

**HNP and the Poor:
An Integrated Policy
Framework for Improving the
Outcomes for the Poor**

Session 6

Authors:

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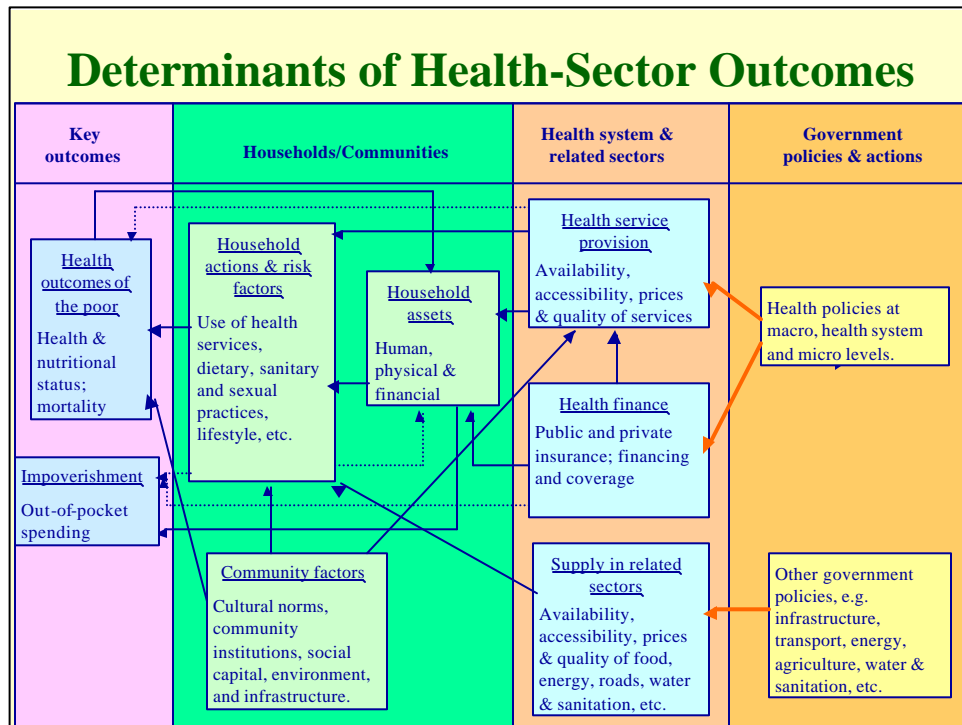
Adam Wagstaff

This is the last of a series of six sessions focusing on the linkages between health, nutrition, population and poverty.

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The previous sessions made use of the above conceptual framework, showing the linkages between the two key outcomes (the health of the poor and impoverishment), household actions and risk factors, and the household, community and health system influences on them. Health sector policies can influence health service provision, but also health financing. Other government policies influence other key sectors. Furthermore—not shown in the chart—government policies can influence household-level influences, and also community-level influences. For example, governments influence the level and distribution of household income and education. They can also influence environment and infrastructure, as well as (and less obviously) social norms and social capital.

It is the role of public policy in shaping health sector outcomes that is the subject of this session.

Objectives of This Session

To answer the following questions:

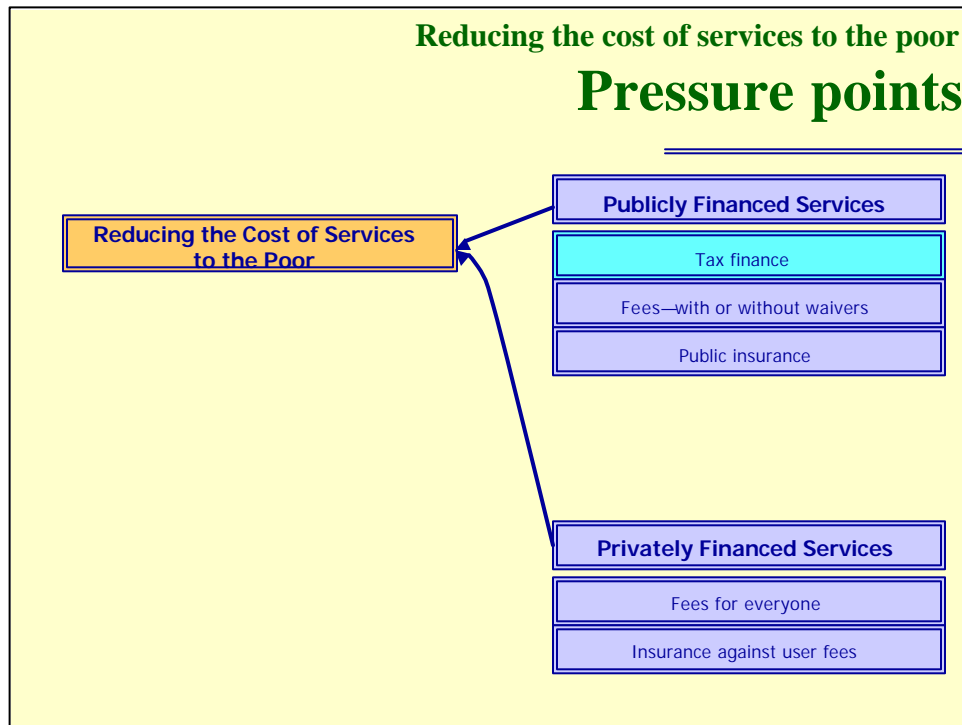
- **What are the policy tools available to developing countries?**
 - (Financing, Provision, Stewardship, Advocacy outside the system, Monitoring and Evaluation)
- **How to develop an integrated policy framework?**
 - Macro Level (including resource allocation)
 - System level (including inputs, reform, piloting, M&E, etc.)
 - Intervention level (planning and implementation)
 - Cross-sectoral Level (intersectoral work/ advocacy)

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Session Outline

- 1. Government policies and actions**
 - **Reducing the cost of services to the poor**
 - **Getting services delivered to the poor**
- 2. Pulling it together and moving ahead**
 - **Benin case example**

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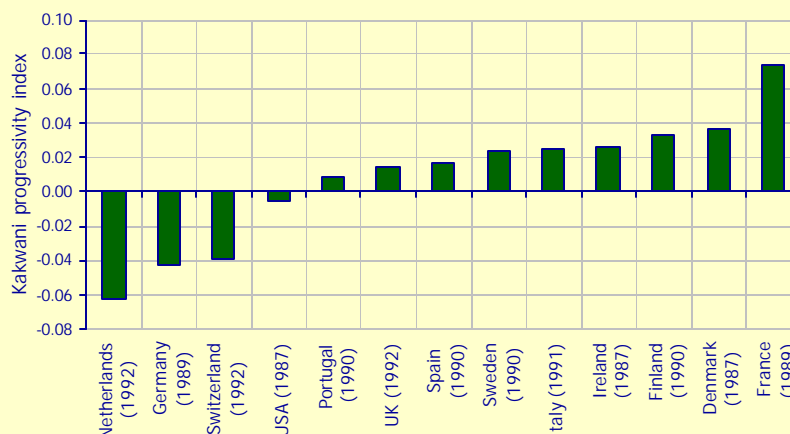
The financial cost of using health services affects whether people use them, and if so how much. As well as affecting the *quantity* of health service use, the price also affects the *expenditure* people incur on health services if they use them. Reducing the cost of health care to the poor thus matters *both* from the point of view of improving their health, *and* from the point of view of reducing the impoverishing effects of ill health. In this section, we explore ways this can be done.

People in all countries—but especially developing countries—make out-of-pocket payments for both public and private health services. Many countries limit the reliance on user fees in the public sector by using general tax revenues to finance at least part of government health spending. We look first at the pros and cons of doing this—from the perspective of the poor. However, even those countries that are heavily reliant on tax revenues make some charges for the use of public sector health services. There are, in fact, some positive arguments for having some user fees. We therefore explore next the issue of how to maximize the benefits of user fees and how best to protect the poor. Finally, in our analysis of financing government spending and reducing the cost of services for the poor, we look at the question of public insurance.

The session then turns to the question of what governments can do to reduce the cost of *private* health services to the poor—or at least, if not reduce the cost, try to help ensure that what is spent on private health services represents value for money.

Tax financing

Is tax-financing is more progressive?

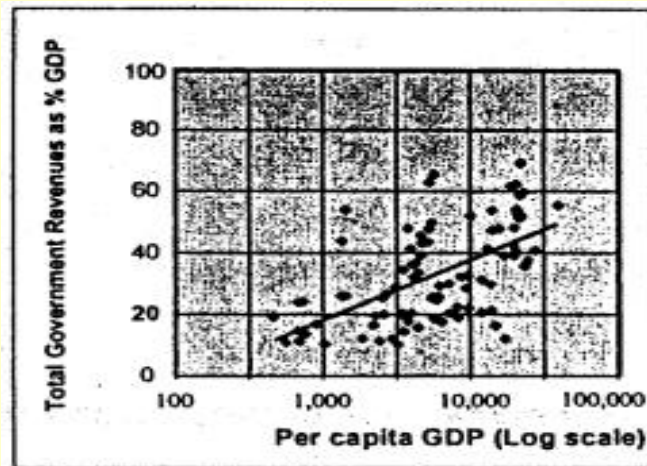


Source: Wagstaff, A, E Van Doorslaer, E, et al. Equity in the finance of health care: Some further international comparisons. *Journal of Health Economics* (18)3: 263-290, 1999.

An advantage claimed for tax-financing is that the taxes used to finance health care are progressive—they absorb a larger share of a rich household’s income than of a poor household’s. This is true in the OECD countries. The chart shows the progressivity of sources of health care finance *other than out-of-pocket payments* in 13 OECD countries. In the Nordic countries, Ireland and the UK, these are almost entirely taxes—general revenues in the case of Ireland and the UK, and local income taxes in the case of the Nordic countries. A positive value of Kakwani’s index indicates a progressive structure. A negative value, a regressive structure. It is striking that in all these countries—whether or not the tax revenues used are general revenues or local income taxes—taxes emerge as a progressive source of financing health care. This is not true of two of the three countries relying heavily on social insurance (Germany and the Netherlands—France is the exception here). And it is not true of Switzerland and the US, both of whom rely heavily on private insurance (this is actually more true of Switzerland than the US which actually makes extensive use of general revenues and payroll taxes for Medicare and Medicaid).

No comparable data are available for the developing countries. Data *are* available for the incidence of taxes in some of the Latin American countries (IADB *Facing up to Inequality in Latin America*), and for some developing countries in other regions (see e.g. S Devarajan and SI Hossain “The combined incidence of taxes and public expenditures in the Philippines”, *World Development* 26(6) 963-977, 1998). In some Latin American countries (e.g. the Dominican Republic and Guatemala), taxes emerge as progressive, while in others (e.g. Chile) they emerge as regressive. Much depends on whether “essential” goods and services are zero-rated or exempt for VAT purposes, though there are also differences in the progressivity of income tax. In the Philippines, the overall tax system emerges as either proportional or slightly progressive, depending on whether expenditure or income is used as the reference. Income tax emerges as progressive, whilst indirect taxes emerge as slightly progressive on expenditure but regressive on income.

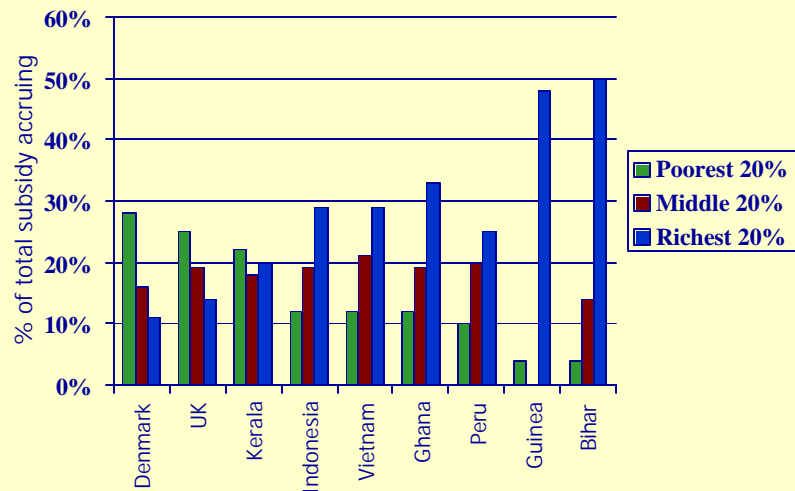
Poor countries have low tax-raising capacity



An additional consideration is that poorer countries seem to have a low capacity to raise taxes—in poorer countries, government revenues as a percentage of GDP tend to be smaller. This reflects the small size of the formal sector, the lack of capacity to collect taxes, and so on. But it may also reflect the lesser social cohesiveness in poorer countries. IADB's report *Facing up to Inequality in Latin America* finds that small government is associated with a high degree of ethno-linguistic fragmentation in a country. The report suggests that this variable captures “the willingness of society to show solidarity with group demands as expressed in public spending”. The report also notes that countries that have tried to raise the progressivity of taxes—by zero-rating for VAT purposes “essential” goods and services, and increasing the steepness of the income tax schedule—have paid a price in terms of lower government revenues.

