

## Meeting the health-related needs of the very poor

There is a growing concern within the international development community that policies aimed at reducing the number of people living below the poverty line could leave the most disadvantaged groups behind.

In line with these concerns, this dossier looks at different strategies for reaching the very poor within the health sector, and at the institutional challenges associated with scaling up health-related interventions to cover broader segments of the population. It also highlights the fact that there are ways outside the health sector to improve health or reduce the impoverishing impact of disease, and that in some contexts these may benefit the poor most.

This dossier is available online at: <http://www.eldis.org/go/topics/dossiers/meeting-the-health-related-needs-of-the-very-poor>

### Contents:

<b>1. Introduction: bringing together health and poverty reduction agendas .....</b>	<b>2</b>
Linkages between health and social protection .....	2
Frameworks of analysis for looking at health and the very poor .....	3
Social protection in transition economies .....	4
Collaboration between health and social sectors .....	4
<b>2. Poverty and ill health .....</b>	<b>5</b>
Measuring poverty .....	5
Categories of poverty .....	6
The case for focusing on the very poor .....	6
Impact of ill health on the poor .....	7
Evidence of the impact of ill health .....	7
<b>3. Targeting the very poor .....</b>	<b>7</b>
Targeted versus non-targeted strategies .....	8
Which targeting mechanism .....	9
Implications of targeting .....	9
Costs of targeting the poorest .....	10
<b>4. Health related strategies for reaching the very poor .....</b>	<b>10</b>
Decreed exemption schemes .....	10
Deferral schemes .....	11
Subsidised exemption schemes .....	11
Voucher schemes .....	12
Community-based health financing schemes .....	12
Health insurance .....	13
Subsidised treatment for specific health conditions .....	13
Regulation of the pharmaceutical sector .....	14
Contracting out .....	14
Abolition of user fees .....	14
<b>5. Other strategies for reaching the poor .....</b>	<b>15</b>
Cash transfers .....	15
Social funds .....	16
Role of civil society .....	16

<b>6. Provider behaviour .....</b>	<b>17</b>
<b>7. Pro-poor health policies .....</b>	<b>18</b>
Inducing a change in policy .....	19
Models and institutional mechanisms .....	19
Factors influencing policy formulation, implementation and outcomes .....	20
Issues for scaling-up .....	20
<b>8. Aid instruments .....</b>	<b>21</b>
SWAps and budget support .....	21
Global health partnerships .....	21
<b>9. Recommended readings .....</b>	<b>23</b>

## 1. Introduction: bringing together health and poverty reduction agendas

The question of how to meet the health-related needs of the very poor brings two distinct strands of thinking together. One is reducing the burden of disease, the focus of health policy, and the other is social protection, which focuses on giving assistance to individuals, households and communities that experience temporary or long-term poverty so that they can better manage risk and increase their security.

This section considers the linkages between health and social protection and reviews different frameworks for analysing health and the very poor. It also looks at social protection in transition economies and the difficulties in operationalising joint health and social protection agendas.

### Four dimensions of analysis

An analysis of health and poverty can be separated into at least four 'blocks' and these provide the structure of this dossier.

- First there is a need to know the conditions in which households live: who are the very poor; what is their livelihood, and what specific challenges do they face in terms of health
- Health care expenditures are a major issue for poor people and they may draw on various entitlements when they require health care. Both formal and informal health assistance schemes need to be looked at, especially those that are targeted at the very poor
- Provider behaviour is a major determinant of the quality of services that people receive and strategies must focus on improving provider performance as well as access to health care
- Finally, it is important to put analysis of health and poverty into context at national and international levels. What are the pro-poor health policies? How policies be integrated in order to develop policies that meet the health related needs of the very poor?

### Linkages between health and social protection

Within the health sector both equity and efficiency arguments are being used to justify a focus on the very poor. Some argue that health policies aimed only at achieving Millennium Development Goals (MDGs) relating to child health and maternal mortality may not benefit the poorest.

In [How much would poor people gain from faster progress towards the Millennium Development Goals for health? \[1\]](#) Gwatkin suggests that many countries are likely to improve their health indicators because of gains by better-off groups. This raises important questions about health equity and social justice, and is contrary to a rights-based approach to development.

Others argue that progress towards reducing the overall burden of disease will be slowed if the very poor are not reached, and that this will compromise efficiency objectives.

Two other concerns within the health sector have focused attention on health and the very poor:

- Health policy has become aligned with the MDGs and their primary focus on treatment and cure. This has shifted attention away from care and support for the chronically ill or disabled, many of whom are among the poorest.
- The high costs of treatment, particularly those associated with in-patient hospital care and on-going management of chronic illness, are recognised as potentially catastrophic for households. [Meessen et al. \[2\]](#) argue that this is a cause of “iatrogenic poverty”.

The shift towards poverty reduction as the overarching goal of international development aid has brought the issue of social protection to the fore. The social protection agenda emphasises the need to understand individuals, households’ and communities’ vulnerability to, and coping strategies in relation to risk or “shocks”. Thinking is informed by a growing body of work on the dynamics of poverty, and more recently, new conceptual work on chronic poverty.

The high costs associated with purchasing medical care are recognised as potentially one of the most significant shocks faced by individuals or households, and a contributing factor to worsening poverty. It is also recognised that other types of shock (e.g. natural disasters, civil war, economic shocks) leave individuals susceptible to ill-health.

[Health and social protection: meeting the needs of the very poor \[3\]](#) analyses the shared agenda between health and social protection and the case for joined up thinking between the two sectors.

### [Frameworks of analysis for looking at health and the very poor](#)

A number of documents have strongly influenced current understandings of social protection. [Social risk management: a new conceptual framework for social protection and beyond \[4\]](#) defines social protection as public interventions to assist individuals, households and communities to manage risk better and provide support to the poor.

In this approach a social risk management framework (SRM) is used to analyse the *intensity* and *frequency* of risk, and the degree to which the impact on different individuals is *correlated*. The framework distinguishes between strategies for *risk reduction* (e.g. immunisation of one’s child), *risk mitigation* (e.g. subscription to an insurance) and *risk coping* (e.g. getting into debt for financing one’s health care).

Transferring the concept of risk to the health sector will enable policy makers to devise intervention strategies based on a more nuanced understanding of health-poverty

interrelationships. Intervention strategies from both within and outside the health sector are needed for dealing with health risk.

An Overseas Development Institute (ODI) [Policy paper on social protection \[5\]](#) argues that the SRM framework fails to pay enough attention to the long-term impact of shocks. It argues that more needs to be done to assist the very poor to emerge from chronic poverty, and to assist the less active poor to live a dignified life.

Recent conceptual work by the Chronic Poverty Research Centre provides another useful analytical framework for looking at health-poverty linkages. [Health and poverty linkages: perspectives of the chronically poor \[6\]](#) identifies six dimensions through which aspects of ill-health interact with other components of poverty to cause chronic long-term poverty. This work provides a useful framework for uncovering some of the underlying processes behind ill-health and chronic poverty, and for identifying entry points for intervention.

### [Social protection in transition economies](#)

Social protection is often not considered as a priority for countries experiencing transition from planned to market economies (China, parts of South East Asia, Eastern Europe and the republics of the former Soviet Union).

In [Iatrogenic Poverty \[2\]](#), Meessen et al show that in many transition countries, the introduction of market mechanisms (including households' higher control on their assets and production) has led to the abandonment of arrangements that provided social protection (e.g. employment for all, free health care), before a sufficient consolidation of social protection mechanisms are available in market economies such as insurance.

Many health care markets in transitional countries are insufficiently regulated. As a consequence, some healthcare providers exploit patients (e.g. by prescribing unnecessary care) to the extent that they are pushed into poverty. Poverty induced by medicine is also called iatrogenic poverty.

[Facing the challenges of health care financing \[7\]](#) explores which health financing and social protection reforms were proposed in countries of Central and Easter Europe and of Commonwealth of Independent States to answer the emerging needs of an environment under transition. The paper reports difficulties in implementing effective (social) health insurance systems, reliance on out-of-pocket payments, and survival of widespread informal payments, which compromise the equity and efficiency of health services.

### [Issues in operationalising joint health and social protection agendas](#)

Despite the shared conceptual ground between the health and social protection agendas, in practice there is limited experience anywhere of effective inter-sectoral collaboration on these issues. Relative to ministries of health, national agencies dealing with social welfare or social development tend to lack both status and funds, which reduces their capacity for engagement and for forging joint work programmes. Nevertheless, the importance of working across sectors in an integrated way is starting to be recognised.

There are opportunities for donor agencies to highlight the shared agenda in higher-level policy processes, such as the PRSP process. Another is to support initiatives to bring citizen

voice into the debate, in recognition of the important role that can be played by civil society in holding governments to account for non-performance on issues of poverty and health.

The identification of opportunities to support joint working between ministries will depend on deepening understanding of institutional capacities and arrangements in different contexts. It will also depend on being in a position to recognise – and respond in a timely way – to opportunities (or ‘political moments’) that lend themselves to the development of integrated policy.

## 2. Poverty and ill health

Many different definitions of poverty are used in the development sector. These range from income and/or consumption-based definitions, to definitions emphasising the multi-dimensional nature of poverty, and highlight its many manifestations, in addition to lack of income. These include:

- lack of productive resources to sustain livelihoods
- limited or no access to basic services such as water, health and education
- hunger and malnutrition
- increased morbidity and mortality
- living in an unsafe or insecure environment
- poor or no housing
- lack of participation in social, cultural and political life
- social discrimination or exclusion.

Broader conceptualisations of poverty suggest that insecurity and vulnerability can be experienced on a number of different fronts simultaneously, and that the different manifestations of poverty can reinforce each other. For example, hunger can lead to malnutrition which can be a causal factor in ill-health. In turn, chronic ill-health can affect an individual's ability to participate in social and community activities, and, in turn, could lead to social exclusion.

### Measuring poverty

Measuring the socio-economic status of a household or the prevalence of poverty in a society raises multiple methodological questions, many of which stem from which definition of poverty is used.

The World Bank position is clarified in [Poverty measurement and analysis \[8\]](#). The World Bank prioritises income as the key measure of poverty by distinguishing between 'the poor', who live below a \$2 a day poverty line and the 'extreme poor', who live on less than \$1 a day. These are absolute measures of poverty (i.e. measures that quantify the numbers of people living below a certain threshold).

For benefit-incidence studies (studies trying to measure to which socio-economic group should benefit from a health intervention), a relative definition of poverty suffices. In [Reaching the Poor with Health, Nutrition, and Population Services: What Works, What Doesn't, and Why \[9\]](#), Gwaktin et al. review specific interventions aimed at reaching disadvantaged groups.

The [Chronic Poverty Report 2004-2005 \[10\]](#) shows that people living in chronic poverty will

make up the majority of the 900 million people still in poverty in 2015, even if the MDGs are met. It is argued that the chronically poor need targeted support, social protection, and political action that confronts exclusion.

## Categories of poverty

Research highlights the importance of distinguishing between 'chronic' poverty (those living in poverty for a long time) and 'transient' poverty (those moving in and out of poverty).

Various poverty characteristics are commonly associated with chronic poverty. These include geographic locations such as remote rural areas, urban slums and conflict zones; and disadvantaged social groups such as castes, tribes, ethnic groups, and refugees. Within households, the elderly, women and children, people living with disabilities, serious illness, widows and orphans are also more likely to live in chronic poverty.

[Escaping poverty: can policy reach the chronically poor? \[11\]](#) explains why taking into account the differences between chronic and transient poverty is important for policy. Chronic or long-term poverty requires policies that target investment to poor households so that poor people can improve their social and economic situation. Temporary or transient poverty affects a much larger group of vulnerable households, and requires emphasis on interventions that support households during hard times, such as social safety nets, insurance and credit programmes.

The very poor, who benefit least from policies for development, are found in all countries, poor and rich, remote rural areas and inner city slums. In practice, however, the priority categories of the very poor differ from country to country. In India research has focused on disadvantaged castes, women, the elderly and residents of remote rural areas. In regions that have experienced conflict, disadvantaged groups include internally displaced people and refugees.

## The case for focusing on the very poor

[Basic services for the poorest \[12\]](#) argues that the provision of effective basic services (i.e. health and other key services) can interrupt the processes that maintain and worsen poverty. Arguments for targeting the poorest include the following:

- **achieving the Millennium Development Goals:** Some MDGs will not be achieved unless the poorest are reached. Other MDGs will be achieved, either fully or partially, by excluding the very poor. However, exclusion will have the effect of worsening and deepening the poverty of those left behind
- **moral case:** Access to basic services is a basic human right. Denying access would be contrary to international and national human rights commitments
- **political and economic security:** Political and economic stability may be undermined if the very poor are denied access to basic services.

[Improving the health of the world's poorest people \[13\]](#) argues that greater efforts can be made to re-orient public health interventions so that they better meet the needs of the poor and vulnerable groups. In contrast, [International perspectives on health inequalities and](#)

[policy \[14\]](#) argues that, while it is important to target 'the poor', a large minority or even majority of the population live in poverty in low-income countries.

Consequently, better health conditions and health systems are a condition for economic growth, but it is not sufficient. This article suggests that a strategy to improve health and welfare may be to first combine economic growth to allow accumulation of wealth and then invest in social policies on health and welfare.

### [The impact of ill health on the poor](#)

In [Poverty and health sector inequalities \[15\]](#), Wagstaff reviews evidence on the relationship between adverse health events and chronic poverty: poverty breeds ill-health and ill-health keeps people poor.

Poor people's use of health services is constrained by several barriers including lack of information, poor access to social networks, inadequate services, and inability to pay. In an attempt to make savings on treatment, some poor people adopt inappropriate health-seeking behaviours such as choosing a below-standard, unregulated health care provider, self-medication or discontinuation of treatment. These actions worsen the financial and health status of the patient, thus creating a vicious cycle.

To pay for health care some people are forced to adopt ex-post strategies. These are strategies to cope with the financial consequences of ill health including the costs of healthcare and loss of wage and production due to illness. Some people may sell productive assets as a coping mechanism and others become indebted, often at high short-term interest rates. These strategies reduce poor people's capacity to negotiate their way out of poverty in future.

The final outcome can be catastrophic, both in terms of health and wealth. According to Xu & al in [Household catastrophic health expenditure: a multicountry analysis \[16\]](#) this is especially the case in transition and Latin American countries. If the affected person remains disabled or chronically ill, or the disease recurs, the negative impact is magnified. If many households experience similar problems, a community's capacity to cope with shocks may be affected.

### [Evidence base on the impact of ill-health on individuals and households](#)

Many studies examine the effects of ill-health including HIV and AIDS on households. Some studies look specifically at the gender-specific effects of the poverty-ill-health vicious circle in cases where the burden of caring for a sick person falls primarily on female members of the household, or where women as key producers and carers are affected by ill-health. The literature in this area is very broad. [\[17\]](#) [\[18\]](#) [\[19\]](#) [\[20\]](#) [\[21\]](#) [\[22\]](#) [\[23\]](#)

## **[3. Targeting the very poor](#)**

A large evidence base highlights the fact that there are widespread inequities in access to public sector health services. Health services provide more and better quality care to wealthier people. Individuals and households suffering chronic poverty often benefit the least from scaled up national health programmes, even if they have special health-related needs.

Inequities may be apparent based on where an individual lives, their social group, socio-economic status, gender, age or other aspects of difference.

