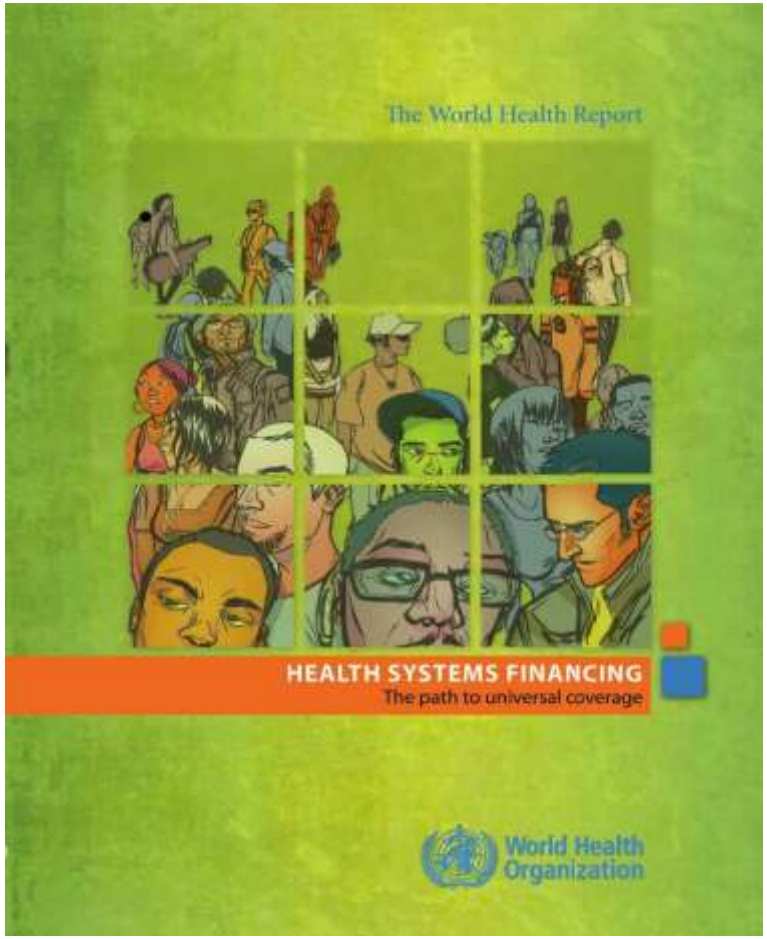

Health financing for UHC and the challenge of informality

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Overview

- Health financing for UHC and the challenge of informality
- Four broad options for coverage expansion, with illustrations from country experience
  - And an important detour on health spending patterns
- Summary messages for your consideration

HEALTH FINANCING FOR UHC AND THE CHALLENGE OF INFORMALITY

Financing for UHC: the overall question to be addressed by any country

- How to alter the system in a way that
  - Reduces the gap between the need for and use of services, across the population,
  - Improves quality of health services,
  - Improves financial protection…
- …given our starting point in terms of
  - existing configuration of the health system, including coverage arrangements,
  - overall current and expected fiscal constraints, and
  - other key contextual factors, such as labor market (informality), public administration structure (e.g. decentralization), geography and population density, politics, etc.?

Two necessary and sufficient health financing conditions for Universal Coverage (Victor Fuchs)

- Subsidization (because some will be too poor or too sick to be able to afford voluntary coverage)
- Compulsion (because some who can afford it are unwilling to buy it)
  - One without the other won't work (subsidies alone not sufficient because rich/healthy will not join; and compulsion without subsidies imposes a heavy burden on the poor and sick)

Context of high informality poses critical challenges to realizing these conditions

- Hard to mobilize much revenue from direct taxation
  - Personal income tax
  - Payroll tax (i.e. SHI contributions)
- Hard to collect voluntary prepayment as well
  - Economics of voluntary health insurance (VHI)
  - Gains (tax avoidance) from maintaining informality
- Hard for system to distinguish differences in capacity to pay (poor from non-poor) within the informal sector
- Not a problem IF system can ensure service guarantees and financial protection on a non-contributory basis
  - E.g. UK, arguably in Sri Lanka, Malaysia, …

