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Are policy reforms enough to improve satisfaction with health care? Evidence from Benin

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Introduction

In 2009, the government of Benin embarked on a series of policy initiatives to increase public access to health services, especially for pregnant women, children under age 5, and the poor.

While health coverage rates remained steady, attendance at health services increased sharply, and at first, public satisfaction with the government's performance in improving basic health services increased as well. However, by 2014, public approval of the government's efforts had dropped sharply. What explains this decrease in public satisfaction, despite the policy reforms?

This paper uses Afrobarometer survey findings and other data to examine mechanisms that might contribute to dissatisfaction at the grass roots with how government is handling health services. Its finding that citizens' negative experiences while visiting public clinics or hospitals are the main factor driving down public assessments of government performance in this area should alert policy makers that they must put in place more than policy reforms in order to satisfy public demand for high-quality basic health services.

Afrobarometer survey

Afrobarometer is a pan-African, non-partisan research network that conducts public attitude surveys on democracy, governance, economic conditions, and related issues across more than 30 countries in Africa. Five rounds of surveys were conducted between 1999 and 2013, and Round 6 surveys are currently under way (2014-2015). Afrobarometer conducts face-to-face interviews in the language of the respondent's choice with nationally representative samples of between 1,200 and 2,400 respondents.

The Afrobarometer team in Benin, led by the Institute for Empirical Research in Political Economy (IREEP), interviewed 1,200 adult Beninese in May-June 2014. A sample of this size yields country-level results with a margin of error of +/-3% at a 95% confidence level. Previous surveys with the same samples sizes were conducted in Benin in 2005, 2008, and 2011.

Key findings

- The proportion of citizens who said the government was doing "fairly well" or "very well" in improving basic health services increased from 58% in 2008 to 66% in 2011, then decreased to 54% in 2014.
- Public perceptions of problems encountered during visits to public health care facilities increased from 2005 to 2011. More citizens deplored dirty facilities, absenteeism by doctors, long waiting times, lack of medicines or other supplies, and lack of attention or respect from staff. However, fewer citizens complained about being unable to pay for services.
- Citizens who paid bribes to get medicine or medical attention were less likely to approve of the government's performance in improving health care.
- When the ratio of inhabitants to doctors increased, the proportion of citizens who approved of the government's performance decreased.
- Rural residents and citizens living within walking distance of a public health facility were more likely to approve of the government's performance.
- Respondents' level of education, gender, and political party affiliation had no effect on popular evaluations of the government's performance in health care.

Basic health services in Benin

As in many developing countries, Benin's public health care system has historically been underfunded and ill-equipped to meet the population's health care needs. In 2009, three years into President Boni Yayi's administration, the government initiated policy reforms designed to improve basic health care services

The policy reforms included 1) free or highly subsidized caesarean sections for women, 2) a waiver of user fees for children under age 5 at public health facilities, 3) strengthening of health financing schemes, 4) the creation of an Indigent Fund to provide free health services to the extremely poor, and 5) the revitalization of primary health care (PHC) by increasing the number of community health workers and improving their capacities to promote PHC and treat common diseases at the household and community levels.

To support these reforms, the government provided more subsidies for the health sector. The proportion of the national budget allocated for health increased from around 8% to 10.12% in 2009, the highest ever, before declining again (Table 1).

