Extending Social Health Protection in the Asia-Pacific Region: Progress and Challenges

Asia-Pacific Regional High-Level Meeting on Socially-Inclusive Strategies to Extend Social Security Coverage

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What is Social Health Protection?

Access to services

Opportunity to make use of and actual benefit from needed health services when required

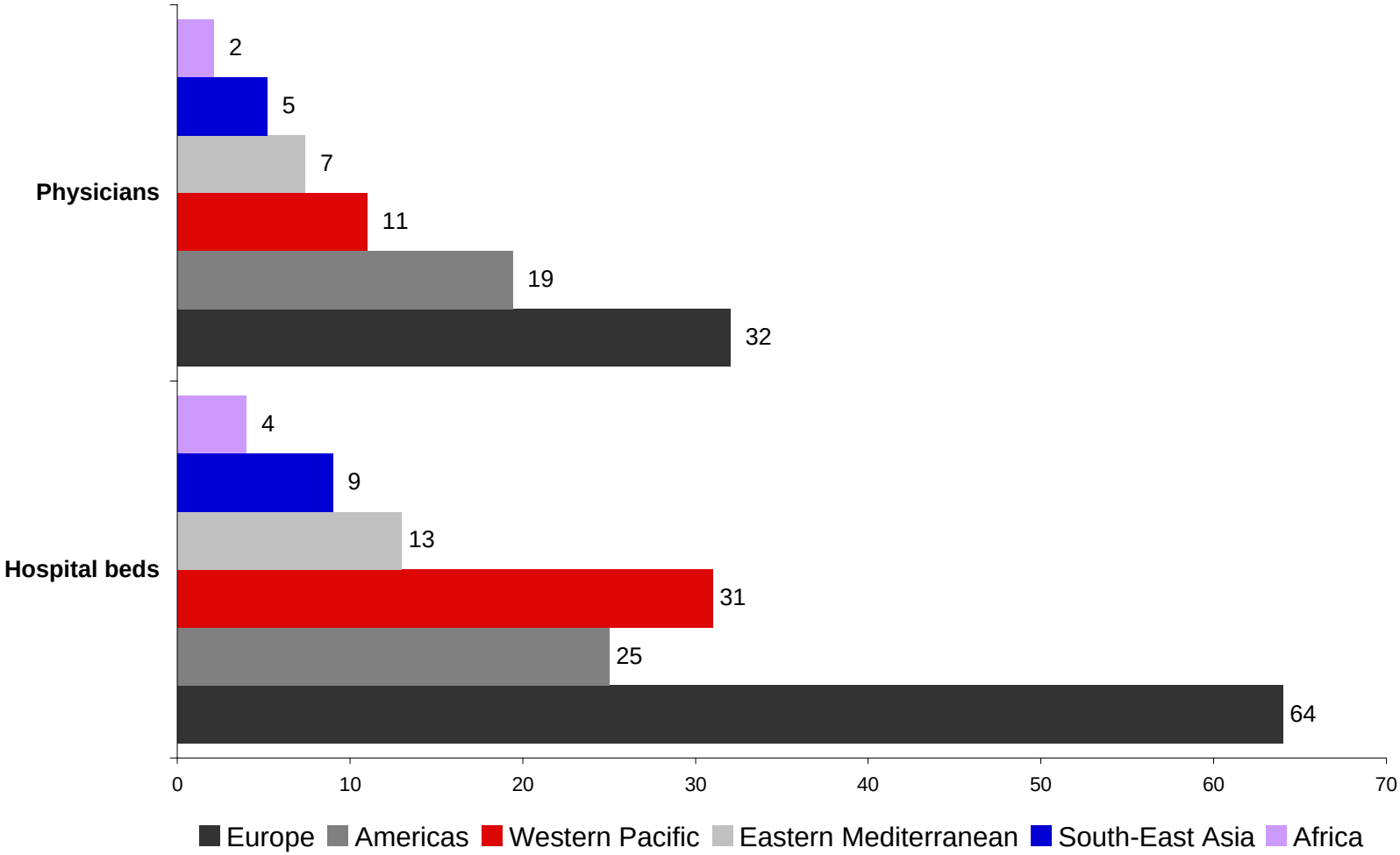
- Combination of physical availability of services, economic ability to afford services, observed high use of services
- Matters because access ensures use of services which is necessary for better health

