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Helpdesk Report: Pro-poor Health Delivery

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Query: Outline a typology/annotated bibliography for 'pro-poor' delivery channels for health services. Ideally, the work would set out a broad typology of the approaches that have been developed specifically to increase access to and utilisation of health services by the poor, with 1 - 3 examples/key studies/documents noted under each. This could include systemic approaches (e.g. equitable health financing) or more targeted approaches (e.g. demand side interventions such vouchers and/or conditional cash transfers).

Enquirer: DFID UK

Content

1. Overview

The typology was adapted from a document on designing health programmes to reach the poor (section 2). Information on pro-poor health policies does not fit neatly into mutually exclusive categories and many of the themes overlap. For example, universal coverage interventions such as abolishing user fees were often discussed as pro-poor targeting. Universal targeting can appear to be targeting the poor but it may be that the less poor are paying for higher quality services. Also the section on health financing approaches refers to community healthcare plans and insurance in this report. Many of the other sections relate to financing, particularly public and private sector financing.

The typology and content featured in the helpdesk report includes the following examples:

- **Targeting** – abolition of user fees and benefits for the poor in Uganda and Cambodia; depravation based resource allocation in Zambia; a health card programme in Indonesia, social health insurance in Indonesia
- **Promoting universal healthcare coverage** – healthcare in South Africa; strategies in East and Southern Africa; anti-retroviral treatment in South Africa; healthcare in Thailand
- **Public spending** – benefit incidence in Asia; public social spending in Africa

- **Increasing availability and access** – mobile health units in India; community health workers in Rwanda
- **Private sector involvement** – a Rockefeller report outlining different private sector financing and delivery models; assessment of private-sector health utilisation for the poor
- **Incentives for providers and clients** – encouraging women to use professional care at childbirth in Nepal; pay-for performance overview
- **Community participation** – meeting the needs of the poor in Kenya; participation and accountability for equity
- **Health financing approaches** – insurance sector reforms in India; a review in low-income countries

2. Typology and case studies

Designing health and population programmes to reach the poor
Ashford, L.S., Gwatkin, D. R., Yazbeck A.S., *Population Reference Bureau*, 2006
http://www.phishare.org/files/4458_DesigningPrograms.pdf

This document notes the following types of intervention and approaches to benefit the poor:

- Directing programme benefits towards the poor
- Promoting universal coverage of basic healthcare
- Increasing the availability and quality of health services
- Developing public-private partnerships
- Creating incentives for health providers and clients
- Increasing community participation
- Health financing approaches

These broad groups are used as a basis for category headings in the rest of this helpdesk report.

In the document, discussions of the categories are followed by some useful case study descriptions including:

- Poverty mapping: identifying where the poor live
- Universal health coverage in Brazil
- Using social marketing to increase equity in access in Tanzania
- Delivering services through a development-oriented women's union in India
- Participatory approaches to improve adolescent reproductive health in Nepal

Reaching the poor with health, nutrition and population services. What works, what doesn't and why?
Gwatkin, D.R., Wagstaff, A. Yazbeck A.S. (eds.), *The World Bank*, 2005
http://siteresources.worldbank.org/INTPAH/Resources/Reaching-the-Poor/complete.pdf

(From chapter 3, pp 47-61)

The features of the programmes covered by the case studies in this volume vary widely. However, most favoured the poor by achieving higher coverage, among them than among the better off, or by producing greater coverage increases among disadvantaged than among more privileged groups and thereby reducing disparities. Together, the findings and results indicate that much better performance on the part of health, nutrition, and population programmes is possible.

There are many ways to achieve results. There is a wide variation among programmes favouring the poor and multiple potentially effective approaches. The challenge is to find the approach that works best in a particular setting.

A brief overview of the case studies is provided, grouped according to success in reaching the poor.

