Appendix E. Summaries of Country Case Studies

1. This appendix summarizes the main findings from the 16 country case studies that were conducted for this evaluation (see Appendix Table A.4). For each country, the main health system and reform issues are described, government and Bank interventions are summarized, and changes in system performance are identified.

Afghanistan

2. Afghanistan is a country emerging from decades of conflict during which health systems and other government functions essentially collapsed. Health outcomes are among the poorest in the world, particularly in the areas of maternal and infant health. Lack of access to and poor quality of basic health care is particularly acute among remote, rural populations, compounded by the continued insecurity in various pockets of the country. Total health expenditures also remain at very low levels, because of the levels of poverty especially in rural areas and the government’s inability to adequately finance public health services. Out-of-pocket payments constitute the majority of private health expenditures, and social protection systems are virtually nonexistent. External resources remain a significant source of funding for the health sector.

3. After the fall of the Taliban regime in 2001, the new government took major steps to rebuild the health system, aided by significant financial and technical investments from the international community. Given the deterioration of public health facilities, nongovernmental organizations (NGOs) were contracted by the government, supplemented by donor funds, to provide basic health care. The Ministry of Public Health deliberately took on a stewardship and policy-making role, rather than service-delivery role. The Ministry defined a standardized “Basic Package of Health Services” and established it as the focal point of the national framework for primary health care, funded almost entirely by external donors.

4. The Bank played an active role in the initial policy discussions to delineate the health sector framework and provided substantial levels of funding for the expansion of basic health care services, particularly in rural areas. The Bank also took the lead in coordinating donor support in the health sector and produced analytic work with direct bearing on policy and lending activities. A series of Bank
lending operations in the health sector has instituted a results-based financing (RBF) approach to NGO-provided primary health care, with monitoring and evaluation processes. Other public sector reform interventions, though limited in scope, have been closely linked to the Bank’s work in the health sector.

5. Bank support has contributed to increased equity in health service utilization for rural populations and females, and improved quality of care in some areas. However, while coverage and quality of care have improved significantly, coverage of important preventive and curative services remains low by global standards, including use of modern contraceptives, antenatal care, assisted delivery, and diphtheria, pertussis, and tetanus immunization. The impact on levels of private spending on health or on poverty is unknown. There has been no impact on financial protection. Limited evidence shows increased efficiency in the use of health funds, although efficiency gains have likely been achieved through harmonized donor activity as well as the use of widely recognized cost-effective interventions in the Basic Package.

6. Bank support has contributed to these outcomes through increasing the level of funding specifically for primary health care, providing strategically-focused and high-quality policy advice to define a clear health policy framework, and funding technical capacity in the Public Health Ministry to implement Bank operations, namely RBF. Other interventions include supporting civil service reforms to increase the availability of skilled personnel and ensuring monitoring and evaluation to assess project impact. Bank support during this time period is marked by strong, pragmatic leadership—both in technical support and donor coordination—and willingness to take risks in championing innovative approaches, while drawing on the multiple prongs of support available through the Bank. However, this support has entailed substantial financial and institutional capacity demands. While institutional capacity has been built in the Ministry to continue to implement RBF of NGO service provision, the longer-term financial sustainability is of great concern as donor assistance is reduced.

Benin

7. Health outcomes in Benin are unsatisfactory, and the country is lagging in reaching Millennium Development Goal (MDG) targets for both maternal and child mortality. Public health facilities are insufficiently funded. Government transfers cover only some 22 percent of annual nonsalary recurrent spending. As a result, out-of-pocket spending is high, in part due to high drug prices that are an important source of revenues for health facilities. Drugs account for some 76 percent of out-of-
pocket spending. The availability and quality of health services are limited. The
distribution of services is heavily skewed toward urban areas and better-off
population groups. Quality is low, both in terms of competence and patient
responsiveness, reflecting weak accountability for results.

8. To help address these health problems, Benin is in the process of introducing
major health financing reforms. They include universal coverage and RBF and the
exploration of the potential for leveraging service provision through public-private
partnership arrangements. Universal coverage and public-private partnerships are
still in the stage of good intentions rather than substantive action. RBF is being
piloted with the help of donors, including the Bank. With Bank support, the
government is also working toward a sectorwide approach (SWAp) to health care
provision, drawing together all donors around a common strategy. It includes (i)
undertaking a diagnostic of community financing, provider payments, the role of
the private sector, and the role of social security; (ii) proposing technical responses
to the issues that might arise from the diagnostic; and (iii) developing a health
financing strategy.

9. The country faces several constraints that are likely to make it difficult to
move forward on any of these initiatives. The government has little in-house
capacity to design or implement major reforms. Public spending on health is low
and falling as a share of the government budget, and actual spending falls short of
budgeted amounts. With limited public funding of health facilities, formal and
informal out-of-pocket payments have become an important source of financing for
the system. The system has only one risk-pooling mechanism, a health equity fund
that provides a defined set of benefits for locally selected poor households. Some
interventions are also free to the public including Cesarean-sections, kidney dialysis,
selected diseases, and medical evacuations. The system is inequitable, with the
quality of care in poorer areas being particularly weak. These areas lack the financial
base for out-of-pocket payments to complement insufficient public funding of
services.

10. The Bank has played a leading role in laying the basis for the reforms that the
government is contemplating. Key products underlying the reform effort were a
Bank 2009 analytical report on health and poverty that is widely recognized as the
catalyst for the reform thinking; and a Health Systems Performance Project that was
initiated in 2010. Both pieces took a comprehensive approach to tackling constraints
in the country’s health system, moving away from a more piecemeal approach that
had previously characterized the relationship. The project, in particular, is providing
technical advice on the main reform initiatives — RBF, universal health insurance,
and improvements to the health equity fund — and is helping the government move
forward on its SWAp initiative. Involvement by the International Finance Corporation (IFC) includes the ongoing development of a private “benchmarking” hospital (i.e., a private hospital that essentially sets standards for care). The Bank and IFC have collaborated closely in developing this initiative. The business development prospects were examined by the Bank team, and a feasibility study for the hospital was conducted jointly by a Bank and IFC team.

11. While it is too early to expect results from the recent health financing strategy design effort, incremental progress is being made in the design process. In the Benin context, the Bank has been indispensable for health systems development to move forward. Neither government nor other donors seem to have the necessary capacity to do so, and they look to the Bank to take the lead in the reforms. The Bank has done so, but the effort is still seen as insufficient. Reforms are still in the crucial early stages of taking shape, and both government and donors express the need for Bank leadership, considering the scope of the reform program that the government is attempting to initiate. In the absence of technical staff to offer timely advice, progress on reform has stalled, with the exception of the effort in RBF, where a Bank initiative is leading the way.

