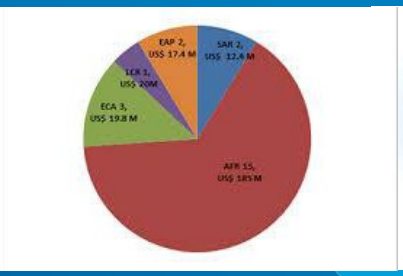
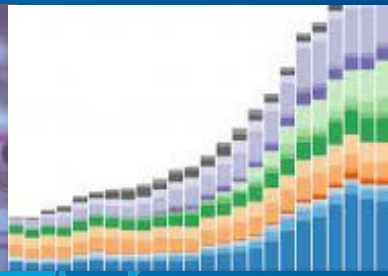
Global Health Care Financing Trends: Lessons for Asian Countries







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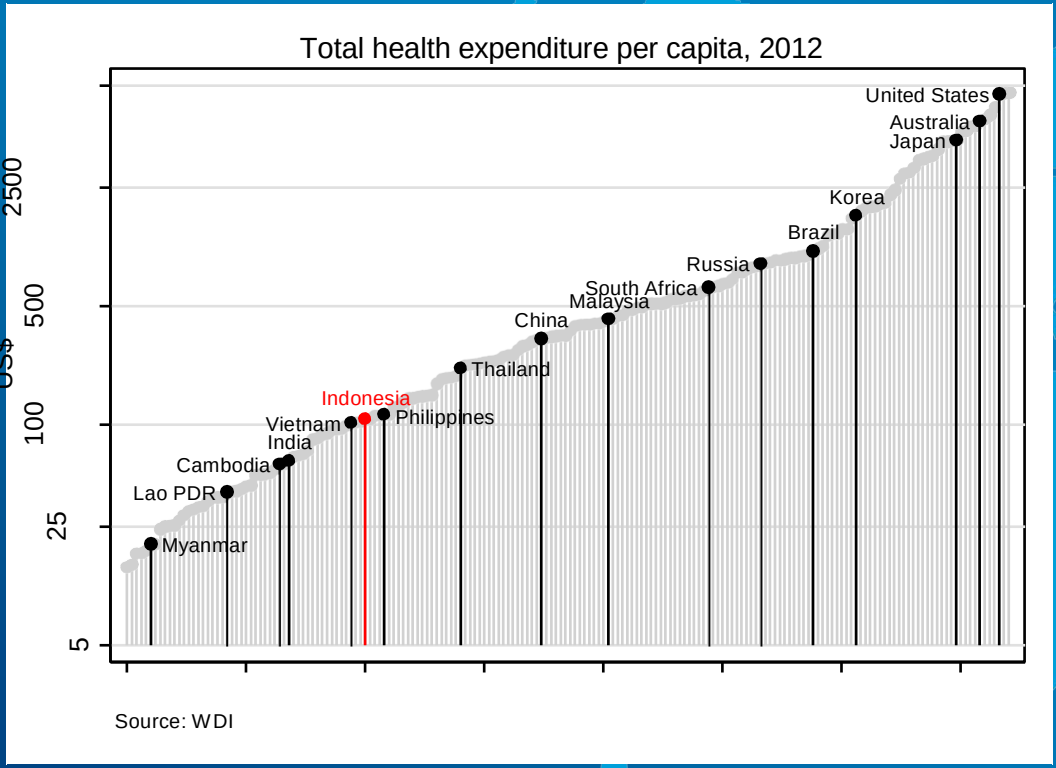
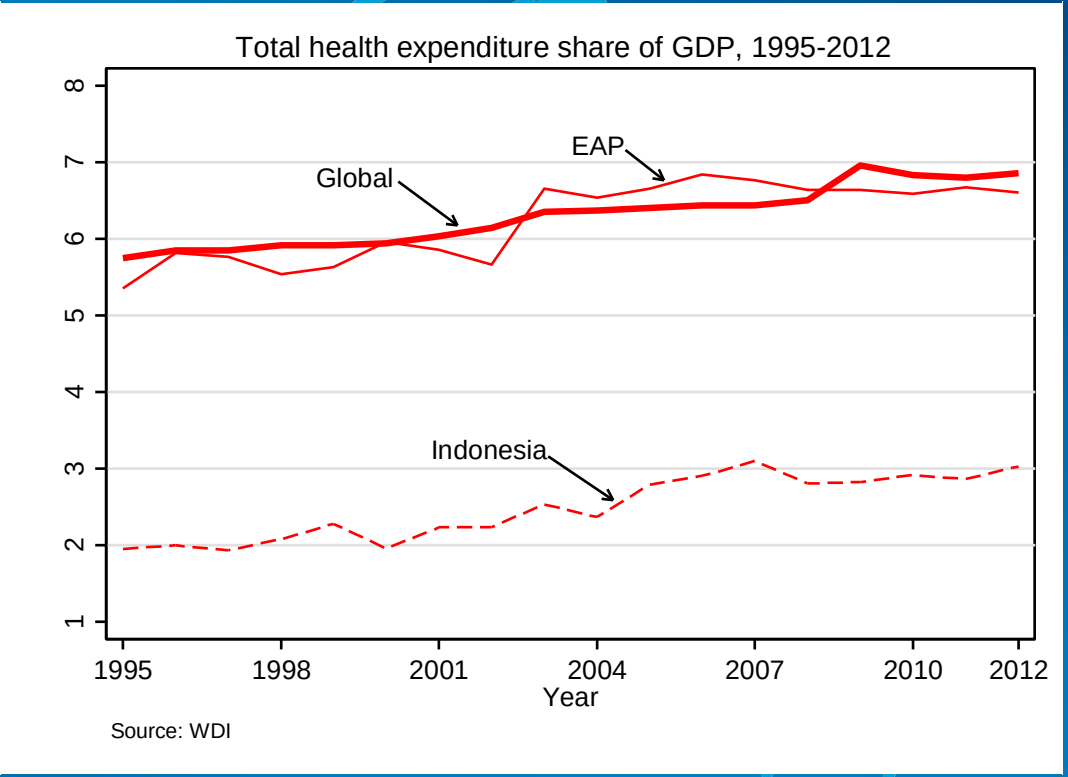
Global Health Financing Landscape



