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Ensuring financial access to quality care

Key to improving reproductive health in South Sudan

Sexual and Reproductive Health (SRH) is a major focus area in South Sudan's national health policy; the Reproductive Health Strategic Plan (2013-2016) has identified the improvement of access to and utilization of health facilities by all individuals as a key strategy for achieving the nation's reproductive and public health goals. The strategy focuses on increasing access to and utilization of antenatal care, postnatal care and facility/skilled deliveries[1].

Access to health care is dependent upon physical, financial and social access to information and services. For example, services should be present in communities at a reasonable distance, they should be affordable and respond to people's preferences and expectations. The SHARP Project's study on norms, preferences and expectations (NPE study[2]), conducted in 2014, found that financial accessibility of reproductive health care – both real and perceived, is a major constraint to the utilization of SRH services in the community. This policy brief draws upon the evidence from published studies and the NPE study around financial access to reproductive health care in Western Bahr el Ghazal State (WBeG), to provide insights for the implementation of the Reproductive Health Strategic Plan, largely in WBeG, and perhaps, in other parts of South Sudan too.

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Problems with accessing reproductive health care

In WBeG, patients incur some form of user fees at the point of seeking care in public facilities. Sometimes this occurs formally in the form of direct charges for services or drugs and materials which are not available in the facilities, or as indirect costs related to travel and stay. Sometimes patients also incur costs informally – as payments sought by health workers and ancillary staff. The NPE study found that patients incurred both formal and informal costs at all levels of care - primary health care units, centres and hospitals. The amount and the appropriateness of such costs notwithstanding, we found that these costs, and the fear of incurring these costs, hindered service utilization.

"It might be money, … maybe there is no money and she is afraid that when she goes they will charge her a lot of money."

(Interview woman under 35, not in union)

These findings are in line with global evidence which shows that expenditures at the point of care can pose a significant barrier to seeking care, particularly amongst the most vulnerable, leading to low utilization of services or forcing individuals and families into poverty (when services are utilized). Evidence also shows that out of pocket expenses at point of care are not a good model for financing health care[3].

While most people in the study areas in WBeG knew the advantages of giving birth at a facility, yet many still chose to deliver with traditional birth attendants (TBAs). One of the most reported reasons to choose for home birth with a TBA was financial constraints. Unlike health facilities, TBAs can be paid with money, goods or food items; they can also be paid later. They are more flexible.

"TBAs can wait even for a year for the women to pay them, but if you go to the hospital and you don't pay they won't let you go home, so women fear."

(Group discussion women above 35)

Some respondents reported not accessing antenatal care services, because of not possessing an antenatal care card, again something that apparently costs some money. Not being in possession of such a card results, in some cases, in being rejected from antenatal and ultimately delivery services. The NPE study findings indicate that fear of formal and informal payments at primary health care unit, centre and hospital level prevents people from accessing antenatal and delivery services.

Implication: Formal and informal user fees, indirect costs, and the fear of incurring expenses, hinder access to reproductive health services and lead to low utilization of services. Therefore, locally appropriate health financing options should be explored.

Besides user fees, other direct costs of treatment (e.g. for medicines) and informal payments, there are also indirect and opportunity costs that deter the poor form seeking health care. These indirect costs include transportation costs, and expenses for food and lodging, and opportunity costs of time of the client and the person accompanying her or him[4]. In the NPE study, many respondents reported that these kinds of costs hinder them or their neighbors from accessing reproductive health care.

"The situation is if labor pain starts at night and there is no transport or no money to pay for transport you look for a traditional birth attendant…"

(Group discussion women above 35)

Implication: Indirect costs and opportunity costs hinder financial accessibility of reproductive health care. Therefore, any financing modality must try to address indirect and opportunity costs too.