12. The technical and leadership contributions of the Bank in health financing have been critical in Benin; however, it is clear that broad and in-depth reform may require Bank expertise on the ground. Supporting and managing from afar seems to have slowed down the effort, even with a willing government and engaged donors. That said, technical support albeit at a distance has been quite well calibrated to local capacity, taking care not to introduce overly sophisticated models of RBF and universal health insurance which would be challenging to manage, administer, and implement when local capacity is limited.

**Plurinational State of Bolivia**

13. Bolivia has one of the highest infant and child mortality rates in the Latin America and the Caribbean Region, with noteworthy rural to urban disparities that largely reflect inequality in access to services. Similarly, while maternal mortality rates are improving slowly, two-thirds of the poorest still deliver at home. The health system is regressive and marred by inefficiencies. The distribution of health staff is unequal, with poorly qualified staff working in rural areas and an oversupply of doctors in urban areas. The salary system does not provide incentives to work in underserved areas. There is little commitment to maintenance, and investments in infrastructure deteriorate quickly. Furthermore, data and analysis are insufficient on the flow of funds in the health sector, equity in access and quality of
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care, and the financial and fiscal impact of health financing reforms. The public
health sector is underfunded as the share of public finances for health has decreased,
which raises concerns about the financial sustainability of various programs.
Coverage of social insurance is limited, the role of the private sector undefined, and
access to health services is unequal.

14. Bolivia has embarked on a number of major health financing reforms over the
past decade. The government instituted a universal right to access in health. The
government introduced free maternal and child health services for all, a universal
benefits package for the elderly, an outreach program for rural and remote
population groups (EXTENSA), and a conditional cash transfer (CCT) program
(Bono Juana) that provides financial rewards for facility visits for maternal and child
care, supported by a push on the supply side through investments in health
infrastructure. It was envisioned that these various programs would be consolidated
and transition to a Single Health System to attain universal coverage. This
consolidation, however, has not yet progressed.

15. The health sector has seen a substantial increase in government financing in
absolute terms because of higher revenues from carbon taxes and an increased
allocation to social security funds. However, the share of general government
expenditures on health has declined between 2005 and 2010, from 10.9 percent to 7.9
percent. Out-of-pocket expenditure still makes up about a third of total health
expenditure. Access is particularly a problem for the poorest, and an unequal
distribution of infrastructure investments and human resources has resulted in the
poor being unlikely to benefit from recent reforms. The government received strong
donor support in the early 2000s, but has become increasingly reluctant to work
with donor organizations since the Morales administration took over in 2006. The
current government strategy, to create a Single Health System, was not costed out
adequately.

16. From the late 1990s until the mid-2000s, the Bank supported the government
in its early stages of decentralization and with a series of adaptable program loans
supporting all of the above-mentioned programs. Bank technical assistance included
sector analyses and expenditure reviews. The set of programs developed and
supported in the 1990s was strong and sustainable, as they outlived many changes
in government and are still the main health programs of the government today.

17. However, after a new government critical of the Bank came into power in
2006, the Bank found it much more difficult to engage. Since then support became
less comprehensive and focused on investments rather than policy dialogue. The
Bank attempted to continue its assistance to health financing. However, the relevant
activities to strengthen the Single Health System were dropped at the request of the government in 2012. Bank support to health is now concentrated in areas where the country is more receptive, particularly in infrastructure and access to essential medicines and services, but not in health financing. Two projects related to financing were approved since 2003. They have been disburse slowly due to insufficient government commitment. There are few or no data on the impact of the current Bank-supported programs. Available indicators suggest moderate progress.

18. In sum, when political support was available, the Bank provided a comprehensive package of funding with associated technical assistance that had a lasting impact on the health financing environment. Without government commitment in recent years, the Bank has been unable to capitalize on its comparative advantage, has found it difficult to engage in policy dialogue, and has not been able to contribute to addressing shortcomings in the system that are widely acknowledged.

Cambodia

19. The overall policy context in Cambodia is challenging. The country has gone through a period of significant internal conflict which has had long-term repercussions on the country’s capacity to develop and implement policies. Although Cambodia is among countries that have achieved the fastest rates of poverty reduction, about 20 percent of the population is still poor. The general health situation of Cambodia has improved over the past decade. The life expectancy of both men and women has increased, and key mortality rates have decreased. However, Cambodia continues to experience relatively high levels of disease burden from both communicable and noncommunicable diseases, as well as from injuries and accidents. The effects of the country’s past are evident with respect to health financing, as the sector is lacking a clear vision for its development and a coherent strategy for the implementation of interventions. The first attempt to articulate a plan was made in 2003. The large number of development partners, also for health financing, is also a complicating factor.

20. The main challenges that can be addressed by health financing reform are high levels of out-of-pocket spending by households, low and inequitable access to services, poor planning and management capacities on the side of the government, and significant inefficiencies in health spending. The key health financing intervention introduced in the early 2000s and supported by many donors, including the World Bank, was the creation of Health Equity Funds (HEF), which
operates as third-party administrators, reimbursing providers for care for those eligible for a fee waiver.

21. The World Bank Group’s main support to the Cambodian health sector over the past decade has been the Health Sector Support Project I and II (2002–2014). The main components of this project have focused on strengthening health systems, including health financing. In particular the Bank, along with a handful of other development partners, has supported the development and implementation of province-based HEF. These contracted NGOs act as third-party administrators to manage the reimbursement to providers for the fees to cover the care given to eligible poor households in some 40 districts. In addition, a series of health systems and financing related analytical and technical reviews have been produced addressing issues of key importance, including health expenditure efficiency, human resources for health and compensation, and mapping of health markets.

22. The Bank’s support through two health projects (along with that of other partners) to the development and funding of the HEFs have contributed to providing coverage to some two-thirds of the poor, with the government committed to scaling up to 100 percent coverage of the poor by 2015. The HEFs have helped to reduce out-of-pocket payments for care by those eligible for assistance. Furthermore, HEFs have been found to reduce the health-related debt of eligible households by about 15 percent on average. Evaluations have not, however, found an impact on nonhealth consumption or on health care utilization. The analytical and technical work has provided Cambodian policy makers with much needed evidence on key issues, including the relatively low efficiency of health spending, in particular for pharmaceuticals.

23. By providing both project support and technical assistance, the Bank has been able to affect health financing outcomes in Cambodia, including financial protection of the poor. The Bank has participated actively in donor coordination initiatives, including the Health Partner Group led by the World Health Organization and the Joint Partnership Group with a rotating chairmanship, and various technical sub-working groups including for health financing. Furthermore, the Bank has engaged closely with other key Cambodian policy makers outside of the Ministry of Health to advance health financing issues. The Bank also has engaged several departments, including Poverty Reduction and Economic Management (PREM) and Development Economics, to inform its health financing work.

