Comparative Equity Performance of Tax-Funded Health Systems in Asia: Findings from the Equitap Project

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Introduction
&
Findings

Introduction

- ## Why does performance of tax-funded systems matter?

  - Tax-funding remains only practical option for most low-income countries, but conventional wisdom questions effectiveness of tax-funded systems

  - Only countries in Asia to equalize equal use of health care:

    - High income economies (social insurance/tax-funded)
    - Tax-funded low/middle income economies

- ## Findings from Equitap:

  - Tax-funded systems do not perform the same - represent full range of performance

  - Conventional wisdom <u>wrong</u> - many tax-based systems reach the poor

Defining Tax-funded Systems

Country	Tax as % of public funding	Tax as % TEH	Social insurance as % TEH	TEH as % GDP
Hong Kong SAR	100	55	0	5.7
Sri Lanka	100	50	0	3.5
Bangladesh	100	27	0	3.3
Nepal	100	24	0	4.0
Malaysia	96	55	1	3.0
India	95	41	1	5.0
Indonesia	94	24	2	3.0

* General revenue funding >90% of public financing
* Social insurance < 5% of TEH

Diversity of Tax-funded Systems

| Country	Population	GDP per capita (1995 PPP$)	IMR
Nepal	20.9 m	1,123	64
Bangladesh	131.1 m	1,427	54
India (Punjab)	2.4 m	2,229	68
Indonesia	209.0 m	2,768	32
Sri Lanka	17.7 m	2,845	15
Malaysia	23.3 m	8,217	8
Hong Kong SAR	6.7 m	23,735	3

