Successful Strategies for Health Systems In Distress

MITIGATING THE EFFECTS OF ECONOMIC DOWNTURNS ON HEALTHCARE UTILIZATION

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How do economic downturns affect the ability of public healthcare systems to continue to provide the same quantity of services and quality of care to patients? Do effective strategies exist that can mitigate the adverse effects of an economic downturn on healthcare utilization—especially among marginalized groups? Using a case study methodology, this report argues that there are, in fact, a multitude of successful strategies that can mitigate such adverse effects. As public policy does not occur in a vacuum, but in a specific political economy context, different strategies may be more or less successful in different contexts.

All successful strategies share certain common attributes. The most important of these is the use of data-drive efforts to identify and target vulnerable groups. Without open access to statistics about who is poor, effective and pro-poor mitigation strategies cannot be formulated. But even with effective targeting, it is often the case that politically powerful groups are more likely than the poor to benefit from these strategies. This implies that political economy considerations need to be factored into the design of these strategies.
1 Background

There is a well-documented link in the public policy literature between increased per capita income and healthcare utilization. One study, for example, found that 10 to 20 percent of improvements in a country’s life expectancy could be predicted by increased economic growth. Another found that economic growth could predict up to 40 percent of health-related improvements. The effect of economic downturn on healthcare utilization, however, is only beginning to be investigated. The concern is that reduced household income, combined with a tightening of public resources and exchange rate depreciation (costlier medical imports), can have an adverse effect on citizen welfare and compromise productivity by increasing poverty, illness and disease. Such losses are likely to be particularly significant in developing country contexts, particularly for the poor.

The ability of any sector to mitigate the impact of an economic downturn is contingent on the existence of instruments, prior to the downturn, that allow for the identification of the most vulnerable groups, as well as the ability to target interventions towards them. Successful mitigation programs in the health sector have been synchronized with social safety net programs and have used the existing targeting instrument to scale up coverage and ensure the take-up of services, particularly preventive care. At the healthcare system level, this implies the need to take a longer-term perspective in order to make the system more resilient. This can also been seen as an opportunity to make the financing and organization of healthcare more efficient.

The objective of the study is to identify successful global experiences in the health and related sectors, such as social protection, in order to help countries develop programs that can withstand future economic downturns. The report analyses four country case studies that illustrate different mitigation strategies that were successful in minimizing the adverse effects of the recent downturn on healthcare utilization, especially among the poor and marginalized.

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1 The findings, interpretations, and conclusions expressed in this paper are entirely those of the author and should not be attributed to the World Bank, its affiliated organizations, or members of its Board of Executive Directors or the countries they represent. The authors can be contacted at: ahamilton3@worldbank
2 See, e.g., Waters, Saadah, and Pradhan (2003); Preston (1975); Pritchett and Summers (1993).
5 It is, also, important to note that the effects of health insurance may also generate their own inefficiencies as insured patients may pay for only a portion of the cost of their healthcare—generating a moral hazard problem where individuals have an incentive to overuse healthcare facilities. See Arrow (1963) and Miller et al (2009).
Why the Case Study Method?

The case study method is particularly useful when the objective of an analysis is to explore in greater descriptive detail the causal links between variables of interest. In this report, we examine the link between certain changes in the health system (independent variable of interest) and the ability of marginalized groups to continue accessing healthcare facilities during an economic downturn (dependent variable of interest). Specifically, the case study method permits the following types of analysis:

1. **Contextual Consideration**: Policy interventions do not occur in a vacuum, but are the result of strategic interactions among different stakeholders nested in intertwining institutional contexts. The case study method, therefore, allows for the analysis of various mitigation strategies, which by their nature take into account the complexities of these contexts. As it investigates a contemporary phenomenon within its real-life context, the case study method has a significant advantage over methodological approaches that attempt to transpose a public policy from one context to another, without analyzing the political economy dynamics that may increase or decrease the likelihood of success.

2. **Differing Successful Mitigation Strategies**: The case study method is able to explore, in great detail, the conditions, advantages and limitations of many different types of mitigation strategies. As a result, the reader is provided with research from cross-sectional evidence concerning the different options available to government and economic policy makers in times of economic downturn.

2.1 Case Selection

A large number of primary and secondary sources were consulted to identify developing countries whose innovative healthcare policies had been adapted to successfully meet the challenges imposed by economic downturns.

The literature review showed that while every mitigation strategy is unique and has a different combination of effects, all successful strategies have two salient attributes.

- Specific response to, or ability to adapt to, an economic downturn; and
- Ability to improve quality of service and/or expand access to the target population.

Mitigation strategies typically focus primarily one or the other of these dimensions. Some attempt to respond to a downturn primarily with efficiency improvements (by, e.g., changing management practices, staff incentives, co-payment regimes); while others focus more on increasing the quality and accessibility of healthcare (Table 1).

2.2 The Country Cases

The four countries selected for the study all employed context-specific mitigation strategies that reflected both of these attributes in various combinations.

