World Bank Seminar

Waivers, exemptions, and implementation issues: Best practice

Ricardo Bitran

June 2002

Bitrán & Asociados

Contents of presentation

A. Case selection

B. Performance indicators

C. Enabling factors

D. Findings

E. Recommendations

Bitrán & Asociados

A. Case selection

Case selection

- Selection criteria included:
  - Regional diversity
    - →Asia (Cambodia, Indonesia, Thailand)
    - →Latin America (Chile)
    - →Africa (Kenya, Ghana, Zimbabwe)
  - Diversity in circumstances
    - →As given by availability of resources (e.g., Thailand vs. Cambodia)
  - Availability of information
- Process:
  - Inquiries with World Bank staff
  - Inquiries with in-country and international researchers
  - Literature search

Bitrán & Asociados

Case selection

Selected indicators	Kenya	Cambodia	Ghana	Zimbabwe	Indonesia	Thailand	Chile
Demographic indicators							
Total population 2001 (millions)	29.8	13.1	19.9	11.4	206.1	62.4	15.4
Life expectancy at birth (years), 1999	47.7	53.7	57.9	40.4	65.7	68.6	75.5
Urban population (percent), 1999	32.2	15.6	37.9	34.6	39.8	21.3	85.4
Economic indicators							
GDP growth rate 1997 (percent)	2.1	1.0	4.2	2.8	4.7	-1.5	7.4
Per capita GDP 1997 (1995 PPP $)	1,020	1,330	1,760	2,680	3,130	6,440	8,440
Poverty indicators	1992	1999	1992	1990	1999	1998	1994
Population under poverty line, Total (percent)	42.0	35.9	31.4	25.5	23.4	12.8	23.2
Rural	46.9	25.2	34.3	31.0	19.5	17.2	21.8
Urban	29.3	40.0	26.7	10.0	26.1	1.5	30.6
Health expenditure							
Per capita health expenditure (current PPP $), 1997	81	96	54	186	55	347	533
Private health expenditure, percent of total , 1997	35.9	90.6	53	38.2	47.4	65.4	48.6
Structure of health expenditure (percent of GDP), 1997							
Private	5.4	6.4	1.6	3.7	1.1	3.9	3.1
Public	2.4	0.7	1.4	2.9	0.6	1.8	3
Total	7.8	7.1	3.0	6.6	1.7	5.7	6.1

* Organized in ascending order of PPP-adjusted per capita GDP in 1995.
** Data from World Development Indicators, 2000/2001 and WHO Report 2000 unless indicated otherwise.
*** Data on poverty of Chile was obtained from USAID, 1998.

Bitrán & Asociados

B. Performance indicators

Revenue from user fees

Country	Revenue
Kenya	• About 3.4% of MOH recurrent expenditure. • Recurrent non-personnel expenditure: 37% in provincial hospitals and 20% in health centers
Cambodia	• OOP expenditure accounts for 82%-84% of total sector financing.
Ghana	• 12% of MOH recurrent spending. In Volta region 80% of non-staff revenue in public hospitals and about 66% in health centers
Zimbabwe	• Approximately 5% of total revenue in government health facilities
Indonesia	• Around 36% at lower level facilities and 12% at higher level facilities
Thailand	• 60% of hospital revenue, 70% of health centers • About 2/3 from insurance plans, 1/3 from OOP
Chile	• About 12% of hospital revenue

- Relatively high revenue except Chile and Zimbabwe.

Bitrán & Asociados

Performance indicators

Country	Targeting system	Performance indicators				
		Coverage	Leakage	Administrative cost of exemptions	Access	Financial burden
Kenya						
Cambodia						
Ghana						
Zimbabwe						
Indonesia						
Thailand						
Chile						

Bitrán & Asociados

Targeting system

Combination of targeting methods

Countries	Description
Kenya	Group targeting, targeting by type of services, and means testing (no clear criteria as to income threshold)
Cambodia	Individual targeting based on proxy means test
Ghana	Group targeting, targeting by type of service, and means testing (no clear criteria as to income threshold)
Zimbabwe	Means testing, income threshold
Indonesia	Geographic targeting and individual targeting. Identification of poor households varied by region. Now uniform poverty proxies are used.
Thailand	Geographic targeting + means testing, income threshold + some group targeting (monks, veterans, children < 12yrs.)
Chile	Income thresholds and other poverty proxies + targeting by type of service (lower level care is free)

