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The impact of achieving universal coverage on financial risk protection for the poor in Thailand: An assessment of the demand- and supply-side responses

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Household out-of-pocket payments, a major source of health care finance in middle- and low-income countries, have been identified as a cause of impoverishment for years. In 2001, the government of Thailand implemented a policy on universal coverage (UC) in access to health care, aiming to guarantee equitable access to health services, regardless of individual income or social status, and to protect household income and assets from medical care costs. With a considerable change in health financing arrangements of the UC policy, empirical evidence suggests a greater health service use and higher government health resources gained by individuals in poorer quintiles, compared to those in the richer groups. The incidence of catastrophic health expenditure in households using in-patient care decreased from 31% in 2000 to approximately 15% after the UC policy was implemented. However, existing studies explored the impact of the UC policy at the early stage of implementation, and the impacts of the policy on households, particularly poor families are rarely investigated. With this knowledge gap, the study aims to investigate the effectiveness of the UC policy in financial risk protection at household level, especially poor households. Two public health insurance schemes, *the UC and Social Security scheme*, will be explored because they cover the majority of poor households of the country with different contracting models. Then, the study will investigate purchaser's capacity to design and enforce contracts of public health insurance, provider responses for the policy on financial risk protection, and the impacts of different contractual arrangements on poor beneficiaries of these two schemes. This will portray the comprehensive impact of the UC policy on the Thai health care system, particularly on the objective of financial risk protection. Research strategies employed will involve three main approaches: (1) secondary data analyses of a nationally representative household survey; (2) documentary reviews on the contracts made by the Social Security Office (SSO) and the National Health Security Office (NHSO); (3) in-depth interviews with purchasers, health care providers in a targeted province, and experts in Ministry of Public Health or academic institutes; and (4) a case study approach for the investigation in financial burden, quality of health services gained, and economic impacts on selected poor and non-poor households in the study site.

Do the Poor Benefit from Public Spending on Healthcare in India: Results from Benefit Incidence Analysis in Tamilnadu and Orissa

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Public spending on healthcare in India has been very low over the past decade. Concerns have been expressed by donors and advocacy groups on the need to allocate more public resources to healthcare. In a recent policy statement, the Central Government has announced its intention to double the spending levels on health from the current level of 0.94% of GDP. At the same time, the efficiency and equity of public spending on health is also often questioned. Analysis of health spending and linking it with health care utilization through Benefit Incidence Analysis would help to assess whether the distribution of public health spending among various sections of the society is pro poor. The decomposition of the BIA results across time and sub region will help to understand the causes behind these utilization patterns. This will facilitate resource allocation decisions to regions and services which

would be of most benefit to the poor. In this study, we propose to estimate the benefit incidence of health for two Indian states, *viz*. Orissa and Tamil Nadu.

The household data from the National Sample Survey Organization for the year 1995-96 and 2004 will be used in this study. Unlike previous studies, the proposed study will (a) carry out a detailed state level and sub-regional analysis of benefit-incidence using decomposition techniques to understand the results (b) will employ unit costs of services estimated at facility level.

How Equitable is Employees' State Insurance Scheme in India? A Case Study of Tamil Nadu

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Out of pocket expenditure by households accounts for a major share of total health expenditures in India. The large financial burden resulting from catastrophic illness often drives families into indebtedness and poverty. Health insurance mechanisms which might protect families from such illnesses are not well developed in India. However, there are a few schemes operated by the Central Government such as the CGHS for its employees, the Employees State Insurance Corporation, and the General Insurance Corporation. The latter is open to the general public. In addition to these, there are schemes designed and operated by NGOs and private initiatives in various forms. Of all of these, Employees State Insurance Scheme (ESIS) is the widest in terms of both geographical coverage as well as number of beneficiaries.

This study of effectiveness of a scheme like ESIS in providing financial protection against illness will shed more light on issues relating to equity in the insurance scheme. ESIS provides financial protection against illness for workers in the formal sector. This covers a broad range of workers engaged in factories, services such as transport, cinema halls, hotels, etc. The scheme covers only workers who are drawing a salary of Rs.7500/per month or less, ensuring that better-off category of employees are excluded from the scheme. In spite of having covered only a segment of workers, the scheme is able to generate adequate funds, part of it translating into surplus. A thorough understanding of financing and utilization of the scheme will help to derive policy lessons to restructure financing mechanism of the health sector.

This study is being carried out in two stages. The first stage will be a detailed review of the scheme based on the information available from ESI Corporation (ESIC), which is the governing board of the ESI scheme. These macro reviews will help to understand financing, service delivery aspects of the scheme and also the pro-poor policies of this scheme.

At the second stage, detailed patients records from two sample facilities of the scheme will be analysed. This will identify who the beneficiaries are, how much they benefit, for which (diseases) they benefit, the distribution of benefits across different beneficiaries, etc. to understand more about equity issues of the scheme.

An attempt will be made to analyze access and utilization of services by workers who are exempted from contribution to the scheme. This study will mainly rely upon standard methods of estimating costs and benefits of services, and contributions to the scheme.

