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

Session 6

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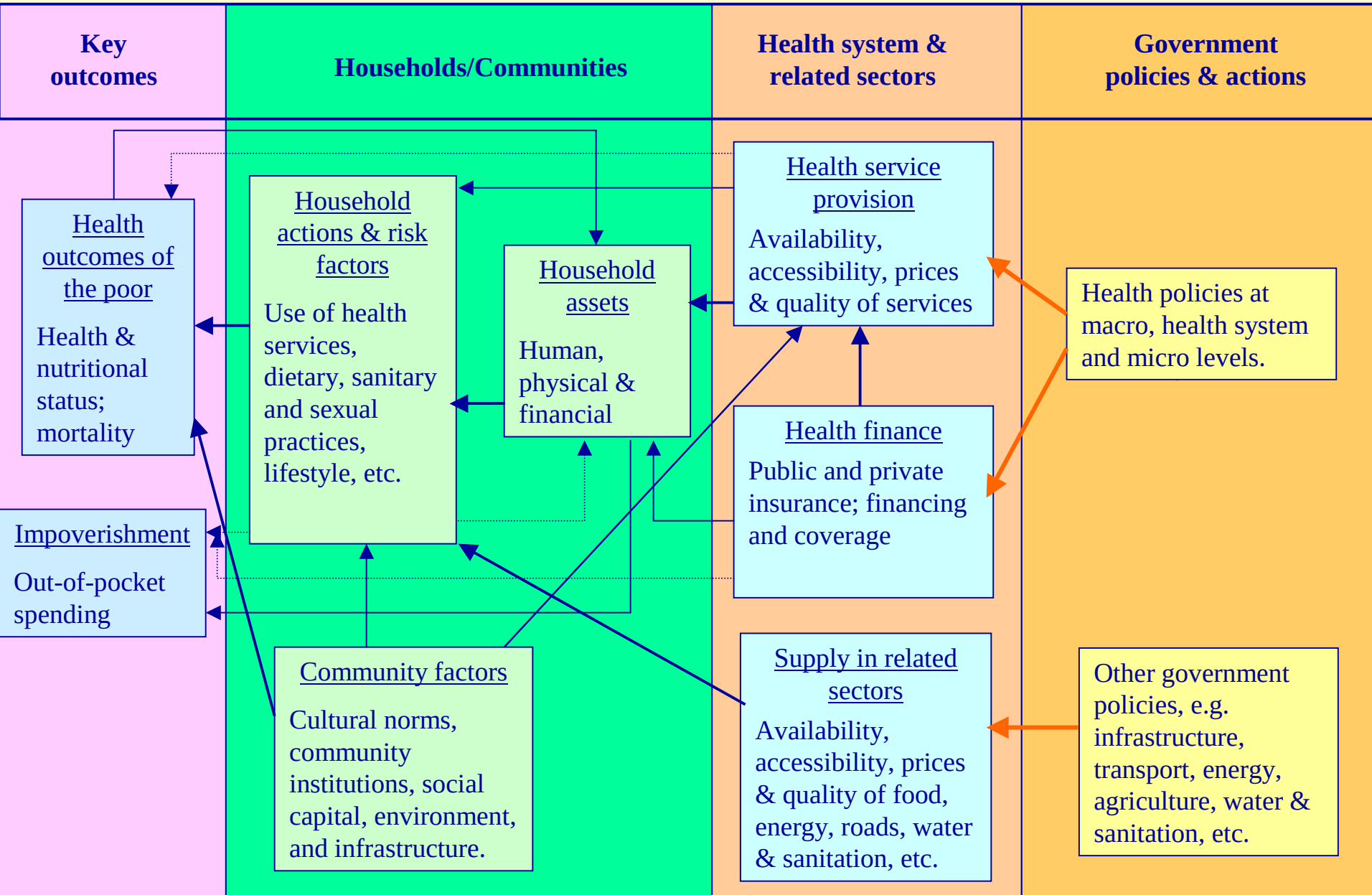
Determinants of Health-Sector Outcomes



Objectives of This Session

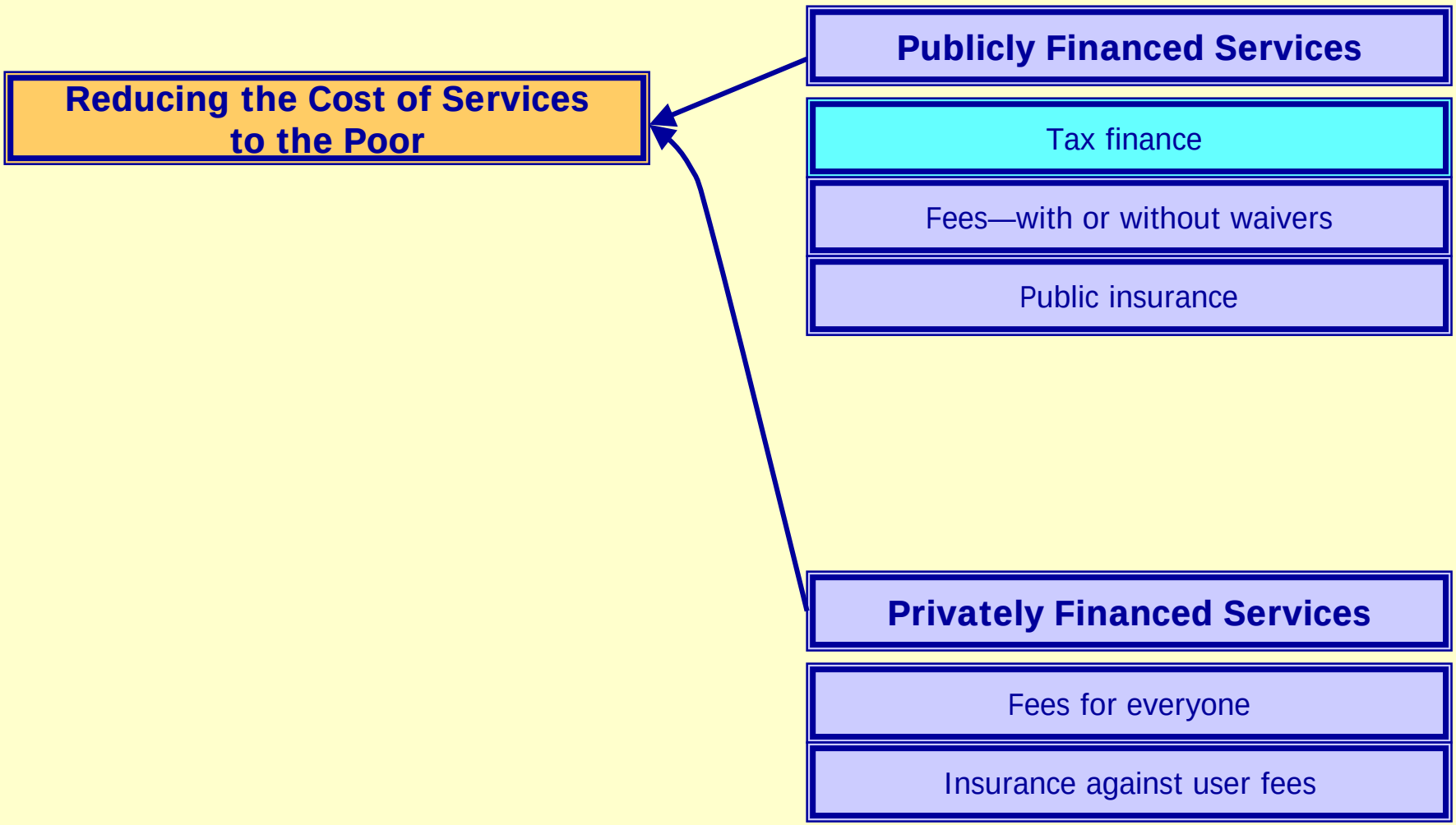
To answer the following questions:

- **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)**

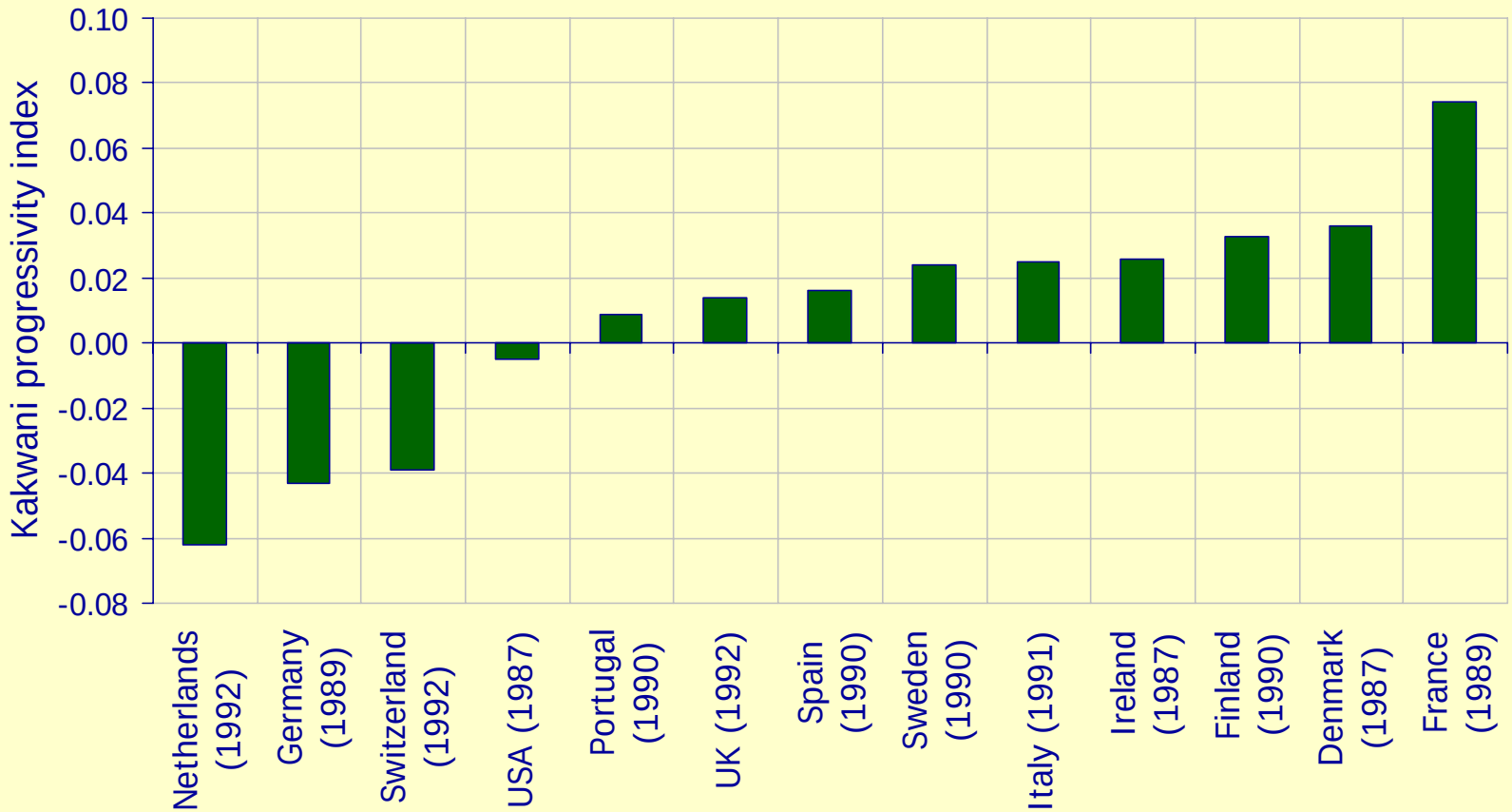
Session Outline

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**

Pressure points

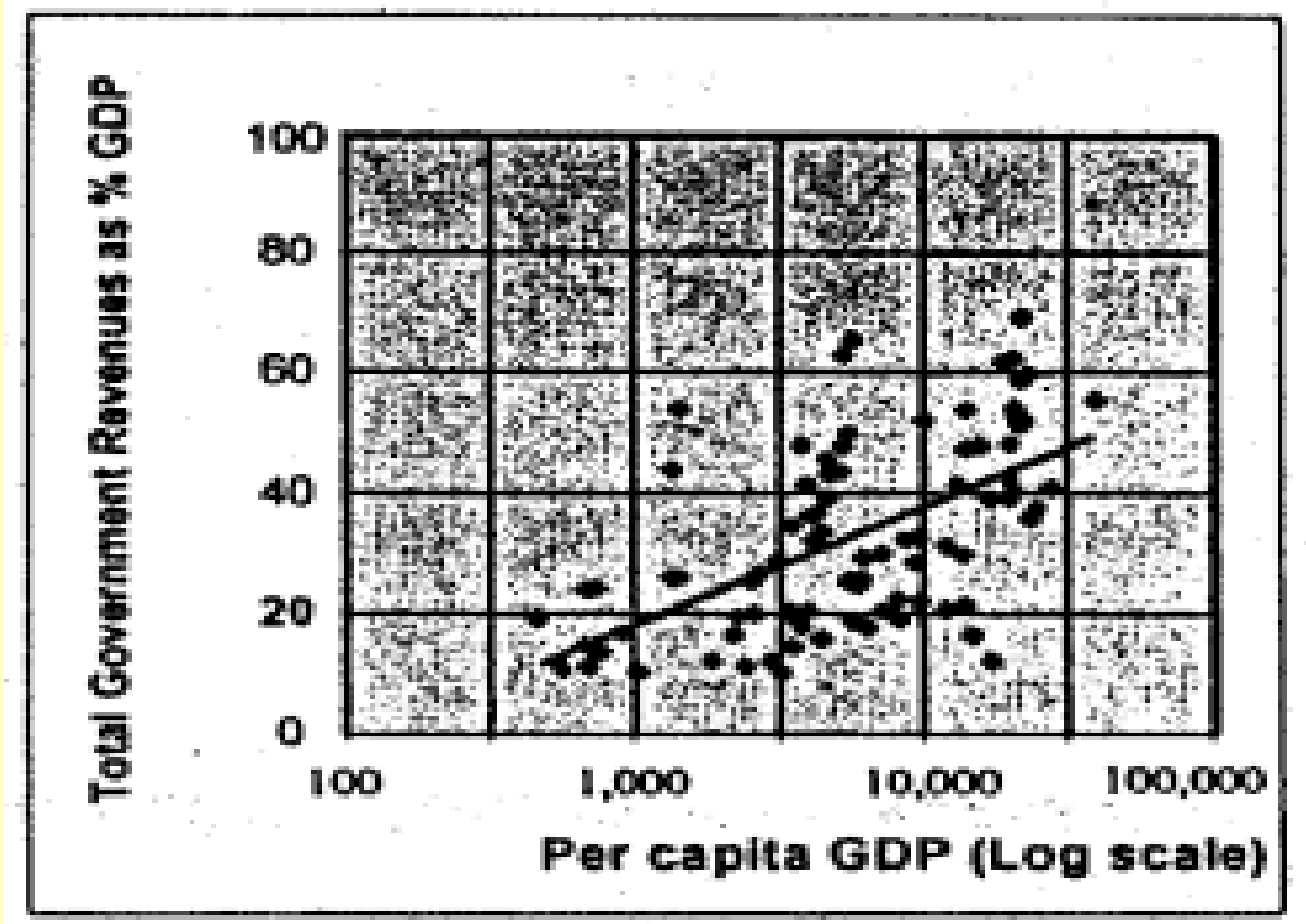


Is tax-financing is more progressive?

