phcpi PRIMARY HEALTH CARE PERFORMANCE INITIATIVE

IMPROVEMENT STRATEGIES MODEL:

ACCESS: FINANCIAL ACCESS

Led by: BILL & MELINDA GATES foundation · THE WORLD BANK IBRD • IDA | WORLD BANK GROUP · World Health Organization

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CORE PRINCIPLES OF ACCESS

This subdomain measures whether patients have affordable, timely access to a PHC facility that is geographically convenient.(1) The basic structural availability of facilities is a starting point for understanding effective service delivery and is measured under inputs. By contrast, this subdomain is considered from the point of view of the patient when trying to access care or at the point of care. By this definition, in order for services to be considered accessible, patients must face no actual or perceived barriers to receiving services. Ensuring access from the users' perspective can help enable patients to receive the right care at the right place at the right time. Access is a linchpin in improving primary health care; even if services are present and high quality at the point of care, if users experience barriers to accessing and using it, outcomes will not improve. The delivery of high quality and appropriate care is discussed in provider competence. The component of access which relates to issues of equity, stigma and acceptability of care are also critical but addressed within patient-provider respect and trust and person-centered care (forthcoming).

Here we consider three elements of access: financial access; geographic access; and timeliness. Each of these components of access may be impacted by a wide array of individual and/or community socioeconomic characteristics—including poverty, gender, sex or sexual identity, caste, ethnicity, age, and race. These social determinants may have a significant impact on access within or between countries, and improvement may require concomitant efforts to improve social disparities. Another important element of access that is frequently overlooked is the role of language, particularly among indigenous populations. Global health interventions that fail to incorporate linguistic access for indigenous populations may contribute to widening health disparities.(2) Thus, while social determinants and context – political, social, demographic, and socioeconomic – underlie all aspects of the PHCPI framework, they are particularly salient within access.

FINANICAL ACCESS

Financial access means that there are no or few cost barriers to receipt of care, including prohibitive user fees, out-of-pocket (OOP) payments, or other costs associated with care seeking such as transportation or childcare costs. Ensuring financial access can be addressed by a number of approaches ranging from community to national-level interventions. Financial access is distinct from financial coverage. While financial coverage means having adequate financial protection, financial access focuses on the local success of interventions to ensure financial access from the patient perspective. An individual may have financial coverage through health insurance, but if he or she must use significant financial resources to access care in practice, financial access is not achieved.

GEOGRAPHIC ACCESS

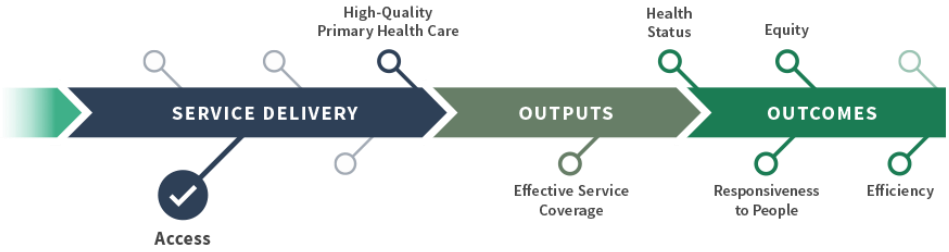
Geographic access is defined as the absence of barriers including distance, transportation, and other physical challenges in accessing care when needed. This is influenced in part by decisions made in allocation of resources, equity, and investments into infrastructure.

TIMELINESS

Timeliness of care includes two elements. First, patients should be able to physically access care with acceptable and reasonable waiting times. Second, hours and days of facility operation should be such that patients can find a time to visit facilities without sacrificing other obligations and duties such as work or childcare and can access care for emergent needs, including on nights and weekends.

WHAT COULD YOUR COUNTRY ACHIEVE BY FOCUSING ON ACCESS?

When done effectively, improved access can contribute to an array of downstream effects:



ACCESS: WHAT ARE THE FIRST STEPS?

STEP 1: ENSURE FINANCIAL AND GEOGRAPHIC ACCESS

In order for patients to be able to receive care when needed, services must be *both* within a reasonable geographic distance – in regard to travel time from patients' homes -- and not prohibitively expensive. Thus, financial and geographic access should be prioritized and addressed at the same time.

STEP 2: ENSURE TIMELY ACCESS

Timely access will not vastly improve utilization of care if financial and geographic access are not first in place. As such, timely care may be a follow-up consideration after financial and geographic access are ensured for all sub-populations.

AT THE SAME TIME, ENSURE ATTENTION TO HIGH-QUALITY CARE AND SOCIAL DETERMINANTS

While it is outside of the scope of this domain, it is important to note that perceived and actual service quality and provider competence are closely linked to access. Even easily accessible care may be underutilized if patients do not believe they will receive appropriate and high-quality services. Thus, accessible but poor-quality services will also do little to improve outcomes. This phenomenon is well documented in childbirth where women's perceptions of quality of care are often more salient than both distance or cost in decisions to bypass a facility.(3)

Finally, it is important to reiterate the strong impact that social factors can have on access to care. In order to improve equity and reduce discrimination it is imperative that "accessibility" means "accessibility for all." To achieve this, access must be assessed not just overall in a particular area but by disaggregated sub-groups, including but not limited to gender, sex, sexual orientation, class, caste, race, ethnicity, religion, and age. A useful tool for evaluating disparities in access is the WHO Health Equity Assessment Toolkit (HEAT). HEAT is a software that can help stakeholders explore within-country inequalities.

