

# UNICO: Demand Side Strategies for Universal Health Coverage (UHC)



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**ABSTRACT:** This article aims to enable a better understanding of the design and implementation of demand-side programs developed in middle-income countries documented by the World Bank through UNICO, with a focus on the progress achieved in identifying beneficiary populations and separating financing from provision.

The article concludes that these programs increased insurance coverage and often also the utilization of key health services. However, their design and implementation faced challenges. The split between financing and provision remained incomplete, since in most cases a large share of the funds financing public providers remain supply-side subsidies and not the funds provided by these demand-side programs. Other challenges remain such as weaknesses in the design of benefit packages and provider payment mechanisms, in the autonomy of providers, in the quality of care, and in ensuring the long-term financial sustainability of these programs.

## Introduction

In the quest towards universal health coverage, several middle-income countries have developed demand-side programs aimed at increasing service coverage and financial protection in case of illness. These programs create or extend previous mandatory health insurance programs, providing coverage to groups that had remained uninsured: the poor, the vulnerable living close to the poverty line, and non-poor/vulnerable informal sector workers.

Based on a review of some of these experiences, this article aims to enable a better understanding of the design and implementation of these programs, with a focus on the progress achieved in identifying beneficiary populations and separating financing from provision. This review is not meant to be exhaustive; it only covers countries whose experiences have been documented by the World Bank through UNICO (the UHC Study Series). Despite the fact that all countries included are middle-income countries, there are significant variations in their level of income, the functioning and organization of their health system. In 2016, GDP per capita in the countries reviewed varied from US\$ 1,708 per capita (in constant 2010 US\$) in Ghana to US\$ 14,465 in Croatia.<sup>1</sup> In addition to these two countries, the review also included: Argentina, Armenia, Colombia, Dominican Republic, Indonesia, Kyrgyz Republic, Mexico, Morocco, the Philippines and Vietnam.

## Demand-side programs: parallel vs. integrated schemes to in-

<sup>1</sup> World Bank World Development Indicators data base.

## sure the poor and vulnerable

Many of the countries reviewed had insurance schemes that already covered formal sector workers and thus designed strategies aimed at identifying the poor and vulnerable, fully subsidizing their coverage within a pre-existing scheme, or within a parallel one created to provide coverage to these population groups.

Croatia, Kyrgyz Republic, the Philippines, Ghana, and Vietnam<sup>2</sup> subsidized the insurance of the poor and vulnerable within existing national health insurance schemes, without generating a parallel program, thus avoiding additional fragmentation. Similarly, Armenia covers the entire population with a basic package of free primary care services through the State Health Targeting Program Law (which generated a split between financing and provision) and different ranges of co-payments for inpatient care, subsidizing the poor and vulnerable.<sup>3</sup>

The Dominican Republic created Family Health Insurance with different financing mechanisms and strategies to cover formal sector workers and their families ("contributive regime"), the poor ("subsidized regime", fully financed by general taxation) and informal sector workers ("subsidized contributive", which was intended to be partially financed by general taxation and household contributions). Similarly, Colombia also created a scheme that originally consisted of different financing mechanisms and strategies to cover different population groups, with "contributive" and "subsidized" regimes, but they were unified in 2012.

<sup>2</sup> In Vietnam, the 2009 Law on Health Insurance merged all the different programs into one, those covering the formal sector and the poor and informal sector workers (Somanathan, 2013).

<sup>3</sup> Rousell, F. et al. 2017.

Two of the upper-middle income countries reviewed created a health insurance scheme to cover all informal sector workers: the Social Protection System in Health (and its main pillar Seguro Popular) in Mexico and Plan Nacer (now known as Programa Sumar) in Argentina. These schemes run parallel to those that cover formal sector workers.

Other countries created parallel schemes to cover the poor and vulnerable but not informal sector workers. This was initially the case in Indonesia with Jamkesmas, and Morocco with RAMED.<sup>4</sup> These schemes ran in parallel to those that covered formal sector employees. Nevertheless, in the case of Indonesia, Jamkesmas merged with two other pre-existing schemes to form the Indonesian national health insurance, Jaminan Kesehatan Nasional or JKN.