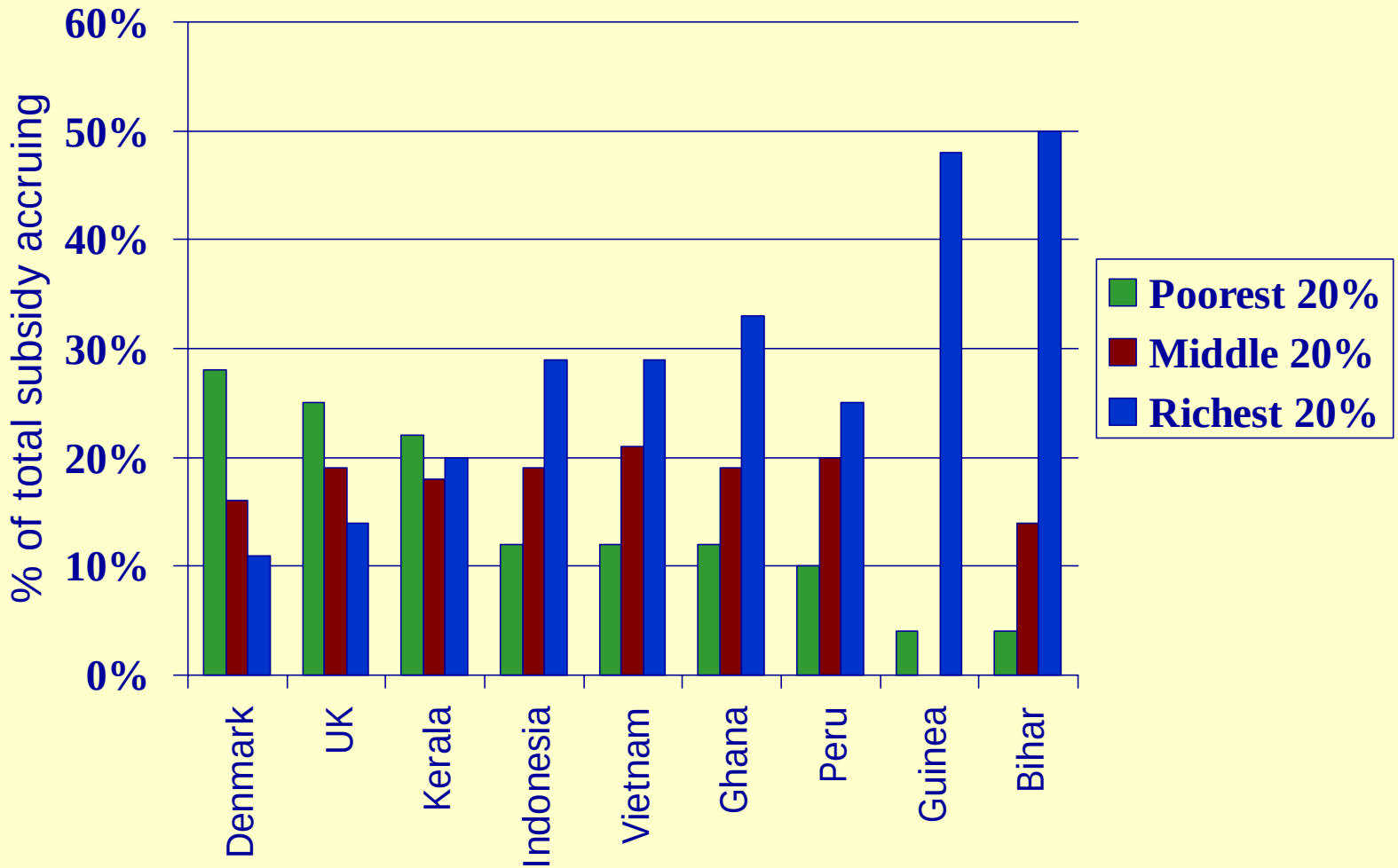


Source: Wagstaff, A, E Van Doorslaer, E, et al. Equity in the finance of health care: Some further international comparisons. *Journal of Health Economics* (18)3: 263-290, 1999.

Poor countries have low tax-raising capacity



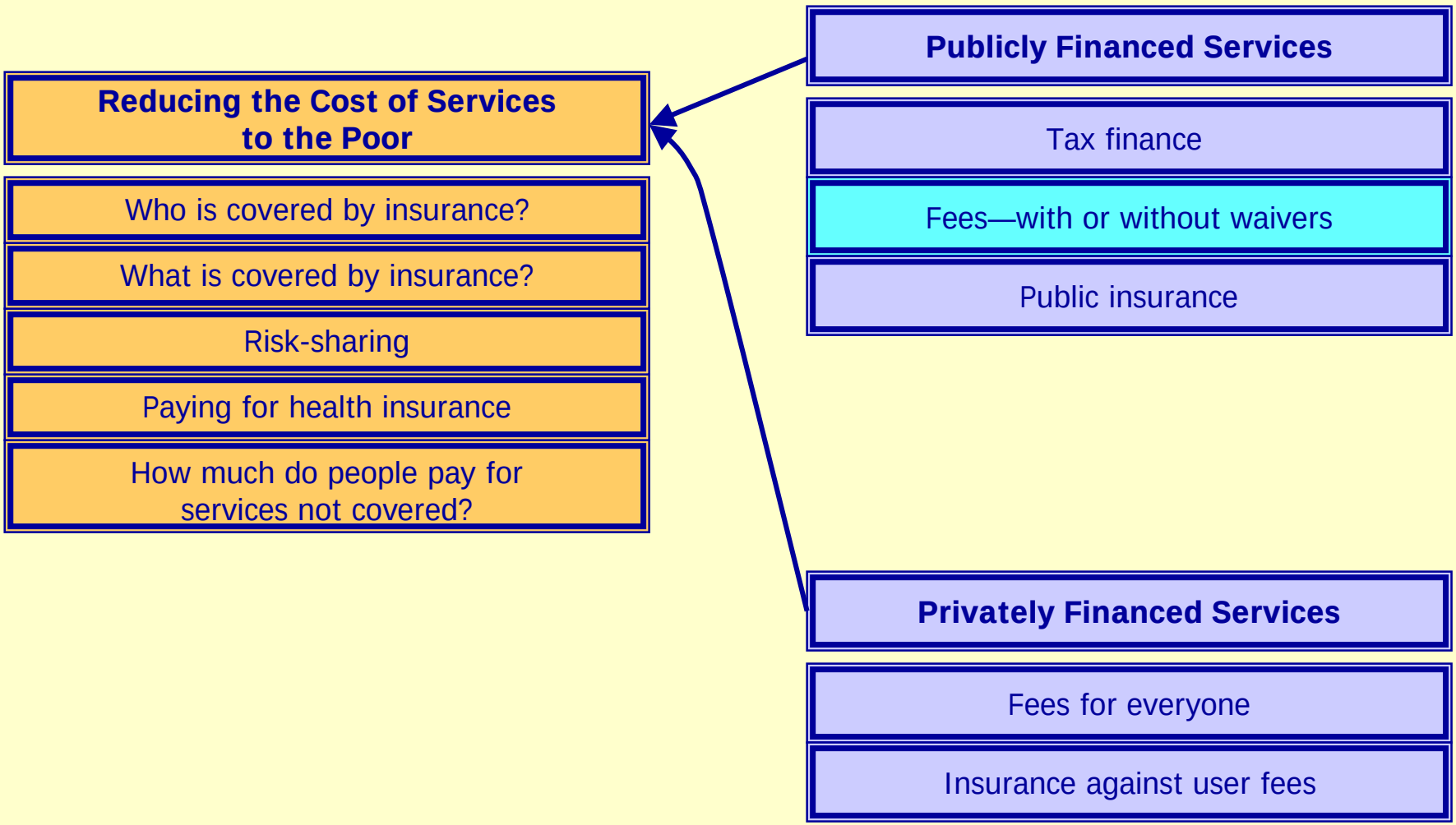
Tax finance doesn't guarantee the poor do well



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

Reducing the cost of services to the poor

Fees



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

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%

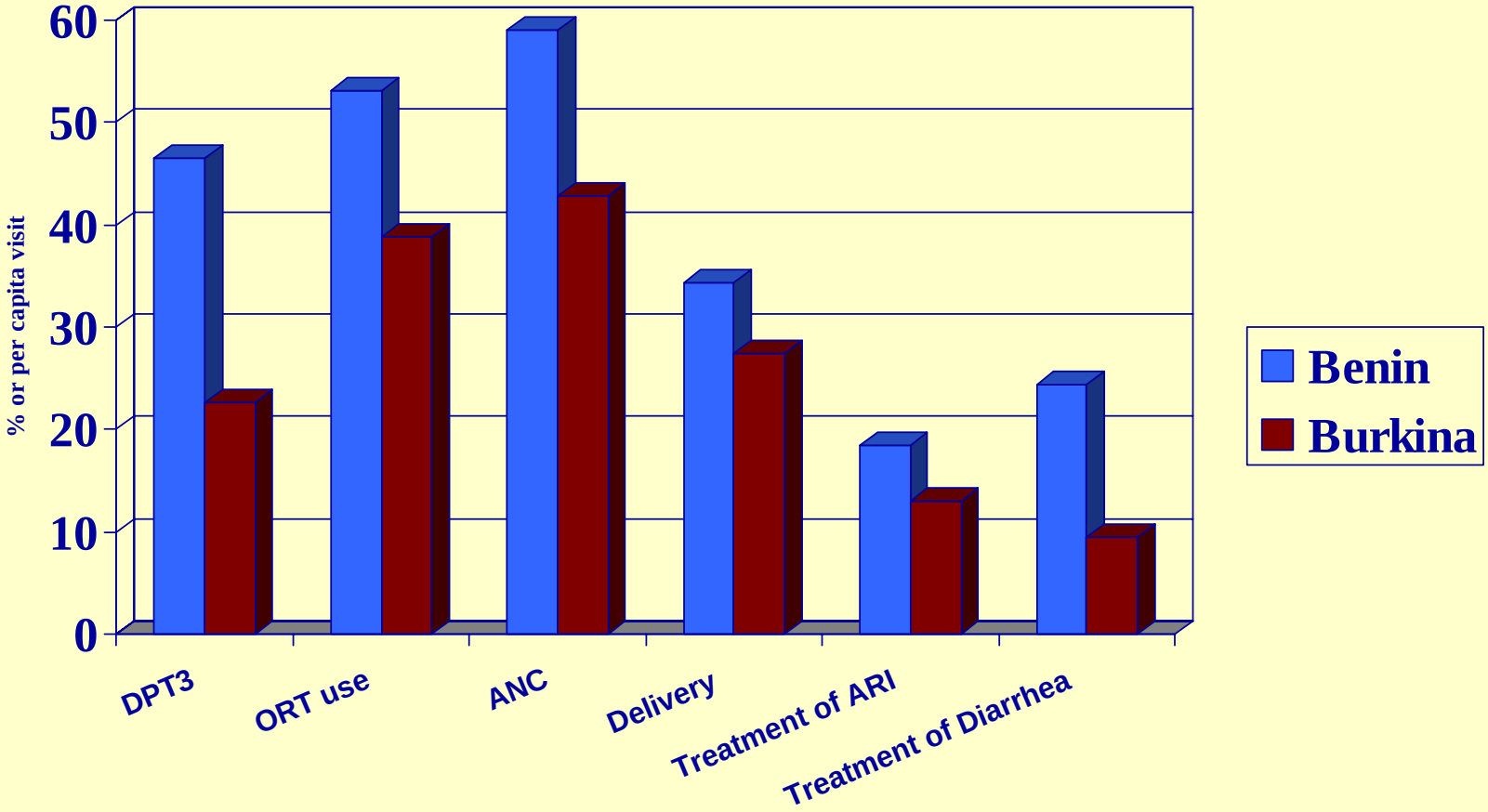
Source:Vogel (1991) Nolan and Turbat (1995) Shaw and Griffin (1995), Soucat and Diop (2001)

