

UNIVERSAL HEALTH COVERAGE IN FRAGILE STATES

EXECUTIVE SUMMARY

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Photo: Adriaen Backer

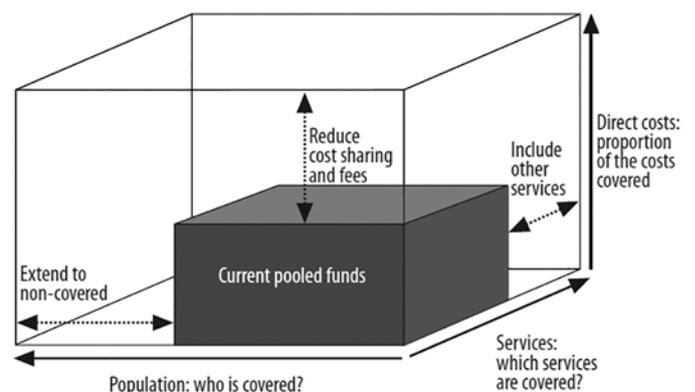
Adority Magodo, Sister in charge at Concession Hospital maternity. Mazowe district, Zimbabwe 2014.

Universal Health Coverage: definition and research

Universal Health Coverage (UHC) is widely emerging in debates in global health policy circles. WHO defines UHC as: *ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services.* This definition points to the central dimensions of health coverage (see figure): Who is covered? Which services are covered? And how much financial protection do people have? The definition refers to the demand and the supply side of health systems – and it triggers debates and requires choices around equity, solidarity and good governance.

Until recently, many of the UHC debates addressed health coverage in middle-income countries and emerging economies. How the debates play out in fragile and transitional states is largely unknown. Therefore, Cordaid commissioned this qualitative study into perceived feasibility of pathways to UHC in fragile and transitional states. The aim of this study is to contribute to the global conversation on sustainable improvements in health, including attention for Universal Health Coverage as part of the global Sustainable Development Goals after 2015.

FIGURE WHO CUBE, THREE DIMENSIONS OF UNIVERSAL HEALTH COVERAGE



Source WHO (2010), <http://www.who.int/whr/2010/en>

Cordaid supports more inclusive approaches in development, which for this research translated into a special focus on the role of civil society organisations (CSOs) in working towards UHC. This also influenced the research methods, as a substantial part of the research was an active, in-depth engagement

with a wide array of people in Afghanistan, Burundi, Rwanda and Zimbabwe. A set of four research questions was leading throughout:

1. Stakeholder awareness: How do stakeholders understand the current UHC agenda and is UHC anything new for stakeholders in health in fragile and transitional states?
2. Specific pathways: Can we obtain a sharper understanding of the particular challenges and requirements for any pathways to UHC in fragile and transitional states?
3. Peace and state building: Is there evidence that UHC contributes to peace and state building?
4. Civil-society organizations: What should be their roles with respect to UHC?

The research consists of two main parts: a literature survey and an interview-based study. In the survey special attention was given to four countries that are known for their progress, in varying degrees, on the road to UHC: Thailand, Colombia, Ghana and Rwanda. In the interview-based study, a total of 77 interviews were conducted with 79 key figures from the health field in four countries that can either be considered fragile or transitional: Afghanistan, Burundi, Rwanda and Zimbabwe. The respondents came from ministries of Health and Finance, from local health policy, patients/consumer organisations, health insurance providers, implementers, academics, NGOs (including donors), MPs, policy advisors and policy/professional bodies.

Literature survey

the literature survey, in chapter 3, first analysed the globally accepted WHO conceptual framework as depicted in the WHO 'UHC Cube'. This framework describes the three dimensions of UHC predominantly found in the literature: who is covered; which services are covered; which proportion of the costs is covered (financial protection). In this research, a twin indicator approach – where one looks at financial protection in combination with healthcare utilization - is used.

“We can arrive at universal health coverage but it will demand a plurality of financial means, a lot of energy, strong will and technical skills, without forgetting to sensitize the population.”