- **Indonesia**’s post-downturn mitigation strategy used existing data on the poor to ensure greater access to the healthcare system in real time, as the crisis was unfolding. It was successful because of strong political will and the availability of data.

- **Thailand** had reformed its healthcare system to increase access and treatment for the poor during the rapid East Asian growth period, and these reforms helped to mitigate the effects of the East Asian Financial Crisis on healthcare utilization. Because of these reforms, Thailand was the only country in which healthcare utilization did not initially fall when the crisis hit.

Table 1: A Typology of Mitigation Strategies

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<th>Pre-Downturn</th>
<th>Post-Downturn</th>
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<tr>
<td>Efficiency Centred</td>
<td>Colombia</td>
<td>Kyrgyzstan</td>
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<td>Access Centred</td>
<td>Thailand</td>
<td>Indonesia</td>
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Note: Efficiency denotes both an overall more effective use of resources and the ability to successfully target benefits to specific groups.

Source: Alexander Hamilton, Roberto Iunes, and Xiaohui Hou

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7 For an introduction to the political economy literature see Corduneanu-Huci, Hamilton, and Massess-Ferrer (2012).
• **Kyrgyz Republic** was able to increase healthcare access and treatment during a succession of economic downturns because of a sustained reform effort that began in the 1990s to adapt to long-term budget constraints. The reforms implemented during and after this economic contraction made it possible to mitigate the effect of budget cuts on the poor, and also ensured that sufficient international donor funds were received to increase health expenditure during the period of contraction.

• **Colombia** made sweeping health sector reforms in 1993 which increased the proportion of poorer groups who were insured and therefore had regular access to the healthcare system. While most of the studies evaluating the success of these reforms do not explicitly take into account the possible effects of the economic contraction and political instability that plagued the country in the late 1990s and early 2000s, the fact that these evaluations clearly show that the number of poor Colombians accessing the public health system increased clearly demonstrates that economic downturns and political crises are not always barriers to effective structural reforms.
3 Adapting to an Economic Downturn: Implementing Pro-Poor Healthcare in Indonesia

3.1 Overview

The Asian Financial Crisis severely gripped Indonesia in July 1997 and had escalated into a full economic and political crisis by May 1998, with GDP declining by 14 percentage points over the duration of the downturn (1997–1999). The downturn caused a set of demand side and supply side shocks which, if left unaddressed, would have caused steep declines in healthcare utilization and expenditure, especially among marginalized groups.

Specifically, the financial downturn had the following direct economic effects:

- Massive devaluation of the rupiah (worth 20 percent of its trade-weighted value by the end of 1998) resulted in inflation (80 percent in 1998), making the importation of healthcare products (between 60–80 percent of healthcare provision) significantly more expensive.
- Rapid contraction in employment conditions (the unemployment rate surged past 15 percent in 1998, with more than 8 million people losing their jobs).
- Increase in the poverty rate from 11 percent before the crisis to 18–20 percent post crisis.

The effects of the economic downturn resulted in a significant decrease in healthcare expenditure by both households and the public sector. This decrease is seen clearly via the following statistics:

- There was a 9 percent reduction in public health spending due to decreased revenue from 1997 to 1998.
- Household expenditure allocated to healthcare declined by 16 percent, from 1.9 percent to 1.6 percent of total household expenditure, during the same period.

Given the rapidly declining level of healthcare utilization associated with the downturn—not to mention the political instability caused by the economic collapse, culminating in the fall of the Suharto regime in May 1998—the Indonesian Government launched the Indonesian Social Safety Net Program (Jaring Pengaman Sosial Kesehatan, or JPS-BK), in August 1998. One of its critical components was the scaling up of a previously minor program, the Health Card.

3.2 Design and Implementation of the JPS-BK: The Health Card

The Health Card program was effectively a targeted price subsidy, as all household members who received the card were entitled to subsidized care by public health care providers. It entitled users to “free services at public healthcare providers consisting of: (1) outpatient and inpatient care; (2) contraceptives for women; (3) prenatal care; and (4) assistance at birth.”

The Health Card had existed prior to the Asian Financial Crisis. However, its uptake was negligible and there were no robust assessments of whether the program was in fact successfully targeting low-income groups. The decision to massively scale up the program was aimed at increasing access of financially distressed and marginalized households to public healthcare.

As the distribution of the Health Cards was not random (focused on the poor), public providers in the local communities identified as likely to receive a surge in demand for services were given additional funds. Specifically, primary health centres (Puskesmas) and village mid-wives (Bidan di desa) were given an additional US$29 million for FY98. While this amount was not sufficient to cover all of the new demand created by the expansion in coverage, it did help to ensure that the quality of treatment would not be significantly affected by increased healthcare utilization.

