The ability of any sector to mitigate the impact of an economic downturn is contingent on the existence of instruments, prior to the downturn, that allow for the identification of the most vulnerable groups, as well as the ability to target interventions toward them. Successful mitigation programs in the health sector have been synchronized with social safety net programs and have used the existing targeting instrument to scale up coverage and ensure the take-up of services, particularly preventive care. At the health care system level, this implies the need to take a long-term approach in order to make the system more resilient. This can also be seen as an opportunity to make the financing and organization of health care more efficient.

The objective of this chapter is to identify successful global experiences in health and related sectors, such as social protection, in order to help countries develop programs that can withstand future economic downturns. Specifically, the chapter analyzes four country case studies that illustrate different mitigation strategies that were successful in minimizing the adverse effects of the recent downturn on health care utilization, especially among poor and marginalized groups.

The Country Case Studies: An Overview

A large number of primary and secondary sources were consulted to identify developing countries whose innovative health care policies were adapted to successfully meet the challenges of economic downturns. This exercise showed that although every mitigation strategy is unique and has a different combination of effects, all successful strategies have two salient attributes. The first attribute of a successful strategy is the specific response or the ability to adapt to an economic downturn. The second attribute is the ability to improve quality of service and/or expand access to the target population.
Mitigation strategies typically focus on one of these attributes. Some attempt to respond to a downturn primarily with efficiency improvements such as changing management practices, staff incentives, and co-payment regimes. Other strategies focus more on increasing the quality and accessibility of health care.

The four countries selected for the study all employed context-specific mitigation strategies that reflected both of these attributes in various combinations.

a. Indonesia’s post-downturn mitigation strategy used existing data on the poor to ensure greater access to the health care system in real time, as the crisis was unfolding. It was successful because of strong political will and the availability of data.

b. Thailand had reformed its health care system to increase access and treatment for the poor during East Asia’s rapid growth period. These reforms helped mitigate the effects of the East Asian financial crisis on health care utilization. Because of these reforms, Thailand was the only country in which health care utilization did not initially decline when the crisis hit.

c. The Kyrgyz Republic was able to increase health care access and treatment during a succession of economic downturns because of a sustained reform effort to adapt to long-term budget constraints that began in the 1990s. The reforms implemented during and after the economic contraction made it possible to mitigate the effect of budget cuts on the poor. The reforms also ensured that sufficient international donor funds were received to increase health expenditure during the period of contraction.

d. Colombia made sweeping health sector reforms in 1993 that increased the proportion of poorer groups who were insured and subsequently had regular access to the health care system. Most of the studies evaluating the success of these reforms do not explicitly take into account the possible effects of the economic contraction and political instability that plagued the country in the late 1990s and early 2000s. However, the evaluations clearly show an increase in the number of poor Colombians accessing the public health system and demonstrate that economic downturns and political crises are not always barriers to effective structural reforms.

Adapting to an Economic Downturn: Implementing Pro-Poor Health Care in Indonesia

The Asian financial crisis gripped Indonesia in July 1997 and escalated into a full economic and political crisis by May 1998, as the country’s gross domestic product (GDP) declined by 14 percent over the duration of the downturn (1997–99) (Rana 1999). The downturn caused a set of demand and supply-side shocks that, if left unaddressed, would have caused steep declines in health care utilization and expenditure, especially among marginalized groups.
Specifically, the financial downturn had the following direct economic effects:

a. Massive devaluation of the rupiah. The currency was worth 20 percent of its trade-weighted value by the end of 1998, which resulted in inflation (80 percent in 1998) and made the importation of health care products significantly more expensive (Levinsohn, Berry, and Friedman 2003).

b. Rapid contraction in employment conditions. The unemployment rate surged past 15 percent in 1998, with more than 8 million people losing their jobs.

c. Increase in the poverty rate from 11 percent before the crisis to 18–20 percent postcrisis (Saadah, Pradhan, and Sparrow 2001).

The effects of the economic downturn resulted in a significant decrease in health care expenditure by households and the public sector. This decrease is evidenced by the following statistics:


b. There was a 9 percent reduction in public health spending due to decreased revenue from 1997 to 1998 (Knowles and Marzolf 2003).

c. Household expenditure allocated to health care declined by 16 percent, from 1.9 percent to 1.6 percent of total household expenditure, during the same period (Frankenberg, Thomas, and Beegle 1999).

Given the rapidly declining level of health care utilization associated with the downturn and the political instability caused by the economic collapse, the Indonesian government launched the Indonesian Social Safety Net Program (Jaring Pengaman Sosial Bidang Kesehatan, or JPS-BK) in August 1998. One of the critical components of the program was the scaling up of a previously minor program, the Health Card program (Saadah, Lieberman, and Juwono 1999).

**Design and Implementation of the JPS-BK: The Health Card**

The Health Card program was effectively a targeted price subsidy, as all household members who received the card were entitled to subsidized care by public health care providers (Yazbeck 2009). It entitled users to “free services at public health care providers consisting of: (a) outpatient and inpatient care; (b) contraceptives for women; (c) prenatal care; and (d) assistance at birth” (Sparrow 2008).

The Health Card program existed prior to the Asian financial crisis. However, its uptake was negligible and lacked robust assessments as to whether the program was in fact successfully targeting low-income groups (Sparrow 2008). The decision to massively scale up the program was aimed at increasing access of financially distressed and marginalized households to public health care.