Respondent, Burundi

Looking at the four countries selected for the literature survey, both Thailand and Colombia are considered to have made major progress towards UHC in recent years, while Ghana and Rwanda are viewed as countries on the way to UHC. Thailand and Colombia show that the route towards achieving UHC can be very different, depending on local historical, socio-economic, institutional and political contexts. Policies can be tax-based or rely heavily on the private sectors; health care can be provided for free or through premium-based schemes. Pre-existing functioning structures and a healthy economy help to reach goals. Challenges that remain are: inequity in access and coverage; heterogeneity of benefit packages, financial sustainability and quality of care. Ghana and Rwanda made



Stewart Chiripanyanga, Registered General Nurse, Nyakudya Clinic, Mazoe District, Zimbabwe 2014.

some progress, mainly in improving care access and financial protection. However, there are major challenges in areas similar to those in Thailand and Colombia: inequity, financial sustainability and quality of care. And in Ghana and Rwanda, inefficiencies in management and administration are added to these.

The literature survey then addressed the question of achieving UHC in fragile states. In this research, fragile states are defined by using the World Bank IRAI threshold. There are notable similarities and differences between the fragile states and the UHC achievers, but not all related to health financing. Fragile states face a lower life expectancy, a higher incidence of mental disorders and morbidity and mortality patterns differ substantially - some related to recent or ongoing armed conflict and subsequent breakdown of health services. The failure to provide health services is often also linked to the failure to raise sufficient funding. Health insurance in the form of premium-based schemes is uncommon in fragile states, due to incapacity in required management and administration. Government commitment to and spending on health is generally lower than in progressing or UHC states; donors often step in.

Three strategies are mentioned for moving towards UHC; these were reviewed in their applicability to fragile and transitional states. Firstly, there is (selective) free health care, the removal of user fees and specific targeting of the poor. Unfortunately, the effects of this strategy are not straightforward until now. Secondly, there are contributory schemes, both insurance premiums and taxes. This will be difficult to realize on a large scale in fragile states, as it requires extensive administrative and regulatory capacities and sustained political commitment. Lastly, there is deepening coverage: through results- and performance-based financing. This could, tentatively, provide valuable instruments to increase healthcare utilization and improve care quality in fragile states, but more research is needed.

Regarding the relationship between fragile states, health and statebuilding, more research is needed as well. However, four

ways can be distinguished in which healthcare systems could relate to nation-building and stabilization: promoting social cohesion; restoring accountability and strengthening the social contract; restoring trust; and strengthening government capacity.

Chapter 4 presents the health policy situation of the four fragile or transitional countries selected for the interview part of the research.

Afghanistan: Since 2000, Afghanistan has deployed several policies on health financing and sustainability. In practice, the general population still pays 76% of the total health expenditure through out-of-pocket payments, despite user-fee exemptions. The further 24% is public healthcare funding, of which international donors provide 75% (and much of its healthcare provisions). Afghanistan offers two packages of healthcare, a basic package of health services (BPHS) and an essential package of hospital services (EPHS), but equity, access and financial protection remain problematic. Over the last years, the government is trying to develop a more diversified domestic financing mix, also to counteract the looming withdrawal of donors.

“(UHC IS) the government's legal task, since access to health services is a human right, a basic right of people, as stipulated in the Constitution.”

Respondent, Afghanistan

Burundi: In Burundi contracting and Performance-Based Financing (PBF) are national policies for the health sector since 2010. At the same time, free healthcare was introduced and integrated with the PBF strategy. In 2012 the insurance scheme Carte d'Assurance-Maladie (CAM) was re-introduced. The combination of these strategies causes strains on the system. A government-led technical support unit, the CTN, has been a pivotal strategic asset in coordinating and integrating health financing and service delivery. Improvements in the utilization and quality of health services, as well as in community participation and data management, have been realised. However, sustainability remains a challenge.

Rwanda: Over the last ten years, Rwanda has worked steadily towards introducing a health financing mix of PBF- and insurance schemes and the community-based health insurance (CBHI) programs known as Mutuelles. PBF has shown a positive impact on quality of health services. The various insurance schemes have shown gradual increase of financial coverage. The ultimate aim of the Rwandan government is to have a functional obligatory health insurance scheme for all citizens, using the CBHI as vehicle. At the moment, CBHI only offers access to public health facilities and their packages of health services, which differ per level of the health system. Concurrently, a system for the poor has been designed, Ubudehe, through which the poorest people are exempt from paying CBHI premiums. Challenges are mainly connected to financial management and the design of the PBF schemes.