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12 Knowles and Marzolf (2003).
14 Yazbeck (2009).
15 Sparrow (2008).
16 Ibid.
17 Ibid.
3.3 Pro-Poor Targeting in Times of Downturn

Given how quickly the targeted scheme was scaled up and rolled out, the JPS-BK program followed a two-pronged strategy to ensure that it reached the poorest groups:

- Funds were targeted according to the results of a prosperity index of 307 districts (urban Kota and rural Kabupaten). The index classified a household as poor if it failed to meet one or more of the following criteria:\(^{18}\):
  - Freedom to worship
  - Eat two basic meals a day
  - Have different clothing for different occasions school/work and home/leisure
  - Home floor is not earthen\(^ {19}\)
- The distribution of Health Cards was guided by local health officials and community leaders who could apply their knowledge to target pro-poor groups within their specific communities.

The program followed a partly decentralized targeting process, involving both geographic and community-based targeting instruments. It was, however, not perfect in its execution. In hindsight, policy-makers may have wished to have made the following modifications to the Health Card distribution process—assuming their objective was to ensure pro-poor targeting:

- **The use of household expenditure data to determine who was poor.** While the prosperity index is correlated to indicators of poverty, it is still a proxy indicator and therefore a more noisy measure of who can be classified as poor. Ideally a more efficient measure of the poverty head count could have allowed for even more efficient targeting. However, given the speed with which the program needed to be rolled out, the prosperity index was the most appropriate up to date indicator available at the time.

- **The use of local elites to make distribution decisions.** Allowing local officials to make decisions about distribution of Health Cards resulted in some leakage to higher-income groups. However, given the speed with which the program needed to be rolled out, the prosperity index was the most appropriate up to date indicator available at the time.

3.4 Impact: Sustaining the Social Safety Net

**By February 1999, 22 million Indonesians, or approximately 10.6 percent of the population, had received the Health Card.**

![Figure 1. Incidence of Health Card Coverage by Income Group (1999)](image)

By 1999, the incidence of Health Card ownership was clearly skewed towards the poorest groups; of the 20 percent of the population classified as poorest (according to the prosperity index), 18.45 percent had received the Health Card (Figure 1). This suggests that despite reliance on the prosperity index, the rapid scale-up of coverage, and the discretion of local elites in distributing the cards, the program was moderately successful in increasing the coverage of marginalized groups—even though a majority of them still remained outside the formal healthcare system. However, almost 4 percent of the wealthiest Indonesians also received a Health Card.

The success of the targeting becomes more mixed, however, if one looks at the percentage of total card holders in each income quintile, rather than the incidence of card ownership by income group. Figure 2 shows that while 34 percent of the cards did reach the poorest quintile and 60 percent reached the two lowest quintiles, a still very large 40 percent went to the top three income quintiles.

Nevertheless, considering that the scheme was scaled up during and immediately after an economic and political crisis in one of the largest developing countries in the world, its relative success should not be dismissed. At the very least, the results suggest that it is possible to implement, albeit imperfectly, a pro-poor health in a very short period of time despite significant economic, political, and geographical obstacles.

Despite the limitations noted above, the rapid scale-up of the Health Card program helped to ensure that the fall in healthcare utilization caused by the economic crisis was partly reversed.
While outpatient visits to all types of medical facilities (public, private, and modern\textsuperscript{21}) declined among all poor households between 1997 and 1998, among the subset of such households that had received Health Cards, this trend was reversed by 1999 (Figure 3). Conversely, outpatient visits continued to decline among households that had not obtained such cards. Among card holding households, while outpatient visits in 1999 had not recovered to their pre-crisis levels, there was a notable recovery in the use of public sector outpatient services (5.3 percent in 1999 vs. 5.0 percent, on average, in 1998). There was also a stabilization in the use of modern facilities (at 10.5 percent). As the Health Card did not cover private sector facilities, it is no surprise that this rate of utilization continued to fall in households with Health Cards (from 6.1 percent in 1998 to 5.8 percent in 1999). However, in poor households without the Health Card, the decline in utilization continued unabated over the one-year period, with public sector outpatient visits declining from 5.0 to 4.8 percent in 1999, and the use of modern outpatient services declining from 10.5 percent to 9.9 percent.

Further, as shown in Figure 4, card holders in the 3\textsuperscript{rd} quintile were most likely to make use of the card when visiting a facility (6.84 percent of this group), compared with 6.51 percent of the poorest quintile.\textsuperscript{22} There is evidence that middle-income groups are more likely to utilize the Health Card because they have better access (in terms of physical proximity) to public health facilities. Therefore, in order to make the scheme more pro-poor, it would have been necessary to ensure better access to public health care facilities by the poor by somehow reducing the transportation costs that limit their access to healthcare.\textsuperscript{23}

3.5 Limitations: Was there Healthcare Access for the Poor?

The Health Card program faced the following limitations\textsuperscript{24}:

- Evidence shows that patients who received treatment using a Health Card received a poorer quality of service vis-à-vis other patients.
- Approximately one third of Indonesian Health Card users did NOT present their Health Cards when attending an eligible healthcare institution.
- Due to the imperfect distribution of the Health Card to the poor as well as barriers to accessing the health centers, the effect of the program on healthcare

\textsuperscript{21} This term has been defined as ‘more recently constructed public and private facilities’ (Saadah, Pradhan, and Sparrow, 2001).

