Towards Universal Coverage of Health Care in the Asia-Pacific Region

Issues, Challenges, Prospects

Ravi. P. Rannan-Eliya
Institute for Health Policy
Sri Lanka

Expert Group Meeting
UNESCAP, Bangkok
30 Nov - 1 Dec 2006

Why does "Universal Coverage" matter?

- Evidence clear that high health outcomes at population level cannot be achieved without high levels of health care use at all income levels
  - South Asia - Kerala, Sri Lanka
  - East Asia - Japan, Hong Kong SAR (China)
- Specific evidence that treatment services necessary pre-condition to reduce mortality from many conditions, e.g. maternal mortality to IHD

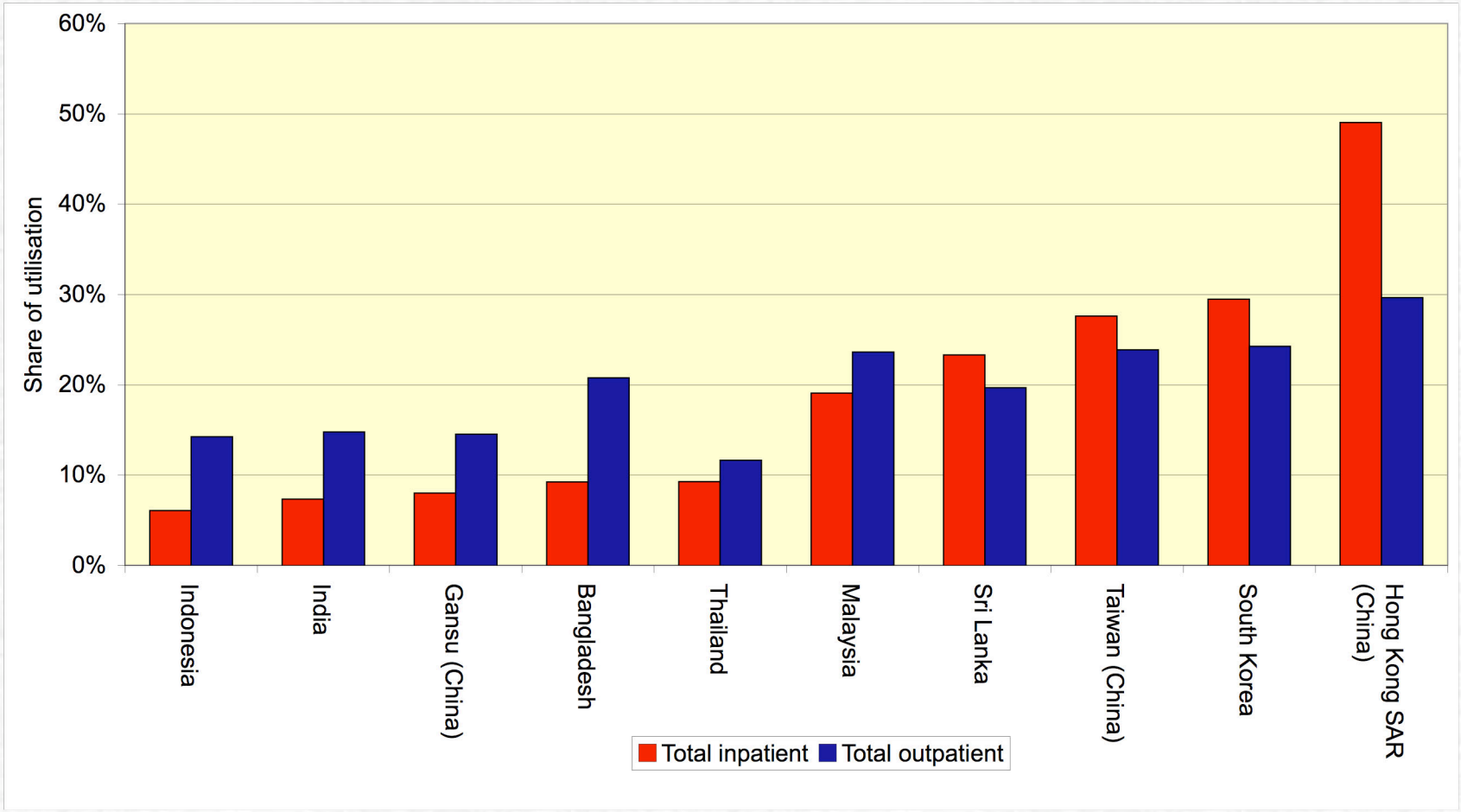
What is "Universal Coverage?"

