

# Assessing outpatient care expenditures to inform the UHC agenda:

Baseline results from a quasi-experimental impact evaluation of a health systems strengthening project in the Democratic Republic of Congo

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## BACKGROUND

# Policy background: UHC under process

- Important milestone reached in 2014
    - with the adoption of resolutions and recommendations from the General Assembly of the National Steering Committee of the Health Sector (CNP-SS) to move forward to effective decentralization and a major reform in the health sector
  - A new public health law reform aimed at implementing UHC
  - WHO AFRO + UHC Partnership support policy dialogue
  - Agreement on a roadmap
- ➔ **Technical and policy process toward UHC are in development**
- ➔ Baseline assessment of financial protection associated with PHC is expected

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## OBJECTIVES

# Aim

- ① To describe levels of total and disaggregated out-of-pocket expenditures (OOPs) for outpatient care, cost distributions and utilization patterns
- ② To investigate whether incurring extreme, high or medium high OOPs is associated with demand- and supply-side factors

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## METHOD

# The « ASSP – Accès aux soins de santé primaires » research project

## Study design:

A population-based study aimed at:

- Baseline, Process and Impact Evaluation
  - of a very large range interventions supported by ASSP
- Focus on selected multi-sectoral interventions for operational research studies:
  - Community Health Endowment
  - Health Workers motivation
  - Family Planning
  - User fee
  - Value for Money Assessment
  - WASH
  - Empowerment
- Timeline: 2014-2107

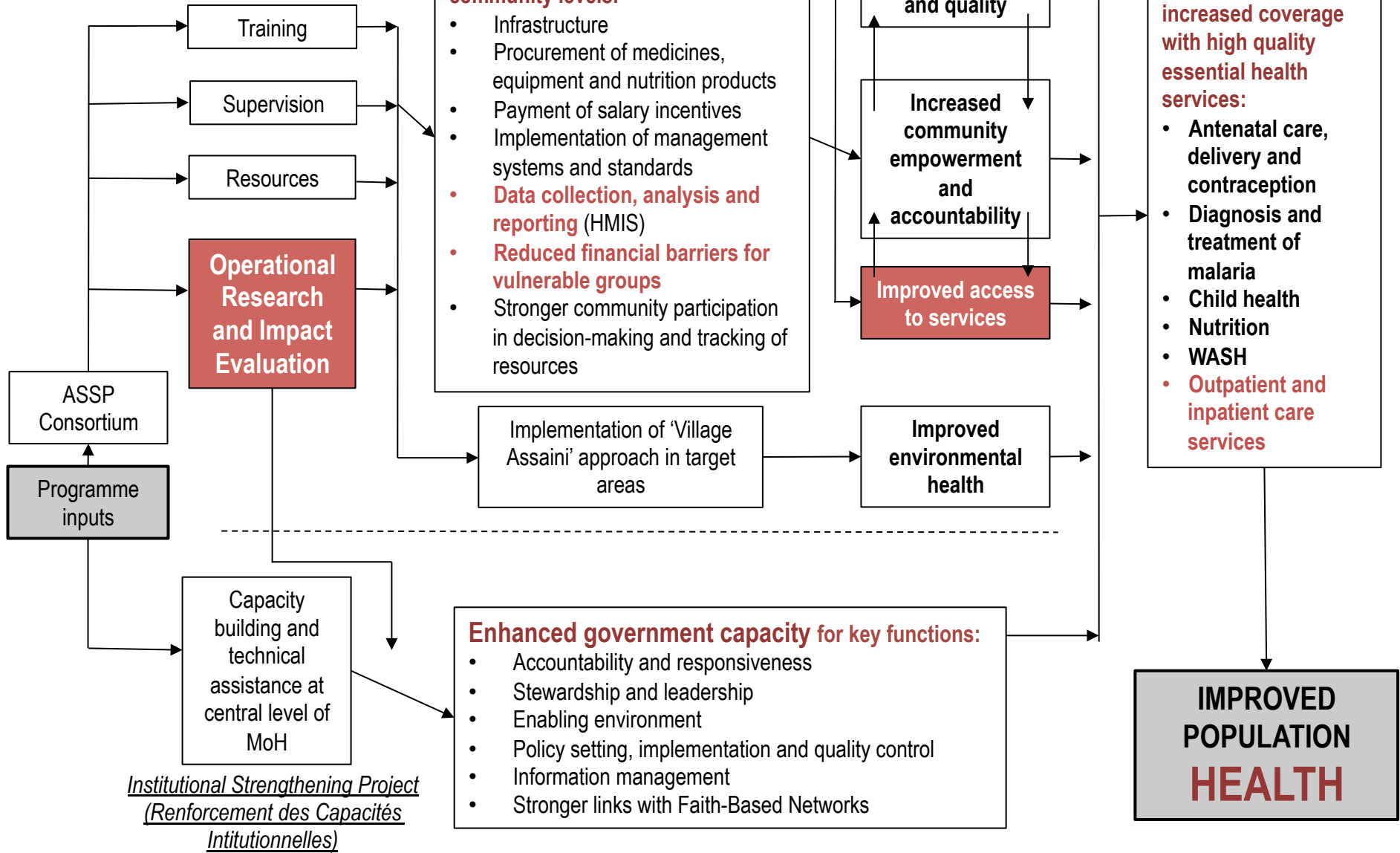
## Funding bodies and Partners:

