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Enhancing Equity in Access to Health Care in the Asia-Pacific Region:
Remediable Inequities

Report prepared for the UN Regional Thematic Working Group on Health

Enhancing equity in access to health care in the Asia-Pacific region: Remediable inequities

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Foreword

The guiding principles of adequate health care and access to these services are within the Alma-Ata Declaration that health is a fundamental human right and that provision of adequate health and social measures are the responsibility of governments, in collaboration with NGOs, civil society and the private sector. While there have been overall improvements in health status in the region as reflected in an increase in life expectancy (from 46 years in 1960 to 69 years in 2005), obstacles to achieving 'Health-For-All' exist. Progress towards achieving the health targets in the Millennium Development Goals in the Asia Pacific region has been uneven. While some countries have improved maternal and child health, close to 5 million children under five years in the region die each year, and the maternal mortality ratio has increased by 16 per cent, which underscores the extreme inequities in health care in the region. Overall, there is a large number of off-track countries in health related MDGs in the region.

Equity in access to health services is an issue in many countries of the region. There is a large disparity in access between the rich and the poor, urban and rural areas, and marginalized groups are underserved in the region including migrants and ethnic minorities. Social relations between women and men in many Asia Pacific societies result in gender in-sensitive health services and limited access to health services among women and girls. Not only is the total health expenditure on health quite low in the region (less than 5 per cent of the GDP in many countries), government spending on health as a proportion of total health expenditure is also the lowest in the Asian and Pacific region, with South Asia being the lowest at 24 per cent. This results in catastrophic expenditures on health in household, which is one of the causes of poverty in the region. The region is also home to 60 per cent of the world's population which lacks access to essential drugs (1 billion).

The UN Regional Coordination Meeting was held on 9 September 2005 at ESCAP in Bangkok with an aim to promote harmonization and alignment of programmes to enhance UN's impact at the regional level as well as to promote synergies with other regional organizations. The key points of discussions focused on measures for enhanced regional cooperation and improved operational coherence of UN programmes, including the need for strengthened coordination and coherence, priority areas for cooperation and the need for alignment with regional priorities. As a result, health was determined as one of the 5 priorities and the "Thematic Working Group on Health" was established. The other TWGs are: environment and development, international migration and trafficking, poverty and hunger, and education for all.

The TWG-Health commissioned this review of existing information on inequities in access to health care in the Asia Pacific region, including health financing and policies influencing equity. The review, by Dr Varatharajan Durairaj, provides a summary of the political, economic and social causes of and the implications of health inequities in the Asia-Pacific region, as well as analyzing policies, strategies and activities which address health care inequities in the region. As the review indicates, there are substantial inequities in access to health care. Accordingly the TWG-H has to focus on a) tracking the inequities

and factors associated with them and b) advocating with governments and other stakeholders for policies and strategies to reduce such inequities.

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ABBREVIATIONS

ADB	Asian Development Bank
DALY	Disability Adjusted Life Year
GDP	Gross Domestic Product
IMR	Infant Mortality Rate
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
NGO	Non-Governmental Organization
NTP	National TB control Programme
OOP	Household Out-of-pocket spending
RCMS	Rural Cooperative Medical Schemes
SC/ST	Scheduled Caste/Scheduled Tribe
TB	Tuberculosis
THE	Total Health Expenditure
TQM	Total Quality Management
TWG	Thematic Working Group
UNDP	United Nations Development Programme
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific

Key Words

Health care access, health financing, health system, health care equity, and health policy

EXECUTIVE SUMMARY

Background and objectives

Adequate health spending so as to achieve universal access to health care is one of the fundamental goals of any national health system. Access to essential health care is a basic human right. Health is also a tool for social inclusion, eradication of poverty and impoverishment, and the development of human capital. Despite its potential benefits (reduced mortality and morbidity), investment in health in a majority of Asia-Pacific countries is below five per cent of GDP. On the other hand, countries such as Malaysia, Sri Lanka, and Thailand have demonstrated the positive impact of better and more efficient health spending. Government spending on health is one of the lowest in the world in ten countries in this region, where the share of household out-of-pocket expenditure is also the highest. Poor overall spending in general, and low government spending in particular, limits access to health care in rural and remote areas resulting in uneven progress towards attainment of good health. Variation in life expectancy within countries is as high as 30.9 per cent among low-income countries compared to six per cent among high-income countries. Low-income countries also have the highest per capita disease burden and extreme poverty. Based on evidence from countries within the Asian and Pacific region, it would appear that benefits of increased and well targeted government spending accrue most to underserved populations in the disadvantaged countries and populations.

This report is an attempt to draw regional attention towards attaining equity in access to health care with an overall goal of achieving universal access to health care. It reviews the available information on inequities in access to health care in the Asia-Pacific region and looks at synergies and gaps in policies, strategies, and activities directed at addressing health care inequities from regional, subregional, national, and subnational perspectives.

Inequities in health spending

Both government and private spending are inequitably distributed across sub-national territories in the Asia-Pacific region. For instance, rural and disadvantaged provinces in China and India are found to receive a lower share of resources for health. Out-of-pocket spending by households is a major source of financing of health expenditures in countries in the region, such as Bangladesh, China, India, Indonesia, Nepal, and Viet Nam. This catastrophic out-of-pocket spending pushes an estimated 37.0 million people in India, 32.4 million in China, and 5.0 million in Bangladesh below the poverty line. More than 20.0 per cent of households' out-of-pocket expenditures is used for accessing government health care facilities in India, Indonesia, Kyrgyzstan, Thailand, and Viet Nam.

Health spending is low in countries in the region where the disease burden is high. Per capita spending per DALY varies between $42 in Afghanistan and $30,130 in Australia. It is estimated that the existing facilities in Afghanistan are adequate to meet only 42.0 per cent of health care needs. Countries like Nepal are unable to spend adequately enough to fund even the basic essential service package. Under-funding is one of the major reasons for poor health outcomes in Tajikistan, while South Asia has the poorest coverage of antenatal care and the lowest skilled attendance of births among all regions in Asia and the Pacific.

Public health functions and preventive services receive a lower proportion of funds in many countries in the region, with a large portion of health care resources being accounted for by curative care facilities.

Physical access to care

Health care facilities are concentrated in high-income and urban areas. For instance, availability of physicians is three times higher in urban and high-income areas in India as compared to rural areas. In China, overall access to health care is better in high-income areas. In Bangladesh, high-income individuals are three times more likely to receive care from qualified providers than low-income individuals. In the Pacific subregion, inequalities in access to care exist between urban and rural areas, men and women and between socio-economic groups. In Papua New Guinea, physician availability is disproportionately

low in rural and remote areas. The average number of persons served per health facility across provinces in Afghanistan varies between 11,800 and 52,000.

The utilization of public facilities and free wards by people in higher income quartiles is significant in India indicating utilization of free and subsidized care by the non-poor. Overall health care utilization and expenditure are also higher among the higher quartiles. Moreover, access to health care including immunization is found to be lower in Indian districts where people from Scheduled Castes and Scheduled Tribes live.

Causal factors

High rates of maternal mortality are associated with limited access to health care services for expectant mothers. This is due to the non-availability of services or due to gender or cultural barriers. Women in Afghanistan suffered due to a combination of lack of trained female birth attendants, gender segregation and restrictions placed on the female population by local traditions. Male members take decisions which have an impact on the health of women in the family, in the case of about 50 per cent of women in India, Nepal and Bangladesh.

Public health care systems suffer from many drawbacks - both structural and functional. Introduction of user fees in some health-care institutions may have played a major role in increasing the inequity in access to health care in Cambodia, China, India, Indonesia, Kyrgyzstan, Thailand, Viet Nam and Pacific islands countries and territories. They act as barriers by preventing the poor from gaining access to public health care institutions even in the presence of schemes to exempt the poor from user fees. The insufficient regulation of the private sector also contributes to the irrational use of medicines and diagnostics which increases the cost of treatment.

National policies and strategies

National policies of many countries in this region imply the intent to provide universal access to health care by strengthening the publicly financed institutions. These policies, however, need to be considered in the context of the levels of economic development of the countries; while low-income countries strive to achieve a minimum standard of care, high-income countries focus more on ensuring quality. Recent efforts in some countries have been advocating for a higher share of government resources for health. The drive for additional resources include steps such as increasing the government health budgets, imposing user fees, expanding social health insurance schemes as well as community-based health insurance schemes. Since the financial requirements of some of the low-income countries in the region for providing a minimum package of affordable health care may far exceed the available means, donors may have to step in to fill the gap.

Strategies adopted by different countries to target the poor varied between shifting resources to primary health care in Kyrgyzstan and India, exempting the poor from user fees in Bangladesh, adjusted/subsidized insurance premiums for the poor in Republic of Korea, and safety nets in Hong Kong. In many countries, the boundary between the poor and those above the poverty line is drawn based on an urban-rural divide assuming that a vast majority of the poor live in rural areas.

What worked and what did not

In the Asian and Pacific region, overall there seems to be a policy push towards improving health outcomes in South and South-East Asia. Malaysia, the Republic of Korea and Sri Lanka continue to do well in ensuring health equity. Good economic performances have contributed to improved health outcomes and equity in East Asia and the Pacific subregion also. The Philippines showed some significant progress in health status due to certain health sector reforms. There are also national measures such as the 'Health Equity Fund' in Cambodia, 'Health Care Fund for the poor' in Viet Nam, 'New Cooperative Medical Scheme (NCMS)' in China and Thailand's 'Universal health-care scheme' that directly address health care in-equities. Preliminary results suggest that Cambodia's 'Health Equity Fund' and Thailand's 'Universal health-care scheme' to some extent reduced inequities in access.

Policies targeting higher expenditure for health met with

limited success. While the health share of GDP and per capita health spending increased in the majority of countries, they are still short of the required levels. A narrow GDP and government revenue base in developing countries made the task of generating additional resources of health more difficult. Government allocations to health care have shown a declining trend in some countries in the region despite encouraging economic performances. Donor contributions for filling the gap have also not materialised fully.

Efforts to develop contributory schemes for risk pooling as an option for financing health care are yet to yield desirable results, except in a few countries. Private insurance plays an insignificant role while social insurance is still at an early stage of development. The implementation of social insurance has not been encouraging in low-income countries where the tax-financed approach has proved to be more successful.

Two countries in this region - Malaysia and Sri Lanka - serve as examples of tax-funded approaches towards universal health-care coverage, where the poor had been effectively targeted. Malaysia's 'client-centric and pro-rural' approach effectively targeted the poor and contributed to poverty reduction. Supplementary measures to provision of health care included nutrition programmes, adequate sanitation and exemption of the poor from user fees for essential services. Similarly, Sri Lanka's success was due to a provision of free health care and making basic health care physically accessible, free education, and related measures such as development of agriculture, and provision of subsidized rice. The expansion and improvement of government health care infrastructure was largely responsible for the improved health status and reduction of health inequities.

Possible future options

The key issues identified in this report as contributing towards health inequities are inadequate allocation of resources to health, low government spending, higher reliance on out-of-pocket spending, poor value for money and pro-rich bias in access to health care.

Generating the resources required for strengthening health systems to provide universal access is the most challenging task in the region. Resource allocation to health is particularly poor in countries and sub-national territories whose resource needs are high. Decline or stagnation in government share of resources for health in some countries, is another area of concern. The immediate requirement is to increase the size of total spending on health to at least 5.0 - 6.0 per cent of GDP in countries where it is low, increase government spending on health to at least 2.5 per cent of GDP, and to reduce the reliance on household out-of-pocket spending to less than 50 per cent of total health spending.

Increase in total health spending achieved by some countries in the region has been mainly due to increased out-of-pocket spending by households. Documentation of the scattered evidence on innovative experiments to streamline out-of-pocket expenditure and scaling them up for the benefit of larger population size would be a step towards efficient organization of health care resources. Given the degree of inequity and the varied health care and socio-economic contexts in the region, a financing model suited to the specific needs of each country may be required to tap the full potential. This may require a mix of approaches.

Community empowerment may be one option to enhance resource targeting. Evidence showed that Asian countries with a strong linkage between government and rural communities performed well in terms of social indicators. Eradication of corruption, provision of performance-linked incentive to government staff, and competition are some measures with potential to improve governance. Sri Lanka's success in controlling the informal payments provides a good example of the role corruption control can play in enhancing access to health care.

