

## HEALTH FINANCING: STRENGTHENING FINANCIAL PROTECTION

### OVERVIEW

Health financing is a recurrent item on the agenda of the GFF Investors Group Meetings. Previous meetings have discussed topics ranging from domestic resource mobilization to improving the efficiency of both domestic and external financing. **In most GFF countries, however, the bulk of domestic health financing comes from households' out-of-pocket payments (OOPs).** It is well established that the need to make such payments causes many households to forego essential care, while others who seek care suffer financial catastrophe or impoverishment as a result of paying for the services they receive. However, the distributional impact of OOPs is much less well understood - who pays the most, which socioeconomic groups are most likely to incur catastrophic payments, what are OOPs spent on, and what are the appropriate policy reforms to reduce the financial barriers to needed services and reduce the risk of severe financial hardship associated with OOPs? The answers to these questions have important implications for the impact that GFF can have on the living standards of women and children, so this paper examines the challenges and opportunities emerging from GFF support to countries, in collaboration with other partners as appropriate, to strengthen systems of financial protection.

### SUMMARY OF FINDINGS

- **Most GFF countries are still heavily reliant on OOPs as a way of funding health services.** Financial protection has improved in a few countries, and where it has, it usually coincided with substantial improvements in the coverage of RMNCAH-N services.
- **Catastrophic expenditures mostly hit the poorest households.** The majority of OOPs are made for outpatient care and drugs, not for big hospital bills.
- **Domestic Resource Mobilization in ways other than OOPs is a necessary, but not sufficient, condition for improving financial protection.**
- **What the GFF can contribute directly depends on the extent of financial catastrophe and impoverishment, who suffers from it, and why.** Such an assessment needs to be an essential part of the work program supported by GFF - but is only possible with reliable and comparable data and a detailed understanding of both provider and household behaviors.
- **User fees for RMNCAH-N services are detrimental to access and – where they exist - should be reduced/removed.** Careful attention needs to be paid to whether such a policy will indeed address the key drivers of low financial protection and access and whether it is financially sustainable.
- **Financial protection is a consequence of the way health care is financed overall, and improving it requires a broader health system approach.** What households need to pay at the point of use is a result of how providers are being compensated by the government or other partners.

### ACTION REQUIRED

The IG Group is requested to endorse the analytical methodology used in this study of financial protection and its application in GFF countries as relevant.

## SECTION 1. OBJECTIVES OF THE PAPER

Improving financial protection was a clear objective of the GFF Business Plan. The concept of *scaled financing* describes the need to raise additional financial resources for RMNCAH-N services, while at the same time reducing reliance on direct out-of-pocket payments (OOPs) as a source of finance. Reducing financial barriers to using services is also part of *smart financing* which is partly focused on efficiency but also seeks to reduce inequities in coverage, some of which is due to the deterrent effect of OOPs on the poor. These concepts are also reflected in the indicators that feature in the results framework, as shown in Box 1.

### Box 1: Equity-related health financing indicators in the GFF results framework

- Country monitors catastrophic and impoverishing health expenditures with data less than three years old
- Country has identified drivers of limited financial protection (especially in relation to RMNCAH-N services)
- Country has implemented reforms to address identified drivers of financial protection (especially related to RMNCAH-N)
- Incidence of catastrophic and impoverishing health expenditures

**The objective of this paper is to describe what is currently known about the nature, distribution and determinants of OOPs for health in GFF countries as the basis for discussing the extent to which increasing financial protection should feature in the health financing work and should be taken into account when defining programmatic impact indicators.** Section 2 of the paper describes briefly what is meant by financial protection and its links to OOPs. Section 3 reviews what is currently known about the extent and distribution of financial protection in GFF countries and Section 4 describes policy options for improving financial protection. The final section reflects on how and what the GFF Secretariat and partners can contribute. Because of recent updates to the way health account data are reported in the Global Health Expenditure Database of WHO, and recent additions to the set of household expenditure surveys available to the World Bank, the data reflects what we know now. This work will continue over the next year, updating data for as many GFF countries as possible.

## SECTION 2. FINANCIAL PROTECTION: WHAT IS IT AND WHAT ARE THE PATTERNS?

### What is it?

Economists typically distinguish between financial *risk* protection and financial protection. The former is an ex ante concept, the peace of mind that comes with the knowledge that people will not be financially ruined if they fall ill and need to pay for health services. In health, this peace of mind is provided by forms of health insurance, or by government funding health services through general revenues. In both cases, people contribute financially to a pool of funds (insurance premiums and/or taxes) before they fall ill, and they can draw on these funds in the event of the need to seek care.

## How to measure it?

It has proven difficult to measure the benefits people obtain from the peace of mind associated with this type of “insurance”. Most analysis has, therefore, focused on what happens when financial protection is not available or not complete.

Some people can afford to make OOPs but for others, they must find the money by foregoing the consumption of necessities such as goods and clothing, selling assets, taking children out of school to work, or borrowing which can lead to indebtedness across generations.<sup>1,2,3,4,5,6,7,8,9,10,11</sup> This type of impact, incurred when OOP absorb an “unaffordable” share of a household’s disposable income, has been labelled “financial catastrophe”.

Analysis typically focuses on **the nature and extent of OOPs in relation to capacity to pay**, relying on household expenditure surveys and health accounts data (where information on OOPs is also derived from household expenditure surveys<sup>i</sup>). A related impact is **when OOPs push people into poverty or deeper into poverty**, and health payments can be one of the most important causes of poverty in a country. Box 2 summarizes differences in the way that financial catastrophe and impoverishment have been defined in the literature while Box 3 highlights how variation in survey design can impact the estimates.

By its nature, analysis of financial protection is concerned only with the financial consequences of OOPs rather than the foregone or delayed care which might result from the need to make OOPs. That side of the absence of financial protection is captured in service coverage data. It is not the main focus of this paper which focuses on the financial impact on households of OOPs, but it is important to emphasize that **data on the financial consequences of OOPs must be interpreted alongside data on service coverage**. For example, in some countries the poorest people do not seem to incur financial catastrophe linked to OOPs, but this could be because they simply do not obtain the services they need or because they are properly exempted from paying fees. The policy implications are very different so sorting out the reasons is critical.

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<sup>i</sup> WHO estimates OOPs as a share of total recurrent health expenditures for years where there are no household expenditure surveys. It calibrates any change in the share on the share of private consumption in GDP from national accounts data.

## Box 2: Thresholds and denominators for defining financial catastrophe and impoverishment

**Financial catastrophe.** Financial catastrophe occurs when households spend an “unaffordable” share of their resources on out-of-pocket health payments (OOPs) in a given time period. This requires deciding the denominator – what resources should be taken into account – and the threshold for affordability. Recent joint work by WHO and the World Bank defined financial catastrophe as OOPs exceeding either 10% or 25% of a household’s total spending.<sup>ii,7</sup> The alternative is to extract from total spending a value for essential items which all households need to survive (such as food, shelter and utilities), and to define financial catastrophe as OOPs exceeding a threshold (varying from 10% to 40%) of the remaining “discretionary expenditures”.

**Impoverishment.** Impoverishment is defined as the situation when a household’s pre-OOPs total expenditure exceeds, and the post-OOPs expenditure is below, the poverty line. Most commonly, international poverty lines are used. The earlier poverty lines of \$1.25 a day for extreme poverty and \$2.00 for moderate poverty in purchasing power parities have been updated to \$1.95 a day and \$3.10 a day respectively.<sup>12,8</sup>

**Comparability.** Due to the variation across studies – in denominators and thresholds for catastrophic payments, and in the poverty line used to calculate impoverishment due to OOPs – comparisons across studies and over time are not easy. For that reason, the joint work between WHO and the WB has agreed on a method for all their work that is consistent with the approach taken in section 3. It shows the incidence of financial catastrophe and impoverishment using the thresholds of 10% of total expenditure and the \$1.95 a day respectively. Given the current debate about the best way to define financial catastrophe, Annex 2 provides data using 40% of non-food consumption as the threshold, and \$3.10 as poverty line.

### Who suffers from the lack of financial protection?

**Financial catastrophe or impoverishment can affect people at all income levels,** with very large, single payments, frequent payments that add up to a large sum, or even from small isolated payments for people living just above the poverty line.

People can suffer financial catastrophe or impoverishment due to OOPs even in social health insurance (SHI) systems or where there are national health services which are designed to protect them from this eventuality.<sup>1,4,8</sup> However, these forms of health financing are certainly protective on average: the incidence of both financial catastrophe and impoverishment is **negatively correlated across countries with the proportion of health spending channeled through forms of compulsory prepayment and pooling** such as SHI and tax financed health services.<sup>3,4,7,8</sup>

A recent analysis of household expenditure surveys dating from the mid-1980s to 2015 suggests that the population weighted global incidence of financial catastrophe has increased over time. The incidence of impoverishment has fallen using a poverty line of \$1.90 per day but has risen using a poverty line of \$3.10.<sup>8</sup> This probably reflects that household incomes have risen in recent years and fewer people live close to the \$1.90 per day international poverty line rather than the fact that OOPs have less of an impact.

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<sup>ii</sup> Income questions are rarely collected in household surveys and responses on income are generally thought to be less reliable than responses on expenditure.

### **Box 3: Variation in survey design can greatly impact estimates of OOPs and financial protection**

#### **Consumption versus health expenditure module**

Some surveys have a separate health module in which information on health spending is asked whereas others have health spending questions in the overall consumption module. Although there are no available data to formally test whether this distinction has any effect on the estimates of OOP health spending, respondents may tend to report higher expenditures when questions about health expenditure are fielded in a separate health module, where a respondent is prompted to think about recent health expenditures.<sup>13,14</sup>

#### **Level of detail**

Some surveys seek a detailed breakdown of health expenditures while others seek more aggregated amounts – at the extreme, just total health spending. Mostly, more detailed breakdowns give higher totals than more aggregated breakdowns, although this is not always the case so it is not possible to devise a universal correction rule to adjust responses for the level of aggregation.<sup>15</sup>

#### **Recall period**

The recall period refers to the period for which households are asked to report their health expenditures. Most household surveys use a 4-week recall period for frequent spending (out-patient care, medication) and a longer (12 months) period for hospital care. Generally, longer recall periods yield lower average spending on an annualized basis as people tend to remember less of what they spend a long time ago.<sup>16,17,18,19</sup> The magnitude of the recall bias has been found to vary substantially across different surveys and countries, making it difficult to propose any correction rule. Some studies use diary methods, in which the respondents are asked to keep a daily (or weekly) record of all their expenses.<sup>20,21</sup> This is likely to reduce recall bias substantially, but it is more time-intensive and impractical when illiteracy rates are high.

#### **Seasonal variations in illness**

Seasonal variations in illness and health care use during the year will influence estimates if the survey does not cover a whole twelve-month period.

Forms of multivariate analysis have been used to explore the association between the incidence of either financial catastrophe or impoverishment and a variety of other socioeconomic characteristics in addition to income. Household size and composition (e.g., proportion of children or elderly people), educational status or gender of household head, place of residence (regional location or rural/urban), and the presence of chronic illnesses have all been associated financial hardship in different settings.<sup>6,11,22,23,24,25,26</sup> Because patterns can differ – e.g. in some countries there is more financial catastrophe in households with a relatively high proportion of elderly people but in other countries this is not the case - understanding the distribution of the burden in the population is critical to the development of appropriate health financing policies.

