CABRI – Health Financing Dialogue 2

Case Study: Health financing in Burkina Faso, between equity and efficiency

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This assessment is being carried out by Oxford Policy Management. The project manager is John Kruger. The remaining team members are Tomas Lievens, Luize Guimaraes and Clara Picanyol. For further information contact John Kruger at john.kruger@opml.co.uk.

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The aim of the case studies developed for the seminar is not to present a research report but to allow participants to apply the approaches, concepts, frameworks and tools presented in the main papers to real life situations. The purpose of the case studies is to present a real life problem to the participants which they should address and work through, using the information presented in the case study, the knowledge from the seminar presentation and their experience.

The case study was developed through an initial desk review of documentation and a country visit to interview the personnel involved in the policy design and implementation of the health sector in Burkina Faso.

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Abbreviations

BI	Bamako Initiative
CABRI	Collaborative African Budget Reform Initiative
CAMEG	Central Purchasing Agency for Essential and Generic Medicines
CARFO	Independent Pension Fund for Civil Servants
CFAF	CFA franc
CHR	Regional Hospital Centres
CMA	Medical Centres with Surgical Unit
CNS	National Health Accounts
CNSS	National Social Security Fund
COGES	Management committee
CPN	Antenatal Care
CSPS	Health and Social Development Centres
DAF	Financial and Administrative Directorate
DEP	Studies and Planning Directorate
DGB	Directorate-General for Budget
DHS	Demographic Health Survey
EmONC	Emergency Obstetric and Newborn (or neonatal) Care
GFBS	General Framework for Budget Supports
GFBS	General Framework for Budget Support
IGR	Quick Win Actions
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MoEF	Ministry of Economy and Finance
MoH	Ministry of Health
MTEF	Medium Term Expenditure Framework

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NGO	Non Governmental Organisation
NHDP	National Health Development Plan
ODA	Official Development Assistance
SERSAP	Society for Public Health Studies and Research
TDH	Terre des Hommes
WHO	World Health Organisation

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1 Case study

"Every year, over 2000 women die in Burkina Faso[1] from pregnancy and childbirth-related complications. Most of these deaths could have been avoided. Many women die because they could not have a blood transfusion due to a shortage of blood. Others die from obstructed labour, infections or hypertension because they were unable to reach a health facility where they could receive adequate treatment, or because they arrived too late. Many of them lose their lives because their families cannot pay the fees required by the medical staff. An even greater number never even get to the health centres because of geographical, financial or cultural barriers (Amnesty International Report, 2009)."

The overall health situation in Burkina Faso has improved over the last decade, however, the country is still far from achieving the Millennium Development Goals (MDG) 4, which is to reduce infant mortality and 5, which is to improve maternal health; the cost of access to Health care appears to be one of the main obstacles to improving the health of the Burkinans.

Since 2005, the Government of Burkina Faso has significantly increased the Health care sector budget and subsidies have been introduced for some priority Health care aspects so that the patient no longer has to pay when he/she goes to the health units. But the improvement of key indicators is long overdue and the National Health Accounts show that household expenses for Health care do not seem to have decreased (in absolute terms).

It was in this context that a scandal occurred. An article published on the 11th of March 2011[2] in the semi-monthly editorial, "The Reporter" denounced the violation of the EmONC (Emergency Obstetric and Newborn Care) subsidy policy. "According to this Law [EmONC], users will be required to pay a very small portion (10% in certain cases) of the cost of Health care, the State paying the bulk of the costs. But a few years after its enactment, the practical results are really distressing. The greed of some of the players responsible for the implementation of the Act and the laxity of the authorities have completely obviated the dynamics of the subsidy… ".

New legislative elections are scheduled for September 2012, and the Directorate-General for Budget (DGB) of the Ministry of Finance (MoF) is required to submit a preliminary budget in July, as the members of Parliament wish to make use of it to prepare their campaigns. Health is one of the priority sectors, especially since the newspapers publicly denounced the lack of impact that budget increases have had on the Health care sector.

A working group was set up to make recommendations to the Government as regards the strategy that should be adopted in the face of media attacks. The group consists of technicians from the Ministry of Health (MoH) and the Ministry of Finance (MoF). Both these categories of experts naturally wish to make the best possible recommendations, but their priorities do not coincide totally.

- The Ministry of Health would like to take advantage of the upcoming legislative elections to take up the challenge of reaching the Millennium Development Goals (MDGs) in Burkina Faso
- The Ministry of Finance on the other hand, is concerned about how to evaluate the Health care sector budget and how to carry out this year's budget adjudication.

[1] The adjusted maternal mortality rate in 2008 : 560 for 100 000 (UNICEF, 2008)

[2] The article was in fact published and the quotes are taken from the text. It is dated March 2011 (source: The Reporter, n 65, from March 1st to March 14, 2011: "Subsidizing child deliveries and obstetric care - SOS the law is being broken". The dates will be adjusted for the case study and the exercise.

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This case study will first present the epidemiological situation in the country, with a brief description of the primary Health care system in Burkina Faso and its funding, as well as the cost of access to Health care for the population. The second section discusses subsidy measures set up in 2006 in response to the context presented above, with a brief analysis of their impact.

It is within this framework that the group will consider proposals for Health care funding reforms that need to be carried out in order to improve the health status in Burkina Faso.

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2 Financial and Health care situation in Burkina Faso 10 years from the MDGs

2.1 Health status of the Burkinan population

The epidemiological situation is characterized by the predominance of endemo-epidemic diseases which account for 40% of the disease burden, with a prevalence rate of 66% (DHS, 2010) for malaria in children (between 6-59 months old).

The **health status of women** is marked by a high level of maternal morbidity and mortality (MM) in spite of a considerable drop from 770/100 000 in 1990, to 560/100 000 in 2008[3]. The preliminary report of the latest Demographic and Health Survey (DHS) suggests that the rate of MM has dropped to 300/100 000.[4] In order to reach MDG 5, the MM in Burkina Faso has to drop to 193/100 000[5].

Box 2.1 Maternal Death

Maternal death is the death of a woman occurring during pregnancy or within 42 days after delivery, whatever the duration or location of delivery, for any cause determined or aggravated by pregnancy or the care it has required. The causes of death may be direct (linked to obstetric complications during pregnancy, labour or the post-partum period) or indirect. There are five direct causes of death: haemorrhages (generally post-partum), infections, eclampsia, obstructed labour and complications linked to abortions. Deaths occurring for indirect obstetric causes are those that result from a pre-existing condition or a complaint that develops during pregnancy but which does not arise from direct obstetric causes even though it may be aggravated by the physiological effects of pregnancy.

Source : UNICEF/UNFPA

Direct obstetrical causes account for approximately 80% of these deaths; haemorrhages, infections and dystocias alone account for over two thirds of these obstetrical causes of death.[6] Malaria, anaemia, HIV/AIDS and hemoglobinopathy account for 20% of female deaths.

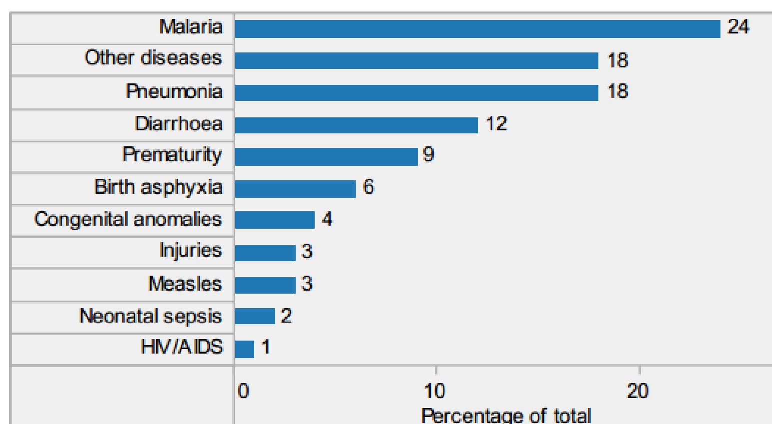
The **child mortality rate** is 129/1000[7]. According to the MOH neonatal morbidity and mortality are mainly due to serious infections and prematurity/low birth weight; Malaria is responsible for 20% of the deaths. Moreover, malnutrition is an alarmingly high cause of decease: in 54% of these cases, deaths are related to malnutrition.[8]

The main causes of death vary according to the child's age and are set forth in the figure below:

Figure 2.1 Main causes of deaths in children under the age of 5

Causes calculated as a percentage of the total mortality of children under the age of 5

[3] WHO, UNICEF, UNFPA, WB, 2010 ; http://www.unicef.org/french/infobycountry/burkinafaso_statistics.html
[4] Data on the WHO website, up dated in May 2012 ; http://www.who.int/gho/countries/bfa.pdf
[5] The objective to be achieved by 2015, is to reduce the 1990 rate of 770/100 000 by ¾ . http://unstats.un.org/unsd/mdg/SeriesDetail.aspx?srid=553&crid=854
[6] Ministry of Health, National Strategic Plan, 2011- 2020
[7] DHS, 2010
[8] Ministry of Health, National Strategic Health Plan, 2011- 2020



Source: WHO, 2012 [9]

A recent simulation showed that infant mortality could decrease by 20% in Burkina Faso, if infants were more widely and rapidly treated for malaria, respiratory infections and diarrhoea (J. Bryce and al, 2010). The recent Demographic and Health Survey (DHS)[10] shows however, that in 2010, only half of the children with one of these three symptoms were taken to a health care centre.

