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Partnering to End Extreme Poverty in Asia through Universal Health Coverage

By Caroline Ly and Kristina Yarrow

Overview

President Barack Obama in his 2013 State of the Union address articulated a vision to end extreme poverty in the next two decades. This vision is a core part of the U.S. Agency for International Development's (USAID's) mission. At the same time, the 2010 World Health Report on Health Systems Financing and the unanimous endorsement of Universal Health Coverage (UHC) by the United Nations in 2012 have paved the way for rich and poor countries alike to take a closer, more critical look at how to raise resources and improve access to health services, particularly for the poor. We know now that partnering with countries to invest in UHC will boost the critical economic growth and social safety nets needed to eliminate extreme poverty. Asian countries have demonstrated regional leadership through platforms such as the ASEAN Plus Three UHC Network to support progress toward sustainable and well-functioning Universal Health Coverage systems.ⁱ In doing so, we realize that relying on economic growth alone will not lead to the elimination of extreme poverty. Instead, investments in key social sectors such as health, particularly through Universal Health Coverage reforms that empower the poor are critical for this vision. Investing in health yields high investment returns and contributes to economic growth. According to the Lancet Commission on Macroeconomic Growth, reductions in mortality accounted for about 11 percent–24 percent of recent economic growth.ⁱⁱ Further, the Commission estimated that health investments required to achieve a Grand Convergence in which developing countries achieve similar maternal and child health outcomes as in developed countries to avert 10 million deaths in 2035 would yield economic benefits worth 20 times their costs.ⁱⁱⁱ

Poor health and health shocks are leading causes of chronic poverty and impoverishment. Universal Health Coverage, defined as ensuring that all people have access to the quality health services they need and are safeguarded from public health risks, without suffering financial hardship for paying for them, offers a health sector approach for ending extreme poverty (WHO 2010). Achieving Universal Health Coverage does not merely mean increasing enrollment in insurance schemes, it encompasses the critical objective of ensuring pro-poor services and supporting the empowerment of consumers. In Asia, however, this may prove more challenging given that along with unprecedented economic advancement across the region, there is also widening disparity and a limited space for civil society.

Universal Health Coverage does not happen immediately. It is both a goal and a process that comprises a series of often incremental policy and programmatic decisions and their implementation. UHC is a priority in many countries across Asia which are in various stages of expanding coverage toward universality. In doing so, they are making decisions to determine which populations, services and costs to prioritize. These decisions have a material impact on policy and programs, and USAID will have an opportunity to help inform their priorities.

This policy dialogue offers the basis for establishing a social compact engaging government, civil society, and the private and public sector institutions that make up the health system. Such a compact promotes the accountability and transparency that are necessary to achieve equitable benefits and increase country ownership and social stability. Such a compact further provides the basis for enhanced aid effectiveness and donor coordination.

The Importance of Asia for USAID

Asia, home to 3.9 billion people and accounting for 30.5 percent of the global economy, is a dynamic region with wide cultural and socio-economic variation.^{iv} It includes high income countries such as Japan and South Korea as well as low-income fragile states such as Afghanistan and Burma. It has experienced rapid economic transition as countries such as Bangladesh, China, Timor-Leste, Turkmenistan, Uzbekistan, and Vietnam have experienced real economic growth rates exceeding 5 percent per year over the last 5 years, and India, Laos, Timor-Leste, Pakistan, Uzbekistan, and Vietnam have “graduated” from low-income to lower-middle-income status in the last decade.^v

Despite this robust growth, Asia is and will continue to be home to the largest populations living in extreme poverty – defined as the percentage of the population that lives below US\$1.25/day at 2005 international dollars. More than 60 percent of those in extreme poverty live in Asia. According to projections to 2030 from the Chronic Poverty Report, India, Pakistan, Bangladesh, and Nepal will continue to be among the top 10 contributors to the extreme poverty populations.^{vi}

Table 1: Asia’s Share of the Global and Extreme Poverty Populations

	% of the global population	% of the population living in extreme poverty	% of the global extreme poverty population
East Asia and the Pacific	34.1	12.5	20.7
South Asia	27.7	31.0	41.7

