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The path to universal coverage

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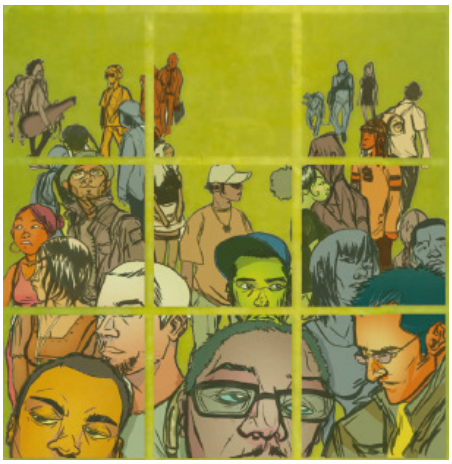

The role of institutional design and organizational practice for health financing performance and universal coverage

World Health Report (2010) Background Paper, No 36

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Abstract

Many low- and middle income countries heavily rely on out-of-pocket health care expenditure, which represents a significant financial burden to households. The challenge for these countries is how to modify their health financing system in order to achieve universal coverage. This paper proposes an analytical framework for undertaking a systematic assessment of the performance of a health financing system on the basis of which to identify adequate changes within the health financing system to enhance its move towards universal coverage.

The distinctive characteristic of this framework is the focus on institutional design and organizational practice of health financing, on which health financing performance is contingent. Institutional design is understood as formal rules, namely legal and regulatory provisions relating to health financing; organizational practice refers to the way organizational actors implement and comply with these rules. Health financing performance is operationalized into nine generic health financing performance indicators.

Inadequate performance can be caused by six types of bottlenecks in institutional design and organizational practice. Accordingly, six types of improvement measures are proposed to address these bottlenecks. By understanding the incentive environment within a health financing system, the potential impacts of the proposed changes can be anticipated.

The framework has been developed deductively by building upon the institutional analysis literature and existing institutional analysis toolkits in the social sectors as well as inductively by feeding back empirical evidence from initial country applications.

The institutional design of a health financing system can be actively developed by modifying legal and regulatory provisions. Organizational practice can be improved through strengthening organizational capacity and enforcement practices.

1 Introduction

Common to many countries is their concern to establish a health financing system that enables them to move towards universal coverage - defined by WHO as access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access (WHO, 2005). This is particularly the case for low- and middle income countries, in light of their heavy reliance on out-of-pocket (OOP) health care expenditure, which represents an important financial burden to households. The challenge is how to improve a health financing system in order to move towards and achieve universal coverage as an overall desired policy goal.

Despite obvious need, some countries may not undertake health financing reforms. In some others, changes in the health financing system may turn out to be inappropriate, sometimes with undesired or even counter-productive effects, despite good intentions and political commitment. Better understanding of the core challenges of a country's health financing system as well as its surrounding context is the starting point for conceptualizing sound health financing reforms or improvement measures with better outcomes for universal coverage. Such measures may range from incremental modifications (e.g., raising provider remuneration rates), to revised policy instruments and mechanisms (e.g., replacing a payment mechanism with another) to policy changes and larger reforms (e.g., moving from a tax-based health financing system to a social health insurance scheme or vice versa). Changes in health financing are the outcome of complex political processes and negotiations. However, prior and during such processes, it is necessary to search for the technically most appropriate measures to improve health financing in order to inform the policy making process.

This paper proposes an analytical framework to undertake a systematic assessment of an (existing) health financing system on the basis of which to identify measures to improve its performance in order to move towards universal coverage. There exist a number of conceptual and analytical frameworks that serve to assess a health financing system (cf. WHO, 2000; Islam, 2007; Kutzin, 2001; Kutzin, 2008; Carrin & James, 2005 for social health insurance schemes). Building upon this work, the distinctive characteristic of the analytical framework proposed here is its explicit focus on institutional design and organizational practice of health financing.

The framework has been developed deductively by building upon the institutional analysis literature (cf. North, 1990; Ostrom, Gardner & Walker, 1994; DiMaggio & Powell, 1991) and institutional analysis toolkits in the social sectors (WB, 2003; Mathauer, 2001; Mathauer, 2004) as well as inductively by feeding back empirical evidence from initial country applications (cf. Mathauer, Xu, Carrin & Evans, 2009; Antunes, Saksena, Elovaino, Mathauer, Kirigia, Musango et al., 2009; Mathauer, Cavagnero, Vivas & Carrin, 2010).

The article is organized as follows: Section 2 provides a conceptualization of health financing performance. Section 3 discusses the role of institutional design and organizational practice and their link to health financing performance. Weak health financing performance is caused by various bottlenecks in institutional design and organizational practice, which are explained in Section 4. Section 5 outlines how to identify appropriate changes in institutional design and organizational practice to address bottlenecks and improve health financing performance. Feasibility considerations relating to planned changes are presented in Section 6. This is followed by a summary of the analytical process steps (Section 7) and conclusions (Section 8).

2 Conceptualizing health financing performance

Any health financing system is based on three key health financing functions to achieve the following objectives: 1) *resource collection* to ensure sufficient and sustainable revenues in an equitable way; 2) *pooling of funds* to ensure that costs of accessing health care are shared thus ensuring financial accessibility; 3) *purchasing/ provision* to ensure that funds to buy and provide health care services are used in the most efficient and equitable way (Kutzin, 2001; Carrin & James, 2005). Achievement of all three health financing objectives ultimately contributes to reaching the policy goal of universal coverage (WHO, 2005).