Considering the significant contribution of high expenditures on essential drugs to out of pocket expenditures, adequate and efficient government drug spending may be the single-most effective strategy to reduce impoverishment and inequity in financing.

Recommendations for the Regional TWG on Health

It is recommended that the joint efforts of the TWG should focus on the four broad issues identified in this report.

1. Following the adoption of the Millennium Development Goals, policies of many countries in the regions have already brought health into the development focus. However, they are not able to define the resource requirements for health or ways to mobilize the same. The TWG could help the governments with context-specific realistic options for raising enough resources for health and for making the case for enhanced aid from donors and the development community at large.

2. Countries in this diverse region, ranging from the developed to the least developed countries are in the process of undertaking health sector reforms. These could benefit from sharing of information and experiences regarding such reforms from other countries in the region. The TWG, in coordination with respective governments, could develop ways to document and share experiences, and suggest ways to adapt, replicate and scale up successful models in other countries.

3. Another area requiring attention from the TWG is the development of sustainable financing mechanisms towards universal health-care coverage. The TWG could work with governments and other agencies to analyze the feasibility of tax-funded mechanisms, as well as social and community-based health insurance schemes for providing universal health-care coverage and reducing health inequities.

4. The TWG could also coordinate with countries in the region to set up a health systems observatory to provide evidence for policy makers to take informed decisions about the health system functioning. The observatory can periodically review the issues of financing, equity, efficiency, and governance. The observatory could also draw up an inter-sectoral plan to map the utilization of resources available within each country and the region so as to achieve the internationally agreed development goals.

5. The TWG could consider the publication of an annual bulletin on issues impacting health equity with a focus on low- and middle-income countries in the region. The bulletin is a cost-effective option for the TWG to inform the countries about their prevailing situation. The successful models in reducing inequities in health and enhancing efficiency can be disseminated by using the bulletin.

CHAPTER 1

INTRODUCTION

Achieving universal access[2] (adequacy of care and extent of population coverage) to health care is one of the fundamental goals of any national health system. However, attainment of this goal is complex in practical terms and the understanding of the term varies across countries depending on the level of socio-economic development and capacity of the health system. This report is an attempt to draw regional attention towards attaining equity in access to health care with an overall goal of moving towards universal access to health care. It reviews the existing information on inequities in access to health care in the Asia-Pacific region. More specifically, it looks at synergies and gaps between policies, strategies, and activities directed at addressing health care inequities from regional, subregional[3], national[4], and subnational perspectives.

1.1 Why do countries need to achieve universal access to health-care?

Health spending to achieve universal access to health care is justified for two reasons - promotion of human welfare and enhancement of human capital. Welfare approach views health as a basic human right and its primary goal is to prevent avoidable ill-health and escapable mortality (Sen, 1999). A girl child born in Japan in 2004 is expected to live 86 years, deliver her child in an institution under skilled supervision and receive appropriate attention during her old age; whereas a girl born in Lao PDR during the same year is expected to live 60 years, deliver her child at home without any skilled supervision and struggle to receive adequate care during old age- if she survives that long (WHO, 2007). Health is also a tool for social inclusion, as healthy individuals are able to participate in social activities and are able to draw greater level of satisfaction from them. On the other hand, ill-health restricts participation in such activities and results in social exclusion. Further, social stigma is associated with certain diseases such as HIV/AIDS, leprosy, filariasis, and TB. Equitable distribution of access to health care also serves as a tool for achieving equitable social welfare as demonstrated in countries like Sri Lanka. Moreover, deprivation of access to health care to achieve human capability is also referred to as human poverty since ill-health limits people's economic capability and contributes to poverty (UNDP, 1990). Hence, enhancement of health must be universally accepted as a major objective of the process of development.

Disadvantaged population groups such as the poor, rural inhabitants, women, elderly, children, disabled, and migrants pose different and difficult set of challenges in the process of health system development. There are differences in the opportunities and resources available between these and other advantaged groups. Dr. Margaret Chan, Director General of the World Health Organization, in her address to the Sixtieth World Health

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2 *Every one in the population has access at an affordable cost to promotive, preventive, curative and rehabilitative health interventions.*

3 *UNESCAP classification of sub-regions is used here and the report covers North and Central Asia, South and South-West Asia, East and North-East Asia, South-East Asia, and Pacific sub-regions*

4 *In all, 46 countries are covered (refer Table-S1 for the list of countries covered). Countries whose life expectancies are below the Asia-Pacific average are listed in Table-S2.*

Assembly on 15th May 2007, remarked, *"If we want health development to work as a poverty reduction strategy, we must have health systems that reach the poor"* (WHO, 2007a). Women face other constraints in making their decisions about their own health and health care and in exercising their rights exposing them to inequitable patterns of exposure to health risks and resulting in inequitable access to and utilization of health information, care and services. Similarly, inequity in access to care among children and adolescents accounts for a major portion of inequity in access between the richest and the poorest in the world (WHO, 2007b). The problems of migrants are unique as they face multiple social, psychological, cultural, economic, health and health care contexts prevalent in countries of origin, transit and destination. Many countries in the region face the challenge of increased numbers of elderly and disabled persons; health systems need to be equipped to deliver health services to these persons.

The human capital approach brings an investment dimension to universal access to health care. It treats health as an essential input to produce human capital. Research has provided clear evidence of the economic benefits of improving health (WHO, 1999, Bloom and Williamson, 1998, Straus and Thomas, 1998, ADB, 1997, Sachs and Werner, 1997, World Bank, 1993, UNDP, 1990, Cropper, 1981, and Shultz, 1961). Many economic successes in the region are built upon a foundation provided by health improvements. While healthy nations/ individuals are able to generate higher economic growth, ill-health impedes it.

1.2 Unfinished agenda and emerging challenges in Asia-Pacific

Despite a significant progress in health achievements during the last three decades (ADB, 1999), attainment of MDGs is uneven in the Asia-Pacific region (World Bank, 2004). Life expectancy is 23.5 per cent (or 15.1 years) lower in low-income countries[5] and 14.6 per cent (10.1 years) lower in middle-income countries[6] compared to the life expectancy of high-income countries in the region.[7] More importantly, the gap between the best and the worst performers has widened from 6.0 per cent among the high-income countries to 30.9 per cent among low-income countries.[8] The gap in life expectancy indicates a potential loss of 5.5 billion person years in India and above 0.2 billion person years each in Bangladesh, Pakistan, Russian Federation, Myanmar and Indonesia. However, life expectancy is fairly uniformly distributed across the geographic sub-regions with East and North-East Asia topping with 71.7 years or 5.1 per cent above the average (World Bank, 2006).

Low-income countries also have the highest per capita disease burden of 0.28 DALY compared to 0.18 DALY in middle-income countries and 0.11 DALY in high-income countries (WHO, 2004). Low life expectancy and high disease burden are also compounded by, and related to poverty. South and South-West Asia accounts for 65.0 per cent of the region's extreme poor (those earning less than one dollar a day) (World Bank, 2006).

The region also has a high rate of migration within and between countries. Migrants have high vulnerability to health problems such as diarrhoea, dysentery, malaria, and sexually transmitted diseases. In addition, they may suffer from lack of access to quality education and be exposed to violence, including gender-based violence.

Poor health outcomes are the results of poor and inequitable access to, and utilization of health services coupled with extreme poverty. Utilization depends on access, which, in turn, is determined by availability and efficient functioning of health care facilities. The direct impact of health care infrastructure on health outcome is best described by the relationship between skilled birth attendance and maternal mortality in Asia-Pacific (Figure-1). Similarly, increased rate of immunization is found to have reduced burden of diseases by about 23.0 per cent (ADB, 1999).

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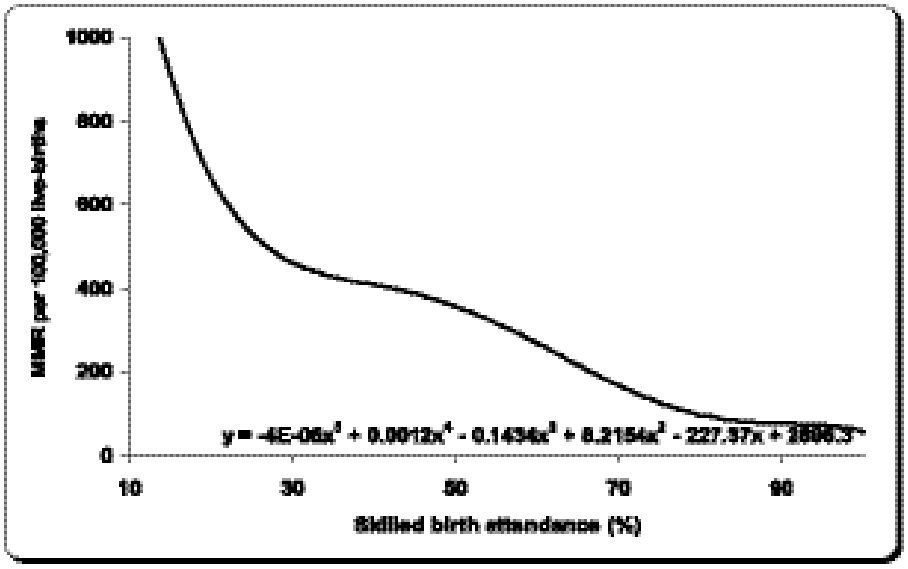
5 *Afghanistan, Armenia, Azerbaijan, Bangladesh, Bhutan, Cambodia, DPR Korea, Georgia, India, Indonesia, Kyrgyzstan, Lao PDR, Mongolia, Myanmar, Nepal, Pakistan, Papua New Guinea, Tajikistan, Timor-Leste, Uzbekistan, and Viet Nam.*

6 *China, Fiji, Iran, Kazakhstan, Malaysia, Maldives, Philippines, Russian Federation, Sri Lanka, Thailand, Turkey, and Turkmenistan.*

7 *Australia, Japan, New Zealand, Republic of Korea, and Singapore*

8 *It is 18.7% among middle-income countries*

Figure-1
Impact of skilled birth attendance on MMR in Asia-Pacific



Source: United Nations, 2006

Despite potential benefits of health investment, total health care spending (public and private) in Asia-Pacific is low at 5.6 per cent of GDP with Pakistan spending as low as 2.4 per cent; health share of GDP is below 5.0 per cent in 21 countries in this region (WHO, 2006). Government share of total health spending is below one-third in 10 countries[9] where unorganised household out-of-pocket expenditures account for a major proportion of health-care spending.

Poor overall spending in general, and low government spending in particular, limits the health-care access for the poor and socially excluded groups. Access is disproportionately low in rural and remote areas. An outcome of the low public investment in health is lower skilled attendance of deliveries, an important determinant of maternal mortality. Delivery by skilled birth attendants is less than 20.0 per cent in Bangladesh, Afghanistan, Nepal, Timor Leste, and Lao PDR. The gaps in public provision in health services are filled by private services in areas where a 'market' exists; but a significant proportion of those who purchase care from the market are pushed towards poverty as a result of such expenditures (Liu et al, 2003).

Within low-income countries, rural people, poor, large families, unskilled labour, ethnic minorities, migrant/ mobile populations and landless households are most affected by lack of access to affordable health care (Lu et al, 2007, Roy and Howard, 2007, Bonu et al, 2003, Data International et al, 2001, ADB, 1999 and Liu et al, 1999). Many disadvantaged populations suffer from multiple inequities based on location, income, social class, and gender. Reduction of gaps in health care, both across and within countries, in this region would result in significant health gains. At the same time, it is not possible to provide a single blueprint to tackle inequity, as conditions differ from place to place.

[9] *Armenia, Azerbaijan, Bangladesh, Bhutan, Cambodia, China, India, Indonesia, Iran, Kazakhstan, Kyrgyzstan, Lao PDR, Marshal Islands, Micronesia, Myanmar, Nepal, Pakistan, Philippines, Sri Lanka, Tonga and Vanuatu.*

1.3 Organization of the report

This report is organized into seven sections. The first section brings out the conceptual elements relevant to the report including the approach of the report and the second section discusses the inequity in health spending and physical access to care. The third section is the section on causal factors, and the fourth is on national policies and strategies to deal with inequity. The last three sections are the review of what worked and what did not, and some recommendations for further action by countries and the Thematic Working Group on Health.