24. The relatively strong health financing capacity that has been present in the local Bank office and the ability to work effectively across sectors explain the ability of the Bank to leverage some of its comparative advantages and to bring added
value to the health financing policy development of Cambodia over the past half-decade or so. A strong health team led by an experienced task team leader has established good relationships with key counterparts and development partners, which has enabled the World Bank Group to “lead from behind” in many important areas, including a public expenditure review (PER) and health expenditure analysis. The relationship between PREM and the Human Development Network has been effective and health has reportedly been at the forefront in much of the overall policy work of the World Bank Group in Cambodia over the past years.

**Arab Republic of Egypt**

25. Health outcomes in the Arab Republic of Egypt are steadily improving. The country is on track to meet its MDG targets for both child and maternal mortality. But the Egyptian health care system is profoundly inequitable when it comes to access and out-of-pocket spending. Only 60 percent of pregnant women in rural Egypt access antenatal care, compared to 90 percent in urban areas. Health spending increased 40 percent faster than growth in gross domestic product, and out-of-pocket expenditures constituted 72 percent of total health expenditures in 2008–2009, up from 62 percent in 2001–2002. The government allocation to health is insufficient and inefficient favoring secondary and tertiary care to primary care, and allocations are not necessarily based on burden of disease and need.

26. Health financing constraints to the system performance include a sharp increase in out-of-pocket expenditures; inequities in health spending and outcomes; fragmented insurance system with low coverage; poor budget allocation to health accompanied by heavy donor dependence for reform implementation; little protection against catastrophic health expenditures; and technical and allocative inefficiencies in the system. The government of Egypt, with some key donor partners, drafted a comprehensive health sector reform program in 1997–1998 to address both service delivery and health financing constraints by creating a Family Health Model (service delivery) and a Family Health Fund (health financing). These models were piloted in five governorates and supported by several donors, with the expectation of scaling nationally.

27. In addition, reform of the Health Insurance Organization was also designed to address the shortcomings of the insurer, in particular to separate its payer and provider functions and make it more efficient. From 1998–2009, the Bank support (Health Sector Reform Project) included providing universal access to a basic package of primary care through the Family Health Model and the Family Health Fund in two governorates, and reforming the insurer. The financing component
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envisioned re-channeling of funds from direct financing to contract financing through Family Health Funds at the governorate level. Facilities that contracted with the Funds to participate in the financing component were called “contracted” facilities. A one-time co-payment was required for opening a file at the facility and a co-payment for each visit. Poor people would be exempt from the co-payments. It was expected that this pilot would serve as a catalyst to effect a transition from a system driven by budget inputs to a “money follows the patient” demand-based system. In 2006 Bank support was revised to include financing for avian influenza and introduce a new subcomponent to link disbursement to actual enrollment and utilization by the poor and uninsured in the Family Health Fund. In 2008–2009, the Bank worked directly with the Ministry of Finance and the Social Insurance Organization to draft a health insurance law.

28. Project evaluations have revealed that the Bank’s health project service delivery component succeeded in increasing provider satisfaction and productivity through the use of results-based incentive systems in the reformed facilities. It also succeeded in increasing patient satisfaction and demand for primary care services by utilizing a family health approach to patient care. The financing component of the pilot project had limited success. Financing of services remained fragmented and the bulk of the costs of family health providers were covered by the donor organizations. The role of the Fund’s was limited to disbursement of provider incentives. The reform also failed to create new sustainable funding sources.

29. The health financing situation has worsened rather than improved. Up to now, Egypt does not have a comprehensive health strategy that clearly outlines its long-term objectives and planned interventions. The health insurance law has not yet been promulgated, and the health insurance reform also has yet to accomplish its key objective. While in 1994 household expenditures accounted for 51 percent of total health expenditures, by 2008 it increased to 72 percent. Public contribution to health as a percentage of total government expenditures declined from 5 percent in 2001–2002 to 4.3 percent in 2008–2009, far from the target of 15 percent for low-income countries. The RBF initiative in the reformed facilities virtually stopped after the donor funding dried up. Overall, the reform process faltered and did not produce the expected outcome.

30. Lack of leadership and governance has been persistent. The reform did not address some of the systemic constraints and missed several opportunities. There is an over-supply of medical specialists, and all graduating physicians are employed by the government irrespective of whether any open position is to be filled. In addition there was discord between the Minister of Health and Minister of Finance and turnover in the leadership at the Ministry of Health. By 2008, donors reduced
their support to Egyptian health reform. With very limited donor funding, the reform efforts slowed down further, followed by the Arab spring uprising (with three new Ministers of Health in the last two years since the political upheaval), effectively halting the reform efforts. The Bank and other partners lacked a clear understanding of the complexity of the political economy. The Bank’s current project does not address several of the systemic constraints, which initially caused the reform to falter.

**Ghana**

31. Any discussion of health financing in Ghana is dominated by the decision taken in 2003, and implemented starting in 2005, to establish a National Health Insurance System (NHIS). The primary objectives were to provide access to health services for those who could not afford to pay fees for service and to protect those who might be impoverished by the medical costs of a serious illness. The NHIS is extremely popular with the public at large and is one of the few programs supported by both the government and its opposition. It provides free access to medical care for children under 18, pregnant women, and the elderly. However, only 35-40 percent of the population is actively enrolled in the NHIS, and the targeting to the poor is only partial at this stage. Nonetheless, the financial protection effect and the impact on utilization tend to be greater among the poor. Critics claim the system is subject to a great deal of fraud and inefficiency, and the failure of the NHIS to expand coverage is inhibiting the achievement of the MDGs. Although the evidence is mixed on the success of the NHIS on providing coverage, from the viewpoint of financial sustainability the system is at a crossroads, and revenues and expenditures will have to be brought into balance to maintain sustainability and expand coverage.

32. Bank support for the NHIS began early in its development. The initial reaction of the Bank and other donors to the introduction of national health insurance in Ghana was that it was premature and ran the risk of re-directing resources to those who could pay the insurance premiums or were already part of a community- or employment-based insurance scheme. The Bank was soon convinced that since the government was determined to go ahead with the NHIS, the Bank and other donors should provide support to the system rather than staying on the sidelines. With some exceptions, other donors remained focused on the MDGs and supporting the key vertical programs in areas such as malaria control, tuberculosis, HIV/AIDS, and vaccination. While the Bank also continued support for vertical programs at this stage, it took the decision to provide a small amount of funding ($12 million) directly to the newly established NHI Authority. The funding was to
focus on setting up the management information system and electronic claims management.