Performance

The poorer countries perform less well than the higher income ones. Cambodia possible exception, but sustainability remains an issue

Institutionalized leakage

1. No attention to this: cannot evaluate; makes improvements difficult

Countries	Performance variable				
	Coverage	Leakage	Adminis-trative cost of exemptions	Access	Financial burden
Kenya	No monitoring therefore no systematic information. On average 2 exemptions per month per facility (<-->42% of Kenyans below poverty line)	No systematic information. Civil servants, public health workers	--	--	--
Cambodia	Overall only 17.7% of users of health care services were exempted from fees.	Overall, individuals from higher income households were more likely to get exempted from user fees than the poor.	--	--	--
Ghana	No systematic monitoring. According to some data, exemptions cover less than 2% of patients	In Volta Region, most exemptions were given to health workers. Evidence of exemptions to government officials.	--	--	--
Zimbabwe	About 20% of urban poor and 10% of rural poor had received assistance with free care	No systematic information. Anecdotal evidence that waivers were sometimes granted on political basis.			--

Bitrán & Asociados

Performance

The higher income countries perform better, but are considering a complete change of the system through major reform

Institutionalized leakage

Countries	Description	Performance variable				
	Targeting system	Coverage	Leakage	Administrative cost of exemptions	Access	Financial burden
Indonesia	Geographic targeting and individual targeting. Identification of poor households varied by region. Now uniform poverty proxies are used.	Around 10.6%, increasing rapidly. In some provinces up to 89% of all poor families.	Possibly as high as 39%. May be related to eligibility criteria that are unrelated to poverty (for example the capacity of families to meet their religious obligations)	--	Improves access slightly..: 15% of health card owners visit an outpatient provider during last 3 months compared to 13% for non health card owners. About 36% of health card owners report not using it.	--
Thailand	Geographic targeting + means testing, income threshold + some group targeting (monks, veterans, children < 12yrs.)	80% of population living below national poverty line has a free health card.	Aprox. 45% of card holders are non poor when compared to national pvty.line.	--	No systematic evidence. Anecdotal evidence that some card holders do not use their cards due to the perception of low quality	No systematic information. In one place proportion O0P expenditure/household income was still much higher than expenditure of other insured
Chile	Income thresholds and other poverty proxies + targeting by type of service (lower level care is free)	Above 90%	Above 50%.	--	Equity in access poor/non poor	--

E. Enabling factors

Enabling factors

- Supply-side
- Demand-side
- Eligibility system (implementation “nuts and bolts”)
- Funding
- Evaluation

Bitrán & Asociados

Enabling factors: Supply side incentives

No country meets all supply-side incentives

Only 2 countries – Cambodia and Chile-- have full cost compensation to providers

		Incentives to provide exemptions				
Country	Existence and level of compensation	User fee revenue kept at facility	Relationship between staff remuneration and user fee revenue	Financial significance of compensation for exempt patients, relative to full price	Time frame of compensation	Compensation of administrative cost
Kenya	N	Y	Staff reluctant to give waivers.	--	--	N, granting of waivers is cumbersome requires ressources but no compensation available.
Cambodia	Y	99%	49% of user fee revenue can be used to pay for salaries; user fee revenue account for up to 95% of staff income	Compensation equal to full fee	Monthly	Y, but it does not include the cost of expatriate staff
Ghana	Y, albeit cumbersome flow from central level to local level facilities	N ==>Y	User fee can only be used to pay for drugs and other non personnel expenditures	--	Evidence that reimbursement lasts on average 4 months	No compensation, evidence that facilities and staff complain on this.
Zimbabwe	Y, albeit cumbersome flow from central level to local level facilities	N==>Y	--	--	Reimbursement takes up to 8 months as it needs approval from Harare.	N
Indonesia	N==>Y	Y/N, health centers can keep 25% of user fee revenue. The balance is distributed with the budget allocation from the prvoince.	--	--	Delays in compensation	N
Thailand	Y	Y	Y	Compensation for exempted patients is lower than payments received from paying patients (insured and uninsured)	--	N
Chile	Y (fees paid for exempted patients equal to fees paid for insured patients)	Y but extraordinary budget allocations take into account user fee collected at facility	N	Fees paid for exempted patients equal to fees paid for patients insured in the public system. Provider is therefore indifferent between attending poor or non poor patient.	--	Not explicit