In the next section, we explore the available data on OOPs from country health accounts in the GFF countries, as well as the results of recent household expenditure surveys that are available.

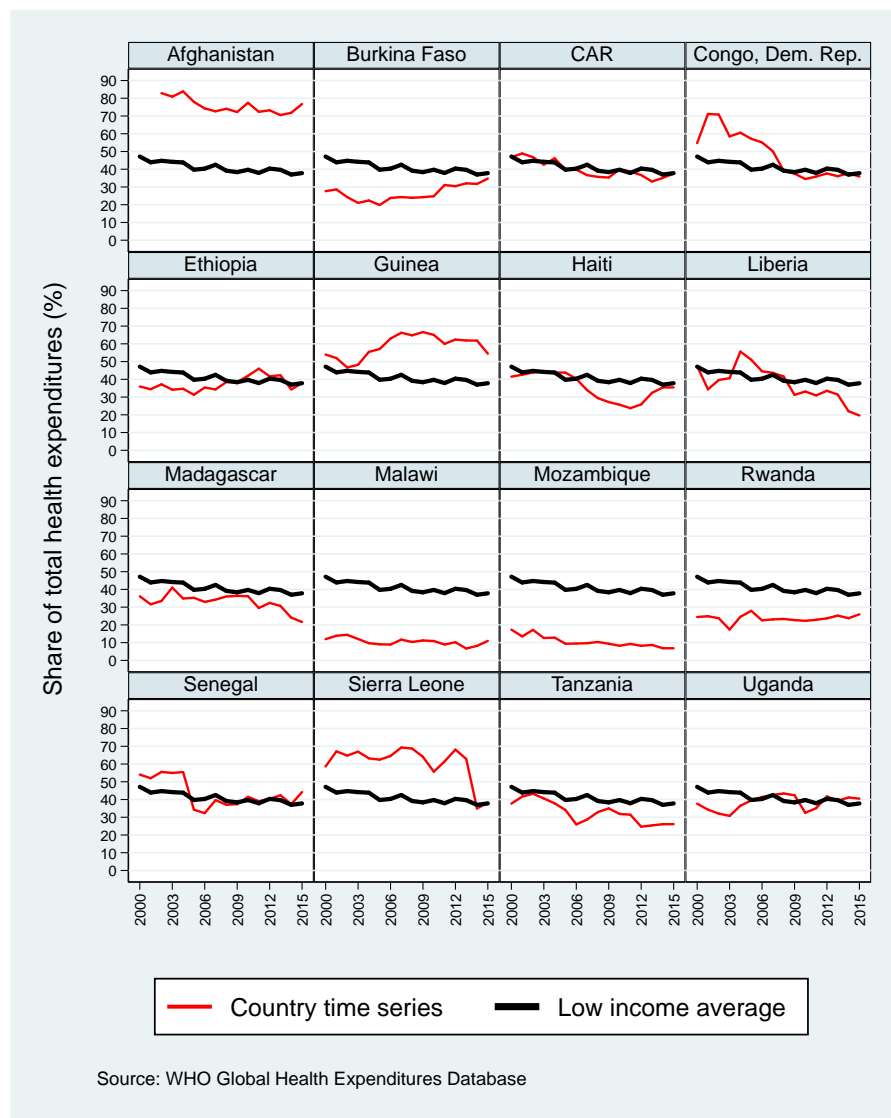
## **SECTION 3. PATTERNS OF FINANCIAL PROTECTION IN GFF COUNTRIES**

### **How big is the problem?**

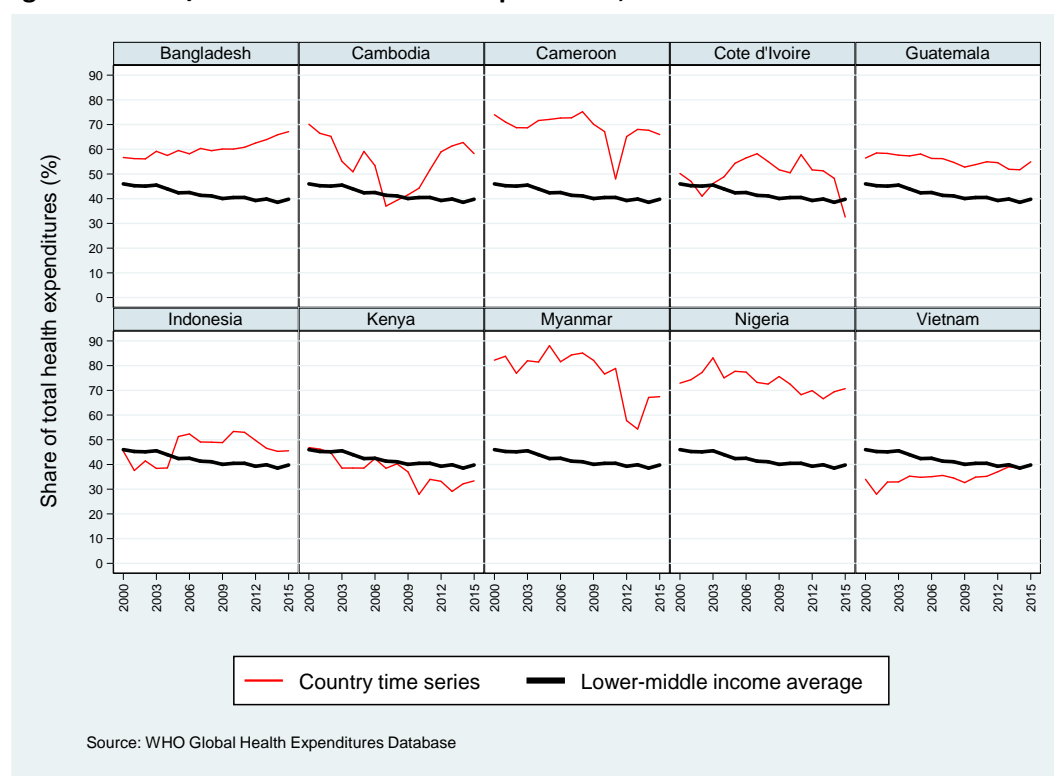
The lack of financial protection in health starts with the need to make OOPs and Figure 1 and Figure 2 show trends in the share of OOPs in country recurrent health expenditures by GFF country divided into low-income (LICs) and lower middle-income (LMICs) countries in turn. **While the share of OOPs has**

**fallen on average in LICs and LMICs, it has fallen consistently in only half of the GFF countries.** In fact, relatively consistent rises can be observed in Bangladesh, Burkina Faso, Ethiopia, Guinea, Indonesia, Rwanda, Uganda and Vietnam, and more recent rises in Cambodia, Cameroon, Haiti, Myanmar and Senegal.

**Figure 1: OOPs/total recurrent health expenditure, GFF LICs 2000-2015**



**Figure 2: OOPs/total recurrent health expenditure, GFF LMICs 2000-2015**



Changes in the share of OOPs, however, do not by themselves always indicate a change in the extent of financial protection. The share could fall, for example, because of a large increase in development assistance of health (DAH) as occurred in Guinea, Liberia and Sierra Leone after the Ebola crisis, even if OOP expenditures were unchanged. The withdrawal of DAH over time in Haiti would have the opposite effect even if OOPs did not rise.

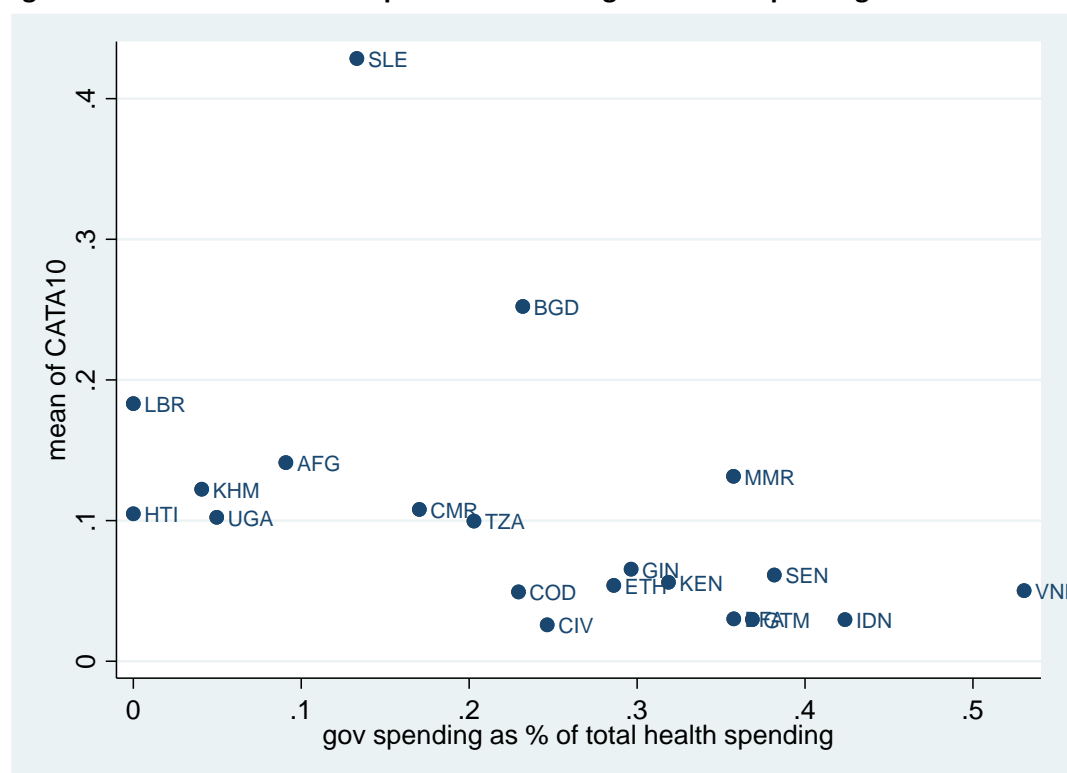
We therefore also checked trends in OOPs per capita over the same period. **In virtually all countries, OOPs per capita increased** (Figure A. 1 and Figure A. 2). Only in Madagascar does there seem to be a steady fall. More recent falls can be observed in Côte d'Ivoire, Indonesia, Uganda and Tanzania, while in Haiti, Malawi and Mozambique, OOPs/capita was relatively flat.

Even then, increasing (or decreasing) OOPs/capita does not necessarily mean reduced (or increased) financial protection. **If incomes are rising faster than OOPs per capita, the latter will be observed to rise, but the incidence of financial catastrophe or impoverishment could fall.** Changes in the share or per capita amount of OOPs are only indicative of likely changes in financial protection, so we consider the evidence on the incidence of financial catastrophe and impoverishment in GFF countries subsequently.

Figure 3 reports incidence of financial catastrophe (CATA10) in the GFF countries that have recent (not older than 5 years) survey data. They are plotted against the share of government spending in total

current expenditures (including expenditure from general government revenues and compulsory health insurance).<sup>iii</sup>

**Figure 3: Indicators of financial protection versus government spending as a share of total spending**



*Note: Bangladesh and Sierra Leone are outliers, most likely caused by data quality issues rather than actual trends in OOPs. These data points are therefore not part of the Global Monitoring Report produced jointly by WB and WHO, and need to be further investigated.*

The incidence of financial catastrophe due to OOPs ranged between 2% and over 30% of the population, while the incidence of impoverishment ranged from close to zero to 9% (Figure A. 3).<sup>iv</sup> As expected, the incidence of severe financial hardship, either financial catastrophe or impoverishment, is negatively correlated across GFF countries with the share of compulsory prepaid and pooled expenditure (called government spending) in total recurrent health spending, and hence positively correlated with the share of OOPs in total health expenditure.

