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

Session 6

Authors:

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Adam Wagstaff
Determinants of Health-Sector Outcomes

Key outcomes
- Health outcomes of the poor
  - Health & nutritional status; mortality
- Impoverishment
  - Out-of-pocket spending

Households/Communities
- Household actions & risk factors
  - Use of health services, dietary, sanitary and sexual practices, lifestyle, etc.
- Household assets
  - Human, physical & financial

Health system & related sectors
- Health service provision
  - Availability, accessibility, prices & quality of services
- Health finance
  - Public and private insurance; financing and coverage
- Supply in related sectors
  - Availability, accessibility, prices & quality of food, energy, roads, water & sanitation, etc.

Government policies & actions
- Health policies at macro, health system and micro levels.
- Other government policies, e.g. infrastructure, transport, energy, agriculture, water & sanitation, etc.
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)
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
Reducing the cost of services to the poor

Pressure points

Reducing the Cost of Services to the Poor

Publicly Financed Services
- Tax finance
- Fees—with or without waivers
- Public insurance

Privately Financed Services
- Fees for everyone
- Insurance against user fees
Tax financing

Is tax-financing more progressive?

Poor countries have low tax-raising capacity
Tax financing doesn’t guarantee the poor do well

% of total subsidy accruing

Source: Van Doorslaer, Wagstaff and Rutten (1993); Hammer et al. (1999); Ajay et al (2000).
Reducing the cost of services to the poor

Fees

Publicly Financed Services
- Tax finance
- Fees—with or without waivers
- Public insurance

Privately Financed Services
- Fees for everyone
- Insurance against user fees

Reducing the Cost of Services to the Poor
- Who is covered by insurance?
- What is covered by insurance?
- Risk-sharing
- Paying for health insurance
- How much do people pay for services not covered?
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
Fees will never raise much revenue

Magnitude of revenues raised through cost recovery in health in Africa

<table>
<thead>
<tr>
<th>Pays</th>
<th>Year</th>
<th>% of MOH recurrent budget covered by user fees</th>
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</thead>
<tbody>
<tr>
<td>Benin</td>
<td>1993</td>
<td>20%</td>
</tr>
<tr>
<td>Bostwana</td>
<td>1983</td>
<td>2.2%</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>1999</td>
<td>14.8%</td>
</tr>
<tr>
<td>Burundi</td>
<td>1982</td>
<td>4%</td>
</tr>
<tr>
<td>Cote D’Ivoire</td>
<td>1993</td>
<td>7.2%</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>1985</td>
<td>15-20%</td>
</tr>
<tr>
<td>Ghana</td>
<td>1991</td>
<td>5-6%</td>
</tr>
<tr>
<td>Guinee Conakry</td>
<td>1993</td>
<td>20%</td>
</tr>
<tr>
<td>Guinea Bissau</td>
<td>1995</td>
<td>5%</td>
</tr>
<tr>
<td>Kenya</td>
<td>1984</td>
<td>2%</td>
</tr>
<tr>
<td>Lesotho</td>
<td>1992</td>
<td>9%</td>
</tr>
<tr>
<td>Malawi</td>
<td>1983</td>
<td>3.3%</td>
</tr>
<tr>
<td>Mali</td>
<td>1986</td>
<td>2.7%</td>
</tr>
<tr>
<td>Mauritania</td>
<td>1999</td>
<td>9%</td>
</tr>
<tr>
<td>Mozambique</td>
<td>1985</td>
<td>8%</td>
</tr>
<tr>
<td>Rwanda</td>
<td>1984</td>
<td>7%</td>
</tr>
<tr>
<td>Senegal</td>
<td>1990</td>
<td>4%</td>
</tr>
<tr>
<td>Swaziland</td>
<td>1984</td>
<td>2.1%</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>1992</td>
<td>3.5%</td>
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• 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
… 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

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
User fees

… how Benin did it

Comparison of cost and price of selected services Benin 1989

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
... 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, IJPMEO, 12 (supplement 1) S1-S172 (1997)
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) *+
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.
... some did, some didn’t. It mattered

Impact of user fees on utilization of curative services: The Africa Experience

- **Decrease**
  - Ghana (public services)
  - The Gambia
  - Swaziland
  - Mali
  - Mozambique
  - Zaire (Kindu)
  - Zambia
  - Burkina Faso (?)