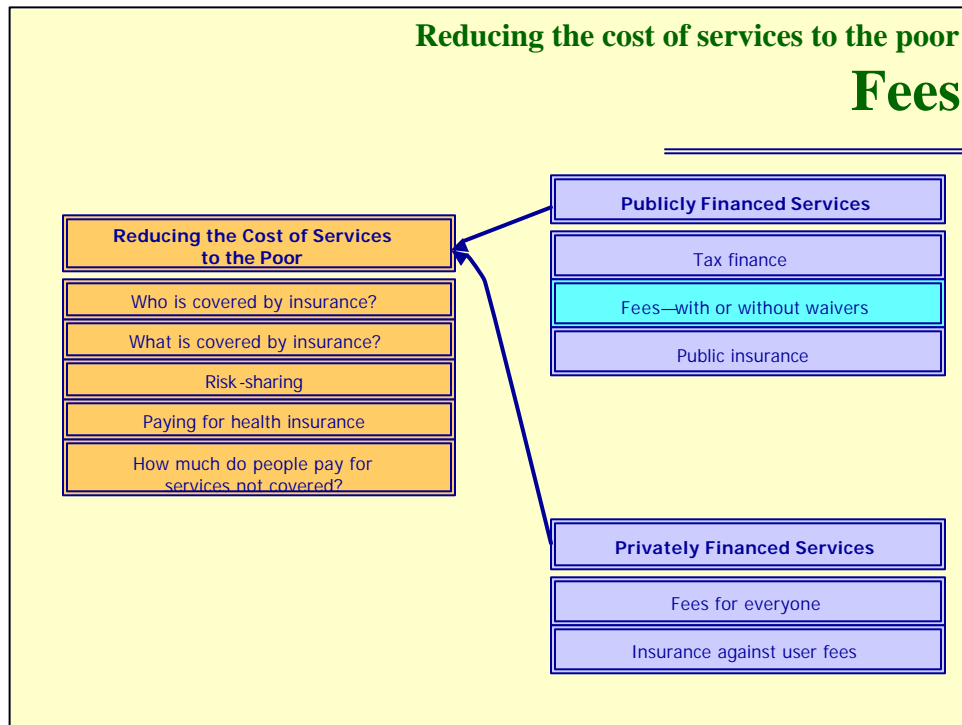
Tax financing

Tax finance doesn't guarantee the poor do well



Source: Van Doorslaer, Wagstaff and Rutten (1993); Hammer et al. (1999); Ajay et al (2000).

There is a further difference with the OECD countries. Countries like Denmark and the UK, both of whom almost exclusively on tax revenues to finance public health care, succeed well in ensuring that publicly funded health care reaches those who need it most—the poor. Indeed, there has been some debate in these countries whether the distribution of subsidized health care is sufficiently pro-poor given the greater medical needs of the poor. The situation with respect to the distribution of health sector subsidies in the developing countries is quite different. In many of these countries, taxes finance only a part of total spending, but it is possible through benefit-incidence analysis (BIA) to see who benefits from the tax subsidy to the health sector. The answer is shocking—the better-off are the principal beneficiaries, sometimes spectacularly so. It seems improbable—to say the least—that this could be rationalized in terms of the better-off having greater medical needs in these countries. Somehow, countries like Denmark and the UK appear to have found ways of ensuring that tax-financed health services do reach those they are intended to reach. The Indian state of Kerala also seems to be well on the way to developing mechanisms too. But the preponderance of pro-rich subsidy distributions in other areas of India and elsewhere the developing world makes it clear that subsidizing health services out of general revenues doesn't guarantee at all that the subsidy will actually benefit the people who need it most—the poor. As with the size of government, a key variable may be ethno-linguistic fragmentation, capturing citizens' willingness to display solidarity with fellow-citizens—affluent voters in Denmark and the UK may be more willing to accept that public spending on health care goes to those who need it most, while affluent voters in less cohesive developing countries may try to ensure that they get their money's worth from public spending on health by lobbying for a high-tech hospital in the capital city.



In most countries the policy of governments to be quasi exclusively providing and financing services has shown its limitations and often left an important gap between the demand and supply of services. Policy of free services failed in a large number of countries to serve population needs and demands and particularly to serve the needs of the poor. Rationing shortages and informal payments requested from users have been frequently reported.

As a consequence, and often to respond to quasi collapse of the health care systems, countries have increasingly introduced alternative sources of financing in the form of user fees or other forms of cost sharing.

The quandary...

- **Increase of user fees—including drug price—leads to decreased utilization, and affects health outcomes negatively**
- **Marginal funding from user fees can improve access, drug supply and quality and lead to raises in utilization, affecting health outcomes positively**

The case has been made powerfully in the early 90s that introduction of these alternative financing schemes would lead to increase in access, and improvements in the quality of basic social services. User fees were also seen as enhancing the efficiency and sustainability of services.

However, the adverse impact of user financing on access to services-especially of the poor- has been increasingly emphasized.

It is now increasingly recognized that user financing can be a useful instrument only if it contributes to improving the quality and accountability of health services without jeopardizing equitable access for the poor.

Fees will never raise much revenue

Magnitude of revenues raised through cost recovery in health in Africa

Pays	Year	% of MOH recurrent budget covered by user fees
Benin	1993	20%
Bostwana	1983	2.%
Burkina Faso	1999	14.8%
Burundi	1982	4%
Cote D'Ivoire	1993	7.2%
Ethiopia	1985	15-20%
Ghana	1991	5-6%
Guinee Conakry	1993	20%
Guinea Bissau	1995	5%
Kenya	1984	2%
Lesotho	1992	9%
Malawi	1983	3.3%
Mali	1986	2.7%
Mauritania	1999	9%
Mozambique	1985	8%
Rwanda	1984	7%
Senegal	1990	4%
Swaziland	1984	2.1%
Zimbabwe	1992	3.5%

Source: Vogel (1991), Nolan and Turbat (1995), Shaw and Griffin (1995), Soucat and Diop (2001)

Experience shows that user fees account at best for a modest fraction of the total recurrent budget of the MOH of most countries. Reviews conducted by Vogel (1991), Nolan and Turbat (1995) and Shaw and Griffin (1995) and Soucat and Diop (2001) show this proportion to vary from less than 1% to a maximum of 20% in Africa. A recent study conducted in Thailand showed this proportion to be around 20% for community, provincial and regional hospitals.

However these amounts usually cover a much larger proportion of non salary recurrent expenditures at local level. In a study of 8 West and Central African countries, the proportion of non salary recurrent cost of PHC centers was shown to be between 50% and 200%.

Keep user fees low ...

- **Early studies showed demand for health care to be price inelastic**
- **However, more recent studies showed demand to be price elastic in several countries of Africa and Latin America**
- **Demand was shown to be highly elastic to price among the rural population, the poorest groups, and for care to young children**
- **However, most of these studies did not provide information on the pattern of use and the quality improvements associated with the introduction of user fees**

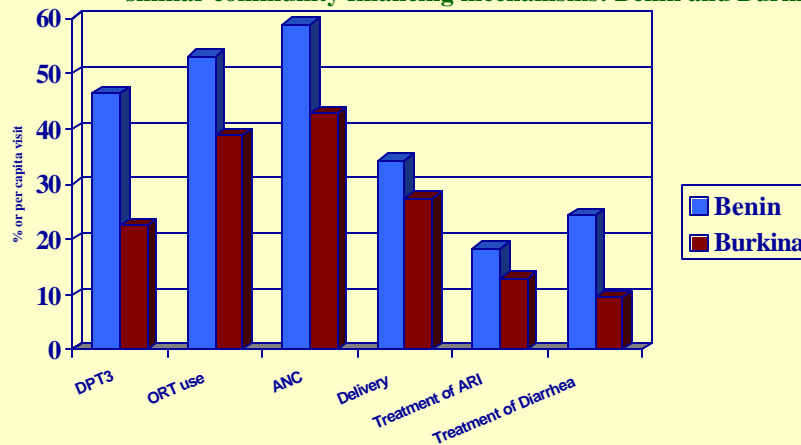
Early studies conducted in the 80s usually concluded that the price elasticity of demand for health services was relatively low. (Heller 1982), Akin (1985). This pointed toward a high willingness and ability to pay for health services.

However at the end of the 80s, other studies have shown that the demand for health care was highly price elastic, with decrease in utilization following the introduction or the raising of fees. In countries such as Peru, Cote d'Ivoire and Burkina Faso price elasticity of demand was shown to be particularly high overall but even higher for poorer groups, rural communities and young children. (Gertler and Van der Gaag, 1989; Sauerborn 1994). In Burkina Faso, the overall price elasticity of demand was -0.8, but it was much higher for infants (-3.6) and children (-1.7), as well as for the poorest (-1.4).

However most of these studies did not account provide information on changes in quality and changes in the pattern of use of service. Overall the evidence supports the proposition that patients base their health demand pattern on a combination of factors including price, travel costs and perceived quality. However the latter factor is difficult to measure.

... Benin did it, Burkina didn't

Comparison of use of services by poorest groups among two countries with similar community financing mechanisms: Benin and Burkina



"Socio-Economic Differences in Health, Nutrition, and Population in Burkina Faso," and "Socio-Economic Differences in Health, Nutrition, and Population in Ben in" February/March 2000. Davidson R. Gwatkin, Shea Rutstein, Kirsten Johnson, Rohini Pandey and Adam Waastaff. HNP/Poverty Thematic Group, The World Bank.

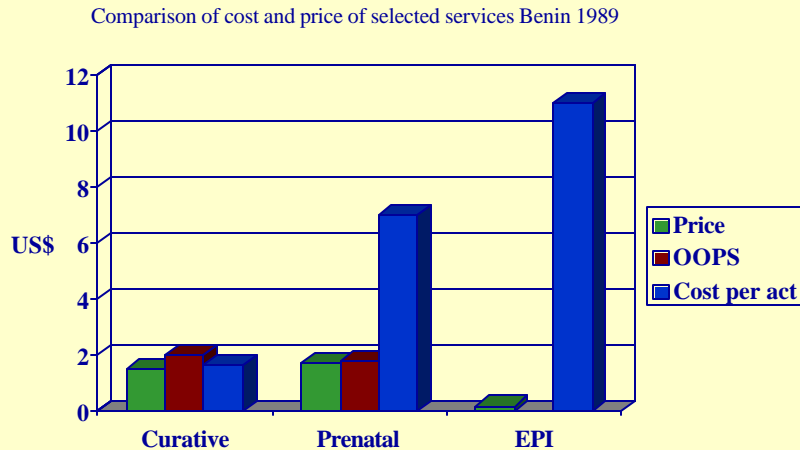
The above mentioned studies had one conclusion in common: price matters. This is illustrated by the example above in which the health seeking behavior patterns of the poorest groups have been compared between two countries. Use by the poor of some key services (immunization, antenatal care, assisted delivery) is higher in Benin than in Burkina, while the economic, demographic and epidemiological situation as well as the organization of the PHC system of these two countries are similar. The pricing structure of health services is however different in both countries. The utilization of the poorest groups as well as the utilization of services by children has been found higher in Benin where prices were overall lower and the subsidy to child care was higher.

Keep prices low for priority services...

- **High level or full subsidies for public goods and interventions with high levels of externalities**
- **Subsidy to preventive care, so as to prevent future costs of curative care**
- **Cross-subsidy of more essential care by less essential care to reduce the price of interventions that highly contribute to health outcomes**

As demand may be price elastic, care should be taken to develop pricing schemes that favor the use of priority services. Those priority services include public goods, those services with a high level of externalities that benefit not only the specific individual that receives those services but encompass broader social benefits: treatment of tuberculosis for example, for which the treatment of one individual benefits all the people who may have been contaminated by this individual; or immunization in which children may be protected by “herd immunity” ie the fact that their peers are immunized and do not transmit diseases to them. Services can be subsidized fully or only partially. Several mechanisms can be used to subsidize essential services, including direct subsidies by the government. Another way to use the pricing instrument is to make priority interventions affordable to the poorest through the cross-subsidization of more expensive essential treatments through a higher mark-up on less expensive, but popular treatments. Programs with revolving drug funds or community financing can use differential pricing of drugs by applying different levels of margin. Such a cross-subsidization has been formalized as the “VEN” pricing.

User fees ... how Benin did it



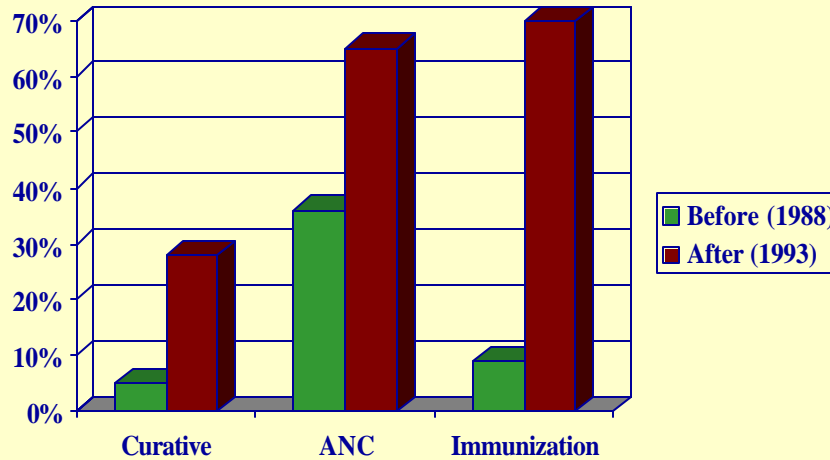
Source: Soucat et al, "Health Seeking behaviour and household health expenditures in Benin and Guinea: the equity implications of the Bamako Initiative" The International Journal of Health Planning and Management, volume 12 supplement 1, 151, June 1997

In Benin, moderating mechanisms were built into the pricing schemes for PHC, so that prices would not deter the poor from access to health services, while at the same time assuring that revenue would be sufficient to cover running costs. To assure affordability for the majority, prices were adapted to the population's capacity to pay. The ceiling for the cost of emergency treatment (including expensive intravenous fluids) for example was US\$7. The pricing system was also designed to cross-subsidize preventive care from curative care revenue. Price of services to children less than 5 were kept as low as possible to address the relative higher price elastic of demand for care to children.

