

Call for proposals

Research on citizen responsiveness
and empowerment in health insurance
programmes

A joint call from the Alliance for Health Policy and Systems
Research (the Alliance) and the Department of Health
Systems Governance and Financing (HGF) at WHO

Deadline:

8 March 2019

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Overview

The Alliance and HGF invite research proposals to better understand how initiatives to empower citizens to be aware of and exercise their entitlements within the context of existent health insurance programmes have succeeded or not in this endeavor. Examples of these include initiatives to inform beneficiaries of their entitlements, those that seek to enable beneficiaries to act on this information as well as mechanisms for accountability including through citizen feedback. This call is aimed at researchers based in institutions in low- and middle-income countries – applications headed by a researcher based in a high-income country will not be considered.

Background

The past two decades have seen the proliferation of publicly funded health insurance [type]¹ programmes across low- and middle-income countries (LMICs), including China, Ghana, India, Indonesia, Mexico, the Philippines, and Thailand. Often, though not always, these programmes engage the private sector for the provision of services.

Rapid economic growth and increasing public revenues, dissatisfaction with existing NHS-type public financing and service delivery models in some settings, an increased acceptance of the role of the private sector in service delivery using public funds, political transitions, as well as the revolution in information technology have all contributed to LMICs exploring health insurance type programmes as a major instrument of financial protection moving towards universal health coverage (UHC) (Frenk *et al.*, 2006; Agyepong and Adjei, 2008; Shroff *et al.*, 2015; Pisani *et al.*, 2017; Tangcharoensathien *et al.*, 2018).

These differ from earlier social health insurance programmes for formal sector employees introduced in many LMICs that linked insurance status to employment and were underpinned by tripartite oversight arrangements bringing together employers, employees and governments. Given the relatively small size of the formal sector in these settings, employment-based health insurance existed in parallel to publicly financed and delivered health services and other health coverage programmes for people outside the formal economy, resulting in a multi-segmented public health system characterized by significant inequities in access (Londono and Frenk, 1997; Knaul and Frenk, 2005).

Recognizing the largely informal nature of economic activity and employment in many LMICs that makes it difficult to identify a clear employer, and in line with the principle of universality that underpins UHC, most of these newly introduced programmes have sought to de-link coverage from employment status – in other words, entitlements are not dependent on making health insurance contributions through payroll deductions. Instead they typically use public funds to pay for the contributions of the poorest and other vulnerable groups, with varying degrees of subsidies for other defined eligible population groups outside formal employment (Lagomarisino *et al.*, 2012; Mathauer *et al.*, 2016; Vilcu *et al.*, 2016; Mathauer and Behrendt, 2017; and Tangcharoensathien *et al.*, 2018)

¹ We use the word health insurance type as a term that encompasses programmes that are characterized by clearly identified and affiliated beneficiaries and a clearly defined benefit package, which may or may not be contributory. They include social insurance schemes and newer publicly funded schemes which use tax financing to pay contributions for poorer groups, and often with a separate purchasing agency resembling a health insurance arrangement.

The problem

Expanding these programmes in terms of the number of people covered, the range of services provided and the extent of financial protection they offer against out-of-pocket and catastrophic health expenditures is increasingly seen as key to these countries moving toward UHC. Thailand's example, where the implementation of the Universal Coverage Scheme has been associated with significant reductions in out-of-pocket expenditures, medical impoverishment and child mortality is illustrative of this (Tangcharoensathien *et al.*, 2018).

However, in many countries, there remain gaps in coverage and financial protection. In several instances, enrolment rates have stagnated, and marginalized groups in particular face barriers to enrolment (Nandi *et al.*, 2012; Agyepong *et al.*, 2016; Williams *et al.*, 2017). People continue to face barriers to the utilization of services and some programmes have reported increased out-of-pocket expenditures for those covered (Selvaraj and Karan, 2012; Karan *et al.*, 2017).

