Puncturing Pessimism

The success of old fashioned tax-funded health systems

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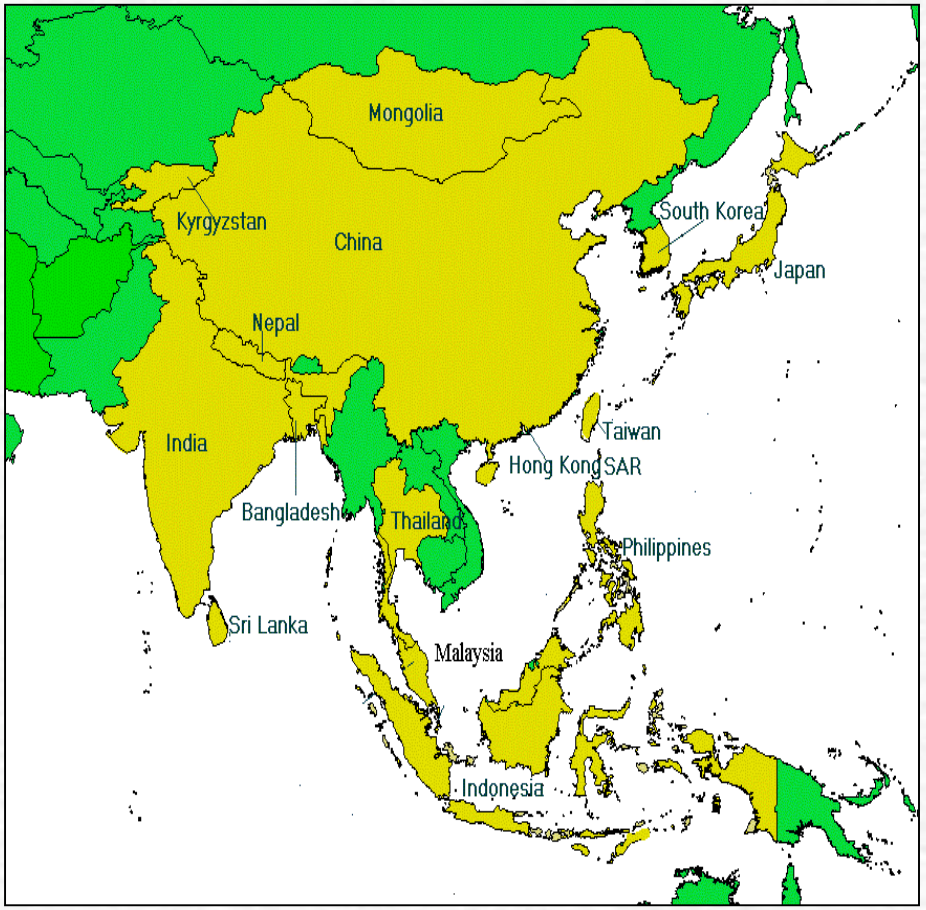
Outline

- Equitap Project
- Introduction to tax-funded systems
- Equity performance
- How is performance achieved?
- Why do some perform better?
- Conclusions

The Equitap Project

- Comparative study of equity in health care systems in 15 Asia-Pacific territories
- Bangladesh, Nepal, India, Sri Lanka, Thailand, Philippines, Indonesia, Malaysia, China, Kyrgyz, Mongolia, Taiwan, Hong Kong SAR, Korea, Japan
- Funded by EU, and initiated by Asia-Pacific NHA Network
- European partners: Erasmus University (Netherlands), LSE (UK)
- Modelled on ECuity



EQUITAP territories

Equitap Project
http://www.equitap.org

Equitap Components

- Profile of health financing
  - Health accounts (OECD SHA)
- Distribution of payments for health care
  - Progressivity of payment mechanisms
  - Concentration indices
- Targeting of government health spending
  - Benefit incidence
- Incidence of catastrophic health spending
- Public opinion surveys
- Policy frames
  - Content analysis, surveys of policy makers
- Equal treatment for equal need (ETEN)
- Health outcomes
- Comparative case studies
  - Tax systems, Extension of social insurance

Introduction to Tax-funded health systems

Conventional wisdom

- Subsidies on government-provided, “free” health services in practice captured by rich
- Need to target to reach the poor
- Better to emphasize pro-poor preventive services to reach the poor
- Conventional civil-service modes of delivery lack incentives for efficiency and serving poor
- Indirect taxation regressive, so redistributive arguments weak

