Health Care Financing

Options for Malaysia

Health Care Financing System

- Fundamental to health care system
- What are the goals of the health care system?

Universal Health Coverage

- Follows from “Health for All” and primary health care
- Key principles
  - Equitable access
  - Equity in financing
  - Financial risk protection

Goals

- Equity in financing
- Equitable access to quality healthcare
  - Ability to pay and location should not be barriers to access quality health care
- Financial risk protection
- Social solidarity, cross-subsidisation:
  - Healthy/sick
  - Rich/poor

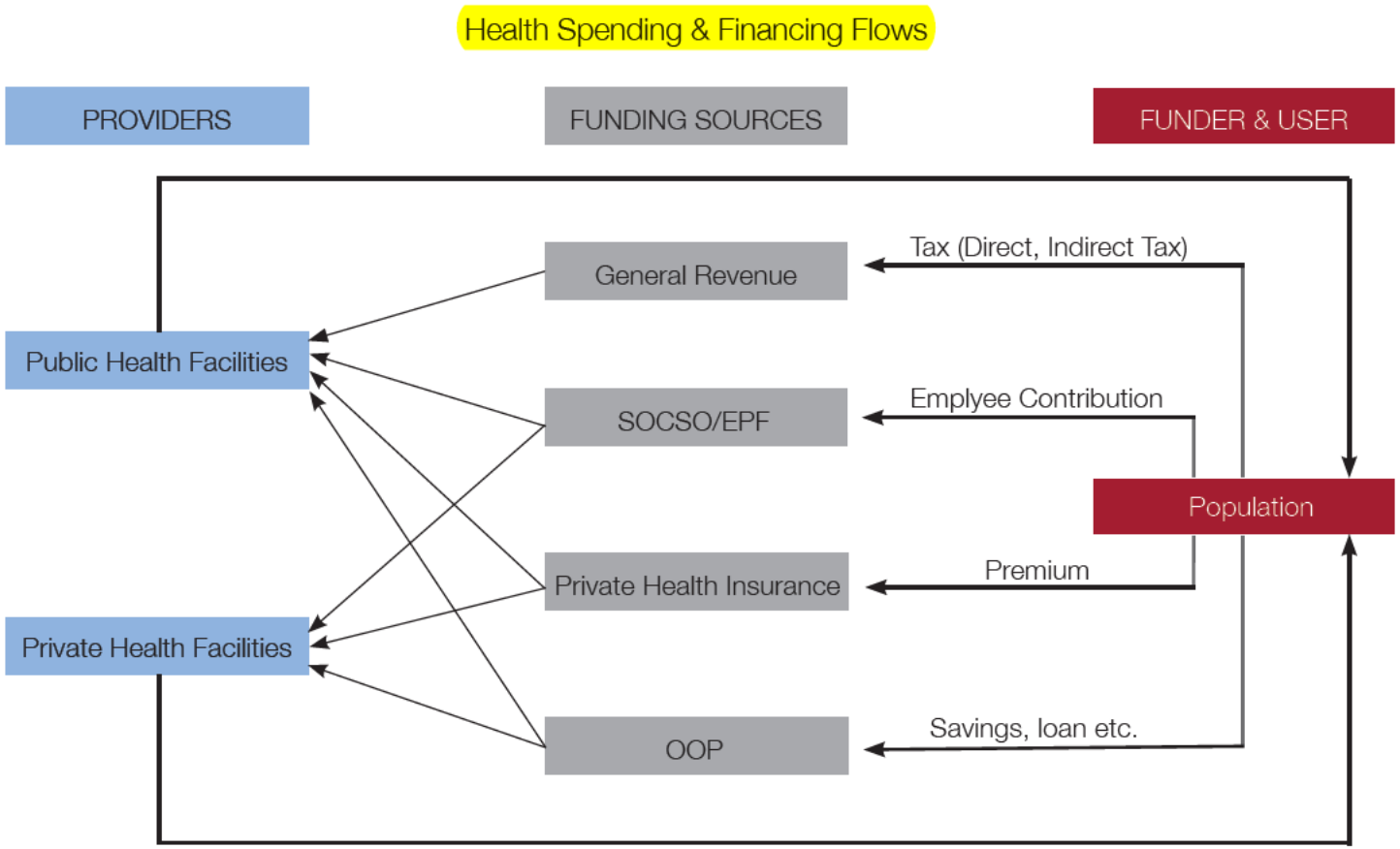
Equity in financing & access

- Revenue Collection
  - Progressive structure
    - Rich pay more, poor pay less
  - Prepaid
    - No charges at the point of utilization
    - Out-of-pocket payment should be low
  - Pooled across the population