### Identifying and enrolling the beneficiary population

Since most of the programs reviewed aimed to increase health insurance coverage for the poor and the near-poor in a few cases, these programs developed complex mechanisms to identify and enroll beneficiaries. These mechanisms evolved over time, but they were mainly based on proxy means tests and validation/certification at community level. Systems used to identify the poor have been increasingly centralized and tend to use a unified registry of social program beneficiaries, to reduce space for exclusion and or inclusion errors. This is the case for SISBEN in Colombia, the SIUBEN in the Dominican Republic, the National Targeting System- Poverty reduction list managed by the National Government Department of Social Welfare in the Philippines, and the National poverty list in Indonesia. In addition to proxy means test, other countries also used categorical criteria such as older population and/or children (e.g. Kyrgyz Republic, Ghana, and Vietnam) and other categories, such as people with certain medical conditions or disease, such as Armenia and Kyrgyz Republic.

### Explicit entitlements

In addition to mechanisms for identifying and enrolling the beneficiary population, the development of explicit benefit packages and the split between financing and provision of services were also central issues for these programmes. With only a few exceptions, such as Colombia, Croatia, and Mexico, there were weaknesses in the definition and costing of benefit packages. In many instances, these packages were meant to include cost-effective interventions aimed at preventing or treating the main causes of the disease burden of the population that could be fully funded with available resources. In practice, in many instances this was not the case; the criteria for selecting interventions to be included in the package were not always clear or transparent, often following historical expenditure trends and political decisions.

Croatia has a generous package for the entire population, explicitly defined for primary care but with a negative list for remaining services. New services and medicines to be included are decided by technocrats, based on their knowledge, taking into consideration scientific evidence and cost implications. Mexico was another example of a country that progressed significantly in the design and costing of a benefit package and in fully funding

its provision.<sup>5</sup> Other countries, such as the Dominican Republic, have explicit packages that were well defined and costed at the beginning but lacked a proper evidence-based system for ongoing revision, which enabled political influences and lack of decision-making transparency to creep in.<sup>6</sup>

Plan Nacer in Argentina also had a well-defined package of services. However, this package was not fully funded by the program, it only provided a top-up for participating provinces. Indeed, its original costing only included the costing of the gap to increase coverage of selected services.<sup>7</sup> In some of the other countries reviewed, no specific and transparent criteria were used to design the package of services, as was the case in Vietnam.<sup>8</sup>

### Separation between financing and provision

In many of these countries, the financing and purchasing split was justified by the need to introduce efficiency gains through competition among providers, and in a few cases also among insurers (Colombia, Dominican Republic, Morocco), all with the idea of fostering strategic purchasing. In some cases, one of the main objectives of the split was to optimize a large and inefficient delivery network, by generating competition between public and private providers: this was the case in Croatia, Armenia and the Kyrgyz Republic. In other cases, an important objective of the reform was to increase allocative efficiency through the development of an explicit and prioritized package of services aimed at preventing and controlling the main burden of disease in these countries (e.g. Mexico, Argentina, Philippines, Colombia, Dominican Republic). This package of services was supposed to be “purchased” from existing providers, who would then become accountable for its provision to the beneficiary population. By attempting to develop an explicit package of services and funding it, these programs aimed to eliminate informal payments, implicit rationing and insufficient drugs and supplies. The new provider-payment mechanisms also aimed to generate incentives for providers for improving efficiency and overall performance.

Despite these efforts, in most examples reviewed in the UNICO series, the purchaser/provider split remained incomplete. The demand-side programs only financed part of the cost of providing the package of services. Countries continue to pay most costs (usually payroll, often other things too) through line-item budgets, with only a part of variable costs covered by the payer.

Only some upper-middle income countries were able to achieve a more complete separation between financing and provision, as was the case in Colombia, Morocco, Dominican Republic and Argentina<sup>9</sup>, but only in the schemes that cover formal sector workers (usually with private providers), not in the programs covering the poor and uninsured, where the split remained incomplete.