- Not sufficient to define in terms of having access
  - Many countries offer free "access", but outcome is different
- Not sufficient to define in terms of health care treatment/outcome
  - Curing sickness not only or even most important policy goal
  - Risk protection/solidarity key motivating principle
    - Germany 1860s - Solidarity principle/Risk protection
    - Japan/Sri Lanka 1930s - Risk protection
    - UK 1940s - Solidarity principle

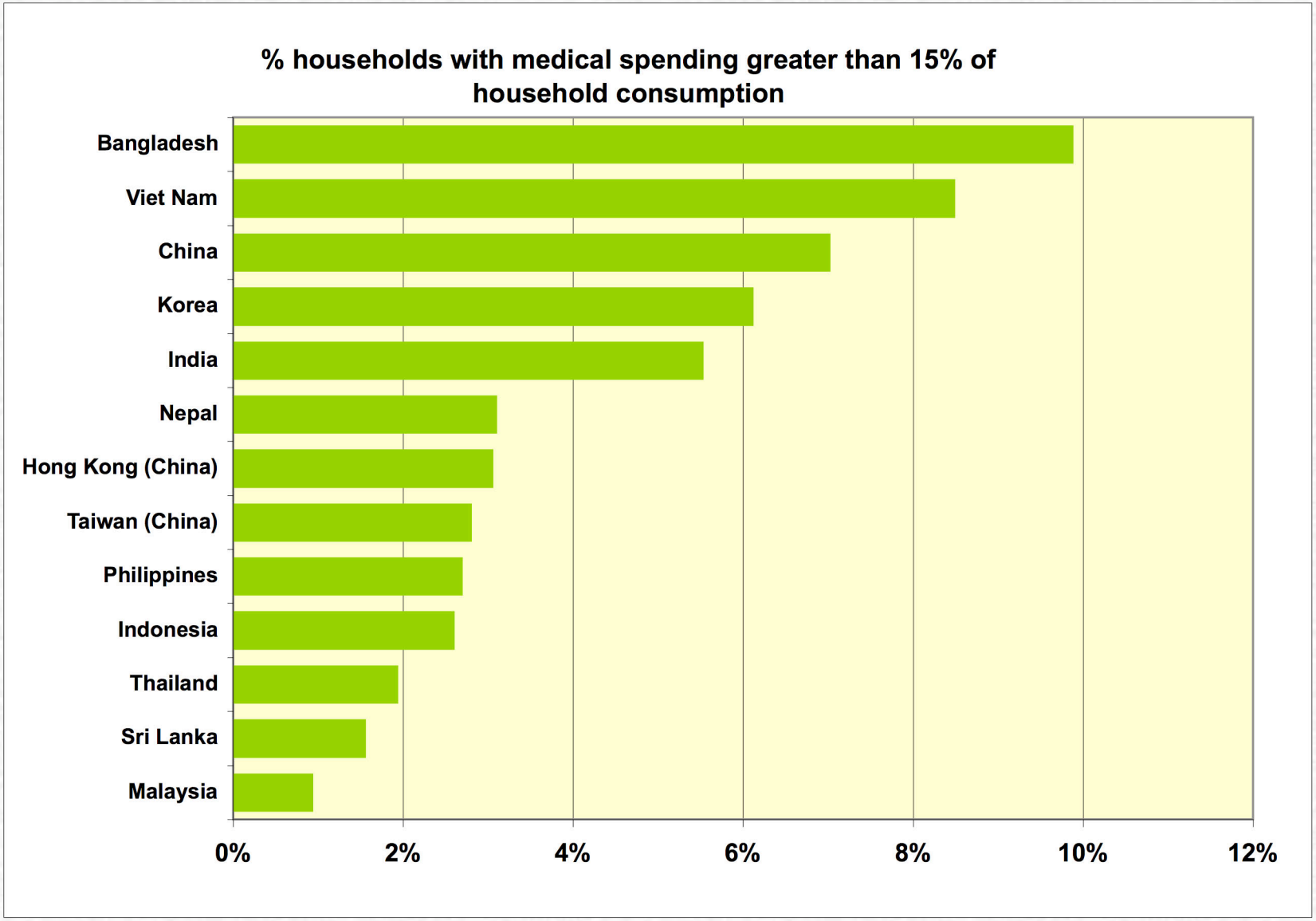
Operational definition of Universal Coverage