Catastrophic impact in Tax-Funded Systems:
Percent households experiencing impact >15% of non-food expenditure
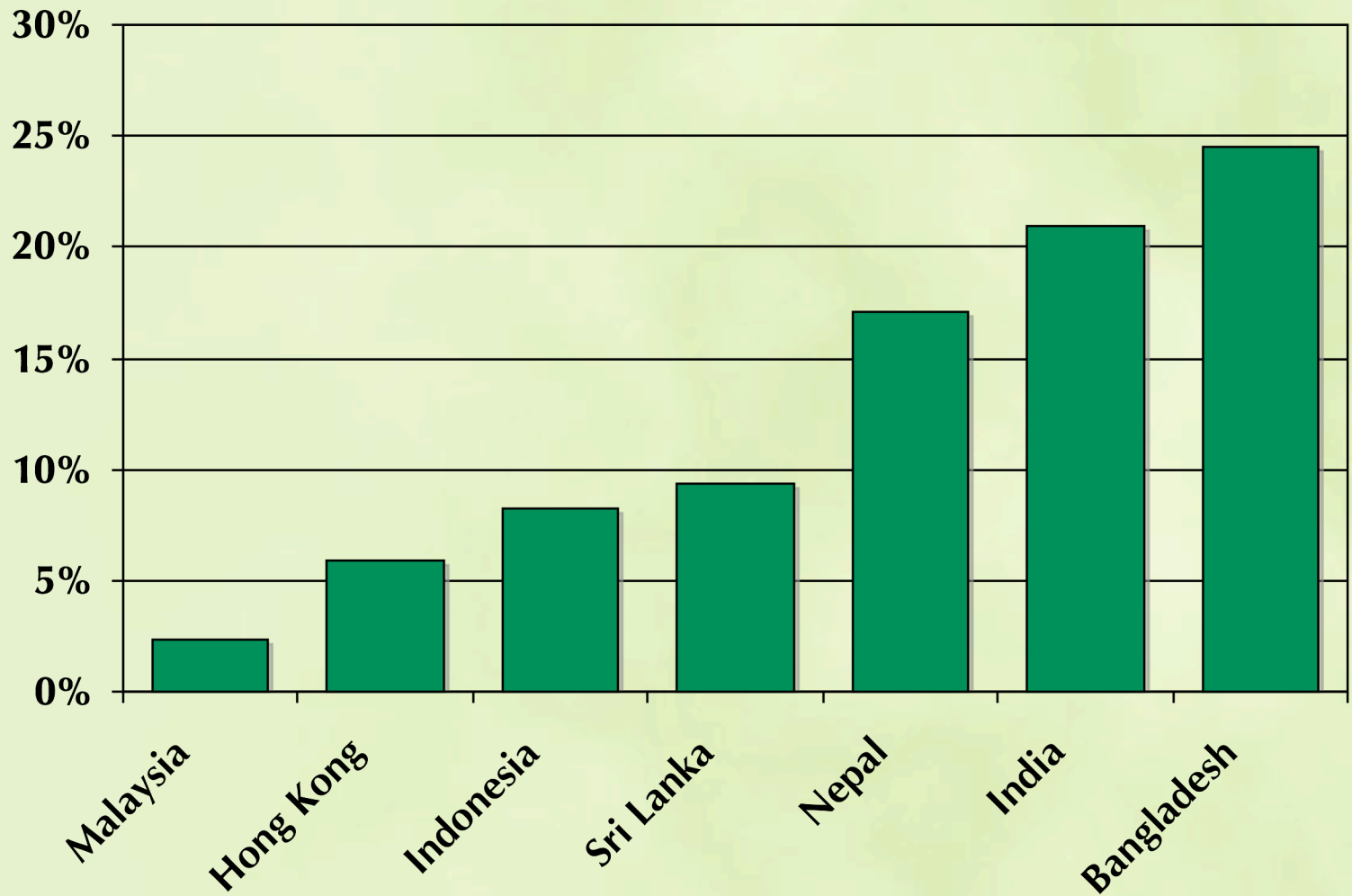
Poverty impact in tax-funded systems:
Head count (<PPP$1/day level)