2.2 Primary Health care organisation in Burkina Faso

The Health care pyramid in Burkina Faso comprises three levels of Health care as shown in the figure below: primary, secondary and tertiary.

- Tertiary care is provided by the Teaching hospitals. Two of these hospitals, the Yalgado UMC in Ouagadougou and the Bobo-Dioulasso UMC in the second largest city of the country, have a maternity service.
- Secondary care is provided by the Regional Hospital Centres (RHC), on referral from primary care services.
- Primary Health care is dispensed at local level by Health and Social Development Centres (CSPS) and at district level, by Medical Centres with Surgical Units (CMA, district hospital). Health and Social Development Centres provide some health care services to mothers and children and offer prevention and awareness raising activities. Medical Centres with Surgical Units offer the first level of treatment and care for pregnant women with complications[11].
- The Management Committees (COGES) created to improve the management and service delivery of the health providers. They are mandated to: i) insure an efficient functioning of the delivery of care; ii) promote the community participation and iii) insure the accessibility to health care. Among their main responsibilities are the following: i) determine the price of the health services and the drugs delivered; ii) define the health care payment modalities. They are a link between the communities the health service provider and the health care administration.

[9] http://www.who.int/gho/countries/bfa.pdf
[10] INSD, DHS, 2010
[11] In 2008, there were 1 352 Health and Social Development Centres and 42 Medical Centres with Surgical Unit.

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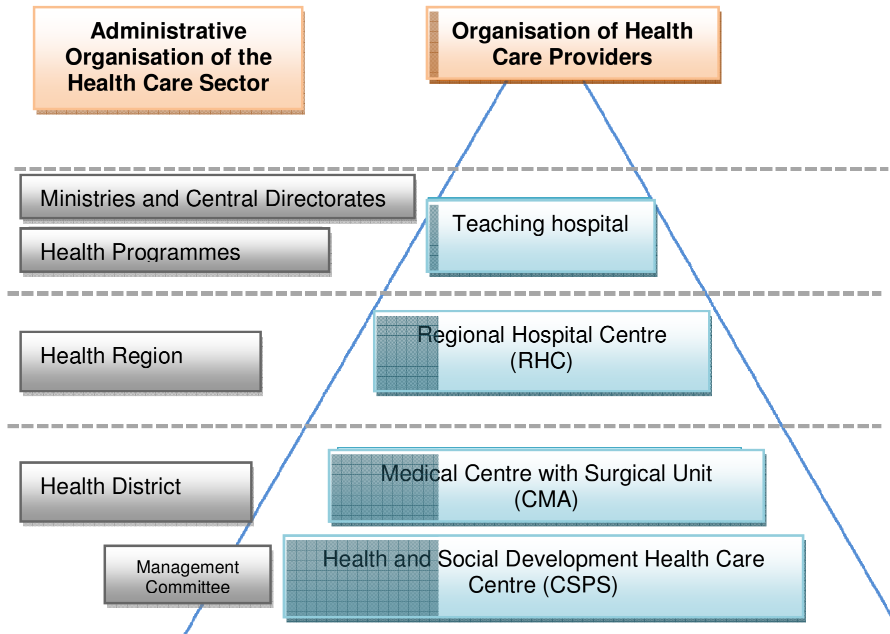
Figure 2.2 Administrative and technical Organisation of Health care services and the Ministry of Health



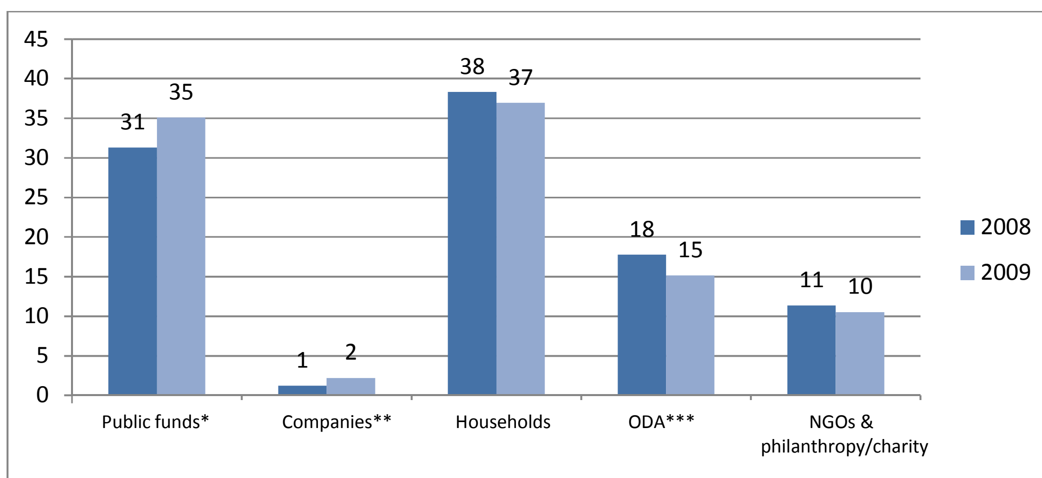
Source: OPM

Apart from the public sector, there is also a private sector. This sector includes profit-making private clinics that are booming, faith-based organisations, Health care institutions run by associations and non-profit-making NGOs as well as a private pharmaceutical sector. Traditional medicine and pharmacopeia also play an important role, especially in the rural areas. However, these 2 last sectors have not been regulated and health data is not available.

2.3 Funding sources for the Health sector

As illustrated in the graph below, the main direct funding source to the health sector are the households, even if a small decrease can be noticed from 2008 to 2009. The companies compose the smallest source of all.

Figure 2.3 Funding of the health sector by sources calculated in percentages of the total funding



Source: based on the 2009 National Health Accounts data (published in October 2011)

* Public funds comprise the State budget, Central government funds, funds from regional and local authorities. In 2008 these amounted to 80.95%, 18.95% and 0.1% respectively ; and in 2009 : 99.83%, 0% and 0.17% respectively.
** Funding from companies include private and parastatal companies.
*** ODA funding includes sources from bilateral and multilateral cooperation.

2.3.2 Government funding: a growing budget

After the cost recovery policy following the Bamako Initiative, the State gradually pulled out of the Health sector in Burkina Faso. The budget allocation dropped from 8,7% in 1970 to 2,4% in 1995 (A. Meunier, 2000). Since the Millennium Declaration and the MDGs, the trend has been reversed and public expenditure for the Health sector through Government funding has increased considerably. The sectoral health budget constitutes 11.48 % of the general budget (in 2011), with a targeted percentage of 12.60% for 2012 based on the General Framework for Budget Support (CGAB) criteria.

Figure 2.4 Evolution of the health budget over the 2007-2010 period[12]

Amounts calculated in million CFAF

2007	2008	2009	2010 Prev.
101 667	98 768	119 130	137 177

Source: finance Act 2007-2008-2009-2010 and annual action plans for 2007-2008-2009-2010

Moreover the budget implementation rate is high, and, unlike other countries, the Minister of Economy and Finance cannot accuse the Ministry of Health of being unable to use the allocated funds.

[12] The budget takes into account the contribution of partners in the shape of General Budget Support.

This high implementation rate has been facilitated by reforms and follow-up action developed by the Ministry of Economy and Finance, such as[13] the implementation of a new mechanism for the release of funds.

