Health financing reforms are a core part of health sector development in low and middle income countries. The current focus of the international debate is on the need to move away from excessive reliance on out-of-pocket payment towards a system which incorporates a greater element of risk pooling (for example through health insurance) and thus affords a greater protection for the poor.

This paper 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'.

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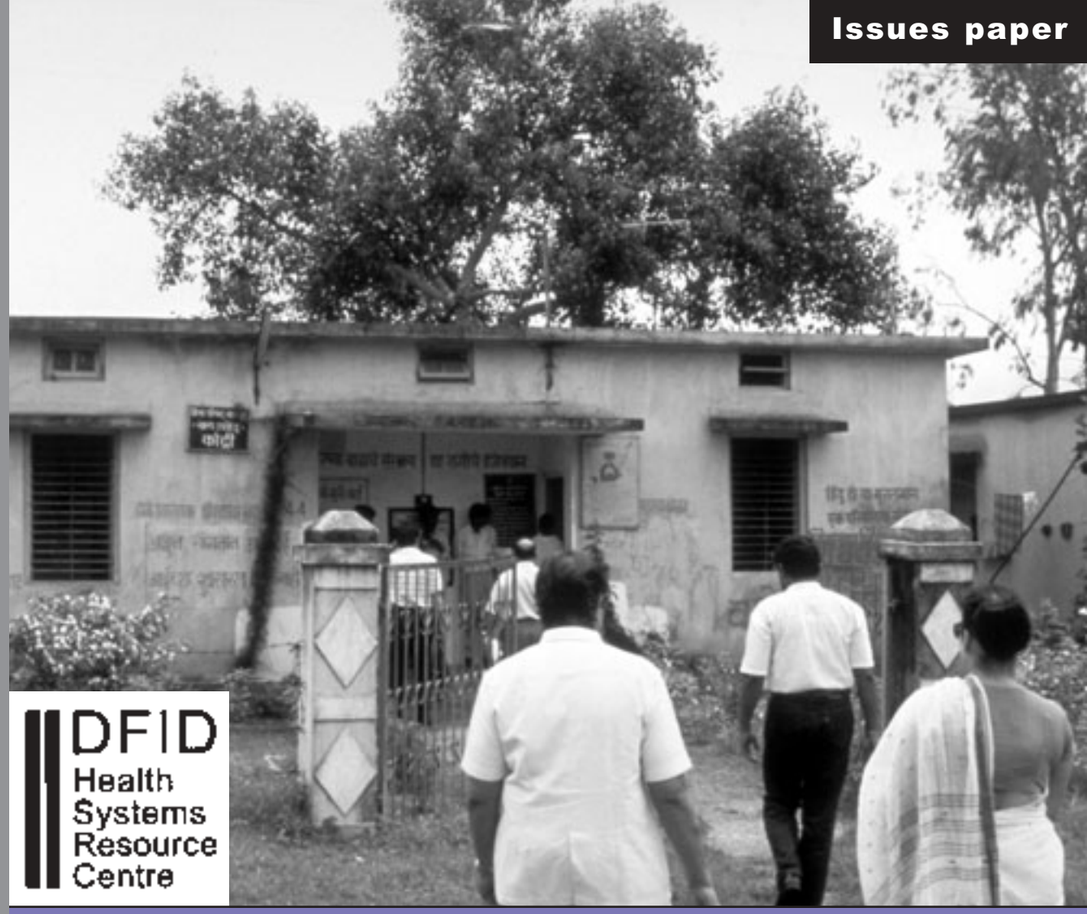

Health financing: designing and implementing pro-poor policies

Sara Bennett
Lucy Gilson

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Contents

1 Introduction

Health financing reforms are a core part of health sector development in low and middle income countries. The current focus of the international debate is on the need to move away from excessive reliance on out-of-pocket payment as a source of health financing towards a system which incorporates a greater element of risk pooling (for example, through health insurance) and thus affords greater protection for the poor. This is a central premise of the WHO World Health Report 2000 *Health Systems: Improving Performance* and features strongly in the World Bank's Health, Nutrition and Population Strategy document and in the poverty reduction strategies being developed in low and middle income countries.

The existing mix of financing mechanisms and sources used in the health sector varies greatly both between and within regions. The overall context of policy change also differs significantly. In view of this it is not surprising that the directions which financing reforms are taking are also varied (see Table 1). In some regions, such as much of Sub-Saharan Africa, the main objective of health financing reform has been to raise more, or more stable, revenues for health care. Equity is largely a secondary objective. Elsewhere, such as in many Latin American countries, there is more focus on addressing fragmented and inequitable financing approaches.