- Large variations in health expenditures: from ~**US$15** in Eritrea, DRC to over ~**US$9,000** in Norway, Switzerland, USA; *Indonesia: US$108.*
- Range: ~**2% of GDP** (Myanmar) to ~**18% of GDP** (USA); *Indonesia: ~3% of GDP.*
- Variations also in how health expenditures are financed: **<20% public** in Sierra Leone, Georgia to **>90% public** in Cuba, Timor-Leste; *Indonesia: ~40% public.*

Health is a Growing Share of the Economy

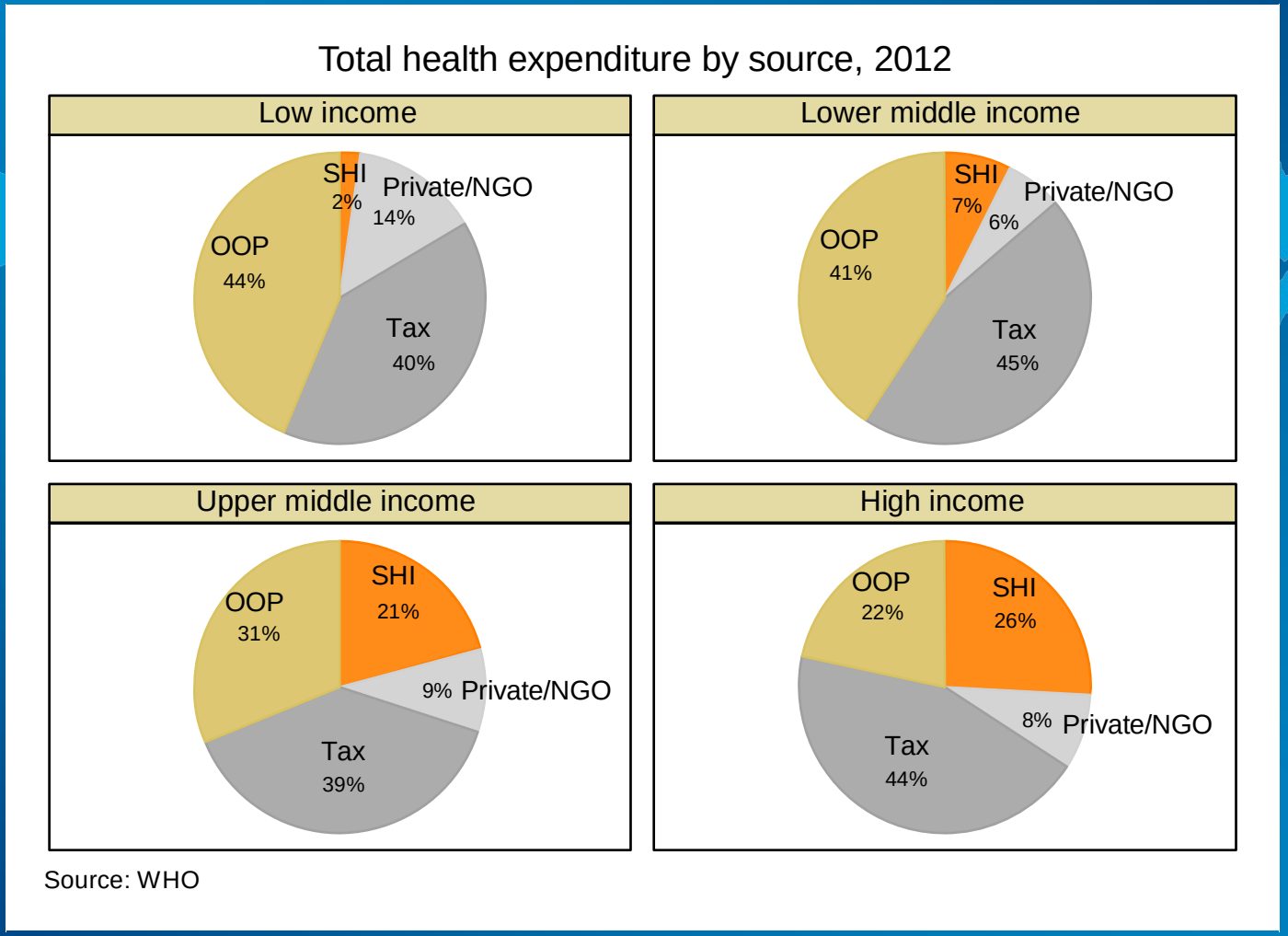
- Health's share of GDP has generally increased by 1% point of GDP since 1995.
- Changes in income, demography, epidemiology, technology, etc., are contributory factors.
- Health industry prominent source of employment and revenues (including from medical tourism, remittances, pharmaceutical/medical equipment trade).



How is Health Expenditure Financed?

- Five different health financing models:
  - Tax-financing (Beveridge)
  - Social health insurance (Bismarck)
  - Out-of-pocket (OOP)
  - Private health insurance
  - Community-based insurance
- Each model is associated with different instruments for revenue generation, pooling, and purchasing of health services; Rarely do we see a "pure" form exist in a country.

Sources of Health Expenditure Change as Income Rises



Source: WHO

Health Financing is a Means to an End

- UHC is now a prominent policy objective across most developing countries.
- UHC is about ensuring that everyone has access to quality health care services as needed without facing undue financial hardship.
- Health financing is not only about how much money is expended by the health sector but also about how efficiently and equitably resources are raised, pooled, and allocated to achieve desired health system objectives such as UHC.

UHC is Not About Insurance Card Distribution…

WHO-WB Measurement Framework
Recommended UHC Indicators

- Access to family planning
- At least 4 ANC visits
- Measles immunization
- Improved water source
- Adequate sanitation
- Non-use of tobacco
- Skilled birth attendance
- Anti-retroviral therapy

- TB case detection and treatment rate
- Hypertension treatment
- Diabetes treatment
- Incidence of catastrophic health expenditure
- Incidence of impoverishment resulting from high levels of health expenditure

UHC ≠ Social Health Insurance

- UHC is a health system objective not a health financing model, and social health insurance is not a necessary precondition for attaining UHC.

- Some countries are attaining UHC using government general-revenue supply-side financing (Sri Lanka, Malaysia, Fiji).

