User Fees in Health: An Asia-Pacific perspective

Ravi P. Rannan-Eliya
Director, Institute for Health Policy

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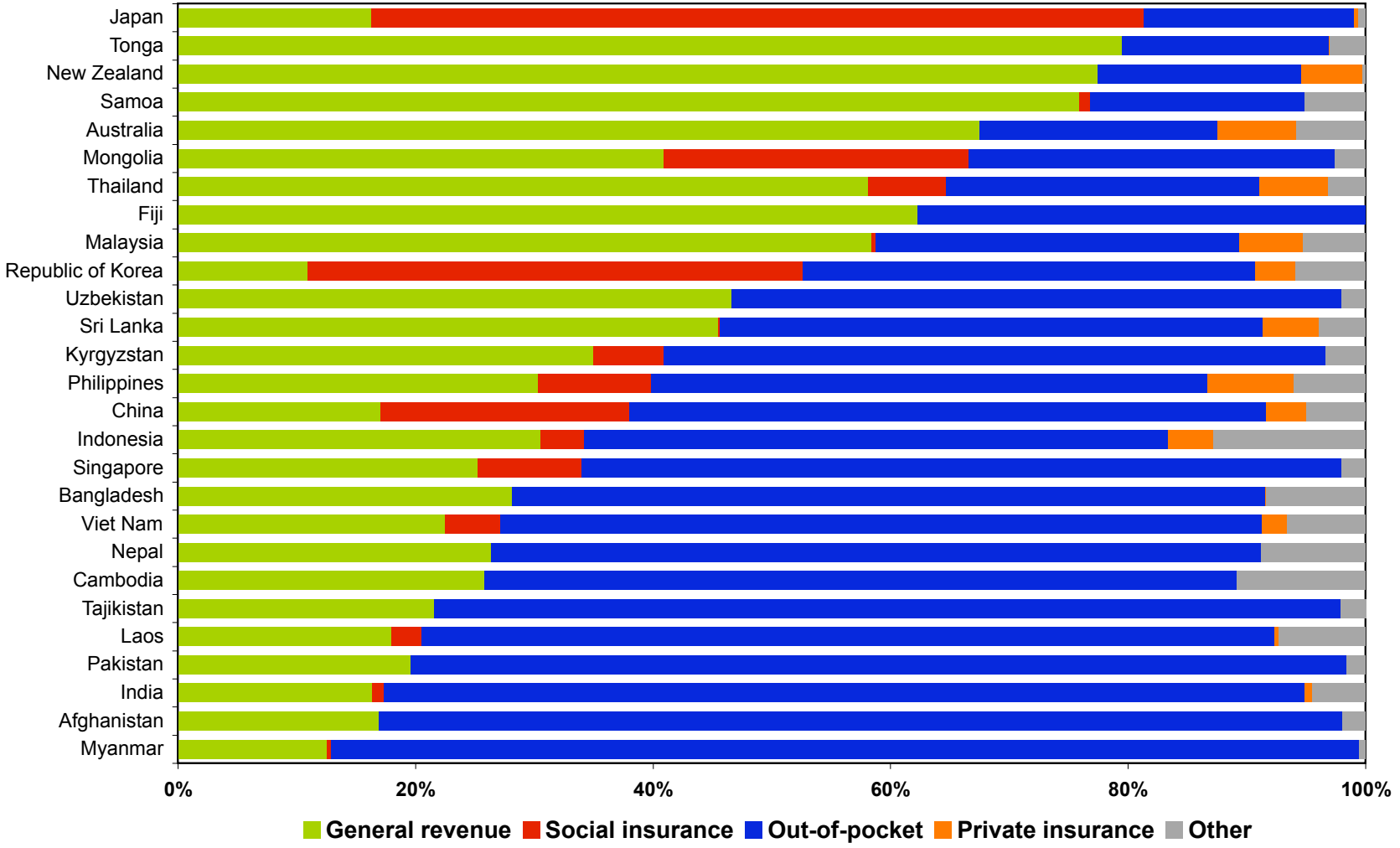
Outline