- A broader project towards HSS



# THEORY OF CHANGE:

*Support to service delivery*



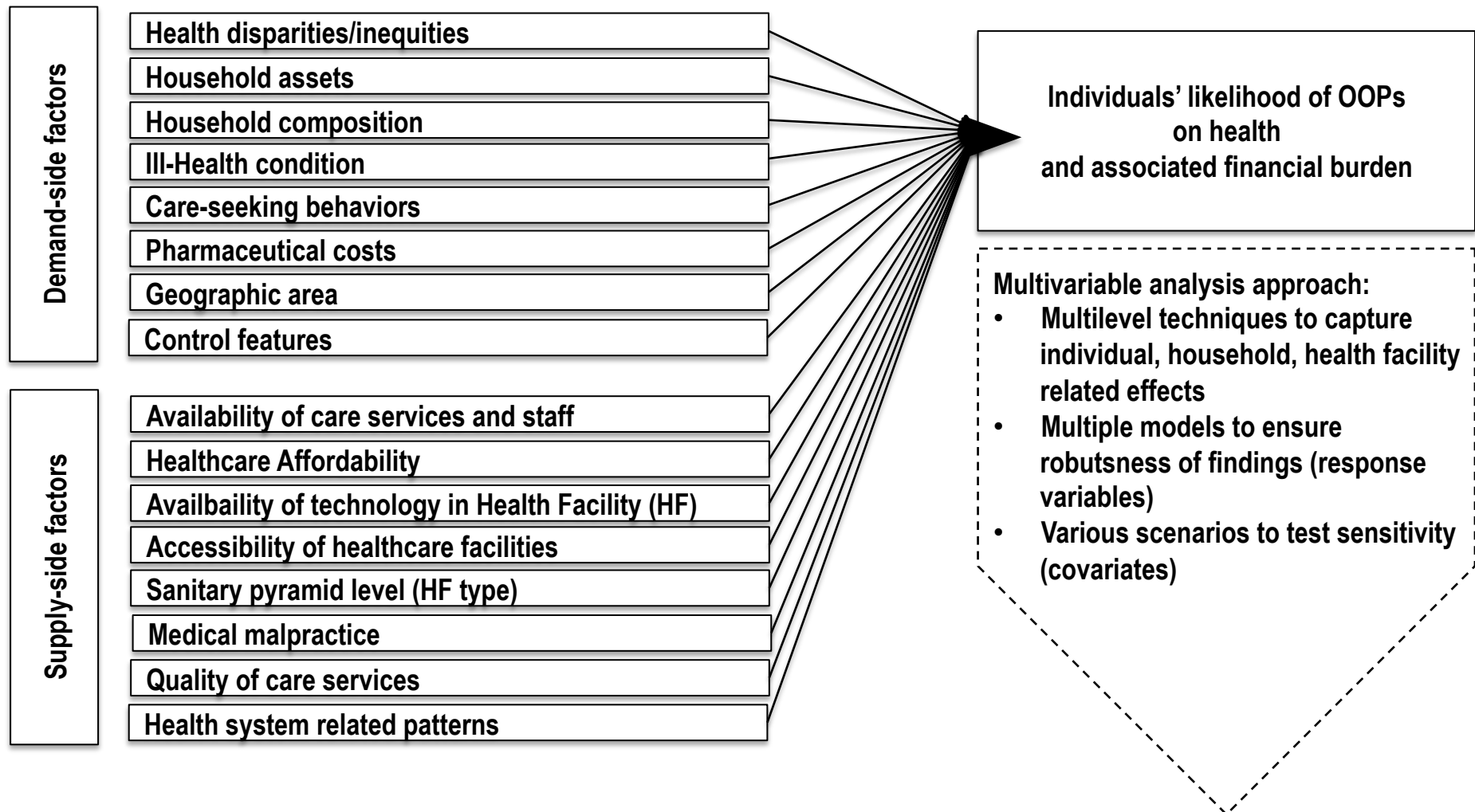
A quasi-experiential village level panel design with a two-stage sampling strategy



# Outpatient survey

- Study period and sites
  - 2014: Baseline study (N=3341)
  - 5 provinces: Equateur, Kasai Occid. /Orient., Maniema, Orientale
- Participants
  - All individuals who reported illness or injury in the 4 weeks prior to interview
- Interviews
  - based on structured questionnaires administered to head of household (
- Data covered:
  - Why care was not sought if this was the case?
  - Where the individuals who did seek care were treated (incl. Informal channels such as traditional healers)?, OOP payments for health?, Satisfaction with services received?