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

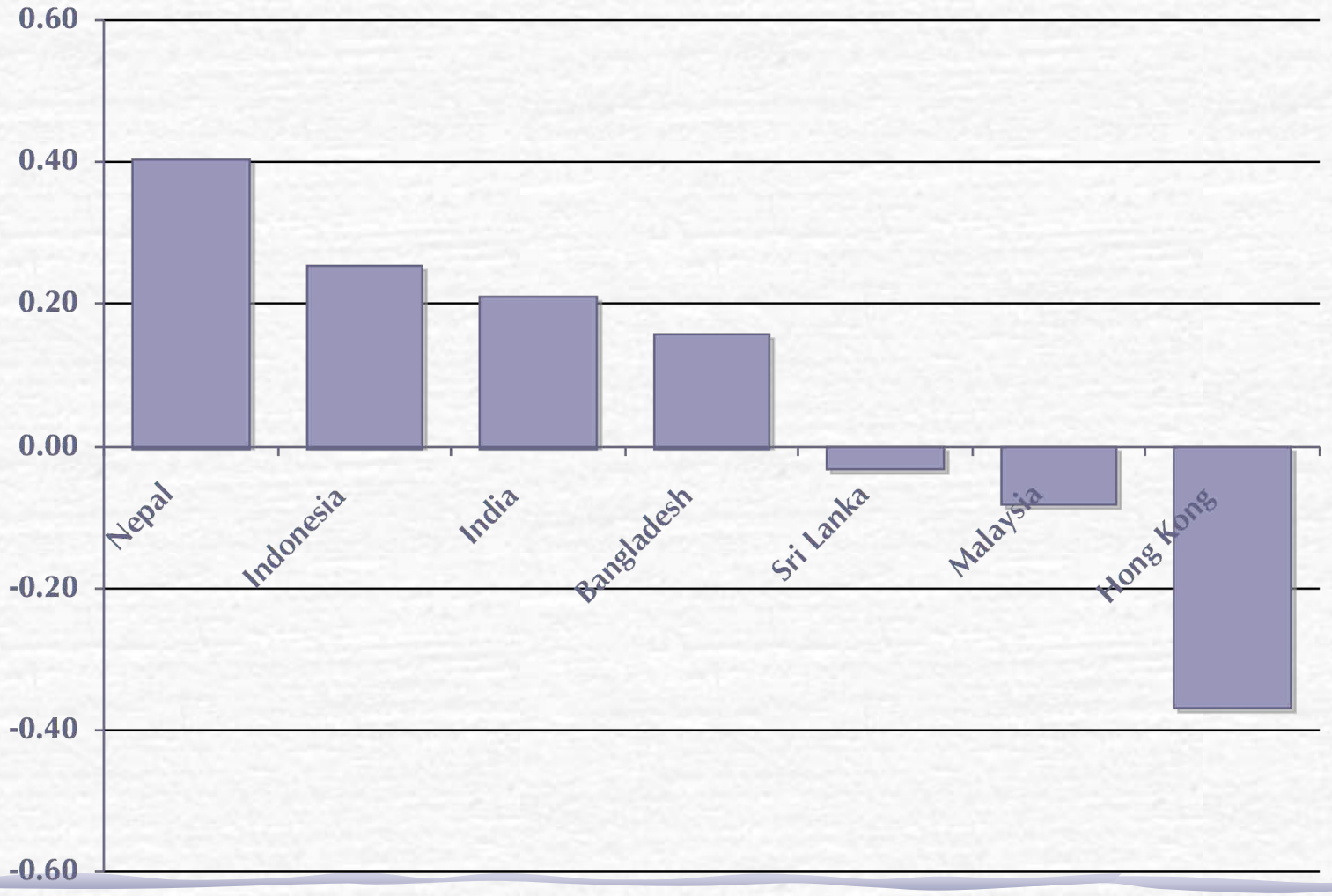
Background

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

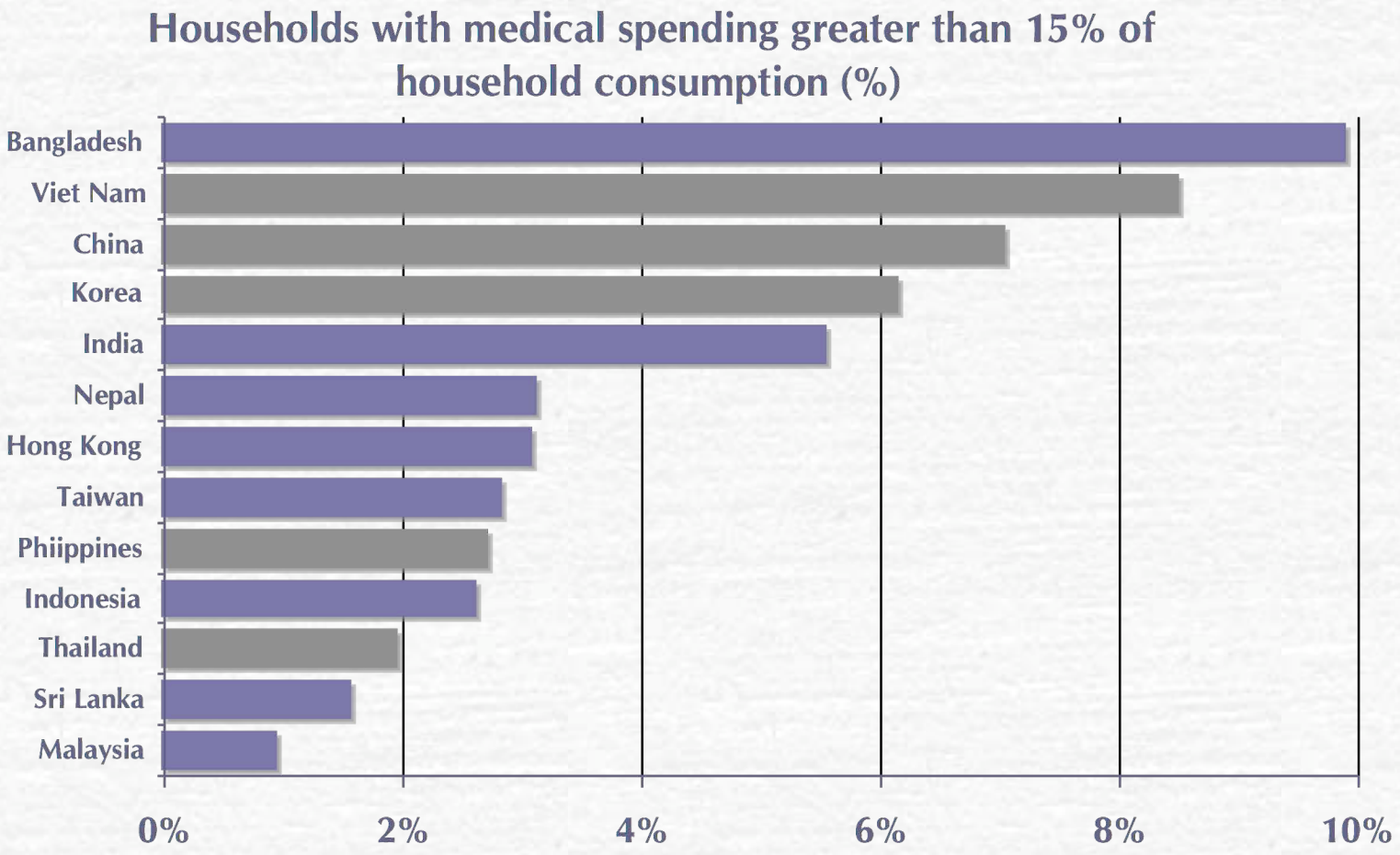
The equity performance of tax-funded systems

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	Pro-poor	Good
Malaysia	Negligible	Negligible	Pro-poor	Good
Hong Kong SAR	Negligible	Negligible	V. pro-poor	Good

