

Financing better health care for all



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Overview

Poor people's access to good health care is limited because they cannot afford it and often live far from quality services. There is evidence that poor people will pay to use health services if the quality is good. Cash transfers have also been highly successful in encouraging women to use health care. And contracting-out can help to improve coverage.

Key words: Health system financing, equity, quality, access.

Mind the development gaps

Many poor people in Africa and Asia still do not have good access to health services. In sub-Saharan Africa, one-in-six children still die from preventable diseases before their fifth birthday. Two thirds of these deaths could be avoided through low cost and easily available health care (WHO, 2008). Sixty percent of pregnant women in South Asia deliver their babies without the help of skilled health care workers. And each year approximately a million people die from malaria. If this continues the Millennium Development Goals for maternal and child health will not be achieved, putting millions of lives at risk.

Poor people are often excluded from good quality health care as it is unaffordable and geographically inaccessible. Generating finances to extend health care to all in an efficient, sustainable and equitable way, is a major challenge for governments. Health care systems are usually financed through a combination of user fees, out-of-pocket charges, taxes and formal or community-based health insurance schemes.

Governments not only need to increase the supply of health services but also have to improve poor people's demand for health care. Incentive schemes, such as conditional cash transfers and contracting-out health services are examples of efforts to make health care affordable, accessible and better quality. But, what really works? Is it better to increase demand for services by improving quality or by giving cash payments to poor people? Should poor people pay for services directly or through an insurance scheme?

Lessons learned

Low user fees increases use of health services: User fees or out-of-pocket payments are impoverishing as well a barrier to poor people's access to health care. Despite this, governments facing cash constraints tend to implement them to generate finances. Few impact evaluation studies have examined the effect of introducing or removing user fees on poor people's access to health care or health outcomes. But, an experimental study of health centres in Sudan, found that when user fees were reduced for children and pregnant women, they used the health services more and were able to buy drugs (Abdu et al., 2004).

In Niger, a study found that use of health services increased despite the introduction of a user fee, only when the quality of services was improved. However, this study also found that poor people's use of the health services was higher when the user fee was a smaller amount (and had been a part of a social financing scheme which combined tax and a small user fee) (Diop et al., 1995).

Health insurance schemes generally improve health care access but not always: Health insurance generally can reduce the risk of poor households having to incur large out-of-pocket expenses thereby encouraging them to seek good health care. The evidence shows that in many cases it has expanded access to health care but the poorest people are missed out, and the average expenses for seeking health care goes down very little.

Studies in Colombia, Mexico and Vietnam found that health insurance had a positive effect on poor people's access and use of health services. In Colombia it increased the chances of children being fully immunised by eight percent (Giedion et al., 2007). Insured households in Mexico were less likely to incur 'catastrophic' expenses (i.e. relatively small expenses that could push households into poverty) on health care and medicines, than uninsured households. Out-of-pocket expenses too were lesser, particularly among the poorest households (Galárraga et al., 2008).

In contrast, in China a public health insurance programme increased health care use by 20 percent, though not amongst the poorest people. Although the programme also had no effect on people's out-of-pocket expenses, the 'catastrophic' expenses of poor people were reduced (Wagstaff et al., 2007). In Vietnam, children's nutritional health improved significantly after formal health insurance systems were put in place, but the poorest groups did not benefit from these positive effects (Wagstaff and Pradhan, 2005).

Community-based health insurance seems to have limited effect on improving access to health care among lower income groups (Gnawali et al., 2008). Although community based schemes succeed in attracting poor people, the poorest ones in the population are still excluded, as seen by two studies in Burkina Faso (Gnawali et al., 2008) and Senegal (Jütting, 2004).

Conditional cash transfers encourage poor women to use good health services: Several Latin American countries, such as Mexico, Colombia and Honduras have been very successful in encouraging poor women to use health care services through their cash transfer programmes. The cash transfers are made to poor people, especially women, conditional on certain criteria such as sending children to schools, seeking regular health care and so on.

Mexico's *Progresa* programme has had a significantly positive impact on health care use (Gertler, 2000), while in Colombia, the proportion of children enrolled in growth monitoring rose by 40 percent (Attanasio et al., 2005). In Honduras, cash transfers increased women's use of antenatal care by 20 percent and growth monitoring of children increased by 21 percent. However, the research also suggested an unintentional effect as the cash payments may have been an incentive for some women to become pregnant (Morris et al., 2004). This aspect might require further research.

However, conditional cash transfers are likely to be effective only when the services are available widely and are of a reasonable quality. In sub-Saharan Africa, particularly in rural areas, where the supply of public services is limited or the quality needs improving, other interventions are necessary. Conditional cash transfer programmes in such areas need to be implemented together with investments in infrastructure in order to have more and better quality health services (Kakwani et al., 2005).

Contracting health care service delivery improves access: Some governments have been able to expand the health services to remote places by contracting to private providers. However, it is still uncertain whether this has encouraged health care use. Services may be 'contracted out' to non-governmental providers who have the complete responsibility of delivering the health care; or they may be 'contracted in' where they work within the public health system to strengthen it. A study in Cambodia, found contracting out to non-governmental organisations in rural areas increased health care coverage over government provision between 4 and 29 percentage points for various health indicators. For example it greatly improved the likelihood of more children being immunised. Also, poor people were the ones to have benefited more from this (Schwartz and Bhushan, 2004). Similar results were seen in an experimental study from India, although health care use remained low (Baqui et al., 2008).