33. The Bank’s support to the insurance authority has been important and generally relevant, although not always timely. In terms of effectiveness, the Bank’s impact has been more muted than it ought to have been given the targeted lending operation with associated technical advice and support, and the substantial program of analytic work. Currently, two important pilot projects on capitation payments and RBF are being supported by the Bank. The support for the first is drawing to a close, and the second is due to begin in the near future. It is unclear at present to what extent they will be mainstreamed in the future and what support the Bank will provide for this mainstreaming.

34. During the initial years of the project, the Bank provided considerable technical support and advice to the insurance authority which arguably would not have been possible without the project being in place. The project funds did not disburse, however, partly due to the new agency’s unfamiliarity with Bank procurement procedures, and by 2009 the project was receiving an unsatisfactory rating. Under new Bank leadership, the project was restructured in 2009, and work was initiated on a pilot on capitation payments from the NHIS to providers financed through a trust fund grant. In addition, a major program of analytic work produced two books on the Ghana health sector, one of which related specifically to health financing. This study is still a fundamental source of background analysis and information on the topic. More recently, changes in Bank staffing have resulted in reduced support for health financing. Partly as a consequence, the Bank’s support for health financing in the past two years has not had the same intense focus as in the initial phase.

35. The policy dialogue and the supporting operational agenda of the Bank seem to have depended largely on the efforts of individual staff. The direction the Bank has taken has reflected the interests of the individual staff and their commitment, rather than a considered World Bank approach reflecting positioning of the health financing issue within the country strategy. Also, the Bank did not take note of the potential of the Ghana case as a pilot in health insurance in a low-income (now lower-middle-income) country and its potential broader applicability in the African context. Overall, the lack of effectiveness of the Bank’s involvement reflects inadequate management oversight and input.
Kenya

36. Insufficient progress has been made in reducing child and maternal mortality in Kenya, making it unlikely that the country will meet its MDG targets. Infant and child mortality has declined between 2003 and 2009; however, the maternal mortality rate in 2008 remained high at 488 per 100,000.1 Huge regional disparities in health outcomes continue to persist. More recent preliminary household survey data show a continued trend of improved access to outpatient and inpatient health care. Government expenditure on health as a share of total government expenditure was halved between 2001 and 2009 dropping from 8 percent to 4.6 percent, moving further away from Abuja commitments.

37. Health financing constraints include inequity in health outcomes; insufficient and inefficient health spending; low insurance coverage; minimal risk pooling; poor access to quality care; catastrophic health expenditures; and poor quality care particularly in rural areas. Some of these constraints are to be affected by Kenya’s ambitious plan to become a middle-income country, as articulated in its Vision 2030.

38. A new constitution promulgated in 2010 has fundamentally changed the governance structure, devolving power to two levels of government: national and county. Several aspects of the planned devolution directly impact the health sector, including direct transfer of funds from the center to facilities through the Health Sector Services Fund (HSSF). User fees for outpatient services and some in-patient are abolished, and block grants from HSSF are to compensate the facilities for lost revenue. This mechanism is designed to improve equity-based resource allocation and efficiency, and ensure equity of services by entrusting the local authorities and communities. Other health financing reforms include moving toward universal coverage through an improved National Hospital Insurance Fund, subsidized health insurance enrollment for about 25,000 poor individuals, and a RBF pilot in Samburu County for maternal and child health services.

39. With support from partners including the World Bank and IFC, the government is in the process of drafting a health financing strategy. Prior to 2009 the Bank was not engaged in health financing issues in Kenya. The relationship between the government and the Bank was particularly tenuous following the withdrawal of a previous health project by the Bank because of management issues. The relationship has improved in the past three years, and the Bank is now actively engaged in health financing issues. The Bank, through its ongoing health project, is providing technical and financial support to the health reform—particularly hospital insurance reform; RBF pilot; and implementation of Kenya’s Essential Package for Health through HSSF grants—in addition to capacity building. The health and
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PREM team supported the Public Expenditure Tracking Survey (PETS). The Bank is only one of two donors (the other donor being the Danish International Development Agency) providing pooled financing to the sector.

40. The IFC’s engagement included two equity vehicles that enable small- and medium-sized enterprises to provide access to health insurance. Advisory Services support the policy dialogue and reforms aimed at strengthening the National Hospital Insurance Fund and expanding risk pooling. The IFC and Bank teams support the government’s efforts to achieve Universal Health Coverage, including reforms of the National Hospital Insurance Fund, and public-private partnerships. IFC support includes convening and facilitating stakeholder dialogue on the role of the Hospital Insurance Fund.

41. Preliminary household survey findings suggest that utilization of primary health care and hospital admission rates are increasing, and more sick people are seeking care when they need it. The early assessments of the Samburu County RBF pilot have also shown improvement in quality of care and increase in access. However, the hospital insurance reform has faltered for political reasons and has yet to show real impact.

42. The Bank assistance in health financing has been recent and limited. In the past, health financing reforms lacked the support of consistent leadership from the government. Government leadership was disrupted by the political upheaval Kenya has faced since the 2008 elections, including the splitting of the Ministry of Health into two ministries and then merging again, a new constitution, and devolution. More recently, the Bank has supported the development of a high level policy dialogue on health financing and devolution, and convened other partners to support the implementation of the health financing strategy.

43. Today Bank and IFC health financing support in Kenya includes an active program and responds to the expectation from various stakeholders for the Bank to play a more active leadership role in health financing. The Bank has started a programmatic analytical work program for the health sector including a fiscal space analysis to inform sustainability of innovative financing options and assessment of efficiency of public and private health facilities. In addition, PREM and HNP teams are preparing a public expenditure review with a focus on the sub-national level. Public sector and government teams are working with the health team to support the government in developing policies and guidelines for “conditional grants” to counties. The next Kenya Economic Update will have health as its focus theme.
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Mexico

44. Mexico, a middle-income country, has relatively good health statistics. Mexico has largely passed the “epidemiological transition” and faces growing health challenges from a variety of noncommunicable diseases. Access to health care and health outcomes are quite inequitable, with important discrepancies largely determined by geographic location, income, and employment status. Formal sector workers (around half of the population) have access to high quality social security services. Informal workers rely on lower quality public health providers and expensive private providers. The government introduced a new reform to improve access and quality for the poorer population, through a program commonly called Seguro Popular (People’s Insurance) in 2004. The reform included a continued increase in public spending on health, transfers made to the state health systems on a per capita basis instead of historical costs, and a guaranteed benefit package for all. The federal government provides most of the funding to Seguro Popular which is co-financed by the states. Enrolled families pay a small contribution according to their estimated income. The bottom 40 percent households are exempt from paying contributions.