\textsuperscript{22} While the difference in utilization is not statistically significant, the similarity in the rate of use suggests that, in practice, the Health Card was not as pro-poor as the initial distribution might have suggested.

\textsuperscript{23} Sparrow, R. (2008).

\textsuperscript{24} Adapted from ibid.
utilization by marginalized groups was more limited than the successful dissemination of the Cards would have otherwise ensured.\textsuperscript{25}

### 3.6 Aftermath: Lessons and Recommendations\textsuperscript{26}

In 2005, the Health Card program was modified in order to increase its reach and effectiveness. Specifically, the Health Card began to be issued by Askes,\textsuperscript{27} with the government paying premiums on behalf of card holders.

This program was also designed to be expanded quickly. Two targets were specifically established:

- January-May 2005—a target of reaching 36.1 million people was set (equivalent to 17 percent of the total population, equivalent to the estimated number of people in absolute poverty in the country). As in the initial program, districts were allocated cards based on the estimated number of poor, and local authorities provided lists of qualifying individuals to Askes branches.
- During the second phase, June-December 2005, a higher target of 60 million was set and a more simplified transfer of funds—directly from the Ministry of Finance to healthcare clinics rather than through Askes—was developed in order to maximize efficiency.

By 2007, despite continued problems in identifying and reaching the poor, the program covered more than 76.4 million people.

### 3.7 Conclusion: Unfinished Agenda

Prior to the Asian Financial Crisis, the Indonesian Health Card scheme was a minor program designed to help marginalized groups gain access to healthcare. The onset of the Asian Financial Crisis in 1997, and its associated political aftershocks (fall of Suharto regime in May 1998), created an adverse environment in which healthcare utilization fell by more than 9 percent during 1997–1998.

The massive scaling up of the Health Card program during this period was no small accomplishment. Access to the Health Card did not fully compensate for the effects of the crisis, it did stop and begin to reverse the fall in healthcare utilization among the poorest groups. Despite the pro-poor distributional objectives, however, more than 40 percent of Health Cards were distributed to middle and upper income groups, who were in fact more likely to use the Health Card as the poorer groups.

\textsuperscript{25} Johar (2009).
\textsuperscript{26} Adapted from International Labour Organization (2008).
\textsuperscript{27} Askes (Persero) are organizations that traditionally provide the health insurance schemes of public sector employees.
4 Prepared for the Consequences of the Downturn by Accident: The Case of Thailand

4.1 Overview

Access to healthcare institutions in Thailand has historically been closely linked to economic growth. The first to receive medical benefits were the politically powerful civil servants in 1963, with insurance schemes designed to target the formal sector. Insurance schemes designed to target the rural poor officially commenced in the 1970s. The end of the Vietnam War and political instability in neighboring countries, coupled with fast economic growth in the 1980s, resulted in an expansion of insurance schemes. For example, it was in 1981, that the voluntary health card was introduced and concerted efforts to train and retain medical professionals commenced. The effectiveness of Government reforms and expansion was, however, limited due to persistent corruption, especially with respect to construction contracts and pharmaceutical procurement. Furthermore, while economic growth saw the level of absolute poverty fall from 23 percent in 1988 to 11 percent in 1996, growth was accompanied by exacerbated inequality, which created new challenges in the implementation of successful social protection programs.

While both health sector and social protection programs did expand quickly with the support of the Government, Thailand still had no comprehensive and universal social protection scheme by the time of the Asian financial downturn in 1997.

The crisis had a significantly adverse effect on the Thai economy and as a result severely restricted public expenditure. More specifically,

- GDP growth slowed significantly, from an average rate of about 7–9 percent in the late 1980s and early 1990s to 0.6 percent in 1997 and a contraction in 1998.
- The devaluation of the Thai baht fell by more than 70 percent, which resulted in more than inflation of more than 10 percent.
- The unemployment rate more than doubled, from 2 percent in 1996 to 5 percent in 1998.
- Real wages fell by almost 6 percent with a disproportionate loss of income among poor members of society.

This downturn resulted in the following adverse effects on healthcare utilization:

- Medical drugs and devices became more expensive. The cost of domestically produced drugs increased by 12–15 percent, while imported drug prices rose even faster at 18-20 percent during 1997–1998.
- Growing budgetary restrictions due to falling revenue (declining economic activity) and rising demands for social services. Specifically, the healthcare budget was slashed by 15 percent in 1998 and by just under 1 percent in 1999.

To minimize the impact of the downturn on actual health utilization, most cuts focused on capital expenditure, although substantial cuts were also made to many programs, including HIV/AIDS treatment and anti-transmission programs.