TOOLS & FRAMEWORKS

As already noted, this subdomain focuses on access to care from the perspective of the patient. However, there are a number of upstream system-level factors that affect patient access to care. Many of these components, including availability of drugs and supplies, infrastructure, workforce, and health financing, are discussed in other modules (forthcoming). When considering access from the patient perspective, it is necessary to conduct a thorough evaluation of the barriers and facilitators patients face when seeking care. The tools and frameworks discussed below are only a few examples of myriad methods for assessing access and can be used to evaluate financial, geographic, or timely access.

TANAHASHI FRAMEWORK

The Tanahashi Framework examines health service coverage as an interactive process between a health service (a specific service intended to meet a health need of a population, in this case primary care) and its target population through five successive dimensions: **availability, accessibility, acceptability, contact**, and **effectiveness**.(4,5) The percentage of the target population with effective coverage depends on coverage reached in the earlier dimensions.(4) Effective coverage depends on the health service's level and quality of interaction with the target population at each dimension and its ability to transform these interactions into a successful health intervention.(4) While some dimensions of the Tanahashi Framework overlap with other components of the PHCPI framework, it is a useful conceptual model for assessing patient-perceived access to care and pathways to comprehensive primary care delivery for all. Using population-specific analysis, the Framework evaluates the bottlenecks and facilitators that subpopulations experience as a way to help identify why some subpopulations access and benefit from the health system and why others do not.(4) These barriers and facilitators are influenced by health system barriers and wider contextual issues in which people live, work, and age.(5) In this way, the Framework highlights the importance of evaluating access experiences of different sub-populations, including those related to socioeconomic or cultural factors.

Evaluating barriers and facilitators at each dimension helps to identify operational bottlenecks, the constraining factors responsible for creating these bottlenecks, and ways forward for effective primary care delivery.(4,5) For example, implementers can use the Tanahashi framework to understand how different health system and contextual barriers may preclude access to high-quality care. Implementers might consider the following barriers to effective coverage at each dimension:

- Availability: **subpopulation for whom the service is available**, consider availability of resources (adequately skilled personnel, availability of services and health education for different diseases, necessary inputs)
- Accessibility: **subpopulation who can use the service**, consider opportunity-costs lost (e.g. child-care, work), limited autonomy, decision making capacity, transport cost and availability, schedules and opening times
- Acceptability: **subpopulation willing to use the service**, consider cultural beliefs (are these at odds with the service and the ability of a subpopulation to access effective coverage), gender responsiveness of services (e.g. same-sex provider where desired), risk of social stigmatization or discrimination from the provider, family, or community
- Contact: **subpopulation using the service**, consider utilization
- Effectiveness: **subpopulation receiving effective care**, consider capacity for treatment adherence (patient compliance ability, poor patient-provider relationships, gender roles and social conditions preventing follow up and management), barriers in diagnostic accuracy (linked

to knowledge of the condition and inputs), barriers in health service delivery (poor provider training, poor accountability systems, weak referral systems)

While this example focuses on barriers to accessing effective coverage, it is also important to also note the facilitators that certain subpopulations experience relative to others, to better analyze disparities in comprehensive and equitable health primary care coverage.

INNOV8

Although not specific to financial, geographic, or timely access, the WHO has developed an approach for evaluating inequities in national health programs, called Innov8.(6) In this model, a multidisciplinary team of stakeholders reviews a national health program with attention to barriers and inequities. The eight-step review process includes:

- Step 1: Complete diagnostic checklist
- Step 2: Understand the program theory
- Step 3: Identify who is being left out by the program
- Step 4: Identify the barriers and facilitating factors that subpopulations experience
- Step 5: Identify mechanisms generating health inequities
- Step 6: Consider intersectoral action and social participation as central elements
- Step 7: Produce a redesign proposal to act on review findings
- Step 8: Strengthen monitoring and evaluation

The eight steps, their development, specific tools to complete the steps, and examples of application are discussed in greater detail in the technical handbook. This method may be useful for stakeholders to understand the landscape of inequities of access before implementing or adapting a health program. Attention to inequities in access from the start will result in a more comprehensive and accessible program and help countries achieve universal and equitable health coverage.(6)

TRIANGULATION

When assessing barriers to care, it is important to triangulate using both qualitative and quantitative data. Together, these two forms of data can provide a more nuanced understanding than either one alone.(7) The order in which evaluators collect qualitative and quantitative data will yield different information. If community engagement has been prioritized in the health system and stakeholders already have baseline understanding of the type of barriers patients face, it may be useful to collect quantitative data specific to those barriers first and then use qualitative methods such as focus groups of in-depth interviews to understand unexpected data or gain a more nuanced understanding of particularly salient quantitative data. Alternatively, if stakeholders do not have a strong baseline understanding of access barriers, starting with qualitative methods may help them understand what kind of quantitative indicators to subsequently collect and assess. Additionally, using qualitative methods that engage the community can help community members feel that they are contributing to decision-making and that their concerns are being heard. A brief discussion on the value of mixed-methods can be found here.

