What have we learnt about the role of health systems for health equity in Asia?

Findings of the EQUITAP Project
www.equitap.org

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Outline

- Equitap project
- What was studied
- Some results
- Explaining differences in tax-financed systems
- Ending thoughts

Equitap Project

- Collaborative project of 17 Asian and European institutions funded by EU, World Bank, DFID, Rockefeller Foundation, Ford Foundation, Governments of Hong Kong, Malaysia, Kyrgyz, Korea and Japan
- Systematic assessment of equity in national health systems & capacity building in Asia ranging from poor to rich nations
- EU INCO-DEV grant 2001-2005 (FP5)
- www.equitap.org

What was studied

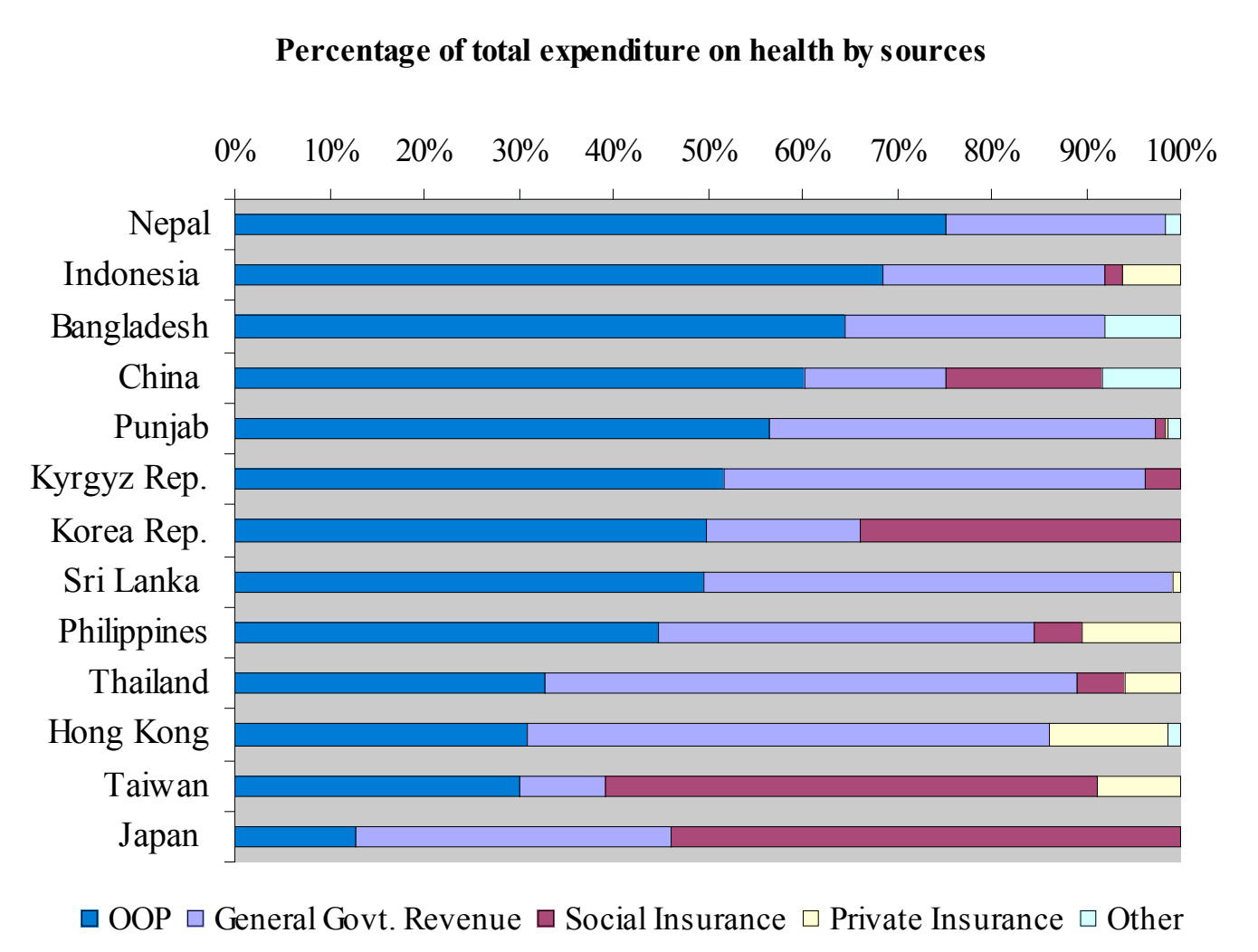
- Object of evaluation: national health systems (states/provinces in India/China)
- Dimensions of health systems equity
  - Who pays for health - burden of financing
  - Access/use of services
  - Benefit of government spending
  - Protection against catastrophic expenses
  - Health outcomes
  - Profiling of health financing
- Approach:
  - Common scientific protocols implemented by country partners
  - Used primarily existing data - household surveys
  - Micro-data analysis linked to macro-data (health accounts)
  - FP5 EU INCO-DEV project led by Southern partner

