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Endorsement of universal health coverage financial principles in Burkina Faso

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ABSTRACT

In West Africa, health system funding rarely involves cross-subsidization among population segments. In some countries, a few community-based or professional health insurance programs are present, but coverage is very low. The financial principles underlying universal health coverage (UHC) sustainability and solidarity are threefold: 1) *anticipation* of potential health risks; 2) *risk sharing* and; 3) *socio-economic status solidarity*. In Burkina Faso, where decision-makers are favorable to national health insurance, we measured endorsement of these principles and discerned which management configurations would achieve the greatest adherence.

We used a sequential exploratory design. In a qualitative step (9 interviews, 12 focus groups), we adapted an instrument proposed by Goudge et al. (2012) to the local context and addressed desirability bias. Then, in a quantitative step (1255 respondents from the general population), we measured endorsement. Thematic analysis (qualitative) and logistic regressions (quantitative) were used.

High levels of endorsement were found for each principle. Actual practices showed that anticipation and risk sharing were not only intentions. Preferences were given to solidarity between socio-economic status (SES) levels and progressivity. Although respondents seemed to prefer the national level for implementation, their current solidarity practices were mainly focused on close family. Thus, contribution levels should be set so that the entire family benefits from healthcare.

Some critical conditions must be met to make UHC financial principles a reality through health insurance in Burkina Faso: trust, fair and mandatory contributions, and education.

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1. Introduction

Recently, numerous studies have been conducted, either to understand the factors enabling certain low and middle income countries (LMIC) to move closer to universal health coverage (UHC) (Giedion et al., 2013; Lagomarsino et al., 2012; McIntyre et al., 2013; McKee et al., 2013), or to measure and monitor their current levels of UHC (The PLOS Medicine Editors, 2014). Nonetheless, extensive work remains to be done on both the action and research fronts (Horton and Das, 2014). The literature emphasizes how important it is to take into account country-specific social and political contexts when engaging in large-scale reforms (McKee et al., 2013; WHO, 2013b) to "*translate UHC into country-specific reality*" (Kutzin, 2013, p. 608). Moreover, "[UHC] *can be achieved in many different ways. There is no single recipe*" (Savedoff et al., 2012). Beyond the well-known and outdated dichotomy between tax-based (Beveridge) and contribution-based (Bismark) models, each country selects a path-dependent strategy adapted to their inherited health system (The PLOS Medicine Editors, 2014). Regarding financial schemes, the current recommendation is to opt for mandatory mechanisms, either tax- or contribution-based (Nicholson et al., 2015), as there is no evidence of the superiority of one over the other (Bump, 2015). However, in most LMICs, the "*recent switch towards a health insurance model*" (Fox and Reich, 2015, p. 406) seems to be at stake, as is the case in Burkina Faso, where the present study was conducted. This contextual adaptation is critically important especially for UHC funding, where the underlying concepts are complex. Therefore, "*reforms to move towards UHC need to be planned very carefully*" (WHO, 2013a, p. 14). UHC is a

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multidimensional concept involving legal, humanitarian, social, public health, and financial aspects. This paper focuses on the financial perspective.

Ghana is often cited as an example in West Africa of progression toward UHC (Mills et al., 2012; Witter et al., 2013), even though numerous challenges remain in terms of equity of coverage (Akazili et al., 2014). Africans, especially francophone populations, are quite critical of their governments' capacity and will to deliver basic healthcare (Abiola et al., 2011). In some West African countries, such as Senegal and Mali, health system performance has stagnated or even decreased (Asunka, 2013). In these conditions, public servants have refused to make financial contributions mandatory, so that governments have had to make them optional, thereby jeopardizing the establishment of national health insurance.

UHC in Burkina Faso is representative of francophone West Africa in general. In 2010, only 0.5% of women and 1.5% of men were covered by health insurance (INSD, 2011). Current health system funding is fragmented and does not allow for cross-subsidization among population segments (Ridde et al., 2014). The 2011–2020 national health development plan (*Plan national de développement sanitaire* - PNDS) aims to increase the public health budget and to implement strategies for moving toward UHC (Zett and Bationo, 2011). Decision-makers have identified several challenges related to the financial aspects of UHC, including a reduced tax base, low political will and governance issues, low contributive capacity of households, and problems in administering health insurance (Zida et al., 2010). A parliamentary workshop held in September 2014 finalized a bill concerning UHC strategies. This bill, scheduled for parliamentary debate in October 2014 (Gouvernement du Burkina Faso, 2013; Siribie and Badiel, 2014), was finally adopted in September 2015 by the National Transitional Council. It stipulates that coverage will be conditional on an (eventually mandatory) contribution, to be set according to each household's capacity. Operational issues such as the healthcare package and third-party payment will be set by decrees (Ministère de la fonction publique du travail et de la sécurité sociale, 2014). A three-year pilot program will be conducted to evaluate different funding models and care packages (WHO, 2014).