45. Health care reform was a government initiative. During the design of the reform, the government asked the World Bank to concentrate on improving the quality and availability of public health providers in geographic areas where Seguro Popular is likely to have a major impact on enrollment. The World Bank did not provide any direct support to the development of the initiative. After the Seguro Popular program was established and operating, the government requested more targeted support from the World Bank. This included a package of technical assistance and financial support. In 2010, the World Bank approved $1.25 billion for the Social Protection System in Health Project to support Seguro Popular. Under the project, the Bank disbursed against the number of enrollees, financing part of the total budget of Seguro Popular. The World Bank also provided operational support including with an Indigenous People’s Plan that played an important role in supporting the expansion of the program in indigenous communities. In addition, the World Bank supported the reform with technical assistance activities that were financed under different sources. These supported workshops, studies, and conferences. The World Bank also provides support to Mexico’s CCT program, known as Oportunidades, which provides incentives for the poor to join Seguro Popular.

46. Early results show that Seguro Popular has been successful in increasing the per capita spending on health and in reducing the gap between the population covered by social security and the informal sectors. This has led to a significant
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reduction in out-of-pocket expenditures, particularly for catastrophic health events. Evidence suggests that it has also led to an increase in health care utilization by the poor. There is no evidence as of yet that this has impacted health outcomes. One area of concern was the possibility that Seguro Popular, along with other social welfare programs, would lead to an increase in informality as it would reduce the incentives to seek formal employment with all of its mandatory benefits. Studies show that while there is some “crowding out,” the impact has been small.

47. Mexico has a high level of technical competence and is able to finance Seguro Popular without support from the World Bank. The Bank’s major contribution was largely in the form of a “trusted adviser” or a “sounding board” that worked with the government in several areas. The World Bank’s financial support served mainly as budget support, with the Bank’s loan substituting existing resources providing the government with more fiscal space. The project did provide operational and fiduciary support to the Seguro Popular program. In particular, the Indigenous Peoples’ Plan was widely seen as a major contribution to the program. On the technical side, the project supported around 50 studies. These ranged from operational support to long-term reform options. All of these studies were financed by the government, as part of its co-financing contribution to the project. In some cases, the World Bank worked with the project team to develop these studies. In addition, the Bank provided independent technical support that served to validate government findings and provide legitimacy.

48. Successes of the first 10 years of Seguro Popular are largely the result of concerted government efforts to implement an ambitious reform program that have continued through three administrations. The Bank did not contribute directly to the success of the Seguro Popular, but it did help to strengthen its performance. In addition, by acting as an “unbiased adviser,” the Bank may have strengthened the political acceptability of the program. The Bank’s project served as an important mechanism to maintain a presence in the sector and to support the government in financing its overall budget. Moving forward, the Bank is continuing its role as an adviser, focusing on selected technical assistance.

Nepal

49. In the past decade, Nepal has made substantial gains in improving the population’s health status, including significant reductions in infant and maternal mortality. This makes it likely that the country will meet most or all of the health-related MDGs. Despite these gains, there are significant issues of health equity, with differences in health care outcomes largely driven by geographic location, caste,
education, and household income. Emerging from a prolonged period of civil conflict, the government has made a strong commitment to increase public spending on health, with a particular focus on eliminating the user fees for most publicly provided services. Nepal has a public health system that focuses almost entirely on providing centrally-financed services. There is no health insurance or formal demand-side health financing. Catastrophic health events have a significant impact on household welfare. The largely unregulated private sector plays a major role in providing health services. These are almost entirely financed out of pocket.

50. Since 2004, the World Bank has been an active member of a health sectorwide approach (SWAp) with other donors. While the World Bank’s country strategies did not include a focus on health financing directly, the Bank assisted in convening others and providing support to donors focusing on health financing. This included providing training through the World Bank Institute Flagship Course, contributing to health financing research, and providing technical input in health financing. In addition, the Bank did focus on improving health care equity with a specific focus on the poor. Development partners collectively, through the SWAp, have been working with the government to develop a health financing strategy to reform the health sector. Although the Bank has not led this process, it has been an active contributor both through knowledge products and working with partners to develop a common understanding of health financing issues. The World Bank Group’s health efforts have been focused almost entirely on the public sector.

51. Nepal has a weak statistical system in all sectors, including health. Little systematic information is collected on health financing and analyses have relied on occasional surveys and estimates. Government spending on health as a percentage of total health expenditure increased from 24 percent to 39 percent between 2000 and 2011. However, it is uncertain whether or not this has translated to lower out-of-pocket payments for households. The increase in attended deliveries suggests a greater use of public health services. There is also indirect evidence that discrepancies between health outcomes for the poor and those for higher-income groups have narrowed. The government’s policy of eliminating fees probably played a role in the increase in attended deliveries as well as in the reduction of child and maternal mortality. However, it is unclear if this has reduced the impact of catastrophic health events.

52. The Bank was providing a coordination role for health financing among donors. This helped developed a consensus on how to move forward and allowed greater coordination. The World Bank did not lead in developing knowledge products, as other partners had more resources for technical activities. However the Bank did provide support in a number of areas, including targeted technical
assistance as well as designing and implementing high-level training for the development community with the World Bank Institute.

Nicaragua

53. Nicaragua has made substantial progress on reaching the health-related MDGs. In Nicaragua, most health services are provided by the public sector. The private sector provides some clinical and hospital services, mostly in cities and for formal sector workers and higher-income groups. There are major differences in access and quality, with poorer regions significantly behind other areas. The government is strongly committed to free health services for all citizens as part of its commitment to improve equity. A major challenge for the government is how to target resources so that they reach the poor within the context of free services. While government spending has increased substantially in recent years, it still remains largely allocated by historical budgets, which have favored richer areas. Another long-standing issue is the low absolute amount of resources spent on health, which seriously impacts the quality of health infrastructure. Donors contribute an important part of health financing, accounting for around 10 percent of total health expenditures. While the government does coordinate this assistance, cooperation among donors is limited. Presently, many donors are leaving or are planning to leave Nicaragua.

54. In January 2007, the government of Nicaragua initiated a demonstration project that extended the Nicaraguan Social Security Institute’s health insurance program for formal sector employees to informal sector workers using microfinance institutions as agents to manage enrollment. The World Bank did not support the government in this program. Instead the Bank focused on results-based financing and improved data collection.

55. The Bank’s primary mechanism of support to the health sector is through investment loans, complemented by a variety of technical work. The current health sector project, Improving Community and Family Health Care Services, focuses on improving financing and efficiency in poorer municipalities by providing RBF to local health centers. The RBF model aimed to improve the level of monitoring and planning. The health project provides a capitation payment to local governments, which is adjusted by local progress on several intermediate and final indicators. In addition, the Bank has supported several technical products. These have generally been well received by the donor community and the government, and have played a role in designing and modifying new health interventions. The Bank also supported
a South–South knowledge exchange with Argentina to support the introduction of RBF.