Source: World Bank Group. (2010). PovCalNet

III Health as a Poverty Trap

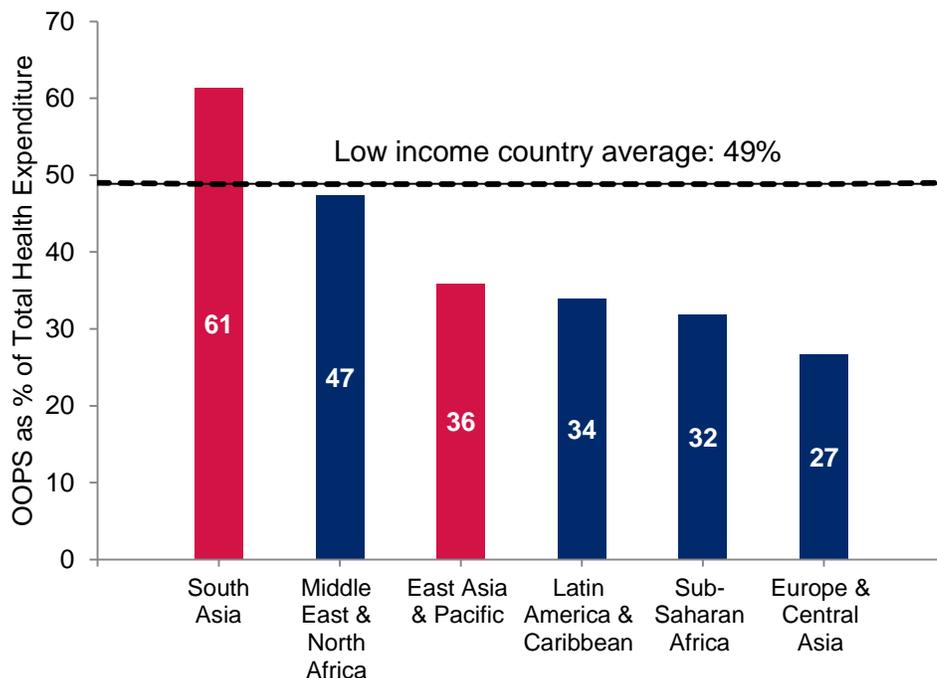
Asia is also a region that offers interesting lessons about the relationship between health and wealth, as well as different pathways for achieving Universal Health Coverage. There are large inequalities within Asian countries, and the poor have worse health outcome indicators and use health care services less than the wealthy. But, does poor health lead to poverty or does poverty lead to poor health? Recent examples in rapidly growing Asian countries such as Bangladesh, Indonesia, Thailand, and Vietnam show that improving health indicators and reducing extreme poverty are clearly linked. Moreover, in these countries, declines in infant and child mortality rates preceded periods of strong and sustained economic growth.^{vii} Specifically, the health investments that trigger declines in infant and child mortality, fertility rates as well as increases in life expectancy can lead to favorable dependency ratios (i.e., the ratio between working age and non-working age populations). Coupled with strong economic policy, favorable demographic change can yield a “demographic dividend” for economic growth. About one-third of the rapid economic growth experienced by the “East Asian Miracle” can be accounted for by the demographic dividend.^{viii} These examples of “Health before Wealth” suggest that countries need to address their poor health outcomes before they can put in place the right preconditions for economic growth.^{ix}

Clearly, an agenda to end extreme poverty must include UHC goals. Ill health prevents the poor from climbing out of poverty and can impoverish the near poor. When a household member falls ill, this can mean diminished labor productivity. In addition, households often make catastrophic financial outlays paid for by selling their productive assets, reducing their consumption, dipping into their savings, or borrowing at high interest rates for seeking health care.