<sup>iii</sup> Country codes: Afghanistan (AFG), Bangladesh (BGD), Burkina Faso (BFA), Cambodia (KHM) Cote d'Ivoire (CIV), Democratic Republic of Congo (COD), Cameroon (CMR), Ethiopia (ETH), Guinea (GIN), Guatemala (GTM), Haiti (HTI), Indonesia (IDN), Kenya (KEN), Liberia (LBR), Madagascar (MDG), Malawi (MLW), Myanmar (MMR), Mozambique (MOZ), Nigeria (NGA), Rwanda (RWA), Senegal (SEN), Sierra Leone (SLE), Tanzania (TZA), Uganda (UGA), Vietnam (VNM).

<sup>iv</sup> The incidence of impoverishment is consistently higher using the \$3.10 per day threshold. Bangladesh seems an outlier here. The numbers from the most recent household survey (2016) are much higher than in a survey 5 years earlier. We are checking whether there are data issues or that the surveys are not comparable.



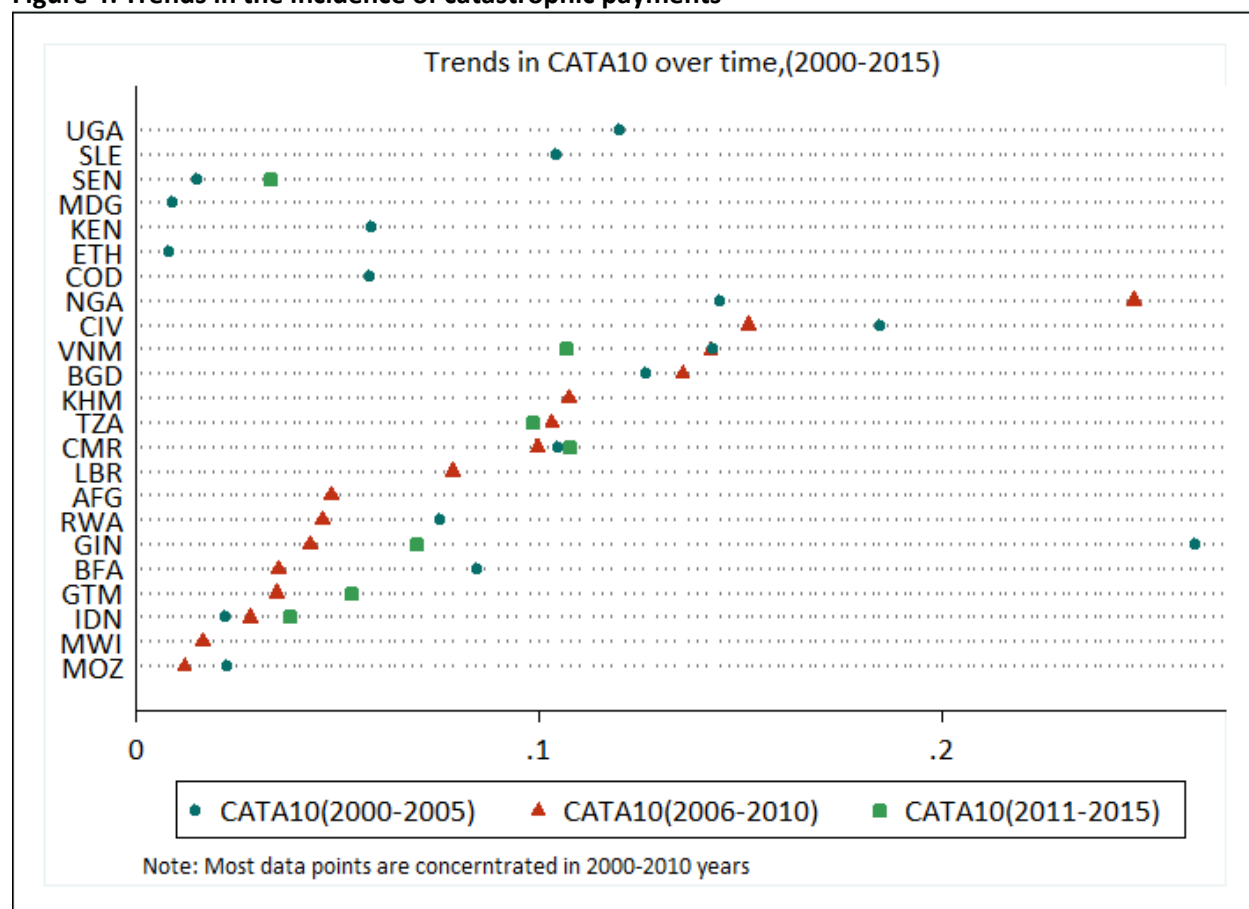
## Has financial protection improved or worsened?

The trends in the incidence of financial catastrophe and impoverishment for the GFF countries for which we could find at least two household expenditure surveys<sup>v</sup> are reported in Figure 4 and Figure 5 respectively. **Financial protection improved in Burkina Faso, Mozambique, Rwanda and Vietnam** (either because both CATA10 and IMPOV190 improved, or one improved with no deterioration of the other).

**Financial protection got worse in Bangladesh, Guatemala, Nigeria and Senegal.** No substantial changes in either indicator were noted in Cameroon or Tanzania, with mixed results (one indicator improved, the other worsened) in Indonesia and Côte d'Ivoire. In Guinea, there was a big improvement in both indicators between the first two surveys, but then a subsequent deterioration.

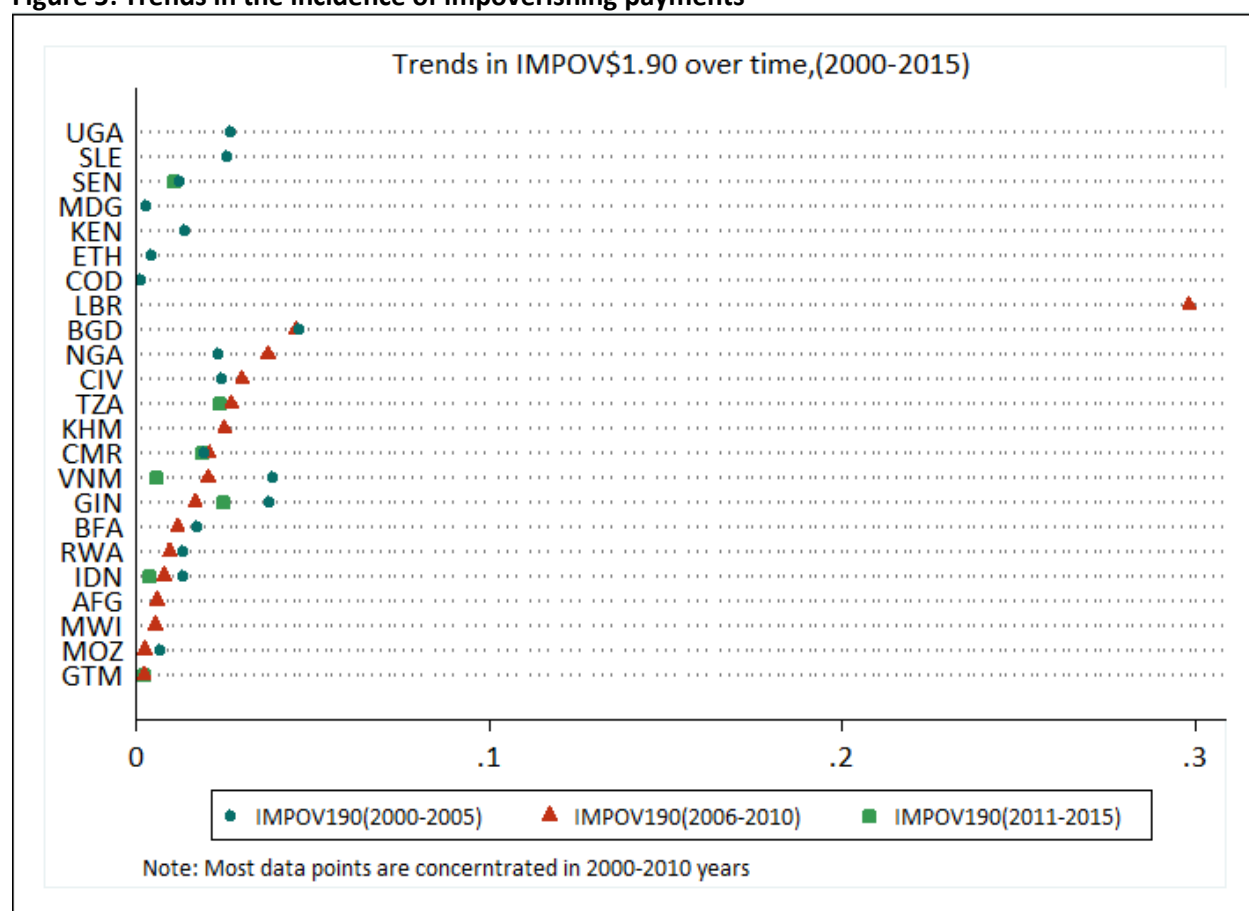
It is important to note that the most recent surveys for some countries were between 2006 and 2010. The results, therefore, are not likely to capture any more recent policy changes that were intended to increase financial protection in health. Regular household surveys are critical to allow policy-makers to assess progress in this area.

**Figure 4: Trends in the incidence of catastrophic payments**



<sup>v</sup> The selection of countries differs from that in the previous section because we divided up the 2000-2015 period in 3 periods and only used countries that had a survey in at least two of these periods.

Figure 5: Trends in the incidence of impoverishing payments



### Should we worry only about financial protection?

Efforts to move closer to Universal Health Coverage (UHC) by increasing service coverage, perhaps through insurance coverage or through the expansion of government or NGO services, can sometimes be associated with increases in OOPs per capita. People have access to and use more services, and if some of them are associated with OOPs, the total OOPs/capita can increase. From a financial protection standpoint, the incidence of financial catastrophe or impoverishment might increase, which is undesirable, but the increased use of needed health services is a good thing. It is, therefore, useful to also consider what has happened to coverage with needed health services at the same time.