- Arrangements for the financing and provision of health services such that there is (i) at the minimum equality in actual use of health services by income level, *and (ii) equity in use in relation to need in case of higher income economies*
- Arrangements for the financing and provision of health services such that households do not make impoverishing payments in order to receive a socially-acceptable minimum level of services

Poorest quintile share of total health care use



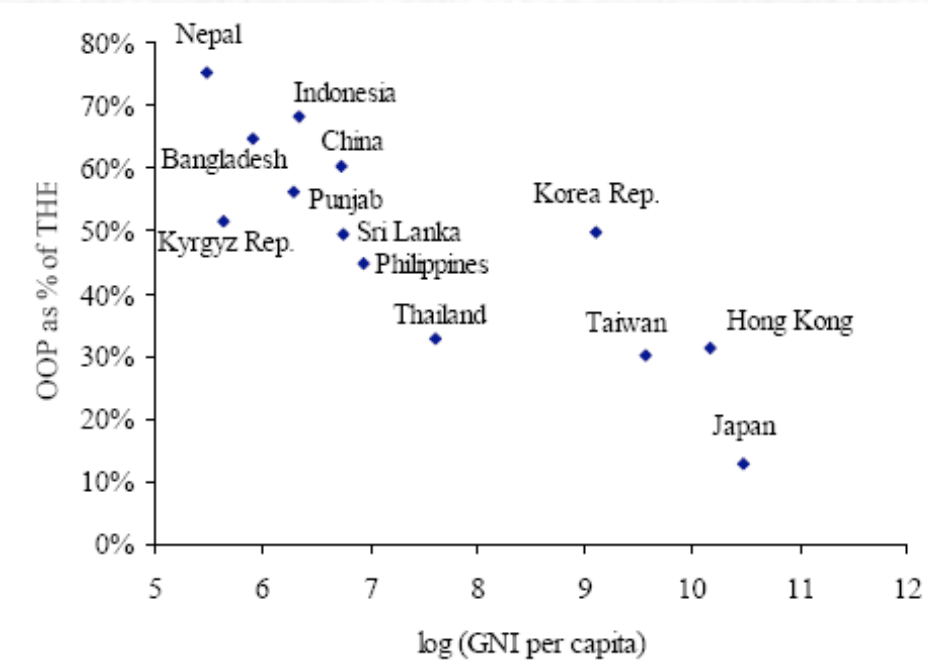
Catastrophic impact

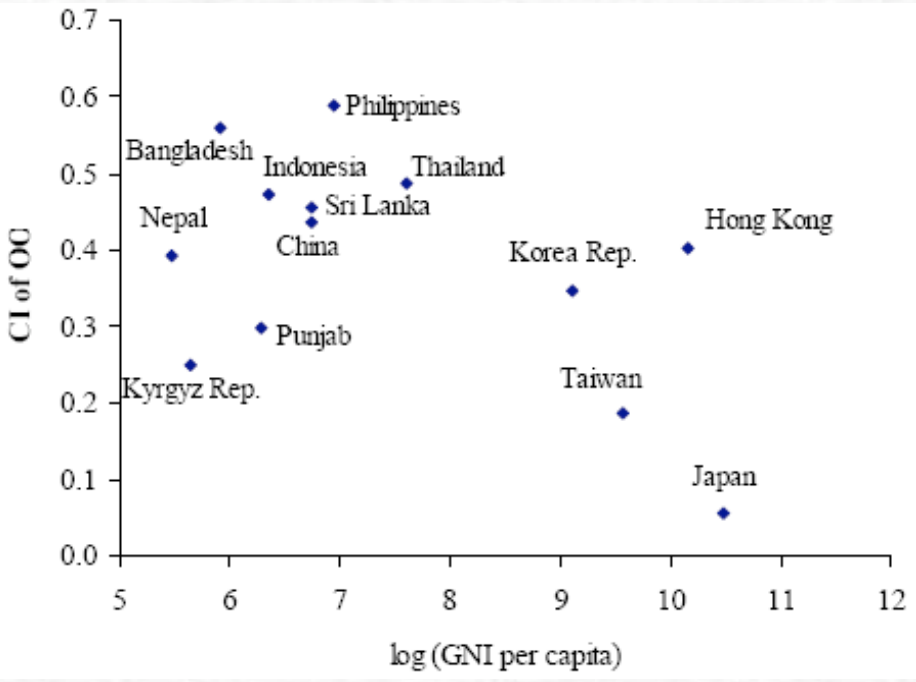


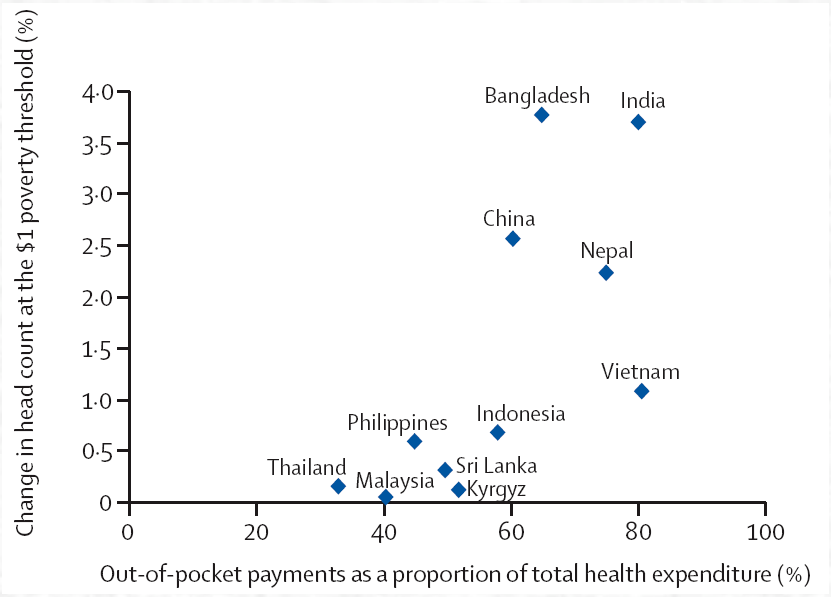
Equal Treatment for Equal Need

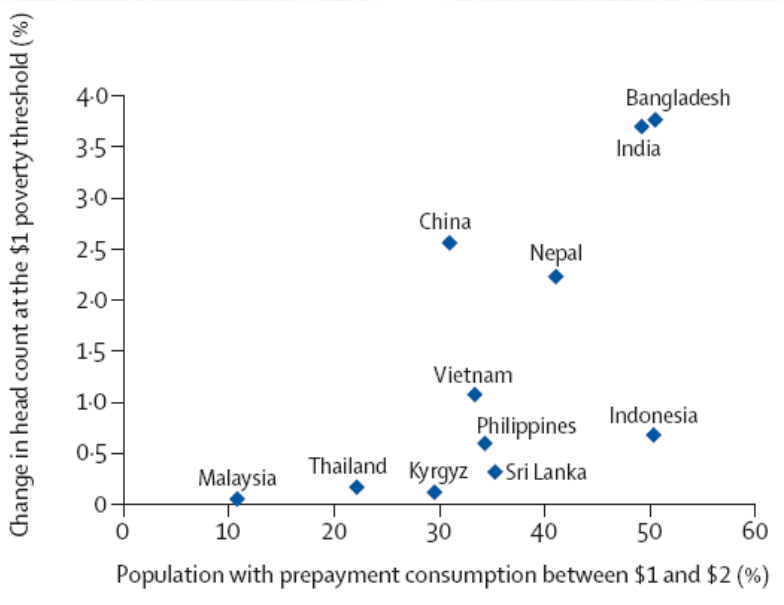
- Hospital services
  - ER
    - Pre: pro poor for both HK and Taiwan
    - Post: still pro poor for HK; pro rich for Taiwan
  - Hospital admissions
    - Pre: all pro poor; Taiwan, being the strongest
    - Post: pro rich for HK; less pro poor for Korea and Taiwan