Risk protection

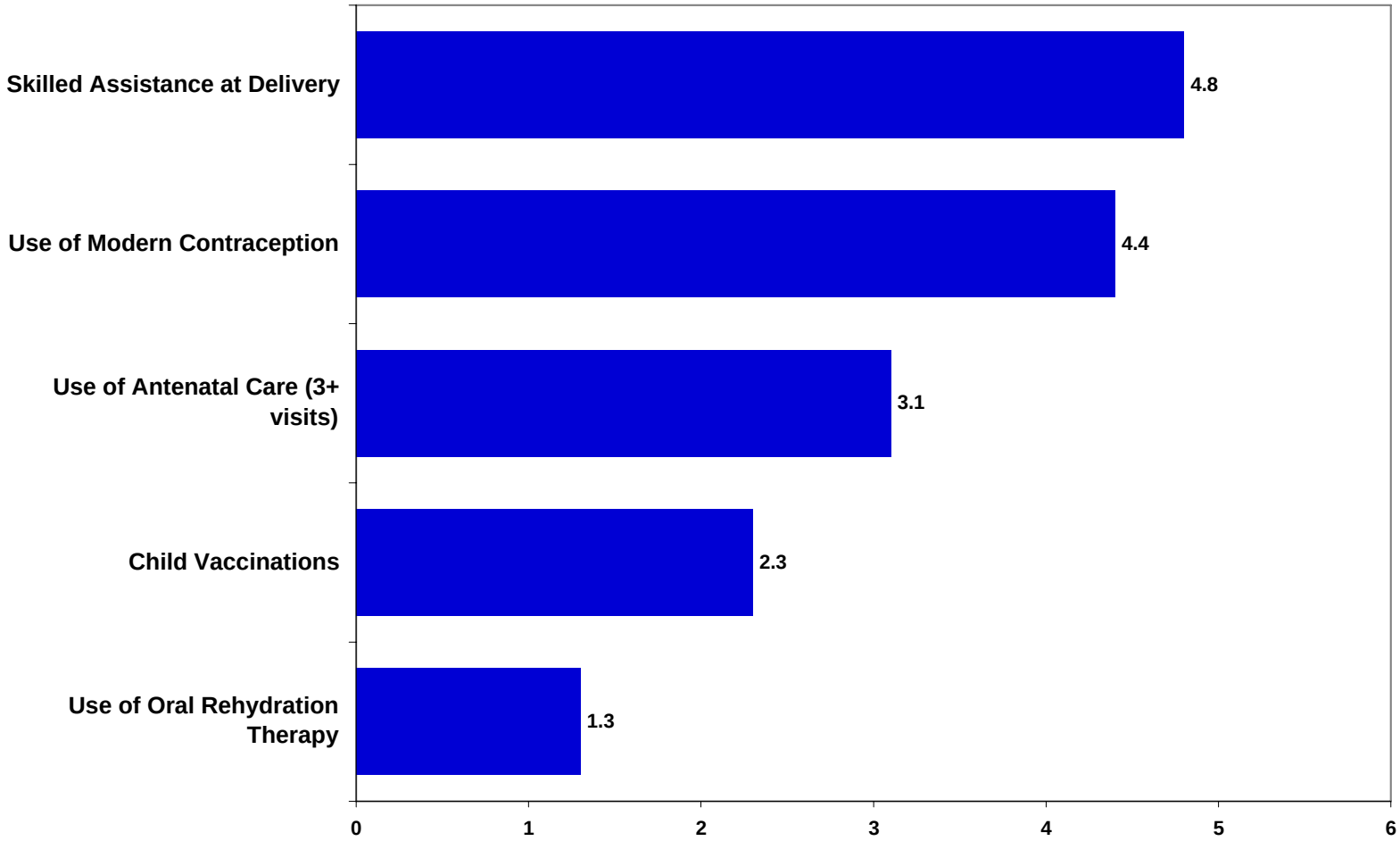
Ensuring households do not have to make impoverishing payments to obtain adequate and needed care