To assess the effectiveness of these cross-subsidies, the out-of pocket expenditures for different types of services in the health centers of Benin was related to the monetary value (ie cost to the system) of the services received. The out of pocket expenditures was measured through both the median price (i.e official fee) and the median revenue per case at health center level as well as through the median household health expenditure per episode as measured through the surveys. For curative care, the figure above shows how the average out of pocket expenditures per case was similar to the average cost per case. Users received a like monetary value of services for their payment regardless of which measure of expenditures is taken. For antenatal care and EPI, on the other hand, the out-of pocket expenditures represented only a fraction of the cost to the system of the services provided, interventions being highly subsidized by public funding so as to stimulate demand.

... and increased utilization of priority services

Impact of introduction of modest user fees associated with quality improvements and community management on utilization of curative and preventive services: Benin 1988-1993

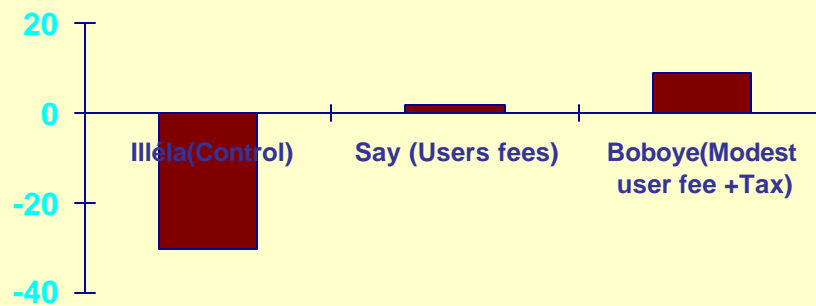


Levy-Bruhl et al., « The Bamako Initiative in Benin and Guinea: improving the effectiveness of Primary Health Care, JHPMEO, 12 (supplement 1) S1-S172 (1997)

The combination of affordable prices for essential curative interventions and high levels of subsidies for prevention and public goods led to dramatic increase of utilization of basic health services on a national scale in Benin between 1988 and 1993, in a context where user fees represent about 20% of the total recurrent expenditures of the MOH. Utilization increased most dramatically among children less than 1 and less than 5, which could be linked to the high level of subsidies and consequent low prices of services for children.

User fees Keep fees low for public goods and preventive care

Change in utilization of antenatal care (%) of the 25% poorest group: Niger 1992-1994



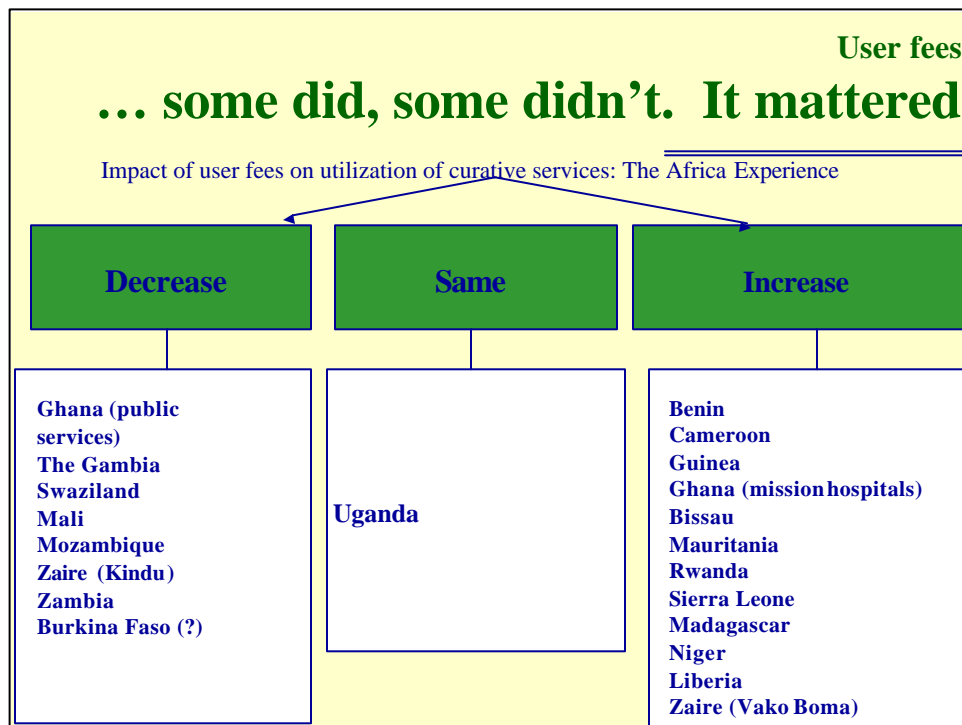
(Diop et al, 1995 "the impact of alternative cost recovery schemes on access and equity in Niger. "Health Policy and Planning", 10:223-40)*+

In Niger, utilization of antenatal care increased among the poorest 25% of the population following the introduction of community financing schemes, as compared to centers where free services were offered. Prices were kept at a minimum level. However utilization increased in a larger extent when user fees were set at a lower level and complemented by a progressive tax system. (Diop et al, 1995 "the impact of alternative cost recovery schemes on access and equity in Niger. "Health Policy and Planning", 10:223-40)

Retain and manage fees revenue at local level

- **The existence of local small marginal sources of funding has shown to be critical to increase access and quality by ensuring continuity of services and compensating from delayed transfers of cash and consumables from government sources**
- **Local retention of funds can be conducive to quality improvements of peripheral services as well as increased empowerment of users.**

In settings where central financing is often delayed or interrupted, these local resources often provide a means allowing the functioning of basic health services on a continuous basis. Community financing of local costs allows for a measure of autonomy and fosters appropriate and timely responses in the face of unplanned expenses. It is therefore important that these revenue remain at local level to contribute to the improvement of access and quality of services to poorer rural areas. Most important is also the potential longer term impact of local generation, use and management of resources in terms of contribution to self reliance and empowerment of populations living in those areas .



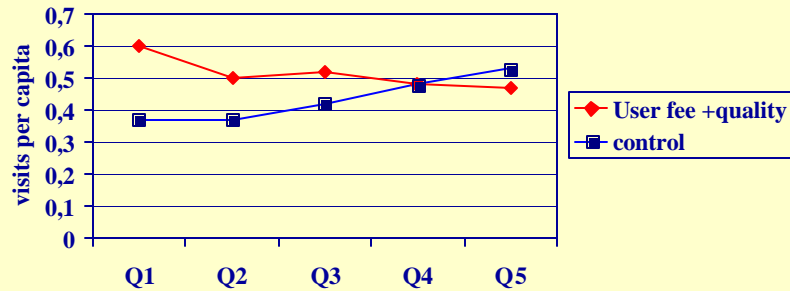
A review of the experience with implementation of user fees in Africa shows how much local retention of funds and the allocation of these funds to quality improvements contributes to mitigating the deterrent impact of payments for health.

In Swaziland, Mozambique, Ghana, the Gambia and Zambia user charges varying from US\$0.15 to US\$1 were introduced or abruptly increased in routine government services without a concurrent improvement of the availability of drugs, access to services and/or quality of care. Subsequent studies show a decline in attendance rates, often by as much as 50%. Even in Zaire, where the quality of services had been of long standing good quality, an increase of the fees without further improvements in the quality of services offered, led to a decrease in utilization rates. In Rwanda, Niger, Cameroon, Guinea Bissau, Mauritania, Madagascar and Liberia utilization increased when fees varying from US\$0.40 to US\$ 1.70 were introduced. User fees were locally retained and managed under community control and were used to improve access, availability of drugs and quality of care.

In Mali, and Ghana, comparisons between different districts or different types of health facilities in the same country have revealed both increases and decreases in utilization rates following price changes. The critical elements determining utilization rates are the size of the price increase, the targeting and timing of improvements in the service offered, and the improvements of availability of drugs.

Local Retention and Quality Improvements

Impact of user fees & quality in Cameroon, 1988-1990



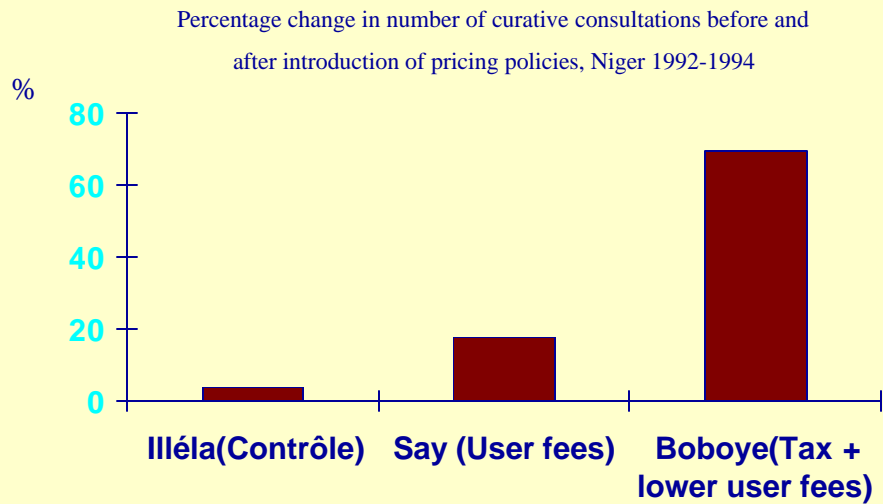
In Cameroon, a study conducted by Litvack et al (1992) showed that utilization of curative services by the poorest 20% increased following the introduction of user fees, and was higher in facilities in which fees were introduced than in control facilities where services remained free. The reason evoked was the revenue generated being locally retained and managed to improve quality of services.

Mix with other revenue sources...

	Advantages	Disadvantages
User fees/ Drug revolving funds	<ul style="list-style-type: none"> ✓ Available cash to finance local functioning costs on a continuous basis ✓ Less risk of bankruptcy, out-of stock ✓ Governance: easy to control revenue and drug consumption ✓ Reduction of number of unsuccessful trips/visits 	<ul style="list-style-type: none"> ✓ Deterrent effect on the use by the poor ✓ Increase over-prescription to increase revenue , “conducting business in the health sector”
Prepayment scheme	<ul style="list-style-type: none"> ✓ Available cash to finance local functioning costs ✓ Promotes service utilization ✓ Does not put the financial burden on the sick 	<ul style="list-style-type: none"> ✓ Reticence to pay for a hypothetical future need ✓ Deterrent effect on the poor who cannot afford the premium ✓ Risk of over-utilization of services or over-prescription leading to bankruptcy ✓ Control of drug consumption difficult
Third Party payment	<ul style="list-style-type: none"> ✓ Promotes service utilization among the poor ✓ Decrease financial burden on households 	<ul style="list-style-type: none"> ✓ Difficulty of means testing/ definition of criteria for benefits ✓ Delayed of funds transfers
Government subsidy	<ul style="list-style-type: none"> ✓ Reduces the price of priority services ✓ Helps provide free essential services 	<ul style="list-style-type: none"> ✓ Rationing of subsidized services ✓ Mainly benefits those who can access the subsidized services, often mostly the richest groups ✓ Transfers reach peripheral areas with delays

Yet there is no universal mechanism or strategy for addressing the variety of situations that arise in terms of financing of health care and its impact on the health and income of the poor. The situation and evolving environment vary from country to country. Financing strategies need to be tailored to the country's priorities and circumstances. Drug Revolving Funds and user fees appear to be the best approach when dealing with problems of drug shortages and poor access and quality of care. However, when the problem is low utilization and high costs, pre-payment and voluntary health insurance schemes may appear as the most appropriate response. In situations where considerable inequities remain, third party payments are called for as poorer households experiment difficulties to finance both user fees and insurance premiums. When the context for community financing is clear, different and complementary financing mechanisms would ideally operate jointly. Since the problems experienced are often complex and evolving, multiple mechanisms are most useful as together they allow for additional flexibility. There is however, a need for careful design, implementation, and management of these mechanisms to ensure that the conditions for sustainability and equity are met and that their individual design incorporates the flexibility needed to respond in a timely manner to rapidly evolving health systems.