Some broad lessons on health financing policy from both theory and practice

- No country gets to UHC via voluntary health insurance
  - Compulsion or automatic entitlement is essential, with subsidies
- Because there are always some who can't contribute directly, all countries with universal population coverage rely on general budget revenues (in whole or in part)
  - And the larger the informal sector, the greater the need for using general revenues (but many innovations in how such funds flow)
- You can't just spend your way to UHC – need to manage resources efficiently from the beginning
  - Move away from the extremes of provider payment methods – unmanaged fee-for-service and rigid line item budgets – as these contribute to system inefficiencies

Common political motivations for UHC

- Reducing explicit inequalities in benefits and funding per capita between groups
  - Mexico, Thailand, South Africa using this as political driver of their reform agendas
- Relatedly, UHC as a means to the end (or the embodiment) of having “fairer societies”
  - Crisis in Europe is a test of the commitment to solidarity
- In many countries (Indonesia?), redressing past inequalities that were caused by the health system
  - By having started explicit social health insurance programs for the formal sector

Why following the historical path of western Europe and Japan has been problematic

- "Starting insurance" with the formal sector
  - Improves access and financial protection for the better off
  - Historically in western Europe and Japan, coverage grew with economic development, growing formalization of the economy and high employment
  - Today, however, developing country governments face decisions on the rationing of scarce medical technology that Western/ Japanese governments did not face a century ago
  - The initially covered groups defend their interests, demand more benefits and subsidies, and concentrate scarce administrative skills on their behalf
  - Exacerbates inequalities, fragments the system, and is very difficult to undo

- So if Indonesia has the political will at this moment to unify the system for formal and informal sector populations, do it

A reminder: health financing is important but not enough for progress towards UHC

- Getting everyone into the scheme will not be enough
- Improvements on supply side (service delivery, human resources, medicines, technologies) essential to improve both access to and quality of health services

ENSURING COVERAGE FOR THE INFORMAL SECTOR: POSSIBLE LESSONS FOR INDONESIA

Some assumptions

- Indonesia's approach will rely on explicit affiliation to the national SHI fund, with explicit guarantees, as the means to progress towards UHC (not a vague promise)
- Contribution-based entitlement for the formal sector, funded from payroll taxes (a historical legacy, even though UHC implies coverage is a right, not an employee benefit)
- Budgets (central?) will (continue to) fund coverage for the poor and near poor (Jamkesmas)
- So focus of the presentation is on non-poor persons in the informal sector, but in context of wider system

Relevant policy options for funding coverage of non-poor informal sector

- No subsidy; non-poor informal sector must contribute a “full premium” or has no entitlement
- Fund coverage for everyone not in formal social security from general budget revenues, automatic entitlement
- Guarantee (and fund from budget) certain services for all; entitlement to “full package” requires contribution
- Complementarity between direct contributions and government subsidies for coverage expansion

1. Unsubsidized contributions by the non-poor informal sector

- Advantages
  - Equitable relative to ability to contribute (if you can do it)
  - Minimizes fiscal impact
  - Would not impact on formalization of the workforce (in effect, it would be a means of formalizing the informal sector)

- Disadvantages
  - This has never worked anywhere (a big disadvantage)
  - Costly to implement, both targeting and revenue collection (so in fact, there would be some fiscal impact)

Why would the health sector be able to do what finance authorities can not?