Figure 2.5 Budget implementation rate for the health sector over the 2008- 2010 period [14]

2008	2009	2010
113%	103.3%	99.10%

Source: finance Act 2007-2008-2009-2010 and annual action plans for 2007-2008-2009-2010

Note: the execution rates can be above 100%, due to the budget mid-year renegotiation

Regarding the achievement of the Abuja commitment of 15% of government expenditures to be allocated to health there are contradictory figures. By counting in vertical programme funding and the recent subsidy for triple combination therapy, certain statistics seem to suggest that Burkina Faso has achieved the 15% goal (in 2008 and 2009 with respectively 15,22% and 15,46%). It should be noted that those figures takes into account all the budget entries of other health-related Ministries and institutions.[15] These statistics should therefore be viewed with caution, as the operating reports of the Abuja Declaration show that Burkina Faso did not achieve this goal.

2.3.3 Official Development Assistance for the Health sector, a high level of assistance but conflicting agendas

Official Development Assistance (ODA) PD has been progressing continually since 2000. In 2007 it was double the amount recorded in 1997 increasing from 396 millions of USD to 861.90 millions of USD. Considered as a prime social sector for the achievement of the MDGs, the Health sector receives a considerable share of this support, as follows:

- A « general budget support» provided to support the Poverty Reduction Strategy Paper.
- Funding through the Health Development Support Project (PADS) 2008-2012, also called "pooled funding" or "basket funding"
- Direct support provided by projects or specific partners.

Figure 2.6 Donor contributions to the Health budget 2007-2010[16]

Amounts in millions of CFAF

2007	2008	2009	2010 Prev.
41 292	75 871	117 952	124 236

Source: Finance Act 2007-2008-2009-2010 and annual action plans for 2007-2008-2009-2010

The Amnesty International report specifies that according to the most recent available official information, donor funding contributed in 2006 to 37.69 % of the reproductive health expenditure, which includes maternal health and family planning.

The international community is divided with regard to the subsidizing of certain health services and conflicting pressures are brought to bear on the Government. Generally speaking, it seems that donors do not unanimously support the total abolition of the cost recovery policy and argue that an

[13] MTEF 2012.
[14] This implementation rate does not include external funding and Interministerial common expenses.
[15] MTEF, 2012.
[16] In view of the fact that the contribution of partners in the form of general budget support also appears in the budget, the ODA percentage for the Health sector has not been calculated, as it could be confusing.

allocation to other sectors of public funding would be more effective in the long term[17]. In fact some of them, based on this theory, argue in favour of a priority investment in the growth, labour and economic development sectors. On the other hand, certain development actors, who are active in the country, blame the Health Ministry for not introducing free health care for all patients and/or at least for the needy.[18]

2.4 Cost of access to Health care in BF

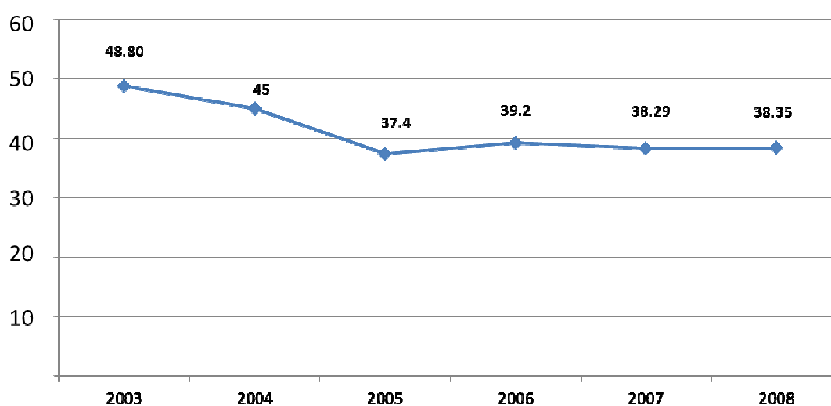
2.4.1 Health care costs: a barrier to access

In Burkina Faso, a few individuals enjoy social protection through the National Social Security Fund (CNSS) and the Independent Pension Fund for Civil Servants (CARFO). This protection, limited to workers in the private and public sectors, has no health care component. Health insurance is under-developed and is limited to individuals in the private sector. There are insurance models (community-based mutual health insurance, cost-sharing systems) in certain areas of the country but they only cover a very small portion of the health care offered by the health structures. In 2008, the average expenditure per capita was 37$ per year ; the WHO minimal standard stipulates that this expenditure should not exceed $34 per capita per year.

The contribution of households to health expenditure dropped from 2003 to 2008, although it remains quite high, compared to WHO recommendation, as can be seen in the graph below.

Figure 2.7 Changes in the contribution of households to health expenditure over the 2003-2008 period

The contribution is calculated as a percentage of total health expenditure



Source: Health Ministry, National Health Development Plan 2011- 2020, based on the National Health Accounts of 2008

In spite of free and subsidized health care measures for certain treatments, the contribution of households rose to CFAF 84 244 millions in 2007 and CFAF 97 504 millions in 2008 ; this is in fact an underestimation as this information does not include household expenses in the private health sector which are unknown.[19] Moreover, these figures do not take into account the indirect costs of access to health care.

[17] Discussion with the Health Ministry in Ouagadougou, May 2012.
[18] With the difficulties in defining and targeting the poor and needy.
[19] Health Ministry, National Health Development Plan 2011- 2020.

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Households still constitute the first funding source for health expenditure in Burkina Faso (the information is available since the publication of the first National Health Accounts – 2007).

2.4.2 The case of the poor

In the health sector, poverty is often associated with the permanent incapacity to pay for health care (V. Ridde and al, 2011). Beyond this obvious fact, the care and treatment of the poor requires criteria that are sufficiently precise, reliable and practical to be implemented on a practical level.

Box 2.2 Definition of extreme poverty (destitution) in Burkina Faso

"The destitute person is someone who, because of a temporary or permanent lack of resources or sources of income due to structural and/or conjunctural factors does not have any personal means or family support to meet his/her basic needs without the assistance of a third party"

Source: The committee on poverty, May 2010 (Ministry of Social Action and National Security, MASSN – Burkina Faso)

In Burkina Faso, 46,4% of the population lives below the poverty line (Valéry Ridde and al, 2011) according to official statistics. The Government finds it very difficult to establish poverty criteria and is concerned that if the criteria are too inclusive, it will not be able to extend coverage to all the poor and that certain people will abuse the system by pretending to be poor in order to take advantage of the system (V. Ridde, 2011).

Since the implementation of the cost recovery policy implementation in Burkina Faso, all health care funding measures introduced in the country include a special coverage for the poor. In spite of the systematic budgetary provision for this purpose, the poor are still not effectively taken care of. The main reason for this deficiency is the absence of criteria and of a process for selecting the poor (V. Ridde, 2011). In conclusion, the resource envelope allocated to the poor in 2006 and amounting to 20% of the annual amount, is practically unused today. According to Amnesty International most people are unaware of the very existence of this envelope.

In addition, national statistics reveal a considerable inequality between quintiles as regards access to health care and health conditions. For the poorest quintile: 39% of deliveries are assisted deliveries; for the wealthiest quintile 91% are assisted deliveries (R. Gwatkin, 2002). As regards asset disposal/debts: 80% of the poor have to sell their goods or incur debts in order to have access to health care, whereas only 43% of the wealthiest quintile find themselves in this situation (Me K. et al, 2009; European Union, 2010).

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3 A Health Funding Reform

3.1 Subsidizing Emergency Obstetric and Newborn Care (EmONC)

In 2003, the Burkinan Government acknowledged that unless radical measures were implemented Burkina Faso would not achieve the MDGs. The progress report on the Millennium Goals for that year indicated that: «this international objective seems very ambitious for Burkina Faso who plans to develop strategies in order to achieve a ratio of 209 deaths for 100 000 live births before 2015 ».

Since 2002, the State has gradually set up subsidies covering up to 100% of the costs for the following preventative services: vaccination, pregnancy monitoring, care and treatment of severe malaria in pregnant women and children under the age of 5. Households do not have to pay fees at the health care centre for routine vaccination of infants of less than a year old. For malaria and antenatal care (CPN), the budget is entirely supported by the State.

It is difficult to identify obvious reasons or a key moment when the Burkina Faso Government decided to increase funding for Maternal and Child Health. Struggling to improve its Maternal and Child Health (MCH) indicators, the Ministry of Health commissioned in 2005 a study to determine how much it would cost the State to subsidize this sector more fully. The gap between the Burkinan MDGs and their maternal and child mortality rate, the pressure brought to bear on the Government by various international institutions, the wide-spread popularity of free health care measures throughout the region and the results of the above-mentioned study that reached the Ministry of Economy and Finance a few months before the 2006 elections, all combined to bring about a rapid financial decision. By March 2006 the Government had signed an increased financial commitment in order to deal with Maternal and Child Mortality by reducing the financial barriers hindering access to maternal and child health care services. The first part below (3.1) presents: i) how MCH became the centre of the Government attention; ii) the definition of the payments modalities for the subvention and iii) the implementation of the policy. The policy impact is then analysed (3.2).

