Elimination of financial barriers to healthcare: Asia-Pacific Perspective

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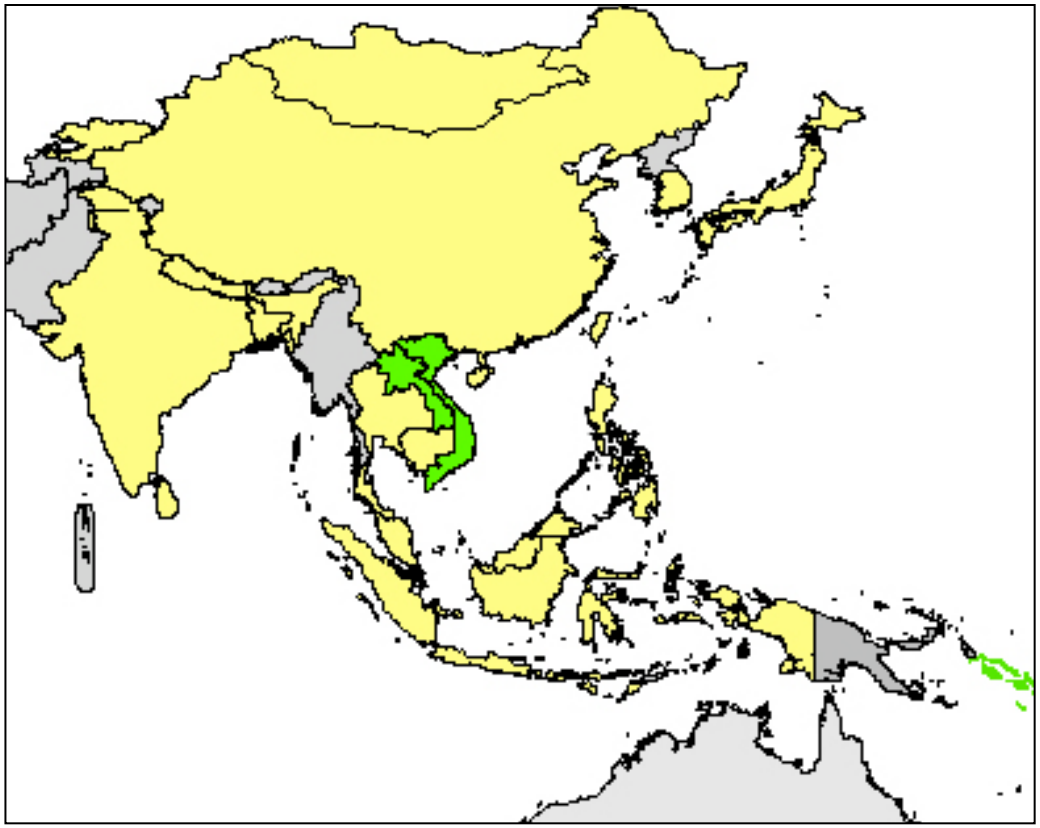
INSTITUTE FOR HEALTH POLICY

Outline

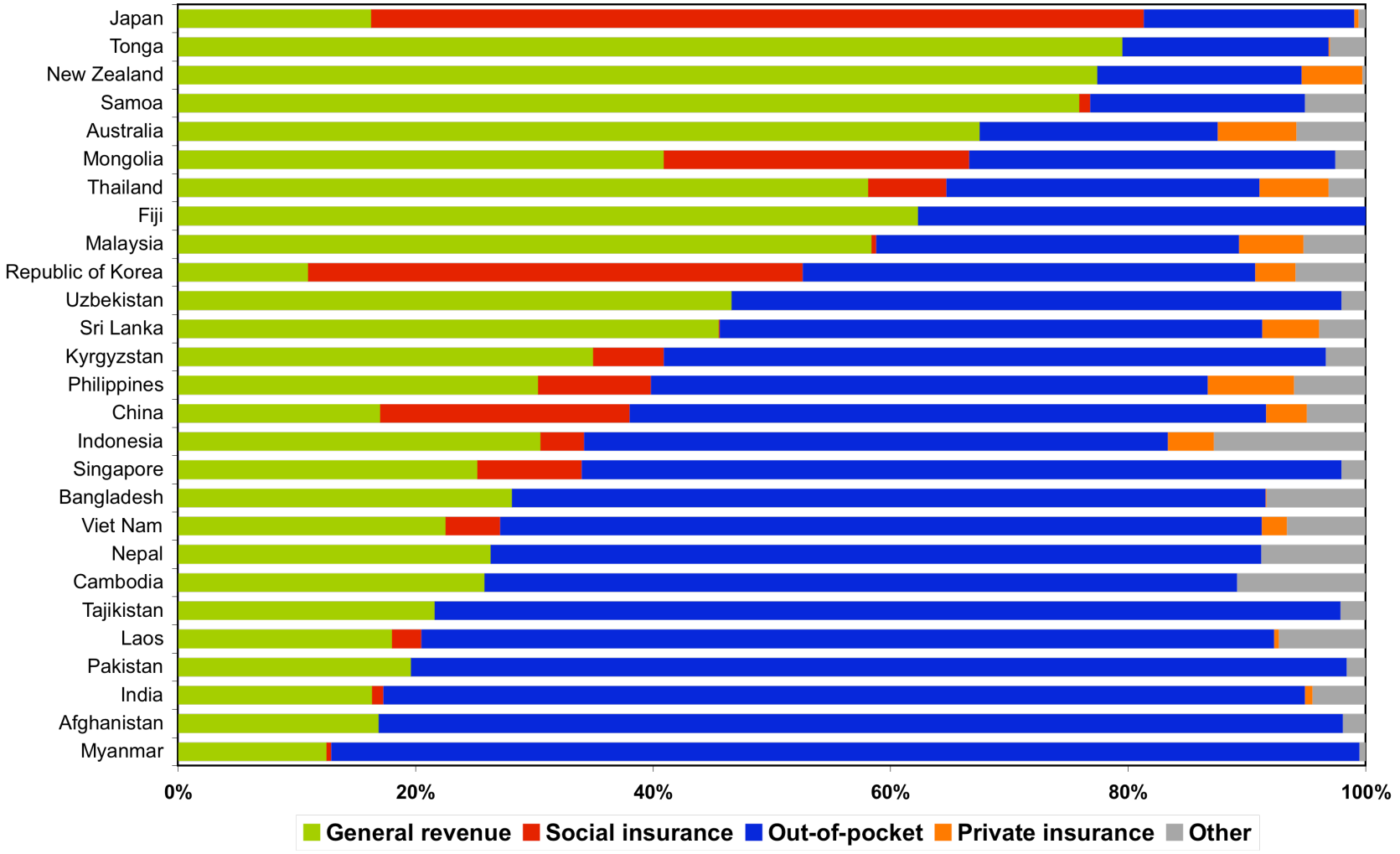
- Equitap
- Asia-Pacific situation
  - Disparities
  - Critical issues
- Rise of Universal Coverage as a goal
- What has worked
- Implementation challenges
- Japanese Takemi Recommendations to G8

