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HEALTH SYSTEMS STRENGTHENING
PRACTICE SPOTLIGHT

FINANCIAL PROTECTION AND SOCIAL AND BEHAVIOR CHANGE

Strengthening financial protection programs through behavior change approaches

SOCIAL AND BEHAVIOR CHANGE SERIES

Social and behavior change is a foundational component of effective and sustainable health system strengthening programming. There is keen interest in improving financial protection efforts and to further accelerate Universal Health Coverage. This brief aims to describe opportunities to improve financial protection programs using behavior change approaches. The Practice Spotlights Social and Behavior Change series supports USAID's Vision for Health System Strengthening 2030 by exploring how social and behavior change approaches can contribute to countries' health system strengthening efforts.

INTRODUCTION

Despite global progress towards universal health coverage (UHC), the number of people facing financial hardship from out-of-pocket health spending has increased.[1] Financial protection programs seek to reduce peoples' exposure to financial risk, impoverishment, and missed care caused by the need to pay directly for health services.[2] Often spearheaded by economists and financing specialists, these programs employ approaches such as establishing insurance systems, capping out-of-pocket spending, relying on prepayment and pooled funds to finance health care, and allowing fee exemptions for vulnerable groups. They are key to accelerating gains in UHC and the Sustainable Development Goals.

However, a purely economic approach to the interconnected, systemic issues that leave households vulnerable to financial hardship is unlikely, on its own, to lead to UHC. This is in part because economic approaches do not account for the cultural, social, religious, and gender factors that may modify the effect of financial incentives. In other words, while economic incentives are necessary, they are insufficient. Successful reforms to health financing systems also require behavior changes by purchasers, providers, patients, and communities. Financial protection programs should, therefore, also consider incorporating social and behavior change (SBC) approaches to support UHC progress.

SBC approaches use systematic, evidence-driven practices to improve and sustain changes in behaviors, norms, and the enabling environment, and are a critical component of effective and sustainable health system strengthening (HSS) programming.[3] Including SBC methodologies and approaches in financial protection efforts can help address the social and behavioral drivers that impact the effectiveness of implementation.

USAID's Vision for Health System Strengthening 2030 highlights the importance of using SBC insights to strengthen health systems, including financial protection programs, to increase progress towards UHC.[4] Applying

SBC principles to financial protection programs can catalyze individual and collective changes and create more supportive implementation environments.

This brief highlights the value of integrating a behavioral lens into the design, implementation, and monitoring of financial protection programming to support UHC progress.

DEFINITIONS

- **Financial protection** is achieved when direct payments to obtain health services do not expose people to financial hardship and do not threaten their standard of living.[4]
- **Health systems strengthening (HSS)** comprises strategies, responses, and activities designed to sustainably improve a country's health system performance.[5]
- **Social and behavior change (SBC)** is a systematic, evidence-driven approach to improve and sustain changes in behaviors, norms, and the enabling environment. SBC interventions aim to affect key behaviors and social norms by addressing their individual, social, and structural determinants (factors). SBC is grounded in several disciplines, including systems thinking, strategic communication, marketing, psychology, anthropology, and behavioral economics.[6]
- **Universal health coverage (UHC)** means that all people and communities can access the quality promotive, preventive, curative, rehabilitative, and palliative health care they need, without being exposed to financial hardship.[7]

FINANCIAL PROTECTION PROGRAMS FOR UHC

The USAID HSS Vision 2030 emphasizes the need for robust, integrated, and viable systems of financial protection.[8] Health financing programs for financial protection are implemented and managed by financing agents (often government entities), which allocate resources for health services provided through the health system. Financial protection results from lowering people's direct payments (out-of-pocket spending) for services at the time of care, and is achieved via prepayment (taxes, contributions, or premiums) and pooling of resources and risks. Protecting people from financial hardship and ensuring access to essential quality services is a core function of a country's health system.

This brief organizes financial protection programs into four categories:* government financing schemes, social health insurance (SHI), community-based health insurance (CBHI), and social protection programs outside of mainstream health financing programs like cash transfers.[9] Each may include a unique package of benefits, focal population, financing agents or institutional units that manage them, service delivery mechanisms, and implementation context. Due to resource constraints, financial protection programs in many low- and middle-income countries (LMICs) focus on protecting key priority populations (often vulnerable groups) or selected priority health services (such as maternal and child health care) based on population needs and equity considerations.[10]

A 2021 literature review conducted by USAID's Local Health System Sustainability Project (LHSS) on financial protection for underserved and socially excluded populations found mixed implementation results, scalability issues, and the need for financial protection programs to better consider contextual factors and non-financial barriers including challenges accessing benefits, lack of trust, and cultural factors.[9] These findings illustrate the potential benefit of incorporating behavioral insights into the design, implementation, and evaluation of financial protection programs.