- Even if mandatory, collection will prove difficult, just as currently it is hard to collect any form of direct taxation from this part of the population
- Will be de facto voluntary pre-payment, with all of the problems associated with that
  - Voluntary health insurance markets function poorly; low levels of coverage everywhere unless substantial subsidies, incentives
- Targeting and collection is costly and difficult

Conclusion: option of “full premium payment” for the non-poor informal sector

- It won’t work, and it will cost you a lot
- Will leave a large number of currently non-poor people at risk for becoming poor as a consequence of uncovered health expenses
- A decision to go with this approach ignores global experience (i.e. it has never worked) and effectively suggests a government that is not really interested in moving to UHC

2. Fully fund coverage from general government budget revenues

- Well-known examples include Thai *Universal Coverage Scheme*, Mexico's *Seguro Popular*
  - Both began with intent to have co-contribution from covered population, but gave up as not worth the cost of collection
- Advantages
  - Administratively simple, no targeting, no additional revenue collection costs or bureaucracy for this purpose
  - Evidence shows clearly that this can work
  - Additional plus for Indonesia compared to Mexico and Thailand: informal sector in same pool as contributors and poor
- Challenges
  - Fiscal constraints limit scope unless strong political commitment
  - May contribute to reducing rate of formalization of labor force

Implementation challenges

- Ability of the government to spend on health from its budgetary resources
  - Explore fiscal context and health spending patterns
- In decentralized budgetary context, can central government decide on what may be local government allocation decisions? What financial role, if any, for local governments?

A snapshot of Indonesia's health spending in regional and global context: what potential for increased public spending?

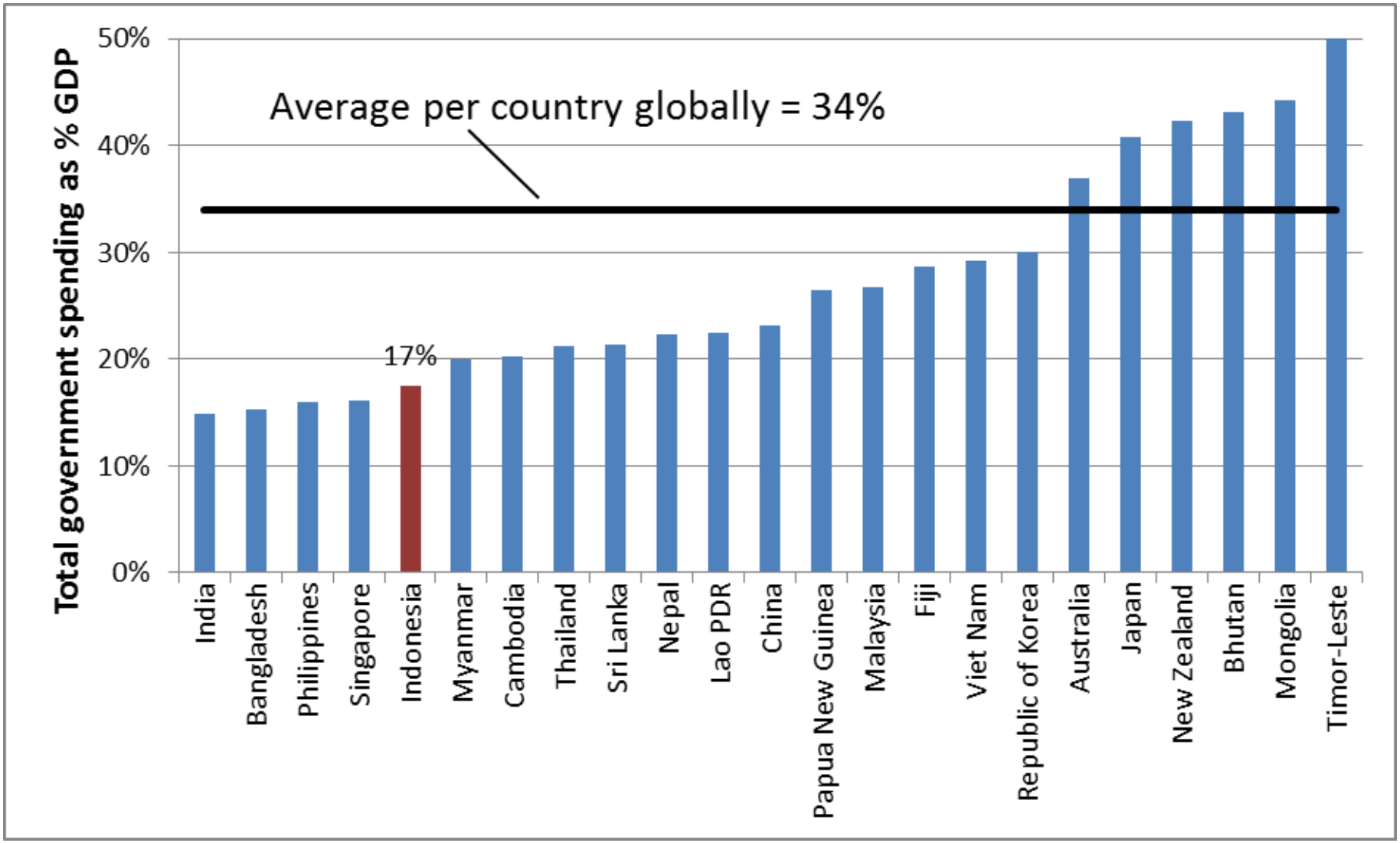
$$\frac{\text{Gov't health spending}}{\text{GDP}} = \frac{\text{Total gov't spending}}{\text{GDP}} \times \frac{\text{Gov't health spending}}{\text{Total gov't spending}}$$