Typology of health systems

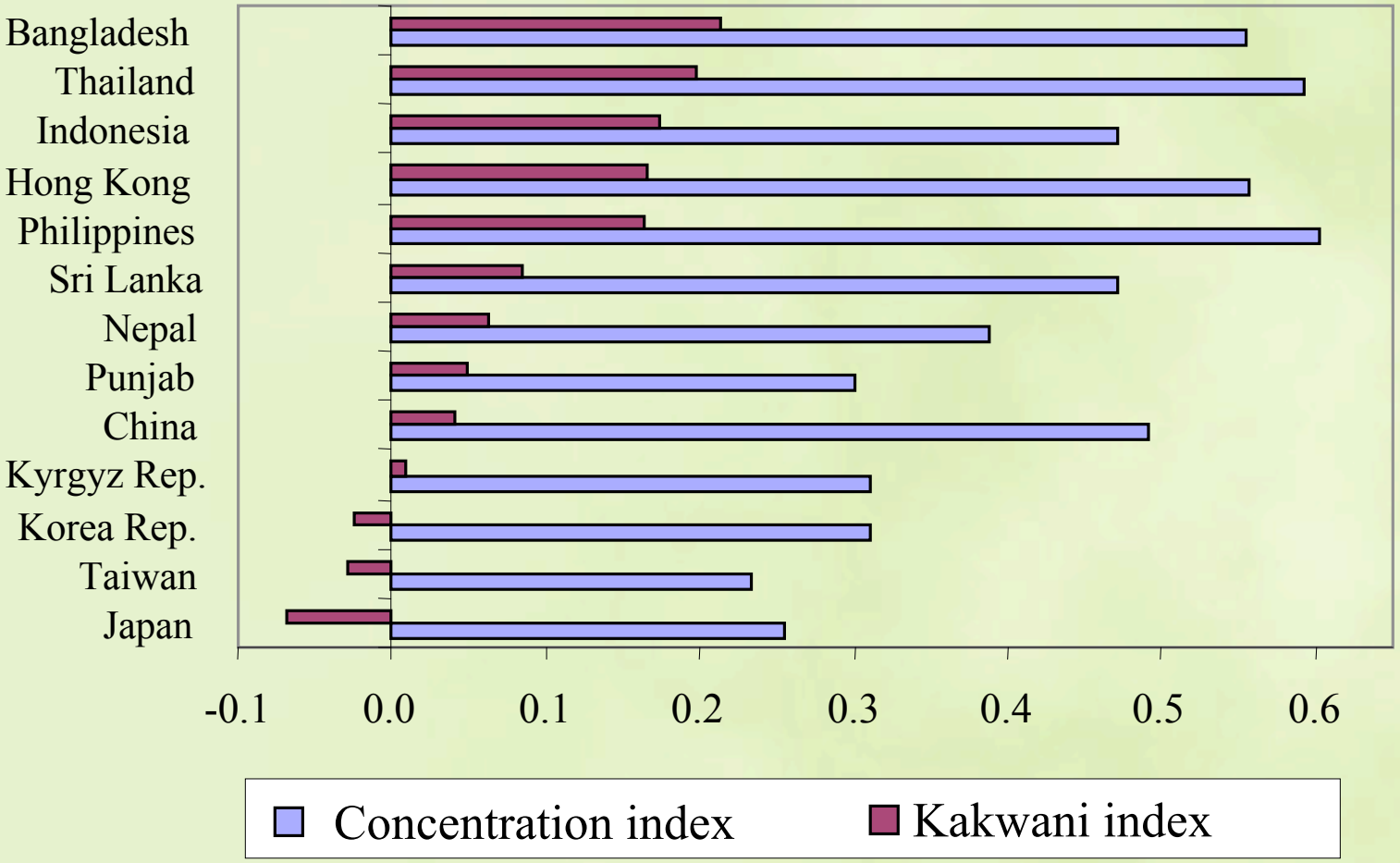
Universalistic, tax-funded systems: No/minimal user fees, no explicit targeting/voluntary self-selection by rich of private sector, emphasis in spending towards hospitals/inpatient care, high density of supply.	Sri Lanka Malaysia Hong Kong
Non-universalistic, tax-funded systems: User fees, means testing, emphasis in spending towards non-hospital care, low density of supply.	Bangladesh Indonesia India Nepal
National health insurance systems: Universal social health insurance, large tax-subsidy for insurance, emphasis in spending towards hospitals/inpatient care	Japan Korea Taiwan (Mongolia/Thailand)
Transition systems: Restricted social health insurance, minimal tax-subsidy for insurance, user charges major mechanism of financing	China Viet Nam