FINANCIAL ACCESS

Financial access means that there are no or few cost barriers to receipt of care, including prohibitive user fees, out-of-pocket (OOP) payments, or other costs associated with care seeking such as transportation or childcare costs. Ensuring financial access can be addressed by a number of approaches ranging from community to national-level interventions. Financial access is distinct from financial coverage, discussed within the System domain of the Improvement Strategies (forthcoming). While financial coverage means having adequate financial protection, financial access focuses on the local success of interventions to ensure financial access from the patient perspective. An individual may have financial coverage through health insurance, but if he or she must use significant financial resources to access care in practice, financial access is not achieved.

WHAT SHOULD I KNOW BEFORE BEGINNING IMPLEMENTATION?

There are many methods for improving financial access to health services. While "financial coverage" addresses the presence of comprehensive financial protection schemes, these methods may not necessarily ensure access in practice if co-payments, deductibles, and/or transportation and other indirect costs remain high. An improvement Strategies module on financial coverage is forthcoming. Financial access, by contrast, concerns financial realities *from the perspective of the patient*. A patient may be enrolled in a financial protection scheme but lack financial access due to prohibitive remaining medical costs or external costs related to seeking care. There are three central questions that health systems stakeholders should ask when assessing financial access and subsequently when planning and implementing interventions:

- Who is not accessing care for financial reasons?
- In what ways are they not covered under the existing system?
- How can financial access be improved for these populations?

Additionally, implementation of any of the strategies discussed will have implications for how the health sector and facilities are financed. Therefore, interventions should be planned and assessed from a whole-system perspective to ensure alignment with financing and payment mechanisms.

WHO IS NOT ACCESSING CARE FOR FINANCIAL REASONS?

In order to develop a targeted intervention, it is important to understand who is not accessing care due to financial constraints. These populations may not always be the most marginalized in society, since financial protection schemes often (but not always) target these individuals specifically. For instance, populations that are often overlooked by financial access reforms include informal sector workers, those who are near-poor but do not meet various benchmarks to be considered impoverished, and migrant populations.(8) The Joint Learning Network for Universal Health Coverage has developed a relevant report compiling lessons on how countries have ensured health coverage for non-poor, informal-sector workers. The populations who are facing financial access barriers will differ between contexts, but their identification will help decision makers better understand gaps in existing financial protection systems. More information on identifying barriers and inequities can be found in frameworks and tools.

IN WHAT WAYS ARE THEY NOT COVERED UNDER THE EXISTING SYSTEM?

After identifying who is not accessing care for financial reasons, stakeholders must understand why. Most fundamentally, there may be no financial protection systems in place. Financial protection can encompass

a number of approaches including but not limited to free care, reduced user fees, or health insurance. However, even in places where there are financial protection systems, these efforts may not adequately reach all populations or may not be designed with contextual realities in mind. For instance, a community project in Burundi - discussed in greater detail in "what others have done" - significantly reduced user fees to improve access to services. However, the financial realities of the target community were not adequately considered, and the reduced user fee still posed a substantial barrier for many individuals.(9) In some instances, public sector transactional cash flow delays (such as those for facility reimbursement) may result in unexpected cash or supply shortages at the facility level. These shortages may be passed to the patients in the form of user fees or other costs. Thus, a benefit scheme must be designed and implemented with consideration of local realities in order to result in tangible and reliable improvements.

Out of pocket payments for care are not the only costs that patients incur when seeking care. Individuals may face prohibitive external or indirect costs related to seeking care such as transportation, lost wages from the patient and/or caretaker missing work to make an appointment, lodging, and childcare or elderly care costs.(10) Thus, the cost of care reported by patients and by providers may be discordant. These external costs are less commonly addressed by health system-focused interventions despite posing significant barriers. When assessing the cost of care and catastrophic health expenditure, it is important to ensure that these indirect costs are considered.

HOW CAN FINANCIAL ACCESS BE IMPROVED FOR THESE POPULATIONS?

While there are many strategies for improving financial access to care (including those that will be addressed in the Financial Coverage Improvement Strategies module - forthcoming), here we focus on four local-level strategies that have been commonly used in LMICs with varying success:

- Community-based health insurance
- Removal or reduction of user fees
- Conditional cash transfers
- Voucher programs.

Community-based health insurance

There are many methods for ensuring health insurance coverage within a population. Governments may choose to develop various schemes for different segments of the population based on employment, income, or age, provide national health insurance to all populations, or decentralize health insurance to communities. Many of these options will be addressed in the forthcoming financial coverage module. However, like all methods of financial coverage, it is important to note that the availability of insurance does not ensure financial access in practice. Here we focus exclusively on community-based health insurance (CBHI) because it is a local-level intervention, and therefore most pertinent to financial access, as experienced by the patient.

Community-based health insurance is a decentralized health insurance scheme that is has been used in a number of LMICs. While CBHI schemes are established by communities and are therefore quite diverse, some common qualities include: pooling of risks and funds at the community level, not-for-profit payment plans most often at a flat rate and not dependent upon health risk, community control in setup and management, and voluntary membership.(11,12) CBHI has often been implemented in areas where there is a significant poor and/or informal worker population, and revenue collection for health insurance administered at the national level would be challenging. As such, CBHI is generally considered a means for improving financial access among these populations that are often overlooked by other insurance schemes.

Given that community control is a defining characteristic of CBHI, these schemes are likely to include benefit packages that are closely aligned to community values and needs, and leadership decisions may be more transparent and accountable than other forms of health insurance.(12,13) Additionally, CBHI schemes can be inclusive of informally employed people, a population excluded from common employment-based insurance.