Closing the evaluation gap

The evidence on the impact of health care financing and delivery schemes on health care use and quality is still mixed and unclear. Systematic reviews of the literature show that most studies are small, offer learning on specific contexts or have a short time-frame (Palmer et al 2004; Lagarde and Palmer, 2006). Whilst user fees could discourage poor people from accessing health services, there is still no clear answer as to whether this is for preventive or curative services. In places where user fees often came with improvements in quality of services it is difficult to say what actually increased use of services. Most health insurance schemes have not been studied over time and there is no knowledge of what has failed (Palmer et al, 2004). Although cash transfers seem

promising, the lessons are largely from Latin America which has relatively better health systems. Would they have the same impact in sub-Saharan Africa where the infrastructure is not as good? Would contracting out services have the same impact if it were to be done on a large scale?

There is a need for rigorous large-scale impact evaluations to examine the impact of the different insurance schemes, contracting-out and particularly the unconditional cash transfers that are more popular in sub-Saharan Africa.

References

Attanasio, O., Gómez, L., Heredia, P. and Vera-Hernández, M. (2005) "The short-term impact of a conditional cash subsidy on child health and nutrition in Colombia." Centre for the Evaluation of Development Policies, Institute for Fiscal Studies.

www.ifs.org.uk/publications/3503

Abdu, Z., Mohammed, Z., Bashier, I. and Eriksson, B. (2004). "The impact of user fee exemption on service utilization and treatment seeking behaviour: The case of malaria in Sudan." *International Journal of Health Planning and Management*, 19, 95-106.

www3.interscience.wiley.com/journal/109857760/abstract?CRETRY=1&SRETRY=0

Baqi, A., Rosecrans, A., Williams, E. Agrawal, P., Ahmed, S., Darmstadt, G., Kumar, V., Kiran, U. Panwar, D., Ahuja, R., Srivastava, V., Black, R. and Santosham, M. (2008). "NGO facilitation of a government community-based maternal and neonatal health programme in rural India: Improvements in equity." *Health Policy and Planning*, 23, 234-243

<http://heapol.oxfordjournals.org/cgi/content/abstract/23/4/234>

Diop, F., Yazbeck, A. and Bitran, R. (1995). "The impact of alternative cost recovery schemes on access and equity in Niger." *Health Policy and Planning*, 10 (3), 223-240.

<http://heapol.oxfordjournals.org/cgi/content/abstract/10/3/223>

Galarrága, O., Sosa-Rubí, S., Salinas, A., Sesma, S. (2008). "The Impact of Universal Health Insurance on Catastrophic and Out-of-Pocket Health Expenditures in Mexico: A Model with an Endogenous Treatment Variable." HEDG Working Paper 08/12, Health Econometrics and Data Group, University of York.

http://www.york.ac.uk/res/herc/documents/wp/08_12.pdf

Gertler, P. (2000). "The impact of Progresa on health, Final report." International Food Policy Research Institute, Washington, D.C.

<http://ageconsearch.umn.edu/bitstream/16010/1/mi00ge02.pdf>

Giedion, U., Díaz, B. and Alfonso, E. (2007). "The Impact of Subsidized Health Insurance on Access, Utilization and Health Status: The Case of Colombia." Mimeo, the World Bank, Washington, D.C.

Gnawali, D., Pokhrel, S., Sié, A., Sanon, M., de Allegri, M., Soares, A., Dong, H., Sauerborn, R. (2008). "The effect of community-based health insurance on the utilization of modern health care services: Evidence from Burkina Faso." *Health Policy*, November (Article in Press).

<http://ideas.repec.org/a/eee/hepoli/v90y2009i2-3p214-222.html>

Jütting, J. (2004) "Do Community-based Health Insurance Schemes Improve Poor People's Access to Health Care? Evidence from Rural Senegal." *World Development*, 32 (2), 273-288.

Kakwani, N. Soares, F. and Son, H. (2005) "Conditional Cash Transfers in African Countries." International Poverty Centre Working Paper Number 9, UNDP, Brazil.

<http://www.undp-povertycentre.org/pub/IPCWorkingPaper9.pdf>

Lagarde, M. and Palmer, N. (2006) "Evidence from systematic reviews to inform decision-making regarding financing mechanisms that improve access to health services for poor people" Policy Brief prepared for the International Dialogue on Evidence Informed Action to Achieve Health Goals in Developing Countries (IDEAHealth), Thailand.

<http://www.who.int/rpc/meetings/HealthFinancingBrief.pdf>

Morris, S., Flores, R., Olinto, P. and Medina, J. (2004). "Monetary incentives in primary health care and effects on use and coverage of preventive health care interventions in rural Honduras: Cluster randomised trial." *Lancet*, 364 (9450), 2030-2037.

<http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2804%2917515-6/abstract>

Palmer, N., Mueller, D., Gilson L., Mills, A. and Haines, A. (2004) "Health financing to promote access in low income settings – how much do we know?" *Lancet*, 364, 1365-1370.

Schwartz, J. and Bhushan, I. (2004). "Reducing inequity in the provision of primary health care services: Contracting in Cambodia." Mimeo, the World Bank, Washington, D.C.

Wagstaff, A., Lindelow, M., Jun, G., Ling, X. and Juncheng, Q. (2007). "Extending Health Insurance to the Rural Population: An Impact Evaluation of China's New Cooperative Medical Scheme." Policy Research Working Paper No. 4150, Impact Evaluation Series No 12, World Bank, Washington, D.C.

http://papers.ssrn.com/sol3/papers.cfm?abstract_id=965078

Wagstaff, A. and Pradhan, M. (2005) "Health Insurance Impacts on Health and Nonmedical Consumption in a Developing Country." Policy Research Working Paper 3563, World Bank, Washington, D.C.

http://papers.ssrn.com/sol3/papers.cfm?abstract_id=708444

Credits

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