WHO PAYS FOR HEALTH CARE IN ASIA

Presented at the 9th Global Forum, Mumbai, India, 12 - 16 September, 2005

Study conducted out by the Equitap Team. Poster prepared by Aparnaa Somanathan, Ruwanthi Elwalagedara, Tharanga Fernando, and Chamikara Perera*

Abstract

The structure progressivity of health care financing in ten countries and territories in Asia are assessed in this paper. Progressivity is defined as departure from proportionality in the relationship between health payments and ability to pay. Survey data on household payments are combined with Health Accounts data on aggregate expenditures by source to estimate distributions of total health financing. In all territories, high-income households contribute more than low-income households to the financing of health care. In general, the better off contribute more as a proportion of ability to pay in low and lower middle income territories. The disproportionality is in the opposite direction in high/middle income territories operating universal social insurance. Direct taxation is the most progressive source of finance and is most progressive in poorer economies with a narrow tax base. The distribution of out-of- pocket (OOP) payments also depends on the level of development. In high-income economies with widespread insurance coverage, OOP payments absorb a larger fraction of the resources of low-income households. In poor economies, it is the better off that spend relatively more OOP. This contradicts much of the literature and suggests the poor simply cannot afford to pay for health care in low-income economies.

Motivation

There is wide variation across Asia in the levels of economic development and the design of health systems. The 14 countries and territories covered in this study span the whole range from Japan, Hong Kong, SAR and Korea – rich, industrialised and urban- to Bangladesh, Nepal and Indonesia – poor, predominantly rural and low-income. In addition, many of these health systems are undergoing reform which aims to make them more equitable. In this context, research on the distribution of payments for health care is useful to determine, at a general level, the relative performance of health systems and to suggest hypotheses about the relation between system outcomes and system design.

Objectives

1. To measure the degree of proportionality in the relationship between payments for health care and ability to pay.
2. To examine the degree of progressivity of different sources of financing in Asia and how they drive overall progressivity of financing in different health systems.

Method

Measurement of ability to pay (ATP):

Value of household consumption used for low and lower-middle income territories.
Value of household expenditure used for upper-middle and high income
All measures of consumption were adjusted using the following equivalence scale:

$e_h = (A_h + 0.5K_h)^{0.75}$

where A is number of adults in household, h and K the number of children in that household.

Summary indices of distribution

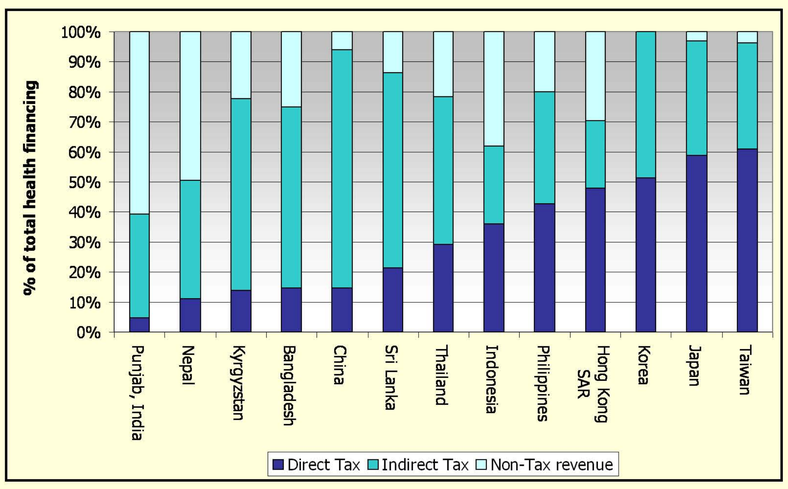
Direction and strength of relationship b/w payments and ATP measured by concentration index (C).
Progressivity defined as departure from proportionality in relationship b/w payments and ATP.
Measurement by