- Healthcare financing situation in Asia-Pacific region
- Impacts of out-of-pocket and user fee financing
- Policy responses
- Current agenda

Reliance on out-of-pocket in healthcare financing in Asia



Out-of-pocket ≠ User fees

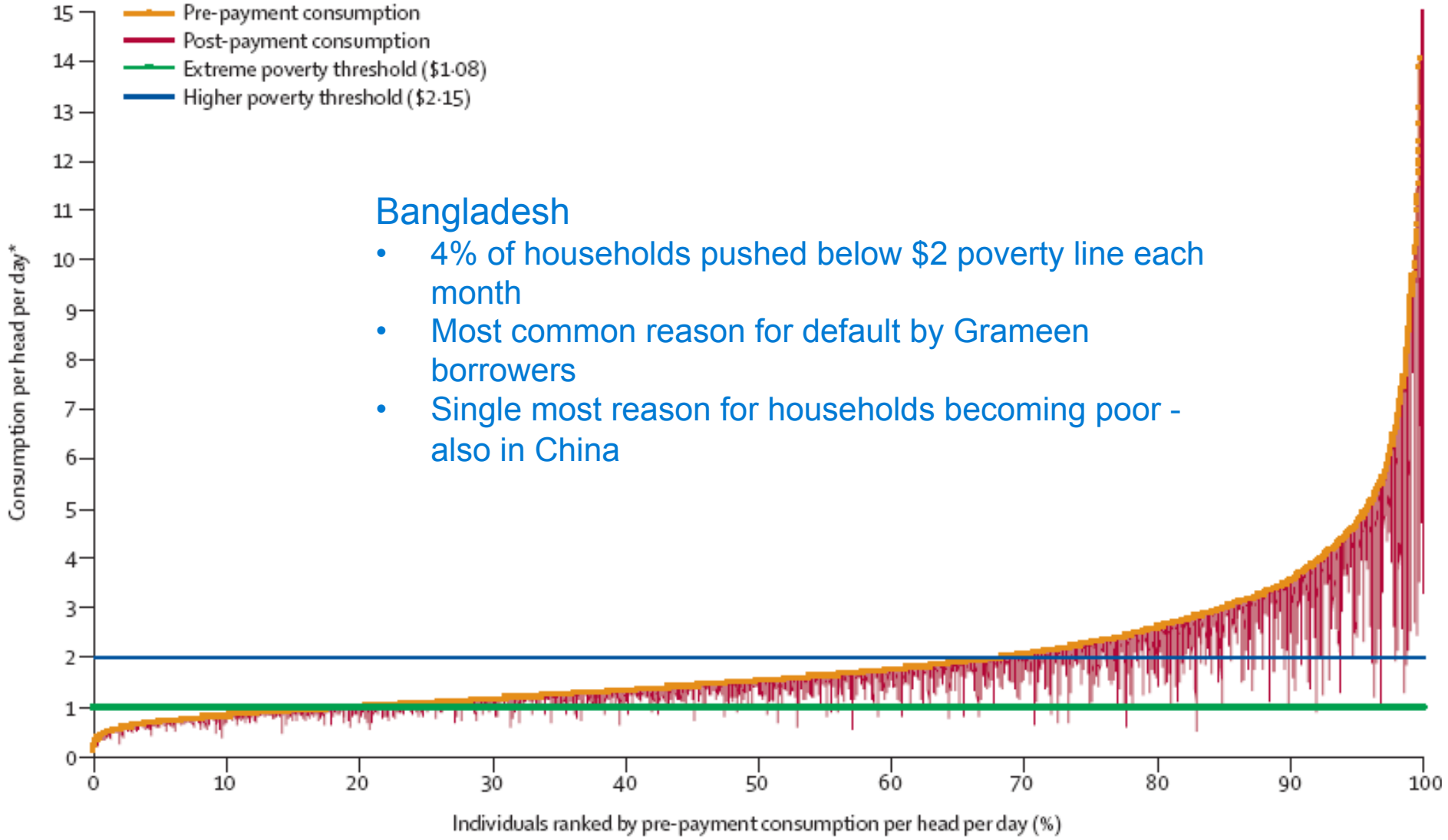
- Countries with significant reliance on official user charges in public sector, with large proportion of OOP being user fees
  - China, Vietnam
- Countries with low official charges, but substantial informal payments in government facilities
  - Bangladesh, Cambodia, Indonesia
- Countries with minimal reliance on public sector user charges, with user fees being trivial part of OOP
  - Sri Lanka, Malaysia, Mongolia, Thailand

