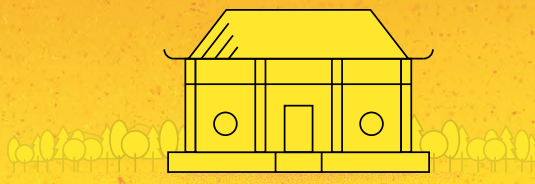
BRIEF 6

Health protection in Asia and the Pacific



Health protection underpins development

Health protection provides financial protection against the consequences of ill health and can underpin broader efforts to achieve universal health coverage. It prevents people from falling into poverty when they are sick or postponing health check-ups until it is too late. As a result of population ageing and the COVID-19 pandemic, health expenditures are increasing in much of Asia and the Pacific. Yet while marked progress has been made in extending health protection, gaps in coverage are significant.

In Asia and the Pacific, health care remains unaffordable to many. The consequences of ill health can be disastrous for individuals, families and society. They include loss of income and productivity, and at worst premature death. Out-of-pocket payments for health care services can push households into poverty: 72 million people were pushed into poverty due to the burden of such expenditure in 2015. Universal access to health care is a human right that could neutralize a major cause of poverty and underpin broader development.

Wide variety of health protection schemes

Health protection in Asia-Pacific is provided through a mix of contributory and non-contributory schemes. Many countries in North and Central Asia and in the Pacific use taxation to fund their health systems. Others, such as China, Indonesia, the Philippines, the Republic of Korea and Viet Nam, favor compulsory contributory health insurance schemes, with subsidies to contributions from low-income households. Schemes combining contributions with funding from tax revenues are the most prevalent, while some countries combine contributory health insurance with non-contributory tax funded schemes targeted at the poor. Private health insurance exists in most countries but coverage is limited.

The urgent need for health protection

Population ageing and increasing demand for higher quality health care makes health protection increasingly necessary. In many countries, high out-of-pocket expenditures remain the main source of health care expenditure and are often a result of the limited availability of publicly funded health systems. Reliance on out-of-pocket payments can lead to catastrophic expenditures for many households. In countries such Bangladesh, Cambodia, China, Georgia, Maldives and Tajikistan, one in five households spend more than a quarter of their total income on health.

Coverage increasing but gaps remain

Affordable health care is sometimes achieved by subsidizing health insurance schemes, complemented by non-contributory schemes. A common approach is to have three tiers of coverage: fully contributory coverage for those in the formal labour market; partially subsidized schemes for workers with contributory capacity; and fully subsidized contributions for groups deemed poor or near-poor. This has supported significant expansions in coverage in parts of the Asia-Pacific region. Significant gaps in coverage remain, particularly among groups that have a lower level of education or are younger and living in rural areas. [The Protection We Want. Figure 6.2 Despite various tiers of health-care coverage, large gaps remain]

In Indonesia, three quarters of those with higher education have health care coverage, compared to only half of those with a lower education in rural areas. Armenia, the Lao People's Democratic Republic, Pakistan and Papua New Guinea have average health-care coverage rates below 20 per cent of the population, but this drops to 5 per cent for the poorest groups. In stark contrast, Georgia and Kyrgyzstan have universal health-care schemes covering 90 per cent of the population. Cambodia has extended health-care coverage to the poorest through non-contributory Health Equity Funds, successfully skewing coverage towards the poorest. In Lao People's Democratic Republic, large coverage gaps led to the introduction of the National Health Insurance Scheme, which aims to achieve universal health coverage by 2025.

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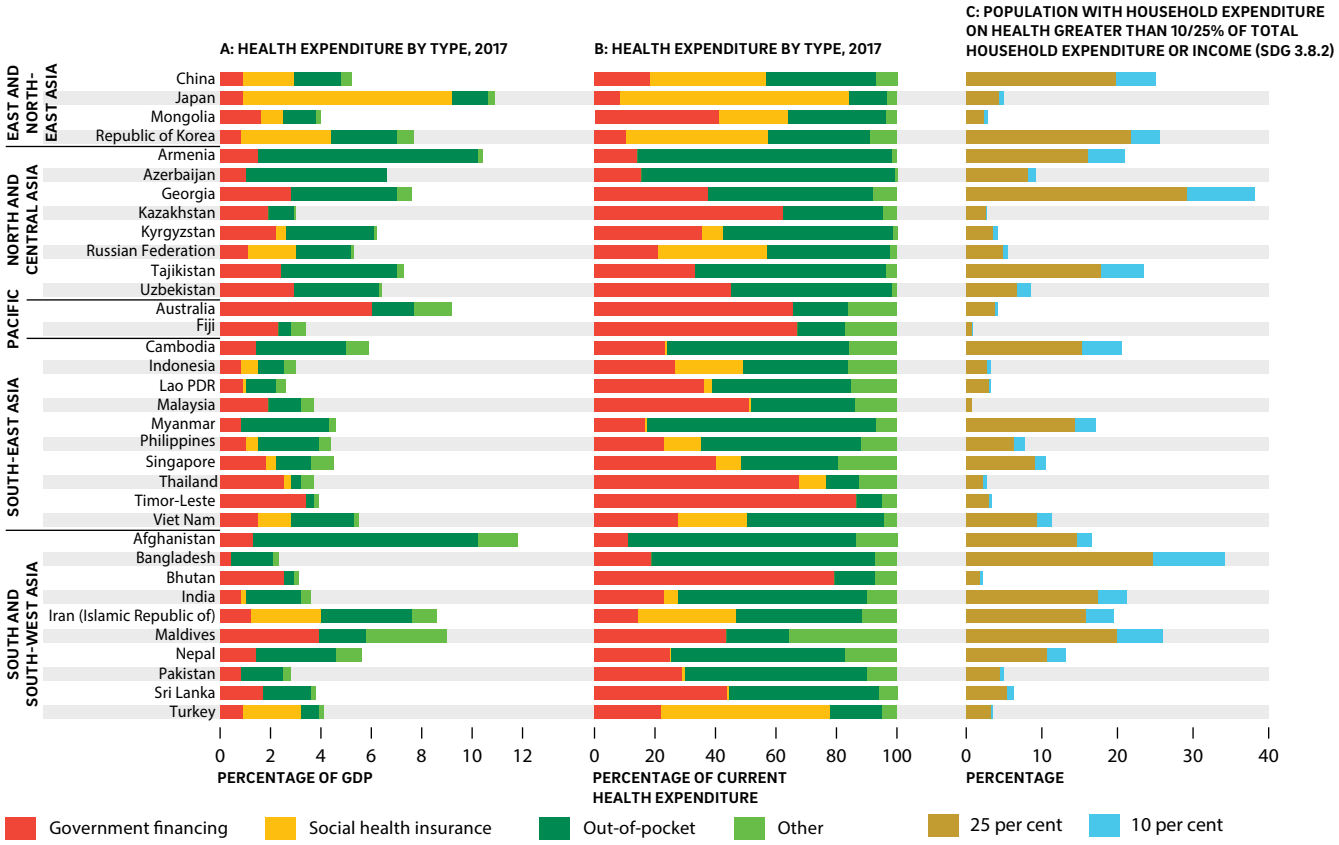
FIGURE 1 Health expenditure indicators, by country, 2017



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

TABLE 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.

This brief presents a summary of Chapter 6 of the ESCAP-ILO publication *The Protection We Want: Social Outlook for Asia and the Pacific*, 2021. For further information, please visit https://www.unescap.org/publications/protection-we-want-social-outlook-asia-and-pacific.