In Argentina, Plan Nacer, today Programa Sumar, only pays a top-up that serves as an incentive to health facilities to provide services included in the benefit package. Health facilities continue to be paid by provinces through line-item budgets that

4 Harimurti et al., 2012 and Dorothee Chen, 2017.

5 Bonilla-Chacin and Aguilera, 2013.

6 Rathe, Magdalena. 2018.

7 Cortés y Romero. 2013.

8 Somanathan et al. 2013.

9 World Bank, 2018.

include salaries, drugs, medical supplies, equipment and capital goods. The resources received by Plan Nacer are small, but in contrast to all other funds financing health services, the facility has the autonomy to decide how to use these resources.<sup>10</sup> In Croatia, even though most health care resources are managed by the Croatian Health Insurance Fund (HZZO) via demand-side financing, local governments (counties) are responsible for the maintenance of infrastructure and capital investments in primary health care centers and minor local public health programs. In Indonesia, it was estimated that the premiums paid by Jamkesmas were not reflective of the true cost of care. It was estimated that over 2/3 of the average costs of care were covered by supply-side subsidies.<sup>11</sup> Salaries, capital and some operational costs continued to be paid by different levels of government (central, provincial, district depending on the type of facility). Also in Vietnam, the government continues to pay supply-side subsidies based mainly on historical norms which are channeled through the Ministry of Health and the Provincial Health Bureaus; supply-side subsidies mainly remain grounded in historical norms.<sup>12</sup> In Ghana, the MOH still pays some supply-side subsidies to health facilities. It pays about 95% of all personnel compensation, but a negligible share of non-salary recurrent expenditures for front-line health care workers.<sup>13</sup> Similarly, in the Dominican Republic, within the subsidized regime, the most important source of funds for service provision are supply-side subsidies, not funds from SENASA, the purchaser agency.<sup>14</sup>

In Mexico, even though Seguro Popular fully funded the premiums for the uninsured, the split remained incomplete since there was no significant change in provider payments. Only in the Fund for Protection against Catastrophic Health Expenditure did the split advanced significantly, but this fund only finances a few high-complexity services; most services financed by Seguro Popular are provided by the States and financed mainly through line-item budgets.<sup>15</sup> In the Philippines, even though resources were mainly financed by the demand-side scheme, the split remained incomplete since PhilHealth did not hold providers accountable for performance, and many did not have the necessary autonomy to retain the received resources. Resources were managed by the LGUs (local government units) for LGU hospitals, since very few of them could retain income and thus the resources they received went back to the LGU who then paid them through line-item budgets.<sup>16</sup>

In some cases, the idea of only providing a top-up inspired the objective of generating performance improving incentives to providers, as was the case in Argentina and Armenia. Prior to reforms, providers mainly received resources through line-item budgets. These top-ups were meant to be received and managed by the facility level and used to change behavior to improve the provision of services included in the benefit package. In some cases, this was not fully achieved, since providers did not have the necessary autonomy, or the rules did not allow them to retain and manage resources. This limited the possibilities for improving

performance, as was the case in the Philippines.

### Demand-side schemes in a decentralized context

Many of these demand-side programs were implemented in highly-decentralized health systems, where lower levels of government are responsible for public service provision. In some cases, the programs tried (not always successfully) to reduce the inequalities in health expenditure and service provision, by changing the allocation of funds across geographic areas, by making resources follow the patient (e.g. Mexico, Argentina, Indonesia, Philippines, Vietnam, Colombia). However, these decentralized contexts also generated extensive implementation challenges. These programs were often developed by the central government but required joint implementation in conjunction with lower levels of government, that not only were in charge of delivering services, but in a few cases also of identifying and enrolling beneficiaries and financing part the scheme. For example, in the Philippines, the identification of the poor was originally supposed to be verified and the final decision made by the local government units. Given various loopholes in the means tests and capacity to verify at that level in 2009, the National Government announced it would pay for the Sponsored Program only if households were on the National Targeting System-Poverty reduction list of households, managed by the National Government Department of Social Welfare, centrally managed to control any manipulation of the list (only 15% of the original beneficiaries cross-matched in the first list of 2010).<sup>17</sup>

