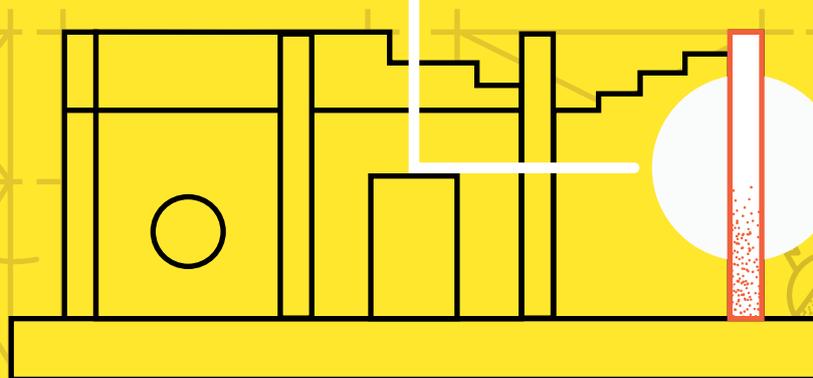


Chapter 6

Protecting the health and well-being of all people: a prerequisite for sustainable development



Universal social health protection is essential to ensure the well-being of people and protect them from falling into poverty. Social health protection provides financial protection against the consequences of ill health and is a core part of a broader effort to achieve universal health coverage.¹³⁹ Despite its importance, health outcomes continue to fall short in many areas. For example, rates of infant and maternal mortality have declined dramatically in recent decades, but they fall short of meeting relevant Sustainable Development Goals targets.¹⁴⁰

Many people are unable to access the care they need, owing to gaps in the coverage, scope and affordability of health care. When individuals forego care, health conditions can result in a plethora of social and economic costs to individuals, families and society, including loss of income, productivity and premature death. High out-of-pocket payments for health-care services can also push households into poverty. Data suggest that in 2015, 13 per cent of households in Asia spent more than 10 per cent of their household income on health, and 72 million were pushed into poverty due to health expenditure.¹⁴¹

Universal access to health care is a human right that has wide-ranging consequences. A healthy population underpins all development efforts. Health is the thread linking nearly every development objective together — as a precondition for and an outcome of sustainable development policies.¹⁴² The COVID-19 pandemic has highlighted how failure to achieve affordable health care can exacerbate disease outbreaks.

6.1 Gaps in coverage and funding

Among all social protection contingencies, the greatest mix of contributory and non-contributory approaches is observed in the provision of social health protection. Many countries in North and Central Asia and the Pacific, as well as a few other

countries in the region, such as Malaysia and Sri Lanka, fund their health systems through taxes (figure 6.1, panel A). Others, such as China, Indonesia, the Philippines, the Republic of Korea and Viet Nam, have systems based on compulsory contributory health insurance schemes that often include subsidies to contributions for low-income individuals and households. Most countries in the region, however, have developed hybrid financing schemes, which combine contributions with funding from tax revenues. An additional approach is the combination of contributory health insurance with non-contributory tax-funded schemes for the poor, such as the Health Equity Funds in Cambodia. Malaysia and Sri Lanka, complement their universal non-contributory schemes with supplementary forms of health insurance, which provide higher levels of protection. Generally, across the region, private health insurance exists in most countries, but the coverage is limited.

6.2 Increasing need for health care makes social protection urgent

The need for health care in the region is increasing, largely driven by population ageing and demand for better services. An analysis conducted by OECD and the World Health Organization (WHO) indicates that across much of the Asia-Pacific region, health expenditure is increasing more rapidly than economic growth.¹⁴³

A large and often increasing part of health expenditure is out-of-pocket payments. In many countries, out-of-pocket expenditures are the main financing source of health expenditure (figure 6.1, panel B). High out-of-pocket expenditures suggest high patient co-payments, or that access and quality of available health care is limited, leading individuals to resort to private care. In the region, out-of-pocket expenditures have fallen as a proportion of total expenditure in Indonesia, Pakistan and Singapore and increased substantially in Cambodia, the Lao

139 International Labour Organization, "Towards universal health coverage: social health protection principles", ILO brief: social protection spotlight, (2020). Available at https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---soc_sec/documents/publication/wcms_740724.pdf.

140 Organisation for Economic Co-operation and Development and World Health Organization, *Health at a Glance: Asia/Pacific 2018: Measuring Progress Towards Universal Health Coverage*, (Paris, OECD Publishing, 2018).

141 World Health Organization, The Global Health Observatory, universal health coverage. Available at <https://apps.who.int/gho/portal/uhc-fp-cabinet-wrapper-v2.jsp?id=1020202>.