CHAPTER 2

CONCEPTUAL FRAMEWORK

As stated in the introduction, the overall objective of this report is to review the existing information on inequities in access to health services in the Asia-Pacific region. Given this objective, equity in access to health services are the key concepts that require focus in this report. Although the report attempts to bring in the intra-country inequities in financing and organization of health services, the evidence provided in this report is limited by the access to data in a short span of time. The specific focus is on policies and strategies to tackle inequity. The approach of this paper is described in Figure-2. The overall goal is to move towards universal access to health services in the region. In order to achieve this, countries need to widen the reach of and access to health services, in the region. This is possible only when countries strive for equity in financing and physical access to care through appropriate policies, strategies and sustainable financing.

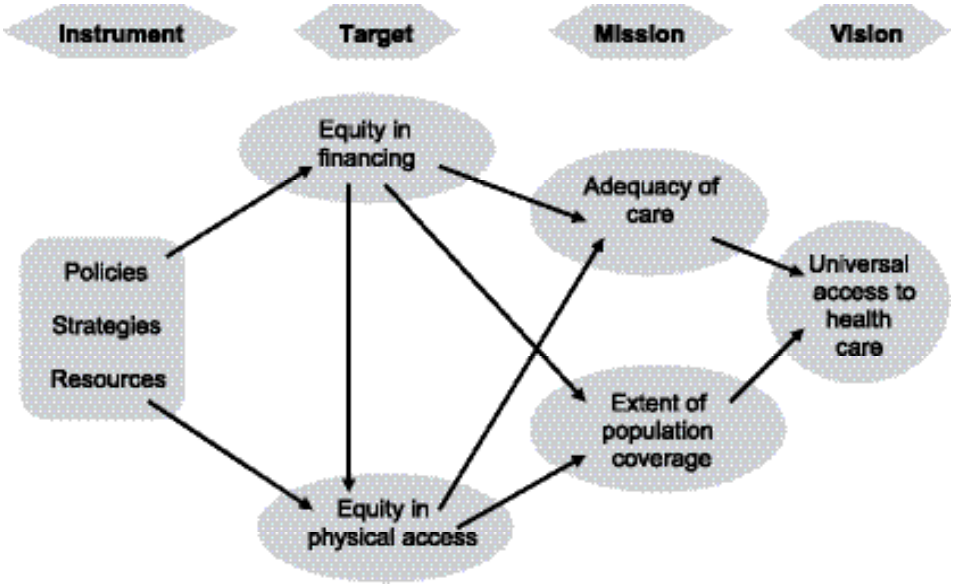
2.1 Equity

Equity is considered as one of the basic requirements of the Primary Health Care approach, and implies fairness and justice (WHO, 1981). Equity is best captured by its absence. Inequity can be characterized as those inequalities which are avoidable, unnecessary, unfair, and potentially remediable (Macinko et al, 2002 and Whitefield, 1992). Equity in health services provision takes two forms - horizontal and vertical equity. While horizontal equity implies equal treatment for equal need, vertical equity means that individuals with unequal needs should be treated unequally according to their differential needs (Zere et al, 2007).

Health care has two sides - organization and financing. Standard definitions of health equity suggest that access to health services should correspond with the need. The focus is to ensure that all people have access to a minimum standard of health services according to the need, not according to the ability to pay. For instance, progress towards an increased average access to health services does not necessarily mean an increased equity because the average moves up with an increased access to even the higher-income section of the population. Equity in access to health services may therefore be defined as equal access for equal need. Disadvantaged populations also suffer from multiple inequities and any strategy targeting a single component of inequity may not yield desirable results.

Measurement of individual inequity may be ideal but comparison of group inequities is more practical. With respect to health care system, it is not easy to define inequity or to provide a single blue print to overcome it. However, it is possible to divide inequity into procedural and outcome components (Levy et al, 2006). This report focuses on the procedural inequity. Procedural inequity can be further sub-divided into provision and financing. Inequity in the provision of care refers to unequal access to health care in comparison to needs while inequity in financing pertains to how revenue is raised to fund health care and how subsidies are distributed. (ADB, 1999). Certain process indicators can be used to analyse whether a health care system is equitable or not. Use of services by types of provider, percentage of government subsidies accrued to different income groups, proportion of target population reached, proportion of people eligible for exclusion and actually excluded from paying for care,

Figure-2
Equity framework for access to health services



distance travelled to reach a free government health facility and cultural/social compatibility of health care provision are some indicators that can be used in practice.

2.2 Access

The definition of access to health services can be viewed from four perspectives; availability, accessibility, affordability and acceptability (WHO, 2001a). Availability explains the relationship between the volume and type of existing services and the volume and type of need. Accessibility deals with the proportion of population units (individuals, houses, and villages) receiving effective care (WHO, 2001b). Affordability is the relative size of the ability to pay to the total financial needs, whereas acceptability addresses the question of social, cultural, religious and gender acceptability among the population.

The issue of 'access' can also be addressed through the quantum of needs (or potential benefits). Several disease burden analyses have concluded that certain population groups such as rural people, ethnic minorities and migrants have lower life expectancy, and suffer from higher and mixed disease burden. Potential benefits are therefore higher for these groups. However, certain practical problems are confronted while one attempts to correct inequity. For instance, the evidence on service benefits is patchy and unreliable (Culyer and Maynard, 1997). Moreover, it is argued that utilization is an inappropriate measure of inequity of access, as it is the outcome of many different complex difficult-to-measure processes (Dixon-Woods et al, 2006).

Access to health care in many developing countries seems to follow the inverse care law meaning that the availability of good quality care is inversely related to the need for it (Gwatkin et al, 2004). Disparities in health spending between the rich and poor in many countries are greater than 100-fold. Although equity justification is provided for government intervention in health, government spending benefits the rich to a great extent. Further, rich-poor disparity is larger for tertiary and secondary care compared to primary care.

CHAPTER 3

INEQUITIES IN HEALTH SPENDING AND PHYSICAL ACCESS

Health spending is a necessary but not a sufficient condition for health and health system development. In other words, higher health spending is no guarantee for better health. However, higher spending can be translated into better health if the resources are spent wisely and equitably. While optimum health spending is an essential condition for health development, its source and use are important for equity consideration.

3.1 Size of spending

While it is agreed that size of health care spending is an important determinant of health outcome, there is no clear prescription for optimal level of national health spending. The global average (6.4 per cent in 2004) can be used as a yardstick for comparison of national health expenditures. Countries in the Asia-Pacific region are some of the poorest health spenders in the world. Health expenditure as a percentage of the GDP is below 5.0 per cent in 22 Asia-Pacific countries (WHO, 2006). However, this proportion has been increasing during the last decade except in Bhutan, India and Pakistan (Table-1). Among Pacific islands, countries and territories, the health expenditure as a proportion of GDP is low in Melanesian countries and reasonably high in Micronesian countries (UNESCAP, 2006).

3.2 Source of spending

One of the major contributing factors towards better health returns has been the way health care resources are organized. Government share in health spending is a crucial factor in health development. At the global level, many governments including that of developing countries share at least 40.0 per cent of total health spending. However, in the Asia-Pacific region, governments of 10 countries contribute less than one-third of the total health expenditures. Table-2 reveals that the government's share has declined in Bhutan, China, India, Lao PDR, Pakistan, and Sri Lanka.

Government spending is inequitably distributed across sub-national territories in China, India and Viet Nam (WHO, 2004a and 2002, and NCMH, 2005). In China, provinces having a higher share of rural population are found to be worse off. Access of the poor to public facilities is poor in Viet Nam. In India, states with better health status allocate more to health and provide better access to primary care facilities (Table-3). It means that the inequity in health status between well and poor performing states is likely to widen, and backward states will further fall behind the states performing well.

Private spending on health is quite high in the Asia-Pacific nations. More particularly, unorganised household out-of-pocket spending is a major source of financing in this region (EQUITAP, 2005). In fact, the Asian and Pacific region presents the worst picture in the world in terms of household out-of-pocket spending. The share of out-of-pocket payment in total health care spending is particularly high in Bangladesh, China, India, Indonesia, Nepal, and Viet Nam (IIPS, 2006, WHO, 2006a and 2002). While government resources in Viet Nam increased at an annual rate of 3.8 per cent during 1996-2004, private household resources increased at 7.3 per cent (WHO, 2002). Although household out-of-pocket spending is significantly high in Bangladesh and Sri Lanka also, the amount spent on services received from

Table-1
Health expenditure (per cent of GDP)

Country	1996	1998	2000	2002	2004
Australia	8.6	8.7	9.0	9.3	9.6
Afghanistan	3.1	3.2	2.8	6.7	6.0
Bangladesh	3.1	3.2	3.2	3.3	3.5
Bhutan	4.3	4.5	4.2	3.6	3.1
Cambodia	10.5	10.8	11.0	10.9	10.1
China	4.7	4.9	5.1	5.5	5.6
DPR Korea	4.4	4.8	5.9	5.8	5.8
India	5.2	5.1	5.0	4.9	4.5
Indonesia	2.5	2.6	2.5	3.2	3.0
Japan	7.2	7.4	7.6	7.9	7.8
Kazakhstan	3.8	4.3	4.1	3.5	3.9
Lao PDR	2.6	2.4	2.5	2.9	3.0
Malaysia	3.1	3.2	3.3	3.7	3.7
Pakistan	3.4	3.7	2.8	2.7	2.4
Russian Federation	6.4	5.7	5.8	5.9	5.3
Sri Lanka	3.5	3.5	3.6	3.6	3.6
Thailand	3.7	3.5	3.4	3.4	3.2

Source: WHO, 2006

government health care institutions is less in these countries (EQUITAP, 2005). In contrast, out-of-pocket payments in accessing government health care institutions are quite significant (above 20.0 per cent of total out-of-pocket payments) in India, Indonesia, Kyrgyzstan, Thailand, and Viet Nam. By and large the bulk of the household out-of-pocket spending goes towards services provided by the private sector, where health care costs are relatively high.

Life expectancy tends to be lower in countries where there is a high proportion of household out-of-pocket health expenditure; life expectancy is better in countries where such expenditures are lower and pooled.

3.3 Catastrophic health expenditures [10]

The share of the household budget allocated towards out-of-pocket payments is as high as five per cent in Bangladesh, China, India, and Viet Nam (WHO, 2002). The share is low (about two per cent) in Indonesia, Kyrgyzstan, Malaysia, Nepal, Philippines, Sri Lanka, and Thailand. Total health spending in China has been growing faster than the growth of GDP between 1978 and 2002 (United Nations Health Partners Group in China, 2005). However, most of the increase came from private out-of-pocket spending. The proportion of out-of-pocket spending rose from 36.0 per cent in 1980 to 68.0 per cent in 2002 with urban residents spending

[10] *Catastrophic health expenditures are defined as a "situation where a household spends more than 40 per cent of its income on health after paying for its subsistence needs, e.g. food. It can be caused by catastrophic illness, either high cost but low frequency events or low cost and high frequency events. Source: Strategy on health care financing for countries in the Western Pacific Region of WHO.*

Table-2

Government health expenditure (per cent of total health expenditure)

Country	1996	1998	2000	2002	2004
Afghanistan	1.5	1.5	1.5	40.1	35.3
Australia	67.4	69.5	68.9	68.1	67.5
Bangladesh	30.7	27.2	25.6	29.6	32.3
Bhutan	86.7	88.5	87.7	85.2	84.3
Cambodia	10.1	10.1	14.2	17.1	18.1
China	41.8	40.9	38.3	35.8	37.4
DPR Korea	88.5	89.2	91.4	91.3	91.2
India	24.9	24.6	24.6	23.7	24.3
Indonesia	27.9	30.4	28.1	34.5	36.9
Japan	80.8	81.1	81.3	81.5	81.8
Kazakhstan	55.1	51.9	50.9	53.2	62.4
Lao PDR	45.2	41.5	31.7	44.5	35.4
Malaysia	50.9	51.2	52.4	55.4	58.3
Pakistan	33.9	32.6	33.0	34.7	28.2
Russian Federation	58.0	57.8	56.1	59.4	59.8
Sri Lanka	49.6	48.4	48.5	45	45
Thailand	54.8	54.8	56.1	60.2	62.1

Source: WHO, 2006

3.5 times higher than the rural residents. Out-of-pocket spending is higher in urban residents in Viet Nam also (WHO, 2002). In other words, an increased share of out-of-pocket resources in total health spending can make health care unaffordable to the rural inhabitants.