**Figure 6: Trends in service delivery**

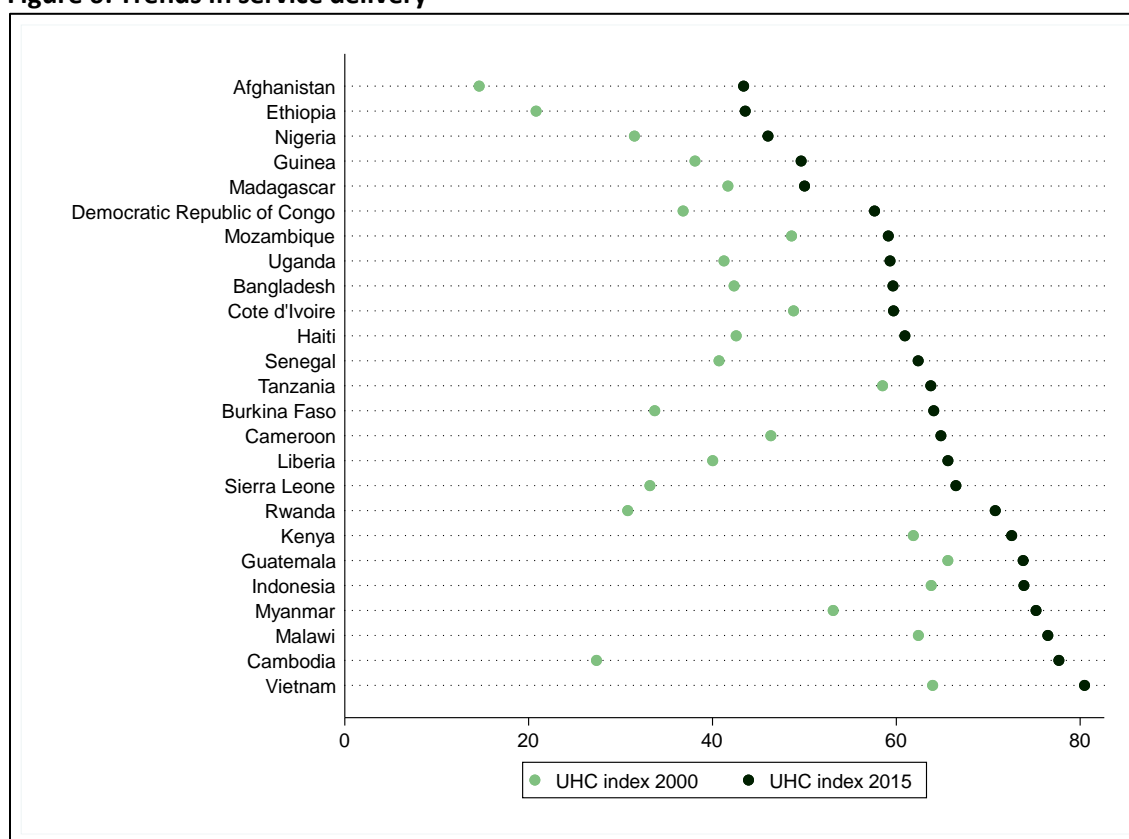


Figure 6 therefore shows trends in a RMNCAH-N-focused service coverage indicator<sup>vi</sup> between 2000 and 2015. All GFF countries have made considerable progress in coverage of key service delivery indicators. **Vietnam, Rwanda and Burkina Faso appear to have done well at both increasing service coverage and improving financial protection. The huge increase in catastrophic spending in Nigeria does not coincide with impressive gains in service coverage, indicating that it is not increased use of essential services that is driving the worsening of financial protection.** To better understand which households are suffering most, and why, the next two sections investigate the distribution and drivers of catastrophic expenditures.

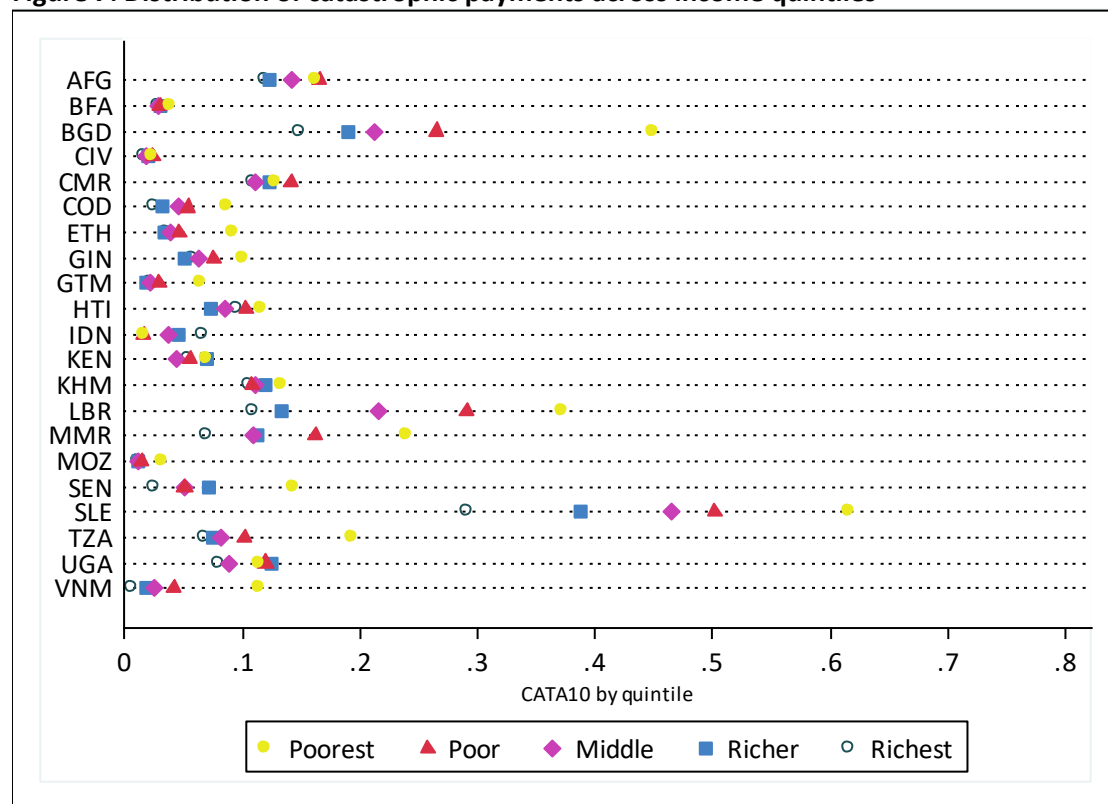
### Who suffers from catastrophic and impoverishing payments?

Figure 7, depicting the incidence of financial catastrophe by income quintile, illustrates that **in most countries the incidence is more concentrated among the poorest groups**<sup>vii</sup>. The exceptions are in Indonesia, Uganda and Cameroon. In Indonesia, for example, the incidence is very low among the poor and, as stated earlier, this could be because the poor do not use the health services they need so avoid OOPs, or because they are well protected by the health insurance for the poor. The high service coverage for Indonesia in Figure 6 however does suggest that OOPs are not the main barrier for RMNCAH-N services in particular.

<sup>vi</sup> The service delivery index is a simple average of the following 4 actual coverage indicators from 2000 to 2015: (1) completion of four antenatal care visits, (2) in-facility delivery, (3) met need for contraceptives, (4) DTP3 vaccination coverage. Data used from DHS/MICS.

<sup>vii</sup> Quintiles are constructed from total household expenditures net of OOPs, to avoid high OOPs making households appear richer than they really are. Q1 is the poorest 20% and Q5 is the richest.

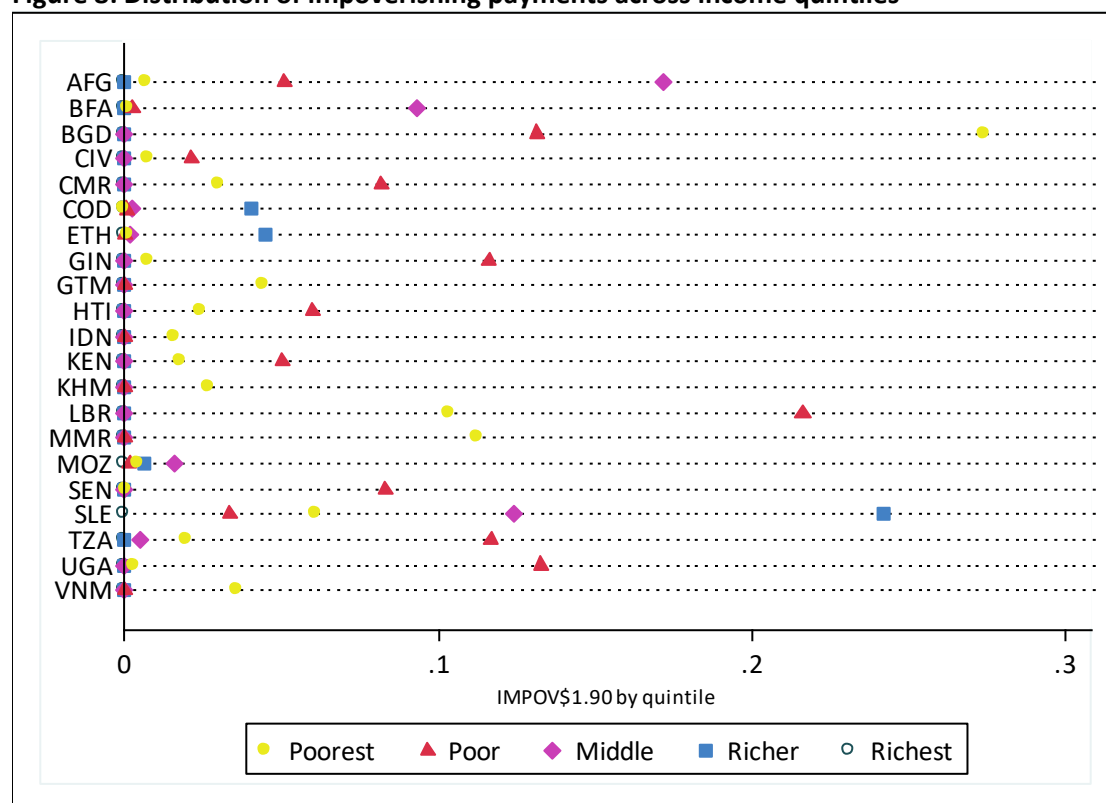
**Figure 7: Distribution of catastrophic payments across income quintiles**



The incidence of impoverishment shows different patterns (Figure 8). In Burkina Faso, Ethiopia, DRC and Senegal it is 0% in the poorest group, because they are already poor. Out of pocket payments make this group poorer, but that is not captured in this indicator. In all of these countries, the incidence is lowest in the richer income quintiles, not surprisingly<sup>viii</sup>.

<sup>viii</sup> Here the patterns differ with the choice of the poverty line – for the obvious reason that different socioeconomic groups are at risk at the different values of the poverty line. The higher the poverty line, the more the higher SES groups are affected by impoverishing payments (Figure A. 5).