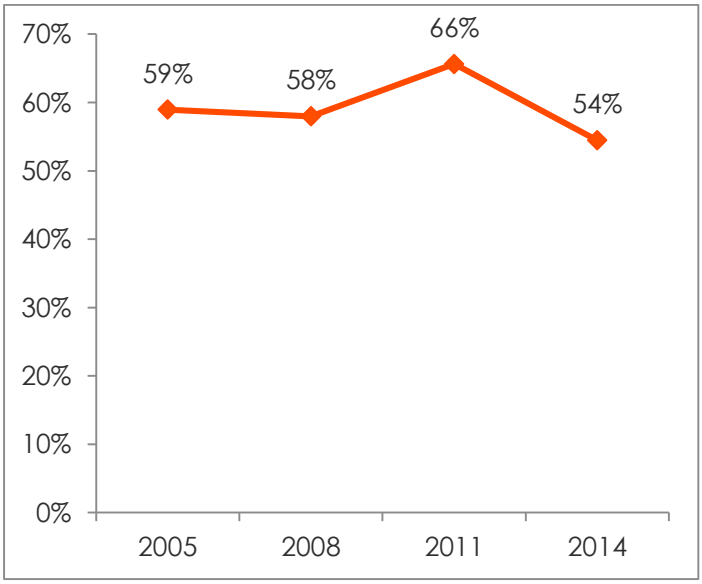
Table 1: Health budget as percentage of national budget | Benin | 2005-2012

2005	2006	2007	2008	2009	2010	2011	2012
8.41%	8%	7.98%	7.23%	10.12%	7.4%	6.29%	6.39%

Source: Ministry of Health

Perhaps in response to these reforms, as well as election-year (2011) communication about the government's achievements and plans, popular perceptions of the government's effectiveness in improving basic health services became more favourable: The proportion of citizens saying that the government was performing "fairly well" or "very well" on health services increased from 59% in 2005 and 58% in 2008 to 66% in 2011 (Figure 1). While health coverage remained around 89% before and after 2009, attendance at health services increased sharply, from 37% in 2005 to 58.5% in 2009 and 63.4% in 2011 (Ministry of Health).

Figure1: Assessment of government performance in improving basic health services | Benin | 2005-2014

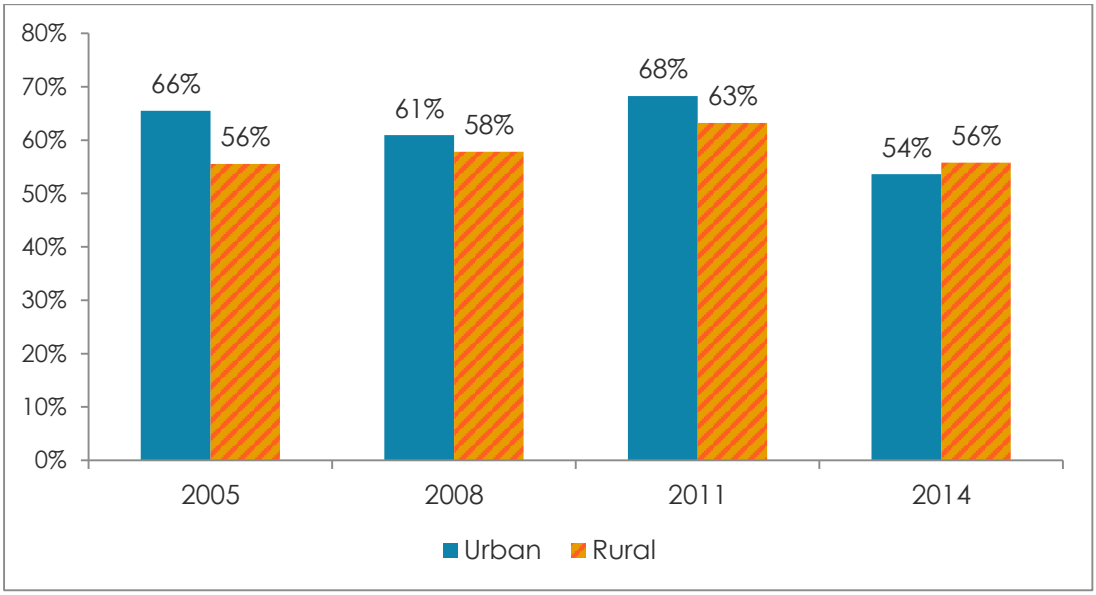


Respondents were asked: How well or badly would you say the current government is handling the following matters, or haven't you heard enough to say: Improving basic health services? (% who said "fairly well" or "very well")

However, public approval of the government's efforts, as expressed by Afrobarometer survey respondents, dropped back to 54% in 2014, perhaps reflecting dissatisfaction with what was actually rolled out in terms of new government policies after Yayi's re-election in 2011. As government spending on health decreased below 2005 levels, health care professionals (like other civil servants) expressed their dissatisfaction through a number of strikes during the period.