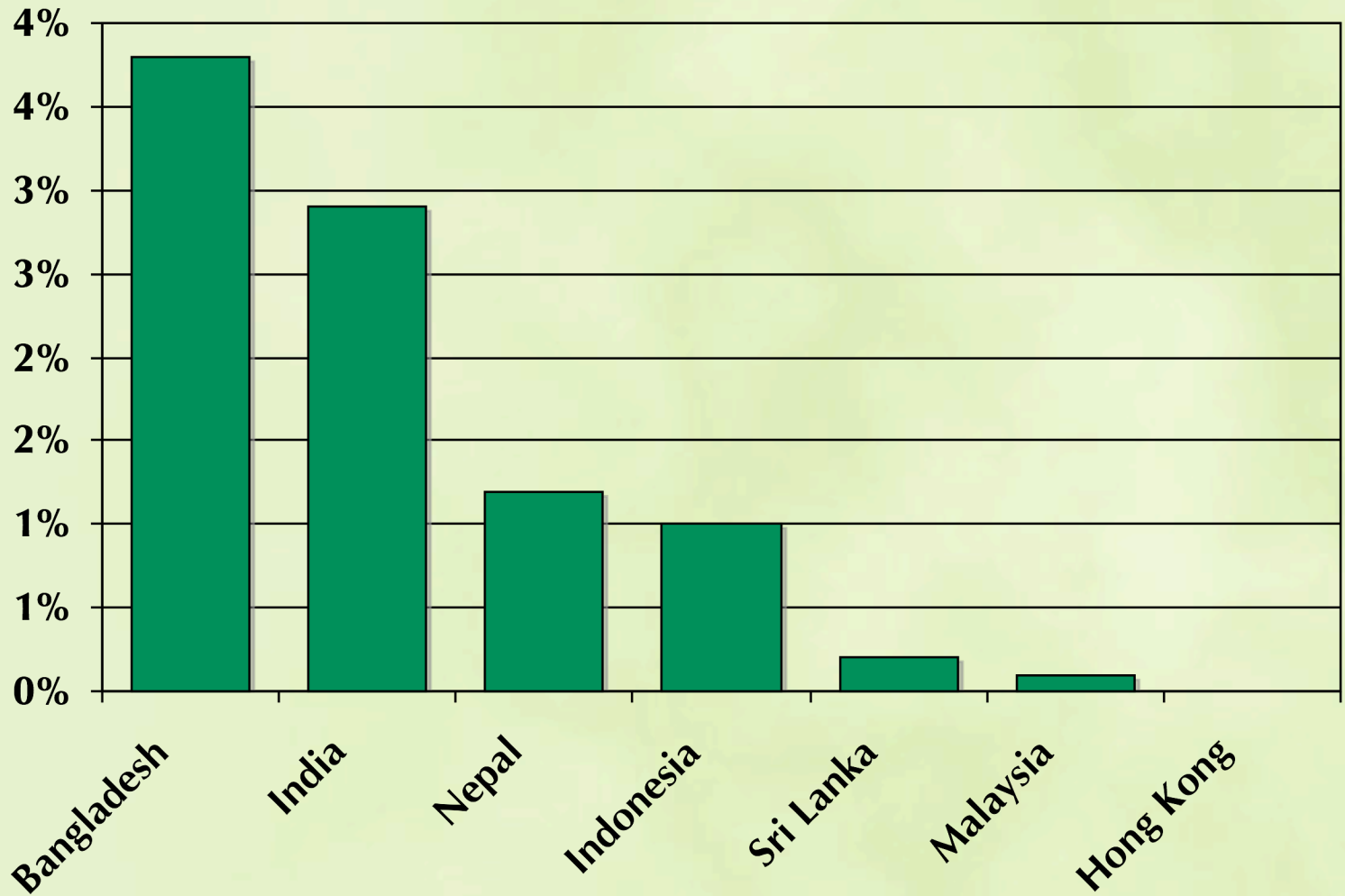
Targeting of government expenditure:
Concentration index for total public subsidies
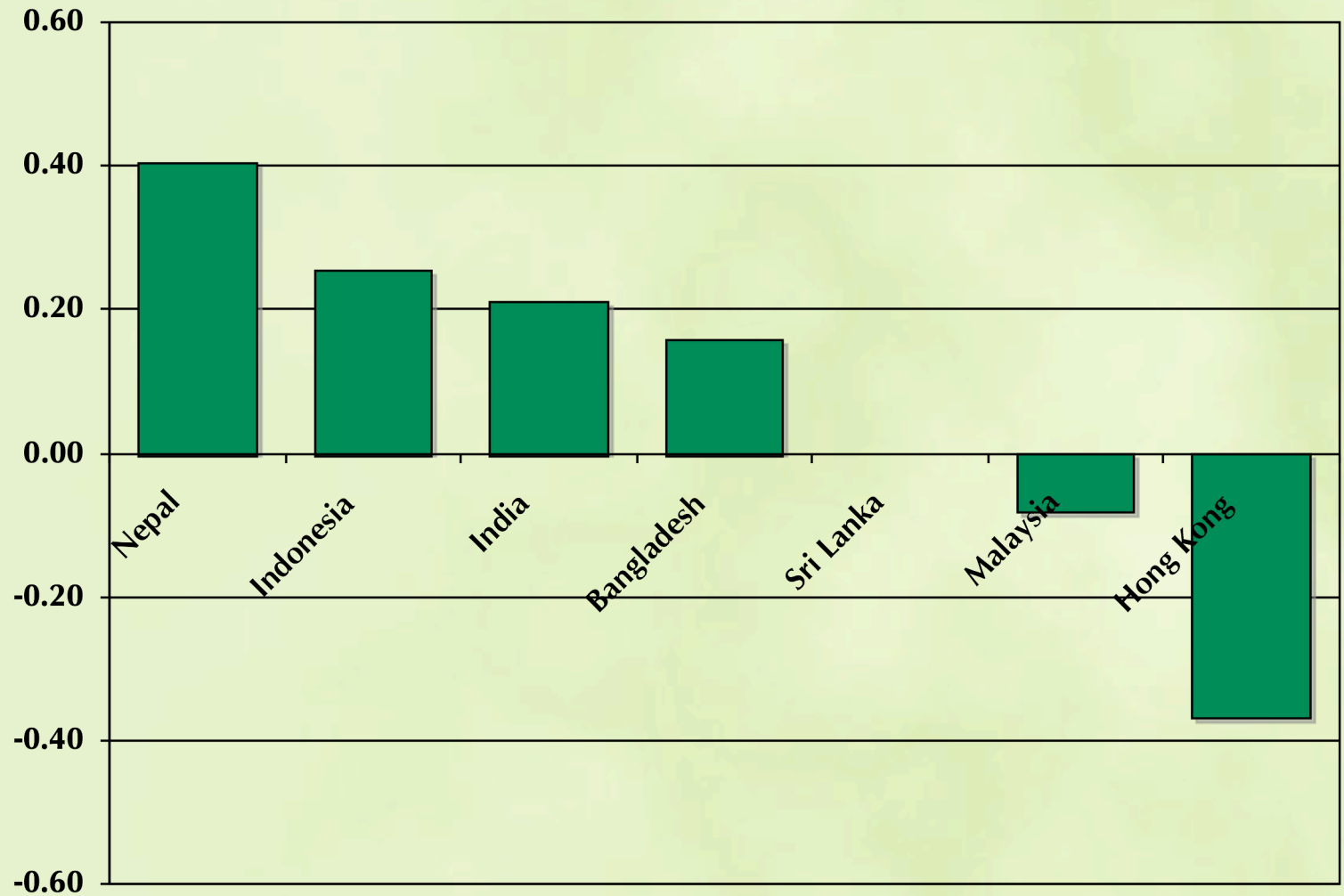
Summary of equity performance of tax-funded systems