Several of these barriers have their roots in health financing policy design and implementation that are not adequately aligned to UHC objectives. At the design level, there are insufficient mechanisms to prevent risk selection. Payment methods may also allow providers to engage in balance billing rather than limiting or prohibiting it. There may be a lack of incentives to ensure the provision of the broadest possible range of services within the given resource envelope. And sometimes, benefit packages only cover high-end tertiary care. At the level of implementation, barriers may include delays in processing identity cards that certify enrolment status, delays in making payments to providers that discourage them from accepting patients covered under a given programme as well as programmes not having the administrative capacity to ensure that services covered are actually provided to those entitled to them.

Moreover, there are other barriers faced by people in effectively exercising their entitlements. The lack of information, whether about eligibility for coverage and subsidized enrolment or enrolment processes is a major barrier to getting enrolled, and lack of knowledge on cost sharing arrangements, benefits and the claims processes constitute hurdles in actually accessing health services.

Even where information is available, there may exist barriers to its effective use. These include the presence of administrative rules that make it challenging for people to process information or that lead to information uncertainty (such as having percentage as opposed to flat co-payments) (WHO, 2018). Linked to this are time consuming processes such as the requirement to re-enrol annually in person, which often leads to citizens dropping out (Agyepong *et al.*, 2016).

Further, accountability mechanisms including complaints and grievance mechanisms as well as mechanisms to engage citizens in the design of benefit packages or to serve on oversight boards, are either absent or poorly developed in many settings. This is compounded by asymmetrical power relationships between citizens and providers/insurance programme managers and the lack of technical knowledge. These factors taken together serve as formidable obstacles to individual citizens effectively holding either providers or insurance agencies and their managers accountable.

In several instances, the informational and power asymmetries have potentially been exacerbated by the introduction of market forces financed by public funds, without adequate understanding and preparedness for how these would play out in the face of these asymmetries (Sen and Gupta, 2017).

Making citizens aware of their entitlements and empowering them to exercise them is key to the effectiveness of these health insurance type programmes that aim to move countries toward UHC. Much of the current research on these programmes has tended to focus on utilization rates, and the impact of these programmes on out-of-pocket and catastrophic health expenses (Nguyen *et al.*, 2011; Aji *et al.*, 2013; Aryeetey *et al.*, 2016; Prinja *et al.*, 2017). There has been some work done on understanding citizen experience of accessing their health insurance entitlements and the barriers to these, both in high income countries (Schoen *et al.*, 2010) and in LMICs, as mentioned in the examples above (Nandi *et al.*, 2012; Agyepong *et al.*, 2016; Sen and Gupta, 2017). However much less is known about efforts made to overcome these barriers, as well as their success (or lack thereof) in meeting their desired objectives.

There is therefore a need to identify and learn from examples of initiatives already implemented (either by governments or civil society groups) as part of health insurance programmes at national and sub-national levels as well as examples of representation, voice, and accountability mechanisms that seek to make citizens aware of their rights and entitlements and enable them to effectively exercise these.

Objectives

The objectives of this research programme are to:

- Support the generation of new knowledge on how **existing** initiatives and institutional arrangements within the context of **existing** health insurance type programmes have been able (or not) to empower citizens to be aware of and effectively exercise their entitlements
- Develop analytically generalizable learning based on this knowledge for researchers, policy and decision-makers, and civil society organizations.

- Share this learning broadly, particularly among policy and decision-makers and civil society organizations with the purpose of informing the design and implementation of health insurance programmes.

The initiatives and institutional arrangements studied must be directly linked to a health insurance type programme. In other words, initiatives must serve to empower citizens to exercise their programme-related entitlements (including enrolment processes, understanding benefit design and claims processes) and provide mechanisms for feedback, grievances and appeals, with the ultimate aim of making people's voice heard and improving design and implementation of the health insurance programme. **Initiatives and institutional arrangements to enhance accountability more broadly that are not directly informing and empowering citizens within a health insurance type programme are not the focus of this call for research proposals.**

Central to the research will be an analysis of the initiative or institutional arrangement's underlying objective, the effectiveness of the initiative in meeting these objectives and the mechanism(s) through which the initiative or institutional arrangement has (or has not) effectively empowered citizens in exercising their entitlements. Such initiatives and arrangements may or may not involve technological innovations.