Impacts of out-of-pocket payment and user fees

- Out-of-pocket payment (OOP)
  - Increased incidence of catastrophic expenditures
  - Increased impoverishment
  - Perverse incentives for providers

- User fees in public sector
  - *All of above, plus:*
  - Reduced access by poor to subsidized care, i.e., greater inequalities in access
  - Legitimization of informal payments
  - Commoditization of medical services
  - Reduced pressures for cost efficiency

OOP >> Impoverishment

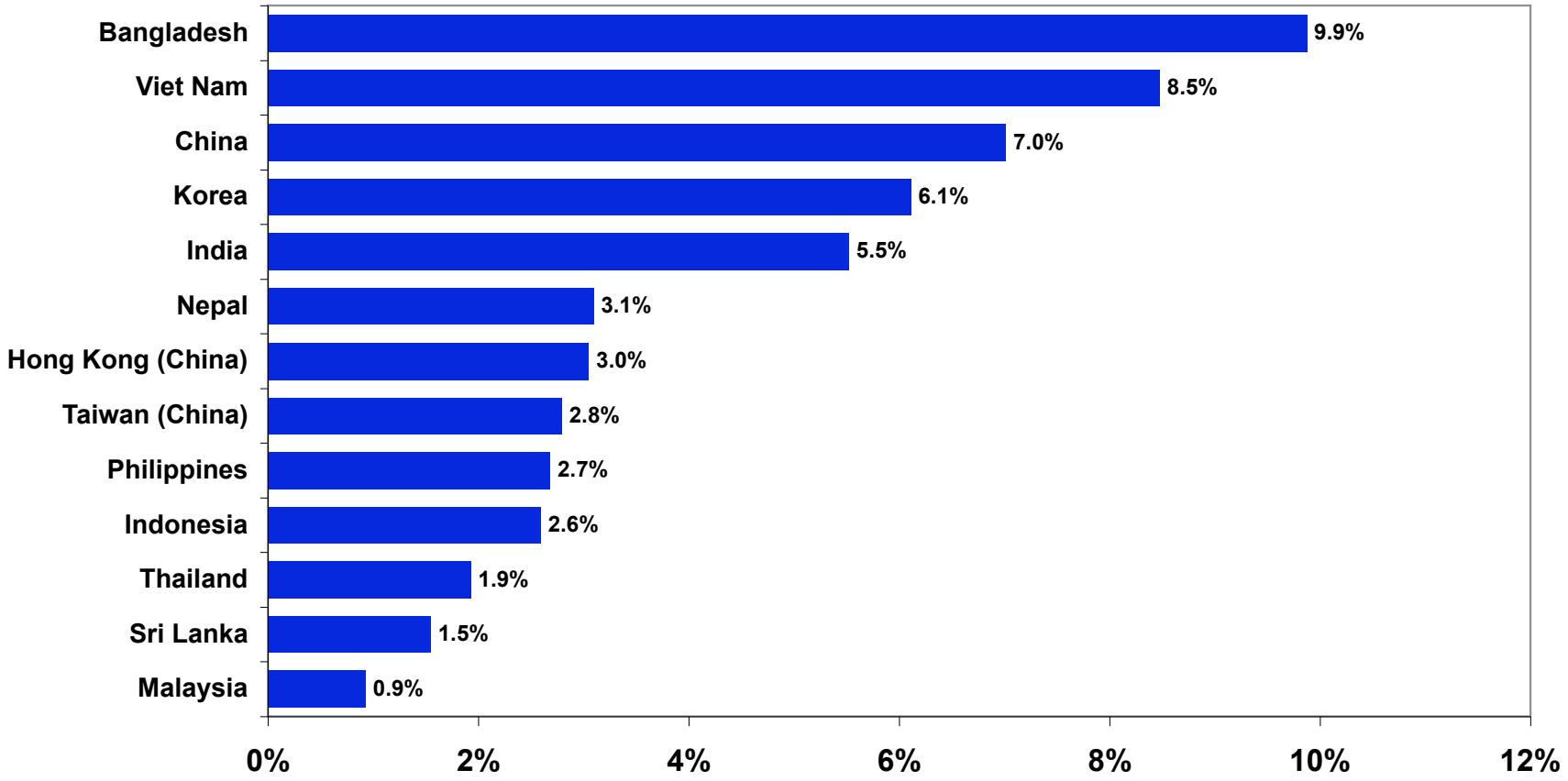


Bangladesh

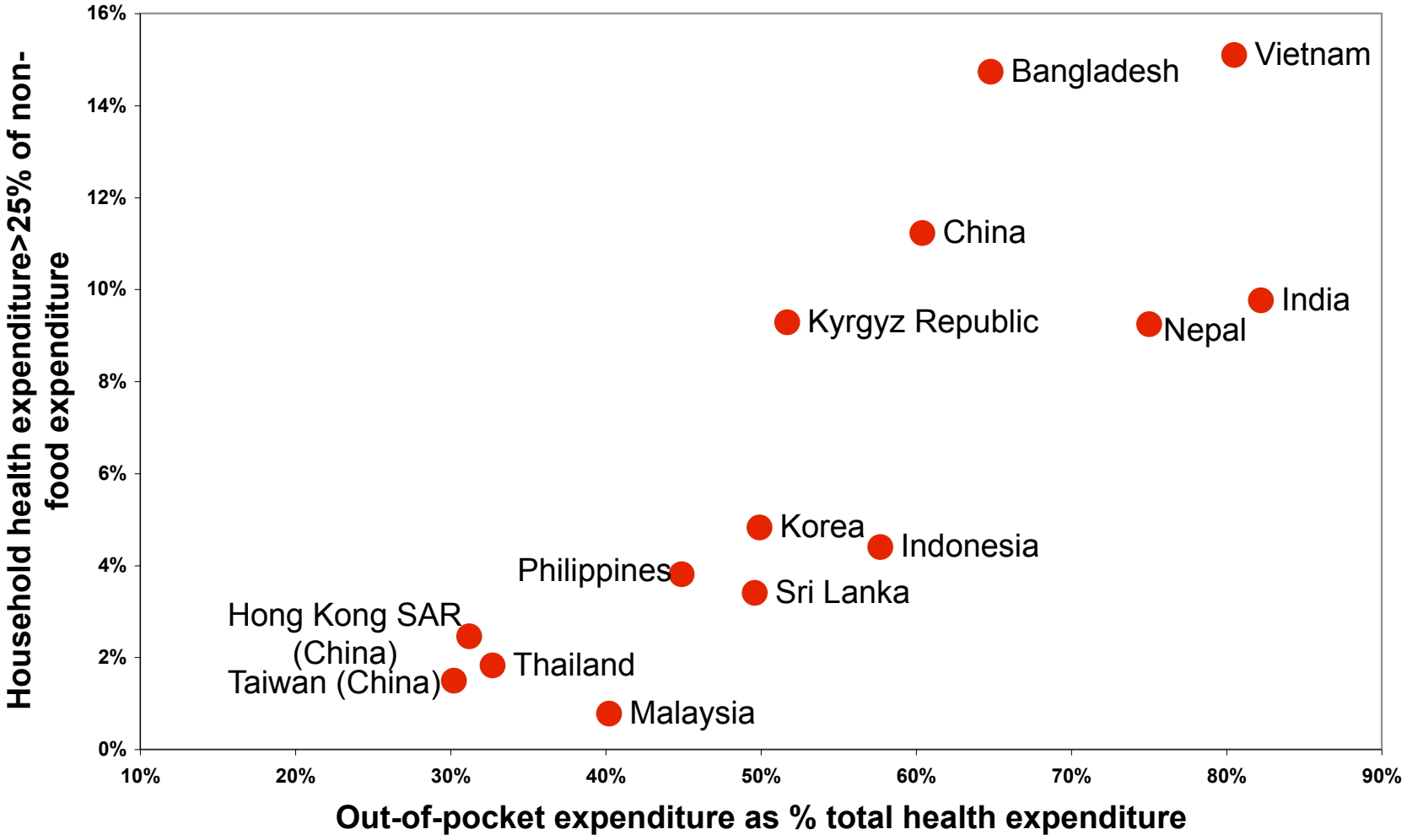
- 4% of households pushed below $2 poverty line each month
- Most common reason for default by Grameen borrowers
- Single most reason for households becoming poor - also in China

