Health Care Financing and Universal Health Coverage for Low- and Middle-Income Countries in Asia

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Soonman KWON, Ph.D.
Dean
School of Public Health
Seoul National National University, Korea
OUTLINE of Presentation
I. Amount and Mix of Financial Resources
II. Tax and SHI Financing
III. Coverage and Financial Protection
IV. Resource Pooling and Governance
V. Purchasing and Payment
VI. Challenges of Population Aging
I. Amount and Mix of Financial Resources

Difficult to determine the *optimum* amount of health expenditure

- Criteria: health expenditure and health outcomes?

- Amount of health care resources/expenditure depends on
  - Income or economic development
  - Political will and commitment
  - System of resource allocation (health care financing mechanism) -> Not only *how much*, but also *how (how effectively)* to spend on health care (or invest in health)
Relationship between Health Expenditure and Outcomes

Source: WHO, World Health Statistics 2010
Data: WHO, WORLD HEALTH STATISTICS 2010
Kwon: HC Financing

* source: World Bank. WDI
Kwon: HC Financing

* source: World Bank. WDI
## Per Capita Health Expenditure at average exchange rate

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<th>Below 50 USD</th>
<th>50-100 USD</th>
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Source: WHO, World Health Statistics 2010
Health Expenditure as a % of GDP and Financing Mix

Source: WHO, 2011
Kwon: HC Financing

* source: World Bank. WDI
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II. Tax and SHI Financing

1. Controversy over Tax vs. SHI

Comparative efficiency and equity of tax and SHI is an empirical question and contextual

- Efficiency and equity in resource generation (revenue collection) and purchasing
- Should not underestimate the cost of institutional change: e.g., capacity

Political attractiveness of ear-marking in SHI?
- Health care systems in many low-income countries are plagued with chronic under-funding
- Willingness to pay SHI contribution is higher than general tax?
1. Controversies (continued)

Question of institutional capacity: if tax administration is inequitable (e.g., income assessment), collection of SHI contribution is also likely to be inequitable

- > comparative efficiency of tax administration vs. SHI agency?

Misperception that government can much reduce its role when SHI is introduced: But the role of government is still crucial in SHI (e.g., subsidy, price regulation, regulation of provider behavior, etc.)

- > In many low-income countries, private sector in growing in cities, but there is almost no regulation of the quality and safety of the private health sector
1. Controversies (continued)

- Key weakness of SHI: the poor cannot afford to pay SHI contribution -> Government should pay contribution (subsidy) for them

- Informalization of labor force due to SHI: possible if informal sector workers do not pay SHI premium or they pay much lower premium than the formal sector

- But, the size of the informal sector in low-income countries depends on economic development rather than on SHI. And there are other benefits associated with the formal sector (job stability, higher income...)}
1. Controversies (continued)

Common challenges for SHI and tax-based health care financing system: effective and prudent control of health care providers (purchasing, payment system) is a key to the quality of care and sustainability of the health care financing system

Recent Dilemma: economic development does not lead to the decrease in the informal sector
- Health care financing system based only on wage in the formal labor market is not financially sustainable
- Increasing attention to financing mechanism that are neutral to labor market structure, e.g., consumption tax, contribution based on all types of income
X: Tax/THE (Tot H Exp); Y: SHI/THE

Kwon: HC Financing
2. Challenges of SHI in low-income countries

In low-income countries, compliance/participation is an issue in the formal sector, too (e.g., Vietnam, Philippines)

<- Employer requirement to pay half of the contribution

Covering the formal sector first and extending to the informal sector may not work in low-income countries

- Informal sector is too big
- Cross subsidy by the formal sector does not work
- Rapid economic development was a key factor in Japan, Korea and Taiwan (shrinking of the informal sector)

-> Without government subsidy, covering the informal sector through SHI is very difficult
3. Challenges of Tax-based Financing in Low-income Countries

Mobilizing sufficient amount of tax revenue for health care (by increasing the policy priority to health care) may not be politically easy.

Direct tax in low-income countries can be less progressive than in high-income countries.

Tax financing based on local governments is likely to be geographically inequitable due to the lack of adequate equalizing (risk sharing) mechanisms.