Table 1: Major trends in health care financing

Trend	Objectives	Countries reforming in this way
Introduce or increase user fees in tax based systems	■ Raise more revenues ■ Encourage more efficient use of resources ■ Create greater accountability to the consumer	Many countries in Sub-Saharan Africa
Introduce community-based health insurance in systems currently based on user fees and tax revenues	■ Reduce financial barriers created by user fees ■ Encourage more efficient use of resources ■ Raise more revenues	Large scale initiatives in Thailand and Indonesia; numerous small scale efforts in many other countries e.g. Zambia, Tanzania, Uganda, India
Shift from tax based to social health insurance type systems	■ Create independent, sustainable source of health finance ■ Raise more revenues	Thailand, many countries in the Former Soviet Union and Eastern Europe; proposed but not implemented elsewhere, e.g. Nigeria, Zimbabwe, Ghana
Consolidate multiple state insurance funds	■ Increase equity and prevent tiering and fragmentation ■ Increase administrative efficiency	Mexico, Colombia and other countries in Latin America.

This paper summarises what is known about the effects of various systems of health care financing upon the poor, and in particular how systems can be designed and implemented so as to be 'pro-poor'.

What does it mean for a health financing system to be pro-poor? The most important dimensions are that the system should:

- ensure that contributions to the costs of health care are in proportion to different households, **ability to pay**
- protect the poor (and the nearly poor) from the **financial shocks** associated with severe illness
- enhance the **accessibility** of services to the poor (particularly with respect to perceived quality and geographic access).

This paper focuses upon how funds for health care are raised. Resource allocation, critical to ensuring that financing policies overall are pro-poor, is covered in '*Allocating public resources for health*', (HSRC 2001). Furthermore, ensuring adequate pro-poor financing does not, in itself, ensure that appropriate services are delivered. Good financing policies must be supplemented by good policies on the organisation and delivery of health care.

Financing and provision aspects of health care are frequently closely linked. In particular enhancing access by improving (perceived) quality of care is closely linked to the question of how to create a pro-poor financing system. Although there are no user fees in a wholly tax funded system to create barriers to accessing care, there are frequently other barriers to accessibility.

- If the perceived quality of care is very low, even the poor may prefer to pay more to use higher quality private sector services.
- There may be significant time and transport costs associated with accessing care, particularly for the poor.
- Even in a system where there are no formal charges, informal charges for care may be widely prevalent.

Tackling these problems is important to ensure that the mix of financing mechanisms in any country promotes re-distribution between the rich and the poor, a central element of pro-poor financing policies.

But who are the poor? In many low income countries, the majority of the population is formally classified as poor. It is important to distinguish between the majority poor and the minority very poor in developing pro-poor policies in countries where this is the case. For example, a user fee system which succeeds in improving quality of care, may benefit the majority poor who can afford to pay the newly introduced fees. But for the

minority very poor, fees may only create another barrier to access or represent an additional burden at times of health crisis.

This paper does not address how to identify the poor (or the very poor) as this is covered elsewhere (*Which health policies are pro-poor?* HSRC 1998). Specific definitions of poverty need to be set at the national level and different measurement techniques will be needed in different situations. It is important to consider whether absolute concepts of poverty (e.g. the population living on less than $1 per day) or relative concepts (e.g. less than 50 per cent median income) are to be used, as 'pro-poor' and 'equity' are not necessarily the same thing. A system can be very inequitable yet still provide a reasonable package of services for the poor. This paper focuses on how to make existing systems more pro-poor. The judgement as to whether basic needs are already being met and whether systems actually need to be made more pro-poor has to be determined at country level.

For both the poor and the very poor, the most important cost burden that results from illness comes from the loss of labour associated with severe illnesses and injuries. Although some financing mechanisms may mitigate the costs of care associated with such health problems, they do not address the consequences of ill health whether through loss of income or loss of services provided by unpaid family members. Pro-poor health care financing mechanisms can only play a limited role in tackling the resource constraints that fundamentally shape the health-seeking behaviour of poorer households and thus their ability to capture the benefits of health care.

2 The principal financing mechanisms

The principal financing mechanisms are defined in Box 1. In general, health care systems, and particularly those in the developing world, depend on a mix of financing mechanisms rather than on only one. For example user fee systems are commonly implemented in the context of existing tax-funded systems. Community-based health insurance schemes are frequently initiated in settings where there are already substantial user fees.