The three health financing objectives can be made further operational. We introduce nine generic health financing performance indicators that are applicable to all types of health financing systems. This builds upon Carrin & James' (2005) work on social health insurance-related performance indicators. Table 1 presents these indicators with their detailed operationalization and guidance which way these indicators should develop for the purpose of universal coverage.

The rationale of the performance indicators is derived from core values of equity in health, solidarity and social justice (WHO, 2008) as well as the objective of using resources as efficiently as possible (WB, 1993; WHO, 2005). Cross-country evidence of health financing systems with universal coverage and existing practice also helps to define some of the indicators (see also references and further observations in Table 1).

Yet, the indicators are not meant for cross-country comparison or ranking. Their purpose is to assess the performance of a given country's health financing system. As such, performance comparisons can be carried out within a country over time and particularly after changes within the health financing system were introduced. Performance may be described as "inappropriate" when a country fails to achieve the levels of health financing performance it could potentially attain, given its resources and priorities. In practice, countries may choose different sets of indicators in line with their political and societal preferences such as their notion of solidarity and equity, their income level and the overall level of financial affordability. Furthermore, countries may not always be in the position to pursue all of the performance indicators simultaneously. Particularly in resource-restricted contexts, it may be difficult to extend both population coverage as well as the benefit package simultaneously. In view of all these considerations, countries may also want to progress via interim stages towards universal coverage. The development of country-specific (intermediate) targets, however, requires a thorough understanding of the current strengths and weaknesses of the health financing system in order to assess its potential for improvement. The foundation for this understanding and the proposed framework is outlined in the next section.

Information to assess quantitative indicators (numbers 1-5, 9 in Table 1) comes from national health accounts, household income and expenditure surveys, ministry budgets, insurance statistics and claims data as well as other country statistics. The qualitative indicators (numbers 6-8) can be gauged through document review as well qualitative interviews with key health financing stakeholders.

Table 1: Health financing performance indicators and their operationalization (more detailed indicator operationalizations are listed in *italics*.)

Health financing performance indicator		
Operationalization	**Guidance**	**Further observations**
1. Level of funding		
▪ THE p.c. (Total Health Expenditure per capita) ▪ THE/GDP (Gross Domestic Product) *Time trends & comparison with similar countries* *· GGHE p.c. (General government expenditure on health)* *· GGHE/THE* *· GGE/GDP (General govt. expenditure) (fiscal space)* *· GGHE / GGE (fiscal space for health)* *· External funding for health / THE (donor dependency)*	↑ for low income countries	Costs to provide a package to reach MDGs and strengthen health systems: 54 US$ p.c. (2005 prices) (HLTF, 2009) Average THE p.c. (in PPP int. US$) in countries of: AFR[a]: 147 AMR[b] 771 EMR[c]: 402 EUR[d]: 1818 SEAR[e]: 640 WPR[f]: 183. Average THE as a share of GDP in low middle-income and low-income countries is 4.8% and 4.6% respectively (Durairaj, 2010) [g] *GGHE/GGE ≥ 15% for Africa (OAU, 2001).* *High donor dependency may reveal a concern for financial sustainability.*
2. Level of population coverage		
▪ % of population covered by a financial risk protection mechanism. (This means that a person is not put at financial risk due to the costs of care.) *Differentiated by quintiles/population groups:* ▪ *% of people covered by a financial risk protection mechanism in each quintile or population group*	100% *Equal population coverage across quintiles or population groups*	Cf. Carrin & James (2005) [h]
3. Degree of financial risk protection		
▪ Prepayment ratio [i]: GGHE/THE (in %) ▪ % of households experiencing catastrophic expenditure in each scheme [j] ▪ % of households impoverishing through out-of-pocket expenditure on health (OOPs) *Differentiated by quintiles/population group:* ▪ *% of households experiencing catastrophic expenditure in each income quintile/population group* ▪ *% of households impoverishing through OOPs in all income quintiles/population groups*	≥ 70% 0% 0% *0% in all quintiles/population groups* *0% in all quintiles/population groups*	The average prepayment ratio among OECD countries is 72.5% (OECD data from 1990-2006); the minimum and maximum for 2006 is 44.2% and 90.9% respectively. 21 OECD countries have a prepayment ratio ≥ 70% since 2000 (cf. Carrin & James, 2005). [k] Average THE minus OOPs as a share of THE is ≥ 79% in OECD countries (data from 1990-2007). Countries with an OOP share below 15% have few households experiencing catastrophic expenditure (cf. Xu et al., 2003). Note that so far no OECD country has a percentage of 0% households, but the share is