... it cushions the effect of fees on use

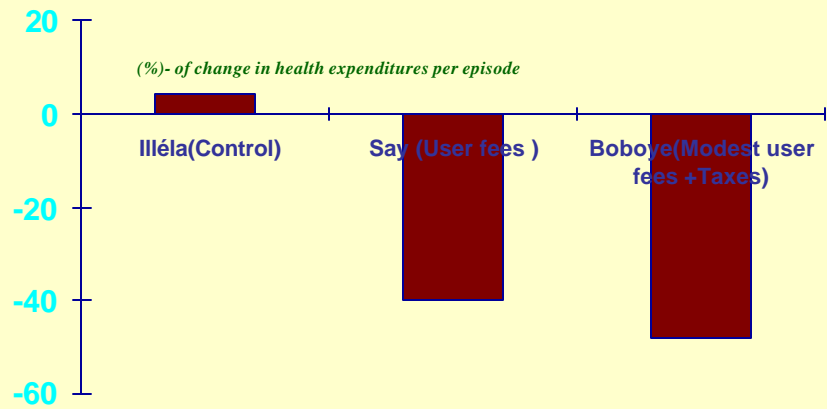


(Diop et al. 1996 "the impact of alternative cost recovery schemes on access and equity in Niger. "Health Policy and Planning", 10:223-40)*+

The study conducted in Niger illustrates the importance of combining different local financing mechanisms so as to maximize benefits and minimize disadvantages of each of them. In Niger, utilization of health services increased in a larger extent in the health centers where user fees were introduced than in control "free care" centers. However utilization increased in an even greater extent in centers in which a combination of mechanisms was introduced, with prepayment through a local tax and modest copayments at the point of use.

...and on out-of pocket spending

Financial benefits to the population of the introduction of community financing:
Niger 1992-1994



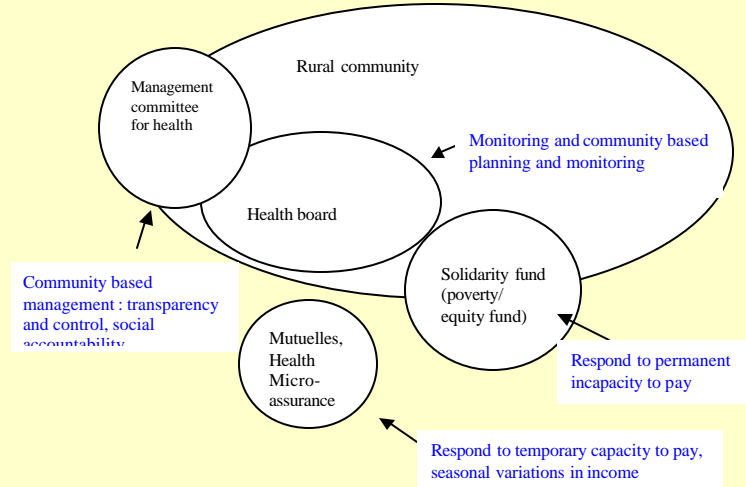
(Diop et al, 1996 " the impact of alternative cost recovery schemes on access and equity in Niger. "Health Policy and Planning", 10:223-40)*+

In Niger the introduction of these local cost sharing schemes led to a decrease in the amount spent on health by households. Because indirect costs and informal payments were reduced the cost of care to households was reduced in both the areas where user fees and prepayments plus taxes were introduced

This is to be done in Guinea.....

Complementary funds at local level: user fees, prepayment and poverty funds,

Guinea I PRSP preparation



As part of the preparation of the I- PRSP , Guinea Conakry has envisioned to further expand the scope of its local financing mechanisms so as to build on the advantages of different instruments. In Guinea, PHC have been offered on a cost sharing basis for the last ten years and local non salary recurrent costs are financed by user fees. The revenue generated is managed locally and under the control of community based management committees. On top of this, experiences of micro-insurance have been developed. Experiences of insurance for emergency obstetric care are particularly promising.

Yet both user fees' financing and micro-insurance have been shown to exclude the poorest with about 15% of the population that can be considered "excluded" on a permanent basis. For those the government of Guinea envisions to develop "poverty funds" to be funded by the regional or the central level and to act a a third party.

Protect the poor ...

- Protecting the poor implies that those with permanent incapacity to pay will benefit from fee exemptions
- yet importance of ensuring that fees are paid by third party rather than waived to ensure provider incentives aren't altered
- difficulties of ensuring that people who get their fees paid by a third party are really poor;

Regardless of whether payments are made in advance (prepayments/ insurance) or at point of service, some groups and among them the poorest remain excluded as they lack capacity to pay at all time. Exemptions and third party payments are therefore essential.

However the performance of exemptions schemes has generally be found quite poor. (Gilson et al, 2000). Noal and Turbat (1995) found that exemption schemes for health in sub-saharan Africa are not only rare but implemented in informal and ad-hoc ways. In practice exemptions schemes often fail in identifying the poor and/or benefit groups that are not always the most needy.

In site exemptions may also alter the benefits of user fees in terms of transparency and incentives to efficiency. Experience with third party payments seems on the other hand more promising, as they operate on the basis of strict purchaser provider split, and combine advantaged of user fees for services management and response to the equity concerns. However the issue of means testing, as well as stigmatization of the beneficiaries of these funds remain important challenges for implementation

... it can be done

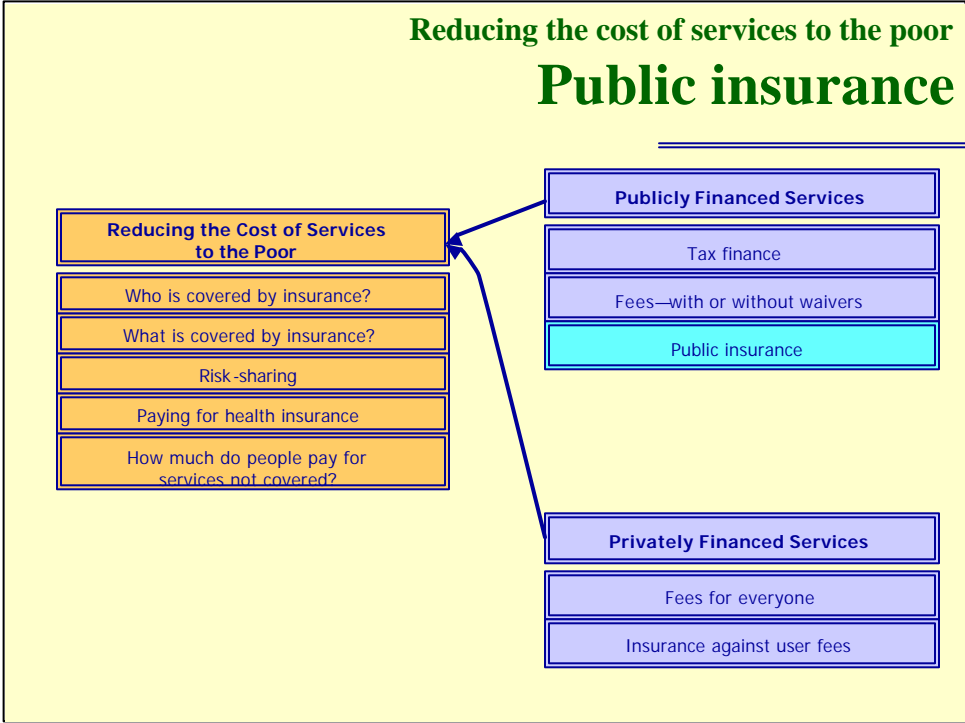
Experience with fee-waivers in China

County/Population Group	Percentage of Child Diarrhea Cases Receiving Treatment		
	Year before PAF (1997/98)	Year after PAF (1998/99)	% Change, Before-After
Nanhua (PAF Benefits to Very Poor Only)			
Very Poor	67.3	81.1	+20.5
Poor	75.5	78.5	+3.9
Non-Poor	77.2	82.5	+6.9
Nanjian (PAF Benefits to Very Poor and Poor)			
Very Poor	69.5	82.3	+18.5
Poor	76.6	79.5	+3.8
Non-Poor	78.4	83.7	+6.8
Huize (Control)			
Very Poor	63.1	64.1	+1.7
Poor	72.2	73.6	+1.9
Non-Poor	75.0	77.4	+3.2

Source: Kelin Du, Kaining Zhang, and Songuan Tang, "A Draft Report on a MCHPAF Study in China"

This slide displays the example of the Poverty Alleviation Fund in Yunnan province, China. The fund was funded under a Bank project. The way it worked was that the clinic collected the vouchers that were paid them in, and then sent them off to the provincial headquarters for reimbursement. In other words, the project paid the user fees on behalf of poor women and children. Services covered included i) routine Prenatal and Postnatal Care ii) Hospital Delivery for High-Risk Pregnant Women iii) First Aid for Severe Obstetric Complications iv) Out-Patient Treatment for Intermediate and Severe Diarrhea and Pneumonia of Infants v) Children Under Three Years Old vi) In-Patient Treatment for Diarrhea and Pneumonia of Infants and Children Under Three Years Old

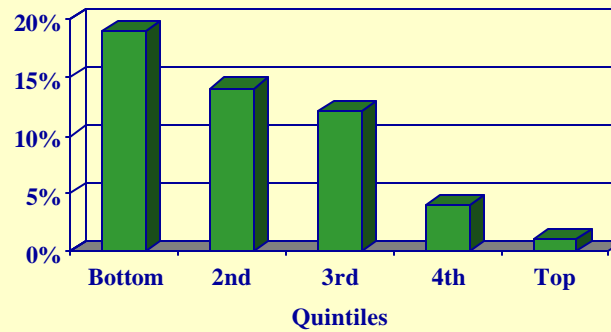
The beneficiaries were the Very Poor (Poorest 5% of Population) and Poor (Next-Poorest 9% of Population) as Identified by Village Councils through a Participatory Poverty Assessment. Both the poor and the very poor received benefits. Treatment levels increased dramatically among the very poor. Yet it increased much less among the poor. When the reason was asked, it was responded that both the very poor and the poor were SUPPOSED to receive benefits; but as the project got going the local community authorities thought that the poor ought to pay. So in fact, they ended up giving benefits only to the very poor.



Public insurance is one way governments can reduce the direct costs to households of using health services. Schemes vary both in terms of who is covered (and for what) and how the scheme is financed. Many social insurance schemes in Latin America cover formal sector workers, and are financed primarily through employer and employee contributions but also in part through general revenues. In Asia, the experience has been different, and the eastern European experience different again. See Paul J Gertler, "On the road to social health insurance: the Asian experience", *World Development*, 26(4) 717-732, 1998; Preker et al., "Erosion of Financial Protection in Health Systems of ECA Transition Economies", World Bank, 2001.

Try to target public insurance on the poor?

% with low income card, Thailand

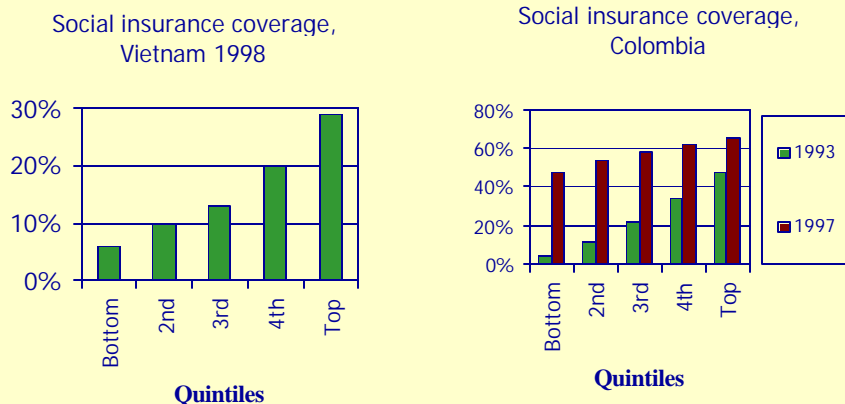


Source: authors,
Title, The World Bank, 2000

The Thai example is one where public insurance was developed as an explicitly pro-poor public insurance program, with a health card being issued to low-income households. This slide shows that the scheme is fairly well targeted on poorer households, but that even in the top quintile there are some card-holders.

Public insurance

Extend social insurance to the poor?



Source: World Bank, Vietnam Health Sector Review, 1999.
 Londono et al., Decentralization and reforms in health services: the Colombian case, The World Bank, 1999.

Many countries have social insurance schemes for some or all workers in the formal sector. Some countries have had such schemes for many years (e.g. the Latin American countries), while others have only recently started to introduce them (e.g. Vietnam). These schemes have typically excluded the poor, and invariably still do. One avenue worth exploring is whether such schemes can be extended to cover the poor.

The coverage of the Vietnam scheme in 1998 is shown in the left-hand slide. Coverage is fairly low overall, but is extremely low in the bottom quintiles, simply because the scheme is geared towards civil servants and large state enterprise workers. The government of Vietnam and donors are discussing ways that the poor—especially the rural poor—might be brought into the scheme. One possibility is that communes join the scheme in their own right with local Communist party officials arranging contributions from villagers, possibly linked to ability to pay.

The right-hand slide shows the case of a country—Colombia—that has succeeded in dramatically extending the coverage of its social insurance scheme to the poor. A subsidized regime was established for poorer groups to sit alongside the existing contributory regime, and an elaborate means-testing system was introduced to determine eligibility for the two schemes. Coverage amongst the poor has increased dramatically.