Equitap: Equity in Asia-Pacific Health Systems

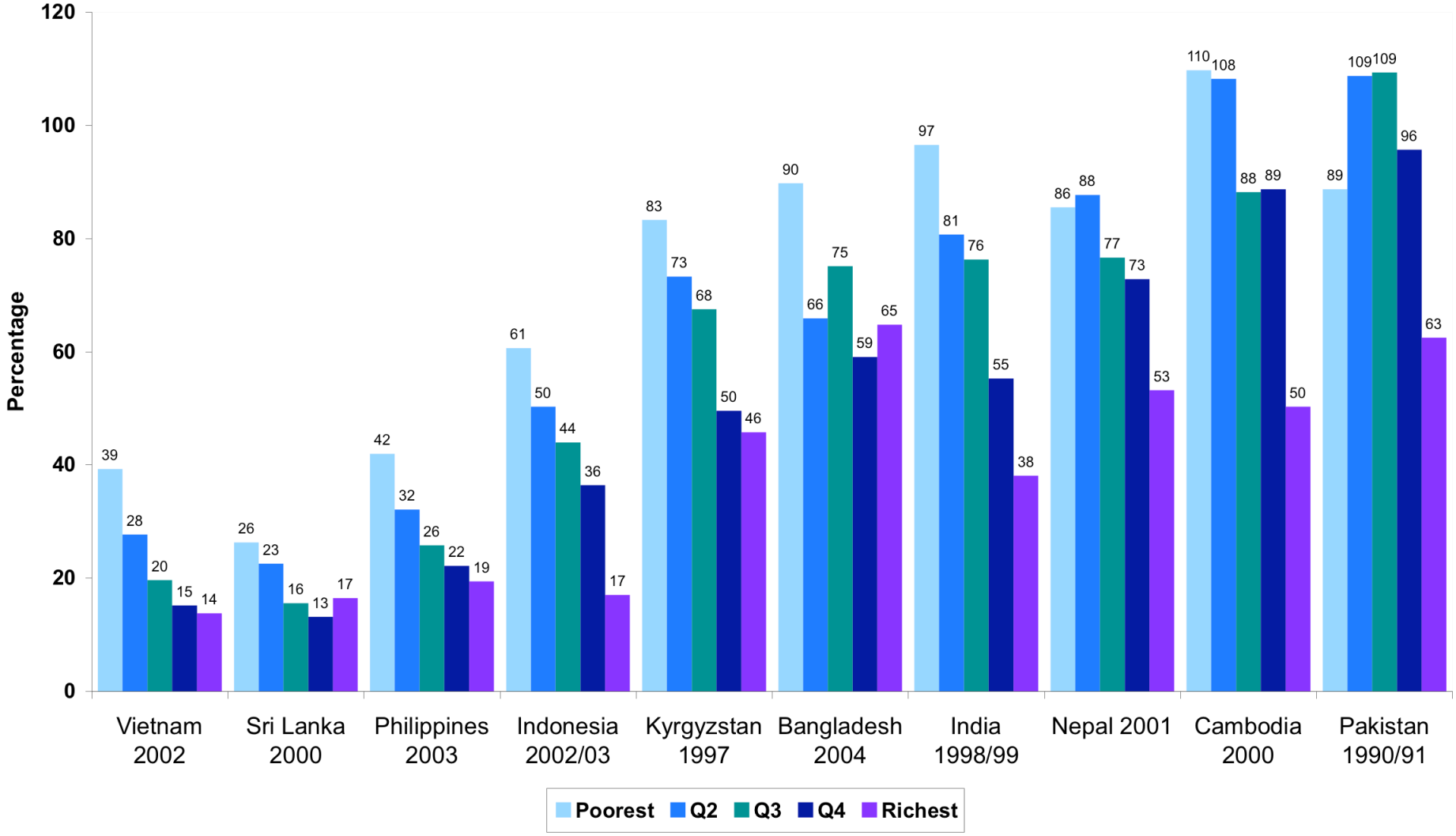
- Collaborative network of Asian researchers established in 2000
- EC funding support through INCO-DEV research grant ICA4-CT-2001-10015
- Initial technical collaboration from European ECuity Network (Erasmus University, LSE)
- Currently expanding Mekong and South Pacific countries
- Systematic comparative analyses of equity at national level:
  - Risk protection
  - Targeting of government spending
  - Distribution of financing burden
  - Healthcare utilization
  - Health outcomes



