Social Science & Medicine 145 (2015) 243–248

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Emerging challenges in implementing universal health coverage in Asia

Caryn Bredenkamp [a, *], Timothy Evans [a], Leizel Lagrada [b], John Langenbrunner [c], Stefan Nachuk [d], Toomas Palu [a]

[a] World Bank Group, USA
[b] Philippines Health Insurance Corporation, Philippines
[c] Bill and Melinda Gates Foundation, USA
[d] University of California, San Francisco, USA

ARTICLE INFO

Article history:
Received 1 May 2014
Received in revised form
28 June 2015
Accepted 23 July 2015
Available online 26 July 2015

Keywords:
Asia
Universal health coverage
Informal sector
Health insurance
Health financing
Benefit package
Health care
Quality
UHC

ABSTRACT

As countries in Asia converge on the goal of universal health coverage (UHC), some common challenges are emerging. One is how to ensure coverage of the informal sector so as to make UHC truly universal; a second is how to design a benefit package that is responsive and appropriate to current health challenges, yet fiscally sustainable; and a third is how to ensure “supply-side readiness”, i.e. the availability and quality of services, which is a necessary condition for translating coverage into improvements in health outcomes. Using examples from the Asia region, this paper discusses these three challenges and how they are being addressed.

On the first challenge, two promising approaches emerge: using general revenues to fully cover the informal sector, or employing a combination of tax subsidies, non-financial incentives and contributory requirements. The former can produce fast results, but places pressure on government budgets and may induce informality, while the latter will require a strong administrative mandate and systems to track the ability-to-pay. With respect to benefit packages, we find considerable variation in the nature and rigor of processes underlying the selection and updating of the services included. Also, in general, packages do not yet focus sufficiently on non-communicable diseases (NCDs) and related preventive outpatient care. Finally, there are large variations and inequities in the supply-side readiness, in terms of availability of infrastructure, equipment, essential drugs and staffing, to deliver on the promises of UHC. Health worker competencies are also a constraint.

While the UHC challenges are common, experience in overcoming these challenges is varied and many of the successes appear to be highly context-specific. This implies that researchers and policymakers need to rigorously, and regularly, assess different approaches, and share these findings across countries in Asia – and across the world.

© 2015 Published by Elsevier Ltd.

1. Introduction

The number of low- and middle-income countries aspiring to achieve universal health coverage (UHC) has been increasing over the last two decades (Garrett et al., 2009). Within the last five years, however, the articulation of these shared aspirations has become markedly louder and stronger. Since 2011, there have been four global resolutions endorsing UHC: the World Health Assembly Resolution on Sustainable Health Financing Structures and Universal Coverage in 2011 (WHA, 2011), the Mexico City Political Declaration on Universal Health Coverage in 2012 (WHO, 2012), the Bangkok Statement on Universal Coverage in 2012 (PMAC, 2012), and the UN General Assembly Resolution in support of UHC in 2012 (UN General Assembly, 2012). UHC now appears in the short list of proposed Sustainable Development Goals (United Nations, 2015) and looks likely to emerge as the unifying central goal for the health sector in the post-2015 period (United Nations, 2013; Vega, 2013; WHO, 2015).

Even though the paths that countries are taking to UHC are different, there is increasing convergence on what the UHC goal is:

* Corresponding author. World Bank Group, 1818 H Street NW, Washington, DC 20433, USA.
E-mail address: cbredenkamp@worldbank.org (C. Bredenkamp).

http://dx.doi.org/10.1016/j.socscimed.2015.07.025
0277-9536/© 2015 Published by Elsevier Ltd.

ensuring that all people have access to needed health services without risking financial impoverishment (WHO/World Bank Group, 2013). Moreover, in many countries, including those in East Asia, attaining UHC is now an explicit policy objective that is described in country health strategies and operationalized in implementation plans. This reflects governments' commitment to good health through developing health policies that are responsive to people's demands for more comprehensive and affordable care, and to delivering on these policies by ensuring the availability of quality services on the ground. The commitment to UHC also places equity concerns front and center: it seeks to address persistent inequalities in health outcomes and access to care, and to provide financial protection to the more than 100 million people who are impoverished by out-of-pocket spending annually (WHO, 2010). This is tied to a broader social and economic rationale for investing in health: good health also improves educational outcomes and workforce productivity, over the long-run promoting economic development (Jamison et al. 2013).

As countries in Asia advance along their respective paths to UHC, a number of common challenges are emerging. This paper explores three of them. First is the challenge of making universal health coverage truly universal: while formal sector workers are easily covered by payroll deductions, and the poorest are often covered through government subsidies, the big challenge is to expand coverage to non-poor informal sector workers, the so-called "missing middle". Second is the challenge of defining a common benefit package that is appropriate to the disease burden, represents good value for money and is socially acceptable. Third is the challenge of closing the gap between legal entitlements and citizens' actual ability to benefit from health services through ensuring supply-side readiness, i.e. the availability of quality health services within sufficiently close geographic proximity. These three challenges are illustrated by examples from East Asia, especially the larger countries of China, Indonesia, Philippines, Thailand and Vietnam.