A number of studies have looked at who benefits from public sector funding of health services. A major contribution in this field is the set of multicountry analyses of Demographic and Health Surveys done by Gwatkin et al.. In [Making health systems more equitable \[24\]](#), Gwatkin states that although inequities are likely to continue they should not be accepted as inevitable. The paper identifies different measures and techniques that have been effective in reaching the poor and empowering patients. These include the establishment of health policy goals that specifically address coverage of the poor, cash transfer programmes, targeting to provide subsidised health insurance, and contracting NGOs to operate services.

These “reaching the poor” measures do not all include a targeting component. A key area of debate today concerns the respective benefits of non-targeted strategies, such as provision of universal free health care services versus specific, targeted strategies for reaching the very poor.

### [Targeted versus non-targeted strategies](#)

For many low-income countries with dysfunctional public health systems and high dependence on the informal sector, universalism remains a long-term strategy. It is also likely that sustaining investment in universal coverage will be difficult in countries reliant on loans or donor aid. In the short-term, targeted strategies for reaching the poor will continue to be needed. In the meantime, more work on the cost implications of rolling out universal coverage in low-income countries is needed.

[Free government health services: are they the best way to reach the poor? \[25\]](#) questions the benefits of concentrating on government health services. It is argued that the goal of equity via provision of universal free health care often remains elusive and that there are other ways for governments to ensure that the poor receive adequate, affordable services through alternative approaches to resource allocation and purchasing.

[Targeting services towards the poor: A review of targeting mechanisms and their effectiveness \[26\]](#) assesses six different targeting mechanisms that have been applied in the health sector in a range of contexts with a single framework. The paper concludes program design and implementation issues are of paramount importance in targeting and its capacity to reach the poor. There is however a gap in knowledge on the “how and why” issues in the literature. Cost of targeting may obviously be an issue. Further research is needed before we can start drawing a comparative analysis with the alternative of universal benefits.

Some countries that are committed to universal provision of free health care, such as Sri Lanka, Malaysia and Hong Kong, have proved to be high performers in relation to health equity. [Access of the very poor to health services in Asia: evidence of the role of health systems \[27\]](#) from Equitap indicates that the ability of countries to reach and protect the poor depends on how health systems are organised and funded, rather than level of economic development, or levels of public spending.

The Sri Lanka health service, in particular, has strong pro-poor credentials. Universal free access to education, which has global support, sets a precedent for universal free health provision. It is important to note other pre-requisites that ensured the success of universal coverage in Sri Lanka, being strong policy and provider commitment to universalism; good geographical coverage of health facilities; investment in improving quality of care in the

public sector; policy commitment to meeting increased demand via supply efficiencies; reliance on tax funding for the public sector.

### Which targeting mechanism?

A variety of different targeting mechanisms can be used to reach the very poor. [Targeting of Transfers in Developing Countries: Review of Lessons and Experience \[28\]](#) reviews the lessons learned from 122 antipoverty interventions in 47 transition and developing countries, with different mechanisms including individual / household assessment using means testing and proxy-means testing, community-based targeting, categorical and geographical targeting, and self selection.

Results are mixed. No single preferred method has emerged for all types of programs or all country contexts. Interestingly, of all variations observed in targeting outcomes, only 20 percent was accounted for by the choice of targeting method. It makes the author conclude that successful outcomes are critically dependent on the method of implementation, rather than on the choice of the method.

In practice, targeting the very poorest can be difficult, particularly where limited population-based data exists and the accuracy of data is questionable. Identifying opportunities to back health interventions onto existing poverty reduction programmes that have already identified the very poor holds promise. [Targeted development programmes for the extreme poor: experiences from BRAC experiments \[29\]](#) looks at BRAC's experience of backing a micro-credit programme onto a World Food Programme feeding programme targeted to the extreme poor.

### Implications and acceptability of targeting

Targeting scarce resources to the very poorest can lead to resentment from other sections of the population. [Arguing for the poor: elites and poverty in developing countries \[30\]](#) argues that aid donors and other external agents could work with developing country elites, who often have some self-interest in reducing poverty, in defining national anti-poverty strategies.

Acceptance by the local population is also important for targeting. BRAC's experience of working with the very poor found that villagers were more sympathetic to people who had experienced an unexpected shock than to those who were always poor [29]. Widows, mothers who had been abandoned with young children and people who had lost everything due to a business reverse or major illness were considered to be deserving of assistance.

The politics of poverty reduction pose special problems for donor agencies whose mandate includes addressing the needs of the very poor. Key questions are how can issues of reaching the very poor be raised up the political agenda in a politically acceptable fashion in low and middle-income countries? What intervention strategies targeted to the extreme poor can be integrated into national government services, and which are better conceptualised as community initiatives or philanthropic efforts?

## Costs of targeting the poorest

Reaching the very poor and meeting their specific needs will usually be more costly than delivering equivalent services to the average population. This raises difficult questions about the degree to which governments and donors should allocate scarce resources for this purpose.

In practice, very little empirical evidence exists on the costs associated with reaching the poorest. [The marginal costs of health services for the poorest \[31\]](#) argues that the limited evidence that exists points to the fact that providing services for the poorest is more expensive than the average cost in any population. However, it is argued that a trade-off between efficiency and equity considerations can be justified in circumstances where higher investment is likely to bring about a higher health impact.

[Targeting in health: a summary of the evidence \[32\]](#) suggests that targeting efforts are worth the time and trouble for equity considerations. It obviously has a cost. Targeting individuals through methods such as means testing can work well, but has failed when it was tried “on the cheap” – with minimal administrative effort and without additional resources to cover the costs of the services provided. Other targeting options must be explored in parallel. Targeting by age and by disease (which are much less expensive) should also be considered, and using several targeting mechanisms at once appears more effective than reliance on a single mechanism.

## **4. Health-related strategies for reaching the poor**

This section looks at a number of health-related targeted strategies, and outlines what is known about the strengths and weaknesses of each strategy.

Some of the strategies (e.g. voucher schemes, community-based health insurance, health equity exemption funds) are referred to in the literature as 'demand-side financing' strategies since they give resources direct to users or to a third party that will act on their behalf with the aim of improving equity of access to health care. [Consumer-led demand side financing for health and education: an international review \[33\]](#) provides a useful overview of selected demand-side financing mechanisms used in the health sector.

One of the best attempts to propose remedies to health inequalities probably reside in a recent project of the World Bank titled [Reaching the poor with health, nutrition and population services: what works, what doesn't and why \[34\]](#). It provides eleven case studies that document how health, nutrition and population programmes have performed in reaching disadvantaged groups. The features of the programmes covered vary widely. It points towards the diversity of multiple potentially effective approaches and calls for reflection and creativity in finding the approach that best suits a particular setting.

### Decreed exemption schemes

In many developing countries, user fees were promoted in the early 90's as a strategy to generate resources for public health facilities. It was hoped that user fees could improve access to health care services by allowing extra investment and allocation in the health system (e.g. for drug availability) and by empowering patients to raise their voice (the principle of community participation).

Evidence suggests that user fees impede access to health care for many poor people. In order to preserve equity in access to care, most governments simultaneously decreed exemption mechanisms for the poor. Results are mixed and highly debated in a number of papers. [Waivers and exemptions for health services in developing countries \[35\]](#) provides a good overview of different approaches in different countries. It shows that waiver and exemption mechanisms are generally ineffective in increasing access for the poor in most countries, particularly in the poorest ones. This is a result of several factors including bad design, lack of financial compensation to providers, administrative costs and lack of clear criteria for identification. The few positive experiences (e.g. Thailand, Indonesia) have provided appropriate response to these issues.

The general incapacity of exemption and waiver mechanisms to reduce the negative effects of user fees has meant that the debate on user fees remains on global and national agendas. A number of organizations have called for the abolition fees, preferring instead insurance mechanisms or subsidised waiver systems.

### [Deferral schemes](#)

Deferral schemes allow individuals to defer payment for treatment or drugs. It is a common practice by health workers facing patients who find it difficult to pay for care, although the process and magnitude of this practice are rarely documented. There is therefore little evidence of their impact on access to or utilisation of health services by the very poor.

Deferrals usually apply to individuals facing transient poverty, as opposed to those facing chronic poverty (which would qualify them for an exemption). Some form of poverty targeting technique may be used in some cases to distinguish both. Others offer deferrals (or exemptions) to individuals in specific age groups and/or to those suffering specific diseases or health conditions.

### [Subsidised exemption schemes](#)

[Access to health care for all? User fees plus a health equity fund in Sotnikum, Cambodia \[36\]](#) is one of the few documented examples of a successful subsidised exemption scheme. The Health Equity Fund improves access to health care services for the poorest by paying healthcare providers on behalf of patients. The tasks of identifying eligible households and payment of financial compensation are entrusted to a purchasing body that is independent from health care providers and supported by an external donor.

In Cambodia, this scheme has been effective in improving financial access to secondary level health services for the poorest. More than 30 experiences are now in operation countrywide. The strategy is also being tested in some Asian and African countries.

Stakeholders in Cambodia have identified several conditions for a successful Health Equity Fund. These include:

- careful design and implementation
- reliable external funding source to cover the health services subsidies
- combination with other interventions aimed at fostering quality of services and providers accountability
- entrustment of provider and purchaser functions to separate actors
- use of a combination of targeting techniques

- inclusion of hospital care and transportation costs in the benefit package in order to alleviate financial barriers.

### Voucher schemes

Voucher schemes are a potentially effective means of targeting health services or health products to specific population groups such as pregnant women, children under five, or the poorest. These schemes may offer subsidised or free access to specific services (e.g. sexual or maternal health) or health care products (insecticide treated nets – ITNs). Voucher schemes hold potential for helping households avoid catastrophic expenditure on specific types of health care, such as emergency obstetric care.

Pre-requisites for voucher schemes to operate successfully include the following:

- strong administrative capacity for implementation
- accreditation system - or at least a system ensuring quality of care – in health facilities involved in the scheme
- method and capacity for identifying of target groups.

Most voucher schemes to date have been implemented on a small scale. There is limited documented evidence on their success, or on the feasibility and cost implications of scaling up pilots. One exception is a voucher scheme in Nicaragua (see [Vouchers for health \[37\]](#)) that provides treatment and prevention services for sexually transmitted infections to high-risk populations such as commercial sex workers, their partners and clients.

As per other targeted strategies for reaching the very poor, community-based targeting of beneficiaries has potential for elite capture and rent-seeking. Another concern is that ITN voucher schemes in particular may undermine ITN social marketing schemes and the development of commercial ITN initiatives.

### Community-based health financing schemes

There is increasing interest in the role of community-based health financing schemes in improving equity and access of the poor to essential health care. These schemes provide a mechanism for community-level pooling of risk in relation to sickness, and sometimes grow out of traditional risk-sharing schemes, such as burial societies in Africa.

[An overview of community-based health financing \[38\]](#) outlines how these schemes are set up, how they operate and their strengths and limitations. [Paying in potatoes: community-based health insurance for the rural and informal sector \[39\]](#) looks at the strengths of community-based insurance schemes that have been set up in Bolivia, Bangladesh and the Democratic Republic of Congo in response to user charges.

Pre-requisites for these schemes to work include: presence of an external organisation with the capacity to design, manage, implement and sustain the scheme; strong community trust in the implementing organisation; availability of local health providers capable of providing essential health services to a basic standard.

These schemes are usually only implemented on a small-scale, and cover relatively limited geographical areas. Existing evidence suggests that the very poor are often excluded, although BRAC has had some success with targeting the very poor in its CFPR/TUP programme. Most

schemes manage at covering the small-scale costs associated with accessing primary services, but fail in covering catastrophic medical expenditure associated with hospitalisation.

## Health insurance

The issue of health insurance is high on the health financing agenda of many developing countries, especially in transition countries where shift from state-planned to market-based economies has produced a decline in public health financing. Insurance programmes are increasingly used to fill the gap ([Time for a change? Health insurance systems in Transitional Asia \[40\]](#))

There are different types of health insurance including private health insurance (PHI); social health insurance (SHI) and community-based health insurance (CBHI). PHI usually covers workers employed in the formal sector whereby part or the entire premium is paid by the employer (as part of the salary package). Whilst SHI aspires towards universal coverage, in practice, CBHI is the only form of insurance likely to capture people working in the informal sector.

CBHI alone might not be able to protect the poor from health and financial shocks. In the absence of subsidy mechanism, the cost of the premium, even if limited, is very likely to prevent them from adhering to the insurance.

Yet, recent evidence shows that well designed CBHI can prevent households from further impoverishment. [Indian community health insurance schemes provide partial protection against catastrophic health expenditures \[41\]](#) demonstrates how two CBHI managed to half the number of households who experienced catastrophic health care expenditures (by covering hospital costs). Improved design and combination with other assistance mechanisms could enhance this protection effect.

Prerequisites for efficient health insurance include:

- good administrative and management capacity for coordination of payments, premium collection and contracting of the provider
- trust of the population in the insurer
- a large number of interested members for ensuring a sufficient pooling
- regulated quality health providers to be promoted through the insurance mechanism.

## Subsidised treatment for specific health conditions

Subsidising treatment for specific diseases, chronic health conditions or emergency obstetric care is a potential strategy for increasing equity of access to health care. This strategy recognises the relationship between untreated disease and risks of impoverishment, through catastrophic or recurrent health care expenditures.

Pre-requisites for these schemes to work include:

- political commitment to subsidisation and timely release of funds
- information to users on which health services are free
- appropriate medical package in health facilities (e.g. HIV/AIDS specialists).

This type of strategy is increasingly pursued, as demonstrated by the inflation of Global Health Partnership (GHP) initiatives as discussed in the last section of this document. They

however lack pro-poor objectives, although the very poor may benefit if awareness raising strategies are oriented appropriately. Consequently, there is limited documented evidence on both the impact and the cost of providing subsidised health care treatment for the very poor.

### [Regulation of the pharmaceutical sector](#)

In many low- and middle-income countries, the poor/very poor heavily rely on drug purchases in the informal sector. Improving the regulation of the pharmaceutical sector and increasing consumer awareness about quality drugs and rationale drug use is then an important area of intervention.

Pre-requisites include:

- strong drug regulatory agencies at country level
- regulatory context allowing agencies to fulfil their remit without political interference
- effective communications capacity for consumer awareness raising.

Since few low-income countries meet these pre-requisites, long-term capacity building of regulatory agencies will be required. Little evidence exists about the relationship between better regulation and health outcomes, especially for the very poor in low-income countries. More research is required on this issue.

### [Contracting out of health care provision](#)

This intervention strategy involves contracting missions, NGOs or private sector organisations to deliver primary health care services and specifying equity and coverage targets in contracts. The Cambodian experience has alimented different papers ([Achieving the twin objectives of efficiency and equity: contracting health services in Cambodia \[42\]](#), [Cambodia: using contracting to reduce inequity in primary health care delivery \[43\]](#), [Contracting for health: evidence from Cambodia \[44\]](#)) that demonstrate that government can reach under-served areas or groups or geographically remote areas by utilising the comparative advantage of NGOs to deliver basic health services.

Pre-requisites for this strategy to work include: capacity within government for, and political commitment to, contracting out; national level capacity to monitor contract delivery; NGOs or private sector service delivery organisations with the capacity to fulfil contractual obligations.

[Buying results: contracting for health service delivery in developing countries \[45\]](#) reviews 10 country experiences of contracting services. Whilst the approach has achieved positive results in terms of better health services, the effects of contracting on equity is still under question.