The distribution of the Health Cards was strategically focused on the poor. Public providers in the local communities identified as likely to receive a surge in demand for services were given additional funds. Specifically, primary health
centers (puskesmas) and village midwives (bidan di desa) were given an additional US$29 million for FY98 (Sparrow 2008). Although this amount was not sufficient to cover all of the new demand created by the expansion in coverage, it helped to ensure that the quality of treatment would not be significantly affected by increased health care utilization.

Pro-Poor Targeting in Times of Downturn

Given how quickly the targeted scheme was scaled up and rolled out, the JPS-BK program followed a two-pronged strategy to ensure that it reached the poorest groups:

First, funds were targeted according to the results of a prosperity index of 307 districts (urban Kota and rural Kabupaten). The index classified a household as poor if it failed to meet one or more of the following criteria (Yazbeck 2009):

a. Have freedom to worship
b. Eat two basic meals a day
c. Have different clothing for different occasions school/work and home/leisure
d. Have a home floor that is not earthen (Sparrow 2008)

Second, the distribution of Health Cards was guided by local health officials and community leaders who could apply their knowledge to target pro-poor groups within their specific communities.

The program followed a partly decentralized targeting process, involving both geographic and community-based targeting instruments. It was, however, not perfect in its execution. In hindsight, policy makers may have wished to have made the following modifications to the Health Card distribution process—assuming their objective was to ensure pro-poor targeting:

a. The use of household expenditure data to determine who was poor. The prosperity index is correlated to indicators of poverty, but it is still a proxy indicator and therefore a more noisy measure of who can be classified as poor. Ideally, a more efficient measure of the poverty headcount could have allowed for even more efficient targeting. However, given the speed with which the program needed to be rolled out, the prosperity index was the most appropriate up-to-date indicator available at the time.

b. The use of local elites to make distribution decisions. Allowing local officials to make decisions about distribution of Health Cards resulted in some leakage to higher-income groups. However, the majority of cards were distributed to lower-income groups (Galasso and Ravallion 2005).

Impact: Sustaining the Social Safety Net

By February 1999, 22 million Indonesians, or approximately 10.6 percent of the population, had received the Health Card. By 1999 the incidence of Health Card ownership was clearly skewed toward the poorest groups: 93 percent of those in the poorest quintile (the 20 percent of the population classified as poorest) had
received the Health Card (figure 4.1). This suggests that despite reliance on the prosperity index, the rapid scale-up of coverage, and the discretion of local elites in distributing the cards, the program was moderately successful in increasing the coverage of marginalized groups, even though a majority of them still remained outside the formal health care system. However, almost 4 percent of the wealthiest Indonesians also received a Health Card.

The success of the targeting becomes more mixed when examining the percentage of total cardholders in each income quintile, rather than the incidence of card ownership by income group. Figure 4.2 shows that although 34 percent of the cards did reach the poorest quintile and 60 percent reached the two lowest quintiles, a very large 40 percent went to the top three income quintiles.

Nevertheless, considering that the scheme was scaled up during and immediately after an economic and political crisis in one of the largest developing countries in the world, its relative success should not be dismissed. At the very least, the results suggest that it is possible to implement, albeit imperfectly, a pro-poor health mitigation program in a very short period of time despite significant economic, political, and geographical obstacles.

Despite the limitations noted, the rapid scale-up of the Health Card program helped to ensure that the fall in health care utilization caused by the economic crisis was partly reversed.

Outpatient visits to all types of medical facilities (public, private, and modern) declined among all poor households between 1997 and 1998, but among the subset of households that received Health Cards, this trend was reversed by 1999 (figure 4.3). Conversely, outpatient visits continued to decline among households that had not obtained the cards. Among cardholding households,
although outpatient visits in 1999 had not recovered to their pre-crisis levels, there was a notable recovery in the use of public sector outpatient services (5.3 percent in 1999 versus 5 percent, on average, in 1998). There was also stabilization in the use of modern facilities (Sparrow 2008) (at 10.5 percent). As the Health Card did not cover private sector facilities, it is not surprising that
the rate of utilization continued to fall, from 6.1 percent in 1998 to 5.8 percent in 1999, in households with Health Cards. However, in poor households without the Health Card, the decline in utilization continued unabated over the one-year period, with public sector outpatient visits declining from 5.0 percent to 4.8 percent in 1999, and the use of modern outpatient services declining from 10.5 percent to 9.9 percent.

Further, as shown in figure 4.4, cardholders in the 3rd and 4th quintiles were more likely to make use of the card when visiting a facility than were cardholders in the two poorest quintiles.2 There is evidence that middle-income groups are more likely to utilize the Health Card because they have better access, in terms of physical proximity, to public health facilities. Therefore, in order to make the scheme more pro-poor, it would have been necessary to ensure better access to public health care facilities by reducing the transportation costs that limit the poor’s access to health care (Sparrow 2008).