- Many other countries are attaining UHC using hybrid models: government general-revenue demand-side financing to augment supply-side financing with or without social health insurance.

Health Financing for UHC

- Reducing dependence on OOP payments – and increasing the share of pooled sources of financing -- is key for attaining UHC.
  - OOP payments are regressive and inequitable and increase the extent and risk of impoverishment resulting from large health care expenditures.
  - OECD: <20% of total health expenditures is OOP (in line with WHO recommendation); *Indonesia ~45% is OOP*.
- Pooling share can be increased either by increasing the share of health expenditure that is general-revenue and/or mandatory insurance financed.

Health Financing ⇔ Economy

Country	Informal employment (2010)	Population living on $2-a-day
Philippines	86%	43%
Indonesia	78%	53%
Vietnam	74%	46%
Thailand	65%	5%

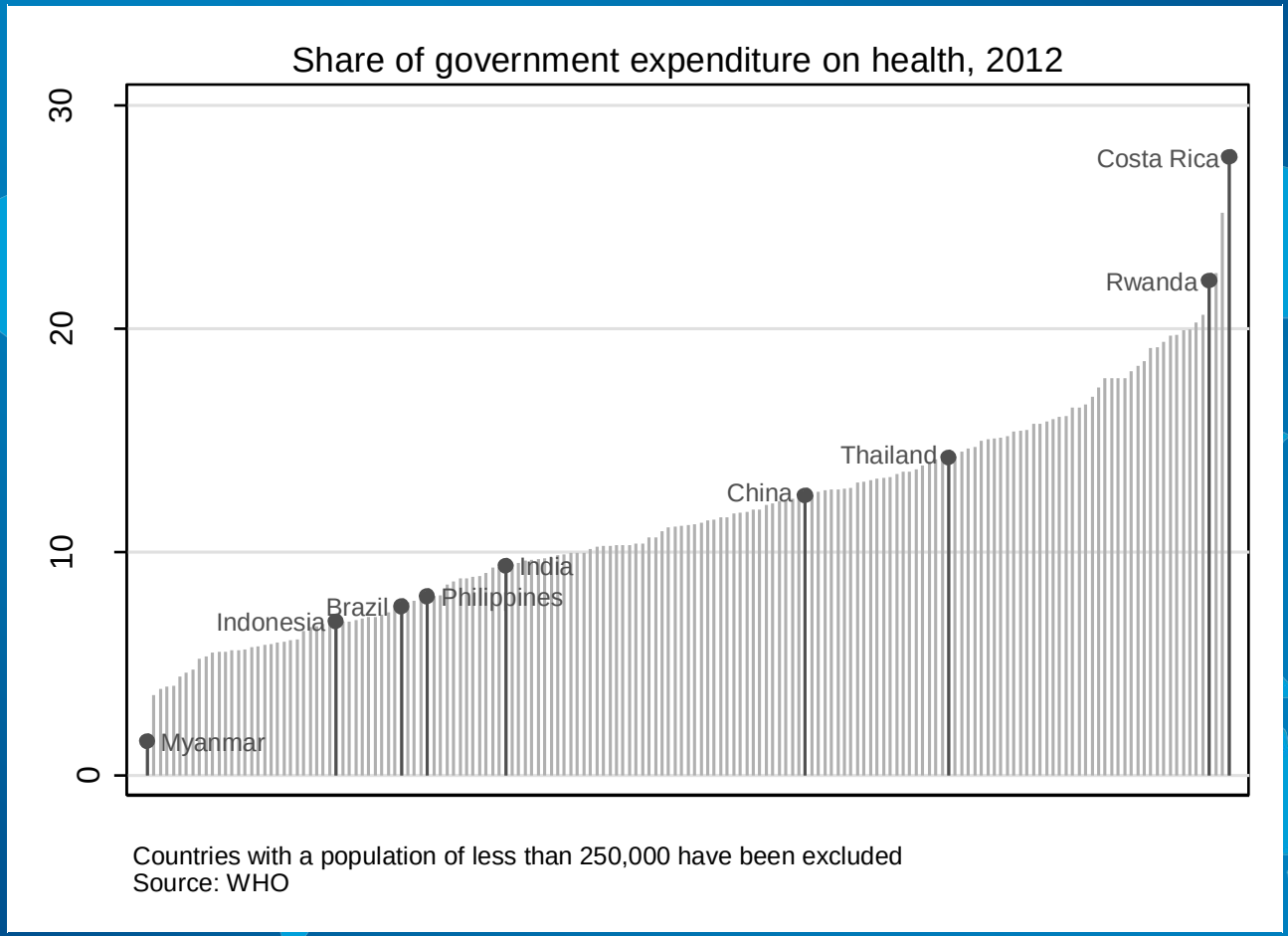
Note: Under assumption all agriculture employment is informal

