Perspective

Access this article online
Website: www.searo.who.int/publications/journals/seajph
Quick Response Code:

Public financing to close gaps in universal health coverage in South-East Asia

Robert Yates

World Health Organization Country Office for Indonesia, Jakarta, Indonesia

Address for correspondence:
World Health Organization Country Office for Indonesia, c/o Gedung Dr Adhyatma, Ministry of Health, Jalan HR Rasuna Said Blok X.5, Kavling 4–9, Jakarta 12950, Indonesia
Email: robyates123@gmail.com

Given the three-dimensional nature of universal health coverage (UHC) – population coverage, services covered and the degree of financial protection – it is difficult to put an absolute figure on the number of people who have effective health coverage in any one country. However, following China's rapid increase in coverage since 2009,[1] it is clear that there are now more people *without* coverage in South-East Asia than in any of the other World Health Organization (WHO) regions. For example, it has been estimated that around 40 million people in India alone are pushed into poverty each year, as a result of health-care costs.[2]

However, the coverage picture across the Region varies tremendously, to the extent that South-East Asia also contains some of the most celebrated examples of countries that have practically reached UHC, even as lower middle-income countries. These UHC success stories include Thailand, whose famous Universal Coverage Scheme has helped improve health indicators and reduce impoverishment resulting from health-care costs since it was launched in 2002.[3] Sri Lanka, too, has often been identified as a country that has outperformed its peers in achieving excellent health outcomes (its infant mortality rate is one fifth of India's) and high levels of financial protection.[4] Furthermore, Bhutan's performance in providing universal free health care to its entire population is seen as one of the major contributors towards improving the country's Gross National Happiness.[5] Finally, both Bangladesh[6] and Nepal[7] have received international recognition for their expansion of coverage of selective packages of cost-effective health services.

How have these countries taken great strides towards UHC while some of their neighbours are struggling to reach population coverage rates of 50%? A common feature of these UHC pioneers is that these governments have used large increases in public financing to fund services for previously uncovered population groups – particularly in the informal sector. Furthermore, they have provided sufficient public financing and management oversight to persuade their populations to use these health units because the services provided are of adequate quality. How much has this cost? For the five countries of the WHO South-East Asia Region that have provided this universal entitlement to free health care (Bhutan, Maldives, Sri Lanka, Thailand and Timor-Leste), the average public health spending was 2.9% of gross domestic product (GDP) in 2012.[8]

In the meantime, the two biggest countries in the Region, India and Indonesia, are providing public financing to their health sectors to a level of only 1.2% and 0.9% of GDP, respectively. Furthermore, in these countries, only people pre-identified as being poor are entitled to be covered by tax-financed government health insurance schemes. This has left hundreds of millions of people (mostly in the informal sector) exposed to the risk of high health-care costs, with millions impoverished each year because they did not have adequate coverage. How might these countries and others in the Region, such as Myanmar and Bangladesh, close their gaps in population coverage?

One school of thought is that fully subsidized services should be restricted to the population living below the poverty line, and that people above this level should be encouraged to join health insurance schemes voluntarily. This has been a common approach in many low- and middle-income countries across the world but to date it has not been successful in reaching full population coverage. Countries tend to get stuck at a coverage rate of around 70%, with the bulk of the uncovered population consisting of near-poor people in the informal sector who cannot purchase health insurance. Thailand found itself in this situation at the start of the past decade, when it managed to reach 70% population coverage using a mixture of targeted social health insurance schemes. Even the richest economy in the world, the United States of America, has not been able to reach universal coverage using voluntary insurance, and around 43 million people remain uncovered.

The alternative approach, which has been shown to work in the success stories of the WHO South-East Asia Region and across the globe, is to close the coverage gap with a large injection of public financing to cover the entire informal sector. This is what Thailand achieved in 2002, with a 0.5% of GDP increase in tax financing, and also how China has increased coverage from 30% to 96% in the past decade, using an additional annual public health spending of 1.1% of GDP.[9] Recent celebrated UHC successes in Brazil, Mexico and Turkey have followed a similar approach using compulsory public financing.