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

… 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



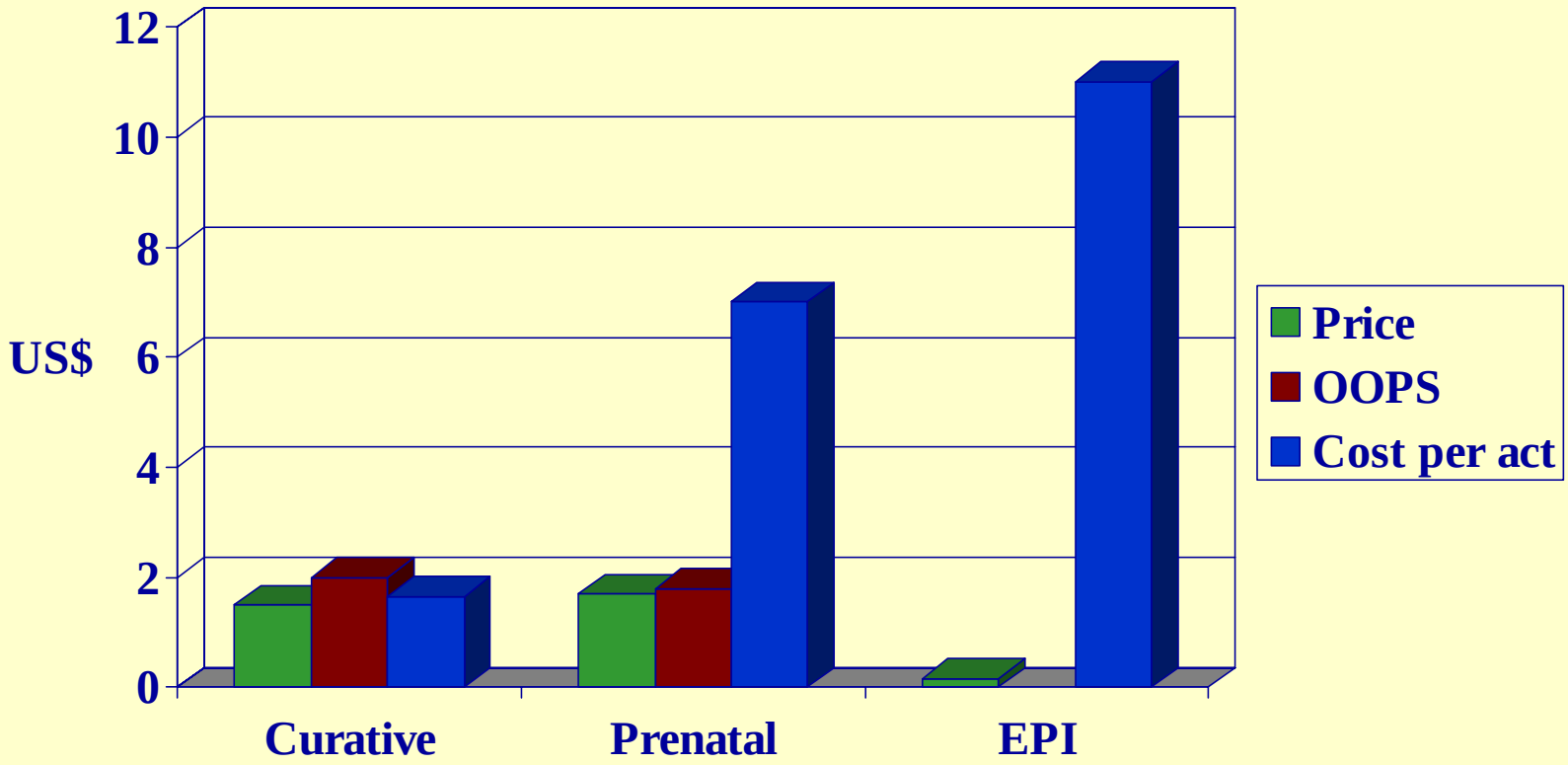
"Socio-Economic Differences in Health, Nutrition, and Population in Burkina Faso." and "Socio-Economic Differences in Health, Nutrition, and Population in Benin" February/March 2000. Davidson R. Gwatkin, Shea Rutstein, Kiersten Johnson, Rohini Pande, and Adam Wagstaff. HNP/Poverty Thematic Group, The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

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

… how Benin did it

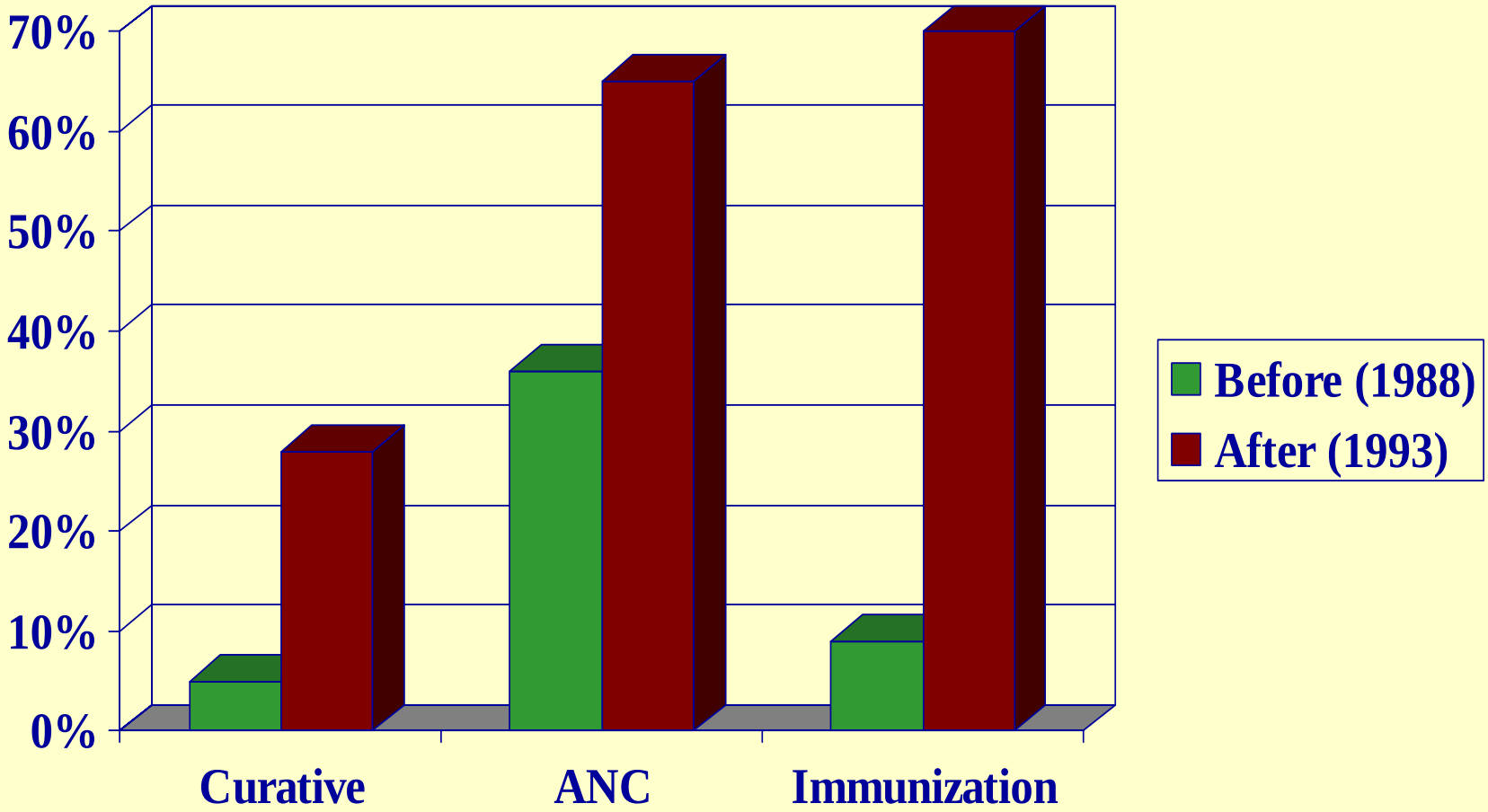
Comparison of cost and price of selected services Benin 1989



Source: Soucat et al, "Health Seeking behaviour and household health expednitures 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

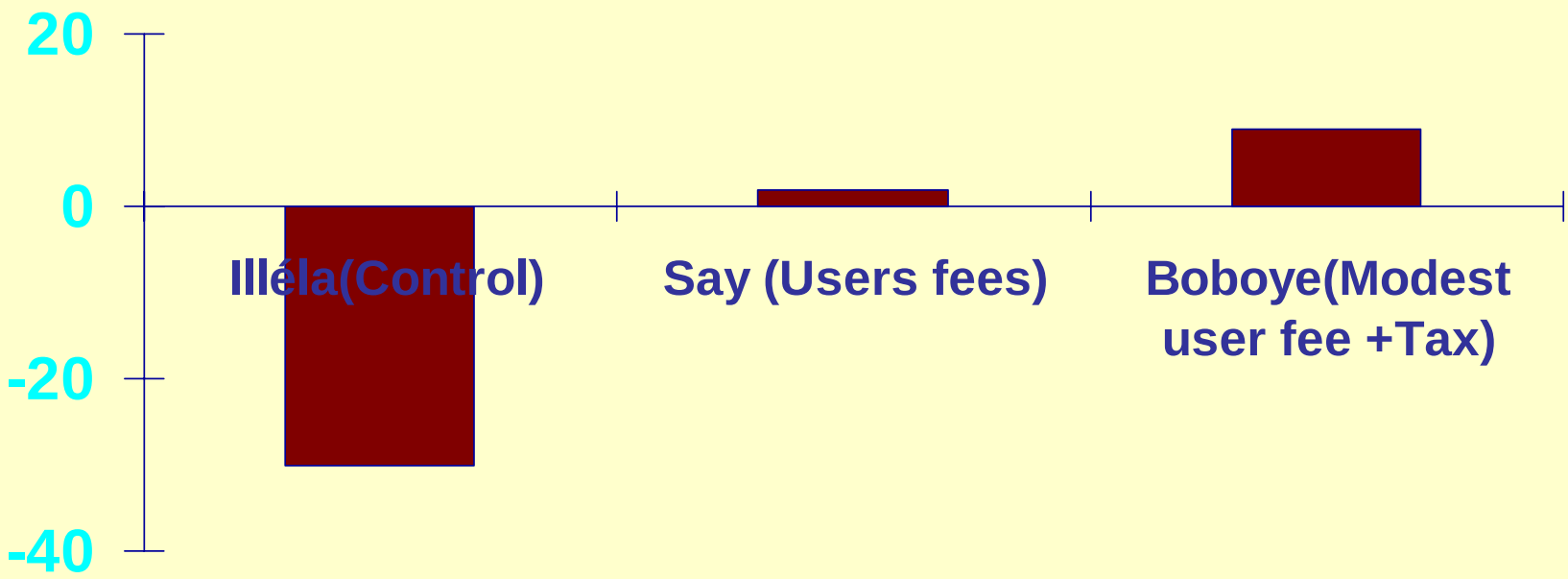
Impact of introduction of modest user fees associated with quality improvements and community management on utilization of curative and preventive services: Benin 1988-1993



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

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) *+

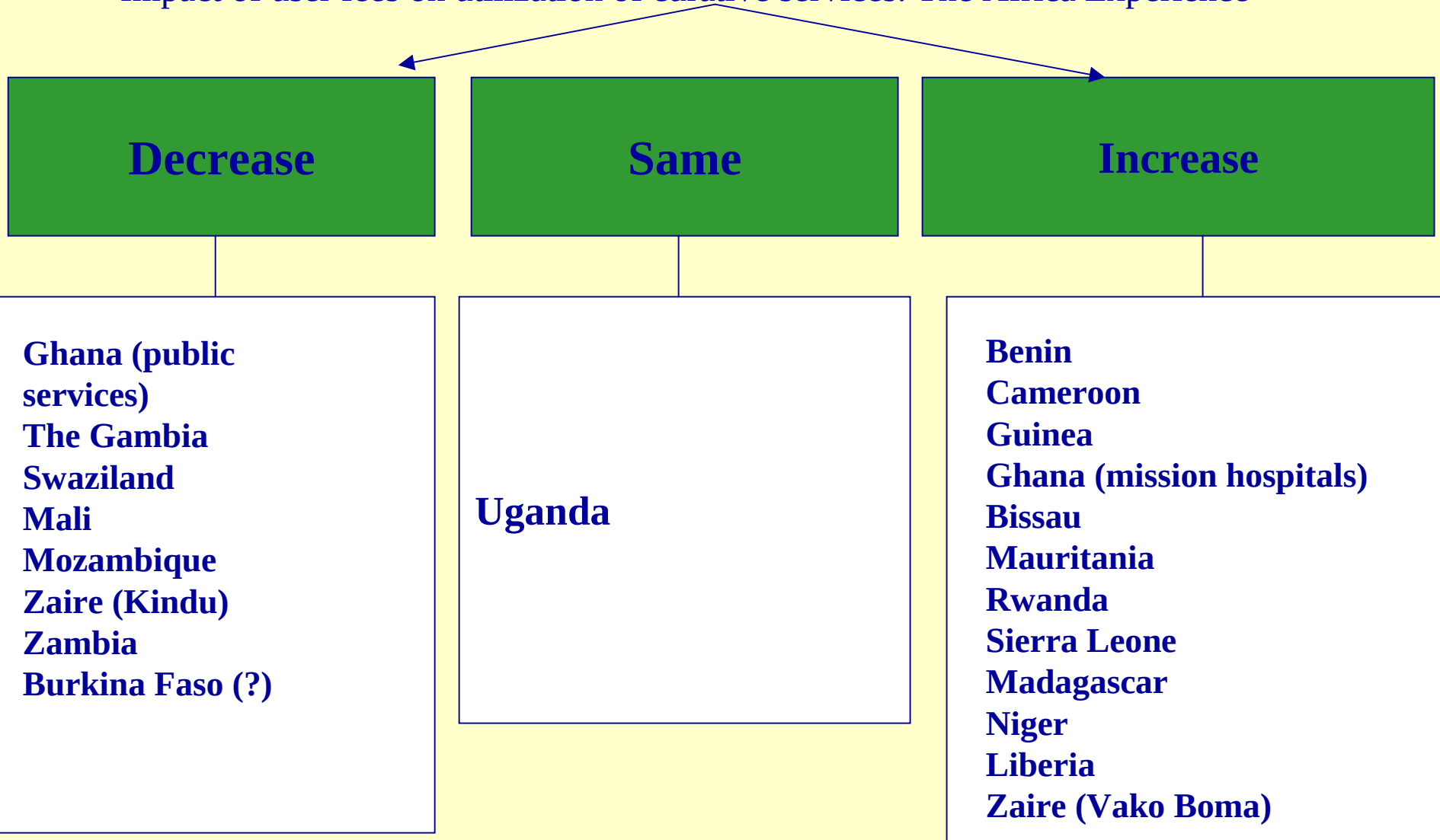
Retain and manage fees revenue at local level

- 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.