- Health financing reforms (e.g., social health insurance) can increase labor costs and encourage informality.
- Informality and poverty can result in higher fiscal burden (e.g., for financing UHC).
- Rising health care costs – due to ageing, NCDs, technology, pharmaceutical prices – can threaten sustainability of health financing reforms and the economy.

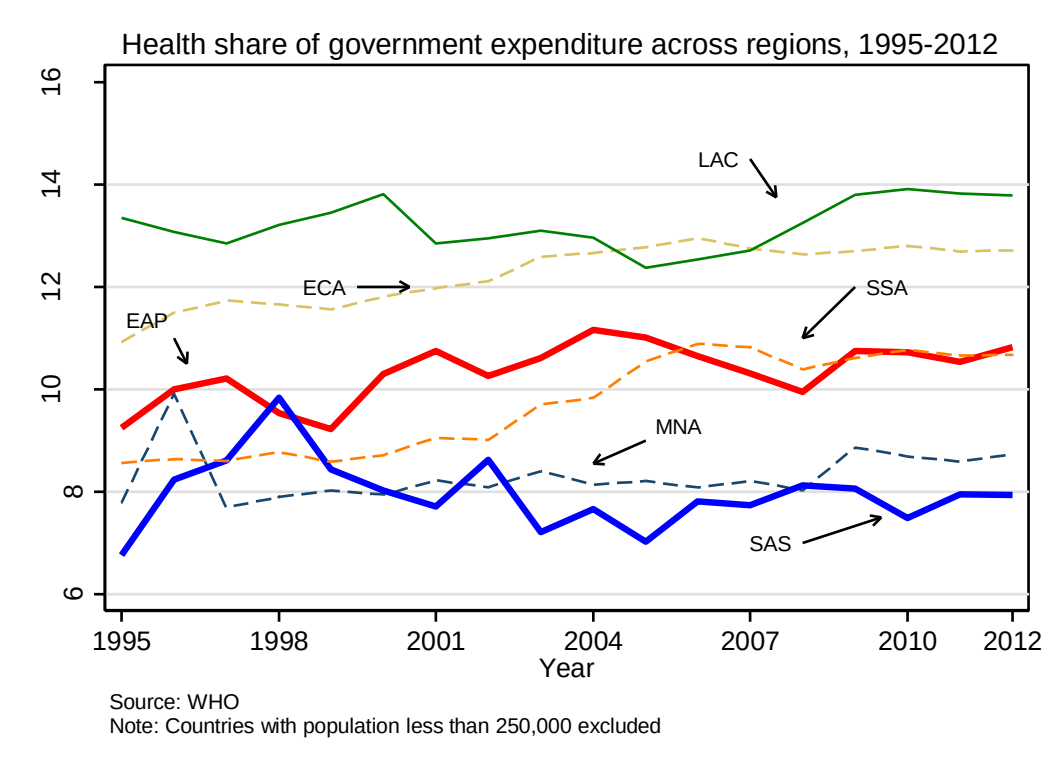
Government Financing is Key Even Under Social Health Insurance Models

- Non-contributory coverage for the poor.
- Expansion of coverage to the non-poor informal sector is a key challenge: voluntary enrollment even with subsidized premiums have led to adverse selection problems.
- Countries such as Thailand have expanded coverage to informal sector by government general- revenue financing.

Health's Share of Government Budget



Some Stylized Empirical Trends



- LAC highest share; SAS lowest share; EAP and SSA shares growing.
- Across countries, health's share of government expenditures is generally higher among richer countries, albeit economic growth and conducive macro-fiscal conditions don't always result in re-prioritization towards health.
- Large variations in prioritization to health across countries even after controlling for income.

