Latest research findings

The impact of violence on individual risk preferences: evidence from a natural experiment

Amela Jakiela and Owen Ozier [1] estimate the impact of Kenya’s post-election violence on individual risk preferences. Because it interrupted a longitudinal survey of more than five thousand Kenyan youth, the crisis creates plausibly exogenous variation in exposure to civil conflict by the time of the survey. The study measures individual risk preferences using hypothetical lottery choice questions, which are validated by showing that they predict migration and entrepreneurship in the cross-section. The results indicate that the post-election violence sharply increased individual risk aversion. Immediately after the crisis, the fraction of subjects who are classified as either risk neutral or risk loving dropped by roughly 26 percent.

Measuring progress towards universal health coverage: with an application to 24 developing countries

The last few years have seen a growing commitment worldwide to universal health coverage (UHC). Yet there is a lack of clarity on how to measure progress towards UHC. Adam Wagstaff, Daniel Cotlear, Patrick Hoang-Vu Eozenou and Leander R. Buisman [2] propose a ‘mashup’ index that captures both aspects of UHC: that everyone—irrespective of their ability-to-pay—gets the health services they need; and that nobody suffers undue financial hardship as a result of receiving care. Service coverage is broken down into prevention and treatment, and financial protection into impoverishment and catastrophic spending; nationally representative household survey data are used to adjust population averages to capture inequalities between the poor and better off; nonlinear tradeoffs are allowed between and within the two dimensions of the UHC index; and all indicators are expressed such that scores run from 0 to 100, and higher scores are better. In a sample of 24 countries for which there are detailed information on UHC-inspired reforms, a cluster of high-performing countries emerges with UHC scores of between 79 and 84 (Brazil, Colombia, Costa Rica, Mexico and South Africa) and a cluster of low-performing countries emerges with UHC scores in the range 35–57 (Ethiopia, Guatemala, India, Indonesia and Vietnam). Countries have mostly improved their UHC scores between the earliest and latest years for which there are data—by about 5 points on average; however, the improvement has come from increases in receipt of key health interventions, not from reductions in the incidence of out-of-pocket payments on welfare.

On the delegation of aid implementation to multilateral agencies

Some multilateral agencies implement aid projects in a broad range of sectors, with aid disbursements showing a strong overlap with those of bilateral donors. The question then arises of why do bilateral donors delegate sizable shares of their aid to non-specialized agencies for implementation? Kurt Annen and Stephen Knack [3] develop a game theoretic model to explain this puzzle. Donors delegate aid implementation to the multilateral agency (ML) to strengthen the policy selectivity of aid, incentivizing policy improvements in recipient countries, in turn improving aid’s development effectiveness. Bilateral donors are better off delegating aid to ML even when they are purely altruistic but disagree on how their aid should be distributed across recipients. Key for our result to hold is that ML searches some middle ground among disagreeing donors. Aid selectivity—in terms of both policy and poverty—emerges endogenously and is credible, as it is the solution to ML’s optimization problem. Moreover, the model shows that if one sufficiently large donor is policy selective in its aid allocations, there is no need for other donors to be policy selective. The World Bank’s aid program
for lower-income countries, the International Development Administration (IDA), is shown to fit the assumptions and predictions of the model. Specifically, IDA is a dominant donor in most of its recipient countries and is much more policy and poverty selective than bilateral aid. Donors view it as a public good, and contribution more to it when bilateral aid is less selective. Potential threats to IDA’s role as a dominant, policy-selective donor include the emergence of nontraditional donors, changes in voting shares, and traditional donors’ increasing use of earmarked contributions.