### [Abolition of user fees](#)

The debate over the abolition of user fees has received much attention following almost two decades of impeding effects on access to health care from the “user fees + exemption” policy, applied in most low- and middle-income countries. The abolition of user fees is strongly supported by a number of influential organisations including DFID, Save the Children UK, the United Nations Millennium Project, the Commission for Africa and Médecins Sans Frontières. Despite this, the number countries that have abolished user fees is small (mainly Uganda and South Africa).

The rationale for abolition is appealing. [The case for abolition of user fees for primary health services \[46\]](#) argues that user fees raise little money and rarely meet their stated efficiency and equity goals. Fees are often associated with reduced use of services, especially by the poor and vulnerable; failure to complete treatment; and delays in seeking treatment. However it underlines the high costs needed to maintain quality of provision after user fee abolition.

In [Removing user fees for primary care in Africa: the need for careful action \[47\]](#) Gilson et al. call for a comprehensive set of accompanying measures to be applied before abolition in order to avoid negative effects on the health system. In [Understanding the impact of eliminating user fees: utilization and catastrophic health expenditures in Uganda \[48\]](#) the authors demonstrate that although utilisation of health services by the poor significantly increased after the abolition of user fees, the incidence of catastrophic health expenditure among the poor did not fall. This is most likely a result of the unavailability of drugs at government facilities.

Pre-requisites for successful abolition of user fees include careful preparation and appropriate accompanying measures in the fields of complementary funding sources, aid budget allocation, political leadership, providers' involvement, salary boosting, communication to the population, data collection and consideration of non-financial barriers on access to health care.

## 5. Other strategies and mechanisms for reaching the poor

There is growing interest among policy makers in strategies outside the health sector that can improve the access of the very poor to health services. Traditionally social protection strategies have focused on:

- access to credit
- relief
- strategies for diversifying livelihoods
- targeted transfers of cash and goods.

There is limited evidence to demonstrate how interventions in one sector, for example improved access to credit, impact on health, and even less information on how such strategies benefit the poor. One exception is the recent experience with cash transfers.

### Cash transfers

This is a mechanism for provision of cash payments direct to the very poor. Based on experience in Latin America, and recent experience in Zambia, cash transfers have proved to have a positive effect on both the health and poverty status of the very poor. Depending on the scheme, transfers may be unconditional, or conditional on beneficiary investment in education, health and nutrition.

There is evidence that these schemes encourage investment in strategies that allow the very poor to move out of long-term poverty (e.g. children's education). In some contexts direct cash transfers have proved cheaper, financially and administratively, than other targeted strategies such as food aid. These schemes also offer good potential for scaling up quickly.

[Lessons offered by Latin American cash transfer programmes \[49\]](#) provides an overview of Mexico's Oportunidades, Nicaragua's Social Protection Network, and Zambia's Kalomo Project, three cash transfer schemes that have had positive impacts on health.

Pre-requisites for cash transfer schemes to be a success include:

- strong evidence base on causes, extent and depth of poverty, and effective systems in place and strong capacity at country level for identifying the poor
- good administrative capacity to manage schemes
- willingness to devise strategies for off-setting political capture of schemes at local level
- strong tax base.

Challenges associated with these schemes include:

- the financial sustainability of cash transfer schemes is an issue in countries reliant on loans or donor aid
- in some countries cash transfers have had the effect of substantially increasing demand for key public sector services. Additional funding may therefore be required to meet this demand
- more research is needed to investigate respective benefits of conditional versus non-conditional approaches. Based on experience in Mexico and Nicaragua the evidence suggests that conditionality may compromise equity goals
- targeting the very poor may prove to be socially and politically unacceptable in cases where assumptions of widespread generalised poverty prevail
- many countries lack a solid evidence base on the nature, severity, and location of poverty, and may therefore need to rely on community-based targeting of beneficiaries. This is prone to elite capture.

## [Social funds](#)

Social Funds provide a mechanism via which funds for community-identified development initiatives can be directly funded and rapidly disbursed by government. Beneficiary communities are expected to play a central role in identifying priority areas for intervention (usually in the health, education or water supply and sanitation sectors), managing funds and project implementation, and in sustaining the interventions in the long-term. In general, Social Funds have successfully distributed resources to communities that are either un-reached or under-served by the government or private sectors.

Some Funds, such as those in Honduras and Bolivia, have demonstrated positive health impacts, such as significantly increased utilisation of fund-supported health centres. The Honduras Social Fund has also been successful in reaching the very poor, although many other schemes have not been able to achieve this. Having found that the poorest groups lacked the capacity to mobilise and access funds during its first phase of operations, the [Malawi Social Action Fund \[50\]](#) is using civil society organisations as a mechanism for reaching the very poor in its second phase. Malawi Social Action Fund provides a useful overview of the challenges associated with scaling up operations institutionally, economically and physically.

## [Role of civil society in reaching the poor](#)

Successful small-scale initiatives aimed at meeting the needs of sub-groups of the chronically poor are often organised by local civil society organisations (charities, NGOs or faith-based organisations). [Study of faith based organizations responses to orphans and vulnerable](#)

children [51] reports on a study in Kenya, Malawi, Mozambique, Namibia, Swaziland and Uganda on the role of faith-based organisations in assisting the poor. The study finds that:

- faith-based organisations (FBOs), which are often present in communities affected by AIDS, tend to be better placed than external agencies to provide appropriate support and deal with complex social issues of children affected by AIDS
- the level of community participation in FBO development activity is high, which increases the potential for sustainability and longevity of these projects
- FBOs support children irrespective of faith
- the overall organisational capacity of local FBOs in terms of governance and financial accountability was on a par with many larger NGOs
- most FBO initiatives receive little or no external technical or financial support and of necessity rely on their own skills and material resources.

The study recommends that donors should support the operation of small grants funds through Religious Coordinating Bodies to support activities initiated by congregations.

There has been an upsurge in interest in the roles that civil society organisations can play in the health sector. The capacity of CSOs to respond to specific problems is their strength. However, some argue that CSOs are more effective when in partnership with government. This is particularly important if small-scale initiatives are to expand.

[Civil society contributions to pro-poor health equity policies \[52\]](#) explores whether civil society organisations contribute to improved provision, coverage of and access to health services in low-income communities.

## 6. Provider behaviour

Health assistance schemes are only part of the solution in improving access to and use of health care services. If appropriate and high quality services do not exist near to target populations, the effects of interventions could be reduced.

Complementary supply-side actions are needed to ensure that services are sufficient. A variety of health policy interventions have developed programmes aiming to improve the quality of staff skills, protocols of treatment, availability of supplies and the environment of health facilities.

Scant attention has been paid to the impact of health assistance schemes on health providers' behaviour, which is influenced by a set of incentives. Evidence suggests that many health sector workers develop "coping strategies" when their expectations in terms of salaries or other working conditions are not met. These strategies may be harmful in terms of access to health care: either they are predatory (under-the-counter fees, sale of public drugs) or they affect the public service organisation (private practice, absenteeism due to training).

In [When staff is underpaid: dealing with the individual coping strategies of health personnel \[53\]](#) Van Lerberghe et al. explores the reasons why different categories of health workers disregard their public work. Reasons include competition for time, brain drain and conflicts of interest. Governments have rarely been proactive in dealing with such problems, mainly because of their reluctance to address the issue openly. The paper calls for a more proactive approach, with systematic reflection about the consequences of policy initiatives on the

individual behaviour of health workers.

Improving the performance and accountability of health workers is not only a matter of salary package and equipment, it also means career prospect, a social environment reinforcing professional ethics, empowerment of patients etc. [Pay and non-pay incentives, performance and motivation \[54\]](#) (in *Towards a global health workforce strategy*) explores the diversity of pay and non-pay incentives, reviews their impact on provider behaviour and outlines some of the key factors in selecting the incentive and making it more effective according to the objective pursued. It illustrates the interrelations and mutual influences that may be created between the health workers, the health system and the health assistance mechanisms.

## 7. Formulating, designing and implementing pro-poor health policies

The evidence base on the effectiveness and impact of health-related interventions targeted to the very poor is weak. It is difficult, therefore, to determine whether successful small-scale or expanded initiatives could be replicated elsewhere, and what scope there might be for scaling up small-scale initiatives.

One gap in the knowledge base is the lack of information on the costs and benefits of operations. Another gap is the lack of information on user perspectives (which institutional mechanisms are more or less acceptable to beneficiaries?) Greater investment in improving the evidence base on reaching the very poor will be needed in future.

### Inducing a change in policy

In their first output on pro-poor health policies, [Which health policies are pro-poor? \[55\]](#), the DFID Health Systems Resource Centre (HSRC) proposes three complementary strategies for pro-poor health policy. It illustrates the need for a systemic approach of pro-poor health policy.

The strategies are:

- ensuring the poor are covered by public health services. Actions include setting appropriate targeting mechanisms to capture the population in need
- improving access to and quality of health services used by the poor. Actions include regulating the supply-side in terms of benefit package, management and institutional arrangements, as well as performance objectives achievements
- avoiding heavy expenditures by the poor on health care which exacerbates their poverty. Actions include the design and implementation of appropriate health assistance schemes

Inducing a successful change requires cohesion in the different steps of policy development (initiation, formulation, design, implementation, monitoring). In [Health financing: designing and implementing pro-poor policies \[56\]](#), Bennett and Gilson state that the outcome of a pro-poor health financing mechanism depends critically upon detailed issues of design and implementation.

These issues include:

- Integrating considerations for the poor during the design phase even for strategies which do not primarily address the poor (e.g. social health insurance scheme)
- Capacity for pro-poor schemes needs to be developed including: broader consultations with the poor; consensus built through public debate; technical skills developed and technicians given influence in policy design; management information systems developed.
- Using financing mechanisms to promote high quality and responsive services for the poor, not only through health services strengthening strategies but also through Reforming existing organisational mechanisms.
- Designing and implementing exemptions mechanisms for strategies which may adversely affect the welfare of the very poor.
- Monitoring and evaluating impact on the poor

### Models and institutional mechanisms

A variety of institutional mechanisms can be used to target the very poor. In [Designing Health & Population Programs to Reach the Poor \[57\]](#), case studies and lessons from the World Bank's 'Reaching the Poor' programmes are presented including examples from Brazil, Cambodia, Tanzania, India and Nepal. The paper concludes that it is possible to achieve better performance in reaching the poor, but there is not any one programme type or model that is more effective than others. There is also no guarantee that an approach that works in one setting will work elsewhere.

The authors recommend a process of experimentation and adaptation following the steps of:

- studying the approaches
- adapting to local conditions
- experimenting through implementation in a few places
- monitoring to verify how the approaches work
- adjust the approach according to findings

Policies may be implemented by government, NGOs, the private sector, research institutes or through public-private partnerships. This dossier provides several examples including: direct cash transfers by government; use of 'Social Funds' by communities to access government funds for locally-identified interventions; service delivery through the NGO sector; contracting out public services to the private or NGO sectors; creation of public-private partnerships for implementation of demand-side financing interventions.

[Poverty and user fees for public health care in low-income countries: lessons from Uganda and Cambodia \[58\]](#), compares policy development processes. The document addresses the strategic question of universal versus targeted solutions on access to health care for the poor (with universal free health care in Uganda and Health Equity Funds in Cambodia), and the contextual factors affected governments' policy decisions regarding their scale and scope.

The paper proposes key technical issues that national policy makers should consider when deciding which health assistance scheme and how it should be implemented? These issues include:

- barriers to health care (poverty levels, health seeking behaviours, main barriers on access to selected health services)
- targeting (political acceptance of targeting, criteria, actors for identification)

- benefit package, resources and incentives (health problems, causes of impoverishment, absorption capacity of selected health facilities, financial resources available, appropriateness of incentives)
- process of the reform (partners and contribution, institutional and legal rooting, accompanying measures, speed, scale and scope).

### Factors influencing policy formulation, implementation and outcomes

The literature identifies several key factors that influence the success of pro-poor health policies.

- The context in which the policy operates is important. Formulating a policy requires a good understanding of local needs, opportunities and constraints (population needs, capacities and commitment of local actors).
- A variety of stakeholders must be taken into account. Health systems depend among others on support from donors, adhesion from the population and commitment of the health workers. It calls respectively for a convincing attitude from the government, specific measure to empower the population and civil society, and complementary measures on the supply side to foster quality and accountability (regulation, incentives and norms).
- No single health assistance scheme is sufficient to meet the needs of entire populations and it is often better to target specific groups. Policy development must be seen as a search for complementarities and synergies between health financing and health assistance mechanisms
- Political commitment is of key importance for nationwide strategies. The strategy must integrate a wider arena than only the health sector, as caring for the poor is more than a technical issue. Others ministries (e.g. social welfare) may be involved.
- Finally, there are no universal solutions, as the strategy depends and impact on the whole institutional setup. It is important to know which conditions made a policy possible, and how this policy changes its environment. It is always the result of a sustained approach that allows adaptation over time in response to experience and changing environment.

A similar set of principles is developed in a recent report of the WHO Commission on Social Determinants of Health: [Challenging inequity through health systems: final report of the Knowledge Network on Health Systems \[59\]](#). It takes a wider look at the health systems and provides recommendations to public and civil society health actors on how to better address equity considerations. It is organised along the lines of mobilising intersectoral relationships; facilitating social empowerment; building up universal health coverage; and strengthening processes of developing and implementing policies. The report also stresses that international actors must support national led health system transformation and action.

### Issues for scaling-up

In [Institutional issues in scaling up programmes for meeting the health-related needs of the very poor \[60\]](#), Kirk and Standing confirm that the scale-up potential of each of health assistance mechanisms will vary depending on the context. One key consideration is the institutional capacity required for implementation.

Other potential institutional obstacles to scaling up include prohibitive or unsustainable costs; the difficulty of using community-based targeting mechanisms (often used in the absence of other population-based data) on a larger scale; how to replicate effective partnerships between

local constituencies and local government on a larger scale (what factors enable these partnerships to work in specific local contexts?); and how to minimise elite capture of targeted benefits in contexts where communities are highly differentiated.

The emphasis within international and national health policy on achieving the MDGs, and the relatively short timescale within which these goals must be realised, has created momentum around the need to scale up rapidly. Although rapid scaling up may be possible in some contexts, in situations where institutional capacity is weak expectations, of the scale and speed of scale-up need to be managed carefully. In these contexts, it may be more realistic to aim for gradual scale up, perhaps starting with a district, and then rolling out to cover a province or region.

## 8. Aid instruments

This section looks at what is known about selected aid instruments and their track record in reaching the poorest.

### SWAps and budget support

Sector-wide approaches (SWAps) and budget support are increasingly used by international donors to support the health services of low and middle-income countries. Currently, however, there is limited evidence of how these different approaches impact on different groups in different contexts, particularly the poorest. Neither of these approaches is inherently pro-poor. Rather their poverty impact depends on national health and other policies.

Donors' scope for influencing the direction of policy will vary from place to place, depending on the strength of their in-country technical teams and the receptivity of host governments to pro-poor arguments. In [Poverty reduction budget support \[61\]](#) DFID highlights the fact that more evidence-based analysis of impact in relation to budget support, especially in relation to the very poor, is needed.

### Global health partnerships

Over 70 global health partnerships (GHPs) currently exist. [AID instruments and the very poor: the case of global health partnerships \[62\]](#) argues that GHPs tend to fall into four main categories as follows:

- research and development GHPs (e.g. new drug development)
- technical assistance or service support GHPs (provide drugs, TA, support to increase access to services)
- advocacy GHPs (raise profile of a particular disease or issue)
- financing GHPs (provide funds for specific disease programmes).