### Progress achieved by these programs and ongoing challenges

All countries which adopted demand-side strategies for UHC increased the coverage of health insurance to a large percentage of the population that had remained uninsured. However, since often this increase in insurance coverage was done through the development of a new insurance scheme, few countries were able to eliminate or even decrease the fragmentation of the resource and risks pools. Most countries increased coverage for the poor and vulnerable, and a few also for informal sector workers. For instance, Seguro Popular beneficiaries went from 11.4 million in 2005 to 52.5 in 2012; by 2014 the Ghanaian national health insurance covered 40% of its population.<sup>18</sup> In the Dominican Republic, insurance coverage went from 870 million in 2007 to 7 million in 2016 (70% of the population), with almost 100% of the poor population already affiliated.<sup>19</sup> As a result, most countries have seen an increase in the utilization of health services, particularly among the poor and previously uninsured population. For instance, Plan Nacer in Argentina increased utilization of services, and there is also evidence that it has improved birth outcomes among those not covered by contributed health insurance.<sup>20</sup>

Many of these demand-side programs were able to mobilize additional resources for health. Most of these resources came from general taxation, although some countries used innovative sources of revenue, as was the case in Ghana where part of VAT was earmarked to fund the National Health Insurance Scheme

10 Cortes et al, 2012 and World Bank, 2018.

11 Harimurti et al., 2012.

12 Somanathan et al., 2013

13 Wang et al., 2017.

14 Rathe, 2018

15 Bonilla-Chacin and Aguilera, 2013.

16 Chakraborty, 2013.

17 Chakraborty, 2013.

18 Bonilla-Chacin and Aguilera 2013; Wang et al. 2017.

19 Rathe, Magdalena. 2018.

20 World Bank, 2018.

(NHIS), and the Philippines, with the earmarking of sin taxes to partly fund the Sponsored program.<sup>21</sup>

There were also benefits to the adoption of explicit packages and the split between provider and purchaser, establishing the basis to strategic purchasing. Even when these strategies were not fully, they contributed towards efficiency with the introduction of innovative payment mechanisms and incentives.

All countries still present important challenges in their path to UHC. As an example, the large differences in health service utilization between geographical regions and income levels have not disappeared. This issue remains a challenge in many of the countries reviewed: Argentina, the Philippines, Vietnam, Ghana and others. In addition, it is not clear to what extent these programs were able to increase effective coverage of health services, since quality of care remains a challenge.

Supply-side capacity restrictions were one of the main challenges faced by most demand-side programs. In many cases, supply did not have the capacity to offer all the services included in the benefit package to all the population groups (e.g. Colombia, Indonesia, the Philippines). In others, providers did not have the necessary autonomy to respond to new incentives generated by different provider payment mechanisms, in some cases they were not able to retain resources obtained from services provided to program beneficiaries. Regulated competition of insurers was not achieved, and governments did not enforce adequate plan supervision (Colombia, Dominican Republic and Morocco), contributing to the system's fragmentation and causing difficulties in ensuring transparency in the design and costing of the benefit package.

Financial sustainability of these schemes remains a challenge: Premiums are not always actuarially based (e.g. Indonesia) and there are no risk-adjustment mechanisms in place in most of the countries. Not all benefit packages are fully financed via demand-side: the supply-side subsidies often hide insufficient resources to fund these programs and persist implicit rationing (e.g. Indonesia, Dominican Republic).

Some of these programs have been facing issues in controlling the cost of provision, partly due to provider payments that incentivize the oversupply of expensive services (e.g. Vietnam).