**Figure 8: Distribution of impoverishing payments across income quintiles**



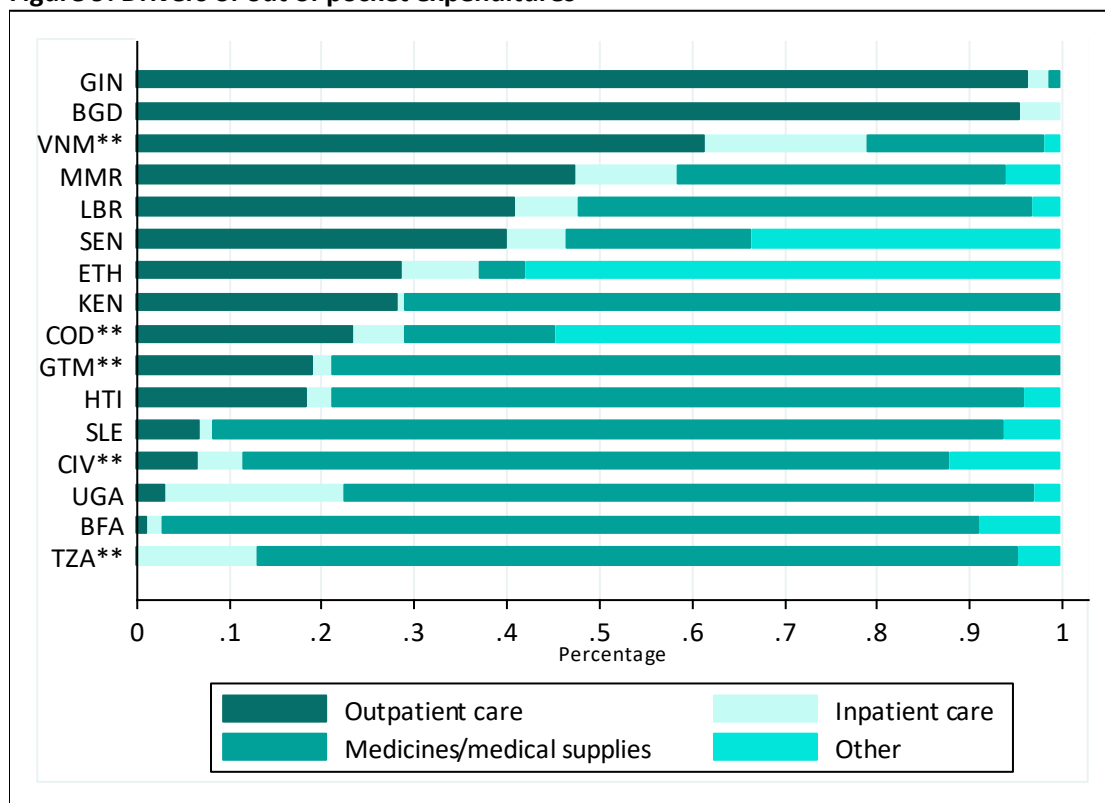
### What are the drivers of catastrophic expenditures?

We also sought to identify the main drivers of financial catastrophe in the GFF countries using the information collected in the household surveys using the categories of inpatient care, outpatient care, medicines and other items.<sup>ix</sup> It should be kept in mind that variations in survey design complicate this kind of cross-country comparison and results should be interpreted with caution.

Figure 9 displays no consistent pattern across settings, but does highlight the fact that **the majority of OOP are related to outpatient care and drugs, and not necessarily to huge hospital bills** (which is often thought to be a key driver of financial catastrophe).

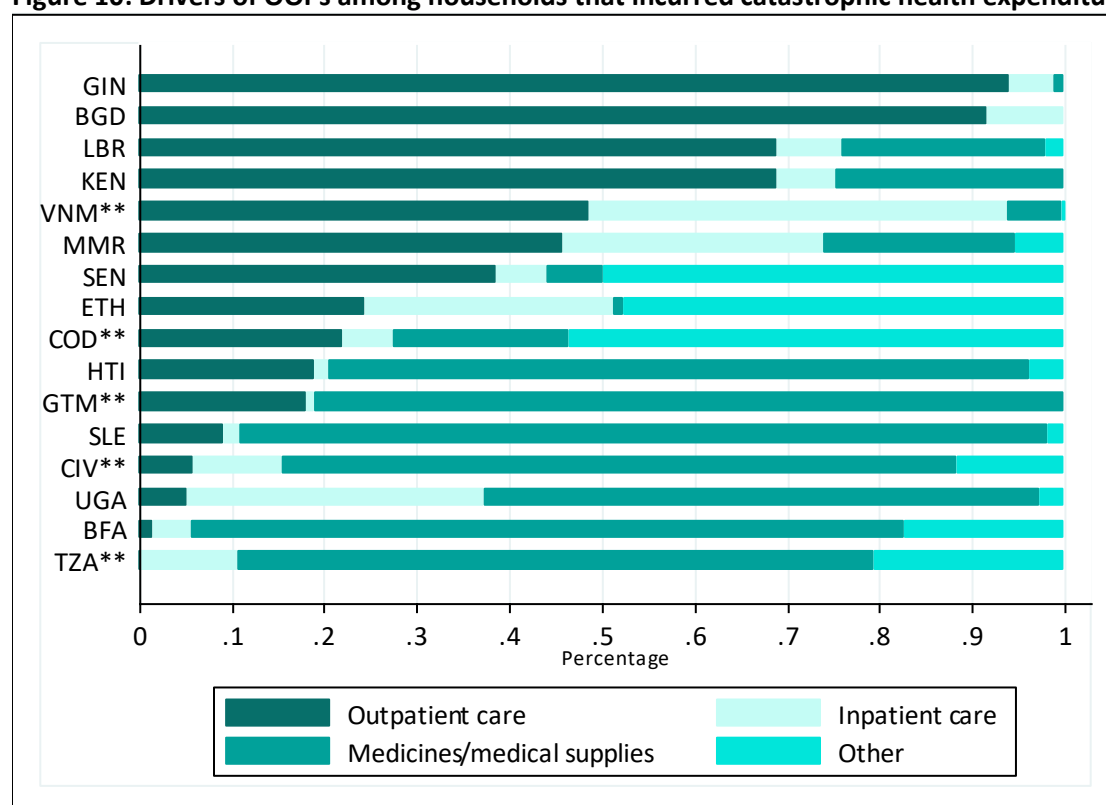
<sup>ix</sup> As this analysis requires merging together different modules of the survey data and intensive data cleaning, we have only completed this analysis for a selected set of countries. This work will be ongoing in the next year. The analysis is complicated by variation in survey design, \*\* indicates that further investigation into the different categories is needed.

**Figure 9: Drivers of out of pocket expenditures**



To develop some understanding of the drivers of catastrophic expenditures, we plot the same breakdown in Figure 10, but only for those households that incurred CATA10. The patterns are very alike, suggesting **that is it not so much one specific type of expenditure that becomes catastrophic, but rather the accumulation of spending.**

**Figure 10: Drivers of OOPs among households that incurred catastrophic health expenditures**



A more detailed interpretation requires knowledge about how OOPs are levied in countries. For example, in some countries medicines are provided during outpatient or inpatient care and patients might not know how much of their costs were related to medicines, which might explain the apparent low expenditures on medicines in Guinea and Ethiopia. Alternatively, medicines for common causes or inpatient visits and hospitalization might be free. Understanding the patterns, and then thinking about what can be done to reduce the major causes of OOPs in each country is critical to the development of appropriate strategies to improve financial protection – examples of such an approach are presented in the next section.

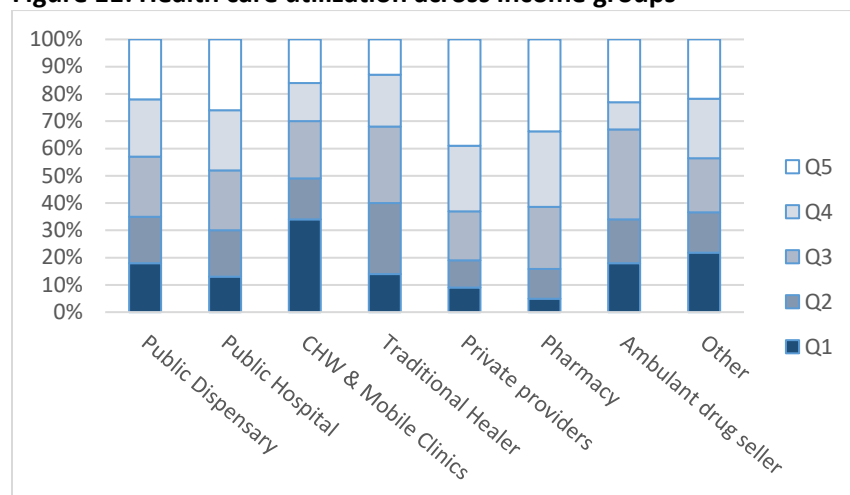
## Country specific analysis of financial protection

### HAITI

In 2012, about 9% of Haitian households incurred catastrophic health expenditures. As in most GFF countries, catastrophic payments are more common among the poorest households, though inequality across quintiles is less than in other GFF countries (Figure 7). This however does not reflect an equitable situation, rather it is a consequence of the low service coverage, especially among the poor. For example: 17% of the richest households self reported to have foregone care when needed, compared to 35% among the poor; coverage of skilled birth attendance is only 10% among the poor, compared to 78% among the rich. Looking in more detail at the service utilization patterns, we see that the poor are less likely to use any type of facility than the rich, except a Community Health Worker or Mobile Clinic (Figure 11).

Regression analysis conducted on the 2012 household data shows that even after adjusting for geographical and demographic characteristics, households in the richest quintile are less likely to incur catastrophic expenditures as compared to those in the poorest. It also appears that while having more young children is not significantly correlated with catastrophic spending, the association is very strong with having elderly persons in the household. Households with at least 1 household members older than 65 were found to be 1.7 times more likely to encounter catastrophic health expenditures than households with no elderly member.

**Figure 11: Health care utilization across income groups**



Source: WB estimates based on ECVMAS II, 2013

Combined with the fact that the main drivers of OOPs are medicines (Figure 9), this suggest that improving financial protection would require focusing on households that suffer financially from caring for elderly members (likely suffering from chronic conditions). It could be argued that a higher priority for GFF and partners in this case would be to support programs aimed at increasing coverage of essential RMNCAH-N services among the poor **without** worsening financial protection (e.g. by strengthening the CHW and mobile clinics).

By 2013 however, the incidence of catastrophic payments increased to 12%, mostly driven by an increase among the poorest (15% in Q1). This increase is likely related to a sharp decline in DAH (from 63% to 48% of current health expenditures), which came after an incredibly high level of external funding in the health sector following the 2010 earthquake. Withdrawal of donors may explain that the mean household health expenditures increased at a higher pace (143%) than that of household expenditures (6%), and especially deteriorated financial protection among the poorest households. This highlights the fact that volatility in external financing can have an important impact on financial protection among the poor and should be avoided.

## SECTION 4. IMPROVING FINANCIAL PROTECTION

Increasing financial protection has proven to be much more difficult than improving utilization of services, not just in GFF countries. The challenges and opportunities to improve financial protection are numerous and can be grouped into three major categories: (i) increasing compulsory prepaid and pooled funding while reducing reliance on OOPs, (ii) improving the management of public finances and policies and the

	Odds Ratio
Expenditure quintiles (ref=poorest)	
poorer	0.799
middle	0.804
richer	<b>0.598*</b>
richest	<b>0.634*</b>
HH with at least one member < 4 years	0.921
HH with at least one member >65 years	<b>1.738*</b>
Head of HH is a woman	1.003
Head of HH is educated	1.32
urban	1.109
Region (ref=North)	
South	0.993
Transversal	0.723
West	0.684
Metropolitan	0.721
Household size	1.022

**Figure 12: Logistic regression of CATA10 on determinants**

(N=4930, bold indicates significance at 10%)



governance of any remaining OOPs, and (iii) **improving the allocation and management of public (including compulsory insurance) funds.**

The potential and options for government to raise more funds for health by getting more efficient in revenue generation, increasing the tax base and increasing the range of revenue generation instruments (including through health insurance) was discussed at a previous IG meeting. This raises more money for health and allows formal user charges and co-payments for health services to be reduced. Ways to improve efficiency in health spending was also discussed at a previous IG meeting, which effectively allows more to be spent on health services and/or improving financial protection. This and the following section focuses on the third challenge.