Some Results

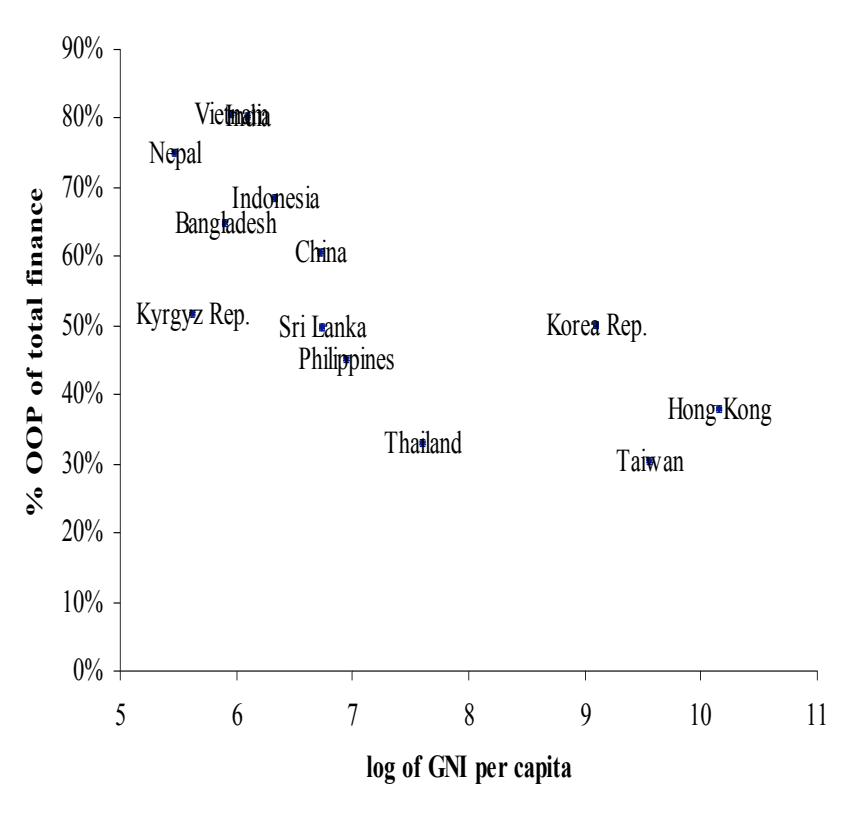
Health financing

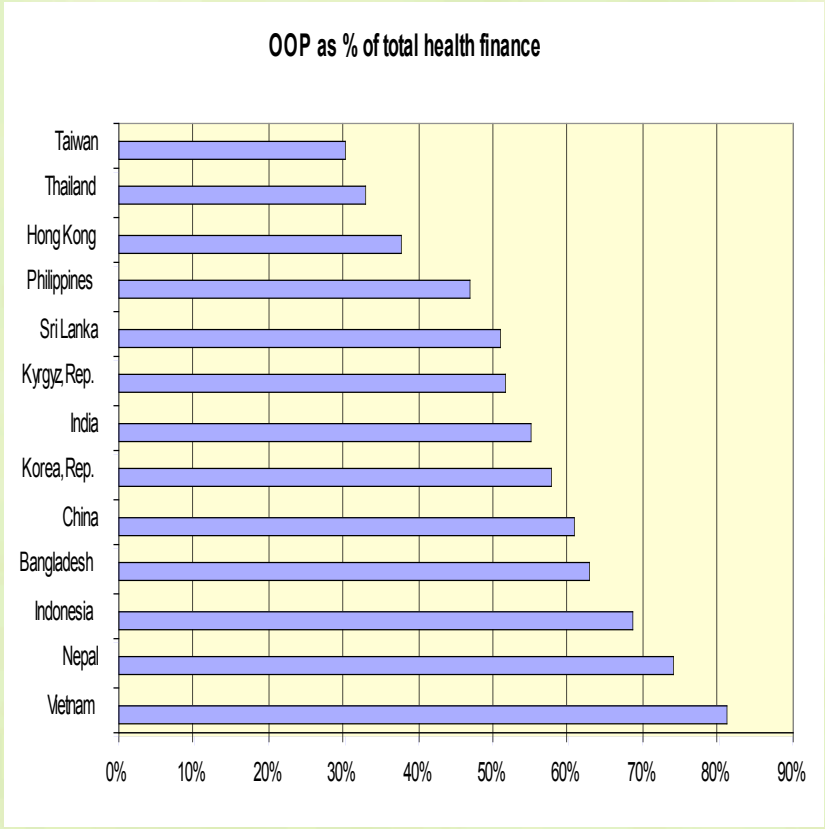


The burden of total health financing

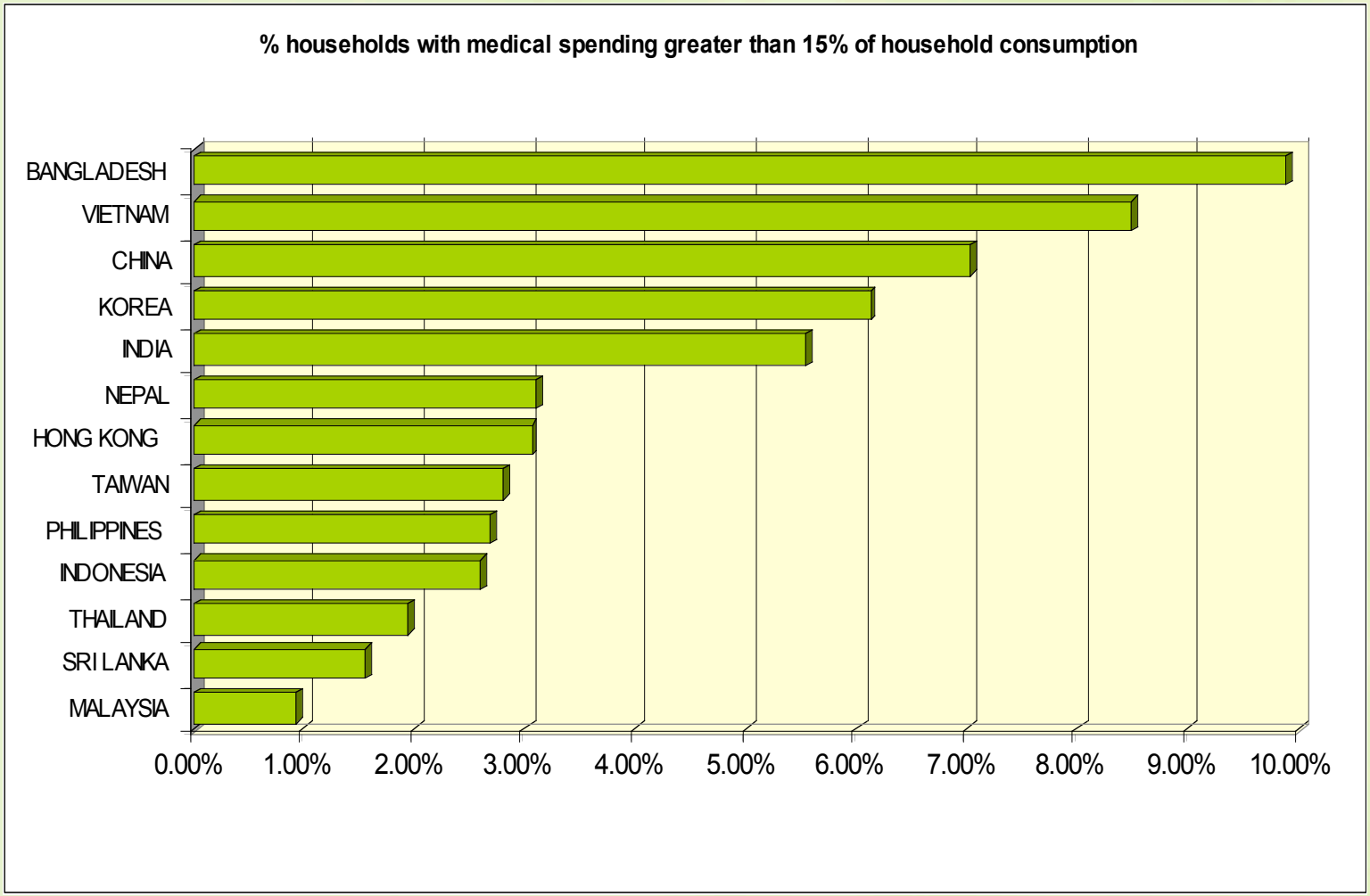