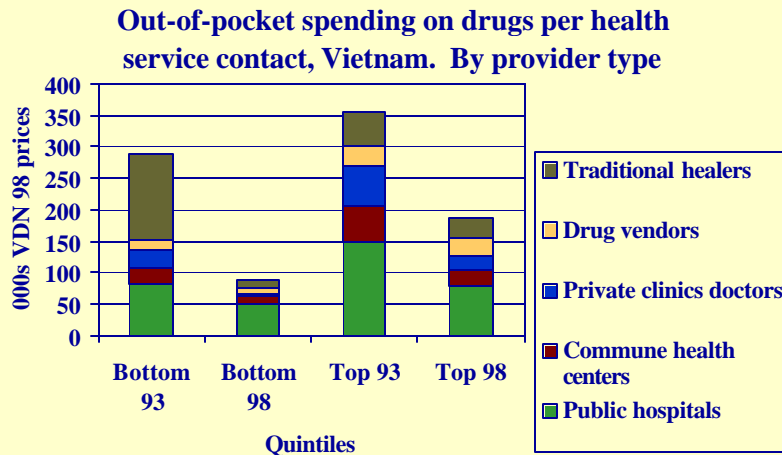
From contributions to tax finance

- **Universalization of social insurance often followed by shift to tax finance—Europe’s experience**
- **Some universalization in Latin America, but no major shift apparent towards tax finance**

What is the future of public insurance in the health sector in the developing world? The European experience over the last 75 years is instructive. Almost all of the existing health financing systems grew out of occupational sickness funds and “friendly” societies. In most countries, these got merged into a national social insurance scheme (or at least a much smaller number of schemes), and in most coverage was widened to include those outside the formal labor market. At this point, or later, the financing of this universal scheme often shifted from contribution-based finance to tax finance. In the UK, for example, the merging took place in the first half of the 20th century, and the shift to the universal tax-financed NHS came at the end of the second world war. In Spain and Italy, the merging took place later, and the universalization and shift to tax finance occurred only in the 1980s and 1990s. The aim in these countries was explicitly to de-link access to health care and contributions, the philosophy being that access to health care was considered a citizen’s right. Relatively few countries—France, Germany and the Netherlands are the main examples—have universalized their social insurance scheme while maintaining contribution-based financing (people outside the formal labor market pay contributions or are exempt depending on the scheme).

In the developing world, there are some countries that have universalized—or nearly so—their social insurance schemes. Costa Rica did so many years ago. Colombia set out to do more recently. Few—if any—to date seem have then shifted from contributions to tax finance. Some of the countries of Europe and Central Asia have actually shifted from general taxation to social insurance contributions (Preker et al., “Erosion of Financial Protection in Health Systems of ECA Transition Economies” World Bank, 2001). But this reflects largely the decline in tax revenues (and perhaps the reduction in solidarity) that has accompanied the transition from communism to free markets.

Government and drugs expenditures

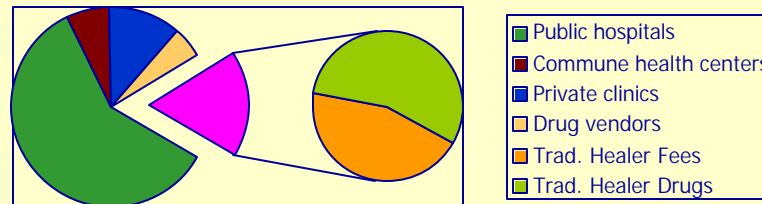


Spending on drugs accounts for a large—often very large—share of household spending out-of-pocket. In Vietnam, in 1993, for example, 96% of household out-of-pocket spending was on drugs. In the bottom quintile, the figure was even higher—98%. By reducing the price of drugs, governments can potentially reduce out-of-pocket spending and any impoverishment that goes with it, as well as making drugs accessible to those who would otherwise find them prohibitively costly.

One country that did this recently is Vietnam (World Bank, *Vietnam Health Sector Review*, 1999). Between 1993 and 1998, drug prices fell dramatically—the CPI grew at an annual rate of 8% over this period, while the price index for medicines stayed unchanged. Spending on drugs per health service contact fell dramatically in real terms, especially in the bottom quintile. Drug spending accounted for only 55% of overall out-of-pocket spending in 1998. One factor behind the reduction in the cost of drugs was the large increase in donor spending on drugs during these years. But trade liberalization and deregulation played a major part—imports increased, as did domestic production, and the distribution system became more competitive. The chart above shows that drug expenditure associated with the use of traditional healers also declined, presumably because as modern medicines became affordable, people switched to them away from traditional medicines.

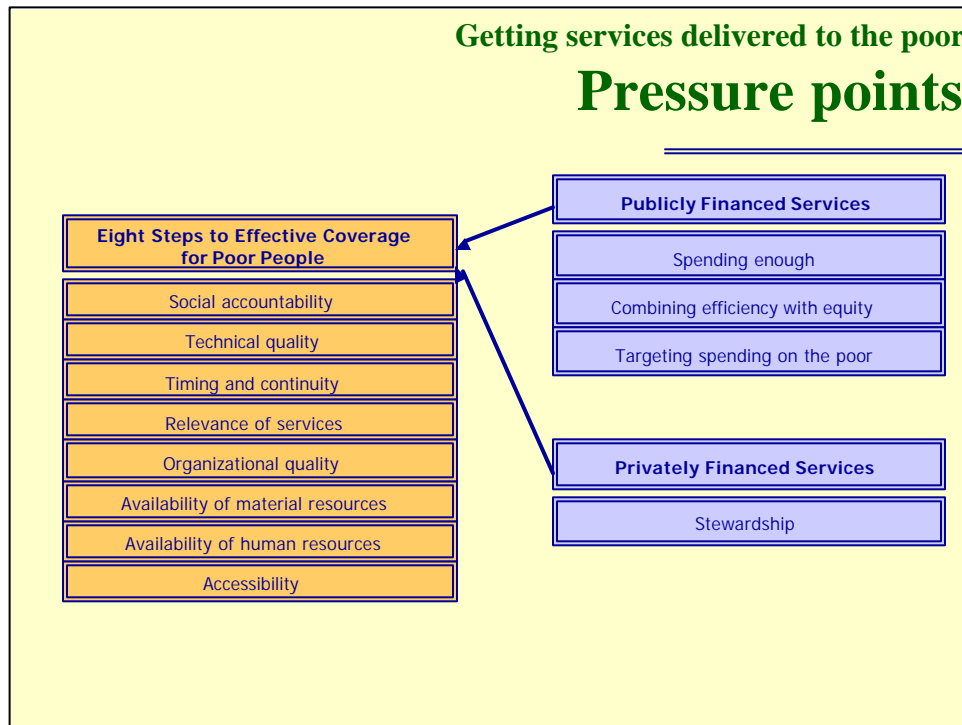
Private finance Government and quality

Total out-of-pocket spending per contact,
Vietnam 1998, by provider



In many countries—in Asia especially—out-of-pocket spending comprises a very large share of total spending. A good deal of this spending is often on fees paid to private providers and on drugs and medicines prescribed by them. Often—especially in the case of traditional healers—these services and medicines are of unproven clinical efficacy, so that people may well become impoverished without any corresponding improvement in their health. In Vietnam in 1998, nearly 20% of out-of-pocket spending was to traditional healers—either for fees or medicines bought from the healers.

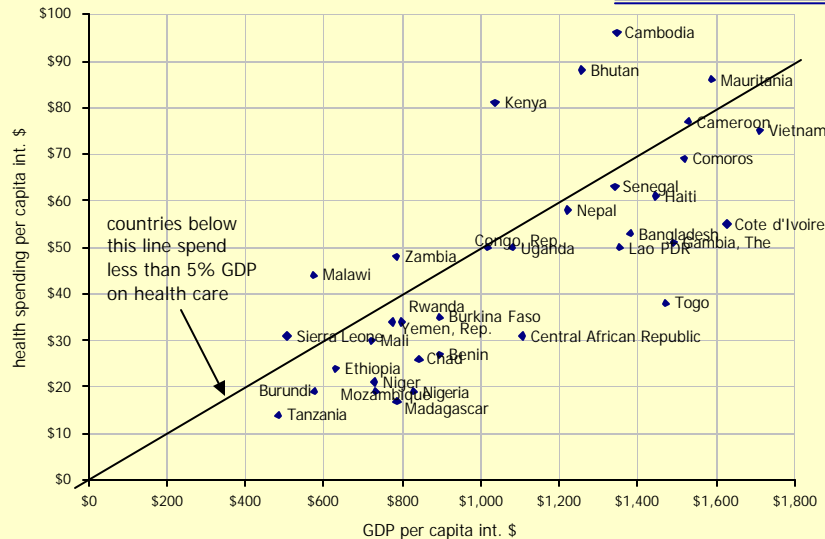
Governments can improve matters by instituting a quality assurance process, and by regulating private providers. A recent World Bank study of health care in urban India (CD Naylor, P Jha, J Woods and A Shariff, *A Fine Balance: Some Options for Private and Public Health Care in Urban India*, Washington DC, The World Bank, 1999) reported a lack of accreditation of many private sector providers, and low levels of quality control in the public and private sectors. In response to these problems, the Indian government recently established a Panel for Quality Assurance in Health Care, which will focus initially on hospital accreditation for the private and public sectors. The emphasis is not to be on writing new laws, regulations and government orders, but rather to work through the private sector and genuinely autonomous bodies, with accreditation being backed up by financing decisions and public information. The government is playing an observer and facilitating role in this process, and the intention is to move on to other areas of quality control once the accreditation issue has been resolved.



So far we have examined the question of making services affordable for the poor. We turn now to other determinants of utilization and of health service effectiveness. The session “The Health System and the Poor” introduced the key eight steps to effective coverage for poor people. What levers and policy instruments do governments have available for influencing these? We need to bear in mind that many health services are paid for privately, but that the government has a role here too—its instruments are less direct but they are nonetheless important. In a country like India, where over 80% of health spending is private, ignoring the policy levers available to influence this part of the health sector would be a critical oversight.

In the context of privately financed services, there are three areas to consider with respect to providing effective coverage for the poor. First, is the government spending enough? Second, is the government spending efficiently, and if not can efficiency improvements be identified? Here it is vital that the distribution of any changes be considered, and that efficiency improvements are made in such a way that if there are any distributional consequences, they favor the poor. Third, can resources be reallocated in such a way as to help the poor and make the system fairer? As far as privately financed care is concerned, the instruments available to the government are those that fall under the heading *Stewardship* (World Health Organization, *World Health Report 2000: Health Systems Improving Performance*).

Spending enough How much is enough?



Source: World Bank *World Development Indicators 2001*. Data are for 1997

It is natural to ask the question whether a country is spending enough on health care. Unfortunately, there is no hard-and-fast rule. In 1997, the average American spent nearly as much on health care as the average Filipino spent *on everything* (\$4000 in international dollars). Better-off countries spend more on health care (see chart), but at a given per capita income, there is still a good deal of variation. In 1997, the average Kenyan was marginally worse off than the average citizen of the Central African Republic. And yet health spending per capita in Kenya was more than double that of the CAR (\$81 compared to \$31). What *does* seem certain is that countries spending \$20-25 per person on health care are probably not spending enough. Beyond that it is difficult to say anything definite. Different international agencies have different—and typically mutually incompatible—recommendations, many of which seem to have been drawn up with advocacy in mind rather than science.

Combining efficiency with equity
Efficiency yes; equity yes

- **Efficiency means getting the mix of services right (*allocative*), getting the input mix right (*input*), and getting as much health from a given bundle of inputs (*technical*)**
- **Efficiency can be increased almost everywhere; but measures to increase efficiency may have adverse effects on the poor. So:**
 - **be alert to adverse distributional effects and try to mitigate against them, and even better**
 - **try to search out measures that will enhance efficiency *and* benefit the poor**

There can be little doubt that health systems around the world exhibit one or other or all of the types of inefficiency mentioned above. Often, there is an over-emphasis on high cost hospital care that generates only modest health improvements and only to the patient concerned, at the expense of cheaper interventions (such as immunization) that offer large health gains for the patient *and* others (so-called externalities). This is an example of *allocative inefficiency*. Often, labor inputs are over-employed relative to drugs and medicines, and expensive labor inputs (physicians) are over-employed relative to cheaper types (physician aides and nurses). This is an example of *input inefficiency*. Finally, health care providers often face little incentive to be efficient, so that the same number of patients could be treated at lower cost and with no reduction in inefficiency. A recent World Bank study in the Dominican Republic found that only 12% of expenditures in public hospitals actually reached patients in the form of services, the rest being absorbed partly by administrative costs but mostly by inefficiency. This is *technical inefficiency*.

There has been much discussion of measures to reduce these three types of inefficiency. But such measures are likely to have distributional consequences—they are unlikely to benefit the poor and better-off equally. Indeed, much discussion has centered on the possibility that health care reforms designed to increase efficiency may have serious adverse consequences for equity. The challenge is to identify the likely distributional consequences of different proposals, and at the minimum find ways of mitigating against consequences that hurt the poor. Even better would be to focus on measures that *enhance efficiency and improve equity*.