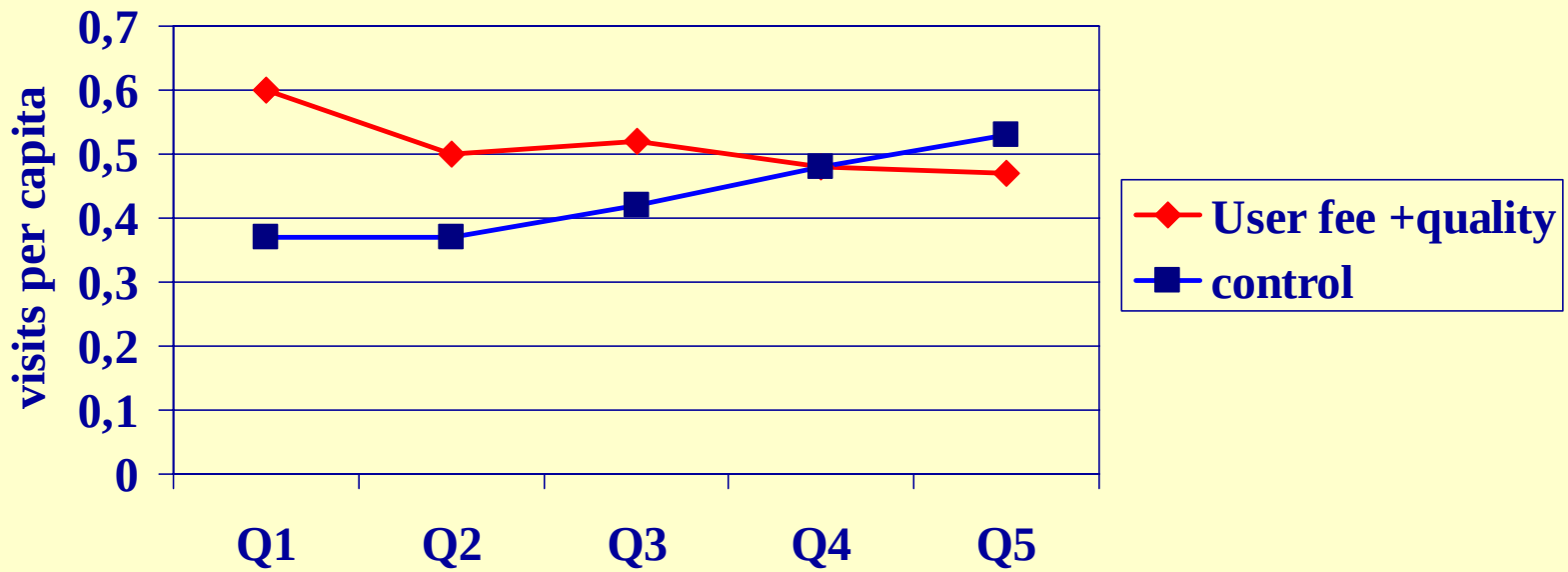
… some did, some didn't. It mattered

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



Local Retention and Quality Improvements

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

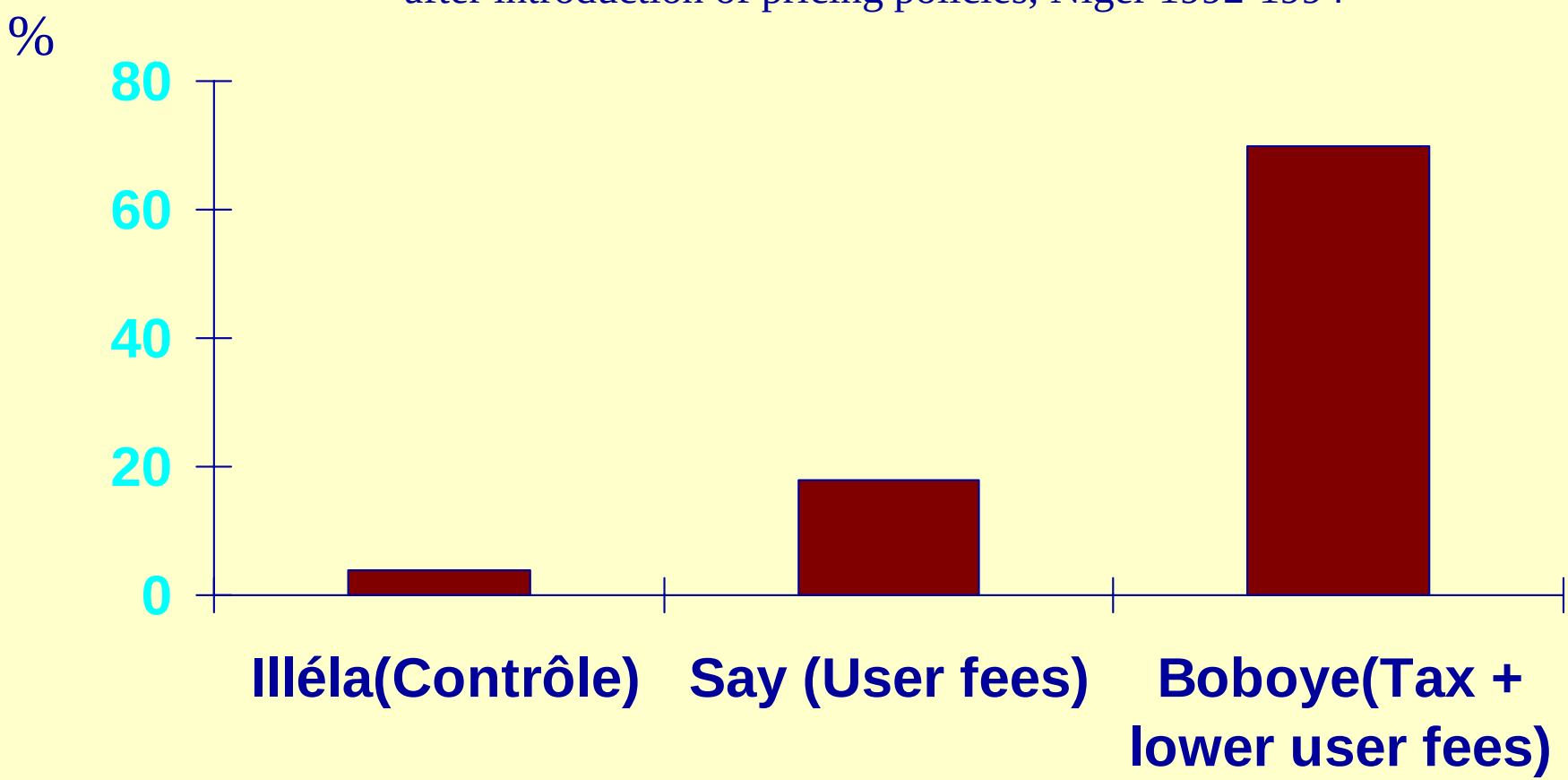


Mix with other revenue sources…

	Advantages	Disadvantages
User fees/ Drug revolving funds	✓ 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	✓ Deterrent effect on the use by the poor ✓ Increase over-prescription to increase revenue , "conducting business in the health sector"
Prepayment scheme	✓ Available cash to finance local functioning costs ✓ Promotes service utilization ✓ Does not put the financial burden on the sick	✓ 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	✓ Promotes service utilization among the poor ✓ Decrease financial burden on households	✓ Difficulty of means testing/ definition of criteria for benefits ✓ Delayed of funds transfers
Government subsidy	✓ Reduces the price of priority services ✓ Helps provide free essential services	✓ Rationing of subsidized services ✓ Mainly benefits those who can access the subsidized services, often mostly the richest groups ✓ Transfers reach peripheral areas with delays

… 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

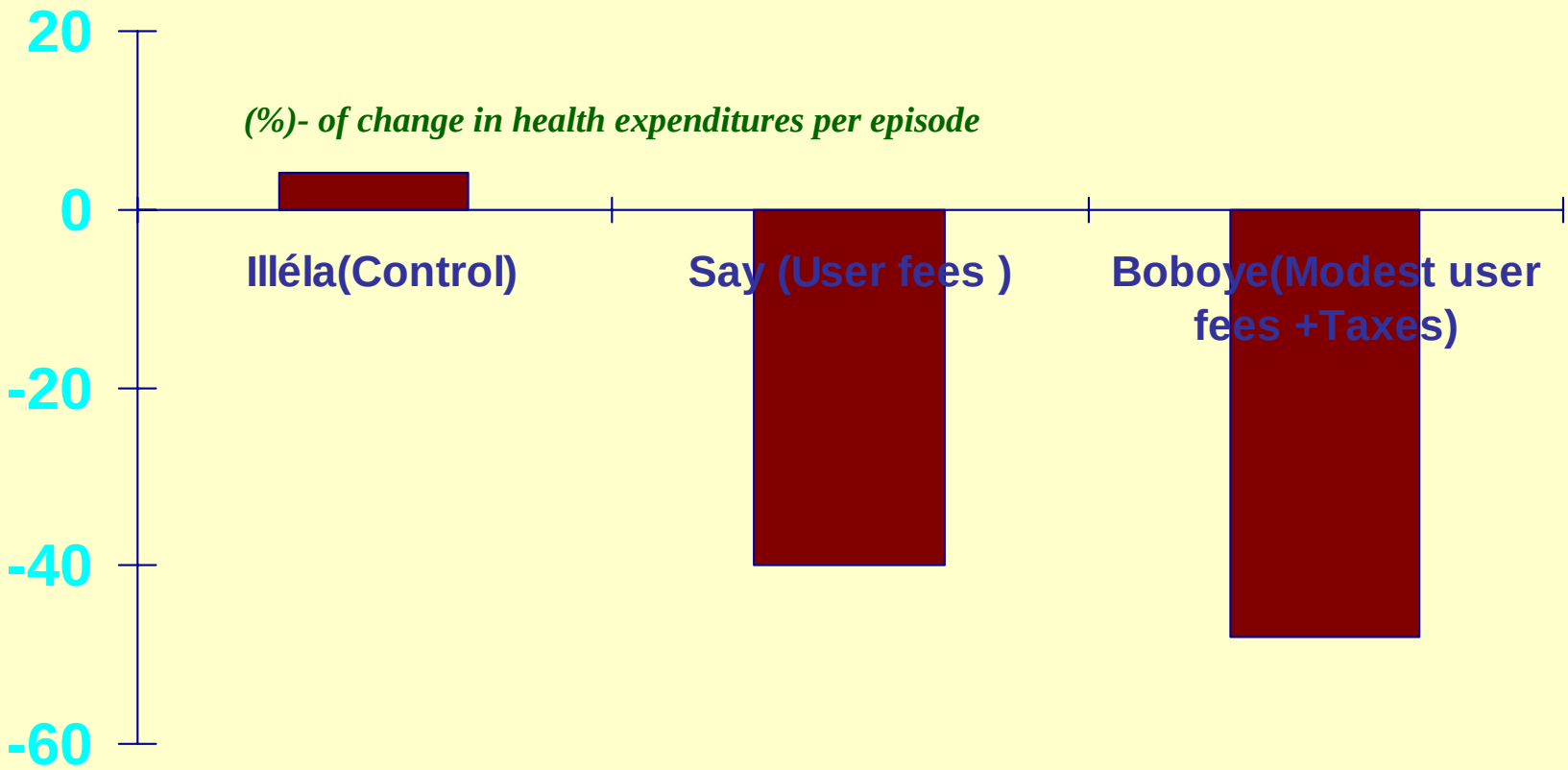


(Diop et al, 1996 “ the impact of alternative cost recovery schemes on access and equity in Niger. “Health Policy and Planning”, 10-223-40) *+

…and on out-of pocket spending

Financial benefits to the population of the introduction of community financing:

Niger 1992-1994

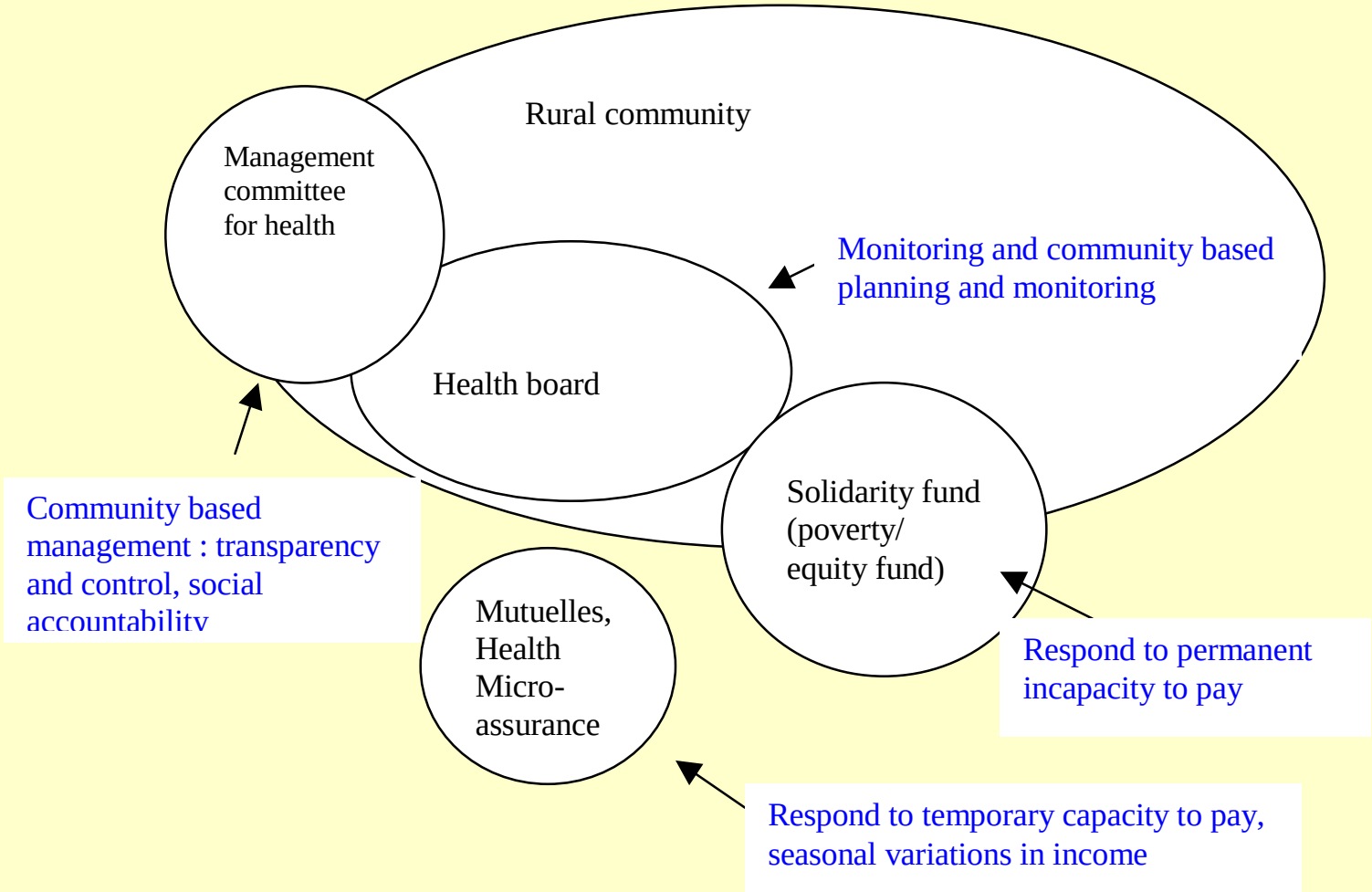


(Diop et al, 1996 " the impact of alternative cost recovery schemes on access and equity in Niger. "Health Policy and Planning", 10-223-40) *+

This is to be done in Guinea…..

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

Guinea I PRSP preparation



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;

… 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"*

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?

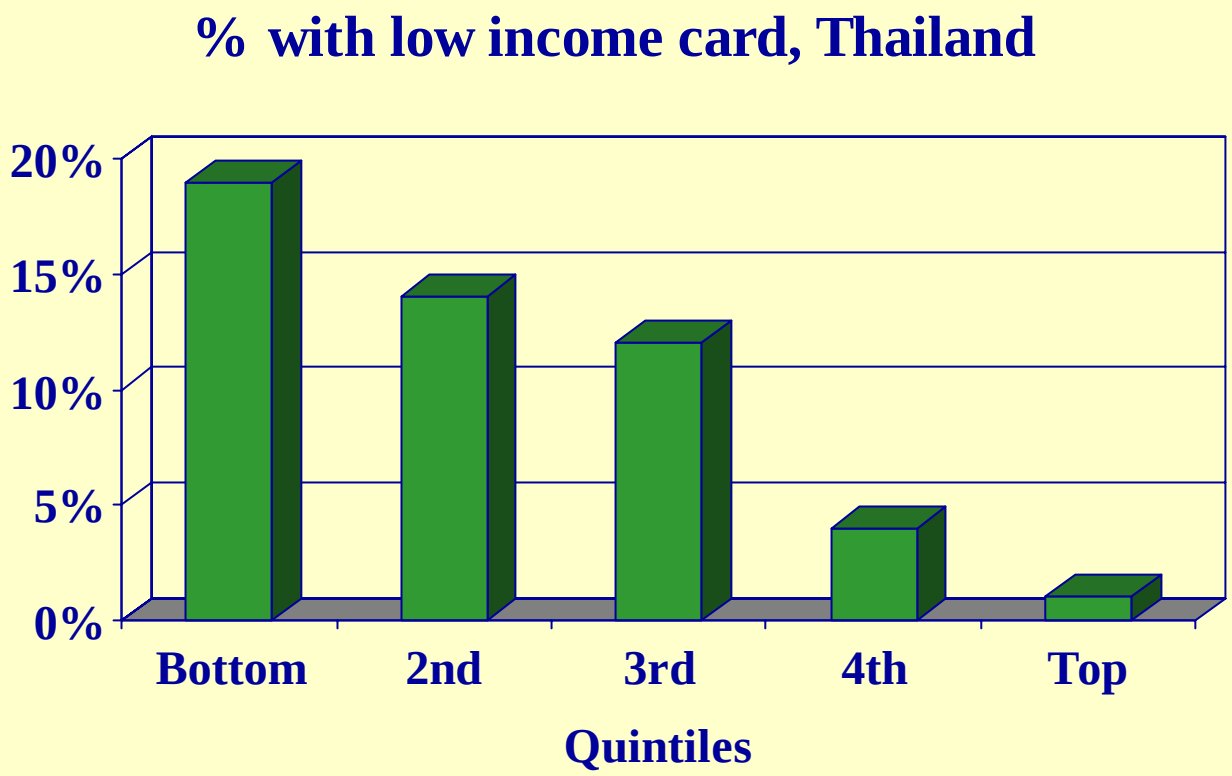
Publicly Financed Services

- 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?

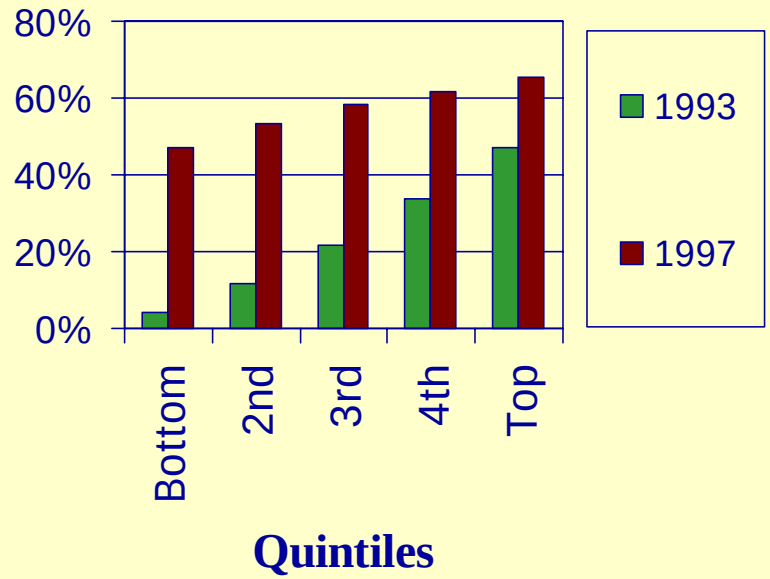


Source: authors,
Title, The World Bank, 2000

Extend social insurance to the poor?

Social insurance coverage, Vietnam 1998

Social insurance coverage, Colombia

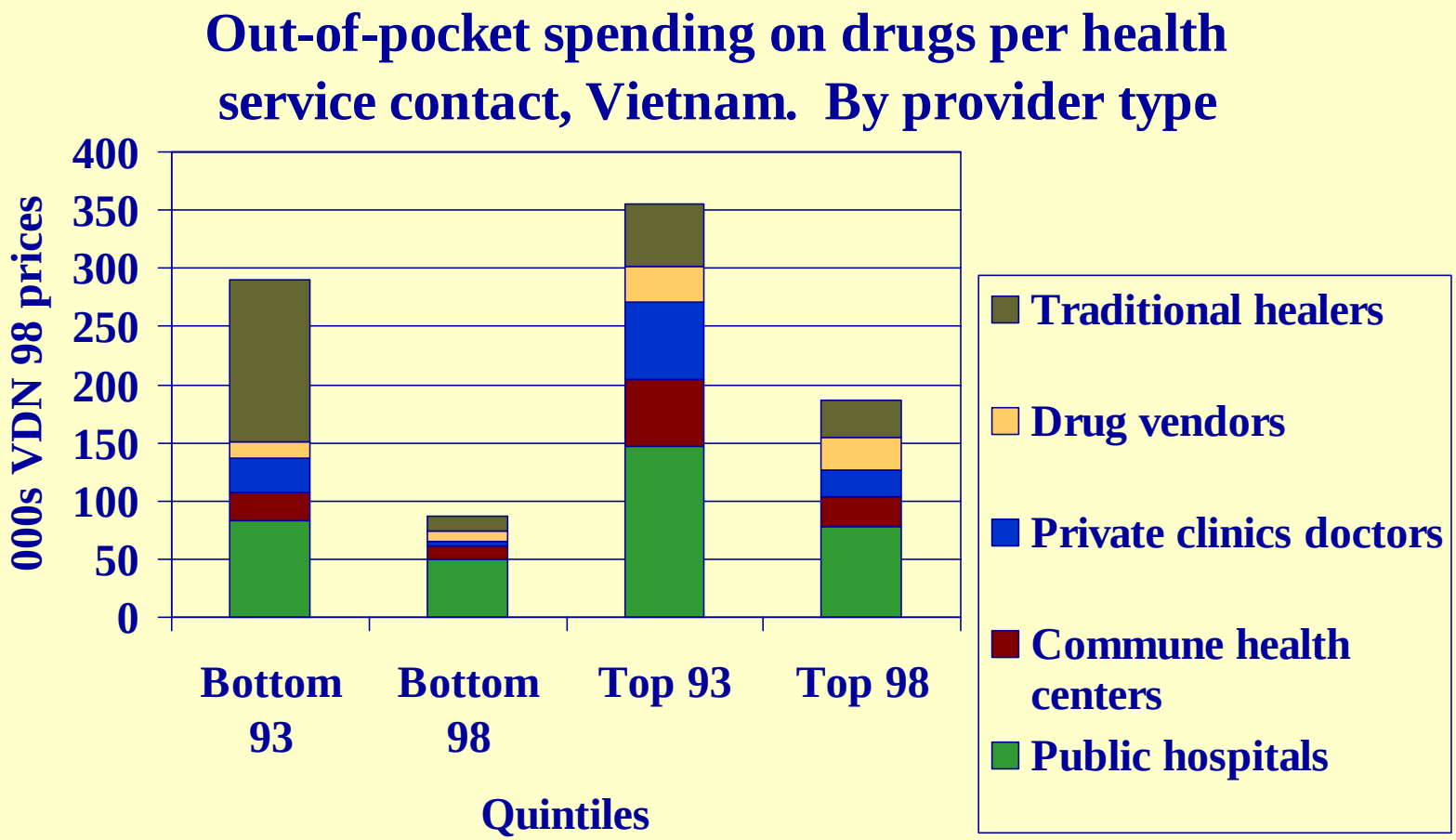


Source: World Bank, Vietnam Health Sector Review, 1999.
Londono et al., Decentralization and reforms in health services: the Colombian case, The World Bank, 1999.