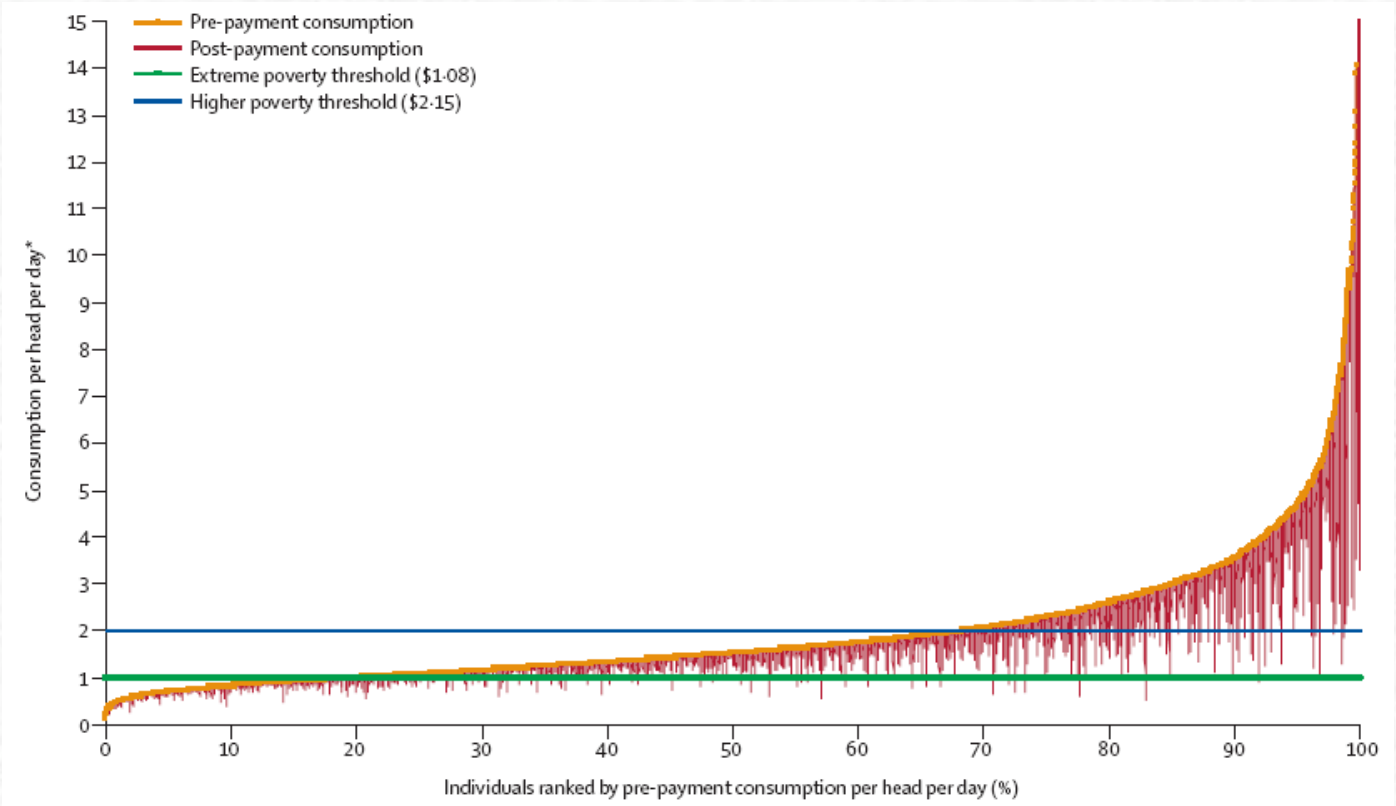
Out-of-pocket payments






Change in head count at the $1 poverty threshold (%)
4·0
3·5
3·0
2·5
2·0
1·5
1·0
0·5
0
0
20
40
60
80
100
Out-of-pocket payments as a proportion of total health expenditure (%)
Bangladesh
India
China
Nepal
Vietnam
Philippines
Indonesia
Thailand
Malaysia
Sri Lanka
Kyrgyz


Change in head count at the $1 poverty threshold (%)
4·0
3·5
3·0
2·5
2·0
1·5
1·0
0·5
0
0
10
20
30
40
50
60
Population with prepayment consumption between $1 and $2 (%)
Bangladesh
India
China
Nepal
Vietnam
Philippines
Indonesia
Malaysia
Thailand
Kyrgyz
Sri Lanka


Pre-payment consumption
Post-payment consumption
Extreme poverty threshold ($1·08)
Higher poverty threshold ($2·15)
Consumption per head per day*
15
14
13
12
11
10
9
8
7
6
5
4
3
2
1
0
0
10
20
30
40
50
60
70
80
90
100
Individuals ranked by pre-payment consumption per head per day (%)

Two paths to UHC

- Historical experience in Europe and Asia the same - Only two paths

- **Beveridge Model**
  - Tax-financed, integrated financing/delivery
- **Bismarck Model**
  - Social insurance financed with tax contribution, split financing/delivery

UHC Examples

Beveridge Model	**Bismarck Model**
Sri Lanka	Mongolia
Malaysia	Thailand
Singapore	Korea
Hong Kong SAR, China	Japan

Bismarck: Asian Experience

- Coverage easy to establish for formal sector workers on contributory basis
- Expansion to universal coverage requires tax financing (& redistributive premiums)
- Coverage first for inpatient services
- Generally not feasible in low-income Asia
- Challenge is how payments are made and cost control

Beveridge: Asian Experience

- Coverage initially established for small urban sector
- Expansion to universal coverage requires additional tax financing
- Emphasis on inpatient services
- Can be implemented in low to high income settings
- Challenge is how inadequate budget constraint is overcome

UHC & National Commitment

- Generation of political commitment always critical to achieving UHC
  - Japan: 1930s, 1950s-60s
  - Korea: 1970s
  - Sri Lanka: 1930s-40s
  - Mongolia: 1990s
- UHC is first a political and social challenge, and secondarily a technical one
- But technical analysis can prepare the ground

