Towards universal coverage in the majority world: the cases of Bangladesh, Cambodia, Kenya and Tanzania

P4H Knowledge-Learning-Innovation Brief No 1, 2016
As a federally owned enterprise, GIZ supports the German Government in achieving its objectives in the field of international cooperation for sustainable development.

Published by
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH

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On behalf of
German Federal Ministry for Economic Cooperation and Development (BMZ)
Division 304 - Health, Population Policy, Social Security
Dahlmannstraße 4
53113 Bonn

GIZ is responsible for the content of this publication.

Druckriegel, Frankfurt
Printed on 100% recycled paper, certified to FSC standards.

Bonn, 2016
Acknowledgements

This document has benefitted from inputs and helpful comments provided by Nina Siegert, P4H Focal point in Tanzania, Dr Bart Jacobs, P4H Focal point in Cambodia, Xenia Scheil-Adlung, ILO, Kai Straehler-Pohl, SV P4H GIZ, David Scheerer, SV P4H GIZ, Martina Pellny, SV P4H GIZ, Michael Adelhardt, Coordination Desk P4H at the World Bank and Alexander Schulze, Swiss Agency for Development and Cooperation, SDC. A first draft was presented by the lead author during the Technical Working Group meeting of P4H in June 2015 and discussed by the TWG members of P4H.
Towards universal health coverage in the majority world: the cases of Bangladesh, Cambodia, Kenya and Tanzania

Abbreviations and acronyms

BMZ ............ Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung
BRAC ........ Non-governmental international development organisation based in Bangladesh
CHE .......... Catastrophic Health Expenditure
GHE ........ Government Health Expenditure
GIZ .......... Deutsche Gesellschaft für internationale Zusammenarbeit
GDP .......... Gross Domestic Product
GNI .......... Gross National Income
GRG .......... Government Revenue Generation
HIV/AIDS .... Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
ID/OP ........ Institutional design/organizational practice
IoI .......... Incidence of Impoverishment
ITM .......... Institute of Tropical Medicine, Antwerp
Kiw .......... Kreditanstalt für Wiederaufbau
KLI .......... Knowledge-Learning-Innovation
MGD .......... Millennium Development Goals
NGO .......... Non-Governmental Organisation
OPP .......... Out-of-pocket
PAH .......... Providing for Health
SAD .......... Swiss Agency for Development and Cooperation
SHP .......... Social Health Protection
TB .......... Tuberculosis
THE .......... Total health expenditure
UHC .......... Universal Health Coverage
UN .......... United Nations
UNDP .......... United Nations Development Programme
WHO .......... World Health Organization

Bangladesh

CPhC .......... Comprehensive Primary Health Care
GK .......... NGO Gonoshasthya Kendra
HCFS .......... Health Care Financing Strategy
HEU .......... Health Economics Unit of MoHW
MoHWF .......... Ministry of Health and Family Welfare, Bangladesh
MoLGRD .......... Ministry of Local Government and Rural Government and Cooperatives
NHAP .......... National Health Protection Act
SBA .......... Skilled Birth Attendant
SWAp .......... Sector-wide approach
TBA .......... Traditional Birth Attendant

Cambodia

CBHI .......... Community-Based Health Insurance
CDHS .......... Cambodia Demographic and Health Survey
CSES .......... Cambodian Socio-Economic Survey
GMIS .......... Government Midwifery Incentive Scheme

HEF .......... Health equity funds
HFP .......... Health Financing Plan
HSP1 .......... 1st Health Sector Strategic Plan (2003 – 2007)
HSP2 .......... 2nd Health Sector Strategic Plan (2008 – 2015)
MoH .......... Ministry of Health
NSSF .......... National Social Security Fund
SFHF .......... Strategic Framework for Health Financing
SHI .......... Social Health Insurance

Kenya

DPHK .......... Development Partners in Health in Kenya
FP .......... Family Planning
GBVRS .......... Gender-Based Violence Recovery Services
GoK .......... Government of Kenya
HAKI .......... Health for All Kenyans through Innovations
HS3F .......... Health Sector Services Fund
ICC .......... Inter-agency Coordinating Committee
MoGC-SD .......... Ministry of Gender, Children and Social Development
MoH .......... Ministry of Health
NHIF .......... National Hospital Insurance Fund
NShIF .......... National Social Health Insurance Fund
NShPF .......... National Social Health Protection Fund
SM .......... Safe Motherhood

Tanzania

CCM .......... Chama Cha Mapiduzi
CHF .......... Community Health Funds
CUF .......... Civic United Front
Go .......... Government of Tanzania
HFS .......... Health Financing Strategy
HSSP-III .......... Health Sector Strategic Plan III
ISC .......... Inter-ministerial Steering Committee
LGA .......... Local Government Authorities
MoHSW .......... Ministry of Health and Social Welfare
MoL .......... Ministry of Labour
NHIF .......... National Health Insurance Fund
NHIS .......... National Health Insurance Scheme (of Ghana)
P4P .......... Pay-for-performance
PMO-RALG .......... Prime Minister’s Office, Regional Administration and Local Government
RBF .......... Results-Based Financing
SHI .......... Social Health Insurance
SHIB .......... Social Health Insurance Benefit
SHIELD .......... Strategies for Health Insurance for Equity in Less Developed countries
SNHI .......... Single National Health Insurance
TIKA .......... Tiba Kwa KAdi
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Rationale & methodological setup

Today and at global level, universal health coverage (UHC) – health for all without financial hardship – has become an ‘umbrella goal’ for health in the post-2015 development agenda. Within the multiplicity of interventions designed to pave the way towards UHC, it is not always obvious to distinguish coherence in governmental and non-governmental cooperation, at national and project level, at supply side and demand side, for a variety of reasons. There is however broad consensus that UHC is a critical contributor to sustainable development and human wellbeing. Improved population health, one desired outcome of UHC, also benefits economic development as such. The World Bank already made this point in its 1993 World Development Report. So did Bloom and Canning in 2000, then Alleyne and Cohen for the WHO Commission on Macroeconomics and Health in 2002. Today, the argument of an economic payoff from investing in health is reiterated and expanded by the Lancet commission on global health, ‘Global Health 2035’. Nicholas and colleagues, for the WISH Universal Health Coverage Forum 2015, argue that UHC is a highly effective way for all countries to deliver health, economic and political benefits.

One group of reasons for scant coherence is related to the still debated views on UHC as a means to an end and/or an end in itself, but also on the relationship between coverage and access, and between universal coverage and universal care, and to how to measure progress. McManus, reporting for the ‘The World We Want 2015’ platform, avoids the access-coverage dilemma by using the composite term ‘universal coverage and access’, and proposes to frame it under the broader health goal ‘maximizing healthy lives’, itself subordinate to the proposed overarching development goal of ‘sustainable well-being for all’. Evans and colleagues, on behalf of the WHO, argue that access is a necessary yet insufficient condition for coverage, defined as the actual receipt of accessible services. Stuckler and colleagues conceptualise universal health coverage as part and parcel of universal health care, whereas People’s Health Movement describes universal coverage as a neoliberal concept at odds with publicly provided universal health care. Bump, in an exhaustively substantiated political-economy examination of history and future of UHC, states that “there has yet to be a thorough discussion of the full parameters of this concept”. In 2013, the WHO and the World Bank formulated a draft framework for monitoring of UHC, focusing on service coverage and financial protection, coupled with equity and quality elements. Subsequent consultations led to a framework with indicators and targets in 2014 and a first global monitoring report in 2015.

Another group of reasons for divergence is related to the fact that UHC – as expert literature repeatedly makes the point – has no single road: its paths are multiple, and are context-dependent. The latter does not mean that “anything goes”: time has come to realise that the unit of analysis should be a population (not a sub-population benefiting from a particular financing scheme), and that approaches that compromise equity are not desirable.

Policymakers in the majority world have thus no easy task to define their road to UHC. As McIntyre highlights: “It is one thing to recognise that a country does not have universal coverage (through noting gaps in financial risk protection and poor access to services), but quite another to be able to assess what kinds of health system changes can move a country towards universal coverage.”

A term slowly replacing ‘developing countries’ – highlighting the fact that the people in these countries are indeed the majority of mankind, thus defining people by what they are, not by what they lack. The term was first coined by Shahidul Alam in the 1990s. See, among others: ‘Majority World’ – a new word for a new age http://masalai.wordpress.com/2009/02/11/majority-world-a-new-word-for-a-new-age
tiple, and further complicated by path dependency and lack of agency of national policymakers face to face with rapidly expanding free-market health care and frequently incoherent and/or context-inappropriate donor preferences. The latter is all the more unfortunate, as countries in the majority world striving to establish UHC (and where the expected return on investment in health is considerable) turn to external development partners for help and advice in drawing up and implementing workable policy.

Against this background, P4H (Providing for Health) – launched as a political initiative for social health protection at the G8 summit in Heiligendamm, Germany, in 2007 – evolved into a global network for country support towards universal health coverage, serving as a platform for information exchange and dialogue as well as a mechanism of coordination of support across sectors and cooperation levels. P4H encourages countries to develop and implement their own national policies and strategies according to their national priorities.

To enhance evidence and knowledge generation among P4H members and supported countries, the P4H partners Swiss Agency for Development and Cooperation (SDC) and the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH in 2014 launched a call for Knowledge-Learning-Innovation (KLI) briefs, of which the present brief is one materialization.

With this KLI brief Towards universal coverage in the majority world, the research unit Equity & Health of the Institute of Tropical Medicine (ITM, Antwerp) aims to provide an update on the state of the art of universal health coverage, from the perspective of policymakers in the majority world who face the difficult challenge of progressing towards universal coverage, in particular with regard to necessary conditions and best practices, including but not limited to health financing.

The aim of this KLI brief is then to contribute to bringing up to date and consolidating the evidence base for the P4H’s policy support towards UHC in the P4H partner countries.

The objectives are to answer the following two research questions:

1. What is known from the existing literature on conditions and practices for advancing towards UHC in low- and middle-income countries?
2. What are the necessary conditions and best practices for advancing towards UHC in P4H partner countries, and what are the lessons learnt from other countries that are considered successful in attaining UHC?

To produce this KLI brief ‘Towards’ universal coverage in the majority world we applied a two-stage process:

1. A scoping review of the existing literature, exploring five dimensions of UHC (the classic triad of population coverage, service coverage and financial protection, plus quality of care and – crosscutting all former dimensions – equity) within a political economy framing that takes into account institutional design and organisational practice of UHC policies and actors respectively, to build up the evidence base required to answer the first research question.
2. A qualitative synthesis of the collected evidence, based on the established framework, to enable answering the second research question.

Given the broad research question (“What is known from…?”), and the context and path dependency of UHC policies – entailing exploration of discussion notes, reports and other types of grey literature that would easily be excluded from a systematic review, a scoping review is arguably a first choice in this case. More than other forms of literature review, a scoping review maximizes breadth of inquiry (ideally specifying its dimensions and boundaries, e.g. making use of a framework that guides the review from data selection up to reporting), without necessarily sacrificing depth of inquiry.

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Footnote: For a full description of P4H, see [http://p4h-network.net/about-p4h](http://p4h-network.net/about-p4h). In 2014, P4H-supported countries are Bangladesh, Benin, Burkina Faso, Cambodia, Cameroon, Chad, Haiti, India, Indonesia, Kenya, Lao PDR, Mali, Mongolia, Nepal, Rwanda, Senegal, Tanzania, Togo, Uganda, Yemen and Zambia. P4H members are the World Health Organization (WHO), the International Labour Organization (ILO), the World Bank, the African Development Bank (AfDB), the Asian Development Bank (ADB), France, Germany, the USA, Spain and Switzerland.
The classic dimensions of ‘population coverage’, ‘service coverage’ and ‘financial protection’ would not have been sufficiently comprehensive. Arguably, service coverage as such is insufficient where quality of care is sub-standard. Similarly, no dimension of coverage can be truly universal without ensuring equity.

We are aware that the term ‘political economy’ covers a range of overlapping or even different interpretations in different disciplines. Our interpretation focuses on a recognized mechanism in collective decision-making, namely the interplay between the rules of the game and what stakeholders actually do, conceptualized by North as respectively ‘institutional design’ (“formal and informal rules, enforcement characteristics of rules, and norms of behavior that structure repeated human interaction”²¹) and ‘organisational practice’ (the practice of “groups of individuals bound together by some common purpose to achieve certain objectives”²²). While we acknowledge that institutional design and organisational practice cannot cover all aspects of political economy and that alternatives exist (public choice theory may come to mind), we argue that considering the ID/OP interplay adds substantial insight into origins, current state and conditions for improvement in each of the three classic dimensions (population coverage, service coverage and financial protection) of UHC in a given context.

While a scoping review addresses the need for comprehensively collecting and mapping of evidence searched for, it “does not address the issue of ‘synthesis’, that is the relative weight of evidence in favour of any particular intervention”¹⁸. We argue that a qualitative synthesis, informed by the established framework, is a rational complement.

In search for a balance between scope and feasibility, GIZ and the contractor agreed to focus the process (review and synthesis) on four P4H partner countries: Bangladesh, Cambodia, Kenya and Tanzania.