Ill health can further trap people already in poverty or impoverish the near poor. For example, childhood malnutrition can permanently disadvantage a child’s lifetime cognitive and economic potential. After age 2, the effects of stunting – one key indicator of chronic malnutrition – is practically irreversible. Stunting reduces children’s cognitive capacity leading to shorter years in school, lower wages, and higher risks of death and disease.^x One study found that stunting can lead to a greater than 20 percent decrease in lifetime earnings.^{xi} Child malnutrition isn’t just a function of lack of access to food or poor sanitation – it can be due to a number of reasons including poor maternal nutrition prior to and during pregnancy. Timely and quality antenatal health care for mothers, training for mothers on appropriate infant feeding practices, access to rotavirus vaccine to prevent diarrhea, and ORS treatment of diarrhea – these are all things that are delivered directly by the health system. It also isn’t the only driver of poverty. There are numerous health reasons for chronic poverty – lack of access to family planning can cause poor families to have more children than they desire, as well as other challenges to joining the labor market such as disabilities, mental health and other chronic disease.

Impoverishing health shocks can prevent progress. Seeking health care can be a costly financial and time burden and can drive non-poor households into poverty. High rates of out-of-pocket spending (OOPS), a highly regressive way of financing the health system, which creates financial barriers to accessing health care, represents 36 percent and 61 percent of the total health spending in the developing East Asia and the Pacific and South Asia regions, respectively.^{xii}

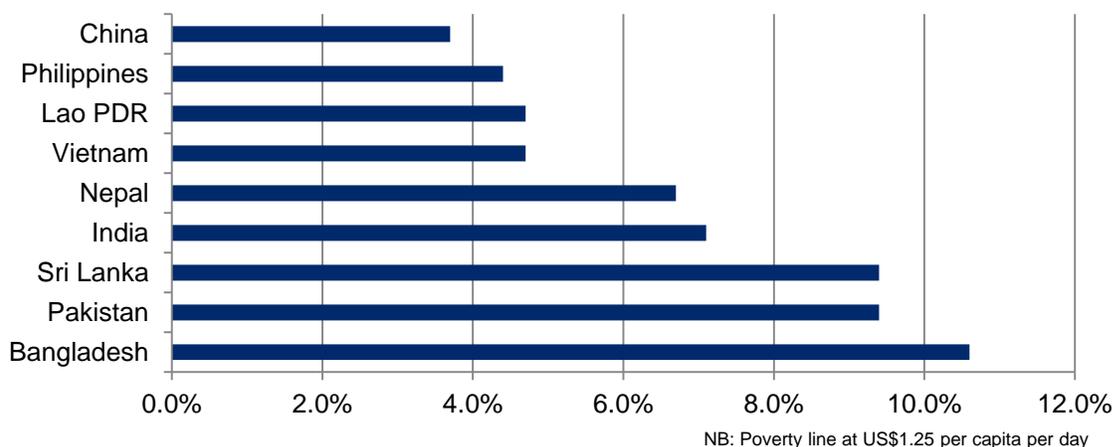
Figure 1: Developing East Asia Has High OOP Spending Compared to Other Developing Country Regions



Source: World Bank Group. (2013). Out-of-Pocket Health Expenditure; Health Expenditure. World Development Indicators (WDI) database

Illness explains a quarter to a third of impoverishment by the non-poor.^{xiii} Data from some countries across Asia have shown that out-of-pocket health spending has led to significant increases in the national poverty rates. Figure 2 looks at how country's poverty rates would change if their citizens did not experience a health problem that necessitated making out-of-pocket expenditures. For example, in Bangladesh, approximately 68 percent of the population lived below the \$1.25/day poverty line in 2003. If no households experienced a health shock that required making an out-of-pocket expenditure, then the poverty rate would have fallen to 57 percent.