The degree to which the financing system as a whole is pro-poor, depends crucially on how the different financing mechanisms interact. For example if a social health insurance system for those people employed in the formal sector co-exists with a tax-funded system for those outside of formal sector employment, then the equity effects depend largely on how well funded the tax-based system is and whether it can deliver a similar package of benefits to the social health insurance system.

It is quite common for different segments of the population to be covered by different types of financing mechanism. This was particularly the case in many Latin American countries, although the situation in this region is now changing. It was common for formal sector employees to be covered by social health insurance schemes, whereas health care services for persons outside the formal sector were generally more limited and/or of a lower quality and were paid for by tax-based financing. This situation is commonly referred to as ‘tiering’ within the health system.

The desirability of alternative financing mechanisms clearly depends upon a number of factors including administrative efficiency, ability to generate revenues and acceptability to the population. The discussion here does not attempt to cover these issues but focuses upon the equity effects of alternative financing mechanisms and only touches upon factors such as administrative efficiency and revenue raising ability where they relate to concerns about the poor.

Box 1: Principal financing mechanisms

Tax-based financing: health services are paid for out of general government revenue such as income tax, corporate tax, value added tax, import duties etc. There may be special earmarked taxes (e.g. cigarette taxes) for health care.

Social insurance financing: health services are paid for through contributions to a health fund. The most common basis for contributions is the payroll, with both employer and employee commonly paying a percentage of salary. The health fund is usually independent of government but works within a tight framework of regulations. Premiums are linked to the average cost of treatment for the group as a whole, not to the expected cost of care for the individual. Hence there are explicit cross-subsidies from the healthy to the less healthy. In general, membership of social health insurance schemes is mandatory, although for certain groups (such as the self-employed) it might be voluntary.

Private insurance: people pay premiums related to the expected cost of providing services to them. Thus people who are in high health risk groups pay more, and those at low risk pay less. Cross-subsidy between people with different risks of ill health is limited. Membership of a private insurance scheme is usually voluntary. The insurance fund is held by a private (frequently for-profit) company.

User fees: patients pay directly, according to a set tariff, for the health care services they use. There is no insurance element or mutual support. This is the most common way of paying for privately provided services in developing countries, and is also used as a component of financing for public sector services.

Community-based health insurance: as for social health insurance, premiums are commonly set according to the risk faced by the average member of the community i.e. there is no distinction in premiums between high and low risk groups. However, unlike social health insurance schemes enrolment is generally voluntary and not linked to employment status. Funds are held by a private non-profit entity.

3 Financing mechanisms and the poor: arguments and evidence

In any country, all mechanisms which make up the system of financing, and their interactions, should be examined by assessing the extent to which health care financing is 'pro-poor'. However, the many permutations and combinations of systems do not allow us to do this in a generic manner and so we simply consider each mechanism in turn.

Sometimes financing mechanisms are seen as being intrinsically pro-poor or anti-poor, but there is frequently a gap between theory and reality. The context and manner in which a financing mechanism is implemented may lead it to have effects quite different from those predicted on a priori basis. This section considers the arguments used for and against different financing mechanisms, and summarises empirical evidence from actual implementation.

3.1 Tax-based financing

Arguments

Tax-based financing is the predominant form of health care financing in most of Sub-Saharan Africa and South Asia. It was formerly the means for funding services in the Soviet Union and much of Eastern Europe. There are strong arguments for why tax-based financing is pro-poor.

- In mature economies, tax-based systems tend to be progressive (i.e. households with higher incomes tend to pay a higher proportion of their income in tax).
- The poor are at least protected from financial shocks associated with large health care costs.
- Pure tax-based financing does not involve user charges at point of payment and therefore financial accessibility may be high.

These arguments have been challenged, particularly in the context of low and middle income countries on these grounds.

- While there may be no fees at point of use, often the services provided by tax-funded systems are biased towards urban services and hospital services. Transport costs and time costs in accessing these services may prevent them being truly accessible to the poor.

- Countries with small formal sectors tend to rely much more on indirect taxes (such as sales tax and value added tax) rather than direct taxes (such as income or corporate tax). Indirect taxes are less progressive than direct taxes, and may even be regressive.

One of the key concerns about tax-based financing is the low level of funding which may be available from this source. Tax-based financing is constrained by limited tax bases in many developing and transitional economies and by the fact that frequently a relatively small share of the total government budget is allocated to health care. Strengthening planning, budgeting and monitoring systems so that ministries of health can better demonstrate how funds are effectively used may help to increase government allocations to health. Donors and international financial institutions may also play a role by linking increased social sector investment to debt reduction and loan disbursements.