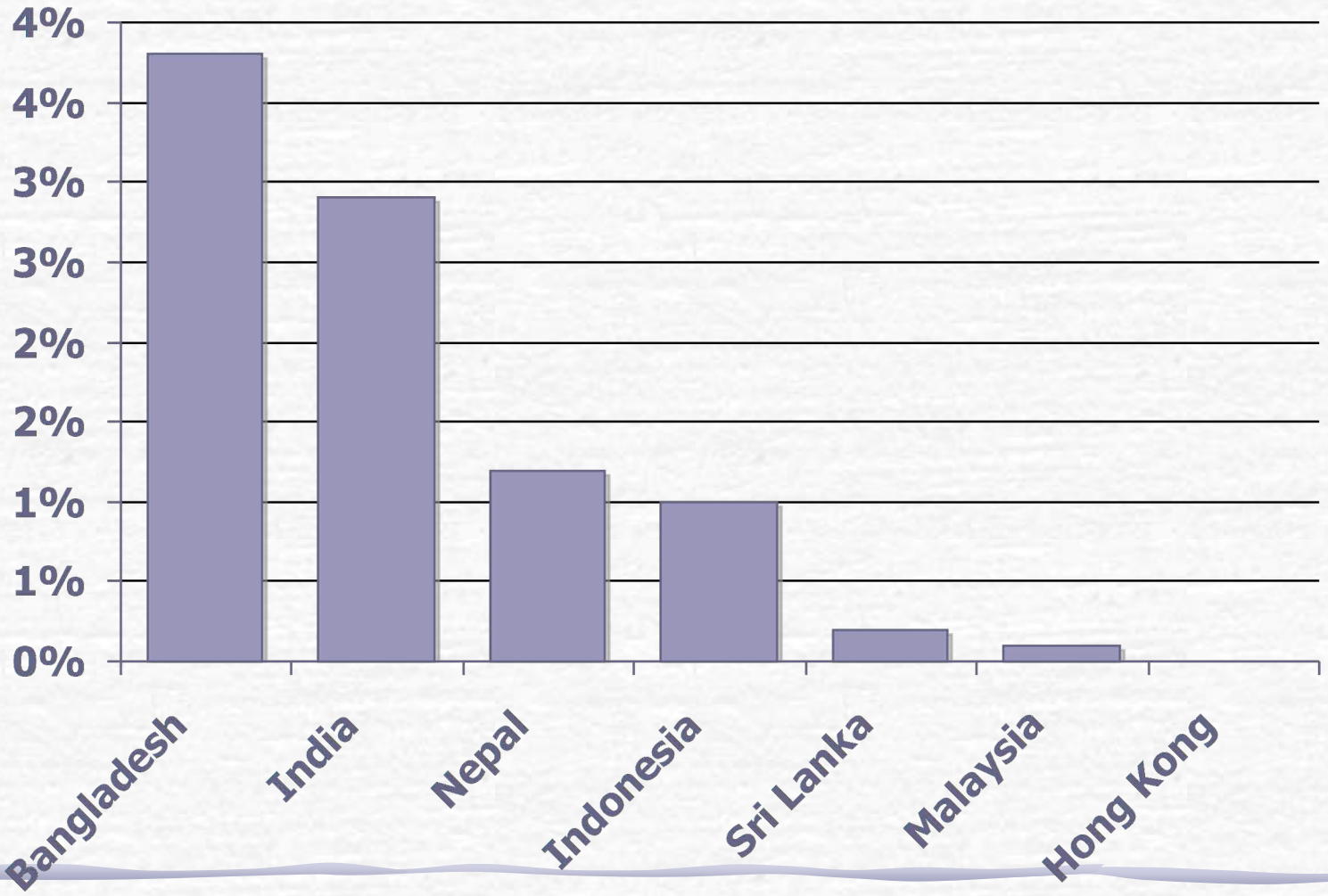
Targeting of government expenditure: Concentration index for public spending



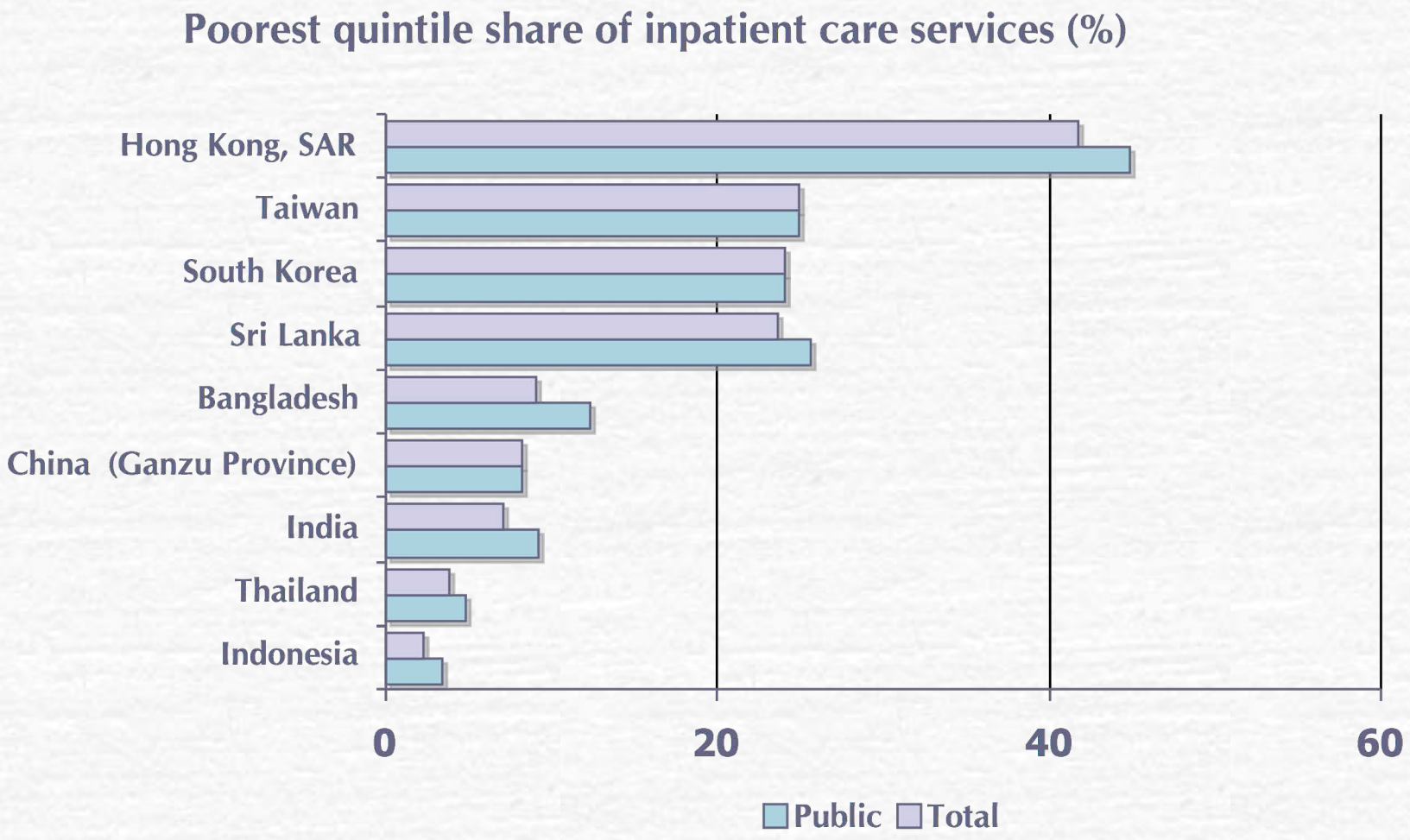
Catastrophic impacts



Poverty impact in tax-funded systems: Head count (<PPP$1/day level)