Despite these constraints, the expansion of coverage during the boom period meant that Thailand was the only country affected by the Asian Financial Crisis in which healthcare utilization did not decline during 1997–1998. In fact, outpatient visits to public health facilities increased by 22 percent between 1996–1998. Several studies have found that this was due in part to the expansion of the Health Card program—made possible by World Bank and Asian Development support—which made access to public health facilities more affordable to households, especially poor households, during the crisis. Further, the well-run program received financial support from the World Bank and the Asian Development Bank during the crisis, which

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28 Wibulpolprasert (2010).
29 Ibid.
30 Ibid.
33 Ibid.
35 Ibid.
37 Ibid.
enabled it to increase provision to poor groups during the downturn.\footnote{38}

\subsection*{4.2 The Health Card: Better Health?}

The Ministry of Health introduced the voluntary Health Card in 1983. Its aim was to enable poor households to access health services. The purchase of a card enables up to five members of the same household to get care at public health institutions at no additional expense.\footnote{39} The Health Card provides coverage for out—and inpatient care, as well as maternal and child care services.\footnote{39}

In 2000, the average cost of an annual voluntary Health Card was 1000 baht, half of which was covered by the Government. This subsidy made the program affordable and attractive for lower—and middle-income households. The card did not provide coverage for privately run medical institutions, which seems to have virtually eliminated leakage to wealthier groups—although data on the demographics of card holders is not always reliable. More recent studies, such as one conducted in the rural Khon Kaen province, have found that proxies for household poverty are generally good indicators of whether a household purchased a Health Card.\footnote{40} As Supakankunti, (2000) has found, at least in Khon Kaen, on average, the household income of a card-owning household was approximately 50,000 baht, or 12,000 baht less than non-card owning households (average income 62,000 baht), and this difference was highly statistically significant (at the 1 percent level). However, statistical analyses have generally found that the best predictor of whether a card is purchased is not income, but rather (a) the presence of illness, and/or (b) the existence of nearby health facilities. This suggests that the structure of the program incentivizes adverse selection.\footnote{41} Furthermore, when it comes to utilization of health services, while Health Card holders who access public hospitals have a lower income than non-card holders who access public hospitals, this difference is not statistically significant once other factors are controlled for. This suggests that while the initial distribution of Health Cards is relatively pro-poor, the actual use of Health Card is by no means restricted to the poorest groups in society with middle income groups who own cards just as likely to use them as their poorer peers.\footnote{42}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{health_card_utilization.png}
\caption{Health Card & Health Utilization 1996–1998}
\end{figure}

\begin{itemize}
\item Source: World Bank Databank as adapted from the Thai Ministry of Health
\end{itemize}

\subsection*{4.3 Impact: What Has the Health System Contributed to Health Improvement?}

The purchase of Health Cards increased 60 percent during the Asian Financial Crisis, from approximately 5 million in 1996 to 8.6 million in 1998; while outpatient visits doubled from just under 11 million to just under 21 million during the same period (Figure 5).

Empirical analyses have generally concluded that the expansion of this affordable program was one of the key factors in preventing the crisis from having a negative impact on healthcare utilization.\footnote{43} This was in stark contrast to the experience of Indonesia and other affected countries, where patient utilization declined as the crisis took hold.

\subsection*{4.4 Aftermath}

Despite the relative success of the program, it did not provide universal coverage, with a large informal economy and marginalized groups remaining uninsured and dependent on out of pocket payments to access healthcare. Following the election of Prime Minister Thaksin Shinawatra in 2001, the card was replaced by a universal health scheme in 2002 that automatically enrolled all uninsured Thais (approximately 18.5 million of a total population of 62 million) and provided treatment for a flat 30 baht fee per visit.\footnote{44} The experience of utilizing the Health Card, especially in rural areas, made it easier to roll out this larger plan.\footnote{45}

\begin{itemize}
\item \footnote{43} Waters, Saadah, and Pradhan, (2003).
\item \footnote{44} Trowse, Mills, and Tangcharoensathien, (2004).
\item \footnote{45} Ibid.
\end{itemize}
4.5 Limitations: Agenda Setting for the Future

Despite its success the Health Card scheme was criticized because:

- It did nothing to ensure the quality of services.
- The best predictor of Health Card purchase was the anticipation of illness rather than any measurable socio-economic indicators.

4.6 Conclusion

By continuously expanding access to health care through various insurance schemes, Thailand was the only country in the East Asia Region that did not experience a fall in healthcare utilization during 1997–1998.\(^\text{46}\) The evidence suggests that this was due in no small part to the existence and expansion of the Health Card in the preceding years. While the targeting towards the poor was not perfect, the program was broadly successful in protecting access to the healthcare system for lower-income groups.

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5 Adapting to a Protracted Downturn: The Case of the Kyrgyz Republic

5.1 Overview

Following the collapse of the USSR and the subsidies it provided, the Kyrgyz Republic suffered a protracted five-year recession, 1991–1996, with per capita GDP declining by an astounding 40 percent. In such a context, policy makers had to increase the efficiency of public service provision in order to try to maintain standards in a constantly contracting budgetary situation. By pursuing a successful round of reforms that enhanced both efficiency and equity in such a difficult situation, the Kyrgyz healthcare system was in a good position to receive international aid to soften the impact of the current financial crisis (starting in 2008). The example of the Kyrgyz Republic provides, therefore, evidence of the policy options available to decision-makers in times of extreme and persistent economic distress.