		below 1% (cf. Xu et al., 2007).
4. Level of equity in health financing		
▪ Total and specific health financing payments (e.g. taxes, contributions, insurance premiums, co-payments, out-of-pocket expenditure for health) / household income	Health financing payments as a share of non-food consumption is equal across all households.	cf. WHO (2000) *How to assess:* Analysis of household survey data, or else approximation through available data on tax burden and share in national income per quintile, OOPs per quintile and insurance contribution rules.
5. Level of pooling across the health financing system		
Health care spending per pool member set in relation to overall health risks of pool members	Equal health care spending per pool member across pools when set in relation to health risks of pool members.	Health risks are determined by sex, age, HIV/ AIDS status, epidemiological and poverty profile of district, distribution of chronic diseases.
Within health financing schemes: ▪ *Link between resource allocation to sub-pools and health care needs/ costs.*	*Resource allocation to sub-pools aligned with health care needs/costs*	*How to assess:* 1st step: estimate health care spending per member: divide estimated total health care spending per pool by estimated number of pool members. 2nd step: Compare average pool spending per member with overall health risk profile of pool members. Higher health risks should go hand in hand with higher average spending per pool member.
6. Level of operational efficiency and **7. Level of equity in the delivery of a given benefit package[l] at a given level of quality standards**		
For each health financing scheme: ▪ Absence of over-provision (e.g. providing too many services and medicines, up-coding), under-provision (e.g. providing too few services and medicines, or of substandard quality), cost-shifting, cream-skimming	No indications for and minimized incentives set by provider remuneration systems for over-/under-provision, cost-shifting and cream-skimming; Outpatient and inpatient utilization rates in line with regional trends; Service quality in line with the country's quality standards; Remuneration rates cover costs and provide appropriate pay to health workers.	Cf. Carrin & James (2005) *How to assess:* Qualitative analysis through discussion with purchasers and providers, as well as assessment of incentives set by provider remuneration schemes.
▪ Absence of over-consumption and under-consumption of services in relation to real health needs	No indication of and minimized incentive for over-consumption, and mechanisms to avoid under-consumption in place (e.g. differentiated copayments, patient appeal mechanisms); Health care seeking rate as a percentage of illness reporting rate is equal across population groups/quintiles; Utilization rates equal across quintiles when accounting for health care needs, and not lower for poorer quintiles.	See also explanations under indicator No. 5

8. Degree of cost-effectiveness and equity considerations in benefit package definition		
For each health financing scheme: ▪ Cost-effectiveness and equity considerations as part of benefit package definition logic.	The benefit package fulfills cost-effectiveness and equity considerations. Cost-effectiveness analyses are being undertaken or its results are being considered;	cf. Carrin & James (2005) *How to assess*: Analysis of actual contents of the benefit package in order to check, inter alia, for services addressing chronic diseases and the disease burden of the poor, services with positive externalities, preventive health services or those with demonstrated high cost-effectiveness.
9. Level of administrative efficiency		
▪ Total administrative costs for all health financing schemes as a share of total health expenditure	↓	The average from National Health Accounts data for low- and middle income countries for 2008 is < 8%, with similar averages since 1995 (WHO 2010).

[a] AFR=African Region; [b]AMR=American Region; [c] EMR=Eastern Mediterranean Region; [d] EUR=European Region; [e] SEAR: South-East Asian Region; [f] WPR: Western Pacific Region, of the World Health Organization.

[g] Recommendation by WHO SEARO/WRPO (2010): THE/GDP > 4-5% for countries in the Asia Pacific region.

[h] Recommendation by WHO SEARO/WPRO (2010): Population coverage > 90% for countries in the Asia Pacific region.

[i] Here, the prepayment ratio is understood as the share of GGHE in THE rather than THE minus OOPs as a share of THE. The former implies a higher degree of pooling among the population and (quasi-)government organization or regulation. The latter also involves private, voluntary prepayment, with a lower degree of pooling of health risks and across different income groups.

[j] Catastrophic expenditure occurs with health care payments at or exceeding 40% of a household's capacity to pay in any year (Xu et al., 2003).

[k] Recommendation by WHO SEARO/WPRO (2010): THE minus OOPs > 60-70% for countries in the Asia Pacific region.

[l] Here, the term benefit package is used in a generic way, referring to a specified package of services, as defined by a health financing scheme. This means that the scheme promises to secure the provision of these services to its member population or that it ensures the reimbursement of a part of the costs of these services.

3 The importance of institutional design and organizational practice in health financing

The focus of this framework lies on institutions and organizations. Based on North's work, institutions are understood as "formal and informal rules, enforcement characteristics of rules, and norms of behavior that structure repeated human interaction", between individuals, within or between organizations, through incentives, disincentives, constraints and enhancement (North, 1989: 1321). Organizations, on the other hand, can be defined as "groups of individuals bound together by some common purpose to achieve certain objectives" (ibid, 1993). To be effective, rules need to incorporate enforcement characteristics to indicate how compliance is monitored and how non-compliance is enforced or penalized. Rules have a purpose and oblige or enhance individuals or organizations to behave in a certain way (Ostrom et al., 1994). As concisely formulated by Meessen, Musango, Kashala & Lemlin (2006), the incentives and disincentives derive from the benefits or disadvantages that actually or potentially accrue to individuals or organizations because of a rule.

In line with the above thinking, this paper argues that the achievement of universal coverage and of the health financing performance indicators is contingent upon two important aspects (cf. Carrin, Mathauer, Xu & Evans, 2008). The first one is the underlying institutional design of the three health financing functions, i.e. the set of institutions, or rules that in total make up the health financing system. Specifically, this refers to the formal rules relating to the health financing functions, i.e. the resource collection rules, pooling rules and purchasing/provision rules. In contrast to informal rules, formal rules refer to written, legally based provisions. Such rules can be stipulated by health financing related policies, and in more concrete form are found in legislation and regulations. In an ideal health financing system, these health financing rules are formulated and designed in such a way as to contribute to reaching the health financing objectives and performance indicators.