Evidence

Studies based upon household data suggest that inequitable access to publicly financed health care is indeed a substantial problem. Because public primary care services are generally perceived to be of poor quality and the private costs (transport and time costs) of accessing public hospitals are high for the poor (see Box 2), the poor often prefer to use the services of private doctors. Yet the rich continue to use public hospital care, especially where there are few alternatives. The result is that the poor may use publicly funded services (particularly hospital services) less than the rich.

Recent work by Wagstaff suggests that in general, tax revenue financing of health care in developing countries is at least mildly progressive, and financing from direct taxes (such as income taxes) is more progressive than other financing mechanisms (Wagstaff 2000). This suggests that higher income people pay a higher percentage of their income in supporting tax funded health care systems. But the evidence on tax incidence is not entirely clear, as the calculation of tax burden and incidence is very complex. The incidence of a tax measures the final tax burden on people of different income levels taking into account both the indirect effects of the tax (such as how income tax affects wage levels) and the direct effects.

Box 2: Barriers to accessing publicly financed health care services in Sri Lanka

'If we go to the general hospital we would go in the morning and expect to come back in the afternoon. I would not be able to work and get my Rs 200. So after work I go to the private doctor or only the pharmacy - this is easy and costs about Rs 100.'

'It is often easier to go to a private place close by than to the Kalubovila (government) hospital…when you consider the time, what you have to spend for the bus. If we feel thirsty, we need to drink something. And if someone is going to Kalubovila two people have to go - while the patient goes to see the doctor another person has to get a place in the medicine queue, so you have to spend for two people.'

Source: Russell 2000

3.2 Social insurance financing

Arguments

In principle, social health insurance is based on mutual support and involves a transfer of resources from relatively richer, healthier people to relatively poorer, sicker people for a package of primary and hospital care. Like tax-based systems, financial accessibility to services should be high, and the incidence of social health insurance premiums should at least be neutral - if not progressive. Consequently, the core values of social health insurance embody a concern for the poor. Insurance also reduces individuals' exposure to risk, and this reduction in uncertainty is of value in itself, particularly for poor people.

However, in implementation, particularly in the context of lower and middle income countries, these values may be subverted. When schemes are initiated they frequently only cover a small proportion of the population who are in formal sector employment. It is important that this part of the population does not benefit at the expense of the poor, yet this may happen in two ways.

- The government may subsidise the social health insurance fund in order to make the new system more palatable to employers and employees. This can be done directly through government contributions or indirectly through the subsidised treatment of members in public facilities. If government resources are limited this may involve withdrawal of some financial support for the basic services provided to the poor.

- The development of a social health insurance fund establishes a significant new purchasing power. If the inputs necessary to provide health care (such as doctors and nurses) are limited, this may attract inputs away from providing services to the poor.

Evidence

When coverage by social health insurance is universal then inequities due to differences in insurance status should not arise and the poor should benefit from the scheme as much as the more affluent. However, there is evidence to suggest that even then there may be differences in access between the poor and the rest of the population. For example, the Korean government successfully expanded its system of social health insurance to the entire population and there was a concurrent expansion in health care facilities and health staff to meet the increased demand. Nonetheless, the poor, the elderly and those who live in rural areas still have lower access to health care, due to the misdistribution of both health staff and facilities which tend to locate in urban centres where there is greater demand and ability to pay.

When only part of the population has coverage, social health insurance is likely to increase the disparities in access between the poor and the rich. The nature of the benefit package to be paid for through the insurance mechanism may introduce differentials in the range of services and quality of care offered to the insured and the uninsured. Most schemes (or proposals for schemes) in low and lower middle income countries depend significantly upon government contributions, and government staff represent a large proportion of beneficiaries. In times of economic expansion (as in Thailand during the early 1990s), it may be possible to launch a social health insurance scheme with government financial support, without adversely affecting services for the poor, but when the economy is stagnant this is unlikely to be feasible. Government resources may be re-directed away from the health care provided to the poor, and health professionals are likely to be attracted towards the better funded service.

3.3 Private health insurance

Arguments

Private insurance is generally confined to a relatively elite and politicised group. There is insufficient ability to pay for private health insurance in most low and middle income countries and consequently even when there is a liberal regulatory environment the private health insurance market tends to be limited. There are some important exceptions to this. In countries such as South Africa and Zimbabwe where there have been gross disparities between income groups, higher income groups have long depended upon private health insurance.

It has been argued that private health insurance is a mechanism through which the demands placed by high income groups on other forms of health care finance

(particularly government and social health insurance finance) can be reduced, thereby freeing more government resources for the poor. However, the strength of this argument depends critically on whether any 'freed' resources are actually used to support health care for the poor as well as upon the regulations governing private health insurance and how it interacts with the rest of the health care system.