Which donors, which funds? The choice of multilateral funds by bilateral donors at the World Bank

The rapid growth of trust funds at multilateral development organizations has been widely neglected in the academic literature so far. Using a simple illustrative model, Bernhard Reinsberg, Katharina Michaelowa and Stephen Knack [4] examine the choice by sovereign donors among various trust fund options. They argue that the choice among the different trust funds involves a fundamental trade-off: larger funds provide donors with the benefit of burden sharing. Conversely, each donor can better assert its individual preferences in a fund with fewer other donors. The theoretical considerations yield testable implications on a range of factors affecting this fundamental trade-off, most notably the area of intervention of the trust fund and competing domestic interests of donor countries. Using a sample of World Bank trust funds, the paper examines the participation decisions of OECD Development Assistance Committee donors over the past decade. In line with the theoretical argument, preference homogeneity among donors as well as indicators for global activities and fragile states assistance are robust determinants of participation in (large) multi-donor funds. In contrast, donors tend to prefer single-donor trust funds in areas in which their national interests dominate. Although they could use bilateral aid for the same purpose, they often prefer to channel their contributions through trust funds at multilateral agencies. Donors thereby reduce their own administrative costs, while benefiting from the expertise of the multilateral agency. These findings confirm prior qualitative case studies and evidence from donor reports, suggesting that reduced reliance on single-donor trust funds—a costly instrument from the perspective of multilateral agencies—can improve the development effectiveness of aid.

New articles and books

Use of standardized patients to assess quality of tuberculosis care: a pilot, cross-sectional study

Studies to date of the quality of tuberculosis care have relied on recall-based patient surveys, questionnaire surveys of knowledge, and prescription or medical record analysis; the results mostly show the health-care provider’s knowledge rather than actual practice. No study has used standardized patients to assess clinical practice. Jishnu Das, Ada Kwan, Benjamin Daniels, Srinath Satyanarayana, Ramnath Subbaraman, Sofi Bergkvist, Ranendra Das, Veena Das and Madhukar Pai [5] report on such a study: a pilot, cross-sectional validation study of a convenience sample of consenting private health-care providers in low-income and middle-income areas of Delhi, India. The authors recruited standardized patients in apparently good health from the local community to present four cases (two of presumed tuberculosis and one each of confirmed tuberculosis and suspected multidrug-resistant tuberculosis) to a randomly allocated health-care provider. The key objective was to validate the standardized-patient method using three criteria: negligible risk and ability to avoid adverse events for providers and standardized patients, low detection rates of standardized patients by providers, and data accuracy across standardized patients and audio verification of standardized-patient recall. They also used medical vignettes to assess providers’ knowledge of presumed tuberculosis. Correct case management was benchmarked using Standards for Tuberculosis Care in India. The authors conclude that standardized patients can be successfully implemented to assess tuberculosis care. Their data suggest a big gap between private provider knowledge and practice. Additional work is needed to substantiate these pilot data, understand the knowledge gap in provider behavior, and to identify the best approach to measure and improve the quality of tuberculosis care in India.

HIV/AIDS services delivery, overall quality of care, and satisfaction in Burkina Faso: Are some patients privileged?

Harounan Kazianga, Seni Kouanda, Laetitia N. Ouedraogo, Elisa Rothenbuhler, Mead Over and Damien de Walque [6] assess the quality of care received in health facilities delivering antiretroviral treatment (ART) in Burkina Faso, based on structured interviews with outpatients, and using multivariate regressions to explore the determinants of the quality of care and highlighting patients’ wealth and purpose of visit, specifically, whether the visit relates to the human immunodeficiency virus (HIV). The authors conclude that requiring HIV-related services guarantees a better quality of
care, without having to pay more. However, requiring HIV-related services also means enduring a longer waiting time at the facility, with wealthier individuals waiting less time.

Assessing Latin America’s progress toward achieving Universal Health Coverage

Two commonly used metrics for assessing progress toward universal health coverage involve assessing citizens’ rights to health care and counting the number of people who are in a financial protection scheme that safeguards them from high health care payments. On these metrics most countries in Latin America have already “reached” universal health coverage. Neither metric indicates, however, whether a country has achieved universal health coverage in the now commonly accepted sense of the term: that everyone—irrespective of their ability to pay—gets the health services they need without suffering undue financial hardship. Adam Wagstaff, Tania Dmytraczenko, Giselle Almeida, Leander Buisman, Patrick Hoang-Vu Eozenou, Caryn Bredenkamp, James A. Cercone, Yadira Díaz, Daniel Maceira, Silvia Molina, Guillermo Paraje, Fernando Ruiz, Flavia Sarti, John Scott, Martin Valdivia and Heitor Werneck [7] operationalized a framework proposed by the World Bank and the World Health Organization to monitor progress under this definition and then constructed an overall index of universal health coverage achievement. They applied the approach using data from 112 household surveys from 1990 to 2013 for all twenty Latin American countries. No country has achieved a perfect universal health coverage score, but some countries (including those with more integrated health systems) fare better than others. All countries except one improved in overall universal health coverage over the time period analyzed.