142 Zoe Boutillier and others, "SDGs and health: a vision for public policy", G20 Insights, Policy Area: 2030 Agenda, 19 May 2017. Available at https://www.g20-insights.org/policy_briefs/sdgs-health-vision-public-policy/.

143 Organisation for Economic Co-operation and Development and World Health Organization, *Health at a Glance: Asia/Pacific 2018: Measuring Progress Towards Universal Health Coverage*, (Paris, OECD Publishing, 2018).

People's Democratic Republic and Mongolia.¹⁴⁴ Lower figures, however, may also indicate that people do not seek health care in the first place, which could also be related to issues of cost, quality or accessibility.

Reliance on out-of-pocket payments can result in catastrophic health expenditure. This happens when expenditure on health care makes up a large share of total household expenditure (figure 6.1, panel C). The indicator of catastrophic health expenditure is also used to measure progress in achieving Sustainable Development Goal target 3.8, with two benchmarks being measured — 10 per cent and 25 per cent of total household expenditure.¹⁴⁵ For example, in Bangladesh, Cambodia, China, Georgia, Maldives and Tajikistan, more than 1 in 20 households spend more than 25 per cent of their total income on health.

As a response to the COVID-19 pandemic, many countries in the region have injected significant additional financial resources into their health sectors. Australia, China, Indonesia, Japan, Malaysia, New Zealand, the Republic of Korea, the Philippines, Singapore and Viet Nam have channelled additional fiscal resources into the health system through COVID-19 stimulus packages.¹⁴⁶ These packages are used to cover a wide range of expenditures in the health sector. For example, Indonesia directed approximately one fifth of its stimulus package to the health sector, including for purchasing testing and treatment equipment.¹⁴⁷

6.3 The poorest are often denied health-care protection

In some countries, affordable access to health care is achieved through subsidized health insurance schemes, often complemented by non-contributory schemes. A common approach taken in some countries, such as Indonesia, the Philippines and Viet Nam, is to have three tiers of coverage: fully contributory coverage for those in

the formal sector (with an employment relationship); partially subsidized schemes for workers deemed to have contributory capacity; and fully subsidized contributions for groups deemed poor or near-poor. Despite different funding mechanisms, the schemes are channelled through the same social protection institution in these three countries. The result is significant expansion of coverage. As an example, in Viet Nam, health coverage has expanded from 4 to 72 per cent of the population since the implementation of the health insurance scheme.

Nevertheless, gaps often remain in such systems.¹⁴⁸ Figure 6.2 depicts groups with different levels of health-care coverage in Indonesia, using CART analysis. Data from the demographic and health surveys indicate that as of 2017, 58 per cent of the population of Indonesia was covered by some form of health coverage.¹⁴⁹ Yet inequalities are still evident. Almost three-quarters of those with higher education had health-care coverage, compared to only approximately half of those with a lower education in rural areas, indicating intersecting disadvantages, possibly aggravated by the country's complex geography. In both rural and urban areas, individuals older than 35 years were more likely to have health insurance, compared to younger age groups.

Using the same CART methodology, it is possible to compare groups with the lowest, average and highest levels of health-care coverage in ten countries (figure 6.3). The average health-care coverage is below 20 per cent of the population in all countries except Indonesia and Georgia. Strikingly the furthest behind groups in Armenia, the Lao People's Democratic Republic, Pakistan and Papua New Guinea all have coverage rates below 5 per cent. By contrast, in Georgia and Kyrgyzstan, universal health-care programmes provide coverage to more than 90 per cent of the population.

The furthest behind groups are generally low-educated, younger rural people in rural areas (table 6.1). The coverage distribution in Cambodia is unusual, as it is slightly skewed towards the poorest segment of the population. Health-care coverage in 2014 was

144 Ibid.

145 Sustainable Development Goal Target 3.8: Achieve universal health coverage, including financial risk protection, access to quality, essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

146 International Labour Organization, "Social protection responses to the covid-19 crisis: country responses in Asia and the Pacific", 25 March 2020. Available at https://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/documents/briefingnote/wcms_739587.pdf.