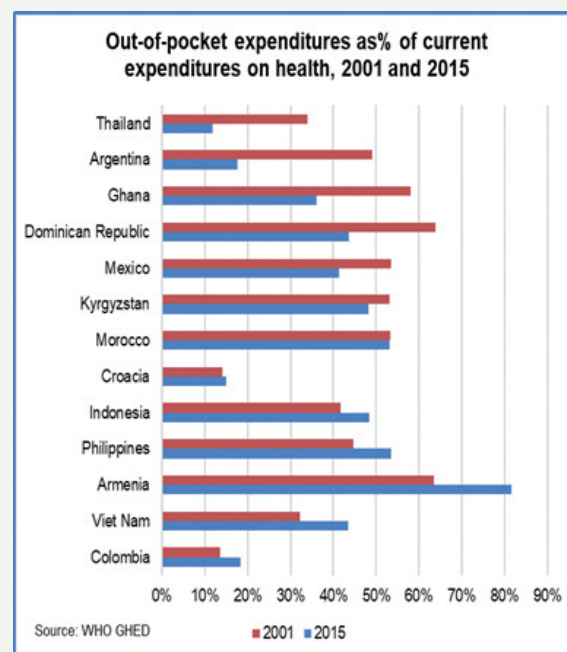
In addition, with demographic and epidemiological transitions, these countries are facing an increasing burden of disease coming from non-communicable diseases, which need long-time contact with the health system and if not controlled, can result in complications and hospitalizations. Technological changes coupled with increasing citizen expectations and demands are also likely to increase health care costs.

In view of these fiscal pressures, some countries place caps on hospital payments, others introduce co-payments or leave complex procedures to be paid out-of-pocket (Armenia, Kyrgyz Republic), with the result of very high direct payments by users; therefore financial protection remains a challenge.

As can be seen in the graph, some countries were able to substantially reduce out-of-pocket payments from 2001 to 2015 and were therefore more likely to offer increased financial protection for their populations. Other countries increased such payments (Armenia substantially, Indonesia, Vietnam, Philippines); Colombia

<sup>21</sup> Wang et al., 2018 and Chakraborty, 2013.

FIGURE 1



bia increased them despite its relatively low percentage; Croatia maintained the same low proportion; and Morocco remained the same at a relatively high level.

## Conclusions

In their efforts to progress towards UHC, many middle-income countries have developed demand-side programs which aim to provide increased coverage to the poor and vulnerable to a package of health services, while also improving financial protection in case of illness. These programs have increased insurance coverage for their target population groups and in some cases, the utilization of key health services too.

These programs aim to improve allocative efficiency by designing an explicit package of services for preventing and controlling the main causes of the burden of disease in the countries, and funding it. They also aim to increase the efficiency and overall performance of providers by trying to separate financing from provision and setting the stage for strategic purchasing of services.

However, with only a few exceptions, these reforms have not been fully developed and continue to be a work-in-progress. There are weaknesses in the design of the benefit package, since the inclusion of services did not always follow a pre-established transparent criterion. The split between financing and provision has also remained incomplete, since in most cases a large share of the funds financing public providers does not come from these demand-side programs but from supply-side subsidies. Most countries also struggle with changing payment mechanisms or ensuring more autonomy of public providers in responding to new incentives. The financial sustainability of schemes remains



an issue in many cases.

In addition, some of these demand-side schemes have been developed as parallel schemes, maintaining and sometimes exacerbating the existing fragmentation of the resource and risks pools (e.g. Mexico, Argentina, Morocco). Others, while developed as part of a strategy directed at the whole population, have come up against political restrictions which prevent, at least temporarily, the elimination of fragmentation (Dominican Republic, Colombia). Some countries attempted to eliminate this fragmentation, as was the case in Croatia, Philippines, Kyrgyz Republic, Vietnam, Indonesia, but a few found this difficult to achieve. For example, in Vietnam even though a unique insurance scheme was used to extend service coverage, the capitation formula used to distribute resources across districts preserves the fragmentation of the resource pools.

The challenge of increasing coverage of these programs to the non-poor informal sector workers remains. Some countries have decided to fully subsidize them, for example Argentina and Mexico, but this mostly remains a financially difficult option.

Despite the challenges and the need to improve or even change some of their policies based on experience, most countries seem committed to continuing their exploration into improving the implementation of these demand-side strategies, along a path towards universal coverage.

## Biographies

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