“We need to understand the needs of the villages; they need to contribute; they need to be informed in the best way.”

Respondent, Rwanda

Zimbabwe: Due to the economic situation in the country, the Zimbabwean health system has come under strain. Private parties now account for most of the health financing, as the government's contribution declined to 18% in 2010. The official free health service is not free in practice, as 'community levies' can be charged, and many people refrain from seeking health care. In 2011 a World Bank-sponsored RBF program was piloted mainly targeting maternal and child health. This proved successful and the government subsequently introduced similar RBF interventions more widely. As a result, the HMIS has improved, accountability has increased and financing at various levels of the health system has been structured. Challenges remain in equity, management and in widening these services to attain a broader UHC. The government is showing increasing commitment and wants to tackle current issues, such as sustainable funding and financial harmonisation, equity, financial protection and access.



A mother at Concession Hospital maternity. Mazowe district, Zimbabwe 2014.

Voices from the field

the findings from the interviews are reflected in chapter 5. These findings are presented in a rich form, with many direct quotes to capture the detail, nuance and variety of opinions, knowledge and experiences of the respondents. The chapter shows that not all respondents were familiar with the term UHC as such, especially in Afghanistan, where some “heard the word UHC for the first time during the interviews”. Most however, did recognize debates and policies that fitted in with the UHC discourse, even though these were sometimes limited to government circles and “there has not been a significant trickle down of this agenda to other levels yet”. Only in Rwanda the term was widely known and used. The link with the ‘older’ agendas of Primary Health Care, Health for All and achieving MDGs was drawn and UHC was often perceived as the next phase in an ongoing global health agenda. However, added values of UHC were also identified: “three aspects are important: quality of services, equity of services and social financial protection.” Increased community involvement was also more often mentioned. Respondents of all countries agreed that for UHC to succeed it takes political will, better governance and leadership as well as long-term commitment. They see this reflected in the roles their governments take. In addition, most felt that donors should take a back seat in this process, while aligning their funds and policies with those of the national government. Generally, the dependency on donor funding was seen as untenable and undesirable and therefore the need to raise domestic funding was stressed by all. On how domestic funding should and could best be increased, experiences and opinions differed, but taxes and premiums featured often. Despite the fact that government commitment was considered essential, there was considerable anxiety about the current weakness of most governments at this stage.

“Donors must be partners in this process and commit to priorities and stop coming up with non-priority ideas and parallel structures.”

Respondent, Zimbabwe

Respondents mentioned UHC-like policies and structures that were already in place in their countries, and those that were needed. These varied in shape and effect, from Performance- or Results-Based Financing, to basic packages, free healthcare and health insurances. Some expressed they had “come to realize that UHC is not merely about health financing but even more about offering the services which people need”. Local contexts were seen to be determining. Many felt their current policies were fine, but “the problem lies in its implementation”. Coverage was considered a problem, as well as access to services especially in remote or unsafe areas; and user fee removal was perceived to be unsustainable. Countries were searching for a balance between reducing out-of-pocket payments and increasing community participation in payment for health care through various ways.

Besides financial sustainability, coverage and quality of care, other major issues were identified, such as equity, limited understanding of health insurance by many people, human

resources in health, management of health systems and sustainability of insurance schemes. Except for Rwanda, most respondents believed the input of Parliament could be improved: “Parliament should be involved in policy formulation regarding UHC from the very beginning.”

Equity being at the heart of UHC is picked up in all countries. Mechanisms to improve coverage for the poor and marginalized are being implemented, but are not always greatly successful in practice. In Afghanistan, Rwanda and Zimbabwe respondents argue that health is actually a human right, which is embedded in the constitution. The UHC debate provides renewed emphasis to this: UHC is “the government’s legal task, since access to health services is a human right, a basic right of people, as stipulated in the Constitution”.



Dorica Kanyemba, Primary Care Nurse, Tsunguzi Clinic, Mazoe District, Zimbabwe 2014.