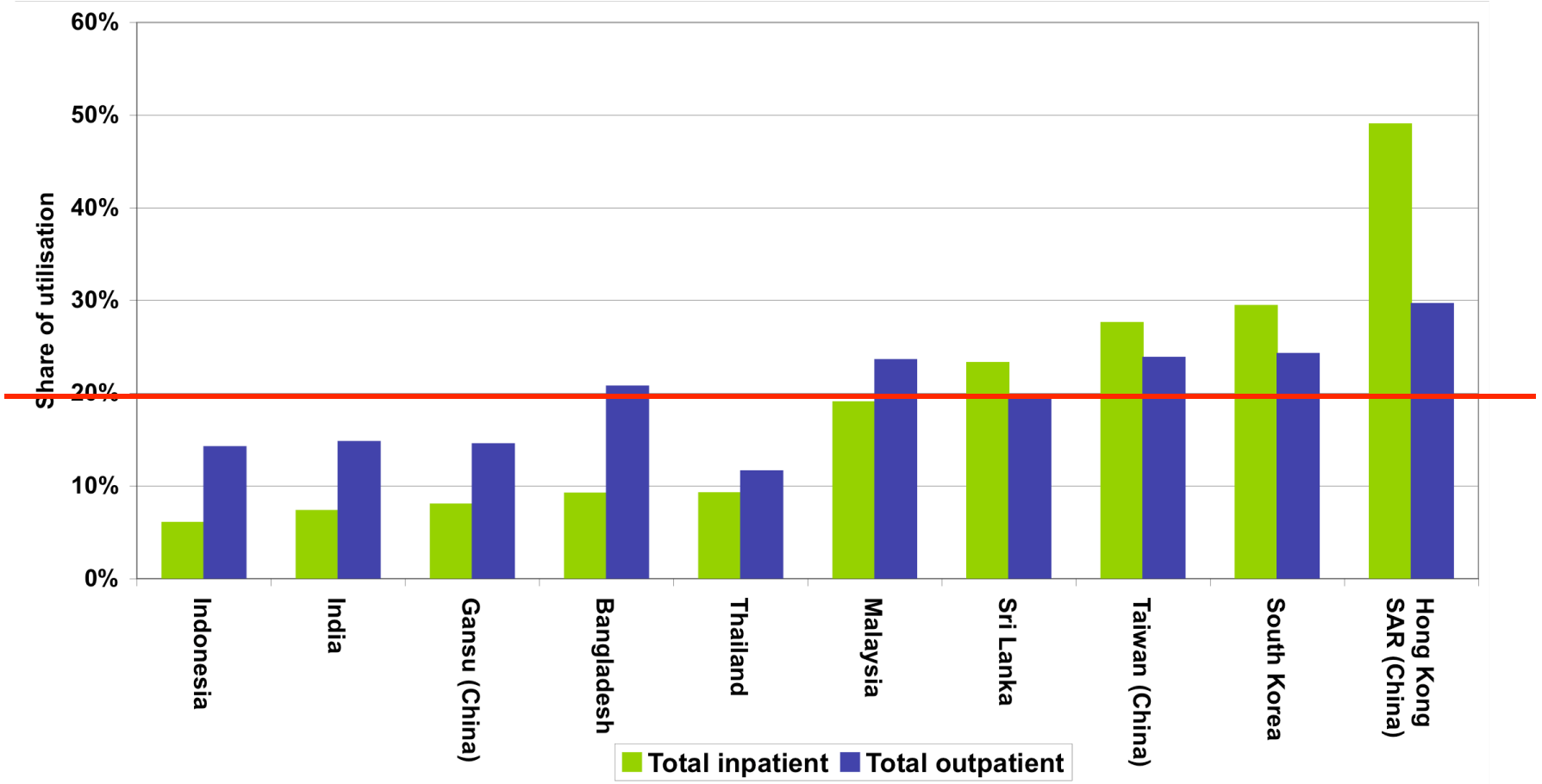
Diverse healthcare financing mix



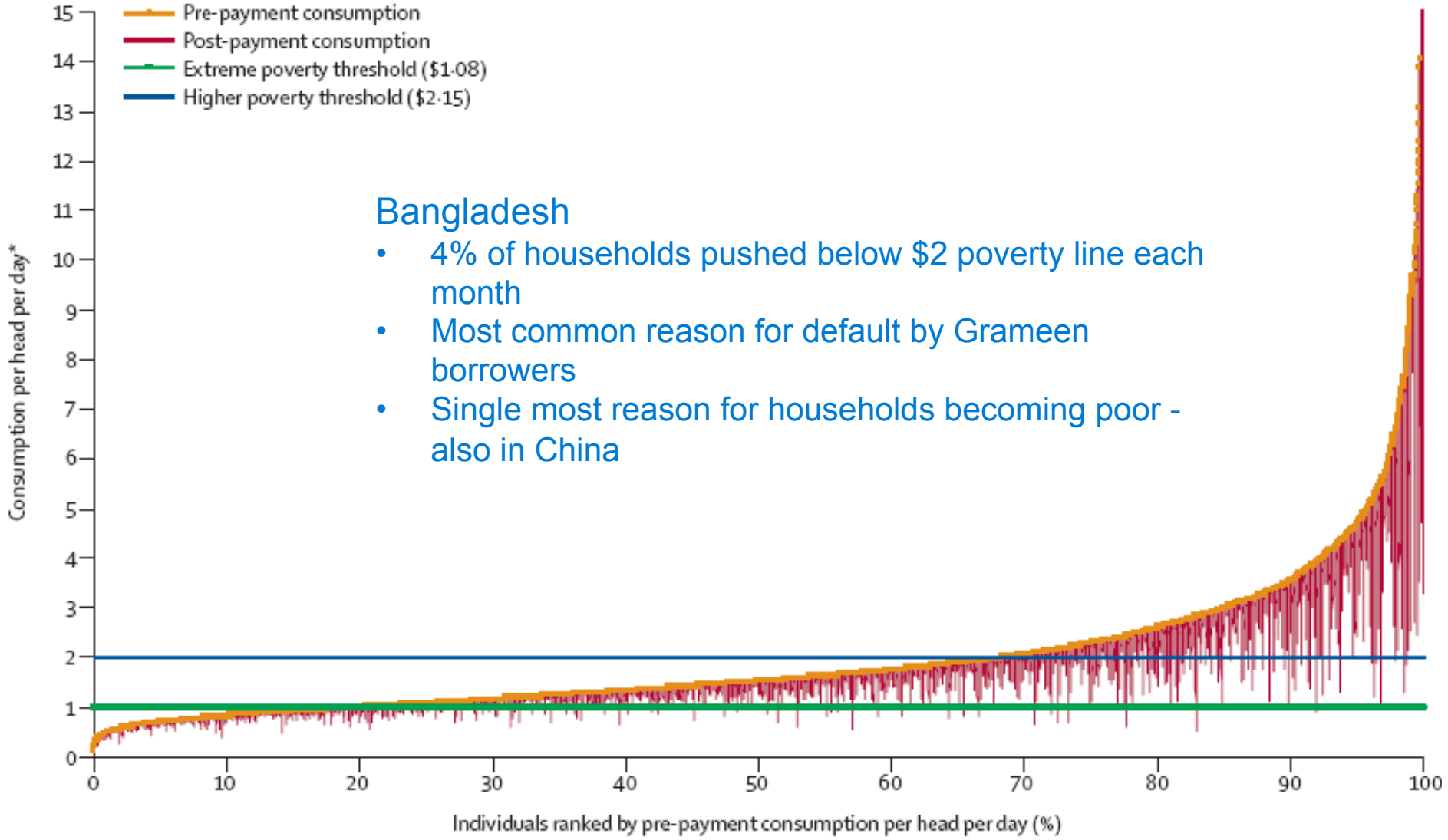
Large health disparities - IMR



Health services often fail to reach poor



Impoverishment a major problem

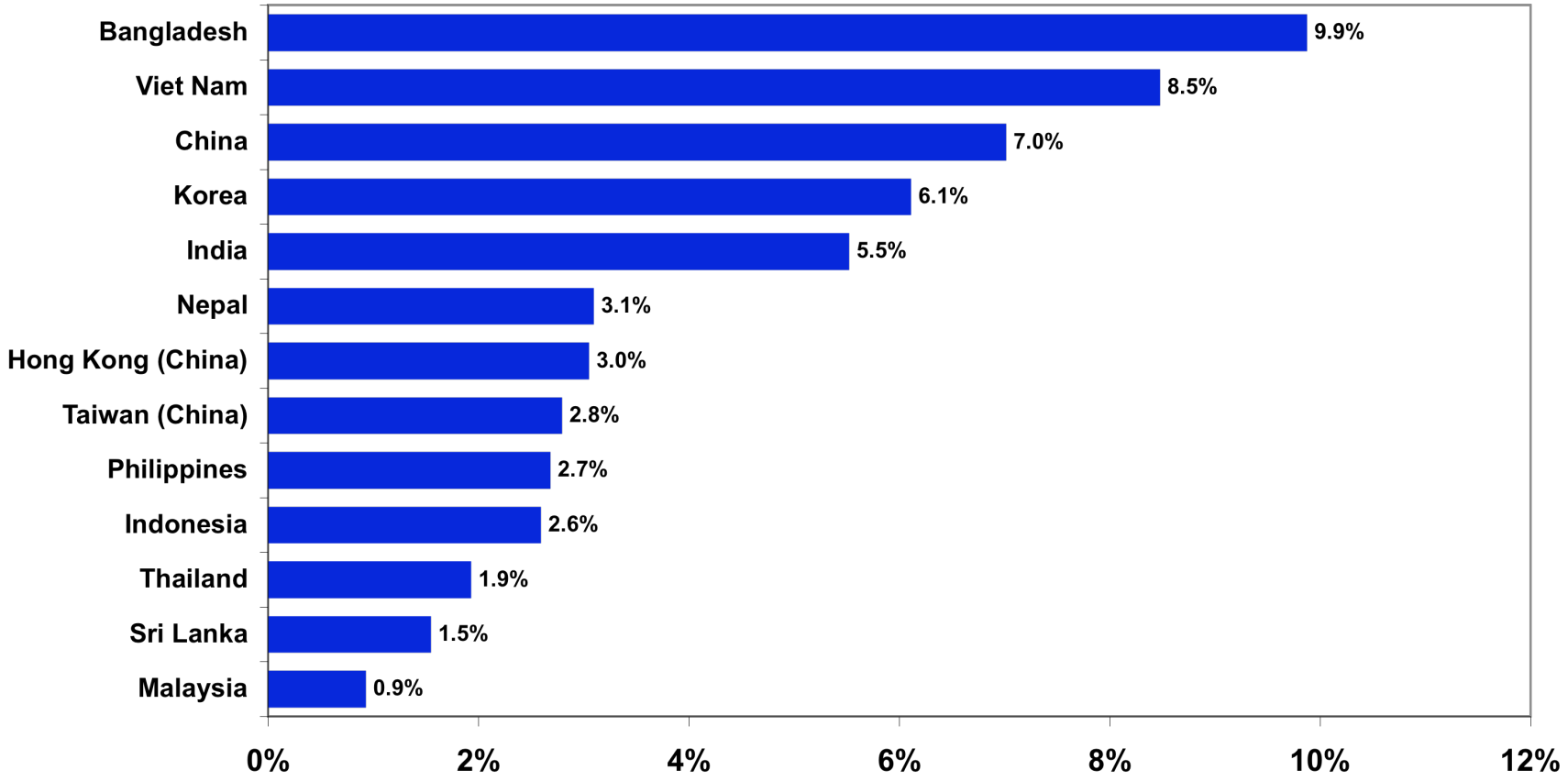