Most successful include:

- Nationwide government maternal and child health immunisation, and child feeding programmes, Argentina.
- Field experiments with government contracts to NGOs to deliver primary healthcare services that the government traditionally provides directly, Cambodia
- Field experiments to distribute insecticide-treated bednets through government-red cross mass immunisation campaigns, Ghana and Zambia
- Three government and NGO feeding programmes for poor children, Peru
- Voluntary counselling and testing services for HIV through a cooperative government-NGO programme in urban government clinics, South Africa

3. Directing programme benefits towards the poor / Targeting

Poverty and user fees for public healthcare in low-income countries: lessons from Uganda and Cambodia
Meessen, B. *The Lancet*, 2006
http://www.eldis.org/go/topics/dossiers/meeting-the-health-related-needs-of-the-very-poor/pro-poor-health-policies/models-and-institutional-mechanisms&id=33775&type=Document

This Lancet article examines two countries' efforts towards making access to healthcare more equitable. It compares the abolition of user fees in Uganda and the establishment of health equity funds in Cambodia and identifies key issues that national policy makers should consider when making pro-poor policy choices for healthcare finance. The article describes the policies undertaken in Uganda and Cambodia, and the effects of these on access to health services for poor people. It also discusses targeting mechanisms and the financial implications of removing user fees and introducing a benefit package for poor people.

Experiences of implementation of a deprivation-based resource allocation formula in Zambia: 2004–2009
Chitah, BM, *EQUINET Discussion Paper 85*, (2010)
http://www.equinetafrica.org/bibl/docs/Zambia_RA%20rep%20Dec%202010.pdf

From about 1994, the Ministry of Health introduced population-based allocation criteria, which were revised and modified during 2002/3 and 2009. Despite the revisions, it has not been clear the extent to which the expectations of the allocation formula have been met and the degree to which the criteria have been modified or implemented according to the results.

This study aims to:

- provide an update of the experiences and progress on the design, review and implementation of an equity-based resource allocation formula in the Zambian health sector
- provide a critical assessment of the formula in terms of weaknesses and strengths, constraints and success factors

- assess its contribution towards relative redistribution of financial resources on a geographic basis (or/and demographic basis)
- identify evidence of the formula associated with health systems strengthening.

Targeting the poor in times of crisis: the Indonesian health card
Sparrow, R., *Health Policy and Planning* 23 (3), 2008
http://heapol.oxfordjournals.org/content/23/3/188.full

This paper looks at targeting performance of the Indonesian health card programme that was implemented in August 1998 to protect access to healthcare for the poor during the Indonesian economic crisis. By February 1999, 22 million people had received a health card. The health card provided a user fee waiver for public healthcare. Targeting of the health card was pro-poor, but with considerable leakage to the non-poor. Utilisation of the health card for outpatient care was also pro-poor, but conditional on ownership - the middle quintiles were more likely to use the card.

Social Health Insurance for the Poor: Targeting and Impact of Indonesia's Askeskin Program
Sparrow, R., Suryahadi, A. & Widyanti, W., *SMERU*, 2010

A first step towards meeting Indonesia's ambition for universal health insurance was made in 2005 with the introduction of the Health Insurance for the Poor (Askeskin) programme, a subsidised social health insurance for the poor and the informal sector. This scheme covered basic healthcare in public health clinics and hospital inpatient care. This paper investigates targeting and impact of the Askeskin programme using household panel data. The findings show that the programme is indeed targeted to the poor and those most vulnerable to catastrophic out-of-pocket health payments. The public health insurance improves access to healthcare in that it increases utilisation of outpatient healthcare among the poor, while out-of-pocket spending seems to have increased for those insured through Askeskin in urban areas.

Allocating public resources for health: developing pro-poor approaches
Pearson, M., *DFID HSRC*, 2002
http://www.tgpsh.or.tz/fileadmin/SHI/Pearson_M._2002._Allocating_Public_Resources_for_Health.pdf

This paper describes the key elements of a needs-based approach for allocating public funding. Public funds may play a relatively modest role in terms of overall health expenditure. However, they are usually the only funds over which Ministries of Health have direct control and are also often the key source of financing for the services used by the poor.