OOP >> Catastrophic impacts on welfare

Households forced to spend more than 15% of income on healthcare



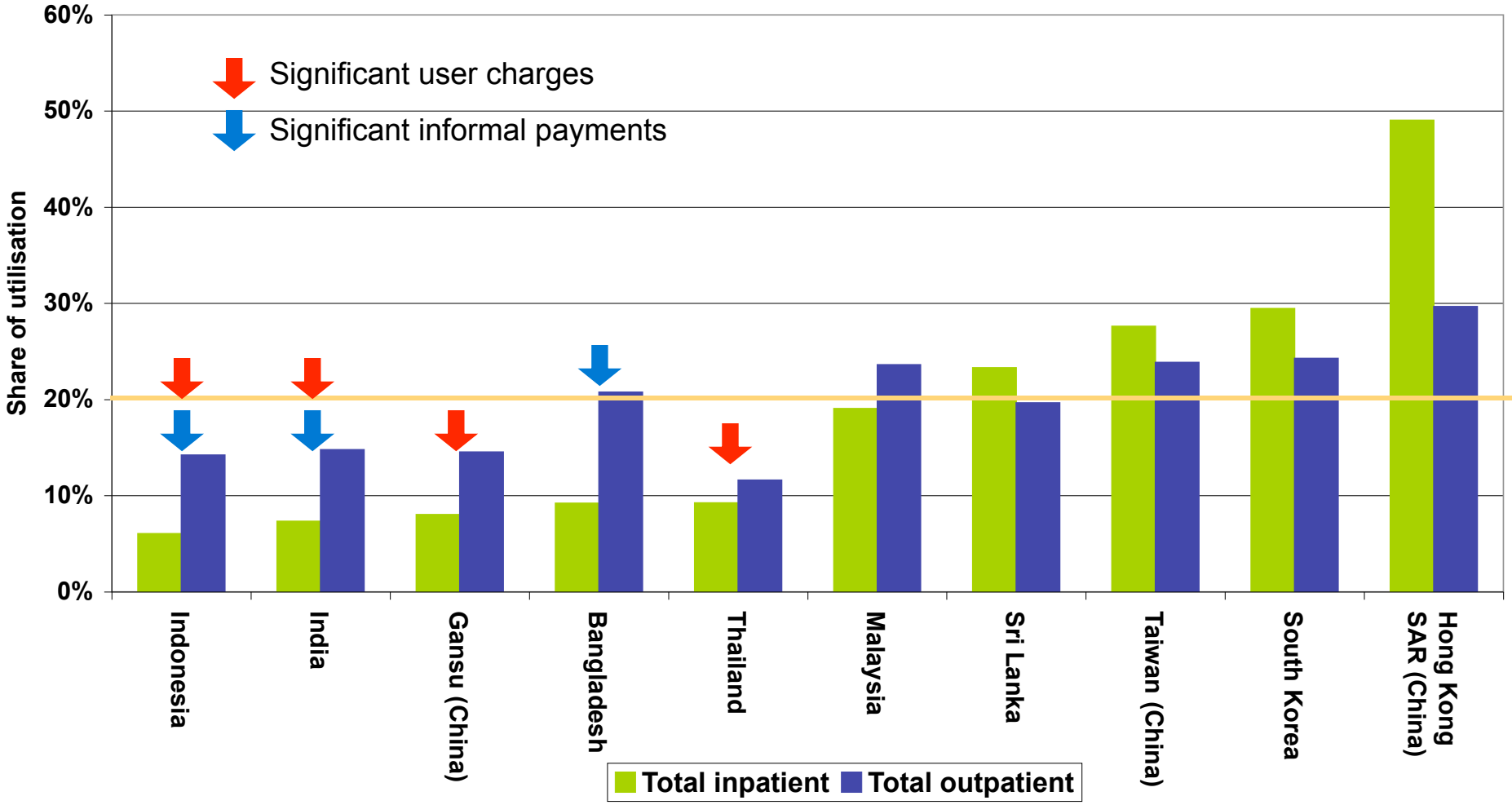
Direct link between catastrophic expenditures and reliance on OOP