Communities should be involved much more, since “the real novelty in UHC is that it requires working much closer at community level.” Community involvement is key in providing the right services: “we need to understand the needs of the villages” and “there are currently health facilities which are underutilized... Community participation is very important for understanding the nature of this problem and for enhancing utilization of health services”. Furthermore, because taxes and premiums paid by the people are considered necessary contributions to health financing, communities have to be involved in how their money is being spent and “a willingness to pay will come if the quality of services improves.”

The impact of UHC on stability and nation-building was not easy to establish. Some respondents believed there was a link, as “improving healthcare makes a country stable”, therefore developing UHC would have “some effects” on stability. However, more respondents felt poverty was a stronger factor: “One reason for instability is hunger... self-sufficiency in food can be the basis for health and peace.” Equitable health care services and financing can work towards stability, however, through “building trust” and by creating social cohesion, others thought.

Finally, the changing roles of civil society were discussed. There is a strong conviction that UHC will never be reached without greater civic involvement: “*The state cannot arrive at UHC on its own*”. International organizations could “*provide technical and financial assistance*”. Civil-society organizations are therefore perceived as having a bigger role to play in promoting accountability. “*They can raise the community voice, share it with government, or question the government as to why services are not equally provided. They can involve the media to do so.*” Local CSOs, “*as members of society, should be involved in all processes.*” They could stimulate research and the use of good data, engage in lobby and advocacy and act as a watchdog.

Conclusions

the two general aims of this qualitative study were to understand and advance UHC in fragile and transitional states and to articulate the specific roles which civil-society organizations (CSOs) – from local to international – may play in the process. Based on the interviews and the literature survey, we come to the following conclusions:

1. Stakeholder awareness

Stakeholders in the countries in this study are generally aware of the UHC agenda, even if the term itself is not always widely used. It is not necessarily seen as something new, many elements of Primary Health Care and Health for all and even the MDGs are also seen as part of UHC. Nonetheless, UHC does appear to have added value. First of all, it requires a more holistic approach, in which equity and rights-based principles are central, accompanied by an integrated financial strategy. Secondly, UHC is clearly felt as a long-term objective and an opportunity to further an integrated national health system under country stewardship. And thirdly, community involvement is vital.

These basic reflections have consequences. Countries want to take the lead themselves, so the roles of many actors in the (international) health scene will have to change. National governments should lead the process, ensuring real political will towards UHC, accountability and good governance while designing and implementing domestic solutions and integrated strategies for health financing and service delivery.

The lead has clearly shifted from donors to governments. International donors and partners should pool their funds with the government and align to and support the government health policies. Communities need to be involved in the development of the health system, to ensure their needs are answered, to reach greater understanding and awareness in communities about the health system and its financial base, and to ensure they get value for money. Service providers have to make sure they provide equitable and sustainable health services and are accountable to the communities they serve.

2. Specific pathways and particular challenges and requirements

There is no ‘one size fits all’ pathway. Each country should make its own inventory of what is currently in place, both in services provided, inclusion of all people and health financing. Starting with their existing health systems and an assessment of what works and what does not (nationally and internationally, as possible examples of best practices), additional or improved instruments, strategies or interventions can be added, improved and scaled up. This can be done either simultaneously



Photo Agrilan Backer

Elisabeth Manjonjori, District Nursing Officer. Mtoko, Zimbabwe 2014.

or one by one, depending on the possibilities within the country. Step-by-step learning and gradual introduction of new components will support progressive realization of UHC. This requires good data, which can be collected and analyzed properly and should serve as input for decisionmaking.

In short, UHC requires combinations of instruments to ensure inclusion of all people, delivery of quality services and ensuring an appropriate and sufficient health financing system. The focus should be on a mix of instruments, which are locally designed and lead to a progressive realization by adding and improving instruments and thus effects over time. Domestic funding is key! Sustained domestic funds for health require accountability and international funding should also facilitate accountability to the population. Eventually, domestic funding needs to be ensured for a sustainable health system. Community responsiveness is essential in this, because domestic funding will include contributions from the community, either through taxes or health insurance premiums. PBF can contribute greatly towards strengthening the system of service delivery (both in quantity, quality and separation of roles from Ministries to communities).