Kakwani index = C - Gini

Data

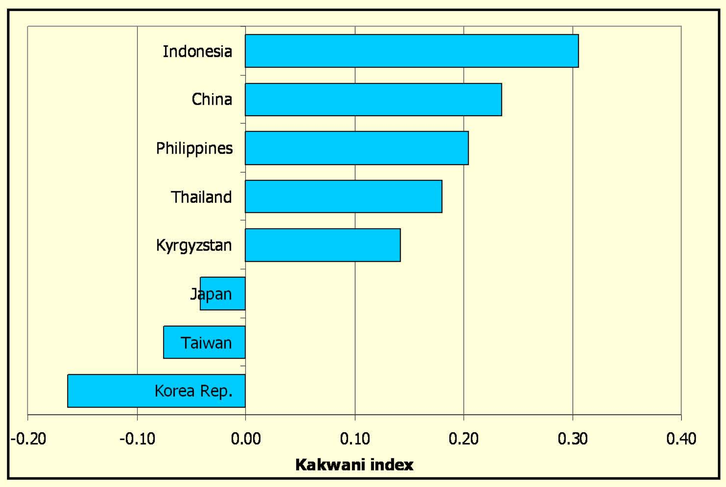
The analysis is based on OOP payments reported in household expenditure or socioeconomic surveys from 14 Asian countries and territories. OOP payments include fees, insurance co-payments, user charges for public care, purchases of medicines, appliances, diagnostic tests etc. Include OOP payments for both traditional and allopathic care, inpatient and outpatient care. National Health Accounts data were used to establish the weights for each source of financing.

Distribution of general government revenue financing



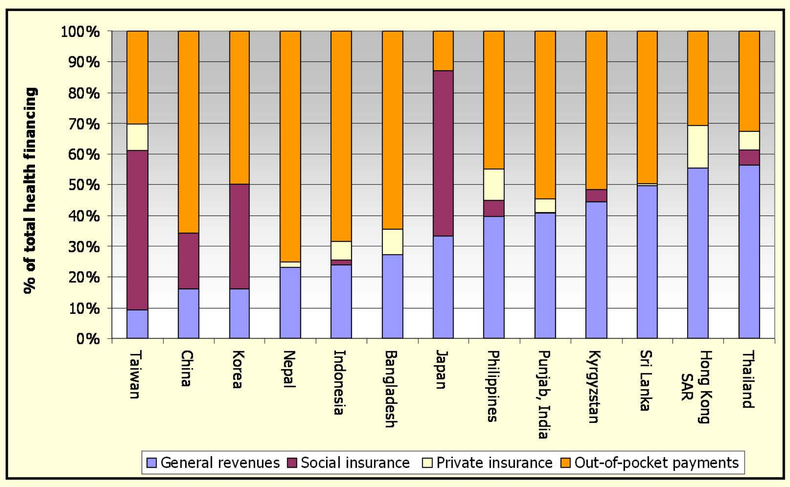
In poorer countries where the income tax base is relatively small, there is greater reliance on indirect taxes (sales taxes, import taxes etc.). As incomes grow and the tax base widens, reliance on direct taxes increases.

Distribution of social insurance financing



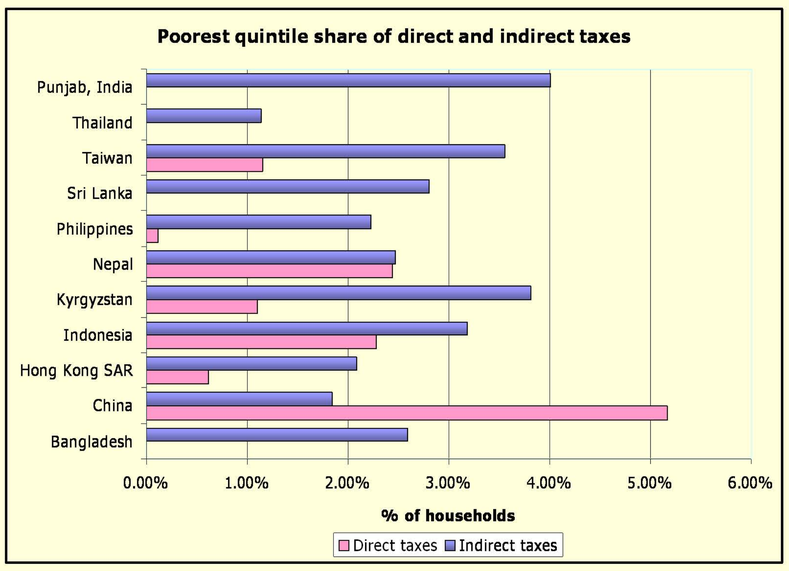
Social insurance is proportional/regressive where it operates as the dominant system of financing. It is however progressive in Indonesia, the Philippines and Thailand because only a limited, disproportionately better-off section of the population (e.g. civil servants) is covered by social insurance.