Normative implications of user fees

- Legitimization of informal payments
  - Associated with greater tolerance for informal charging
    - Bangladesh, China, India
  - Tendency for informal payment to be more prevalent in countries with history of formal charges
    - Bangladesh, Indonesia, India
- Commoditization of medical care
  - Cognitive dissonance between concept of medical care as merit good versus private good
    - Malaysia vs. Indonesia
- Reduced pressure on governments and managers to look for efficiency improvements to expand access to care

Public sector fees >> Reduced access by poor to all services



Policy responses to problems of out-of-pocket financing

Approaches that have not worked

1. **Targeting of public services through means testing**
   - Repeatedly proven impossible to cheaply and reliably target the poor or to reduce inequalities in access:
     - Japan, Sri Lanka, Malaysia, Thailand, Indonesia, Nepal
2. **Voluntary community health insurance**
   - No success in scaling-up (>10% of population)
   - Works least well in the poorest communities with low levels of social capital,with limited protection because of low incomes
     - Japan, Thailand, China, India, Vietnam
3. **Social health insurance without tax funding**
   - Difficult to extend coverage to poor, informal workers, owing to poor capacity to pay and difficulties in collection
     - Japan, Korea, Thailand, China
4. **Private health insurance**
   - Fails to cover informal sector workers, the poor

Only three approaches have worked

1. **Expansion of tax-funded, integrated health services**
   - Australia, New Zealand, Brunei
2. **Expansion of tax-funded, integrated health services *with* parallel, private provision**
   - Kerala, Sri Lanka, Malaysia, Hong Kong, Samoa, Solomon Islands
   - Only one that has worked at all levels of per capita GDP
   - Difficult to get right
3. **Social health insurance *with* general revenue subsidies**
   - Japan, Korea, Taiwan, Thailand, (Mongolia?)
   - Only at a per capita GDP >$2,000
   - Requires sustained government commitment and capacity

Implementation challenges

1. Managing the increases in patient demand with user fee reduction

- When user fee abolition/reduction was effective, it has always increased demand for services, with risk of failure to match supply with demand
  - Sri Lanka, Malaysia, Indonesia, Taiwan

- Two supply-side strategies have proved necessary:
  - Improved drug logistics systems have been critical
    - Sri Lanka
  - Achieving better value for money through sustained improvements in public sector productivity or tight control on prices in insurance systems
    - Sri Lanka, Malaysia, Hong Kong
    - Japan, Taiwan