| Country	Catastrophic impact	Poverty impact	Targeting of government spending	Health outcomes
Nepal	Large	Large	Pro-rich	Poor
Bangladesh	Large	Large	Pro-rich	Poor
India (Punjab)	Large	Large	Pro-rich	Poor
Indonesia	Modest	Modest	Pro-rich	Poor
Sri Lanka	Negligible	Negligible	Proportional	Good
Malaysia	Negligible	Negligible	Pro-poor	Good
Hong Kong SAR	Negligible	Negligible	V. pro-poor	Good

Underlying Differences

User fees in public sectors

Country	Official fees	Informal fees
Bangladesh	IP care - modest charges	Very common
Hong Kong SAR	IP and OP care - nominal charges	Negligible
India	IP and OP care - modest charges	Common
Indonesia	IP and OP care - varying charges by facility	Common
Malaysia	IP and OP care - nominal charges	Negligible
Nepal	IP and OP care - modest charges	Very common
Sri Lanka	IP and OP care - free	Infrequent

Distribution of use of public and private inpatient care by quintiles (standardized rates)
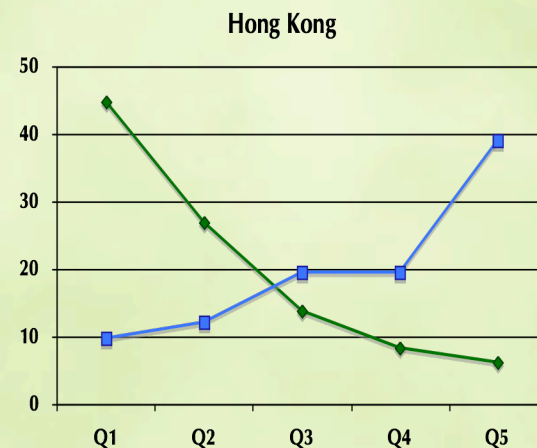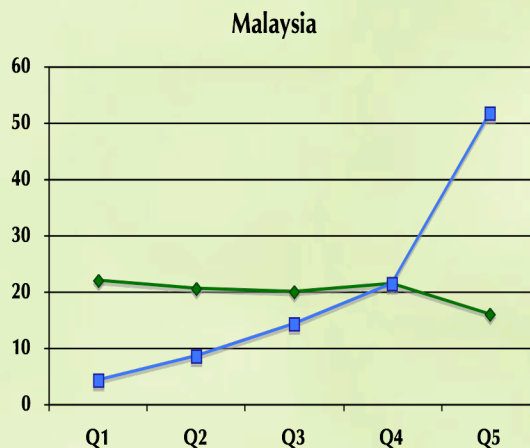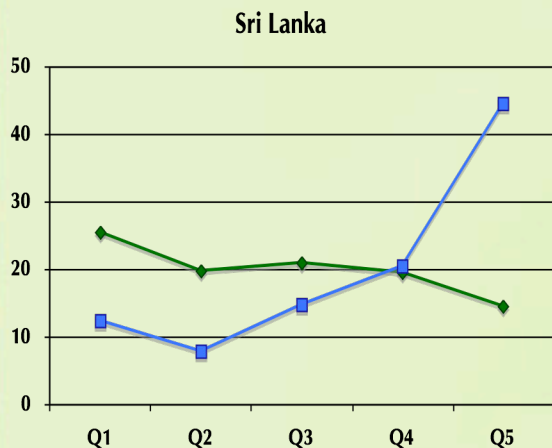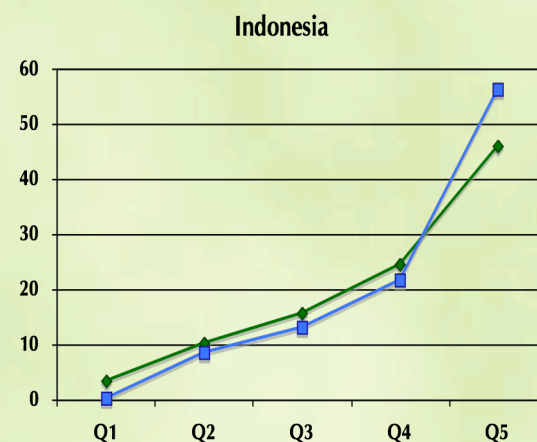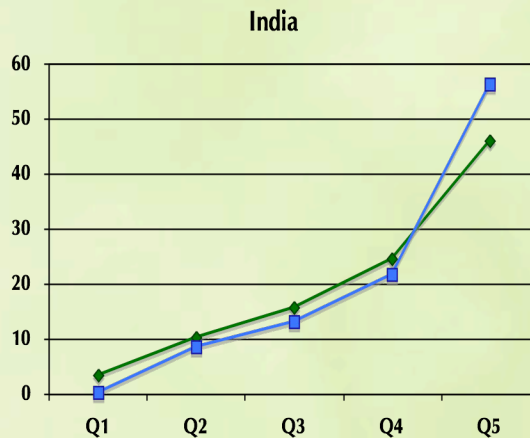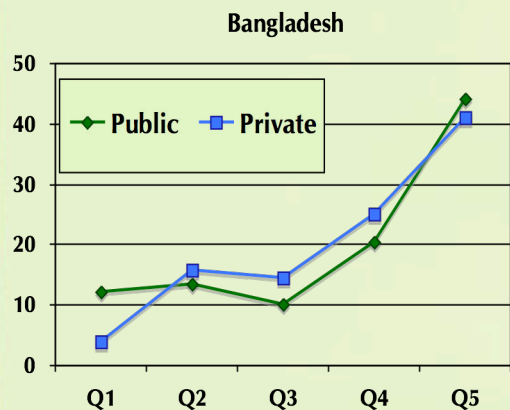
Distribution of use of public outpatient care by quintiles (standardized)
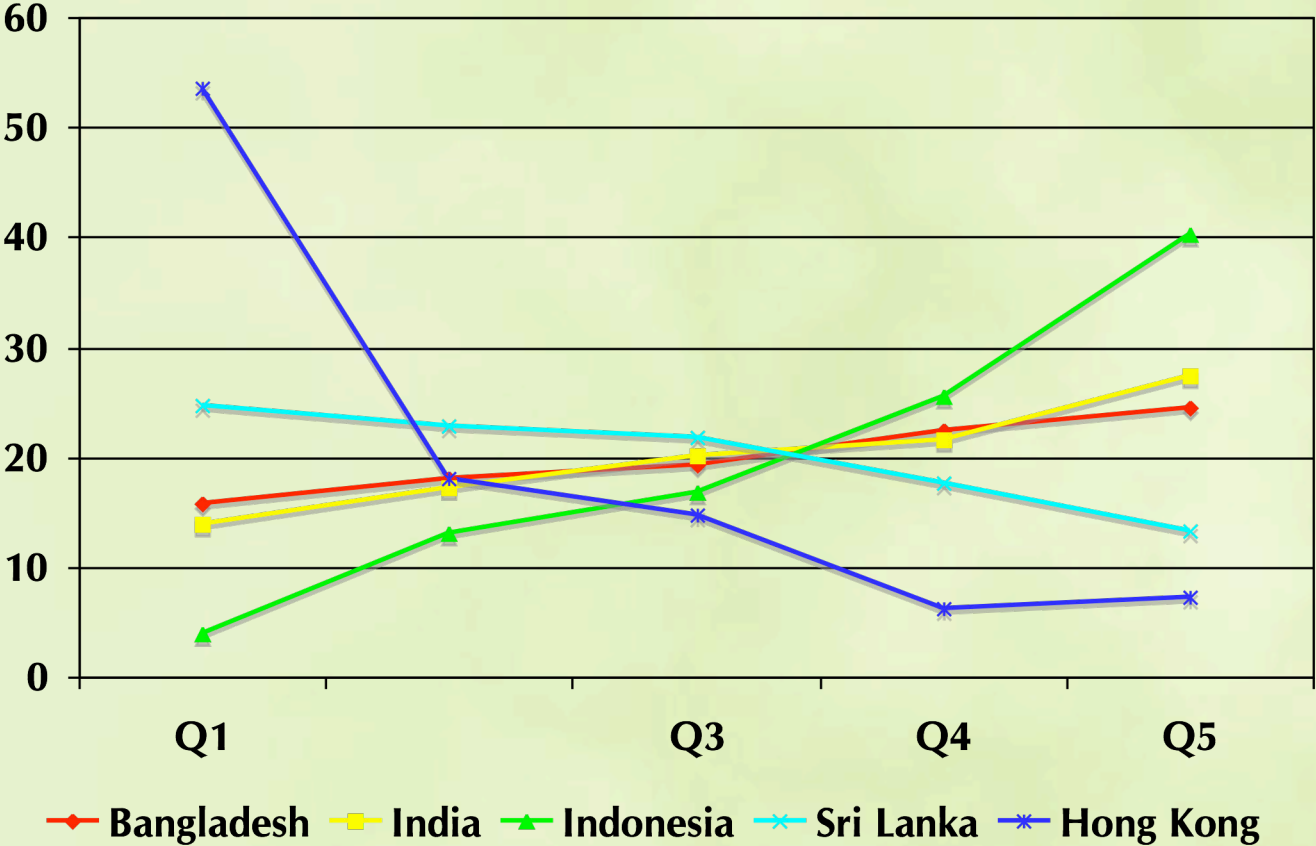
Observations