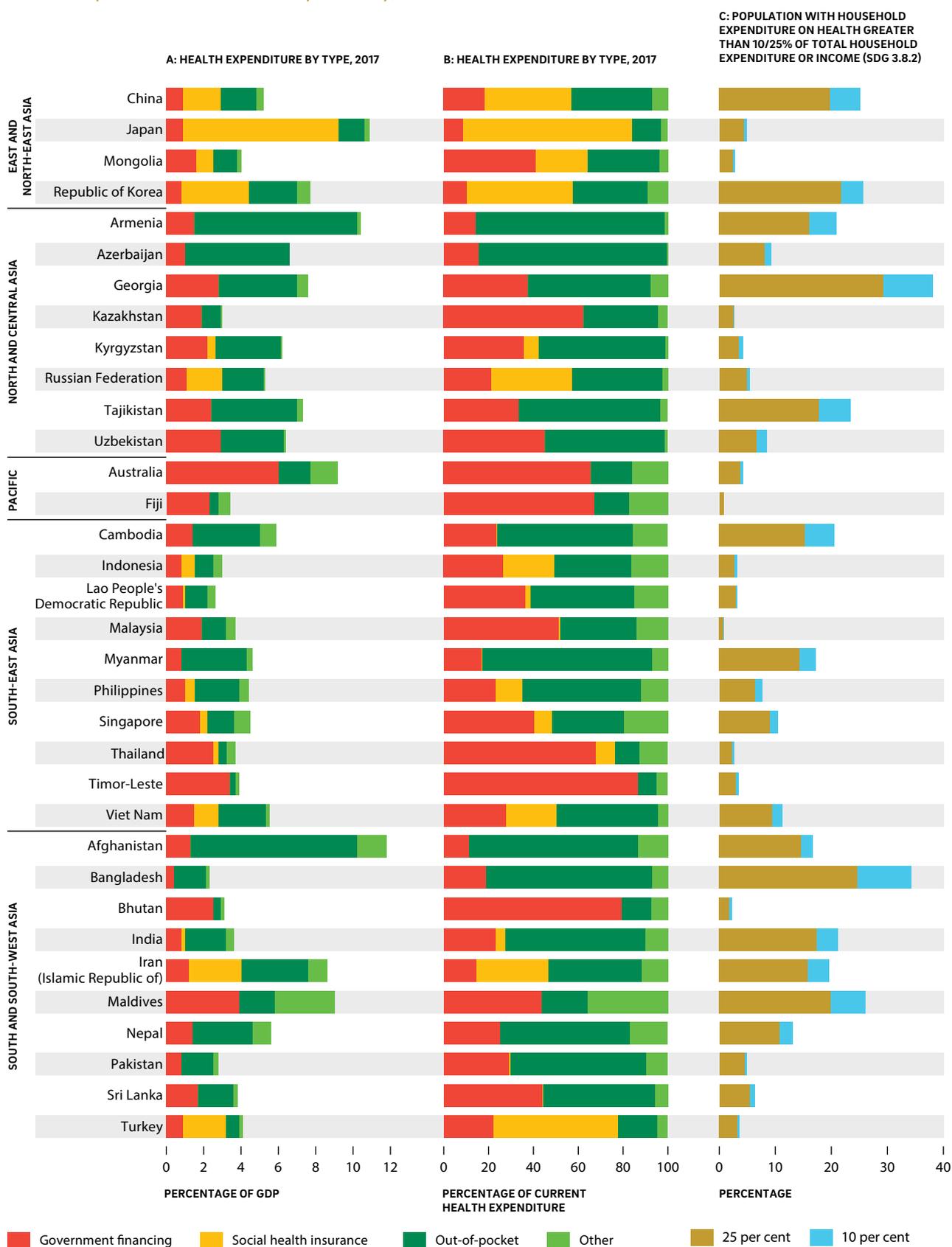
147 KPMG, Indonesia: Government and institution measures in response to COVID-19", 22 April 2020. Available at <https://home.kpmg/xx/en/home/insights/2020/04/indonesia-government-and-institution-measures-in-response-to-covid.html>.

148 Quynh Nguyen, and Nuno Meira Simoes da Cunha. *Extension of Social Security to Workers in Informal Employment in the ASEAN Region* (Geneva, ILO, 2019).

149 Subsidized programme "Jaminan Kesehatan Nasional/Badan Penyelenggara Jaminan Sosial Penerima Bantuan Iuran Jaminan Kesehatan" and nonsubsidized program "Jaminan Kesehatan Nasional/Badan Penyelenggara Jaminan Sosial Bukan Penerima Bantuan Iuran Jaminan Kesehatan".

