

Improving access to health care services for the poorest

The case of health equity funds

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This document is one in a series of four policy briefs on mechanisms to promote access to health services for the poor in low-income countries (abolition of user fees, health equity funds, special health insurance provisions, and targeting of the poor).



Following upon the Bamako Initiative, many countries instituted mechanisms by which health care users pay fees, complementing the funds allocated to the health system by the State and other sources. At the same time, to guarantee access to health care for everyone, recommendations were issued that exempted the poorest from paying for services. However, numerous studies have shown the failure of these exemption strategies: either they are not applied, or they benefit those who are not poor. This failure is explained particularly by the fact that when no compensation is provided, every exempted patient represents a financial loss for health facilities.

Health equity funds first appeared in the early 2000s in Cambodia as a means of improving access to care for the poorest in a context of user fees. The principle is as follows: an independent fund identifies the poorest people and pays the health facilities for the services they provide to them. Many African countries have become interested in the concept since then, but modalities for adapting the approach to African situations remain to be studied. The objective of this paper is to present health equity funds and their results, in order to inform decision-makers who may be interested in implementing them in Africa.

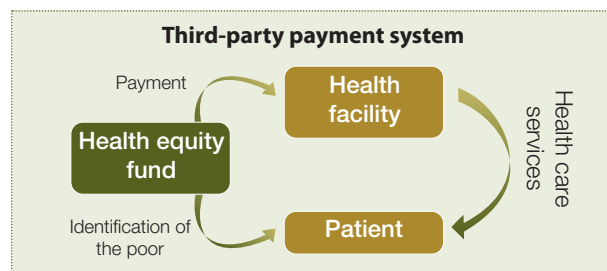
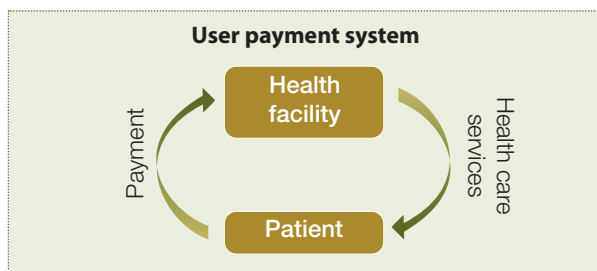
METHODS

This paper is based on a review of the literature (scientific publications and grey literature produced by actors in the field) on health equity funds (HEFs) in Cambodia and elsewhere, as well as on information gathered from key informants and the experience of one of the authors with the development and monitoring of HEFs in Asia and Africa.

HOW EQUITY FUNDS WORK

- Objectives**
- Improve access to health care services for the poorest patients
 - Prevent households from slipping into poverty because of health care costs
 - Contribute to the funding of health facilities

Principle The HEF approach creates a “third-party payer” system that guarantees payment to health facilities for services provided to the poorest patients. Traditionally, health facilities provide services to patients in exchange for payment. However, the poorest are unable to make this payment. The third-party payer principle replaces this system by dividing it into two elements: 1) identification of the patients who need financial assistance and 2) payment to the health facility by a third party (the HEF) for services rendered.





Operator The HEF can be operated by an NGO, a local association, or any other civil society actor independent of the care provider. In some cases, however, the function is carried out by hospital personnel specially assigned to this purpose. Most often, the operator's offices are located directly within the health facility. The operator is in charge of monitoring and assisting patients during their episode of illness, carrying out the administrative management of the HEF, negotiating with the health facility and making payments. He takes part in identifying the poor, or is the primary agent.

Identifying the poor

- Pre-identification occurs before patients need services: at a given point in time, the poorest of all the communities' households are identified. This is usually done based on the knowledge of reliable local actors, validated or not by other actors, using a specific set of criteria and methods. "Health cards" may be distributed which certify that the household may benefit from the HEF in case of illness.
- Post-identification occurs after the illness has occurred, at the health facility (hospital, health centre) when the patient presents for service. In this case, poverty criteria are applied to verify the patient's eligibility.
- The two approaches may be used together.

Services covered The services covered vary from one HEF to another. Good coverage of hospital services is the minimum requirement if health and social protection objectives are to be achieved. The package of services covered could, depending on the case, extend to primary care centre fees or to related costs (transportation, meals, lodging for a nurse).