Bangladesh

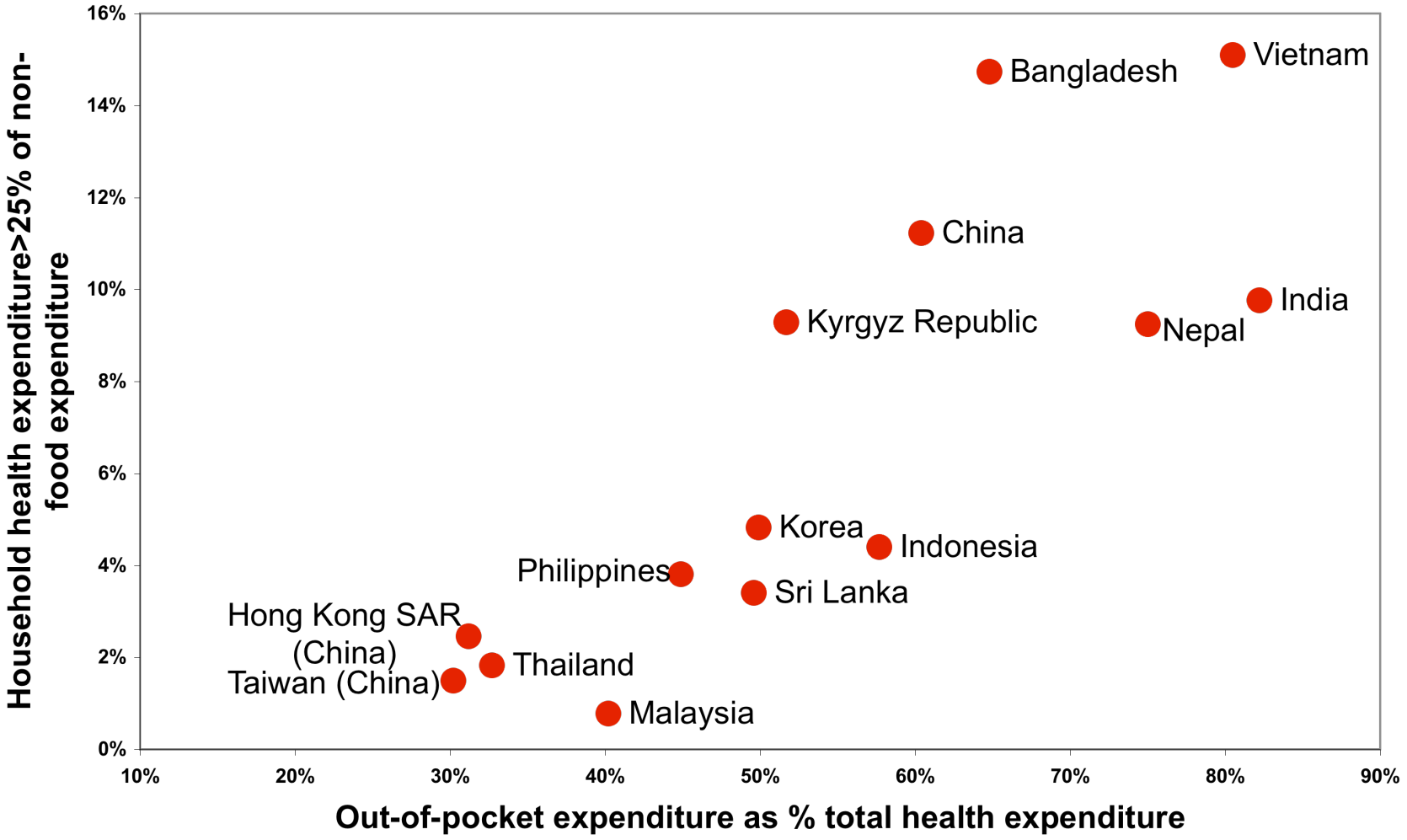
- 4% of households pushed below $2 poverty line each month
- Most common reason for default by Grameen borrowers
- Single most reason for households becoming poor - also in China