Large disparities in coverage exist between countries and within countries

Global disparities in availability of services

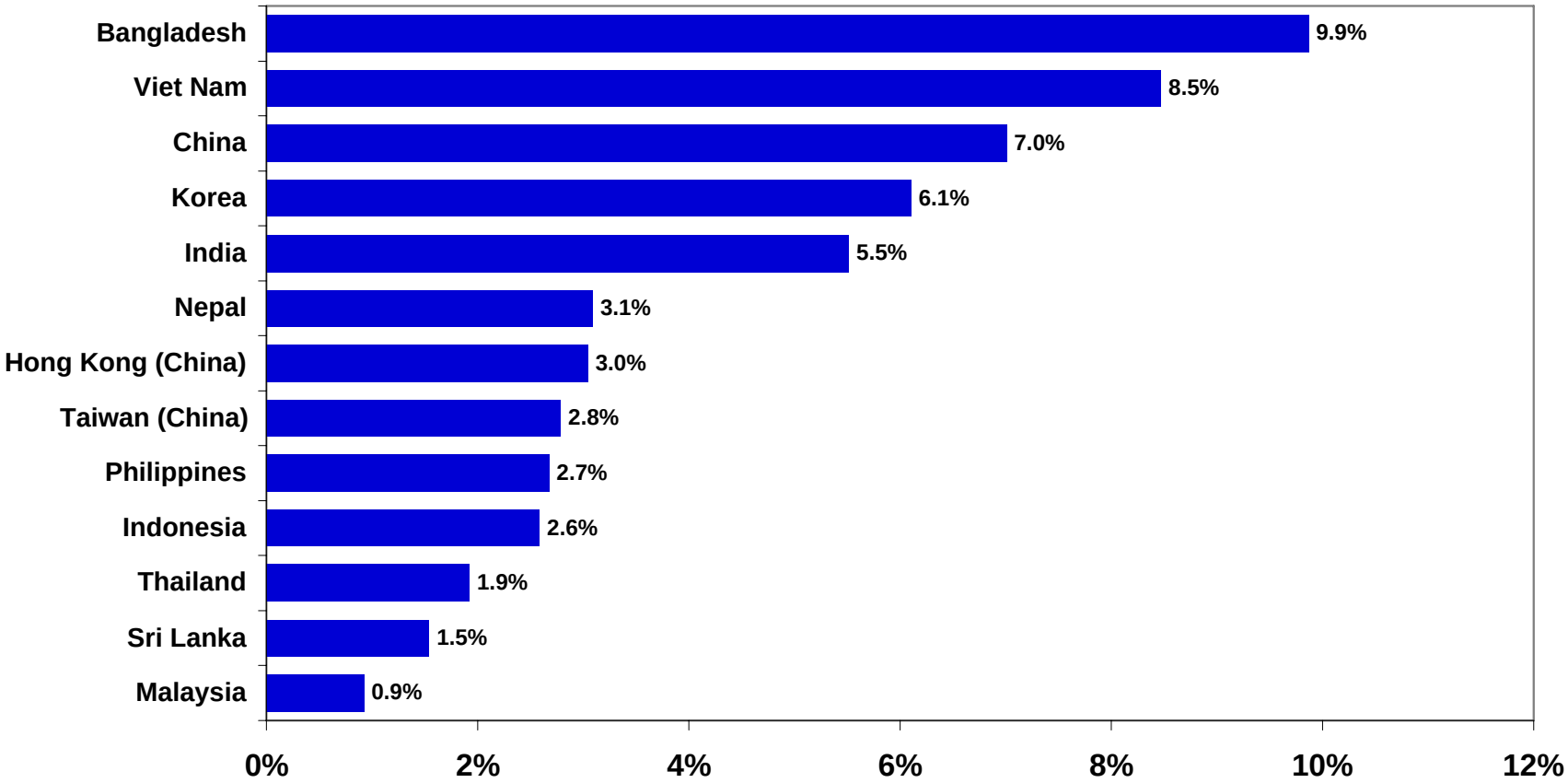


Global disparities in use between rich and poor



Impoverishing medical expenses common