56. There are limited data on changes in equity in Nicaragua. For the poor, public facilities are often the only source of health care. However, Nicaraguans of all income groups rely on the private sector for drugs and other health services. The World Bank’s present project is quite recent (approved in 2010), and it is too early to assess its impact. Government officials indicated the project has played an important role in increasing the monitoring and planning by local health authorities as they adjust to the introduction of capitation payment for health. The government has shown interest in expanding this model. The Bank was able to focus its technical and operational experience to strengthen its collaboration with national and local officials, providing appreciated support to data collection and results-based financing. However, this support was not integrated with the other health financing functions.

Rwanda

57. Rwanda has experienced strong economic growth and introduced major health financing reforms during the past decade, including almost universal health insurance coverage through community-based health insurance (mutuelles). The government contracts with public and faith-based health facilities and provides results-based payment in hospital and health centers. More recently, conditional cash transfers were introduced for unsalaried volunteer community health workers. In-kind incentives were given to pregnant women to seek prenatal and maternal care. Health indicators have improved substantially, and the country is on track to reach the MDGs for maternal and child health.

58. The government introduced fiscal decentralization to districts with needs-based monthly block grants (including based on poverty level) to health centers and hospitals. Civil service reform is ongoing, including decentralization of the public sector wage bill to districts and devolution of personnel management authority to the service provider level. Government spending on health in 2011 is estimated at 11.6 percent of general government expenditures and below the Abuja target of 15 percent. To increase equitable insurance enrollment, the health insurance premium for households in the lower two quintiles is fully subsidized by the government and external contributions. About half of private spending on health is out of pocket despite high insurance enrollment, suggesting an insufficient insurance benefit package. The government has received strong donor support for these reforms, and donors contribute about 60 percent of total health financing. In 2009, the government
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introduced a Division of Labor policy, limiting the number of donors by sector. Bank support was redirected to other sectors because of substantive financing from the U.S. government and the Global Fund.

59. Constraints to health system performance that could be addressed through health financing reforms include high donor dependency and low levels of domestic financing for health care; concerns about the financial sustainability of RBF, the sustainability of community-based health insurance, and payments to community health workers, which are all heavily donor funded; fragmentation of funding because of a high financing share for malaria and HIV/AIDS; the division of labor policy which contributes to the health sector being dominated by vertical funds; and insufficient data and analysis on the flow of funds in the health sector, equity in access and quality of care, and the financial and fiscal impact of health financing reforms.

60. From 2005 to 2010, basic health service utilization indicators increased as did patient satisfaction. Insurance enrollment increased from about 30 percent in 2005 to 80 percent in 2011. Inequity in utilization of basic health care decreased across income groups. Household survey analysis in 2005 found the insured spent 6.8 percent of their income on health while the uninsured spent 13.4 percent. Catastrophic health spending was reported by 2.2 percent of insured compared to 8.6 percent of uninsured individuals. The insured report significantly higher utilization of care than the uninsured. However no recent analysis is available on utilization and financial protection by insurance status. Various studies on RBF found mixed effects. RBF mainly increased the use of services with higher unit payments which were easier to control by providers. But service use for other rewarded services did not change. Studies found having health insurance is a positive predictor for service use, and RBF without measures to address demand-side barriers has limited effect on equity in service use.

61. Prior to 2009, Bank support to health financing was comprehensive and addressed issues of governance in health financing and insurance through the medium term expenditure framework, health financing and insurance laws, and policy formulation. The Bank was instrumental in supporting health insurance policy, including funding insurance subsidies for the poor, and the scale-up of RBF under the HIV/AIDS project and general budget support operations. The Bank also provided analysis and advice on the level of government health spending on health; on equity in insurance enrollment and in access to care by subsidizing premiums and co-payments for the poor; and on improvements to quality of care by providing financial and policy support to the roll-out of RBF in the sector. The Bank also
produced several health reports and comprehensive analysis on the sustainability, equity, quality, and fiscal impact of reforms.

62. Bank advice helped to introduce income-dependent insurance contributions and subsidized insurance enrollment for lower-income groups; however, there is no recent analysis on the insurance effectiveness, and the Bank did not leverage its budget support to promote increased government spending on health toward the Abuja target, nor did the Bank assist in the development and implementation of an overarching, fiscally sustainable, health financing strategy. Recent Bank analytical work has been limited to impact evaluations of RBF reforms, with no examination of process issues, or of the impact of other Bank-supported health financing reforms.

63. When the government introduced the Division of Labor policy in 2009, the Bank’s work led by Health, Nutrition, and Population ended. Rwanda continued to receive Bank support under the Regional Laboratory Project and a Social Protection program. This support to community health workers is linked to RBF health reforms but not to any broader health system financing strategy or policy dialogue. The Bank does not participate in donor collaboration on health financing reforms anymore. The Bank therefore has not had the opportunity to contribute to policy dialogue on health financing. It has been absent from technical discussion on provider payment reforms to introduce case-based payments in hospitals, and did not conduct an analysis of the fiscal impact of RBF. Important factors of success in health financing reform in Rwanda prior to 2009 included strong financial and technical donor support and government capacity and willingness to put in place credible reforms supported by donors. Continuation of this success will depend on continued analysis and policy dialogue regarding the impact of health financing reforms and their fiscal impact and financial sustainability.

**Tanzania**

64. Tanzania has experienced strong economic growth in the past decade; however, growth was not inclusive and poverty remains high at 87 percent of the population. Health outcomes have improved and the country is on track to reach the child mortality MDG but reports insufficient progress in reducing maternal mortality and high-fertility rates. Beginning in the 1990s, Tanzania embarked on a series of health financing reforms with the support of the World Bank, introducing user fees, creating a National Health Insurance Fund for civil servants and the formal labor force, and setting up two Community-Based Health Insurance Schemes for the poor rural and urban populations. More recently, the government piloted several RBF schemes which it intends to roll out nationally. To improve equity in
access, maternal and child health services and services for people over the age of 65 and the poor are waived from payment; however, there is no clear identification strategy for the poor, and informal payments are common.

65. Decentralization was pursued, whereby the Regions plan and budget for themselves, although the majority of public financing comes through the central government. The health sector is still largely underfunded at $30 per capita, and government contributions to health fluctuate around 10 percent of general government expenditures, significantly below the 15 percent Abuja target. The health sector has benefited from strong donor support that accounts for 40 percent of total health expenditure, the majority of which is channeled through a joint government and donor basket funding mechanism that makes up the majority of the recurrent budget, apart from personnel expenditure.

66. Constraints to health system performance that could be addressed through health financing reforms include high donor dependency and low levels of domestic financing for health care; fragmentation of the various insurance schemes; large amounts of financing being channeled through vertical programs such as malaria and HIV/AIDS; limited financial protection due to low insurance enrollment; high levels of out of pocket expenditures; and poor quality of services.