- It is important to consider whether or not those purchasing private health insurance are allowed to 'opt out' of the primary financing mechanism or whether they must continue to contribute to the solidarity fund. Allowing the middle class to opt out of the primary financing mechanism may not only damage the potential of this mechanism to subsidise health care for the poor, but may also reduce political pressure to maintain high standards of care under this scheme if they seek their care outside the public sector.

- The tax treatment of private insurance premiums (i.e. whether private insurance premiums are taxable or not) is an important factor. Proponents of private insurance sometimes argue that making private insurance premiums tax exempt will encourage more people to purchase private insurance thus freeing up more government resources for the poor. However exempting premiums from taxes will also direct significant subsidies to those already purchasing insurance.

Evidence

Private health insurance covering groups that are more affluent commonly captures significant government subsidies, even if the government does not explicitly subsidise private health insurance. For example in South Africa, not only has the government given tax-breaks on private health insurance contributions, but the following additional means of capturing government subsidies have been identified:

- expensive cases are 'dumped' on the public system by insurers once their insurance benefits have been exhausted in private hospitals
- insured patients frequently claim to be uninsured and thus escape paying for care in public hospitals
- fees charged by public hospitals to private insurers do not recover the full costs of care
- poor billing systems often fail to charge and recover fees from insured patients.

In Chile it was also found that higher income persons covered by the private insurance entities (ISAPREs), captured a larger than average subsidy from government.

In practice, issues of political economy mean that the regulations governing private insurance cannot ensure that this will be a 'pro-poor' financing mechanism.

3.4 User fees

Arguments

The impact of user fees on the poor has been subject to more argument and discussion than any of the other financing mechanisms discussed here. It has been proposed that introducing or increasing user fees in a tax financed system would be pro-poor for two main reasons.

- Tax-financed systems are skewed towards subsidising urban hospital services at the expense of rural and primary care services. Introducing user fees for select (urban and hospital) services could redirect subsidies to the rural poor.
- Increasing resources available for health care would allow governments to expand or upgrade their network of rural, primary care services, hence improving the accessibility of such services for the poor.

Many counter arguments have emerged, mainly focusing on the feasibility of achieving the benefits outlined above.

- Low household income levels mean that the revenue generating potential of user fees in low income countries is low, limiting the scope to improve the quality and accessibility of rural primary care services.
- It is often not politically feasible to re-allocate government subsidies as desired.
- It is difficult in practice to design price discrimination schemes that protect the poor whilst charging the more affluent.

In addition to these practical arguments, it has been argued that user fees undermine political support for the goal of universal coverage of basic health care services.

Evidence

In virtually all cases where user fees were increased or introduced there has been a concurrent decrease in service utilisation. The magnitude of this drop in utilisation was frequently larger, and the effect of a longer duration, amongst the poor part of the population. Although there is little evidence on the additional burden that fees may place on household resource levels, at a minimum they are likely to act as an additional deterrent to accessing care (especially for the very poor) whilst catastrophic costs could have much greater impact.

While the effects to date of user fees on the poor appear almost universally negative, in virtually all cases this has been a result of poor design, planning and implementation. Increases in user fees have rarely been accompanied by improvements in quality, and very little attention has been paid to the design and implementation of effective exemption mechanisms. Neither those responsible for implementation nor the wider community have had much involvement in the design of systems that most immediately

impact on them. Although well structured systems of user fees can effectively limit demand for non-basic services, this has rarely been the primary purpose of such schemes in developing country contexts.

Experience from a few small scale user fee schemes with heavy technical assistance inputs and evaluation components suggests that if appropriately designed and implemented, user fees may deliver benefits to the poor. There are also some encouraging signs from large scale systems in countries such as Kenya where more attention has been paid to ensuring appropriate planning and implementation.

However, in countries with low average household incomes, it is probably not possible to raise more than 10–20 per cent of service delivery costs through user fees. There also is evidence that wealthier areas can generate more revenue than poorer areas. Allowing local facilities to retain fee revenue can, as a result, introduce differentials in the resources available between geographical areas that could lead to differential health care provision between areas. Revenue retention is important in order to improve quality of care, but it must, therefore, be accompanied by a resource allocation mechanism that re-allocates resources from wealthier to poorer areas. A final and particularly important design problem for a pro-poor fee mechanism is that fee systems generally offer little or no incentive to exempt the poor or very poor from payment as they are primarily associated with raising revenue to support quality improvements.