Using targeted vouchers and health equity funds to improve access to skilled birth attendants for poor women: a case study in three rural health districts in Cambodia
Ir, P. et al., *BMC Pregnancy and Childbirth* 10(1), 2010
http://www.biomedcentral.com/content/pdf/1471-2393-10-1.pdf

In many developing countries, the maternal mortality ratio remains high with huge poor-rich inequalities. Programmes aimed at improving maternal health and preventing maternal mortality often fail to reach poor women. Vouchers in health and Health Equity Funds (HEFs) constitute a financial mechanism to improve access to priority health services for the poor. This article assesses their effectiveness in improving access to skilled birth attendants for

poor women in three rural health districts in Cambodia and draws lessons for further improvement and scaling-up.

4. Promoting universal coverage of basic healthcare

Have pro-poor health policies improved the targeting of spending and the effective delivery of healthcare in South Africa?
Burger, R. & Grobler, C. *Stellenbosch Economic Working Papers*, 2006
http://ideas.repec.org/p/sza/wpaper/wpapers26.html

Since 1994 there have been a number of radical changes in the public healthcare system in South Africa. Budgets have been reallocated, decision-making was decentralised, the clinic network was expanded and user fees for primary healthcare were abolished. The paper examines how these recent changes have affected the incidence of spending and the accessibility and quality of healthcare.

The paper finds that between 1995 and 2003, there have been advances in the pro-poor spending incidence of both clinics and hospitals. The increased share of the health budget allocated to the more pro-poor clinic services has contributed further to the improvement in the targeting of overall health spending. Also, it appears that the elimination of user fees for clinics and the expansion of the clinic network have helped to make health services more affordable and geographically accessible to the poor and were associated with a notable rise in health service utilisation for individuals in the bottom two expenditure quintiles.

South Africa's spending on clinics and hospitals is well targeted and more progressive than other developing country public health systems. Unfortunately, it appears that to a considerable extent, this result is driven by perceptions that services offered in public hospitals and clinics are of a low and variable quality. These perceptions seem to be encouraging most of those who can afford to pay more for health services to opt out of the public health system, thereby increasing the pro-poor incidence of public health spending. Complaints by users of public health facilities include long waiting times, staff rudeness and problems with drug availability. Dissatisfaction with health services is significantly higher in the public sector than in the private sector and the gap has expanded slightly over time. It is consequently not surprising that a substantial and increasing share of individuals – also including the very poorest – prefer to consult private providers.

Strategies to improve equitable domestic financing to reach universal coverage in East and Southern Africa
HealthNet Consult with Health Ecnomics Unit, UCT and TARSC, *EQUINET Policy Brief 23*, (2010)
http://www.equinetafrica.org/bibl/docs/POL%20Brief%2023%20domfin.pdf

Key messages:

- Inadequate financing is limiting progress in achieving universal coverage of health services in the region. Governments should aim to meet the Abuja commitment and move rapidly towards reaching spending of at least US $45 per capita per year on health.
- Universal coverage is not likely to be achieved without improved public domestic financing of the health sector. Domestic financing is however not increasing and countries are currently too reliant on out-of-pocket spending, which creates catastrophic burdens for poor communities, and external funding, which is not reliable and often not delivered in a way that supports universal coverage.

- Taxes and/or social health insurance (SHI) provide the most equitable way of raising domestic public resources for health. ESA countries have however, made little progress in improving tax funding to health and while many countries have policies and designs for SHI, little progress has been made in implementing it.
- Countries could improve progressive tax financing through ensuring that taxes are higher for higher income levels, collecting dedicated taxes ear-marked for health, and improving tax collections.
- To encourage increased revenue to the public sector, Ministries of Health need to demonstrate the capacity to absorb and efficiently and accountably use resources in areas of health need. Monitoring and research needs to be implemented to demonstrate health outcomes, encourage good practice and inform policy dialogue.

