Expanding Coverage and Improving Health in Low Income Countries: Some Things We Know and Some Things We Need to Know Better

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Beginning with a truism

Universal health coverage with effective interventions will produce the highest attainable outcomes a health system can achieve
Some problems applying this in practice

- We don’t have unlimited resources – in low income countries, we have VERY limited resources: (2007 data)
  - OECD Average Per Capita Health Spending: PPP$ 2915
  - Low Income Country Average Per Capita Health Spending: PPP$ 67

- Health systems have multiple goals:
  - Health status: Average level
  - Financial protection: X
  - Citizen satisfaction: Distribution

- Health systems have limited capacities to implement
  - OECD Countries Average Nurses Per 1000: 9.3
  - Low Income Country Average Nurses Per 1000: about 1

- Lets explore the health status questions – some things we know about expanding coverage and improving health; and some things we need to know more about
COUNTDOWN TO 2015
DECADE REPORT (2000–2010)
Taking stock of maternal, newborn and child survival

www.countdown2015mnch.org
FIGURE 5
Coverage of interventions varies across the continuum of care

Median national coverage of interventions across the continuum of care for 20 Countdown interventions and approaches in Countdown countries, most recent year since 2000 (%)

Source: Countdown 2015 Decade Report
Figure 8: Average coverage levels of selected reproductive, maternal, newborn, and child interventions in the poorest and richest wealth quintiles of 38 CountDown countries with a Demographic and Health Survey and available data, by intervention.

Source: The Lancet 2010; 375: 2032–44
FIGURE 15
Too few children with diarrhoea or pneumonia receive correct treatment

Children with diarrhoea or pneumonia receiving correct treatment (%)

- High
- Median
- Low

- Philippines
- Korea, Dem. Rep.
- Iraq
- Botswana, Somalia
- Chad
- Haiti

Source: Countdown 2015 Decade Report
Expanding Coverage and Improving Health: What’s the Best Path?

- Health outcomes – the aggregation problem
- UHC is a long-term goal – what is the best path to get there?
- We know – with some confidence – that improving access, distribution, and quality can all improve outcomes
- We don’t know very well
  - What’s the right mix of these attributes, given limitations to funding and capacity?
  - What’s the right “health systems technology”?
  - How to best use what we know?
Getting the mix right is important

India’s Janani Suraksha Yojana (JSY) Program – large scale implementation of supply and demand side financial incentives for safe motherhood services

- Recent evaluation showed:
  - “…significant effect on increasing antenatal care and in-facility births”
  - Implementation “…highly variable by state…from less than 5 to 44% of women giving birth receiving cash payments from JSY…”
  - “encouraging” findings regarding perinatal and neonatal mortality benefits, uncertain effects on maternal mortality
  - Concerns about “the need for improved targeting of the poorest women and attention to the quality of obstetric care in health facilities”

[Source: Lim et al, Lancet 375 p 209, June 5, 2010]

- Such incentives are powerful instruments to effect change at scale
- The right mix of expanding access, targeting those most in need, and improving quality (both clinical and administrative) could make a huge difference to outcomes
Linking Strategies for Expanding Coverage to Costs, Effectiveness, and Funding: An example

Note:
1. “Level of subsidy” measured on the y-axis refers to the percentage of the price of the health good procured from private providers that is subsidized by the budget increment.
2. “Level of Education” measured on the y-axis refers to the percentage of the population hitherto unaware of the benefits of the health good that is covered by the budget increment.
3. “Level of access” measured on the y-axis refers to the percentage of transportation and access costs that consumers incur in procuring the good from the public providers that is subsidized by the budget increment.
4. “Level of quality” measured on the y-axis refers to the percentage improvement in the quality of the health good produced in the public sector.

Building up what we need to know

- “Health systems technology” – how do different financing and payment mechanisms, delivery strategies, regulation and behavior change approaches affect access, quality, and distribution
  - More applications, learning better from more experiences
  - Strengthen global information sharing -- clearinghouse
  - Prospective modelling – e.g. MBB, projection models

- Using what we know
  - Widen common understanding of the problem
  - Train health system leaders and managers
    - To better understand health system approaches
    - To better use existing knowledge
    - To encourage creation of new country-based knowledge
Thanks for your attention!

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