The four categories of financial protection programs are defined using the Organization for Economic Co-operation and Development's (OECD) System of Health Accounts classifications:[11]

- Government financing schemes are funded by domestic revenues allocated for health spending and automatically enroll the eligible population. Common examples include free care policies, government purchased and/or subsidized insurance, and performance-based financing.
- SHI schemes are ring-fenced funds that finance and manage health care on behalf of their enrollees, and

* Private voluntary health insurance is another mechanism for increasing financial protection, but it is inherently inequitable and does not align with global best practices for achieving UHC.

typically raise revenues through contributions from employee wages and/or employers. The eligible population is required to participate in the scheme, though enrollment is not always automatic, requiring actions by the individuals and entity managing the scheme.

- CBHI is a type of voluntary health insurance designed for informal sector households, usually managed at the community level. CBHI schemes sometimes provide additional coverage on top of existing government schemes. They typically have small risk pools and limited benefits and population coverage and are difficult to bring to a larger scale without government subsidies.
- Social protection activities like cash transfers and vouchers are a financial protection approach that may be financed and managed outside the health financing system. Cash transfers provide individuals or households from a specific population with either money or subsidized payments. They can be conditional, requiring an action by the recipient, or unconditional, without any necessary actions.

These four categories and the many design and implementation variations represent distinct approaches to reduce financial risk. Historically, many implementers of these approaches have not incorporated a social and behavioral component. Integrating systematic insights about the behaviors of individuals, communities, and institutions can lead to more effective programming that is responsive to the social drivers of and barriers to financial protection.

SOCIAL AND BEHAVIOR CHANGE FOR FINANCIAL PROTECTION

The behavioral aspects of financial protection are critical to consider and can be influenced through the tailored application of behavioral science principles, community engagement approaches, social and behavioral change communication (SBCC) strategies, and use of the socio-ecological model.

- Behavioral science uses insights on human behavior to design programs that support key behaviors. Design examples include creating heuristics or mental shortcuts to lessen the impact biases have on decision-making, environmental shaping to narrow the gap between intention and action, and reducing friction to make it easy and convenient to participate in the program.[12]
- Community engagement aims to strengthen the link between people and systems by increasing the participation, collaboration, and voice of communities for better programming and results.[13] It includes institutionalizing community participation at each program phase (design, planning, budgeting, financing, execution, monitoring), conducting routine communication, and developing programming that is flexible and responsive to community needs.[14]
- SBCC is the strategic use of communication strategies via marketing and public information campaigns to reach and engage communities, raise awareness, promote program uptake, and influence positive behavior changes.[14] Initiatives include two-way communication and tailored messaging through communications designed for a specific audience via their preferred news source.
- The socio-ecological model is a useful framework for analyzing social programs. It looks at all levels of society that influence behavior, including the individual, interpersonal (familial, peers, households), community, services and institutions, and policy and environmental levels.[15] The model suggests that programs should target their engagement by level, iteratively and deliberately, to drive change by considering the complex dynamics between and within each level.

These four SBC approaches, theories, and models are illustrative examples, with more options to choose from within the behavioral literature and programming. The selection and mix of SBC components for each financial protection program will depend on which are best suited to the unique environment and behavioral barriers to implementation. The following case studies describe the design, implementation, and outcomes of four different financial protection programs with some examples of integrated SBC and opportunities for inclusion to improve outcomes.

CASE STUDIES

Cash transfers in Ghana and Senegal

Cash transfers are a common social protection program in which the government provides payments to individuals or families to improve welfare or encourage a

specific action. Conditional cash transfers require an action by the recipient to receive the cash. Several LMICs have introduced unconditional and conditional cash transfer programs to foster health care utilization and health-seeking behavior, including through subsidized insurance premiums and/or co-payments. Linking cash transfers to subsidized insurance premiums is an example of an integrated social protection program that encourages care seeking and aims to lower financial risks via increased insurance enrollment.

Ghana's Livelihoods Empowerment Against Poverty (LEAP) 1000 cash transfer program provides bimonthly cash payments for extremely poor households and waives premium costs if they enroll in the National Health Insurance Scheme (NHIS). Eligible households include those identified as extremely poor with orphaned or vulnerable children, persons with severe disabilities who are unable to work, persons over 65 years, pregnant women, and/or infants. The NHIS requires everyone to self-enroll each year, using this process to account for changes in individual circumstances and eligibility status.[16] LEAP 1000 participants who do not renew miss out on their automatically subsidized premiums.