From contributions to tax finance

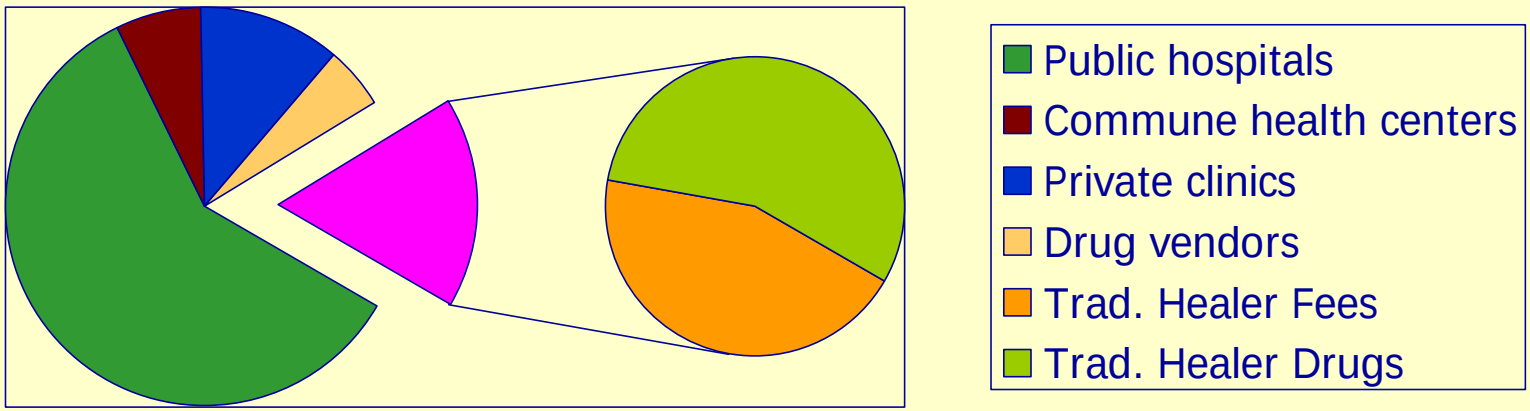
- Universalization of social insurance often followed by shift to tax finance—Europe's experience
- Some universalization in Latin America, but no major shift apparent towards tax finance

Government and drugs expenditures



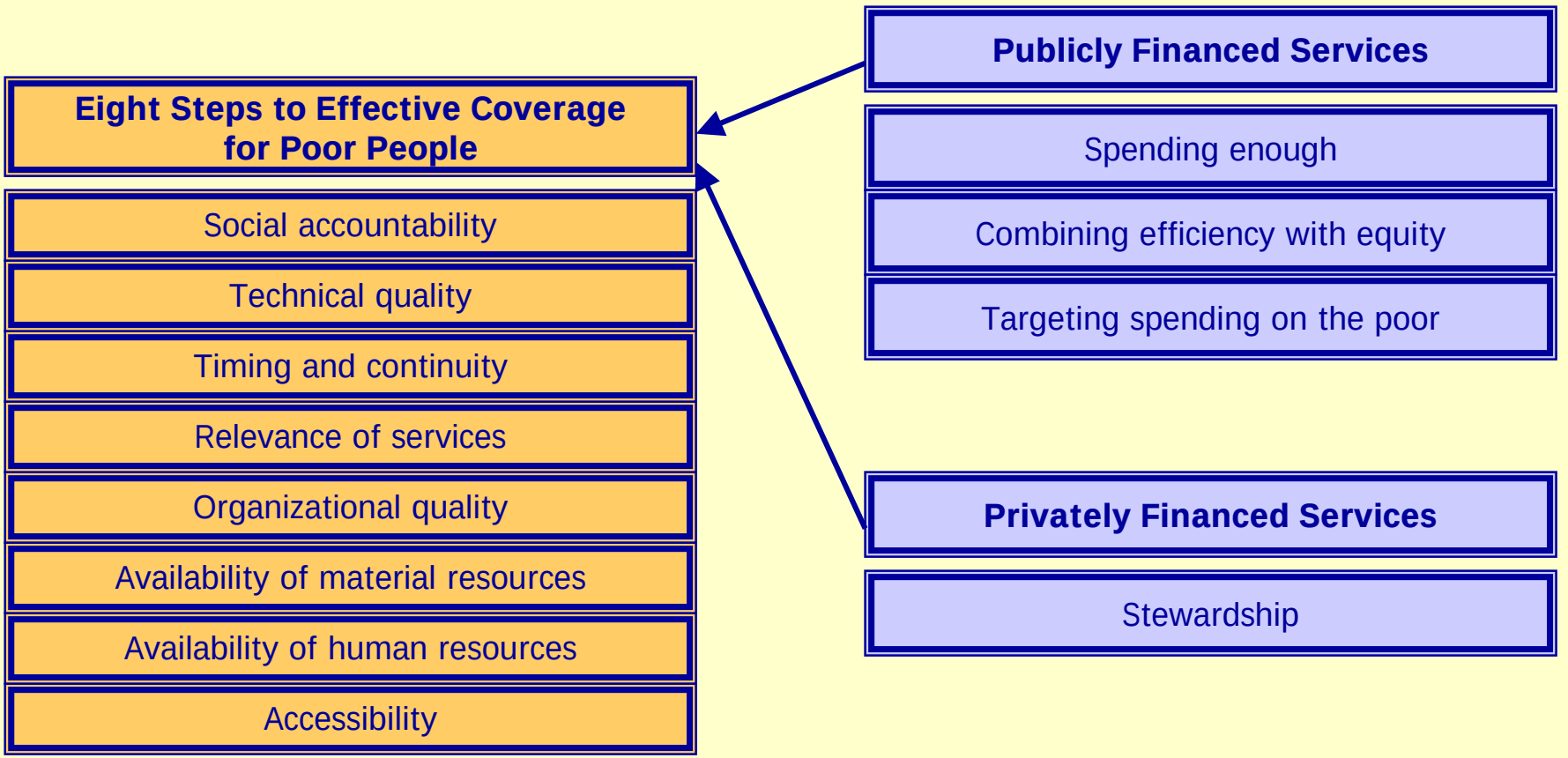
Government and quality

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



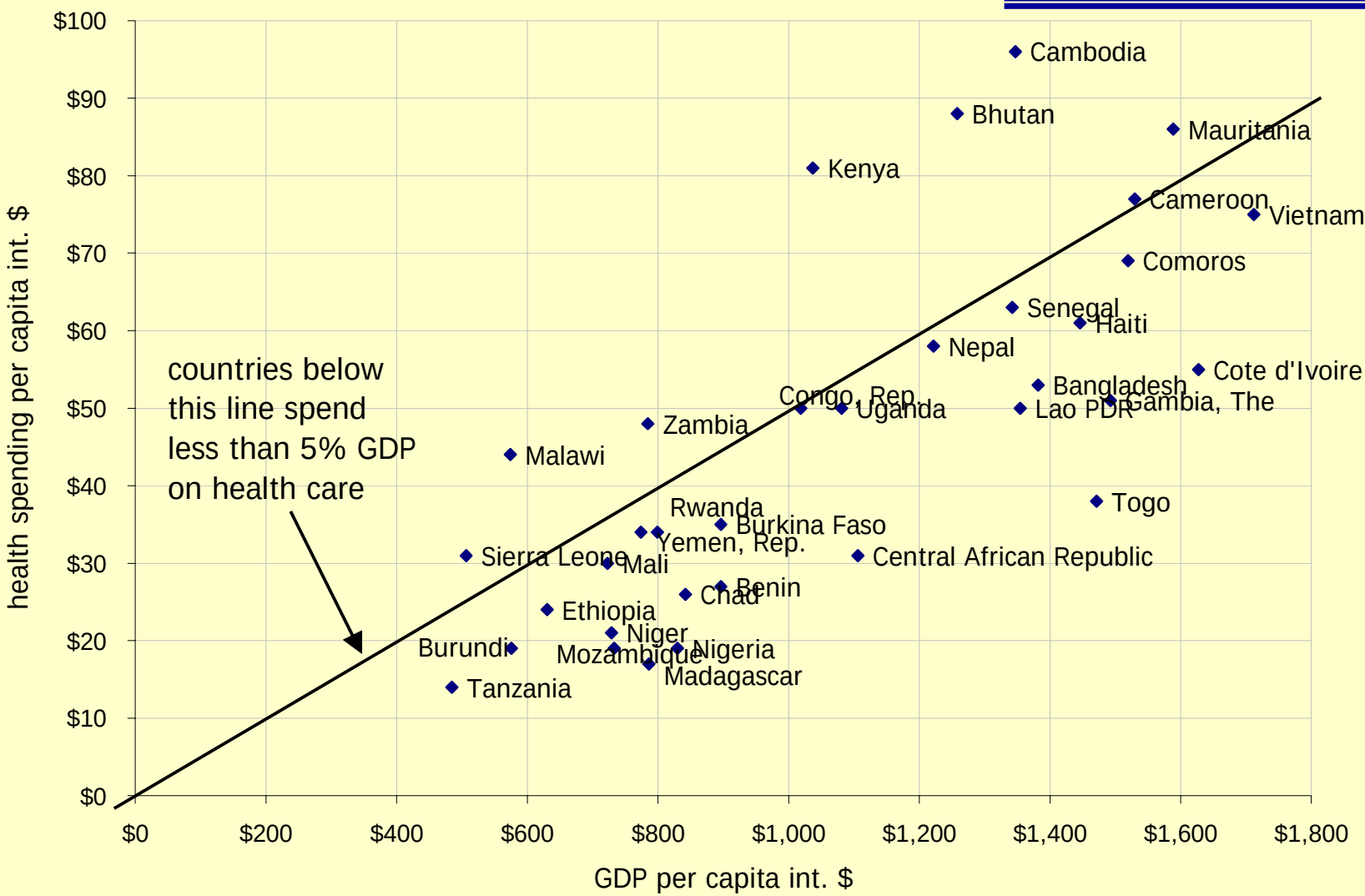
Getting services delivered to the poor

Pressure points



Spending enough

How much is enough?



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

Efficiency yes; equity yes

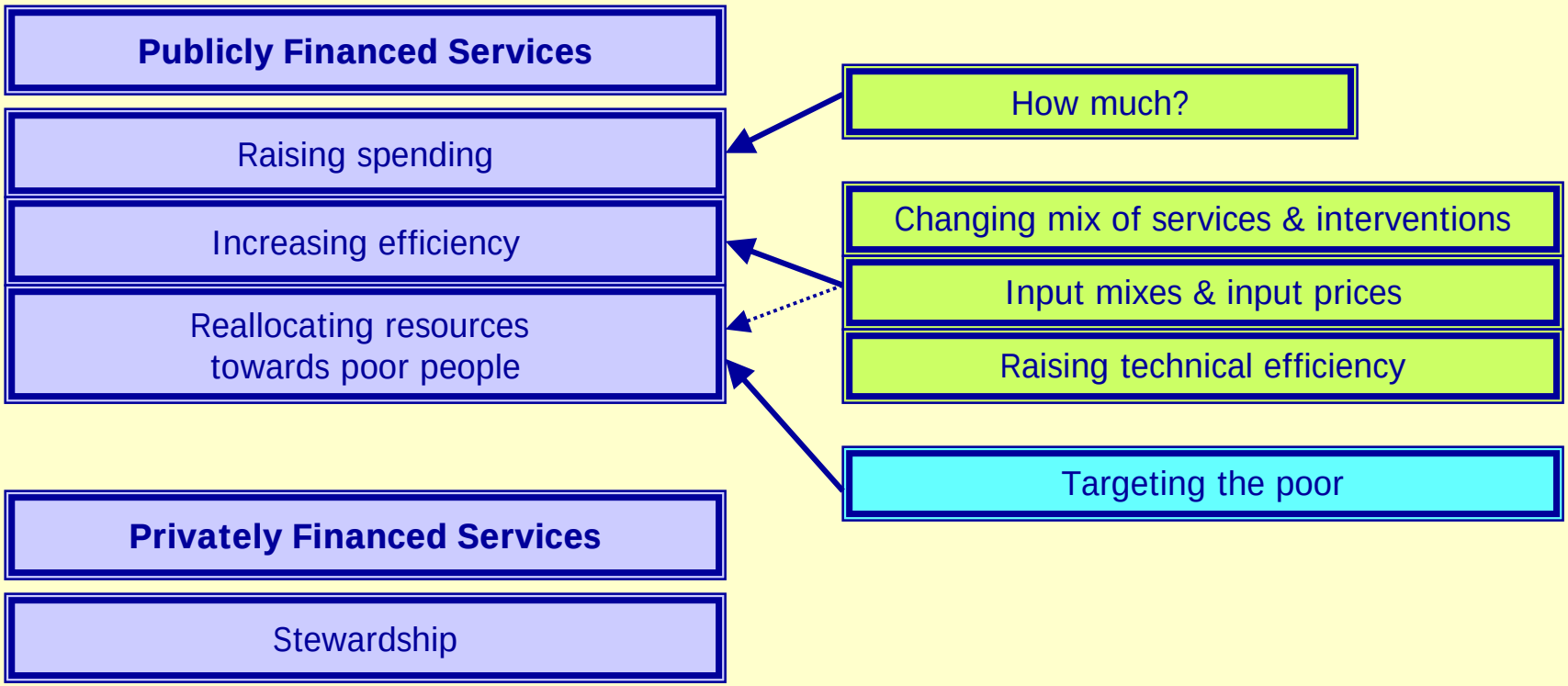
- **Efficiency means getting the mix of services right (*allocative*), getting the input mix right (*input*), and getting as much health from a given bundle of inputs (*technical*)**
- **Efficiency can be increased almost everywhere; but measures to increase efficiency may have adverse effects on the 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**