HEF/ health facility relationship There can be different levels of formality. Ideally, the working arrangements between the HEF and health facilities are spelled out in a contract. The rights and obligations of both parties are specified: services provided, monitoring procedures, size and frequency of payments, etc. Prices can be based on individual interventions, fixed daily rates per patient, or fixed rates per episode of illness. The frequency of reimbursement should be set up in such a way as to not inhibit the health facility's cash flow.

LESSONS FROM THE CAMBODIAN HEALTH EQUITY FUNDS

HEFs appeared in Cambodia in the early 2000s, supported at first by international NGOs. There was always a diversity of models. From the start, these NGOs worked diligently to demonstrate the contribution of health equity funds to the health and social landscape by publishing their results, presenting their operational options at national workshops and carrying on continuous advocacy. Others followed their example and the experiences multiplied. Their persuasive arguments produced a consensus on a national policy, supported by substantial financial commitments from partner agencies. In 2008, the country had 30 hospital HEFs that reported to the Ministry of Health. The broad parameters were established, but without imposing a standardised model. Some are still managed and funded by international NGOs. Others enjoy external institutional funding promoted through Ministry of Health channels.

→ Data on the performance of Cambodian health equity funds

Identification : In the Cambodian experiences, the proportion of persons identified as eligible to benefit from HEFs ranged between 12% and 24% of the total populations of the villages involved. This is much higher than the 3% of patients who were exempted from fees before the creation of HEFs. In addition, a study of six HEFs showed that there were very few targeting errors. The great majority of those selected were "real" poor people: only 6.5% of the beneficiaries belonged to the richest third of the population.

On the other hand, other analyses show that HEF beneficiary status should not be permanent. Four years after an identification process in one HEF, 43% of those who had received an HEF health card were no longer indigent. Conversely, 44% of the people who did not have this card were nevertheless indigent. Because the condition of indigence changes, the identification process must be regularly reviewed. It also appears that pre-identification processes are more effective in selecting the very poor than the poor in general. It seems that the most effective



solution in Cambodia is for pre-identification to be done in the community and post-identification, in the health facility.

Pre-identification appears to be well-accepted by the people. In a study of six HEFs, 80% of those surveyed stated that this way of proceeding was fair. Also, public distribution of health beneficiary cards was apparently not associated with any feeling of stigma.

Utilisation of services : The HEFs have helped to increase the proportion of poor among hospital users. In four hospitals associated with HEFs, in 2003-2004, the poorest made up 7% to 52% of hospitalised patients. Moreover, this did not interfere with the services provided to the other patients who were able to pay. One study showed the importance of external funding for access to services:

In 2003, the HEF was based solely on local funds. Among those benefiting from the HEF were :

- Rate of assisted deliveries = 2.3/1,000 inhabitants/year
- Rate of curative visits = 0.21/person/year

Starting in 2005, the HEF enjoyed external sources of funding (funding agencies) :

- Rate of assisted deliveries = 4.4/1,000 inhabitants/year
- Rate of curative visits = 0.65/person/year

➔ Some possible explanation

Three factors help explain the advantage of HEFs over traditional exemption models:

- The HEF takes into account expectations on both the supply side (need to recover costs) and the demand side (inability to pay). The influx of new patients from the HEF translates into increased revenues for health facilities, thereby helping to balance their budgets.
- The HEF is based on a realistic budget calculated by estimating the health care needs to be covered.
- The principle of third-party payment confers upon the HEF a relative independence from the health facilities. This prevents resources from being squandered, by limiting the health facilities' reimbursement to services delivered to the poorest. It also allows for better response to the needs of the target population (independent identification, coverage of non-medical services such as transportation costs).

OVERVIEW - Performance of Cambodian HEFs

- Effective targeting of the poor...
- ... as long as identification is kept up-to-date
- Procedure well-accepted by the people
- Increase in utilisation of services by the poor, especially when the HEF is supported by external funding
- Maintenance of service utilisation by the non-poor



→ Some lessons learned

a. There must be enough funding to cover the needs of the target population.

Local resources are not enough, particularly for hospital services. This is the case today and is likely still to be the case in 10 years. It is therefore illusory to hope to sustain health equity funds through self-funding by the population. On the other hand, it is possible to stabilise the sources of funding by showing international funding agencies that investing in social assistance can be an effective strategy for improving health and reducing poverty. Documentation and advocacy are therefore essential. The commitments undertaken in recent years by all partners to address the linkages between poor health and poverty provide a strong framework of arguments (e.g. the Millennium Development Goals).

b. There must be a coordinator who is a “mover and shaker”, a champion, at all stages of developing the approach.