- **Same**
  - Uganda

- **Increase**
  - Benin
  - Cameroon
  - Guinea
  - Ghana (mission hospitals)
  - Bissau
  - Mauritania
  - Rwanda
  - Sierra Leone
  - Madagascar
  - Niger
  - Liberia
  - Zaire (Vako Boma)
Local Retention and Quality Improvements

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

visits per capita

Q1  Q2  Q3  Q4  Q5

User fee +quality
control

0  0,1  0,2  0,3  0,4  0,5  0,6  0,7
# User fees

## Mix with other revenue sources...

<table>
<thead>
<tr>
<th>User fees/ Drug revolving funds</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✓ Available cash to finance local functioning costs on a continuous basis</td>
<td>✓ Deterrent effect on the use by the poor</td>
</tr>
<tr>
<td></td>
<td>✓ Less risk of bankruptcy, out-of stock</td>
<td>✓ Increase over-prescription to increase revenue, “conducting business in the health sector”</td>
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<tr>
<td></td>
<td>✓ Governance: easy to control revenue and drug consumption</td>
<td></td>
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<td></td>
<td>✓ Reduction of number of unsuccessful trips/visits</td>
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</table>

<table>
<thead>
<tr>
<th>Prepayment scheme</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✓ Available cash to finance local functioning costs</td>
<td>✓ Reticence to pay for a hypothetical future need</td>
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<tr>
<td></td>
<td>✓ Promotes service utilization</td>
<td>✓ Deterrent effect on the poor who cannot afford the premium</td>
</tr>
<tr>
<td></td>
<td>✓ Does not put the financial burden on the sick</td>
<td>✓ Risk of over-utilization of services or over-prescription leading to bankruptcy</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Third Party payment</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>✓ Promotes service utilization among the poor</td>
<td>✓ Difficulty of means testing/ definition of criteria for benefits</td>
</tr>
<tr>
<td></td>
<td>✓ Decrease financial burden on households</td>
<td>✓ Delayed of funds transfers</td>
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<table>
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<th>Government subsidy</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
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<td></td>
<td>✓ Reduces the price of priority services</td>
<td>✓ Rationing of subsidized services</td>
</tr>
<tr>
<td></td>
<td>✓ Helps provide free essential services</td>
<td>✓ Mainly benefits those who can access the subsidized services, often mostly the richest groups</td>
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<tr>
<td></td>
<td></td>
<td>✓ Transfers reach peripheral areas with delays</td>
</tr>
</tbody>
</table>
… it cushions the effect of fees on use

Percentage change in number of curative consultations before and after introduction of pricing policies, 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)
Financial benefits to the population of the introduction of community financing:


- Illéla (Control)
- Say (User fees)
- Boboye (Modest user fees + Taxes)

(Diop et al. 1996 “the impact of alternative cost recovery schemes on access and equity in Niger. “Health Policy and Planning”, 10-223-40) *+
This is to be done in Guinea.....

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

Guinea I PRSP preparation

Management committee for health

Rural community

Health board

Solidarity fund (poverty/equity fund)

Mutuelles, Health Micro-assurance

Respond to permanent incapacity to pay

Respond to temporary capacity to pay, seasonal variations in income

Monitoring and community based planning and monitoring

Community based management: transparency and control, social accountability
Protect the poor …

- Protecting the poor implies that those with permanent incapacity to pay will benefit from fee exemptions.
- Yet, the 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;
### Experience with fee-waivers in China

<table>
<thead>
<tr>
<th>County/Population Group</th>
<th>Percentage of Child Diarrhea Cases Receiving Treatment</th>
<th>Year before PAF (1997/98)</th>
<th>Year after PAF (1998/99)</th>
<th>% Change, Before-After</th>
</tr>
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<tr>
<td><strong>Nanhua (PAF Benefits to Very Poor Only)</strong></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Very Poor</td>
<td>67.3</td>
<td>81.1</td>
<td>+20.5</td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>75.5</td>
<td>78.5</td>
<td>+3.9</td>
<td></td>
</tr>
<tr>
<td>Non-Poor</td>
<td>77.2</td>
<td>82.5</td>
<td>+6.9</td>
<td></td>
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<tr>
<td><strong>Nanjian (PAF Benefits to Very Poor and Poor)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Poor</td>
<td>69.5</td>
<td>82.3</td>
<td>+18.5</td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>76.6</td>
<td>79.5</td>
<td>+3.8</td>
<td></td>
</tr>
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<td>78.4</td>
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<td></td>
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<td>Poor</td>
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<td>75.0</td>
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Reducing the Cost of Services to the Poor

Public insurance

Reducing the Cost of Services to the Poor
- Who is covered by insurance?
- What is covered by insurance?
- Risk-sharing
- Paying for health insurance
- How much do people pay for services not covered?