* Two distinct groups of tax-systems according to performance:
  * (1) Poor risk protection, poor targeting (BAN, NEP, IDO, IND)
  * (2) Good risk protection, good targeting (SRI, MYA, HKG)
* Use of public & private provision
  * Both pro-rich in Group (1) countries
  * Public provision pro-rich in Group (1), pro-poor in Group (2)
* Targeting of government spending
  * Group (2) - not explicit or direct
* Consistent with Besley-Coate Hypothesis
  * Under budget constraint, public services can be universally-provided; if richer individuals opt for private care, targeting will be pro-poor
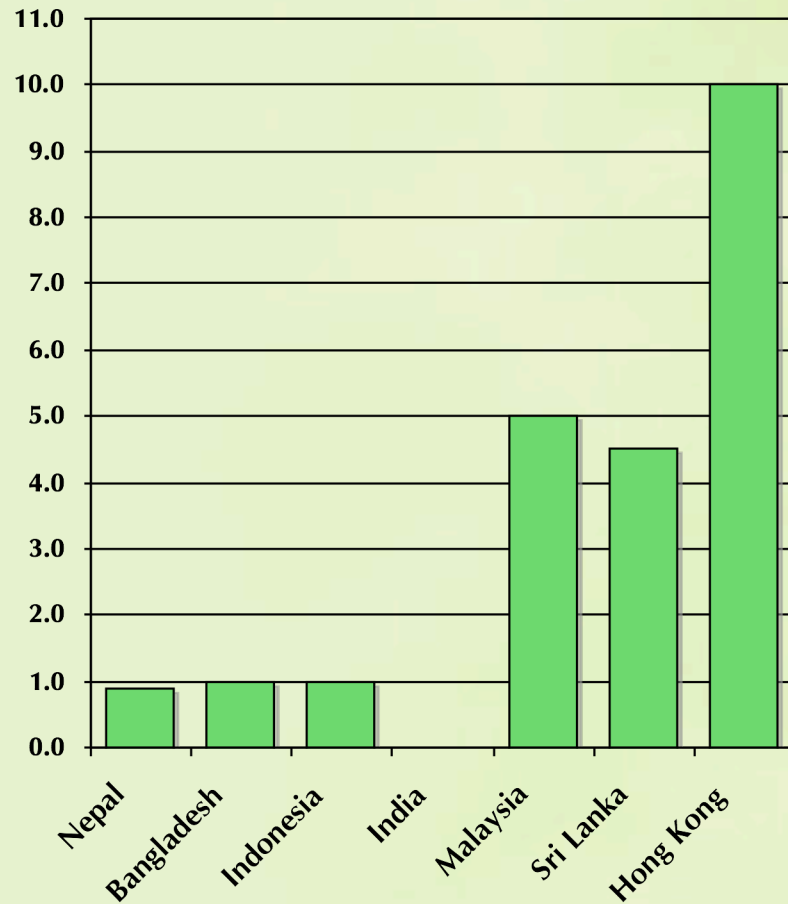
Explaining the Differences

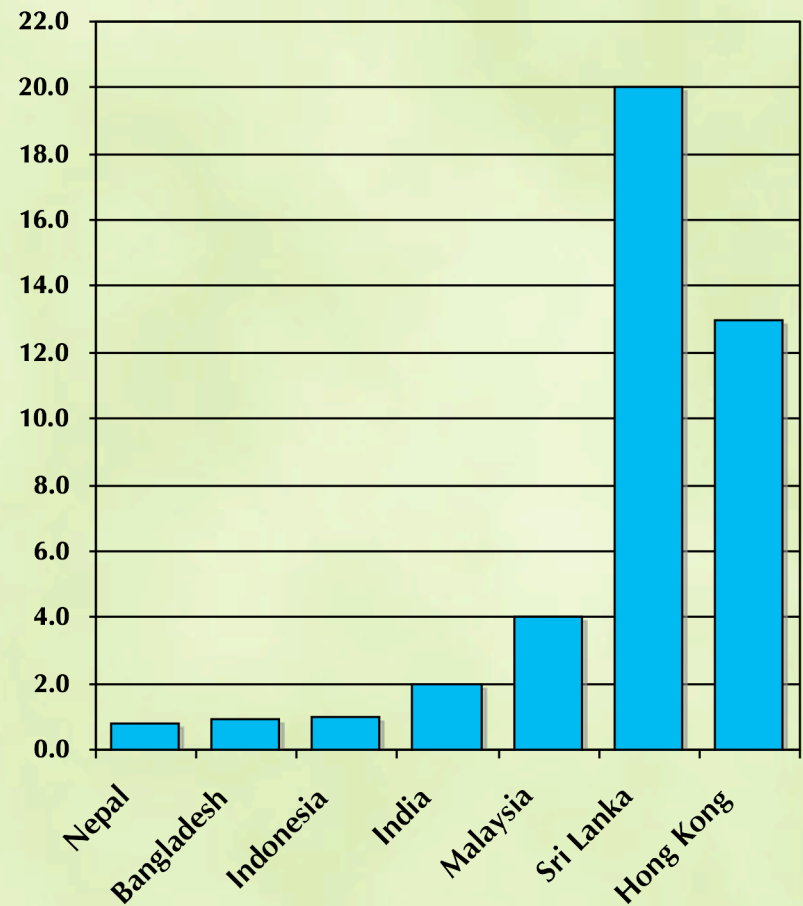# Achieving universal access under budget constraints: The level of supply of health care