Households forced to spend more than 15% of income on healthcare



Experience in Social Health Protection in Asia-Pacific

Successful in achieving universal coverage

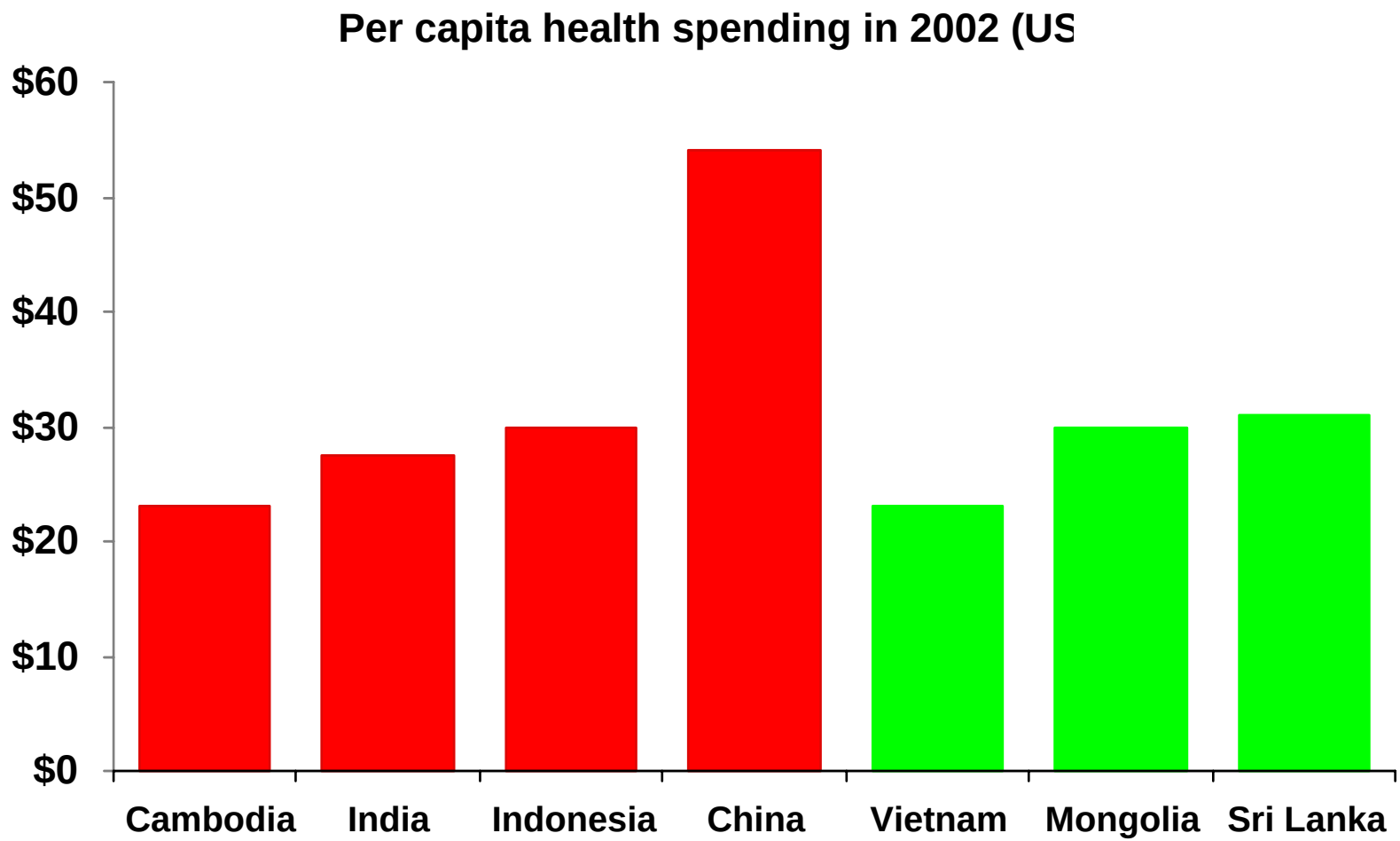
- (Mongolia?)
- Sri Lanka
- Thailand
- Malaysia
- Korea
- Hong Kong (China)
- Australia