Role of technical efficiency gains in Sri Lanka after user fee abolition

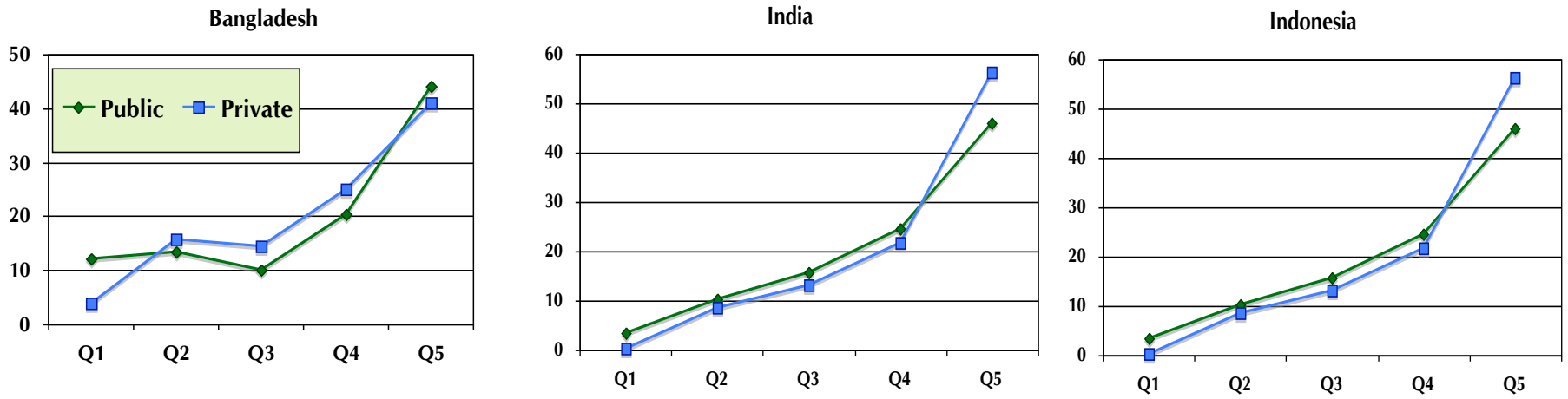
Year	GDP (US$ 2006 per capita)	IMR	Govt. health spending (US$ 2006 per capita)	Outputs (Out-patients per capita)	Outputs (In-patients per capita)
1948	322	92	5.4	1.1	0.09
1960	352	57	6.8	2.3	0.14
12 yrs	+9%	-38%	+ 25%	+110%	+55%

Contribution of increased spending = <25%
Contribution of technical efficiency gain = >75%

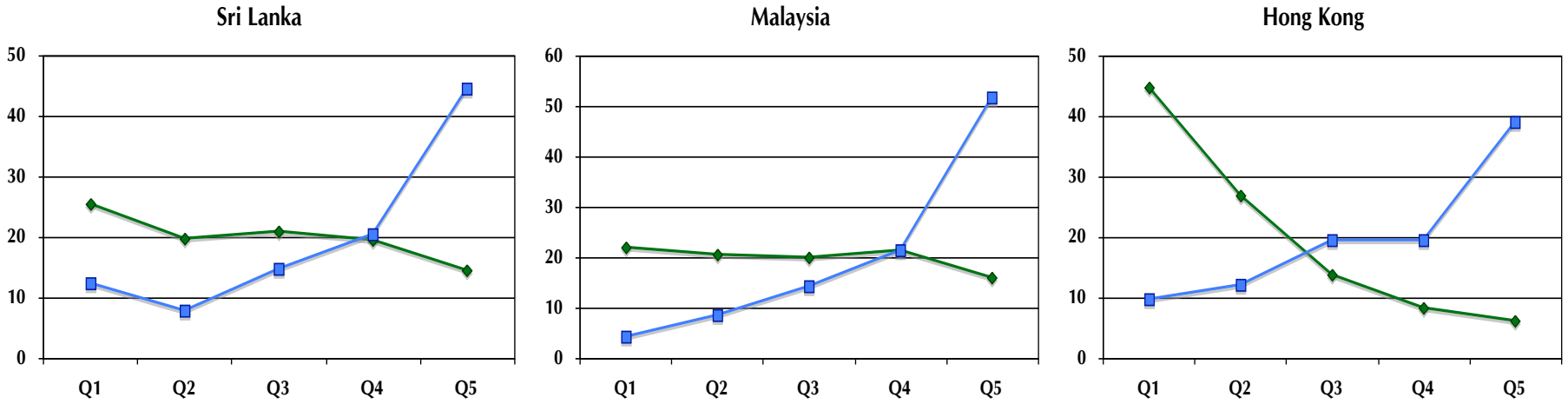
2. Financing unrestricted access to free care with limited public budgets