### **Benefit packages should be designed to incentivize the most efficient use of scarce resources.**

**Benefits packages should include the services that people need.** Including preventive and outpatient care is essential to allow for gatekeeping and avoid over-use of expensive hospital care. Health insurance schemes that initially restricted benefits to inpatient care because these were thought to be the most important cause of very high OOPs, have had limited impact on financial protection. If people are incentivized to use hospital services for which they are less than 100% insured, insurance coverage can actually lead to increased OOPs.<sup>27,28</sup>

China's New Cooperative Medical Scheme (NCMS) initially only covered inpatient care. While the scheme was found to increase utilization, it did not improve financial protection as households were incentivized to use more expensive services. In the **Philippines**, the expansion of Philhealth coincided with a worsening of financial protection - OOPs increased by 150% from 2000 to 2012, and catastrophic expenditures tripled. In part this was caused by medicines being excluded from the benefit package while responsible for 70% of health expenditure among the poorest households incurring catastrophic spending.<sup>27,28</sup>

### **Supply side should be ready to deliver the benefit package.**

When services are not available or of poor quality/responsiveness, a large share of the population will still rely on OOP-financed private provision. **Countries that have been successful at improving financial protection have typically first invested heavily in preparing the supply side, before incentivizing the demand side through health insurance mechanisms.** Large geographic inequalities in supply-side readiness pose challenges. Output based payment mechanisms typically reward those areas that are

In the decades leading up to the introduction of the Universal Coverage Scheme (UCS) in 2001, **Thailand** invested heavily in health service delivery, facilities and human resources. In addition to expanding coverage, the reform also introduced new payment schemes and reorganized public health care providers to promote the efficient delivery of care. Among other changes, Thailand introduced gatekeeping, a single purchaser, closed-end capitation, and prospective payment for inpatient care. While the Thai UHC scheme has been shown to have increased utilization and financial protection, effects have been more limited in rural areas, possibly reflecting persistent geographic barriers to access.<sup>29</sup>

equipped to provide services and penalize those which are not, and hence can contribute to increased inequities. Quality improvement programs, including **accreditation** can help ensuring that facilities are able to deliver quality services. To avoid only accrediting facilities in areas with a well-functioning supply side, Thailand and Malaysia for example, started with relatively achievable accreditation standards coupled with a commitment to continue upgrading requirements over time.<sup>29,30</sup> Resource allocation formulas applied to transfers from central to local governments can also

increase equity if kept transparent, simple and explicitly needs-based.<sup>31</sup>

**Carefully crafted incentives are needed to ensure that essential services actually get delivered to those who need them most.**

**The efficient delivery of benefit packages needs to be enforced. In the first place, this means defining them explicitly and informing both providers and beneficiaries of entitlements and establishing adequate accountability mechanisms.**

User fee removal schemes for maternal and child health do not lead to improved financial protection if providers are not adequately compensated for the free care they are supposed to provide.<sup>32</sup> While there is no single provider payment mechanism that fits every context or objective, there is general agreement that input-based financing is almost always inefficient. Blended payment methods, such as capitation with some priority services paid for fee-for-service are increasingly considered good practice for purchasing primary care.

China's NCMS relied on a fee-for-service (FFS) scheme, which provides incentives for providers to increase care volumes. This was exacerbated due to distorted price schedules, which rewarded the provision of high tech diagnostic services, and a 15% markup on prescription drugs.<sup>33</sup> In the **Philippines**, prior to 2011, regulation of physician fees was absent and physicians could balance bill patients – that is, the practice of charging patients for the difference between the actual price of a service and the amount reimbursed under the patient's benefit plan. This was one of the major barriers to enhancing financial protection.<sup>35</sup> Under **Ghana's** National Health Insurance Scheme, providers were initially paid on a FFS basis (including for drugs), which led to concerns about oversupply of services. In response, some piloting with capitation payments has started but have not been taken to scale yet.<sup>34</sup>

**Public subsidies should be effectively targeted at the poor.**

In many countries government health spending is still pro-rich. **Improving financial protection requires a shift to financing a basic benefit package and corresponding supply-side strengthening. Individual targeting can be costly and have limited impact on improving financial protection and/or negative side effects on quality.**<sup>36</sup> Especially when identification of the poor is the responsibility of providers for whom an exemption of paying user fees effectively means a loss of income, exemptions are unlikely to be applied. Cambodia's Health Equity Funds – in which NGOs played an important role in both identifying the poor and compensating providers for the care provided - have been shown to effectively reduce OOPs among the poor.<sup>37</sup> Demand side subsidies, such as (conditional) cash transfer programs can be another approach through which to compensate households for (specific) health care use. Again, attention needs to be paid to whether individual targeting is cost-effective. A combination of geographical and individual targeting (e.g. through proxy means tests), as was the case in Mexico's PROGRESA (now PROSPERA) or Philippine's Philhealth is likely more efficient.

## **SECTION 5. HOW CAN THE GFF CONTRIBUTE TO IMPROVING FINANCIAL PROTECTION?**

Much of the current work of the GFF in health financing contributes to improving financial protection indirectly. For example, the GFF:

- helps countries identify possible sources of additional pre-paid and pooled revenues for health, and then to address ways of realizing these increases. This work is generally taken with other partners as appropriate (including the WBG, Gavi, the Global Fund, USAID, WHO, UNICEF) and the

ministry of finance. This allows countries to reduce OOPs, thereby improving financial protection. One option is to remove any remaining OOPs for RMNCAH-N services;

- assists countries to improve the efficiency of service delivery, particularly for RMNCAH-N services, freeing up resources for additional financial protection (and effective coverage with services) as appropriate.

**What the GFF can contribute directly on financial protection, however, depends on the extent of financial catastrophe and impoverishment, who suffers it, and why. This requires an assessment of the extent and causes of financial hardship and the links to the use of RMNCAH-N services, something that has not been done systematically in the initial process of developing an Investment Case in first wave countries.** In response, the GFF secretariat has developed, in collaboration with the World Bank, an approach that countries can use to do this, which would be the basis of the development of appropriate policies and strategies to improve financial protection subsequently. The approach has not yet been discussed more broadly so is presented here for feedback from the IG group before finalization.

**Box 4: Steps for countries to assess inequalities in financial protection for subsequent policy development**

1. Assess the current incidence of financial catastrophe and impoverishment due to OOPs following the approach used jointly by WHO in the UHC Global Monitoring Report. This can only be done if there is a recent household expenditure survey. Survey data cleaning is sometimes complex and technical support to country teams will often be required. ADEPT is a tool for analysing survey data and deriving most possible indicators of the absence of financial protection. It is useful to also look the depth of poverty and the mean catastrophic overshoot to see how bad the absence of financial protection is.
2. Assess who suffers most from the lack of financial protection – by expenditure quintiles and any other socioeconomic characteristics included in the survey. It will be expensive, though not impossible, for the GFF and partners to fund new household expenditure surveys and in many countries it will not be necessary because there are regular surveys conducted by others – e.g. statistical offices and WB, UNICEF and USAID (LSMS, MICS and DHS). Care must be taken when trying to compare data over time from different survey instruments.
3. Where possible, identify the main sources of financial catastrophe and impoverishment – inpatient, outpatient, medicines etc. Frequently, however, the data are not particularly good or detailed.
4. Consider trends in financial protection over time as frequently as possible. And changes in who suffers, the sources and in the average incidence. This requires surveys that use the same survey instrument with the same financial protection indicators defined in a uniform way.
5. Consider the results in the context of service coverage data – e.g. if there is no impoverishment or financial catastrophe in the lowest expenditure quintile, why? Is it because they do not use needed services, perhaps because of the fear of OOPs? Or are they protected financially for the services they use?
6. The data also need to be interpreted in the light of known policy changes or trends in utilization – e.g. is an apparent high incidence of catastrophic payments in the rich due to their opting out of government services and paying for private sector or overseas treatment? If so, should the government be worried about it?
7. Identify possible entry points for improving financial protection. Certainly free RMNCAH-N services is one option, so this requires identifying the extent to which OOPs are charged for these services – officially or unofficially. If they are charged, for what, and are there exemptions? Sometimes, however, RMNCAH-N services will be near free or free, so the lack of financial protection must come from payment for other types of services. While this may be outside the direct purview of the Investment Case, the broader health financing work supported by GFF and partners needs to ensure that the available funds for the health sector are used as efficiently and equitably as possible. This enables government to spend more, and more effectively, on the health needs of the poor and vulnerable.

### Concretely, it is proposed that:

- all GFF countries undertake such an analysis at the start of preparing the Investment Case (if not recently done already), and repeat it regularly (ideally within 3-year periods). The GFF partnership can contribute by supporting regular household surveys that collect detailed household expenditure data.<sup>x</sup>
- survey design and data analysis should be done in close collaboration with the WB and WHO teams working on the Global Monitoring Report to ensure comparability (across time and countries). The GFF secretariat can facilitate this coordination.
- results of the analysis feed into the operational agenda.
  - if OOPs are related to the use of RMNCAH-N services, identify the most effective strategies to reduce them.
  - if not (but coverage is low), identify strategies to increase coverage without worsening financial protection.

Such strategies are already supported by various partners in a number of GFF countries:

### Defining benefit packages in the Investment Case

- In **Liberia**, the development process inherent to the Investment Case enabled balancing important RMNCAH-N needs with available resources, thereby helping define an equitable and effective package of services, which can feasibly be delivered to the populations most in need. Informed by evidence, this process sharpened strategic direction and signaled the need to focus on emergency obstetric and newborn care, antenatal care, postnatal care, neonatal care, family planning, adolescent health, human resources, supply chain management, and referral systems. While these services may by themselves not be important drivers of OOPs, not having them in a basic package will drive up OOPs incurred elsewhere.

### Strengthening supply side readiness to deliver the package:

- Drugs and commodities are a key driver of OOPs in many countries, even in settings where they are supposed to be available free of charge. When public facilities suffer from regular stock outs, households are forced to buy from the private sector. In **Senegal**, the GFF process supports the nationwide expansion of the Informed Push Model – a supply chain innovative model which uses private distributors to address stock outs of essential family planning commodities in public health facilities. This expansion will bring about 100 family planning commodities to the last mile, substantially reducing the average stock out rate of family planning commodities to less than two percent.
- Low numbers and unequal distribution of human resources for health in the public system limit the capacity of systems to deliver the essential benefits package, especially in those areas where needs are highest, and drive people to seek care from private providers. Improving the distribution of health workers is therefore key to the GFF agenda in many countries. The Investment Framework of the **Democratic Republic of Congo** prioritizes improving the coverage and quality of supply-side RMNCAH-N services in 14 priority provinces. Specifically,

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<sup>x</sup> DHS surveys can include a module on OOPs, but do not collect information on total consumption (needed to calculate CATA and IMPOV). In the absence of -or in between- other household surveys, such information is useful and OOPs modules should therefore be integrated in DHS where possible.

it focuses on human resources, aiming to decentralize medical personal, strengthen incentive mechanisms and ensure appropriate training and continued learning.

- Weak provider incentives limit the performance of providers in the public system both in delivering quantity and quality. Results-Based Financing approaches are supported in many of the GFF countries and, and can be used to ensure that user fee removals are effective, as was the case in **Sierra Leone's** Free Health Care Initiative.