Out-of-pocket payments

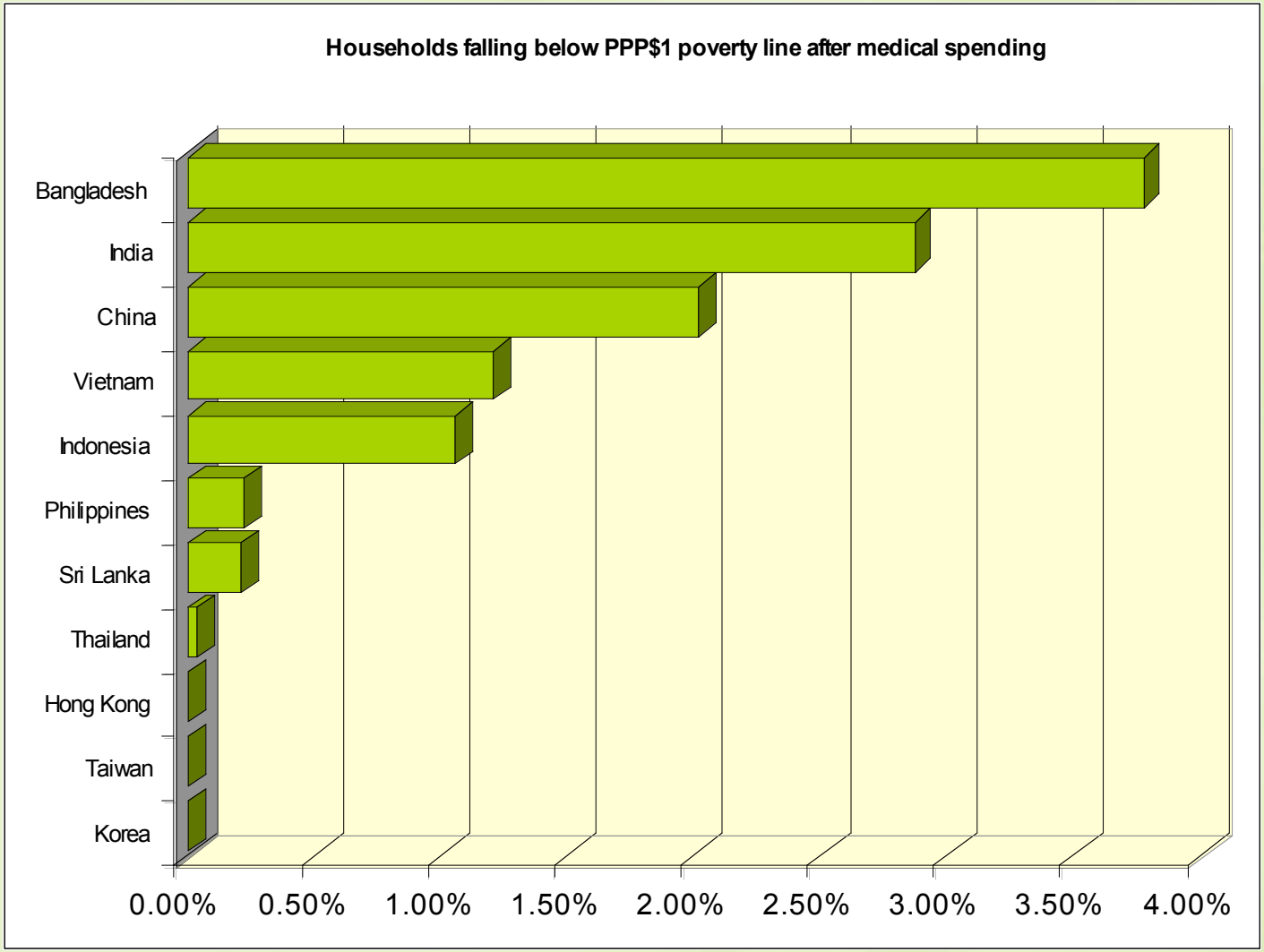




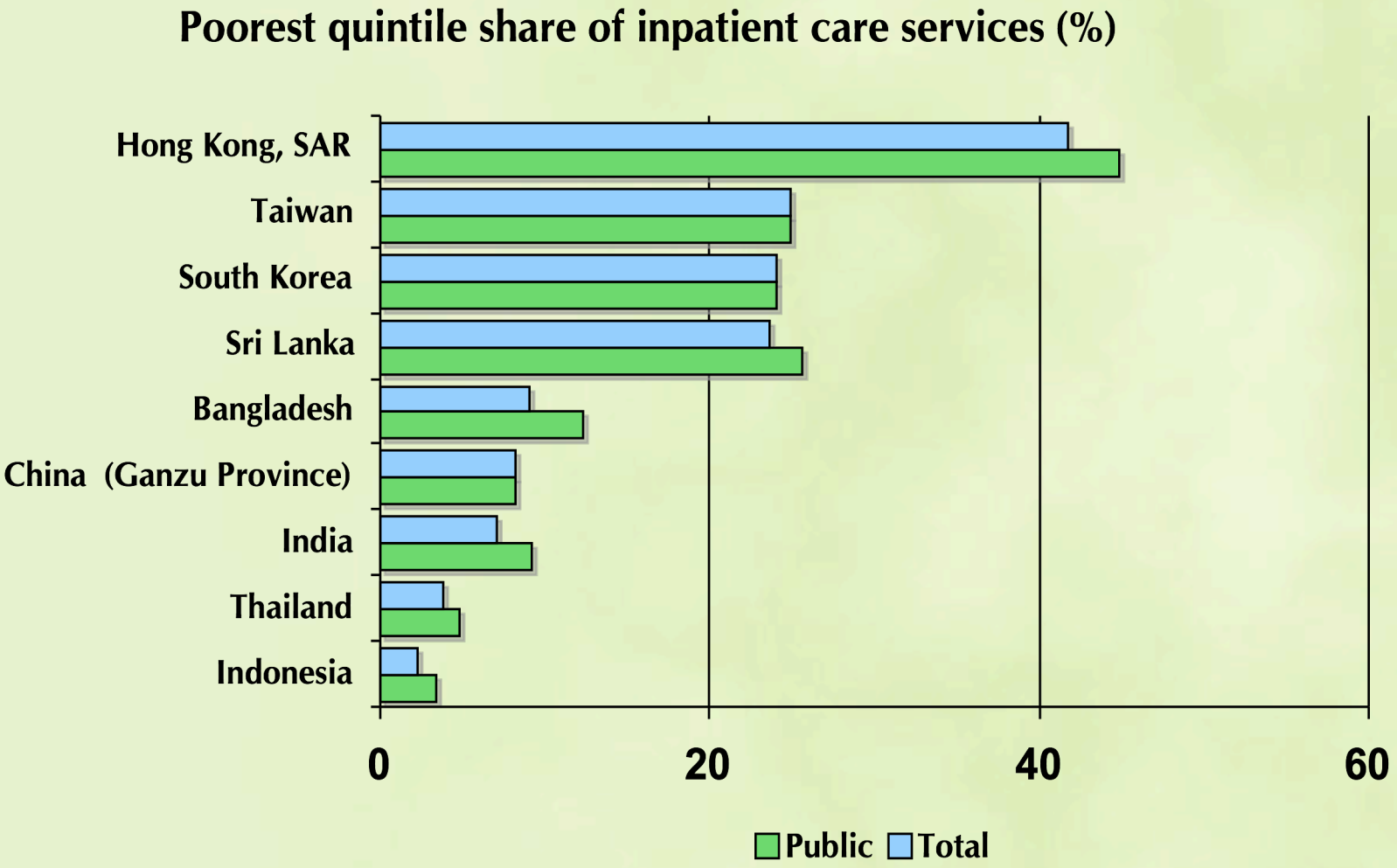
Catastrophic impact



Poverty impact



Targeting of public subsidies



Who benefits from public subsidies?

