Rationalizing health service subsidies in Senegal

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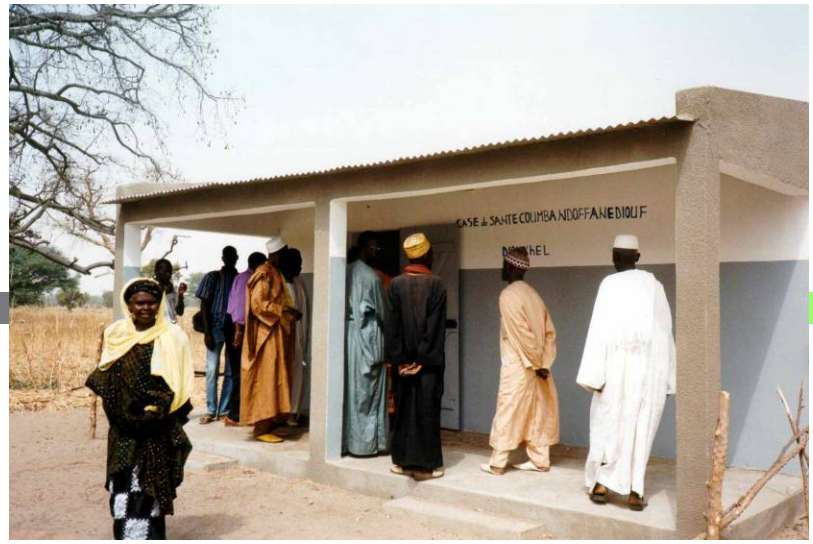
Organization of presentation

- Background to Senegal's health subsidy regime
- Motivation for analysis of regime
- Analysis questions
- Findings on regime overall
- Findings on cesareans and deliveries initiative
- Recommendations on cesareans and deliveries initiative
- Conclusions

Background



- Senegal employs user payments for health services as a part of its financing strategy (Bamako Initiative)
- To complement this policy, it has put in place a set of subsidy initiatives to reduce barriers to access to services for specific groups and specific services

What would be the “ideal” set of subsidies from a public health perspective?

- What kinds of services? Which ones specifically?
- Which population groups?

Senegal's subsidy initiatives address:

- Poor
- Children (vaccinations)
- Mothers (deliveries, césarians)
- Elderly (Sésame initiative)
- Preventive services (vaccinations, insecticide treated nets)
- Communicable diseases (TB, polio, measles, pertussis; blood safety)
- Chronic diseases (diabetes,TB, HIV/AIDS)
- Diseases with significant economic impact (malaria)
- High cost items that could empoverish families (health evacuations)

MOH interest in analysis of subsidies

- MOH wants subsidies to be “rationalized”
- What questions would you seek to answer to help the MOH rationalize the subsidies?

Questions to answer

- What is the overall concept?
- How is it funded?
- Is it effective in attaining its stated purpose?
- Is it efficient in operation?
- What effects does its mechanism have on the behavior of key actors (providers, consumers, others)?

Questions to answer

- Are there accountability mechanisms associated with the initiative?
- What monitoring and evaluation is conducted?
- Are there alternatives to the way the initiative works?
- Does (could/should?) the initiative link to other programs?
- Does the initiative address poverty reduction?

What we found about overall regime

- Each subsidy initiative has its own implementation set up and is managed by a different unit of the MOH
- Funding adequacy varies by initiative and rarely is sustainable
- Little analysis of efficacy or efficiency
- Some incentives and disincentives apparent

What we found about overall regime

- Few accountability mechanisms
- Spotty monitoring and evaluation
- Newer initiatives not built on experience of earlier
- Little integration with other initiatives
- Weakest initiative: the one that targets the poor

Specific findings on subsidy for cesareans and deliveries

- History
  - Announced late ’04, begun operation in ’05
  - Consistent with National Health Development Plan (PNDS), MDG commitment, and PRS
  - Under technical leadership of Direction de la Sante, Division of PHC (DSSP)
  - Steering Committee studied all aspects
  - Piloted before national rollout

Cesareans and deliveries

- Operation
  - Provide government health centers and posts with kits from National Supply Pharmacy (PNA)
    - Initial order of 437 cesarean and 2,000 delivery kits from PNA for about $620,000
  - Provide hospitals with funds (about $40,000) in advance
  - 5 pilot regions with high levels of poverty
    - Kolda, Ziguinchor, Fatick, Matam, and Tambacounda
  - After some issues during pilot, program put under Division of Reproductive Health (DSR)
  - Free cesareans rolled out to all regions except Dakar in 2006, but free deliveries only in pilot regions

General results

- Growth in number of cesareans performed
- Need to hire supplementary obstetricians
- Covered: service, kits, 5-8 days of hospitalization, and drugs and supplies
- Spending on the program ($000):

	2004	2005	2006	2007
PNA	$620	$343	$400	$479
Hospitals	$41	$473	$469	$400
Total	$661	$816	$869	$879

General results

- Medical personnel overall pleased with initiative, but want better quality kits
- Also, worry about the effects of cesareans being free, while ordinary deliveries are paid
- Mbour charges 3000 FCFA ($6) for care after a cesarean
- Kits well received, but fears that hospitals might run out of funds
- Many poor left out of the scheme—initiative covers only 40% of below poverty line, while many non-poor benefit

Financial issues

- Real cost of the cesareans to hospitals (65,000 FCFA) exceeds the payment (55,000 FCFA)
- Funds allocated to hospitals for initiative likely to run out before year is over
- Lost revenue also a worry, since health committees and personnel bonuses are funded by user payments

Recommendations

- Reorient to preserve strengths and increase impact
- Study reasons for delivering at home and not using antenatal services
  - Price not necessarily the biggest barrier
  - Private delivery space might be more important

Recommendations

- Extend nationally but target subsidy to 48% of pop below poverty line
- Identify poor through collaboration between decentralized health authorities and local social development and solidarity services
- Cover cost of including all poor of estimated 890 million FCFA ($1.8 million) by supplementing current allocation with portion of district decentralization grants for drugs

Conclusions

- Senegal hits all of the right services from a public health point of view with its subsidy regime
- However, taking a systematic approach to evaluating the regime could lead to significant gains in effectiveness, quality, equity, and efficiency
- This approach could help other countries to achieve more from their subsidy policies for health