

Equitable access to quality health for the most vulnerable: vision or reality?

An ex-post impact study of five health projects of the Swiss Red Cross

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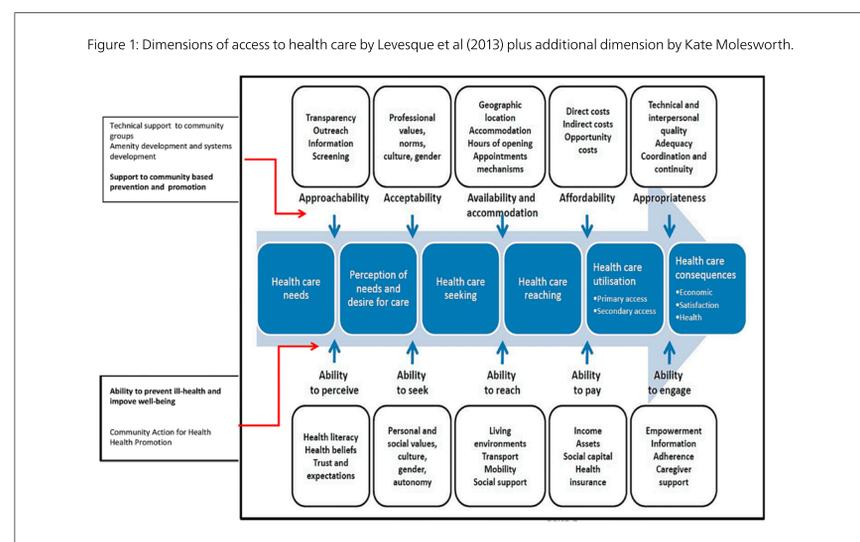


Background

The core aim of the Swiss Red Cross (SRC) health projects is to enable equitable access to quality health services, particularly for the most vulnerable. While regular evaluations confirmed improved access during project implementation, the long-term effects after SRC phase out have never been assessed. Therefore an analytical review (look-back study) of selected health projects was commissioned to understand the long-term impact on equitable access.

Methods

Five country reviews were conducted: in Laos (Health Financing; since 2002 ongoing SRC support), Cambodia (Quality of Primary Health Care from 2004–2011), Bolivia (Health Promotion and Empowerment from 2002–2012), Ghana (Eye Care from 1996–2006) and Nepal (Community Health from 2005–2012) between July and December 2014. A common methodology based on selected OECD/ODAC evaluation criteria and the framework of access to health care developed by Levesque et al. (2013) was used (see figure 1). Semi-structured interviews were held with local authorities, service providers, beneficiaries and SRC local delegations. Information was triangulated with secondary data from previous project reports and evaluations, the local Health Information Management Systems, as well as transect walks and observation.



Results

In all projects service delivery in health centers and hospitals continued to function well. However, mobile outreach services were the first to be discontinued due to lack of funds. After SRC phase out, an initial dip in patient numbers was registered in all projects. However, patient load and service delivery gradually picked up again. Present utilisation even surmount the number of utilisation during SRC project implementation.

Establishing community groups and local «champions» supporting health promotion, health education and working on determinants of health has positively influenced health information, perception and health care seeking. Communities are better informed and a change of traditional beliefs and health practises is observed. Organisational capacity-building and the establishment of sound funding mechanisms and/or continued affiliation and supervision by local entities is crucial to sustained functioning and motivation of community group members. Community groups play an important role in creating demand, in service monitoring and maintaining service accountability to users after project completion. This helps to ensure that health systems provide the most appropriate services with which communities can optimally engage.

«Light» health facility support, continued investment in outreach services, the integration of traditional medicine and practises as well as patient-centred care enhance longer-term sustainability in health system access and use by marginalised and poor community members. Acceptability is fostered where health workers serve their own community and when Government policy supports staff retention with low job rotation. Incentive payments on staff and overall facility performance as well as continuous professional development are highly effective in raising professionalism related to strengthened service quality and reliability.

Financial enabling mechanisms such as free health benefit packages, health equity funds, transport payments and community-managed revolving safe motherhood funds have strong impact on access to care. Influencing policy level and creating sustainable pro-poor business models which can be handled by the local communities help to avert catastrophic health expenditure. In projects where financing mechanism and/or outreach services collapsed, the profile of beneficiaries shifted from the project's rural pro-poor, to one where the majority of users are from the urban middle-class.

Conclusions

Access to services is sustained and health care utilisation even increased after the phase out of SRC support. However, equitable access for the most vulnerable and poor has been compromised over the years particularly in those cases, where investments and health financing was not sustained.

Two over-arching features which impact on the sustained access to health services found in the review are i) the effectiveness of SRC establishing strong partnerships with regional and central government; and ii) the potential of SRC adopting in some cases a stronger business model and sustained ownership of its investments post-completion. These include elements such as transport, direct and indirect costs and outreach service funding, autonomous health facility budget, supervision and motivation of community groups and «champions». The maintenance of these elements are pivotal to sustained access of the rural and remote poor.

Understanding and tackling access barriers not only during project implementation, but anticipating and addressing them prospectively for the future of a project is important. Regular data collection and ongoing operational research is necessary to monitor and compare relative access gains from the start of a project beyond project completion.