Based on the agreed five dimensions within a political economy arena, a framework for data collection and analysis was elaborated, based on the three-dimensional UHC cube of World Health Report 2008²³, with the following modifications:

1. Integration of the quality aspect in the service coverage dimension;
2. Consideration of equity as a core feature of each dimension (population coverage, service coverage and financial protection);
3. Consideration of equitable re-design of existing coverage policies (inner cube) in each dimension as prerequisite for expansion (curved part of the arrows in inner cube);
4. Consideration of expansion of each dimension as justifiable only when equitable (straight part of the arrows in outer cube);
5. Conceptualisation of the cube(s) as embedded in and resulting from a political economy dynamic, shaped by the interplay between institutional design (structure, rules of the game) and organisational practice (agency, behaviour of the actors);
6. Assessment of design and practice (more or less favourable for UHC) in their particular context and background (context and path dependence).
The following keywords were used: ‘universal health’, ‘population coverage’, ‘service coverage’, ‘quality’, ‘financial protection’, ‘out-of-pocket’/OOP’, ‘equity’, ‘political’/politics’, ‘institutional design’, ‘organisational practice’, and country name (‘Bangladesh’, ‘Cambodia’, ‘Kenya’ and ‘Tanzania’). Following Jesse Bump’s logic, our first search term was ‘universal health’, because it captures also ‘universal health insurance’ and ‘universal health financing’, which would have been excluded by searches for the full term ‘universal health coverage’.

Boolean operators were applied and the initial selection was limited to publications of the last decade (2005 onwards). Earlier publications were taken into account if and only if they were needed to make sense of the search results from the last decade.

The framework for data collection and analysis can be summarised in the graphical representation on the right:

Sources used for data collection were PLoS Medicine, PubMed, the LSHTM collection Resilient and Responsive Health Systems, P4H Intranet, the World Bank Open Knowledge Repository, Google Scholar, and the research unit’s own database on UHC.

A total – for the four countries – of 749 documents went through the process, of which ultimately 275 were included for analysis. Besides, 240 ‘generic’ documents were included, on UHC but not specifically linked to the four countries.

Data collection was closed in the first semester of 2015. Analysis was concluded mid 2015.

An overview of the selection is given in the following table:

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Two researchers then independently screened all results for relevance. This was done stepwise, first on title, then on abstract, ultimately on full text. Duplicates were eliminated from the list of included documents, and snowballing technique was applied to the reference list of all included documents.
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Bangladesh
At independence in 1971, Bangladesh was a desperately poor and densely populated country with appalling health indicators, seen as a hopeless case by many. Four decades later – having doubled its population to nearly 160 million and still a low-income country – it was praised as an example of good health at low cost. Compared with other countries in the region, Bangladesh gradually achieved longer life expectancy for men and women, lower total fertility rate and lower infant, under-5, and maternal mortality rates. A particular social consciousness after the Liberation War, lasting political commitment, leadership, innovation, engagement with civil society and empowerment of women have been described as drivers of Bangladesh’s exceptional health improvements.24–27

Yet progress was more often than not inequitable, and an increase in non-communicable diseases and an ageing population are bringing new challenges to the health system.28 While Bangladesh has performed better than most neighbours and is on track with several health MDGs, marked geographical and wealth inequalities persist, particularly in under-5 and maternal mortality and nutritional outcomes.29,30 This is well recognised by all stakeholders. BRAC founder Abed, introducing ‘The State of Health in Bangladesh 2006’, summarises:

“We are mortified to find that the access of poor women to safe delivery is about one-fifteenth that of the well-to-do groups, and that some disadvantaged groups in Bangladesh have immunization coverage as low as 10 per cent”.

The report goes on stating:

“Despite aggregate gains inequities in health continue to be pervasive. There are major differences in health status and health care consumption between different groups. The difference between rich and poor, between urban and rural residents, between urban middle and higher classes and urban slums, between men and women, between the dominant Bangalees and ethnic minorities are disturbing.”

The subsequent 2011 report ‘Moving towards Universal Health Coverage’ sees three components of unacceptable coverage: limited coverage of priority interventions such as skilled attendance at birth, inequities in the patterns of coverage, and shortfalls in financial protection arising from a health care system that is financed primarily by individual households.32 Chowdhury and colleagues, introducing the Lancet’s Bangladesh series ‘Innovation for Universal Health Coverage’, speak of the ‘Bangladesh paradox’: “Gains in health outcomes have been achieved despite inadequate health systems inputs, such as health workforce density, distribution and composition, health-sector financing, and the ratio of public versus private expenditures”. They add on that “poverty and income inequality remain a persistent challenge” and see part of the problem in “poor governance and overdependence by both government and NGOs on donors for policy formulation”. Adams, Rabbani and colleagues argue that any further progress “requires stronger governance and longer-term systems thinking that addresses health workforce shortages, shortfalls in effective coverage of services, and enhanced engagement of partners within and beyond the health system”. El Arifeen and colleagues give an overview of the Bangladesh health service delivery, characterised by community-based approaches, government-NGO partnerships and early adoption of innovations. They also point to the other side of the coin: in a context of a rise in chronic diseases, unregulated growth of the private sector, expansion of urban slums and persistent inequities, service delivery needs a clearer definition of the roles of government, private sector and NGOs to increase accountability and improve policy, regulation and implementation.33

A 2010 Bangladesh health sector profile report concludes that “the gains in reducing maternal and child mortality and reducing and eliminating key infectious diseases have been mainly achieved by limited but effective vertical programmes, such as immunisation and family planning, as well as non-health interventions such as the increase in female literacy, income generation and access to safe drinking water”. A similar point was made earlier in a World Bank impact study that was particularly critical of the nutrition programme.34 The 2010 report adds that “Low investments in health and weak health systems continue to be major barriers to improving service delivery (…) Human resource constraints – recruitment, retention and deployment of adequately trained staff with the appropriate skill mix – remains the single most intractable issue hampering effective delivery of services” and advocates
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for a “health systems approach to begin to address the triple needs of reproductive health, communicable and non communicable diseases.”

In a comment on the Lancet’s Bangladesh series, Amartya Sen distinguishes four key elements behind the country’s accomplishments in health, and social transformation in general:

1. commitment to women empowerment, historically embedded in the struggle for independence and the following search for a proper identity, and the use of women’s agency in society;
2. espousal of a multiplicity of public and private instruments for social advancement;
3. intelligent use of community-based approaches in service delivery; and
4. improved ability to face natural disasters.

Equitable expansion of population coverage

Utilisation of health services tends to be far better for high-income groups, with service provision particularly deficient in remote areas and in urban slums. The higher the level of service provision (primary, secondary, tertiary) the greater the income inequality in utilisation. Financial allocations and utilisation follow a similar pattern: “Health care expenditure of the MoHFW at different levels show that 27 per cent of the primary health care allocation is going to the richest quintile and 21 per cent to the poorest quintile. At all three levels primary, secondary and tertiary the poor receive less healthcare resources provided by the public sector than the rich people, as opposed to the policy objective as well as meeting universal health coverage.”

Adams, Ahmed and colleagues, in the Lancet’s Bangladesh series, describe the public sector as poor care for poor people and the private sector as skewing access to quality care by those most in need. The Bangladesh Health Watch warned “attempts to shift to a more market based health service delivery may actually end up hurting the poor by contracting their access to good quality care”. Since about a decade, several authors have described a mixed picture: while NGO-state partnerships such as the Urban Primary Health Care Project have decreased financial exclusion of urban poor from healthcare services, cultural, political and social exclusion still limit the capabilities and access to society’s resources of the populations living in ‘illegal’ settlements.

While Bangladesh after independence has made successful efforts to move from a deficient urban-based healthcare delivery system to a decentralised rural approach with a focus on primary health care, it hardly adapted to a fast rate of urbanisation. Coverage of the urban population, particularly the urban poor, is problematic. Walsham and colleagues, in their report on the 2010 joint Conversation Event of the Local Government Division (Ministry of Local Government, Rural Development and Cooperatives) and Local Consultative Group Urban Sector, summarise the catch-22 for the urban poor: “While some cities – such as Chittagong – have developed considerable capacities in health, in the majority of towns and cities services are largely limited to vaccinations and other vertical health programmes such as HIV/AIDS and TB. As a result, in accessing primary healthcare services, the urban poor are frequently forced to choose between expensive or variable quality private services, or the inappropriate use of secondary facilities such as government hospitals.”
The persistence of inequitable access for the urban poor is confirmed by Osman \(^{40}\), Ahmed and colleagues \(^{41}\), and Adams, Rabbani and colleagues \(^{33}\). For Afsana & Wahid \(^{42}\), progress is dependent on a coordinated effort to address the health challenges of an ever-growing population of slum dwellers.

Inequities in access and utilisation are clearly reflected in health outcomes: “There still exist significant rich-poor gaps in under-five mortality, severe malnutrition and maternal mortality. The rich-poor gap in rates has reduced in magnitude but the ratio of rich-poor rates has been maintained almost at a constant level. Gender gaps have been closed in life expectancy, under-five mortality and certain types of morbidity, but it still remains in under-nutrition” \(^{31}\). Inequities in urban settings, and their evolution over time, are documented in detail in the 2006 and 2013 Bangladesh Urban Health Surveys \(^{43,44}\). Particularly the health of slum populations – today making up about a third of all people living in city corporations but growing twice as fast as their surroundings – is of concern. In slum areas, under-five mortality, which was at 81/1000 in 2002–2006, came down to 57/1000 in 2009–2013, still twice that of non-slum areas. Still 1 out of 2 under fives in slum areas is stunted (low height-for-age), whereas wasting in non-slum under fives rose from 1 out of 2 in 2002–2006, to 1 out of 3 in non-slum areas. And 1 out of 5 under fives in slum areas is wasted (low weight-for-age, same as in 2002–2006), whereas wasting in non-slum under fives rose from 1 out of 10 to 1 out of 6, surpassing the WHO-specified emergency level of 15 per cent in both slum and non-slum urban areas \(^{42–48}\).

**Equitable expansion of service coverage**

Public service provision is far from ideal in Bangladesh: while in urban areas service provision fails to match demographic changes, rural environments altogether lack qualified providers for common childhood infections \(^{47}\). Besides, the national Essential Services Package does not cover non-communicable diseases and health workers are not trained to manage these conditions \(^{28}\). As a consequence, urban and rural patients turn to private, often unlicensed providers. The situation is particularly problematic for the poor: “Since the quality of curative care at public facilities falls below even what the poor are willing to accept, the poor have no option but to rely on (...) very low standard market services” \(^{35}\).

Over the last decade, there has been a rise in healthcare consumption, but the rise in curative care consumption by the poor and particularly by poor women has been more in terms of quantity than quality of services \(^{31}\). Huda and colleagues give a compelling description of the current situation: “The coverage of many critical health services is still quite low. The country’s health system is struggling to meet basic standards for quality of care because of a shortage of skilled health workers, the large number of unregulated private service providers, irregular supplies of drugs, inadequate public financing, high out-of-pocket expenses, and lack of proper monitoring and supervision mechanisms” \(^{48}\).

Access to obstetric care is a particular case: until the late 1990s, training of traditional birth attendants (TBAs) was part of official policy, supported among others by the World Bank. Despite a documented associated reduction in mortality, the policy was abandoned following the international trend toward skilled birth attendance \(^{48}\). One major NGO, Gonoshasthay Kendra (GK), still trains and employs trained TBAs for service delivery – with a positive impact on maternal and neonatal mortality \(^{34,30–55}\). The government introduced a programme of community-based skilled birth attendants (SBAs) for home delivery in 2003–2004, but successful piloting was followed by fragmentary implementation. An increase in institutional deliveries lifted skilled birth attendance from below 15 per cent \(^{55–58}\) to over 30 per cent \(^{30}\), but had no positive impact on equity in access. A study examining data from 1995–2010 found that although wealth- and education-deprived mothers increased their utilisation of care relative to mothers of higher socio-economic status, the absolute gap in utilisation between socio-economic groups has increased over time \(^{57}\). Appropriateness of care is another issue: the latest Urban Health Survey documented an overall rise in C-section rates – from 16 per cent in slum areas (where institutional deliveries make up 37 per cent of the total) to a worrying 44 per cent in non-slum areas (where institutional deliveries make up 65 per cent of the total) \(^{44}\).
Towards universal coverage in the majority world: the cases of Bangladesh, Cambodia, Kenya and Tanzania

A distinctly Bangladesh-specific case of an inequitable service gap is to be found in climate-related health problems. Haque and colleagues document how vulnerable villagers have no other choice than to turn to unqualified treatment at high prices.

**Equitable expansion of financial protection**

Between 2001 and 2007, total health expenditure (THE) more than doubled in real terms (to about 16 US$ per capita per year) but rose only modestly as a share of GDP (to about 3.4 per cent). Over the same period, the share of public spending – including the contributions of development partners – in THE declined and out-of-pocket (OOP) spending rose. Today, almost two-thirds of health spending in Bangladesh is OOP, and a quarter of people falling ill and not seeking care report that high cost is the reason for forgoing treatment. Adams, Ahmed and colleagues summarize: "growing privatisation of health financing, mainly through out-of-pocket expenditure, is both inefficient and inequitable. Roughly 4–5 million people per year are pushed into poverty because of healthcare costs in Bangladesh, with millions more – especially poor people – deterred from seeking care".

To date, health insurance plays a minor role in financial protection, offering limited coverage and far from reaching critical scale. The Bangladesh Health Watch, while recognising that "NGO-led micro-health insurance and private-for-profit health insurance schemes (...) as a whole touch a very small fraction of the Bangladesh population with little prospect for significant expansion over time", sees moving towards pre-payment financing and shifting official development assistance toward health insurance as imperative. Actually, a range of actors advocate for insurance arrangements to move closer to UHC, as does the government in its 2012–2032 health-financing strategy document.

**Institutional design**

Complementary to Bangladesh’s government health sector, a large non-government sector plays a major role in the delivery of healthcare services. Leading the government health sector is the Ministry of Health and Family Welfare (MoHFW), but with separate health services and family planning directorates. A further division is observed in primary health care, coordinated in rural areas by the MoHFW, but in urban areas by the Ministry of Local Government and Rural Government and Cooperatives (MoLGRD).