Financing equitable access to antiretroviral treatment in South Africa
Cleary, S. & McIntyre, D., *BMC Health Services Research*, 10(Suppl 1):S2, 2010
http://www.biomedcentral.com/1472-6963/10/S1/S2

While South Africa spends approximately 7.4% of GDP on healthcare, only 43% of these funds are spent in the public system, which is tasked with the provision of care to the majority of the population including a large proportion of those in need of antiretroviral treatment (ART). South Africa is currently debating the introduction of a National Health Insurance (NHI) system. Because such a universal health system could mean increased public healthcare funding and improved access to human resources, it could improve the sustainability of ART provision. This paper considers the minimum resources that would be required to achieve the proposed universal health system and contrasts these with the costs of scaled up access to ART between 2010 and 2020.

Equity in financing healthcare: impact of universal access to healthcare in Thailand
Limwattananon, S., Tangcharoensathien, V. & Prakongsai, P., *EQUITAP Project: Working Paper # 16*, 2005
http://www.equitap.org/publications/wps/EquitapWP16.pdf

This paper exploited five different data sets of the national household survey in pre- (years 2000 and 2001) and post- (years 2002 and 2004) universal healthcare coverage periods to analyse trends and patterns of the distribution of utilisation and out-of-pocket payments for public healthcare in relation to the distribution of household living standards. Benefit incidence of public healthcare spending, in general, has been progressive, in favour of the poor.

5. Public spending and benefit incidence analysis

Who benefits from public spending on healthcare in Asia?
O'Donnell, O. et al., *EQUITAP Project: Working Paper #3*, 2005
http://www.equitap.org/publications/wps/EquitapWP3.pdf

This paper examines the benefit incidence of public healthcare subsidies in eleven Asian territories, including India, Indonesia and two provinces of China. The use of concentration indices and a high degree of consistency in the application of methods provide results that, unlike much of the existing evidence, are comparable across countries. Unlike many studies that examine utilisation data only or assume constant unit costs, exploit detailed health accounts to allow for variation in unit expenditures across health services, facilities and regions. This study distinguishes between hospital and non-hospital care and between

inpatient and outpatient care. It examine not only the distribution of quantities of healthcare but also that of the value of subsidies.

Hong Kong is the only territory that achieves a strong pro-poor distribution of all public health services. Public healthcare is more moderately pro-poor in Malaysia and Thailand and is evenly distributed in Sri Lanka. In the remainder of the low-income territories examined, the better-off receive more of the subsidy than the poor. The pro-rich bias is greatest in Nepal, Heilongjiang (China) and Indonesia, followed by India, Gansu (China), Bangladesh and Vietnam.

Benefit incidence analysis
http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/EXTPSIA/0,,contentMDK:20472485~menuPK:1108016~pagePK:148956~piPK:216618~theSitePK:490130~isCURL:Y~isCURL:Y~isCURL:Y,00.html
in particular
Public Social Spending in Africa: Do the Poor Benefit?
Castro-Leal, F., *The World Bank*, 1999
http://siteresources.worldbank.org/INTPSIA/Resources/490023-1121114603600/12925_toolkit_paper_chapter2.pdf

Education and healthcare are basic services essential in any effort to combat poverty and are often subsidised with public funds to help achieve that purpose. This paper examines the effectiveness of public social spending on education and healthcare in several African countries and finds that these programmes favour not the poor, but those who are better-off. It concludes that this targeting problem cannot be solved simply by adjusting the subsidy programme. The constraints that prevent the poor from taking advantage of these services must also be addressed if the public subsidies are to be effective.