Equally crucial for the performance of a health financing system are the organizations involved in health financing. Institutions and organizations are closely interrelated, and hence organizations do not operate without an institutional context. Health financing-related organizations include, inter alia, political and regulatory bodies, ministries and related executive agencies, purchasers, health care providers, civil society and membership organizations. Of specific interest are their activities in undertaking the health financing functions and the specific tasks relating thereto - in other words their organizational practice relating to health financing. Here, organizational

practice is understood as the way organizations do or do not implement and comply with formal rules, which is also dependent upon their organizational capacity. In an ideal situation, organizations implement and comply with the rules, and have the capacities required to do so, in order to work towards health financing objectives and performance indicators.

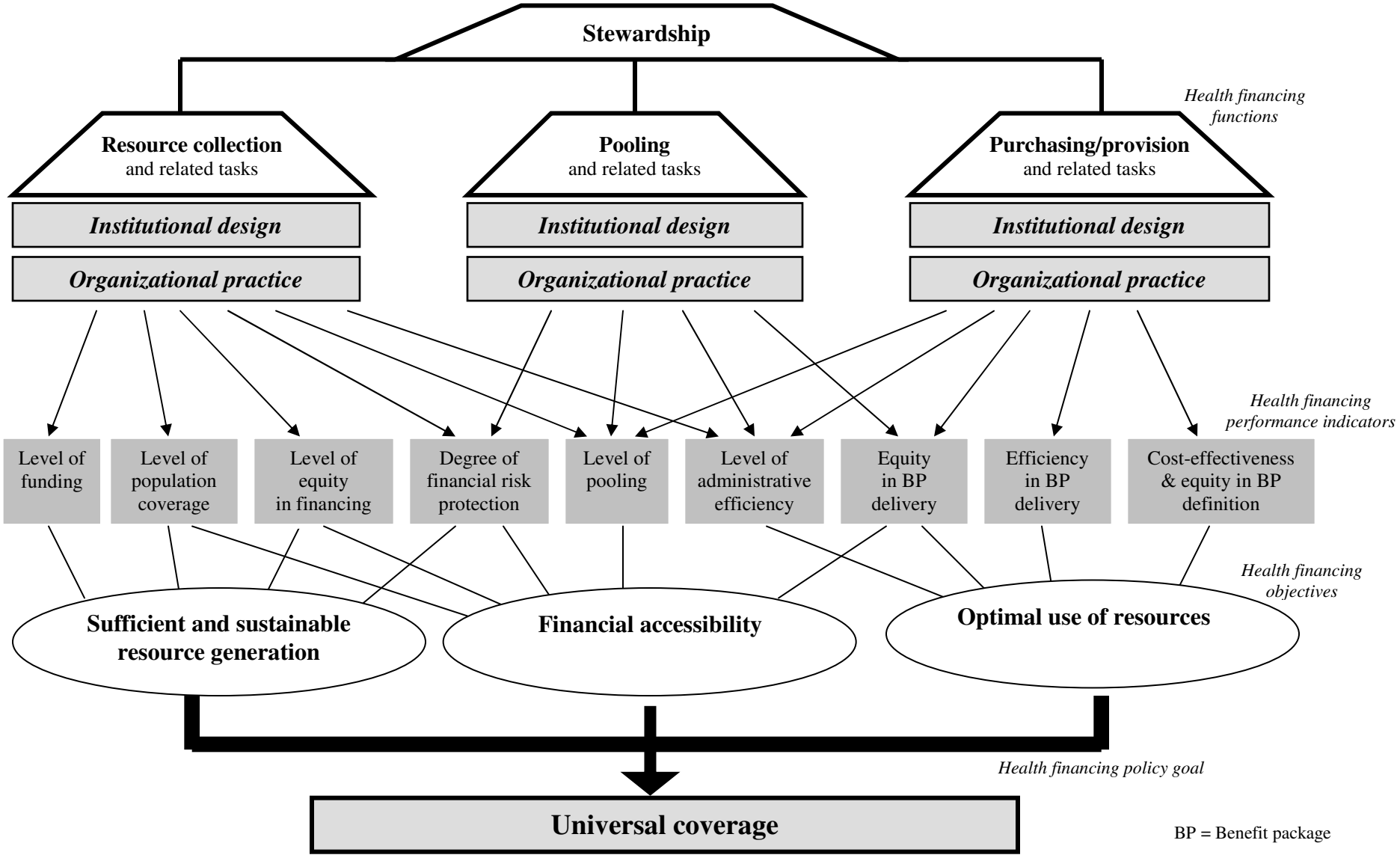
In reality, however, organizational practice is not only influenced by the rules and the respective incentives these create, but also by the specific interests of organizations and individuals. These interests are shaped by a number of factors, including preferences, prevailing informal rules and cultural norms, as well as motivations of solidarity and professionalism. Yet, considerations of utility and profit maximization can be equally considered as dominant human and organizational motivators for organizational practice and individual behaviour (DiMaggio & Powell, 1991).

Rules do not therefore contain inherent or internal incentives or constraints that are fixed. It is the organizational and wider context that ultimately determines actual or potential benefits or disadvantages as perceived by organizations and individuals. With a good knowledge of the context, the effect of these incentives can be anticipated with high plausibility.