The non-government sector includes NGOs and informal private providers. The non-government sector provides the overwhelming majority of outpatient curative care, while the government sector delivers most preventive and hospital care. NGOs – more than 2,000 in number – typically deliver types of service and reach groups that could not have been reached with existing government capacity. There are thus seen as an “extender of government”.

**Organisational practice**

In practice, there has been a great deal of flexibility and fluidity between government and non-government health sectors. The government has fostered collaboration, working with a series of NGOs on complementary health initiatives. This has been a two-way exchange, with government providing support but also learning from these organizations. Beyond service delivery, government and civil society developed parallel efforts for community empowerment. While the involvement of non-government actors is hailed by many as innovative, it has also raised critical thoughts, particularly with regard to health equity. Schurmann & Mahmud question the civil society role of NGOs, because of their overlaps in terms of public service provision, their engagement in market-based activities and their accountability.
Towards universal coverage in the majority world: the cases of Bangladesh, Cambodia, Kenya and Tanzania

Bangladesh

reduction of population growth has been their overriding access to primary health care since the late 1970s, an instrument. While these plans have emphasized the role of the Planning Commission as most powerful policy instrument at health policy level, one has to look at the five-year strategic plans as most powerful policy instrument. Strengthening of management authority and alternative financial modalities were not implemented, while some pilots were abandoned on structural reorganization, decentralization of management and political considerations. Furthermore, they describe how low institutional literacy, persistent client-patron relationships in the Bangladeshi social fabric and political exclusion at national and local level curb the ability of transformation in favour of the poor.

Rodriguez Pose and Samuels identify donor assistance, in addition to the partnerships between government and NGOs, as a crosscutting contributor to Bangladesh’ health progress. They describe how – in 1998 and with donor support – the government adopted a sector-wide approach (SWAp) for the health sector, which allowed the government to position itself as a coordinator of the other actors, and to shift from a fragmented project mode to a more regulated programme modus operandi. While recognizing donors as instrumental, Rodriguez Pose and Samuels also point to a persisting challenge: external aid channelled through the NGO sector, and strong links between donors and NGOs, do not always facilitate the essential regulation function of national government.

At health policy level, one has to look at the five-year plans of the Planning Commission as most powerful policy instrument. While these plans have emphasized increasing access to primary health care since the late 1970s, reduction of population growth has been their overriding goal. Whatever the objectives were, poor implementation has been persistent for decades: “strategic decisions on structural reorganization, decentralization of management authority and alternative financial modalities were not implemented, while some pilots were abandoned on political considerations. Strengthening of management for efficient and effective planning, budgeting, financing, program implementation and project cycle management fell flat, because of lack of understanding and support from the policy makers from the highest echelon. Strategic decisions towards enhancing the skill of public sector managers through management training did not materialize. Equity based allocations to neglected programs and marginal population was forgotten in the national plans.” This critical view from civil society was expanded in the subsequent 2011 report: “The government ownership and leadership in policy formulation and reform are not strong enough; most of the steps are influenced by the donors.”

Barkat, in his ‘Political economy of health care in Bangladesh’ formulates three policy suggestions: “(1) public health must be seen as real public goods, and accordingly, shall be addressed by the State; (2) the Government must see investing in people’s health not just as a social sector investment but an investment towards accelerated economic development and poverty eradication; (3) the people – especially the poor and marginalized people – must know about their health rights and must be adequately empowered to exercise and assert those rights”. He adds a critical note: “serious suggestions – usually termed as ‘radical’ by the establishment – are seldom respected and acted upon by weak government who relies more on donor-driven development prescriptions (…) than on home grown development philosophy.”

Beyond blaming, Bangladesh Health Watch gives place to recognition and encouragement – “The government’s leadership and ownership is vital to achieve UHC in the country (…) The high level policy makers need to have commitment to adopt a home grown and contextualized policy and strategy” – and sees “many reasons for a concerted mobilization towards universal health coverage in Bangladesh beginning immediately” (italics in the original).

A more optimistic view, and a proposal for a way forward, is formulated in the 2007 World Bank paper ‘To the MDGs and beyond’. This document, focusing on the determinants of maternal and child mortality, recognizes that rapid population growth in metropolitan slums is not matched by commensurate growth in services, that social progress is needed for which current economic growth and delivery models are insufficient, and advocates for a major shift in government policy toward slum dwellers – with and without tenure. For this to be possible, the government needs to restructure urban governance to become workable, and above all to recognize that people moving to urban areas are not transient – their problems must be addressed on a long-term basis. According to the authors, the way forward lies in improving accountability and transparency of public services by harnessing what they call the ‘creative tension’ between the major stakeholders: national government, NGOs/public service providers and local governments. Each of these stakeholders should realise the importance of true partnership: the national government should move beyond simple contracting, lo-
cal governments must learn how to seek input and meaningful participation from the community, and the NGOs should recognise that they cannot scale up their successes in a sustainable manner without partnership with government, particularly local government. Inspired by the experience of the NGO Gonoshasthaya Kendra (GK), a major health service provider, the authors advocate bringing in local government and community groups into service delivery to foment accountability. The unique linkage of service provision, local government and the community – as pioneered by GK in its Comprehensive Primary Health Care (CPHC) model – is seen as a condition for sustainability and systemic expansion and described in detail in a 2011 evaluation. Joarder and Sarker focus on the potential of community empowerment to boost accountability and demand for UHC. El Arifeen and colleagues stress the need for a clear definition of roles of government, private sector and NGOs to increase accountability. Ahmed and colleagues see a role for participatory governance to improve regulation and accountability.

**Current situation and way forward**

Despite persisting challenges, past success in areas such as family planning, child mortality and immunisation motivates key players within Bangladesh to see universal coverage as an attainable goal for continuing to achieve ‘good health at low cost’. Likewise, equity – though far from achieved – remains at the core of the policy discourse. This should not be surprising, as Bangladesh’ commitment to equity was already articulated in the 1972 constitution and development strategy, which then extended to the health sector.

In 2012, the government presented a strategy for gradual progress towards UHC by 2032, as a response to the triple challenge of inadequate health financing, inequity in health financing and utilisation, and inefficient use of existing resources. Authored by the Health Economics Unit of the Ministry and Family Welfare, this Health Care Financing Strategy (HCFS) had been shaped by a three-year iterative preparation with the involvement of government officials, academics, external experts and development partners, and with strong support of Providing for Health. While the strategy was clear in its choice for, among others, interventions, insurance mechanisms and results based financing, it was less clear in specifying how to reach a single risk pool, not necessarily fully internalised by all stakeholders, only weakly linked to a broader national social protection strategy, and still in need of choices to be made in all three health financing functions, of the definition of an explicit benefit package and of indicators of financial protection.

In 2013 then, several options were explored to move forward to a Bangladesh Health Protection Fund, regarding resource generation, risk pooling and strategic purchasing. Consensus was reached on the need for efficiency gains on top of budget increases, on the need for an autonomous government agency to drive the implementation of the HCFS, and on the need to urgently define a benefit package. Suggestions were made to also make use of earmarked taxes and fees from export earnings and remittances. Utilising the political momentum after the collapse of a garment factory, a ‘Workers Health and Welfare Fund’ was proposed, which would innovatively include a contribution from international buyers and their customers. In constructing an implementation plan for the HCFS, three scenarios were foreseen: a considered unlikely high-priority scenario, a step-wise medium-priority scenario, and a low-priority scenario in case of failure of transitional implementation. In 2013 also, the Planning Commission drafted a National Social Protection Strategy, which however hardly took into account the MoHFW’s Health Care Financing Strategy.

Discussion and planning, among internal and external stakeholders, went on in 2014, particularly after the MoHFW’s Health Economics Unit (HEU) presented a draft National Health Protection Act (NHPA). The draft act envisages the establishment of a National Health Protection Authority – chaired by the Minister of Health and Family Welfare – and a National Health Protection Fund, provision of services (all those not mentioned in a list of excluded services) by public and accredited private providers, with utilisation of services conditional upon a cardholder’s payment of a registration fee to the first-service provider. External stakeholders welcomed the draft NHPA as a unique opportunity to build consensus and move closer to UHC, but also formulated critical
comments – from both a technical and a political-economy perspective. Among the technical issues, a range of gaps were identified: absence of a time frame for implementation, lack of clarity on how an initially fragmented approach will lead to single pool, on how to curb the potential exclusionary effects of a registration fee, on the voluntary respective mandatory character of the cardholders’ contributions, on how to target those eligible for subsidies and how to determine such subsidies, and so on. The intention to define a list of excluded services, instead of one of essential services, was frowned upon. The point was also made that the NHPA “will only contribute to a meaningful improvement, if the extent of infrastructure and availability of skilled health work force in Bangladesh guarantees the availability of health care (…) for all”, which will require significant investments. At the political-economy side, the formulation of the draft NHPA by one ministry independent from all others was questioned. As one commenter put it: “the MoH(FW) can’t do this alone and given the inherently political nature of these reforms they really should be led by the Prime Minister”.

In this context, it seems wise to remember El Arifeen and colleagues’ plea for a clearer definition of the roles of government, private sector and NGOs to increase accountability and improve policy, regulation and implementation. For equity becoming a reachable target – more than just a repeated policy discourse – there is indeed a need for action beyond the health sector. Bangladesh would strongly benefit from systematic intersectoral cooperation as in a Health-in-All-Policies approach; a significant first step would be to integrate social health protection for universal coverage and social protection at large – as was advocated by Walsham in the 2014 UNDP ‘Social Protection in Bangladesh’ report specifically for the benefit of the urban poor, but notably absent from the current draft of the National Social Protection Strategy.

In fact, it is quite useful to draw a parallel between Bangladesh’s efforts for universal health coverage and for social protection. Bangladesh has witnessed a proliferation of safety nets and other social protection programmes over time, programme proliferation has been fuelled by competitive patronage politics as well as by a lack of coordination, many existing programmes still have a rural focus only, and elite capturing of programme benefits is significant. As David Hulme expressed at the launch of the 2014 UNDP report:

“Bangladesh has 80 to 90 social protection programmes operated by 20 ministries. These schemes have been successful in disaster management, food relief and income poverty reduction, but they are now not meeting contemporary needs and are not effective and efficient.”

Earlier studies have also highlighted that effective coverage of the plethora of social protection initiatives is actually quite low. Talking about the future of social protection in Bangladesh, Neal Walker (UN resident coordinator in Dhaka) hit the nail on the head when claiming “I do understand that effective action may require decades, but it is my view – that kind of thinking will only lead to failure”, making a case for urgency in action and integrity of programmes within a comprehensive approach, backed up by sustained political leadership. Situation and prospects in health coverage are strikingly similar. Following up on Bangladesh Health Watch’ call half a decade ago for immediate mobilisation for universal health coverage, today is the day for immediate and concerted action. This should be respectful of past innovative advancements, adapted to the actual context and changing specific needs, but above all within a unified approach with clear roles for all.
Towards universal coverage in the majority world: the cases of Bangladesh, Cambodia, Kenya and Tanzania

Cambodia
The Kingdom of Cambodia (hereafter Cambodia) started restructuring its health system in 1996, three years after restoration of its monarchy following decades of conflict. A multi-tier health system with ‘operational districts’ as entry point was established, and user fees were introduced. This was a courageous move to make progress, at a time when human resources were decimated, poverty widespread and life expectancy lower than 50. At the start of the reform out-of-pocket spending accounted for 82 per cent of health expenditure, donor funding for 14 per cent and government spending for 4 per cent. Community-based health insurance schemes were introduced from 1998 onwards. Contracting of NGOs for public delivery started in 1999. The first health equity fund was set up in 2000. By 2012, out-of-pocket spending accounted for 61 per cent of health expenditure, donor funding for 15 per cent and government funding for 24 per cent.

Despite exceptional economic growth in the last decade, Cambodia is still a low-income country with disappointing development indicators. While the proportion of poor dropped from more than 50 to about 20 per cent, a major proportion of its 15 million-plus population – especially so in the predominant rural economy – lives in near-poverty yet vulnerable conditions and health care has become a poverty trap by itself. Moreover, health improvements lag behind economic progress, and health indicators remain among the lowest in the region. Maternal mortality halved between 2005 and 2010, and is diminishing still, but remains more than 3 times higher than in Vietnam and more than 6 times higher than in Thailand. Malnutrition started declining after 2010 only. Where substantial improvements were made, as in under-5 mortality, equity remains a major concern: children in the lowest wealth quintile or from rural areas have a three times greater risk of dying before age 5 than those from the highest wealth quintile or from urban areas respectively. Overall access and financial protection, as measured by out-of-pocket payments related to household capacity to pay, have improved, but actual healthcare costs as well as equity gaps are increasing over time. Out-of-pocket expenditure per capita and per year increased from 15 US$ in 2004 to 28 US$ in 2009 and to 50 US$ in 2013. It is worth noticing that total health expenditure in Cambodia almost doubles that of comparable low-income countries.

A first Health Sector Strategic Plan (HSP1 2003 – 2007) was launched in 2002, envisaging equitable quality health care and focusing on the poor and areas in greatest need. Weak implementation led the government to declare improving the health status of all Cambodians a political priority and to develop a second Health Sector Strategic Plan (HSP2 2008 – 2015) in 2008. The HSP2 added reduction of the burden of non-communicable diseases to the objectives already formulated in the HSP1 and was followed by a detailed Strategic Framework for Health Financing (SFHF 2008 – 2015). The SFHS specified five strategic objectives: (1) to improve government budget and to improve efficiency of government resource allocation for health; (2) to align donor funding with MoH plans and priorities and to strengthen coordination of donor funding; (3) to remove financial barriers at the point of care and to develop social health protection mechanisms; (4) to improve efficiency of use of resources at service delivery level; (5) to improve production and use of evidence for policy development.

