

Draft for discussion

HEALTH FINANCING – EXECUTIVE SUMMARY

Evidence from systematic reviews to inform decision making regarding financing mechanisms that improve access to health services for poor people

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Executive Summary

BACKGROUND

Increasing evidence indicates that many vulnerable groups are effectively excluded from accessing reasonable quality health care in low and middle income countries. Even services established as highly cost-effective have been seen as failing to reach those in need.

Financial barriers have been recognized as primary obstacles for those trying to access health services. In low and middle income countries (LMICs) chronic under-funding of health systems has sometimes led to the adoption of health financing mechanisms whose beneficial effects are disputed. Given this growing concern several innovative financing mechanisms have been developed that aim to encourage greater service provision efficiency and a greater uptake of existing services.

This policy brief reports the findings of a series of systematic reviews that assessed the impact of five health financing policy options on access to health services, particular for poor populations.

POLICY DECISIONS AND OPTIONS

This policy brief focuses on five health financing options that have been proposed as mechanisms to improve access to health services for poor people and to reduce the financial burden represented by health care, namely:

- **User fees:** charges levied on any aspect of health services at the point of delivery. It has been argued that the additional revenue they generate, directly, or indirectly through better allocation of resources, can be used to improve the quality and availability of government health services, thereby benefiting the poor. Counter arguments advocating the removal of user fees as a mechanism to improve financial accessibility for the poor, have gained increasing currency during the last decade
- **Community Based Health Insurance (CBI):** a form of voluntary, not-for-profit insurance mechanism that often involves some form of community management. CBI schemes are typically based on a collective entity defined by, for example, geographi-

cal, professional, or religious affiliations. CBI has been introduced as a method of increasing revenue for health care, while reducing payments at the point of use. CBI also allows for the redistribution of resources from the healthy to the sick

- **Social Health Insurance (SHI):** a form of compulsory insurance, that aims to provide universal coverage. The compulsory nature of such schemes should reduce adverse selection and enable extensive redistributive mechanisms between healthy and sick people, as well as between poor and better off groups
- **Contracting out:** the hiring of a non-state provider (often an NGO) to provide health services for a specific geographic area and period of time, on behalf of the government. This has been advocated as a more efficient way to provide health services, and as an effective solution when available services in underserved areas need to be increased
- **Conditional Cash Transfers (CCT):** provide monetary transfers to households on condition that they comply with pre-defined requirements. CCT programmes have been justified on the grounds that demand-side subsidies are necessary to address barriers constraining poor people's use of health and other social services.

METHODS

Both published and grey literature was searched using search strategies developed in conjunction with PubMed. To be included, a study needed to have been implemented according to one of the following three study designs: randomized controlled trials, interrupted time series analyses, or controlled before-after studies. In addition, the studies had to provide an objective measure of at least one of the following outcomes: health care utilization, health expenditure, health outcomes or equity outcomes.

A quantitative re-analysis of time series data was undertaken for studies with sufficient data where an appropriate method had not originally been used.

Each study was independently assessed by two reviewers, according to a set of quality criteria designed to identify major bias in the study design or analysis.

Other relevant studies are used in this brief to answer specific implementation issues and provide additional relevant information.

RESULTS

User fees: 17 studies were included in the systematic review but many were significantly flawed. The reduction or removal of fees appears to increase utilisation for poorer groups, although the level of evidence is weak. Experiences to date in removing user fees suggest that the planning of such policy changes should be done with caution in order to avoid adverse effects. Evidence from a number of studies suggests that introducing or increasing user fees has a detrimental effect; others contradict this claim and argue that if the quality of care is improved simultaneously, this can improve access and utilisation for poorer groups. The studies which have demonstrated positive effects on utilization (through combining user fees and quality improvements) have been small-scale studies whose replicability at the national level has proven difficult. This is due particularly to

the limited revenues typically raised through user fees. There is also strong evidence that poorer groups are more sensitive to price variations and that exemption policies are seldom well managed or effective enough to protect the poor from the detrimental effects of user fees.

Community-based insurance: only one study met the inclusion criteria for this systematic review. It is therefore unclear to what degree such limited evidence should be used to generalise whether CBI has a positive effect on access to care for poorer groups. Descriptive case-studies have shown that disadvantaged populations are less able to enrol in such schemes. Further, these studies have also suggested that the technical skills required to design, implement and sustain CBI schemes may limit their replicability. Finally, reviews of existing CBIs in low and middle income countries have emphasized their limited scale and a rather disappointing capacity to mobilize revenue.

Social health insurance: we were unable to identify any studies meeting our inclusion criteria for this type of financing mechanism. Few examples exist of social health insurance schemes operating at a large scale in developing countries and even fewer have evidence related to their impact. Without careful design and implementation it is possible that developing social insurance may have unforeseen negative impacts on equity. There are also attendant issues regarding the complexity of extending such SHI schemes to a national level and the feasibility of developing adequate technical capacity in developing country contexts.

Contracting out services: three studies were included in this systematic review. All provided rather weak evidence for the claim that contracting out increases service delivery in previously under-served areas. A study based in Cambodia showed that contracting out services increased access for poorer groups, though these findings were undermined by methodological weaknesses. Other descriptive literature on contracting out highlighted issues regarding the capacity of non-state providers to deliver services on a large scale if contracting out were to be scaled up. Widespread contracting of health services, particularly if donor driven, may also undermine government's stewardship role within the health sector.

Conditional Cash Transfers (CCT): good evidence from six different experiments of conditional cash transfers was synthesized in this review. Offering conditional cash transfers to targeted poor populations is an effective mechanism to increase the uptake of preventive health services, and sometimes improving health status. However the use of conditional cash transfers seems relevant only in settings where functional primary health care systems exist already. Substantial management capacity is needed to run CCT schemes.

DISCUSSION

This policy brief is constrained by its focus on a limited number of financing mechanisms. It also reviews studies that employ specific study designs, and focuses only on evidence from low and middle income countries. Although the brief is transparent in its approach and methodology, it could be strengthened by focusing more on how contexts

influence the effects of the mechanisms themselves. In addition a broader range of financing mechanisms could be included and consideration given to the effects of different combinations of financing mechanisms.

There remain substantial evidence gaps in the field of health financing. More high quality impact evaluations are needed, particularly related to insurance mechanisms and contracting out. Given the uncertainty concerning the effects of such schemes and the serious risk of adverse effects, policy makers are advised to include impact evaluations alongside health financing reforms. In addition, other study designs that provide complementary evidence associated with implementation issues, and people's attitudes are needed.

The capacity of government to manage and administer alternative health financing schemes is critical to all of the mechanisms considered. For social health insurance both the rate of participation in the formal labour market, and the income per capita will influence the likely success of any scheme. The state of existing health systems is also a crucial consideration. Contracting out may work well in contexts where public health systems have deteriorated, provided there is a pool of health care providers who can bid on contracts. Societal attitudes and values are particularly important when considering user fee policies, and health insurance mechanisms.