**While all these examples can be linked to an agenda of improving financial protection, that link is not explicitly made yet in most GFF countries. It is therefore not obvious whether the above-mentioned strategies always address the most important drivers of OOPs, and/or whether they could/should be adjusted to do so.** If user fees represent only a small fraction of OOPs, while the bulk is caused by spending on drugs in the private sector (as appears to be the case in Sierra Leone), an RBF scheme would have limited impact on financial protection unless it was combined with an incentive scheme or contracting model to increase availability of drugs and other commodities.

## SECTION 6: CONCLUSION

**Most GFF countries are still heavily reliant on OOPs as a way of funding health services, leading to problems of foregone care, financial catastrophe and impoverishment.** The share of OOPs in the overall health budget has fallen in recent years only in about half of the GFF countries. On the other hand, financial protection, as measured by the incidence of catastrophic and impoverishing payments, has improved in a few countries, and where it has, it usually coincided with substantial improvements in the coverage of RMNCAH-N services.

In all GFF countries for which data are available, **catastrophic expenditures mostly hit the poorest households.** Impoverishing payments, however, are rarer among the very poor because they already lived in poverty before making any OOPs. These payments, therefore, drive them further into poverty. To the extent that the survey data are comparable across countries, most OOPs are made for outpatient care and drugs, not for big hospital bills although country-specific analysis is critical to devising an appropriate country response.

**Increased Domestic Resource Mobilization (not from OOPs) is a necessary, but not sufficient, condition for improving financial protection.** Resources should be well managed and spent wisely: (i) benefits packages should be designed to ensure appropriate use of preventive and primary care; (ii) the supply side should be ready and properly incentivized to those services and (iii) public subsidies should be effectively targeted at the poor.

**What the GFF can contribute to improved financial protection directly depends on the extent of financial catastrophe and impoverishment, who suffers it, and why.** All GFF countries should (regularly) undertake an assessment of the extent and causes of financial hardship and the relationship with the use of RMNCAH-N services. This analysis should feed into the prioritization process of the Investment Case. Countries need to be explicit about the extent to which improving financial protection should be a priority and if so, which strategies should be designed to improve it. IG partners can contribute by highlighting the importance of financial protection in their constituencies, contributing to the finalization of the country approach suggested in this document (through funding surveys and technical assistance in a coordinated way), and the alignment around the proposed strategies.

**User fees for RMNCAH-N services are detrimental to access and – where they exist - should be reduced/removed.** While the GFF is very supportive of user fee removal for RMNCAH-N services, careful attention needs to be paid to whether such a policy will indeed address the key driver of low financial protection and access and whether it is financially sustainable. As the analysis in this paper suggests, user fees for RMNCAH-N services alone are not the sole driver of out-of-pocket payments. In addition to a broader focus on OOPs, and increased analysis on what drives OOPs in individual countries, a key focus to ensure sustainable financing will be to raise more public pre-financed and pooled resources.

**The analysis presented in this paper is a first step towards a better understanding of the (lack of) financial protection in GFF countries and the ways in which GFF and partners can contribute to protect the poor.** It is meant to kickstart discussion on the way forward and solicit feedback from partners leading important work in this topic.

## ANNEX 1

**Figure A. 1: Trends in OOPs/capita, GFF LICs, 2000-2010**

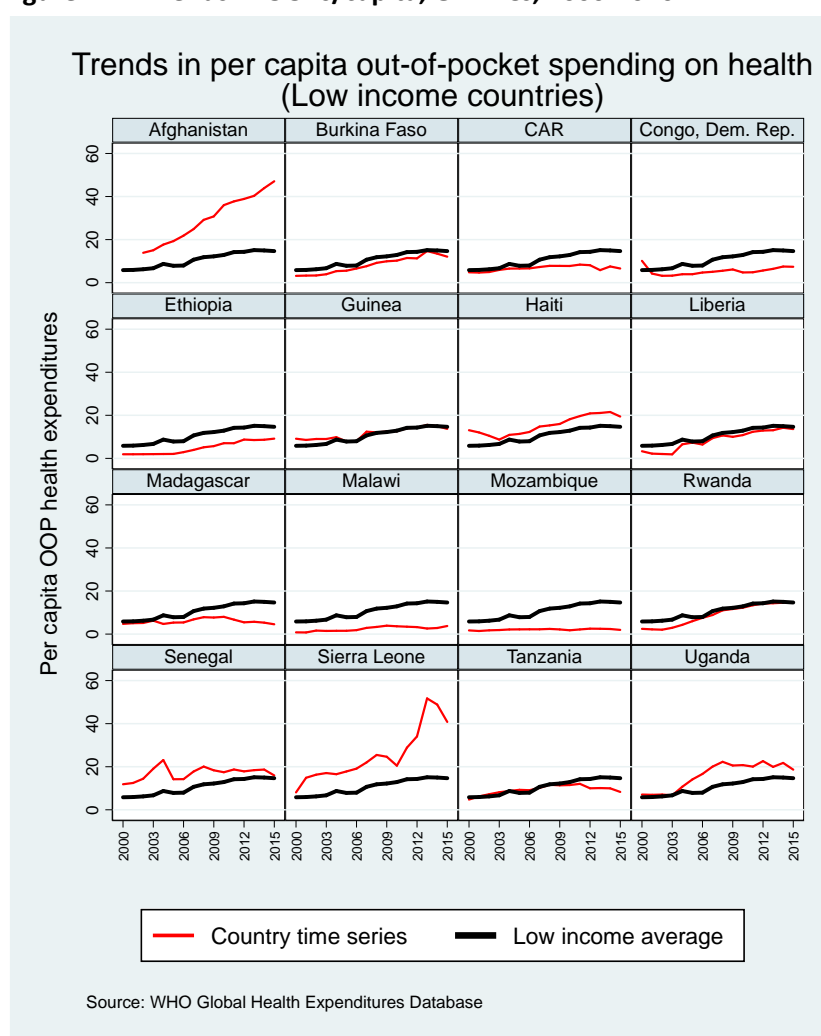
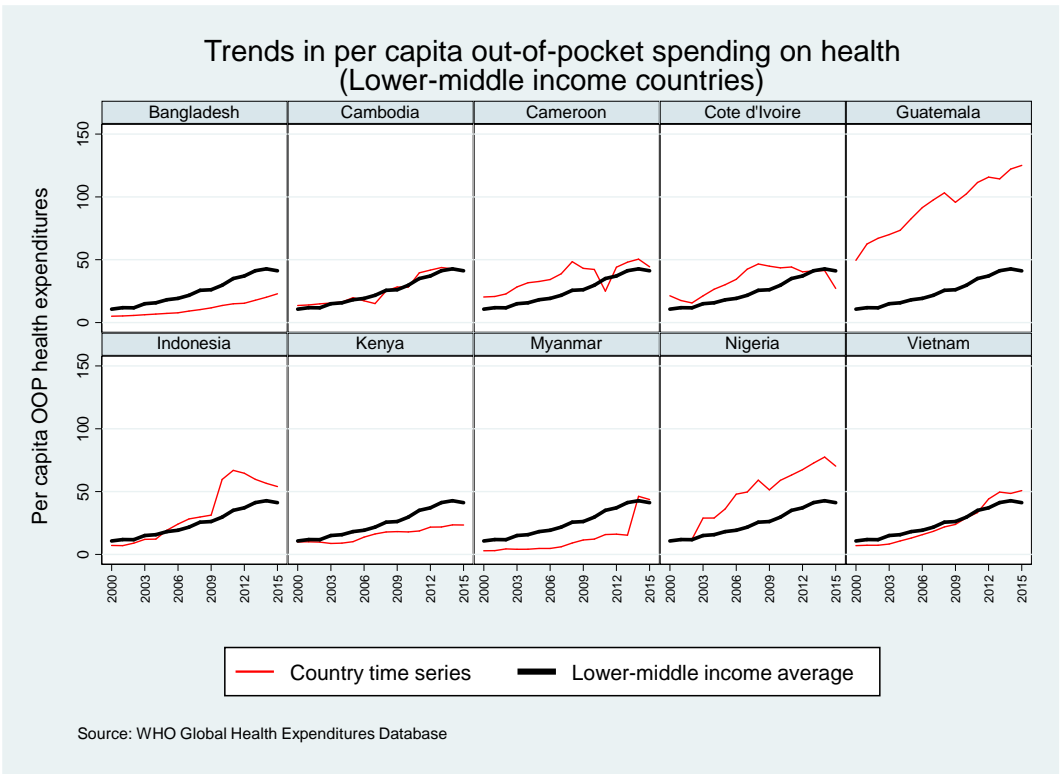