Financing Kenyan health centres and dispensaries: Exploring the implementation and effects of direct facility funding

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Health centres and dispensaries are a major source of primary level care for poor groups in rural areas of Kenya, but a number of problems have been documented with their performance. This partially reflects inadequate access to resources at the facility level, especially since the reduction in official user fees charged. Moreover, there are concerns that the reduction in funds has in turn reduced community engagement through facility committees.

To address these issues, direct facility funding has been piloted in all government facilities in Coast Province since 2006. The pilot is perceived to have been highly successful and nationwide scale up is planned, although no formal evaluation has taken place. Very few examples of similar funding mechanisms exist internationally for such peripheral health facilities. The funds can cover basic operating and maintenance expenses at facility level. The money is transferred directly into the facility's bank account, and each facility prepares a workplan and budget. As far as possible facility management committees (made up of community members and the facility in-charge) should be involved in planning and use of funds.

This study is based on a conceptual framework which maps out how direct facility funding may be hypothesized to increase utilization, improve quality of care, and reduce the financial burden of health care on households. The study aims to document these hypothesized pathways, and any breakdowns in the chain, as well as looking for other unexpected consequence of facility funding.

The study will be a post-hoc assessment of the implementation and effects of direct facility funding in Coast Province health centres and dispensaries, including a comparison with 2 districts in other provinces where direct facility funding has not yet been introduced. The study will be conducted in 2 purposively selected districts in Coast Province (Kwale and Tana River) and 2 districts outside of Coast (in Nyanza and North Eastern Province). The study will focus primarily on intermediate/ process outcomes that can be more easily linked with the direct funding intervention, and will involve careful documentation of other factors affecting health facility operation which have changed during the period 2006-2007.

Data collection will be based on a mix of quantitative survey data, qualitative in-depth interviews and secondary data from the Health Management Information System (HMIS). In each district a structured survey will be conducted at a random sample of 15 public health centres and dispensaries. The structured surveys will comprise an interview with the facility in-charge, record reviews, and exit interviews. In addition, in-depth interviews will be conducted with the facility in-charge and members of the health facility committee (HFC) at a sample of 6 purposively selected health facilities in each district, as well as with district staff and other stakeholders. District level feedback meetings will be held after completion of data collection in each district.

Final study results will be disseminated through multiple approaches, including a seminar for policy makers and other stakeholders, one-to-one meetings, and a summary report which will be circulated to senior MOH staff.

Benefit and financial incidence analysis of different healthcare financing mechanisms in Enugu and Anambra states, Nigeria

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In an effort to cope with the spiraling cost of health care, the Nigerian National Health Policy articulates funding of health sector from budgetary sources, and recognizing additional avenues of revenue such as health insurance schemes and direct financing by employers of labour. Government health budgets declined in real terms in response to macroeconomic problems at the time while demand for health services increased, partly because of population growth and successful social mobilization.

Presently, public expenditures in Nigeria account for 20-30% of total health expenditures, which leaves 70-80% of the expenditures uncontrolled for in terms of value for money and their potential to generate health gains (Soyibo 2004). Hence, private expenditures accounts for 70-80% of the expenditures and the dominant private expenditure is out-of-pocket spending (OOPS), which is about US$ 22.5 per capita and accounts for 9% of total household expenditures (Federal Office of Statistics 2004). Half of those who could not access care did not so because of its costs (Federal Office of Statistics 2004). The dominant reliance on this non-pooled financing instrument and the related absence of risk sharing transfers the largest financing burden on the poor and the clear absence of exemption mechanisms and pre-paid instruments is largely responsible for impoverishing health expenditures (Velenyi, 2005; Preker, 2005).

Nigeria introduced user fees as an additional mode of financing government health services within the framework of the Bamako Initiative revolving drug funds (Uzochukwu et al, 2002; Ogunbekun et al., 1996). The introduction of user fees was arguably in response to the severe problems in financing health services in Nigeria, like in most of sub-Saharan Africa. Other financing mechanisms that also used to pay for healthcare include community-based health insurance, general tax revenue based funding of the public sector and the National health insurance scheme, which was started in 2005.

There is paucity of existing information of socio-economic and other differences in the benefit and financial incidences of the different financing mechanisms in health, especially with regards to financial protection of the poorest and other vulnerable groups. Such information is required by policy makers and programme managers to develop and implement financial risk protection strategies that could reduce the inequity in financial access to and utilization of healthcare services by the poor and ensure that the poor and vulnerable groups are not impoverished by healthcare spending. Information on equity in healthcare financing is needed to help develop pro-poor policies for reducing the burden and catastrophe associated with payments for health. These are important if the health-related millennium development goals (MDGs) are to be met in Nigeria.

This study therefore aims to generate new policy-relevant knowledge for health care financing by determining the benefit incidence and financing incidence of different healthcare financing mechanisms in Anambra and Enugu States, southeast Nigeria. This will inform policy formulation and implementation of interventions that will improve healthcare financing and expenditures in such a way as to protect the poorest and most vulnerable groups from catastrophic and the potentially impoverishing costs of accessing and utilizing healthcare services. The study will be undertaken in close collaboration with relevant policy makers in the study area to ensure integration of findings into policy and action. A combination of cross sectional and longitudinal study in four rural and four urban towns in the two states, using a combination of quantitative and qualitative methods will be the study approach.