This person needs to orchestrate the work and ensure the connections are secured between the various decision levels (political, operational, financial), sectors (health, social, others) and actors (health facilities, population, partners).

c. There must be a variety of actors and clear separation of responsibilities.

Responsibilities must be assigned to those who are able to carry them out, while avoiding conflicts of interest. For example, avoid asking hospital staff to do identification, because they have neither the skills nor the time; separate HEF funding from the health facilities' other sources of funding. Many different actors are available (administrative, health and social authorities; health facilities; the population; local associations and NGOs; others). The choice will depend on the objectives and opportunities in each setting.

d. A combination of methods must be used to identify beneficiaries.

There is no single method; the choice will depend upon the context and the actors on site. Using different methods makes it possible to compare outcomes and reduce errors (including the non-poor and excluding the poor). One possible approach is to use a list submitted by the local population according to their own criteria, validated through a survey by external actors according to more formal criteria and ultimately approved by local authorities.

For more information on criteria and methods for identifying the poor, refer to our policy brief on targeting.

e. The package of services covered must be based on the obstacles encountered by people when trying to access services.

In Cambodia, this means, at the very minimum, covering all hospital services and the costs of transportation between home and hospital. The major problems from the patient's perspective are addressed:

- No ceiling placed on expenses and no services excluded (except for non-essential services related to comfort, or services that cannot be funded, are unavailable at the level involved, or are already covered by another program, such as the AIDS program).
- Inclusion of non-medical services (e.g. private transportation) if these constitute a repeated deterrent to going to hospital.

f. The target population must be assured of service availability.

The fear of not being admitted or of still being required to pay is a major reason why some people would never consult. It is therefore important to solidify people's knowledge and confidence in the health care services and the HEF (policy of ongoing communication). In addition, the quality of care must be maintained and the experience must respond to people's expectations.

g. Health facilities must be reimbursed fairly and regularly according to the conditions agreed upon between the HEF operator and the facility. If the operators do not respect their commitments, the health facilities are likely to abandon theirs as well, and people will lose confidence in the system. Conversely, when contracts are respected, health facilities will be more inclined to participate.



EXPERIENCES OF HEALTH EQUITY FUNDS IN AFRICA

Since 2001, in Mali and in Mauritania, initiatives have been developed collaboratively between civil society and local public actors. In 2002, Benin's Ministry of Health launched its first version of an indigence fund using public funding. Since 2005, the ministries of health of Madagascar and Kenya have launched processes of reflection on the development of HEFs piloted by the central governments. However, at this time, most of these initiatives are stalled or producing poor results. Implementation modalities are very important, yet current experiences are limited in this respect. We observe two main scenarios:

→ Too locally anchored and not pragmatic

The Mali, Mauritania and Burkina Faso exercises opted to base themselves on local financial and human resources, with two consequences:

- Structural underfunding because of not having estimated beforehand the budget required to meet the program's objectives, and a dependence on local funding that soon proved to be inadequate.
- A very restrictive identification of beneficiaries. In Mali, after three years of operation, the Sélingué medical assistance fund supported only 2% of hospitalised patients, of whom only 9% were recognised as indigents and qualified for total exemption from payment. In Mauritania, leaving identification to local associations resulted in only 2% of the population being declared indigent. A recent exercise carried out in Burkina Faso's Ouargaye district confirmed that it is possible to have indigents be pre-identified by communities, but that this selection is very restrictive if it is exclusively local: only six inhabitants per 1,000 were designated as indigents by selection committees set up in 124 villages.

→ Too centrally anchored, resulting in inadequate or precipitous action

In Kenya and in Madagascar (with the exception of a GTZ-supported pilot project in Marovoay), the process has remained at the conceptual stage, producing consultations, workshops for discussion, and the creation of theoretical and budgetary models, but all without any implementation. Funding is not an issue; several solid financial partners have expressed interest in principle.

What is missing is the designation of any clearly identified person(s) who would have the mandate to pilot the implementation of HEFs according to clear instructions. Absent such person(s), potential operational actors do not get involved and HEF development suffers from a lack of coordination.