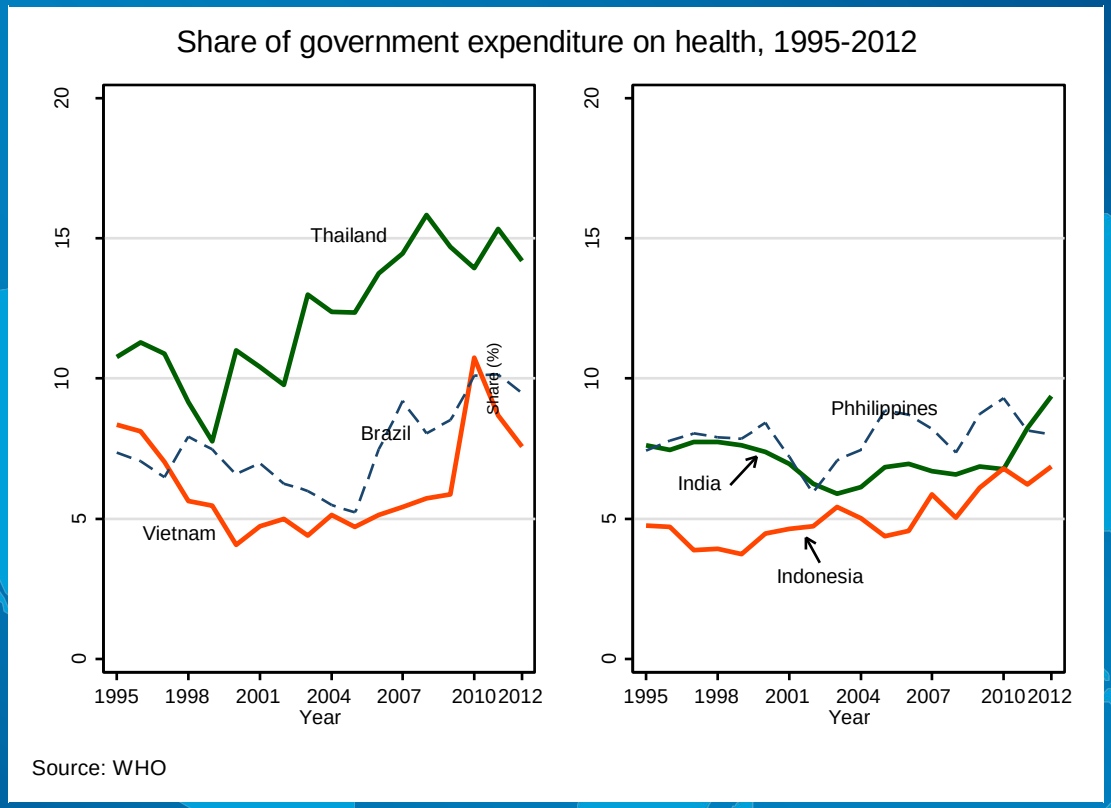
How to Re-Prioritize Health?

- Empirical work on prioritization has been sparse; Econometric analyses suggests that factors such as **democratization**, **lower levels of corruption**, **ethno-linguistic homogeneity**, and **more women in public office** are correlated with higher shares of public spending on health; however, these findings are not robust and are sensitive to model specification.

- **Efficiency considerations are important**: efficiency is in itself a source of effective fiscal space; but can also be important for attracting additional public resources.