Major initiatives include the Global Aids Vaccine Initiative (GAVI - [www.vaccinealliance.org](http://www.vaccinealliance.org)) and the Global Fund for AIDS, Tuberculosis and Malaria (GFATM - [www.theglobalfund.org](http://www.theglobalfund.org)).

The strengths of GHPs are recognised as:

- GHPs have improved the overall allocation of funds to health.
- More GHP money goes to the poorest countries than other forms of OECD financing.

- GHPs are targeting the diseases of the poor.
- GHPs support evidence-based interventions and are therefore cost-effective.
- Some GHPs focus on neglected diseases (such as trachoma, schistosomiasis, lymphatic filariasis) and are therefore helping to challenge the narrow focus of the global health targets. The Schistosomiasis Control Initiative ([www.schisto.org](http://www.schisto.org)) in particular could bring treatment to a huge number of people.
- Some commodity prices have fallen as a result of GHPs (e.g. ARVs and TB).
- There is evidence at global level that GHPs have stimulated better information about commodity pricing and have streamlined procurement processes. There is also a very clear role for GHPs in mitigating the effect of supply constraints of artemisinin combination therapy (ACT), a treatment for malaria.
- Health programmes will benefit from new technologies developed as a result of GHP funding.

Weaknesses of GHPs include:

- GHPs lack pro-poor objectives; increased coverage is used as a proxy indicator for reaching the poor, and a trickle down effect is assumed.
- Funding to GHPs is crowding out funding to public health systems (and these have the potential to reach the very poor).
- Coverage of the traditional six vaccines has not gone up in GAVI countries; undue emphasis is being paid within GAVI to increasing access to new vaccines.
- The reduction in commodity prices is not translating into cheaper commodities at local level.
- Some commodity purchases cannot be sustained financially after the funding period.
- The high transactions costs associated with engaging with GHPs at country level undermine already weak health systems.
- GHPs such as GFATM and GAVI exclude the weakest countries with the weakest capacity to access funds.
- The 'light touch' approach of GHPs is inappropriate in contexts where systems are weak - sending in donated drugs and expecting weak health systems to be able to deal with them is short-sighted.
- Few governments feel they have the scope to steer GHPs in an appropriate direction without running the risk of losing funds.

Some argue that criticising GHPs for failing to deliver on issues that lie outside their comparative advantage (i.e. their lack of direct contribution to systems development, and the fact that they are not targeted directly to the poor) is unhelpful. They need to be seen as providing part of the solution. Entry points for donor agencies include the following:

- At global level, focus on how to leverage more pro-poor ways of delivering GHPs.
- At country level, support GHPs to develop more explicit poverty objectives.
- Focus on complementary interventions - for example if GHPs do not contribute directly to systems development, what complementary support can be provided to systems strengthening efforts?
- Identify areas where global alignment on political/technical issues can be supported. For example, DFID could feed into the debate about the costs and benefits of reaching the poor with insecticide-treated nets (ITNs) to protect against malaria. This could help to address issues such as the impact of voucher schemes on development of the commercial bednet sector, or on the effectiveness and sustainability of ITN social marketing programmes.

- Lobby for improvement in the evidence base on how specific GHP-supported programmes (e.g. TB control) are reaching the poorest.

## 9. Recommended readings

### 1. How much would poor people gain from faster progress towards the Millennium Development Goals for health?

**Authors:** D. R. Gwatkin

**Publisher:** The Lancet, 2005

This article, published in The Lancet, explores what further progress towards the health objectives set out in the United Nations Millennium Development Goals (MDGs) will mean for the poor. The author notes that, unlike the MDGs overall, these health objectives do not focus specifically on poor people. Rather, they call for improvements in national averages that can be achieved through gains in both advantaged and disadvantaged groups. As a result, any reduction in society-wide average rates of death or illness can provide a wide range of outcomes for poor people.

The author emphasises that the effects of expanding health services tend to be unequally distributed. He argues that expanded health services typically reach better-off groups before disadvantaged ones. Therefore, efforts to accelerate progress towards the MDGs by providing additional resources to the health sector are unlikely to primarily benefit poor people. The author suggests that a more likely scenario is faster progress among privileged groups and a rise in poor-rich health disparities. In order to avoid such an outcome, efforts to achieve the health MDGs will need to focus on reaching disadvantaged groups more effectively in addition to merely expanding health activities. [adapted from author]

Please note: To access this paper, you will first be asked to register with The Lancet. This process and access to the paper is free of charge.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=18805&type=Document>

### 2. Iatrogenic poverty

**Authors:** B. Meessen; Z. Zhenzhong; W. van Damme; N. Devadasan; B. Criel; G. Bloom

**Publisher:** Tropical Medicine & International Health , 2003

This article, published in Tropical Medicine and International Health, examines the issues surrounding “iatrogenic poverty” – poverty caused by spending on medical treatment. In countries which have moved from a planned to a market economy, access to health care has become more dependent on ability to pay; demand for medical services has grown rapidly; and it has become easier for households to use risky strategies to pay for health care, such as mortgaging or selling their assets. Consequently, in countries such as Cambodia and China, health care costs are now among the most important causes of household poverty.

Noting the growing interest in voluntary insurance schemes as a way of financing health care, the article argues that these schemes will take years to consolidate and go to scale, and if they are not well-designed will contribute to rapid cost escalation. Measures such as rationing, empowerment of patients through health education, and registration of medical workers would help. But in order to address the problems of health care-induced poverty, the article argues that a straightforward transfer of resources to the poor is needed. It also contends that fee waivers for the poor have often not worked, and identifies promising alternative schemes that are currently being developed.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=19819&type=Document>

### **3. Health and social protection: meeting the needs of the very poor**

**Authors:** G. Bloom

**Publisher:** Institute for Development Policy and Management, Manchester, 2005

This paper from the DFID Health Systems Resource Centre explores the policy implications of bringing together work on the burden of disease and on social protection. It argues that the analysis of responses to health-related risks must take into account the existence of major structural inequalities and highly segmented health and social protection systems. Better-off people tend to benefit from well-organised systems, while the poor depend on arrangements largely outside the law. This exposes the poor to risks of overpayment for ineffective and dangerous interventions.

The paper goes on to discuss strategies for prevention of health-related risks, mitigation of the impact of illness and coping with the consequences of major illness shocks. It concludes that countries should not base health policy solely on the objective of reducing the burden of disease. They also need to take into account the impact of health-related shocks on livelihoods, particularly of the poor. It is important to ensure that interventions benefit the poor. This will involve a combination of measures to improve the performance of unorganised health systems, to extend coverage of organised health services at an affordable cost and to reduce the financial burden of major illness. [adapted from author]

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=18525&type=Document>

### **4. Social risk management: a new conceptual framework for social protection and beyond**

**Authors:** R. Holzmann; S. Jørgensen

**Publisher:** World Bank, 2000

This paper, published by the World Bank, examines the concepts of social protection and risk management. It argues that social protection should be redefined as public interventions to assist individuals, households, and communities better manage risk, and to provide support to the critically poor. It outlines a framework in which social protection is presented as a safety net as well as a spring-board for the poor; and as a type of investment rather than a cost. The framework aims to focus less on the symptoms and more on the causes of poverty, and to take

account of the reality that less than a quarter of the world's population has access to social protection programmes.

The paper suggests that the proposed framework of social risk management could be productively applied to rethink the design and implementation of social protection programmes. It argues that the concept offers policy designers an integrated approach and legitimates many interventions as risk management mechanisms, including micro-finance institutions; targeted credit arrangements for the poor, for women, or in remote areas; and social investment funds. The paper concludes with areas for further research including how government interventions can facilitate informal risk management arrangements; and theoretical and empirical guidelines for the balance between risk prevention, mitigation and coping.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=19546&type=Document>

## 5. Policy paper on social protection

**Authors:** A. Shepherd; R. Marcus; A. Barrientos

**Publisher:** Department for International Development, UK, 2004

This paper, produced by the Overseas Development Institute (ODI) for DFID, examines mechanisms for social protection in low income countries, clarifying the meaning of social protection and its role within poverty reduction. It argues that social protection policies can help to fulfil states' obligations to ensure basic rights for all individuals; can have a positive rather than a restraining impact on economic growth; can help to shape the pattern of economic growth in favour of the poor; and can be affordable even in low-income countries.

The paper recommends that social protection should be linked with efforts to enhance livelihoods, so that vulnerability to shocks (unexpected events affecting household income) is reduced in the longer term. It argues that a combination of different policy instruments is needed to make a significant difference, and offers a set of criteria by which individual instruments can be judged in particular contexts. For most low income countries, some combination of strengthened safety nets, cash transfers conditional on children attending school, and basic social assistance, is likely to be most effective. The paper also argues that: targeting is a less than ideal approach to protection; the role and effects of informal provision should be acknowledged; and national ownership of policies agreed with donor agencies is essential.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=14554&type=Document>

## 6. Health and poverty linkages: perspectives of the chronically poor

**Authors:** U. Grant

**Publisher:** Department for International Development Health Systems Resource Centre , 2005

This paper from the DFID Health Systems Resource Centre maps out the linkages between ill health and chronic or long-term poverty, drawing from perspectives of the poor. It identifies factors that underpin a descent into chronic poverty, including the type, nature and timing of health shocks, who is primarily affected, types of households, and costs of treatment. It then looks at coping strategies such as the sale of assets, which can increase vulnerability. Finally, the paper identifies points in the downward spiral of ill health and poverty at which intervention will most likely make a difference.

The authors stress that advances in health will impact positively on other forms of deprivation. The response to ill-health should therefore be seen both in terms of medical components and as part of the wider socio-economic and political response to poverty reduction. The paper concludes that interventions are required to reduce barriers to adequate food and asset building, alongside quality and timely health care. It recommends continued support for a number of well-recognised priorities for health services, such as maternal and child health, in addition to a number of potentially new priority areas, including: mental health, curative services for main household earners, and regulation of predatory private sector health providers. [adapted from authors]

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=19921&type=Document>

## 7. Facing the challenges of health care financing

**Authors:** A. Dixon; J. Langenbrunner; E. Mossialos

**Publisher:** European Observatory on Health Systems and Policies, 2004

This article, published by the European Observatory on Health Systems and Policies as chapter 3 of the book "Health Services in Transition: Learning from Experience," examines efforts to strengthen health care financing in the transitional economies of eastern Europe and the former Soviet Union. It reports that social health insurance, which has been central to financing reform in many countries, appears to have been successful in higher-income countries with higher levels of formal employment, but not in lower-income countries such as Albania, Kazakhstan and Romania. General government revenues continue to play a significant funding role. Major challenges include the weak macroeconomic context, corruption, the low level of autonomy given to providers, and the absence of routine information systems.

The article argues that, while economic recovery and capacity building will go some way towards increasing the revenue collected through taxes, further efforts to improve compliance with social health insurance will be needed, including dealing with corruption. Defining a more realistic benefits package will also be a key strategy in making the system financially sustainable and targeting public revenues at the poorest segments of the population. The article recommends that, for financial reforms to succeed, they need to be accompanied by reforms in the provision of care.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=20070&type=Document>

## 8. Poverty measurement and analysis

**Authors:** A. Coudouel; J. S. Hentschel; Q. T. Wodon

**Publisher:** Poverty Reduction Strategies and PRSPs, PovertyNet, World Bank, 2002

This chapter, aimed at policy makers, offers a primer on poverty, inequality, and vulnerability analysis from the World Bank. The authors take a broad look at tools for analysis and provide a brief introduction to each topic. They go on to outline why certain information is essential in policymaking and how this information can be generated. The chapter includes a guide to resources on poverty analysis.

The authors argue that the richest understanding of income poverty can be gained if several rounds of multi-topic household surveys are present, especially if they contain a panel component of identical households being visited at different points in time. Income poverty can then be complemented with an examination of other dimensions of poverty and how the dimensions are related to each other. For example, health poverty analysis of the determinants of malnutrition often reveals that a mother's education is a key determinant of the nutritional status of her children. The chapter recommends that determinants of different dimensions of poverty should be compared and common factors singled out for policy interventions [adapted from author].

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=33704&type=Document>

## **9. In Reaching the Poor with Health, Nutrition, and Population Services: What Works, What Doesn't, and Why**

**Authors:** D. Gwatkin; A. Wagstaff; A. Yazbeck

**Publisher:** World Bank, 2005

This book, from the Reaching the Poor Program (RPP), provides eleven case studies that document how health, nutrition and population programmes have performed in reaching disadvantaged groups. The studies were commissioned in an effort to find better ways of ensuring that health, nutrition and population programmes benefit those that need them most. The case studies focused on Africa, Asia and Latin America. Topics examined include: health, nutrition, and population topics related to the Millennium Development Goals (MDGs): nutrition; infant and child health; reproductive health; and AIDS, malaria, and tuberculosis.

The authors conclude that it is possible for health, nutrition and population programmes to reach the poor more effectively than they are doing at present. However, there is no one strategy that would be appropriate in all cases. The authors highlight the need to find better and more feasible approaches to service delivery for the poor to be reached effectively and to ensure flexibility. They suggest the need to learn from and draw on what has worked elsewhere, rather than simply duplicating programmes. This requires: studying approaches of successful programmes; adapting to local conditions; experimenting with adapted approaches in various and multiple settings; monitoring these experiences; and adjusting approaches according to findings. [adapted from author]

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=22146&type=Document>

## 10. Chronic Poverty Report 2004-2005

**Publisher:** Chronic Poverty Research Centre, UK, 2004

This major report from the Chronic Poverty Research Centre (CPRC) examines what chronic poverty is and why it matters, who the chronically poor are, where they live, what causes poverty to be persistent and what should be done about it. A section of regional perspectives looks at the experience of chronic poverty in sub-Saharan Africa, South Asia, Latin America and the Caribbean, transitional countries and China. A statistical appendix brings together data on global trends on chronic poverty, estimating that the number of people trapped in chronic poverty is between 300 and 420 million people, with South Asia accounting for 44 per cent of the figure and Sub-Saharan Africa for 29 per cent.

The report highlights that people in chronic poverty will make up the majority of the 900 million people still in poverty in 2015 even if the Millennium Development Goals are met. It argues that they need targeted support, social assistance and social protection, and political action that confronts exclusion. The authors call for a policy framework that prioritises livelihood security for all, puts more chronically poor people in a position where they can take up opportunities, takes empowerment seriously and recognises obligations to provide resources. Chronic poverty will not be seriously reduced without real transfers of resources and sustained, predictable finance. [adapted from author]

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=18135&type=Document>

## 11. Escaping poverty: can policy reach the chronically poor?

**Authors:** D. Hulme; Chronic Poverty Research Centre, IDPM, UK

**Publisher:** id21 Development Research Reporting Service, 2002

The past few years have seen remarkable consensus on and commitment to poverty reduction from governments around the world. This has resulted in the Millennium Development Goals (MDGs) which seek to reduce global absolute poverty by 50 per cent by 2015 and to reduce other forms of human deprivation.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=9299&type=Document>

## 12. Basic services for the poorest

**Authors:** D. Hulme

**Publisher:** Chronic Poverty Research Centre, UK, 2004

This Powerpoint presentation, produced by the Chronic Poverty Research Centre, explores the issues surrounding basic services for the severely poor (those who are far below a poverty line) and the chronically poor (those below a poverty line for all or much of their lives). It asks who and where are the poorest people in the world, what are their social characteristics, why is service delivery important for them, why they don't get services, and what can be done

to improve the situation. Examples are given from Bangladesh, rural Nepal, Thailand, and India.