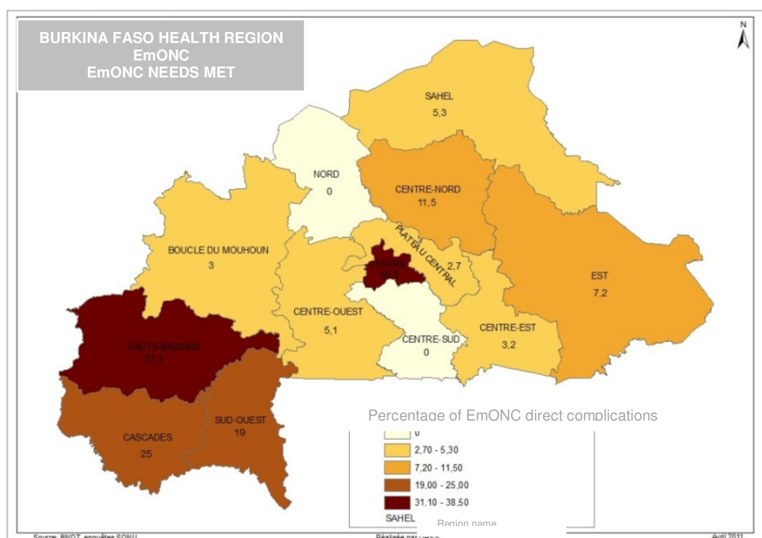
3.1.1 Definition of priority services: Maternal and Child Health

There are various reasons why the Government of Burkina Faso decided to prioritize maternal and child health care services, such as the mediocre quality of country indicators, international pressure and the evidence of improved maternal and child health resulting from policies that facilitate access to health care and increase the percentage of assisted deliveries (V. Ridde et al, 2012).

An evaluation of needs in Emergency Obstetric and Newborn Care conducted by the MOH shows that only very few of the EmONC needs were addressed by the public service delivery, as illustrated in the map below.

Figure 3.1 Obstetric complications treated by EmONC

Percentage of obstetric complications treated in health units by region



Source: Ministry of Health, Evaluation of needs in Emergency Obstetric and Newborn Care, coupled with the Reproductive health mapping of services offered in Burkina Faso (draft publication), mimeo[20]

The main causes of high maternal mortality rates, also known as the « 3 delays » are as follows: delay to decide to seek care, delay in getting to a health centre, delay in receiving care when at the health centre (Thaddeus S., et al, 1994).

Moreover, many health-related reasons explain the low health and specially MCH indicators in Burkina Faso. In particular, the poor quality of curative services, the inadequate motivation of health care personnel, the various cost recovery mechanisms that reinforce the financial inaccessibility of health care services, the quasi-absence of risk-sharing mechanisms, and unhelpful attitudes in the health centres. The National strategy of Emergency Obstetric and Newborn Care (EmONC) highlights that, faced with such problems, people would much rather use self-medication or traditional medicine than go to the health centres[21].

The Ministry of Health in Ouagadougou defined a series of evidence-based services – in particular a series on the reduction of maternal mortality published by the Lancet in 2008 which announces the implementation of higher impact measures and Quick Win Actions (IGR) for the sector. Sixty high impact interventions have been selected as well as fourteen “tracer interventions” to ensure follow-up.

Box 3.1 Selection of Quick-Win Actions in Burkina Faso

- Assisted deliveries (active management in the third phase of childbirth)
- Infant and young child feeding
- Washing of hands with soap
- Prevention, control and management of malnutrition
- Management of low weight at birth
- Refocused antenatal care (Birth preparedness, ATV or anti-tetanus vaccination, iron, folic acid, DIPI or artificial insemination, LLINs, nutritional advice, HIV screening/counselling,

[20] It should be noted that official statistics are incomplete, particularly due to the fact that there is insufficient information as regards rural areas and that births and deaths occurring outside of the medical centres are not taken into account.
[21] National strategy of Emergency Obstetric and Newborn Care (EmONC), 2006.

diabetes, hypertension)
- Prevention of mother to child transmission (PMTCT)
- Managing maternal health conditions which could affect breast-feeding
- Family planning
- Integrated management of childhood illnesses
- Expanded Programme on Immunization
- Emergency Obstetric and Neonatal Care (EmONC)
- Screening and treatment of communicable and non-communicable diseases
- Prevention of health care acquired infections

These interventions are split into basic and complementary activity packages defined according to the level of health care provided.

3.1.2 Definition of financial resources: the subsidy

In Burkina Faso, the authorities have chosen to provide subsidies rather than payment exemptions, leaving the user to pay a portion of the price of the services. This policy is not the result of a scientific decision, but expresses the preference of the policy-makers. Many policy-makers and clinical practitioners in Ouagadougou believe that it is important for the user to feel a sense of responsibility by contributing to the payment. Unlike neighbouring countries, Burkina Faso has developed its health policy thoughtfully and in stages.[22]

Box 3.2 Free health care vs subsidized health care

The issue described here is that of exempting the patient from user fees at the point of service. Hence the document mentions « free health care ». It is in fact not free, as on the one hand, patients might still have to pay other costs of access to care and on the other hand, this exemption creates expenses for the health system that have to be covered. We will therefore refer to it as exemption for the patient from direct payments that are subsidized by third-party payers.

3.1.3 EmONC Policy development and implementation

Unlike certain countries that have radically abolished cost recovery mechanisms following a political statement, Burkina Faso has proceeded gradually. A chronology of the development of EmONC is appended in annex A.

In 2005, a subsidy policy for emergency obstetrical care was formulated. It has been implemented for caesarean sections since October 2006 and for deliveries since January 2007.

The Government subsidy policy works with quick win actions as presented above and has also commissioned a health and health funding study in order to examine three options in regard to the impact of subsidies on reducing the cost of health care access for households and on their ability to pay. Three case scenarios were examined: 60%, 80% or 100% subsidized maternal health care. The recommendations made by this study led the Government to subsidize 80% of maternal health care in the health centres, and 60% in the hospitals – which was an additional motivation for patients to use primary health care services. The detailed list of subsidized health care services and their rates are presented in the figure below.

[22] JP. Olivier de Sardan and V. Ridde, draft publication.

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Figure 3.2 Detailed list of subsidized services and their rates

Service	Current rate (CFAF)	Subsidy rate	Applicable rate (CFAF)
Health and Social Development Centres			
Eutocic delivery	4 500	80%	900
Distocic delivery	18 000	80%	3 600
Medical Centres with Surgical Unit			
Eutocic delivery	4 500	80%	900
Distocic delivery	18 000	80%	3 600
Treatment and care of puerperal toxaemia and eclampsia	18 000	80%	3 600
Intensive care given to newborn infants up to 7 days old	18 000	80%	3 600
Manual vacuum aspiration	18 000	80%	3 600
Caesarean section	55 000	80%	11 000
Laparotomy (EP and RU)	55 000	80%	11 000
RHC/UMC			
Eutocic delivery	4 500	60%	1 800
Distocic delivery	18 000	80%	3 600
Treatment and care of puerperal toxaemia and eclampsia	18 000	80%	3 600
Intensive care provided to newborn infants up to 7 days old	18 000	80%	3 600
Manual vacuum aspiration	18 000	80%	3 600
Caesarean section	55 000	80%	11 000
Laparotomy (EP and RU)	55 000	80%	11 000

Source: Ministry of Health, Enforcement manual on the National EmONC Subsidy Strategy for Deliveries and Emergency Obstetric and Neonatal Care in Burkina Faso, April 2006

It should be noted that the exclusion of total exemption was not motivated by financial reasons but by the concern that free health services would encourage the population to use them in an irresponsible manner. This stance was confirmed in an official document published in June 2007: « Free health care is one of the scenarios that have been considered. We have however chosen to carry on using subsidies instead as we have seen that free health care decreases the level of responsibility of the recipients ».[23] There is no scientific evidence to corroborate this theory. In Burkina Faso, it is based on the recommendations of the report on the cost-effectiveness of susidies, carried out for the purpose of developing the EmONC policy. The corresponding budget policy has thus been developed for each step in advance and not after the fact, and it is therefore a realistic solution within the broader national budget.

One of the consequences of the cost study was that the Ministry of Economy and Finance, reassured by the small additional amount requested, agreed to integrate it very rapidly into the budget which surprised the Ministry of Health (V. Ridde and al, 2011).