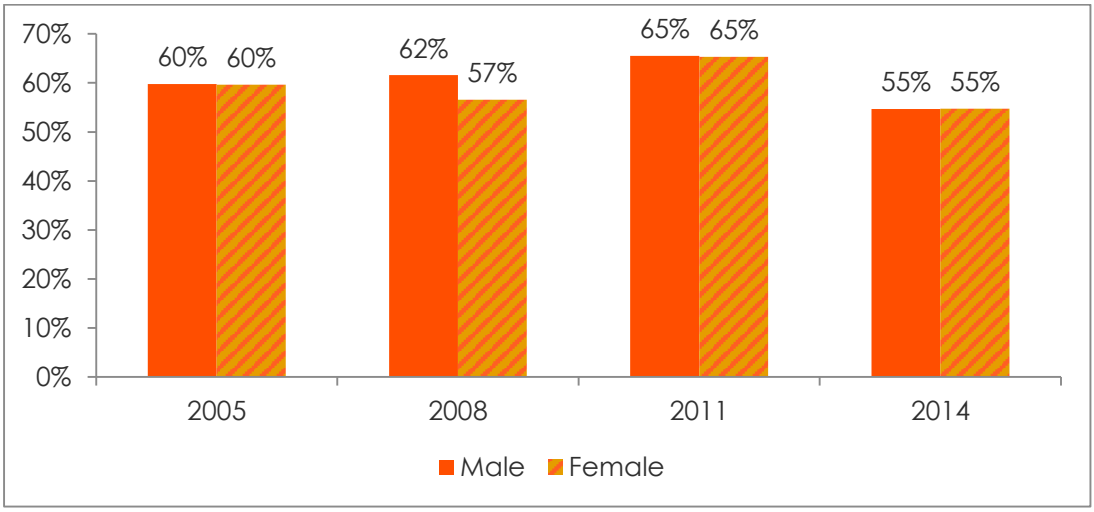
Urban residents were significantly more likely than rural dwellers to approve of the government's efforts to improve basic health services in 2005, but that difference disappeared in later survey rounds (Figure 2). Men and women were about equally likely to approve of the government's effectiveness in the sector (Figure 3)

Figure 2: Assessment of government performance in improving basic health services | Benin | by residence location | 2005-2014



(% who said "fairly well" or "very well")

Figure 3: Assessment of government performance in improving basic health services | Benin | by gender | 2005-2014



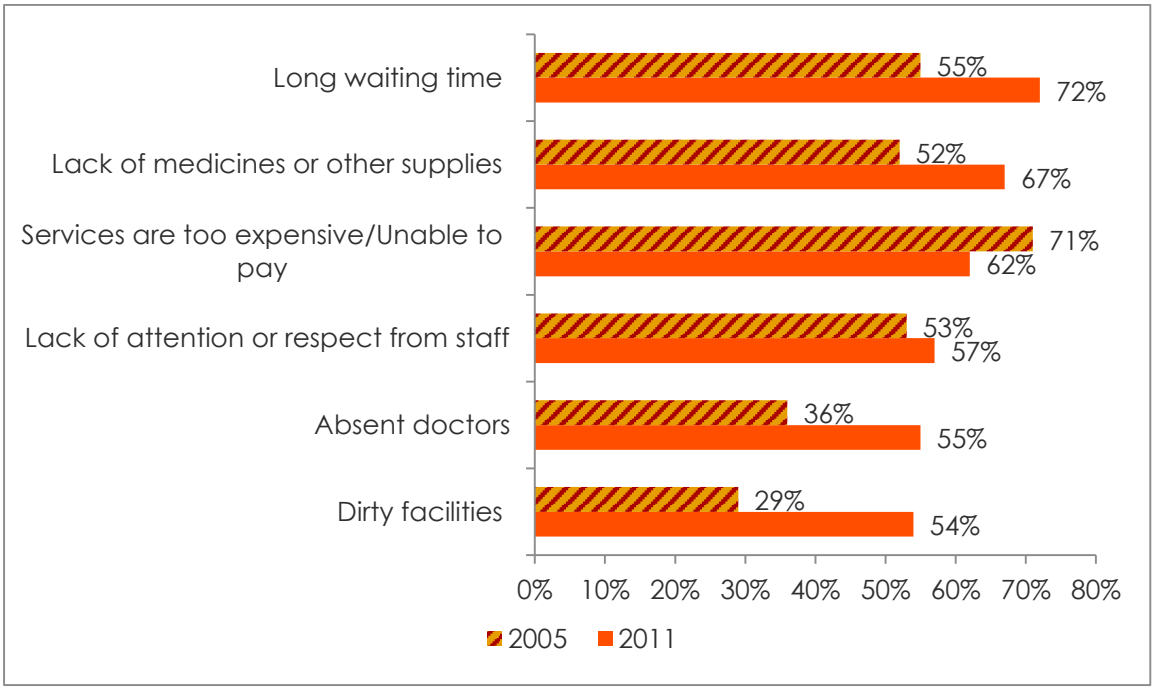
(% who said "fairly well" or "very well")