Targeting & use disparities



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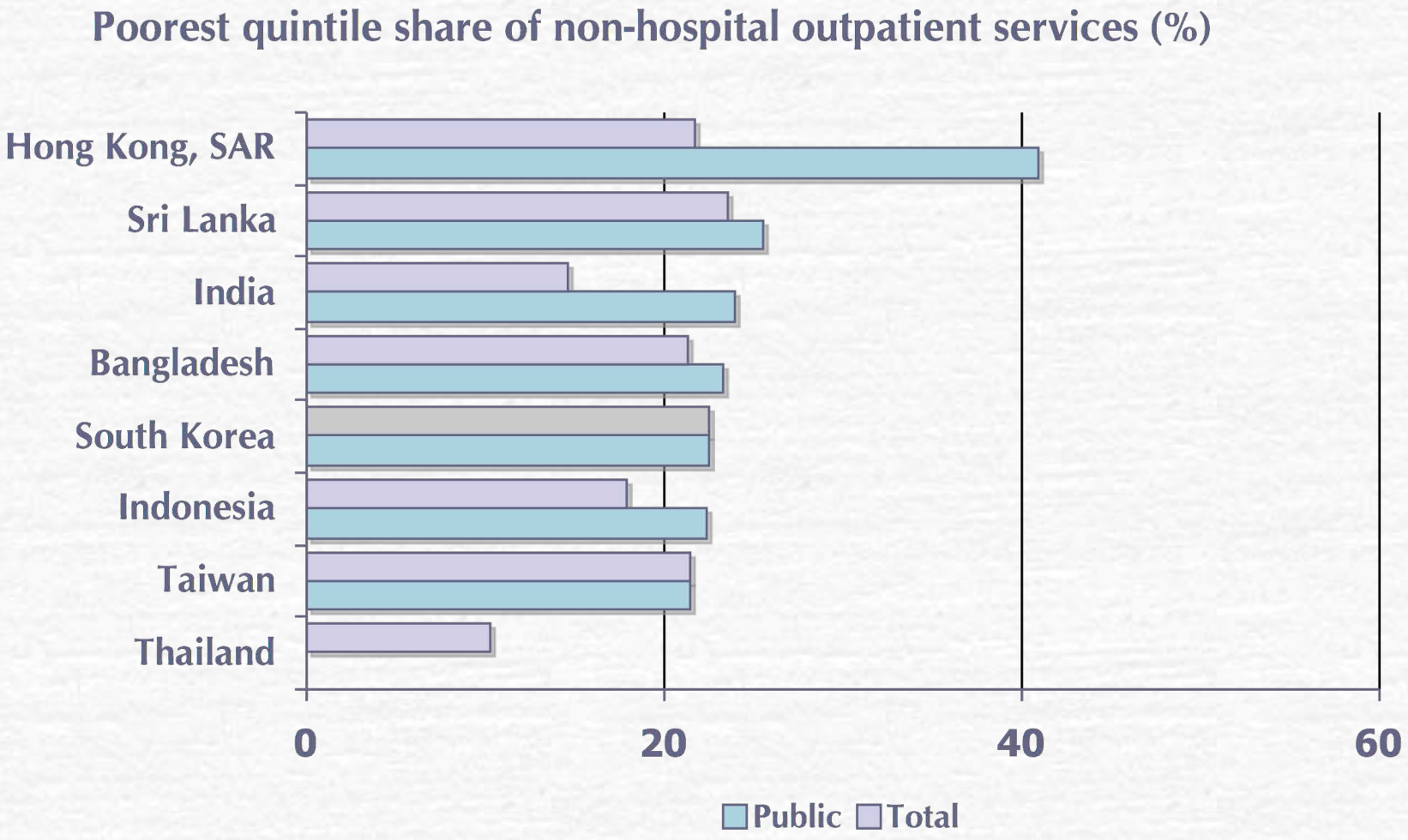


How is performance achieved?

Targeting in public sectors

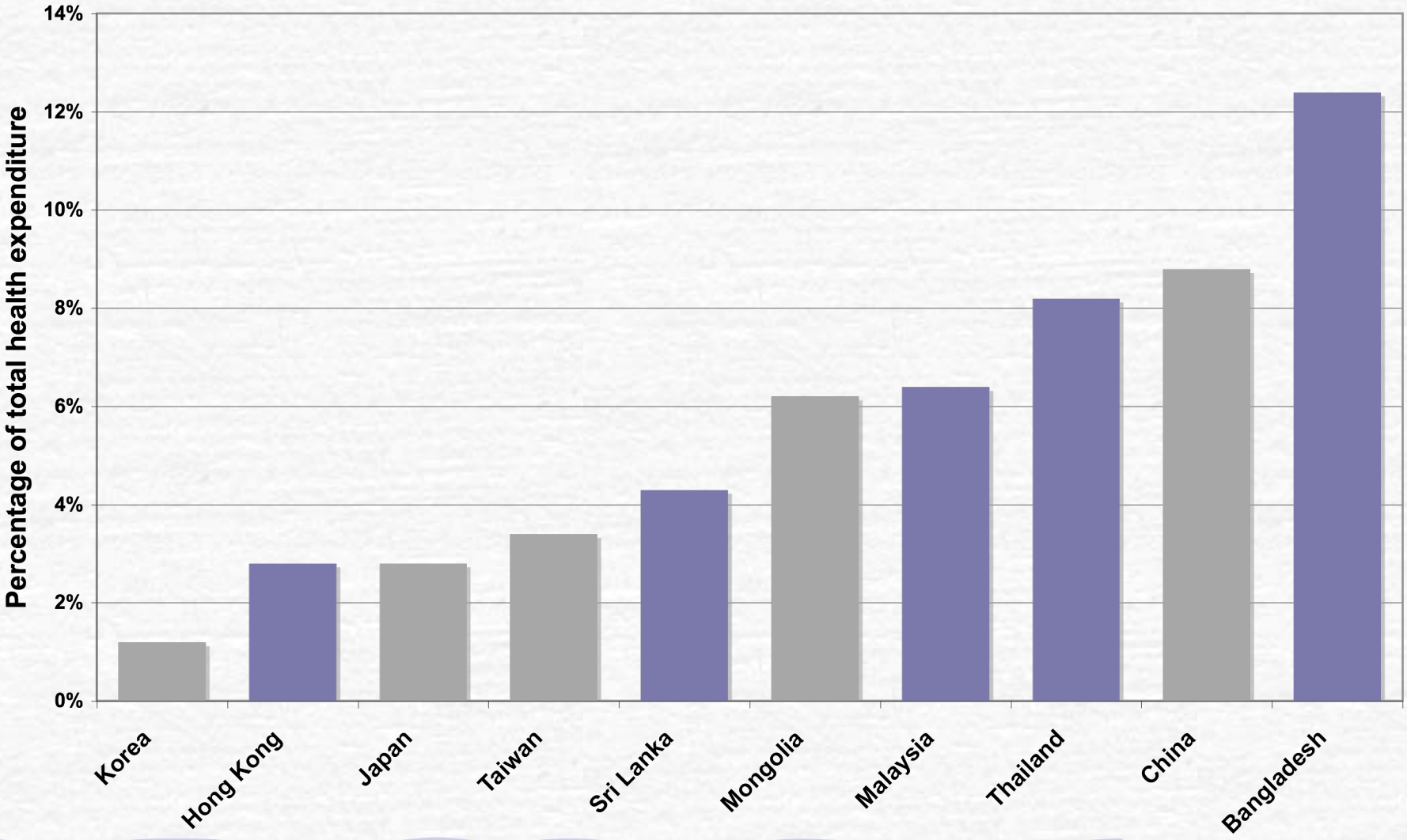
-- Extent of targeting ++

Country	Approach	User fees
Indonesia	Geographical targeting, means tested health cards	Varied
Bangladesh	Poor exempt from fees or pay reduced fees	Modest
Nepal	Poor exempt from fees or pay reduced fees	Significant
India	Informal exemptions	Varied
Malaysia	Poor exempt from fees	Negligible
Hong Kong SAR	Poor exempt from fees	Negligible
Sri Lanka	No means testing	No fees