3.5 Community-based health insurance

Arguments

Community-based health insurance schemes have frequently emerged, or been promoted, in contexts where there is high user financing of health care. They aim to mitigate some of the worst equity effects of user charges by spreading contributions between the healthy and the sick, and allowing people to spread their contributions over time in a predictable manner, rather than paying only when they fall sick. Such schemes should therefore enhance accessibility of health care for the poor. Furthermore if hospital care is included in the benefit package they will protect the poor against catastrophic health care costs, and if a sliding scale of premiums is implemented, then contributions will reflect ability to pay. Unlike social health insurance schemes, community-based health insurance normally covers those outside of formal sector employment.

Most of the counter arguments arise from the feasibility of ensuring that these pro-poor benefits actually materialise.

Evidence

Community-based health insurance schemes, where they have operated successfully, offer considerable benefits to the majority poor. However the very poor require special

arrangements to enable them to access benefits under the scheme (such as subsidies from government or from higher income scheme members), and few schemes have effectively implemented these arrangements.

There is some evidence of geographical inequities under such schemes, where those living closer to health facilities tend to utilise services more than those living in remote rural areas.

Where community-based health insurance is a dominant source of health care financing (as it was in China during the period of the Cooperative Medical System) then, as with user fees, government needs to play a re-distributive role between schemes to ensure that schemes in poorer areas do not offer poorer benefits. More broadly, a strong government regulatory framework for such schemes (as exists in Thailand for example) helps ensure both their success and their ability to serve poorer households.

In many instances however, community-based health insurance schemes have failed to meet their intended objectives. Poor scheme design, misplaced adaptations to design during implementation and limited understanding of the concept of insurance amongst the target population (and few attempts to inform them) have contributed to poor performance. Such schemes must be developed with sensitivity both to technical concerns and to local contexts and understandings.

4 Designing and implementing pro-poor financing schemes

From the evidence cited above it is apparent that regardless of the theoretical arguments about whether or not a particular financing mechanism is pro-poor or not, what happens in practice depends critically upon the detailed issues concerning the design and implementation of the financing mechanism.

4.1 Integrating a concern for the poor during the design phase

Many financing reforms are not specifically concerned with improving services for the poor, but they nonetheless have implications for the poor. These implications should be forecast during the design stage and plans made for how they will be handled.

For example if introducing a social health insurance scheme for the formal sector, the following questions should be asked:

- What will be the magnitude of government subsidies to the scheme? Can government finance this while maintaining levels of funding for the rest of the population?
- Are there sufficient health care inputs to meet the demand generated by the new scheme without attracting resources away from providing services to the poor? If not what plans are in place to expand the supply of such inputs?
- How and when might it be possible to integrate poorer groups (such as farmers and those on social welfare) into the scheme? It is particularly important that concern for the poor influences the mix of financing mechanisms used to fund health care. The Latin American experience points to the tiering problems that can result from using different financing mechanisms to fund the care provided to different population groups. Current attempts to address this problem emphasise the need to build a coherent financing approach that promotes integration across mechanisms rather than (further) fragmentation.

4.2 Building capacity to develop pro-poor schemes

Financing reforms are frequently undertaken at times of economic crisis when there is a financial imperative to raise more money for the health sector. There may be a rush to implement reforms as a way to ameliorate the situation. This type of hurried implementation will rarely deliver the potential benefits of financing reform and the effects upon the poor are likely to be particularly adverse.

Implementing health care financing reforms that benefit the poor demands building capacity in several dimensions.

- Health sector policy making in developing and transition countries is typically closed, confined to discussions between an elite group of bureaucrats, politicians and external advisers. Granting the poor a voice in the policy making process may help ensure that health financing policies work better for the poor. Although not easy, a first step may be to encourage broader consultation with groups representing and working with the poor, such as non-governmental organisations, religious organisations and other specific interest groups.

- The new policy needs to be clearly communicated to the general public and consensus built about the desirability, rationale and direction of reform. Without such consensus the intended reforms may be blown off track during implementation. Providing information about the policy is critical. For example, with user fees there is evidence that the poor maybe deterred from using health services because of uncertainty about how much they cost and the potential embarrassment of not being able to pay. By encouraging public debate, wider publicity about reforms can also lead to feedback that informs policy development.

- Designing pro-poor financing reforms requires considerable technical skills. For example, the impact on the poor of the total mix of financing mechanisms must be considered as well as the interaction between, say, financing mechanisms and resource re-allocation mechanisms. Such skills must be developed within each country, and it is also important that mechanisms exist to draw technicians into policy-making in appropriate ways. Technicians must neither dominate policy-making nor be ignored by it. Involving implementers in designing policies can also improve the likelihood of their implementation.