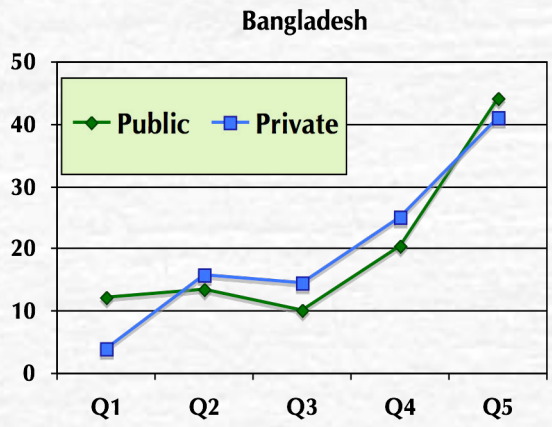
Knowledge gaps illustrated by Asia-Pacific experience

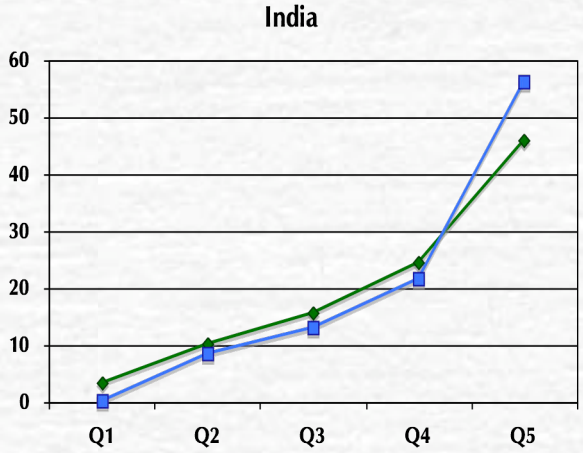
- Implementing Beveridge model when the budget is only half-full
- Role of technical efficiency gains & health system productivity in expansion coverage
- Managing costs in a FFS-based SHI system
- Trade off or not between cost-effectiveness and risk protection
- Managing costs with physician dispensing

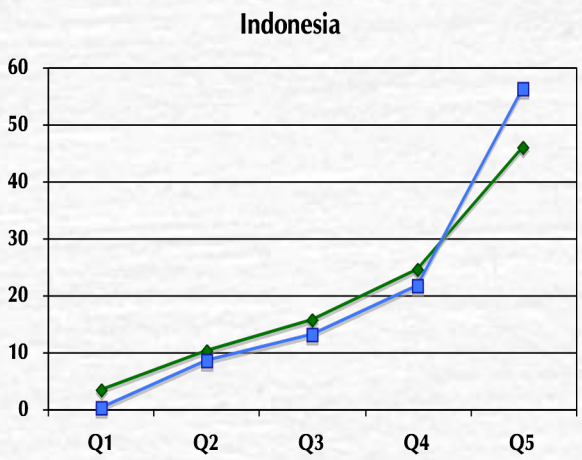
Non-inflationary fee-for-service experience

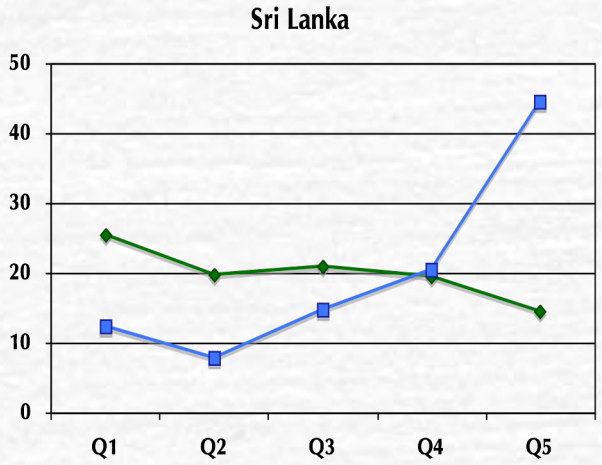
- Conventional wisdom:
  - Fee-for-service is cost inflationary
- But…
  - Prevalent in low-cost systems in Japan and Taiwan, China
  - Importance of fee-setting mechanisms and scope