Varying incidence of catastrophic expenditures

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



With direct link between catastrophic expenditures and reliance on OOP



Growing convergence since 1930s in both developed and developing Asian countries in normative views of what universal coverage is and why it is important

Critical expansions

- 1930s
  - Japan and Sri Lanka: High levels of rural impoverishment in exacerbated by sickness led to recognition of need for budgetary financing for risk protection and expanding coverage
- 1950-90s
  - Establishment of universal systems of access and delivery in Japan, Korea, Malaysia, Sri Lanka, Hong Kong, Korea, Taiwan
- 2000s
  - Moves to address incomplete coverage with reduction of financial barriers in Mongolia, Thailand, China, Nepal, etc

What Universal Coverage should mean

Access to services

Opportunity to make use of and actual benefit from needed health services when required

- Combination of reduction of financial barriers, physical availability of services, and observed high use of services
- Matters because access ensures use of services which is necessary for better health

Risk protection

Ensuring households do not have to make impoverishing payments to obtain adequate and needed care

Successes and failures

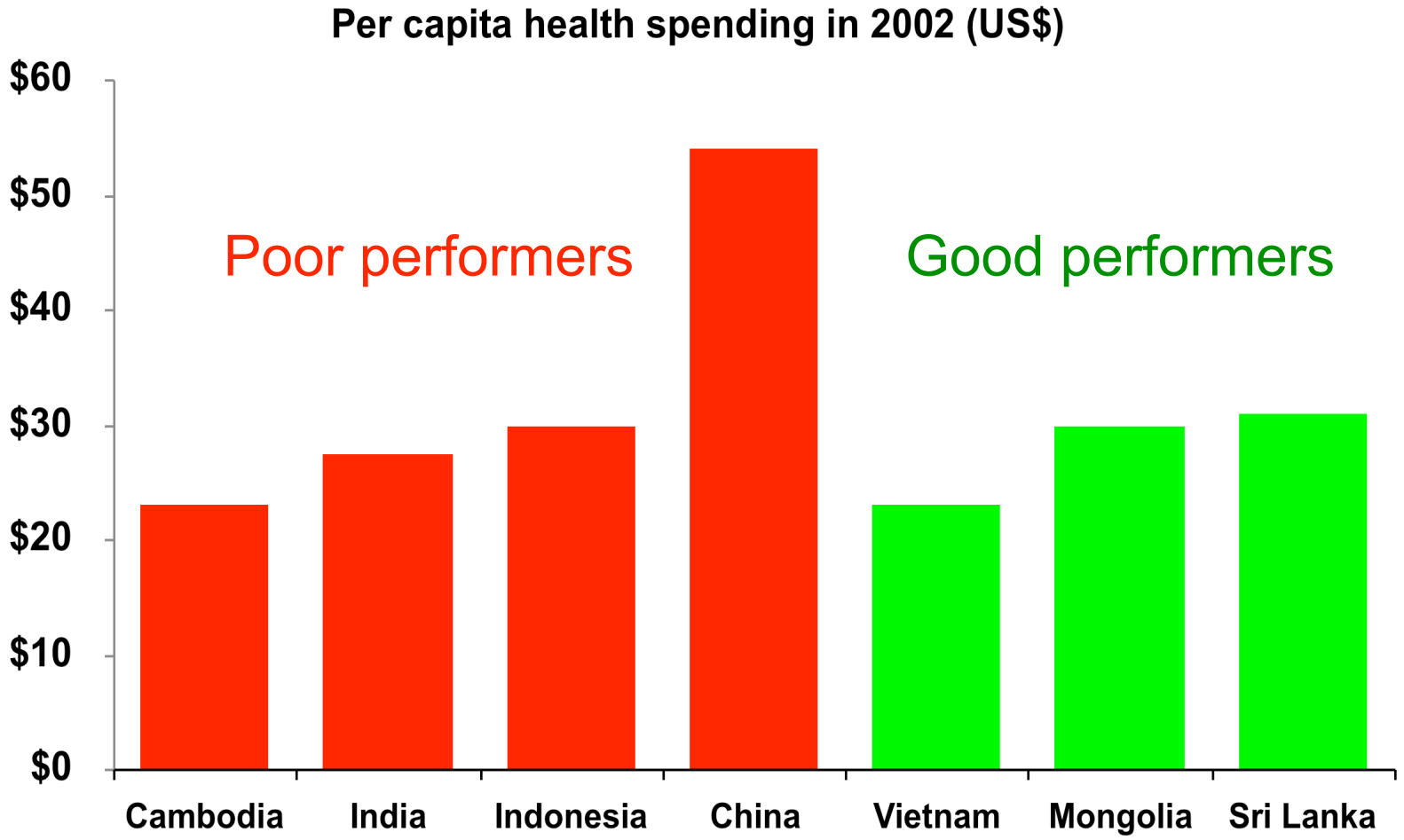
Successful in achieving universal coverage

- *Mongolia?*
- Sri Lanka
- Thailand
- Malaysia
- Korea
- Hong Kong
- Australia

Poor and informal sector largely not covered

- Laos
- Nepal
- Bangladesh
- Cambodia
- India
- China
- Indonesia

High expenditures not essential to achieve good coverage



Strategies for expanding coverage and reducing financial barriers

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, Indonesia
4. **Private health insurance**
   - Fails to cover informal sector workers, the poor