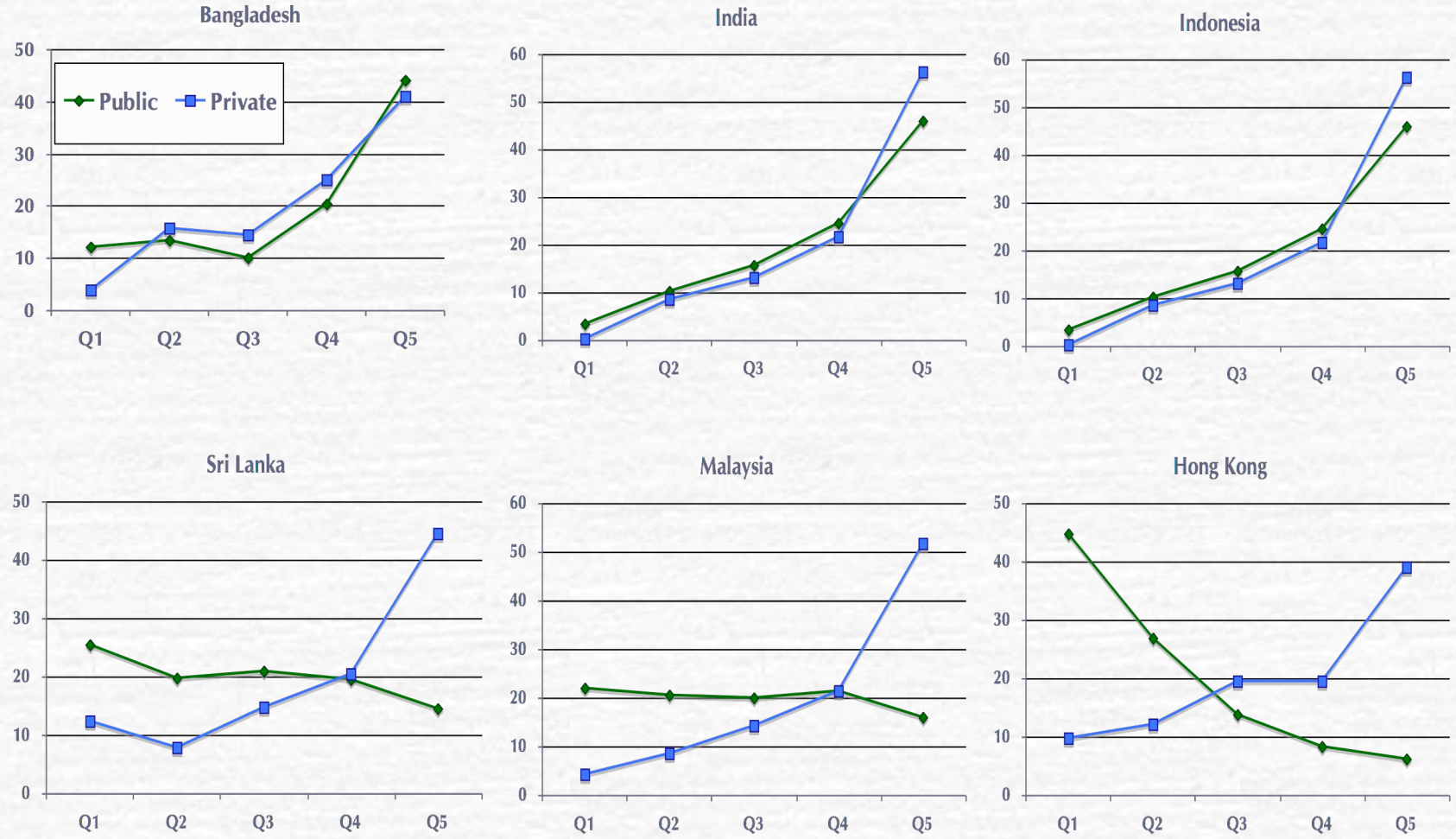
User fees in public sectors

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

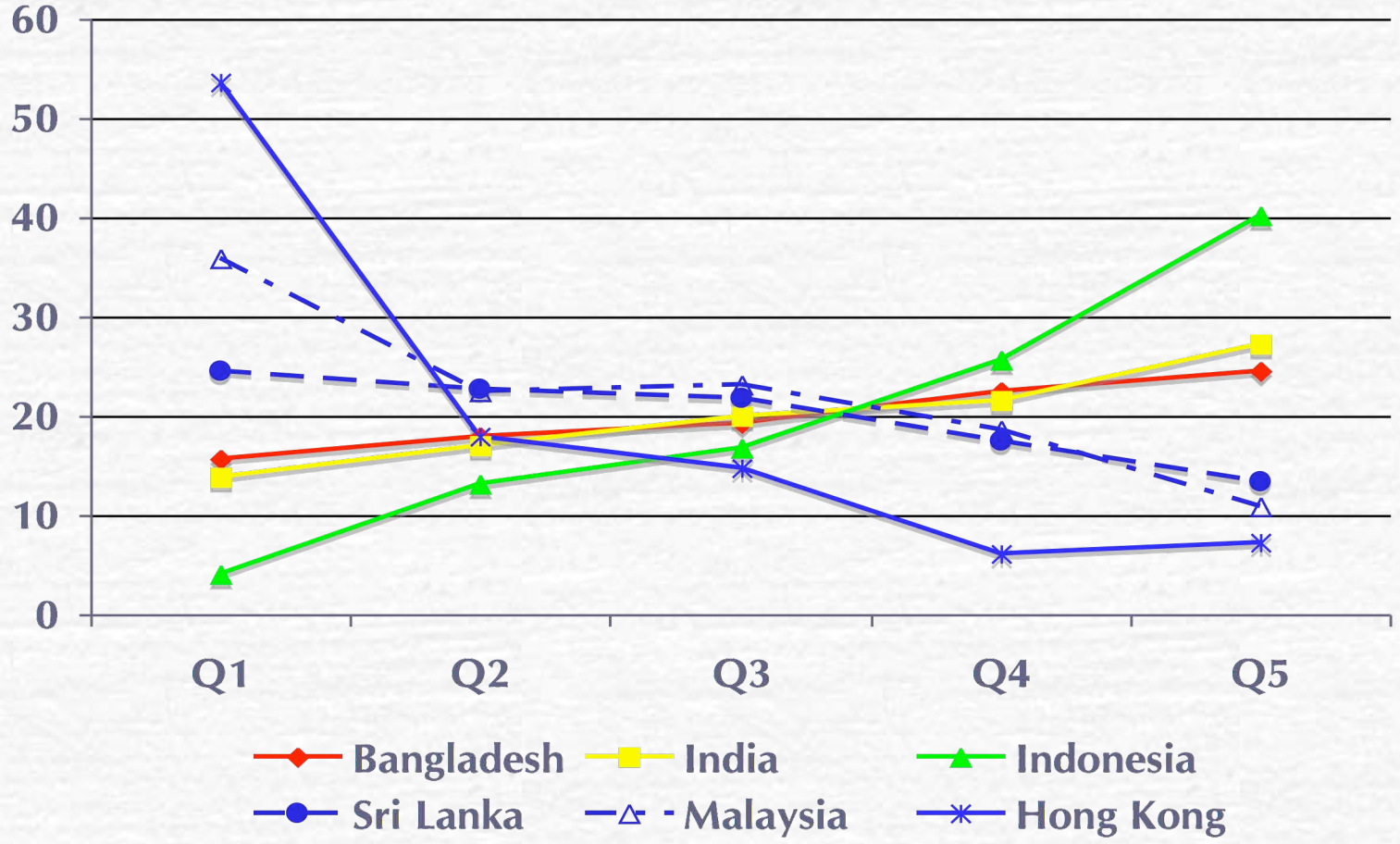
Preventive spending



Use of public and private inpatient care by quintiles



Use of public outpatient care by quintiles



Observations

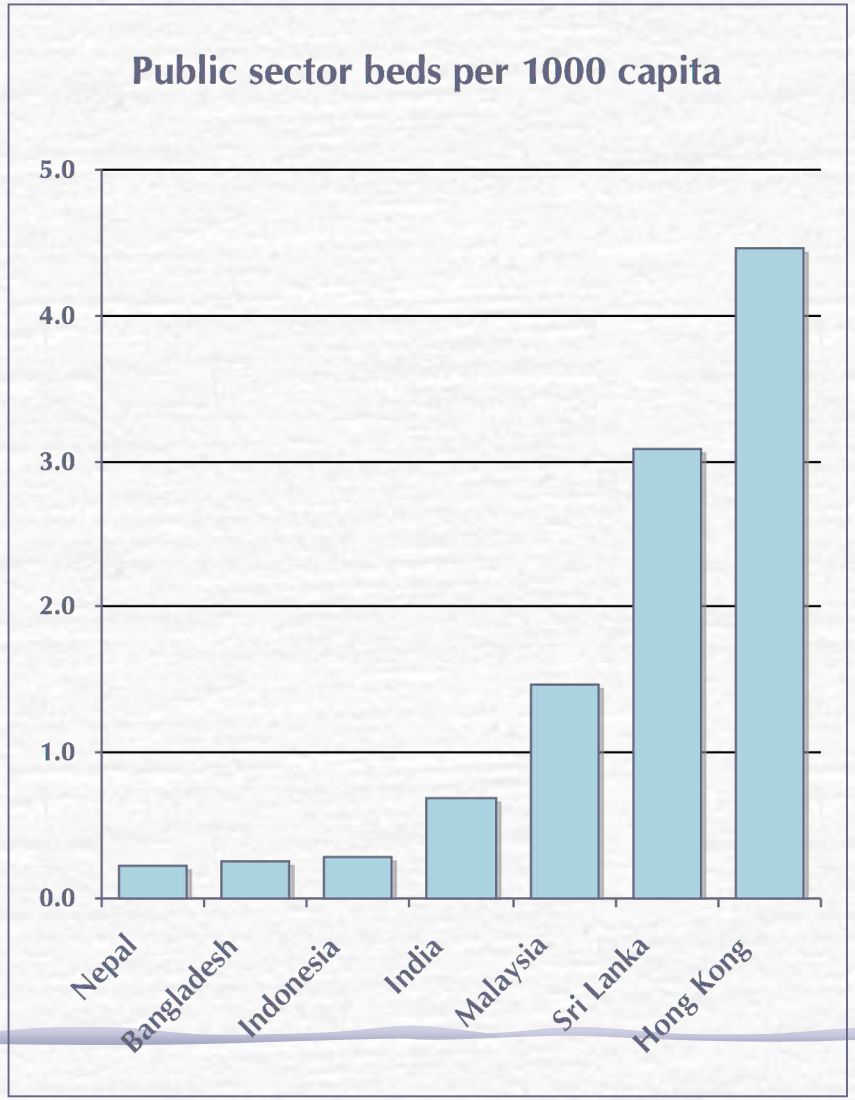
- Two distinct groups of tax-systems according to performance:
  - (1) Poor risk protection, poor targeting (BAN, NEP, IDO, IND)
  - (2) Good risk protection, good targeting (SRI, MYA, HKG)
- Use of public & private provision
  - Both pro-rich in good performers
  - Public provision pro-rich in good, pro-poor in bad performers
- Targeting of government spending
  - Good performers - not explicit or direct
  - Good performers - allocate budgets more to hospital services, less to preventive care
- 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