Poor and informal sector largely not covered

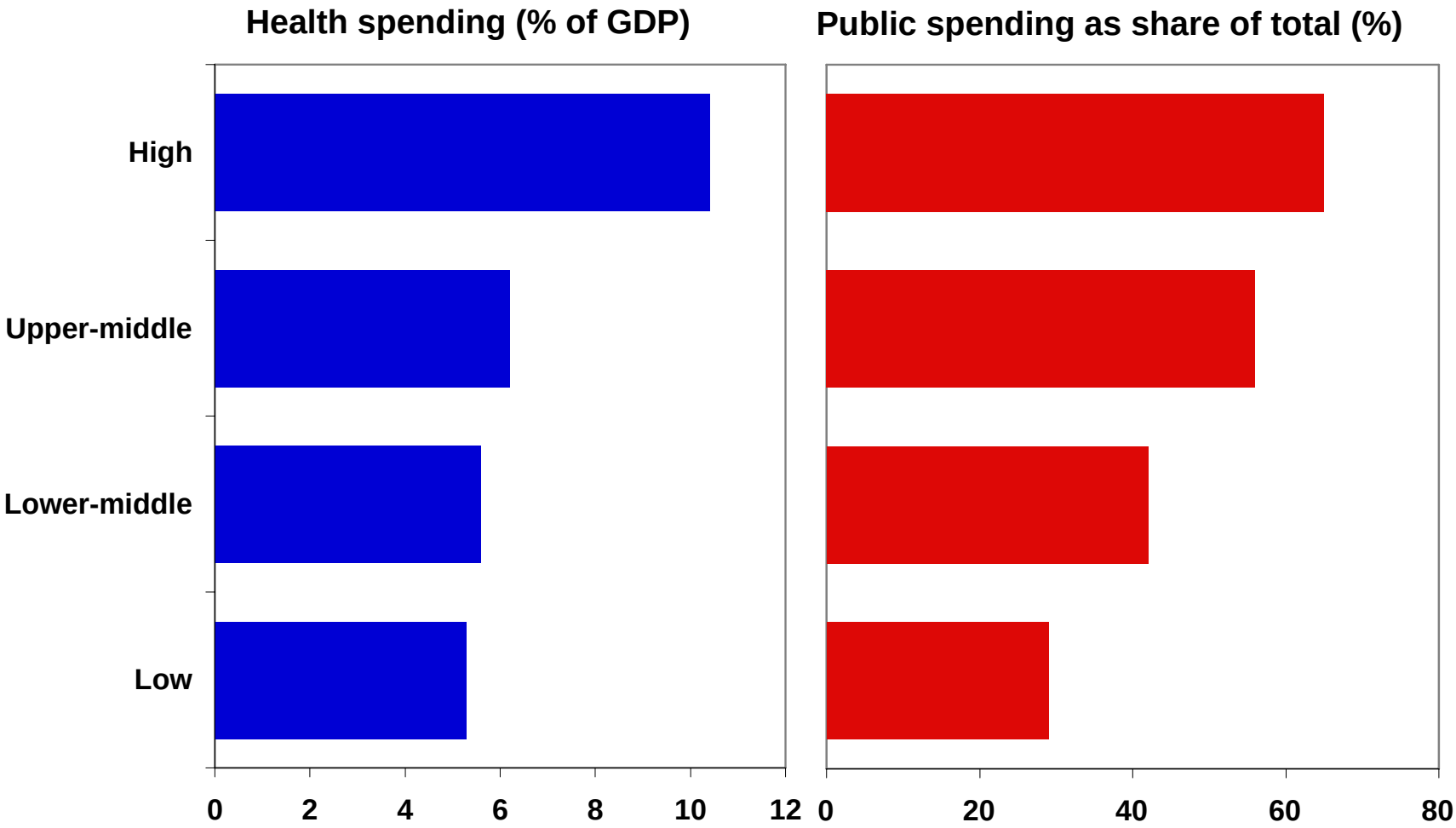
- Laos
- Nepal
- Bangladesh
- Cambodia
- India
- China
- Indonesia

High levels of financing are not essential to achieve adequate social health protection