Box-1

Impoverishment due to household out-of-pocket spending

Out-of-pocket payments impoverish an estimated 37.0 million people in India, 32.4 million in China, and five million in Bangladesh. In other words, about 2.7 per cent of population (or 78.3 million people) become impoverished in the developing countries due to out-of-pocket spending on health. It pushes the rate of poverty up by 33.0 per cent in Viet Nam, 18.9 per cent in China, 16.8 per cent in Bangladesh, and 11.9 per cent in India. About 3.7 per cent of people slip below the poverty threshold of US $1/day in Bangladesh and India if the out-of-pocket spending is subtracted from their income. In Georgia too, people, especially the poor, borrowed loans or sold assets to meet the health expenditure contributing ultimately to the impoverishment (Gotsadze et al, 2005).

Table-3
Geographic inequity among Indian states (2001-02)

Group of states	Health spending		PHC/CHC[11] utilization by the poorest two quintiles (%)
	Per capita (US $)	Share of govt. (%)	
Well performing	24.30	20.5	49.1
Moderately performing	26.10	17.2	35.9
Poor performing	17.50	17.6	32.0

Source: WHO, 2005 and NCMH 2005

Out-of-pocket spending impoverishes a significant proportion of the population in the Asian and Pacific region (Box-1).

Catastrophic payments are more prevalent in Bangladesh, China, India, and Viet Nam (WHO, 2005). More than 25 per cent of people in these countries spend in excess of 5 per cent of their household budget on health. If catastrophic payments are financed through current income, it affects the level of consumption of other goods. On the other hand, if catastrophic payments are financed through selling of assets and loans, it results in long-term effects through a debt spiral.

Access to essential drugs is an important public health goal. However, the highest proportion of out-of-pocket spending on health is spent on the drug purchase (WHO, 2002 & 2006a and EQUITAP, 2005). The share of medicines in out-of-pocket spending is high in poor and rural countries such as Bangladesh, India, and Viet Nam. As a result, a large amount is spent on self-medication, which is acknowledged as a major problem in rural societies of South Asia.

3.4 Ensuring effectiveness of existing resources

While many countries in the region spend less on health and some disadvantaged areas receive lesser resources (more importantly, public resources), it is also true that the full value for existing investments is not obtained in some countries. Therefore, disparities in health status can be attributed to factors other than GDP and health care spending. Some countries like Malaysia, Sri Lanka, Thailand and the Indian province of Kerala stand as examples of better and more effective health spending (ADB, 1999). Sri Lanka's achievements in life expectancy (73 years in 2003), with a per capita GDP of $ 935, can be equated with a country whose per capita GDP is $ 2,500. China has also produced better health outcomes in the past with relatively low levels of GDP and health care spending. On the other hand, countries like Nepal and Papua New Guinea are not able to derive the full benefit from their existing investments, while countries like Lao PDR not only seem to spend less, but also spend inefficiently, resulting in poor health outcome.

Health care spending may be contextualised by the disease burden, which may be taken to indicate needs. Better value for investments can be obtained if more spending is directed towards preventive care, and on populations with high disease burden. As it can be seen from Table-4, per capita spending and per capita disease burden tend to be inversely related - where disease burden is high, per capita spending is low and vice versa. In fact, the health share of GDP is declining (although not very significantly) as the intensity of the burden increases. This is because the proportionate spending of GDP on health is less in low-income countries where the intensity of the disease burden is high. Countries like Nepal are unable to spend adequately enough to fund even the basic essential service package

11 *PHC - Primary Healthcare Centre*
CHC - Community Health Centre

Table-4
Per capita disease burden Vs per capita spending

Country	Per capita DALY loss	Health spending ($)	
		Per capita	Per DALY
Australia	0.10	3,013	30,130
Japan	0.10	2,347	23,470
Malaysia	0.14	396	2,829
China	0.15	311	2,073
Russian Federation	0.28	571	2,039
Kazakhstan	0.25	393	1,572
Thailand	0.20	274	1,370
Sri Lanka	0.18	137	761
Indonesia	0.21	116	552
Cambodia	0.38	186	490
DPR Korea	0.21	77	367
India	0.27	82	304
Bangladesh	0.26	74	285
Pakistan	0.29	51	176
Lao PDR	0.38	57	150
Bhutan	0.70	64	91
Afghanistan	0.62	26	42

Source: WHO, 2006 & 2004

(World Bank, 2006 and 1993). Disparity in health spending is translated into disparity in health care provision too. In Afghanistan, for instance, it is estimated that existing facilities are adequate to meet only 42.0 per cent of health care needs (Strong, 2005). Under-funding is one of the major reasons for poor health outcomes in Tajikistan and many other countries (World Bank, 2006a, WHO, 2006a, 2004a & 2002, NCMH, 2005 and EQUITAP, 2005).

Actual size of health care needs of the less developed regions and countries may either be unknown or be under-stated due to a paucity of data. The majority of the disadvantaged populations are not connected with the formal health care system and therefore, their actual health status or disease burden may not be known. This is particularly the case for migrant workers in many South Asia countries, particularly those who are 'unofficial' or 'unregistered'. Causes of mortality/ morbidity are not established in many countries and so, it is difficult to apply equity principles to sub-national resource allocations.

Spending on preventive care is often seen as the most cost-effective way of health spending. However, in many countries, a large portion of health care resources is accounted for by curative care facilities (WHO, 2006b, UNESCAP, 2006, World Bank, 2005 & 1995, Government of India, 2002 and Mahapatra and Berman, 1995). This is true for even government resources. Public health functions and preventive services are poorly funded in many Pacific islands countries and territories.

3.5 Pro-rich bias in physical access

As demonstrated in countries like Sri Lanka, better access to health care infrastructure yields desirable results to a great extent. Establishment of maternity homes in Sri Lanka during the 1940s resulted in drastic improvement in skilled attendance of deliveries in 1950s (Sanderatne, 2000). On the contrary, the proportion of births attended by skilled personnel is below 25 per cent in Bangladesh, Afghanistan, Nepal, Timor-Leste, Lao PDR, and Pakistan and is below 50 per cent in Cambodia, Bhutan, Papua New Guinea and India (United Nations, 2006). The life-time risk of maternal mortality is particularly high in South Asia (UNICEF, 2006). South Asia has the poorest coverage of antenatal care and the lowest skilled attendance of births. South Asia also tops in the prevalence of under-weight under-5 children with 78 million under weight under-5 children.

Distribution of health care facilities is another indicator for inequity in physical access. Population served by a health facility varies between 11,800 and 52,278 across various provinces in Afghanistan (Strong et al, 2005). Similarly, physician availability is three times higher in urban and high-income inhabitations in India (NCMH, 2005). In Papua New Guinea, physician availability is low in rural and remote areas (WHO, 2006). In Bangladesh, high-income individuals are three times more likely to receive care from qualified providers (Table-5). The difference is more than five times with regard to in-patient care (Data International Ltd et al, 2001).

China provides another example of a pro-rich bias in access (Box-2). Although overall access improved in rural China during 1989-97, the improvement, particularly drug availability, was better in wealthier areas (Akin et al, 2005). In TB treatment, the lowest income group spends disproportionately high amounts even in places where the National TB Control Programme (NTP) is in operation (Xu et al, 2006). In Viet Nam, wealthier individuals and

Box-2

East-West disparity in access to health care in China

Regional economic pattern is allowed to influence health outcomes in China (WHO, 2004a). Disadvantaged provinces in the western region have shown a slow progress in the decline of IMR, and MMR and in the increase in life expectancy. Rates of infant and child mortality are 3-5 times higher in those provinces (WHO and Government of China, 2006). *The east-west disparity has been widening since the 1980s. About 70.0 per cent of those referred by doctors for hospitalization did not get hospitalized and 38.0 per cent of those who could not seek out-patient care cited non-affordability as the reason for their non-treatment. The gap in non-hospitalization rates between top and bottom income quintiles widened during 1993-2003 from 15 per cent to 24 per cent in urban areas and 19 per cent to 22 per cent in rural areas. The share of out-of-pocket spending in total health expenditure is as high as 90.0 per cent in rural China (compared to 50.0 per cent in urban areas). Decentralization and striving hard for resources by decentralized health care units resulted in under-provision of cost-effective services and over-provision of specialized expensive services. Availability of doctors (6 per 10,000 population) is half in rural areas compared to urban areas and availability of nurses is still poor in rural areas.*

Based on data from three national health surveys, it has been demonstrated that China's rapid economic growth has produced some undesirable consequences relative to the goal of achieving equality of health for all (Liu et al 1999). In particular, the study demonstrated some rising disparities in health care utilization rates and access to care between the rural and urban populations for the same time period.

Source: WHO and Government of China, 2006 and WHO, 2004a

Table-5

Utilization of health services among different income deciles in Sri Lanka and Bangladesh

Income Deciles	Proportion of people reporting sick annually		Proportion of sick seeking care from qualified providers annually	
	Sri Lanka	Bangladesh	Sri Lanka	Bangladesh
1	11.4	6.7	81.9	14.2
2	11.8	7.6	81.7	14.4
3	11.3	7.7	82.8	12.2
4	12.9	7.5	86.5	18.0
5	13.3	7.7	83.4	20.0
6	12.4	7.3	83.7	19.3
7	14.0	7.3	81.4	21.0
8	14.4	6.6	81.8	20.8
9	15.1	6.5	82.5	30.3
10	15.1	6.1	82.7	36.3
Overall	13.2	7.1	82.8	20.3

Source: Data International Ltd et al, 2001

the insured have higher hospital admission rates and longer stays in hospital, than the poor and the uninsured (Sepehri et al, 2005).

In India, health care utilization and expenditure are higher among the higher income quartiles (Roy and Howard, 2007). The utilization of public facilities and free wards by the upper quartiles is significant indicating high levels of utilization by the non-poor of free and subsidized care meant for the poor.

Inequalities in access exist between urban and rural areas, men and women, and across socio-economic groups in the Pacific region also. (UNESCAP, 2006).

3.6 Social inequity

Significant gaps in immunization exist between various social groups in the Asia-Pacific region (ADB, 1999). Most migrants and mobile populations have limited access to adequate health care. The marginalization of migrants or their exclusion from social participation in host communities compounds the risk of poor health associated with material deprivation and relative poverty (International Organization for Migration, 2005). Although income-based inequities declined for the first dose of polio vaccine in north India between 1993 and 1999, children from upper caste households and male children had a significantly higher likelihood of being vaccinated compared to children from SC/ST (Scheduled Caste/Scheduled Tribe) households and female children (Bonu et al, 2003). Not only vaccination, overall access to health care is found to be lower in districts where there is predominance of populations from the scheduled castes and tribes. (Ager and Pepper, 2005).

CHAPTER 4

CAUSAL FACTORS

Causal factors include those within and outside the health sector. While low incomes and narrow revenue base of the countries call for more drastic measures including external efforts to fund those countries, health system factors demand efforts from within.

4.1 Low incomes and GDP

The size of spending on health by each country and its health status, to some extent, depends on its economic context. A scatter diagram illustrating the relationship between GDP per capita and life expectancy at birth in 34 low and middle income Asia-Pacific countries reveals that life expectancy increases with GDP per capita, and the trend continues till the per capita GDP reaches about US $10,000 (Figure-3). The expenditure on health as a proportion of GDP declines during the initial phase of GDP growth (up to a per capita GDP of US $1,500) and registers a sharp increase after that (Figure-4). The same pattern is observed globally also. However, the Asia-Pacific region, in general, accounts for 61.0% of the world's population but shares only 33.9 per cent of world's wealth (Davies et al, 2006). Distribution of wealth within the region too is skewed leaving many countries disadvantaged (Figure-S2). For instance, Japan, with only 3.4 per cent of share in population, accounts for 29.1 per cent of the region's wealth. On the other hand, China and India, with a joint population share of 61.2 per cent in the region, share only 38.1 per cent of the region's wealth. Figure-S1 brings out the inequity in the distribution of wealth in the region. Countries like Afghanistan, Myanmar and Nepal have poor per capita GDP (less than US $250) incomparable with any other country in the Asia Pacific coupled with low life expectancy.