# Conceptual framework of predictors of OOPs and multivariate analysis approach



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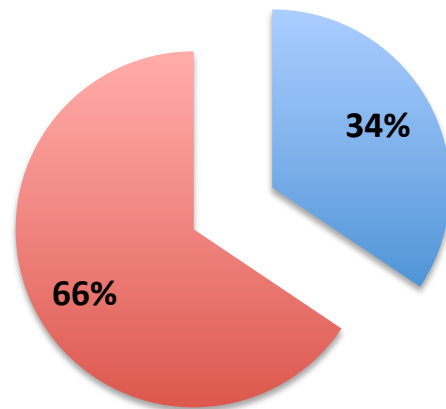


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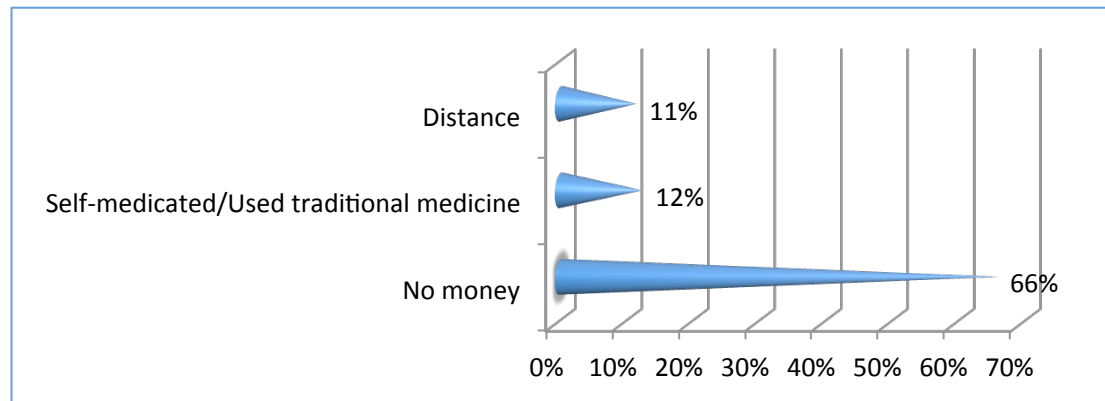
## KEY FINDINGS

# Service and population coverage\*

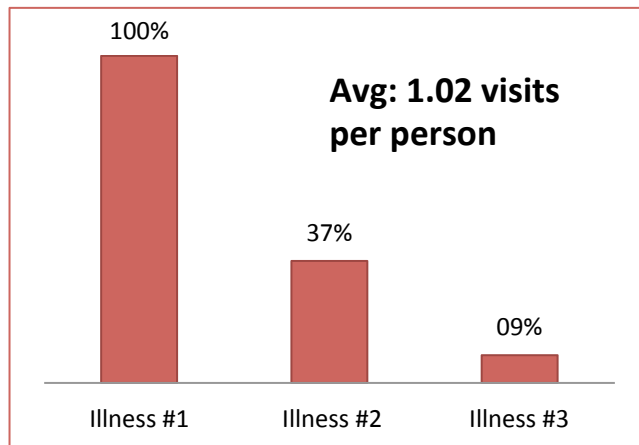
■ Did not use OP care ■ Used OP care



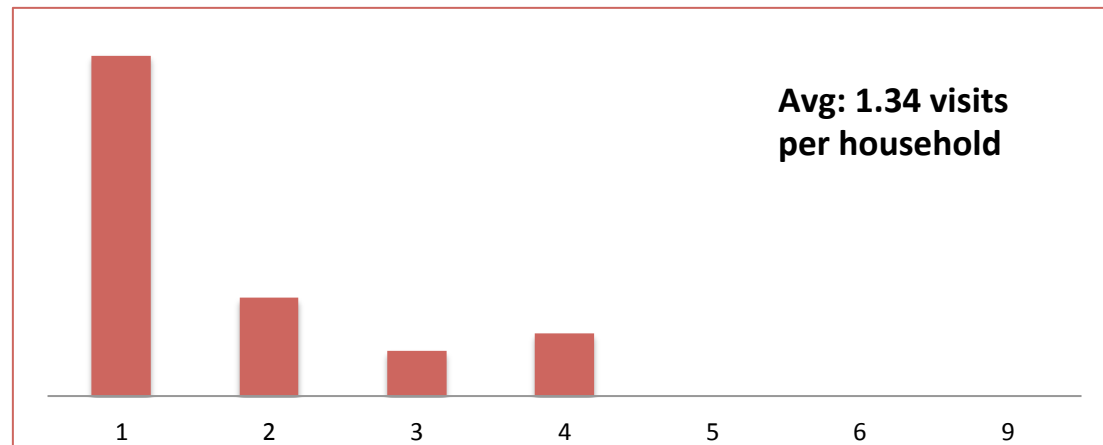
Main reasons for not using care:



Up to 3 OP visits by individual



Up to 9 visits by household

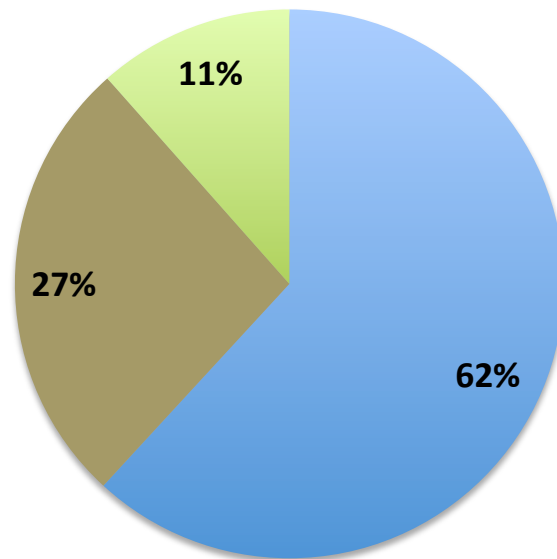


\*All estimates are weighted

# Service and population coverage (cn't)

## Place where outpatient care was received

- Public medical sector
- Private medical sector
- Other



## Acessibility

- Avg time to reach HF: 64 min  
(Female: 40 min vs. Male: 95 min)
- 89% were  $\geq 30$  min per trip