Inequality of Opportunity: The New Motherhood and Apple Pie?

The last few years have seen a surge in interest in quantifying – and hence giving some policy teeth to – the concept of inequality of opportunity. The idea behind the concept is simple yet powerful. Not all inequality is bad. The bad bit of inequality (‘inequality of opportunity’) is the part that emerges because of factors over which we have no control (our ‘circumstances’). By contrast inequality that emerges because of our different choices and efforts (holding constant our circumstances) is fine, and to be encouraged. In an Editorial in Health Economics, Adam Wagstaff and Ravi Kanbur [8] argue that the idea is not quite as useful as it might at first glance appear, and is in fact rather dangerous. But turned upside down, it might yet be useful.

Inequality of opportunity: Reply to Pedro Rosa Dias and Erik Schokkaert

In a reply to Pedro Rosa Dias and Erik Schokkaert on their Editorial, Ravi Kanbur and Adam Wagstaff [9] say they welcome the comments of as a means of stimulating further debate on the usefulness of estimates of inequality of opportunity, especially for policy purposes. Rosa Dias and Schokkaert broadly agree with many of their criticisms of the Paes de Barros et al. approach to measuring inequality of opportunity, but Kanbur and Wagstaff disagree that these criticisms are already well appreciated in the literature, arguing that strong health warnings are in order. Kanbur and Wagstaff also argue that Rosa Dias and Schokkaert do not sufficiently engage with a number of their points, including on talent and on luck. And while Kanbur and Wagstaff agree that a strong focus on the income–health gradient leaves out many other considerations, they nevertheless continue to argue for this focus on pragmatic grounds in the realm of policy.

Encouraging health insurance for the informal sector: A cluster randomized experiment in Vietnam

Subsidized voluntary enrollment in government-run health insurance schemes is often proposed as a way of increasing coverage among informal sector workers and their families. Adam Wagstaff, Ha Thi Hong Nguyen, Huyen Dao and Sarah Bales [10] report the results of a cluster randomized experiment, in which 3000 households in 20 communes in Vietnam were randomly assigned at baseline to a control group or one of three treatments: an information leaflet about Vietnam’s government-run scheme and the benefits of health insurance, a voucher entitling eligible household members to 25% off their annual premium, and both. At baseline, the four groups had similar enrollment rates (4%) and were balanced on plausible enrollment determinants. The interventions all had small and insignificant effects (around 1 percentage point or ppt). Among those reporting sickness in the 12 months prior to the baseline survey the subsidy-only intervention raised enrollment by 3.5 ppts (p = 0.02) while the combined intervention raised enrollment by 4.5 ppts (p = 0.02); however, the differences in the effect sizes between the sick and non-sick were just shy of being significant. The results suggest that information campaigns and subsidies may have limited effects on voluntary health insurance enrollment in Vietnam and that such interventions might exacerbate adverse selection.