Government health spending as share of the economy

Fiscal capacity in any year

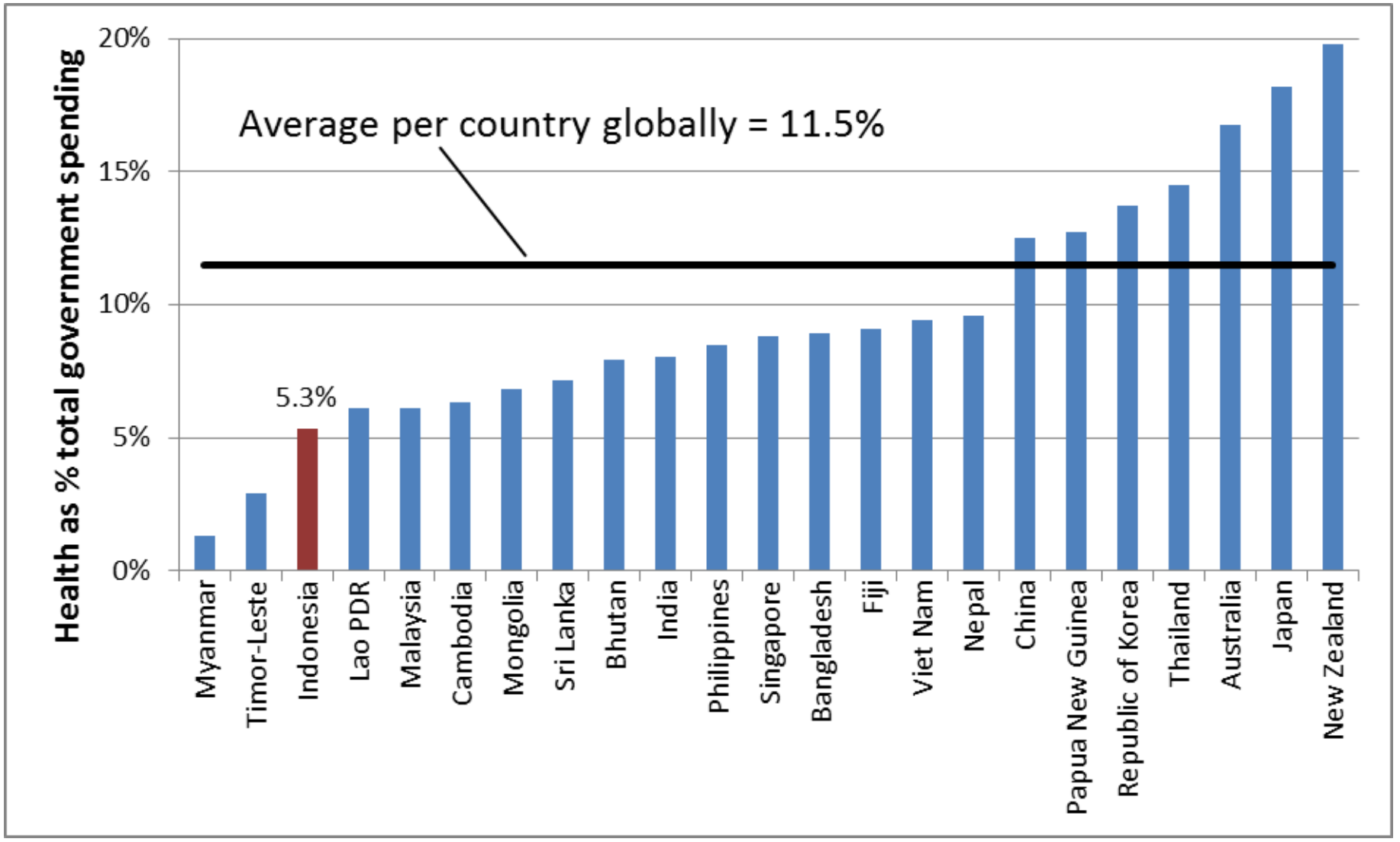
Public policy priorities

Asian countries have small public sectors relative