A recent study found a small increase in NHIS enrollment among LEAP 1000 participants. This suggests that while integrating cash transfers with fee waivers for health insurance can increase enrollment, further improvements are needed for eligible households to fully benefit from NHIS services.[16] Self-enrollment into NHIS is required annually, which is inconvenient and can be a behavioral barrier to initiate and maintain enrollment status, particularly among extremely poor populations.[17] In the general population, those unenrolled in the NHIS reported that their lack of enrollment was impacted by the expensive fees, not realizing their enrollment expired, travel difficulties, lack of trust in NHIS management, long wait times, and confusion about their fee exemption status.[17] The challenges with enrollment and related determinants are applicable not only to the LEAP 1000 population, but also more broadly, as everyone is required to re-enroll each year to utilize services managed via the NHIS.

These insights on the user experience illustrate how the LEAP 1000 program and general NHIS processes produce friction or obstacles, making it difficult for the eligible population to use and receive any potential economic benefits. Data plays a crucial role in improving implementation. Research on how and for whom financial protection programs work can provide key information on the determinants of enrollment and service utilization, and in turn help leaders to design behaviorally led approaches that improve program performance. The city of Goaso, for instance, motivates enrollment and fosters trust by engaging traditional leaders to increase registration.[18] Specifically, traditional leaders require community members to have their NHIS card to visit the palace, an approach that appeals to cultural norms and the community's interest to visit the palace. Similar adaptations for the LEAP 1000 program and processes are needed to better address the existing cognitive, physical, or procedural enrollment barriers.

Senegal has a similar program, called the National Program for Family Security Grants (Programme national de bourses de sécurité familiale (PNBSF)). PNBSF targets mothers from households in extreme poverty with children ages 6 to 12 years, providing them with conditional cash transfers, and covering CBHI enrollment fees.[19] PNBSF is a national program that aims to increase service utilization by providing 25,000 FCFA (approximately 41.88 USD in January 2024 exchange rates) every three months for five years and paying annual CBHI contributions for each family member.

An assessment of PNBSF implementation identified challenges that affected participants' ability to receive cash transfers, including a lack of transparency and inconsistent communication at the community level, socio-cultural and religious barriers, administrative bottlenecks, and limited community involvement in management and accountability.[10] An impact evaluation found that enrollment in CBHI under PNBSF had no impact on access to care, forgoing of care, or out-of-pocket payments for the target population.[20] These findings suggest that free enrollment in CBHI for the general population was insufficient, especially without behavioral interventions, to improve service utilization and to provide effective financial protection. PNBSF's behavioral obstacles, on top of CBHI's, were too numerous and significant for the program to operate as intended.

The highlighted challenges show how programs that fail to incorporate social factors and behavior change processes may not achieve desired levels of financial protection. To inform changes, program designers must gain a deeper understanding of what drives behavior, including the factors and biases affecting people's use of

the benefits package, how service delivery mechanisms work, and the implementation context. This information can be gathered through formative research that examines the behaviors and engagement of cash transfer participants, providers, and the social protection and insurance managers. Behavioral science approaches to understand and address behavioral barriers include automating insurance enrollment, reducing friction through improved wait times and care experience, and solving administrative bottlenecks.

Finally, the socio-ecological model can be used to better understand the factors that may impact the uptake of a desired behavior, like service utilization, across the levels of the model. This can lead to program designs that target engagement at each level of the model via SBCC and community-based strategies that feature institutionalized community participation, two-way tailored communication, and responsive and adaptative programming. Following redesign, the implementation experience will also provide valuable learnings to understand how and if the program is working and whether iterative changes are needed.

Social health insurance in the Philippines and India

SHI programs are typically characterized by compulsory enrollment, eligibility for benefits when premiums are paid and/or subsidized, and a documented benefits package. The ability of these programs to provide financial protection, especially for the poor, depends on how these components are implemented.[21] While SHI programs are often designed for civil servants and those employed in the formal sector, some countries have expanded SHI eligibility to the broader population based on economic or health status.

Government-paid SHI premiums for the poor aim to reduce their direct health payments and increase health protection. Yet this approach alone can be insufficient to ensure risk protection. The Philippines' national SHI scheme, called PhilHealth, includes a government-paid premium subsidy for the poor. Its initial implementation encountered behavioral obstacles. For example, people in the eligible population were often unaware of their benefits and enrollment requirements, making them unable to use their insurance.[22] Women also reported cultural and financial barriers to accessing care, including needing permission and money to go for treatment and not wanting to go alone.[23]

A study assessing service use by the poor under PhilHealth found that while it increased facility-based deliveries, there was no impact on the other services included in the benefits package.[23] To address enrollment concerns, behaviorally informed shifts were implemented, simplifying the process with point-of-care registration by nurses and then universal entitlement under the 2019 UHC bill.[24, 25] These changes are notable as they address some behavioral barriers to SHI use. In the future, it will be important to evaluate the effects of these changes and determine whether other efforts to improve health and benefits literacy, or overcome cultural barriers to service use, are also needed.