Only three approaches have worked

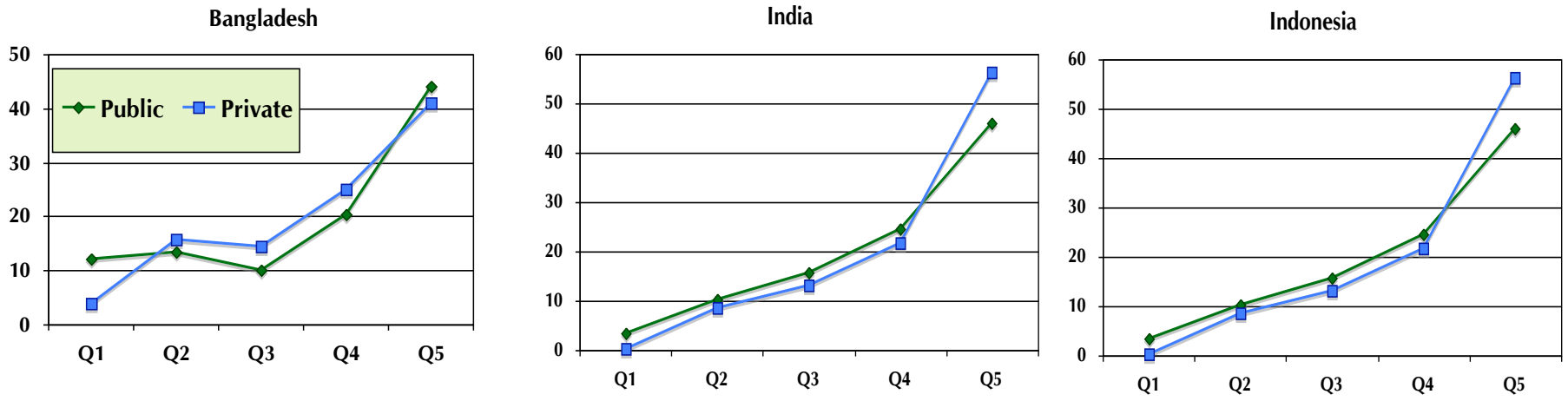
1. **Expansion of tax-funded, integrated health services**
   - Australia, New Zealand, Brunei
2. **Expansion of tax-funded, integrated health services *with* parallel, private provision**
   - Kerala, Sri Lanka, Malaysia, Hong Kong, Samoa, Solomon Islands
   - Only one that has worked at all levels 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

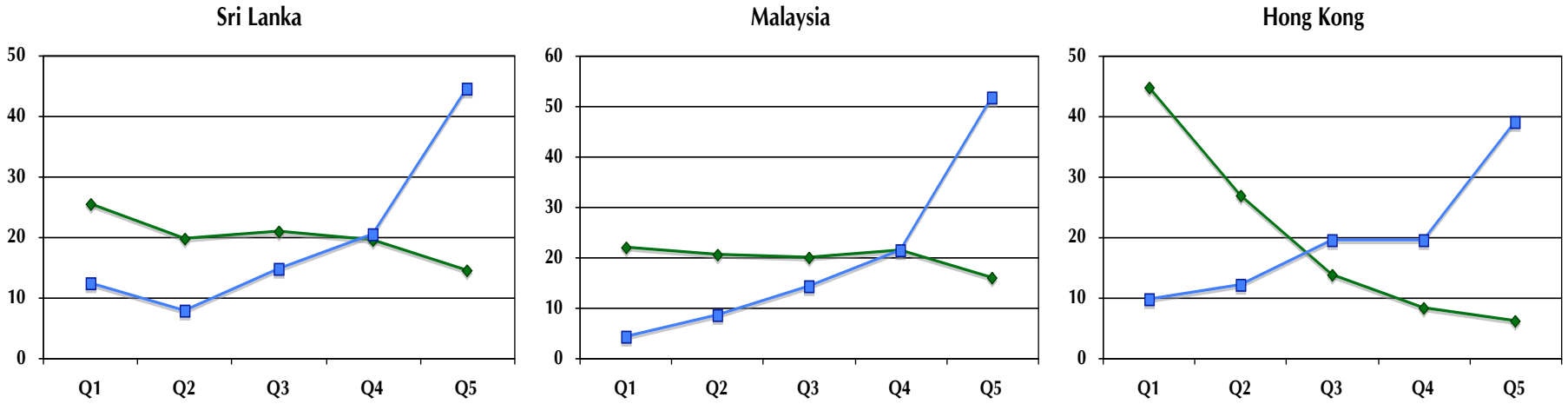
1. How to finance universal access with limited public budgets

- 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
  - Public financing focused on providing everyone risk protection for expensive care and basic services for poor

Differences in public-private mix in tax-financed systems



Use of public and private inpatient services by income quintiles



2. How to meet increased demand for services with limited budgets

- When coverage expansion has been effective, it has always increased demand for services, with risk of failure to match supply with demand
  - Japan, Sri Lanka, Malaysia, Indonesia, Taiwan

- Two responses have proved necessary:
  - Increased financing
  - 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

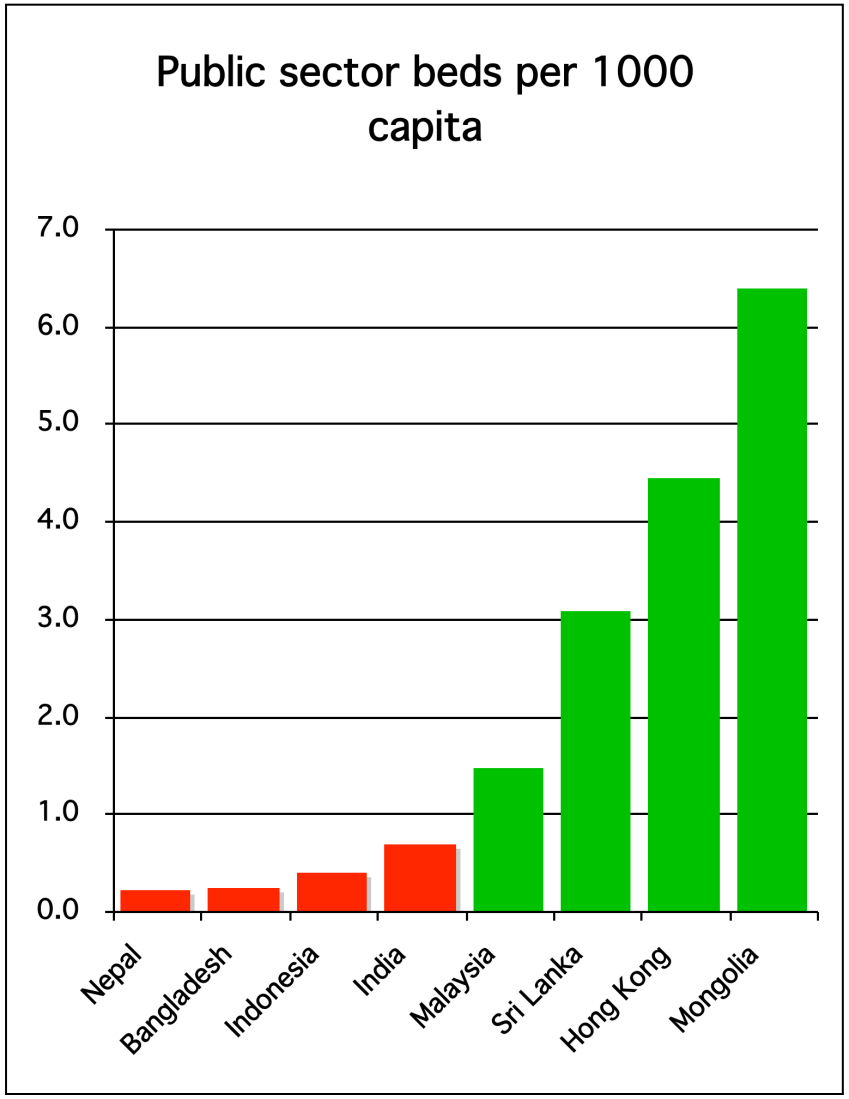
Year	GDP (US$ 2006 per capita)	IMR	Govt. health spending (US$ 2006 per capita)	Outputs (Out-patients per capita)	Outputs (In-patients per capita)
1948	322	92	5.4	1.1	0.09
1960	352	57	6.8	2.3	0.14
12 yrs	+9%	-38%	+ 25%	+110%	+55%