Effects of price, information, and transactions cost interventions to raise voluntary enrollment in a social health insurance scheme: A randomized experiment in the Philippines

Joseph Capuno, Aleli Kraft, Stella Quimbo, Carlos R. Tan Jr. and Adam Wagstaff [11] report the results of a cluster randomized experiment, in which 3000 households in 20 communes in the Philippines were randomly assigned at baseline to a control group or one of three treatments: an information leaflet about the scheme and the benefits of health insurance, a voucher entitling eligible household members to 25% off their annual premium, and both. At baseline, the four groups had similar enrollment rates (4%) and were balanced on plausible enrollment determinants. The interventions all had small and insignificant effects (around 1 percentage point or ppt). Among those reporting sickness in the 12 months prior to the baseline survey the subsidy-only intervention raised enrollment by 3.5 ppts (p = 0.02) while the combined intervention raised enrollment by 4.5 ppts (p = 0.02); however, the differences in the effect sizes between the sick and non-sick were just shy of being significant. The results suggest that information campaigns and subsidies may have limited effects on voluntary health insurance enrollment in Vietnam and that such interventions might exacerbate adverse selection.
experiment testing two sets of interventions encouraging enrollment in the Individually Paying Program (IPP), the voluntary component of the Philippines' social health insurance program. In early 2011, 1037 unenrolled IPP-eligible families in 179 randomly selected intervention municipalities were given an information kit and offered a 50% premium subsidy valid until the end of 2011; 383 IPP-eligible families in 64 control municipalities were not. In February 2012, the 787 families in the intervention sites who were still IPP-eligible but had not enrolled had their vouchers extended, were resent the enrollment kits and received SMS reminders. Half the group also received a ‘handholding’ intervention: in the endline interview, the enumerator offered to help complete the enrollment form, deliver it to the insurer's office in the provincial capital, and mail the membership cards. The main intervention raised the enrollment rate by 3 percentage points (ppts) (p < 0.11), with an 8 ppt larger effect (p < 0.01) among city-dwellers, consistent with travel time to the insurance office affecting enrollment. The handholding intervention raised enrollment by 29 ppts (p < 0.01), with a smaller effect (p < 0.01) among city-dwellers, likely because of shorter travel times, and higher education levels facilitating unaided completion of the enrollment form.

Getting incentives right? The impact of hospital capitation payment in Vietnam

Ha Thi Hong Nguyen, Sarah Bales, Adam Wagstaff and Huyen Dao [12] evaluate the impact on cost and utilization of a shift from fee-for-service to capitation payment of district hospitals by Vietnam's social health insurance agency. Hospital fixed-effects analysis suggests that capitation leads to reduced costs. Hospitals also increased service provision to the uninsured who continue to pay out-of-pocket on a fee-for-service basis. The study points to the need to anticipate unintended effects of payment reforms, especially in the context of a multiple purchaser system.

On the blogs

Poverty is falling faster among Africa’s female headed households

Writing on Let’s Talk Development, Dominique van de Walle [13] blogs about her recent work on female-headed households (FHHs) in Africa. She reports that poverty has fallen more rapidly in FHHs, and that a decomposition of the change in poverty indicates that, rather than putting a break on poverty reduction, FHHs are contributing appreciably to the overall decline in poverty despite their smaller overall share in the population. Van de Walle notes, however, that the reason for the more rapid decline in in poverty among FHHs is unclear—obvious hypotheses are not supported by the data.

What have we learned in the last 12 months about Universal Health Coverage?

Also writing on Let’s Talk Development Adam Wagstaff [14] asks what have we learnt about UHC in the last 12 months. He argues we’ve learnt about (a) what countries are doing in the pursuit of UHC, (b) what UHC is, (c) what the data tell us about UHC attainment, (d) how far various programs and policies have helped move countries towards UHC, and (e) how we can measure progress towards UHC in one number.

What works to keep adolescent girls in school? Part 3

Writing on Development Impact, Berk Ozler [15] concludes his three-part series about the effectiveness of measures to keep adolescent girls in school with a look at how to relax household constraints on schooling choices. He argues it’s important to increase the availability of jobs for women and disseminate information about the availability of such opportunities and the real returns to schooling. He argues for reducing the costs of schooling, in particular by building “girl-friendly” schools and decreasing the opportunity costs of schooling. Last, he concludes that conditional cash transfer programs can improve school attainment and have knock-on effects, delaying marriage and lowering (desired) fertility. But, he says, policymakers need to weigh the implied trade-offs in such programs, and carefully consider key design parameters, such as targeting, conditions, as well as the duration and timing of payments for cost-effectiveness.

References


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