Ethical approval was not required for this research because the authors did not collect new, or analyze previously collected, human subjects data; the research relies solely on existing and publically-available literature.

2. Covering the informal sector

Among the countries that are taking a social health insurance path to UHC, it seems that a common pattern of coverage is emerging. Relatively comprehensive coverage of civil servants and the formal sector is fairly easily attained through payroll deductions (whether in the form of earmarked contributions to health insurance schemes or income tax) and complemented by the inclusion of the poor through government subsidies. This has been the pattern in Vietnam, Indonesia, and the Philippines, for example. However, it has typically resulted in a "missing middle", made up mostly of informal workers and their families. Covering this group is proving challenging.

The negative statistical relationship between GDP per capita and the proportion of the labor force in informal employment (Bitrán, 2013) makes it easy to assume that the high economic growth experienced in the region over the last decade will translate into more formal sector jobs, creating a strong tax base from which to fund UHC. Indeed, in the decade ending 2011, the elasticity of employment to output has been quite high, at 0.33 in Thailand, 0.3 in China and 0.22 in the Philippines (Hanusch, 2013). Yet, the nature and quality of the jobs created is often part-time, short-term and/or contractual, and labor market informality is not only high by global standards, but has proven very persistent over time (World Bank, 2014). This implies that there is likely to be limited ability to raise public revenue from income- and labor-related taxes.

Beyond mandating, and enforcing through legal action, contributions from the informal sector (which may not be feasible), there are two basic approaches to extend coverage to this group: (i) encourage contributions from the informal sector through financial and/or non-financial incentives and information campaigns, or (ii) use general tax revenues to cover not only the poor, but also the informal sector.

Vietnam used premium subsidies of 70 percent to finance its recent health insurance coverage expansion (Tangcharoensathien et al., 2011). To complement full government subsidies of the insurance premiums of the poor, the Philippines used a system of discretionary local government subsidies for the enrollment of the near-poor until 2012 before extending a full insurance subsidy to the near-poor in 2014 (Bredenkamp and Buisman, 2015). China almost completely (at 85 percent) subsidizes the premiums of the rural population (Yip and Hsiao, 2008) and contributes 60 percent (on average, with adjustments for income) on behalf of urban non-working populations (Liang and Langenbrunner, 2013). Similarly, health insurance schemes in the higher-income countries of Japan, South Korea, and Taiwan provide a partial subsidy to informal sector workers (Kwon, 2011).

Premium subsidies are not the only policy intervention that has been tried to increase enrollment; other interventions have included education about the concept of health risks, information campaigns about the schemes, assistance with the actual enrollment process, and the introduction of more convenient ways to pay premiums, for example, using convenience stores or mobile phones. Still, success often remains elusive. In experiments in Vietnam (which involved a combination of a 25 percent subsidy and provision of an information kit) and Philippines (where the intervention was a 50 percent enrollment subsidy, provision of an information kit and SMS reminders to enroll), for example, these packages resulted in enrollment increases of only 1 and 5 percentage points respectively (Wagstaff et al., 2014; Capuno et al., 2014). Interestingly, in the Philippines experiment, a follow-up intervention which added assistance with filing out insurance forms and mailing them resulted in as much as a 36.5 percentage point increase. In China, the setting of enrollment targets for local government officials helped to raise enrollment rates (Liang and Langenbrunner, 2013), while in Korea a mix of enrollment mandates and effective tracking of income and property has increased the administrative pressure to enroll (Jeong, 2010). In Indonesia, which aims to fully cover its 70 million unenrolled informal sector workers by 2019, the government has initiated pilots to identify what works best. However, early results suggest subsidies, education, information and convenience will likely not make a large difference to enrollment among rural informal workers, with only a limited take-up among the urban informal sector (J-PAL, 2015).

A much easier and quicker approach to achieve high levels of coverage among the informal sector is to link coverage with citizenship or national residence, and to enroll the whole (as opposed to only the poor) informal population using general government revenues. Thailand embarked on this path and saw coverage rates improve significantly and relatively quickly (Li et al., 2011; Tangcharoensathien et al., 2011; Limwattananon et al., 2014). Many other countries, including China, Korea and Taiwan, also rely on general revenues to cover the informal sector (Annear et al., 2015). This approach can also be more equitable than social health insurance; the latter is often regressive because of maximum ceilings on contributions that are typically imposed even when contributions are set proportional to income (Kwon, 2009). However, sole reliance on a tax-financing approach to reaching this group can have an immediate and long-term negative budgetary impact and may not be an option in countries with relatively low tax mobilization. It might also induce an increase in informality if

Download English Version:

https://daneshyari.com/en/article/7331435

Download Persian Version:

https://daneshyari.com/article/7331435

Daneshyari.com