67. The World Bank Group was active in health financing in the 1990s and early 2000s, when it was instrumental in setting up the National Health Insurance Fund, assisted with the decentralization process, and was a vital partner in the pooled donor fund that channeled funds to the Regions. However, its engagement in health financing was reduced in the mid-2000s, partly because of changes in Bank resources as well as reduced demand for health financing assistance by the government as other donors began providing more health financing technical assistance.

68. The Bank’s most recent project, the Basic Health Services Project, did not explicitly address health financing constraints related to the level and allocation of government financing to health; weaknesses in the NHIF management and the scale-up of CHF; and the provider and payer split. Thus, Bank active support decreased over time, compared to the Bank’s previous leadership in this area, and was taken over by other donors (i.e., the German Agency for International Cooperation and Swiss Development Cooperation) and technical advisers working on health financing reforms placed at the Ministry of Health. The Bank did provide a strong financial contribution to the pooled donor fund, and the Bank participated in joint government and donor coordination mechanisms over the past decade. The IFC, in collaboration with the U.S. Agency for International Development (USAID), recently conducted a well-received private sector assessment.
69. World Bank and other donor coordination reduced donor project fragmentation and supported country ownership. However, it is not clear how donor support through the Basket Fund has contributed to improving health services and enhancing health status. The World Bank Group seems to have missed a number of opportunities to provide the expected level of analytical support and leadership to influence Tanzania’s development of its health financing strategy. One Bank study that is praised by the Bank is not perceived as well integrated by donors and the government. There was also a missed opportunity to provide World Bank Group expertise or to fund consultants to help in developing the health financing options papers currently under development. As a result, the health financing dialogue is led by other donors.

**Turkey**

70. Health status in Turkey, as reflected in life expectancy at birth, has shown steady improvement since the early 1990s, rising from 65 years in 1990 to 74 years in 2011. At the same time, the country has made remarkable progress toward attaining MDG goals. The Health Transformation Program, introduced in 2003, aimed at strengthening key health systems functions of governance, financing and service delivery. The main elements of the program were in place by 2010, and the program is being refined under a subsequent and ongoing strategic plan for the health sector, covering the period 2010–2014. Major health financing reforms that were put in place under the Program included the introduction of universal health insurance, which integrated the various insurance schemes, including the Green Card program for the poor, under the umbrella of the Social Security Institution. The Social Security Institutions became a single payer and undertook reforms to provider payment mechanisms, including RBF. A private sector system, including private, voluntary insurance, continues to run in parallel with the public system. Today, 97 percent of the nonpoor population and 85 percent of the population in the poorest decile is covered by insurance. Increased public health expenditures generated by implementing the Health Transformation Program have been kept affordable because of additional financing, efficiency gains from changes to provider payments and more appropriate referral systems, price controls on drugs, and reduced cost pressures as a result of the elimination of dual practice.

71. The Bank played a key role in the whole process of conceiving, developing, and implementing the Health Transformation Program through extensive informal brainstorming sessions and timely and targeted technical advice. The Bank provided technical support within a country context favorable to reform, including strong political underpinnings, a dedicated team of professionals led by the Minister of
Health, and a strategy of “quick wins” that maintained broad support for the longer-term aims of the program. While the informal discussions are mentioned as the most effective knowledge transfer mechanism both by the Turkish authorities and Bank staff, formal products also played an important role. A key product was a health sector report produced in 2003, which developed the roadmap for reform. Other key products were a PER in 2007, discussing options for efficiency improvements in health spending; and a health sector report in 2011, focusing on the financial sustainability of universal health insurance. Important lending activities were two policy loans in 2004 and 2009, respectively, which served as vehicles for providing technical support for the Health Transformation Program. Legal and regulatory actions related to the reform were supported by two sets of development policy loans.

The IFC appears to have played a modest role in reform, possibly because the Health Transformation Program was a public sector-focused initiative. Early on, there was fairly close collaboration between the Bank and IFC in reforming the pharmaceutical distribution system. Subsequently, IFC’s focus has been on promoting private hospitals as investment targets; raising the quality of private services; and supporting local manufacturers of medical equipment. While all of these efforts are relevant to the ongoing reform process, and especially in trying to define an appropriate role for the private sector, there does not seem to be close collaboration between Bank teams and the IFC in these efforts.

Outcomes of the Health Transformation Program have been positive. Total health expenditure in Turkey rose from 5.5 percent of GDP in 2005 to 6.7 percent of GDP in 2011. Public sector funding rose from 68 percent of total health expenditures in 2005 to 75 percent in 2011. Out-of-pocket payments fell from 22 percent of total health expenditures to 16 percent. Access to care reached 97 percent of the population, and utilization of primary care services had increased from less than 2 visits per client in 2004 to 2.8 visits in 2008. User satisfaction with primary care (reflecting a gradual transformation to family practice) rose from 69 percent in 2004 to 86 percent in 2008. Maternal mortality fell from 29 per 100,000 in 2005 to 20 in 2010; under-five mortality fell from 24 per 1,000 in 2005 to 15 in 2011; infant mortality fell from 19 per 1,000 in 2005 to 12 in 2011; and life expectancy rose from 72.1 years in 2005 to 73.9 years in 2011.

In assessing the influence of the Bank in the health reform process in Turkey, it should first be recognized that the Health Transformation Program consisted of a coherent and comprehensive package of measures to improve performance in the system. The merit of the reform may be that it was broad-based. It looked at the health sector as a system of interlinked elements that could not easily be tackled
piecemeal. This effort at coherence appears to have been at least in part Bank-driven. It is reflected in policy discussions between Turkey and the Bank during the years preceding the reform, and is reflected in the previously mentioned 2003 analytical and advisory assistance product which is recognized as forming a roadmap for launching the reform. The coherence of the reform was sustained through subsequent, often informal, dialogue and analysis between a committed group of Bank professionals and an equally committed group of clients. This sustained dialogue and support appears to have been a significant element contributing to the overall success of the Turkish reform, which is internationally trumpeted as a successful model of health systems reform.

75. In summary, factors of success included a country context receptive to a systemic approach to reform; political stability and economic growth creating the space for reform initiatives to thrive; and the ability of reformer to combine quick wins with longer-term change to sustain support for reform. The Bank was able to add value within this context by building on the technical and interpersonal skills of Bank staff who established long-term and sustained relationships of trust. These relationships fostered technical advice and dialogue which were sustained throughout the reform process.