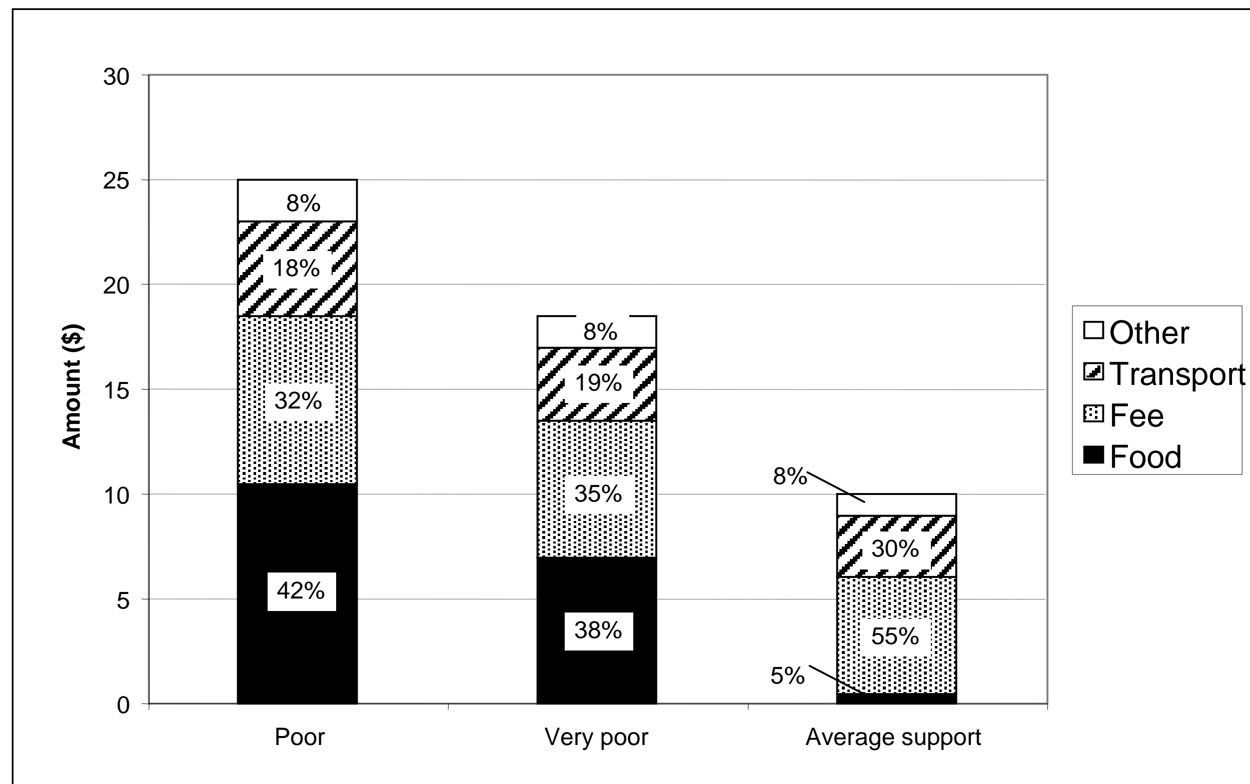
Enabling factors: Demand side, implementation

The nuts and bolts: implementation of beneficiary identification system

	Factors influening the demand for exemptions					Eligibility system					
Country	Access costs to exemption system	Social importance of stigma	Discrimination of the exempted	Accesibility to subsidized services withouth formal exemption	Other alternatives	Existence of national policy	Clarity of policy	Relationship between exemption criteria and national poverty criteria	Who decides	Responsiveness of eligibility criteria to local circumstances	Adjustment of fees and (if applicable) income criteria to changing economic variables (for example inflation)
Kenya	--	--	--			Y	N	N	Local community leaders==>health care facilities	Evidence that facilities replace income criteria by other poverty proxies	N, implied lack of control on fee policy of each facility
Cambodia	No high	Important according to annecdotal information	N	N	Not good	N, only national user fee policy exists	NA	N, eligibility established on ad hoc basis in each setting	In equity funds (EF), decision made by EF staff, sometimes in coordination with health staff. In other facilities, decision made by health staff	Y	Y
Ghana	--	--	--			Y	N, waivers for "paupers"	N	Health facility staff	--	N, implied lack of control on fee policy of each facility
Zimbabwe	Evidence that participation costs are high and may deter demand	Anectdotal evidence	--			Y	Y	Elgibility criteria increasingly out of date due to inflation	Social Welfare Office	Evidence that it was almost impossible to determine income threshold based on available information	N, income criteria was not adjusted for inflation and increasingly below the national poverty line
Indonesia	Y, anectdotal evidence that participation cost may deter demand	--	--			Y	Y	No, some of the eligibility criteria are non poverty related	Local community	--	--
Thailand	--	Y, anecdotal evidence	Y, anecdotal evidence			Y	Y	N, eligibility criteria way above poverty lines	Community	Evidence that it was almost impossible to determine income threshold based on available information	N
Chile	N	--	N			Y	Y	N, eligibility criteria way above poverty lines	Municipality or facility	--	Y