FIGURE 6.1 Too high out-of-pocket expenditures is a critical challenge for the region

Health expenditure indicators, by country, 2017

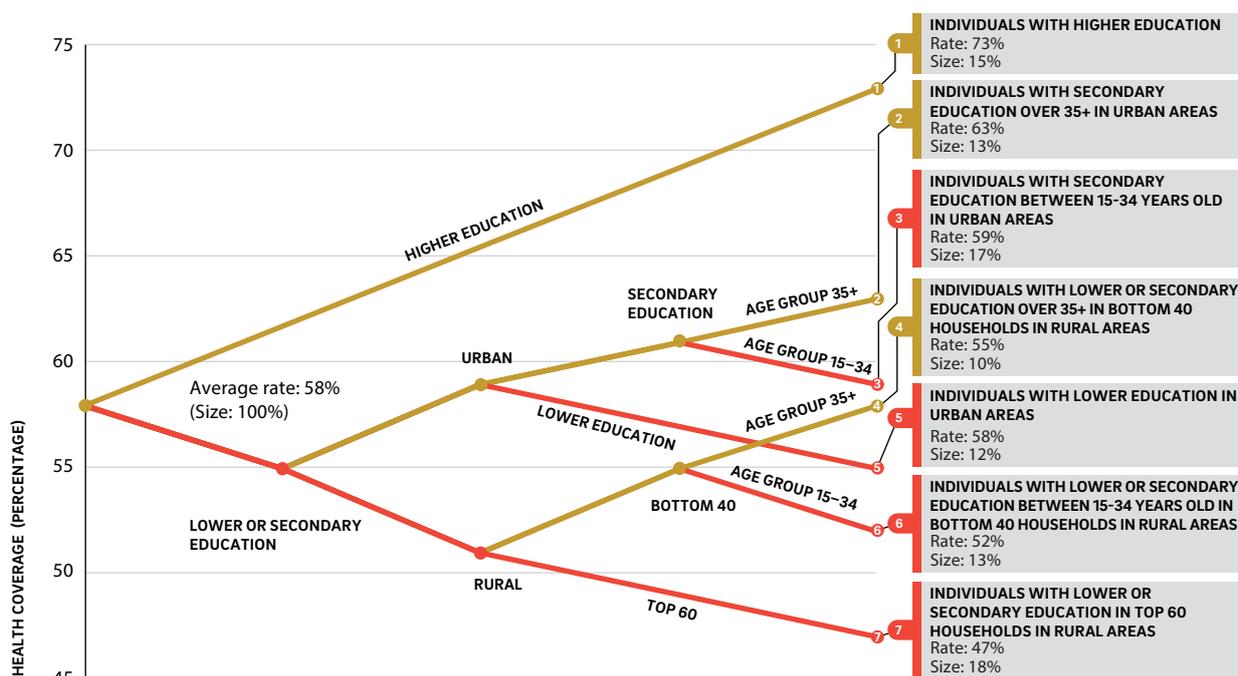


Sources: WHO (2019) Global Health Expenditure Database (December 2019 update), Available at <https://www.who.int/data/gho/data/themes/topics/financial-protection> (accessed on 3 August 2020).

Note: ENEA, East and North-East Asia; NCA, North and Central Asia; SEA, South-East Asia; SSWA, South and South-West Asia.

FIGURE 6.2 Despite various tiers of health-care coverage, large gaps remain

Classification tree of health-care coverage in Indonesia, 2017



Source: ESCAP elaboration based on Indonesia Demographic and Health Survey 2017.

Note: For more information on the methodology, please see: ESCAP (2020). Leaving No One Behind: A methodology to identify the furthest behind in Asia and the Pacific. *Social Development Division Working Paper 2020/01*.

lowest among the top 60 of the wealth distribution. Cambodia has extended health-care coverage to those most in need through non-contributory Health Equity Funds; private or employer-linked schemes are less developed. It is estimated that the Health Equity Funds have provided free access to some three million vulnerable individuals.¹⁵⁰ Despite this important scheme and the launch of the National Health Insurance in 2016, 73 per cent of all Cambodians remain without health coverage. In Georgia, on the other hand, more than 90 per cent of the population has been covered by a tightly defined package of state-funded benefits since 2013. The highly decentralized system is focused on ensuring universal access through autonomous medical providers, while guaranteeing high-quality services, primary care, and financial protection.¹⁵¹

The Lao People’s Democratic Republic is a case in point for progress. Analysis conducted in 2017 indicated that only 15 per cent of the population had health-care coverage, mostly through a civil servant scheme.¹⁵² Only around 3 per cent were covered through the non-contributory community-based health insurance or health equity funds. Of those with some form of health insurance, the vast majority were highly educated and half of them were in the richest quintiles of the wealth distribution.¹⁵³ These gaps were one of the main drivers for introducing the National Health Insurance Scheme, which is intended to cover the most vulnerable segment of the population and contribute towards achieving universal health coverage by 2025.¹⁵⁴

150 Peter Annear and others, “Protecting the poor? Impact of the national health equity fund on utilization of government health services in Cambodia” 2006–2013”. *BMJ Global Health*, vol. 4, No. 6 (2019).