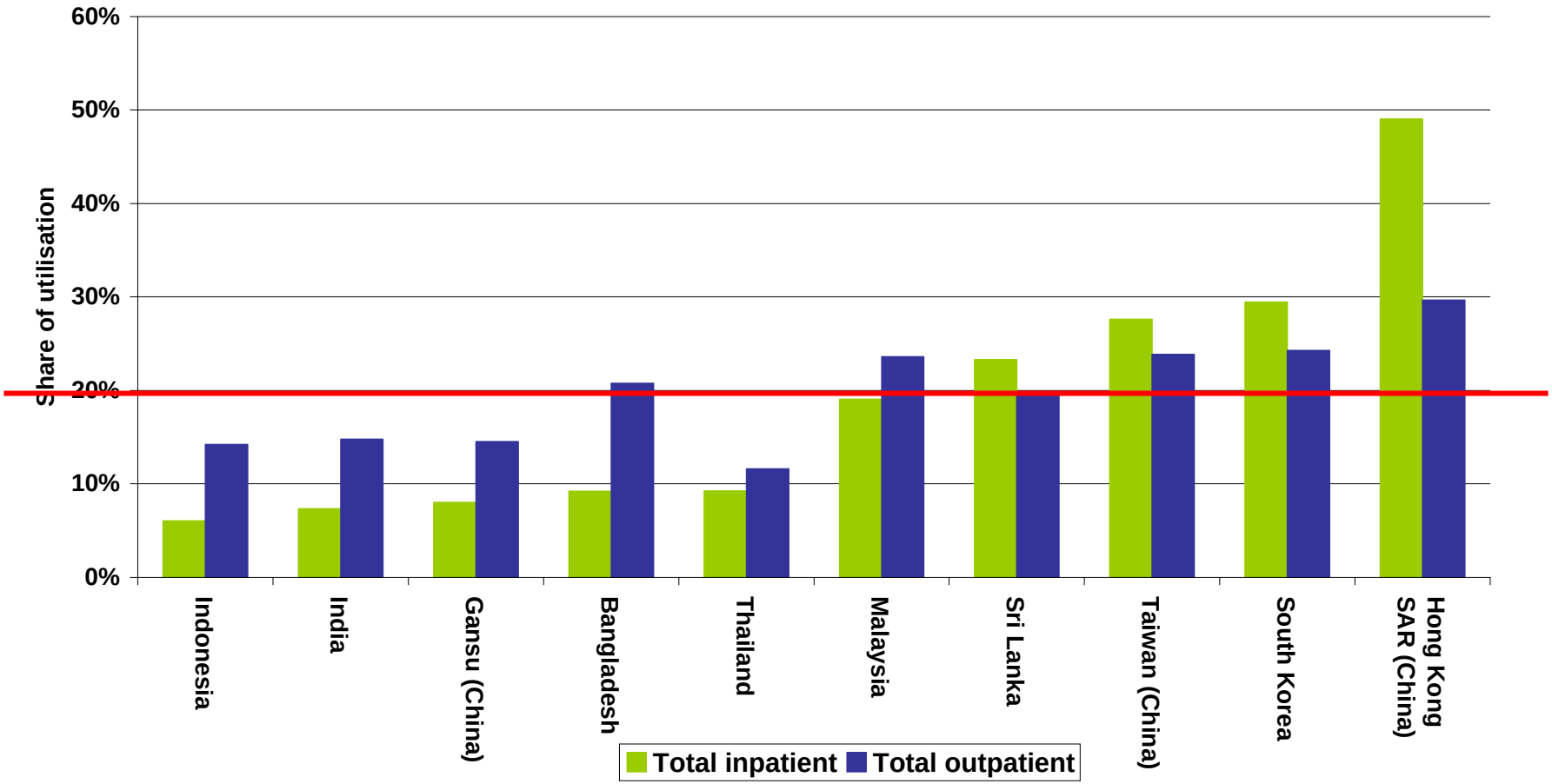
Good and bad performance