**Limitations**

The Health Card program faced the following limitations (adapted from Sparrow 2008):

a. Evidence shows that patients who received treatment using a Health Card received a poorer quality of service compared with other patients.

b. Approximately one-third of Indonesian Health Card users did NOT present their cards when attending an eligible health care institution.

c. Due to the imperfect distribution of the Health Card to the poor as well as barriers to accessing the health centers, the effect of the program on health care utilization by marginalized groups was more limited than the successful dissemination of the cards would have otherwise ensured (Johar 2009).
Lessons and Recommendations

According to the International Labour Organization, in 2005, the Health Card program was modified in order to increase its reach and effectiveness (ILO 2008). Specifically, the Health Card began to be issued by Askes, with the government paying premiums on behalf of cardholders. This program was also designed to be expanded quickly. Two targets were specifically established to aid the rapid expansion of the program. The first phase of the expansion, January–May 2005, established a target of reaching 36.1 million people, which was equivalent to 17 percent of the total population and equivalent to the estimated number of people in absolute poverty in the country. As in the initial program, districts were allocated cards based on the estimated number of poor. Local authorities provided lists of qualifying individuals to Askes branches. During the second phase, June–December 2005, a higher target of 60 million was set and a simplified transfer of funds, directly from the Ministry of Finance to health care clinics rather than through Askes, was developed to maximize efficiency. Despite lingering problems in identifying and reaching the poor, by 2007 the program covered more than 76.4 million people (ILO 2008).

Prior to the Asian financial crisis, the Indonesian Health Card scheme was a minor program designed to help marginalized groups gain access to health care. The onset of the Asian financial crisis in 1997 and its associated political after-shocks, including the fall of the Suharto regime in May 1998, created an adverse environment in which health care utilization fell by more than 9 percent during 1997–98.

The massive scaling-up of the Health Card program during this period was no small accomplishment. Access to the Health Card did not fully compensate for the effects of the crisis, but it did stop and begin to reverse the fall in health care utilization among the poorest groups. Despite the pro-poor distribution objectives, more than 40 percent of Health Cards were distributed to middle- and upper-income groups, who were more likely to use the Health Card than the poorer groups.

Coverage Expansion during the Economic Boom Time: The Case of Thailand

Access to health care institutions in Thailand has been closely linked historically to economic growth. In 1963 politically powerful civil servants were the first to receive medical benefits through insurance schemes designed to target the formal sector. Insurance schemes designed to target the rural poor officially commenced in the 1970s (Wibulpolprasert 2010). The end of the Vietnam War and political instability in neighboring countries, coupled with fast economic growth in the 1980s, resulted in an expansion of insurance schemes. For example, in 1981 the voluntary health card was introduced, and concerted efforts to train and retain medical professionals commenced. The effectiveness of government reforms and expansion was limited because of persistent corruption, especially with respect to construction contracts and
pharmaceutical procurement (Wibulpolprasert 2010). Furthermore, while economic growth reduced the level of absolute poverty from 23 percent in 1988 to 11 percent in 1996, growth was accompanied by exacerbated inequality, which created new challenges in the implementation of successful social protection programs (Wibulpolprasert 2010).

Both health sector and social protection programs expanded quickly with the support of the government. Yet, at the time of the Asian financial downturn in 1997, Thailand did not have a comprehensive and universal social protection scheme (World Bank 1999).

The crisis had a significantly adverse effect on the Thai economy and resulted in severe public expenditure restrictions. Specifically, the downturn had the following effects:

a. GDP growth slowed significantly, from an average rate of about 7–9 percent in the late 1980s and early 1990s to 0.6 percent in 1997 and a contraction in 1998 (Supakankunti 2000).

b. The Thai baht fell by more than 70 percent, which resulted in inflation of more than 10 percent.

c. The unemployment rate more than doubled, from 2 percent in 1996 to 5 percent in 1998 (Supakankunti 2000).

d. Real wages fell by almost 6 percent with a disproportionate loss of income among poor members of society (World Bank 1999).

This economic downturn resulted in the following adverse effects on health care utilization:

a. Medical drugs and devices became more expensive. The cost of domestically produced drugs increased by 12–15 percent, and imported drug prices rose even faster at 18–20 percent during 1997–98 (World Bank 1999).

b. Budgetary restrictions grew due to falling revenue and rising demands for social services. Specifically, the health care budget was slashed by 15 percent in 1998 and by just under 1 percent in 1999.

To minimize the impact of the downturn on actual health utilization, most cuts focused on capital expenditure, although substantial cuts were also made to many programs, including HIV/AIDS treatment and antitransmission programs.

Despite these constraints, the expansion of coverage during the boom period meant that Thailand was one of the few countries affected by the Asian financial crisis in which health care utilization did not decline during 1997–98. In fact, outpatient visits to public health facilities increased by 22 percent between 1996 and 1998 (Waters, Saadah, and Pradhan 2003). Several studies have found that the increase was due in part to the expansion of the Health Card program. The program made access to public health facilities more affordable to households, especially poor households, during the crisis (Waters, Saadah, and Pradhan 2003).
Further, the program received financial support from the development agencies during the crisis, which enabled it to increase provision to poor groups during the downturn.4

**The Health Card: Better Health?**
The Ministry of Health introduced the voluntary Health Card in 1983. The program goal was to enable poor households to access health services. The purchase of a card enables up to five members of the same household to obtain care at public health institutions at no additional expense. The Health Card provides coverage for outpatient and inpatient care, as well as maternal and child care services (Supakankunti 2000).