## Quality

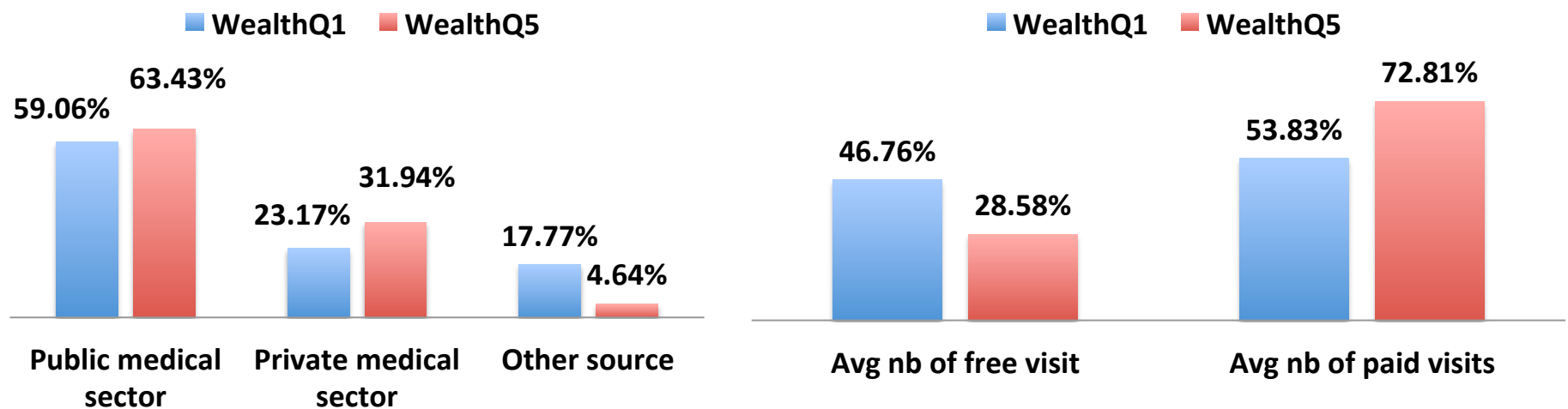
**No dissatisfaction reported: 11.77%**

### Dissatisfaction with care received:

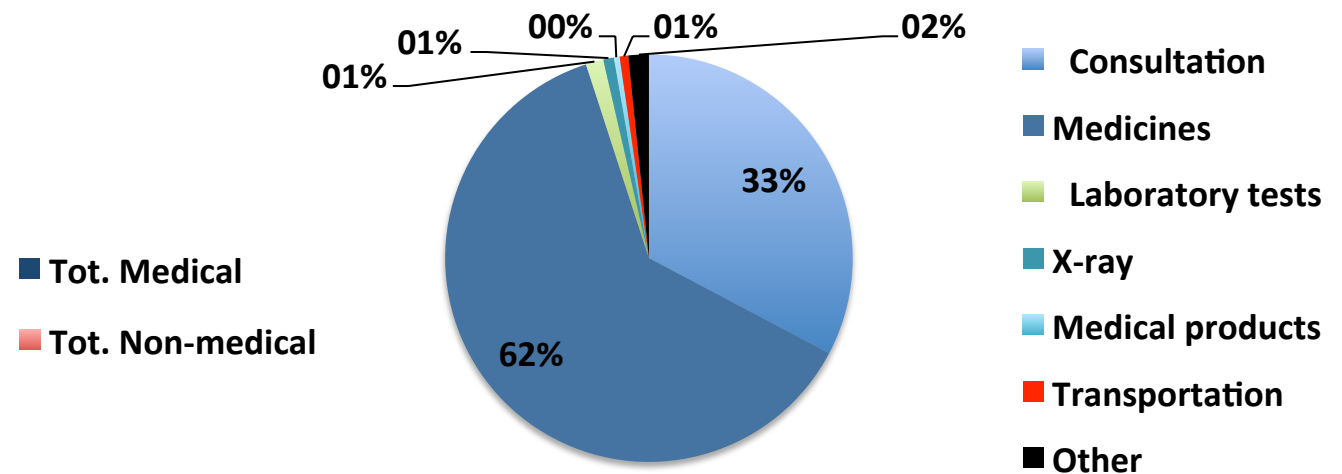
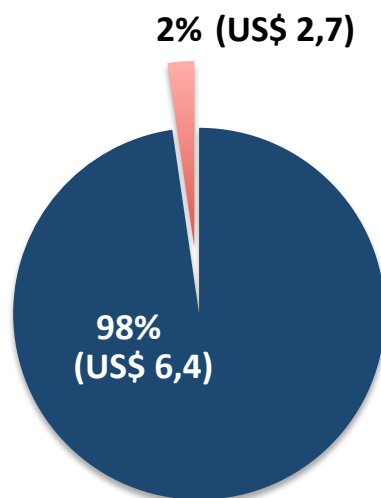
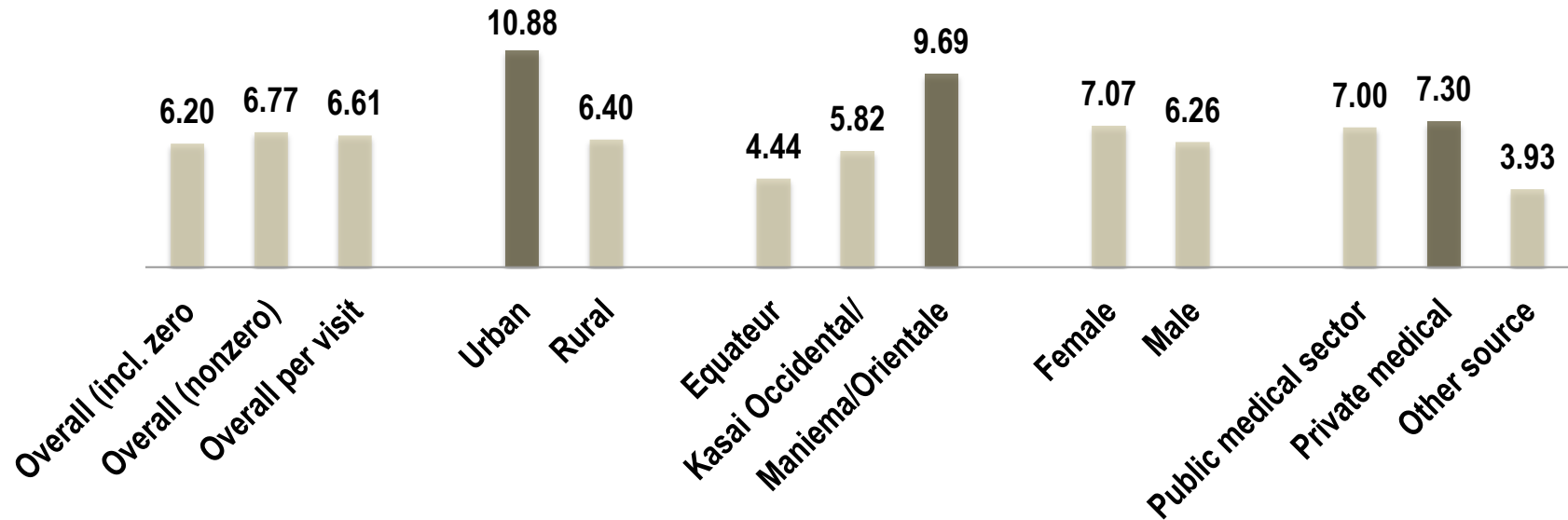
- Health providers' explanation: 37.39%
- Provider skill: 48.17%
- Equipement in HF: 49.85%
- Time until attended to: 68.84%
- Drug supply: 77.49%

# Equity in healthcare utilization

Wealth gap in utilization rates (%):