Experiences in public health care facilities

Many scholars have pointed out that public-sector provision of health care is a critical issue in the global South, and one marked by significant challenges. Studies indicate that absenteeism among public-sector health workers is a major problem (Chaudhury, Hammer, Kremer, Muralidharan, & Halsey Rogers, 2006). Absenteeism can reduce the supply of health services and weaken government effectiveness in the sector. Even when medical personnel is present, poor-quality care can be a major problem (Das & Hammer, 2004, 2007; Das & Gertler, 2007; Das, Hammer, & Leonard, 2008).

In Afrobarometer surveys in 2005 and 2011, respondents were asked about problems they encountered at public health facilities. The proportion of respondents reporting problems grew dramatically, especially the proportion complaining of dirty facilities (a 25-percentage–point increase between 2005 and 2011), absence of doctors (19–point increase), long waiting times (17 points), and lack of medicines or other supplies (15 points) (Figure 4). The only problem encountered less frequently was the high cost of services, reflecting the free services put in place in 2009. Interestingly, this increase in negative experiences at public health facilities occurred alongside an increase in public approval for the government's performance in the sector – perhaps due to public anticipation of policy reforms announced by the government.

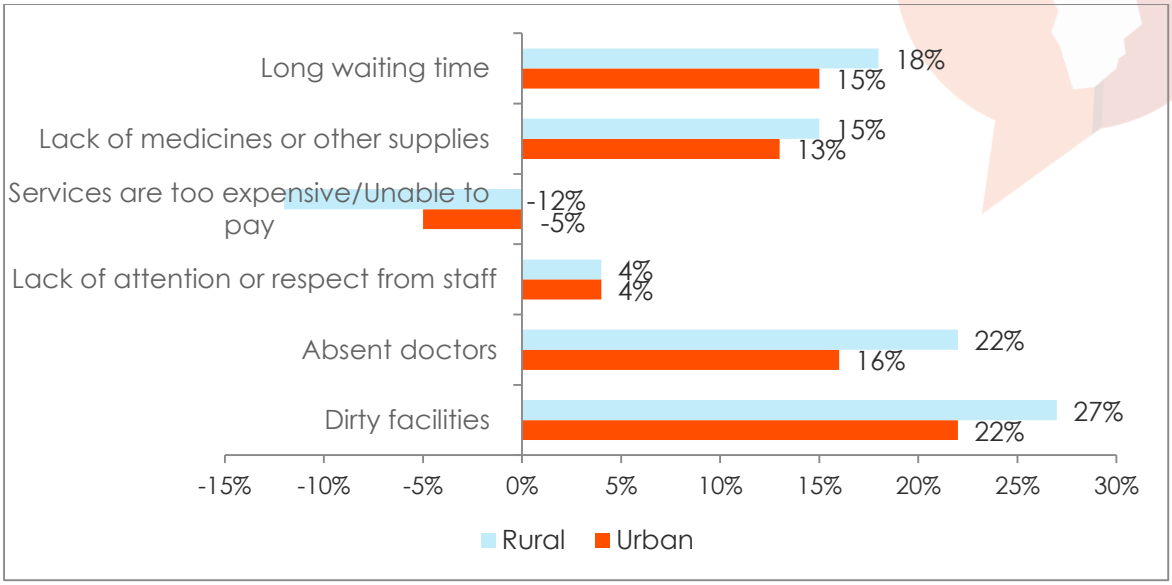
Figure 4: Problems experienced in public clinics | Benin | 2005 and 2011