Equity of tax-based health care financing in low-income countries depends on:
- Availability: delivery system in disadvantaged areas
- Quality and responsiveness of the public delivery system
HC Financing in Low-income Countries
HC Financing in Lower Middle-income Countries
HC Financing in Upper Middle-income Countries
4. Tax vs. SHI: What is a right perspective?

How resources are pooled is as important as which types of resources is used

-> Role of purchaser/fund pooling

**Mixed** Financing: neither pure tax-financing nor pure SHI in Asia

- Tax-financing: not as universal as Europe, targeting the poor, the better-off rely on the private sector (e.g., Sri Lanka, Malaysia)

- SHI: full tax-subsidy to the poor and at least partial subsidy to the self-employed (e.g., Japan, Korea, Taiwan, China)

e.g., Thailand: greater role of tax-financing in terms of financing mix, but with a strong role of purchaser
Goal of SHI: different dreams in the same bed?

- Social insurance as a mechanism to generate resources: in low-income countries where public hospitals collapsed, with a need to start from ground zero

- Social insurance (as a purchaser) as a mechanism to discipline and incentivize public hospitals: in low-income countries with some reasonably operating public hospitals

-> But, SHI cannot discipline public providers in rural areas where there is no competition among providers

-> Comparative difficulty of introducing SHI vs. introducing purchasing under tax-financing for health?
5. Bureaucratic Politics

Ministry of Health (MoH) tends to prefer SHI
- Fragmented financing: Ministry of Fin for state budget, Ministry of Labor & Soc Welf (MoLSW) for employees
- Budget negotiation dominated by Ministry of Finance
- SHI viewed as a stable source of funding to health: can contribute to the power of the MoH (e.g., Malaysia, Uganda)

Fights between the MoH and MoLSW
- Formal sector employees are usually covered by social security scheme, subject to MoLSW
- Informal sector people are covered by insurance schemes subject to MoH
6. How to Mix/Combine Tax and SHI?

Tax subsidy for the SHI premium of the poor and informal sector

- Tax financing for primary care (guaranteed/free access) and SHI for secondary and tertiary care?
- Early detection and promotion saves future cost
- e.g., Kyrgyzstan, Mongolia

- Tax financing for catastrophic care/expenditure?
- Improve financial sustainability of health insurance

SHI for specific sector?
- Pharmaceuticals, long-term care (LTC)
III. Coverage and Financial Protection

1. Population Coverage

Status of Population Coverage of SHI in Asia

- Universal coverage: Japan, Korea, Taiwan, Thailand
- 80+% (China, Mongolia), 60+% (Philippines), 50+% (Vietnam, Indonesia)

With stagnant economic growth, the road to universal coverage is rugged in low-income countries

Should pay more attention to the poor or need the bottom-up approach (the poor first)
CBHI (Community Based Health Insurance)

E.g., Lao PDR, Cambodia, Rwanda, Nepal

a. Advantages: Responsive to community needs and improved awareness on prepaid financial scheme

b. Limitations
- Limited risk pooling and low financial sustainability
- Limited impact on health care delivery: limited financial leverage of an insurer
- Financial barrier for the poor to join: no subsidy
- Voluntary enrollment: adverse selection

Need planning and regulation by the government
- CBHI as a transition toward larger pooling mechanisms
2. Benefit Coverage

a. Population coverage is not sufficient condition to (financial) risk protection, which also depends on the **breadth of service coverage** (types of services covered) and **depth of coverage** (copayment and ceiling on benefits)

e.g., Philippines, Vietnam: very high OOP in spite of more than 50% of population coverage

b. The major issues in the benefit package are to decide
- which services to include in the benefit package
- at which level of patient cost sharing
- based on what type of decision making process
Financial Protection (WHO)

Figure 1: Three ways of moving towards UC

Source: WHR 2008
c. Controversies over Out-of-pocket Payment

National average of OOP pay is not the key
-> Need to check who pays how much and why

- If OOP pay is mainly paid (voluntarily) by the rich to opt out to use the private sector?
- If OOP pay is paid by the worse off in the use of essential health care and medicines in the public sector?

