

Overview of Health System Reforms in Asia and Potential Impacts on the Rural Poor

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Dr. David Oldfield

Asia Policy Research Co., Ltd.

david@asiapolicyresearch.com

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Health System Reforms

- **What is it?**
 - Sustained, purposeful, fundamental change (Data for Decision Making Project, 1995).
- **Objectives: to make public health systems more effective, efficient, and equitable.**

Major Approaches to Reform in Asia

- **Decentralization**
- **Autonomy for public service providers**
- **Government service purchase (contracting)**
- **Alternative approaches to health care financing**

Decentralization

- **Overall purpose: to make health services more responsive.**
- **Indonesia:**
 - Decentralization to districts.
 - Slow process since 1987.
- **Philippines experience since 1991:**
 - Created a weakened and fragmented public system.
 - Revenue to local government units not sufficient, so services fell into disarray.
 - Emphasis more on building institutions and increasing health financing, rather than delivering services and achieving impact.
- **Another Phil initiative: Sentrong Sigla Certification (SSC)**
 - Strategy for efficient & effective local health care.
 - Local mechanism for recognizing required quality standards.

Autonomy

- Avoids issue of privatization.
- Strengthens accountability.
- Thailand's pre-30 baht experience: Ban Phaew District Hospital
 - 1998 corporatized, then autonomy.
 - New authority: recruit own staff from outside the civil service system, board of directors oversee operations instead of MOPH & MOF, own organizational structure.
 - Outcomes:
 - From debt to positive balance of accounts.
 - More efficient.
 - More responsive to community's needs.
 - Less bureaucratic administration, more focus on health services.

Government Service Purchase (Contracting): Variables

1. Reasons for contracting out:

- Increase efficiency**
- Improve quality**
- Improve performance delivery**
- Promote access to health care**
- Reduce costs**
- Improve health outcomes**

2. Service providers:

- Public**
- Non-profit**
- Institutions (i.e., hospitals)**
- Private**
- For-profit**
- Individuals/groups**

Contracting Arrangement Variables

3. Types of services contracted out:

- Clinical
- Inpatient
- Preventive
- Non-clinical
- Outpatient
- Curative

4. How providers are paid:

- Input-based
- Output-based
- Performance-based
- Cost-based
- Outcome-based

Country Experiences with Contracting

- **Philippines**
 - LGUs form PPPs for specific public services, e.g., reproductive health and tuberculosis control programs.
 - Under framework for performance-based budgeting: use of health services management agreements. MOU specifying terms and conditions for grant-in-aid.
- **Bangladesh**
 - Urban PHC services contracted to local NGOs.
 - Government financed but private sector provided.
 - Public monitoring and supervision by the health departments of the municipalities.
 - Now setting up PPPs with NGOs for VCT & other HIV/AIDS-related outreach for high risk groups.

More Country Experiences with Contracting

- **Cambodia**
 - Contracting NGOs in districts: immunization, family planning, antenatal care, nutrition, common disease treatment, and other forms of primary health care.
 - NGO authority over MOH staff for bonuses.
- **Afghanistan**
 - Performance-based Partnership Agreements (PPAs) in 34 provinces.
 - Due to urgent need to re-introduce PHC services.
 - NGOs contracted to provide services.

Impact of Service Purchase Systems

- **Minor improvements in quality of health care...**
- **But significant improvements in the other indicators**
 - Provision, coverage/access, & utilization often increase.
 - Cambodia equity in financing: contracting out of services reduced out-of-pocket payments by over 70%
- **Improved access to services often offset by greater costs to government purchaser**
 - Cost of services often high (e.g., Cambodia district health services, Bangladesh nutrition services, Afghanistan PHC/immunization).
 - Afghanistan: per capita costs \$3.80-5.10, excluding management costs.
- **What's best for contracting?**
 - Multiple competitors & frequent transactions vs. few dedicated partnerships?

Risks Found in Contracting in Western Asia

- From various experiences in Afghanistan, Bahrain, Pakistan, Lebanon, Jordan, Iran, & others:
 - Reliance on donor funds.
 - Limited number of providers in rural areas.
 - Weak monitoring & evaluation mechanisms (i.e., independently collected or verified?).
 - Danger of missing opportunity for long-term health system development (e.g., Lebanon's long experience with contracting).