Considering what can be done to improve services for the poorest, the presentation identifies three overarching issues: creating knowledge about service delivery that benefits the poorest; increasing financing of basic services for the poor and poorest by rich countries; and fostering socio-political change to achieve social inclusion. Specific lessons include that: much of pro-poor policy generally will be good for the poorest; geographical targeting can be used; social protection and livelihood promotion can be linked; services can be packaged for the poorest, as in the Progresa project in Mexico; and user-charge exemption fees can target the poorest.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=20506&type=Document>

### **13. Improving the health of the world's poorest people**

**Authors:** D. Carr; Health Bulletin

**Publisher:** Population Reference Bureau , 2004

This bulletin, produced by the Population Reference Bureau (PRB), highlights the poor-rich health divide that leaves more than 1 billion people worldwide excluded from both essential basic care and the benefits of advances in health and medical technology because of their extreme poverty. Key factors that contribute to these persistent health inequalities include lack of responsiveness by health systems to the needs of the poor; low quality of care; and the reality that public spending on health (justified on equity grounds) benefits non-poor groups more than the poor. In addition, few countries have taken measures to track progress in reducing socioeconomic disparities in health.

Recommendations for addressing these inequalities include:

- shifting the focus of public health from the majority to meet the specific needs of poor and vulnerable groups
- focusing on the preventable and treatable diseases which most affect poorer people; adopting a comprehensive pro-poor approach to policy
- in the long term, influencing the many social and economic determinants of health disparities by improving access to vital services and opportunities, and by reducing discrimination and isolation.

[adapted from author]

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=15099&type=Document>

### **14. International perspectives on health inequalities and policy**

**Authors:** D.A. Leon; G. Walt; L. Gilson

**Publisher:** British Medical Journal , 2001

While it is important to target "the poor", inequalities and inequities are not simply about the most deprived members of society. In low-income countries a large minority or even majority of the population live in poverty. In developed countries there are fine inequalities in health status that span the full socioeconomic spectrum. This article provides an overview of the debate around inequity, inequalities, poverty, and health, drawing together current international understandings of the problem.

Although health may not necessarily be a priority to all governments, most governments wish to initiate economic growth. If health facilitates economic growth, then health should become a priority of governments. This causal link is problematic and caution is emphasised. This article suggests that the following strategies may improve health and welfare:

- Priority should be given to economic growth to allow for the accumulation of wealth which is subsequently invested in programmes to tackle ill health and poverty.
- A support led strategy in which investment in social policies may bring about improved health and welfare should be implemented.

In addition, this article explores aetiological mechanisms that drive socioeconomic differences in health. These vary according to disease and context. Moreover, even among those living in absolute poverty, there are differences in the extent to which parents can use resources to influence children's morbidity and mortality.

Finally, this article suggests paying attention to understanding the time scales over which changes in the circumstances of different socio-economic groups could translate into differences in health status. What are the lag periods between exposure and onset of disease? How does this lag time effect policy-making and health-strategy issues? [adapted from author]

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=29031&type=Document>

## **15. Poverty and health sector inequalities**

**Authors:** A. Wagstaff

**Publisher:** World Health Organization , 2002

What evidence is there of inequalities in health between the poor and non-poor, and what are the consequences for the poor of health care expenses? This article, which forms part of a series of 'Theme Papers' produced by the World Health Organisation, outlines the main causes of health inequalities and discusses the effectiveness of policies intended to combat them. The author focuses on the developing world, but uses examples from the developed world to supplement his arguments.

The article begins by drawing on studies that explain the existence of health inequalities between the poor and the non-poor. This is followed by an examination of the causes of these inequalities, which include both proximate determinants (factors at household and community levels) and underlying determinants (resources, community factors, and health systems). The latter part of the paper addresses the issue of the burden of health care costs for poor people and how public policies might seek to counteract this.

The literature on health inequalities points to a number of key findings:

- Inequalities between the poor and non-poor tend to be more pronounced for objective indicators of ill-health (such as malnutrition and mortality), than for subjective indicators (where individuals are interviewed).
- Socioeconomic inequalities in health seem to be widening rather than narrowing.
- Unlike in wealthier countries, the poor in developing countries tend to use health services less than the better-off, and receive less of government subsidies to the health sector.
- Higher levels of knowledge, literacy and education result in higher usage of health services.
- Geographical and environmental factors that influence health care usage include transport links, and community sanitation.
- The availability of health services and staff, and the accessibility of health centres are also important variables in determining service utilization and health outcomes.

Implications for health policy are:

- Policies aimed at combating health sector inequalities should aim to reduce inequalities in both the supply side (for example the quality and availability of health services) and the demand side (such as inequalities in income, knowledge and access).
- Health ministries should work more closely with other ministries, and should also take a wider view by, for example, exploring alternative delivery methods.
- More studies are needed on the impact of programmes and policies on health sector inequalities.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=11663&type=Document>

## 16. Household catastrophic health expenditure: a multicountry analysis

**Publisher:** The Lancet, 2003

This Lancet article investigates the extent of catastrophic health expenditure in 59 countries. It defines household expenditure as catastrophic if a household's financial contributions to the health system exceed 40 per cent of their income remaining after subsistence needs have been met. The paper finds that payments from out-of-pocket health expenses varied widely between countries, from less than 0.01% in Czech Republic to 10.5% in Vietnam. Countries in transition and Latin America have higher rates of catastrophic spending. Three key preconditions for catastrophic payments were identified: the availability of health services requiring payment; low capacity to pay; and the lack of prepayment or health insurance.

The paper concludes that people, particularly those in poor households, can be protected from catastrophic health expenditures by reducing a health system's reliance on out-of-pocket payments and providing more financial risk protection. Other more complex strategies can reduce the financial consequences of payment for services such as progressive fee schedules, highly subsidised or free hospital services, and the provision of certain health services to the poor.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=33695&type=Document>

## 17. The impact of the introduction of user fees at a district hospital in Cambodia

**Authors:** B. Jacobs; J. Price

**Publisher:** Health Policy and Planning, 2004

This paper, published in Health Policy and Planning, describes the introduction of user fees at a district referral hospital in Kirivong Operational District in Cambodia. It examines the impact on health care seeking behaviour, the ability to pay and consultation prices at private practitioners. It reports that consultation fees charged by private providers increased in tandem with price increases introduced at the referral hospital. The paper argues that the introduction and subsequent increase in user fees created a “medical poverty trap”, with significant impacts on both health and livelihoods. These impacts included untreated illness, reduced access to care, long-term impoverishment, and irrational use of drugs leading to drug resistance.

The paper recommends that two interventions should be implemented immediately to address the medical poverty trap: regulation of the private sector, and reimbursing health facilities for services provided to patients who are exempted from paying user fees because they are poor. In the longer term, the paper advocates changing from direct payments at the point of service delivery to a social health insurance system in which healthy, high-income groups subsidise health care for low-income groups. For such a system to include the poorest, it may be necessary to subsidise membership fees.

This document is not freely available online. Photocopies can be obtained from the [British Library of Development Studies](#). There is a charge for this service.

## 18. Indian community health insurance schemes provide partial protection against catastrophic health expenditure

**Authors:** N. Davadasan; W. Van Damme; B. Criel

**Publisher:** Health Services Research [journal], 2007

This article in BMC health services research examines two Indian community health insurance (CHI) schemes, ACCORD and SEWA, to determine whether insured households are protected from catastrophic health expenditure (annual hospital expenditure greater than 10 per cent of annual income). The paper finds that in the absence of CHI schemes, patients would have had to pay out of pocket (OOP) payments for their hospitalisation. With the CHI schemes, 67 per cent and 34 per cent of patients did not have to make any OOP payments for their hospital expenses at ACCORD and SEWA, respectively. Both CHI schemes halved the number of households that would have experienced catastrophic health expenditure by covering hospital costs.

Despite this, some households still experienced catastrophic health expenditure due to: low annual income; benefit packages with low maximum limits; exclusion of some conditions from the benefit package; and use of the private sector for admissions. The article concludes that CHI appears to be effective in halving the incidence of catastrophic health expenditure among hospitalised patients. This protection could be further enhanced by improving the design of CHI schemes, especially by increasing the upper limits of benefit packages, minimising exclusions and controlling costs.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=31230&type=Document>

## 19. Pathways out of and into poverty in 36 villages in Andhra Pradesh, India

**Authors:** A. Krishna

**Publisher:** World Development, 2005

This article, published in World Development, develops a Stages of Process methodology to analyse pathways in and out of poverty in Andhra Pradesh, India. It finds that fourteen percent of households in the 36 villages studied escaped from poverty over the past 25 years, but another 12 percent of the 5536 households fell into poverty during the same time. Ill health and high healthcare costs, social and customary expenses, high-interest private debt, and drought were found to be most often associated with falling into poverty. On the other hand, diversification of income sources and land improvement were most closely related with escape. Some other factors, including industrial growth and education, had only very slight and indirect effects on poverty in these villages.

The study concludes that escaping poverty and falling into poverty are responsive to different sets of factors. Setting up poverty monitoring stations to conduct similar micro-level inquiries on a more regular basis could help keep track of these factors and their effects. The author argues that two different sets of poverty policies will be required in future: one set to assist escape, and another set to prevent descent [adapted from author].

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=33706&type=Document>

## 20. Paying out-of-pocket for health care in Asia: catastrophic and poverty impact

**Authors:** E. van Doorslaer; O. O'Donnell; A. Somanathan

**Publisher:** Equitap , 2005

This Equitap paper analyses the extent of out-of-pocket (OOP) payments for healthcare in 14 countries in Asia, and the impact of these payments on household's income and resources and vulnerability to poverty. It finds that the heavy reliance on OOP financing for healthcare has important consequences for living standards: in Bangladesh, China, India, Nepal and Vietnam, OOP payments absorb more than a quarter of household resources in at least one in ten households. OOP payments push a lot of families further into poverty: in 11 low/middle income countries, 2.7 per cent of the total population are pushed below the threshold of \$1 per day due to payments for health care.

The paper concludes that the extent of the negative impacts from OOP payments depends on three factors: the degree of reliance on OOP financing; the nature and distribution of OOP payments; and the public sector user-charging policy and the effectiveness with which the poor are exempted from charges. The authors provide examples where targeted exemptions, implemented through a health card, have some success in shielding poor families from high payments for health care.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=24169&type=Document>

## **21. Medical expenditure and rural impoverishment in China**

**Authors:** Y. Liu; K. Rao; W. Hsiao; Ministry of Health: China

**Publisher:** Department of Population and International Health, Harvard School of Public Health, 2003

Due to escalating medical costs and lack of insurance coverage, medical spending causes financial hardship for many rural families in China, despite continued economic growth and increasing income in the country as a whole. This paper, published in the Journal of Health, Population and Nutrition, reviews the escalation of medical costs and lack of insurance coverage. It goes on to analyse the impact of poor health on poverty generation and discusses the key implications this case study may have for policy and future studies.

Rural China represents an interesting case. About 70 per cent of the 1.29 billion population live in rural areas and are primarily engaged in the informal sector, particularly agriculture. Thirty years ago, China was the first large nation to establish a community-based insurance system for its rural population. Although there have been numerous reform initiatives aimed at controlling medical inflation, since the inception of market reforms in the early 1980s the rural insurance system has collapsed. Medical expenditure has therefore become a significant source of transient poverty in rural China. [Adapted from author].

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=14580&type=Document>

## **22. Equity, privatization and cost recovery in urban health care: the case of Lao PDR**

**Authors:** C. Paphassarang; K. Philavong; B. Boupaha; E. Blas

**Publisher:** Health Policy and Planning, 2002

This article, published in Health Policy and Planning, reports on a study that assessed the impact of privatisation and cost recovery on health care equity in the Lao PDR. The study compared two urban neighbourhoods of different socioeconomic status, using in-depth interviews and focus group discussions to assess perceptions and utilisation of health care services. Findings revealed a strong preference for private health services among both socioeconomic groups, including private clinics and treatment abroad for those with high socioeconomic status, and private pharmacies for poorer socioeconomic groups. Unwelcoming attitudes of health staff and procedural barriers were cited as the main disincentives to using public sector services.

The authors note that, since use of private services limits patients to what they can afford, the poor generally access drugs alone, with no examination, no diagnosis and only limited advice. This often means receiving inappropriate and insufficient medication. They conclude that equity in health care remains theoretical rather than practical in Lao PDR and the social goals of health reform have not been achieved. Further privatisation, they argue, is not likely to improve this situation. Rather, they propose a system of public neighbourhood health posts in urban areas with significant populations of low socioeconomic status.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=18348&type=Document>

### **23.** Explaining the incidence of catastrophic expenditures on health care: comparative evidence from Asia

**Authors:** O. O'Donnell; E. van Doorslaer; R. P. Rannan-Eliya

**Publisher:** Equitap , 2005

Heavy reliance on out of pocket (OOP) financing of health care in most developing countries leaves households exposed to the risks of unforeseen medical expenditures. This paper looks at the incidence of catastrophic medical expenditures across households in six Asian countries/territories which differ in levels of income, degree of reliance on OOP financing, and the incidence of catastrophic payments. These countries are Bangladesh, Hong Kong, India, Sri Lanka, Thailand and Vietnam.

The paper finds that the probability of incurring catastrophic payments is generally higher in rural areas and lower among households with a sanitary toilet and safe drinking water. This suggests that public health interventions might be effective measures to protect households from the risk of burdensome payments for health care. There is also evidence from Vietnam and Thailand showing that health insurance is effective in protecting against catastrophic payment risks. The paper concludes that the development of public or private prepayment mechanisms based on resource pooling offers protection from catastrophic risks to those that are currently able to respond to unforeseen medical needs. They would also make health care more affordable and accessible to poorer households operating within very tight and inflexible budgets that cannot currently respond to health shocks.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=33691&type=Document>

### **24. Making health systems more equitable**

**Authors:** D. R. Gwatkin; A. Bhuiya; C. G. Victora

**Publisher:** The Lancet, 2004

This article, published in The Lancet, looks at the challenges involved in making health systems more equitable and examines a range of mechanisms for achieving this. The authors find that health systems are consistently inequitable, providing more and higher quality services to the well-off rather than to the poor, who need them more. They identify several measures that can help to resolve this inequity, including: establishing goals for improved coverage in the poor, rather than in entire populations, and use of those goals to direct planning toward the needs of the disadvantaged; use of one or more of the several techniques that have been effective in at least some settings; and empowering poor clients to play a more central role in health system design and operation.

The authors recommend that health policy makers experiment with a wide range of possibilities, monitor progress carefully to see how well they work, and retain those that prove effective. They acknowledge that this process is not guaranteed to bring greater efficiency in health systems. However, they suggest that equity in coverage is at least as important a basis for change as efficiency. [adapted from author]

NB: To access this paper, you will first be asked to register with The Lancet. This process and access to the paper is free of charge.

Available online at: <https://cms.eldis.org/go/topics/dossiers/meeting-the-health-related-needs-of-the-very-poor/targeting-the-very-poor&id=17467&type=Document>

## **25. Free government health services: are they the best way to reach the poor?**

**Authors:** D. Gwatkin

**Publisher:** World Bank, 2003

Equity is a frequently stated justification for government involvement in the health care market. This is often taken to mean directly providing all segments of the population with a wide range of government-operated health services at no cost. Yet evidence suggests that this goal often remains elusive, especially in poor countries; that governments serve only some of the population; and that the people served are disproportionately concentrated among the better-off. When this happens, government health services, far from promoting equity, work against it.