Public sector beds per 1000 capita

Physicians per 1000 capita
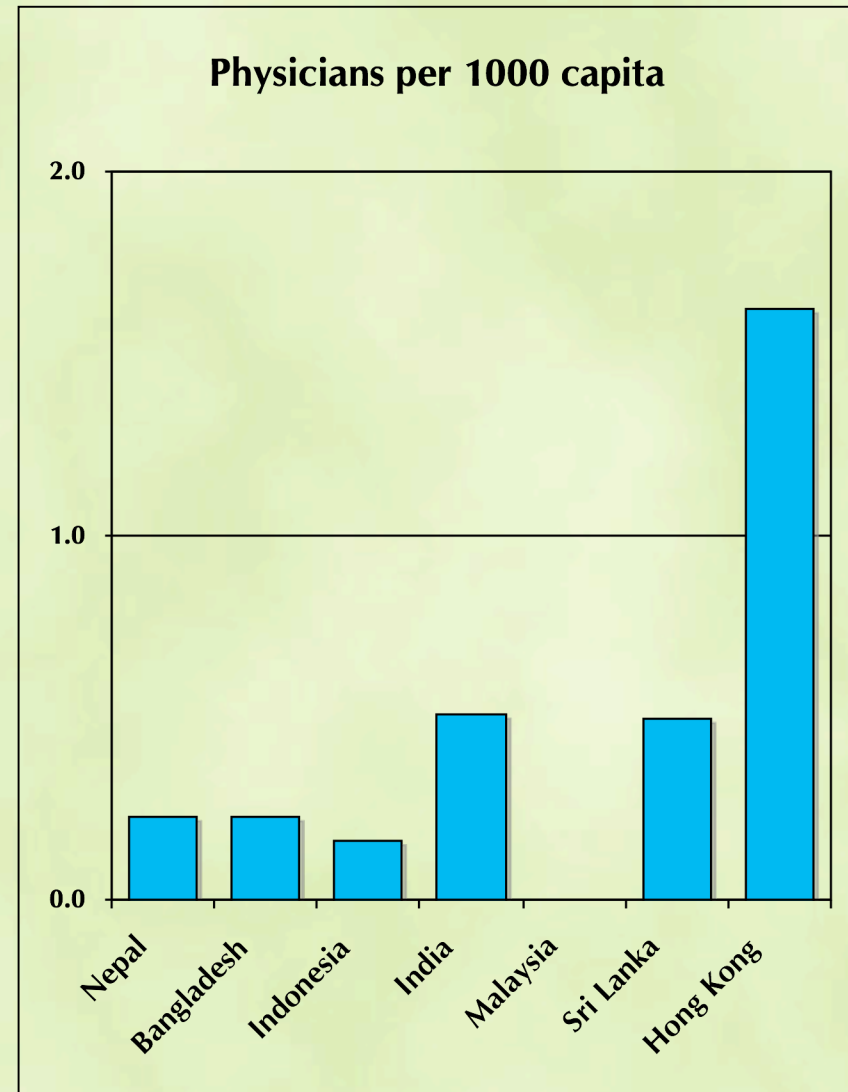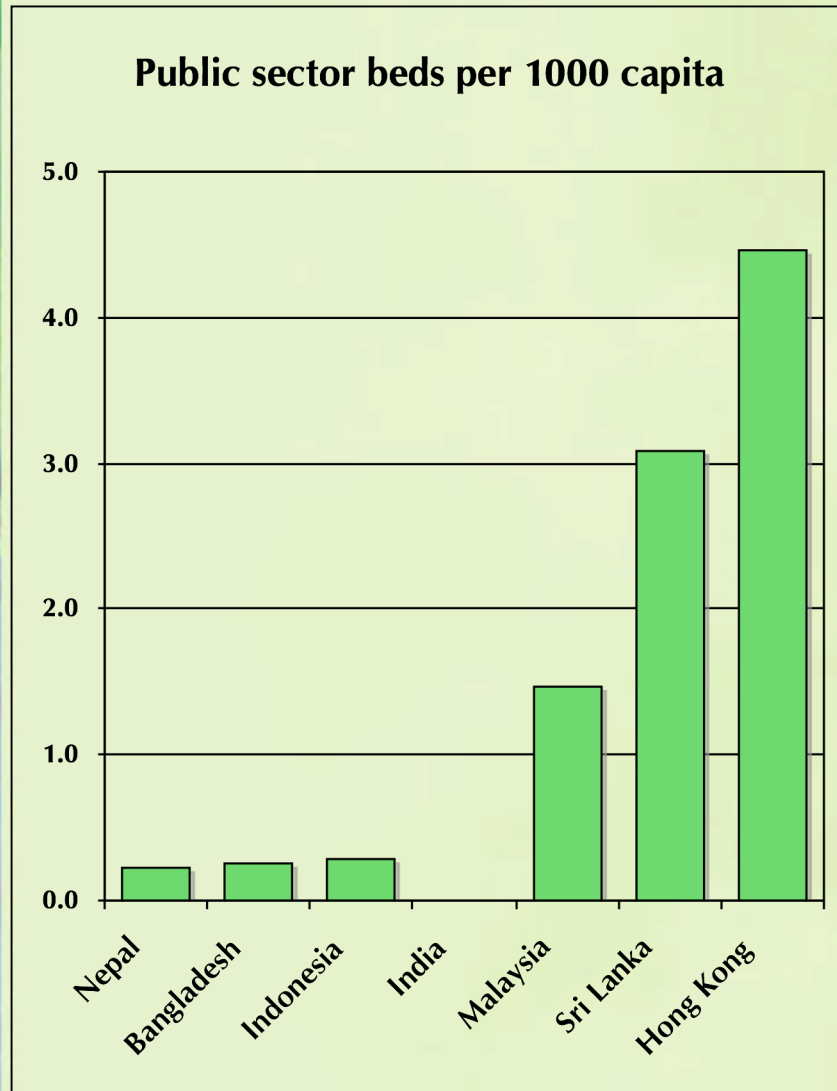
Achieving universal access under budget constraints: The level of use of health care