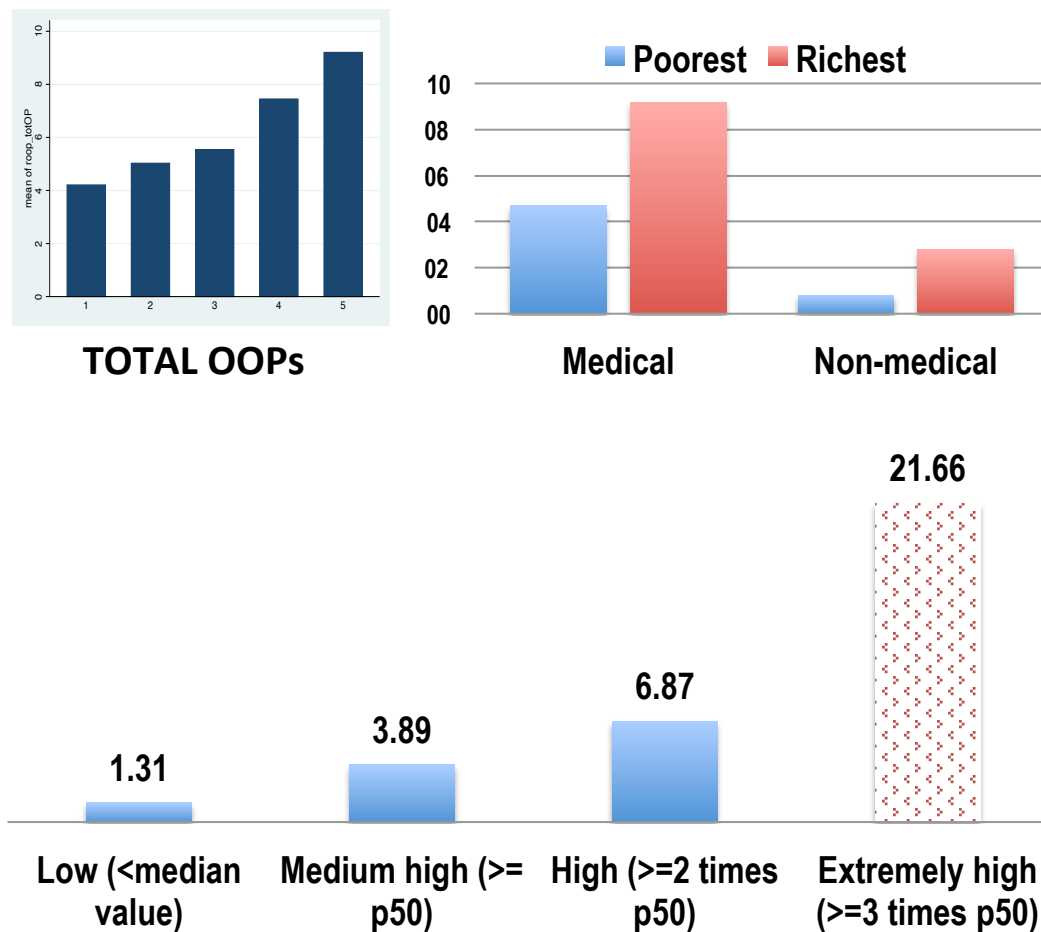


# OOPs (in US\$) and financial burden

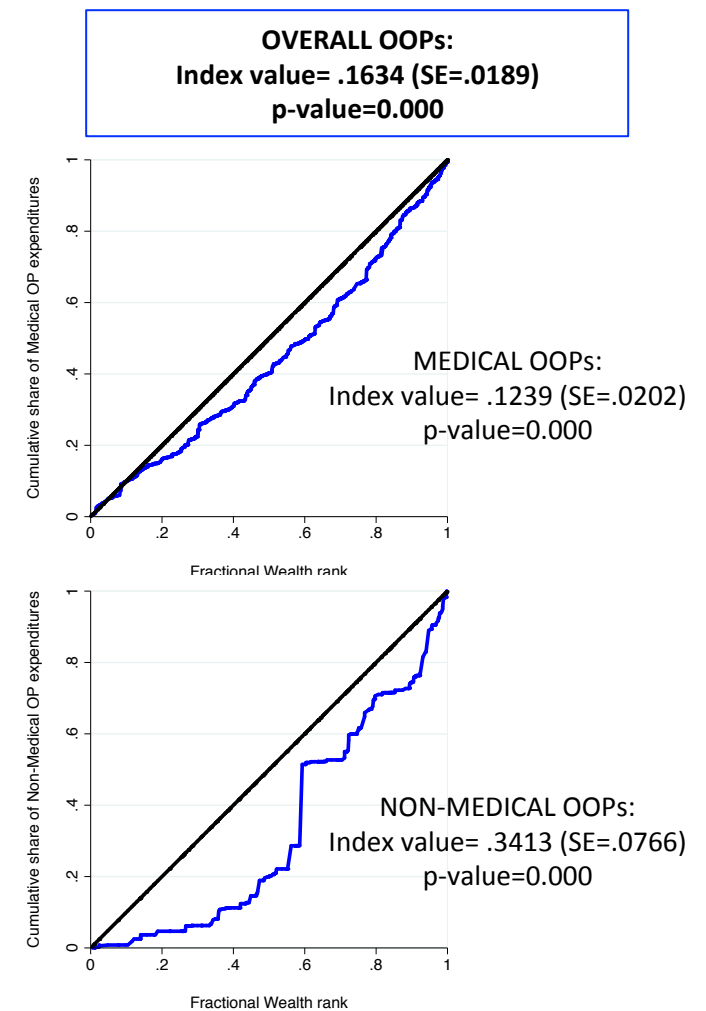


# Equity in OOPs for outpatient care

## Reported OOPs by wealth quintiles (in US\$):



## Pro-rich distributions of OOPs:





# Multivariable logistic regression analysis for « high » levels of expenditures ( $\geq 2$ times the median)

Determinant	Adjusted OR	SE	p-value	
Wealth Q1 - Poorest (vs. Richest)	0,37	0,16	0.023	**
Wealth Q2	0,44	0,16	0.022	**
Wealth Q3	0,46	0,16	0.031	**
Wealth Q4	0,49	0,14	0.012	**
Owens a transportation mean	0,43	0,12	0.002	**
Large household size ( $\geq 6$ members)	1,77	0,50	0.042	**
Days lost: One Month or above	<b>3,97</b>	0,19	0.005	**
Share of oops on drugs	0,21	0,12	0.007	**
Equateur (vs. Maniema/Orientale)	0,23	0,09	0.000	***
Kasai Occidentale + Orientale	0,37	0,14	0.011	**
Under 5 years old	0,58	0,11	0.003	**
HF has functional ultrasound	<b>3,84</b>	1,98	0.010	**
HF has functional centrifuges	0,35	0,16	0.021	**
HF at Operational level 2 (HGR)	<b>50,59</b>	77,19	0.011	**
Dissatisfaction index: Score 4	<b>2,90</b>	1,22	0.013	**

Statistical significance of \*\*\*:  $<.0001$  ; \*\*:  $<.05$  ; \*:  $<.10$

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## DISCUSSION

# Several study limitations

- Household **consumption/expenditures or income data** were not available
  - which prevents calculation of « catastrophic expenditures »