5.2 The Recession and Health Reforms

The 1991–1996 recession resulted in a massive decline in health expenditures—from 3.6 percent of GDP in 1991 to 1.9 percent of GDP by 2000—a 47 percent decrease in expenditure. Compounding this dire downturn was the fact that the majority of healthcare expenditure, 75 percent, went to administrative costs—leaving few resources for actual patient care. Since the collapse of the Soviet Union, the Kyrgyz economy has been adversely affected by (1) the Asian Financial Crisis (1997–1998), (2) a winter crisis and drought in 2008–2009, and (3) the current economic downturn (2008–2012). Compounding these economic downturns was political instability, which seemed to plague the country. This culminated, in April 2010, with uprisings against and the ultimate ousting of the incumbent President Kurmanbek Bakiyev by protesters and the holding of new elections in November later that year. While this transition was ultimately successful, the violence (over 1000 injuries), displacement (over 400,000 people) and deaths (at least 100) and political uncertainty it engendered, did not, initially, facilitate the stabilization of the country, even though they did provide a possible basis for further reforms.

As a consequence of the shortage of funds, the average out-of-pocket expense faced by a typical patient was the equivalent of US$46 in 2008, or about five times the average monthly level of individual consumption. In effect, more than 50 percent of healthcare expenditure in the country was raised by out-of-pocket payments, with patients contributing to the cost of medicines, equipment, and the salaries of healthcare professionals. As a result, healthcare was unaffordable for a large percentage of the population.

Kyrgyzstan begun implementing its five-year health system reform program in 2001. The so called ‘Manas Health Sector Reforms’ were part of a ten-year reform program aimed at (1) increasing the efficiency of the health system; and (2) reducing out-of-pocket expenses, especially for the poor. The main logic behind these reforms was to split the purchase and provision of services in order to realize efficiency gains, with the Mandatory Health Insurance Fund (MHIF) becoming the main purchaser of individual health insurance, which was financed by general taxation and payroll taxes. The main elements of the reform were:

- **Rationalization of health financing.** Before the reforms, there had been separate healthcare financing schemes at the national, regional, and oblast (district) levels, resulting in duplication and waste. The reform organized financing at the regional level and abolished municipal and city level resource pools. It was hoped that such a reform would allow for the more efficient allocation of resources across oblasts.

- **Consumer-focused purchasing methods.** Prior to the reforms, providers had been paid based on input
criteria and line item budgeting, and managers had little leeway to shift spending across line items. By shifting to capitation and case-based payments to hospitals (based on actual demand), the reforms aimed to create incentives for resources to be focused on the needs of patients.\textsuperscript{56}

- **A more transparent benefits regime.** By clearly defining which services are covered under the benefit package, and introducing a flat co-payment regime, reform aimed to displace informal payments, which had become highly regressive. Furthermore, because hospitals would receive higher payments for treating the uninsured (mostly the poor), this reform was expected to enhance equity of access.

- **Downsizing the hospital sector.** By reducing the number of hospitals from 1464 to 784, the reforms potentially could have increased barriers to healthcare. However, by focusing on eliminating inefficiencies (excess administrative costs and duplication of services), the reforms aimed to free up more resources to finance patient care. As a result of this reform, the percentage of the health budget devoted to administration fell below 75 percent for the first time since independence.

5.3 Results

As the reforms were rolled out sequentially in different oblasts, it was possible to identify the impact of the reforms across the country and over time.

By carrying out a baseline survey in all parts of the country before any reforms were implemented, and then conducting a survey when the reforms had been implemented in half the oblasts, it became possible to identify the treatment effect of the reforms.\textsuperscript{57} The following effects were identified:

- The introduction of a transparent co-payment scheme resulted in a slower growth rate of out-of-pocket expenses, which grew by only about US$5 in reformed oblasts, compared to US$15 in unreformed oblasts, between the years 2000–2003.\textsuperscript{58}

- In particular, out-of-pocket expenses declined for low-income groups in reformed oblasts, compared with a slight increase with out-of-payment in unreformed oblasts.

\textsuperscript{56} Yazbeck (2009).

\textsuperscript{57} Original results are from Jakab (2007) and World Bank (2008). Of course, because the rollout of the reforms was not random the baseline survey was absolutely crucial in ensuring that the marginal effect of the reforms could be identified.

\textsuperscript{58} The World Bank (2008).

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\textbf{Box 1: Effective Reform Attracts International Donors}

The decline in resources devoted to health, coupled with the first stage of the Manas reforms, attracted resources from international donors. In 2004, 10 donors, led by the International Development Association, adopted a sector-wide approach (SWAp) focusing on health expenditure (the first of its kind in the ECA region). In return for continued Government commitment to expand the Manas reforms, the donors agreed to provide financial support to improve access and ease the effects of the sharp economic downturn on healthcare utilization. As recent evaluations have shown, both the SWAp and the Manas reform schemes have been successful in reducing the financial barriers to healthcare access. In short, by reacting to the effects of an economic downturn by increasing efficiency, the Kyrgyz health care system was able to attract financial support from abroad in order to ease the budget burden.