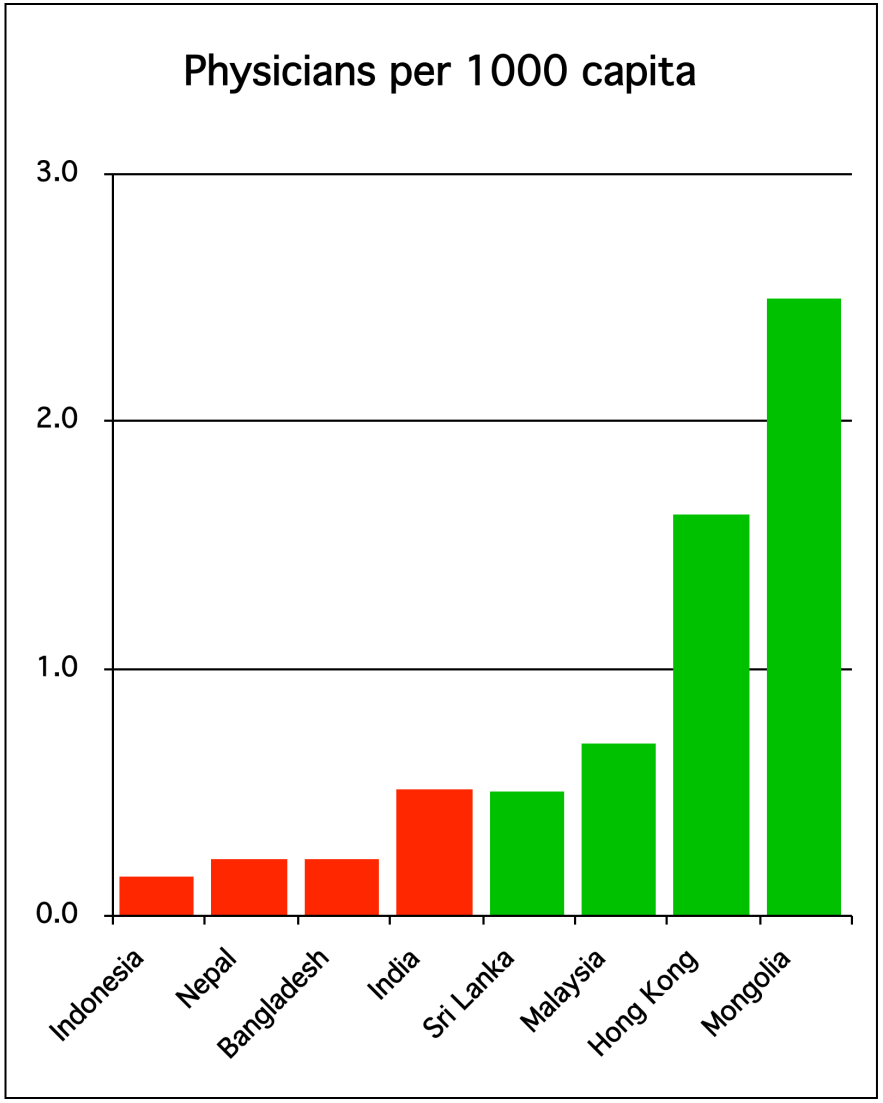
Contribution of increased spending = <25%
Contribution of technical efficiency gain = >75%