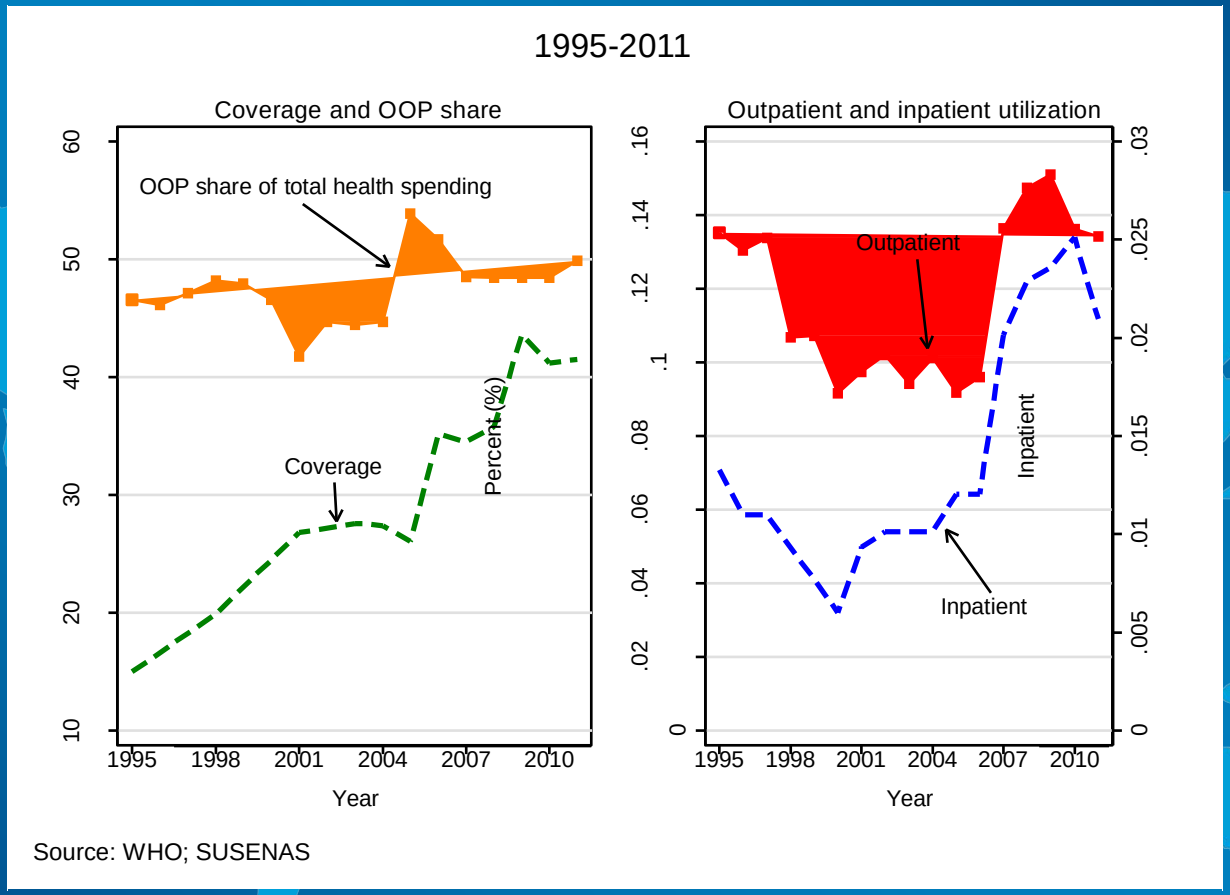
- Evidence from case studies suggests that country-specific **political economy considerations are key**, and that **results-focused reform efforts** – in particular efforts to explicitly expand the breadth and depth of health coverage as opposed to efforts focused only on government budgetary targets – are more likely to result in sustained and politically-feasible prioritization of health.