to the size of their economies. Indonesia appears to have especially low fiscal capacity



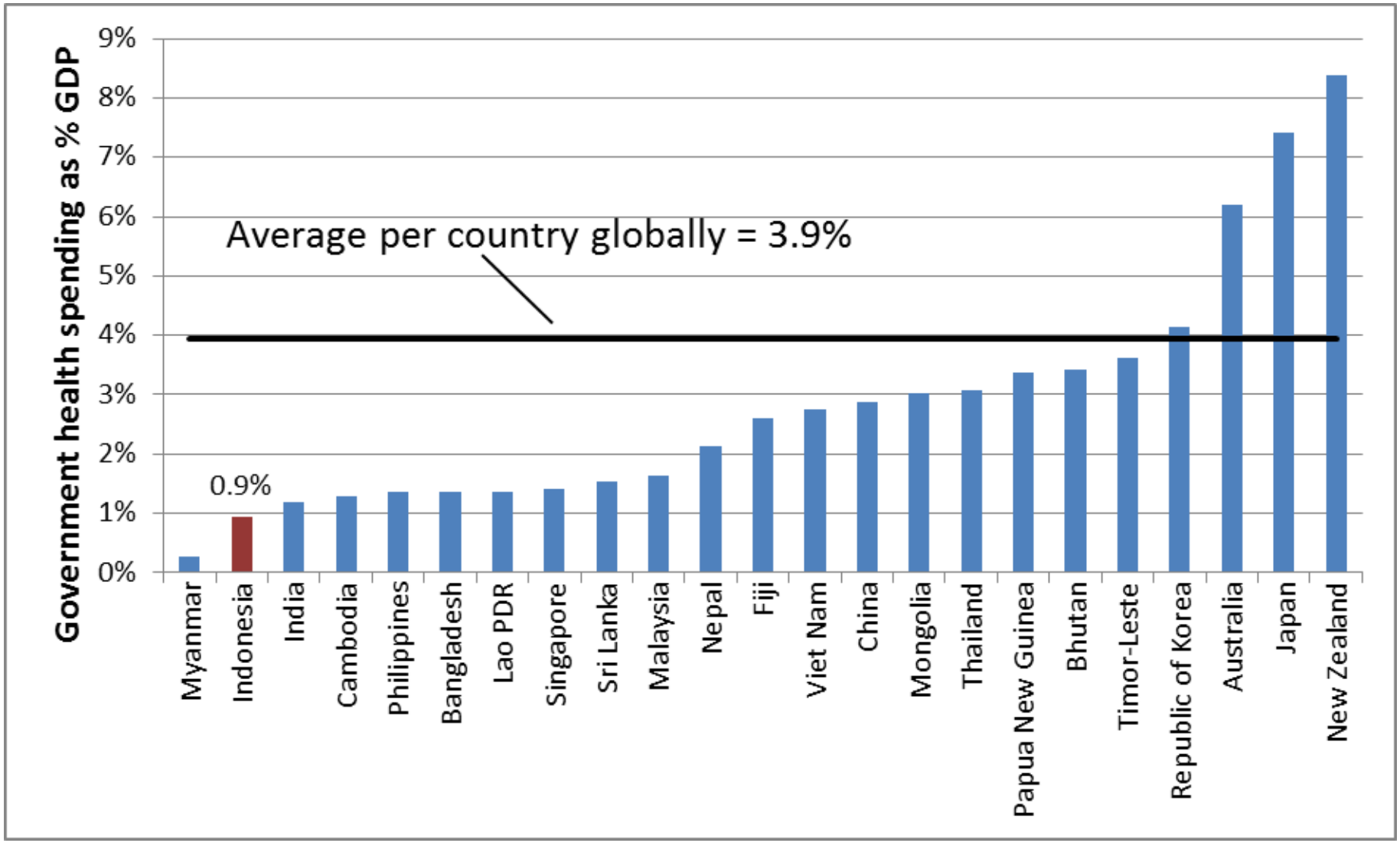
Source: WHO estimates for 2011, countries with population > 600,000