Uzbekistan

76. Uzbekistan is not on track to achieving MDG goals in under-five mortality and maternal mortality. The Uzbek government finances health care and provides automatic coverage to the population in the public sector. The Bank’s interventions have spanned three consecutive projects. Health I (1998–2004) reconstructed and equipped rural primary care facilities in three pilot oblasts and trained primary care physicians and facility managers. It introduced a system of capitation payments, with autonomy for facilities to reallocate savings as they saw fit. This pilot was perceived to be so successful that the Ministry of Finance enthusiastically endorsed its rapid national scale-up under the latter part of Health I and Health II (2004–2011). Attempts to replicate this success in urban primary care facilities under Health II and Health III (2011–2018) have encountered political resistance. Similarly, attempts at hospital rationalization, based largely on Bank efforts to introduce case-based payments, have also stalled at regional and central levels.

77. The introduction of per-capita financing for rural primary facilities has improved funding predictability and accountability in management and the use of public funds. The share of primary health care and outpatient health services in the overall public health expenditure structure rose from 41 percent in 2004 to 45.2
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percent in 2011. The introduction of a modern treasury system in 2009 has increased reliability in the flows of funds, reduced delays in cash releases, and improved transparency and financial reporting. However, it has also decreased the financial and managerial autonomy of rural primary care facilities.

78. Bank support was able to reverse the poor quality of rural health care through increases in the clinical competencies and management skills of personnel and, with the capitation reforms, through increased incentives to provide higher-quality care. There were initial positive effects of oblast-level pooling of primary health care funds, in particular an immediate improvement in equity of resource allocation. Less progress in the urban primary care and inpatient sectors has stemmed from political resistance and overestimation of capacity to implement sophisticated provider payment reforms in hospitals. Subsequent treasury reform (supported in part by PREM) re-introduced rigidities in spending that reduced intended increases in autonomy and flexibility at health institutions. This created a strong contradiction between public financial management reforms and health financing reforms that has not been resolved.

79. Positive outcomes with rural primary care reform were due largely to effective synergies with government priorities, positive demonstration effects from early pilots, and crucial on-the-ground implementation support from USAID. Once political roadblocks were encountered in the crafting and implementation of urban primary care and hospital reform, however, a coherent strategy for movement forward has not been developed. With the stalling of these reforms for political reasons, Bank priorities have shifted elsewhere, even within the social sector. Also, Bank-supported public finance management reforms (the treasury reform) have not been consonant with health finance reforms, reversing important gains in autonomy for rural primary health care centers and decreasing incentives for those centers to generate savings.

Vietnam

80. The Vietnamese health sector has made considerable advances over the past decades, and health outcomes are now comparable with much richer countries. Changes have also been made to the way health services are funded. In particular, Vietnam has introduced a series of health financing reform initiatives over the past decade to expand population coverage of health insurance, reduce out-of-pocket payments by patients, and enhance access to services, especially for the poor and vulnerable groups. One key government health financing reform has been the introduction of Health Care Funds for the Poor, province-level special funds to
finance the health services provided to those identified as poor. Another program provides free health care for children under six. Both of these programs were integrated into the national health insurance system with the consolidation of social health insurance more generally.

81. Donor spending on health makes up a very small share of total resources for health and the majority of this support goes to vertical disease specific programs resulting in fragmentation of service delivery and policy development. A donor coordination mechanism has been introduced in Vietnam in which the World Bank is an active partner. The World Bank has been moderately successful in providing support to the reform process through both operations and analytical work. Through its support to the Health Care Funds for the Poor in several regions, the Bank contributed to the effective implementation of the main policy initiative to address the challenges of the poor. Furthermore, there is strong indication that the World Bank Group has led much of the development partnership dialogue on health financing and systems reform in Vietnam.

82. The Health Care Funds for the Poor program was found to enhance access to care and reduce out-of-pocket payments of the target groups. Furthermore, it enabled the government to improve the allocative efficiency in health spending by focusing on those most in need in certain geographic areas, such as remote and mountainous regions. Along with the policy of free health care for children under six, the Health Fund for the Poor enhanced financial protection for vulnerable groups, such as the poor and ethnic minorities. Contribution payments to the national health insurance system operated by Vietnam Social Security are subsidized by the government for the poor.

83. Through the long-term engagement with the government, the Bank has been able to build a strong relationship across several sectors that is based on mutual trust and understanding. This is evident in the health sector where the Bank is seen as a dependable partner. Furthermore, the relatively stable political situation in Vietnam with few changes of key counterparts has also been favorable to the Bank’s work. Finally, the ability to work on several levels in the Vietnamese health sector, from district to province to central level, has benefited the Bank’s understanding of the sector.

84. A relatively strong indication suggests that the Bank has been strategic in its support to the health sector in Vietnam more generally and to the health financing reforms specifically. For instance, the Bank exhibited patience in not pursuing RBF-type of funding when the government expressed limited preparedness for this type of support. In addition, the Bank’s project support and analytical support provided a
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strong position from which to lead the policy dialogue. The Bank’s technical support, also across other sectors, was generally seen as being of high quality, which further strengthened the Bank’s collaboration with the government and other partners.

Republic of Yemen

85. The Republic of Yemen is a low-income country characterized by a significant proportion of poor, rural, and geographically dispersed population groups. These traits contribute to significant geographic and financial barriers to health services. Health outcomes are generally poor, particularly for maternal and child health. Health service utilization is marked by low coverage of the overall population and inequity in coverage between urban and rural populations and between upper- and lower-income populations. Financing of the health sector in Yemen is characterized by low total health expenditures, low levels of public expenditures, high out-of-pocket expenditures, and little to no financial protection mechanisms.

86. The government has laid out an ambitious health sector reform agenda, as reflected in its various development and health sector strategies over the past decade. Government initiatives have included decentralizing the health system, introducing user fees in public health facilities, exempting the poor from payments, and exploring social health insurance options. However, the government has thus far been unable to translate its strategic objectives into effective policy choices. The fragile security situation (most recently, civil unrest occurred in 2011) has also negatively affected the government’s ability to provide financing for the health sector and to deliver basic services through the public health system.

87. Given the significant financial and capacity constraints of the public health sector, the Bank and other donors have mostly focused on vertical health programs to address immediate health needs, including maternal and child health and communicable disease control programs. The Bank through the Global Partnership of Output-Based Aid (GPOBA) provided financing to two private health care providers supported by the IFC and one nongovernmental organization. The feasibility of a more integrated approach is unclear and may be limited by weak strategic capacity at the government, and the overall lack of capacity in the health sector. The Bank has therefore taken a very gradual and slow approach to supporting the health sector and has not initiated a major health finance reform agenda in Yemen. The initial steps in this approach have been to expand service delivery to improve access and coverage of basic health services.
88. The impact of Bank support on overall health financing has been modest thus far because of the limited extent of the Bank’s engagement on this issue. However, Bank support has contributed to increased access to public health services and has helped to draw attention, including donor financing, to some of the more prevalent health challenges in Yemen.