Outpatient visits per capita per year

Country	Value
Nepal	~0.9
Bangladesh	~1.0
Indonesia	~1.0
India	
Malaysia	5.0
Sri Lanka	~4.5
Hong Kong	10.0

Inpatient admissions per 100 capita

| Country	Value
Nepal	~0.8
Bangladesh	~1.0
Indonesia	~1.0
India	2.0
Malaysia	4.0
Sri Lanka	20.0
Hong Kong	13.0

Comparison of public hospital provision in historical Sri Lanka, Malaysia and Hong Kong with contemporary Nepal, Bangladesh and Indonesia
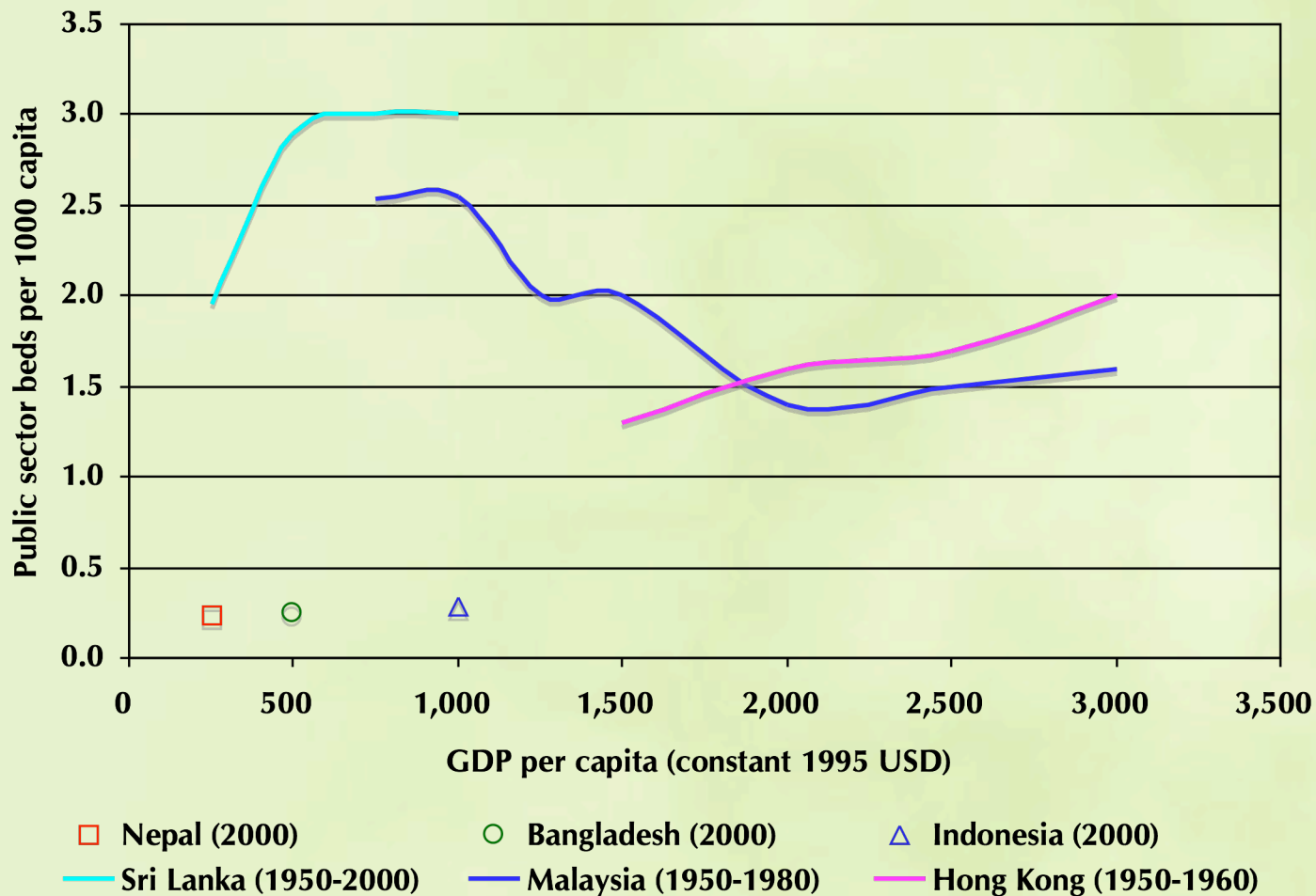
Comparison of public outpatient use in historical Sri Lanka, Malaysia and Hong Kong with contemporary Nepal, Bangladesh and Indonesia
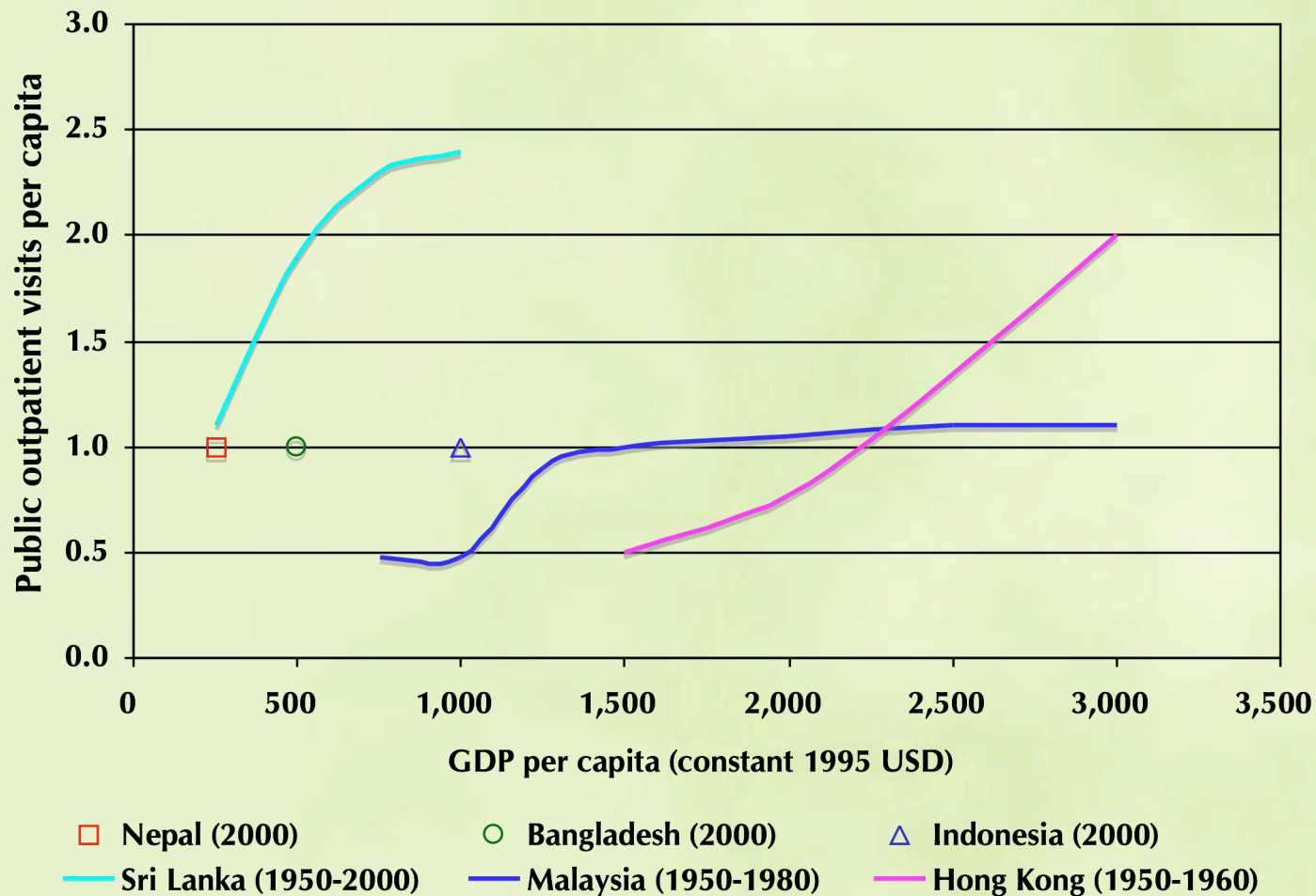
History and Governance

Country	History	Governance 1950s
Nepal	Independent monarchy	Poor
Bangladesh	British colony - indirect rule	Poor
India	British colony - indirect rule	Poor to fair
Indonesia	Dutch colony - indirect rule by East India Company	Very poor
Malaysia	British Crown Colony - direct rule	Good
Sri Lanka	British Crown Colony - direct rule	Good
Hong Kong SAR	British Crown Colony - direct rule	Good

Critical mechanisms

* High levels of public provision early on:
    * Much higher than seen in most LDCs
    * Critical to ensure effective universal access by poor
    * Easier to equalize use when demand is not volume constrained
* Prioritization of public spending to hospitals/inpatient care:
    * Higher than regional average
    * Critical to ensure adequate risk protection
* Reliance on indirect targeting:
    * Voluntary self-selection of wealthy to private sector - Group 2 countries never solved how to means-test
* Good governance:
    * Efficient public sector delivery
    * Public service mission ethos
    * Less prevalence of informal fees/no history of rent extraction
    * Accountability pressure for high allocations to inpatient care & effective universal access

Policy messages

🌿 Need to take seriously and understand good-performing tax-funded systems

🌿 Indirect targeting more effective than direct targeting - requires change of perspective and agendas

🌿 High levels of public supply with limited budgets requires attention to technical efficiency and mechanisms for improving productivity

EQUITAP

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