Health Care Financing Options

- **Universal health coverage**
- **Community health insurance**
- **Health equity funds**
- **Health loan funds**
- **Voucher schemes**

Universal Health Care

- **Thailand's 30 baht scheme**
 - Capitation subsidies to health facilities cover rest of costs.
 - Rising costs overall and per capita basis for facilities.
- **Philippines**
 - Goal: Philippines' National Health Insurance Program (NHIP) or PhilHealth for universal coverage by 2010.
 - PHIC covers about 64% of the population.
- **Indonesia**
 - National Development Plan 2004-09: universal health insurance for the poor by 2009.
 - Fuel subsidy compensation fund for insurance for poor.
 - Conflicts with decentralization strategy.
- **Vietnam**
 - Politburo Resolution 46 (2005): goal of Universal Health Insurance (UHI) by 2010.

Community Health Insurance

- **Member premiums; community pooling and decision-making.**
- **Popular in countries with limited ability for universal health insurance.**
- **Alternative to user fees.**
- **Typically fail because insufficient participation rates.**
- **Lao PDR:**
 - **CBHI piloted 3 districts; covers informal workers & families.**
 - **91% members from higher wealth quintiles.**
 - **High admin costs, unnecessary diagnostics, over-prescribe drugs.**

Health Equity Funds

- **Cambodia's Sotnikum District, Siem Reap (New Deal)**
 - HEF due to high “official” user fees and no exemptions.
 - HEF managed by NGO.
 - **Success factors:** (i) donor funding; (ii) separation of roles (i.e., hospital vis-a-vis NGO); (iii) proper identification of the eligible poor; and (iv) inclusion of non-medical costs in benefits package.
 - **Downside:** high admin costs to operate HEF.
- **Vietnam**
 - **PM Decision 139 in 2002:** provincial people’s committees establish Health Care Funds for the Poor (HCFP).
 - **Local financing burden & non-reimbursed cost of services harder on poor provinces and populated districts.**
- **Lao PDR**
 - **Three small HEFs; all pre-identify poorest in the district for health cards to obtain free services.**

What Has Been the Impact of Reforms, especially on Rural Poor?

- Coverage expanding (or reestablished), but...
- Reform harmed public health, basic services provision, & equity?
- Equity worsening, not improving.
 - Especially from user fees & two-tier systems.
- Quality questionable, thus decline in utilization public facilities.
- Too little focus on outcomes of reform
 - Too much on technical design & implementation.

Some Rural & Poor Disparities

	U5 mortality Rural-urban risk	U5 stunting Rural-urban risk	U5 mortality Wealth quin ratio highest to lowest	Births attended by skilled health personnel; Quin ratio highest to lowest
Cambodia	1.4	1.2	2.4	5.5
Thailand	1.5	2.2	--	--
Vietnam	2.2	--	---	1.7

Impact of Health Financing Reforms

	Private expenditure on health as % total health expend.	OOPs as % total private health expend on health
Cambodia	74.2	85.4
China	62.0	86.5
Lao PDR	79.5	90.3
Myanmar	87.1	99.4

Why Limited Impact on Rural Poor?

- **Decentralization and health financing alternatives require strong management skills, which are scarce.**
- **Decentralization hasn't led to shift in financing from central to local or urban to rural.**
 - E.g., Lao PDR
- **User fees and community-based health insurance schemes are typically not equitable.**
 - Greater burden on poor; user fees reduce utilization.
- **Exemption mechanisms for the poor difficult to design & implement well.**
 - Accounts for low priority in DCs.

Why Limited Impact on Rural Poor?

- **Unresolved issue of incentives for health professionals to serve in rural & border areas.**
- **Too much focus on financial resources to improve health services?**
 - **Equal or more gains obtainable from greater productivity and efficiency, e.g., Sri Lanka**

Thoughts for Discussion

- **Have we evaluated rigorously and sufficiently (cases of reforms) to really know what will work and where?**
- **Meaningful reform will likely entail difficult, unpopular decisions in many instances.**
 - **Unpopular with Ministries of Finance, populations, or development partners.**
- **Sum of the parts (small projects) aren't necessarily adding up to the whole (need for wide-scale reform).**