Contiguous with the HSP1, a social health insurance Master Plan (SHI Master Plan 2003 – 2007) was drafted in 2003, approved in 2004 and divulgated in 2005. The plan proposed the parallel development of compulsory insurance for public and private sector employees and dependents, voluntary community health insurance schemes for those in the informal sector able to contribute, and donor-funded (eventually government-funded) health equity funds for the others. Benefits would be comprehensive, not based on a minimum package, and uniform for the first two categories.

Following the HSP2 and contiguous with the Strategic Framework (SFHF 2008 – 2015) that proposes gradually bringing together the segmented health financing efforts into a single mixed approach to move towards universal coverage, in recent years both a social health protection Master Plan (SHP Master Plan 2008 – 2015) and a Health Financing Plan (HFP) were developed. The SHP Master Plan eventually envisages one national health insurance agency, and universal coverage. The Plan however, after been submitted to and amended by the Council of Ministers, was never finalised by the MoH. Elements of the Master Plan were absorbed into the HFP, drafted in 2012 – 2013 and adopted in 2014, which still proposes the establishment of three social health protection...
schemes, each for a different population group and under a different ministry: a National Social Security Fund (NSSF) for private formal sector employees under the Ministry of Labour and Vocational Training, a National Social Security Fund (NSSF-C) for civil servants under the Ministry of Social Affairs, Veterans and Youth Rehabilitation, and a National Social Health Protection Fund (NSHPF) for the informal sector under the Ministry of Health. Currently, the HFP is being revisited following review by the Ministry of Economics and Finance.

To achieve equitable expansion of population coverage out of pocket donor funding government spending

Cambodia was one of the few countries in the world where the introduction of user fees – in 1997, endorsed by the 1996 National Charter on Health Financing – actually led to increased service utilisation, though excluding the poor despite exempting them. While the positive effect on overall utilisation has been attributed to formal user fees replacing excessive informal fees, the negative impact became clear when service providers (mainly at hospital level) reacted to the absence of compensation for the exemption policy by rejecting the poor. In search of more equitable population coverage, a range of pro-poor targeted initiatives saw the light, among them a Cambodian innovation: health equity funds.

Health equity funds (HEFs) are third-party schemes that reimburse empaneled health facilities for a defined range of services to (usually) pre-identified beneficiaries. The first HEFs were introduced in 2000, among them the Sotni-kum H EF to complement a performance-based financing scheme in a contracted NGO hospital. Ever since, H EFs have been set up – on their own or in combination with contracting, pay-for-performance, community health insurance arrangements and/or additional targeting instruments – all over the country. Mainly initiated and funded by non-government agencies, H EFs have enjoyed increasing support by government actors, as expressed in the 2003–2006 National Poverty Reduction Strategy, the 2003–2007 and 2008–2015 Health Sector Strategic Plans, and the 2008–2015 Strategic Framework for Health Financing and Social Health Protection Master Plan.

In 2007, following the 2006 decree Prakas 809, the government initiated its own (non third-party) subsidy schemes. In 2003, a H EF Framework was developed, followed by guidelines for H EF and government subsidy schemes alike in 2009. Accordingly, H EFs reimburse the user fees of the services, which are nominal and mainly intended as staff incentives, while the MoH subsidizes all other costs. H EFs are the most widespread SHP scheme in Cambodia, and seen as a platform for extension towards universal health coverage. Nationwide expansion – to all health districts as well as all health centres and public hospitals – is scheduled for 2015.

As of December 2013, H EFs were active in 52 out of 81 operational districts, covering in theory about 2.4 million of the poorest Cambodians. Yet effective population coverage, translated in utilisation, is lower as a significant proportion of eligible households do not fully use H EF service. As H EFs operate in a range of configurations (with and without contracting, pay-for-performance, community health insurance arrangements and/or additional targeting instruments) and at different service levels, estimating the single impact of H EFs on pop-
In 2013, HEFs were active in 52 (64.2%) out of 81 operational districts, covering about 2.4 million of the poorest Cambodians.

While Cambodia – contrary to many other low-income countries – has addressed social health protection for the poor in the informal sector, together with a nationwide targeting mechanism termed ID-Poor, little progress has been made for the poor in the formal sector. A National Social Health Protection Fund for private sector employees – ideally covering about 1 million people, mainly working in the garment industry or in rubber plantations – was supposed to become operational in 2014 but failed to realize and is rescheduled for 2015.

Equitable expansion of service coverage

Any discussion on service coverage in Cambodia has to be framed within its particular context of pronounced user preference for private care, for a variety of reasons.

Lack of confidence in government services was documented already a decade ago, when Cambodia’s track record of health-related debts struck the world127, and is still a major determinant of service utilisation. Concerns on the quality of government health services are widespread127,128, despite the existence of a Master Plan for Quality Improvement in Health since 2010.

Public services score low in availability (distance, restricted working hours, longer waiting times than private clinics, absence of staff during working hours), staff behaviour (particularly in hospitals and with poor patients) and perceived quality (inadequate examination, ineffective and limited variety of prescriptions, no prescriptions upon demand). Private providers by contrast, following patients’ treatment preferences whether or not they are medically justified, are popular but largely unregulated, promoting inefficient and often harmful care121.

Understandably, effective service coverage is sub-optimal: as documented in the latest Demographic and Health Survey, 15 per cent of people suffering a minor condition have to seek care from a second provider because of unsuccessful initial treatment, and 5 per cent continue to seek help from a third. For those with a serious ailment, the figures are 35 per cent and 14 per cent respectively78,95. For all conditions combined, 29 per cent of rural

In absolute terms and compared to health equity funds, the share of community-based health insurance (CBHI) in population coverage has decreased over time95. Moreover, channelling HEF subsidies through CBHI schemes – once considered a strategic move to boost coverage while avoiding stigmatisation of HEF beneficiaries123 – has been shown to be less cost-effective in providing access to the poor than direct reimbursement of the healthcare providers124.

Equitable expansion of population coverage beyond targeting the poor has been less documented. At district level, Ir and colleagues noted increased access to institutional deliveries when complementing existing HEFs with a voucher scheme for maternal health services125. At national level, Liljestrand and Sambath confirmed the potential of a combined HEF-voucher design to improve access – and to reduce maternal mortality – while advertising to the concomitant need for addressing non-financial barriers and quality issues at the supply side128. Dingle and colleagues, analysing utilisation of a range of reproductive and maternal health services over 10 years, documented equitable expansion of population coverage in all of them. However, coverage of two of the most critical services – institutional deliveries and skilled birth attendance – remains highly inequitable97.

ululation coverage is no easy task. There is however consensus that HEFs have increased access to services for the identified poor, albeit less than expected114–118. The 2004 and 2009 Cambodian socio-economic surveys indicated increased access to medical care in case of illness, overall and among the poorest. Inequity however remained substantial, with more than 20 per cent in the poorest subgroups not seeking care when ill, compared to less than 10 per cent in the wealthiest subgroup. Additionally, there is growing concern over the non-coverage by HEFs of the near poor87,98. The 2011 socio-economic survey confirmed low coverage and limited impact on access of HEFs. Only 46 per cent of the poor were covered by HEFs and possessing a HEF card increased health seeking in public facilities by 34 per cent but did not increase the overall demand for care when sick. Utilisation of HEF cards for outpatient care – for which 85 per cent of all patients rely on private or non-medical providers – remains low122.

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Understandably, effective service coverage is sub-optimal: as documented in the latest Demographic and Health Survey, 15 per cent of people suffering a minor condition have to seek care from a second provider because of unsuccessful initial treatment, and 5 per cent continue to seek help from a third. For those with a serious ailment, the figures are 35 per cent and 14 per cent respectively78,95. For all conditions combined, 29 per cent of rural

In 2013, HEFs were active in 52 (64.2%) out of 81 operational districts, covering about 2.4 million of the poorest Cambodians.

While Cambodia – contrary to many other low-income countries – has addressed social health protection for the poor in the informal sector, together with a nationwide targeting mechanism termed ID-Poor, little progress has been made for the poor in the formal sector. A National Social Health Protection Fund for private sector employees – ideally covering about 1 million people, mainly working in the garment industry or in rubber plantations – was supposed to become operational in 2014 but failed to realize and is rescheduled for 2015.

Equitable expansion of service coverage

Any discussion on service coverage in Cambodia has to be framed within its particular context of pronounced user preference for private care, for a variety of reasons.

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residents (80 per cent of the population) seek first treatment with public medical providers, and 56 per cent with private medical providers (others forego treatment or go to non-medical providers). In urban settings, these figures are 26 per cent and 66 per cent respectively. Coverage is particularly weak for people needing hospital care, living in rural areas, living with chronic conditions, and older people. In 2010, 58 per cent of diabetes patients being treated had uncontrolled blood sugar levels, while 39 per cent of treated hypertensive patients had no blood pressure measurements.

While health equity funds, Cambodia’s foremost innovation, have been relatively successful in expanding access to health care for the poor, their effectiveness in improving quality of care was and is constrained by prevailing levels of low wages, low resourcing, inadequate training, and unregulated private practice. By contrast, performance-based incentive schemes – and particularly so the nationwide Government Midwifery Incentive Scheme (GMIS) introduced in 2006 – noticeably improved service access, service quality and health outcomes. No single intervention however, including HEFs and the GMIS, reaches its full potential for improvement without concomitant efforts at demand and supply side, and beyond the health sector.

Equitable expansion of financial protection

Financial protection is a core dimension of universal coverage, and it certainly is in Cambodia where catastrophic health expenditure, medical debt, sale of assets, borrowing, debt bondage and other forms of medical impoverishment are well documented and actual healthcare cost is still on the rise.

Comparison of data from the 2004 and 2009 Cambodian socio-economic surveys (CSES) show a mixed picture: in five years, the average monthly spending per person seeking care had increased 235 per cent and average OOP payment per person 198 per cent, while the proportion of families incurring catastrophic health expenditure (CHE) and that of families facing indebtedness due to illness decreased from 6.0 per cent to 4.3 per cent and from 5.3 per cent to 3.8 per cent respectively. The 2011 CSES shows a further decline of CHE to 2.8 per cent and of indebtedness, but also highlights a range of inequities: of the poor, 18 per cent incur debts because of health expenses; in rural areas, families having a chronically ill member spend 125 per cent of per capita income for his/her care. Financial protection is particularly problematic for older Cambodians: while people of 60 and above account for only 6 per cent of the population, they accounted for about 50 per cent of OOP on health in 2013.

While the Social Health Protection Master Plan 2008 – 2015 envisages one national health insurance agency encompassing three big schemes to be developed, today financial protection efforts are still scattered over a range of arrangements, of which health equity funds (HEFs) are the most prominent and most documented one. A 2011 study on the impact of HEFs on financial protection found that HEFs do not reduce the propensity to incur healthcare payments, but do reduce the amount spent on health care by 29 per cent on average. The effect is larger for the poorer households (35 per cent) that HEFs target, for households that mainly rely on public health care (43 per cent), which is what HEFs cover, and for those that live within 5 km of a district hospital (46 per cent), which is were HEFs are typically located.

Other recent sources give a less positive picture. In the 2010 Cambodia Demographic and Health Survey (CDHS), only 4 per cent of those in the poorest quintile reported having services paid for by HEFs, and 1 per cent by community-based health insurance schemes. Out-of-pocket expenditure for health has reached 61 per cent, the overwhelming proportion of it being paid to private providers. A 2014 World Bank study echoes a finding from the 2011 Cambodia Socio-Economic Survey (CSES): despite a high theoretical coverage of HEFs and similar schemes, a majority of the poor do not have HEF cards, and those with cards not always use them. About 10 per cent of the poor report using a HEF card or similar, another 10 per cent report using an ID-Poor card (issued since 2007 for the government subsidy schemes) – leaving 80 per cent of the poor that do not access free or subsidised treatment, and largely unprotected. Besides, inequitable coverage is manifest through leakage, with 5 per cent
of those in both the 3rd and 4th wealthiest quintiles reporting use of ID-Poor or other subsidised cards for getting treatment.\textsuperscript{87}

**Institutional design**

During the 1990s, except for the Health Coverage Plan and the National Charter on Health Financing (both in 1996), the locus of policy design and development was less nationally owned than donor-driven, as the development of CBHI schemes, contracting arrangements and HEFs illustrates. From 2002 onward, first with the Health Sector Strategic Plans – then with the consecutive social health insurance and social health protection Master Plans, Cambodian government has become more directive in setting out policy lines. Though external actors still have a significant role in agenda setting and policy formulation, government has strengthened its autonomy, despite aid dependency and weak implementation capacity. A major gap in the institutional capacity however is noticeable in the absence of governance over the private sector.\textsuperscript{80,133}

**Organisational practice**

A historical and political perspective is needed to understand the complex configuration of actors and powers in Cambodian health policy. In the immediate post-Khmer Rouge years, international actors were instrumental in both service delivery and policy making. All along the difficult years of political consolidation and recovery – up to the turn of the century, while Cambodian human resources slowly regained a critical mass, international actors were given remarkable free reign and strengthened their position as policy actors. With violence finally under control (post-1998), government gradually found the time to become the ultimate decision maker in social policy, including health. Government support for the health sector however has not been at par with its emphasis placed on economic growth.\textsuperscript{80} This has contributed to a rapid growth of a disparate and unregulated private sector. History, including the long policy vacuum, to some extent explains the Cambodians’ lasting preference for traditional and private providers.\textsuperscript{134}
The current picture is one of a range of stakeholders—government and international actors including donors, technical experts and NGOs—in which the government has the last word, yet the external actors still have a sizeable influence, and from which the health workforce and the general public are largely absent. The latter democratic deficit is further complicated by Cambodia’s political culture’s track record of what has been termed patronage and clientelism, an elite pact (by rent-seeking businessmen, politicians, generals and technocrats) and generalised corruption.