- Implementing new forms of health care financing will require new skills for the people working in the health care system. For example under a social health insurance system, accountants and financial managers in public hospitals will need to be able to estimate costs, set prices, and bill the health insurance scheme in a timely manner if public funds are not to cross-subsidise care for the more affluent. Similarly, with the introduction of user fees or community-based health insurance, training in financial skills, amongst others, will be needed for health sector staff.

- All new sources of finance will require new systems, particularly for financial and information management purposes. If such systems are not properly developed then, for example, it will be difficult to monitor the effect of new forms of finance upon the poor, and to ensure that extra revenue is really being used to enhance quality of care or that exemption systems are being effectively implemented.

- Financing reforms should be carefully phased both so as to build upon existing capacity and to ensure proper fit between different elements of the reform. For example, exemptions mechanisms should be in place before introducing charges. If there is a widespread system of informal payments this will need to be addressed prior to introducing a social health insurance scheme, and financial systems need to be developed from the start so that fee revenues or premiums feed directly into improvements in the quality of care. Developing a well thought-out sequence of reform implementation is particularly important for complex reforms such as social health insurance.

4.3 Using financing mechanisms to promote high quality and responsive services for the poor

One of the key ways in which financing reform may improve the access of the poor to health care is through improving the quality of care of publicly funded (and potentially privately funded) services. User fees and community-based health insurance may do this directly by providing more resources for the delivery of services to the poor. Social health insurance and private health insurance may do this indirectly by freeing up government resources previously used by high income households and re-directing these to the poor.

In reality, these benefits in quality improvements for the poor have rarely materialised. What measures need to be taken to ensure that they do?

The promised increase in resources for health services for the poor must actually materialise. User fees and community health insurance are unlikely to raise substantial levels of funding. Without strengthening financial management systems (as described above) resources may anyway leak from the system, sit unused in bank accounts or simply be eroded by inflation. Often, but particularly for social health insurance and private health insurance, the presumed benefits for the poor depend upon a shift in resource use. There needs to be a clear political commitment to making this transfer (and the pattern of resource allocation should be monitored).

Frequently however, it seems that the most promising way in which financing mechanisms may improve the quality of services for the poor is not through raising extra revenues, but through the organisational reforms necessary to implement them. Revenues gained from user fees or community-based health insurance may be a

catalytic factor in the development of community health committees and other local organisations with responsibilities in health care management. Giving such committees a role in fund management may be an effective mechanism to get them directly involved in local health policy decision-making. At the same time, although the evidence is inconclusive, the very fact that clients pay for services might make providers feel more responsive to them.

Community-based health insurance may stand a better chance of bringing about service improvements for the poor than user fees. Pooling funds may allow such schemes to use their purchasing power to negotiate special deals with providers, or certain quality guarantees. This is perhaps particularly the case where the fund is purchasing from private providers. Although community-based health insurance schemes have not always taken advantage of this opportunity some, such as UMASIDA in urban Tanzania, have done so to considerable effect. UMASIDA will only contract with providers who meet certain conditions (such as offering health education services, having access to a qualified medical officer, prescribing by generic name), and provider behaviour is monitored by the scheme to ensure that it is appropriate and meets the requirements of the contract. In rural areas, the choice of providers is likely to be rather more limited.

Whether or not social health insurance schemes manage to improve the quality of care of services accessed by the poor depends considerably on whether or not they cover the poor. However even if not covered, the poor may benefit from some of the organisational reforms associated with such schemes. For example, systems of accrediting providers often accompany social health insurance schemes. Such systems offer incentives for providers to improve quality for both those covered by the health insurance scheme and those not covered. If the uninsured use the same facilities as the insured, many accreditation standards require measures that affect all patients, not just the insured group and they emphasise developing a culture of quality throughout the organisation. Furthermore, dissemination of information on accreditation may provide the poor with important information to guide their health care decision-making. But policy makers need to be very aware of the possible reactions of providers if large institutional purchasers (such as social health insurers) manage to negotiate particularly good rates for their beneficiaries. Rates for uninsured groups, including the poor, may increase as a result in order for providers to maintain their levels of profit or surplus. This has occurred in the US, although there is no evidence from elsewhere.

4.4 Designing and implementing exemption mechanisms

Both user fees and community based health insurance schemes will adversely affect the welfare of the very poor unless there are effective exemption mechanisms in place. Few countries have established effective mechanisms, but there are many important lessons from the mistakes made.