How to improve efficiency *and* equity

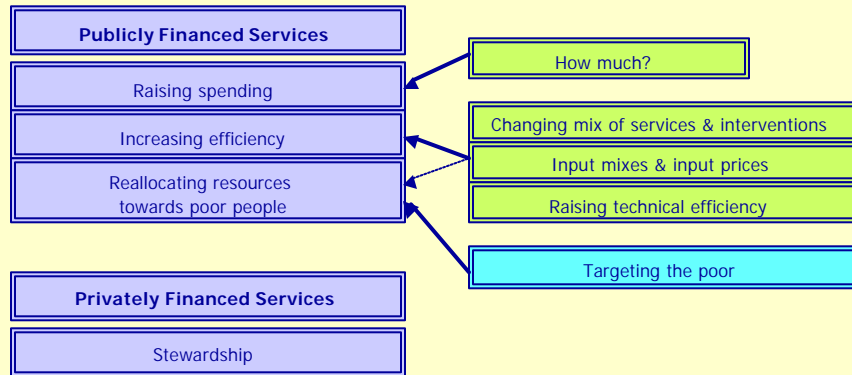
- **Allocative efficiency—often changes here may benefit the poor (e.g. shifting to interventions aimed at communicable diseases), but beware of insurance benefits of free hospital care**
- **Input efficiency—shifting away from labor costs may benefit the poor by freeing budgets for drugs**
- **Technical efficiency—performance-based incentives need to take into account the higher costs of reaching the poor**

Relocating resources towards traditional public health interventions (such as immunization) probably enhances allocative efficiency. But this may *also* benefit the poor, since they suffer disproportionately from communicable diseases and their immunization rates tend to be lower. One has also to bear in mind, however, the non-health benefits from different services. For example, by providing hospital care free at the point of use, a health system is in effect providing an insurance benefit in the form of reduced risk of large hospital expenses.

Reducing the emphasis on labor inputs (which sometimes absorb as much as 70% of health budgets) is probably good for efficiency *and* good for equity. With labor costs absorbing such high shares of budgets, little room is left for spending on drugs. The better-off are able to get round this by purchasing their own with relatively little impact on their living standards. The poor are less able to cope, and either forgo the drugs or purchase them out-of-pocket and suffer a serious drop in their living standards.

A much-discussed way of improving technical efficiency is to change incentives. Sometimes this can have negative equity consequences. Examples include shifting from paying hospitals through historic budgets to paying according to cases treated, shifting from paying providers a salary to paying them according to services delivered, and shifting from getting services produced in-house by salaried employees to getting them provided by other agencies (e.g. NGOs) who get paid according to services delivered. The danger with such measures is that the provider searches for the easiest-to-reach patients first, leaving the hard-to-reach (often the poor) until the end if the contract makes this worthwhile, or ignoring them altogether if it doesn't. The secret is to tilt the payment mechanism such that contracts are more generous for delivering services to hard-to-reach groups, such as the rural poor. Such schemes have been used in Brazil, and are being considered for other Latin American countries including Bolivia.

Applying pressure The issues



The effectiveness of targeted schemes is insufficiently documented and they may be less effective than generally accepted. A review of a vast range of targeted social programs in Latin America found that the share of benefits of the poorest 40% of those programs ranged from 59% to 83% (Grosh,1994) . This appears as quite successful but empirical evidence from other regions may show as low as 5% of benefits reaching the intended targets and the low 59% of benefits captured by the 40% poorest cannot be really be considered a success for a targeting scheme .

Targeted schemes are also often shown to have high administrative costs, on average higher than non targeted schemes.

Grosh (1994) found that there is no single best method for targeting. Yet it seems that the inaccuracy of targeting decreases when the size of the unit targeted decreases. This is in favor of carefully designed targeting program that take into account the most peripheral level.

Four different approaches to targeting

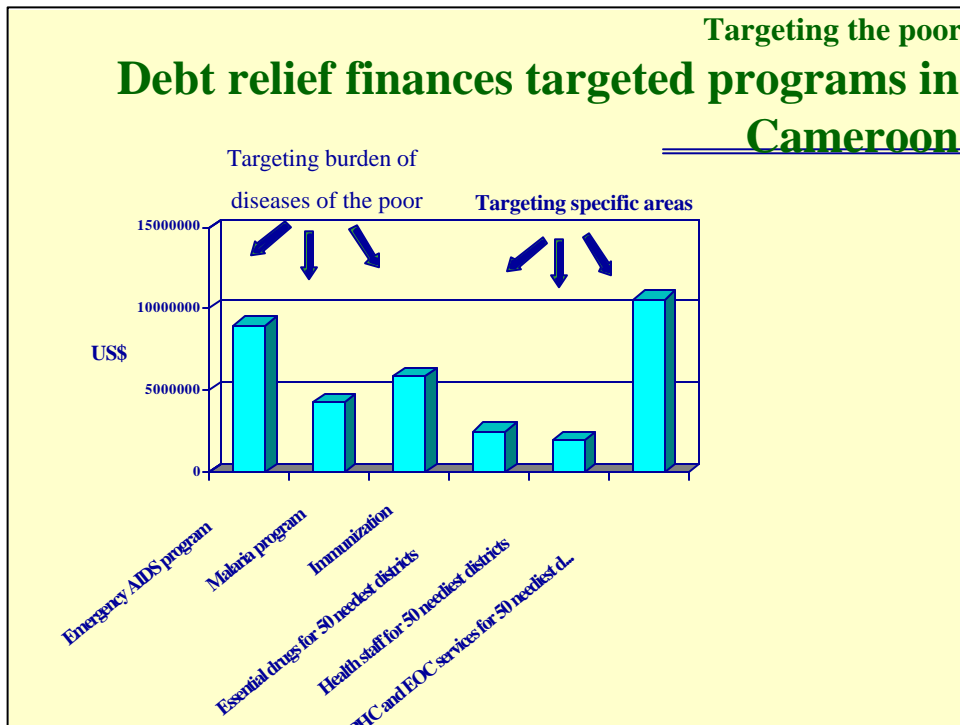
- **Targeting *pro-poor health interventions*: resources flow to address the burden of diseases of the poor**
- **Targeting *pro-poor health services*: basic social services, primary health care - preventive, and basic curative services as well as health promotion- and essential surgery services**
- **Targeting *poor areas*: rural/ urban, remote regions, slums**
- **Targeting *poor households and communities*: low-income communities and households**

Targeting can be conducted through four different approaches:

- Targeting *pro-poor health interventions*: resources flow to address the burden of diseases of the poor, including the burden of communicable diseases
- Targeting *pro-poor health services*: resources purchase services ? such as preventive, and basic curative services as well as health promotion? that benefit the poor to a larger extent than the rich. Resources flow to basic social services, primary health care and essential surgery services. Recurrent costs ? salary and non-salary? of these services are covered. Resources mobilized allow increasing the proportion of personnel working for those services.
- Targeting *poor areas*: Resources flowing to regions with the most health needs and highest level of poverty. Resources flow to under-served areas, such as rural areas or urban slums. Health workers receive adequate incentives to work in poor remote areas. Marginalized ethnic groups are reached
- Targeting *poor households and communities*: Resources flow directly to low-income communities and households. These flows benefit a large proportion of these poor communities and households. Transfers are fair in regard to the country's poverty profile.

Targeting the poor

Debt relief finances targeted programs in Cameroon



As part of the debt relief process, some countries have attempted to develop « pro-poor » programs that complement and reorient their more traditional health policies. In Cameroon for example, targeted programs were developed along two approaches:

- targeting the burden of diseases of the poor, this included malaria, HIV/AIDS, TB and immunizable diseases

- targeting neediest, poorest districts: a list of about 50 districts has been elaborated for which three specific programs (essential drugs, equipment and human resources) were specifically developed

Various Instruments can be used for targeting

- **Needs based resource allocation**
- **Purchasing of services to providers**
- **Transfers**

Several financing instruments can be used to ensure effective targeting:

-first and foremost, the allocation of resources to areas or specific groups on the basis of needs. Needs can be measured according to population size, poverty levels or burden of diseases etc..

-second, the purchase of service to health services providers by purchasers, whether central government, local states, private insurance or other third party payers

-third, the direct transfers of funds to specific entities, groups or individuals

Resource Allocation Can be Better Oriented

- **Criteria need to be defined:e.g UK Resource allocation working party, Thailand discussions on using population, standardized mortality ratios, poverty headcount and morbidity (AIDS, malaria)**
- **Problem of absorption of poor areas that can also be poor performing areas, problems with decreased funding for richer areas, closing hospitals is not popular..**
- **Needs based budgeting can be contradictory to performance based budgeting?**
- **In decentralized settings importance of role of centralized governments in redistribution: topping funding of poor local governments**

Resources allocation can be done on the basis of various criteria that relate to geographical areas or individuals. Allocation can be made more pro-poor by taking into account not only the population size (ensuring vertical equity ie equal allocation on a per capita basis to poor and rich areas/individuals) but also the burden of diseases, and the poverty level to increase horizontal equity (unequality of the unequal, with higher subsidies to the poor who need more) . In Thailand for example, discussions are currently taking place as to whether to include poverty headcount, standardized mortality ratios and number of AIDS cases in the Thai resource allocation working party.

Allocation of resources on the basis of poverty criteria often raises important issues, not the least important being the absorption capacity of poorer areas. Switching resources from rich to poorer areas also often poses political dilemmas and closing hospitals on the argument of equity is no more popular than doing it on the basis of efficiency criteria.

Also needs based budgeting may often be contradictory to performance based budgeting as poorer areas are often also the least well performing and poorer groups may be more costly to reach. The trade -off between efficiency and equity is often a delicate issue. This can however be partially addressed by the separation of providers and purchasers ie allocation on the basis of needs to purchasers and on the basis of performance to providers. “Investing in the weakest” would therefore as much an argument as “rewarding the strongest”.

Finally decentralization may aggravate disparities of resources allocation , and the role of the central government is essential in mitigating this effect by redistributing resources and topping funding for poorer local governments

Pro-poor purchasing is also possible...

- **Purchasing of services that have the greatest impact on the poor: communicable diseases, reproductive health, malnutrition, children's health interventions**
- **Purchasing of specific programs aimed at bridging the gap between poor and rich**
- **Purchasing of income protection (e.g: insurance, safety nets) to the poor against catastrophic illnesses**
- **Purchase of specific programs aiming at increasing poor's participation and empowerment**

Fund holders, whether from central or local government, private or public insurance schemes or any mechanisms for third party payments can use their purchasing power to influence the type, quality and quantity of services that are provided to the poor. These "purchasers" can address market failures and contribute to redistribution towards the poor by purchasing "packages" of pro-poor services ie:

-packages of services that have the greatest impact on the burden of diseases of the poor, ie communicable diseases malnutrition, reproductive health, children's health interventions

-specific programs that aim at bridging the health outcome gap between the rich and the poor eg: rural health programs, social programs for specific ethnic groups

-programs that provide safety nets and protection from the impoverishing effect of illness through increased health expenditures and related indirect costs

-programs that promote the involvement and participation and involvement of the poor in health issues, including participatory planning and co-management of services,

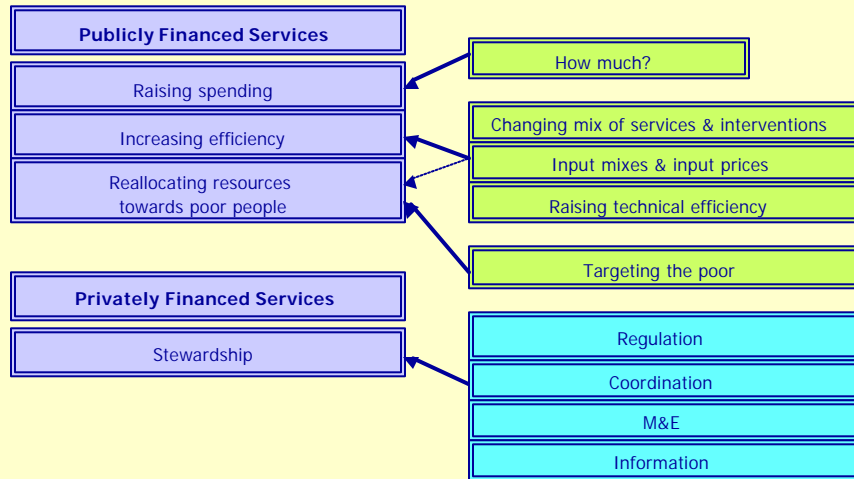
Transfers

- **Drug revolving funds: eg direct subsidy to drug stock**
- **Social funds for health (Cambodia)**
- **Community savings schemes**
- **Equity and Poverty funds**
- **Direct subsidy of individuals/ households**

.....means testing often a problem

Transfers is the third instrument that can be used to make targeting a reality. These transfers can aim at subsidizing the supply side such as transfers for drug revolving funds in the form of drugs donations for example or community based health systems. But these transfers can also be used as demand side subsidy, including transfers to community savings schemes, social funds, community development funds or poverty funds to act as local third party payers. Transfers can also be made directly to individuals in the form of bonus for compensating loss of revenue from illness or other type of benefits.

Applying pressure The issues



The role of stewardship of the state is particularly important when it comes to designing pro-poor policies. Because the balance of powers is rarely in favor of the poorest, those latter need the government even more than wealthier groups to create an enabling environment conducive to their security and well-being. .