Respondents were asked: *Have you encountered any of these problems with your local public clinic or hospital during the past 12 months? (% who said "once or twice" or "a few times" or "often")*

The pattern of increasing problems was consistent in both urban and rural areas, but in rural areas, complaints about dirty facilities and absent doctors increased more steeply than in urban areas, while complaints about the cost of services decreased more sharply (Figure 5).

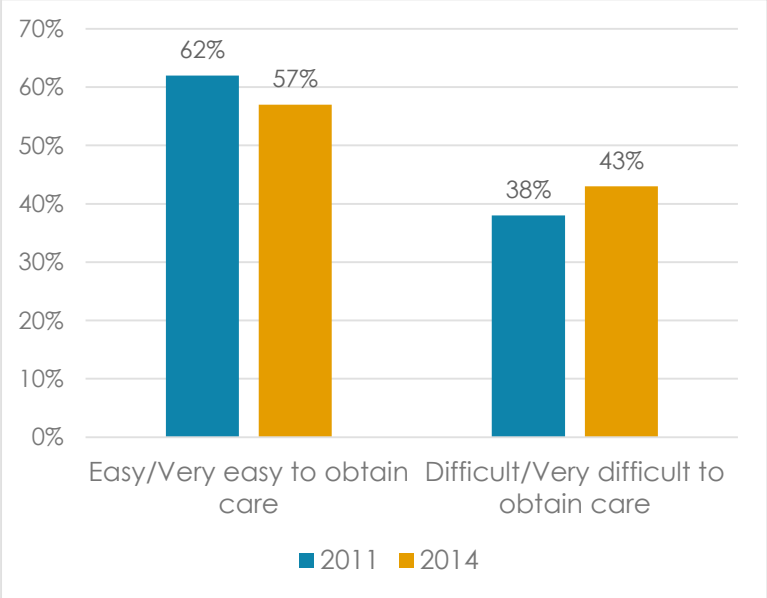
Figure 5: Problems experienced in public clinics | change from 2005 to 2011 | by urban vs. rural residence



(% who said "once or twice" or "a few times" or "often"]

While the over-time comparison is limited to 2005-2011 because the question about problems encountered was not asked in the same way in the 2014 survey, responses to a question about the ease or difficulty of obtaining health care services suggest that the perception of problems may have continued to increase during the 2011-2014 period: The proportion of citizens who said it was "difficult" or "very difficult" to obtain medical services at a public clinic or hospital increased from 38% in 2011 to 43% in 2014 (Figure 6).

Figure 6: Ease/difficulty of obtaining health care services | Benin | 2011-2014



Respondents were asked:
In 2011: *Based on your experience, how easy or difficult is it to obtain the following services from government: Medical treatment at a public clinic or hospital? Or do you never try and get these services from government?*
In 2014: *In the past 12 months, have you had contact with a public clinic or hospital? If yes: How easy or difficult was it to obtain the medical care you needed?*

But even among those who experienced problems during visits to public clinics or hospitals, assessments of the government's performance improved between 2005 and 2011 – perhaps due to perceptions or expectations of the policy reforms (Table 2).