Figure 2: Share of Poverty Headcount due to Out-of-Pocket Spending 2002/2003



Source: World Bank. 2012. Health equity and Financial Protection datasheet – East Asia & the Pacific; South Asia. Washington, D.C.: World Bank

Evidence of Effective UHC Interventions in the Region

The broad aspirational goals for Universal Health Coverage do not include guidance for any particular type of intervention or form of organization of the health system. Developing countries have transcended beyond the typical archetypes of social health insurance financed through earmarked taxes or direct service delivery through general revenue financing. Instead, these reforms come in different shapes and sizes. Some common characteristics include improving revenue collection mechanisms so that they are fair and affordable, helping people move away from direct OOPS and toward prepayment and risk pooling, improving value for money with strategic purchasing, and a special effort of covering the poor through subsidies.^{xiv} Many of these reforms across Asia have increased access and utilization of health care and financial protection, as well as health care outcomes.^{xv} Countries such as China and Bangladesh successfully piloted schemes. In Bangladesh, the pilot voucher program to improve maternal and child health successfully increased pre- and post-natal care and facility-based deliveries, while reducing OOPS and the costs of these services, and decreasing neonatal mortality rates by 30 to 46 in home-based interventions.^{xvi} Bangladesh has adopted UHC as a national policy goal,^{xvii} and USAID is providing technical assistance to support implementation of their health financing strategy.

Vietnam and Indonesia have reached partial coverage of their populations, 60 percent^{xviii} and 65 percent,^{xix} respectively, and have recently taken additional steps to expand their coverage. Analysis of various UHC schemes in Vietnam (public voluntary health insurance, social insurance and the health care fund for the poor) showed that they had improved financial protection – significantly decreasing OOPS for the beneficiary insured and providing evidence of positive impacts on their nutrition indicators.^{xx} Now, close to two-thirds of the population are covered by Vietnam’s State Health Insurance system, and it is considering expanding its benefit package to include HIV and AIDS services.^{xxi,xxii} USAID is supporting reforms that improve the efficiency of its social health insurance system in order to support the inclusion of HIV and AIDs into their benefits package. In January 2014, Indonesia set out on the path toward UHC with the goal of covering its entire population of 250 million people by 2019. Jaminan Kesehatan Nasional (JKN) combines different existing government-sponsored schemes for the civil servants and the formal sector and the poor into a single payer system that aims to move coverage from the current half of the population to the entire population. In Indonesia, USAID is partnering with key government and other stakeholders to undertake implementation research cycles around UHC that aim to provide policymakers and practitioners with real-time data on the rollout of JKN and an opportunity to make improvements along the way.

USAID collaborates with countries that are more advanced in their approach toward UHC to share their lessons. In March, we sponsored a recent health financing course on Universal Health Coverage in Bangkok that gave participants from all across Asia the opportunity to learn from each other and the example set by Thailand. Thailand’s Universal Health Coverage program rapidly scaled up health service delivery for their population shortly after the Asian Financial Crisis from 63 percent to 96 percent between 2001 and 2006. As a result, it increased outpatient care among the poor and the elderly and reduced out-of-pocket spending.^{xxiii} The number of households that fell below the national poverty line due to catastrophic health expenditures fell from about 119,000 to 44,000 between 1998 and 2009.^{xxiv}

The Future for UHC in Asia

The dynamic economic environment in fast-growing Asia means that the role of USAID and the overall development assistance architecture will need to evolve as well. Individual countries and the region at large will need to grapple with growing migrant populations and the need for portable schemes that ensure access for migrant labor populations across porous borders. A large and growing informal sector, individuals not covered by the labor and social security provisions, will continue to test how countries communicate expanded coverage to remote and often marginalized communities. Equally as important will be the question of how to finance and address the changing mix of population health needs arising from demographic trends and the emergence of non-communicable diseases.

As many of the developing countries in Asia continue to grow, they will have sufficient resources to afford a basic package of health services for their entire population. However, the increasing share of out-of-pocket health spending particularly in lower-middle income countries means that governments tend to under-invest in their health sector relative to their economic potential. As these countries grow wealthier, the public health systems fall behind. Further, the priorities of the public health system may fall out of line with the health needs of the poorest and most vulnerable populations in the countries. There is a window of opportunity to ensure that growing domestic resources are directed strategically within the health sector and that development partners link programming to appropriate policy and technical assistance. The vision should be that domestic resource mobilization crowds out development dollars as countries advance toward the UHC goals they have committed themselves to achieving.

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