The purpose of this document, produced by the World Bank, is to illustrate that there are many ways for governments to pursue the goal of ensuring that the poor receive adequate, affordable services through alternative approaches to resource allocation and purchasing. The first section summarises the information known about the distribution of benefits from government health services across social groups, in order to document the regressive pattern that now frequently exists and the need for significant changes in approach if the poor are to benefit. The second and third sections illustrate the kinds of changes that might be considered. [adapted from author]

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=13122&type=Document>

## **26. Targeting services towards the poor: A review of targeting mechanisms and their effectiveness**

**Authors:** K. Hanson; E. Worrall; V. Wiseman

**Publisher:** Health Systems Resource Guide, 2006

This chapter analyses the alternative approaches to targeting the poor that have been used in healthcare delivery and draws together evidence from a range of countries about their effectiveness. The authors emphasise the importance of programme design and implementation issues and argue that successful programmes will need to identify these issues and devote adequate resources to overcoming them.

The authors propose a conceptual framework for understanding the key elements of targeting policies. These elements are: who is targeted; what is the targeted benefit; what is the targeting method; and what evaluation criteria are used to measure the impact. The paper then uses this framework to assess six different targeting mechanisms that have been applied in the health sector in a range of contexts. These approaches are: resource allocation formulae, contracting Non-governmental Organisations (NGOs), user fee exemptions, cash transfers, vouchers and market segmentation strategies using self-selection.

A critical issue identified in the chapter is the availability of good information for programme design and evaluation. Most evaluations in this area have focused on the main targeting outcomes (coverage, under-coverage and leakage) and have neglected the other issues of concern to policymakers such as cost and sustainability. Future research in this area needs to consider a broader range of outcomes, and more systematically compare the costs and consequences of alternative methods of directing resources towards those most in need.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=22157&type=Document>

## **27. Access of the very poor to health services in Asia: evidence of the role of health systems**

**Authors:** R. Rannan-Eliya; A. Somanathan

**Publisher:** Department for International Development Health Systems Resource Centre , 2005

This paper, produced by Equitap, summarises evidence on the role of health systems in protecting the very poor in Asia. Based on an extensive review of health system performance in the region, the authors identify key factors common to health systems that effectively reach the poor. These include national policies that stress universalism, and a reliance on tax-funding and public sector delivery. They argue that the poor do worst in countries which maintain significant user charges or tolerate a high incidence of informal fees in government facilities.

The authors highlight the successes of many local projects in improving access to health services for the poor. However, they emphasise that no local models for the delivery of health services have been successfully scaled up to national level. They conclude that it is not individual projects but health systems that have the capacity to increase access to health services and overall social protection for the poor. Moreover, they stress that the funding and organisation of health systems has a greater impact than levels of economic development, or public spending. [adapted from authors]

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=19917&type=Document>

## **28. Targeting of Transfers in Developing Countries: Review of Lessons and Experience**

**Authors:** D. Coady; M. Grosh; J. Hoddinott

**Publisher:** World Bank, 2004

This book provides a general review of experiences and lessons learned with methods used to target interventions in developing countries. The objective is to convey available targeting options, anticipated results, and relevant information to assist in optimising the implementation of the chosen option.

A brief review of targeting, discussing the benefits and costs of targeting, methods for assessing targeting performance, and a taxonomy of targeting methods is provided. In addition, the authors analyse quantitative evidence on targeting outcomes derived from an extensive review of existing studies. A qualitative analysis of common targeting methods is

also provided, including a review of international experience, how the method works, what determines how well it works, what its costs are likely to be, and appropriate circumstances for its use.

The book puts forward the following five core messages about targeting effectiveness:

- **Targeting can work...:** across all programmes for which the authors could obtain information on targeting performance, they found that the median programme provides approximately 25 percent more resources to the poor than would random allocations. The best programmes were able to concentrate a high level of resources on poor individuals and households
- **...but it doesn't always:** in approximately 25 percent of cases targeting was regressive so that a random allocation of resources would have provided a greater share of benefits to the poor. For every method considered, excepting targeting based on a work requirement, there was at least one example of a regressive programme
- **There is no clearly preferred method for all types of programmes or all country contexts:** in the sample of programmes, 80 percent of the variability in targeting performance was due to differences within targeting methods and only 20 percent was due to differences across methods
- **A weak ranking of outcomes achieved by different mechanisms was possible:** interventions that use means testing, geographic targeting, and self-selection based on a work requirement are all associated with an increased share of benefits going to the bottom two quintiles relative to targeting that uses self-selection based on consumption
- **Implementation matters tremendously to outcomes:** targeting performance improved with country income levels (the proxy for implementation capacity), the extent to which governments are held accountable for their actions, and the degree of inequality.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=23647&type=Document>

## **29. Targeted development programmes for the extreme poor: experiences from BRAC experiments**

**Authors:** I. Matin; CPRC

**Publisher:** Chronic Poverty Research Centre, UK, 2002

This paper, published by the Chronic Poverty Research Centre (CPRC), analyses Income Generation for Vulnerable Group Development (IGVGD), a programme initiated by the Bangladesh Rural Advancement Committee (BRAC) which aimed to link food aid with training, savings and credit. Linking microfinance with food aid was seen as a way to include the chronically poor, who the paper argues were failed by conventional microfinance programmes. However, the IGVGD programme relied on the assumption that participants could progress from receiving food aid to using microfinance in a linear way, when in fact their needs changed over time in a way which was complex and cyclical. In addition, IGVGD targeting was mainly mediated by local government, meaning that the right to participate was distributed as a form of patronage by local elites.

The paper concludes by introducing a new BRAC programme, Challenging the Frontiers of Poverty Reduction (CFPR), which aims to address some of the issues arising from the

IGVGD programme. The author argues that a major challenge for this programme will be to understand and address the factors outside of households that create poverty traps. The paper also advocates transforming the socio-political relationships at various levels that perpetuate poverty.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=10856&type=Document>

### **30. Arguing for the poor: elites and poverty in developing countries**

**Authors:** N. Hossain; M. Moore

**Publisher:** Institute of Development Studies, Sussex, UK, 2002

This paper, published by the Institute of Development Studies (IDS), suggests that aid donors should engage more actively with the national elites of developing countries in defining anti-poverty strategies. It argues that this does not depend on those elites being altruistic or especially “pro-poor”. Elites have some self-interest in reducing poverty, and are more likely to appreciate, explore, and be willing to act on that self-interest if they are sympathetically and constructively engaged in drawing up policies, and in shaping the ways these policies are labelled and justified. The paper also argues that history supports this case, and that contemporary elites in developing countries are in some ways more likely to be pro-poor than nineteenth century European elites, and in some ways less so.

The paper concludes by identifying types of environment where there is likely to be a positive and direct response from national elites to the phenomenon of poverty and deprivation. Examples of these environments are where the condition of the poor is perceived to pose a threat to the elite, in terms of social and political unrest, large-scale migration to cities, crime, weak national military capacity, or disease; and where proposed actions against poverty are not seen as a threat to sections of the elite.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=30030&type=Document>

### **31. The marginal costs of health services for the poorest**

**Authors:** C. Waddington

**Publisher:** Department for International Development Health Systems Resource Centre , 2005

This paper, published by the DFID Health Systems Resource Centre, explores the cost-effectiveness of targeted health services for the poorest by assessing marginal costs (the extra cost of providing a service to one more person, or an additional group of people). The paper reviews the empirical evidence with a focus on demand- and supply-side interventions, and user fees for primary health services. Based on this review, the author concludes that providing services for the poorest is more expensive than for the population as a whole. However, these higher costs may in some cases be offset by the greater health needs of the poorest, and hence the possibility of a higher impact.

The author recommends exploration – in the planning phase – of how new or expanded interventions can be adapted, if necessary, to reach the poorest, and how much this will cost.

She also highlights the trade-off between equity and economic efficiency that does, at times, exist. Concentrating on the almost-poorest within a country, for example, may be more cost-effective and cheaper than services for the poorest, but would be less equitable. The paper concludes by asking how efficient it is to specifically target the poorest, and what political compromises may be needed between equity and acceptability. [adapted from authors]

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=19923&type=Document>

### **32. Targeting in health: a summary of the evidence**

**Authors:** D.R. Gwatkin

**Publisher:** Poverty and Health, PovertyNet, World Bank, 2000

This paper, published by the World Bank, examines attempts to focus health sector development programmes on the poor. Drawing particularly on a series of case studies undertaken in Latin America in the late 1980s and early 1990s, it notes that although none of the programmes studied were perfect, the more carefully targeted ones were much more successful in reaching the poor than the less carefully targeted ones. The administrative costs of targeting were below 10 per cent of total programme costs. However, other studies describe the failure of many targeting programmes, particularly in Africa, leaving a mixed picture overall.

The paper suggests that it is worth the time and trouble to explore carefully the targeting options available in any particular setting, but that more than targeting will be required for the development of highly progressive, pro-poor initiatives. Targeting individuals through methods such as means testing can work well, but has failed when it was tried “on the cheap” – with minimal administrative effort and without additional resources to cover the costs of the services provided. Targeting by age and by disease should also be considered, and using several targeting mechanisms at once appears more effective than reliance on a single mechanism.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=19580&type=Document>

### **33. Consumer-led demand side financing for health and education: an international review**

**Authors:** T. Ensor

**Publisher:** Oxford Policy Management , 2003

This paper, published by Oxford Policy Management, examines "demand side financing" of health and education services. This involves placing purchasing power into the hands of consumers, for instance through issuing them with vouchers they can use to pay for services. The paper's review of international evidence suggests that vouchers have been successful in raising the consumption of key services among key groups. Impacts include increases in enrolment and reduced drop-out rates for schools, and increased clinic utilisation and compliance with treatment regimes for health programmes. However, vouchers on their own may not be able to improve the quality and distribution of services.

The paper argues that there is some scope for extending voucher schemes in low income countries for health services. Such schemes should perhaps focus primarily on fixed packages of key services aimed at easily identifiable groups. This itself will require the development of capacity in administering the financing schemes and also accrediting providers. Extending demand side financing to services such as hospital coverage is unlikely to be appropriate in most low income countries, since it would involve issuing vouchers that could be used to purchase insurance, and low income countries tend to lack developed insurance markets.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=19881&type=Document>

### **34. Reaching the poor with health, nutrition and population services: what works, what doesn't and why**

**Authors:** D. Gwatkin; A. Wagstaff; A. Yazbeck

**Publisher:** World Bank, 2005

This book, from the Reaching the Poor Program (RPP), provides eleven case studies that document how health, nutrition and population programmes have performed in reaching disadvantaged groups. The studies were commissioned in an effort to find better ways of ensuring that health, nutrition and population programmes benefit those that need them most. The case studies focused on Africa, Asia and Latin America. Topics examined include: health, nutrition, and population topics related to the Millennium Development Goals (MDGs): nutrition; infant and child health; reproductive health; and AIDS, malaria, and tuberculosis.

The authors conclude that it is possible for health, nutrition and population programmes to reach the poor more effectively than they are doing at present. However, there is no one strategy that would be appropriate in all cases. The authors highlight the need to find better and more feasible approaches to service delivery for the poor to be reached effectively and to ensure flexibility. They suggest the need to learn from and draw on what has worked elsewhere, rather than simply duplicating programmes. This requires: studying approaches of successful programmes; adapting to local conditions; experimenting with adapted approaches in various and multiple settings; monitoring these experiences; and adjusting approaches according to findings. [adapted from author]

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=22146&type=Document>

### **35. Waivers and exemptions for health services in developing countries**

**Authors:** R. Bitrán; U. Giedion

**Publisher:** World Bank, 2003

The problem with user fees is that the poorest people might not be able to pay them, and so not get the health care they need. This discussion paper from the World Bank Institute's Social Safety Net Primer series examines the policy issues around social protection in user fee systems. The authors present evidence from a number of countries that have implemented

exemption or waiver systems for the poor, and discuss lessons learned and implications for best practice.

The paper includes a summary of the background issues and policy debate over user fees, the concept of equity and the rationale for waivers and exemptions. It discusses ways of identifying beneficiaries, sets out a variety of potential protection mechanisms, and examines the evidence from practice from Kenya, Cambodia, Ghana, Zimbabwe, Indonesia, Thailand and Chile. It concludes with an analysis of the performance, financing and design and implementation features of the various systems.

Important findings include:

- A wide variety of differently designed systems are in operation, but assessing their performance and relative merits is made difficult by a lack of monitoring and evaluation data.
- Coverage of the poor by waiver systems is low in the poorer countries, particularly where providers are not compensated for granting waivers, such as Kenya. Richer countries achieve higher coverage, but experience problems with waivers being claimed by ineligible patients.
- No systematic efforts have been made in the countries to assess either the administrative costs of the waiver system, or its impact on utilisation of health services or on out-of-pocket expenditure by the poor.
- The lack of clear, easily-verifiable criteria for granting waivers hampers the success of policy, and where such criteria are not revised in response to cost of living and other changes they can become inappropriate.
- In most countries featured, people are deterred from claiming waivers because they feel ashamed of admitting that they are poor.
- Where procedures are not clear and staff resources inadequate, the administration of waivers can be cumbersome, leading to delays and postponements.

An important implication of these findings is that there is a need for consistent monitoring of waiver systems, without which it is difficult to assess the relative merits of the various systems currently in operation. Nevertheless, a number of lessons for a successful waiver policy can be learned, as follows:

- Greater benefits have resulted in countries which have carefully designed and implemented waiver systems than in those which have improvised such systems
- Systems which compensate providers for revenue lost through waivers are more successful than those where the provider is expected to absorb the loss
- Where compensation systems are in place, performance improves when the reimbursement is made promptly
- Widespread dissemination of information among potential beneficiaries can improve health service utilisation levels among the poor
- Confusion and misallocation of resources can be avoided through clear and easy-to-apply criteria for eligibility

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=15472&type=Document>

### **36. Access to health care for all? User fees plus a health equity fund in Sotnikum, Cambodia**

**Authors:** W. Hardeman; W. Van Damme; M. Van Pelt; I. R. Por

**Publisher:** Health Policy and Planning, 2004

This paper, published in Health Policy and Planning, presents the experience of a Health Equity Fund managed by a local non-governmental organisation (NGO) in Sotnikum, Cambodia. The aim of the Health Equity Fund was to identify the poor and pay the costs of hospitalisation on their behalf (including indirect costs such as food and transportation). The paper identifies four major constraints to access faced by the poor: financial, geographical, informational and intra-household. Findings show that the Health Equity Fund was effective in helping the poor to overcome many of these constraints, leading to a steep increase in numbers of poor people accessing the hospital. The Fund effectively improved financial access for the poor, reduced expenditure on poor-quality private sector services, and was very cost-effective, with minimal “leakage” to non-poor.

The authors conclude that Health Equity Funds managed by motivated local NGOs can contribute more effectively to poverty reduction than a system of waivers for poor patients. However, they acknowledge that in the longer term, and on a larger scale, problems may arise such as leakage to non-poor who may adapt their self-reported status. Further research and experimentation are recommended in different contexts and with different set-ups. [adapted from authors]

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=19415&type=Document>

### **37. Vouchers for health: using voucher schemes for output-based aid**

**Authors:** P. Sandiford; A. Gorter; M. Salvetto

**Publisher:** Public Policy for the Private Sector [World Bank], 2002

This note, published by the World Bank, examines a donor-supported scheme in Nicaragua, which involved giving vouchers for sexual health services to commercial sex workers and their partners and clients. The highest rates of voucher redemption were among the poorest women and among groups with the highest initial rates of sexually transmitted infections (STIs). The programme reduced the prevalence of gonorrhoea in the female sex worker population by about 5 per cent per year, and the prevalence of syphilis by 10 per cent per year. Women who attended follow-up consultations also stayed free of STIs for longer.