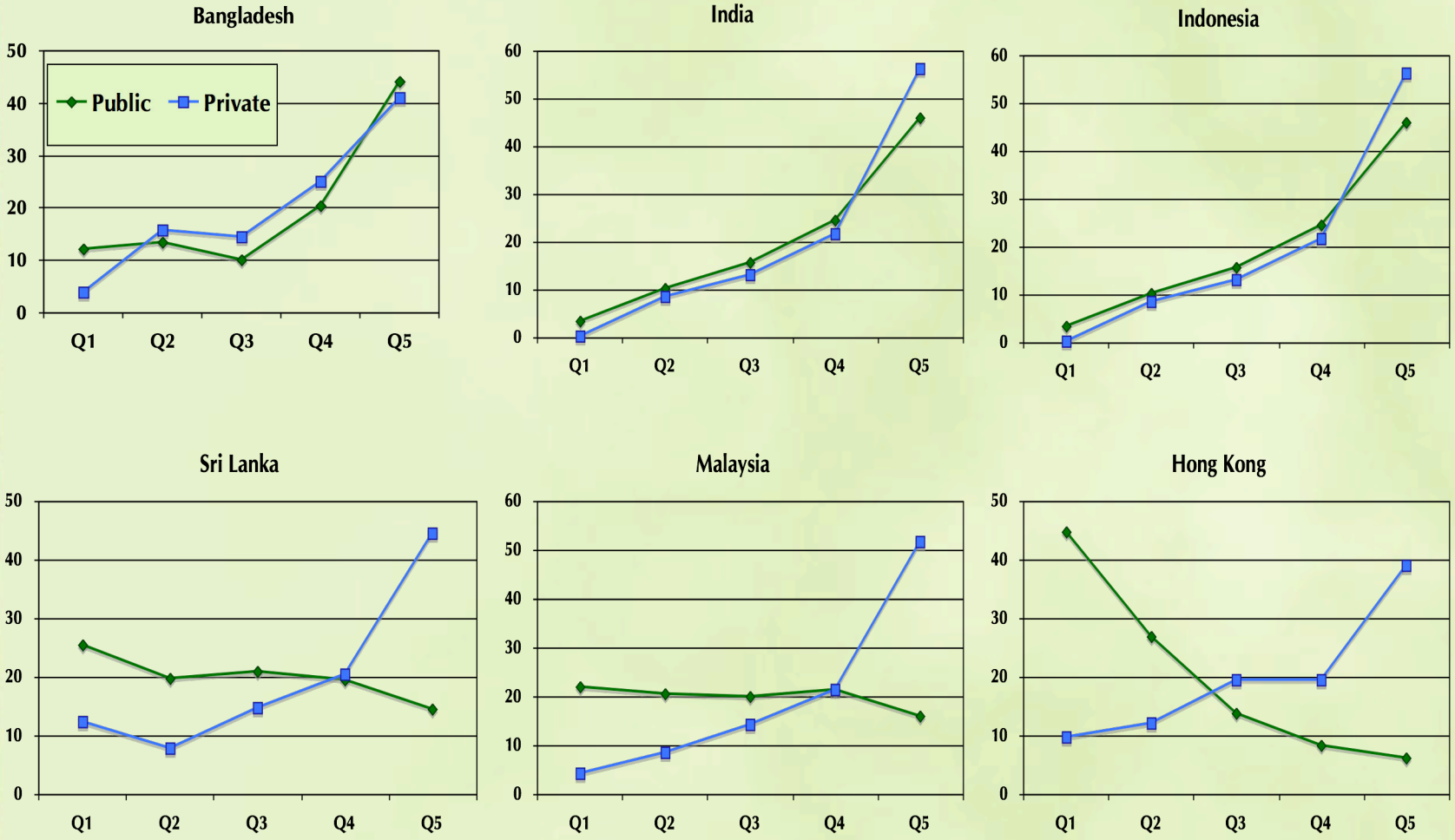
- Public subsidies for health are
  - strongly pro-poor in Hong Kong
  - moderately pro-poor in Malaysia, Sri Lanka and Thailand
  - pro-rich in Bangladesh, Indonesia and Vietnam
- Subsidies typically not pro-poor but narrow differences in living standards in all countries except in Nepal
- No evidence found at the systems level that currently in fashion approaches are effective
- All the pro-poor systems were found to be tax-funded, civil-service model public sector systems

Explaining Differences in Tax Systems

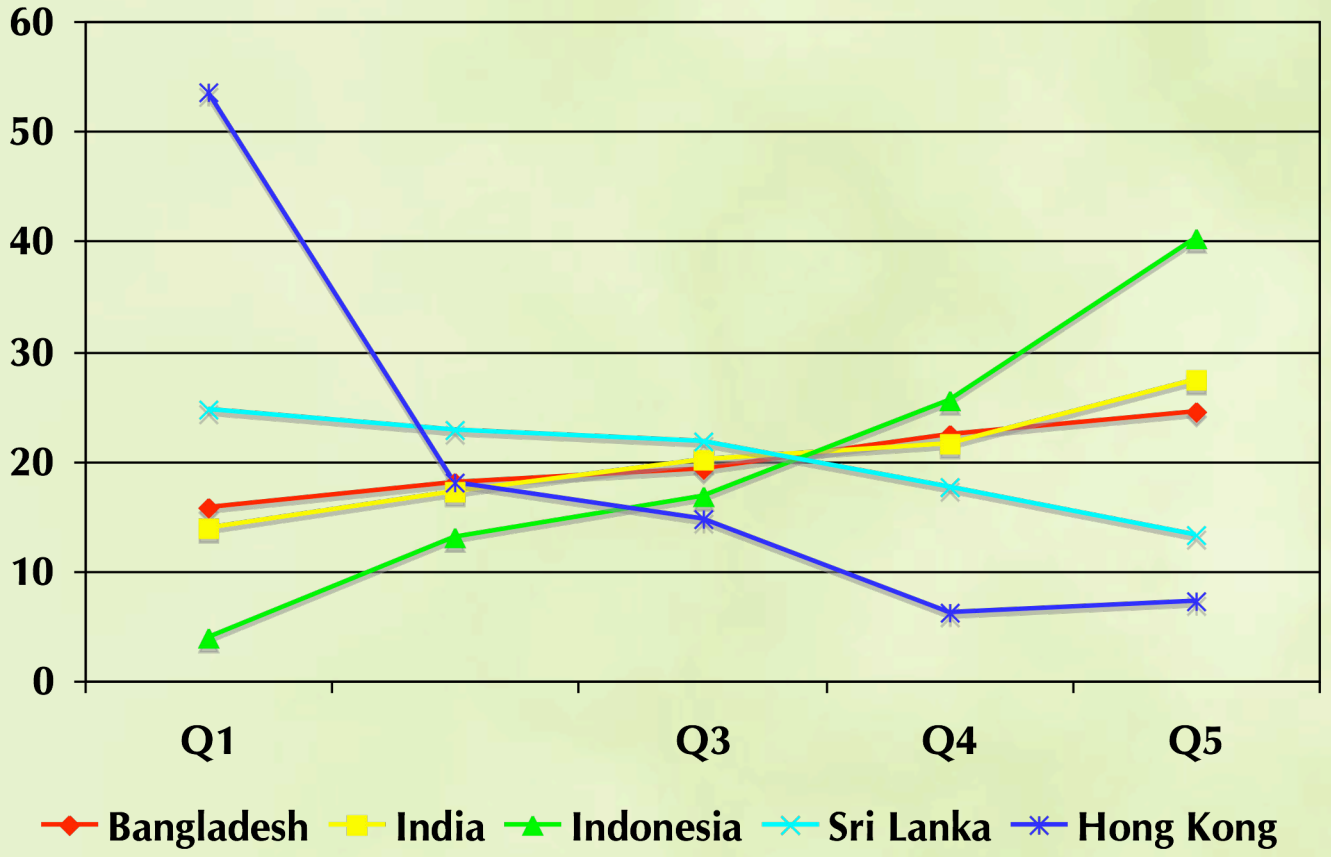
Summary of equity performance of tax-funded systems