The decision to use reproductive health services that are not free of charge depends on the perceived quality of the services on offer. As expected, some health facilities are more equipped or better staffed than others, or have better security or more flexible opening hours, and have earned a reputation for providing quality care. While conducting the NPE study, it became clear that people prefer going to specific health facilities that they perceive as facilities of high quality care. This even applied when facilities are far from where they live, or charge fees, or ask clients to buy drugs and materials elsewhere, when they are not available at the facility. The NPE study findings show a clear willingness to pay when people saw value for the money spent.

With regard to opportunity costs, many people accept them as long as they believe or perceive that they are able to receive good quality services in return. For example, various respondents in Cabi reported that people from far-away places have started to visit Cabi, because the primary health care unit, which has recently been upgraded, provides good services.

"They come even from [far away] surrounding areas like Beselia and Abushaka … they all come here. They come during the day and also at night and the staff here are ready to help anyone that comes. All women come here… If the mother is weak or sick they keep her until she gets better."

(Interview community-based worker)

Implication: People are willing to pay if quality of care can be assured; this of course only applies to those with ability to pay – and not to the poorest and most vulnerable. Any health financing options should be such that it can also influence quality of services; they should be such that it allows people to also influence or 'claim' quality.

Options to improve financial access and quality of reproductive health services

Demand side financing options like 'voucher schemes', where vouchers are provided to families to pay for services, could be an option to improve financial access to reproductive health services. Vouchers target and deliver subsidies to individuals and families, who in the absence of the subsidy would likely not seek care. Evidence shows that such demand side financing initiatives, if implemented with due consideration of local realities, can result in greater utilisation of services by the most vulnerable and also lead to a positive response from providers to provide good quality care. While evidence of the use of voucher schemes in post-conflict settings is not yet available, in the context of WBeG, this option is worth consideration.

Similarly, options which build on (existing) community solidarity arrangements for financial risk protection, can be leveraged to ensure that those who need care, do not forego it for lack of money at that point of time[6]. In post-conflict settings, where financing based on tax revenues is weak, community based health financing strategies have the potential to work well and bridge the gap. Community-based arrangements for risk pooling and risk sharing are based on an ethic of mutual aid and the collective pooling of health and social risks; an arrangement where community members participate in the management of the pooled resources[7]. Such a form of community financing for health has three features: community solidarity and control, voluntariness, and prepayment. Such arrangements don't need to address all costs of care, nor all forms of care; what they address can be tailored to local situations, and decided upon by communities themselves. Evidence from Rwanda and Burundi shows that voluntary, community-based social (and health) insurance can ameliorate the inequitable effects of user fees[8].

The NPE study found that at the village level there was both interest and willingness to share the costs that commonly hindered people from seeking reproductive health services. The following suggestion came from a young male community member, recently trained as a member of the village health committee in Cabi.

"If it is a motorcycle, we could collect money. If now someone is sick, like in Nguwa or Beselia and if we, the health committee, heard that someone is sick in Nguwa and we have money in the safe, the money is not important, the money that we are collecting is for these people. We take it and buy gas for the motorcycle owner and then we tell him to go and get the sick person from such and such location. He will go and bring him/her to the hospital here."

(Group discussion male under 35)

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Recommendations:

Communities should be encouraged and supported to develop solutions to their problems.

Different forms of community-based risk pooling arrangements, using existing local community solidarity mechanisms should be explored, promoted, and facilitated.

The establishment and strengthening of village health committees should continue. These committees can play an important role in holding and managing community funds, and ensuring community accountability.

This should however not be construed as a recommendation for establishment of full-fledged and formalized community health insurance (CHI) schemes in WBeG. We think that the situation is not yet right for this to happen. A recent review of evidence[9] cautions against precipitately rushing into formal CHI initiatives. It draws lessons from struggles faced by such initiatives in sub Saharan Africa and recommends that CHI initiatives should be launched only when the appropriate governance, oversight and management capacities and arrangements are in place. Our recommendation is perhaps more fundamental; we contend that working with existing community structures and solidarity mechanisms at a smaller scale is more feasible in the current context and that working with them on a concrete agenda (health related risk protection) will also help to strengthen these structures.

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