Table 2: Assessment of government performance by respondents who experienced problems | Benin | 2005-2011

Problems experienced at least "once or twice"	% who said gov't was performing "fairly well" or "very well"	
	2005	2011
Dirty facilities	44%	53%
Absence of doctors	44%	55%
Lack of attention or respect from staff	49%	55%
Services are too expensive	52%	55%
Lack of medicines	48%	55%
Long waiting time	53%	60%
Paid bribe to obtain medicine or care	47%	50%

Health care personnel

Benin's health system includes both public hospitals/clinics and private health centres that are recognized by the government. More citizens use public facilities than private facilities.

According to Ministry of Health (MoH) records, the number of doctors, midwives, and nurses in Benin's public health system exceeds World Health Organization (WHO) standards.

Between 2005 and 2010, the number of doctors varied between 1.2 and 1.4 per 10,000 residents (WHO standard: 1 per 10,000). The number of nurses varied between 2 and 2.2 per 5,000 residents (WHO: 1 per 5,000), and the number of midwives was between 1.1 and 1.6 per 5,000 residents (WHO: 1 per 5,000). This would suggest strong government performance in support of health care services.

National University Hospital Centre in Cotonou (Source: The author)

While the number of functional hospitals in the country varied little, an increase

of even one hospital at the regional level can have a significant impact on the availability of services. The ratio of inhabitants to doctors, nurses, and midwives worsened slightly between 2005 and 2011, but then improved significantly in 2012 (Table 3).

Table 3: Selected health care indicators | Benin | 2005-2012

	2005	2006	2007	2008	2009	2010	2011	2012
Health coverage rate (%)	90	90	N/A	89	89	88	N/A	N/A
Attendance rate of public health services (%)	37	53	52	53.8	56.8	58.8	61.4	63.4
Number of functional hospitals	26	26	26	28	28	27	27	27
Number of inhabitants per doctor	7,377	7,006	7,472	7,511	7,979	7,979	8,411	5,849
Number of inhabitants per nurse	2,446	1,920	2,045	2,245	2,469	2,469	2,447	1,823
Number of inhabitants per midwife	1,451	1,725	1,510	1,345	1,563	1,563	1,712	1,524

Source: Ministry of Health

Plausible factors in decreased satisfaction

To understand which factors may be important in explaining levels of public satisfaction with the government's efforts to improve basic health services, a linear regression was used to examine changes over time. The main hypothesis was that negative experiences in public health facilities drive down public approval of government performance in the sector.

The outcome of interest (dependent variable) is citizens' assessment of government performance in improving basic health services. Possible factors that are examined include problems encountered in public health facilities in 2005 and 2011, the number of functional hospitals in the region, and the number of inhabitants per doctor, nurse, and midwife. Control variables include whether the respondent paid a bribe to obtain care, the respondent's residence location (urban vs. rural), the existence of a health facility within walking distance of the respondent's residence, and the respondent's sex, education level, and political party affiliation.

Estimations produced by the regression are shown in Table 4. Two models for each year (2005 and 2011) allow for comparisons. The first model takes into account the main interest variables and health indicators. The second model adds control variables.

Table 4: Public assessment of government efforts to improve health care – linear regression

	Model 1		Model 2	
	2005	**2011**	**2005**	**2011**
Problems encountered in public clinics	-0.29*** (0.03)	-0.28*** (0.04)	-0.35*** (0.06)	-0.38*** (0.07)
Functional hospitals in the region	0.104** (0.03)	-0.04 (0.03)	-0.02 (0.06)	-0.08 (0.06)
Number of inhabitants per doctor	-0.68*** (0.11)	-0.11 (0.06)	-0.66** (0.19)	-0.07 (0.15)
Number of inhabitants per nurse	0.23* (0.13)	0.1 (0.08)	0.03 (0.23)	0.29* (0.13)
Number of inhabitants per midwife	0.98*** (0.13)	0.21* (0.1)	1.08*** (0.25)	0.24 (0.21)
Paid bribe to get medicine or medical attention	~	~	-0.02 (0.05)	-0.2* (0.08)
Residence location (urban)	~	~	0.009 (0.1)	-0.08* (0.09)
Clinic within walking distance	~	~	0.21* (0.1)	0.2* (0.1)
Education	~	~	-0.05 (0.05)	0.07 (0.05)
Political party support (ruling party)	~	~	0.0002 (0.003)	-0.00015 (0.0005)
Gender (male)	~	~	0.05 (0.09)	0.003 (0.09)
Constant	-0.2 (0.68)	1.82** (0.7)	0.69 (1.24)	-0.16 (1.27)
Prob > F	0.0000	0.0000	0.0000	0.0000
R^2	0.202	0.054	0.211	0.15
Number of observations	1035	1095	334	363