- No developing Asian government has been able to afford UK NHS ("Beveridge") model
  - Cost of government financing free care for all: 5-8% of GDP
  - Actual government budgets: 2-3% of GDP
- So only able to pay for 40-60% of overall needs through public financing
  - Typical outcome is that limited public services are captured mostly by rich, leaving poor without services
  - Rationing through spatial barriers, or informal costs
- Successful Asian countries have solved this by successful mix of public and private financing
  - Abolition of user fees may be a critical element to differentiate public and private provision

Differences in public-private mix in tax-financed systems



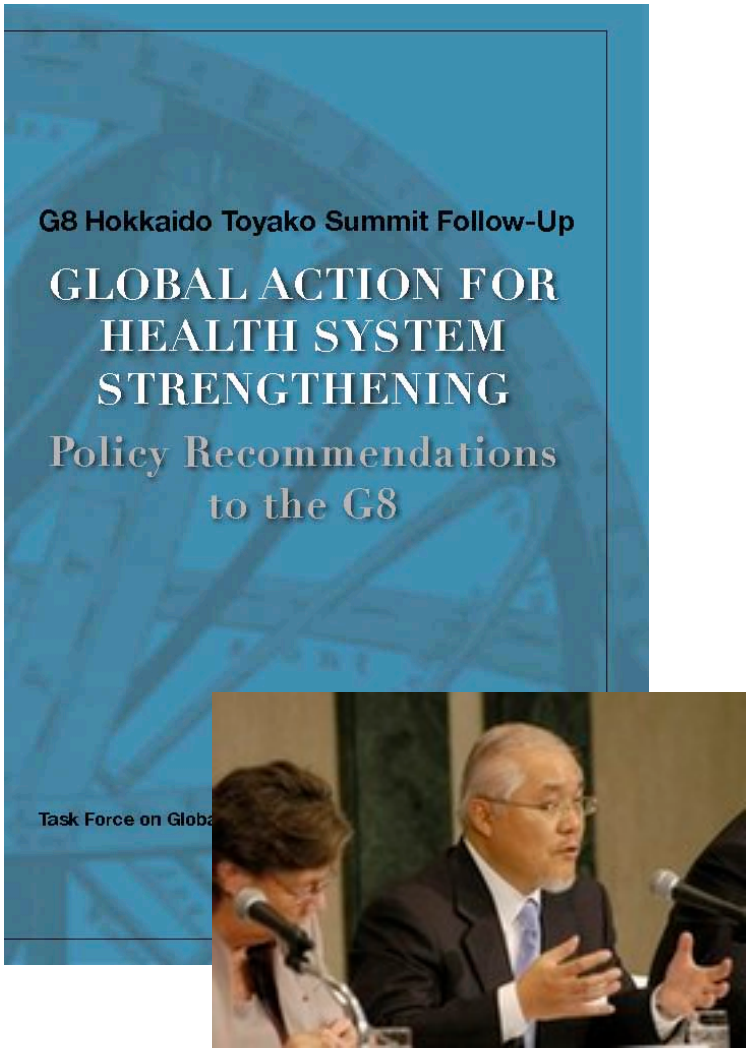
Use of public and private inpatient services by income quintiles



Current Regional Agenda

- Growing consensus at regional level to prioritize public financing
  - ILO High Level Meeting, Delhi 2008
  - UN ESCAP Experts Meetings 2007-2008
- ADB-led Initiative to look at how to address OOP barriers to MNCH care in region
- Japanese G8 Initiative
  - Takemi Taskforce mandated in 2008 to prepare recommendations for global health agenda

Takemi Taskforce Report to G8



- Taskforce focused on G8 actions for strengthening health systems with inputs from G8 and H8 experts
- Recognizes links between Japan's human security agenda and EU's stress on solidarity
- Report to Government of Japan to be basis of Japan's recommendations to Italy as chair of G8 in 2009
- Key recommendations in financing include:
  - Prioritize G8 support for country policies that place public financing at the core, either taxation and/or SHI
  - Support countries that wish to abolish user fees, especially for MDGs 4, 5 and 6 services