Figure 1 provides a summary overview of the analytical framework. Health financing functions are concretized by their institutional design, i.e. the rules, and the actual organizational practice, i.e. the way these rules are implemented. This determines the attainment in health financing performance indicators and health financing objectives and ultimately the level of universal coverage. Figure 1 also features stewardship as an important overarching function in health financing, having an effect on the other three health financing functions. Stewardship involves setting the meta rules, which define who sets the specific health financing rules, and how and when these rules can be changed. Furthermore, stewardship entails the provision of strategic direction and coordination for all the different health financing actors involved. Stewardship is usually exercised by government or quasi-government agencies (cf. WHO, 2000; WHO, 2008).

Figure 1: Summary overview of the analytical framework

Source: further developed from Carrin et al. (2008)



BP = Benefit package

Health financing rules may cover a wide range of aspects in order to specify the way a health financing system is supposed to work. Table 2 lists the various health financing rules and aspects, which illustrates the level of detail required when assessing the institutional design of a health financing system.

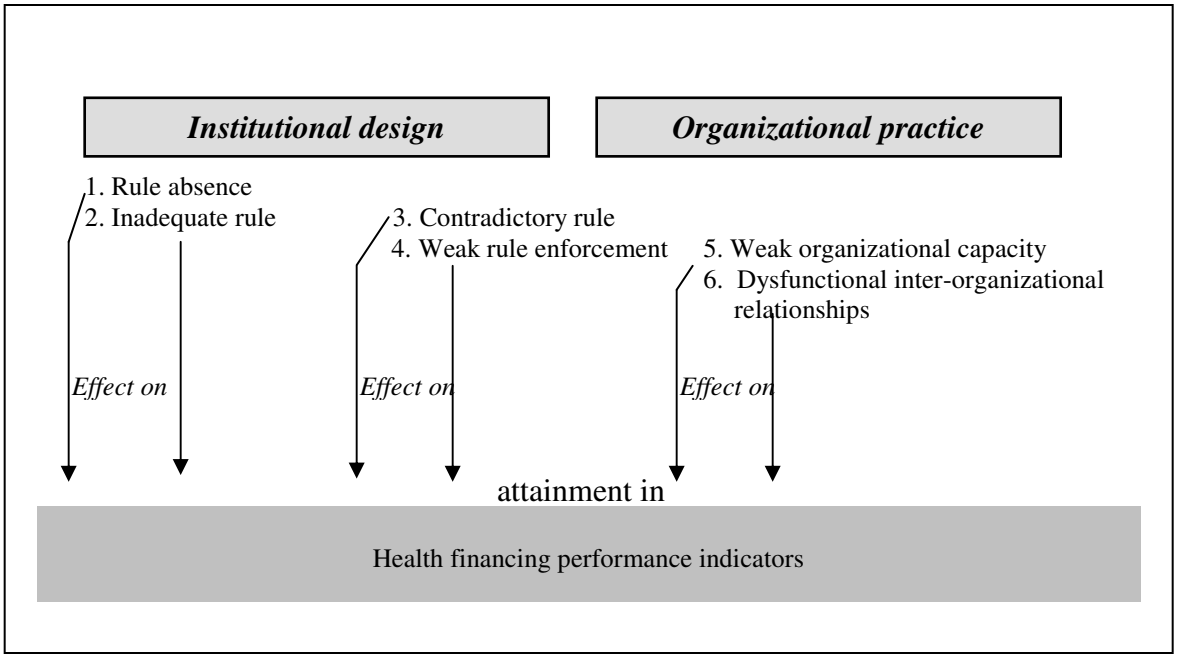
4 Understanding institutional and organizational bottlenecks to health financing performance

As institutional design and organizational practice are fundamental determinants for health financing performance, it is important to understand the strengths as well as the bottlenecks in institutional design and organizational practice. For a detailed understanding, we propose to analyse performance weaknesses along the following six types of bottlenecks, as outlined in Figure 2 and explained further below. To identify the reasons for inadequate health financing performance, each health financing function and task can be scrutinized against these six bottleneck factors. These bottleneck factors exist because rules are not automatically implemented and complied with by organizations when they give important weight to their own interests. In contrast, strengths can be identified by turning round bottleneck factors into a positive formulation. In order to identify the reasons for good or low performance, it is important to understand the prevailing incentive environment for organizations and individuals. Moreover, since several rules usually affect a health financing performance indicator, most often, the bottlenecks are interrelated and several ones in combination explain the attainment of a health financing performance indicator, as depicted in Figure 1.