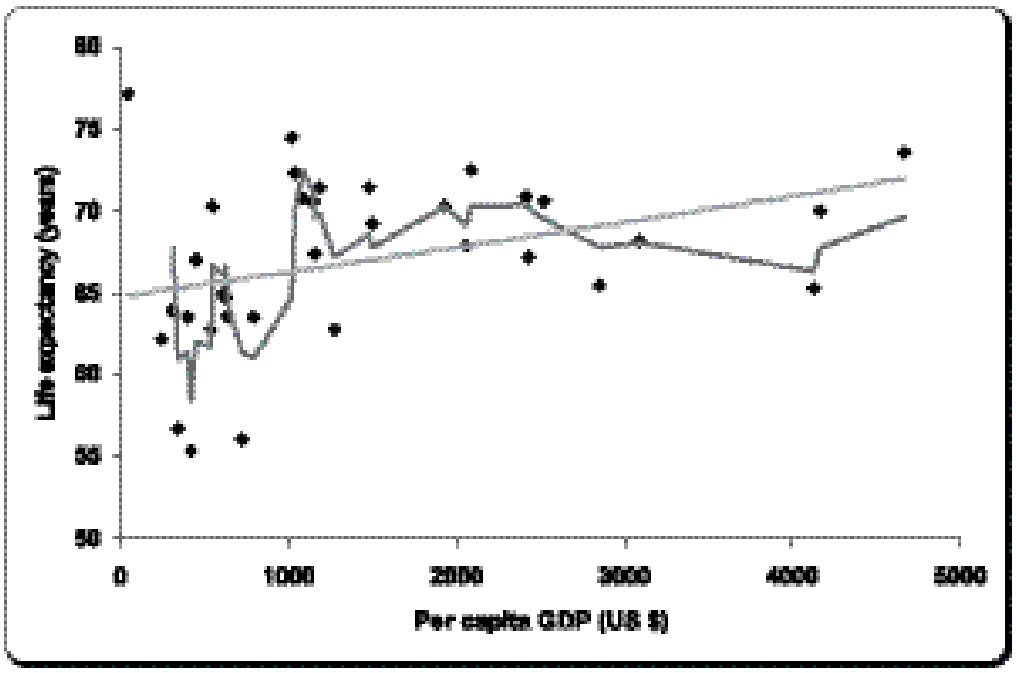
Within countries too, the distribution of wealth is greatly unequal (Davies et al, 2006). For instance, the top 10 per cent of population owns 65.4 per cent of wealth in Indonesia and 52.9 per cent in India. On the other hand, the lowest 10 per cent own 0.0 per cent in Indonesia and 0.2 per cent in India. Even the bottom 40 per cent share a mere 2.8 per cent in Indonesia, 4.0 per cent in Australia, 4.8 per cent in India, 8.7 per cent in Japan, and 9.6 per cent in China. Poverty is 20-50 per cent higher in rural areas compared to urban areas; it is still higher among families with five or more members (World Bank, 2004). There is seasonal poverty in countries like Mongolia where poverty is 41.6 per cent higher during winter than during summer (World Bank, 2005). Poverty is also high among unskilled informal sector labour and landless households within the region (UNICEF, 2007).

4.2 Poor revenue base of governments

While income is a major factor determining the overall health spending between and within nations, the government's financial role seems to be limited by its tax collection capacity and the revenue base. The broader the revenue base, the higher would be the possibility for the government to invest in sectors like health. The Asia-Pacific region is the most disadvantaged region in the world with the narrowest government revenue base of 16.6 per cent of GDP (WHO, 2006). In other words, the spending ability of governments in Asia-Pacific is weak. The revenue base of many provincial governments within the Asia-Pacific countries too is weak (WHO and

Figure-3[12]

Per capita GDP and life expectancy in low and middle income Asia-Pacific countries in 2004



Source: World Bank, 2006 and WHO, 2004

Government of China, 2006, NCMH, 2005, Bossert and Beauvais, 2002 and World Bank, 2002).

Nevertheless, the government share of health spending has not increased even in countries like China, India and Viet Nam where the economy has been doing well recently. For instance, economic revival in Viet Nam has not helped the health sector where the government share has declined from 32.7 per cent in 1996 to 28.5 per cent in 2004 (WHO, 2002). In India and China, the share of government in the total health expenditures showed a declining trend as the GDP grew. Nevertheless, growth of GDP has influenced the health sector favourably in Malaysia where total health spending and the share of government increased during the last decade. Per capita spending and government share of the total health expenditure have been increasing in Thailand also.

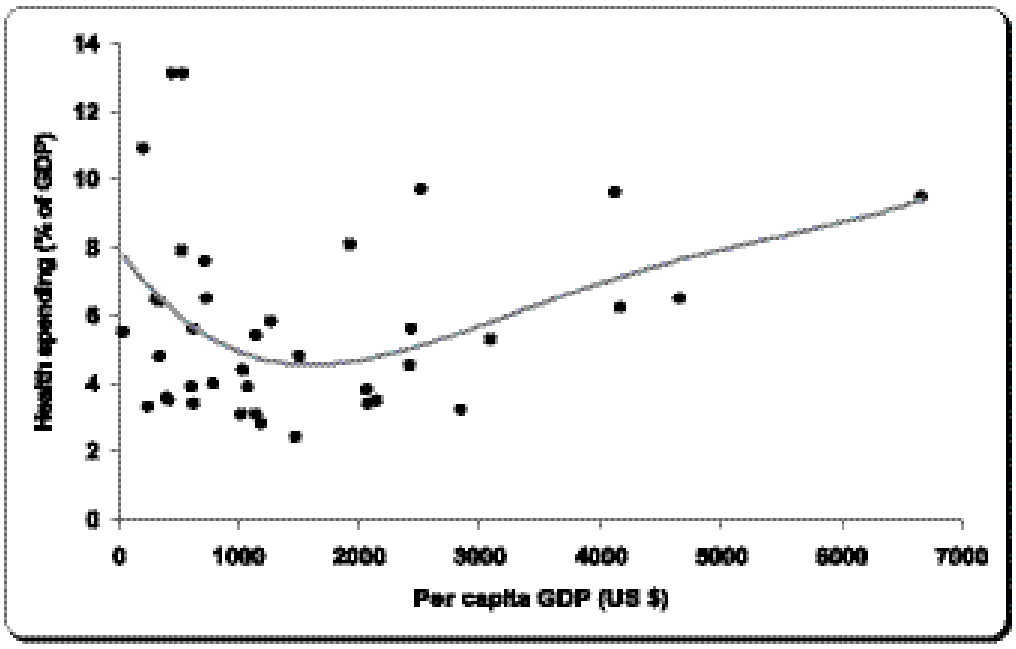
[12] *Scatter, moving average and trend line*

4.3 Health system factors

Due to the lack of health care and other support facilities in many areas, people are unable to access essential health care services such as immunization even if there is a felt need. Access to free government care is inequitable between rich and poor because the system to exempt poor does not work well in almost all countries where poverty is high. Social insurance is also concentrated in a small section of population. A number of economic, social and cultural factors have an impact on the access to health services. For example, women in Afghanistan suffered due to a combination of lack of female health care delivery staff, gender segregation and restrictions placed on the female population by local traditions (Strong et al, 2005). Only 24 per cent of doctors are women and 40 per cent of health care facilities do not have any female health providers at all.

In many countries, women's access to health care is restricted by their weak decision making power within the

Figure-4
Per capita GDP and health expenditure in Asia-Pacific



Source: WHO, 2006 and World Bank, 2006

household (UNICEF, 2007, Varatharajan et al, 2006 and IIPS, 2000). For more than 50 per cent of women in India and Nepal, a male family member takes a decision concerning the health of women; the percentage is 48.1 per cent in Bangladesh. Rural women are more disadvantaged and only about 25 per cent of rural women can take decisions to seek health care for themselves. They are also not allowed to keep or spend money even if they earn it. High rates of maternal mortality are associated with limited access to health care services for expectant mothers. Even children's access to health care is restricted due to their mothers' lack of decision making power.

Better accessibility, appropriateness, effectiveness and efficiency of the public health care system largely enhance its utilization by the population (World Bank, 2006b). If efficient, public health care systems can serve as important factors in determining the treatment cost even in private health care institutions. Elimination of inefficiency also acts as a source of finance for the public health care system, as it is equivalent to a significant increase in the resource availability. Those who would benefit most by improved efficiency are the poor and disadvantaged, who use government facilities more than other groups. However, many studies and reports in the region acknowledge that the public health care system suffers from many drawbacks - both structural and functional (World Bank, 2006a, 2006b & 2006c, WHO, 2006, 2004a & 2002, NCMH, 2005, EQUITAP, 2005 and Liu et al, 2003). There is also irrational use of resources due to lack of regulation of the private sector.

Introduction of user fees may contribute to increasing the inequity in access to health care. User fees as a policy to enhance government resources to health exist in several Asia-Pacific countries including Cambodia, China, India, Indonesia, Kyrgyzstan, Thailand, Viet Nam and Pacific island countries and territories (UNESCAP, 2006, EQUITAP 2005 and Jacobs and Price, 2004). User fees may prevent the poor from gaining access to government health care institutions. More than one-fifth of the out-of-pocket payments is incurred in accessing government health care institutions in India, Indonesia, Kyrgyzstan, Thailand,

and Viet Nam (EQUITAP, 2005). In Cambodia, user fees while enhancing quality may have prevented the poor from accessing public health care facilities (Jacobs and Price, 2004).

The inefficiency of government health care systems combined with the absence of risk pooling mechanisms, are resulting in unreasonably high household out-of-pocket health spending and resultant impoverishment. Organized forms of private spending through risk pooling mechanisms hardly exist in many countries due to a variety of reasons. While governments openly acknowledge the existence of household out-of-pocket spending, financial barriers to health care and the resultant impoverishment, actions to rectify these gaps are inadequate. The main reason for this inadequate action seems to be governments' inability to raise adequate resources for health.

CHAPTER 5

NATIONAL POLICIES AND STRATEGIES

The greatest challenge in Asia-Pacific is to find adequate resources to address diseases/conditions affecting the most disadvantaged populations. While the relative proportion of the poor in the total population has decreased in many countries, the numbers of poor people have increased in absolute terms, indicating that countries are required to deal with more poor people. The disease burden and its intensity are also disproportionately high in poor and rural countries. Hence, the key inequity found in Asia-Pacific nations is the mismatch across, and within countries between needs expressed in terms of disease burden and resource allocation expressed in terms of GDP share. Gaps in resource requirements are as high as billions of dollars.

The MDGs have provided a major international policy direction to developing countries and donors to re-orient their focus vis-à-vis health. The focus of the international organizations such as WHO and the World Bank has also shifted towards helping countries develop and work towards a more complete set of health goals that would suit their situation (World Bank, 2006b and WHO, 2003).

5.1 Universal access to health care

National policies of many countries in this region imply an intent to provide universal access to health care by strengthening the publicly financed institutions (UNESCAP, 2007). Table-6 summarizes some national polices concerning equity in the region. While equity in access to health care refers to the provision of basic essential services in Bangladesh, India, Kyrgyzstan, Nepal and Sri Lanka, it means provision of high quality care in Hong Kong and Indonesia. In Malaysia, Mongolia, Philippines, Republic of Korea and Thailand, the policy on equity targets affordability of care. In essence, the policies address physical access to minimum care, quality of care and affordability or removal of financial barriers. They also reflect the economic strengths of the countries. While low-income countries strive to achieve minimum standard of care, the focus of high-income countries is on quality and affordability.

There has been a drive to enhance physical access to care through social marketing, decentralization, strengthening of the government health care system, regulation/accreditation of private sector and shifting efforts towards preventive and primary health care. In the Pacific region, countries such as Fiji, Samoa and Vanuatu focussed their policies on improving policy, planning and management of health services as well as health care financing arrangements (UNESCAP working paper, Tukuitonga, 2006).