6. Increasing the availability and quality of health services

Access to health services in under privileged areas: a case study of Mobile Health Units in Tamil Nadu and Orissa
Dash U. et al, *CREHS research report*, 2008
http://www.crehs.lshtm.ac.uk/downloads/publications/Mobile_health_units.pdf

This report provides an assessment of what gains are achieved through Mobile Health Units (MHUs) in relation to access to care in the inaccessible areas of Tamil Nadu and Orissa. A case study approach has been adopted to access the role of the MHUs and, more specifically, the study attempts to:

- assess the gains presented by MHUs, in terms of access to care
- identify and analyse factors which hinder or enable the better implementation of MHUs
- propose policies to improve the overall design and implementation of MHUs in the future.

Community Health Workers in Rwanda Improve Access to Care
Binagwahoo, A.*Open Forum, Health and Human Rights: An International Journal*, 2009
http://www.hhropenforum.org/2009/08/chws-in-rwanda/

Access to care in resource-constrained countries has three major barriers to overcome: finances, infrastructure, and geography. Community health workers (CHWs) are an unavoidable solution for both infrastructure and geography. The Government of Rwanda has

recognised that CHWs are necessary in order to improve access to health in rural communities. By using CHWs, with their approach to health at the community level, Rwanda hopes to solve 80% of health problems in the country.

7. Involvement of the private sector

Innovative Pro-Poor Healthcare Financing and Delivery Models
Dimovska, D. et al., *Results for Development Institute*, 2009
http://www.rockefellerfoundation.org/uploads/files/58b820ed-8263-49c4-a89e-7c25beac17eb-innovative.pdf

This is a report of a selection of current private sector health innovations. It describes 33 innovative financing and delivery programmes. These programmes range from donor-driven initiatives to large-scale government-subsidised efforts to for-profit businesses. It categorises the programmes by five financing and delivery mechanisms:

- Service delivery mechanisms
- Risk-pooling mechanisms
- Government and provider self-regulation mechanisms
- Provider purchasing and contracting mechanisms
- Supply chain mechanisms

Can working with the private for-profit sector improve utilization of quality health services by the poor? A systematic review of the literature
Patouillard, E. et al., *International Journal for Equity in Health*, 2007
http://preview.equityhealthj.com/content/6/1/17

There has been a growing interest in the role of the private for-profit sector in health service provision in low- and middle-income countries. The private sector represents an important source of care for all socioeconomic groups, including the poorest and substantial concerns have been raised about the quality of care it provides. Interventions have been developed to address these technical failures and simultaneously take advantage of the potential for involving private providers to achieve public health goals. Limited information is available on the extent to which these interventions have successfully expanded access to quality health services for poor and disadvantaged populations. This paper addresses this knowledge gap by presenting the results of a systematic literature review on the effectiveness of working with private for-profit providers to reach the poor.

Public Stewardship of Private Providers in Mixed Health Systems.
http://www.rockefellerfoundation.org/uploads/files/f5563d85-c06b-4224-bbcd-b43d46854f83-public.pdf

This is a synthesis report from the Rockefeller Foundation-sponsored initiative on the role of the private sector in health systems in developing countries.

8. Creating incentives for health providers and clients

Encouraging women to use professional care at childbirth. Does Nepal's Safe Delivery Incentive Programme work? Evidence from the district of Makwanpur
Powell-Jackson, T. & Wolfe, R., *Towards 4 + 5*, 2008

http://www.towards4and5.org.uk/PDFs/briefing_paper_2.pdf

In 2005, the Government of Nepal introduced an innovative financing scheme, known as the Safe Delivery Incentive Programme (SDIP), as part of its strategy to increase the use of maternity services. The SDIP provides cash to women who deliver in a health facility and an incentive to health workers for attending deliveries. Across the developing world, there is increasing interest in whether such financing policies work to reduce barriers that women face when seeking healthcare at childbirth.

This briefing note reports on the impact of the SDIP in Makwanpur, a district of Nepal. It shows that the intervention has proved successful in raising utilisation of professional delivery services, but a high proportion of households continue to incur catastrophic healthcare payments when seeking care.