Benin provides another illustration of being too centrally anchored. National decision-makers monopolised the discussion on operational modalities. The model is administratively heavy and produces very little in the way of results. There are three reasons for this:

- lack of involvement of operational partners (health facilities, social services, population representatives) in the reflection on what model to implement;
- immediate issuance of a decree on HEF functioning that cut short any discussion of other possible operating modalities;
- no pre-testing of the HEF in one or two pilot health regions.

Extracting lessons from the limitations observed will be helpful in moving these experiences forward.



ADVICE FOR HEALTH EQUITY FUNDS DEVELOPMENT

a. Make sure the context lends itself to this approach.

- Health system funding: HEFs work better where there is already a cost-recovery system in place. However, they are not incompatible with a policy of free health care services, within which they would serve to subsidise non-medical expenses that inhibit access to care (transportation, lodging costs, purchase of medicines, etc.).
- Health facilities: HEFs will direct patients' choices toward the selected health facilities. It is therefore essential that these be appropriately regulated to respond to the demand: quality of care and services, and efficient systems of supervision, supply and control.

b. Choose one or more development model(s).

There are two major options:

- Initiative left to non-public actors (civil society, NGOs), with ultimate regulation by national authorities.
- Process piloted by the central government (ministries of health, social affairs, etc.) and implemented by local actors.

There is no single model; diversity is needed to respond to the specific requirements of each local context.

c. Determine the actors and their functions.

It is essential to identify at an early stage who will be in charge of developing the HEFs and determine their respective functions:

- A coordinator must be appointed to carry out a detailed action plan for program implementation and serve as the "orchestra conductor".
- Actors need to become involved from various levels: ministries, funding agencies, local authorities, and civil society. Within these, individuals must be designated for specific mandates (model development, studies, coordination of funding, development of field operations, etc.). There must be complementarity between sectors (particularly the health and social sectors) and arenas of action (political, operational, community).
- More broadly, consultations and debates need to be organised with a variety of actors to ensure the model responds to the expectations of the greatest number of people.

d. Determine the funding modalities.

Funding will have a direct impact on the volume of activity (number of HEF beneficiaries and package of services covered). Experience shows that models based on community funding are unable to cover hospital services. However, there is nothing to prevent the use of multiple approaches: funding of hospital services by an external funding agency and (partial) funding of primary care by communities.

e. Select pilot areas.

It is important that the implementation areas be representative of the diversity of the country's environments and that they allow for a comparison of results from which lessons can be drawn. Ideally, all the actors involved will participate in selecting the sample areas.

f. Agree on objectives and models.

The coordinator must work to obtain consensus from all the partners on certain key points, through a series of consultation sessions.

- The main objective of HEFs (to improve access to health care services for the poorest) normally goes without question. On the other hand, the secondary objective (preventing impoverishment due to health care expenses, for example by choosing also to include some non-medical services in the package of services covered) may provoke some discussion.
- Certain key elements must also be decided, such as the target population (how do we define the beneficiaries? do we set a limit on the percentage of the population to be included?), the actors to involve (community, local authorities, civil society, etc.), the package of services and the level of care covered (hospitals, health centres), etc.



g. Provide a realistic budget.

Several factors must be considered in estimating the budget:

- The size of the catchment area.
- The estimated proportion of the poor in this area who require support.
- The expected utilisation of services by the target population.
- The costs of the package of services to be covered; this requires an estimate beforehand of the costs of medical treatments in the selected health facilities.

h. Implement and evaluate.

One operator (local association, NGO, or other) is designated in each region for the HEF implementation. The central government actors should then detach themselves from the operations and only intervene to carry out their functions of regulation and supervision. It is impossible to detail here all the activities to be carried out for implementation. However, four key activities are worth noting:

- Develop the capacities of operators in their roles of HEF coordination, identification of the poor and social protection.
- Ensure the commitment of the health facilities, for example through clear contracts that balance their rights and obligations.
- Organise communications to engage the population's commitment.
- Document and monitor the HEFs' operations and results.

CONCLUSION

Health equity funds should not be seen as a turnkey approach, but rather as one tool that can contribute to a variety of strategies in the war against poverty being waged by governments and civil actors. Thus, health equity funds could be part of a user fees abolition strategy by helping patients overcome non-medical barriers to access to services. Likewise, there is currently a growing reflection on the synergies between health equity funds and health insurance, in which health equity funds might pay the insurance premiums of the poorest patients. It is up to decision-makers and operational actors to identify opportunities among the palette of tools available to move forward in developing those social protection systems that are best adapted to the social values of their national contexts.