Demand-side enabling factors: mitigating access costs

Cambodia: Mean patient expenditure per hospitalization and average support by Sotnikum equity fund, 2001 ($)



Enabling factors

Country	Factors influening the demand for exemptions		Promotion	Funding	Reach	Monitoring and evaluation	
	Access costs to exemption system	Social importance of stigma	Dissemination of information	Public resources avialble to finance exemptions	Defined benefits package	Systematic evaluation of exemption policy	Systematic evaluation of user fees
Kenya	--	--	Majority of potential beneficiaries not aware of exemptions	Not applicable as exemptions are not compensated	N	N	N
Cambodia	No high	Important according to annecdotal information	It varies. Sotnikum EF currently promoting scheme, but cautiously, to keep EF sustainable	Generous and provided by donors; sustainablity of generalization with public funding currently not possible	N, but basic packages for primary health care and hospital care being implemented	Y	N
Ghana	--	--	Majority of potential beneficiaries not aware of exemptions, health staff not knowledgable of exemption categories	Funding covers only about 22% of resources required to cover exemptions	N	N	N
Zimbabwe	Evidence that participation costs are high and may deter demand	Anectdotal evidence	About 50%of the population have never heard of the waiver policy	Smaller allowances than actually required.	N	N	N
Indonesia	Y, anectdotal evidence that participation cost may deter demand	--	Evidence that potential beneficiares are often unaware of exemptions and that health staff does not know policy well.	Insufficient. No systematic data	N	Some	N
Thailand	--	Y, anecdotal evidence	Problems revealed that the poor have difficulties accessing information on health card	Insufficient.	N	N	N
Chile	N	--	--	All care is compensated	N==>Y	N	N

D. Summary of findings

Findings

- Virtually no systematic performance monitoring.
- Several cases show very poor performance (Kenya, Ghana, Zimbabwe)
  - Incongruence of incentives
  - Lack of clear policies and guidance
  - Insufficient funding
  - Difficulties in using income threshold (those setting rules knew little about actual implementation problems)
- Some good, low-income performers (e.g., Cambodia), but sustainability and generalization are major issues.
- Narrowing of benefits included in waivers and exemptions is important, as Cambodia wants to do.
- Performance improves with income, institutional capabilities.
- Some systems have a long history, evolving and getting better over time (Thailand, Indonesia, Chile); they happen to be in the richest countries.

Bitrán & Asociados

Findings

- In poorest countries, funding inconsistent with poverty levels.
- Dissemination of information on waivers/exemptions among target beneficiaries is weak.
- Understanding of waivers/exemptions policy among implementers sometimes limited.
- Conception of waiver/exemption methods incoherent with local circumstances (e.g., guidelines mandating use of income threshold).

Bitrán & Asociados

D. Recommendations

Recommendations

- Well though out, careful implementation makes a difference.
- Monitoring (performance assessment) must precede and accompany waiver/exemption initiatives.
- Funding must accompany and be consistent with implementation and waivers
- Incentives of agents should be aligned:
  - Compensation of providers for revenue forgone (price levels, payment systems)
  - Granting entity must see a benefit to the awarding of waivers/exemptions (e.g., higher budget).

Bitrán & Asociados

Recommendations

- Clear, simple policy guidance is required.
- Technical assistance for those designing and implementing waiver/exemption systems is required (e.g., Morocco, Suriname).

Bitrán & Asociados

Recommendations

- Assessing equity implications of existing user fee system is necessary:
  - Services used mainly by the poor are subsidized?
  - Are the poor waived/exempted?
  - Are the non-poor getting subsidized care?
- Cost recovery from the non-poor must be optimized.
  - Knowledge of full costs is essential (e.g., Chile's public hospitals under-estimate costs and thus charge below-cost prices.

Bitrán & Asociados

Recommendations

- Income criteria as basis for waivers/ exemptions has proved very hard to implement; proxy means tests do better.

Bitrán & Asociados