However, there are many notable challenges associated with CBHI, specifically regarding equitable access. A recent review of 49 papers from Africa, Asia, and South America found that wealthier individuals were more likely to pay for CBHI, and price was a significant determinant of membership in these schemes. The review suggested five strategies that may mitigate these inequalities in CBHI. Many of these suggestions also apply to other types of insurance as well:

- Offer flexible payment plans
- Provide premium subsidies or eliminate premiums for the poor
- Eliminate copayments for the poor
- Remove or reduce any waiting periods between premium payment and utilization of services
- Avoid delayed reimbursements to both the patient and the facility that make patients pay out of pocket at the time of care.(11)

However, it is important to note that because pools are relatively small, when premiums are lowered to accommodate poorer individuals, it is often accompanied with a reduction in financial protection and benefits. Thus, these strategies must be designed with financial sustainability in mind.

The WHO has developed a Health Financing Policy Brief on CBHI that addresses many of the challenges associated with these schemes. Most fundamentally, although CBHI is often used as a strategy to increase financial access among traditionally overlooked populations, premiums still prevent access for the poorest populations. Both Ghana and Rwanda have experienced success in their CBHI schemes, and Rwanda is discussed in greater detail in Evidence of Implementation. However, in both cases, the CBHI was linked in a national system and included government tax revenues, and in Rwanda participation was required.(12) Therefore, both of the more successful implementations of CBHI have incorporated elements that are not community-based. The WHO suggests drawing from these successes and retaining decentralized, community-based arms but connecting them into a larger pool that can support greater sustainability and financial protection.

Removal of user fees

Beginning in the 1980s, user fees became a popular health financing mechanism in LMIC because they were considered to increase revenue, improve efficient use of services, and improve access by subsidizing fees for the poor using these newly generated funds.(14) However, numerous reviews across multiple settings have found that when user fees are implemented, there is a consistent accompanying decrease in access – particularly among the poor.(15) Despite this, it is important to note that many studies evaluating the effects of removal of user fees are not designed such that they measure both changes in utilization and changes in service delivery quality. Both of these considerations are crucial, as an increase in utilization may have a negative effect on quality and subsequently health outcomes if facilities are inadequately equipped to respond to growing demand.

High out of pocket payments are correlated with catastrophic and impoverishing health care costs,(16,17) and these payments are often regressive, representing a larger proportion of a poor individual's income compared to wealthy individual's income. Consequentially, a model developed in 2005 estimated that abolition of user fees coupled with adequate efforts to ensure financing through other mechanisms could avert 233,000 annual deaths of children under five in 20 African countries.(18) Thus, removal of user fees is a common and tangible solution for LMIC seeking to increase financial access to services and

What it is
What others have done
How to get started
How to succeed

subsequently improve health outcomes, including child mortality. However, it is important to note that despite the observed benefits of removing user fees, countries must have plans to supplement the lost revenue and keep quality consistent.

There are three ways that countries can address the removal or reduction of user fees. First, countries may choose to abolish or reduce user fees for all individuals. This is of course dependent upon available financial resources and has serious financial implications including loss of discretionary revenues at facilities. Some strategies that may facilitate removal or reduction of user fees will be addressed in the forthcoming Health Financing module.(19) Second, certain populations may be specifically selected for exemption through the use of waivers. These populations might be determined by socioeconomic status or demographics. For instance, the poorest members of society, pregnant women, or children under five are common recipients of free or reduced fee services. Finally, removal of user fees may apply only to specific services such as antenatal care. These methods are not mutually exclusive, as exemptions may apply for both specific groups and selected services. It is important to note that removal of user fees is likely to increase utilization of services which may overwhelm health systems that are not prepared to provide the volume and quality of services being demanded. This was the case in 2013 in Kenya where user fees were removed for maternal health services without adequate preparation for increased demand. This case is discussed in "how others have done it".(20)

When removing or reducing user fees for only a segment of the population, it is important to consider the effects on access to services for the rest of the population. Access may change for other populations through a number of different mechanisms.(21) For instance, user fee reduction or exemption for children under five may encourage parents to bring all children – even those older than five – to access health services. Alternatively, if user fee reduction or exemption increases utilization among the target population and results in over-crowding of facilities, non-targeted groups may choose not to seek care, seek care at non-public and potentially more expensive facilities or from informal providers, or may bypass to higher-level facilities. Therefore, it is important for implementers to be attuned to these potential impacts during evaluation and build robust monitoring systems to identify any unintended effects .

In order to facilitate a smooth transition, the World Health Organization provides four important preconditions and considerations for health systems removing user fees:

- "Sufficient financial resources need to be provided and effectively transferred to the facility level to compensate for both the loss of revenue at the provider level…and for the desired increase in use of services.
- Provider payment and financial transfer methods must be in place – prior to the policy coming into being – through which the promised free services are effectively purchased and through which health workers are incentivized.
- Efforts are needed to improve and make health services available, bringing them closer to the most distant and vulnerable population groups [this is addressed in the geographic accessibility module]…
- Policy makers need to look for synergies in implementation and ensure that reform initiatives lead towards a coherent health financing architecture."(22)

The first two considerations are the most relevant to financial access but also may be the most challenging to effectively implement. While many studies evaluate the effects of user fee changes on utilization, as reported above, few have compared and evaluated how countries have achieved user fee reduction or removal from a financial sustainability perspective. Examples of strategies that various countries have undertaken are discussed in greater detail in "How others have done it".