Most Asian governments give low priority to health. Indonesia is at the extreme –10th lowest in the world in 2011



Source: WHO estimates for 2011, countries with population > 600,000

As a result, most of Asia, and particularly Indonesia, has very low public spending on health relative to the size of the economy



Source: WHO estimates for 2011, countries with population > 600,000

Combination of fiscal capacity and priorities determines government health spending

$$\frac{\text{Total gov't spending}}{\text{GDP}} \times \frac{\text{Gov't health spending}}{\text{Total gov't spending}} = \frac{\text{Gov't health spending}}{\text{GDP}}$$

	GDP per capita	Public spending as % GDP	Health as % of total public spending	Government health spending as % GDP
Indonesia	4,668	17.5%	5.3%	0.9%
Malaysia	15,589	26.7%	6.1%	1.6%
Viet Nam	3,398	29.1%	9.4%	2.7%
China	8,373	23.1%	12.5%	2.9%
Thailand	8,703	21.1%	14.5%	3.1%
Australia	40,859	36.9%	16.8%	6.2%

Source: WHO health expenditure estimates for 2011

Can the Indonesian government spend more? It is a question of priorities

Government health spending with Indonesia's fiscal constraint but other countries' priorities

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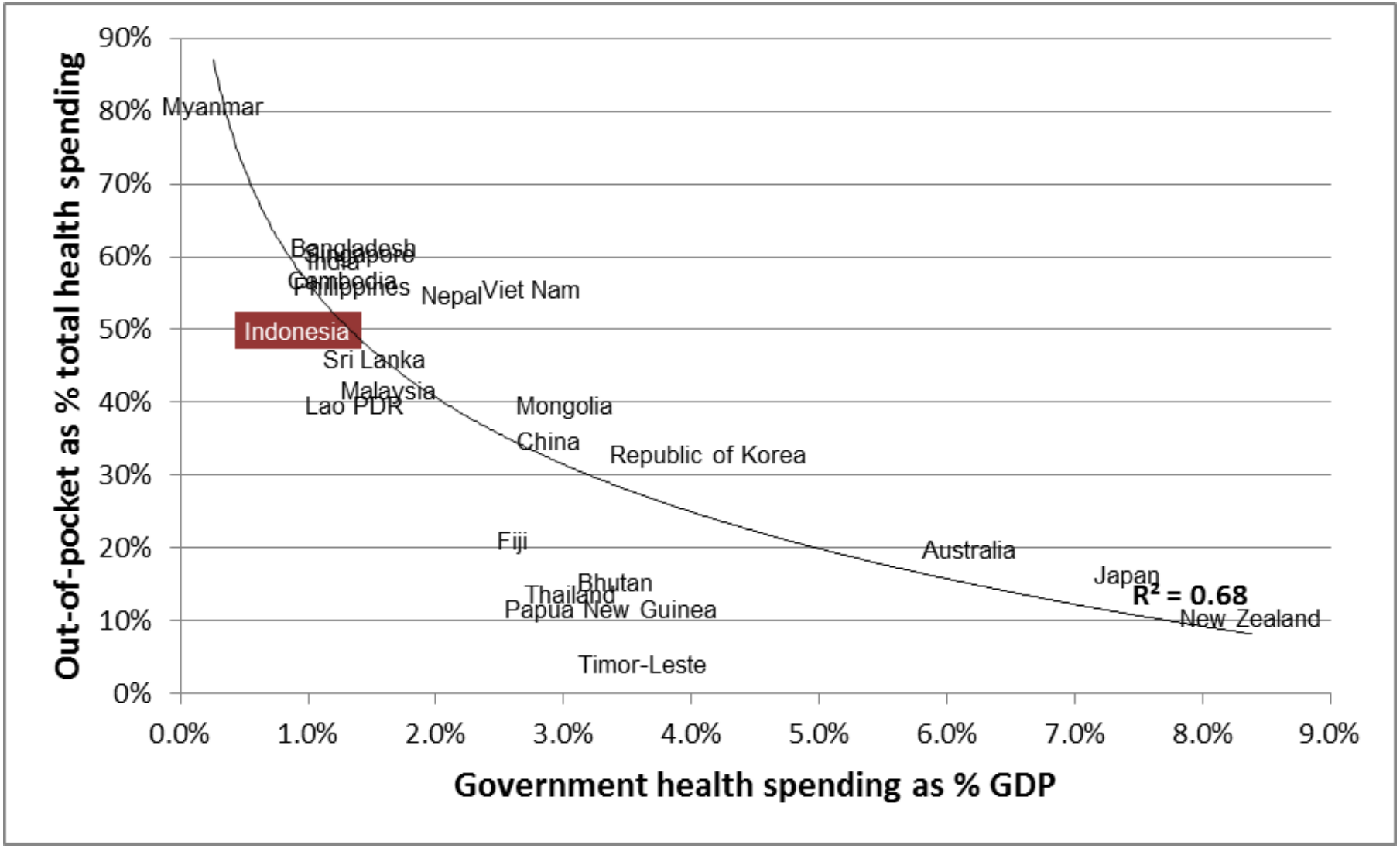
Source: WHO health expenditure estimates for 2011, applying different country resource allocation priorities to Indonesia's fiscal level

It matters: in general, public spending on health reduces dependence on out-of-pocket spending



Source: WHO estimates for 2011, countries with population > 600,000

Tentative conclusions on the "easiest option"

- Despite very limited fiscal capacity, Indonesia has scope to increase public spending on health if your political rhetoric about the importance of UHC is matched by a shift in the allocation of public resources