Repayment is based on a fixed rate required for each service, which is defined at national level. Before the implementation of this policy, districts received monetary advances which were based on the number of expected medical procedures. Later on, they were reimbursed according to the number of medical procedures that had actually been carried out (on a fixed rate basis). The Ministerial decree defines this flat rate as the maximum amount that can be received, but the

[23] Amnesty Internationale, 2009.

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reality on the ground is very different. There is no monitoring system to generate systematic and precise information on the number of times EmONC makes use of the services in question or what type of services are being accessed (which determines their cost); various studies have shown however that the implementation of the Ministerial decree is variable. When the actual costs amount to less than the fixed rate, the entire amount (of the fixed rate) is requested, but when the costs are higher, the system is flexible and accepts a higher invoice than the fixed rate (accompanied by supporting documents)

Information for the patients:

- 80% of the cost of deliveries and caesarean sections (or 60% in the case of hospital structures) is subsidized by the State; women have to pay the remaining 20% (or 40% in the case of hospitals). The Payments made by patients are used to partially cover the cost of medical services, medication and various supplies needed for the deliveries. Complications and post-natal care during the first week following the delivery are also covered.
- Funds paid by the patients to health centres have the same function as funds paid by patients in terms of the Bamako initiative, except in regard to the health care personnel,(as explained hereunder); the funds are managed by the Management Committees in order to meet operational costs of the structure.
- Free transport from a Health and Social Development Centre to the hospital is provided for pregnant women
- The subsidy covers 100% of the costs incurred by pregnant women without means.

Information for health care staff :

- The subsidy cancels the premiums that used to be received by the health care staff. According to an official decree (Bocoum Yaya F. and al, 2009), bonuses are paid to health agents according to their medical activities. They are entitled to 20% of the payment made by patients for medical procedures and consultations. It has been decided however that this provision would not apply to services rendered in terms of EmONC.
- Traditional mid-wives are no longer allowed to practise
- The health care personnel must submit their request for reimbursement to the district (within 30 days after the procedure); and is paid the aforesaid subsidies within a maximum period of three months.
- The personnel should handle requests for additional medication and purchase it at the district Generic Medicines Agency. The payment period of the agency is three months; hence the centre must be able to purchase the necessary medication without having to advance funds.

The support of the Ministry of Economy and Finance, and the political will at the time produced un-hoped for results: the implementation of the subsidies was very rapidly enforced. In less than 6 months time, the laws were enacted and the subsidy policy implemented. Although a well formulated policy requires technical and substantive work, the hasty implementation did not allow the technicians to work out the implementation details that are so important for the success of a reform and the communication strategy was also bungled. There is no scientific evaluation of the policy, however the available data seems to show that the implementation of the repayment terms of EmONC has met with a number of difficulties. Consequently certain aspects planned in the initial design, have not been applied, such as the recognition of the additional work load and its effects on the health care staff, or the effective implementation of the 100% subsidized health care for the poor. The reform provides for the total exemption of payments for the poor, and a budget line was included to cover the estimated financial requirements. Due to the fact that the identification of the poor has still not been made available, this part of the policy has not yet been set up.

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The formulation of the EmONC policy in Burkina Faso is based on a high quality piece of technical work that was received and evaluated by the Government. It seems however that at some point, politics overtook the technicians. Less than a month after the Ministry of Health made its request based on the cost study, a Presidential decree was issued (March 2006) to validate a new budget line, but the Ministerial decree defining the implementation procedures was only signed 6 years later, in February 2012[24]. Hence, once the subsidies had been approved, the accompanying implementation measures were no longer considered as a priority. This mistake seems to have arisen, in part at least, from the separation between the financial legislation (which has been entirely integrated into the budget) and the implementation legislation that covered implementation support activities such as communication strategies and policy evaluation (V. Ridde and al, 2011).

There is no magic solution to a fair and effective health reform. Although many African countries have introduced a certain level of free health care over the last decade in response to various pressures and motivations, it should be noted nonetheless that when these reforms were too radical or hastily prepared, the implementation was problematic and the medium-term impact was negligeable. An overview of the literature on this subject brings to light the half-hearted effects of the exemption policies as well as the pressures and shocks such policies bring to bear on fragile health systems (V. Ridde, B. Meesen, 2010).

3.1.4 "Free health care" bubbles funded by ODA

In 2008, *Terre des Hommes* and *HelpAge*, two NGOs working in two districts of Burkina Faso, confronted with the cautious development of public subsidy policies and the lack of national interventions on behalf of the poor, organised health care services that were totally free of charge to children under the age of 5. This means that over and above the EmONC subsidies, *Terre des Hommes*, becomes a third-party payer and takes on the co-payment. Consequently, the exemption covers curative services offered by the health care personnel to children under the age of five and to pregnant women throughout the public health units of the two districts included in the project (V. Ridde and al, 2011).

The exemption from payment takes into account fee scheduling, hospitalisation, medication, medical consumables and biomedical examinations available in these health units and needful to provide health care to the target population. The following health services are not covered: i) pathologies covered by vertical or specific programmes (EmONC, MCS, severe cases of malaria); ii) chronic pathologies in pregnant women and children; and, iii) Regional or national referral hospital care.

An external scientific assessment that demonstrates the impact of these projects is not available for the time being, but a recent report by *Terre des Hommes*, highlights the project's achievements in enabling a sevenfold increase in the number children under the age of 5 who have access to health centres[25] *(SERSAP, 2010)* and in increasing health centres' resources (K Blanchet and al, 2011). Building on this work and a similar project set up by *HelpAge*, increasing pressure is being brought to bear on the Government to change its approach to EmONC and to move from the partial subsidizing of health care to the introduction of health care that is totally free of charge (at least for a package of priority health treatments) at the point of contact.
Today the Government supports these interventions, but a comprehensive financial estimate still needs to be provided to determine their sustainability and possible application at national level. It

[24] The presidential decree that created the budget line, was signed in March 2006, but the decree setting out its implementation at parliamentary level, was only signed in 2012. Thus from 2006 to 2012, EmONC was undertaken in accordance with an implementation manual (developed in 2006).
[25] Society for Public Health Studies and Research (SERSAP) 2010

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should be noted that these exemption mechanisms require extensive recourse to external funding and do not only concern a payment exemption (J.P. Olivier de Sardan, V. Ridde, 2011). The cost estimate provided to the Government as a basis to work with, does not include support costs such as technical assistance provided by the NGO to set up the management system, bonuses paid to the health care staff, staff training, monitoring and supervision and the rehabilitation of infrastructures

3.2 Impact of the EmONC policy

As a baseline study was not carried out before introducing EmONC, it is difficult to evaluate its impact in a scientific manner. An assessment was carried out in 2011 (available as a draft publication[26]); it does not include funding or policy costing information.

3.2.1 The main successes of EmONC

Medical health expenditure has significantly decreased between 2006 and 2010 (V.Ridde, and al, March 2012), despite the fact that 50% of the women, who were officially supposed to pay 900 CFAF, reported paying more. This drop in expenditure appears to be mostly due to the fact that since EmONC, medication is generic, bought (for the most part) from Management Committees at a fixed price (V.Ridde, and al, March 2012).

The rate of assisted deliveries has significantly increased. It increased from 48.7% in 2006[27] to 67.1% according to the last DHS (2010), which represents almost a 20% increase. The National Health Development Plan objective which was to increase the coverage rate of assisted deliveries from 34 to 60% has been exceeded. The comparison between data from 2003 and 2010 DHS below shows the increase in percentage of deliveries in a health facility. It also highlights the remaining significant difference between rural and urban areas.

