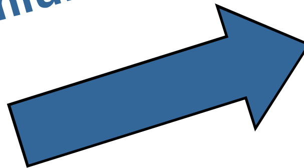
- Exploration of:
  - risk perceptions and traditional risk-sharing arrangements
  - community preferences for a benefit package
- Calculation of cost of benefit package
- Informed scenarios used to explore households willingness to pay (WTP) for CBI
  - Median WTP for average household of 8 (4 adults, 4 children) = 11.45€
  - Actuarial projections $\Rightarrow$ 12.20€
- Study results were fed back to the newly created CBI scheme

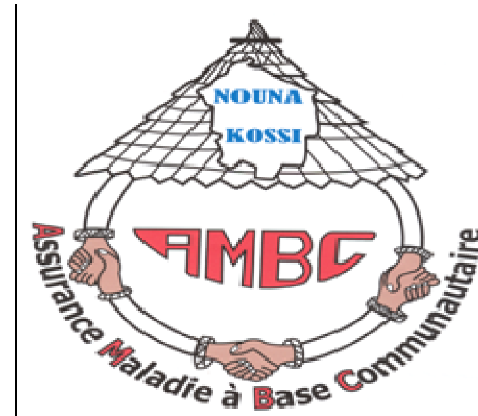
Organisational structure



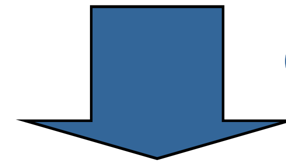
Local community

Premium payment

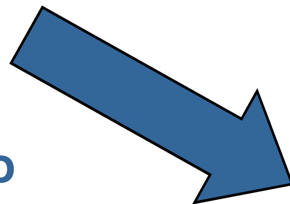




CBI



Contracting



Access to services free of charge

Healthcare providers

Group 2 studies: impact analysis research

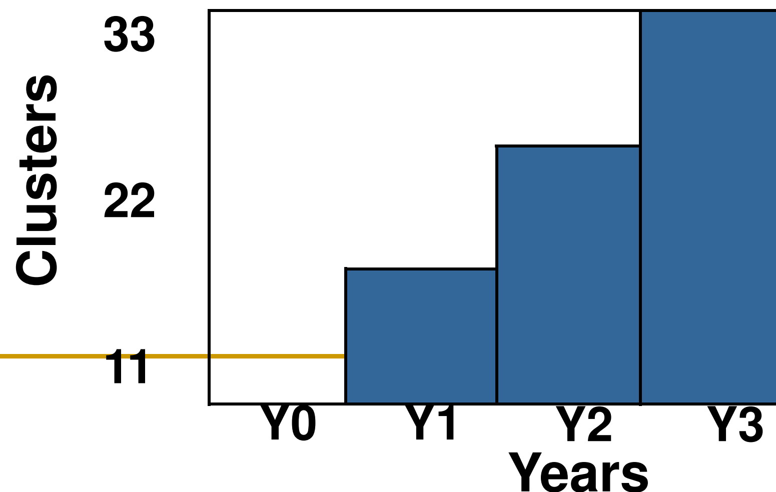
- Main tool to measure impact: HH survey from HDSS

  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

Cotisations
administration (10%)
Scenario D
Scenario C
Scenario B
dépenses de santé

Funding gap

2.55
2.90
3.40
3.70

0% 6.60% 8% 15% 20% 25% 30% 35% 40% 45% 50% 55% 60% 65% 70% 80% 100%

Taux d´adhésion

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)

Lesson (3)

- Children subsidies can absorb the deficit completing the premium as per adult

Conclusion

- CBI improve **access to heath 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!