Current situation and way forward

Cambodia today is still far removed from universal coverage. All the same, transition to universal coverage is prominent on the agenda of the policy community. Currently, the main focus is on the demand side, envisaging extension of social health protection schemes. Yet, as a recent Health Systems in Transition review formulates it: “the period of piloting and experimentation (…) is over. Health-system policy needs now to return to strengthening the supply side. Improving the quality of care is now the most pressing need (…). In the public sector this requires attention to funding, management processes and the remuneration of public-sector workers. For the private sector, it poses the immediate necessity for extended regulation, accreditation and enforcement.”

Convergent with international evidence pointing to the need for strong political commitment and beyond the functional requirements, government and non-governmental actors in the Cambodian policy community are increasingly aware that meaningful progress towards universal coverage cannot rely only on demand-side efforts but needs a system-wide approach with well-defined and strong national ownership. The latter could benefit from all actors’ alignment with the cause of universal coverage, transcending their particular agendas and interests, from involvement of the general public as ultimate stakeholder, and should encompass a deliberate shift from political clientelism towards a rights-based modus operandi. A system-wide approach should at least include substantial improvements in resources and performance of public health services, and concomitant regulation of private services, with particular attention for the needs of vulnerable groups, including but not limited to rural populations, the elderly, people living with chronic conditions and the increasingly important group of near-poor. The growing number and vulnerability of near-poor is not an exclusively Cambodian phenomenon. The presence of a ‘missing middle’—largely in the informal sector and hard to cover with health insurance—has been described as a common and resistant consequence in many a country where coverage efforts started with prioritizing service coverage for targeted groups over population coverage. In the particular case of Cambodia, moving towards effective population coverage requires, possibly more than demand-side efforts like subsidized insurance, serious efforts to boost the quality of the supply slide.

The actual plan to extend social health protection for universal coverage in Cambodia by building on the existing health equity funds (HEFs) has a strong rationale. It can rightly be argued that Cambodia’s HEFs represent a structural advantage over other countries with similar challenges, but without HEFs. Fernandes Antunes and Jacobs make a favourable comparison with the situation of Ghana before the establishment of its National Health Insurance Scheme. It should however be recognised that HEFs in their actual form, though they reduce OOP payments by 29 per cent on average, still leave 44 per cent of their beneficiaries spending out-of-pocket and have no significant impact on effective coverage measured as healthcare utilisation. It should also be recognised that the existing fragmentation of initiatives is ineffective, inefficient and inequitable, and hard to overcome. Therefore, equitable population coverage through the establishment of a single national fund—the sooner the better, and earlier than foreseen in the SHP Master Plan—should receive priority attention, conditional upon harmonisation of initiatives, genuine national ownership, and political support at the highest possible level.
Kenya is a low-income, multi-ethnic, East African country with a population of around 40 million. Kenyans face a heavy burden of diseases, comprising mainly preventable communicable diseases including malaria and HIV/AIDS, plus an increasing amount of non-communicable conditions. Despite the country’s improved overall economic growth, Kenya still struggles with high levels of poverty, inequality and unemployment. The country is unlikely to meet the Millennium Development Goals (MDGs), especially poverty reduction and health-related MDGs. Major efforts to boost progress are the establishment of a new constitution with clear implications for the UHC agenda, in particular through the devolution of responsibilities to counties and the declaration of access to quality services as a right, and the development of a social security policy under the Ministry of Gender, Children and Social Development (MoGC-SD).

Kenya’s actual constitution, adopted in 2010, explicitly includes health and social security in its Bill of Rights, section economic and social rights. The overall goal of the National Health Policy, congruent with the Government of Kenya’s 2008 – 2030 development programme ‘Vision 2030’, is “attaining the highest possible health standards in a manner responsive to population needs”. The aim is to attain “universal coverage with critical services that positively contribute to the realization of the overall policy goal”.

But health services are still not accessible to many Kenyans, with current level of access being estimated at 52 per cent as per the 5-km radius norm. In 2010, the share of health expenditure from total general government expenditure was 4.6 per cent (down from 8 per cent in 2001 – 2002), a third of the amount committed to at Abuja in 2001. Per capita health spending was estimated at 42.2 US dollar, 30 per cent below WHO recommendations. Kenya has nevertheless made several attempts to introduce healthcare financing reforms to eliminate chronic under-funding of the sector and to ensure universal access, in line with its Vision 2030 programme. In 2004 an inter-sectorial taskforce put forward the National Social Health Insurance Fund (NSHIF), whereby the entire population would be systematically enrolled in the existing National Hospital Insurance Fund (NHIF), aiming at universal access and significant reduction of out-of-pocket expenditure. In addition to member contributions, the government would contribute on behalf of the poor. The NSHIF would operate as a single risk pool, endorsed by parliament, but then vetoed by the President for reasons of economic feasibility, sustainability, opposition from the private sector, and concerns expressed by the NHIF.

Learning from this experience, the Ministry of Health (MoH) established a Task Force in 2006 – later known as the Interagency Coordinating Committee (ICC) – for health sector financing, comprising representatives of relevant stakeholders including development partners. A draft health financing strategy was developed in 2009. The draft strategy aims at an equitable financing system, documents policy options and highlights priority reforms towards universal health coverage. Envisioned action points include implementing a national health insurance scheme, channelling funds directly to health facilities without passing through the district, increasing resources to underserved and disadvantaged areas, and scaling up output-based financing so far used for reproductive health services only. While stakeholders reached a consensus on what needs to be done, they did not agree on how exactly it should be done. When the aimed national health insurance will be put in place remains uncertain. Main obstacles for progress were the lack of in-depth stakeholder analysis and of social impact assessment, making it difficult to articulate and bridge the interests of the various stakeholders. A similar multi-stakeholder process led to the development of the 2014 – 2030 Kenya Health Policy. The MOH is energetically taking forward the UHC agenda in Kenya. So far, a Technical Working Group has been constituted to define a comprehensive UHC strategy for the country, to develop a roadmap and an options paper.

Equitable expansion of population coverage

Two years after decolonization, Kenya abolished user fees and maintained free services though tax funding up to 1988. Subsequent decades were characterized by significant changes in healthcare financing with the
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Kenya

led to the introduction of the Health Sector Services Fund, a voucher programme, piloted from 2006 onwards: “it is the voucher programme’s intention to relieve the public sector of the high number of normal deliveries (as the sector suffers of excess utilisation and, therefore, cannot provide services adequately) and increase the utilisation of private facilities by making them affordable to voucher clients”. This pilot programme offers three packages of subsidised services – safe motherhood (SM), long-term family planning (FP) and gender-based violence recovery services (GBVRS) – to poor women in four counties and two slums. While the programme increased facility-based deliveries (part of its SM package), its impact on awareness, availability and utilisation of family planning services was low (particularly so where faith-based providers were involved), and that on violence recovery services minimal. While for-profit and faith-based private providers welcome the programme as a profitable business model that allows them to improve service quality, public providers express disappointment with guidelines that restrict their utilisation of programme funds in the benefit of patients.

A cross-sectional household survey from 2007 shows the Kenyan health sector to be inequitable with benefits not distributed on the basis of needs. The study defines the private-for-profit sector to be pro-rich, the public sector to have an equal distribution and the private nonprofit sector to be pro-poor. At the hospital level, larger pro-rich disparities were recorded for inpatient compared to outpatient benefits, while primary healthcare services were pro-poor. Today, the majority of the Kenyan population is still not able to afford to pay for health care, the poor are less likely to utilize health services when they are ill, and wide disparities in utilisation exist between geographical regions and between urban and rural areas.

Equitable expansion of service coverage

Kenya is struggling to build a health system that can effectively deliver quality health services. Kenya’s health service delivery system is characterized by an underdeveloped infrastructure, a shortage of human resources and essential medical supplies, and limited administrative and management capacity. The government is the main provider of health services owning 51 per cent of all health facilities, followed by private-for-profit (34 per cent) and private nonprofit (most of them faith-based) providers (15 per cent). The lack of health workforce capacity to provide health services to the entire population is a major challenge for ensuring equitable service coverage. Attaining universal health coverage is further constrained by the perceived poor quality of public healthcare delivery. It is argued that good quality services, particularly related to drug availability and interpersonal relationships between patients and providers could boost trust in the public system and create popular support for national health insurance.

An alternative option is presented in a 2011 costing study that – besides noting that on average only 25 per cent of the service needs are covered – advocates increased channelling of patients to underused private facilities for increased service coverage. It worth noting that the latter is also one of the objectives of a reproductive health vouchers programme, piloted from 2006 onwards: “it is the voucher programme’s intention to relieve the public sector of the high number of normal deliveries (as the sector suffers of excess utilisation and, therefore, cannot provide services adequately) and increase the utilisation of private facilities by making them affordable to voucher clients”. This pilot programme offers three packages of subsidised services – safe motherhood (SM), long-term family planning (FP) and gender-based violence recovery services (GBVRS) – to poor women in four counties and two slums. While the programme increased facility-based deliveries (part of its SM package), its impact on awareness, availability and utilisation of family planning services was low (particularly so where faith-based providers were involved), and that on violence recovery services minimal. While for-profit and faith-based private providers welcome the programme as a profitable business model that allows them to improve service quality, public providers express disappointment with guidelines that restrict their utilisation of programme funds in the benefit of patients.

Since 2005, a concerted effort has been made to increase the number of skilled health workers available at the lower levels of the public health system, i.e. the needy districts with the lowest health indicators. Nonetheless, government personnel remains heavily skewed in favour of hospitals and the better-off districts. Increasing the unconditional production of health workers, particularly
physicians, may not be the most appropriate strategy in the short term to reduce health worker shortages because of the high vacancy and physician migration rates\textsuperscript{161}.

In 2010, a Health Sector Services Fund (HSSF) was introduced to compensate facilities for lost revenue associated with user fee removal under the 10/20 policy\textsuperscript{157,158,159}. In line with the devolution envisaged in the Constitution of the same date\textsuperscript{170}, the HSSF provides funds directly to primary health facilities (1) to cover basic recurrent costs – adjusted to include a focus on poverty and regional disparities in service delivery; (2) for operational activities within and outside the facility; and (3) related to performance\textsuperscript{152}. Active involvement of community members in facility management should ensure that funds are spent appropriately. This approach has led to improvements in the reported quality of care, staff motivation and patient satisfaction, greater transparency and improved oversight of user fee revenues\textsuperscript{169–171}.

Concomitantly, the national health insurance fund (NHIF) has also made efforts towards more comprehensive coverage and introduced quality control mechanisms at hospital level\textsuperscript{172}. The draft Kenya Health Sector Strategic Plan III defined an essential package and set targets for population coverage and cost recovery, aiming at progressive realisation of UHC in its three classic dimensions\textsuperscript{142}.

Equitable expansion of financial protection

Despite the intentions of the government to achieve universal health coverage, health financing in Kenya remains deficient, fragmented and lacking substantial risk and income cross-subsidization\textsuperscript{152}. According to the 2009–2010 National Health Accounts, total health expenditure (THE) in absolute terms had increased, but remained constant as percentage of GDP (5 per cent). At the same time, government health expenditure as percentage of total government expenditure dropped from 8 to 4.6 per cent. Within THE, donor funding through NGOs rose from 6 to 28 per cent, and OOP came down from 43 to 25 per cent\textsuperscript{139,147,156}.

Kenya’s fragmented financial risk pools without adequate regulatory framework have negative consequences on cross subsidization\textsuperscript{144}. Health insurance coverage is largely limited to formal sector employees whose membership is compulsory, in contrast with a small number of informal workers based on voluntary contributions. The largest health insurer in the country is the National Hospital Insurance Fund (NHIF). As of June 2010, the NHIF was able to reach about 18 per cent of Kenyans or roughly 2.5 million actively contributing members with 7.5 million dependents\textsuperscript{173}. Because of this high dependency ratio, the contribution level is set high, making it unaffordable for many low-income families. The NHIF covers more than 50 per cent of the cost of curative health care in government hospitals and has been going through a series of reforms in recent years as part of a transformation process to a national health insurance scheme. Reforms include: outreach activities to increase coverage among the informal sector, a more comprehensive cover to those seeking inpatient care in government and faith-based facilities, and a broader benefit package for outpatient care\textsuperscript{152,158}. Over the last decade, several reports have highlighted that NHIF may need to become more transparent. There is also widespread concern regarding NHIF’s inefficiencies, and a belief that NHIF is out of reach for the poor\textsuperscript{173–175}. As one report notes, while the private sector plays an increasingly prominent role in service delivery, stronger NHIF involvement will be needed to secure adequate risk pooling, sustainability and equitable resource allocation\textsuperscript{176}.

Although a number of well-established commercial firms provide health insurance, their contribution to overall health expenditure in the country is almost negligible (about 1.0 per cent), despite the high premiums they charge. These insurances often fail to cover people with chronic conditions like HIV/AIDS, or when they do, the premiums are unaffordable\textsuperscript{152,172}. A range of micro-health, community-based and provider-based insurance schemes adds to the fragmentation, and remains marginal in terms of population coverage\textsuperscript{152,163,173}.