Figure 3.3 Comparison of percentage of deliveries occurring in a health care institution between 2003 and 2010 by areas

Living area	2003	2010
Ouagadougou	95.3	97.4
Urban areas (average)	87.3	93.8
Rural areas (average)	31.3	60.8
Total average	38.4	66.3

Source : DHS 2003, DHS 2010

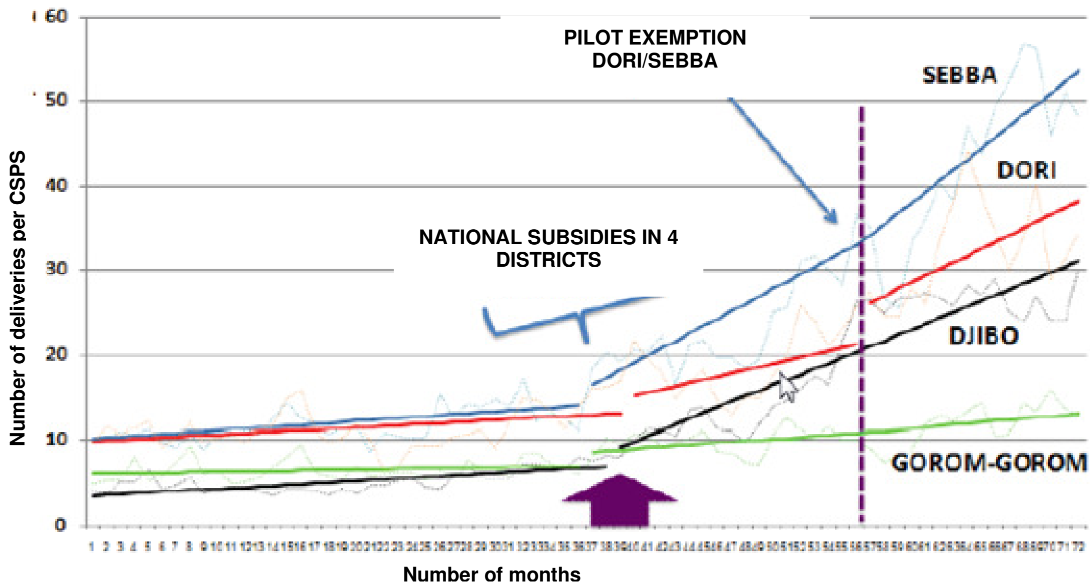
The figure below shows the trend in the rate of assisted deliveries. The increase after the introduction of EmONC is marked. Moreover, the figure shows a difference between 2 districts where deliveries are 100% subsidized through a project set up by HelpAge (Sebba and Dori)[28], and 2 other districts where the women still have to pay the 900 CFAF (Djibo and Gorom Gorom). The increase is very marked for all 4 districts; however, it is even greater in the districts where treatment is free for the patients.

[26] Ministry of Health, Evaluation of needs in Emergency Obstetric and Newborn Care, coupled with the Reproductive health mapping of services offered in Burkina Faso (draft publication), mimeo

[27] Studies and Planning Directorate, Ministry of Health, 2006 ; http://www.cns.bf/IMG/pdf/TBS_2006.pdf.

[28] In both these districts the NGO 'HELP' pays the 900 CFAF per delivery out of ECHO funding.

Figure 3.4 Evolution of the monthly average number of deliveries per Health and Social Development Centres in 4 districts



Source: Haddad S. and al, 2011

The 'Terres des Hommes' project records similar trends, as shown in the graph below, which compares two districts where the EmONC services are fully subsidized (Tougan and Séguénégua) and two control districts that only receive (partially subsidized) EmONC services.

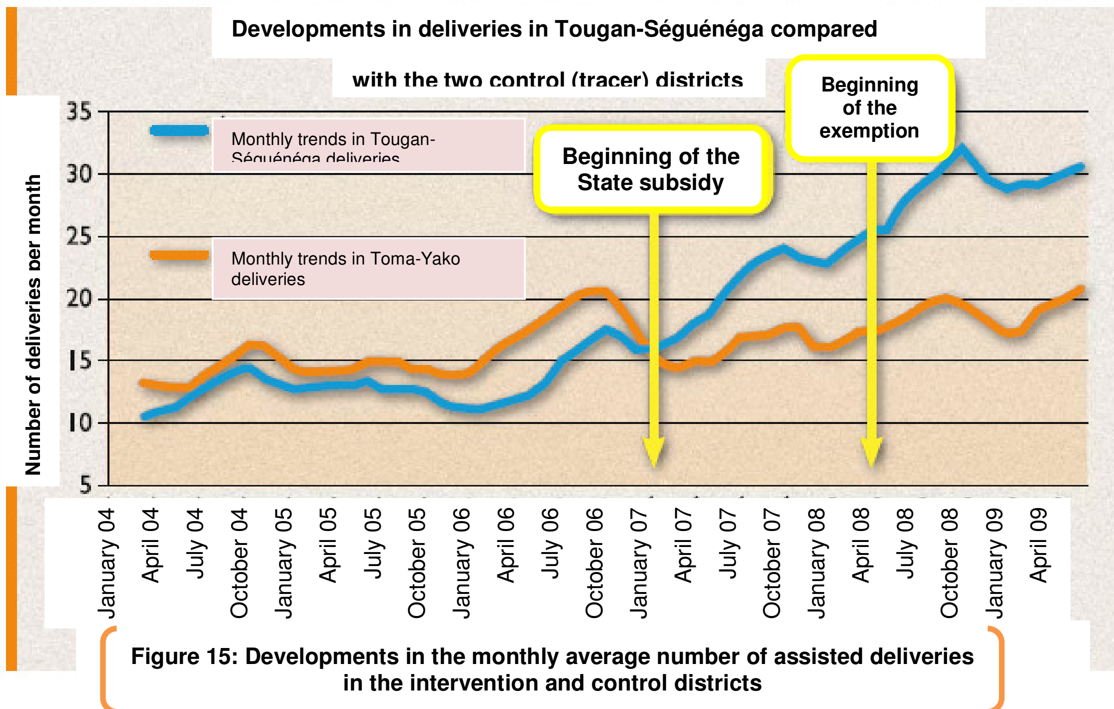


Figure 15: Developments in the monthly average number of assisted deliveries in the intervention and control districts

Source: Blanchet K., and al, 2011

Note that both figure 3.4 and 3.5 show the number of deliveries: the noticed increased could therefore be bias by birth rates increase. The percentage data by district is not available.

Maternal mortality has dropped from 770/100 000 in 1990, to 560/100 000 in 2008[29]. The preliminary report of the latest Demographic and Health Survey (DHS) suggests that the MM rate has dropped to 300/100 000.[30] It's difficult to attribute this drop to EmONC as the trend was already observed before it was set up.

The information on the progressiveness of EmONC is somewhat contradictory. It appears however that **the subsidies haven't benefited the rich more than the poor** (M. de Allegri and al, 2011)**.** Valéry Ridde and al, consider that the equal utilisation of services even increased in 2010.[31] Moreover, the prevalence of households that are victims of catastrophic health expenditure has significantly dropped since the introduction of EmONC[32].

Box 3.3 Catastrophic health expenditure, definition

Catastrophic spending occurs when households spend more than 40% of their disposable income (after deduction of subsistence expenses) on health (WHO, 2005)[33].

3.2.2 What requires more investment

Household expenditure is still higher than the 34$ standard of the WHO. Subsidies do not cover: i) some of the direct costs of services such as consultations for children under 5 years of age; ii) indirect costs, such as assistants, food and transport. Transport from the health centre to the hospital is included in the case of referral, but the transport from the village to the health centre remains payable by the family and continues to be an important financial barrier, especially if the woman has to make several trips to and from the health centre; and, iii) illegal costs, such as dishonest invoices, "gifts" to the health care staff, illicit sales of medication or favours (there are no official statistics regarding this, but a recent comparative assessment of free healthcare policies in Burkina, Mali and Niger mention them as obstacles[34]). A comparison between subsidy policies in Niger, Mali and Burkina Faso, shows that women in Burkina Faso pay decidedly more than the fixed rate of CFAF 900 for strictly medical costs (between CFAF 1300 and CFAF 1800)[35].

The financial sustainability of the NGO experience is not guaranteed. TDH and HelpAge pilots seem to show that allowing free access to health care at the point of contact has positive impacts on utilization rates and health outcomes. However, to make access to health care free of charge at the level of the health care providers, even if it is only for certain categories of population and/or specific services, means that funds must be mobilised/raised in order to cover these subsidized costs. In the long run, and if this policy is to be sustainable, the effective implementation of these measures requires such financial provision. Burkina Faso can learn some lessons from experiences carried out with ODA support, but as long as the needed funds are not allocated, (as in the case of pilot projects whose ambition it is reach the national level) it will be difficult to obtain results similar to those obtained by these targeted interventions.

[29] WHO, UNICEF, UNFPA, WB, 2010 ; http://www.unicef.org/french/infobycountry/burkinafaso_statistics.html
[30] Information on the WHO website, updated in May 2012 ; http://www.who.int/gho/countries/bfa.pdf
[31] V. Ridde and al, 2012.
[32] Ibid.
[33] WHO, Designing health financing systems to reduce catastrophic health expenditure, Geneva, WHO, technical, 2005
[34] JP. Olivier de Sardan and V. Ridde, draft publication.
[35] Ibid.