In 2000 the average cost of an annual voluntary Health Card was 1,000 baht, half of which was covered by the government. This subsidy made the program affordable and attractive for lower- and middle-income households. The card did not provide coverage for privately run medical institutions. This restriction seems to have virtually eliminated leakage to wealthier groups, although data on the demographics of cardholders are not always reliable. More recent studies, such as one conducted in the rural Khon Kaen province, have found that proxies for household poverty are generally good indicators of whether a household purchased a Health Card (Supakankunti 2000). As in Khon Kaen province, Supakankunti (2000) found that on average, the household income of a card-owning household was approximately 50,000 baht, or 12,000 baht less than non-card-owning households (average income 62,000 baht), and this difference was highly statistically significant (at the 1 percent level). However, statistical analyses have generally found that the best predictor of whether a card is purchased is not income, but rather the presence of illness and/or the existence of nearby health facilities. This suggests that the structure of the program incentivizes adverse selection (Supakankunti 2000). Furthermore, when it comes to utilization of health services, Health Card holders who access public hospitals have a lower income than non-cardholders who access public hospitals, but this difference is not statistically significant once other factors are controlled for. This suggests that while the initial distribution of Health Cards is relatively pro-poor, the actual use of Health Cards is by no means restricted to the poorest groups in society. Middle-income groups who own cards are just as likely to use them as their poorer peers (Supakankunti 2000).

**Impact: What Has the Health System Contributed to Health Improvement?**
The purchase of Health Cards increased 60 percent during the Asian financial crisis, from approximately 5 million in 1996 to 8.6 million in 1998. Outpatient visits doubled from just under 11 million to just under 21 million during the same period (figure 4.5).

Empirical analyses have generally concluded that the expansion of this affordable program was one of the key factors in preventing the crisis from having a negative impact on health care utilization (Waters, Saadah, and Pradhan 2003).
This finding was in stark contrast to the experience of Indonesia and other affected countries, where patient utilization declined as the crisis took hold.

**Limitations: Agenda Setting for the Future**

Despite its success, the Health Card scheme was criticized because it did nothing to ensure the quality of services. Moreover, the best predictor of Health Card purchase was the anticipation of illness rather than any measurable socioeconomic indicators.

**Lessons and Recommendations**

Despite the relative success of the program, it did not provide universal coverage. Marginalized groups remained uninsured and dependent on out-of-pocket payments to access health care. Following the election of Prime Minister Thaksin Shinawatra in 2001, the card was replaced by a universal health scheme in 2002. The scheme automatically enrolled all uninsured Thais, approximately 18.5 million of a total population of 62 million, and provided treatment for a flat 30 baht fee per visit (Towse, Mills, and Tangcharoensathien 2004). The experience of utilizing the Health Card, especially in rural areas, made it easier to roll out this larger plan (Towse, Mills, and Tangcharoensathien 2004).

By continuously expanding access to health care through various insurance schemes, Thailand did not experience a decline in health care utilization during 1997–98 (Waters, Saadah, and Pradhan 2003). The evidence suggests that this was due in no small part to the existence and expansion of the Health Card program in the preceding years. While the targeting toward the poor was not perfect, the program was broadly successful in protecting access to the health care system for lower-income groups.
Adapting to a Protracted Downturn: The Case of the Kyrgyz Republic

Following the collapse of the USSR and the subsidies it provided, the Kyrgyz Republic suffered a protracted five-year recession from 1991 to 1996. Per capita GDP declined by an astounding 40 percent. In such a context, policy makers had to increase the efficiency of public service provision in order to try to maintain standards in a constantly contracting budgetary situation. By pursuing a successful round of reforms that enhanced both efficiency and equity, the Kyrgyz health care system was in a good position to receive international aid to soften the impact of the financial crisis that started in 2008 (World Bank 2008). The example of the Kyrgyz Republic provides evidence of the policy options available to decision makers in times of extreme and persistent economic distress.

The Recession and Health Reforms

The 1991–96 recession resulted in a massive decline in health expenditures—from 3.6 percent of GDP in 1991 to 1.9 percent of GDP by 2000—a 47 percent decrease in expenditure (World Bank 2008). Compounding this dire downturn was that the majority of health care expenditure, 75 percent, went to administrative costs, leaving few resources for actual patient care (Purvis et al. 2005). Since the collapse of the Soviet Union, the Kyrgyz economy has been adversely affected by the Asian financial crisis (1997–98), a winter crisis and drought in 2008–09 (UNDP 2012), and the current economic downturn (2008–12).5

Political instability, which seemed to plague the country, further compounded these economic downturns. The instability culminated in April 2010 with uprisings by protesters against the incumbent president Kurmanbek Bakiyev and his ultimate ouster. The transition was ultimately successful, but the violence (more than 1,000 injuries), displacement (more than 400,000 people), deaths (at least 100), and political uncertainty it engendered did not, initially, facilitate the stabilization of the country, even though it did provide a possible basis for further reforms (UNDP 2012).

Due to the shortage of funds, in 2008 the average out-of-pocket expense faced by a typical patient was the equivalent of US$46. This amount was five times the average monthly level of individual consumption. In effect, more than 50 percent of health care expenditure in the country was raised by out-of-pocket payments, with patients contributing to the cost of medicines, equipment, and the salaries of health care professionals (Kutzin 2001). As a result, health care was unaffordable for a large percentage of the population (Yazbeck 2009).

In 2001 the Kyrgyz Republic began implementing a five-year health system reform program. The “Manas Health Sector Reforms” were part of a 10-year reform program aimed at increasing the efficiency of the health system and reducing out-of-pocket expenses, especially for the poor (Yazbeck 2009).