Conditional cash transfers

Conditional cash transfers (CCTs) are a demand-side financing mechanism that can be used to improve financial access to care. In CCT programs, individuals or families receive payments contingent upon a certain behavior – in the case of health, it is often utilization of specific services. CCTs have been implemented extensively in LMIC.(23) Even if the conditions tied to CCTs are not health-related, the payments can also be used to help individuals overcome financial barriers related to accessing health services, such as out of pocket payments, travel costs, or childcare.(24) A systematic review of such programs found that they can, but do not always, improve access to health services and ultimately health outcomes.(23) Important considerations for the success of a CCT program include:

- Efficient targeting of poorer groups – specific individuals or leaders within a community may be made responsible for identification of eligible households. Alternatively, there may be existing social security programs that have similar eligibility criteria as the intended program, and implementers can use their existing lists.
- Monitoring systems to ensure requirements are being met – implementers must plan programs with consideration of how they will ensure that individuals or households are fulfilling the required behaviors. Examples of monitoring strategies include check-ins with patients and providers during facility visits or home visits. Regardless of the method, however, monitoring will necessarily incur costs and require human resources to implement but is important to ensure that the program is being implemented with fidelity.
- Presence of high quality services and resilient staff and system to withstand increased demand – as with interventions that remove or reduce user fees, health systems must be capable of providing high quality care both at baseline and when demand increases as result of the program.(23)

The size of the transfer needed to result in positive effects on health has not been extensively studied and differs based on context. Therefore, it is important for implementers to consider the cost-effectiveness of a CCT intervention.(24) Additionally, it is important to consider perverse incentives that may arise as a result of eligibility criteria. For instance, a review of CCT programs found that eligibility related to pregnancy was correlated with an increase in fertility.(24) One potential challenge with CCTs may be stigma associated with the receipt of reduced or free services, although this phenomenon is not well studied in the literature. More details regarding CCTs can be found in a WHO technical brief on CCTs for health, which reviews how CCTs are used, the impact of such programs, and additional implementation considerations.(25)

Voucher programs

A second, demand-side method for improving financial access to health services is vouchers. During voucher programs, vouchers are distributed to a specific subset of the population and these are used to obtain free or reduced fee services at the point of care. The facility is subsequently reimbursed. These programs are especially common for antenatal care or delivery. Some of the benefits of voucher programs include:

- Voucher programs enable targeting of low-income or high-risk individuals through distribution.
- By making vouchers only redeemable at facilities that meet specific quality standards, vouchers may encourage quality improvement processes at non-qualifying facilities.
- Voucher programs require the use of an information system to track distribution and collection of vouchers. These data can be used to monitor providers.(26)

There are several important considerations for stakeholders when planning a voucher program:

- Coverage of voucher – Implementers must consider the services and individuals eligible for a transportation voucher. Vouchers may be provided for specific services such as antenatal care/delivery or emergency services or to certain portions of the population, most often poor individuals or other high-risk groups. Sometime, vouchers are used specifically for transportations, in which case specifics related to the cost of vouchers and whether they are flat-rate or flexible often must be negotiated with local transportation organizations.
- Method for identifying recipients and distributing vouchers – after identification of the target population, systems must be put in place to distribute vouchers. This may occur in communities as part of proactive population outreach or in facilities. For instance, transportation vouchers for delivery may be distributed when women attend antenatal care visits. However, in these cases, it is important to identify the target individuals who may qualify but are unable to seek care in these settings and reach them through alternative means.
- System for detecting fraud and tracking vouchers – Implementers should ensure that there are ways to detect fraudulent vouchers and track the distribution and use of vouchers. As always, any data management tool should be easy to use and compatible with the available infrastructure.
- Buy-in – In order to ensure use of vouchers, community members must be aware of the conditions for use. This may be achieved through community meetings, discussion at clinics, radio shows, or other accessible means of communication. (27)
- Facility capacity – As with other interventions to improve access, patients must be met by competent providers and effectively run facilities in order to ensure that patients receive high quality and timely care. These facilities must be sufficiently resilient to respond to increased demand.

In addition to the removal of financial barriers at the point of care, ensuring financial access also requires that patients do not face prohibitive costs related to seeking care which are external to the health system, for example transportation costs. Transportation vouchers are a common strategy used in LMIC to improve both financial and geographic barriers related to transportation. This requires partnership with a local taxi or other transportation group. Transportation vouchers and interventions intended to ease geographic or transportation-related barriers to care are discussed in greater detail within geographic access. As with other interventions that increase access to care, it is important to ensure that the health system can support increased demand without compromising quality. Additionally, because many voucher programs are donor-funded and/or specific to vertical programs, they should be planned with long-term sustainability and comprehensiveness in mind.(28)

What it is
What others have done
How to get started
How to succeed

WHAT HAS BEEN DONE ELSEWHERE TO IMPROVE FINANCIAL ACCESS?

A number of low and middle-income countries (LMIC) have introduced primary health care teams in the last few decades. While many of these reforms have experienced success in expanded service coverage and comprehensiveness of services, there is a lack of information on the process of building care teams or the training and support needed to foster effective teamwork in these settings.