Two Sets of Country Examples



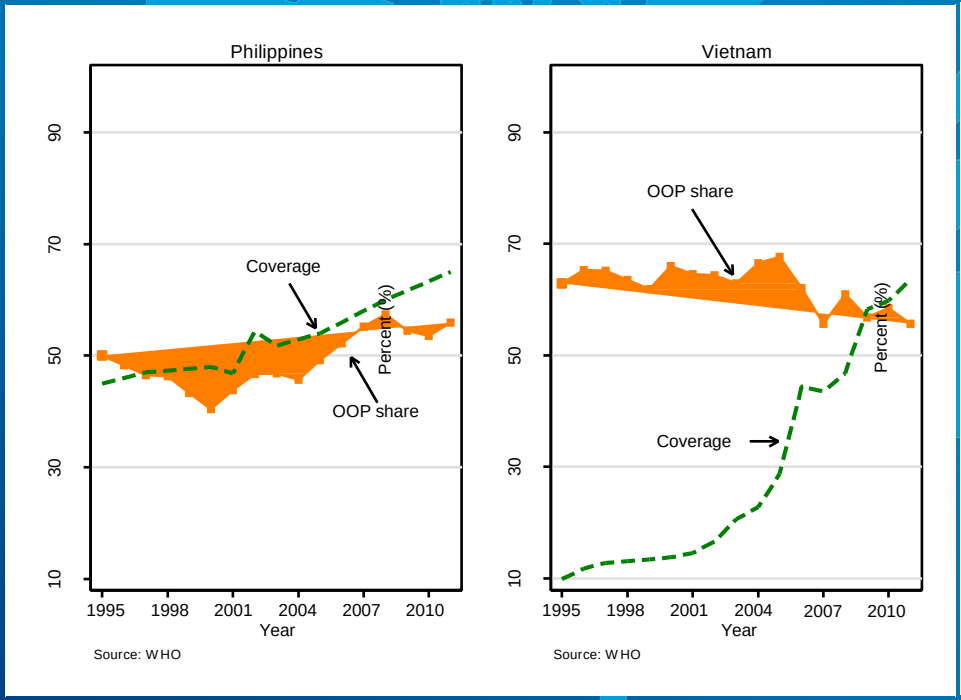
Vietnam: government health spending to increase at a higher rate than increase in total government expenditure. Enshrined as legal decree, resulted in increase in prioritization.
Brazil: matching earmarks for health spending at both federal and local government levels.
Thailand: 2001 commitment to UHC, some indications that re-prioritization for health occurred concomitantly with a decline in military expenditure.

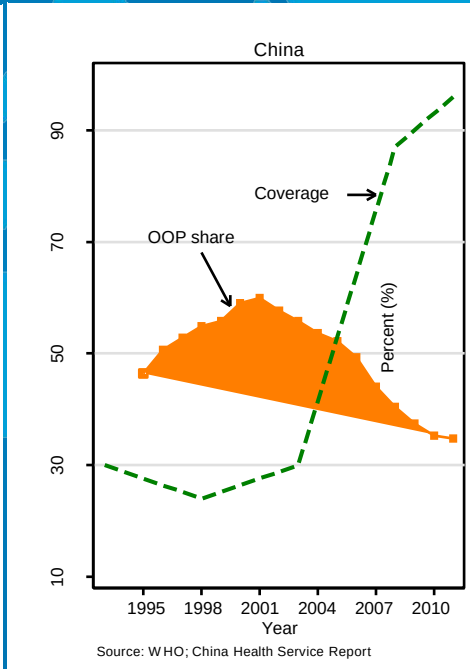
Expansion in Social Health Insurance Not Always Associated with Declining OOP

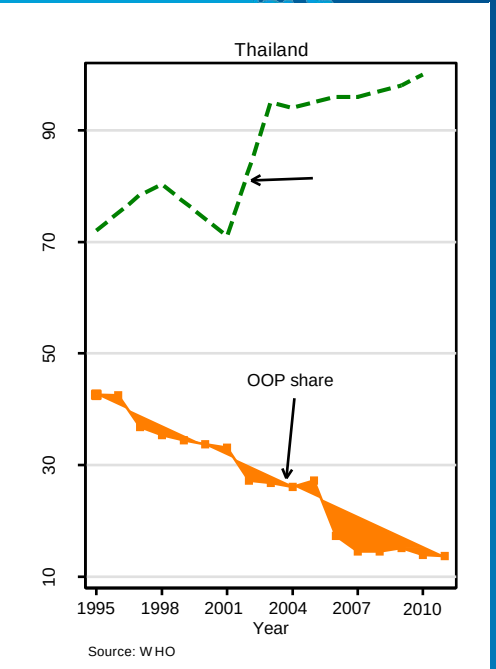


Steady increase in proportion of population covered, especially since 2005; rise in outpatient/inpatient utilization rates but OOP share of total health spending has remained high.

OOP Spending Remains High Despite Rising Social Health Insurance Coverage in Many Countries







In Summary

- Health financing is a means to an end; health financing is not only about the level of health expenditures, it is also about how resources are raised, pooled, and allocated to attain UHC.
- Issues of government financing and re-prioritization of health within the government budget are key for attaining UHC.
- More focus is needed on health service coverage and financial protection, not just on how much is being spent and how many cards have been distributed.