The main logic behind these reforms was to split the purchase and provision of services in order to realize efficiency gains. The Mandatory Health Insurance
Fund (MHIF) would become the main purchaser of individual health insurance, which was financed by general taxation and payroll taxes. The main elements of the reform were:

a. Rationalization of Health Financing. Before the reforms, there had been separate health care financing schemes at the national, regional, and oblast (district) levels, resulting in duplication and waste. The reform organized financing at the regional level and abolished municipal and city-level resource pools. It was hoped that such a reform would allow for the more efficient allocation of resources across oblasts.

b. Consumer-Focused Purchasing Methods. Prior to the reforms, providers had been paid based on input criteria and line-item budgeting. Managers had little leeway to shift spending across line items. By shifting to capitation and case-based payments to hospitals, based on actual demand, the reforms aimed to create incentives for resources to be focused on the needs of patients (Yazbeck 2009).

c. A More Transparent Benefits Regime. By clearly defining services covered under the benefit package and introducing a flat co-payment regime, reform aimed to displace informal payments, which had become highly regressive. Furthermore, because hospitals would receive higher payments for treating the uninsured (mostly the poor), this reform was expected to enhance equity of access.

d. Downsizing the Hospital Sector. By reducing the number of hospitals from 1,464 to 784, the reforms potentially could have increased barriers to health care. However, by focusing on eliminating inefficiencies (excess administrative costs and duplication of services), the reforms aimed to free up more resources to finance patient care. As a result of this reform, the percentage of the health budget devoted to administration fell below 75 percent for the first time since independence.

Impact: Effective Reform Can Attract Funding for Continued Reform

As the reforms were rolled out sequentially in different oblasts, it was possible to identify the impact of the reforms across the country and over time. By carrying out a baseline survey in all parts of the country before any reforms were implemented, and then conducting a survey when the reforms had been implemented in half the oblasts, it became possible to identify the treatment effect of the reforms. The following effects were identified:

a. The introduction of a transparent co-payment scheme resulted in a slower growth rate of out-of-pocket expenses, which grew by only about US$5 in reformed oblasts, compared to US$15 in unreformed oblasts, between the years 2000 and 2003 (World Bank 2008).

b. In particular, out-of-pocket expenses declined for low-income groups in reformed oblasts, compared to a slight increase with out-of-pocket payment in unreformed oblasts.
c. At the district level, there was an 84 percent reduction in nonmedical expenditures among reformed oblasts between the years 2000 and 2003, which resulted in the release of extra funds for medical care.

d. The initial success and effectiveness of the health reforms, coupled with continued political support, made it easier to attract external funding from international development agencies prior to and after the subsequent economic downturn (box 4.1). Although the economic downturn resulted in a dramatic decrease in public health expenditure in 2008—from 3.2 percent of GDP in 2007 to 2.7 percent in 2008—this decline was more than compensated for by 2009 (figure 4.6). Expenditure rose to 3.5 percent of GDP as a result of donor support coupled with deficit spending by the government (Mogilevsky et al. 2011).

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**Box 4.1 Effective Reform in the Kyrgyz Republic Attracts International Donors**

The decline in resources devoted to health, coupled with the first stage of the Manas reforms, attracted resources from international donors. In 2004, 10 donors, led by the International Development Association, adopted a sectorwide approach (SWAp) focusing on health expenditure (the first of its kind in the Europe and Central Asia region). In return for continued government commitment to expand the Manas reforms, the donors agreed to provide financial support to improve access and ease the effects of the sharp economic downturn on health care utilization. As recent evaluations have shown, both the SWAp and the Manas reform schemes have been successful in reducing the financial barriers to health care access. In short, reacting to the effects of an economic downturn by increasing efficiency, the Kyrgyz health care system was able to attract financial support from abroad to ease the budget burden.


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**Figure 4.6 Public Health Expenditure in the Kyrgyz Republic, 2006–09**

![Figure 4.6](http://dx.doi.org/10.1596/978-1-4648-0060-3)
**Limitations: Dependence on Donor Support**

The reform programs did not address the lack of qualified medical professionals, whose numbers have been declining since before the collapse of the USSR. This deficit could result in severe cost and access problems in the future (International Crisis Group 2011). Moreover, given the significant budgetary constraints and dependence on donor support, the gains from the reforms remain vulnerable to changes in donor priorities (Mogilevsky et al. 2011).

**Lessons and Recommendations**

The relative success of the health reforms provided incentives for development partners to support the Kyrgyz health care system during the current economic downturn. The example of the Kyrgyz Republic demonstrates that even when faced with a severe and protracted budgetary crisis, the pursuit of reforms can directly mitigate the adverse effects on health care utilization and show a commitment to reform that attracts partnership and assistance from development agencies.

**Targeting System for Social Programs: The Case of Colombia**

Colombia illustrates how the allocation of resources in a more efficient and equitable manner in a pre-crisis context can mitigate the adverse effects of an economic downturn. Colombia’s 1993 reforms to the health care system helped to reduce the system’s vulnerability to crisis by expanding access and efficiency of the system, and reducing the need for out-of-pocket payments. The reforms further established a versatile and sophisticated mechanism—the Selection System of Beneficiaries for Social Programs (SISBEN)—for identifying and potentially targeting the poor.

According to the Colombian Constitution (1991), public health care provision is a constitutional right:

> Public health … [is a] public service for which the state is responsible. All individuals are guaranteed access to services that promote, protect, and rehabilitate public health. It is the responsibility of the state to organize, direct, and regulate the delivery of health services … to the population in accordance with the principles of efficiency, universality, and cooperation.