The cost of the scheme was low compared to consultations in public facilities. However, the note argues that reducing costs further by charging the beneficiaries is unrealistic and would exclude the poorest, who also have the greatest health needs. As it is, the costs to the beneficiaries in transport and lost income are significant, and for some constitute a reason not to use their voucher. The note concludes that the scheme provided access to, and increased the use of, high-quality, tailored sexual health services in a non-stigmatising manner for commercial sex workers and their regular sexual contacts. It also reduced the risk of STIs, including HIV, among the general population.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=19887&type=Document>

### **38. An overview of community-based health financing**

**Authors:** ; PHRPlus

**Publisher:** Partners for Health Reformplus , 2004

This PHRplus document aims to answer basic questions about community-based health financing (CBHF) that might be posed by policymakers and technical assistance providers. The report outlines how schemes are set up and how they operate, and provides an overview of their advantages and limitations. Topic areas covered include how CBHF schemes can: contribute to better health, improve access to financing, benefit people living with HIV/AIDS, and expand popular participation in the health sector.

The final section of the report links CBHF to broader health systems issues. The authors argue that the primary advantage of CBHF schemes is that they provide a means to pool risks for otherwise hard-to-reach populations outside of formal sector employment. Moreover, these schemes can be a part of national healthcare financing systems, as they can help meet some of the needs of rural “middle class” and workers in the informal sector while complementary financing strategies can address the needs of other groups. However, due to the limited evidence base, it is unclear if CBHF schemes contribute to overall system equity, even if they do succeed in providing coverage to poorer people within their communities. [adapted from author].

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=17248&type=Document>

### 39. Paying in potatoes: community-based health insurance for the rural and informal sector

**Authors:** R. L. Hope

**Publisher:** The Lancet, 2003

Out-of-pocket payments for health care, known as user charges, are widespread throughout the developing world. They were introduced as part of sweeping reform in the 1980s and 1990s, especially in Africa, often as conditions of International Monetary Fund or World Bank loans under structural adjustment policies. The policies have been criticised for their failure to raise enough revenue, and for their adverse effects on equity. Without money in their pocket, the poorest groups simply cannot access health care. However, in response to user charges, community-based health insurance schemes have arisen, protecting the rural and informal sector.

This essay, published in The Lancet, examines the strengths of these community-based health insurance schemes, and provides several short examples of schemes in Bolivia, Bangladesh, and the Democratic Republic of Congo. The author concludes that although community-based health insurance can offer many advantages over user charges if appropriately designed, it cannot and should not be a substitute for strong government involvement in providing health services for the poor. [adapted from author]

Please note: To access this paper, you will first be asked to register with The Lancet. This process and access to the paper is free of charge.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=13822&type=Document>

#### **40. Time for a change? Health insurance systems in Transitional Asia**

**Authors:** Tim Ensor; Centre for Health Economics, University of York, UK

**Publisher:** id21 Development Research Reporting Service, 2002

The transition from state-planned to market-based economies in some Asian countries has produced a decline in public funding of health systems. Insurance programmes are increasingly used to make up this shortfall. How does this affect access to healthcare? What can be learnt from the performance of social insurance schemes in Latin America?

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=10570&type=Document>

#### **41. Indian community health insurance schemes provide partial protection against catastrophic health expenditures**

**Authors:** N. Davadasan; W. Van Damme; B. Criel

**Publisher:** Health Services Research [journal], 2007

This article in BMC health services research examines two Indian community health insurance (CHI) schemes, ACCORD and SEWA, to determine whether insured households are protected from catastrophic health expenditure (annual hospital expenditure greater than 10 per cent of annual income). The paper finds that in the absence of CHI schemes, patients would have had to pay out of pocket (OOP) payments for their hospitalisation. With the CHI schemes, 67 per cent and 34 per cent of patients did not have to make any OOP payments for their hospital expenses at ACCORD and SEWA, respectively. Both CHI schemes halved the number of households that would have experienced catastrophic health expenditure by covering hospital costs.

Despite this, some households still experienced catastrophic health expenditure due to: low annual income; benefit packages with low maximum limits; exclusion of some conditions from the benefit package; and use of the private sector for admissions. The article concludes that CHI appears to be effective in halving the incidence of catastrophic health expenditure among hospitalised patients. This protection could be further enhanced by improving the design of CHI schemes, especially by increasing the upper limits of benefit packages, minimising exclusions and controlling costs.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=31230&type=Document>

#### **42. Achieving the twin objectives of efficiency and equity: contracting health services in Cambodia**

**Authors:** I. Bhushan; S. Keller; B. Schwartz

**Publisher:** Asian Development Bank Institute, 2002

How do health indicators between Cambodian districts compare with conventional government provision of health services and those in which the services have been contracted out to non-governmental organisations (NGOs)? This briefing paper from the Asian

Development Bank (ADB) summarises findings from an ongoing study that began in 1998 on the feasibility, impact and cost-effectiveness of government contracting with NGOs to deliver health services.

The authors provide some brief introductory statistics relating to health indicators in Cambodia, before explaining how study districts were selected. They differentiate between a 'contracting-out' model, in which contractors had full responsibility for the delivery of specified services in a district, directly employed their staff and had full management control; and a 'contracting-in' model in which contractors provided only management support to civil service health staff and costs were covered by the government. Results are compared for three contracted-in, two contracted-out and four control districts, based on the efficiency and equity of the services provided.

The results from the study show that:

- Contracting increases coverage – contracted-out districts increased use of public health services to 1.7 contacts per capita per year, and contracted-in districts to 1.2 contacts.
- Contracted-out districts witnessed large increases in immunisation rates and the use of reproductive health services.
- Contracting decreases costs – recurrent costs for contracted-in districts were \$26.4 per person per year and \$22.7 for contracted-out districts.
- Contracting increases efficiency – people in contracted-out districts lost about 15 per cent less time on illness and seeking health care compared to control districts. The figure for contracted-in districts was five per cent.
- Contracting increases equity – the use of health services by the poorest households was found to be greatest in contracted-out districts. This was due to improved access to health services and lower costs in these districts.

Based on the Cambodian experience, the authors conclude that successful contracting requires:

- predetermined and objectively verifiable performance indicators, coupled with well-defined performance targets
- political support for contracting at both central and local levels
- civil service arrangements that allow government health care professionals to work for NGOs at market wage rates.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=11627&type=Document>

### **43. Cambodia: using contracting to reduce inequity in primary health care**

**Authors:** J.B. Schwartz; I. Bhushan

**Publisher:** Health, Nutrition and Population Division, Human Development Department, World Bank, 2004

This discussion paper, published by the World Bank, examines the impact on equity of giving contracts to international non-government organisations (NGOs) for the delivery of primary health care. It compares five rural districts in which contracts were given to NGOs, with four districts in which traditional government provision was used. Between 1997 and 2001,

coverage of primary health care services had increased substantially in all the districts. But in districts with NGO contracts, people in the poorest half of the population were more likely to receive primary health services than people in similar circumstances in districts where the services were still provided by the government.

The paper concludes that NGOs outperformed the government in targeting services to the poor, even when controlling for expenditure, initial circumstances, and demographics. It notes that it is difficult to generalise these results to other countries, because the lack of physical infrastructure and large numbers of government health workers in rural areas in Cambodia particularly lent themselves to innovative approaches. However, it suggests that similar projects in Bangladesh, Afghanistan and Pakistan may help to clarify whether the Cambodian experiment provides an effective model for other developing countries.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=20251&type=Document>

#### **44. Contracting for health: evidence from Cambodia**

**Authors:** E. Bloom; I. Bhushan; D. Clingingsmith

**Publisher:** Brookings Institution, 2006

This Brookings Institution report assesses the impact of contracting out the management of government health services to NGOs in Cambodia. The contracts specified targets for maternal and child health service improvement. Contractors were required to provide all preventative, promotional and curative health care services mandated for a district, and were responsible for services at district hospitals, sub-district health centres and remote health posts. The paper finds that contracting programme caused large increases in the services outcomes targeted by it: receipt of vitamin A by children under 5 was increased by 42 per cent and receipt of antenatal care by pregnant women increased by 36 per cent.

The report also finds evidence of improved management of government health centres particularly in the availability of 24-hour service, the actual presence of staff scheduled to be there, supervisory visits, and the presence of supplies and equipment. The programme led individuals to reduce visits to untrained service providers such as drug sellers and traditional healers. The authors conclude that overall, the contracting project was very effective in improving service delivery in the project area.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=24336&type=Document>

#### **45. Buying results: contracting for health service delivery in developing countries**

**Authors:** B. Loevinsohn; A. Harding

**Publisher:** The Lancet, 2005

This article, published in the Lancet, examines the effectiveness of contracting out health care delivery to non-state entities including NGOs, universities, and for-profit companies in developing countries. It discusses the potential benefits and anticipated difficulties of contracting, and examines the extent to which these have occurred during implementation. Using data from ten developing countries the paper finds that contracting for delivery of

primary care and nutrition services can be very effective and that improvements can be achieved rapidly. Contractors provided greater quality care and achieved better coverage than the government even in poor and remote areas.

The paper concludes that under real world conditions and at a large scale, contracting has achieved impressive and rapid results. The authors recommend that future efforts at contracting should continue to include rigorous evaluations to better determine its effectiveness, obtain robust estimates of the effect size, and test it under various conditions. Such operational research should also address remaining issues such as the effects of contracting on equity, the usefulness of performance-based bonuses, its cost-effectiveness compared with grants to NGOs, and different approaches to establishing the price of contracts. [adapted from author]

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Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=24335&type=Document>

#### **46. The case for abolition of user fees for primary health services**

**Authors:** M. Pearson

**Publisher:** Department for International Development Health Systems Resource Centre , 2004

This issues paper, published by the DFID Health Systems Resource Centre (HSRC), was one of several feeding into Department for International Development (DFID) policy discussions in mid-2004. It examines evidence on the impacts of user fees for primary health care, evaluates the cost implications of abolishing user fees, and considers what line donors should take on the issue. The paper argues that the case for abolishing user fees is strong: they raise little money, rarely meet their stated efficiency and equity goals. They are often associated with reduced use of services, especially by the poor and vulnerable; failure to complete treatment; and delays in seeking treatment. However, the paper also claims that there are some circumstances in which user fees can improve access.

The paper recommends that removing fees needs to be accompanied by a range of actions including increased and well directed funding if it is to lead to sustained improvements in access for the poor. It also suggests that user fees may be a relatively minor issue in terms of the whole poverty reduction agenda, and that it may be more useful for DFID to push a broader line, such as making essential services more affordable for poor people. Other recommendations for donors include considering tactical as well as technical issues in deciding what approach to take.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=19925&type=Document>

#### **47. Removing user fees for primary care in Africa: the need for careful action**

**Authors:** L. Gilson; D. McIntyre  
**Publisher:** British Medical Journal , 2005

This paper, published in the British Medical Journal, argues that African countries should move away from user fees for health, and outlines what actions should accompany their removal, drawing on experiences from South Africa, Zambia and Uganda. It argues that user fees are the most regressive form of health financing available and contribute to the unaffordable cost burdens imposed on poor households. Although fees for primary care are relatively low, they can encourage inappropriate self treatment, use of partial drug doses, or act as a barrier to early use of health facilities. They can also contribute to the impoverishment of vulnerable households.

The paper argues that funding must be increased before removing fees. Fee removal is likely to result in substantial and sustained increases in utilisation, which could easily lead to drug shortages, staff difficulties, and falling quality of care. The authors recommend increasing health funding from general taxation, and suggest that this would be made easier if African countries' debts were cancelled. Practical strategies include: giving a specific government unit responsibility for coordinating fee removal and other actions needed to strengthen the health system; establishing new funds at the local level; public information campaigns; and better planning for drug and staff availability.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=20600&type=Document>

#### **48. Understanding the impact of eliminating user fees: utilization and catastrophic health expenditures in Uganda**

**Authors:** K. Xu; D.B. Evans; P. Kadama  
**Publisher:** Social Science and Medicine, 2006

This paper explores whether the abolition of user fees in Uganda in March 2001 has led to greater access health facilities for poor people and has reduced the risks of catastrophic health expenditures. Using data from National Household Surveys undertaken in 1997, 2000 and 2003, the paper finds that utilisation of first level government health facilities among the poor increased much more rapidly after the abolition of fees. Unexpectedly, the incidence of catastrophic health expenditure among the poor did not fall. This is likely to be because the frequent unavailability of drugs at government facilities after 2001 forced patients to purchase from private pharmacies.

The paper concludes that the abolition of user fees at public facilities made these services more accessible for both poor and non-poor households, although for the non-poor there is no evidence that the abolition of fees increased demand for services. The elimination of fees can have unintended consequences, particularly where fees were used to replenish pharmaceutical stocks, provide financial incentives for staff, or to upgrade infrastructure. The paper recommends that countries thinking of removing user charges should first examine what types of activities and inputs at the facility level are funded from the revenue collected by fees, and then develop mechanisms to ensure that these activities can be sustained subsequently.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=33699&type=Document>

#### **49. Lessons offered by Latin American cash transfer programmes**

**Authors:** G. Ningenda; L.M. Gónzales-Robledo

**Publisher:** Department for International Development Health Systems Resource Centre , 2005

This paper, published by the DFID Health Systems Resource Centre, discusses and compares cash transfer programmes intended to tackle poverty in Mexico, Nicaragua, Zambia and Malawi. The paper argues that transferring cash to families has many advantages: it is simple to administer and gives the families freedom to decide how to spend the money. However, in both Mexico and Nicaragua, targeting required a sophisticated set of data, and targeting the extreme poor remained difficult because the programme excluded families which were not close to both a school and a health centre. Sustainability is also an issue: the African programmes relied on support from donors, which may be less reliable than funding the programmes domestically.

The paper argues that there is not enough evidence from the Latin American programmes to determine whether conditions such as attendance at schools or health centres should be included in cash transfer programmes. It also notes that imposing such conditions increases demand for the services; the Nicaraguan programme coped with this by contracting non-government organisations to provide them. Key recommendations include incorporating the creation of job opportunities in the programmes as they are developed on a larger scale; and making provisions for evaluation of the programmes.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=19929&type=Document>

#### **50. The Malawi Social Action Fund experience in scaling up local activities for the poor using civil society organisations**

**Authors:** C. Kamwendo

**Publisher:** Department for International Development Health Systems Resource Centre , 2005

This paper from the DFID Health Systems Resource Centre discusses the experience of the Malawi Social Action Fund (MASAF) in delivering interventions that target the poor. It argues that MASAF has been successful not only in providing safety nets for the poor, but also in enabling communities to take charge of their own development. MASAF interventions are also reported to be cost-effective in comparison with other community development models. The author highlights a number of features as key to the success of this model, including: a decentralised and participatory approach, the sub-management of projects by civil society organisations, and direct management of financial resources by communities.