3. How to ensure limited public financing and services benefit the poor

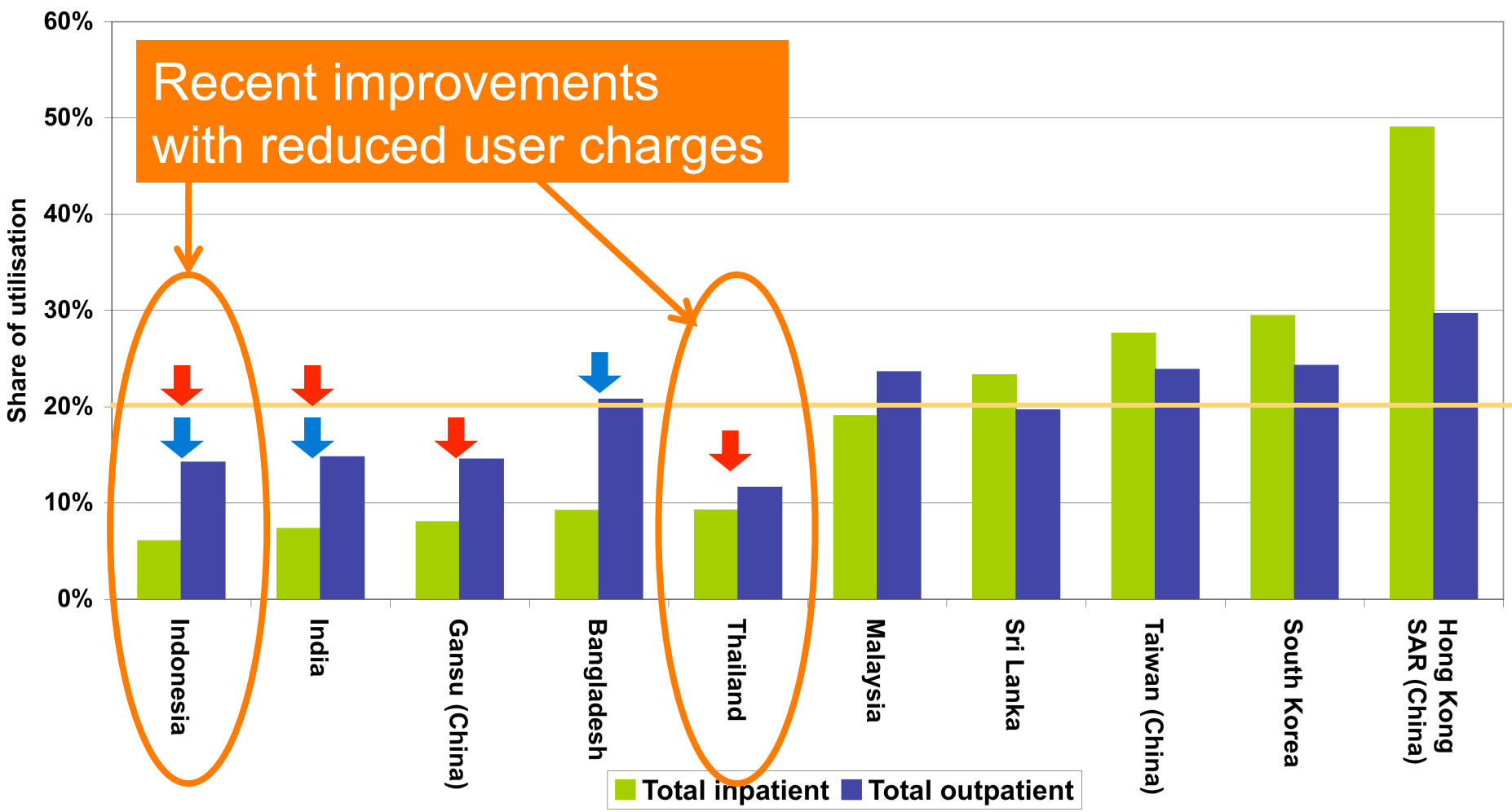
- Public financing and coverage not enough to ensure services reach poor
- Two major barriers:
  - Financial barriers: User fees or insurance co-payments
  - Distance and physical access
- Requires significant investment in service provision, particularly in rural areas

High levels of supply critical to reach the poor





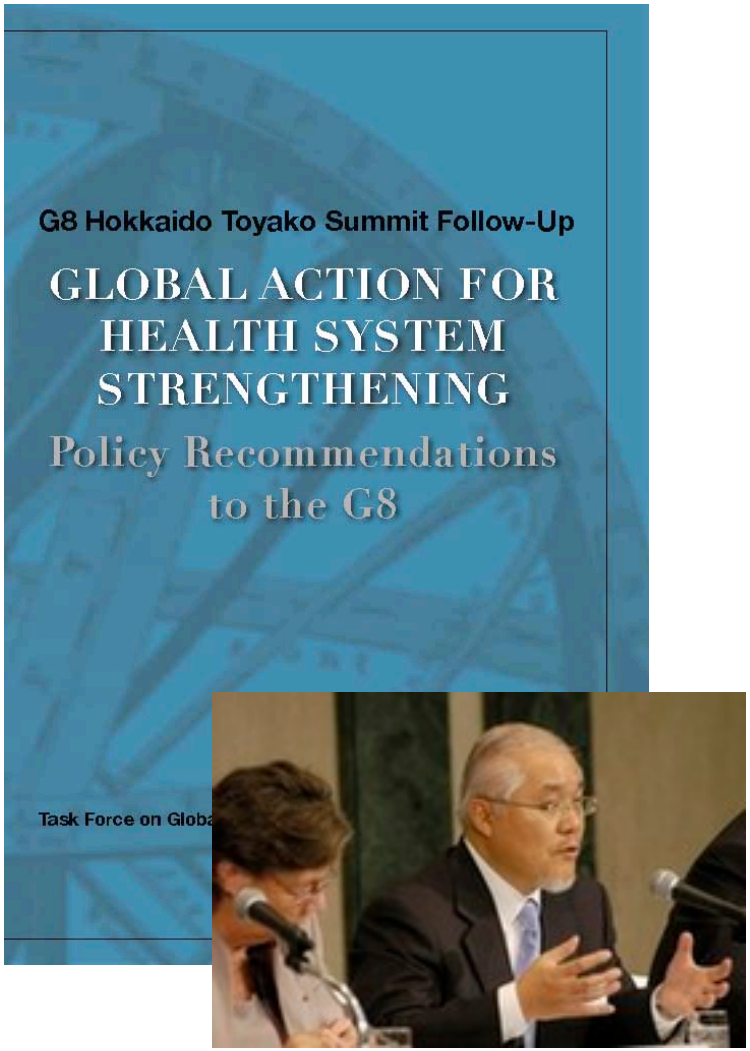
Reducing financial barriers critical



Key Messages

- **Universal coverage is feasible at low incomes with limited spending**
  - GDP per capita < $500, & Public spending <2% of GDP)
- **Only two successful approaches**
  - Tax-financed, government provision, with voluntary, parallel private provision (≠ Beveridge model)
  - Social health insurance, with tax financing to cover the poor
- **Expanding coverage has required:**
  - Commitment of budgetary resources by government
  - High levels of health service provision
  - Control of costs and productivity in health system
  - Reduction in user payments for publicly-financed care
- **In successful countries politics of accountability and the linkage of rights to coverage to citizenship**

Japanese Takemi Taskforce



- Japanese effort to focus G8 actions for strengthening health systems
- Based on expert review and consultations
- Builds on links between Japan's human security agenda and EU's stress on solidarity
- Recognizes importance of country policies in achieving better value for money, and need for countries to lead policy development
- Report submitted by Government of Japan as Japan's recommendations to Italy as chair of G8 in 2009

Takemi recommendations for G8

1. Complement support for *increasing money for health* with added support for *improving the value of health spending through support for better country-led health financing and systems policies.*

2. Translate technical consensus on public financing into commitment by G8 to prioritize support to countries that prioritize public financing
   - **Support for countries that abolish user fees, starting with MDG 4, 5 and 6 services**
   - **Coherent message through IHP+ and P4H**

3. Invest in the ability of developing country partners to make better health financing policy through investing in national policy capacity, supporting countries to share best practices

Thank you