In contrast, the SHI scheme Vajpayee Argoyashree (VAS) from Karnataka state in India succeeded in increasing utilization and reducing the financial burden of tertiary care for households below the poverty line.[26] The scheme covers free care at the point of service, requiring no premium or co-payments for select tertiary services, and was uniquely designed in a way that supported the eligible population to make use of VAS benefits. Behaviorally informed interventions included organizing camps in rural areas for health screenings, with referrals and transportation to tertiary care as needed. The SHI scheme integrated behavioral science, community engagement, and SBCC strategies to increase enrollment and use of the VAS. The behaviorally aware design and implementation of VAS, which included community outreach through health camps, easy enrollment, cashless treatment, and contracting with private facilities, is hypothesized to have contributed to its success.[26]

Those who possessed a card for below-the-poverty-line status -- about a third of the eligible population -- were automatically enrolled. This convenience removed obstacles to entry, shaping the context and reducing friction for enrollment. Free care meant cashless treatments, thus removing financial risks. Contracting with both public and private providers increased geographic access to health services and potentially higher quality care. These elements were key design choices that supported VAS implementation through a blend of behavioral approaches.

The experiences of PhilHealth and VAS suggest that an SHI, or any insurance coverage aiming to address inequities, should include SBC approaches to support eligible users' comprehension of their benefits and how to access care, and reduce behavioral barriers to enrollment. VAS's automatic enrollment of one-third of the eligible population removed a key barrier to entry that was faced by PhilHealth. The health camps served as convenient communication and advocacy channels to promote understanding of health risks, VAS benefits, and service use. This may have also increased consumers' trust in VAS. For its part, PhilHealth has demonstrated adaptive changes over time, despite its challenges. It could benefit from further integrating a behavioral lens into its implementation, focusing on the perspectives of the user and the overall health system.

IMPLEMENTATION CONSIDERATIONS

The cases above show how integrated SBC approaches can strengthen financial protection by addressing societal drivers and barriers. Historically, health financing programs have sometimes ignored important social and behavioral factors that strongly moderate the direct effects of economic incentives, perhaps assuming that the effects of incentives alone would be sufficient to achieve desired behavior changes. The SHI examples demonstrate ways to better align programming with population needs and preferences by integrating behavioral insights. Effectively integrating SBC into financial protection can support programming that drives individual and collective change and leads to enabling social, market, policy, and physical environments.[3] The following are key recommendations to consider when designing, implementing, and monitoring financial protection programs that integrate behavioral approaches.

Make financial protection programs easier to participate in using behavioral science.

Since financial protection programs require individuals to complete actions for effective implementation, they need to be designed for easy participation and convenience. Current efforts have created obstacles that leave eligible populations susceptible to financial risks. Integrating behavioral science into programming can resolve these barriers by creating a supportive and enabling environment that makes participation easy for providers, patients, and communities. Design examples include automatic benefits enrollment and entitlement, separating the need for financial contributions from the moment of care provision, clinical job aids to address biases to improve patient care and reception, and use of digital tools and biometrics.

Institutionalize community engagement, including iterative problem-solving.

Community engagement and iteration need to be institutionalized into financial protection efforts to mitigate the under-prioritization of social factors. Shifting from an ad-hoc to a structured approach to connect with communities will address the existing disconnect and help in more proactively solving future challenges. When programming centers community perspectives, it allows for adaptations based on needs. Community engagement in financial protection programs should include two-way communication, the establishment of core engagement standards, and community governance responsibilities to ensure that programming is accountable to the community. The approaches used should align with the broader system, including government frameworks, policies, strategies, and accountability frameworks. Protocols for routinely monitoring and assessing program implementation, including whether the program is accepted by the community, reaching the target population, effective, and sustainable, need to be established and governed by the community.

Target behaviors across all levels of the implementation ecosystem.

SBC approaches are relevant across the implementation ecosystem. Groups whose behavior can be targeted include, but are not limited to, patients, community members, and health care providers; policymakers and staff within government agencies; and private sector institutions. The health sector often focuses on individual behaviors, frequently patients and providers, but the success of financial protection programs is dependent on actions and behaviors at both the individual and institutional levels. Engagement across the levels of the socio-ecological model (individual, interpersonal, community, services and institutions, policy and environmental) should be targeted by level while accounting for systems dynamics between and across levels. Example approaches include using the socio-

ecological model to identify behavioral challenges at each level, selecting SBC approaches relevant to each level, and designing tailored programs that support behavior change. SBCC strategies should be adopted using language and communication means deemed appropriate for the focal audience and desired outcomes.

CONCLUSION

Integrating behavior change into the design, implementation, monitoring, and evaluation of financial protection programs is a promising approach as part of addressing financial barriers to health care. With increasing numbers of people experiencing hardship from health spending, there is need for innovative thinking and action, including financial protection programming that advances UHC by integrating behavioral insights to address the social drivers of and barriers to financial protection.

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