Regulation is even more important for the poor

- **The poor typically lack leverage on markets and are more likely to be affected by market failures due to insufficient information**
- **Regulation and its enforcement are therefore likely to be more important for the poor, as they lack other means to exert control and need the power of the government to back them up**
- **This is particularly critical in the areas with high levels of market failures due to unbalance of knowledge ie food and drug quality control, as well as drug and health services prices**

« Voices of the poor » and the World Development Report of 2000 have emphasized that being poor is not only defined by a low income but also by the lack of access to basic services as well as reduced opportunities. Poor people are more sensitive to market failures as they lack leverage on markets and are typically less informed than richer groups. Poor people are therefore more likely to lack information about quality and price of services. This lack of information particularly problematic when it comes to food and drug quality control. Typically poor people are for example more likely to purchase their drugs from drug peddlers than richer groups.

Pro-Poor input market regulation

- **Importance of international quality assurance/ certification for poor countries who cannot afford quality assurance mechanisms and/or face high risk of corruption**
- **Importance of pricing policies: price control price capping tier pricing**
- **Licensing, TRIPS agreement and compulsory licensing**

The rapid expansion over the last years of the market of low quality and fake drugs is posing a grave threat to the health of the poor. In Cambodia for example, over 90% of drugs in the market were found to be fake.

To respond to the problem of control of low quality/fake drugs two strategies are currently showing some success: i) ensuring availability of quality drugs at affordable cost that are marketed/franchised through drug peddlers who have the authority to sell it only if they commit to comply with set prices ii) and developing pre-packed blisters that are well sealed (like banknotes) so it is hard to falsify. These blisters have WHO certificate on the box and are color coded to make the dosage eail understandable

Pricing policies are also important, especially in low-income countries of Sub-Saharan Africa, where the largest share of out-of pocket spending goes to the purchasing of drugs. Countries have implemented different set of policies to void escalation of drug prices due to market failures. Most countries have established lists of essential drugs for which the lowest cost of procurement is seeked in order to keep prices low. Price capping and tier pricing of essential drugs have been experimented with some success by a large number of countries.

Currently the global debate is focused on the issue of drug prices for low income countries. Trade agreements such as TRIPS are increasingly questioned by middle income and low income countries and compulsory licensing is even considered for life saving drugs that are currently under patent.

Monitoring and Evaluation

- **It is difficult to anticipate the effect of supposedly pro-poor policies, hence it is critical to be able to monitor the outcome of whatever measure is implemented and document the reasons for their success or failure**
 - **Some examples of what should be monitored**
 - Health Outcomes
 - Out of pocket spending
 - Health outputs
 - Health performance dimensions
 - Public spending
 - Revenue generation
 - Qualitative information (reasons for non use)
- ...allby region, level of poverty, income group,**

There is no blueprint of pro-poor policies and each country needs to tailor its approaches to local problems and contexts. Poor people have been found to be difficult to reach and monitoring and evaluation are therefore essential to understand the processes and the outcomes of these policies. Learning by doing and “trial and error” are important management approaches when it comes to designing and fine-tuning policies to reach, protect and involve the poor. Few countries integrate information that can allow to evaluate the impact of health and other policies on the health of the poor. This should be increasingly called for so countries can have a better grasp on what works and what does not work in terms of addressing the needs of the poor.

**Inter-sectoral links are even more important
for the poor**

- **Because poverty is the result of an intricacy of factors, importance of multi-sectoral work is probably higher for the poor than for the average population**
- **As a consequence importance to coordinate with agencies whose scope of work may not be mainly health (other ministries/sectors, UNDP for the UN, non health NGOs, etc**

Poverty is an outcome of an intricacy of factors and the poor are most often caught in vicious cycles that keep them in vulnerable and uncertain position. Attacking poverty and its linkages with poor health requires therefore much more than just improvements of health services. Multisectoral approaches focusing on key constraints identified at household and community level are essential to the success of poverty reduction programs. Coordination of health activities throughout sectors is therefore particularly important for the poor, as tackling the roots of the poverty problems that affect health require most often broad social programs. Coordination of intersectoral work with other ministries and development agencies that aim at addressing household determinants of health is therefore key policies to support pro-poor programs.

Poor Need More, and Tailored, Information

- **General “blanket” information is generally seen not to be enough for most vulnerable groups**
- **Information will work for the poor if oriented towards the specific gaps of knowledge of these poor**
- **The poor may also not be reached by the same channels as the general population: need to tailor communication plans to habits of the poor.**

Poor people have been shown to be typically less informed than richer groups. The poor have on average lesser levels of education and have less access to information means. Even in richer OECD countries, poor people are more often excluded from the broad circuit of information.. To be effective for the poor information activities need to be based on thorough analysis of the specific information gaps of the poor groups. The poor may also not be reached through traditional channels and innovative strategies may need to be designed to reach the unreached. Reaching specific vulnerable groups usually needs tailored and intense communication strategy, based on outreach

On the content of information to be provided there is on the other hand an increasing consensus about the package of information for health to be provided to the poor: this includes information about cost effective health interventions contributing to investment in human capital, communication for behavior change, consumer information about quality sources use and prices of drugs, and information on sources of care/providers price and quality.

Session Outline

- 1. Government policies and actions**
 - Reducing the cost of services to the poor
 - Getting services delivered to the poor
- 2. Pulling it together and moving ahead**
 - Benin case example

Self Explanatory slide: No text needed

Orienting the health sector towards serving the poor

**The case of Benin, West Africa
1985-1998**

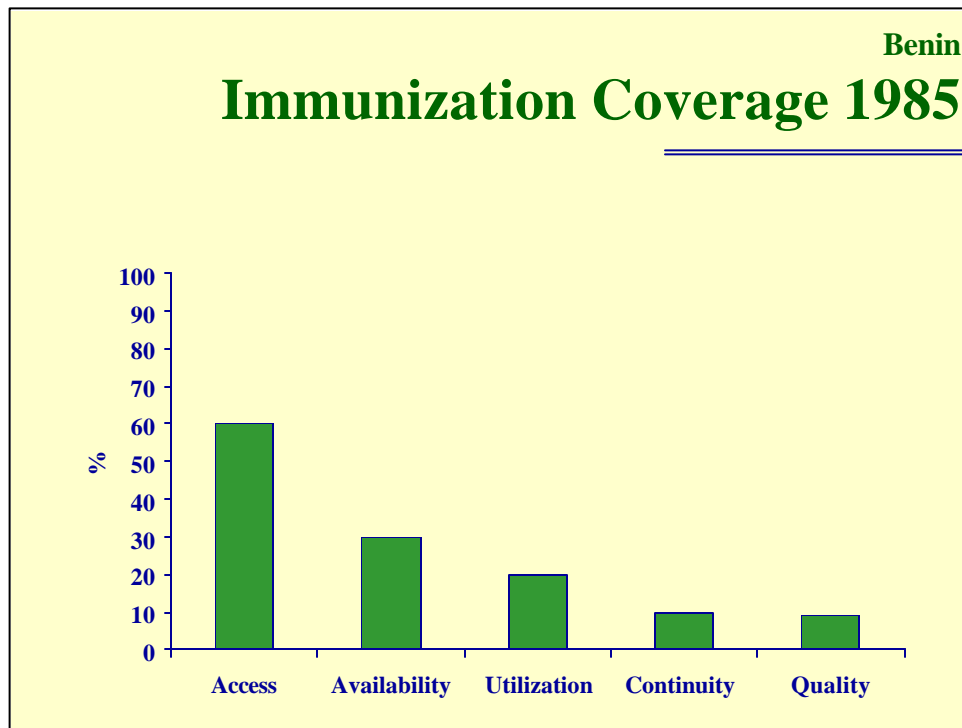
Benin in 1985 was in a disarray. After years of *marxims-beninism* the system was collapsing.. This cumulated in 1989 with the collapse of the banking system and the incapacity of the government to pay salaries. In this context, the Benin health sector has been reorganized over the last years with a clear orientation towards better serving the poor and the vulnerable groups

Poor Health Outcomes in 1985

- **Outcomes**
 - **IMR 114 per 1000**
 - **U5MR 203 per 1000**

- **Tracers of health sector performance**
 - **DPT3: 9%**
 - **Utilization of ANC: 1 visit 36%, 3 visits 5%**
 - **Access to functioning PHC services <30%**
 - **Curative care utilization: 0.09 visits per capita**

In Benin (6 million inhabitants) in 1985, the health story was one of poor outcomes and very poor sector performance with a high level of under 5 mortality at more than 200 per 1000. In 1985, less than 9% of children were immunized by DPT3 and use of primary care services was less than 0,01 visit per capita per year. Quality of the few available services was perceived to be sub-standard and although 30% of pregnant women had made one antenatal care visit, less than 5% benefited from 3 visits or more. Access to functioning health services was very low at less than 30%. The majority of peripheral health centers experienced shortages of drugs and supplies that were exacerbated by wastage of available resources such as using the limited MOH budget to purchase non essential drugs. Eighty percent of the MOH budget was used for paying wages leaving only US\$0.5 per capita for operating costs and drugs. Moreover this budget was disproportionately distributed, favoring urban areas over rural and hospitals over basic services. Services were centrally managed and theoretically free of charge, but patients had to bear the costs of drugs and of informal fees. Out of pocket spending was about US\$5 per capita per year, yet households considered out-of pocket costs excessive in terms of the little that was received in return.



In Benin in 1985, mothers gave the absence of regular vaccinations services as the primary cause for partially or unvaccinated children. Access to immunization through fixed strategies and immunization was very low. Access was limited by long distances and lack of affordable transport, particularly in rural areas and for preventive care. Due to lack of transport or fuel, health staff were not able to travel to villages for outreach activities. There were severe vaccines shortages and the cold chain was often non existent or ineffective. Utilization of immunization services was consequently low, and drop out high.

Determinants of immunization coverage were measured using the following indicators:

Denominator: children having reached their first birthday during the past year

Access: proportion of children living at less than 5km from a health center or less than 2km of an outreach post

Availability: proportion of time without shortages of childhood vaccines

Utilization: proportion of children having received at least one immunization shot

Continuity: proportion of children fully immunized before their first birthday observing intervals and minimum age

Quality: proportion of children fully immunized with vaccines stored at correct temperature

Sector Performance 1986

- **Review of immunization and child health program: immunization used as a tracer of health sector performance**
- **Review of survey and service data regarding reasons for non performance of the sector**

The health sector was reorganized on the basis of an analysis of the hurdles hampering performance regarding maternal and child health services including immunization. In 1986, survey and service data were reviewed and analyzed to identify “pressure points” on which to trigger for a better performance of the system.

Hurdles to Performance

- **Low access to services**
- **Shortages of drugs and vaccines**
- **Very low utilization**
- **Low continuity and high drop-out**
- **Absence of quality**
- **No social accountability**

Hurdles identified included low access to services, shortages of drugs and vaccines, low utilization, high drop outs and low quality as well as absence of accountability of the health system towards the users and in particular the poorest among them.

The Pressure Points

Households and communities	Health system		Government policies and actions	
	Health service provision	Health financing	Health service provision	Health financing
Key outcomes.	Physical accessibility of services.	Who is covered by insurance?	Macro.	Macro.
Health-related household actions and risk factors.	Availability of essential drugs	What is covered by insurance?	Health system level.	Health system level.
Household influences on actions.	Availability of human resources	Risk-sharing.	Micro.	Micro.
Community factors.	Organizational quality.	Paying for health insurance.		
	Service relevance.	How much do people pay for services not covered?		
	Timing and continuity.	Affordable pricing of services		
	Technical quality.			
	Social accountability.			

Strategies or pressure points to improve effectiveness were as follows:

- improve physical access to care by specifying catchment areas and client population for each health center, as well as organizing regular outreach activities to village more than 5km away
- improving availability of essential drugs and other supplies through the establishment of drugs revolving funds and the creation of a central medical store
- integration of various health interventions to reduce missed opportunities
- improve continuity of care through follow up, active channeling and canvassing
- improved quality of care through the use of standardized diagnosis and treatment flow charts and implementation of routine supervision procedures
- ensuring the accountability of health staff and communities for on-going adaptation of strategies in order to improve coverage through the local monitoring and micro-planning processes
- development of affordable pricing schemes including subsidies to the most essential services

Benin

Pressure Points



Benin's strategies therefore exerted pressures on seven of the eight dimensions of performance of health systems in providing effective coverage to the poor with essential services. Interestingly, no pressure was exerted at that time on the human resources availability dimension. This latter was considered untouchable, given the context of economic crisis and structural adjustment. The government was paying the salaries and the communities providing financial incentives, and this was considered a solid enough basis. This proved in the future not to be true and human resources availability and motivation proved to be a major limitation to performance gains.