5.2 Policies targeting higher spending

In an attempt to make the national policies and strategies operational, recent national efforts have all advocated higher share of resources for health (WHO, 2006c). Since the financial requirements of the low-income countries far exceed the needs, donors need to step in to fill the gap. Organizations such as the United Nations Development Programme (UNDP) have been working on strategies to attract more resources towards achieving the MDGs (UNDP, 2006). National and sub-national level drives for mobilization of additional resources include measures such as increasing the government budget for health (tax-based

Table-6

National policies on equity in access to health care in Asia-Pacific

Country	Policy statement
Bangladesh	Ensure basic/essential health services particularly to the poor communities
Hong Kong	Everyone should have equitable access to quality health care for comparable needs
India	Reduce inequities and allow disadvantaged sections of society a fairer access to public health services
Indonesia	Provide quality, equitable and affordable health services to all Indonesian people including the poor
Kyrgyzstan	Shift from a system of reliance on hospitals to the development of primary health care services
Malaysia	Legislate to ensure affordable health care
Mongolia	Provision of government financing to cover drug costs for catastrophic or prolonged illness regardless of ability to pay
Nepal	Provision of essential health care services within 30 minutes of travel time
Philippines	Universal coverage of health through Social Health Insurance to reduce out-of pocket expenditures
Republic of Korea	Reform Social Health Insurance to ensure equitable contributions based on the ability to pay
Sri Lanka	Government provision of a minimum standard of care based on needs irrespective of class, creed, economic status, age, gender, etc.
Thailand	Universal coverage of equal access to quality health services through health insurance

Source: UNESCAP, 2007

finance), imposing user fees (with exemptions for the poor), and introducing risk pooling mechanisms such as social health insurance and community-based financing (Dixon-Woods et al, 2006, WHO and Government of China, 2006, UNDP, 2006a, Laverack, 2006, Varatharajan and Anandan, 2006, Government of India, 2005, NCMH, 2005, Liu et al, 2003, WHO, 2002, Bossert and Beauvais, 2002, and ADB, 1999).

5.3 Reaching the poorest

Strategies adopted by different countries to cover the poor effectively vary from shifting resources to primary health care in Kyrgyzstan and India, exemption from user fees in Bangladesh, adjusted/subsidized insurance premiums in Republic of Korea, and safety nets in Hong Kong (UNESCAP, 2007). In the majority of the countries, the boundary between the poor and the rich is drawn based on rural-urban divide assuming that a vast majority of the poor live in rural areas. In addition to the poor, other disadvantaged groups identified by the policies are children, disabled, elderly, migrants and women. In order to enhance the poor people's access to health care, a new intervention called 'Health Equity Fund' was piloted in Cambodia (Hardeman et al 2004). Details of the Health Equity Fund are given in Box-3.

Box-3
Cambodia's Health Equity Fund

In September 2000, the task of identifying the poor and exempting them from paying the user fee in a poor rural area of Cambodia was assigned to a local NGO (Non-Governmental Organization) through the 'Health Equity Fund'. The Fund identifies the poor and pays the user fee on their behalf. So, it acts as a 'third party payer' for those patients who cannot pay the user fee. Poor patients are identified using a socio-economic status score based on the details provided in a self-reported questionnaire. The heath care delivery staff identifies patients who cannot pay the user fee and refers them to the NGO. The NGO also actively searches for the poor among those who might have already paid the user fee. The second type is based on the observation of the patients who may lack essential food, cloth, utensils, mosquito net, etc.; it tries to prevent the impoverishment by way of borrowing and selling of assets.

All the identified patients are assessed for their ability to pay based on physical appearance, food security, housing, occupation and assets. The criteria used for including the extreme poor are flexible to capture all dimensions of poverty. The level of required financial support is determined on a case-by-case basis. The support varies from a partial payment to full coverage of hospitalization expenses including transport charges, food and other essential items. Follow-up visits are made to ascertain further needs.

An assessment of the functioning of the Fund indicated that the probability of identifying and supporting an extremely poor person was high although the chance for falsely including the non-poor did exist. The Fund thus helped in reducing the inequity in access based on income, location and gender.

Source: Hardeman et al, 2004

Similarly, Viet Nam introduced a scheme called 'Health Care Fund for the poor' in 2003 (Box-4). China's New Cooperative Medical Scheme is also designed to relieve the rural residents of an excessive burden from financing health care. Thailand's universal health-care scheme under implementation since 2001 has been another effort to improve the access to government health care facilities. Tamil Nadu state of India in 1997 brought a simple re-organization of drug supply to government health care institutions in order to enhance the access to drugs in rural areas, especially for primary care (Box-5). Decentralized governance of public health care facilities was another policy receiving attention in the region (Varatharajan et al, 2004, Bossert and Beauvais, 2002).

Box-4
Health Care Fund for the Poor in Viet Nam

In order to serve the poorest and the disadvantaged, the government of Viet Nam in 2003 brought out a scheme known as 'Health care fund for the poor'. The scheme, receiving funds from central and provincial governments, laid out clear eligibility criteria to identify the beneficiaries, who are identified based on the processes already in place. Although other disadvantaged groups were identified easily, the most difficult group to identify was the poor. Fresh household surveys were conducted to identify them. The proposed beneficiary list was finalized after a public debate and vote at the commune level. Eligibility certificates were issued to all identified beneficiaries. Care could be obtained at all levels of government facilities and certain contracted private facilities. Beneficiaries were not required to make any deposits or co-payments at the facilities. Although the scheme was introduced in 2003, it has undergone many modifications until 2006 based on experience.

An analysis of the scheme's impact on access to care found an increased utilization of services and reduced risk of catastrophic out-of-pocket spending. However, the favourable impact was seen only in the utilization of in-patient services. In the case of out-patient services, even the poor patients incurred considerable amount of out-of-pocket spending. Moreover, even among poor, those better-off benefited more.

Source: Wagstaff, 2007

Box-5
Managing drug delivery to primary health care centres

In 1995, India's Tamil Nadu state implemented a successful model for efficiently managing the drug delivery to government health care institutions such as Primary Healthcare Centres (PHCs). Tamil Nadu Medical Service Corporation (TNMSC), an autonomous government agency, supervised by a 9-member board[13] and managed by outsourced/deputed staff, implements the model. According to the model, each PHC is allotted an annual fund, known as 'passbook value' which is determined by patient load, to be used periodically to order the required medicines. The Medical Officer heading the PHC periodically prepares the order for medicines keeping in mind the budget, the WHO model list of essential drugs, medicine utilization, seasonal morbidity and expected patient load. During an emergency, the PHC can draw medicines at anytime to the extent necessary. The PHC can overshoot the budget by 10.0 per cent in any year and during an emergency.

The ordered medicines reach the PHC in 10 days from the district level computerized warehouses. Functioning round the clock, the warehouses adhere to international norms and are maintained through annual maintenance contracts. They are also insured against unforeseen calamites. A State level demand assessment is based on a computer-generated mathematical model which incorporates disaggregated consumption patterns. District warehouses stock requirements for three months' duration, while a stock of two months' duration is in the pipeline. Purchase orders are placed once in 15 days for items that go below the five-month 'reserve' level of stock. The computers automatically allot items, quantity and place to be supplied.

The procurement of stock is through an 'open tender system' and only from manufacturers/direct importers with 'good manufacturing practice' certificate. Suppliers are levied liquidated damages for delayed supply and are 'blacklisted' after three such delays. Frequent quality testing is done through random testing. Suppliers/manufacturers with three consecutive batches of failed samples are 'blacklisted'.

The successful functioning of this model is one of the major reasons for the state reporting a lower level of household out-of-pocket spending (NCMH, 2005). The model enhanced the range of drug choice available to the rural population through government health care institutions at a reduced budget. As a result, utilization of primary care facilities increased thus reducing the reliance on household out-of-pocket spending.

Source: Senthil Arasi, 2004

[13] *Its members are State Health Secretary (Chair person), Directors of Medical Education, Medical Services, Public Health, TNMSC, Drug Control, and RCH, Government Chief Engineer (buildings), and a representative from the state Finance Department.*

CHAPTER 6

WHAT WORKED AND WHAT DID NOT

In general, there seems to be a desire to move towards desirable level of equity in the region. Malaysia, Republic of Korea, and Sri Lanka are recognized good performers and continue to do well (ADB, 1999). The Philippines also showed some good progress in health status due to certain health sector reforms. Reasonably good economic performance resulted in poverty reduction from 29.5 per cent in 1996 to 11.6 per cent in 2002 in East Asia and Pacific region (World Bank, 2006). There are good models developed within the region that can be adapted taking into account the specific country situations.

6.1 Policies targeting higher spending

Policies targeting higher expenditure for health met with limited success. While the public expenditure as a proportion of GDP and per capita health spending has been increasing in the majority of countries, they have not reached the required level. The major challenge for the low-and middle-income countries is not about getting the numbers right but how to get there given their inelastic fiscal situations. Policies which advocate an increase in public health expenditure as a proportion of GDP need to address the ways to do so. Narrow revenue bases in developing countries make their task difficult. Malaysia proved to be an exception as it was able to increase government resources to health. On the contrary, government allocation to health care as a proportion of the GDP declined in China, India and Viet Nam despite their encouraging economic progress. The generation of donor funding to fill the gap has not been adequate (WHO, 2003).

User fees as a policy to enhance government revenue have met with limited success. It was successful to a limited extent in tertiary facilities such as Teaching Hospitals. However, it has failed to enhance resources for and access to primary health care. Despite its potential benefits, the real impact of collaboration or partnership (public-private or private-private) on enhancing resources for health care is also largely unknown; where it is known, it is found to have very limited impact or the evidence is inconclusive.

6.1.1 Health insurance

Efforts to develop risk pooling options as part of the strategy for sustainable financing of health care are yet to yield desirable results in many countries of the region. Effective coverage of social insurance is below 50 per cent of total health spending even in countries where it has been under implementation for a long period of time. Economic development, in particular its tendency to lead to the expansion of formal sector employment and strengthening of government capacity, is an important pre-condition for successful implementation of a social insurance strategy to achieve universal access to health care (UNESCAP, 2007). The urban health insurance reform initiated in China in 1994 seems to have resulted in some improvement in equity in access to primary care (Liu et al, 2002). Although it was seen as an improvement over the earlier approaches of the government, the evidence is limited and on a small scale. Many pre-payment schemes in China have collapsed, ultimately resulting in heavy out-of-pocket payments (EQUITAP, 2005a). Despite the best efforts by many governments, private health insurance plays an insignificant role in most countries of the Asia Pacific while social insurance is still at an early stage of development in this region. In developing countries with a large informal sector, only the tax-financed approach has proved successful.

6.2 Universal coverage

Universal coverage has been achieved in Australia, Japan, Mongolia, New Zealand, the Republic of Korea, and Thailand through a mix of general and earmarked taxation and social and private health insurance (WHO, 2005a). China, Indonesia, Lao PDR, the Philippines and Viet Nam have introduced social health insurance but the challenge there is to extend the coverage to the population employed by the informal sector which accounts for the majority of the population. Universal coverage is also promoted through establishment of safety nets targeting vulnerable and low-income populations.

Cambodia's experiment with 'Health Equity Fund' seems to have had some success in eliminating inequity in access to health care based on income, location and gender (Hardeman et al, 2004). However, Viet Nam's 'Health Care Fund for the poor' has had mixed impact on access to health care (Wagstaff, 2007). The poorest 20 per cent constituted over 50 per cent of the beneficiaries indicating that the scheme targeted the poorest. Still, the scheme appears to have not met its targeted level of coverage. Moreover, some of the poor people still incurred considerable out-of-pocket spending despite being identified for receiving 'free care'. China's NCMS is still in the process of expansion and so, results would be known only in future.

Thailand's universal health care scheme seems to have had a desirable impact on access to care in public sector institutions. There has been a 40-50 per cent increase in out-patient visits to public sector institutions in 2003 (Pachanee and Wibulpolprasert, 2006). As a result, the proportion of people skipping treatment declined from 16.8 per cent in 1991 to 5.7 per cent in 2003 and those on self-medication declined from 37.8 per cent in 1991 to 22.5 per cent in 2003.

The progress towards holistic achievement of the health-related MDGs suffered from certain drawbacks especially from an equity point of view, as indicators were expressed in national averages without accounting for subnational variations. Improvement in national averages may mask a worsening situation among disadvantaged groups such as the rural population or the poor. The targets and indicators which track MDG achievement do not address comprehensive health system strengthening (UNFPA, 2006). It is clear that in many low-and middle-income countries the health-related MDG targets will not be attained - or, more importantly, sustained - in the absence of significant all round strengthening of their health systems. As a result, some developing countries view the MDGs as unreachable and as another form of conditionality.

6.3 Learning from successes

Two experiences of countries in this region - Malaysia and Sri Lanka - are analyzed below as examples of achieving good health outcomes at lower levels of economic development through tax-funded approaches which effectively expanded access to health care for disadvantaged population.

6.3.1 Malaysia's success

Malaysia's experience of health system development is often cited as a good example. The country's approach to health system development can be termed as 'client-centric and pro-rural'. The country's Total Quality Management (TQM) approach aiming at resource utilization and client satisfaction can be regarded as one example for its client-centric approach (UNFPA, 2006). In Malaysia, health is treated as an integral part of development. Health sector interventions are further enhanced by strengthened nutrition programmes, improved sanitation, home visits and exemption from user fees for essential services. The government budget towards health was increased and the poor were targeted through specific policies, strategies and actions.