\textsuperscript{58} The World Bank (2008).
While the economic downturn resulted in a dramatic decrease in public (taxpayer-funded) health expenditure in 2008, from 3.2 percent of GDP 2007 to 2.7 percent in 2008, this decline was more than compensated for by 2009, with expenditure rising to 3.5 percent of GDP as a result of donor support coupled with deficit spending by the Government.\(^\text{59}\)

### 5.4 Limitations

The reform programs, however, did not address the lack of qualified medical professionals (declining since before the collapse of the USSR), which could result in severe cost and access problems in the future.\(^\text{60}\) Moreover, given the significant budgetary constraints and dependence on donor support, the gains from the reforms remain vulnerable to changes in donor priorities.\(^\text{62}\)

### 5.5 Conclusion

The relative success of the health reforms provided justifications for donors to support the Kyrgyz healthcare system during the current economic downturn. The example of the Kyrgyz Republic, therefore, demonstrates that even when faced with a severe and protracted budgetary crisis, the pursuit of reforms can not only directly mitigate the adverse effects on healthcare utilization, but also demonstrate the commitment to reform that donors require before stepping in to help.

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59 The importance of ensuring counter-cyclical development aid in order to ensure healthcare utilization is noted in Schneider (2011).

60 Mogilevsky (2011).


6 Targeting System for Social Programs: The Case of Colombia

6.1 Overview

Colombia illustrates how changes in the governance of the healthcare system—that is, the allocation of resources in a more efficient and equitable manner in a pre-crisis context—can mitigate the adverse effects of an economic downturn. Colombia’s 1993 reforms to the healthcare system helped to reduce the system’s vulnerability to crisis by:

- expanding access and efficiency of the system, and reducing the need for out-of-pocket payments; and
- putting in place a versatile and sophisticated mechanism—the Selection System of Beneficiaries for Social Programs (SISBEN)—for identifying and potentially targeting the poor.

According to the Colombian Constitution, public healthcare provision is a constitutional right:

‘Public health… is a public services for which the state is responsible. All individuals are guaranteed access to services that promote, protect, and rehabilitate public health. It is the responsibility of the state to organize, direct, and regulate the delivery of health services … to the population in accordance with the principles of efficiency, universality, and cooperation…’

Yet, despite this formal mandate, the healthcare system in Colombia, before the 1993 reforms, the system was characterized by low efficiency, lack of access by the poor, and large out-of-pocket payments.

In fact, barriers to healthcare access among the poorest groups were so significant that, in 1992, only 1 out of 6 sought medical care when they became ill. Of all those treated in public hospitals, only 20 percent came from the poorest quintile, with middle-income groups being responsible for more than 60 percent of public healthcare utilization. Not only was utilization biased towards the middle class, but, as Figure 7 indicates, because of a lack of private health insurance, the poor were most likely to make out of pocket payments (91 percent) compared to their middle-income users (69 percent).

Dependence on out-of-pocket payments for health care made the poor more vulnerable to a sudden fall in income. Further, the fact that the healthcare system was financed primarily through general tax revenue and the payroll tax system meant that the entire system was vulnerable to the effects of a broad economic downturn.

6.2 The Reforms: Using Proxy Means Testing To Expand Health Insurance

The 1993 Colombian healthcare system reforms represent one the most ambitious attempts by a developing country to expand healthcare access, especially for marginalized groups, by focusing on mitigating inefficiencies in the management of healthcare resources.

The reforms were predominantly focused on changing how the healthcare system worked (governance reforms), and not just on expanding access. This mix of reforms therefore, represents a contrast to many reform programs around the world that focused exclusively on expanding access to healthcare without significantly altering the governance of the healthcare system.

Figure 7: Out of Payments by Income Group

Source: Espobar, 2005

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65 Yazbeck (2009).
66 Ibid.
SUCCESSFUL STRATEGIES FOR HEALTH SYSTEMS IN DISTRESS

Two mail elements of the 1993 healthcare sector reforms improved the access to and quality of healthcare received by the poor:

- Citizens whose income fell below a certain threshold were eligible for a fully subsidized health insurance scheme (SR).
- Insurance agents were now able to allocate funding (purchase healthcare) from different providers, thereby enabling them to avoid hospitals that were likely to provide poor quality services.

To realize these changes, Colombia took steps to develop an efficient poverty index, and to shift subsidies from hospitals to patients.

1. The poverty index, SISBEN, was absolutely pivotal in ensuring that households eligible for the subsidy scheme were identified. The SISBEN index included the following measures:
   - Access to and quality of a household’s living accommodations
   - Access to and quality of essential public services
   - The number of durable goods the household possesses
   - Education attainment
   - Income level.