- Ensure that the exemption system is given high priority by politicians and bureaucrats alike: an effective exemption mechanism may be key to the success of the scheme both in terms of the revenues collected and in terms of welfare impacts.
- Prevent establishing incentives not to exempt – perhaps by limiting the amount of revenue that can be retained locally from fees or by identifying specific and different sources of funding for the exemptions, and by giving equal weight to the goal of exemption and to revenue generation in implementation guidance.
- Communicate the exemptions policy to health workers and the general population whilst allowing some flexibility in implementation to enable exemption mechanisms to be adapted in response to local circumstances, but only within limits set by clear central guidance.
- Provide clear central guidelines on eligibility criteria so that they distinguish between the poor and the non-poor, are reasonably easy to implement at the local level; and to monitor performance against these guidelines: how many exemptions are given, to whom, by whom?
- Encourage exemption screening to take place close to the household in the community or local health care facility through mechanisms that involve both community members and health workers and by individuals trained for the task.
- Avoid the capture of exemptions by non-poor groups such as civil servants, otherwise revenues from the scheme will be limited, but recognise that allowing some degree of capture by more wealthy groups, particularly within local communities, may build sustained support for the exemption mechanism.

4.5 Monitoring and evaluating impact on the poor

Only through monitoring and evaluation can the actual effects on the poor be determined. Box 3 suggests some key indicators relevant to health care financing and the poor that can guide baseline and subsequent data collection.

Monitoring and evaluation systems should allow rapid corrective action to be taken when problems are identified. It is important that the factors constraining the implementation of pro-poor policies are investigated through the monitoring process by talking with implementers and the wider public. In this way, monitoring and evaluation systems may be an important component of strategies to strengthen implementation capacity.

Box 3: Potential indicators for monitoring the impact of health financing reform on the poor

Distribution of utilisation and expenditure

- Distribution of utilisation of services and expenditure on health care by socio-economic group (in both private and public services).
- Distributions of providers and facilities e.g. percentage of facilities in rural areas.

Affordability

- Price of specific health services as a percentage of household income.

Exemptions

- Percentage of cases exempted.
- Social and economic characteristics of those receiving exemptions.

Indicators for health systems with an insurance sector

- Insurance coverage levels of disadvantaged groups.
- Economic, social and geographical characteristics of insured and uninsured.
- Extent of cross-subsidy between different insurance funds.
- Utilisation rates by insured and uninsured (if possible controlling characteristics of insured and uninsured such as age and gender).

5 Key lessons

- It does not make sense to assess whether or not a single financing mechanism is pro-poor; such an assessment must be carried out with respect to the complete mix of financing mechanisms and their interaction with resource allocation approaches and organisational contexts.

- The very poor are unable to make any significant financial contribution for health services: governments must secure health care financing for them, and particularly for their use of hospital care, either through direct payment from tax revenues or cross-subsidies in insurance-based systems.

- Government must play an important role in protecting the poor, not only through financing health care services, but also through providing regulatory and policy frameworks for the various forms of financing.

- User fees and community-based health insurance are unlikely to be equitable or sustainable if they are the prime source of health finance. In order to protect the interests of the poor they should be viewed only as a means to 'top-up' other financing systems (such as tax revenues and social health insurance).

- Given the substantial equity dangers of private insurance systems and the difficulty of establishing an effective regulatory framework for this industry, private insurance should rarely be encouraged.

- Although a financing system may in design be pro-poor, it is important to think about whether or not it is feasible to implement this design. In practice political pressures may prevent shifts in resource allocations to the poor, and limited government capacity may hinder the effective implementation of exemption schemes to protect the poor, or may prevent the promised gains in quality of care from actually materialising.

- Poor people's access to health care is often constrained by low quality care, high transport costs, long waiting times and inconvenient opening hours. Financial reforms, which deliver improvements in these dimensions of quality at a moderate price, particularly in relation to hospital care, will probably benefit the poor.

- Exemption mechanisms are inherently difficult to design and implement, but they deserve much greater priority than they have received to-date.

- The effective development and implementation of pro-poor financing policies is never a once-only action, but always the result of a sustained approach that allows adaptation over time in response to experience and changing circumstances. Within such an approach, it is essential that as much attention is given to strategies that build and maintain support for the policies over time, as to technical adaptations of policy design.

- Pro-poor financing mechanisms can only be developed with adequate understanding of the circumstances, needs and potentials of poor people. Mechanisms must be found to gather their views and experiences as one of the foundations for developing and assessing policy.

- The greatest loss that the poor may suffer as a result of illness is the loss of their own labour. Ministries of health need to work closely with ministries of social welfare to develop schemes that mitigate the indirect costs of severe illness.

Further reading

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