Malaysia expanded the network of free government health care facilities during the 1960s (UNESCAP, 2007). Political will was the major requirement for the health system development in Malaysia. There was also an emphasis on providing care to the poor including hospital care. Accessible and equitable health care was extended to most of the population, at a relatively low cost. This is evident by analysing almost all the commonly used indicators. For instance, a recent study found that the majority of the population in Malaysia had access to affordable essential medicines and the average availability of key medicines in the public health clinics for the country was estimated as 95.4 per cent (Saleh and Ibrahim, 2005).

6.3.2 The Sri Lankan experience

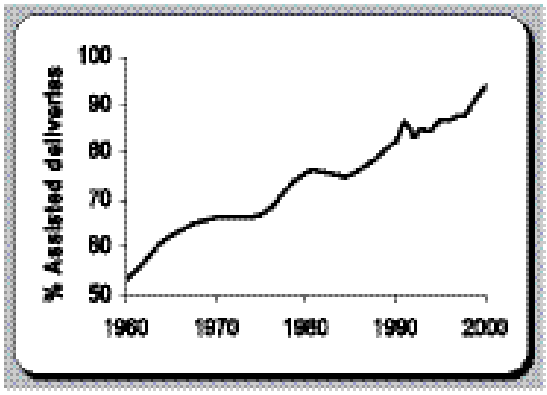
Sri Lanka is the one of the poorest countries in Asia to have achieved universal coverage, and was able to do so when its per capita GDP was below US $ 500 (UNESCAP, 2006). The positive achievements were the outcome of a mix of policies - free health care, free education, development of agriculture, and subsidized rice (Gunatilleke et al, 1998). Sri Lanka recognized very early the importance of the government role and higher spending on health. Government spending was consistently above 1.5 per cent of GDP since 1950 and was even above 2.0 per cent of GDP during the 1960s (Central Bank of Sri Lanka, 2004, WHO, 2002b and Sanderatne, 2000).

The expansion and improvement of the health care infrastructure was largely responsible for the decline in mortality and improved health status. In fact, the decline in the crude death rate coincided with the development of health care facilities in the country during the 1930s. In the 1940s, maternal homes were established in the 1940s such that by 1950 over half of the deliveries occurred in institutions. By 1950, Sri Lanka had built an infrastructure that was more extensive in rural areas than is the case of present-day South Asian countries. Although the population grew faster during the 1950s and 1960s, the number of health care facilities improved faster, resulting in an improved per capita access to health care facilities. As a result, births attended by skilled personnel increased from 53 per cent in 1960 to 93.9 per cent in 2000 (WHO, 2003a) As a result, maternal deaths declined significantly during 1960-2000. This example demonstrates the gains of health spending and Figure-5 provides evidence of the impact of health system development on maternal mortality. Overall access to out-patient and in-patient care also improved such that the access to health services during the 1960s was equivalent to that of a developed country and was more than 3-4 times that of present-day access in countries such as Indonesia, Bangladesh and India (UNESCAP, 2007).

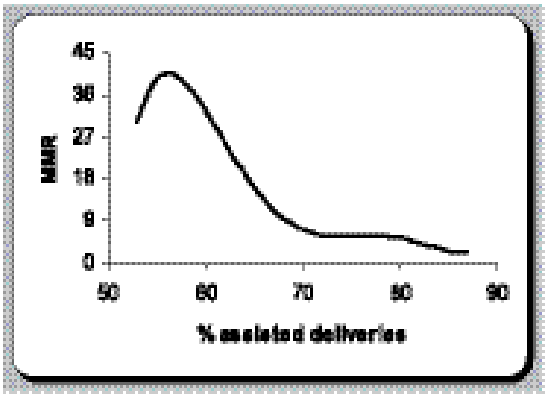
One of the major factors responsible for the substantial expansion in government health services since the1930s was the government's realization that lack of health care services was a major cause of impoverishment of the rural population and that the provision of free government health care services would help mitigate this situation (UNESCAP, 2007). Presently, Sri Lanka does promote private sector health services by allowing it to operate along with the public sector essentially to filter the rich from using the tax subsidy meant for the poor; the rich voluntarily use private sector services and willingly bear the out-of-pocket spending, especially for out-patient care. For in-patient care, which has the catastrophic potential, both the rich and the poor approach the public sector facilities.

Figure-5
Sri Lanka
Assisted births and their impact on maternal health

Trend in assisted deliveries



Impact on maternal deaths



Source: WHO, 2003a

CHAPTER 7

POSSIBLE FUTURE OPTIONS

Key issues identified in this report are the inadequate allocation of public resources to health, higher reliance on household out-of-pocket spending, inefficient use of existing resources and pro-rich bias in access to health care. Resource allocation to health is particularly poor in countries and sub-national territories whose resource needs are high. The examples from Malaysia and Sri Lanka demonstrate that the role of government is crucial in health system development especially wherever the level of poverty is significantly high. Inadequate government spending forces the population to use out-of-pocket resources financed through savings, foregone consumption, borrowing, and distress selling of assets. Catastrophic out-of-pocket spending has the potential to impoverish people. Although some forms of inequities are highlighted in the report, they are indicative but not exhaustive given the broad nature of the report. One way to start re-orienting the health systems towards serving the poor better is to establish objectives and targets to ensure that the poor benefit fully from the services provided.

7.1 Mobilization of resources

Mobilizing sufficient health care resources to strengthen health systems in order to provide universal access to health care is one of the most challenging tasks in the region. The amount of resources for health available at present in many countries in the region is hardly adequate even to meet the minimum essential needs, including immunization. They do not match with levels of spending in other regions or the reasonable optimum of 5.0 per cent of GDP. Even governments of countries such as China, India and Viet Nam, whose economies have been doing well, are not committing adequate resources for health. Hence, the imperative is to increase the size of spending for health to at least 5 per cent of GDP in countries where it is presently lower. Out of this, at least half or 2.5 per cent of GDP should come from the government if the health care access of the poor and other disadvantaged populations is to improve.

Higher budgetary allocation through tax-based sources, contributions to social health insurance, community financing through micro finance, earmarked funds for health through taxing of tobacco, petroleum and other products, and voluntary contributions are some of the options available to mobilize resources for health. Efficient use of the existing resources itself would act as an advocacy tool for achieving higher resource allocation to health (WHO, 2006c). Nevertheless, given the narrow revenue base in many developing countries in the region, even a sharp increase in allocations for health as a proportion of the total government budget, may yield limited resources for health. Hence, in least developed countries, there is a need to bring in external (donor) resources whose contributions have been below expectations.

7.2 Streamlining out-of-pocket spending

Efficient organization and use of the existing resources not only serves as an advocacy tool but increases resources available for health. With efficient use of the resources, a significant proportion of resources, could be saved and released for alternative uses. On the other hand, the share

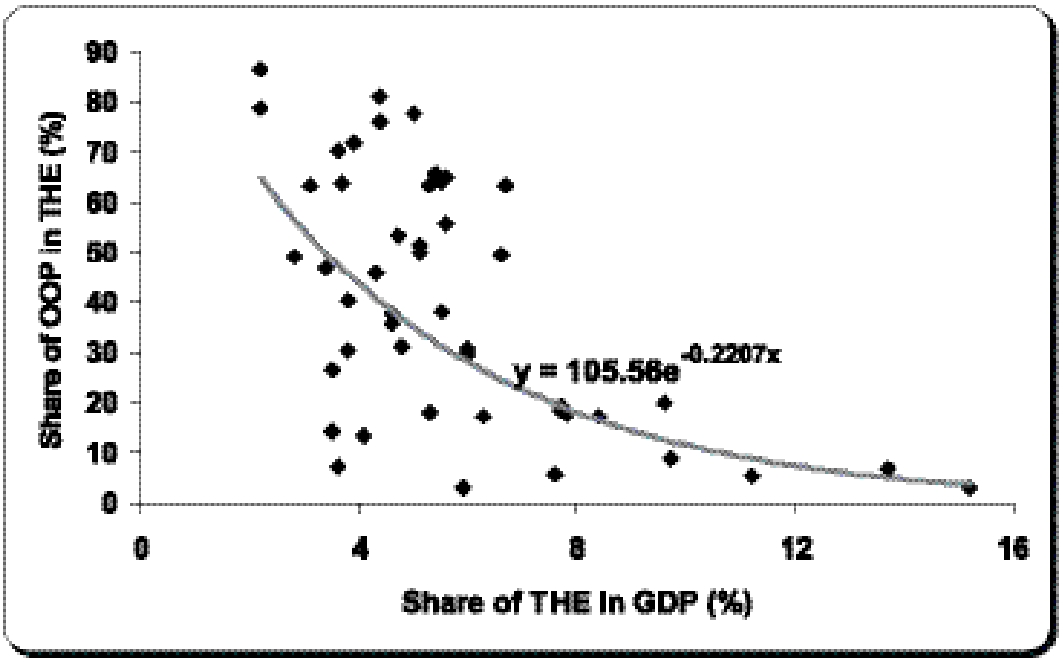
of out-of-pocket resources in total health care spending indicates the inefficient organization of health care resources. An outcome of high out-of-pocket spending is health shocks,[14] after which those affected spend less on food and other essentials (Wagstaff, 2007a).

Increased total health care spending in many countries in the region has been fuelled by an increase in out-of-pocket spending by households. Hence, it is necessary to find innovative ways to streamline private out-of-pocket spending. Documentation and dissemination of the scattered evidence on innovative experiments to streamline out-of-pocket expenditure would be a step towards effective regional cooperation contributing to the efficient organization of health care resources in the region. Given the degree of inequity and varied health care and socio-economic context in the region, mixed financing models may be required, rather than a single model like tax funding, social health insurance or community health financing.

Evidence in the Asia-Pacific region shows that the share of household out-of-pocket (OOP) spending on health declines with an increase in total health expenditure (Figure 6) and an increase in government health spending as a proportion of GDP. In other words, the relative share of household out-of-pocket spending can be reduced by increasing the size of total resources allocated to health. However, reductions in OOP are not automatic, but only achieved if the increased quantum of total resources for health also increases significantly the share of pre-paid (government/contributions) resources.

Figure-6

Share of Total Health Expenditures (THE) in the Gross Domestic Product (GDP) versus out-of-pocket (OOP) as a share of THE in Asia-Pacific



Source: *WHO, 2007*

[14] *Measures of household health shocks used include a recent death of a working-age household member, a long inpatient spell, and a recent sizeable drop in the body mass index of the household head.*

7.3 Resource targeting

Resources meant for the poor and other disadvantaged groups have not reached them properly. Government subsidies meant for the poor are disproportionately utilized by the non-poor in some countries of the region. Expenditure that is incurred by the poor (or marginal poor) even while accessing the government health care system is a serious problem. Government resources tend to be concentrated in national capitals, cities, and other urban areas where a 'market for health care' also exists. At the same time, rural and disadvantaged areas lack adequate infrastructure, staff and drugs. Rural people suffer from a double disadvantage as they incur transport expenses for accessing health care, and suffer from wage losses. They are required to travel long distances to receive primary and tertiary care.

Community empowerment may be one option to enhance resource targeting (WHO, 2006c). Evidence from some Asian countries shows that strong linkages between government and rural communities have contributed to improvements in social indicators. Country experiences also highlight the significance of monitoring health and development polices at the local level. Removal of or limiting user fees in disadvantaged geographic areas such as rural areas, where a vast proportion of disadvantaged people live is another way to target the needy. Targeting rural areas seems to be the current policy for targeting health care resources in China and India (WHO and Government of China, 2006 and Government of India, 2005). One disadvantage of this approach, however, is that the rural population is widely scattered and has a relatively low population density. It means that services have to be distributed as per geographic norms, not on the basis of population norms, as it is presently followed in many countries.

Another aspect of resource targeting is service targeting in order to correct the discrepancy across services. For instance, a large share of out-of-pocket spending is concentrated on drugs partly due to low or inefficient government spending on drugs. Tamil Nadu state in India has demonstrated that a simple re-organization of their drug supply and distribution not only improved the drug availability drastically in government health care institutions but also released about 25 per cent of government drug spending for other purposes. It also significantly reduced the reliance on household out-of-pocket spending, as indicated by the evidence that the state has one of the lowest shares of total and out-of-pocket health spending in the country (NCMH, 2005). Hence, higher and efficient government spending on drugs may be the single-most effective strategy to reduce impoverishment and inequity in health care financing.