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



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

Various Instruments can be used for targeting

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

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

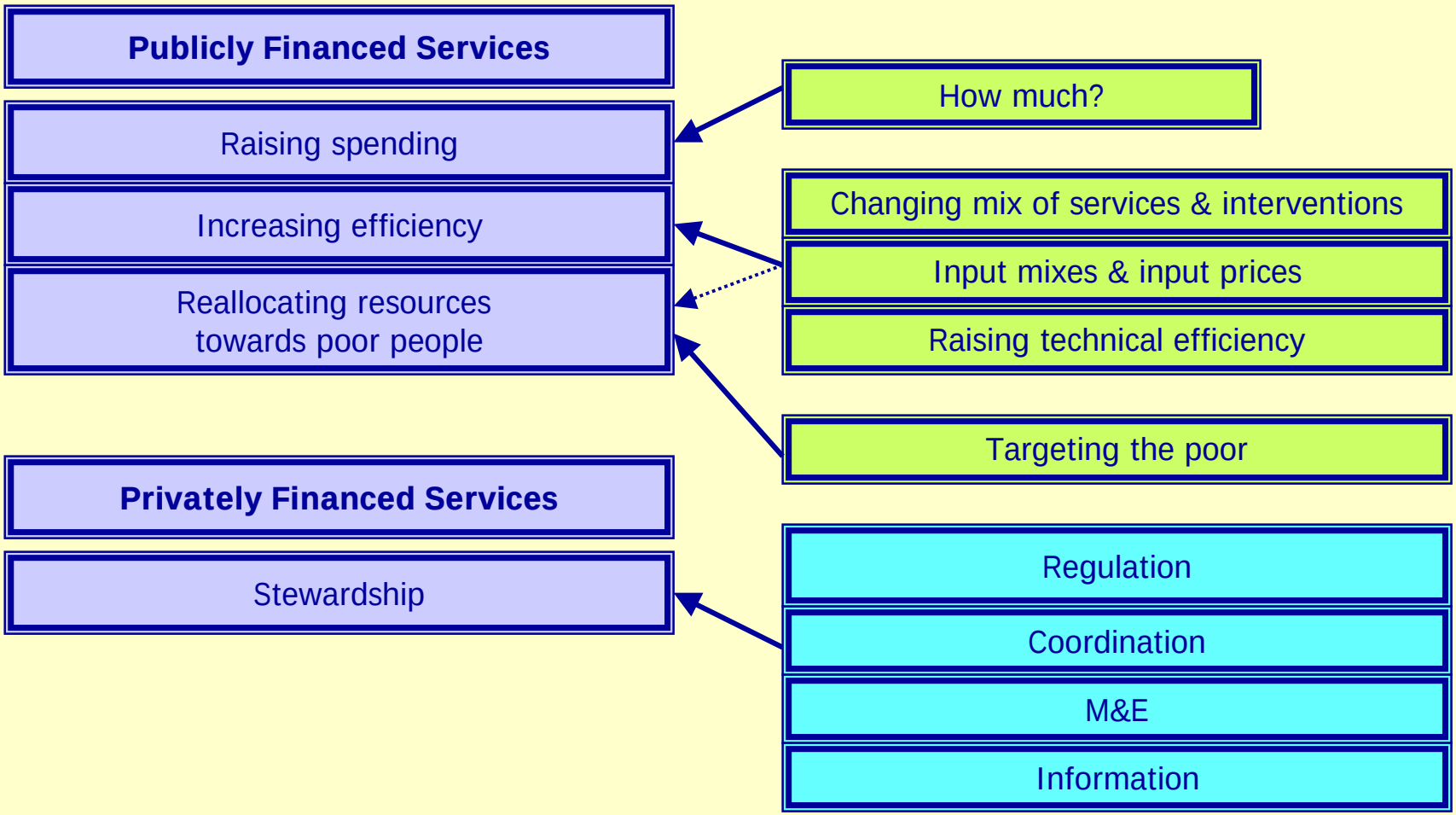
Transfers

- **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



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

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.

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

Orienting the health sector towards serving the poor

The case of Benin, West Africa

1985-1998

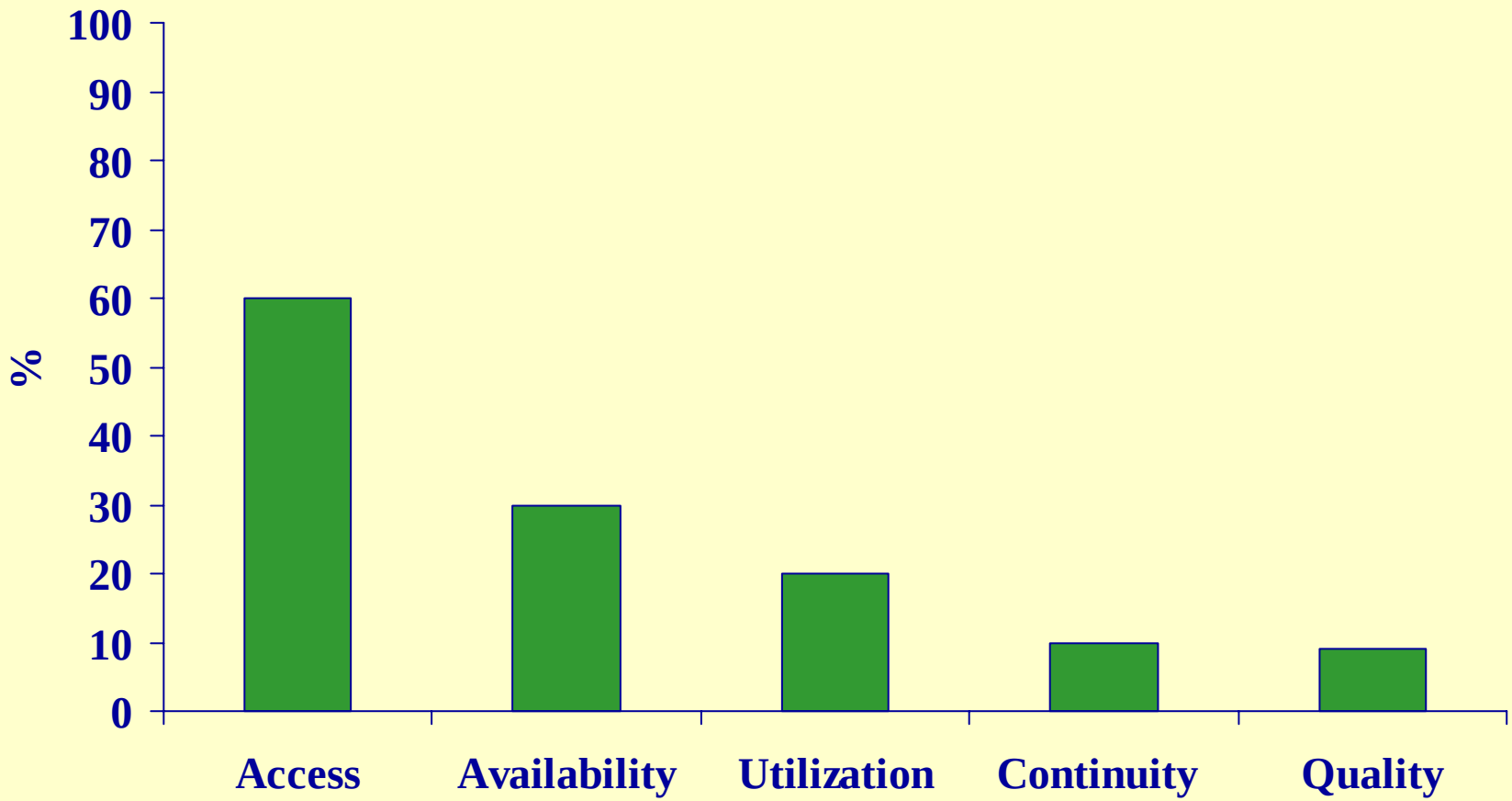
Poor Health Outcomes in 1985

- **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



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

Benin

The Pressure Points

Households and communities	Health system		Government policies and actions	
	Health service provision	Health financing	Health service provision	Health financing
Key outcomes. Health-related household actions and risk factors. Household influences on actions. Community factors.	Physical accessibility of services. Availability of essential drugs Availability of human resources Organizational quality. Service relevance. Timing and continuity. Technical quality. Social accountability.	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? Affordable pricing of services	Macro. Health system level. Micro.	Macro. Health system level. Micro.