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In the absence of an information campaign, few people really know what is covered and which treatments they still have to pay for. This confusion has created a situation where medical staff may require illegal payments for medicine and services that ought to be free of charge or subsidized. The lack of information can also undermine the patient's trust: when patients don't know which treatments are covered, they might avoid going to the health centre because they fear that the health care services may not be subsidized.

Without a reliable, systematic information and monitoring system it is not possible to obtain data to systematically monitor the EmONC services usage or the practical obstacles that arise in connection with the subsidy policy. Various sources report that since the subsidy policy has been implemented, families have been paying more that the amount stipulated by the policy. Many families complain for instance that they had to purchase gloves as well as other articles and products because the medical staff had none in stock. Amnesty International in their assessment of the maternal situation in Burkina Faso, reports that almost all the women they met who had given birth, stated that they had to buy their own products for the delivery, including the bleach used to clean the labour room.[36]

The increased workload of the health care staff that is associated with the subsidy, and their lack of motivation (due to the above-mentioned withdrawal of bonuses for EmONC services) appears to be the main causes of the frustration experienced by the health care staff.

Low impact on the poor. Although the subsidy policy has set aside 17 % of the available funds – which amounts to approximately 5 billion CFAF (about 7.6 million Euros) for the 2006 -2015 period – in order to ensure that poverty-stricken women receive free treatment, this provision has not yet been applied, mostly due to the fact that the Government has not defined the criteria applicable to the poor which would allow them to be identified as such.[131]

[36] Amnesty International, 2009.

4 Way forward

Having broadly outlined the epidemiological and health sector funding situations in Burkina Faso, we will now discuss possible recommendations as to (i) health funding in the country (ii) methods for the purchasing of services and possibly (iii) the implementation of a health funding reform. We have suggested a few key issues and points to consider for each of these three topics. The two first topics are covered in detail on the key note; the theoretical frameworks the latter providers should help the group reflection and the study case task.

4.1 Health Funding

4.1.1 The financial gap between the estimated financial means required to achieve the MDGs and the available budget

The MTEF measures the difference between the available budget and the amounts required to carry out the operational plans of the health sector. The comparison between available resources and the cost of the programmes over the entire period, shows a financial shortfall of CFAF 486 252 million. The financial need is distributed as follows, CFAF 103 140 million in 2012, CFAF 159 095 million in 2013 and CFAF 224 017 million in 2014.

Figure 4.1 Synthesis of the budget framework (in millions of CFAF)

Wording	2012	2013	2014	Average 2012 - 2014	Total 2012 - 2014
Total (estimated) Cost of the programmes	328 076	390 099	462 150	393 442	1 180 325
(Estimated) available Funds	224 936	231 004	238 133	231 358	694 073
Gap	- 103 140	- 159 095	- 224 017	- 162 084	- 486 252

Source: MTEF 2012 – 2014

Achieving MTEF goals, in accordance with the National Health Development Plan and the MDGs, will require the mobilisation of additional funds in the amount of CFAF 103 140 million by 2012, CFAF 159 095 million by 2013 and CFAF 224 017 million by 2014.

Box 4.1 The financing of HIV/AIDS in Burkina Faso, a sustainable approach?

In the wake of the financial crisis, ODA funding dropped considerably. This change has had a dramatic effect on certain sectors and in particular on HIV funding. Burkina Faso, and the rest of the world perceived the cancellation of round 11 of the World Fund last year as an ominous sign. Burkina Faso commissioned a study in order to estimate the financing needs for HIV and to suggest a sustainable funding method for the sector. The study concluded that the estimated financial gap for the fight against HIV/AIDS amounts to CFAF 7.9 billion in 2010, and will drop to CFAF 1.3 billion in 2020, which represents 0.18% of the GDP in 2010 and 0,01% of the GDP in 2020. Hence, according to this study, the total need for additional resources will amount to approximately USD 86 million in 2020.[37]

[37] Source: OPM, 2011. Note: the limitations of the methodology are presented in the OPM report. As is the case for all financial projections, the results should be interpreted with caution.

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4.1.2 Key questions and possible ways forward

How can the health sector budget be increased?
What present sources of funding can and/or should be reallocated to increase their contribution to the health sector?
What new funding sources could and/or should complement health sector resources?
What are the conditions and consequences of the various options for Burkina Faso?

Reallocation of available budget resources to the health care sector

- This is possible through budget adjudication; however, in view of the fact that Government funding of the health sector has increased considerably over the last few years, a results request pending a further investment in the sector.
- Moreover, the repercussions of the 2008 financial crisis still affect Burkina Faso. Consequently, the Ministry of Economy and Finance prefers to prioritize economic growth at present.

Box 4.2 State budget priorities, 2012 budget management

Government priorities for the year 2012 aim to promote a significant increase in the (economic) growth rate and, hence, of the financial potential of the State, by appropriate public investment and support to private investment, within a sustainable macro-economic and financial framework.
In view of the limited budgetary resources and in order to optimise the effects of public intervention, the Government wishes to focus its attention on the well-defined priorities of the Strategy For Accelerated Growth And Sustainable Development (SCADD), and, in regard to new investments, with a special emphasis on the rural development, infrastructure and job promotion and security sectors, whilst maintaining budgetary efforts for social sectors so as to consolidate achievements and continue progressing towards the MDGs.

Source: Quarterly information bulletins from the Directorate-General for Budget and Budget Info, Ministry of Economy and Finance, N. 004, January 2012.

Health sector budget increase thanks to the expansion of fiscal space

- In 2009, Burkina Faso registered a slight drop in its growth rate, but the real GDP increased to 5,2% in 2010 and is likely to continue increasing. In the long term, and all things being equal, the GDP should increase by 5,6% per year, and tax revenue should remain at 15,7% of the GDP[38]. In such a context, no significant expansion of fiscal space is expected.
- The health sector can expand its fiscal space by investing for instance, in the increasing contribution of the population via the development of mutual health insurance; it should be noted however, that such an approach is difficult to implement in a country where almost half the population lives below the breadline.
- Moreover, the introduction of innovating funding mechanisms (such as private-sector contributions, airport taxes, mobile connection taxes, etc) can also increase funding sources for the health sector. (See the key note for more examples on these sources and their use).

[38] Sources : OPM, 2011

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4.2 The purchase of health care services

4.2.1 Effectiveness of health care services purchasing methods

"The Ministry of Health is the highest fund-consuming Department in the country![39]" Today, despite a considerable increase in the budget allocation over the last decade, the Ministry of Health is always asking for more funds. In the area of health, there are no limits, and the budget will always be inferior to the needs. It is important for the country to focus on productive sectors, training and growth, especially during this period of financial crisis. Burkina Faso was not only affected by the financial crisis but also by the repercussions or the war in the Republic of Côte d'Ivoire.

4.2.2 Key questions and possible ways forward

What can the Ministry of Finance do to ensure a better use of health care sector resources?
What requirements could the Ministry of Economy and Finance impose on the Ministry of Health for the latter to demonstrate their rational and efficient allocation of the National Budget?
What undertaking can the Ministry of Economy and Finance require from the Ministry of Health in order to respond to media criticism regarding the poor allocation and use of Health sector funds?

How can the efficiency of funds allocated to the health sector be improved?

What measures can the Ministry of Health implement in order to improve?

- Their technical efficiency : **using resources to provide a certain quality of services at the lowest possible price**
- Their allocative efficiency: **allocating resources to high impact activities.**

The allocative efficiency of resources, determines to what extent resources are directed to the highest impact activities.

- Should a Government exempt the entire population from health care payments in order to simplify treatment and care, with the risk that the poorest sector of the population might not be the first to benefit from such a system? Or should it implement a more cost-effective solution by only targeting certain population groups? The question of which exemption policies to implement is still hotly debated (Hanson, K. and al, 2007; Mkandawire, T., 2005). It is quite natural to establish priorities in view of the fact that Governments work within a limited budget, and that the ethical and moral issues are just as complex as the implementation technicalities.

- Hence it would be a good idea to re-prioritize the EmONC-subsidized activities and services. As the introduction of EmONC is based on quick win actions, this element has been taken into account. Certain political aspects, however, have partially influenced the design and implementation of the policy to such an extent that its expected efficiency has not materialized in practise. The main reasons for the limited impact of EmONC are the non-implementation of the pro-poor component, and the fact that transport from the villages to the health centres is not covered. If this latter activity was included in the subsidized services, not only would it be very difficult to implement, but funds would have to be taken from the EmONC package to cover the costs of transport.

[39] Interview with the MoF, DGB, May 2012.