  - Do we need such indicator by type of care/disease or for all?
- Weaknesses related to **sensitive data collection**
  - which acknowledges possible missclassification or mis-reporting (but minor effect)
- Choice of health facility linked to **main care-seeking pattern** (first illness reported)
  - but relatively few resorted to multiple care facilities over the 4 weeks of study period, which constitutes another limit
- Evidence reported here purposely focused on **outpatient care**
  - This was an attempt to attribute effects of catastrophic cost to likely smaller amounts spent on health compared to inpatient spending

# Implications for UHC and health financing reform

Expenditures studies may contribute to inform policy-making in UHC

– Use of baseline data for UHC assessment

Several challenges ahead:

- Wealth and geographic disparities
- Skewed distribution of OOPs across group (“extreme” risk)
- Inability of insurance schemes if any to effectively cover PHC expenses & Levels of co-payments arrangements
- Go beyond subsidized care towards vulnerable groups
- Capacity to pay & Price elasticity to demand
- Price transparency & charging practices across location of care
- Beyond quantity, quality matters

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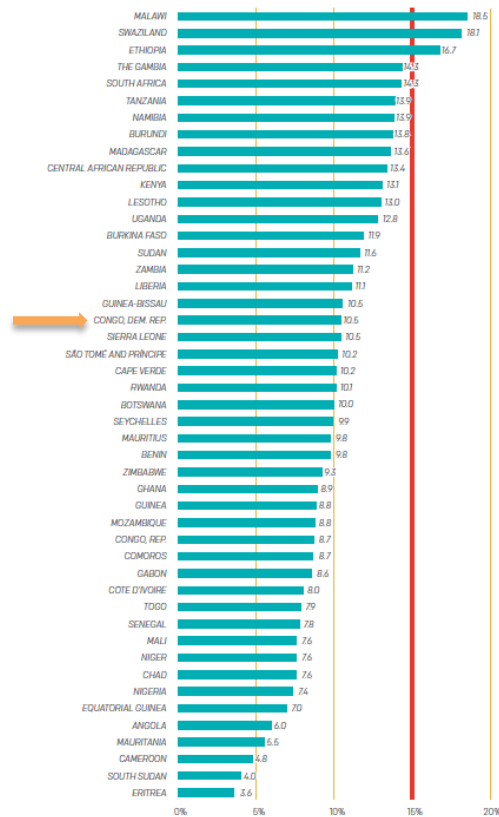
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# Appendix