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

Distribution of use of public and private inpatient care by quintiles (standardized rates)



Distribution of use of public outpatient care by quintiles (standardized)

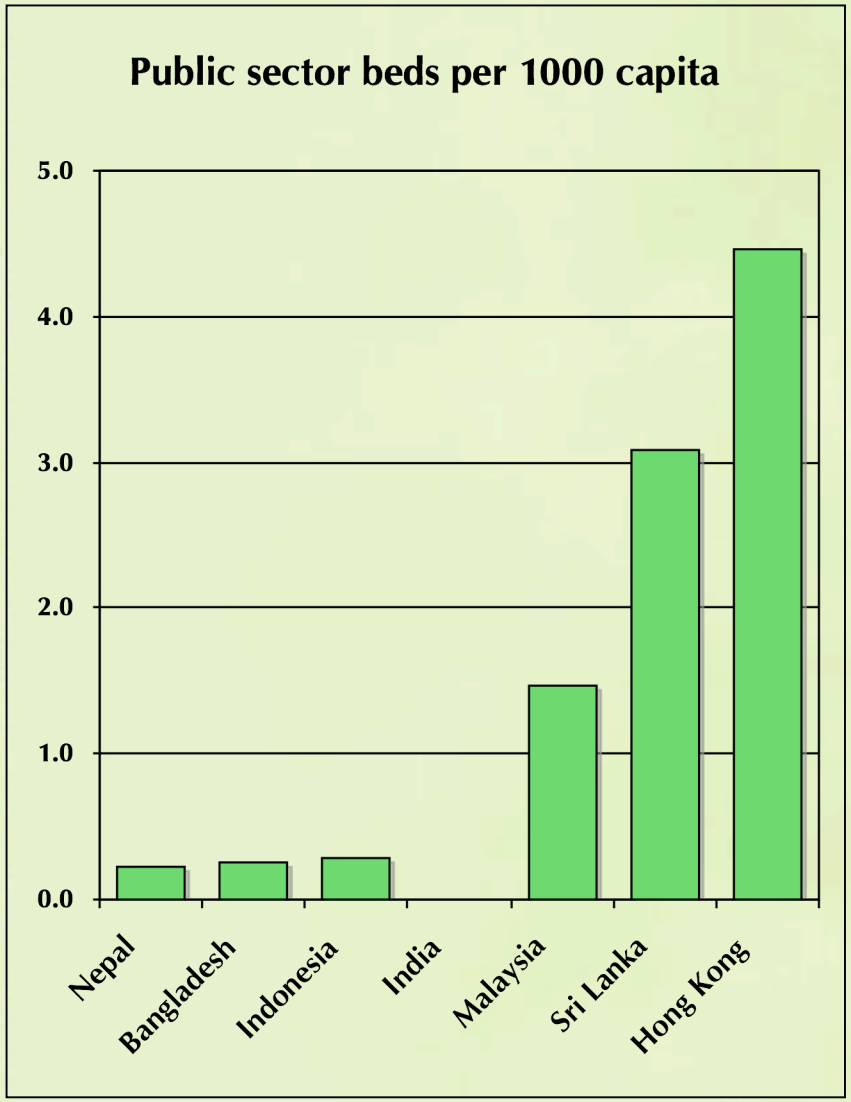


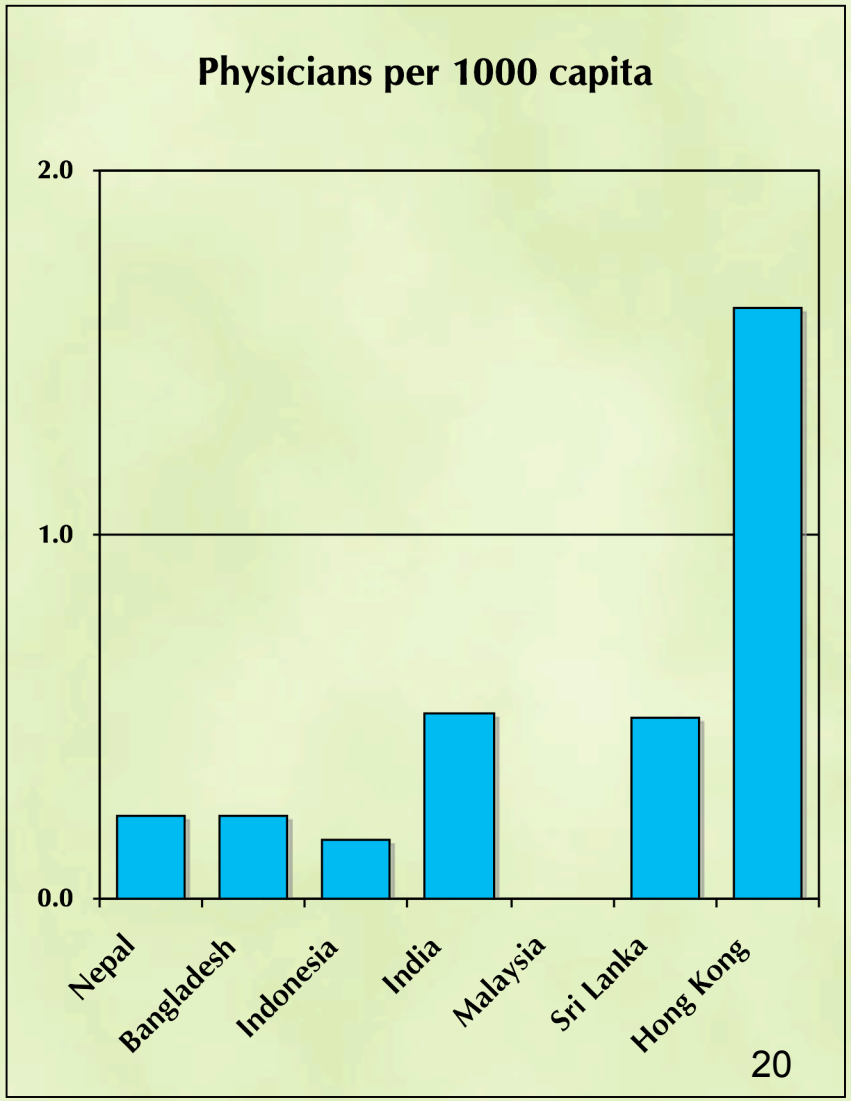
Observations

- 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 poor performers