Figure A. 2: Trends in OOPs/capita, GFF LMICs, 2000-2010

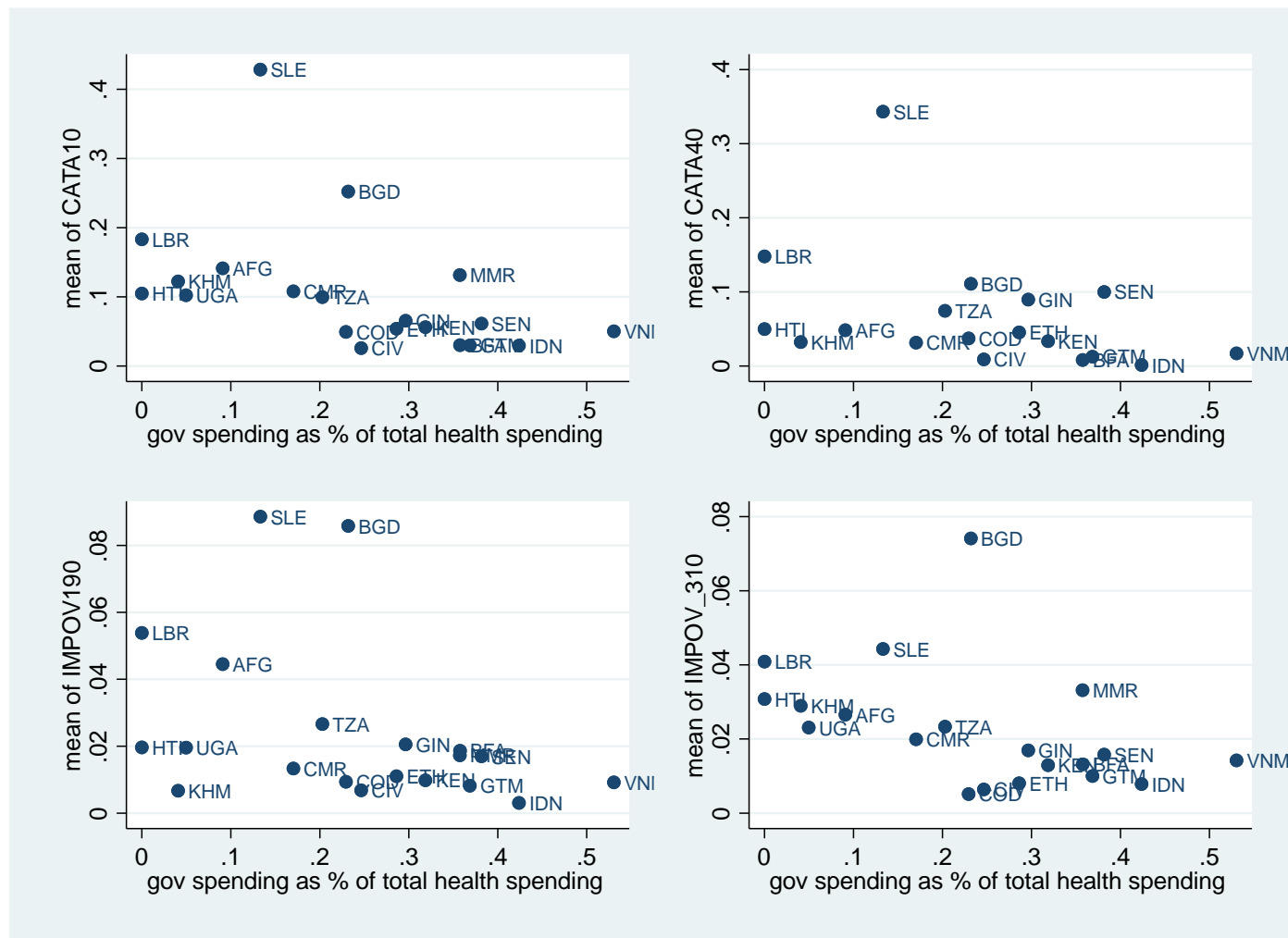




## ANNEX 2

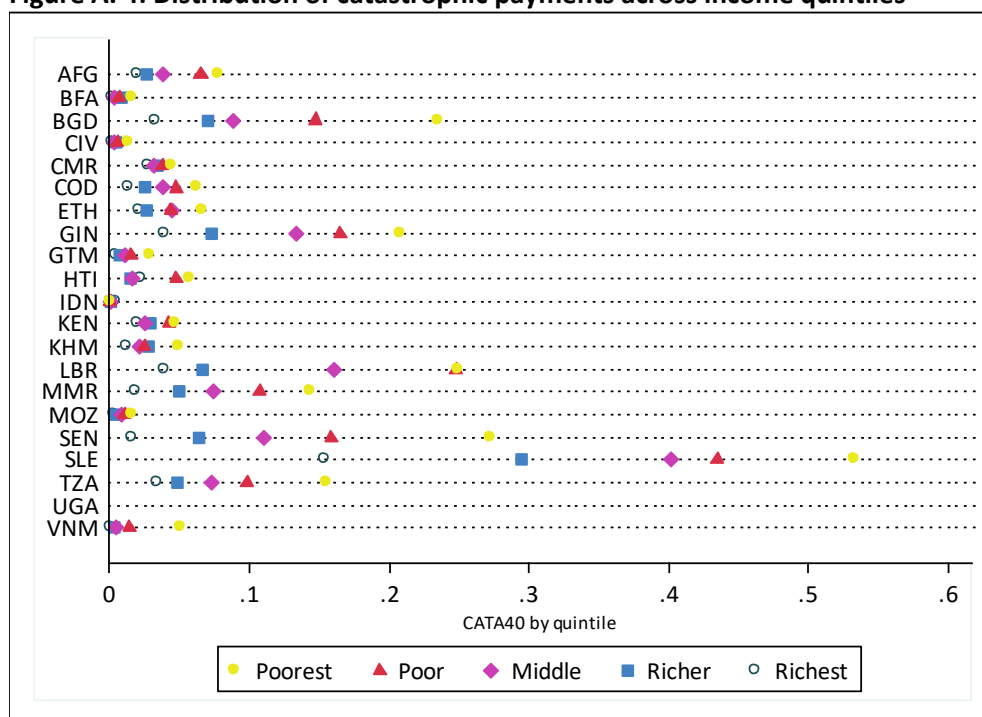
### FINANCIAL PROTECTION INDICATORS FOR GFF COUNTRIES USING DIFFERENT THRESHOLDS

Figure A. 3: Indicators of financial protection versus government spending as a share of total spending



*Note:* Bangladesh and Sierra Leone are outliers, most likely caused by data quality issues rather than actual trends in OOPs. These data points are therefore not part of the Global Monitoring Report produced jointly by WB and WHO.

**Figure A. 4: Distribution of catastrophic payments across income quintiles**



*Note: Uganda is omitted from the Figure because the data does not contain non-food expenditures.*

**Figure A. 5: Distribution of impoverishing payments across income quintiles**

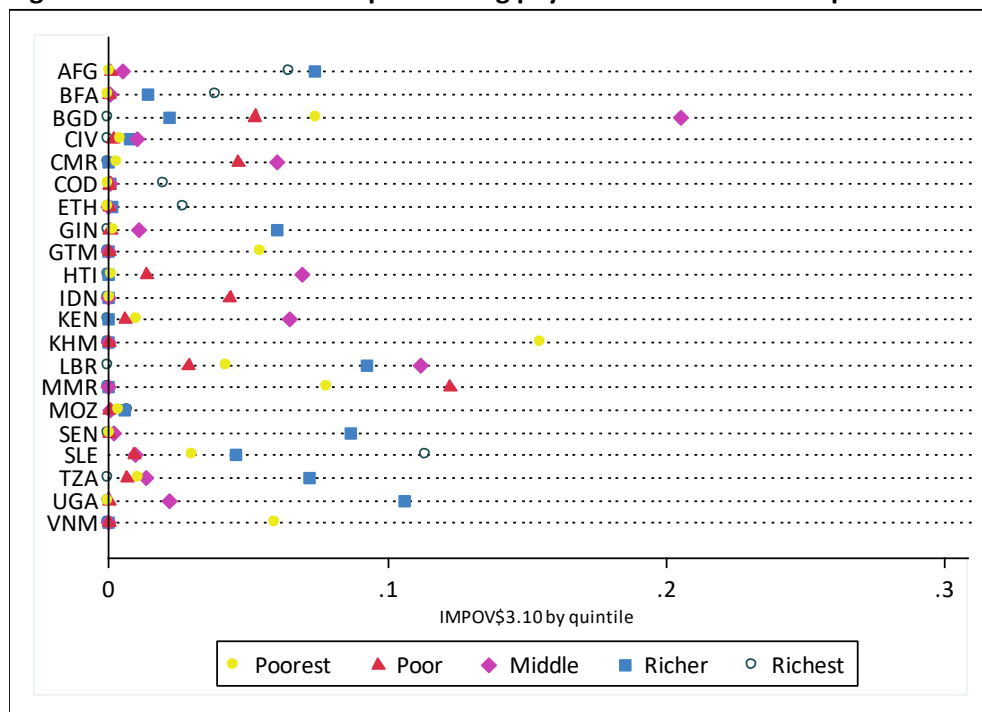


Figure A. 6: Trends in the incidence of catastrophic payments

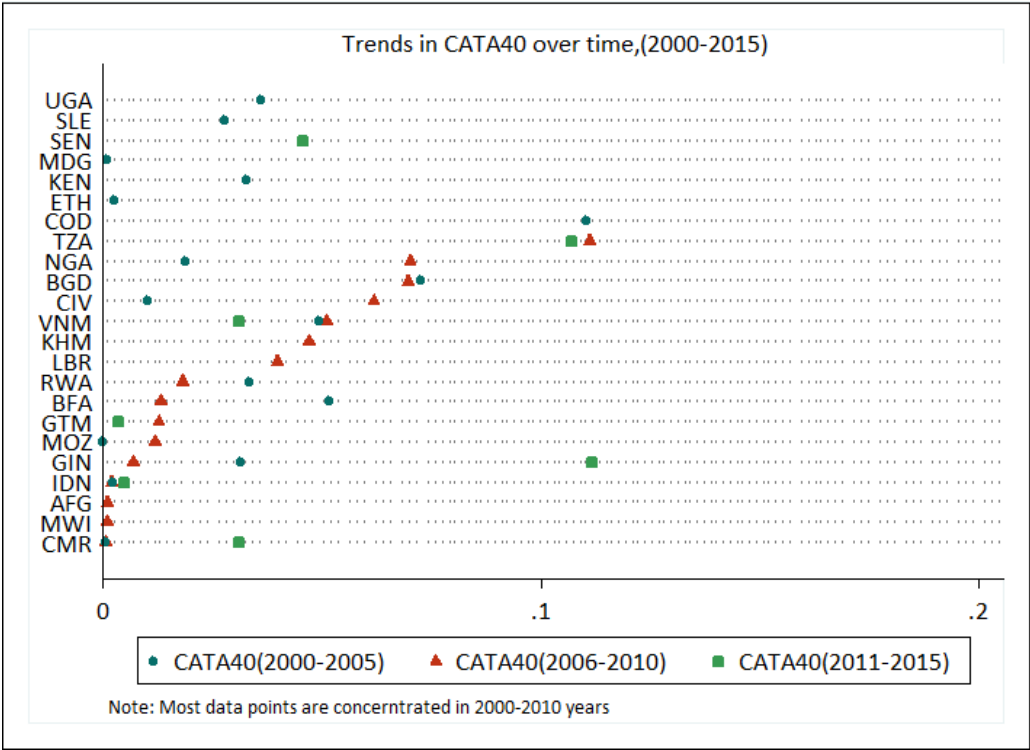
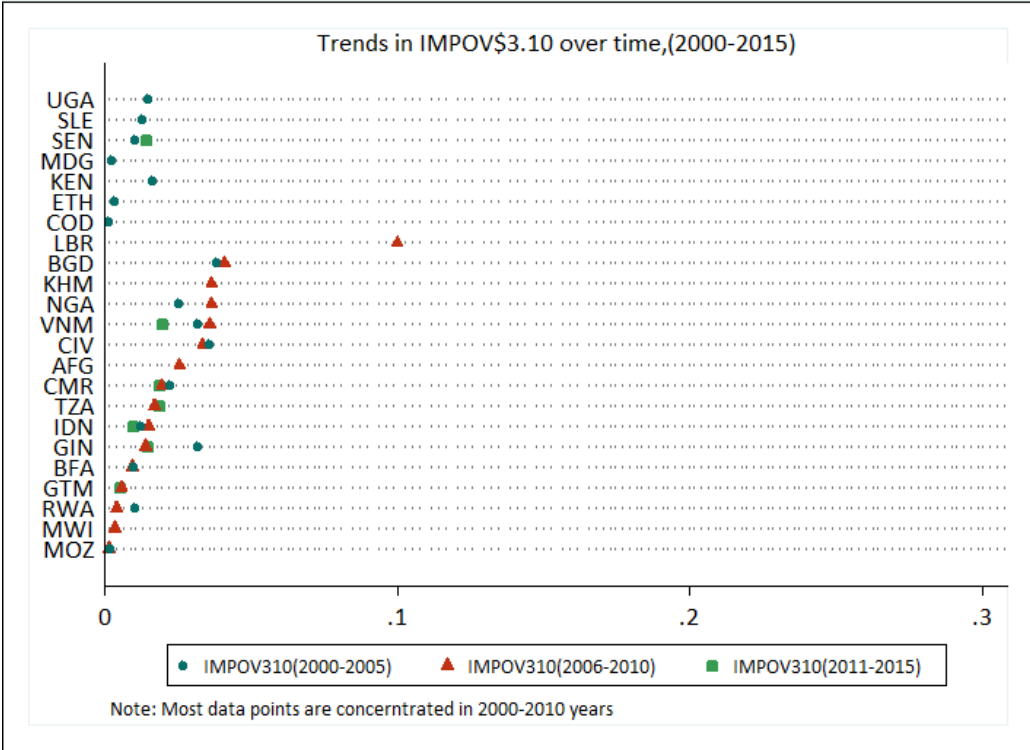


Figure A. 7: Trends in the incidence of impoverishing payments



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