Benin

Pressure Points

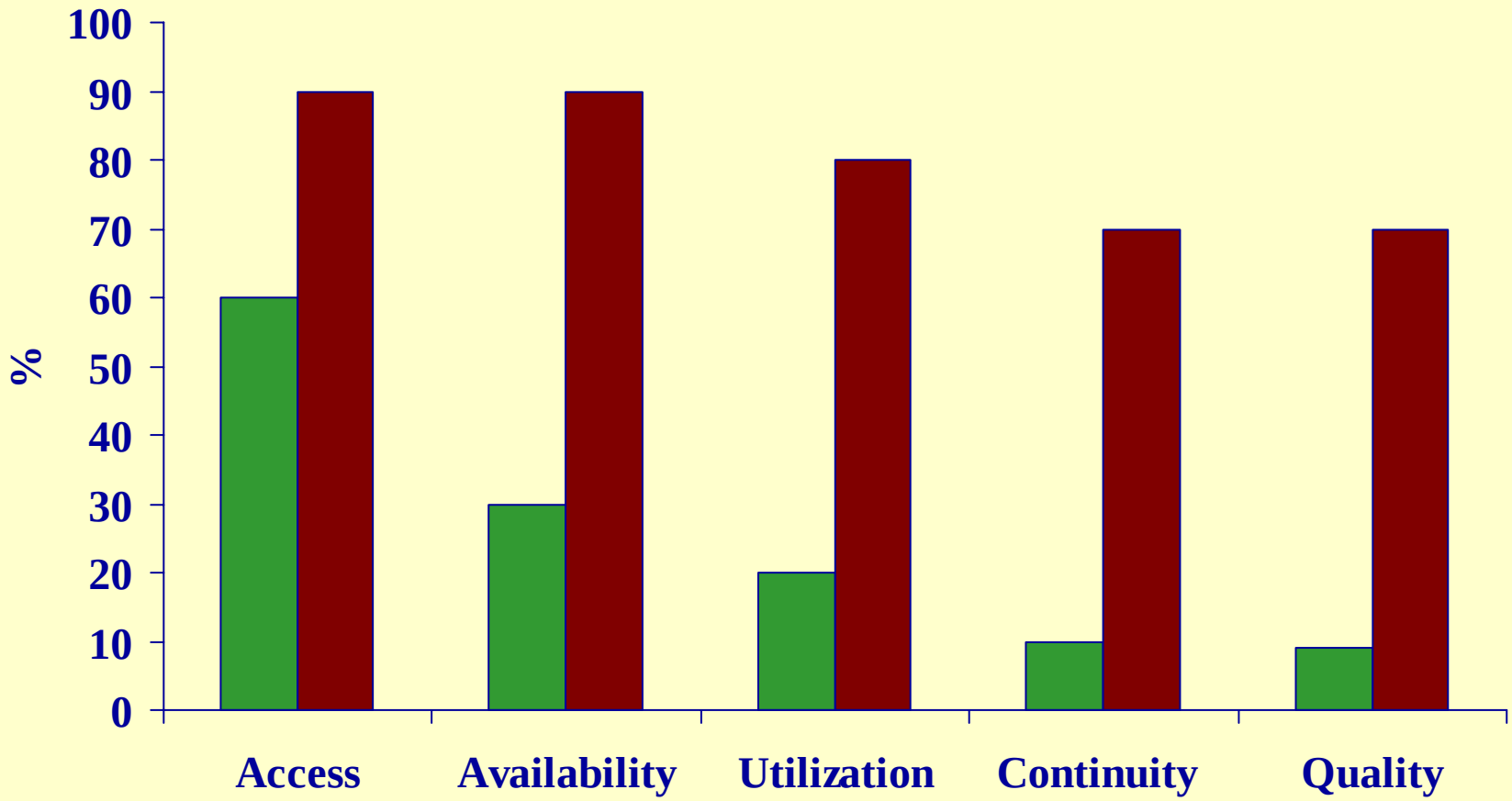
Poor-friendly Reorganization

- **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

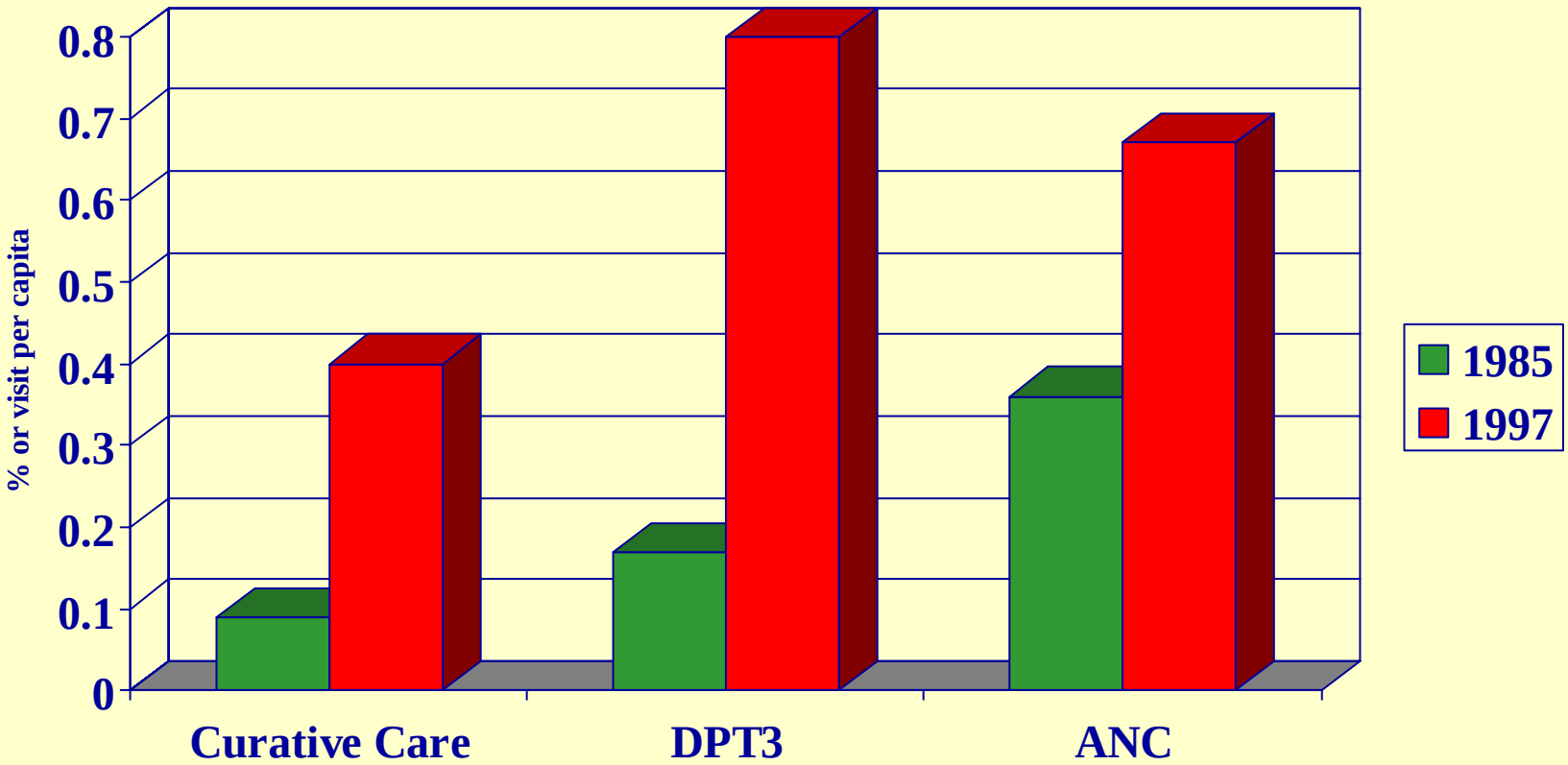
- **Allocating resources to interventions addressing the burden of diseases of the poor: financing a basic care package addressing communicable diseases and child health**
- **Allocating resources to the poor specifically: increase resources for low-income areas (Northern Benin)**
- **Affordable Pricing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

Immunization Coverage 1985-1998



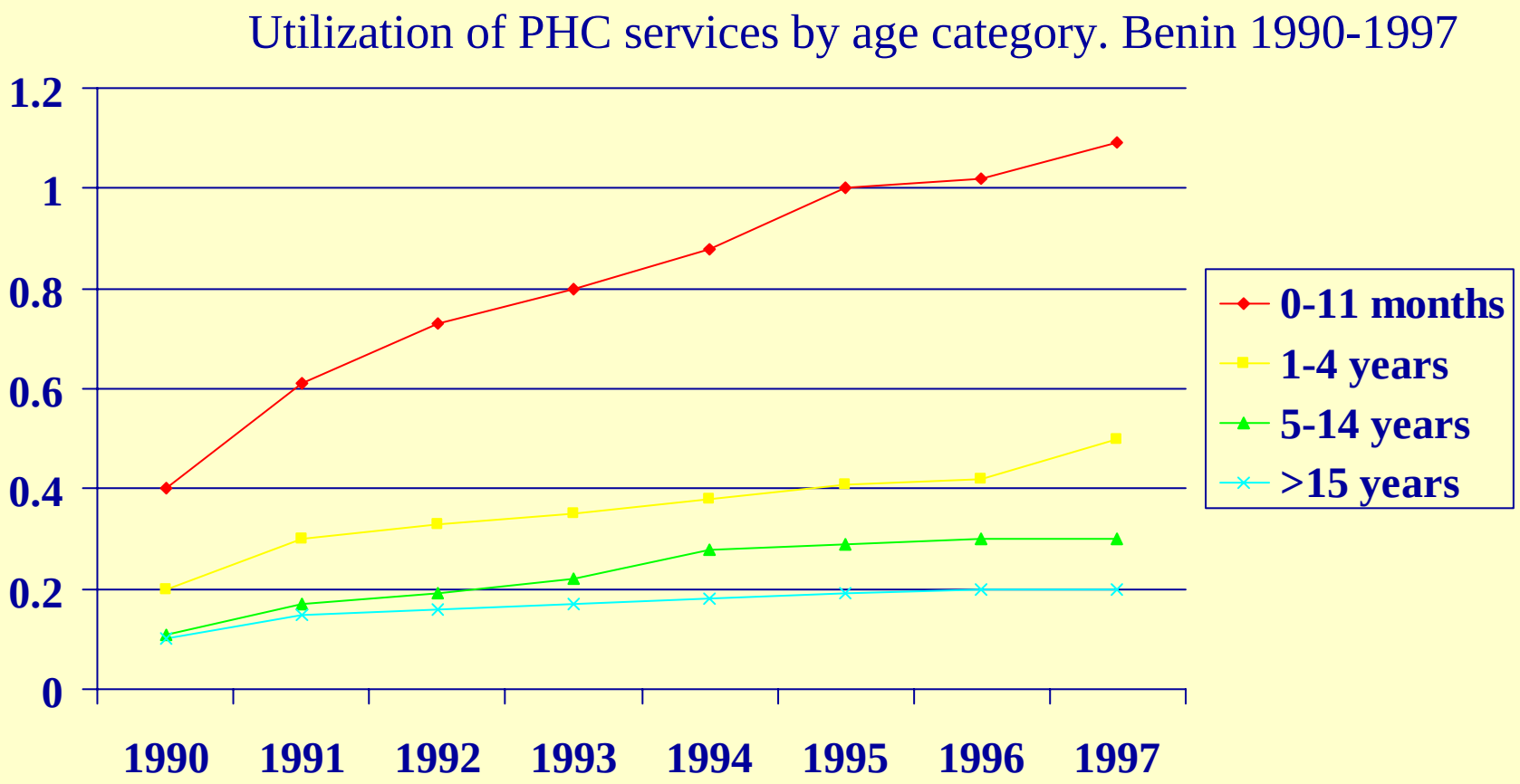
Source: SNIGS MOH Benin

Improvement in Key Indicators



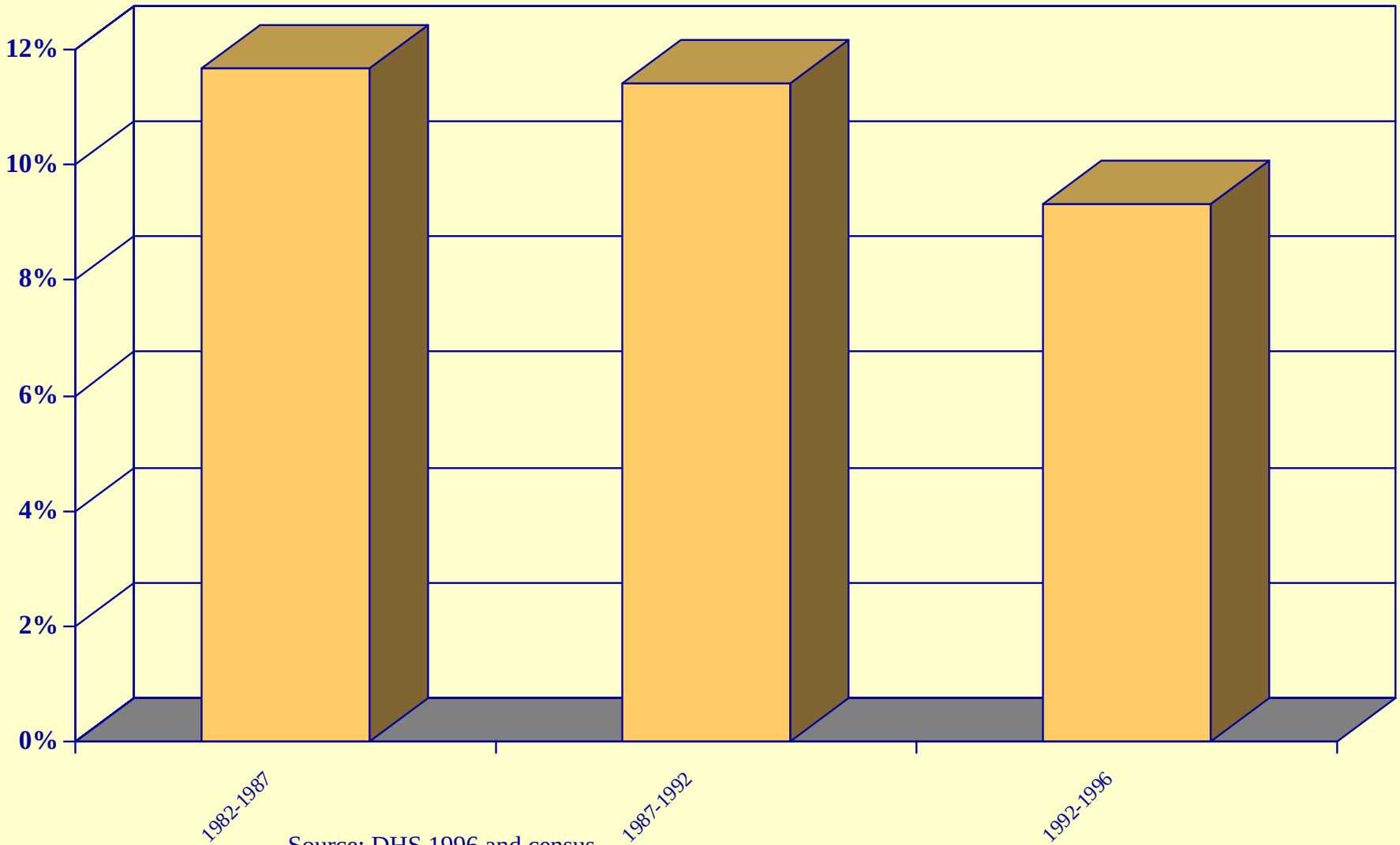
Source: SNIGS MOH Benin

Utilization of PHC Services



Benin 1982-1996

Decrease of Infant Mortality Rate

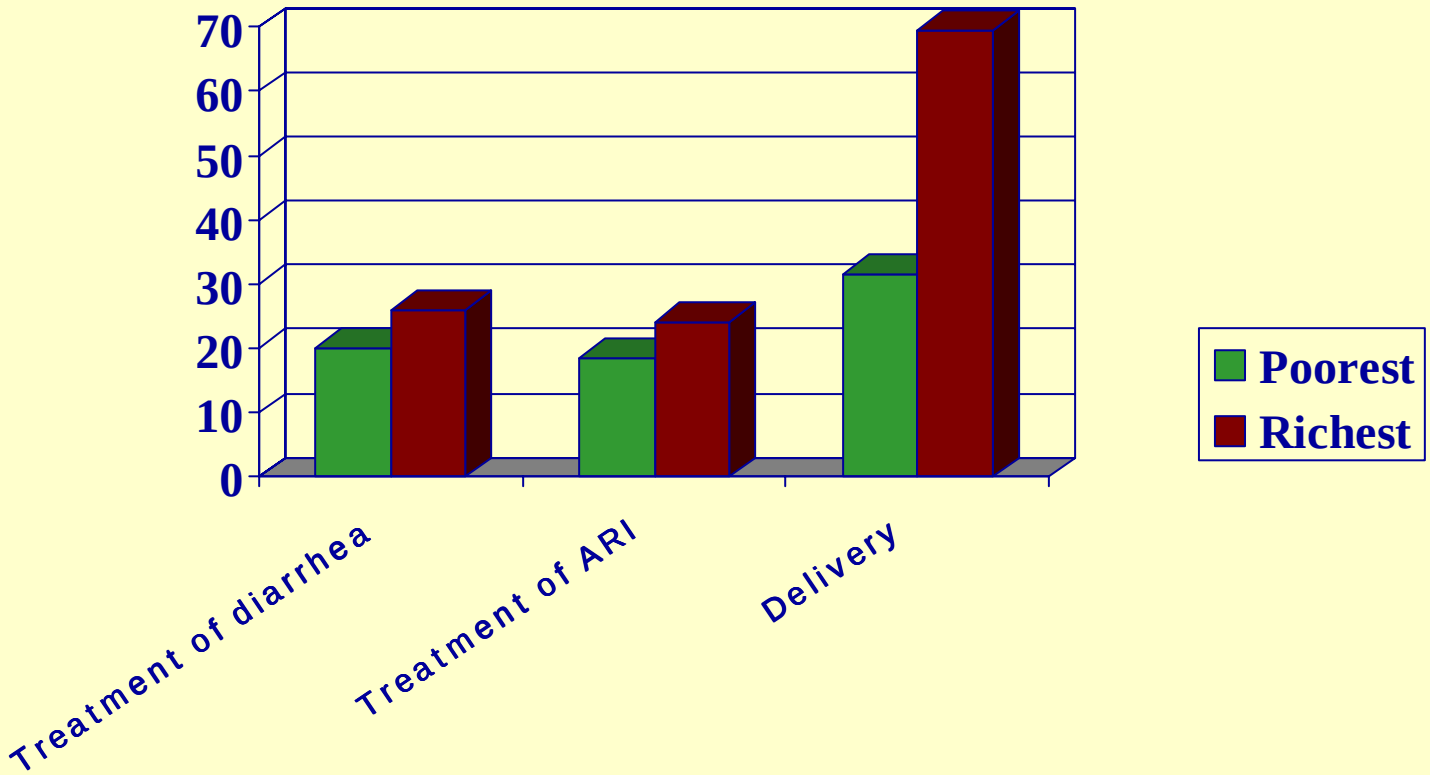


Source: DHS 1996 and census

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



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

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Pressure Points