Table 2: Health financing rules and respective rule aspects

Rules relating to health financing functions	**Aspects to be specified by the rules** inter alia
Revenue collection	
Taxation rules:	Tax types, taxation rates, tax basis, population/income groups eligible for taxation
Resource allocation rules:	Level of public spending on health (e.g. mandated, historical, needs-oriented, aligned with population growth/inflation); resource allocation criteria for decentralized health financing schemes; MOH budget formulation procedures (e.g. top-down, bottom-up), MOH budgeting formulas (e.g. line items, programs, other)
Insurance enrolment rules:	Population groups covered, membership basis (e.g. individual, group, family), membership type (voluntary or mandatory), enrolment procedures
Insurance collection rules:	Contribution rates, contribution basis, calculation methods, contribution shares of employee/employer, ceilings, collection methods/ points/ schedule, exemption criteria, opting out criteria.
Copayment/user fee rules:	Services/benefits requiring copayments, copayment schedules, ceilings, fee exemption/waiver criteria and procedures
Pooling	
Pooling rules:	Pools/funds and amounts to be pooled, use of donor funds
Risk equalization rules:	Risk equalization mechanisms and fund transfer procedures, criteria for risk equalization
Purchasing and provision of services	
Purchasing and provision rules:	Purchasing structure (single or multiple, competing or non-competing), eligibility of providers, provider accreditation, contracting (selective or collective), performance contracts, level of autonomy of providers and decentralized purchasers
Provider payment rules:	Unit being purchased (e.g. inputs, services, outcomes), provider payment mechanism (e.g. capitation, fee for service, DRG), remuneration rates (uniformity or regional differentiation), retrospective or prospective price setting, retrospective or prospective payment, claims management schedule and procedures, claims review, utilization review, payment schedule and transfer procedures
Rules relating to the benefit package (BP):	Contents, BP limits (e.g. maximum of days, maximum amount, deductibles), definition process and criteria applied, referral system, costing procedures of services and of benefit package
Rules relating to benefit package consumption:	Copayment rules (see above), patient appeal mechanisms, patient rights, deductibles to induce desired patient behaviour
Rules relating to fund management:	Auditing and other accountability activities, public reporting, performance management, internalization or externalization of surplus or deficit, building up reserves
Relating and applicable to all of the above rules:	Rule monitoring, rule enforcement, penalties in case of non- compliance, data/information management, impact monitoring

Figure 2: Institutional and organizational bottlenecks to health financing performance



1. Rule absence

If a critical aspect of a health financing function is not specified by a rule, organizations operate without a regulatory basis or may not undertake an important health financing task because of a lack of incentives. Such a situation may easily turn out to work against the health financing objectives and associated performance indicators.

2. Inadequate rule

In some instances, a prevailing rule may not represent the best or most efficient institutional design to achieve the health financing objectives and performance indicators. A rule may be inadequate, because it is not logically linked with the health financing performance indicators. As such, the rule in itself and the prevailing incentive environment would not contribute to attaining the health financing performance indicators. Even when political will exists, rules may be inadequately developed, or be deemed to be socially suboptimal if they have been designed and created to serve the interests of those with bargaining power only.

3. Conflictive rule

Even if well designed with a strong logical link to the health financing performance indicators, a rule and its incentive environment may be overridden by or conflict with other rules. The rule

may also not be consistent with the country context, prevailing cultural norms and attitudes (for example, the notion of solidarity) or the country's management and administration capacities. Within a contradictory incentive environment, organizations may then try to avoid or obstruct rule compliance.

4. Weak rule enforcement

Lack of or weak rule enforcement is caused by absent or inappropriate enforcement characteristics within a rule, thus providing weak incentives to undertake a health financing task. This may allow organizations to pursue their specific interests rather than implementing and complying with the rule.

5. Weak organizational capacity for rule implementation, monitoring and enforcement

Even with strong incentives and willingness to implement rules, organizations may be unable to implement, monitor or enforce a rule effectively due to weak organizational capacity. Low organizational capacity may result from lack of leadership, inadequately skilled human resources, shortage of financial resources, poor (information technology) infrastructure or inappropriate organizational procedures and structures (cf. Horton, Alexaki, Bennett-Lartey, Brice, Campilan, Carden, et al., 2003).

6. Dysfunctional inter-organizational relationships

Many of the health financing tasks are undertaken by several organizational actors. Ideally, this occurs within a coordinated division of labour. More often, however, the incentive environment varies across organizations, and conflicts, mistrust, inadequate communication and collaboration between organizations may negatively affect rule implementation or enforcement.

Assessing how well health financing performance indicators are attained and explaining this by identifying the bottlenecks in institutional design and organizational practice are important steps in themselves. It is also the starting point to derive appropriate measures to improve health financing performance, which will be outlined in the following section.

The type of analysis proposed here requires a detailed assessment and contents analysis of legal and regulatory provisions. This involves checking definitions, clarity, coherence, scope, purpose and effects of the rules. The contents analysis needs to be combined with qualitative interviews with health financing stakeholders and observation to analyse whether and how the legal

provisions are adhered to and put into practice and to understand organizations' and individuals' interests and motivations, their relations among each other, as well as the incentive environment.

5 Changing institutional design and organizational practice for health financing performance improvement

In order to improve health financing performance, we propose six types of changes to address the six types of bottlenecks as outlined above.

1. Rule setting

Where previously absent, the setting and introduction of a new rule or specific rule aspects serves to overcome a regulatory gap. New rules must be adequately formulated and logically linked to the health financing performance indicator(s) in order to create a proper incentive environment.

2. Rule redesign

A rule's purpose, or the detailed health financing aspects it specifies, may need to be reformulated, in order to create or strengthen the logical link(s) with the health financing performance indicator(s). A rule redesign usually results in a revised incentive environment with the aim of making organizations work better towards the health financing performance indicators.

3. Rule alignment

To ensure that a rule is not contradicted by other health financing rules and that it is in line with the country context, norms and capacity levels, the prevailing rules may need to be aligned with each other. The rule under discussion may also need to be adapted, while at the same time maintaining its logical link(s) with the health financing performance indicator(s) via conducive incentives. Alternatively, public awareness raising and information provision may be required to overcome attitudes that are non-conducive to rule compliance and the achievement of the health financing performance indicators.