Despite this formal mandate, before the 1993 reforms, the health care system in Colombia was characterized by low efficiency, lack of access by the poor, and large out-of-pocket payments (Escobar et al. 2010).

In fact, barriers to health care access among the poorest groups were so significant that, in 1992, only one in six people sought medical care when they became ill. Of all those treated in public hospitals, only 20 percent came from the poorest quintile, with middle-income groups being responsible for more than 60 percent of public health care utilization (Yazbeck 2009). As figure 4.7 indicates, the lack of private health insurance resulted in further inequity because 91 percent of the poorest quintile made out-of-pocket payments as compared to 69 percent of richest quintile users (Escobar 2005).
Learning from Economic Downturns

The Reforms: Using Proxy Means Testing to Expand Health Insurance

By focusing on mitigating inefficiencies in the management of health care resources, the 1993 Colombian health care system reforms represent one of the most ambitious attempts by a developing country to expand health care access, especially for marginalized groups.

The efforts were predominantly focused on governance reform or changing how the health care system worked, not just on expanding access. This mix of reforms represents a contrast to many reform programs around the world that focused exclusively on expanding access to health care without significantly altering the governance of the health care system (Miller, Pinto, and Vera-Hernández 2009).

The 1993 health care sector reforms improved the access to and quality of health care received by the poor by establishing an income threshold. Those citizens whose income fell below the threshold were eligible for a fully subsidized health insurance scheme (Miller, Pinto, and Vera-Hernández 2009). Quality of care was improved as insurance agents were allowed to allocate funding or purchase health care from different providers, thereby enabling them to avoid hospitals that were likely to provide poor-quality services.

To realize these changes, Colombia took steps to develop an efficient poverty index, and to shift subsidies from hospitals to patients. The poverty index, SISBEN, was absolutely pivotal in ensuring that households eligible for the subsidy scheme were identified. The SISBEN index included the following measures (Yazbeck 2009):

a. Access to and quality of a household’s living accommodations
b. Access to and quality of essential public services
c. The number of durable goods the household possesses

Figure 4.7 Incidence of Out-of-Pocket Payments for Inpatient Care by Income Group in Colombia, 1992

d. Education attainment
e. Income level

Shifting the subsidy from hospitals to patients was supposed to empower patients to shop for the best-quality treatment by hospitals that made the most efficient use of resources. However, this element of the reform was not fully implemented and its expected positive effects were therefore not fully realized (Escobar et al. 2010).

**Impact**

Between 1992 and 2007, the share of insured Colombians rose from 20 percent to 80 percent of the population (CENDEX 2008). Furthermore, as figure 4.8 indicates, these gains were concentrated among the poorest income groups. Access to health care among the poorest quintile increased especially quickly—from 9 percent of the poorest in 1992 to 49 percent in 2003. This increase resulted in a significantly smaller percentage of potential patients claiming that they could not access health care because of a lack of money (Yazbeck 2009).

The reforms halved the out-of-pocket expenses of the poor. While the uninsured poor spent 8 percent of their income on out-of-pocket expenses in 2003, the insured poor spent only 4 percent.

By 2003 the percentage of respondents in every income group who indicated a lack of money as the reason not to seek health care was significantly lower among the insured compared to the uninsured (figure 4.9). This was particularly true among the lowest income groups.

Furthermore, the creation of the SISBEN index encouraged local municipalities to share information with the central government, thereby facilitating better coordination and distribution of benefits across the country (Yazbeck 2009).

![Figure 4.8 Insured Population by Income Group in Colombia, 1992 and 2003](source: Escobar 2005.)
The reforms increased not only the percentage of the poor who were insured and had access to public health care facilities but also their use of these facilities. Using a matching technique, a recent evaluation study found that the reforms significantly increased the utilization of public health facilities by the poor and previously uninsured (Trujillo, Portillo, and Vernon 2005).

Finally, there is evidence that the scheme significantly reduced extreme expenditures on health care by one-third, thereby reducing the susceptibility of the poor to the effects of income shocks (Miller, Pinto, and Vera-Hernández 2009). The evidence for this is that despite a deteriorating economy (GDP declined by 4.3 percent between 1997 and 1998) and rising unemployment (from 8.5 percent in 1995 to 20.2 percent in 2000), implementation of the program continued to bring health care to Colombians in increasing numbers, even during the period of escalating political violence in the early 2000s (Escobar et al. 2010).

**Limitations**

Despite its success, the impacts of the reforms are of a more limited scope than would have been possible for the following reasons:

a. The complexity of reforms, duplication, and to some extent a loss of political will to implement the reforms over time affected results. This has meant that initial efficiency gains were not as great as hoped. The reforms have not mitigated the issue of strong union membership—generating resistance to change and/or the lack of managerial expertise in the public health care system limited the efficient component of the reforms (Escobar et al. 2010). Until resistance from unions to limit reforms is abated and managerial expertise is improved, the ability to realize the full potential of the reforms will remain constrained.
b. In many cases, an individual insurer enjoyed a geographical monopoly, which reduced the efficiency effects that might be associated with competition for patients (Miller, Pinto, and Vera-Hernández 2009).

c. There is evidence that households and local officials may have manipulated the SISBEN index to obtain coverage. The scheme generated revenue for the municipalities based on the number of participants. This provided incentive for local government officials to inflate the number of eligible households (Camacho and Conovor 2009).

d. Expansion of the program is conditional on overcoming financial constraints (Yazbeck 2009).

e. Although more insulated from economic shocks than before, the insurance system ultimately relies on payroll taxes and general government revenues, both of which decline during times of crisis.