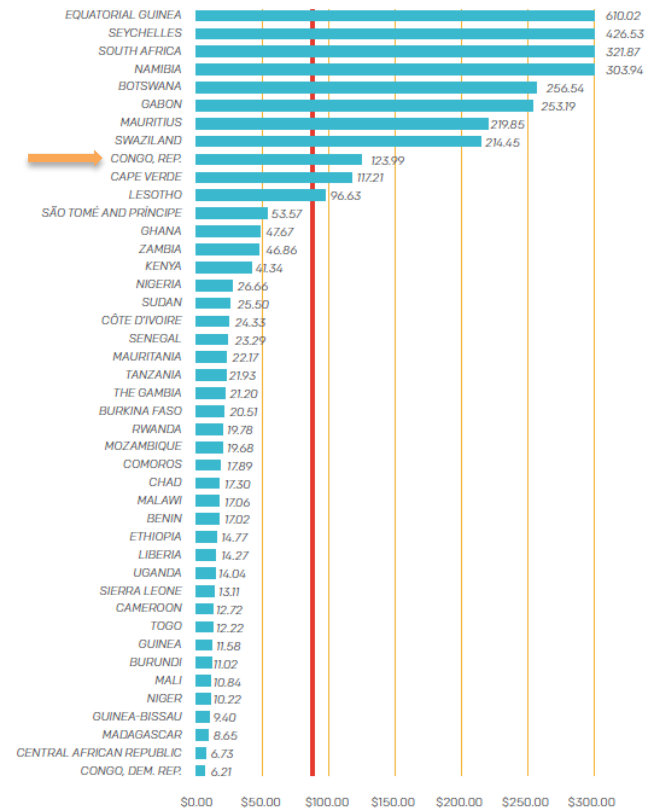
# Public financing for health: Overview

**GGHE as a % of General Government expenditure, 2012-14 Average**



**DRC = 10,5%**

**GGHE per capita in US\$ (2012 prices), 2012-14 Average**



**DRC = USD124**

# Progress in DRC

## UHC (WHO definition)

- « Cube » Coverage
  - Spectrum of good-quality essential health services according to need
  - Entire population throughout the life-course
  - Protection from financial hardship, including possible impoverishment, due to oops for health
- Equitable distribution

## Health-related SDG

- DRC ranked 21 on 31 SubSaharan Africa for avg health outcomes



MPA Curative Activities	MPA Preventive Activities
<ul style="list-style-type: none"> <li>- Growth monitoring for under-fives</li> <li>- Prenatal and postnatal counseling</li> <li>- PMTCT (ARV and Cotrimoxazole)</li> <li>- FP counseling and services</li> <li>- Immunizations</li> <li>- Infection prevention &amp; blood safety</li> <li>- Distribution of IPTp and LLINs</li> <li>- HIV information</li> <li>- Vitamin A &amp; other micronutrients</li> <li>- HIV/AIDS: PMTCT &amp; blood testing</li> </ul>	<ul style="list-style-type: none"> <li>- Clinic-based IMCI</li> <li>- Testing/treating diseases, including NTDs</li> <li>- TB: Sputum collection/forwarding to CDTs</li> <li>- Nutritional rehabilitation</li> <li>- Minor surgery</li> <li>- Normal labor &amp; delivery services</li> <li>- IPTp for pregnant women</li> <li>- STI syndromic treatment and referrals</li> <li>- S/GBV Post-exposure prophylaxis &amp; counseling</li> <li>- Acute respiratory infection treatment</li> <li>- Other basic curative care</li> </ul>
MPA Promotional Activities	MPA Community Activities
<ul style="list-style-type: none"> <li>- Condom use for dual protection</li> <li>- Environmental sanitation</li> <li>- Exclusive breast feeding</li> <li>- Healthy eating &amp; food handling</li> <li>- Iodized salt</li> <li>- Improved latrines</li> <li>- ORT and diarrheal disease control</li> <li>- Fistula awareness and prevention</li> <li>- Vegetable gardens, fish farming, livestock</li> </ul>	<ul style="list-style-type: none"> <li>- Community-based IMCI (c-IMCI)</li> <li>- Food safety and food handling</li> <li>- Potable water improvements, ( e.g., spring capping)</li> <li>- Household sanitation, (e.g., improved latrines)</li> <li>- Community water treatment</li> <li>- Disease/Vector control (e.g., LLINs &amp; tsetse control)</li> <li>- Community based IEC</li> <li>- Distribution of FP commodities</li> <li>- S/GBV Community awareness and prevention</li> </ul>
Complementary Package of Activities (CPA)	Management/Administrative Activities
<ul style="list-style-type: none"> <li>- Internal medicine, surgery, OB/GYN, and pediatrics</li> <li>- Long acting &amp; permanent contraception methods</li> <li>- Post-abortion care (PAC)</li> <li>- Blood screening, storage &amp; collection</li> <li>- Multi-drug resistant (MDR)TB sputum collection</li> <li>- PMTCT-plus with ARV prophylaxis</li> <li>- TB-HIV co-infection screening and treatment</li> <li>- Rehabilitation and Physiotherapy</li> <li>- Lab Tests: parasites, HIV, TB &amp; Bacterial</li> <li>- Biochemical medical Imaging: Radio/Echography</li> </ul>	<ul style="list-style-type: none"> <li>- Increase availability of essential services</li> <li>- Resource Mgmt (human, material, financial)</li> <li>- Continuous health personnel training</li> <li>- Train/Mentor (community) outreach workers</li> <li>- Links/Referrals from private health providers</li> <li>- Management of health information</li> <li>- Management of pharmaceutical information</li> <li>- Managing resources, applied research</li> </ul>