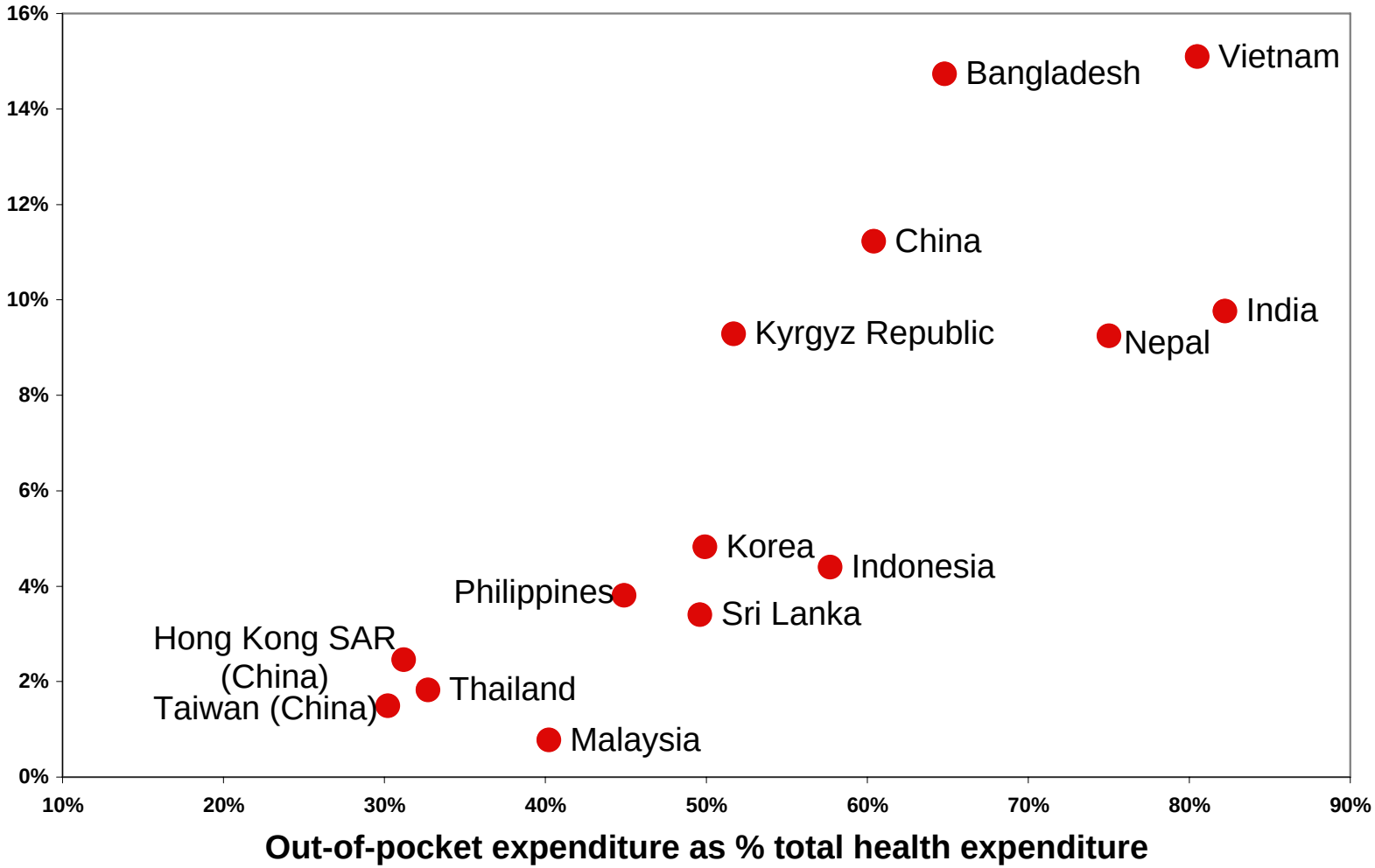
Public financing more important than total spending