- Why people use private health care providers? What’s wrong with public sector providers?:
  low (objective) quality, low perceived quality, waiting time
2. Benefit Coverage (continued)

d. Potential Tradeoffs among population coverage, benefit coverage, financial protection

- Too extensive benefit coverage and high premium may deter the extension of population coverage
- Too low benefit coverage leads to limited financial protection (i.e., limited role of health insurance in protecting people from financial difficulty)
- E.g., (Low) benefit ceiling with zero copayment (first dollar coverage) is worse than copayment with no (or very high) benefit ceiling
2. Benefit Coverage (continued)

e. Decision Making Process and Criteria

The decisions on which services to cover at which level of patient cost sharing should be based on objective criteria through a transparent process.

- Instead of a single criterion, various factors need to be considered in the decision making.
- E.g., cost effectiveness, medical necessity, financial burden on patients, impact on the fiscal status of health insurance.
- Need procedural fairness: citizen participation.
3. Financial Resources for Universal Coverage

1) Improve Efficiency
E.g., Drug procurement, provider payment system, efficient resource allocation between curative care and public health, efficient resource allocation among regions considering population needs (e.g., Malaysia)

2) User Fee under tax-financing
- Need to consider people’s ability to pay, access for the poor, transportation cost to facilities, etc.
- Need capacity to administer the exemption mechanism for vulnerable population (based on objective criteria)
- SHI is very difficult to introduce when people can use health care free or almost free (e.g., Malaysia)
3) Government Subsidy

Without subsidy to the poor and informal sector, universal coverage is very difficult through SHI
- Full subsidy to the poor
- Full or partial subsidy to the informal sector
E.g., China and Mongolia vs. Philippines and Vietnam
E.g., partial subsidy to the informal sector in Korea, Taiwan

Premium contribution of the informal sector
- High cost of premium collection
- Funds from the premium of the informal sector is usually small: many SHI systems charge lump-sum premium (not related to income) from the informal sector (exception: Japan and Korea where premium is based on both income and asset)
IV. Pooling and Governance

1. Degree of Centralization

a. Single scheme

- Equity and solidarity across schemes
- Better risk pooling and financial sustainability
- Potential inefficiency or lack of responsiveness?

(but there is rarely consumer choice among plans in multiple schemes in low-income countries anyway)

e.g., Single scheme: Korea, Taiwan, Philippines, Mongolia, Vietnam
1. Degree of Centralization (continued)

b. Multiple schemes without competition

- Inequity and social stratification in case of different benefit coverage across schemes: benefit coordination can be difficult due to oppositions by enrollees (who enjoy generous benefits), e.g., Thailand
- Difference in risks and fiscal capacity of schemes
  - need risk adjustment across funds, e.g., Japan

c. Multiple schemes with competition

- potential cream skimming due to imperfect risk adjustment: no experience in Asia
2. Incremental Approach

Incremental Approach before achieving uniform benefit package for all people: can be controversial!

a. Differential benefit packages for the formal sector who contributes premium and those who are subsidized (e.g., Thailand)
   -> Potential of (inequitable) two-tiered SHI system

b. Uniform benefit package for all, but the formal sector can purchase supplemental private health insurance
   -> Political support for SHI can decline (especially by the formal sector), and private health insurance can oppose to the extension of SHI benefit package
3. Organization and Governance of Health Insurance

a. Need to avoid the coordination problem across ministries and should function as a means to achieve health policy goals

Independent agency working closely with MoH:
- Korea, Taiwan, Japan, Philippines
Social security agency: Vietnam (PM), Mongolia (MoLSW)
MoLSW (formal sector) and MoH (informal sector):
- China, Thailand, Lao PDR, Cambodia

b. Separation of purchasing (financing agency) and delivery
- If MOH is the main provider of health care (e.g., public hospitals), it is not easy for them to be a prudent purchaser or to have a tough negotiation with respect to providers
V. Purchasing and Payment

1. Purchasing

Problems of fragmented purchasing

-> Need to maximize purchasing power by reducing the role of budget allocation to public providers, and instead channeling funds (e.g., as a premium subsidy for the poor and informal sector) to purchaser/H Ins agency, which distributes funds (by reimbursement) to public and private providers

e.g., problems in many former socialist countries

Need to increase financial and administrative autonomy of public hospitals: capacity of public hospitals
Government Policy for Autonomized Hospitals

Government role is very important in the change in hospital governance and autonomy