COMMUNITY-BASED HEALTH INSURANCE – RWANDA & LAOS

A community-based health insurance (CBHI and called *Mutuelles* in French) program was established in Rwanda in 1999 to improve utilization of services following reinstatement of user fees in 1996.(29) Although it was managed by the Rwandan Ministry of Health, the program was decentralized with branches at various health centers. The *Mutuelles* demonstrated tremendous growth following implementation; in 1999, it was piloted in only three districts, and as of 2013 it covered 74% of people without another source of insurance. Enrollment in the *Mutuelles* was associated with increased utilization of care and decreased catastrophic health spending. However, consistent with literature on equity effects of CBHI,(11) compared to enrollees with higher income, the poorest quintile experienced less utilization and greater catastrophic health spending based on data from 2000 to 2006.(30) The copayments for the *Mutuelles* still presented a significant financial barrier for these individuals. A successive pilot program removing user fees for the poorest population enrolled in the *Mutuelles* found increased utilization among this population by nearly 100%,(31) and in 2010, the Government of Rwanda introduced a sliding scale premium payment to increase enrollment among poor populations.(29) Although the sliding scale has improved equity considerably, payments remained slightly regressive. This case highlights the value of pairing multiple financial access strategies, including removal of user fees, discussed in greater detail below. It is important to note that much of the success of this *Mutuelles* can be attributed to subsidization and centralized risk pooling by the government, which required significant infrastructure and coordination but provided greater protection.(12)

In Laos, CBHI programs intended to expand financial access to the poorest and most vulnerable have also come under the purview of the government in order to increase risk pooling and improve financial sustainability. There are four health insurance plans in Laos. Two of these plans cover civil servants and salary workers, and the other two plans are CBHI programs. A voluntary CBHI plan managed by the Ministry of Health is offered to informal workers and self-employed individuals. Additionally, this plan is also purchased by the government and offered to some of the lowest income individuals in the country.(32) This strategy was intended to not only improve access for this segment of the population, but also to increase the size of the risk-pool. An evaluation of the CBHI plans in Laos found that those enrolled in CBHI were more likely to use both inpatient and outpatient services. Additionally, they were more likely to access lower-level facilities and utilize referral systems, contributing to stronger continuity and coordination of care. Finally, those enrolled in CBHI were more likely to use public facilities. In Laos, private facilities have few resources, which often results in the provision of drugs without significant consultation time, advice, or a diagnosis.(33) Again, it is important to note that although CBHI in Laos is organized at the local level, the government has contributed to its success by purchasing insurance and increasing the risk pool.

USER FEES – BURUNDI, AFGANISTAN, AND KENYA

User fee waivers for poor individuals were introduced in select areas of both Burundi and Afghanistan in 2005.(9,34) In Afghanistan, community leaders were responsible for identifying recipient households during the waiver program. These households received waiver cards for use in facilities. However, this system was not entirely effective – 42% of cards were used by the wealthiest three quintiles while only 19% of people in the poorest quintile received a card, revealing the importance of effective identification

What it is
What others have done
How to get started
How to succeed

systems in program implementation. Despite this challenge, there was an increased use of health services among individuals who had a waiver, and this trend was even more apparent among poor households.(34)

A few years after the pilot waiver program, Afghanistan instituted a national ban on user fees at facilities providing an established basic package of health services. There was a marked increase in curative care utilization following the ban but not preventive and promotive care, likely because these services were mostly free prior to the ban. Despite this increase in utilization of services, perceived and actual quality of care were not affected, demonstrating remarkable resilience in the face of increased utilization.(19) Some strategies that contributed to the successful impact of fee removal on utilization and resilient quality of care in Afghanistan included: health education and awareness about drug use, stricter prescription practices, and supervision and monitoring to ensure adequate supplies and staffing.

In Burundi, a community project provided fee waivers for extremely impoverished households coupled with a reduced user fee for all other community members. In a community with widespread poverty, the waiver program was only able to encompass 8.6% of the population. Additionally, the reduced flat fee still posed a significant barrier to care for those who were not exempt; 87% of the population still did not have sufficient money to seek care for their last illness.(9) However, the program did show some evidence of success; relative to the entire country, the province where it was implemented experienced increased access to care (58% vs. 70%, respectively). This intervention showed mixed results in the intended effect of improved access and illustrates the value of community input in design and implementation, particularly to calibrate interventions to local realities.

Following a four-decade cycle of user fee removal and re-introduction in Kenya, user fees were abolished in all public dispensaries and health centers and for all maternal services in 2013. However, implementers faced a multitude of challenges that compromised the potential benefits of the new financing arrangement.(20) Increased utilization following user fee removal coupled with inadequate preparation to meet the demand resulted in high provider burden and workload. Providers reported inadequate incentives and motivation following this shift. Additionally, few county or facility-level stakeholders were consulted during the planning process resulting in a lack of buy-in and motivation. As described in “What it is”, these challenges that often arise during abolition of user fees could be preemptively avoided through careful planning processes that ensure facility-level support to withstand accompanying increases in service utilization.