Publicly Financed Services
- Tax finance
- Fees—with or without waivers
- Public insurance

Privately Financed Services
- Fees for everyone
- Insurance against user fees
Try to target public insurance on the poor?

% with low income card, Thailand

Source: authors, *Title*, The World Bank, 2000
Extend social insurance to the poor?

Social insurance coverage,
Vietnam 1998

Social insurance coverage,
Colombia

Public insurance

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
Out-of-pocket spending on drugs per health service contact, Vietnam. By provider type

- **Bottom 93**
- **Bottom 98**
- **Top 93**
- **Top 98**

- **Quintiles**
  - Traditional healers
  - Drug vendors
  - Private clinics doctors
  - Commune health centers
  - Public hospitals

00s VDN 98 prices

0 50 100 150 200 250 300 350 400
Total out-of-pocket spending per contact, Vietnam 1998, by provider

- Public hospitals
- Commune health centers
- Private clinics
- Drug vendors
- Trad. Healer Fees
- Trad. Healer Drugs
Getting services delivered to the poor

Pressure points

Eight Steps to Effective Coverage for Poor People

- Social accountability
- Technical quality
- Timing and continuity
- Relevance of services
- Organizational quality
- Availability of material resources
- Availability of human resources
- Accessibility

Publicly Financed Services

- Spending enough
- Combining efficiency with equity
- Targeting spending on the poor

Privately Financed Services

- Stewardship
Spending enough

How much is enough?

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
Combining efficiency with 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
Applying pressure

The issues

Publicly Financed Services
- Raising spending
- Increasing efficiency
- Reallocating resources towards poor people

Privately Financed Services
- Stewardship

How much?
- Changing mix of services & interventions
- Input mixes & input prices
- Raising technical efficiency
- Targeting the poor
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
Debt relief finances targeted programs in Cameroon

Targeting the poor

Targeting burden of diseases of the poor

Targeting specific areas

Emergency AIDS program
Malaria program
Immunization
Essential drugs for 50 needest districts
Health staff for 50 neediest districts
PHC and EOC services for 50 neediest d...
Various Instruments can be used for targeting

• Needs based resource allocation

• Purchasing of services to providers

• Transfers
Targeting the poor

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
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
Targeting the poor

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
Applying pressure

The issues

Publicly Financed Services
- Raising spending
- Increasing efficiency
- Reallocating resources towards poor people

Privately Financed Services
- Stewardship

How much?
- Changing mix of services & interventions
  - Input mixes & input prices
  - Raising technical efficiency
- Targeting the poor

Regulation
Coordination
M&E
Information
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 i.e. food and drug quality control, as well as drug and health services prices
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
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)

...all ........by region, level of poverty, income group,
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)
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.
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
Orienting the health sector towards serving the poor

The case of Benin, West Africa

1985-1998
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
Benin

Immunization Coverage 1985

Access
Availability
Utilization
Continuity
Quality

%
Benin

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
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
## The Pressure Points

<table>
<thead>
<tr>
<th>Households and communities</th>
<th>Health system</th>
<th>Government policies and actions</th>
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<tbody>
<tr>
<td></td>
<td>Health service provision</td>
<td>Health financing</td>
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<tr>
<td>Key outcomes.</td>
<td>Physical accessibility of services.</td>
<td>Who is covered by insurance?</td>
</tr>
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<td>Health-related household actions and risk factors.</td>
<td>Availability of essential drugs</td>
<td>What is covered by insurance?</td>
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<td>Service relevance.</td>
<td>How much do people pay for services not covered?</td>
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<td>Timing and continuity.</td>
<td>Affordable pricing of services</td>
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Benin

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:
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
Benin

Immunization Coverage 1985-1998

Source: SNIGS MOH Benin
Improvement in Key Indicators

Source: SNIGS MOH Benin
Utilization of PHC services by age category. Benin 1990-1997

- 0-11 months
- 1-4 years
- 5-14 years
- >15 years

SNIGS-FAC
Benin 1982-1996

Decrease of Infant Mortality Rate

Source: DHS 1996 and census
Benin

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
Utilization of Public Services

- Treatment of diarrhea
- Treatment of ARI
- Delivery

Poorest vs. Richest

DHS
## The Pressure Points 2000

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<td>Paying for health insurance.</td>
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<td>Household influences on actions.</td>
<td>Availability of human resources</td>
<td>Affordable pricing of services</td>
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Benin

Pressure Points

Effective Coverage

Social Accountability
Technical Quality
Timing and Continuity
Relevance of Services Mix and utilization
Organizational Quality
Availability of Material Resources
Availability of Human Resources
Physical Accessibility