Over the last decade, several health-financing innovations have been introduced. At the supply side, there is the Health Sector Services Fund (HSSF) already discussed. At the demand side, several targeted initiatives were set up, of which the KfW-funded reproductive health voucher programme is the most developed and still in expan-
This voucher programme increased facility-based deliveries, improved women’s choice of facilities and reduced out-of-pocket spending\textsuperscript{166,173,177–179}. Besides, it is seen as an important governance case in preparation of a nationwide health insurance scheme\textsuperscript{165,178,179}. Alongside this programme, several social franchise networks exist for reproductive, maternal and child, and HIV/AIDS services\textsuperscript{173}. In addition to existing but rather unsuccessful GoK waivers programmes for the poor at public facilities, GIZ is piloting since 2012 the means-tested HAKI (Health for All Kenyans through Innovations) initiative to boost access to public and private facilities\textsuperscript{173,178}.

Overall, the Kenyan health sector is still underfunded and healthcare contributions are regressive. The poor thus contribute a larger proportion of their income to health care than the rich. As for the poorest, the catastrophic nature of their health spending remains largely hidden by the fact that food, shelter and other basic necessities already exhaust the bulk of their resources, often forcing them to forego health care in case of need. Of the near poor who do use healthcare services, each year an important part ends up in poverty. Lack of effective financial protection remains a core deficiency in the Kenyan health system\textsuperscript{152,180,181}.

### Institutional design

Health care in Kenya is provided through public, private-for-profit and private nonprofit facilities. Healthcare services are arranged in tiers running from level 1 (dispensary, the lowest level of care) to level 6 (referral hospitals, the highest level of care). Public health facilities, which mainly cater to the poor, are to be found in the lower levels of care while private-for-profit facilities are concentrated in the higher levels of care\textsuperscript{157,156}.

From 2010 on, the health system in Kenya has been going through a major transition with the implementation of the new constitution. The responsibility to deliver essential health services (mainly primary level care) is being devolved to the 47 counties while the national government remains responsible for policymaking and operating the national referral hospitals\textsuperscript{182}.

This devolution of health service provision is aimed at improving health outcomes through better service delivery. Yet difficulties arise when the transfer of functions does not adequately match with required resources\textsuperscript{138}. County governments have not only been mandated with the budgeting role, they will also set sectorial priorities. It is therefore not guaranteed that essential social services such as health would receive adequate funding to ensure efficient health-service delivery at county level\textsuperscript{182}. Given the already existing regional disparities in access to health services, inadequate planning and financing of health-service delivery might result in worsening of health indicators in some regions. Moreover, devolution makes the environment for health financing and possible health financing reform more complex\textsuperscript{182}. Health insurance is not in the list of devolved functions, therefore in principle the function is retained by the national government. However, the counties may choose to create their own pools, the implications of which for NHIF are not entirely clear\textsuperscript{173}. The proposed 2014 – 2030 Health Policy recognises that actual devolution is still a transitional state, with details of functions under national and county governments still to be defined\textsuperscript{147}.

### Organisational practice

From 2001 onwards, when the president directed his ministers to take action on establishing a mandatory health insurance for all Kenyans, the interaction between the stakeholders involved has been intense and complex. The fact that Kenya more than a decade later still has no overarching national scheme in place make a closer look at what went wrong with organisational practice all the more worthwhile. Actors’ perception of the cost of the proposed design and its implication to the economy generated opposition. This was partly due to inadequate communication strategies towards a range of key players. Private-for-profit sector actors opposed revenue collection under a public authori-
ty and insisted on competition to protect their ‘business space’. Mistrust and perceived lack of government’s commitment towards transparency and good governance affected active engagement of all key players. While involvement of global actors was key in the design phase, international support weakened as a number of donors perceived a universal approach as a threat to the vertical programmes they were funding.\textsuperscript{153}

Despite the setback of the earlier insurance plans, the Kenyan government kept up its commitment towards UHC. The ministries of public health and of medical services jointly presented a ‘Vision 2030 sector plan for health’ in 2008, a position paper ‘Social protection in health: policy and financing strategy’ in 2009, and a health finance strategy plan ‘Financing options for universal coverage’ in 2010\textsuperscript{152,168}.

In the 2010 strategy plan several areas of consensus were identified. These include the need for UHC, the examination of out-of-pocket payments, the improvement of effectiveness, efficiency and quality of health service delivery and administration, the design of a uniform basic package of essential health services accessible to the whole population, the development of purchasing capacity complemented by some level of autonomy for healthcare providers, and lastly the need to retain the public-private mix in health services delivery. Grey areas included: the financing of community-oriented public health, the relevance of a separate AIDS Trust Fund, the creation of a mandatory insurance system, the establishment of new intermediary health financing institutions, the content of a universal benefit package as part of UHC and the criteria used in its formulation, and the mandate and tools of purchasers and the organization of oversight and auditing\textsuperscript{148,176}.

Gradual implementation has been recommended to obtain universal coverage with effective risk protection at the least cost possible. Compulsory payroll contributions were considered to have greater political acceptance as well as greater acceptability to workers as opposed to increased taxation\textsuperscript{172}. The implementation of the Community Strategy, a flagship project in Vision 2030, would promote community engagement, ownership and participation in health care, as well as supporting on-going reforms. Eventually, these reforms would lead to better governance and accountability\textsuperscript{148}.

The earlier 2009 position paper, besides preparing the 2010 strategy plan, also drew attention to a particularly weak spot in Kenya’s policy environment: aid dependency. More than 20 donors are active in health, disbursing funds through public and private actors. A substantial part is directed toward specific programmes and quite some donor funding for health is off-budget, leaving the government with very little oversight\textsuperscript{168}. All development sectors considered, alignment of donor funding with government needs is poor\textsuperscript{183} and aid dependency has made Kenya extremely vulnerable to a downturn in donor support\textsuperscript{184}.

Today and in health, the coordination of development support is organised through various Interagency Coordination Committees (ICCs) led by the government. An additional forum for information exchange, coordinating support for various technical and support system ICCs and the division of labour among development partners is the Development Partners in Health in Kenya (DPHK) group. This forum is seen as an effective platform for scaling up support for the Kenyan UHC agenda, both technically and politically\textsuperscript{176}.

Current situation and way forward

The process to come to a comprehensive health financing strategy paving the way for UHC in Kenya has been long and is still inconclusive. Besides, the actual plethora of uncoordinated schemes is both costly and ineffective. On the one hand, contradicting views and restrained involvement of important national stakeholders protracted and at times paralysed the process, while more donor-driven pilot schemes added up to fragmentation — the latter being an increasing source of frustration for government actors, aid dependency notwithstanding, as a recent donor report noticed\textsuperscript{172}. On the other hand, the opportunity to land up at workable strategic choices —
grounded in Vision 2030 and the 2010 constitution and driven by the government’s maintained commitment to UHC – has never been greater.\(^{148}\)

A recent analysis of difficulties over the last 10 years of policy formulation concluded that progress is possible, by widening the design focus to a systemic approach, which should involve stakeholder engagements, improve the healthcare delivery system, enhance transparency and develop institutional leadership throughout the process.\(^{153}\) The need for institutional leadership had also been stressed earlier in an external review, supported by P4H, that made a plea for reviving the Interagency Coordinating Committee on Health Financing “headed up by a government official of the highest possible level in order to overcome possible contradicting views of ministries and stakeholders who may have vested interests not consonant with the GoK’s ambitions for social health protection and universal health coverage”. The same report emphasized that establishing universal health coverage cannot be achieved by the health sector alone: “Intersectoral involvement, coordination and agreement within the Government and between the ministries of health, social welfare, labour and finance is (...) a key pre-requisite for successful reform.”\(^{148}\)

These recommendations have not fallen on deaf ears: in August 2014, the Ministry of Health delivered its ‘Kenya Health Policy 2014 – 2030’ in which it explicitly links the hitherto separated development of social protection and universal coverage strategies by aiming at the establishment of “a social protection mechanism to progressively facilitate attainment of universal coverage.”\(^{147}\) This policy document not only endorses a multi-sectoral approach, it goes one step further by adopting a Health-in-all-Policies strategy for that purpose: “(Our) multisectoral approach is based on the recognition of the importance of the social determinants of health in attaining the overall health goals. A ‘Health in all Policies’ approach will be applied to attain the objectives of this policy. The relevant sectors include, among others, agriculture – including food security; education – secondary-level female education; roads – focusing on improving access among hard-to-reach populations; housing – decent housing conditions, especially in high-density urban areas; and environmental factors – focusing on a clean, healthy, unpolluted and safe environment.”\(^{147}\)

In a subsequent Technical Concept Note, November 2014, the Ministry of Health laid down a series of envisaged health financing reforms for universal health coverage. Its proposed model encompasses optimising on mixed sources of funding from both general revenues and health insurance premiums, reducing fragmentation of existing pools under a single agency, introducing strategic purchasing and less reliance on line item budgeting to make space for provider incentives. To make more funds available, a list of possible action points are put forward for consideration:

1. to maximize efficiency gains by reducing wastage at all levels of the health system;
2. to gradually increase government funding for health from the current 4.6 per cent to 15 per cent (Abuja target);
3. to expand insurance funding from the current 6 per cent to 40 per cent of total health expenditure by mobilizing mandatory contributions from the informal sector, but excluding indigents and the vulnerable groups;
4. to mobilize additional resources from external sources;
5. to raise additional revenues at county level; and
6. to fix co-payment at no more than 10 per cent.

The Concept Note’s last paragraph resume Kenya’s actual challenge: “Success of this complex reform process depends on political will and the right management approach. The strategies and management principles recommended include: (a) Advocacy for the importance of the reform and its implications; (b) Analyzing the interests of the main stakeholders; (c) Informing all stakeholders and actors on the proposed reforms for ownership; (d) Developing a 5-year implementation plan based on a logical framework with a solid component for internal and external monitoring, as part of the UHC roadmap; (e) Avoid fragmentation of the approach by accommodating donors and external experts with preferences to specific target groups and strategies; and (f) Give the process time to grow organically with full support from all stakeholders while staying the course towards UHC.”\(^{144}\).
Tanzania
The United Republic of Tanzania (hereafter Tanzania) is the most populous East African multi-ethnic low-income country. Between 2007 and 2012, its economic growth fluctuated between 8.8 and 5.1 per cent. Over the same period, poverty headcount at national poverty lines declined—a first significant improvement since the 1990s—from 34 to 28 per cent of its now nearly 48 million population. All the same, still 44 per cent of Tanzania’s adult population earns less than 1.25 US$ a day. Nearly 70 per cent of the population is still rural; agriculture accounts for half of the employment workforce. Tanzania is on track to meet the child health and HIV/AIDS related Millennium Development Goals, but lags behind in maternal health and education. In 2013, under-5 mortality had come down to 52 per 1,000; maternal mortality was at 410 per 100,000. According to a 2015 mid-term review of the national health plan, the country only lags behind its objectives on one dimension: skilled birth attendance. Tanzania’s population is expanding fast (a 45 per cent increase between 2000 and 2013), which poses challenges in terms of population health and to the country’s health system, noticeable because of the double burden of diseases: on the one hand, the country still faces a high prevalence of communicable diseases mostly affecting the younger population (45 per cent of the population is younger than 15); on the other hand, the number of people suffering from chronic conditions is rapidly increasing, under the effects of two combined factors—a high number of people living with HIV/AIDS and a growing share of older people in the population (5.5 per cent of the population is over 60).

For several decades, Tanzania has been one of sub-Saharan Africa’s top recipients of international aid. Development assistance accounted for 10 per cent of GNI in 2013; aid dependence is particularly pronounced in health, still increasing and accounting for nearly half of the total funding. Total expenditure on health more than doubled from 2005 till 2013 (from 21 to 49 US$ per capita). Government spending on health relatively increased until 2010, but came down again. Out-of-pocket expenditure came down from 32 per cent in 2009–2010 till 27 per cent in 2011–2012 but is still a main component of total health expenditure. More than 17 per cent of the extremely poor households spend at least 5 per cent of their total expenditure on health.

About 2 per cent of the population incurs catastrophic health care expenditures and 1 per cent becomes impoverished because of OOP payments. In 2007, the Government of Tanzania (GoT) adopted a National Health Policy whose main objective is “to improve the health and well-being of all Tanzanians with a focus on those most at risk”. This paved the way for its commitment to universal health coverage so as to ensure that all citizens have access to quality services and be protected from financial risk. To realize this vision, the GoT decided—as part of the Health Sector Strategic Plan III 2009–2015 (HSSP III)—to develop a Health Financing Strategy. In the same year, the Ministry of Health and Social Welfare (MoHSW) commissioned the analysis of the then-current regulatory framework and requested suggestions for the design of a new one. This new framework should address the strong fragmentation of the health financing system, which had deepened by the emergence of several health insurance schemes.

In April 2010, the MoHSW and the health financing technical working group drafted a first strategy development plan. The MoHSW called upon the P4H network for support, which P4H committed to provide. In 2012, the GoT established an Inter-ministerial Steering Committee (ISC) to guide and oversee a Health Financing Strategy (HFS). The committee comprises directors from key ministries responsible for finance, labour, and industries, as well as departments responsible for decentralization, public service, and planning. Efforts are focused on ensuring a multi-sectoral approach. The ISC has been consulting several stakeholders and has been liaising with government decision-making bodies.