  - Public provision pro-rich in poor performers, pro-poor in good performers
- Targeting of government spending
  - Good performers - not explicit or direct
- 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

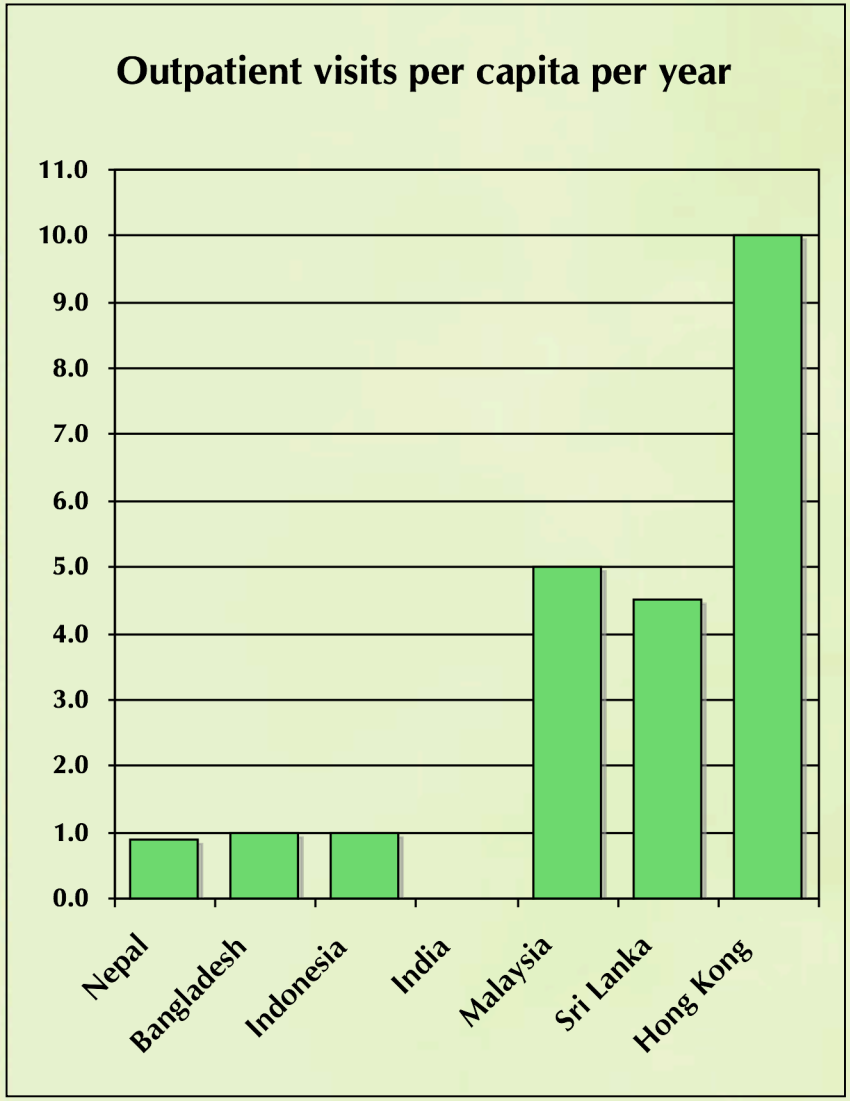
How?

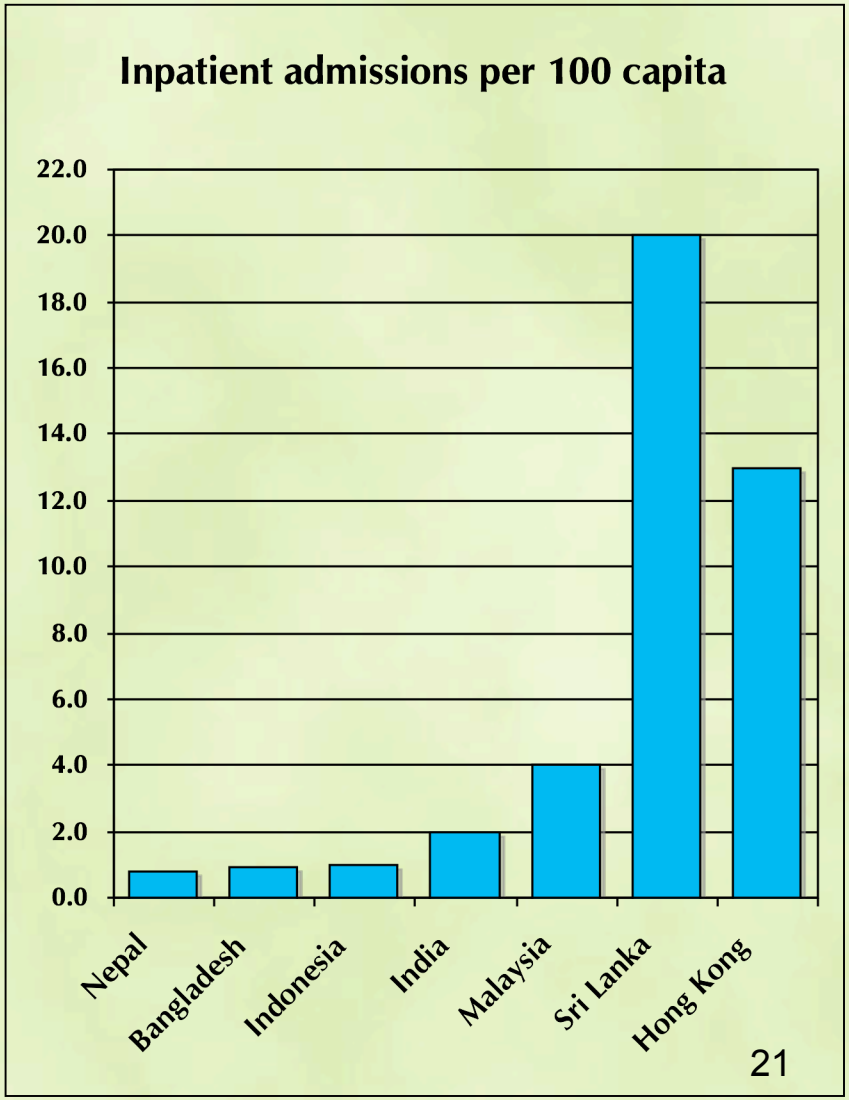
Achieving universal access under budget constraints: The level of supply of health care