  - Doubling the share of public spending allocated to health would still put government below the global average health prioritization
- But even if this happens, government health spending still likely to be at best only about 2% of GDP in 5 years (unless a massive shift in overall fiscal context)
- So "fully funding" universal population coverage from general budget transfers is unlikely, unless there is a massive shift in priorities and the overall fiscal outlook

3. Stepwise progress through selective universalization of services

- Make certain services universal/guaranteed for entire population, irrespective of whether or not they are insured
  - Expands coverage via services rather than population affiliation
  - During transition, everyone would have “some coverage”, but “insured” population would have more
  - In line with priorities and capacity, increase scope of service coverage guaranteed to all, funded from general revenues

- For example in Moldova in 2009
  - About 72% of the population was insured under the national single payer system, funded from general budget transfers (51%), payroll tax (47%), and self-employed contributions (1.3%)
  - Decided to make PHC universal, irrespective of insurance status, as a step towards UHC

Conclusions on stepwise service expansion

- A possibility to consider – would reflect public commitment to at least something for everyone
  - Brings more explicit budget financing commitment
  - Universalizing certain services from budget revenues can reduce amount needed for premiums to get insured for the rest
  - Easier to implement than contributory-based affiliation to the insurance scheme
- Risks
  - Would service scale-up continue, or permanent two-tiered system?