In 2011, the MoHSW commissioned an in-depth review of the regulation of Social Health Insurance (SHI). The regulatory framework had remained highly fragmented with separate regulation guiding different insurance operations, often without regard to the specific requirements of health insurance. Among other things, the review revealed that the policy objective of social health protection was not reflected in the legislation. In 2012, two influential publications saw the light that facilitated the ISC’s task to develop an evidence-informed strategy. Within the broader SHIELD (Strategies for
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Health Insurance for Equity in Less Developed countries study\(^{201}\), Borghi and colleagues modelled the implications of moving towards UHC using insurance mechanisms in Tanzania. They showed that expanding financial protection would significantly impact utilisation, especially so in public outpatient services. Moving towards UHC by offering the whole population a minimum benefit package through the biggest two existing schemes (NHIF and CHF/TKA, see further) would require a doubling in the proportion of GDP for health from 3 to 6 percent in the short term. For this purpose, using existing reserve funds of the National Health Insurance Fund (representing about 15 years’ worth of claims at current expenditure levels\(^{193}\)) would however go a long way, with additional resources to be generated through increases in the rate of VAT and/or expanding the income tax base. Borghi and colleagues also pointed out the importance of improved cost regulation to make the proposed path to UHC sustainable\(^{202}\).

Haazen, in his 2012 World Bank study ‘Making health financing work for poor people in Tanzania’, built further on the modelling exercise pioneered by the SHIELD team, calculated that a lower raise in GDP for health would be sufficient for extension of coverage, as long as robust economic growth continued. Like Borghi and colleagues, he stressed the need for cost control and regulation, and added that “the fiscal transfers required and the redistributive effects of major health financing reforms make political leadership essential”\(^{193}\).

In 2013, the MoHSW supported by P4H partners launched stakeholder consultations with the private sector, including civil society organizations, labour unions, employer organizations, social and private health insurers, health service providers, academia and development partners. By the end of the year, the ISC reached a consensus and produced a list of recommendations for the HFS formulation. At the core would be a single SHI, compulsory for all Tanzanians. The SHI would then entitle to a unique minimum benefit package, with subsidised access for duly identified poor. Private health insurance would be allowed to offer complementary packages. Service quality would be enhanced by applying results-based financing and by granting more autonomy to public service providers and competition between public and private providers.

Based on the ISC’s recommendations, in 2014 two consecutive HFS drafts were produced and discussed\(^{187}\). Further technical advancements were made, including a fiscal space analysis early 2015\(^{203}\). At the same time a third HFS draft was completed\(^{190}\), which allowed the process – led by the MoHSW – in search of high-level political approval to take centre stage\(^{204}\). In June 2015, the Ministry announced that, instead of handing the HFS in for cabinet approval, it would develop a cabinet paper for the Single National Health Insurance (SNHI) legislation, to which the HFS would be added as supportive document\(^{205}\).

**Equitable expansion of population coverage**

At the turn of the 1990s, Tanzania embarked in the development of a two-pronged strategy, composed of contributory and non-contributory arrangements.

On the one hand, the country gradually set out several health insurance options targeted at different population groups: the Community Health Funds (CHF, 1997 onwards) and the TiBa kwa KAdi (TIKA, 2009 onwards) for respectively the rural and urban solvent population working informally, the National Health Insurance Fund (NHIF, 1999 onwards) in charge of covering the civil servants, and the Social Health Insurance Benefit (SHIB, 2006 onwards) for formal employees in the private sector. However, the overall level of population coverage remained low (2015 estimates vary between 16 and 22 percent of the total population\(^{190,191}\)). Furthermore, little is known on the effective coverage provided by these schemes.

On the other hand, since the introduction of user fees in 1993, Tanzania has developed a wide range of exemption policies in the public health sector. Such is the case for either a specific set of services – e.g. pregnancy care, HIV/AIDS, tuberculosis, cancer, chronic conditions, leprosy, polio – or for vulnerable groups – e.g. children under five, people above 60. These waivers did not always obtain the desired effect and today still favour the better-off people more than the poor\(^{193}\). Earlier data had already shown
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The wide discrepancy in the distribution of facilities between urban and rural areas in Tanzania, therefore tackling the distance barrier to access to health care that particularly affects the poorer segments of the population. Surprisingly, however, the figures displayed in the Health Sector Strategic Plan III (HSSP III) showed that in 2009, 90 per cent of the population was already living within 5km of the closest health facility.

Equitable expansion of service coverage

The government remains the main health service provider at country level, owning between 60 per cent and 65 per cent of the facilities in the country, while the private sector accounts for 35 – 40 per cent of the facilities in 2010. The government however is unable to deliver quality services to the whole population. Despite recent indications of better performance, Tanzania still faces severe shortage and strong inequities in terms of distribution of healthcare facilities, drugs and medical supplies, and human resources.

A 2012 assessment, conducted on a sample of 1,297 public and private facilities, showed that most health facilities score low for basic amenities. More than half of health centres and one third of hospitals did not possess a minimum of basic equipment.

The 2009 – 2015 HSSP III envisages improving health service performance by focusing on priorities related to: infrastructure expansion and improvement, strengthening referral services, increasing the number and quality of human resources, improving management capacity at local government level, and increasing and broadening mechanisms of health financing.

Data from household surveys indicate that, in the first half of the plan’s implementation, some inequities are being reverted – by sex, urban/rural residence and socioeconomic position – for several indicators, including child mortality and immunization and malaria coverage. However, for most anthropometric indicators in children and for skilled birth attendance, large inequalities still persist and utilization of outpatient care shows no increase between 2009 and 2012. Rates of institutional delivery have remained static for over 20 years, and lack of quality appears to be a principal cause. McMahon and colleagues, in an in-depth qualitative study, provide a frightening account of disrespectful maternity care. Baker and colleagues, applying Tanahashi’s model to identify bottlenecks in maternal and newborn care, confirm lack of service quality as a major issue.

Shortage and inequitable distribution of human resources is still problematic in the Tanzanian health sector. Production, attrition and retention of health professionals are far from ideal, with 48 per cent of positions being filled with qualified health workers compared to the national standards. In 2008 – 2009, GoT piloted a financial incentive initiative to address inequity in 36 presumably understaffed districts. It turned out however that the selection was discretionary, not based on staffing numbers per population, and actually reinforced the exiting inequities instead of correcting them. Performance is further affected by high levels of absenteeism and low productivity. A study in two districts in the Arusha region documented 26 per cent of staff to be absent, ranging from 22 per cent in urban to 34 per cent in rural facilities.

Pay-for-performance (P4P) was introduced nationwide in Tanzania in 2008. Challenges with the design and implementation arrangements and a lack of external funding for the performance payments caused the GoT to pilot a revised model in the Pwani region. A 2013 assessment of the Pwani experience concluded that P4P would improve overall efficiency and motivation among staff, made some suggestions for design improvement and recommended a phased scale-up of the model. Now termed
results-based financing (RBF), this purchasing mechanism became a core component of the subsequent HFS drafts and its design was further developed in a series of MoHSW documents. Phased roll-out is foreseen, starting with the Shynianga region in 2015.

**Equitable expansion of financial protection**

The share of out-of-pocket payments (OOPs) within THE gradually decreased from 42 per cent in 2002 down to 27 per cent in 2012, reaching again 32 per cent in 2013. Over the same period, we observe a trend towards substitution of OOPs by donor funding. However, direct contributions of the patients at the point of use remain a predominant feature of the national health financing system: OOPs constitute the second financing source, behind donor funds which represent 48 per cent of THE, and before general tax revenue (21 per cent of THE) and prepayment schemes (3 per cent of THE). The low contribution of prepayment schemes suggests a limited effective coverage of the still limited insurance population coverage (16–22 per cent, as estimated in 2015).

Tanzania introduced user fees in 1993 to reduce government spending and to address budgetary deficits, as part of broader structural reforms. Subsequently, utilization of health services decreased. In order to address barriers induced by the introduction of user fees, several risk pooling mechanisms were developed. The country identified operational priorities and opted for an incremental roll-out, exemption policies mitigating the risk associated with ill health for those who were left aside temporarily.

Community Health Funds (CHF, since 1997) and the National Health Insurance Fund (NHIF, since 1999) are meant to leverage additional funds, build community ownership and create stronger accountability of service providers. The NHIF is mandatory for public servants, with other formal sector employees being able to opt into the scheme. The CHF targets the rural population. An urban version of CHF was launched in 2009: TIba Kwa KAdi (TIKA). In 2006 the Social Health Insurance Benefits scheme (SHIB) was launched to cover private formal sector workers. So far, these mechanisms have failed to achieve significant population coverage (about 8 per cent by CHF and TIKA combined, 6 per cent by NHIF, 1 per cent by SHIB and the majority of the population uses tax-funded public services where they have to pay user fees. While studies reveal that the population is willing to prepay for health care, lack of awareness and trust has played an important role in the failure to expand CHF, TIKA, NHIF and SHIB. Over the last decade, a number of micro-insurance and other private insurance schemes have also been established, with even more limited coverage and adding up to the already existing fragmentation. A recent review reveals a lack of coordination on investment planning, unregulated premiums, and a mishmash of benefits.

As in other countries that opted for a phased implementation and the prioritization of specific segments of the population, scaling up population coverage has proven very challenging. The combination of fragmented risk pools and inefficient exemption policies left a vast majority of the population without financial protection.

In 2009, in a strong effort to expand coverage and to enhance risk pooling, the government pushed for NHIF to take over the CHF/TIKA management. Although NHIF accepted the responsibility of implementing the scheme (which they consider as a form of cross-subsidization), the government plan has ever since been stumbling on NHIF resistance towards further attempts to enhance pooling between the two schemes. NHIF claims not to be able to raise sufficient revenue to cross-subsidize the CHF members, and requests firm funding commitments from the GoT – particularly preserving the matching grants from central level – as a preamble to any further merger.

Yet, embedding the CHF within the NHIF Organisational structure brought more intensive and qualified supervision closer to the district through improved data systems and supervision. CHF membership more than doubled. Still the reform proved unable to institute changes to the CHF design or district management structures, partially because the unaltered legislation limits facility capacity to use CHF revenue. Besides, the revenue generated is cur-
rently insufficient to offset treatment and administration costs, the reform did not improve the revenue-to-cost ratio, and administrative costs have increased\textsuperscript{221}.

**Institutional design**

Alongside a majority of government-owned facilities (65 per cent)\textsuperscript{208}, health services are delivered by a large number of faith-based providers and a growing number of private-for-profit providers. The MoHSW is responsible for policy formulation, supervision and regulation for all health services, and manages the tertiary health services\textsuperscript{209}. The Prime Minister’s Office, Regional Administration and Local Government (PMO-RALG) oversee the districts with their hospitals, primary healthcare centers and dispensaries\textsuperscript{193}. The health system is organized around three functional levels: council (primary level), regional (secondary level), and referral hospitals (tertiary level). Over time, decentralization substantially changed budget financing. Management and (partly) financing of social services, including primary and first-level referral health care, moved to Local Government Authorities (LGAs). A system of central-local intergovernmental transfers (‘block grants’) was introduced, together with a pooled funding mechanism for donor funding (the ‘health basket fund’)\textsuperscript{225}. Three ministries (MoHSW, MoL and PMO-RALG) have their – sometimes competing – schemes within a fragmented health insurance landscape\textsuperscript{200}. These public schemes are regulated and overseen by the Social Security Authority. Besides, private schemes are overseen by the Tanzania Insurance Regulatory Authority. Explicit policies regarding competition in health insurance, including risk selection and risk rating, do not yet exist\textsuperscript{200}.

**Organisational practice**

From independence in 1961 until the mid-1980s, Tanzania was a one-party state, with a pan-African socialist model of development. In 1992, the country adopted a multiparty democracy and a liberal development approach under the ruling Chama Cha Mapinduzi (CCM) party. Since the early 2000s, the governing party’s focus is on the achievement of the MDGs and poverty reduction, and the Ministry of Health and Social Welfare committed to expanding insurance coverage to 45 per cent by 2015. By contrast, the opposition parties ‘Civic United Front’ (CUF) and Chadema demand increasing resources for health, user fee exemptions, eventually free primary health care for all and the development of a community health insurance scheme in the meantime. Until now – and at least until the next elections, foreseen for October 2015 – the dominant position of CCM relative to opposition has given it power to push through its desired policy changes, and also left little political influence for civil society which voiced concerns about equity in the allocation of and funding for human resources for health. Private insurers prefer managed competition on the way to UHC, but have little bargaining power in the fragmented landscape. The NHIF management – and the MoHSW, also responsible for CHF/TKA – supports a single insurance model with the NHIF controlling the sector and limiting the potential influence of other actors. The donor community – contributing near half of the health sector budget – is influential in national health policy debates. All the same, Tanzania demonstrated leadership in meeting the 2010 targets of the Paris Declaration and is considered to be a role model in terms of donors’ alignment. While some donors continue to support scattered initiatives – e.g. community-based insurance schemes – the majority is supportive of the HFS strategy development process and identified priorities of the government. Within the government, the Ministry of Finance – that also controls the basket fund to which all development partners contribute – is particularly powerful\textsuperscript{226}.

**Current situation and way forward**

The 2009 – 2015 Health Sector Strategic Plan III committed to the expansion of pre-payment schemes as a means of generating complementary financing for health service provision\textsuperscript{202}. It envisaged an expansion of NHIF
and CHF and the expansion of the benefit package available to CHF members to cover inpatient care\textsuperscript{227}. However, the relative lack of success of CHF, as well as the delays in the TIKA rollout (still to be implemented in most urban areas, noticeably in Dar es Salaam), made the government reconsider its strategy.