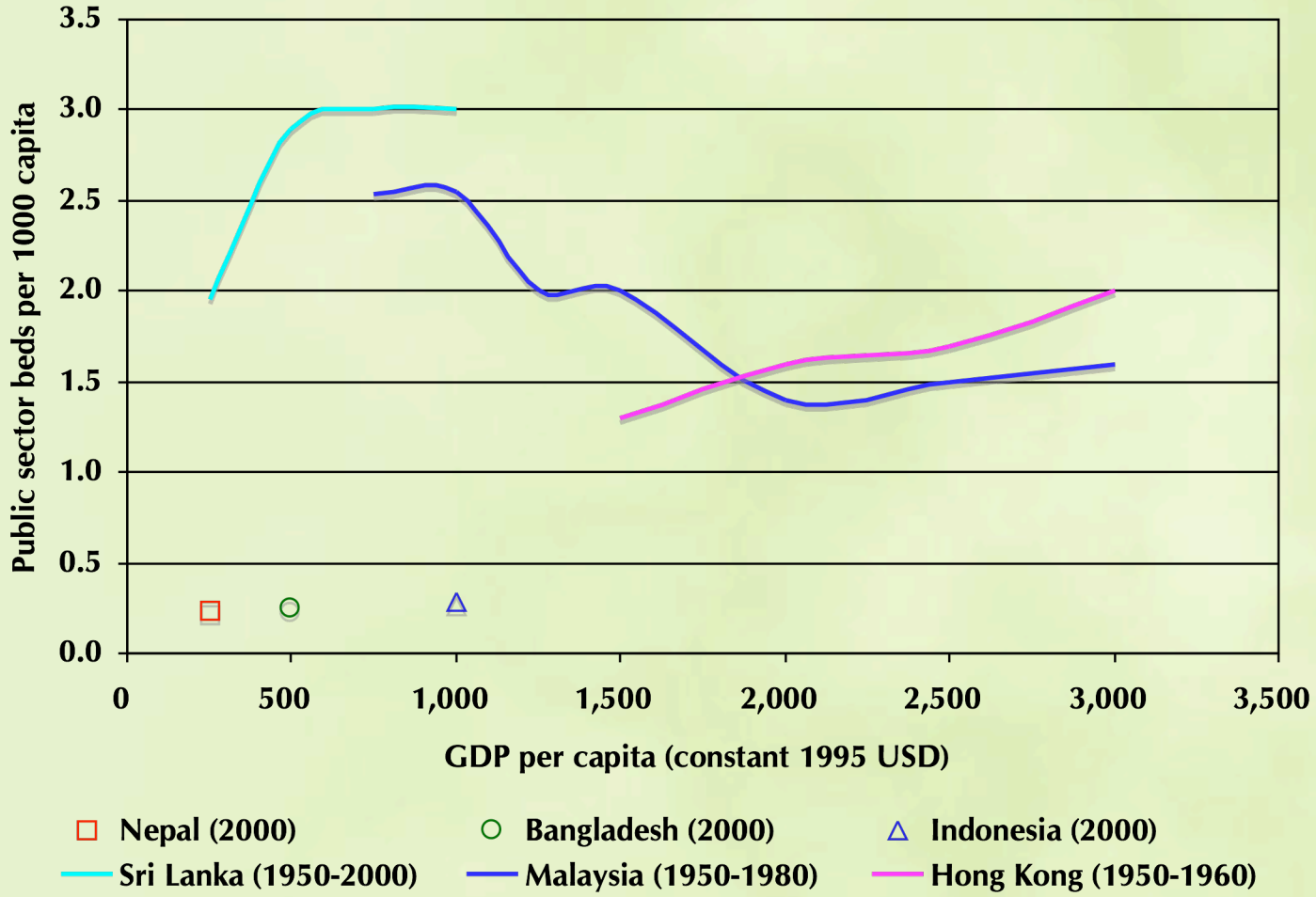


Achieving universal access under budget constraints: The level of use of health care





Comparison of public hospital provision in historical Sri Lanka, Malaysia and Hong Kong with contemporary Nepal, Bangladesh and Indonesia



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

Critical mechanisms

- **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 public spending to hospitals/inpatient care:**
  - Higher than regional average
  - Critical to ensure adequate risk protection
- **Reliance on indirect targeting:**
  - Voluntary self-selection of wealthy to private sector - Good performers never actually solved how to means-test or explicitly target the poor
- **Good governance:**
  - Efficient public sector delivery
  - Public service mission ethos
  - Less prevalence of informal fees/no history of rent extraction
  - Accountability pressure for high allocations to inpatient care & effective universal access

Ending Thoughts

Ending thoughts

- Not all systems are the same
  - Need for multiple dimensions of analysis rooted in awareness of local contexts, institutional cultures and histories
  - Policy debates not driven by evidence?
- Health systems comparative analyses provide unique perspective to identify strategic lessons
  - Common in Europe and OECD, but insufficient in developing regions
- Health systems research capacity in developing countries
  - Possible to undertake high quality work with appropriate levels of funding and institutional approaches
  - Problems of inadequate funding and problems of current funding mechanisms
  - Need for regional ownership