4. Strengthening rule enforcement

Rule enforcement can be reinforced by specifying enforcement characteristics of a rule, so that the incentives to comply with the rule are more pronounced.

5. Strengthening organizational capacity

Organizational capacity of specific organizational actors can be enhanced through a number of measures of organizational development. These include reinforcing management leadership, staff training, an improved financial basis, infrastructure improvements, or revisiting organizational procedures and structures, through which organizations gain the ability to better implement rules.

6. Improving inter-organizational relationships

Trust-building and conflict management measures, improving the division of labour, transparent communication and collaboration procedures, inter alia, can all help enhance inter-organizational relationships and thus strengthen rule implementation and rule enforcement.

Most often, a combination of several improvement measures is necessary to improve the health financing performance indicators. The crucial question is whether a performance improvement can be achieved through mere strengthening of organizational capacity or rule enforcement, or whether there is need for rule alignment or rule redesign. It may therefore be necessary to think through several options. Moreover, when potential changes in institutional design and organizational practice within a health financing scheme seem unlikely to yield critical improvements in health financing performance, a shift to another type of scheme, e.g. from a dominantly tax-based health financing system to a SHI scheme, or vice versa, may even need to be examined.

The choice of one improvement measure over another is ultimately guided by the plausible anticipation of its impacts. It is therefore important to anticipate the impacts of proposed changes with respect to all performance indicators, with respect to a specific health financing scheme as well as the overall health financing system, in order to avoid that such changes create trade-offs between different health financing schemes.

Furthermore, as health financing is not an isolated area, effects also need to be assessed with respect to the overall health system as well as beyond. There could also be effects on, for example, economic growth, the labour market (employment, wages, production), consumption prices, income distribution, poverty levels and social capital (cf. WB, 2003; Kutzin 2008).

For purposes of illustration, Table 3 below uses the case of collecting (voluntary) social health insurance contributions from informal sector workers. The table provides hypothetical examples

for the six bottleneck factors in institutional design and organizational practice and proposes improvement measures to overcome these bottlenecks. The anticipated effects of such changes on the health financing performance indicator(s) are equally outlined.

Table 3: Examples of bottlenecks, possible improvement measures and anticipated impacts on health financing performance relating to the collection of (voluntary) informal sector insurance contributions

Bottlenecks	**Improvement measures**	**Anticipated effects on HF performance indicators**
Rule absence	*Introduction and setting of a new rule or specific rule aspects*	
There are no specific rules for setting the amount of contributions of informal sector workers. In practice, contributions are set arbitrarily and thus vary from SHI regional office to office.	Specify contribution logic for informal sector workers and define/set contribution amounts.	Increased health financing equity.
Inadequate rule	*Rule redesign*	
Contribution amounts for informal sector workers are set at a too high level, such that membership is unaffordable for most of them.	Revisit the contribution logic and contribution amounts of informal sector workers and adjust them to ability to pay and affordability.	Increased population coverage, as more informal sector workers may afford to enrol; Increased resource mobilization; Increased financial risk protection.
Conflictive or non-aligned rule	*Rule alignment*	
Informal sector workers do not like to make contribution payments to the local government offices, which are in charge of local collection. Many therefore refrain from enrolling.	Assess whether other decentralized or local organizations (e.g., NGOs, post-offices) could collect contributions; or set up transparency mechanisms at local government offices to overcome reluctance.	Increased population coverage; Increased resource mobilization through prepayment.
Weak rule enforcement	*Strengthening rule enforcement*	
Taxi drivers specifically are mandatory members, yet there are no compliance mechanisms to ensure that they register. As a result, many evade enrolment.	Introduce and specify penalty fines for defaulters and increase number of inspectors/collectors to ensure rule compliance.	Increased population coverage and financial risk protection; Increased resource mobilization through prepayment.
Weak organizational capacity	*Strengthening organizational capacity*	
Local government offices are not able to effectively collect contributions from informal sector workers due to lack of skilled staff.	Train or recruit staff with appropriate skills.	More efficient resource mobilization; Reduced administration costs.
Dysfunctional inter-organizational relations	*Improving inter-organizational relationships*	
Working relations between the SHI regional offices and local government offices are poor; there are thus delays in exchanging necessary data and information between the two organizations, which slows down the process of collecting contributions and thus increases administration costs.	Clarify and specify reporting and communication requirements between the two organizations; identify reasons for misunderstandings.	Reduced administration costs.

6 Feasibility considerations

In addition to identifying the most appropriate technical changes in institutional design and organizational practice to achieve improvements in health financing, a number of feasibility considerations need to be taken into account.

First, the scope of improvement in health financing performance is not independent from the country's fiscal balance, and proposed changes also need to be assessed with respect to their fiscal sustainability. However, this is not a clear-cut concept, as fiscal space in health partly depends on a country's fiscal context, but partly on the country's priorities for health (cf. Kutzin, 2008).

Second, as discussed above, stewardship is critical. The stewards' implementation capacity and their willingness to introduce changes need to be assessed in order to be sure whether proposed changes can be successfully implemented. Implementation capacity refers to the ability to plan, implement and manage institutional and organizational change.

