ASSESSING THE RESOURCE REQUIREMENTS FOR THE SOCIAL PROTECTION AGENDA OF SDGS IN ASIA - HEALTH CARE SCHEMES

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Introduction – Definition of SHP

- „Social health protection is designed to alleviate the burden caused by ill health and reduce the indirect costs of disease and disability, such as lost years of income due to short and long-term disability, care of family members, lower productivity, and the impaired education and social development of children. ... An effective social health protection system provides universal access to needed health care that is affordable, available, of adequate quality and offers financial protection in times of illness, injury and maternity. “
- *ILO Definition of Social Health Protection*

Introduction – Approaches of SHP

Coverage	Financing: Contribu-tions	Fully Tax funded	Tax Subsidies	Donor Funding
UHC	Social Health Insurance	NHS Model	Subsidized universal care	Selective subsidies, Loans
Formal Sector	Coverage of civil servants, military and large enterprises	Free care for public sector	Subsidized care for public sector	Loans for system setup
Informal Sector	Micro Insurance, voluntary Insurance	In NHS Model omly	Subsidized care	Subsidy for selected care, loans for system setup
The poor	Micro Insurance	Exemption from Contribution	Subsidized Care, vouchers	Vouchers, subsidized insurance

Introduction: The Need for Pooling

There are good arguments for the extension of coverage through risk pooling by SHP:

- The risk of falling into poverty because of high cost health cases. Especially low income countries, a catastrophic sickness incident may lead to whole families losing their assets and becoming poor.
- Existing basic networks of health providers. In almost all countries there are networks of health professionals and facilities. What is lacking, is the pooling mechanism.
- Health is the pre-requisite for participating in all economic activities. So, assisting people in staying and getting healthy is paramount.
- Unlike pension systems, health protection provides immediate benefits and visible benefits for contributions. In this regard, it is easier to achieve compliance, understanding, trust and participation.
- Social health protection creates job opportunities.

Coverage Patterns in Asia

- High income countries like Japan and Korea with broad coverage and full-fledged social health insurance schemes, with coverage rates up to 100%;
- Upper middle income countries like China, Malaysia and Thailand with developed schemes, but with coverage rates below or near 100%;
- Lower middle income countries like Indonesia, Philippines, Sri Lanka, Vietnam, partly with developed general social health insurance schemes and coverage rates up to 80%
- Low income countries like Myanmar, Nepal, with large coverage gaps and no general social health protection schemes and coverage rates around 20%.

Qualitative Coverage Gap

The qualitative or vertical coverage gap refers to the support value of pooling mechanisms. The support value is defined as the percentage of actual health costs that are covered by existing pooling instruments. The support value is influenced by:

- Purchasing mechanisms (if prices are negotiated and fixed, health insurance can define coverage and co-payments. If prices are not fixed, like for example in many hospitals in the Philippines, only flat amounts can be reimbursed, which leave a more or less large share to be paid by the patient).
- Reimbursement levels (the level of payments for certain care types like hospitalization, outpatient and drugs)
- Benefit package (for example many micro insurance schemes have a very limited coverage of catastrophic care, thus leaving high payments to the patient).

Often even in case of simpler treatments cost coverage is way below 100% (excluding official co-payment). It is also common in many countries that apart from official coverage, under the table payments are charged.

Quantitative Coverage Gap

- The quantitative or horizontal coverage gap refers to population coverage, meaning the degree of risk pooling through social insurance, private insurance, micro insurance or other instruments. Risk pooling is very different in the observed 16 countries.
- World Bank estimates coverage in China at 87%
- WHO estimates coverage in Indonesia at around 50%
- Coverage in Mongolia lies around 70%, similar coverage rates may be found in other central Asian countries.
- Coverage in the Philippines, Thailand, Vietnam is approaching 90%.
- Cambodia, Laos, Myanmar, Nepal have low coverage rates far below 50%.
- In general, we estimate that among the countries dealt with in this paper, average coverage of social health protection is not much higher than 50% of the population.

Cost Estimate of Coverage Extension

	Target per capita Expenditure in US$ ppp	Population (Mn)	Estimate current Pooling per capita in US$	Out of Pocket Payment per Capita (WHO)	Target Pooling per capita in US$	Gap per Capita in US$ ppp	Gap Total (Bn US$ ppp)	Gap in % of total expenditure	Gap in % of GDP
Azerbijan	1.232,53	9,40	292,20	755,10	739,52	447,32	4,20	36%	2,45%
Cambodia	229,47	15,60	47,27	135,93	137,68	90,42	1,41	39%	2,59%
China	950,02	1.376,00	496,74	233,76	570,01	73,27	100,82	8%	0,51%
India	401,09	1.310,00	100,54	166,86	240,65	140,11	183,54	35%	2,29%
Indonesia	726,97	257,50	158,98	140,42	436,18	277,20	71,38	38%	2,51%
Kazakhstan	1.739,19	17,60	586,39	481,71	1.043,51	457,12	8,05	26%	1,83%
Lao	374,17	6,80	60,09	38,42	224,50	164,42	1,12	44%	2,89%
Mongolia	855,46	2,96	330,02	235,08	513,27	183,26	0,54	21%	1,50%
Malaysia	1.771,83	30,33	673,01	367,19	1.063,10	390,09	11,83	22%	1,45%
Myanmar	345,14	53,80	51,03	52,47	207,09	156,06	8,40	45%	2,97%
Nepal	161,87	28,50	71,86	65,54	97,12	25,26	0,72	16%	1,03%
Philippines	485,67	100,70	152,28	176,62	291,40	139,12	14,01	29%	1,88%
Sri Lanka	273,34	20,70	213,82	155,48	464,00	250,18	5,18	32%	2,10%
Thailand	1.074,26	67,96	875,04	75,06	644,56			0%	0,00%
Timor Leste	159,80	1,25	91,76	9,74	95,88	4,13	0,01	3%	0,18%
Vietnam	395,99	91,70	246,80	143,70	237,59			0%	0,00%
All	727,27	3.390,79	258,87	221,19	436,36	177,49	601,83	24%	1,71%

Cost Estimate - Continued

- The total costs for the 16 countries is estimated to be 601.83 Bn Us$ ppp or 1.71% of GDP.
- The defined gap ranges from 0% of GDP in Thailand (which is owed to the existing comprehensive coverage) up to nearly 3% in Lao and Myanmar. The average lies at 1.71%.

Cost Estimate - Methodology

- We took as target an expenditure for health of 7% of GDP, which is slightly above that of Thailand (The average health expenditure for middle income countries is 5.8 and the for upper middle income countries is 6.2 % of GDP. If we want to improve this, the target must be above).
- We took the same target for all countries with the following justification: Health costs do not all correlate with GDP level. Some like salaries do, others like construction partly do, technology and drugs, especially branded drugs, do not. Finally, the poorer the country the higher the probability of development aid.
- We compared this expenditure per capita with the current pooling per capita.
- We defined a target pooling per capita which we set at 60% of the target expenditure per capita. Comparing the current pooling per capita with the target pooling we arrive at the gap per capita.
- Multiplying this with the population numbers we arrive at the total gap amount.

RECOMMENDATIONS

- The options countries have to cover the gap in expenses and pooling are:
  - Shifts in public budget,
  - Improvement of tax efficiency,
  - Introduction of contribution financing (pooling),
  - Loans from development banks in combination with higher tax efficiency
- Existing health expenses (out of pocket) can be pooled.
- Additional expenses on the top of these may be needed in order to achieve sufficient coverage.
- A general tax financed system is the preferred option. In absence of political possibilities to introduce this, social health insurance in a second choice.