Structure of health care financing in Asia

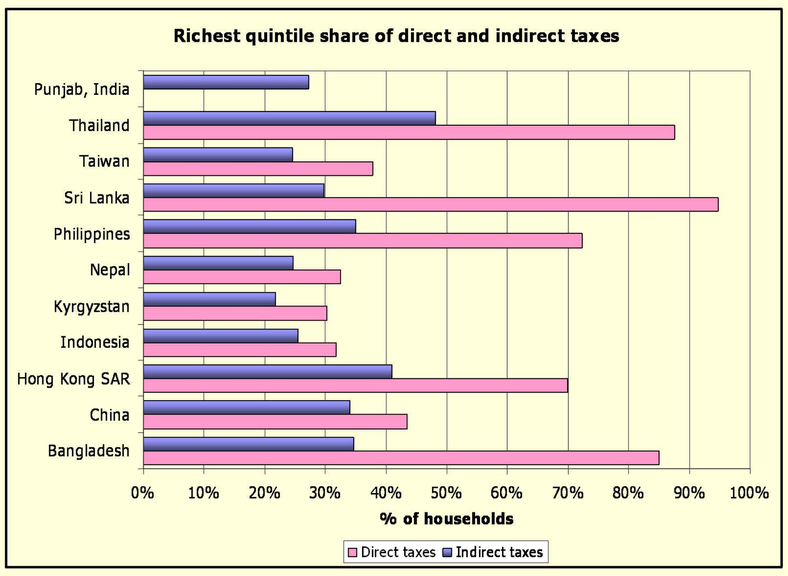


- Out-of-pocket (OOP) payments account for at least 30% of total health financing in all territories and 70% or more of total financing in very low income countries
- General classification of health systems in Asia:
  - Health systems that are financed predominantly through a combination of direct (OOP) payments and general government revenues: Bangladesh, Hong Kong, India (Punjab), Indonesia, Sri Lanka and Thailand (pre-2001)
  - Health systems that rely primarily on social insurance systems of financing and varying levels of direct payments: China, Japan, Korea and Taiwan

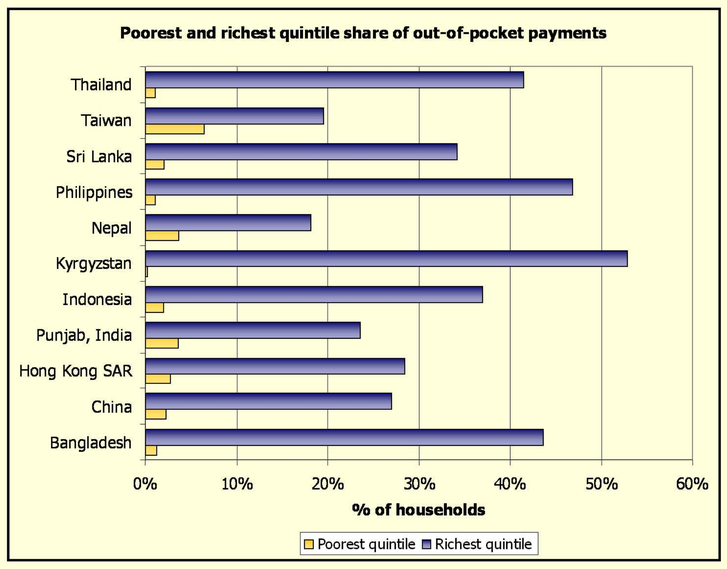
Poorest and richest quintile payments of taxes



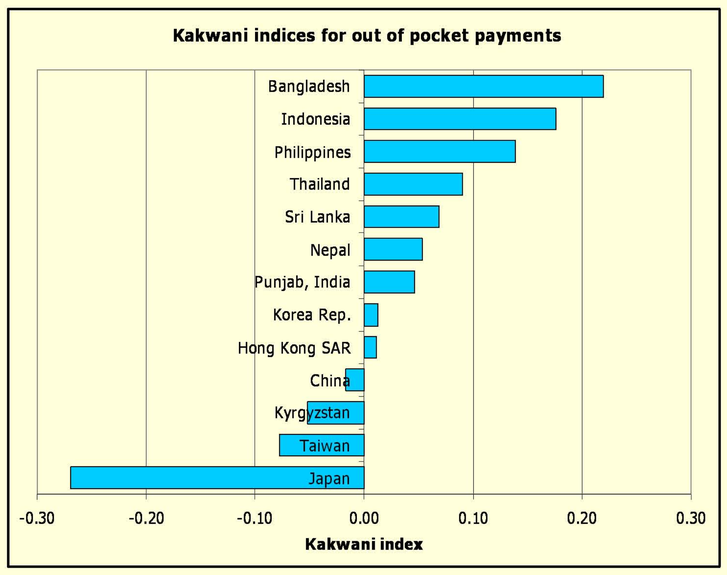
In the low-income countries, the poor are more likely to be in informal sector and thus pay a disproportionately share of taxes relative to their ATP. The distribution of direct taxes is highly progressive as a result. The progressivity of indirect taxes depends on whether they are levied largely on luxury goods (e.g. Thailand) distribution is relatively progressive; where they are levied also on food and other goods that poor also consume (e.g. Sri Lanka) distribution is mildly regressive