CONDITIONAL CASH TRANSFERS (CCTS) – INDIA & MEXICO

The Indian government launched the Janani Suraksha Yojana (JSY) CCT program in 2005 in reaction to under-utilization of skilled birth attendants throughout India. The program provided a cash incentive for institutional deliveries, though specific implementation details – such as who received a CCT, the size of the incentive, and parity-determined eligibility - differed by state.(35) JSY has since reached 52 million beneficiaries. The anticipated outcomes and impact of this program were increased institutional delivery and in turn decreased maternal and neonatal mortality. Despite a documented increase in institutional births during the five years following implementation of the program, studies have not found a corresponding decrease in maternal mortality. Authors suggest two potential explanations: women with complications who are most likely to benefit from an institutional birth may not be entering the program, and/or while more women are accessing services, the quality of services is poor, and as a result, there is no impact on health.(35) Thus, as in the case of the reduced user fee program in Burundi, this program demonstrates the necessity of developing reliable systems to identify recipients and ensuring that the incentivized services are high quality. Quality in particular is a demonstrated bottleneck to measurable improvement, even when mechanisms are in place to ensure financial access.

A CCT program established in 1997 in Mexico was designed to address both supply and demand-side interventions to improve quality of care. This program – called *Oportunidades* – provided cash transfers to

women upon completion of a prenatal care plan and educational program. The educational program was designed to empower women to seek care, identify quality care, and advocate for their health needs.(36) Women in low-income households within marginalized communities were eligible for enrollment, and compliance with conditions was tracked through certification at public clinics and schools. Higher quality care was measured by indicators assessing receipt of prenatal procedures consistent with national clinical guidelines. Enrollees were found to receive 12.2% more prenatal procedures, and this increase was not attributable to increased utilization alone. Researchers concluded that this improved quality was likely due to the empowerment component of the program; women who received the educational program were able to more effectively advocate for their health needs. *Oportunidades* demonstrates how CCTs can be used to promote knowledge and health literacy in addition to incentivizing service utilization.

VOUCHER PROGRAMS - CAMBODIA

As discussed in “What it is”, voucher programs are most commonly used for maternal health services. In 2007, Cambodia implemented a voucher program as a strategy to reduce the maternal mortality ratio through skilled birth attendance. This was implemented in conjunction with other reforms including a Health Equity Fund and performance-based contracting. The voucher program was implemented in three rural districts and targeted poor women.(37) Three criteria were used to select facilities that would receive vouchers. They were required to: 1) provide the minimum package of services, 2) have at least one skilled midwife, and 3) have a record of high utilization for antenatal care and delivery. As mentioned in “What it is”, criteria such as these have the potential to catalyze improvements in non-qualifying facilities. Eligibility for participants was determined using pre-specified criteria that was used in the Health Equity Fund. Selected women received vouchers for three prenatal care visits, delivery, and one postnatal visit, as well as all transportation services and hospital referral, if needed. The voucher management agency reimbursed the health centers once a month. Utilization was moderate – 44.6% of the individuals who received vouchers used them for delivery. Of the women who did use the vouchers, most were satisfied. They reported using the vouchers because they enabled them to get free care, they felt safer delivering in the health centers, and they were able to get their infants vaccinated immediately. Women who did not use the vouchers reported a few barriers. First, many lived far away from facilities and were concerned that transportation would exceed the amount covered by the voucher. They also often had responsibilities in the home that kept them from accessing services. Additionally, some were not satisfied with the quality of services or reported that they feared midwives would request informal payments.

WHAT QUESTIONS SHOULD BE CONSIDERED TO BEGIN IMPROVEMENTS?

The questions below may be a useful starting place for determining whether financial access is an appropriate area of focus for a given context, how one might begin to plan and enact reforms, and for identification of relevant stakeholders to include when planning improvement efforts:

WHAT SORT OF FINANCIAL PROTECTION DOES THE EXISTING HEALTH INSURANCE PROGRAM(S) IN THE COUNTRY OFFER PATIENTS (I.E. WHAT ARE THE COPAYS AND PREMIUMS)? WHO IS AND IS NOT INCLUDED IN THESE INSURANCE SCHEMES?

A detailed analysis of the current landscape of health insurance is a necessary prerequisite for implementing or improving systems related to financial access. Some strategies for assessing access and inequities in access are discussed in "frameworks and tools". A mix of qualitative and quantitative data may be best to assess barriers to access.

WHAT COST IS CONSIDERED PROHIBITIVE FOR THE POOREST SEGMENT OF THE POPULATION?

Understanding how much the poorest population can afford to spend on health care services (if anything at all) can help adequately calibrate intervention details. This relates to all forms of payment including but not limited to insurance, user fees, and transportation.

WHAT EXTERNAL COSTS (NOT INCURRED AT THE POINT OF CARE) ARE PRESENTING FINANCIAL BARRIERS TO CARE?

These may include transportation costs, childcare, and lost wages for work. If these are common and substantial, services may be designed to circumnavigate these costs. For instance, community health services may help avoid transportation costs (more information on community-based care can be found in the Proactive Population Outreach module), and weekend appointments can alleviate the burden of lost wages for some patients (more information on timely access to care can be found in the timeliness module).

ARE THERE SYSTEMS IN PLACE TO TARGET THE MOST VULNERABLE POPULATIONS FOR CCT OR USER FEE WAIVERS? DO PROGRAMS PROMOTE EQUITY, AND ARE THEY PRO-POOR?

In order to ensure that these interventions reach the target populations, there must be clear and reliable systems for identifying participants. Depending on how participants are selected and the eligibility criteria, there may be pre-existing records or programs in place with lists that can be used.