Today, Tanzania envisages the creation of a new social health insurance as a mandatory Single National Health Insurance (SNHI), accompanied by performance-based-financing mechanisms to increase quality outcomes in health services delivery\textsuperscript{187}. This SNHI aims at reducing fragmentation in health sector resource pooling and should increase the size of revenue collectively available for funding health services. The harmonization of health sector funding resources should also help to improve efficiency in allocation and use of funds\textsuperscript{187}. Technical preparation has progressed a lot. End of 2013, development partners provided a detailed costing study with options for a minimum benefit package\textsuperscript{228}. Early 2015, the SNHI scenarios of the current HFS draft were completed with a fiscal space analysis\textsuperscript{203}. All in all – despite the commitment of the Inter-ministerial Steering Committee, strong donor support and exceptional advancement of the technical preparations – it is still felt that the HFS’ concept of SNHI has not yet gained sufficient government support, neither from within the MoHSW nor across linked line ministries\textsuperscript{204}. Two major issues then arise: first, to gain government support at the highest level; second, to maintain that momentum after the coming elections. Election results are of course not predictable. But the fact that in Ghana momentum for NHIS was maintained even with alternating parties in power, might give hope to the SHI advocates in Tanzania too.
Transversal findings & lessons learnt

On population coverage

No other dimension of universal coverage receives as much attention from researchers and policymakers as population coverage. Still, in the countries under study, progress in population coverage leaves much to be desired. Where population coverage is narrowly conceptualized as insurance coverage, progress in effective coverage is often lagging behind. This is by no means a new or unknown phenomenon. Joseph Kutzin already in 1998 posited that the insurance function of a health system (effective health care risk protection), and not mere membership of an insurance scheme, should be considered a policy objective. Anne Mills in 2007 noted “Inclusion within a financing scheme does not guarantee access to benefits (health care)”.

Moreover, while population coverage is slowly on the rise, expansion of population coverage is rarely equitable, as illustrated among others by the excluded slum populations in Bangladesh and the growing ‘missing middle’ in Cambodia.

Effective coverage, different from population coverage, is a metric of health system performance composed of need, use and quality. Effective coverage quantifies “the gap between actual and potential benefits from health services” and can be defined as “the fraction of potential health gain that is actually delivered to the population through the health system, given its capacity”. See Lindelow M, Nahrgang S, Dmytraczenko T et al. Assessing progress toward universal health coverage: beyond utilization and financial protection, in Toward universal health coverage and equity in Latin America and the Caribbean: evidence from selected countries (T Dmytraczenko & G Almeida, eds.), Washington, 2015; and Ng M, Fuliman N, Dieleman J et al. Effective coverage: a metric for monitoring universal health coverage. PLoS Medicine 2014, 11(9): e1001730.

On service coverage

In all four countries under study, quality of care and equity in service delivery are key challenges. Quality of care is a necessary condition for substantial expansion of service coverage, which points to the need for health systems strengthening hand-in-hand with UHC efforts. Supply-side deficiencies including lack of quality of care also limit the impact of non-systemic efforts to increase equity in service delivery.

On financial protection

Assessing financial protection at country level is no straightforward exercise. Two common indicators to assess financial protection are the incidence of catastrophic health expenditure (CHE) and the incidence of impoverishment (IoI) due to out-of-pocket (OOP) payments. Both indicators have their disadvantages.

Catastrophic health expenditure over time and space has been measured in a variety of ways in terms of available resources (shares of total expenditure, non-food expenditure or expenditure net of basic needs) and thresholds (shares ranging from 10 to 40 per cent of the resources mentioned before): CHE figures are thus hardly compa-

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vii Effective coverage, different from population coverage, is a metric of health system performance composed of need, use and quality. Effective coverage quantifies “the gap between actual and potential benefits from health services” and can be defined as “the fraction of potential health gain that is actually delivered to the population through the health system, given its capacity”. See Lindelow M, Nahrgang S, Dmytraczenko T et al. Assessing progress toward universal health coverage: beyond utilization and financial protection, in Toward universal health coverage and equity in Latin America and the Caribbean: evidence from selected countries (T Dmytraczenko & G Almeida, eds.), Washington, 2015; and Ng M, Fuliman N, Dieleman J et al. Effective coverage: a metric for monitoring universal health coverage. PLoS Medicine 2014, 11(9): e1001730.

viii Two less straightforward and much lesser used indicators are poverty depth, expressed as the extent to which out-of-pocket payments worsen a household’s pre-existing level of poverty, and the mean catastrophic overshoot, defined as the average amount by which households affected by catastrophic expenditures pay more than the threshold used to define catastrophic health expenditure. See, among others: Boerma T, Eozenou P, Evans D, et al. Monitoring progress towards universal health coverage at country and global levels. PLoS Medicine 2014, 11(9): e1001731.
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Besides, it can be argued that CHE as indicator of financial protection only expresses a fraction (‘the tip of the iceberg’) of the financial hardship that UHC per definition wants to avoid. Incidence of impoverishment (IoI) has two major disadvantages. First, households that are already below the poverty line are not accounted for when still made poorer because of out-of-pocket payments. Second, different countries (and different authors) use different poverty lines, resulting in incidences that are hard to compare or even to make sense of.

These considerations – and for practical purposes the lack of data on CHE and IoI in our country series – has led us to focus on levels and trends of out-of-pocket payments (OOP) as proxy for (lack of) financial protection. Even so, assessing equity in financial protection remained a difficult task, as this would require stratified OOP data, which only in a minority of countries are (partly) available.

Judged by the WHO target for OOP and at aggregate country level, financial protection is unsatisfactory in all countries under study, is hampered by fragmentation of insurance schemes and other social protection initiatives, and rarely equitable.

On institutional design & organisational practice

While context- and path-dependency as expected lead to different pictures, important transversal findings and patterns can be distinguished here, such as the core role of health systems strengthening when embarking on and sustaining UHC policies, and the explicit political nature of fragmentation/harmonisation processes.

Taken together, our findings and lessons learnt cover six interrelated areas of concern:

1. health systems strengthening;
2. the choice of health financing mechanisms;
3. fragmentation vs. harmonisation of health financing;
4. the need for a political approach;
5. the need for better data and monitoring; and
6. fiscal space for progress towards UHC.

(1) Health systems strengthening

Not only is quality of care in all cases under study a major determinant of progress in service coverage, it eventually also influences population coverage and financial protection, and equity in each dimension. Health systems strengthening (HSS), leading to quality of care, can thus be considered a condition for progress towards UHC.

This finding has practical consequences, in current times where the global promotion for UHC seems to overshadow the discourse for health systems strengthening. Evidence strongly suggests that HSS efforts should be part of all UHC policies. Where health systems are particularly weak, it might be wise to focus on HSS first.

Our case for health systems strengthening resonates with one of the conclusions of a recently published Government of Japan/World Bank two-year multi-country programme.
search programme on progress towards universal health coverage.\textsuperscript{11} Reich and colleagues concluded that “countries need to match their commitment to UHC with their capacity to deliver health services”, thereby focusing on the need to improve availability and distribution of human resources for health. Our evidence suggests that strengthening is needed in all building blocks of health systems.

(2) The choice of health financing mechanisms

Our review does not allow drawing conclusions on comparative advantage of tax-based versus insurance-based health financing mechanisms for UHC, as the four countries in our series all opted for an insurance-based approach. It does allow however to notice once again that countries that rely on schemes based on voluntary affiliation have serious difficulties to progress towards UHC. This finding confirms a lesson repeatedly expressed by eminent health economists: compulsion, with subsidisation for the poor, is a necessary condition for universality.\textsuperscript{13} No country has ever attained universal coverage by relying mainly on voluntary contributions to insurance schemes, whether they are run by non-governmental organisations, commercial companies, communities or governments.\textsuperscript{14}

The practical consequence of this finding comes with a caveat: while there is need to reconsider support for all forms of voluntary health insurance, it would not be ethical to make voluntary insurance mandatory as long as quality of care is sub-standard.\textsuperscript{15}

(3) Fragmentation versus harmonisation of health financing

In all four countries under study health financing is fragmented, i.e. separate risk pools exist, and financial protection remains sub-optimal and inequitable.

This finding has practical consequences. Evidence suggests that in countries where health financing is fragmented, harmonisation of risk pools, at least by introducing cross-subsidisation, ideally reaching a unified risk pool, should be considered a policy priority.

(4) The need for a political approach

Where health financing is fragmented, and where efforts are made towards harmonisation, this happens to be an extremely difficult task, which is essentially political as it is conditional on bringing in line a range of actors with different interests and power stakes.

This finding has practical consequences, including for UHC policy support by external actors. Evidence suggests that to make progress towards UHC more successful by harmonising and eventually unifying risk pools, technical support has to be complemented by political support and capacity building.

When external actors would decide to include political support in their development cooperation, this raises a number of questions: Is there a need to adapt the skill profile of staff in development cooperation? How to match ethics and political interference?

(5) The need for better data and monitoring

Finding sufficient, coherent and comparable data for monitoring process toward UHC was not an easy task. For monitoring process in the equity aspects of UHC – which needs stratified data – the task was even more difficult.


\textsuperscript{15} Adopting Kutzin’s definition of universal health coverage as the insurance function of a(ny) health system, the same ethical caveat goes for all mandatory contributions, including in tax-based health systems.

Also this finding might have practical consequences for UHC policy support. External actors might add efforts for data collection and monitoring to their support package, or make their support conditional on it.

(6) Fiscal space for progress towards UHC

A question repeatedly popping up in health policy circles is “Does this country have enough fiscal space for UHC?”, with fiscal space typically considered low in low-income countries. None of our country reviews allows us to answer this question. Review of most recent generic literature however indicates the need to reframe the question itself. McIntyre and Meheus, focusing on domestic funding and fiscal space, found that government revenue generation (GRG) – and not GDP by with a country’s wealth is measured – is the strongest predictor of government health expenditure (GHE).\footnote{McIntyre D, Meheus F. Fiscal space for domestic funding of health and other social services. Centre on Global Health Security Working Papers, Working Group on Financing, Paper 5. London, 2014.} Ortiz, Cummins and Karunanethy describe a wide range of options to expand fiscal space.\footnote{The data presented by Ortiz, Cummins and Karunanethy also confirm the link between GRG and GHE as first evinced by McIntyre and Meheus. For the countries in our review – Bangladesh, Cambodia, Kenya and Tanzania – GRG is respectively 10.8 per cent, 17.7 per cent, 20.5 per cent and 21.5 per cent, and GHE 1.2 per cent, 1.3 per cent, 1.8 per cent and 2.8 per cent of GDP. See: Ortiz I, Cummins M, Karunanethy K. Fiscal space for social protection: options to expand social investments in 187 countries. Extension of Social Security Working Paper 48. Geneva, 2015.}

The practical consequence is that national policymakers need technical and political support to expand their fiscal space for UHC. Ultimately, the question should be “Do we want fiscal space for health?”. In recent history, both Thailand and Ghana answered this question positively. Thailand did so in the aftermath of a serious economic crisis, introduced its Universal Coverage Scheme and became an economic stronghold in its region. Ghana introduced its National Health Insurance Scheme and moved up from low- to middle-income country status. While a univocal causal relationship between UHC and economic progress might be hard to prove, evidence at least suggests that UHC can indeed contribute to economic progress and wellbeing, beyond health.
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About P4H

What is P4H?

The P4H – Social Health Protection Network is a response to the global challenge that around 100 million people are pushed into poverty each year paying for health care out-of-pocket (OOP) at the time of need. Many more are too poor to consider going to a doctor in the first place. But poverty and OOP payments are not the only barriers for access to health care. For an estimated 1.3 billion people, health care is not available. For an even greater number, without any income support, sickness or disabling injuries lead to severe financial penalties.

To address these issues, many low- and middle-income countries are now striving to establish universal health coverage (UHC), and turning to external development partners for help and advice in drawing up and implementing comprehensive and coherent policies. Increased global demand for support, coupled with the growing momentum behind UHC initiatives, has led to a marked increase in the number of actors and investments. Unfortunately, a lack of coherence, both at the country and DP level, often gets in the way of progress.

The main thrust of P4H efforts is coherent, enhanced support for the creation and extension of sustainable health and social protection systems, based on the values of universality and equity. The launch of P4H is an important landmark in coordinated international support to accelerate countries’ transitions towards UHC.

P4H was launched as a political initiative at the G8 summit in Heiligendamm/Germany in 2007. Since then, P4H has evolved into an innovative support network for UHC and social health protection (SHP), based on a model that takes global multi- and bilateral cooperation to the next level. The network combines three functions serving as:

- a platform for information exchange, dialogue and capacity development;
- a mechanism for coordination of multi-/bilateral technical support across sectors and cooperation levels;
- a marketplace for collaboration and complementary investments for scaling up support and filling any support gaps.

P4H members

A unique composition: The P4H Network comprises a broad mix of multi- and bilateral development partners and investors in UHC and SHP with different mandates, purposes, comparative strengths, and sector affiliation.

Founding members of P4H are Germany and France, other bilateral members are Switzerland, Spain and the USA. Multi-lateral members are the World Health Organization (WHO), the World Bank, the International Labour Organization (ILO), the African Development Bank (AfDB), the Asian Development Bank (ADB). The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM) is associated member.

P4H combines the political commitment and financial contributions of its bilateral members with the respective normative and technical support of the multi-lateral members and the wealth of expertise, experience and connections of the affiliated bilateral implementing organisations (e.g. AFD, KfW, Expertise France and GIZ). Since 2009, the operational start of the P4H network, the initiative has been active in over 30 partner countries.

P4H works with a lean management structure and draws on the global, regional and country structures of its members. To facilitate collaboration and coordination between partners at global, regional and country level, P4H members have established a coordination team – the P4H Coordination Desk – hosted by WHO in Geneva and the World Bank in Washington.
Towards universal coverage in the majority world: the cases of Bangladesh, Cambodia, Kenya and Tanzania
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