**Lessons and Recommendations**

The governance and targeted nature of the health reforms undertaken in Colombia significantly expanded the coverage of and access to public health care by poor and marginalized groups. The scheme was not perfect, but the reforms did reduce the necessity of out-of-pocket expenses for the poor seeking health care and thereby increased health care utilization. Further, the scheme was successful despite the onset of an economic downturn in 1997, and the political instability and conflicts from 1995 to 2003 (Escobar et al. 2010). This suggests that over a long period of time, similar reforms can result in improvements in the utilization of health care by the poor despite economic contractions and significant political instability.

**Lessons across Sectors: Health and Social Protection**

The country case studies illustrate that there are numerous methods of mitigating the effects of economic downturns on population health and the health delivery system. Reforms to improve efficiency and increase system resilience are but one way to stabilize and strengthen health sectors. There are ample opportunities for the health sector to collaborate with other sectors to further improve equity and accessibility to health services for the poor and vulnerable, particularly during economic downturns. The country case studies show that countries with social protection systems, particularly the social safety net programs, were able to develop responses more effectively before and during the global economic crisis. Countries that did not have an effective social safety net program found it more difficult to identify and protect the most vulnerable when the economic downturn hit. In light of these findings, the discussion turns to collaboration between the two sectors and the possible benefits.

The social protection sector has become increasingly important over the past two decades among developing countries. The financial crisis in 2008 has
made it even more relevant as it has become one of the key driving sectors in poverty reduction and development. Social protection is seen as “public interventions that assist individuals, households, and communities to manage risk better and that provide support to the critically poor” (World Bank 2001). In response to the financial crisis in 2008, and to better link with essential services, the UN System Chief Executives Board (CEB 2009) established the Social Protection Floor (SPF) Initiative as a joint effort to promote access to essential services and social transfers. An SPF is the first level of a comprehensive national social protection system guaranteeing universal access to essential services, including health services, and providing social transfers to guarantee income and food security. The most recent World Bank social protection and labor strategy paper (World Bank 2012a) stressed that social protection and labor programs “improve resilience, equity and opportunity by helping people insure from different types of shocks, reducing poverty and destitution and promoting opportunity through more investment.” The following discussion focuses more on the social safety net, one of the most important pillars within the social protection system (Robalino, Rawlings, and Walker 2012) because of its close linkage with the health sector and the relevance in mitigating the impact of economic downturns.

The linkages between social safety net programs and health are wide and deep. Social safety net programs directly affect health status. Beneficiaries in social safety net programs, including those in the cash transfer programs or public work programs, receive additional income with which they can purchase more food. The evaluation of some cash transfer programs finds that beneficiaries eat more and eat better (Hoddinott and Skoufias 2004). Social safety net programs can lead to an increase in the use of health services, particularly for women and children when the regular seeking of preventive care is a condition or co-responsibility for receiving cash benefits. This results in greater uptake of preventive health services, which ultimately contributes to a lower infant and maternal mortality rate. Social safety net programs can have a direct impact on the removal of social and economic barriers to basic health services in the form of insurance, cash transfers, or granting direct access to public facilities for the poor and thereby helping to achieve more equitable outcomes in the health sector. Not only does the social safety net directly affect the ultimate goal of health status and risk protection, but also it directly or indirectly interacts with health financing, payment, and delivery systems.

Such close collaboration has manifested in designing and implementing the targeted or government-subsidized health insurance in a few countries. However, based on a 24-country survey in the World Bank Universal Coverage for Health (UNICO), only a minority are using the same targeting approach for the health insurance program as in the social protection targeted programs (World Bank 2012b). This sends a clear message that there is still ample space for further collaboration between the two sectors. Two key areas for intersector collaboration are targeting and integrated systems.
A Targeted Approach to Improving Health

Mitigating the impact of economic crisis on access to health for the poor and the vulnerable can be achieved by providing direct access to health services. Another form of mitigation is to provide the poor and vulnerable with access to some forms of health insurance, so that they can purchase health services. In either case, there is a need for an effective way to identify the poor and vulnerable during or before the economic crisis. The most successful mitigation programs in the health sector are those that are able to link with social safety net programs and use the existing targeting instrument to scale up coverage. Grosh et al. (2008) have laid out different methods for targeting. Table 4A.1 in annex 4A presents the main targeting methods along with the associated advantages and disadvantages.

Integrated System to Improve Efficiency and Effectiveness

There are significant similarities among different types of social programs in the delivery of services or transfers to the poor (Palacios 2013). Today’s technology can enable an effective management information system (MIS) to facilitate inter-sector collaboration and improve the overall governance and transparency of the system. Such integrated systems can assist all the relevant programs including assessing eligibility, identifying and registering beneficiaries, providing information on availability and quality of services, supporting and monitoring delivery of benefits, and facilitating coordination of different programs at different levels (UNICEF 2012).

Integrated systems or database collaboration between the health and social protection sectors would complement targeting by improving identification efforts and ensuring that benefits go to unique individuals. Further, integrated systems help reduce duplicate or ghost beneficiaries and overlap of similar benefit packages. The biometric identification initiative described in Gelb and Clark (2013) is an example that can facilitate such identification.