HOW WILL THE SYSTEM BE MONITORED TO IDENTIFY GAPS AND CHALLENGES AND SUBSEQUENTLY SPREAD AND LEARN FROM SUCCESS?

Prior to implementation, a monitoring and evaluation plan should be put in place, and systems should be established to measure and track any relevant indicators. In particular, it is important that this system can track inequities and in access and unintended or perverse incentives that may arise as a result of the program.

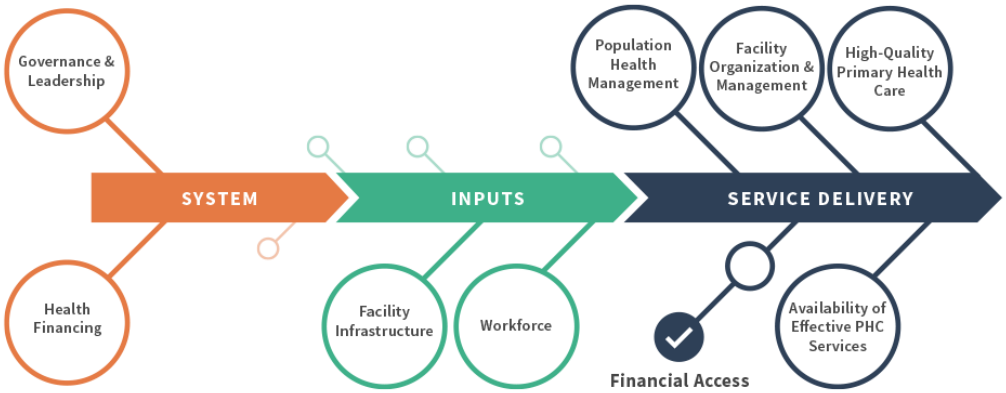
What it is
What others have done
How to get started
How to succeed

WILL LOCAL FACILITIES BE ABLE TO HANDLE INCREASED DEMAND FOR SERVICES AND STILL PROVIDE HIGH-QUALITY CARE? IF NOT, WHAT ADDITIONAL RESOURCES ARE NEEDED TO PREPARE?

Increased accessibility to services will likely increase demand for services at the point of care. Facilities should have plans in place to continue delivering high-quality services to patients when this occurs. Facility leaders can evaluate current workflow and demand and use this information to identify and proactively solve potential challenges that may arise with increased demand.

WHAT ELEMENTS SHOULD BE IN PLACE TO SUPPORT EFFECTIVE IMPROVEMENTS?

In order for interventions aimed at improving financial access to be most successful, the following elements of the PHCPI Conceptual Framework should be in place or pursued simultaneously:



C4.B & C5 PROVIDER COMPETENCE & HIGH-QUALITY PRIMARY HEALTH CARE

Regardless of financial, geographic, and timely access to services, it is unlikely that patients will access care if they perceive that providers lack competence, services are not tailored to their needs, and care is not delivered with trust and respect. Additionally, if patients do seek care that is not high quality, it is unlikely to result in improved outcomes. Thus, if patients are not accessing services, it is important to understand whether it is due to perceived quality of care or accessibility, and if both are lacking, they may have to be addressed in tandem to improve utilization of care and subsequent positive health outcomes and impact.

A2. HEALTH FINANCING

In order to secure financial access for a given population, there must be conducive national policies in place. Any strategy for improving financial access will have implications for how the health sector and facilities are managed. As such, multi-level interventions should be planned and assessed from a whole-system perspective to ensure alignment with financing and payment mechanisms.

C2.B FACILITY MANAGEMENT CAPABILITY AND LEADERSHIP

Certain approaches to improving access require logistical changes within a facility, such as scheduling outreach activities, instituting user fee waivers, capacity for fiscal management, adopting new appointment systems, or shifting provider schedules to facilitate greater coverage. For all of these changes to be effectively integrated, facilities must have strong leadership and management to communicate, implement, monitor, and adapt necessary changes with internal and external stakeholders.

C2.D PERFORMANCE MEASUREMENT AND MANAGEMENT

As with any changes to a health system, it is important to have a clear system in place to evaluate the efficacy of a given intervention. Performance measurement and management systems with clear targets, measurement activities, and plans for improvement should be designed in conjunction with service delivery changes to monitor changes in access and adapt approaches as needed.

What it is
What others have done
How to get started
How to succeed

B2 & B4 FACILITY INFRASTRUCTURE & WORKFORCE

Following implementation of reforms intended to decrease financial barriers to care, facilities must be adequately prepared to meet increased demand for services. Therefore, sufficient infrastructure and human resources must be in place prior to reforms in order to ensure high-quality and timely services for all patients seeking care.

C1.A & C1.D LOCAL PRIORITY SETTING & COMMUNITY ENGAGEMENT

In order to understand who is not accessing care due to financial barriers and why, it is important to have existing systems for community engagement and participation. Sub-national and national governance structures should have mechanisms to solicit input from the community to both understand gaps in access to care and identify feasible and acceptable responses that will tangibly improve access to services.

A1.C SOCIAL ACCOUNTABILITY

In addition to engaging community members in the identification of barriers to care and potential interventions to improve access, social accountability mechanisms should be in place to ensure that community members are able to monitor and react to health systems interventions and changes.

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