In countries where service delivery is very limited or mainly provided by international actors and/or where the legitimacy of government is still very fragile, certain early steps can be identified. These countries can use PBF to increase quantity and quality of service delivery, making sure not to exclude any groups in society. Community involvement can be realized in establishing basic service delivery packages (and thus answering to community needs). At the same time, there should be accountability from health facilities to the communities they serve (giving them value for money). Equally, there should be clear roles and responsibilities for stakeholders within the health system as the importance of accountability is increasing. Available funds (domestic and international) should be

pooled to support an integrated health system. With health services available and of good quality, countries can work towards health financing, including pooling the contributions from the people themselves.

3. Peace and state building

In fragile, post-conflict and very low-income states, international involvement of both donor organizations and NGOs is large. This often undermines the legitimacy and the capacities of the local governments. Leadership in implementing UHC by national governments, including accountability to their people (rather than to the international actors), can increase the legitimacy of the government. International actors should be supporting this. Although there is no documented causality between the impact of health services and peace and state building, increasing service delivery through state regulation, ensuring inclusion of all groups in society is likely to support stability. The reverse is certainly true: providing services to limited parts of the population only will lead to instability.

4. Civil-society organizations

At local level, community involvement is important, for example in identifying the health needs, verification of services provided and to hold stakeholders accountable for their part in the health system. Local NGOs or CBOs may represent the community at different levels. However, good representation of the variety of voices in society is a precondition.

International civil society should focus less on direct service delivery (only when it is not possible by local actors, e.g. in emergency situations). Handing over of these tasks must happen in a sustainable way. International NGOs should instead focus on facilitation and technical assistance at the explicit request of local stakeholders. Areas of interest can be capacity building and evidence based analysis and data; facilitating multi-stakeholder encounters and deliberations; and assisting domestic policy development and practical planning.



Community dialog for health project. Zabul, Afghanistan 2013. Project implemented by Cordaid and (local partner) HADAAF.

Furthermore, international civil society can support the countervailing powers within systems to promote equity, accountability and access. This can entail supporting representation of various voices from society; answering requests of local civil society for capacity development; and engagement in independent verification of results.

Universal Health Coverage in fragile states

The worldwide attention for Universal Health Coverage as part of the global Sustainable Development Goals after 2015 is very important, as the MDG health goals have not yet been achieved in many countries.

“UHC is a great opportunity to improve healthcare, but will only work if radical changes in donor behaviour occur!”

Simone Filippini, CEO, Cordaid

This report shows that for fragile and transitional states, the road to achieving UHC will be more complex, requiring an increased focus on community needs and national ownership in the design and implementation of health policies.

Therefore, the international community – funders and NGOs alike – have to ensure that the pathway to UHC in fragile and transitional states will be given the extra attention and tailored support that it needs, taking into account their particular challenges and requirements.

“Ensuring community accountability in the pathway to UHC is crucial to Cordaid Healthcare.”

Remco van der Veen, Director Healthcare, Cordaid

What does this mean for international NGOs like Cordaid?

International NGOs need to shift their focus combining service provision with facilitating national dialogues and community involvement to secure inclusive national health policy making. This will go hand in hand with better alignment and pooled funding methods so as to create more space for national ownership and accountability to the population. This is crucial to achieve sustainable domestic mobilization of funding.

The findings of this qualitative study inspire Cordaid to further its mission on building flourishing communities by:

- Focusing more on providing capacity development to local organizations and communities involved in policy dialogues,
- Supporting national governments through technical assistance in formulating better and more responsive policies for universal health coverage,
- Making the link with the international level by advocating for a rethink of existing approaches on universal health coverage in fragile and transitional countries,
- Capitalizing on the opportunities that the UHC discourse and activities provide for restoring state – civil society relations within countries.

ABOUT CORDAID

Cordaid is based in the Netherlands and has country offices in 11 countries. It has been fighting poverty and exclusion in the world's most fragile societies and conflict-stricken areas for a century. It delivers innovative solutions to complex problems by emphasizing sustainability and performance in projects that tackle security and justice, health and economic opportunity. Cordaid is deeply rooted in the Dutch society with more than 300,000 private donors. Cordaid is a founding member of Caritas Internationalis and CIDSE.

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