The financial principles underlying UHC sustainability and solidarity are threefold: 1) contribution by *anticipation* (with or without smoothing) of potential future risk (in our case, adopting a household budget management approach that included anticipating risks, rather than pre-payment, which had not yet been implemented); 2) *risk sharing* (cross-subsidization of those in need of healthcare), with non-refundable contributions that only benefit healthcare users; and 3) *socio-economic status solidarity*, referring to cross-subsidization among different socio-economic status (SES) levels, with larger contributions from those who are better off financially (Goudge et al., 2012). Very little is known in Africa about population endorsement of UHC financial principles during early stages of strategy implementation, as is the case in Burkina Faso. As far as we know, only Goudge et al. (2012) have addressed this question, in the contexts of Tanzania, Ghana, and South Africa. To attain UHC goals, WHO strongly encourages academics to improve knowledge in this area (WHO, 2013b). The present study was conducted within this context of knowledge needs at the national and international levels. Its objectives were twofold: 1) to measure population endorsement of the three UHC financial principles, and 2) to discern which management configurations (e.g. which institutions and implementation levels) would achieve the greatest adherence among the population as strategies are implemented to move toward UHC.

2. Methodology

Because health system funding, population exposure to health insurance concepts, and decision-makers' preoccupations are different in Burkina Faso than in the countries studied by Goudge et al. (2012), their methodological approach needed to be adapted to our study context. Additionally, an important limitation of Goudge et al.'s (2012) study is that it considered only prospective measures ('hypothetical scenarios'). Especially in the African context, however, desirability bias (Boutin, 1997) may strongly affect results of surveys on such a complex and sensitive issue. We addressed this concern by reporting responses to both prospective questions (indicating willingness) and retrospective questions (actual practices), to strengthen response reliability.

Our study is a variant of sequential exploratory design (instrument development design) (Creswell and Plano Clark, 2007). In a first (qualitative) step, we adapted an instrument proposed by Goudge et al. (2012) to Burkina Faso. Then, in a second (quantitative) step, we incorporated this adapted instrument to measure endorsement of UHC financial principles within the specific context.

2.1. Instrument adaptation (qualitative phase)

We interviewed representatives of financial services to households, to benefit from their experience in communicating with and educating the local population, and to adapt the vocabulary and explanation of the complex concepts involved in this study to the local context. Nine heads of community-based health insurance (CBHI – *mutuelle de santé*) schemes, two heads of micro-finance institutions (MFIs), and a representative from the national CBHI network (*Réseau d'appui aux mutuelles de santé* - RAMS) were interviewed individually.

We then set up focus groups to: 1) assess people's comprehension of the concepts by having participants illustrate them with examples from everyday life, which then were used to develop corresponding vignettes in the questionnaire, and 2) test graphic illustrations to be used in the questionnaire for choosing preferred scenarios of SES solidarity. Focus groups were stratified by area (rural vs. urban), household SES (high, middle, and low), and gender (household heads and influential spouses separately) to capture diversity of activities and practices, as well as potential divergences in their understanding of the abstract concepts involved. In total, 68 people participated in 12 groups of four to six people (except for one group with nine women). The results were subjected to thematic analysis.

2.2. Household survey (quantitative phase)

The households sample was drawn from an annual cohort that had already been observed over a three-year period in two districts of central Burkina Faso: Kaya and Zorgho (Druetz et al., 2015). The Kaya district was selected due to the presence of the Kaya Health and Demographic Surveillance System (HDSS), which follows approximately 8000 households (around 50,000 individuals) (Kouanda et al., 2013). Zorgho is a comparable district, with the exception that there is no fee exemption intervention in place, as there is in Kaya. In both districts, households were randomly sampled from the cohort, while ensuring an equal distribution by area type—half urban, half rural. We then interviewed each household head along with the most influential spouse (as determined by the household head's responses to the series of questions beginning with, "Who finds money when savings are insufficient to deal with unexpected expenses regarding …"). Our sample consisted of 1255 respondents from 619 households.

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