Access for the poor achievable at low incomes



Risk protection at low incomes affordable with public financing



What has worked in extending social health protection in poor countries?

Available financing mechanisms

Historical approach

- Out-of-pocket payment

Risk-pooling approaches

- Tax-funded, integrated health services
- Social health insurance
- Community health insurance
- Private or voluntary insurance

Approaches that have not worked

- Out-of-pocket payment with exemptions for the poor
  - Has proven impossible to cheaply and reliably target the poor & has failed to reduce inequalities in access. E.g., Thailand, China, Indonesia
- Voluntary community health insurance
  - No success in scaling-up (>10% of population)
  - Works least well in the poorest communities with low levels of social capital, e.g., China, India, Vietnam
  - Limited protection because of low incomes
- Social health insurance without tax subsidies
  - Difficult to extend coverage to poor, informal workers, owing to poor capacity to pay and difficulties in collection, e.g., Japan, Korea, China
- Private health insurance
  - Never able to cover informal sector workers, the poor

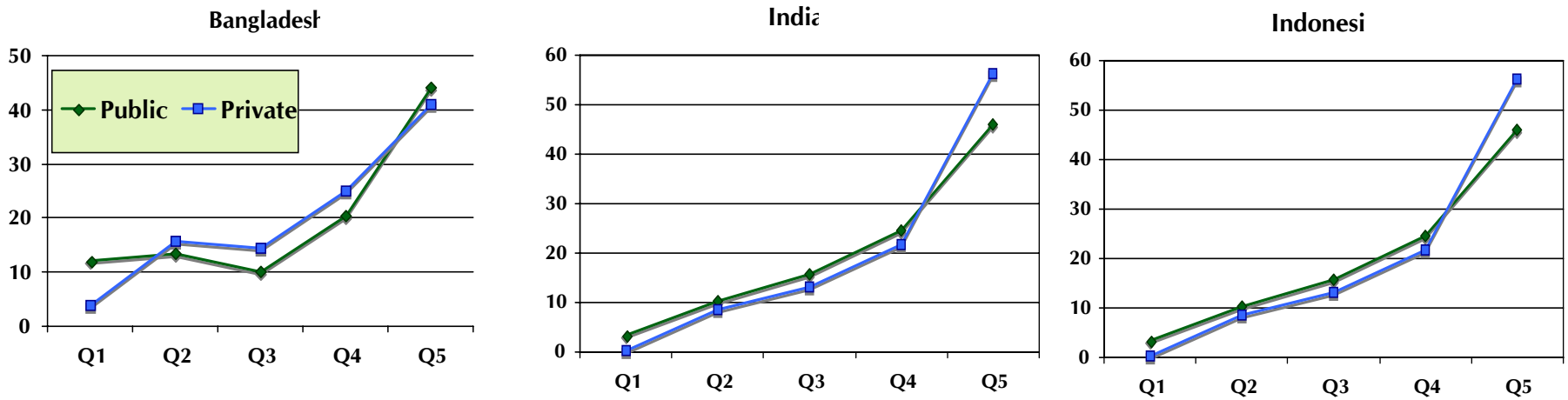
Only two approaches have worked

1. **Tax-funded, integrated health services *with* parallel, voluntary private provision**
   - Only approach that has worked at all levels of per capita GDP
   - Difficult to get right
   - Kerala, Sri Lanka, Malaysia, Samoa, Hong Kong (China)
2. **Social health insurance *with* general revenue subsidies**
   - Worked only in middle and high income countries
   - Requires sustained government commitment and capacity
   - Japan, Korea, Taiwan (China), Thailand (Mongolia?)

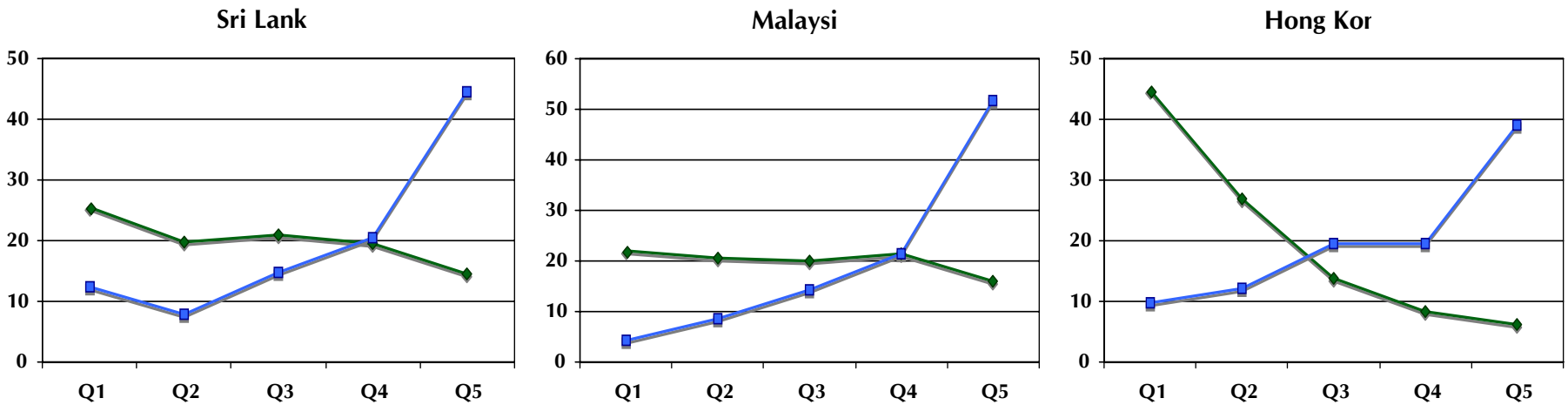
Tax-funded, integrated government health services

- Traditional UK Beveridge model not feasible in developing countries
  - » Depends on sufficient financing for public services that most healthcare demands are met by public sector
  - » Costs 5-8% of GDP in tax subsidies
- Poor countries lack sufficient budgetary resources to replicate UK/New Zealand
  - » Can afford only 1-2% of GDP in tax subsidies
  - » So only able to provide 40-60% of overall needs through public services
  - » Typical outcome is that limited public services are captured mostly by rich, leaving poor without services
- Successful countries manage to solve this through their management of public and private provision

Differences in public-private mix in tax-financed systems



Use of public and private inpatient services by income quintiles



Social health insurance with general revenue subsidies

- Historical experience
  - » Japan, Korea, Taiwan (China): Social insurance linked to employment will not expand beyond formal sector without government subsidies for poor and informal workers
- Requires sustained government commitment to expansion of coverage
  - » The smaller the size of the formal sector, the greater the share of financing from budget. E.g., Mongolia ~60%, Thailand ~60%
  - » To be affordable, government must be able to control prices paid and prevent excess charging

Key Lessons

- **Adequate social health protection is feasible at low income**
  - GDP per capita < $500
  - Public spending <2% of GDP)
- **Only two successful approaches**
  - Tax-financed, government provision, with voluntary, parallel private provision
  - Social health insurance, with tax financing to cover the poor
- **Reaching the poor/informal sector always requires:**
  - Commitment of budgetary resources by government
  - High levels of health service provision
  - Control of costs and productivity in health system
- **Successful countries stress universalism and link rights to coverage to citizenship**