Further lessons learned highlight the importance of: support and public endorsement from political leaders, an enabling policy environment, strong accountability and transparency mechanisms, and a significant measure of autonomy for communities. This means that operating principles must be shared and valued by all that have a stake in project implementation. In addition, the authors emphasise the importance of drawing on existing cultural values and indigenous institutional strengths to ensure that participation is legitimised and guaranteed. [adapted from authors]

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=19920&type=Document>

## **51. Study of faith based organizations responses to orphans and vulnerable children**

**Authors:** G. Foster

**Publisher:** Synergy Project, USAID, 2004

This study reveals how faith based organisations (FBOs) are supporting orphans and vulnerable children. The study took place in six countries: Kenya, Malawi, Mozambique, Namibia, Swaziland and Uganda.

Main findings of the study include:

- FBOs, which are present in affected communities, tend to be better placed than external agencies to provide appropriate support and deal with complex social issues of children affected by AIDS
- the level of community participation is high, which increases potential for sustainability and longevity of these projects
- FBOs support children irrespective of faith
- the overall organisational capacity of local FBOs in terms of governance and financial accountability was on a par with many larger NGOs
- most FBO initiatives receive little or no external technical or financial support and of necessity rely on their own skills and material resources

The study recommends that donors should support the operation of small grants funds through Religious Coordinating Bodies to support activities initiated by congregations.[Adapted from author]

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=14774&type=Document>

## **52. Civil society contributions to pro-poor health equity policies**

**Authors:** R. Loewensen

**Publisher:** Training and Research Support Centre , 2003

This paper, published by the World Health Organization's Training Research and Support Centre (TARSC), examines the role of civil society organisations (CSOs) in improving the responsiveness of health services, and in advocating and developing pro-poor policies that enhance health equity. Many studies have argued that CSO interventions support the health needs of poor people and reach population groups poorly served by the state, such as indigenous populations, poor rural and urban communities, those in informal settlements, and women. However, some have described CSO services whose coverage of poor communities was patchy, and which failed to offer better access to the poor than state services.

CSO contributions range from specifically providing or enhancing use of services in low-income communities, to increasing pressure and political momentum for wider pro-poor policies. The paper notes the need for more research into how CSO action organises the experience of poor people, facilitates service outreach, strengthens the voice and agency of

poor people, and engages with the political and economic interests that influence health outcomes in poor communities. It concludes by noting the importance of research which is participatory and linked to action, as a way of ensuring stronger links between research and health equity outcomes.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=19880&type=Document>

### **53. When staff is underpaid: dealing with the individual coping strategies of health personnel**

**Authors:** W. Van Lerberghe; C. Conceição; W. Van Damme; P. Ferrinho

**Publisher:** Bulletin of the World Health Organization : the International Journal of Public Health, 2002

Health sector workers respond to inadequate salaries and working conditions by developing various individual “coping strategies”—some, but not all, of which are of a predatory nature. This paper in the World Health Organization (WHO) Bulletin, reviews what is known about these practices and their potential consequences (competition for time, brain drain and conflicts of interest). By and large, governments have rarely been proactive in dealing with such problems, mainly because of their reluctance to address the issue openly. The effectiveness of many of these piecemeal reactions, particularly attempts to prohibit personnel from developing individual coping strategies, has been disappointing.

The paper argues that a more proactive approach is required. Governments will need to recognise the dimension of the phenomenon and systematically assess the consequences of policy initiatives on the situation and behaviour of the individuals that make up their workforce. One way to increase pressure would be to include a formal “human resources impact assessment” as a condition for the approval of health projects or components of sectorwide approaches. [adapted from author]

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=11591&type=Document>

### **54. Pay and non-pay incentives, performance and motivation**

**Authors:** V. Hicks; O. Adams

**Publisher:** Prince Leopold Institute of Tropical Medicine, Antwerp, 2003

This chapter in the book ‘Towards a Global Health Workforce Strategy’ provides an overview of the current evidence on the effect of pay and non-pay incentives on health workers’ performance and motivation. The review is organised into three sections: the first presents the range of both pay and non-pay incentives; the second presents a review of evidence about the impact that incentives have on provider behaviour; the third section outlines some of the key factors in making incentives more effective.

The paper shows that non-financial incentives play a role in retaining sufficient numbers of personnel and the right mix of skills in the health workforce. It argues that to incentives more effective it is important to extend the scope of research and evaluation to include a range of

professions including nurses, primary health care workers and managers of health facilities. The paper concludes that human resources for health must be seen as an interrelated system involving staff with a complex mix of skills and motivations. The effects of incentives aimed at one group of professionals will reverberate through the entire system. Policy makers need to know if specific incentives will reinforce health system goals or upset a delicate balance between workers.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=33698&type=Document>

## 55. Which health policies are pro-poor

**Authors:** DFID HSRC

**Publisher:** Department for International Development Health Systems Resource Centre , 1999

How can health policies and health system developments improve the health of poor people? This initial working paper for the UK Department for International Development (DFID) by the DFID Health Systems Resource Centre (HSRC) is their first output on pro-poor health policies. It looks at the options for health policies and health system development to improve the health of poor people, and attempts to clarify issues and set out an agenda for further work.

Poverty can be defined in a number of ways, however it is important to know the characteristics of the poor and vulnerable at a country level. The paper begins by considering definitions of 'poor' and discussing approaches to measuring poverty, followed by what studies have shown about the health of the poor and their use of and need for health services. This information forms the basis for designing interventions and monitoring their impact. Three strategies for pro-poor health policy are discussed: ensuring the poor are covered by public health services; improving access to and quality of health services used by the poor; and avoiding heavy expenditures by the poor on health care which exacerbates their poverty. Resource allocation and Sector Wide Approaches (SWAs) are also considered.

Rather than improving equity as a goal, pro-poor health policies are those that ensure the following:

- Public health services actually reach the poor. Both geographical targeting and targeting by disease are found to be the best methods.
- Access and quality of personal health services is improved. Options to be considered include: the identification of a basic package which focuses on providing key interventions; management and organisational reforms in the public sector; regulating and improving performance of the private health sector.
- Heavy expenditure on health care by the poor is avoided. Possibilities include exemptions or waivers of user fees targeted at specific groups for services used by the poor, health insurance such as social insurance and community health insurance and local solidarity schemes.
- Resources are adequately allocated. In many countries basic services and primary health care are not receiving an adequate proportion of the health budget, and difficulties exist in getting staff to move to less favoured regions and services.

The paper concludes by suggesting that further work needs to be performed on the following issues:

- Encouraging the poor in accessing appropriate healthcare. The poor need to be included and participate in the policy process in order that appropriate healthcare systems are developed.
- Trying to do too much with too little. Ministries of Health need to work with the resources they've got in producing an affordable and effective range of services.
- Reorienting health systems towards provision of primary health care.
- Improving public sector performance. Factors to consider include organisational structure and management, resource allocation, human resources, monitoring and supervision roles, and drugs. Similarly, private sector performance needs improving.
- Financing health systems. Private expenditure, which accounts for the majority of health expenditure in most developing countries, is an inequitable means of financing.
- Increasing knowledge about what causes ill health in the poor. More evidence and research is required.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=28435&type=Document>

## 56. Health financing: designing and implementing pro-poor policies

**Authors:** S. Bennett; L. Gilson

**Publisher:** Department for International Development Health Systems Resource Centre , 2001

How should health care be financed in developing countries, and how does the system of financing impact health care for the poor? This issues paper, written for the UK Department for International Development (DFID) by the DFID Health Systems Resource Centre (DFID HSRC) summarises what is known about the effects of the main health care financing systems, and how they can be designed and implemented to be 'pro-poor'.

Health care systems in the developing world are often paid for using various combinations of five major financing mechanisms. How these mechanisms work is described, followed by an evaluation of the impact of each on the poor. Issues relating to the design and implementation of any financing mechanism have a critical impact on what happens in practice. These are highlighted, followed by the key lessons learnt.

The impact of the principal health care financing mechanisms on the poor are summarised as follows:

- **Tax-based financing:** service delivery is often inequitable, biased towards urban areas and hospitals rather than the rural poor; reliance on indirect taxation raises questions of equity; limited tax base provides low level of funding.
- **Social insurance financing:** often only people in formal sector employment covered; redirects money away from the poor; even with universal coverage inequitable access remains a problem.
- **Private health insurance:** those able to afford often benefit from capturing government subsidies, such as private insurers dumping expensive cases on the public system; regulations to encourage the redirection of resources towards the poor cannot be ensured.

- **User fees:** often results in less people using the service, especially amongst the poor; design and implementation has been poor; requires reallocation of resources from rich to poor areas; there is no incentive to exempt the poor from payment.
- **Community-based health insurance:** offers considerable benefits to poor where operated successfully, however very poor require special arrangements to allow access; geographical inequities require redistribution.

Design and implementation issues, and key lessons learnt include the following:

- The implications of the methods of financing for poor people's health care need to be considered during the design stage.
- Capacity for pro-poor schemes needs to be developed including: broader consultations with the poor; consensus built through public debate; technical skills developed and technicians given influence in policy design; management information systems developed.
- Reforming existing organisational mechanisms is often the best way to improve quality of service for the poor. Community-based health insurance is probably more pro-poor than user fees, whilst for social health insurance to be considered pro-poor requires the poor to be covered or guarantees made that rates for the uninsured will not rise.
- User fees and community-based health insurance require exemption mechanisms for the very poor, few mechanisms established to date have been effective.
- Key lessons include: pro-poor assessment should be carried out on the mix of mechanisms used; the very poor are unable to make financial contributions, health care should be provided; private insurance should rarely be encouraged.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=10892&type=Document>

## **57. Designing Health & Population Programs to Reach the Poor**

**Authors:** L. S. Ashford; D. R. Gwatkin; A. S. Yazbeck

**Publisher:** Population Reference Bureau , 2006

This report, by the Population Reference Bureau, analyses programmes and interventions aimed at promoting greater access to quality health care services for poor people. It notes that poor people are more likely to suffer from health problems and less likely to use health services than more well off people. Lack of information, lack of empowerment, inaccessible services, unresponsive service providers and prohibitive costs are all barriers to quality health care for the poor. The report highlights some approaches that benefit poor people including: promoting universal coverage of basic health care; creating incentives for health providers and clients and increasing community participation.

Case studies and lessons from the World Bank's 'Reaching the Poor' programmes are presented including examples from Brazil, Cambodia, Tanzania, India and Nepal. The paper concludes that it is possible to achieve better performance in reaching the poor, but there is not any one programme type or model that is more effective than others. There is also no guarantee that an approach that works in one setting will work elsewhere, thus it is necessary to experiment and adapt programmes to best suit each individual context.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=24175&type=Document>

## **58. Poverty and user fees for public health care in low-income countries: lessons from Uganda and Cambodia**

**Authors:** B. Meessen; W. Van Damme; C. K. Tashobya; A. Tibouti

**Publisher:** The Lancet, 2006

This Lancet article examines two countries efforts towards making access to health care 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 health-care 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.

The article highlights key questions for a health-financing policy that is favourable to poor people. These relate to barriers to health care; targeting; the benefit package, resources and incentives; and process of the reform. The article concludes that unfair public health systems are not inevitable, since there are solutions. The comparison between the two countries confirms that the context in which the policy operates matters. Before formulating a policy, it is necessary to have an in-depth understanding of the local needs, constraints, and opportunities.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=33775&type=Document>

## **59. Challenging inequity through health systems: final report of the Knowledge Network on Health Systems**

**Authors:** L. Gilson; J. Doherty; R. Loewenson

**Publisher:** Commission on Social Determinants of Health, WHO, 2007

The final report of the World Health Organisation's (WHO) Health Systems Knowledge Network looks at how inequity can be addressed through health systems. Key recommendations, primarily aimed at Ministers of Health, government officials and civil society organizations, include the importance of: mobilising intersectoral relationships; facilitating social empowerment; building up universal health coverage, and; strengthening processes of developing and implementing policies. The report also stresses that international actors must support national led health system transformation and action.

The WHO Commission on the Social Determinants of Health concludes that both technical analysis and political commitment are needed to strengthen health systems and address health inequity. Technical analysis can help identify which features of health systems to nurture and protect. Political action and commitment is needed to confront the powerful actors, institutional constraints and socio-cultural norms that act as brakes on health system development for health equity [adapted from author].

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=32922&type=Document>

## **60. Institutional issues in scaling up programmes for meeting the health-related needs of the very poor**

**Authors:** E. Kirk; H. Standing

**Publisher:** Department for International Development Health Systems Resource Centre , 2005

This paper from the DFID Health Systems Resource Centre reviews current strategies for scaling up successful interventions to meet the health-related needs of the poorest in developing countries. Findings show that all mechanisms for targeting the poorest suffer from elements of leakage, as well as weak institutional and governance structures. However, these problems are outweighed by the distributive benefits of some schemes. Demand-driven financing (involving the provision of resources to supply services for a distinct group) also has potential for reaching the poorest. However, parallel interventions on the supply side are needed to ensure quality is raised in addition to coverage.

The authors identify several institutional obstacles to scaling-up small-scale interventions. These include prohibitive or unsustainable costs, problems with scaling up targeting mechanisms (which often rely on local knowledge to target the poor effectively), and the risks of capture of decentralised resources by local elites. Effective collaboration between local constituencies and local governments or agencies is also harder to replicate on a regional or national scale. Key principles for successful scaling-up are identified as: a gradualist approach, a serious commitment to shifting power to the local level, a focus on ease of replication, and working within existing structures. [adapted from author]

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=19919&type=Document>

## **61. Poverty reduction budget support**

**Publisher:** Department for International Development, UK, 2004

The objective of this paper is to summarise DFID's policy on the provision of Poverty Reduction Budget Support (PRBS). It aims to increase consistency in the implementation of poverty reduction budget support in DFID country programmes; and outline some of the benefits and risks associated with the provision of poverty reduction budget support, based on initial experience. DFID believes that PRBS is the aid instrument most likely to support a relationship between donor and developing country partners, which will help to build the accountability and capability of the state.

However, experience of PRBS is still at an early stage. Preliminary comparison of actual outcomes of PRBS with its anticipated benefits and risks suggests that some of the benefits are medium term, rather than immediate. Few of the expected benefits (local ownership, alignment, and harmonisation) are automatic. Complementary measures, such as appropriate technical assistance and policy dialogue, are needed. The paper concludes that DFID will continue to work with its development partners – both developing countries and other donors

– to assess the effectiveness of this instrument and to review practices in the light of what is learnt.

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=18049&type=Document>

## **62. AID instruments and the very poor: the case of global health partnerships**

**Authors:** H. Wells

**Publisher:** Department for International Development Health Systems Resource Centre , 2005

This paper, produced by the DFID Systems Health Resource Centre, reviews the literature on Global Health Partnerships (GHPs) and their impact on the health needs of the very poor. The paper explores ways in which and to what extent GHPs currently target the very poor and asks what future role GHPs should play in this respect. The author notes that GHPs are self-targeted to the extent that they focus on diseases that are mainly faced by the poor, or on services that the poor stand to benefit from. In addition, GHPs have achieved some success at a global level, particularly in generating additional funds, allocating resources and reducing commodity prices.

However, the author highlights several areas of concern, including differences in the profile of the poor at country level, which may mean these most vulnerable groups are not reached through GHPs. Local variations may also mean that global level principles or actions, such as commodity price negotiations, are irrelevant, undermined or even reversed by a range of situations in country. Also, the focus of GHPs on particular diseases may result in the neglect of other priorities. To enable a more accurate assessment of impact on the poor, the author calls for more sensitive systems for the monitoring and evaluation of GHPs than coverage figures alone. [adapted from authors]

Available online at: <http://www.eldis.org/go/topics/resource-guides/health-systems&id=19922&type=Document>