151 Erica Richardson and Nino Berdzul (2017). “Georgia: Health system review”. *Health Systems in Transition*, vol. 19, No. 4, pp. 1–90.

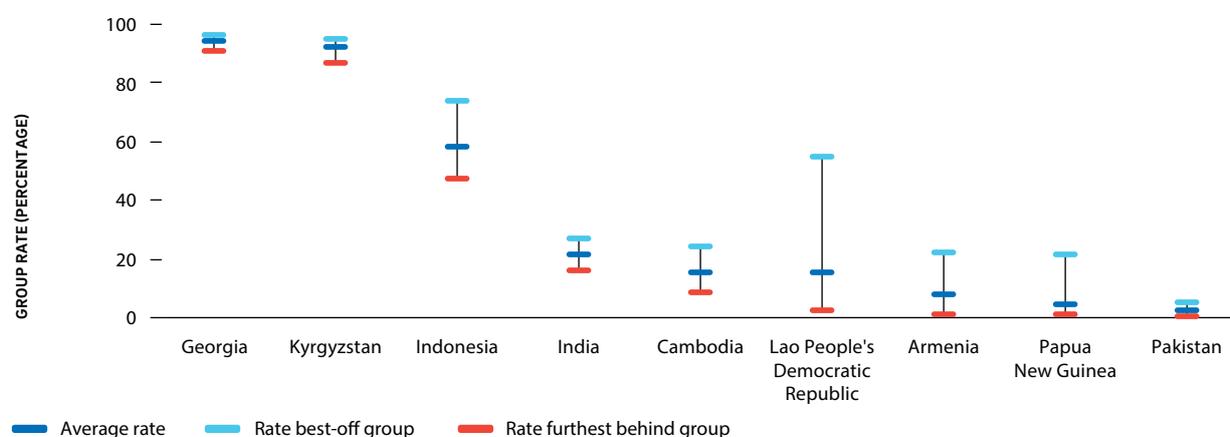
152 Based on latest available Multiple Indicator Cluster Survey (2017). Available at: https://mics-surveys-prod.s3.amazonaws.com/MICS6/East%20Asia%20and%20the%20Pacific/Lao%20People%27s%20Democratic%20Republic/2017/Survey%20findings/Lao%20PDR%202017%20MICS%20Social%20Indicator%20Survey%20II%20Survey%20Findings%20Report_English.pdf

153 Ibid.

154 International Labour Organization (2020), “Expansion of Lao People’s Democratic Republic’s national health insurance accelerates progress towards universal health coverage”, 4 February. Available at https://www.ilo.org/asia/media-centre/articles/WCMS_735797/lang--en/index.htm.

FIGURE 6.3 Countries with universal health-care systems have high coverage and minimal gaps

Gaps in access to health-care coverage, latest year available



Source: ESCAP elaboration based on latest demographic and health surveys and multiple indicator cluster surveys.
 Note: Data for Kyrgyzstan refer to women only. For a description of the composition of the furthest behind groups, please see table 6.1.

TABLE 6.1 Characteristics of the groups with the lowest access to health care, selected countries, latest year available

WHO ARE THOSE LEFT BEHIND IN TERMS OF ...

...HEALTH CARE COVERAGE										
COUNTRY	YEAR OF SURVEY	WEALTH	RESIDENCE	EDUCATION	AGE GROUP	EMPLOYMENT STATUS	GENDER	COVERAGE OF THE MOST DISADVANTAGE GROUP	SIZE OF THE MOST DISADVANTAGE GROUP	GAP FROM MOST ADVANTAGE GROUP (PP)
Armenia	2015–2016			Lower or secondary education		Not working		1%	25%	21 pp
Cambodia	2014	T60	Rural	Secondary or higher education				8%	23%	16 pp
Georgia	2018	B40		Lower or secondary education	15–34 years old		Female	91%	11%	5 pp
India	2015–2016	B40			15–24 years old			15%	13%	11 pp
Indonesia	2017	T60	Rural	Lower or secondary education				47%	18%	27 pp
Kyrgyzstan	2018		Urban	Lower or secondary education	15–34 years old			86%	13%	8 pp
Lao People's Democratic Republic	2017	B40	Rural	Lower or secondary education				2%	26%	52 pp
Pakistan	2017–2018			Lower or secondary education	15–24 years old			0%	16%	5 pp
Papua New Guinea	2016–2018		Rural	Lower education		Not working		0%	43%	21 pp

Source: ESCAP elaboration based on latest demographic and health surveys and multiple indicator cluster surveys.
 Note: Data for Kyrgyzstan refer to women only. PP (pp) refers to percentage points.