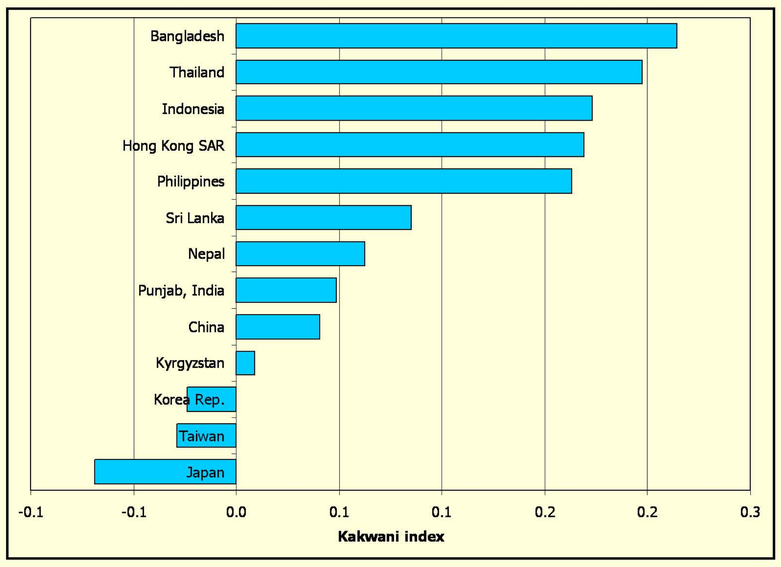
Distribution of out-of-pocket financing



OOP payments tend to be progressive in low-income countries and proportional/regressive in richer ones. They are also more progressive where they are a more important source of health financing. A possible explanation is that in low income countries the poor simply cannot afford to incur OOP payments; in many cases large OOP payments represent barriers to use of health care by the poor; in high income countries, where there is a greater degree of insurance cover, the poor do use services and incur OOP payments as a result.



Distribution of overall health financing



Health care financing of the richer territories, with the exception of Hong Kong is proportional to slightly regressive. By contrast, financing is progressive in all of the low and low-middle income countries.

Conclusions

The burden of health care financing tends to become less concentrated on the better-off in more developed economies due to two factors that are associated with rising national incomes:

1. Changes in the mix of financing
- ***Reliance on out-of pocket payments for health care falls and social insurance is typically established. This tends to be broadly proportional as contributions are levied as a fixed percentage of earnings.***
- ***Tax base is broadened, allowing greater reliance on tax financing and the opportunity to shift the balance of taxation from indirect to direct sources.***

2. Changes in the distribution of specific financing sources:
- ***Direct taxation becomes less progressive but not necessarily less redistributive, as the tax base is broadened.***
- ***Social insurance contributions are spread more evenly across the population as a system matures from partial to universal coverage.***
- ***Absolute poverty is lower and OOP payments are less of a barrier to health care consumption, causing the poor to incur a disproportionate***

Caveats

- Distribution of health payments is of interest from economic, political and equity perspectives.
- Distribution of payments not sufficient to infer violations of equity principles that concern the relationship b/w payments and utilization: need to examine who uses health care and who benefits from public subsidies à go to www.equitap.org

Funded by EU INCO-DEV
Grant No ICA4-CT-2001-10015, and product of the Equitap Project
(www.equitap.org)

Eddy van Doorslaer, Owen O'Donnell, Ravi P. Rannan-Eliya, Aparnaa Somanathan, Shiva Raj Adhikari, Baktygul Akkazieva, Charu C. Garg, Piya Hanvoravongchai, Deni Harbianto, Alejandro N. Herrin, Mohammed Nazmul Huq, Shamsia Ibragimova, Anup Karan, Tae-jin Lee, Gabriel M. Leung, Jui-fen Rachel Lu, Badri Raj Pande, Rachel Racelis, Sihai Tao, Keith Tin, Laksono Trisnantoro,Chitpranee Visasvid, Yuxin Zhao

Institute for Health Policy
4th Floor,72, Park Street, Colombo 2,
Sri Lanka
Email:info@ihp.lk
www.ihp.lk

IHP