While proposals for studies that measure the effectiveness of specific initiatives and/or institutional arrangements are welcome, given the Alliance's focus on health systems, it is imperative that the research go beyond solely measuring effectiveness and delve deep into underlying mechanisms that explain effectiveness or lack thereof.

Possible areas for research were discussed during a consultation of practitioners and experts working in this area in late January 2019. The areas mentioned below are only indicative of what research teams can propose and teams are encouraged to go beyond these themes and questions.

Areas for potential research might include:

- a. Culturally and context appropriate information channels and campaigns on enrolment procedures, benefit packages and utilization of services particularly among communities in remote and rural areas as well as urban slum dwellers. For example, which information provision mechanisms (such as community forums, meetings and use of other "unbiased" organisations) and which information sources and (social) media are effective in reaching those population groups? What roles can providers play in information provision and information seeking?
- b. The use of patient advocates to provide information on entitlements and enrolment and more broadly enhance access to services.

- c. Measures to empower beneficiaries (through information provision and grievance redressal mechanisms for example) to address implicit rationing of services to relatively disempowered segments of beneficiaries. Implicit rationing can take the form of longer waiting times, the non-provision of all services provided in the benefit design as well as provision of lower quality services to these segments of beneficiaries.
- d. Measures to facilitate enrolment processes including through the use of mobile phones and automatic reenrolment policies.
- e. Institutional arrangements and rules intrinsic to the design of the health insurance programme that directly influence access to information and the ability of citizens to use this information, and measures to empower beneficiaries to overcome barriers posed by these arrangements and rules. Examples include institutional arrangements where insurers are responsible for enrolment as well as information provision and are thus incentivized to put less focus on informing beneficiaries of their entitlements, or complex co-payment rules that are difficult for citizens to process.
- f. Analysing accountability initiatives set up as part of insurance health programmes such as benchmarks and provider report cards including how effective these are in influencing provider and/or insurer behaviour.
- g. Institutional arrangements and initiatives to engage citizens in informing policy design and implementation. These can take the form of citizen involvement in priority setting exercises for benefit design, as well as their involvement in oversight boards.
- h. Mechanisms to seek feedback and to enable/facilitate complaints, including social media, that in particular target and help marginalized population groups (e.g. remote and rural populations, people with disabilities, people not being served, urban slum dwellers, migrant populations).

A protocol development workshop due to be held in the second half of 2019 **will seek to align and harmonize protocols to ensure that the research programme is able to generate larger cross-cutting lessons pertinent to this area of work.** A previous Alliance and HGF supported research programme provides an example of how this harmonization has worked in practice (<https://www.tandfonline.com/toc/khsr20/3/2>).

Eligibility

- Researchers based in institutions in low- and middle-income countries (LMICs) are eligible to apply. Teams are encouraged to engage a member of a civil society organization on the core research team, and this will be viewed favourably in the selection of teams.

- Teams should be gender-balanced with women comprising **at least** 50% of the research team.
- The experience of researchers, as reflected in the proposal as well as the CV of the principle investigator, should be in the topical areas of health financing, particularly health insurance, as well as in methodologies needed to carry out the research proposed.
- Individuals from high-income countries are **not** eligible to apply as principle investigators. Collaborations between organizations based in LMICs and individuals and organizations in high-income countries are acceptable on the condition that **not** more than 15% of the total grant value can go to individuals or organizations based in high-income countries.

Work duration and budget

A maximum of **eight studies** will be funded in as many countries. **Individual research projects will be funded for up to a maximum of US\$ 75,000.**

The research projects are expected to run for a maximum of 18 months. By submitting a proposal, **principal investigators commit to attending the protocol development workshop, to be held in the second half of 2019, and an analysis and writing workshop toward the end of 2020.** The proposed budget should **exclude** the cost of participation in these workshops, the Alliance will cover the cost of attendance of up to two team members to attend the workshops.