7.4 Efficiency and good governance

Many national governments and international organizations acknowledge that government facilities in developing countries are functioning at the sub-optimal level due to inefficiency and lack of proper governance. Eradication of corruption, provision of performance-linked incentive to government staff, and competition are some measures with potential to improve governance. Sri Lanka's success in controlling the informal payments provide a good example of the role corruption control can play in enhancing access to health care. Weak human capital is another area requiring attention. Countries and regions are being now ranked based on their governance with an overall aim to enhance efficiency and governance. However, there are no easy and quick measures and sustained efforts are required to remedy the situation.

CHAPTER 8

RECOMMENDATIONS FOR THE REGIONAL TWG ON HEALTH

This report has identified four key impediments in the process of attaining universal access to health care in the region. First, the quantum of resources available for health care in general and from the government in particular is low in many countries. Although there is no clear prescription for the optimal health spending, at least 5-6 per cent of GDP can be used as a general benchmark. The spending would still fall short of the world average. Second, the share of household out-of-pocket health spending is unacceptably high in the region. Again, there is no clear acceptable limit for the level of out-of-pocket spending. However, it normally should not exceed 50 per cent of the total health spending in any country if catastrophic health expenditures are to be avoided. Third, benefits from the available resources, including government resources, are largely drawn by the advantaged sections of the population such the rich, men and urban inhabitants. Lastly, there are efficiency issues concerning the cost-effective spending of the available resources. Efforts of the TWG should be focused on these four broad issues.

8.1 Draw up realistic options for the countries

Following MDGs, policies of many countries in the region have already brought health into the development focus. However, defining the resource requirements for health or finding realistic options to get there is proving to be difficult. Ideally, a minimum overall health spending of 5.0 per cent of GDP, with at least half coming from government spending and less than 50 per cent of total health care resources being sourced from household out-of-pocket spending are targets for countries in the region to work towards. While many countries are aware of the issues, the small revenue base restricts the ability to generate resources on a sustained basis. Introduction of policies such as user fees have not contributed resources, especially for essential care. It also increases out-of-pocket spending. In this context, *the TWG could help the governments with context-specific realistic options for raising more resources for health.* Flow of external resources to health is still limited for countries in the region. *The TWG may help in tracking the flow of developmental assistance for health from developed nations and other donors towards disadvantaged countries in this region.*

Governments of countries in the region whose economies are performing well can allocate more to the health sector. While going through the process of economic reform, countries had hoped that resources for health could be raised through improved efficiency and higher incomes of the citizens. This does not seem to have materialised fully, and disparities are increasing. Using various available forums, the TWG could continue to advocate that governments allocate more resources for health. Mobilization or streamlining of donor resources could be an option in least developed countries.

8.2 Learning from successful experiments

Countries in this diverse region, ranging from the developed to the least developed countries are in the process of undertaking health sector reforms. Sharing of information and experiences regarding such reforms could help countries in the region.

The TWG, in coordination with respective governments, could develop ways to document, and share as well as suggest ways to adapt, replicate and scale up successful models of ensuring health equity between countries in the region. Joint efforts are needed to pool resources so that they flow synergistically in a positive direction. There is also a need to accord priority to models that have been successful in addressing multiple inequities.

8.3 Development of non-insurance health financing mechanisms

Another area requiring attention from the TWG is the analysis of various options available for sustainable health financing in the region. Implementation of risk pooling tools such as social health insurance and community-based health insurance could be further explored. *The TWG could work with governments and other agencies to develop viable health financing options taking into account the specific needs of countries within the region.*

8.4 Regional health observatory

The TWG could also coordinate with countries in the region to set up a health system observatory to inform policy makers about the functioning of health systems. The observatory can periodically review the issues of financing, equity, efficiency, and governance. Such an observatory could help the governments to look beyond government resources while advocating countries to sustain their efforts to increase government resources. The observatory could also draw up an inter-sectoral roadmap for effectively utilizing resources available within each country so as to achieve national and regional health goals. Routine health system assessment similar to the one undertaken by the UN Thematic Group on Health in China is another option for the TWG (United Nations Health Partners Group in China, 2005 and WHO, 2004a).

8.5 Health equity bulletin

The TWG could consider the publication of an annual health equity bulletin with a focus on low- and middle-income countries in the region. The bulletin is a cost-effective option for the TWG to inform the countries about their equity scenario. The successful models in reducing the inequity and enhancing efficiency can be promptly disseminated and shared using the bulletin as a knowledge management tool.

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Supplementary Tables
Table-S1. Countries covered by this report

Country	Population			
	Million	Share (%) in Asia-Pacific	GDP (million $)	Per capita GDP ($)
China	1,304.5	33.307	1,931,714	1,480.8
India	1,094.6	27.948	694,703	634.7
Indonesia	220.6	5.631	254,298	1,153.0
Pakistan	155.8	3.977	96,115	617.0
Russian Federation	143.2	3.655	590,365	4,124.1
Bangladesh	141.8	3.621	56,590	399.0
Japan	128.0	3.267	4,622,771	36,127.8
Philippines	83.1	2.121	90,100	1,084.8
Viet Nam	83.0	2.118	45,211	544.9
Turkey	72.7	1.855	302,786	4,168.5
Iran, Islamic Rep.	67.7	1.729	163,447	2,414.3
Thailand	64.2	1.640	161,688	2,517.2
Myanmar	50.5	1.290	11,064	219.0
Korea, Rep.	48.3	1.233	688,962	14,266.0
Afghanistan	28.6	0.730	5,952	208.3
Nepal	27.2	0.693	6,716	247.5
Uzbekistan	26.6	0.679	12,030	452.4
Malaysia	25.4	0.647	118,318	4,667.9
Korea, Dem. Rep.	22.5	0.574	13,763	612.0
Australia	20.3	0.519	637,327	31,363.0
Sri Lanka	19.6	0.500	20,055	1,024.2
Kazakhstan	15.2	0.387	43,152	2,849.1
Cambodia	14.1	0.359	4,884	347.1
Azerbaijan	8.4	0.214	8,680	1,034.9
Tajikistan	6.6	0.166	2,073	318.5
Lao PDR	5.9	0.151	2,487	419.9
Papua New Guinea	5.9	0.150	4,249	721.7
Kyrgyzstan	5.2	0.132	2,145	416.0
Turkmenistan	4.9	0.123	6,167	1,276.0
Georgia	4.5	0.114	5,126	1,145.7
Singapore	4.4	0.111	107,498	24,706.5
New Zealand	4.1	0.105	98,944	24,073.9
Armenia	3.1	0.077	3,577	1,185.9

Country	Population			
	Million	Share (%) in Asia-Pacific	GDP (million $)	Per capita GDP ($)
Mongolia	2.6	0.065	1,612	631.2
Timor-Leste	1.0	0.025	338	346.3
Bhutan	1.0	0.023	729	794.1
Fiji	0.9	0.022	2,619	3,088.6
Solomon Islands	0.5	0.012	258	540.0
Maldives	0.3	0.008	800	2,430.5
Vanuatu	0.2	0.005	316	1,499.3
Samoa	0.2	0.005	357	1,930.3
Micronesia, Fed. Sts.	0.1	0.003	226	2,058.2
Tonga	0.1	0.003	213	2,083.3
Kiribati	0.1	0.003	73	737.7
Marshall Islands	0.06	0.002	135	2,149.5
Palau	0.02	0.001	134	6,678.0

Table-S2

Countries with life expectancy below Asia-Pacific average in 2004

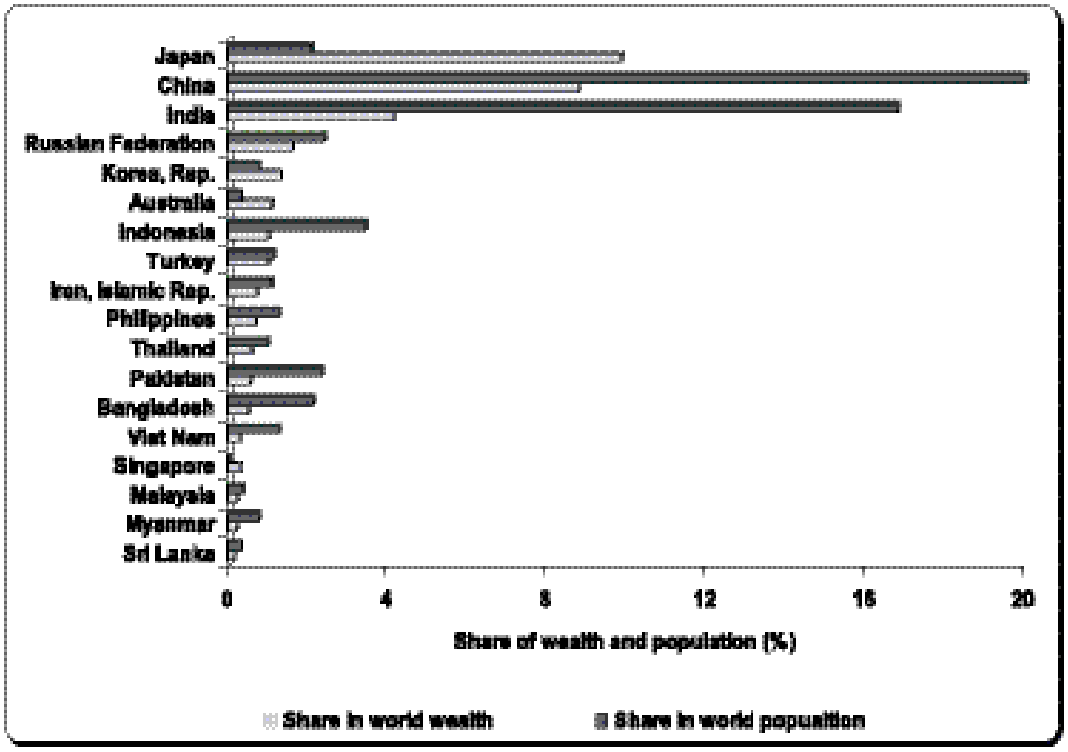
Country	Life expectancy (Years)	Distance (%) from average in the		Distance from the best in the		Person years lost (million) [15]
		Sub-region	Asia-Pacific	Sub-region	Asia-Pacific	
India	63.5	5.0	7.9	17,2	28.8	5,472.92
Bangladesh	63.5	5.0	7.9	17.2	28.8	709.11
Pakistan	64.9	2.7	5.5	14.6	26.0	560.78
Russian Federation	65.2	3.4	5.1	10.9	25.5	472.40
Myanmar	60.8	10.5	12.7	20.9	34.5	389.00
Indonesia	67.4	- 0.3	1.6	9.1	21.4	242.61
Nepal	62.2	7.2	10.1	19.6	31.5	170.94
Cambodia	56.6	18.7	21.0	29.9	44.5	161.45
Korea, DPR	63.6	12.7	7.7	28.6	28.6	110.19
Lao PDR	55.3	21.5	23.8	32.9	47.9	78.20
Papua New Guinea	56.0	24.1	22.3	42.7	46.1	73.59
Kazakhstan	65.4	3.1	4.7	10.6	25.1	46.95
Uzbekistan	67.0	0.6	2.2	7.9	22.1	39.89
Tajikistan	63.9	5.5	7.2	4.9	28.0	28.93
Turkmenistan	62.7	7.5	9.3	15.3	30.5	28.00
Mongolia	64.6	11.0	6.0	26.6	26.6	9.96
Bhutan	63.5	5.0	7.9	17.2	28.8	4.59
Solomon Islands	62.7	10.9	9.3	27.4	30.5	2.77
Kyrgyz Republic	68.2	- 1.2	0.4	6.0	19.9	1.55
Maldives	67.2	- 0.8	1.9	10.7	21.7	0.43
Fiji	68.2	1.9	0.4	17.1	19.9	0.25
Micronesia	67.9	2.8	0.9	17.7	20.5	0.07

[15] *Person years lost = (average life expectancy in Asia-Pacific - actual life expectancy in the reference country)*

Supplementary Figures

Figure-S1

Distribution of population and wealth in Asia-Pacific



Data source: Davies et al 2006

Figure-S2

The extent of wealth-population disparity in Asia-Pacific