*Results shown are standardized beta coefficients (with standard deviations in parentheses); *p <0.1, **p < 0.05, ***p < 0.01.*

As shown in the table, the strongest factor in explaining levels of public satisfaction is the experience of problems during visits to public health facilities. In both 2005 and 2011, citizens who encountered dirty facilities, absent health care staff, lack of attention from the staff, lack of medicines, and long waits were less likely to say that

the government was doing "fairly well" or "very well" in improving basic health services. The policy reforms that occurred in 2009 were clearly not enough to improve citizens' assessment of public health care.

In addition, the findings suggest that citizens who pay bribes to obtain medicine or medical attention are less likely to say the government is performing "fairly well" or "very well" in improving basic health services. This relationship is more significant in 2011 than in 2005. This could be an inadvertent consequence of the policy reforms if the reforms led to a scarcity in medicines or encouraged practitioners to demand payment for services that were supposed to be free (Banerjee, Deaton, & Duflo, 2004; Institutional Reform and Capacity Building Project, 2010). Furthermore, the proportion of the national budget allocated for health was shrinking, which might have encouraged practitioners to ask for bribes.

Experiences at public clinics are not the only drivers of popular assessments of government effectiveness. An increased number of functional hospitals in certain departments (regions) in Benin contributes to public approval of government efforts in the 2005 survey, but not in 2011 – perhaps because the policy reforms were not accompanied by upgrading of public facilities.

Higher ratios of inhabitants to doctors are weakly associated with less public approval of government performance in improving basic health services. (The opposite is true for nurses and midwives, a curious finding that requires further investigation.) Besides the number of doctors, their qualifications could also be a relevant issue, as scholars who have evaluated the competence and knowledge of physicians in developing countries have found that their knowledge is weak and there is a gap between what they know they should do and what they do (Das & Hammer, 2004, 2007; Das, Hammer, & Leonard, 2008)).

The findings suggest that respondents' education level, gender, and political party affiliation have no effect on citizens' evaluation of government performance. Urban residents are less likely to approve of the government's efforts than rural citizens, which may be a reflection of the policies' greater impact on the rural poor. Residents living within walking distance of a clinic are more likely to approve of the government's efforts in the health sector.

Conclusion

This analysis suggests that new policies in the health sector are not enough to improve public satisfaction with basic health services if citizens encounter dirty facilities, absent care providers, long waiting times, and lack of medicines when they visit public clinics.

While we did not measure respondents' actual experiences in 2014, we know (based on the 2011 data) that problems experienced at public clinics and hospitals were the most important explanation of dissatisfaction with government performance in health. We also know that overall rates of attendance, and therefore exposure to these problems, increased from 2011 to 2014. Thus, we infer that even though government is doing increasingly well in expanding access to health care, the ironic fact is that – if service quality is not improved – this simply increases the number of people who experience problems at those facilities, thus bringing down levels of public satisfaction with government performance.

To further explore this data, please visit Afrobarometer's online data analysis facility at www.afrobarometer.org/online-data-analysis.

In addition to improving the quality of health care services, actions should be taken to reduce corruption in public clinics; having to pay a bribe undermines public appreciation of the government's efforts to improve health care.

Physician training might also be a need, along with a review of the uneven distribution of doctors; some regions may not have enough practitioners to achieve improvements in basic health services.

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