It is encouraging to note that these lessons appear to be being heeded now in countries of the WHO South-East Asia Region with lower coverage rates. In India, the recently elected government has announced that it will publicly finance a package of 50 essential medicines and diagnostic services free of charge to the entire population. Furthermore, at the state and provincial levels in India and Indonesia, political leaders are recognizing that they can close coverage gaps using local tax revenues. The free health card distributed to over 3 million people in Jakarta since November 2012 is perhaps the most striking recent example of a provincial government using tax resources to rapidly scale up population coverage. Moreover, as the architect of these reforms has just been sworn in as President of Indonesia, expectations are running high that this policy will soon be extended to the entire population.[10]

With health coverage becoming a more politicized and fiscal space that is growing in many countries, it will be fascinating to watch the WHO South-East Asia Region for developments in UHC in the coming years. In particular, it will be interesting to see whether national political leaders in these countries try to emulate their domestic and international peers in increasing public health financing to reach UHC. Evidence from within the region suggests that this would be a very good idea. Not only would such a policy improve health indicators and reduce impoverishment resulting from health costs, it would also potentially bring huge political benefits to the leaders who bring health services and financial protection to their uncovered populations.

REFERENCES

1. Yip WCM, Hsiao WC, Chen W, Hu S, Ma J, Maynard A. Early appraisal of China's huge and complex health-care reforms Lancet. 2012 Mar 3;379(9818):833-842. http://211.144.68.84:9998/91keshi/ Public/ File/36/379-9818/pdf/1-s2.0-S0140673611618801-main.pdf - accessed 26 November 2014.
2. Reddy KS, et al. High level expert group report on universal health coverage for India. New Delhi: Planning Commission; 2011. http:// planningcommission.nic.in/reports/genrep/rep_uhc0812.pdf – accessed 26 November 2014.
3. Evans TG, Chowdhury AMR, Evans DB, Fidler AH, Lindelow M, Mills A, Scheil-Adlung X. Thailand's universal coverage scheme: achievements and challenges: an independent assessment of the first 10 years (2001–2010). Nonthaburi: Health Insurance System Research Office; 2012. http://www.jointlearningnetwork.org/uploads/files/ resources/book018.pdf - accessed 26 November 2014.
4. Rannan-Eliya R, Sikurajapathy L. Sri Lanka: "Good practice" in expanding health care coverage. Colombo: Institute for Health Policy; 2009.
5. Tobgay T, Dophu U, Torres CE, Na-Bangchang K. Health and gross national happiness: review of current status in Bhutan. Journal of Multidisciplinary Healthcare. 2011;4:293–8. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3155859/ - accessed 26 November 2014.
6. Chowdhury AMR, Bhuiya A, Chowdhury ME, Rasheed S, Hussain Z, Chen LC. The Bangladesh paradox: exceptional health achievement despite economic poverty. Lancet. 2013 Nov;382(9906):1734-45.
7. Engel J, Glennie J, Adhikari SR, Bhattarai SW, Prasai DP Samuels F. Nepal's story: understanding improvements in maternal health. London: Overseas Development Institute; 2003. http://eudevdays.eu/sites/ default/files/8624.pdf - accessed 26 November 2014.
8. World Bank. Health expenditure, public. (% of GDP). Washington: World Bank Group. http://data.worldbank.org/indicator/SH.XPD. PUBL.ZS - accessed 26 November 2014.
9. Meng Q, Xu L, Zhang Y, Qian J, Cai M, Xin Y, Gao J, Xu K, Boerma JT, Barber SL. Trends in access to health services and financial protection in China between 2003 and 2011: a cross-sectional study. Lancet. 2012;379(9818):805–814. http://211.144.68.84:9998/91keshi/Public/ File/36/379-9818/pdf/1-s2.0-S0140673612602785-main.pdf - accessed 26 November 2014.
10. Jakarta Post. New cards are first steps toward prosperity for all, says Jokowi. Jakarta: Jakarta Post. 2014 Nov 03. http://www.thejakartapost.com/news/2014/11/03/new-cards-are-first-steps-toward-prosperity-all-says-jokowi.html - accessed 26 November 2014.

How to cite this article: Yates R. Public financing to close gaps in universal health coverage in South-East Asia. WHO South-East Asia J Public Health 2014; 3(3-4): 204–205.

Source of Support: Nil. **Conflict of Interest:** None declared.