Application process

To apply, please submit a proposal of **a maximum of 10 pages** by **8 March 2019**. Proposals submitted after this deadline will not be considered. Successful applicants can expect to be notified within **six weeks** of the deadline. WHO may, at its own discretion, extend this closing date for the submission of proposals by notifying all applicants thereof in writing.

Submissions of proposals should be made to alliancehpsr@who.int. Please use the subject: **WHO Bid Ref. Request for Proposals: Citizen Responsive Insurance**

Submissions of **no more than 10 pages (1.15 spaced, Times New Roman Font 11, regular margins)** should:

1. Provide a **brief description** of the insurance programme in place as well as the specific initiative or institutional arrangement within this programme that seeks to empower citizens to exercise their entitlements.
2. Put forth **a clear research question and hypothesis** that contributes to the overall aim of the research programme as described under the objectives section above.

3. Locate the research question within the **larger existent literature** in the area under study.
4. Put forth **a conceptual framework** that will guide the research, including how this will inform the development of study tools and questionnaires as well as frame the analysis.
5. Provide **information on data sources and methods proposed to be used**, including demonstrating how these will contribute to addressing the research question outlined.
6. **Provide details of the research team** including the position and qualifications of the principal investigator and other team members. The description of the team should also give an indication of the team's capacity for research in the topical area of health financing, particularly health insurance as well as in conducting health systems research more broadly. The team must provide information about the gender breakdown of the core research team, **noting that, to be eligible for funding, 50% of the core research team must comprise female researchers.**
7. Provide an estimate and itemized budget summary for activities over an 18-month period.

In addition to the proposal, teams must submit a CV of the PI, as an attachment in the same email.

The Alliance is an engaged funder. A peer-reviewed publication is required as are dissemination activities and policy products, including one or more policy briefs.

Evaluation of research proposals

Research proposals will be judged by a minimum of two external reviewers based on criteria that will include:

- The potential of the proposed research study to contribute to the overall aims of the research programme.
- Quality of the research proposal in terms of a clearly elucidated research question, well defined hypothesis, relevant conceptual framework, data sources and methods and an analysis plan that demonstrates how the research team will apply the conceptual framework to the data obtained.
- Qualifications and experience of the team.
- Value for money.

Notes for applicants

1. WHO may, at any time before the closing date, for any reason, whether on its own initiative or in response to a clarification requested by a (prospective) applicant, modify the bid by written amendment. Amendments could, inter alia, include modification of the project scope or requirements, the project timeline expectations and/or extension of the closing date for submission.
2. All prospective applicants that have submitted a bid will be notified in writing of all amendments to the bid and will, where applicable, be invited to amend their submission accordingly.
3. Applicants should note that **WHO reserves the right to:**
 - a. Award the contract to an applicant of its choice, even if its bid is not the lowest;
 - b. Accept or reject any bid, and to annul the solicitation process and reject all bids at any time prior to award of contract, without thereby incurring any liability to the affected applicants and without any obligation to inform the affected applicants of the grounds for WHO's action;
 - c. Award the contract on the basis of the Organization's particular objectives to an applicant whose bid is considered to be the most responsive to the needs of the Organization and the activity concerned;
 - d. Not award any contract at all;
 - e. WHO has the right to eliminate bids for technical or other reasons throughout the evaluation/selection process. WHO shall not in any way be obligated to reveal, or discuss with any applicant, how a bid was assessed, or to provide any other information relative to the evaluation/selection process or to state the reasons for elimination to any applicant.
4. WHO is acting in good faith by issuing this request for bids. However, this document does not obligate WHO to contract for the performance of any work, nor for the supply of any products or services.
5. **WHO reserves the right to enter into negotiations** with one or more applicants of its choice, including but not limited to negotiation of the terms of the bid(s), the price quoted in such bid(s) and/or the deletion of certain parts of the work, components or items called for under this bid.
6. **Within 30 days** of receipt of the contract, the successful applicant shall **sign and date** the contract and return it to WHO according to the instructions provided at that time. If the applicant does not accept the contract terms without changes, then WHO has the right not to proceed with the selected applicant and instead contract with another applicant of its choice.

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