On the other hand, information and communication technology (ICT) systems also offer new opportunities and challenges for the design and delivery of social programs. The system permits a one-stop shop for all social programs, including social protection programs and health programs, due to its multicapacity to make transactions, transfer cash to beneficiaries, and utilize health services or other forms of social assistance in a more transparent manner. India, for example, uses biometric information integrated smart cards to identify beneficiaries and accomplish cashless transactions when RSBY beneficiaries seek health services in the empanelled hospitals. Overall, encouraging social safety net programs and health programs to share the same database and same identification technology can greatly improve information accuracy, enable effective monitoring and tracking, increase the efficiency and effectiveness in service delivery, and thus ultimately create the desperately needed fiscal spaces and improve the program governance and accountability.
The health sector interacts both directly and indirectly with many sectors and cannot operate within a vacuum. In fact, reticence to collaborate with other sectors would most likely result in inefficiency and ineffectiveness. The continued and increased collaboration between the social protection and health sectors will allow a more inclusive, equitable, and efficient social system for the poor.

**Annex 4A  Advantages and Disadvantages of Different Targeting Methods**

**Table 4A.1** Advantages and Disadvantages of Different Targeting Methods

<table>
<thead>
<tr>
<th>Type</th>
<th>Advantages</th>
<th>Disadvantages</th>
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<tbody>
<tr>
<td>Means tested: Eligibility is based on income. Information on household income and/or wealth are collected and verified.</td>
<td>Rigorous indication of eligibility; administratively demanding.</td>
<td>It usually requires a high level of literacy and documentation of economic transactions; costly to verify the accuracy of the information; it measures the current income, not the more permanent welfare status.</td>
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<tr>
<td>Proxy means tested: Eligibility is based on a score, which is statistically derived from household survey data based on observable characteristics such as location and quality of housing, ownership of goods, demographic structure of household, education of members.</td>
<td>Depending on construction of the score, this method can provide a more multidimensional measurement of poverty; since based on easily observable characteristics, it can be easier to collect than income data; asset indicators (economic, social and human) may better reflect poverty over time, compared to income.</td>
<td>Requires recent and national representative sample for statistical derivation and testing; administratively intensive to collect information required to compute the score; insensitive to the quick change of household welfare; exclusion errors if particular causes of vulnerabilities are not considered in the score formulation.</td>
</tr>
<tr>
<td>Community-based targeting (CBT): Community members are part of the eligibility assessment and/or verification based on assumption that they are familiar with the welfare of the households in the community.</td>
<td>May increase ownership and validation of program and in some contexts strengthen existing community mechanisms; relies on local information on individual circumstances; less costly to collect necessary information.</td>
<td>A subjective targeting method: Local actors may have other incentives besides good targeting of the program; difficult to apply in urban settings; may increase tensions between selected and unselected groups.</td>
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<tr>
<td>Categorical: Eligibility defined based on broad social categories and/or groups such as age, physical ability, gender, ethnicity, social status.</td>
<td>Administratively simple; some specific health services can be better targeted (like immunization).</td>
<td>Verification of status may be a challenge in some cases; may not address structural vulnerabilities and/or impacts of particular risks on families and communities that are not strongly associated with the categories; stigma associated with targeting particular groups.</td>
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<tr>
<td>Geographical: Selection of beneficiaries based on location, often through mapping to identify poorest regions or districts.</td>
<td>Low administrative costs as household level assessment is not required; efficient where poverty or vulnerability is geographically concentrated; have no direct labor disincentives.</td>
<td>Requires sufficiently reliable data to poverty map estimation; can be politically more complicated as geography or vulnerability are correlated with other political or social dimensions; performs poorly if poverty is not spatially concentrated.</td>
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Table 4A.1 Advantages and Disadvantages of Different Targeting Methods (continued)

<table>
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<tr>
<th>Type</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-selection: Program design components (size or type of transfer, timing of benefits, location of payments, etc.) make the program attractive only to specific groups who self-select to participate.</td>
<td>Limited technical capacity required.</td>
<td>The noncoverage and leakage rate could be high; certain self-selection criteria can be stigmatizing or impose heavy costs on participants.</td>
</tr>
</tbody>
</table>

Sources: Based on Grosh et al. 2008; UNICEF 2012.

Notes

1. This term has been defined as “more recently constructed public and private facilities” (Saadah, Pradhan, and Sparrow 2001).

2. While the difference in utilization is not statistically significant, the similarity in the rate of use suggests that, in practice, the Health Card was not as pro-poor as the initial distribution might have suggested.

3. Askes (PERSERO) are organizations that traditionally provide the health insurance schemes of public sector employees.

4. A substantial portion of this development loan was allocated to mitigating the social impacts of the crisis, including providing support for the Health Card (World Bank 1999).

5. Although, unlike many other countries in the region, the current economic downturn did not cause an actual downturn but only an economic slowdown in GDP growth.

6. Original results are from Jakab (2007) and World Bank (2008). Because the rollout of the reforms was not random the baseline survey was absolutely crucial in ensuring that the causal effect of the reforms could be identified.

7. The importance of ensuring countercyclical development aid in order to ensure health care utilization is noted in Schneider (2011).

8. Income was initially included as a variable but was dropped.

9. That is, we do not discuss unemployment, disability, and pension, which all fall under the social protection arena.

10. RSBY (Rashtriya Swasthya Bima Yojna) is a health insurance program for poor households (households below the poverty line) in India.

Bibliography