4. Subsidized participation with strong public commitment to universality

- Explicit reliance on general budget transfers, but retaining contributions

- In high-income countries with payroll tax and contributory-based entitlement, general budget transfers play key role
  - No country gets to universal population coverage without some budget transfers, because some are always unable or unwilling to contribute
  - Japan: 25% of insurance revenues from general budget transfer
  - Hungary: over half of insurance revenues from general budget
  - Germany: small but increasing role for general revenues as government seeks to minimize impact on labor market

Challenges of de facto voluntary participation, even subsidized

- Low participation, high dropout after acute health events
- Difficult to draw and maintain boundary between who should be fully subsidized and who only partially subsidized
- Most countries still don't reach high coverage through this route
- But 2 countries have – China and Rwanda. What can we learn from them?

China and Rwanda have achieved 90% or more coverage with their "voluntary" schemes

- Common element 1: cost of the "premium" much less than the perceived value of the benefit, stimulating demand
  - Substantial subsidies on the supply side and the demand side, and same benefit package as rest of population in the scheme
  - Population aware that not being covered means risk of high out-of-pocket spending
- Common element 2: role of local governments
  - Strong incentives/instructions for local officials to inform people and enroll them into the coverage program, (both countries), and
  - Explicit role for local budgets to subsidize (China)
- Common element 3: very strong (authoritarian) governments able to implement these measures

Premium subsidies

- Contributions set on basis of affordability, not actuarially
- China: explicit private:public funding link in NCMS
  - "voluntary" contribution by individual matched (much more than 1:1) by subsidies from local and central governments (subsidy per person more than tripled between 2008 and 2012)
  - Supply side strengthening measures
- Rwanda has supply side subsidies for salaries, fully subsidizes contributions for 25% of population, and sets two contribution rates linked to income for the rest
- Uncovered face high OOP barriers and burden
- Result: expected benefits of buying into the scheme much greater than costs of joining

Role of local governments

- Very strong incentives for local officials to engage
  - Rwanda: part of district mayor's pay depends on getting their population enrolled in the scheme
  - China: local officials go door-to-door; they are also judged in part on health insurance scheme enrollment
- Both countries have strong central government with ability to instruct/guide local government actions

Conclusions on partial subsidization

- May be highly relevant to Indonesia given…
  - Getting close to universal participation requires strong, explicit role for budget subsidies
  - While prioritization for health should increase if UHC is an important political commitment, overall fiscal capacity still limited, so may not be feasible to implement "easiest option" of just covering all informal sector from budget
  - Explicit link between individual contribution and budget subsidy, as in China, may give finance authorities confidence that they "know what they are buying" in giving a greater share of revenues for health – transparency in funding mechanism
  - Given decentralization, UHC strategy must have a clearly defined role for local governments. Just leaving matters between the scheme and population won't be adequate.

SUMMARY MESSAGES

A reminder: experience shows that you can't simply spend your way to UHC (if you could, my country would be leading the way)

- Attention to managing system resources efficiently from the beginning
- Match request for more funds with a commitment to be accountable for transparent and effective use of public resources, reporting on progress, etc.
- Among other things, will require the single fund to prioritize its attention on improving purchasing, not on revenue collection

Summary messages for your consideration

Single pool with common package is pro-equity and efficiency – good basis for UHC

Priority for health in public spending must increase, or UHC will be empty promise

Any serious attempt to reach the non-poor informal sector must include budget transfers

Explicit role for local government as part of the approach

Partner request for more funds with commitment to accountability for efficient use