Poor-friendly Reorganization

- **Seven steps:**
 - 1. Increasing access to rural areas:**
 - 2. Increasing availability of essential drugs:**
 - 3. Improving organizational quality**
 - 4. Increasing demand/use:**
 - 5. Ensuring continuity:**
 - 6. Assuring quality:**
 - 7. Increasing accountability towards communities:**

Seven steps:

1. Increasing access to rural areas: revitalization of PHC/MCH centers and outreach(transport)
2. Increasing availability: procurement of low cost essential drugs, Drug Revolving Funds
3. Improving organizational quality: package of essential services (communicable diseases and MCH), opening hours, performance based payment of health staff.
4. Increasing demand/use: pricing of treatments at minimal cost for ensuring financial recovery of non salary recurrent cost, cross-subsidy, locally decision made exemptions
5. Ensuring continuity: active channeling, defaulter tracking, community based activities and monitoring (nutrition)
6. Assuring quality: standards of care, supervision procedures, monitoring
7. Increasing accountability towards communities: management committees, bi-annual participatory monitoring, ownership of local revenue and local retention of funds

Three Financing Instruments

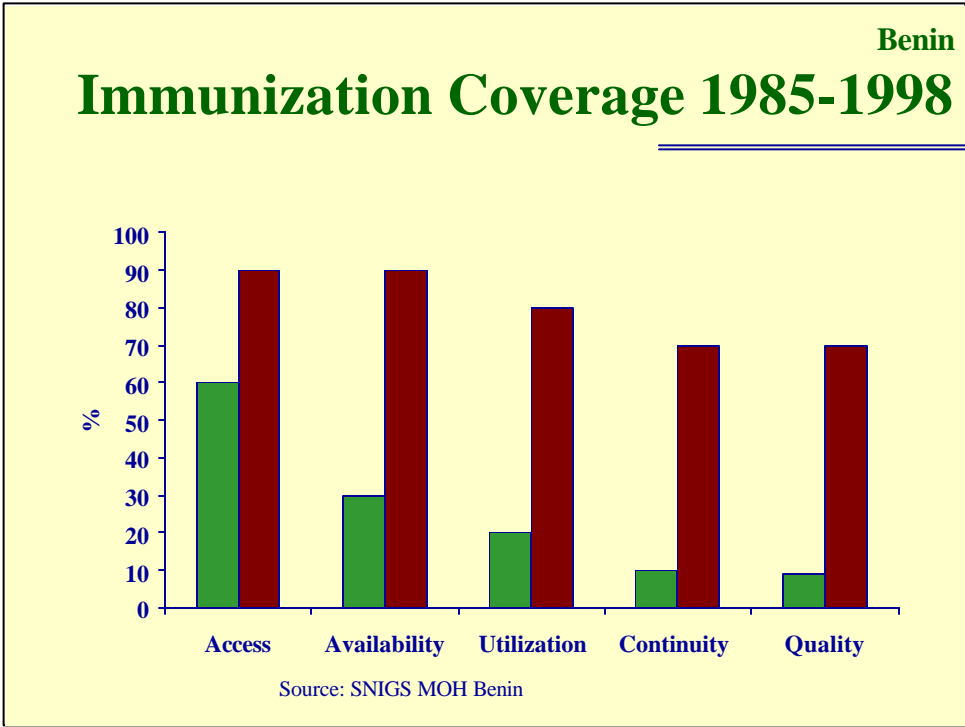
- **Allocating resources to interventions addressing the burden of diseases of the poor: financing a basic care package addressing communicable diseases and child health**
- **Allocating resources to the poor specifically: increase resources for low-income areas (Northern Benin)**
- **Affordable Pricing of the basic package of services**

Three financing instruments were used in addition to exerting pressure on the performance dimensions of the health system:

-first donor and user fees resources were oriented towards the financing of interventions addressing the burden of diseases of the poor: the core health package in Benin emphasized preventive care, immunization and reproductive health but also and mostly, integrated care to children less than 5

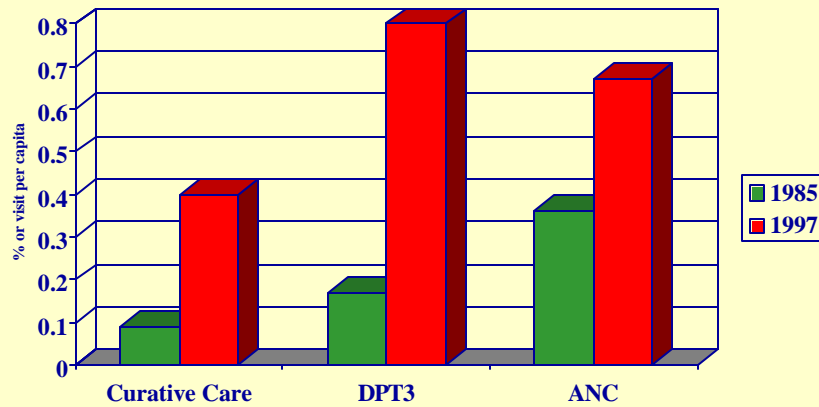
-second some resources were specifically allocated to low income provinces of the North. Specifically, as quite a few health centers were not breaking even financially in those regions, the centers received additional subsidies in form of drug donations for the drug revolving fund and equipment (refrigerators, motorbikes..etc)

-finally major attention was given to the pricing scheme so as to favor continuous use (establishing prices per full treatment, rather than separate payments for drugs) and maintain very low prices for preventive services (free immunization, low price deliveries and ANC) as well as for child health services. This was specifically addressing the relative higher price elasticity of demand for children services than for adult services.



Results show. All the indicators of performance for immunization have improved overtime . Longitudinal analysis shows that progressive improvements have been made regarding the accessibility of services and their use by the target population. Immunization coverage in Benin is the highest in the West and Central Africa region, a very good performance when compared to countries with much higher GDP such as Cameroon, or Cote D'Ivoire . The coverage rate has remained at a high 85% over the last 10 years . Differences among regions are slight, yet remain. Northern poorer regions display on average lower levers of immunization overage than richer southern provinces.

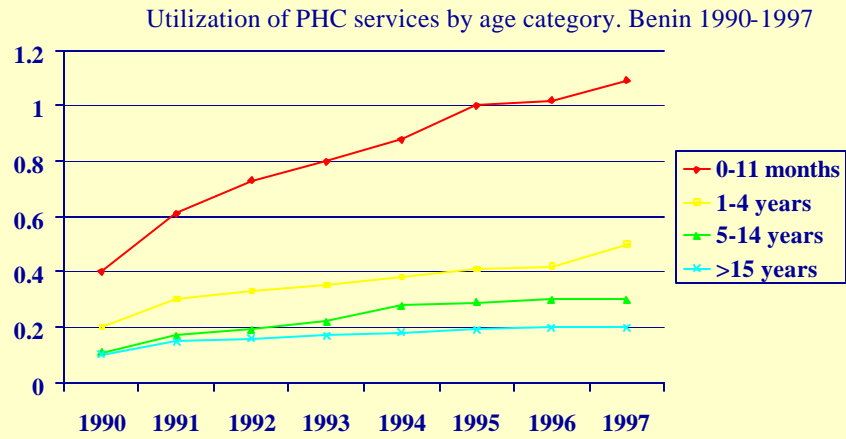
Improvement in Key Indicators



Source: SNIGS MOH Benin

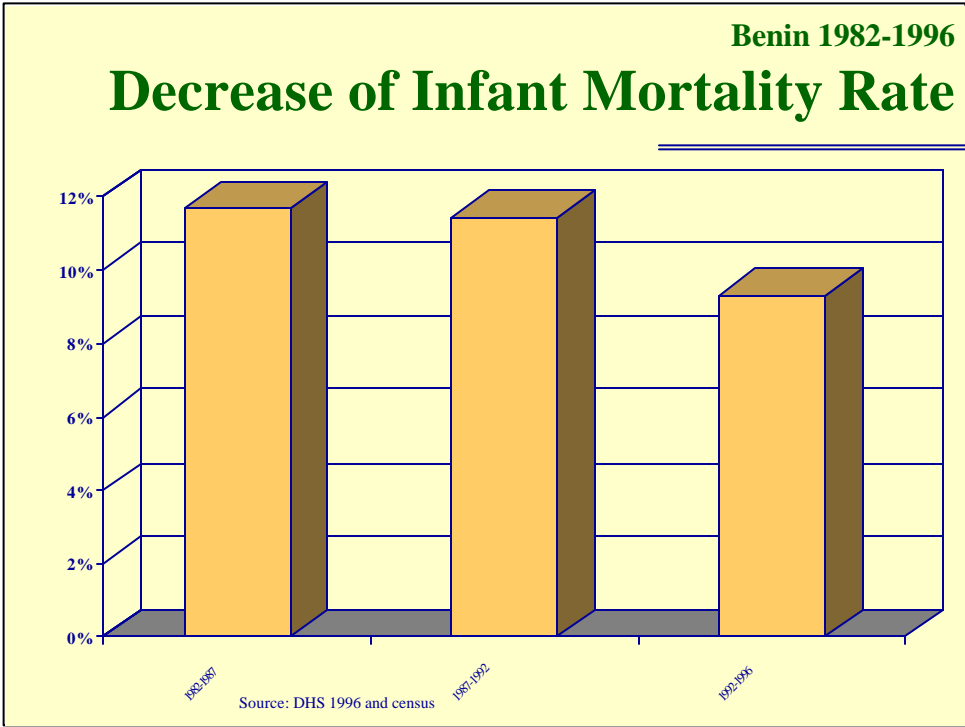
Not only immunization coverage, but all key tracer indicators have improved overtime , including coverage with antenatal care, assisted deliveries and curative care. Curative care improved from less than 0.1 visit per capita per year to 0.4 visits. The coverage with three visit for antenatal care has also dramatically improved.

Utilization of PHC Services



SNIGS-FAC

Utilization of PHC services has increased particularly among young children, less than 1 and less than 5.



Over the period the IMR and the U5MR has decreased significantly, in a context where GDP per capita has remained stable and the level of education of girls has no changed or has even decreased. In some neighboring countries such as Cote D'Ivoire or Burkina, U5 MR have increased during the same period.

The reorganization of the health system is likely to have contributed to this outcome.

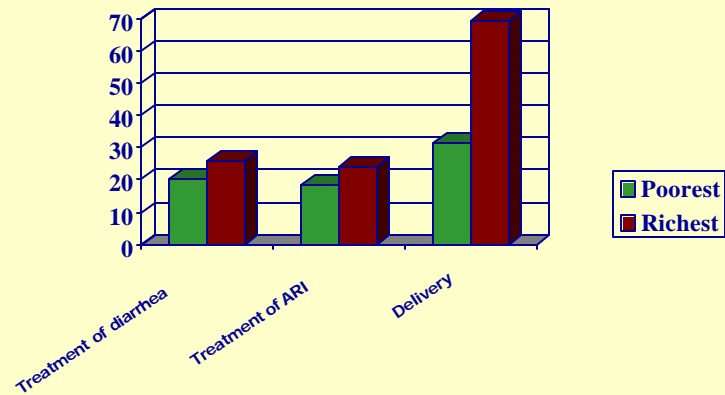
Remaining issues

- **Public sector: insufficiency of human resources, low expenditures,**
- **Levels of utilization still less than one visit per capita and per year**
- **Expansion of the private sector, increase in private expenditures (up to US\$ 20)**
- **Quality of care**
- **Still problems of equity**

Yet, the situation of the Benin health system is far from ideal today and huge challenges remain ahead. Results in terms of performance were mainly obtained through the orientation of private spending towards essential effective services. But public spending on health remains quite low. The current debate lays in how to use debt relief resources to correct this situation. Although utilization of basic services has raised to one of the highest levels in West and Central Africa it still can be considered quite low when related to the incidence of illness episodes (1 to 2 episodes per capita per year). Availability, quality and motivation of human resources remains a very difficult issue. Addressing it is likely to open the “Pandora box” of salary and reform of civil services issues. Quality of care is still an issue especially when it comes to integrating counseling as part of the duties of health staff. The private health sector has expanded, particularly in urban areas driven by a demand for better quality services. Although the coverage of the poor with key interventions has improved, there is still a large gap between the 20% richest and the remainder of the population

Benin

Utilization of Public Services



DHS

Poorest groups still use services in a lesser extent than the rich although the gap is lower than in neighboring countries. This gap is however striking for assisted deliveries calling for specific strategies to address the issue of maternal and perinatal mortality among the poor.

The Pressure Points 2000

Households and communities	Health system		Government policies and actions	
	Health service provision	Health financing	Health service provision	Health financing
Key outcomes.	Physical accessibility of services.	Risk-sharing.	Macro.	Macro.
Health-related household actions and risk factors.	Availability of essential drugs	Paying for health insurance.	Health system level.	Health system level.
Household influences on actions.	Availability of human resources	Affordable pricing of services	Micro.	Micro.
Community factors.	Organizational quality.		Public-private partnerships	
	Service utilization			
	Timing and continuity.			
	Technical quality.			
	Social accountability.			

The situation is therefore dynamic and the pressure points in 2000 are different from those of 1986. Physical access is no longer a major problem, nor availability of consumables and supplies. On the other hand the issue of recruitment, hiring and motivation of health staff has come at the forefront after almost 10 years of frozen hiring. Issues of equity of use and coverage are also becoming more acute, now that the supply is well functioning and new financing mechanisms have been emerging. Pressure point now encompass the organization of prepayment schemes, micro-insurance and third party payments to respond to both temporary and permanent incapacity to pay..

Pressure Points



It is therefore important to recognize that pressure points are to vary overtime along the maturation of the health system. The above pyramid of dimensions exemplifies how important it was for Benin to first ensure the basic functions of the system i.e access and availability were restored first so that in a second stage be able to increase overall performance. Because access and availability are no longer a problem and utilization has increased, Benin can now focus on tackling disparities and facilitating the organization risk sharing and solidarity mechanisms.