- The Government might also consider re-prioritizing allocation in favour of the poor. Health agents in Burkina Faso are still reluctant to entirely do away with health care payments [40], Nonetheless, in view of the indicators demonstrating the inequality of conditions between quintiles, this is a legitimate issue. All the more so, that certain experiences, authorized by the Government and set up by NGOs, have organized 100% free treatment for certain patients. Maybe scaling-up methods and approaches could be extracted from such experiences.

Technical efficiency determines whether resources have been used to provide a certain quality of services at the lowest possible price.

- Repayment of EmONC is based on a fixed rate required for each service, which is defined at national level. Before the implementation of this policy, districts received monetary advances which were based on the number of expected medical procedures. Later on, they were reimbursed according to the number of medical procedures that had actually been carried out (on a fixed rate basis). The Ministerial decree defines this flat rate as the maximum amount that can be received, but the reality on the ground is very different. There is no monitoring system to generate systematic and precise information on the number of times EmONC makes use of the services in question or what type of services are being accessed (which determines their cost); various studies have shown however that the implementation of the Ministerial decree is variable. When the actual costs amount to less than the fixed rate, the entire amount of the fixed amount is requested, but when the costs are higher, the system is flexible and accepts a higher invoice than the fixed amount (accompanied by supporting documents)

- In addition, one of the main costs and the source of many frustrations arise from the purchase and provision of medication. Although the system of decentralised central purchasing agencies operating through Management Committees works well, EmONC is continually hampered by stock-outs and/or a so called lack of supplies that oblige patients to purchase medication (often not generic), which should be included in the subsidized services. If this is indeed a priority, how can the supply of medication, specifically for subsidized services, be more efficiently managed?

- *All things being equal,* the production boundary for health care services could be pushed back, if the medical staff was motivated to offer a better quality (and more friendly) service to the patients. Thus the integration of financial incentives for the staff into the purchasing of services (as was the case previously for EmOnc staff who received bonuses based on services offered) could have a significant impact on the volume and quality of services offered.[41] In Burkina, the authorities are reluctant to openly address the question of health care staff payments. This issue has been neglected in the sector reforms, and consequently adaptation strategies have been developed, some of which undermine the overall performance of the health system (Nicolas Meda and al, 2003).

4.3 The implementation of a Health Funding Reform

What implementation changes and/or adjustments can be proposed in order to improve the impact of EmONC?

[40] JP. Olivier de Sardan and V. Ridde, draft publication.
[41] Reference to documentation and debates on PBF. We are not taking a stand here as regards this methodology but introducing it as a possible recommendation.

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The working group has undertaken to make recommendations to the Council of Ministers on health funding in Burkina Faso, but it should be noted that other organisational methods can strengthen and/or significantly improve health funding reforms. Health economists often forget to consider the organisational aspects of the proposed reforms even though costs, efficiency, quality and access also depend to a large extent on organisation. Hence, it is important when implementing a reform to take into account other aspects of the health system such as the organisation of the system and the relationships between the institutions and various levels of services and health care practitioners.

The development of EmONC was based on quick win actions for maternal and child health as defined by the Lancet[42] ; moreover the Ministry of Health decided to subsidize 80% of the costs, on the basis of the impact and cost-effective assessments carried out in order to define the policy. Technical and allocative efficiency were therefore taken into account from the inception of EmONC.

The implementation of the policy seems to be somewhat problematic, and this is partly due to the lack of certain accompanying measures. Difficult access to health care centres, transport costs, the frequent lack of free medication, demotivated staff and the lack of information provided to patients as to which services are subsidized, does not allow services defined as Quick Win Actions to reach their full potential. The disinformation of the health care staff and their frustrations because of the impact of the policy on their workload are also hindrances to the implementation of the policy (Walker, L. & Gilson, L., 2004. *;* Witter, S. and al, 2007. Moreover, certain adaptations of the system, such as for example the use of fixed rate repayments in an initially unplanned way, undermine the effectiveness initially planned for in the technical design of the policy.

[42] The Lancet Series: Maternal Mortality, 2008.

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5 The task

Since 2000, the Government of Burkina Faso has significantly increased the Health care sector budget and subsidies have been introduced for some priority health care services, especially maternal and child care services, so that the patient no longer has to pay when he/she goes to the health units. However, the improvement of key indicators is long overdue and the National Health Accounts show that household expenses for Health care do not seem to have decreased (in absolute terms).

It is in this context that a scandal occurred. An article published on the 11th of March 2011[43] in the semi-monthly editorial, "The Reporter" denounced the violation of the EmONC (Emergency Obstetric and Newborn Care) subsidy policy. “According to this Law [EmONC], users will be required to pay a very small portion (10% in certain cases) of the cost of Health care, the State paying the bulk of the costs. But a few years after its enactment, the practical results are really distressing. The greed of some of the players responsible for the implementation of the Act and the laxity of the authorities have completely obviated the dynamics of the subsidy…“.

New legislative elections are scheduled for September 2012, and the Directorate-General for Budget (DGB) of the Ministry of Finance (MoF) is required to submit a preliminary budget in July as the members of Parliament wish to use it to prepare their campaigns. Health is one of the priority sectors, especially since the newspapers publicly denounced the lack of impact that budget increases have had on the Health care sector.

A working group was set up to make recommendations to the Government as regards the strategy that should be adopted in the face of media attacks. The group consists of technicians from the Ministry of Health (MoH) and the Ministry of Finance (MoF). Both categories of experts naturally wish to make the best possible recommendations, but their priorities do not coincide totally.

- The Ministry of Health would like to take advantage of the upcoming legislative elections to take up the challenge of achieving the Millennium Development Goals (MDGs) in Burkina Faso
- The Ministry of Finance on the other hand, is concerned about how to evaluate the Health care sector budget and how to carry out this year's budget adjudication.

The working group is responsible for proposing at least 3 measures to improve access to health care and health conditions of the population, as well as the efficiency of the budget allocation to the health sector. The proposals should be implemented under the next Government.

[43] The article was in fact published and the quotes are taken from the text. It is dated March 2011 (source: The Reporter, n 65, from March 1st to March 14, 2011: “Subsidizing child birth and obstetrical care - SOS the law is being broken”. The dates will be adjusted for the case study and the exercise.

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Annex A EmONC development timeline

2004	
November- December	Meetings of technical work group on policy development
2005	
February	Policy Development workshop
September	Policy Development workshop
2006	
Jan-March	Costing study conducted for estimating cost efficiency of different subventions scenarios
March	Adoption by Council of Ministers
April	National Validation Workshop
May	Application Degree
May-August	Regional Orientation workshops for the Regional Health departments and health districts
September	National workshop
September	Memo from Secretary General (SG) of Health requesting that its application become effective on 1st of October 2006
2007	
May-July	Baseline evaluation conducted
November-February 2008	Development of posters and information brochures on the subsidy
2008	
March	Collaboration workshop on application problems
March-May	Design and broadcast of audio and video public awareness advertisement
April-September	Design of EmONC software program (SYGSONU)
2009	
June	Beginning of Collaboration with the Ministry of Economy and Finance
October	Joint visit by the Ministries of Health and of the Economy and Finance to 6 Health regions, 9 health districts, 5 regional hospitals and 1 teaching Hospital

Source: Adapted from V. Ridde and al, 2011

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Annex B List of people consulted

Name	Organisation	Position
	Ministry of Health	Director of Administration and Finance Department (DAF)
Amadou Sangare	Ministry of Economy and Finance	Director General of National Budget
Christophe Barrat	Agence Française de Développement (French Development Agency)	Deputy-Directeur
Gabriel Compaoré	ASMADE	
Jean-Benoit Perrot-Minnot	Agence Française de Développement (French Development Agency)	Macro and Human Development Unit, Policy officer
Leopold Ouédraogo	WHO	
Lorraine Gallagher	European Union Delegation in Burkina Faso	Economy sector and social sectors programme manager
Marcel Kambiré	Ministry of Social Affairs	Responsible for the mutual insurance companies
Maturin Kone	GIZ- MoF	Technical counsellor to the Ministry of Economy and Finance
Maurice Hours	UNICEF	Chief Health and Nutrition Programme
Nitiema Abdoulaye	Ministry of Health	Permanent Secretary of the National Health Development Plan
Ousmane Diadié Haidara	World Bank	Health and Human Development specialist
Pierre Yaméogo	Ministry of Health	Dpt. of Family
Samuel Kabore	Centre d'Analyse des Politiques Economiques et Sociales (Economic and Social Policy Analysis Centre)	Researcher
Mr. Sankara	Ministry of Health	Director of Health and Women department
Seynou Saibou	Ministry of Public Service, Labour and Social Security, Health Insurance steering committee	Permanent Secretary

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