References :

- Annear PL, Bidgeli M, Eang RC, Jacobs B, 2008, Providing access to health services for the poor : Health equity in Cambodia. In "Health and social protection: experiences from Cambodia, China and Lao PDR", issue 23 in the 'Studies in Health Services Organisation & Policy' series; Institute of Tropical Medicine, Antwerp, 189-226.
- Annear PL, Wilkinson D, Chean MR, Van Pelt M, 2006b, Study of financial access to health services for the poor in Cambodia. Phase 1: Scope, design, and data analysis. For the MoH, WHO, AusAID and RMIT University. 30th April 2006. Phnom Penh.
- Bitran R, Turbat V, Meessen B, Van Damme W. Preserving Equity in Health in Cambodia: Health Equity Funds and Prospects for Replications. Online Journal of the World Bank Institute . 2003. Washington, World Bank.
- Hardeman W, Van Damme W, Van Pelt M, Por I, Kimvan H, Meessen B, 2004. Access to health care for all? User fees plus a Health Equity Fund in Sotnikum, Cambodia. Health Policy Plan ; 19: 22-32.
- Ir P, Decoster K, Hardeman W, Horemans D, Van Damme W, 2008, Challenges in identifying the poor: An assessment of household eligibility for Health Equity Funds after four years of pre-identification in Oddar Meanchey, Cambodia. In "Health and social protection: experiences from Cambodia, China and Lao PDR", issue 23 in the 'Studies in Health Services Organisation & Policy' series; Institute of Tropical Medicine, Antwerp, 385-407.
- Jacobs B, Price N, 2006. Improving access for the poorest to public sector health services: insights from Kirivong Operational Health District in Cambodia. Health Policy Plan ; 21: 27-39.
- Jacobs B, Price N, 2008, A comparative study of the effectiveness of pre-identification and passive identification for hospital fee waivers at a rural Cambodian hospital. In "Health and social protection: experiences from Cambodia, China and Lao PDR", issue 23 in the 'Studies in Health Services Organisation & Policy' series; Institute of Tropical Medicine, Antwerp, 437-467.
- Jacobs, B., N. Price, and S.O. Sam, A sustainability assessment of a health equity fund initiative in Cambodia. Int J Health Plann Manage, 2007. 22(3): p. 183-203.
- Meessen B, Chheng K, Decoster K, Heng TL, Chap SC, 2008, Can public hospitals be pro-poor? The health equity fund experience in Cambodia. In "Health and social protection: experiences from Cambodia, China and Lao PDR", issue 23 in the 'Studies in Health Services Organisation & Policy' series; Institute of Tropical Medicine, Antwerp, 469-490.
- Men CR, Meessen B, 2008, Community perceptions of pre-identification results and methods in six health equity funds areas in Cambodia. In "Health and social protection: experiences from Cambodia, China and Lao PDR", issue 23 in the 'Studies in Health Services Organisation & Policy' series; Institute of Tropical Medicine, Antwerp, 409-436.
- Noirhomme M, Meessen B, Griffiths F, Ir P, Jacobs B, Thor R, Criel B, Van Damme W, 2007, Improving access to Hospital care for the poor: Comparative analysis of four Health Equity Funds in Cambodia. Health Policy and Planning; 22; 246 – 262.
- Noirhomme M, Thomé J-M, 2006. Les fonds d'équité, une stratégie pour améliorer l'accès aux soins de santé des plus pauvres en Afrique? In L'Assurance maladie en Afrique francophone, Dussault G, Letourmy A, Fournier P (eds); The World Bank: Washington, 432-451.
- Ridde, V., Yaogo, M., Kafando, Y., Sanfo, O., Coulibaly, N., Nitiema, P.A., Bicaba A. A community-based targeting approach to exempt the worst-off from user fees in Burkina Faso, Journal of Epidemiology and Community Health, in press
- Van Pelt M, Morineau G, 2008, When slum dwellers seek health care; Exploring a community-based health equity fund's impact on indebtedness for health care and on utilization of health services. In "Health and social protection: experiences from Cambodia, China and Lao PDR", issue 23 in the 'Studies in Health Services Organisation & Policy' series; Institute of Tropical Medicine, Antwerp, 491-518.

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