2. Shifting the subsidy from hospitals to patients was supposed to empower patients to shop for the best quality treatment by hospitals that made the most efficient use of resources. However, as noted below, this element of the reform was not fully implemented and its expected positive effects were therefore not fully realized.

### 6.3 Results

**Between 1992 and 2007, the share of insured Colombians went from 20 percent to 80 percent of the population.**

Furthermore, as Figure 8 indicates, these gains were concentrated among the poorest income groups. Access to healthcare among the poorest quintile increased especially quickly—from 9 percent of the poorest in 1992 to 49 percent in 2003—a 444 percent increase. This resulted in a significantly smaller percentage of potential patients claiming that they could not access healthcare because of a lack of money.

The reforms halved the out-of-pocket expenses of the poor. While the uninsured poor spent 8 percent of their income on out-of-pocket expenses in 2003, the insured poor spent only 4 percent.

By 2003, the percentage of respondents in every income group who indicated a lack of money as the reason not to seek healthcare was significantly lower among the insured compared to the uninsured (Figure 9). This was particularly true among the lowest income groups.

Furthermore, the creation of the SISBEN index encouraged local municipalities to share information with the central

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68 Ibid.
69 Yazbeck (2009).
70 Ibid. Income was initially included as a variable but was dropped due to its lack of predictive capacity.
72 CENDEX (2008).
73 Yazbeck (2009).
government, thereby facilitating better coordination and distribution of benefits across the country.\textsuperscript{74}

The reforms increased not only the percentage of the poor who were insured and had access to public health care facilities, but also their use of these facilities. Using a matching technique, a recent evaluation study found that the reforms significantly increased the utilization of public health facilities by the poor and previously uninsured.\textsuperscript{75}

Finally, there is evidence that the scheme significantly reduced extreme expenditures on health care by one third, thereby reducing the susceptibility of the poor to the effects of income shocks.\textsuperscript{76} The evidence for this is the fact that, despite a deteriorating economy (GDP declined by 4.3 percent between 1997–1998) and rising unemployment (from 8.5 percent in 1995 to 20.2 percent in 2000), implementation of the program continued to bring healthcare to Colombians in increasing numbers, even during the period of escalating political violence in the early 2000s.\textsuperscript{77}

### 6.4 Limitations

Despite its success, the impact of the reforms are of a more limited scope than would have been possible. This is namely due to:

- The complexity of reforms, duplication, and to some extent a loss of political will to implement the reforms over time. This has meant that initial efficiency gains were not as great as hoped. The reforms have not mitigated the issue of strong union membership—generating resistance to change and/or the lack of managerial expertise in the public healthcare system limited the efficient component of the reforms\textsuperscript{78}. Until resistance from Unions to limit reforms is abated and managerial expertise is improved the ability to realize the full potential of the reforms will remain constrained.

- In many cases, an individual insurer enjoyed enjoys a geographical monopoly, which reduces the efficiency effects that might be associated with competition for patients.\textsuperscript{79}

- There is evidence that households and local officials may have manipulated the SISBEN index in order to obtain coverage. As the scheme generated revenue for the municipalities for each person enrolled, there was an incentive for local government officials to inflate the number of eligible households.\textsuperscript{80}

- A majority (51 percent in 2003) of the poor remain uninsured and hence vulnerable to the effects of an economic downturn, just as before the reforms were introduced.

- The system provides fewer benefits for the poor on the SR scheme compared to those covered by pre-existing insurance schemes.\textsuperscript{81}

- Expansion of the program is conditional on overcoming financial constraints.\textsuperscript{82}

- While more insulated from economic shocks than before, the insurance system ultimately rely on payroll taxes and general government revenues, both of which decline during times of crisis.

### 6.5 Conclusion

The governance and targeted nature of the health reforms undertaken in Colombia significantly expanded the coverage of and access to public health care by poor and marginalized groups. While the scheme was not perfect—with significant political economy dynamics limiting the efficiency goals, and financial constraints limiting the expansion of coverage—the reforms did reduce the dependency of the poor on out-of-pocket expenses and increased healthcare utilization. Further, the scheme was successful despite the onset of an economic downturn in 1997 as well as political instability and conflicts from 1995 to 2003\textsuperscript{83}. This suggests that such reforms over a long period of time can result in improvements in the utilization of healthcare by the poor despite economic contractions and significant political instability.

\textsuperscript{74} Yazbeck (2009).
\textsuperscript{75} Trujillo, Portillo, and Vernon (2005).
\textsuperscript{76} Miller, Pinto, and Vera-Hernández (2009).
\textsuperscript{78} Ibid.
\textsuperscript{79} Miller G, Pinto D, M. Vera-Hernández (2009).
\textsuperscript{80} Camacho and Conovor (2009).
\textsuperscript{81} Ibid.
\textsuperscript{82} Ibid.
Arrow, K. (1963) ‘Uncertainty and the Welfare Economics of Medical Care,’ The American Economic Review S3(5)