- Autonomy is given, not because the goal (efficiency and equity of health system) is changed, but because we want to achieve the goal more effectively
- Government needs more sophisticated policy tools: from command-and-control to steer-and-channel
- Monitoring of hospital behavior and performance is key (e.g., fee/charge, type of patients, clinical outcomes)
- If public financial resources to public hospitals (e.g., state budget, health insurance reimbursement) are limited, hospitals become profit-maximizer (e.g., China, Vietnam)
2. Payment System to Health Care Providers

Crucial impact on the efficiency and equity of health care financing because health providers play a key role in health care resource allocation (information asymmetry)

Directions for Reform
- Capitation for primary care
- (Regulated) fee-for-service for targeted areas, which need an increase in productivity/consumption
- Case-based payment (e.g., DRG: Diagnosis Related Group) with budget cap for inpatient care, and need to start with a **simple classification** system rather than a highly sophisticated one
3. Delivery of Care

1) Health Care Delivery

Expand and improve the quality of delivery system especially in disadvantaged areas
- Human resources: financial incentive, military duty?
- Physical resources: investment

2) Quality of Care

a. Licensing and accreditation
b. Quality evaluation by financing agency (purchaser)
   - Monitoring of provider behavior and performance
   - Provide information to consumers
   - Financial incentive for providers
VI. Challenges of Population Aging

Rising demand for health and long-term care
- Health status, mental health, disability

Declining family support
- Migration of young workers from rural to urban areas
- Increased labor participation of women
- Increased number of the elderly living alone

Insufficient financial capacity of the elderly
- Limited pension and public assistance for the elderly
Old-Age Dependency (65+/(20-64))

Kwon: HC Financing
Aging and Health System Reform

Coordination of various policies and programs
- Central and local governments
- Coordination among Ministries of Health and Soc Welf.
- Coordination among different components of health system, such as financing, service delivery, and human resource

Financing for health and long-term care
- Reduce financial barrier to health and long-term care
- Improve equity in access and service utilization
Aging and Health System Reform (continued)

Human resources for health
- Education and training for health professionals need to be re-oriented to respond to the needs of the elderly, cope with multi-morbidities and collaboration as a team

Service delivery
- Strengthen primary care and continuum of care
- Coordination between health and LT care
- Balance between institutional and community-based care
Thirty years of national health insurance in South Korea: lessons for achieving universal health care coverage

Soonman Kwon*

Accepted 21 June 2008

South Korea introduced mandatory social health insurance for industrial workers in large corporations in 1977, and extended it incrementally to the self-employed until it covered the entire population in 1989. Thirty years of national health insurance in Korea can provide valuable lessons on key issues in health care financing policy which now face many low- and middle-income countries aiming to achieve universal health care coverage, such as: tax versus social health insurance; population and benefit coverage: single scheme versus multiple schemes; purchasing and provider payment method; and the role of politics and political commitment. National health insurance in Korea has been successful in mobilizing resources for health care, rapidly extending population coverage, effectively pooling public and private resources to purchase health care for the entire population, and containing health care expenditure. However, there are also challenges posed by the dominance of private providers paid by fee-for-service, the rapid aging of the population, and the public-private mix related to private health insurance.

Keywords Health care financing, health insurance, universal coverage, Korea
Health Care Financing in Asia: Key Issues and Challenges

Soonman Kwon, PhD

Abstract
This article examines the major elements of health care financing such as financial risk protection, resource generation, resource pooling, and purchasing and payment; provides key lessons; and discusses the challenges for health care financing systems of Asian countries. With the exception of Japan, Korea, Taiwan, and Thailand, most health care systems of Asia provide very limited financial risk protection. The role of public prepaid schemes such as tax and social health insurance is minimal, and out-of-pocket payment is a major source of financing. The large informal sector is a major challenge to the extension of population coverage in many low-income countries of Asia, which must seek the optimal mix of tax subsidy and health insurance for universal coverage. Implementation of effective payment systems to control the behavior of health care providers is also a key factor in the success of health care financing reform in Asia.

Keywords
health care reforms, heath economics and financing, health insurance, health systems, health care services
Direct household payments for health services in Asia and the Pacific

IMPACTS AND POLICY OPTIONS

S Kwon, Q-Y Meng, V Tangcharoensathien, S Limwattananon and CD James

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THANK YOU !!!

Prof. Soonman KWON

kwons@snu.ac.kr (Seoul National Univ.)
http://plaza.snu.ac.kr/~kwons (Homepage)