POLICY DIALOGUES

Inequalities in Maternal Healthcare Spending: Evidence from Burkina Faso

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MAIN MESSAGE

This brief examines how public and overall health spending on institutional delivery services have become more egalitarian as policies targeting universal maternal care have been rolled out in Burkina Faso. Over time, we observe increased equality for both public and overall health spending, albeit the distribution of benefits remained pro-least-poor even by 2017, especially so at hospital level. Regional differences in the distribution of public and overall benefits persisted, but became considerably smaller over time, especially for overall spending. Further policy action is needed to tackle persisting causes of inequality and reduce regional differences.

CONTEXT & MOTIVATION

Maternal mortality and neonatal mortality in Burkina Faso have been estimated respectively at 341 deaths per 100,000 and 24,7 deaths per 1,000 live births. Since over 80% of these deaths are attributable to preventable causes, over the last few years, Burkina Faso has implemented a number of policies to increase equitable access to maternal care services and hence reduce maternal and neonatal mortality. First, in 2002, fees were removed for antenatal care services. Second, in 2007, the government implemented the SONU policy, calling for an 80% reduction in user fees for all, but fully exempting ultra-poor women from any payment for delivery services. Last, in 2016, building on the positive experience of several pilot initiatives, the government introduced the *gratuité* and removed user charges for all healthcare services, including delivery, for pregnant and lactating women. In addition, between 2014 and 2018, 12 districts piloted a Performance Based Financing Program with a strong focus on maternal and child services. These policies have resulted in remarkable increases in use of institutional delivery. Today, 70% to 95% of all women deliver in a health facility across Burkina Faso. Out-of-pocket spending on maternal care services has dramatically decreased, albeit not completely disappeared, as a result of these policies. Moreover, these policies have produced benefits across all socio-economic groups, without increasing or decreasing exiting equity gaps in utilization.

However, it is not clear if the introduction of these policies has produced changes in the distribution of health spending across socio-economic groups. This study uses Benefit Incidence Analysis to assess how equitably spending on institutional delivery services has been distributed over time in Burkina Faso.

METHODS

The study considers two levels of analysis, one for public spending (including exclusively recurrent government spending on delivery services) and one for overall health spending (including donor and private spending on delivery services). In both cases, the study examines what proportion of health spending has reached delivering women across socio-economic groups, from the poorest to the least poor. Estimates are presented for 2003, 2010, 2017 to capture changes over the pre-SONU, post-SONU, and post-*gratuité* & post-PBF time period.

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Key words Health, Maternal, Spending, Inequality, Distribution

Themes Health Financing, Health Inequality, Health Spending, Institutional Delivery

Geography Burkina Faso

Find out more about this project: afd.fr/en/carte-des-projets/assessing-equity-health-spending-sub-saharan-africa

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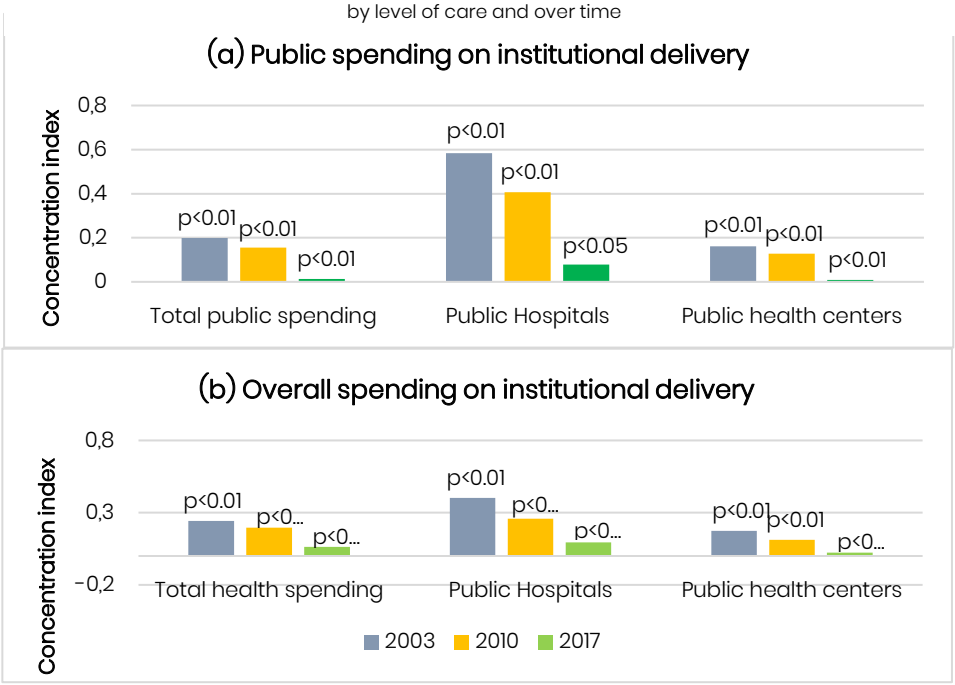
Utilization rates for institutional delivery are extracted from the 2003 and the 2010 Demographic Health Survey and the 2017 Endline Survey of the PBF Impact Evaluation (given absence of any other recent nation-wide data source). Unit costs come from the National Health Accounts. Descriptive geo-spatial analysis helps visualize disparities in both public and overall health spending on institutional delivery across regions within the country.

Distributional incidence of public and overall spending on institutional delivery by level of care and over time



RESULTS

Equality increases in public spending on institutional deliveries over time

Public spending on institutional delivery has become increasingly more equitable from 2003 to 2017. Over time, a larger proportion of public spending reaches poorer women, albeit the overall distribution still remains slightly pro-least-poor even in 2017. Distributional inequalities are larger at the hospital than at the health center level, where by 2017 public spending almost reaches the line of equality (Figure 1).

Equality increases in overall spending on institutional deliveries over time

Overall spending on institutional delivery has also become increasingly more equitable from 2003 to 2017. This means that over time, a larger proportion of overall spending reaches poorer women, albeit the overall distribution still remains more pro-least-poor than when considering public spending alone. Similarly, for overall health spending, distributional inequalities are larger at the hospital than at the health center level, where by 2017, spending almost reaches the line of equality (Figure 1).

Geographical disparities in the distributional incidence of public and overall spending persist, but become smaller over time

Regional differences in the distributional incidence of both public and overall spending persist, but becoming considerably smaller over time. This is probably a function of the generalized reductions in distributional inequalities noted earlier as a result of the implementation of national policies. Heterogeneity across regions remains larger for overall compared to public spending, possibly indicating the role of donor and private spending in the health sector. The most striking example appears to be the Sud-Ouest region, experiencing the most pro-poor distributional incidence of public spending and the most pro-least-poor distribution of overall spending of all regions.

RECOMMENDATIONS

- Promotion of health financing reforms that remove user charges for institutional deliveries must be sustained as a means of ensuring that investments in health continue to reach increasingly poorer women.
- Deeper investigation into the origin of the regional differences observed is needed to seek out suitable solutions to close existing gaps.
- Government and development partners are advised to channel resources towards the regions which currently experience substantial inequalities in the distribution of health spending, targeting specifically causes of inequality in service utilization among poorer women.

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