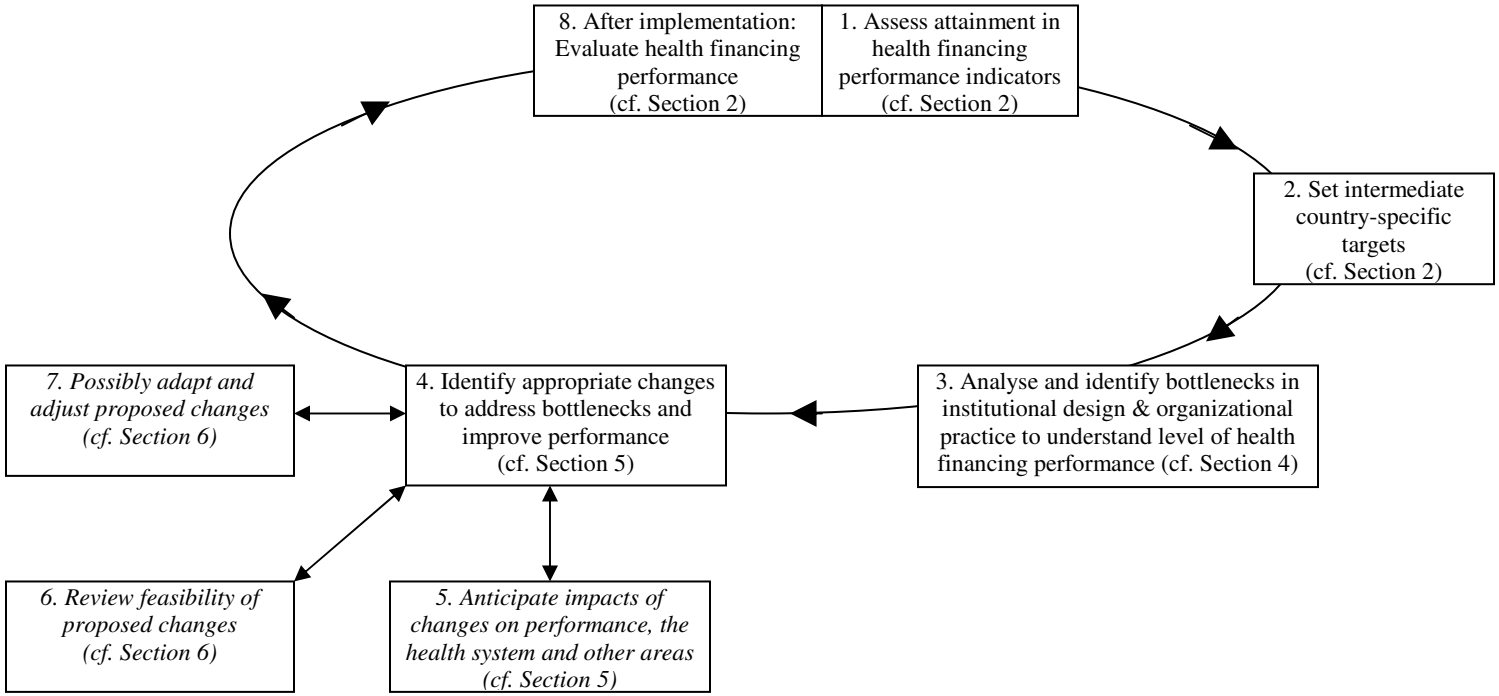
Third, there is need to reflect on whether the proposed changes in the institutional design and/or organizational practice are politically feasible and desirable, in other words, whether powerful interest groups will support and drive these changes (cf. Oliver & Mossialos, 2005). Trade-offs may occur between what appears to be the best and most reasonable option from the institutional-organizational analysis and what is politically feasible.

In sum, these feasibility considerations may also point to the need of possibly adjusting the proposed changes to ensure that these will lead to the desired health financing performance enhancement.

7 Overview of the process of the analysis

Figure 3 outlines the analytical process and depicts the steps involved. Reference to the respective section of this article is provided in brackets.

Figure 3: Analytical process steps



8 Conclusion

This article provided a detailed conceptualization of health financing performance and suggested generic health financing performance indicators that are applicable in any type of health financing system. The critical role of institutional design and organizational practice for health financing performance was explained. Performance weaknesses can be caused by various bottlenecks in institutional design and organizational practice. Once the causes of weak performance are understood, appropriate changes in institutional design and organizational practice can be identified. It should be noted that the logic of this framework can in principle also be applied in high-income countries where 'maintaining' universal coverage rather than moving to it has also become an important policy goal.

While not all impacts can be fully planned ahead and while some uncertainty around the actual implementation results remains, the proposed approach reduces the need for experimentation with institutional arrangements as suggested by some authors like Meessen et al. (2006). The framework's value added lies in the systematic and comprehensive assessment of why the health financing system is working well or inadequately on the basis of which to find a set of appropriate remedies. The focus on institutional design and organizational practice as proposed in this framework thus goes beyond a descriptive or evaluative analysis of a health financing system that only looks at what currently works and what does not, but it offers an explanatory perspective.

Institutional design of a health financing system and its respective schemes can be actively shaped and developed, by modifying legal and regulatory provisions and by strengthening organizational capacity and enforcement practices. Formulating and implementing health financing reforms towards universal coverage will thus require a multitude of inter-related decisions based on the above analytical steps. As pointed out by Carrin et al. (2008), these institutional design choices to be taken are thus far more detailed than the "simple" question of whether a predominantly tax based system, social health insurance or a mixed system is preferred. This search for the best institutional design cannot be undertaken by outsiders, but must come from the organizational actors involved in the health financing system.

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