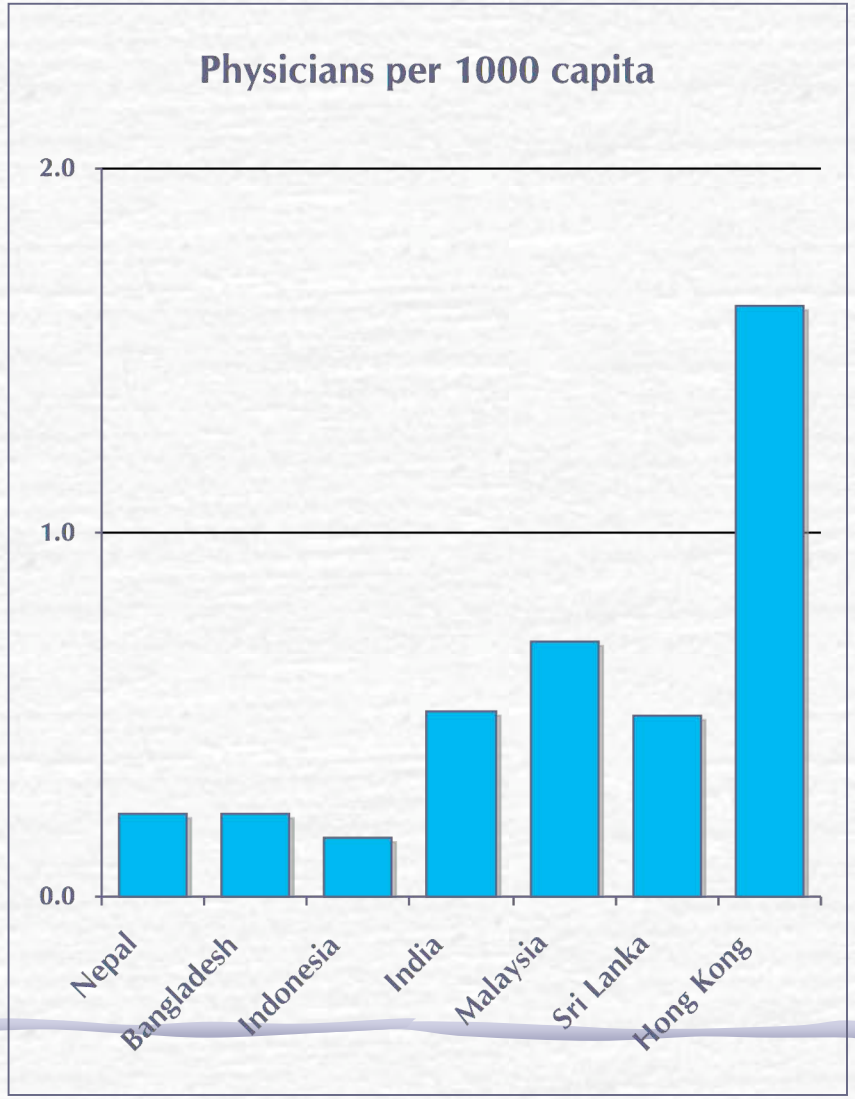
Why do some perform better

Explanations

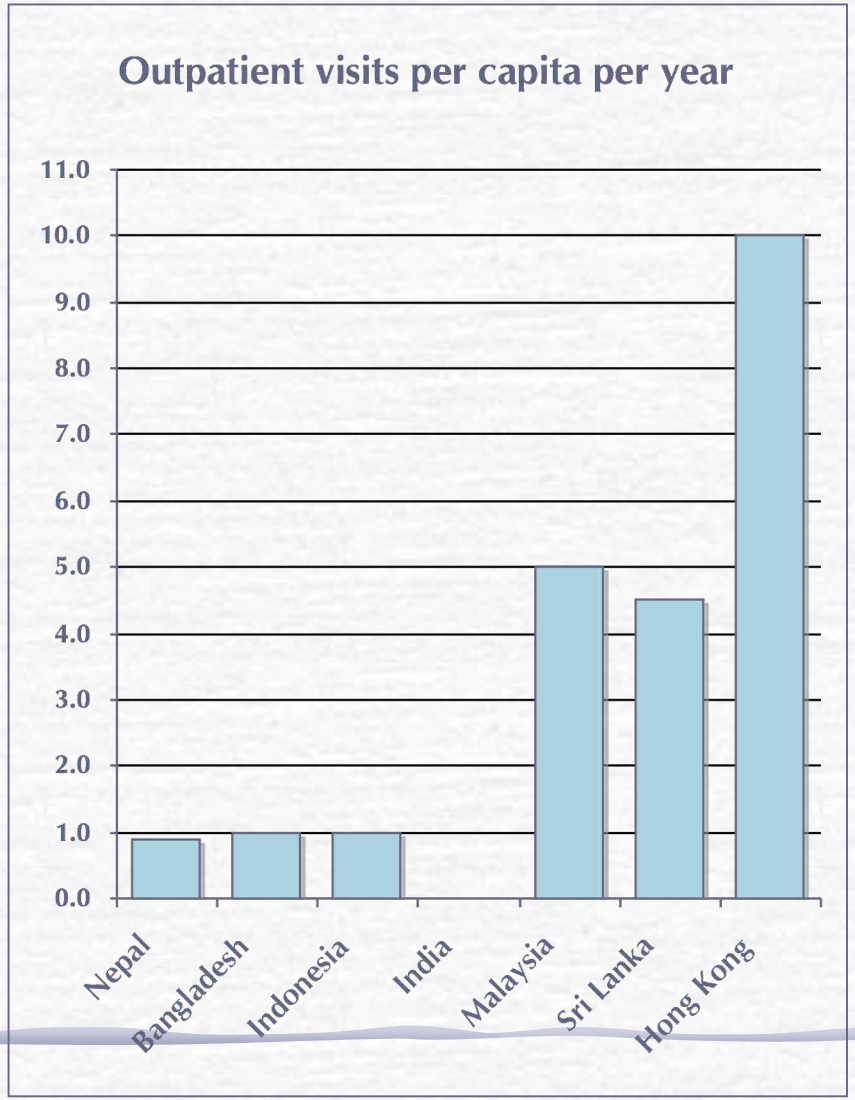
- Health care provision
- Social behavior
- Budget allocations
- Technical efficiency
- Governance