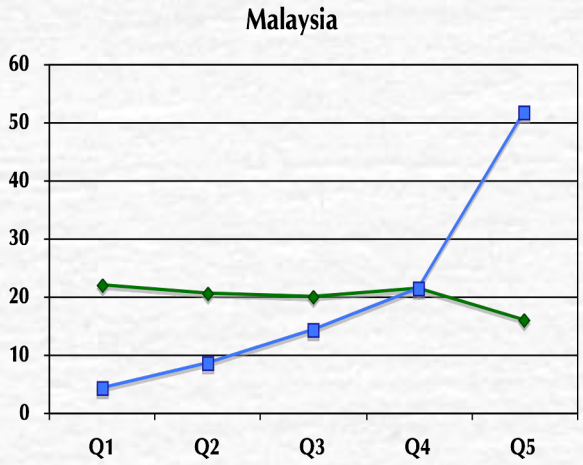
Use of public-private inpatient services by income quintile

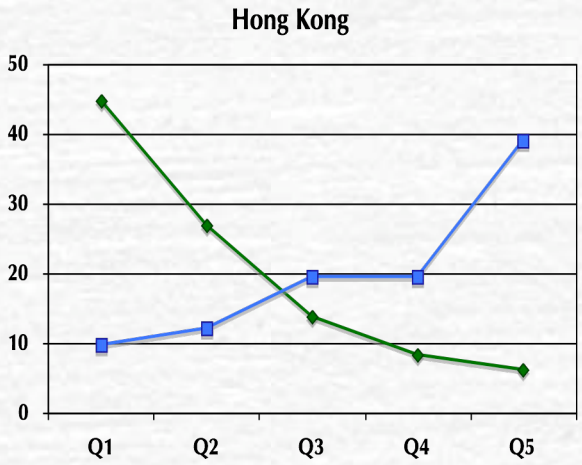












Technical Efficiency Gains in Coverage Expansion

- With exception of Mongolia, countries with UHC are low spenders
  - Japan, Hong Kong (China), Singapore, Malaysia, Sri Lanka
- Evidence that technical efficiency gains financed large part of expansion coverage
  - Sri Lanka 1948-60: >75% of expansion funded from productivity improvements
  - Technical efficiency gains can resolve gap between blue-sky cost projections and likely resource availability

Health system productivity inputs to IMR decline 1962-87

Country	Income	Education	Doctors	Technical progress
Japan	8	10	2	80
Korea	9	35	5	51
Hong Kong	9	31	5	55
Malaysia	8	29	5	58
Sri Lanka	4	20	-2	79
Thailand	10	21	3	66
Indonesia	14	49	22	15
Bangladesh	4	26	39	31

Source: Jamison et al. (2004)

Trade-offs between risk protection and against allocative efficiency

- Conventional wisdom:
  - Both goals (health outcomes/risk protection) difficult to achieve within budget constraint
- But…
  - Regional countries who have done better in health outcomes terms also emphasize risk protection more
  - Recent data suggest high health performers allocate more than other countries to hospitals and inpatient services

Lessons 1

- Two approaches have worked:
  - Tax-based, integrated financing/provision
  - Social health insurance
- Universal coverage requires commitment of tax financing by governments to fund poor
- Universal coverage is affordable based on historical experience:
  - 1.5-2.0% of GDP in public expenditure
  - US$ 5-25 per capita public expenditure

Lessons 2

- Learning from international experience has been critical
  - Eg: Japan, Korea, Thailand, Sri Lanka, Mongolia
  - BUT - mostly from Europe/North America
- Regional lesson learning
  - Beginning to happen, e.g., Equitap, Asia-Pacific Health Systems Observatory proposed, etc
  - Need to support and encourage collaborative policy-relevant work by regional researchers to build a better regional self-understanding, as well as sharing with the world