Can "Pay for Performance" Increase Utilization by the Poor and Improve the Quality of Health Services?
Eichler, R., *CGDEV*, 2006
http://www.cgdev.org/doc/ghprn/PBI%20Background%20Paper.pdf

This discussion paper describes 'Pay for Performance' and how this improves access and quality for the poor.

9. Increasing community participation

Meeting the health related needs of the very poor, DFID Workshop Paper, Healthcare access of the very poor in Kenya
Sohani, S. B. *DFID HSRC*, 2005
http://www.eldis.org/fulltext/verypoor/11_agakhan.pdf

This paper reviews a model of healthcare delivery for the poorest, developed in Kenya. It illustrates that a pro-poor health system can be developed if the true representatives of the poorest are enabled to participate in healthcare delivery, and good governance and proper systems are established. With the active involvement of the community in a mutually supportive manner, the utilisation of services and access to basic healthcare for the poorest can be improved.

Participation and accountability in health systems: The missing factor in equity?
Loewenson, R., *Equinet Africa*, 2000
http://www.equinetafrica.org/bibl/docs/partic&account.pdf

This paper discusses how to improve equity in health systems. In particular, it argues that social dimensions such as social networking, participation and governance are critical factors for vertical equity in health systems.

10. Health financing approaches

Health Insurance for the Poor
Ahuja, R., *ICRIER*, 2004
http://www.icrier.org/pdf/wp123.pdf

Community based health insurance (CBHI) is more suited than alternate arrangements to providing health insurance to the low-income people living in developing countries. The universal health insurance scheme, launched recently by the Prime Minister of India, is only one of the forms that CBHI can take. While analysing the proposed scheme, we examine alternate forms of CBHI schemes prevalent in the country.

The development of private health insurance market in the country will not leave the poor unaffected. Insurance sector reform can affect the poor through its effect on the provision of health services (i.e., cost, quality and access) used by the low-income people as well as through its access to financing of healthcare. This paper explores how insurance sector reforms alter health insurance prospects facing the poor in India, and what changes on the health front affecting the poor have happened or are likely to happen as a result of insurance sector reforms.

The paper concludes that in diverse settings of India all forms of CBHI have a role to play and therefore need to be encouraged by the government through appropriate interventions. Formal insurance providers can also be reigned to serve low-income population. At the same time, developments in formal health insurance market need to be guided so as to minimise cost escalation of healthcare provision.

Community-based health insurance in low-income countries: a systematic review of the evidence
Ekman, B., *Health Policy and Planning* 19(5), 2004
http://www.wpro.who.int/NR/rdonlyres/D91E6EC1-6F10-4894-B865-E72B42155676/0/CBhealthinsuranceart04.pdf

Health policymakers are faced with competing alternatives, and for systems of healthcare financing. The choice of financing method should mobilise resources for healthcare and provide financial protection. This review systematically assesses the evidence of the extent to which community-based health insurance is a viable option for low-income countries in mobilising resources and providing financial protection. The review contributes to the literature on health financing by extending and qualifying existing knowledge. Overall, the evidence base is limited in scope and questionable in quality. There is strong evidence that community-based health insurance provides some financial protection by reducing out-of-pocket spending. There is evidence of moderate strength that such schemes improve cost-recovery. There is weak or no evidence that schemes have an effect on the quality of care or the efficiency with which care is produced. In absolute terms, the effects are small and schemes serve only a limited section of the population.

The main policy implication of the review is that these types of community financing arrangements are, at best, complementary to other more effective systems of health financing. To improve reliability and validity of the evidence base, analysts should agree on a more coherent set of outcome indicators and a more consistent assessment of these indicators. Policymakers need to be better informed as to both the costs and the benefits of implementing various financing options. The current evidence base on community-based health insurance is mute on this point.

11. Additional information

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