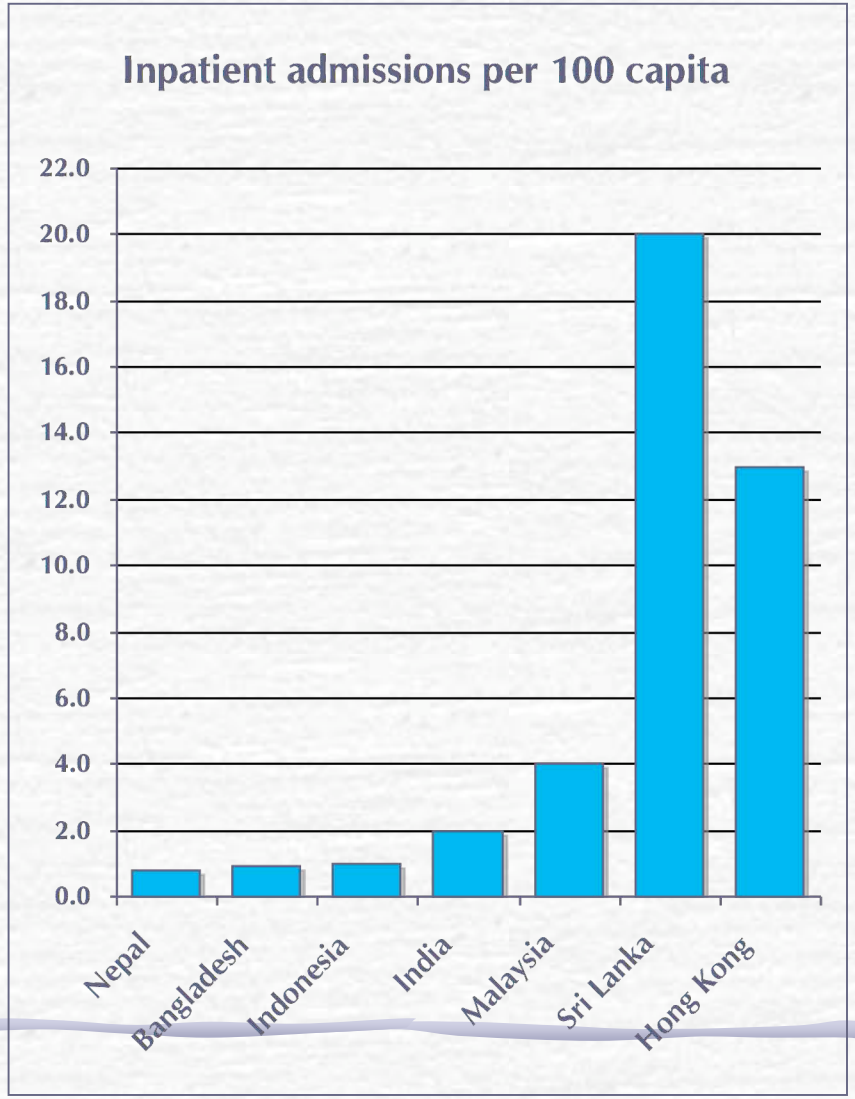
High levels of health care provision



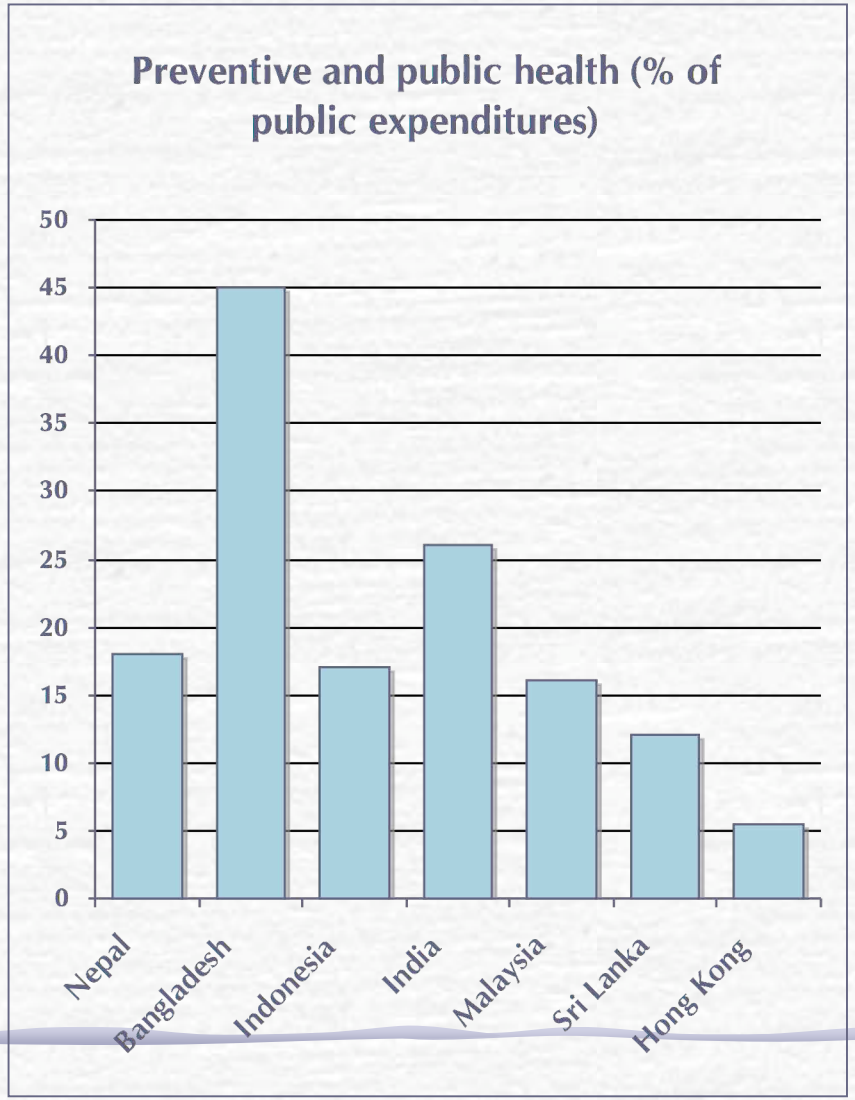


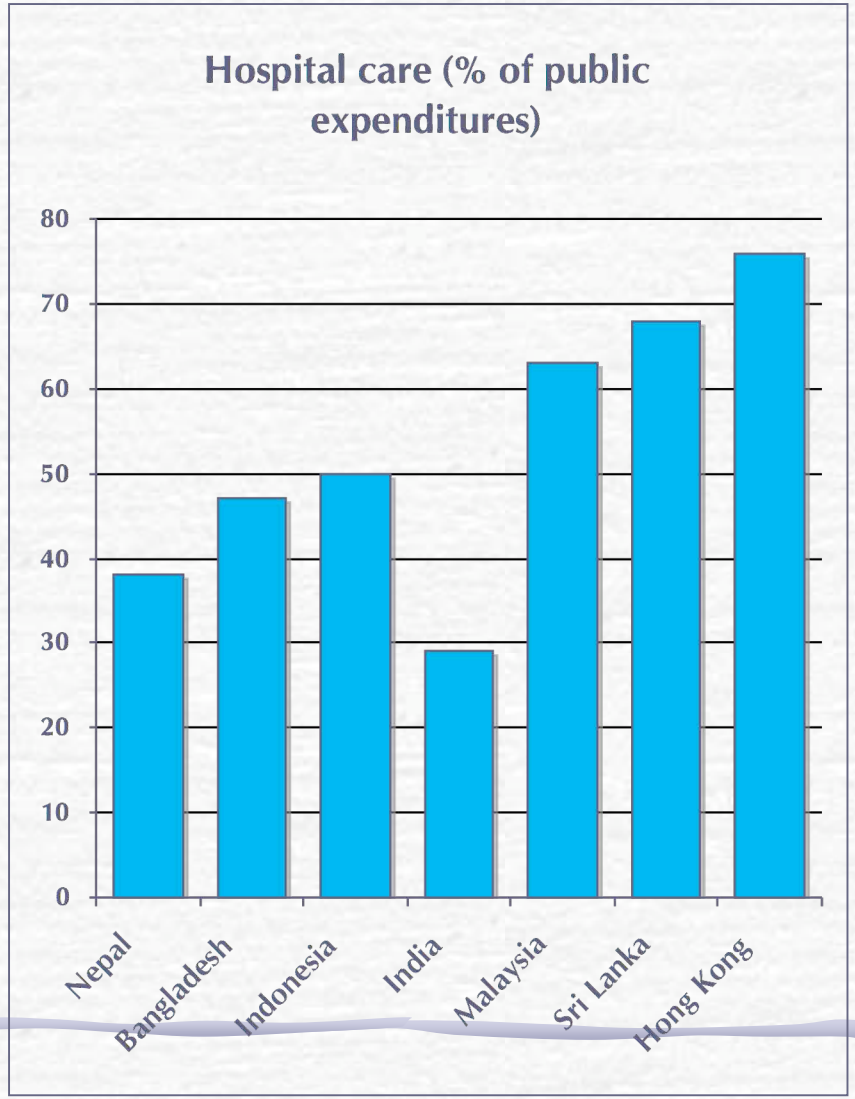
Social behavior: High health care use





Budgeting: Preventive vs. Hospital care





Technical efficiency gains during scaling-up: Sri Lanka

Year	GDP (US$ 1995 per capita)	IMR	Health spending (US$ 1995 per capita)	Outputs (Out-patients)	Outputs (In-patients)
1948	255	92	4.3	1.1	0.09
1960	279	57	5.4	2.3	0.14
12 yrs	+9%	-38%	+ 25%	+110%	+55%

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

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

Conclusions

Critical factors

- **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 spending on hospitals/inpatient care:**
  - Higher than regional average
  - > Critical to ensure adequate risk protection
- **Reliance on indirect targeting:**
  - Good performers did not persist in chasing holy grail of means testing
  - > Voluntary self-selection of wealthy to private sector
- **Good governance:**
  - Less prevalence of informal fees/no history of rent extraction
  - Accountability pressure for high allocations to inpatient care & effective universal access
  - Efficient public sector delivery
  - Public service mission ethos

Policy messages

- Need to take seriously and understand good-performing good performing tax-funded systems
- Indirect targeting with parallel private provision 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