HC Financing system must also be

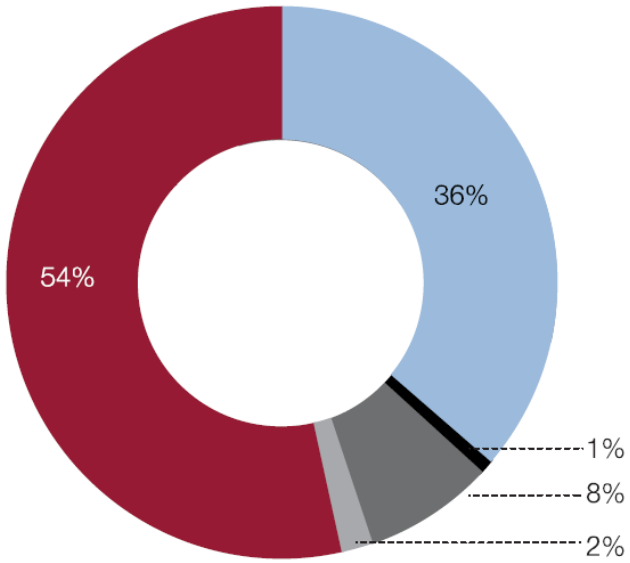
- Sustainable
  - Financial flow, purchasing and payment mechanisms must be able to withstand upward cost pressures
- Result in good health outcomes
  - Allocation to the different types of health care services must correspond to health needs
  - Payment mechanisms must not incentivise under-treatment or over-treatment

Figure 74. Health Spending and Financing Flows



Sources of health financing

Figure 72. Sources of Health Expenditures in Malaysia, 2013



About 50% public, 50% private

Data Source: Malaysian National Health Accounts (System of Health Accounts Framework, 2013)

Figure 73. Out-of-Pocket Expenditures as a Share of Total Health Expenditures, Malaysia and Selected OECD and Other Countries, 2000 & 2013

What are the issues?

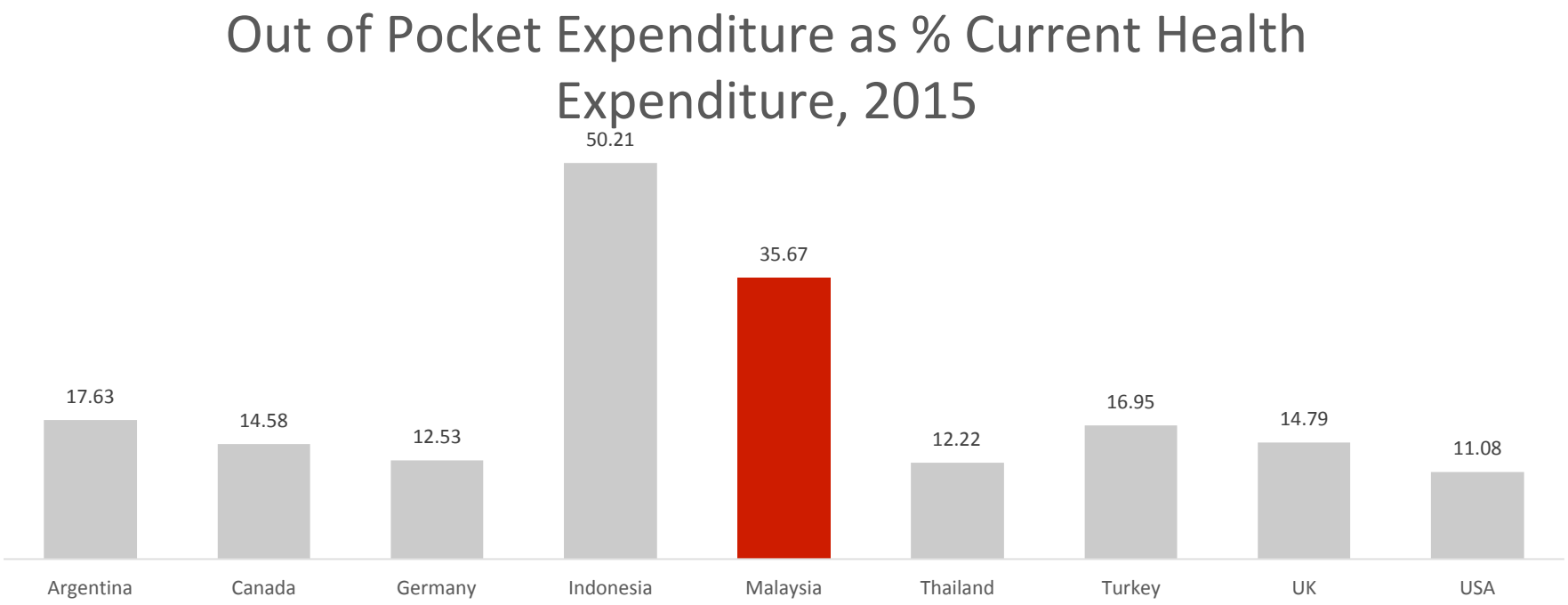
- Public sector
  - Long waits, lack of choice/ continuity of care
  - Pressures of doctors and specialists leaving
    - Levels of remuneration, service conditions
    - Increased work burden
  - ***Inadequate financing***
    - Reflected in rising private health expenditures

Issues/Challenges

- Private sector
  - Increasing charges
  - Increasing health insurance premiums
  - 94% of OOP is spent in private sector
    - Payment at the point of service
    - No pooling of risk

Issues/Challenges

- Out-of-pocket expenditure is high



Issues/Challenges

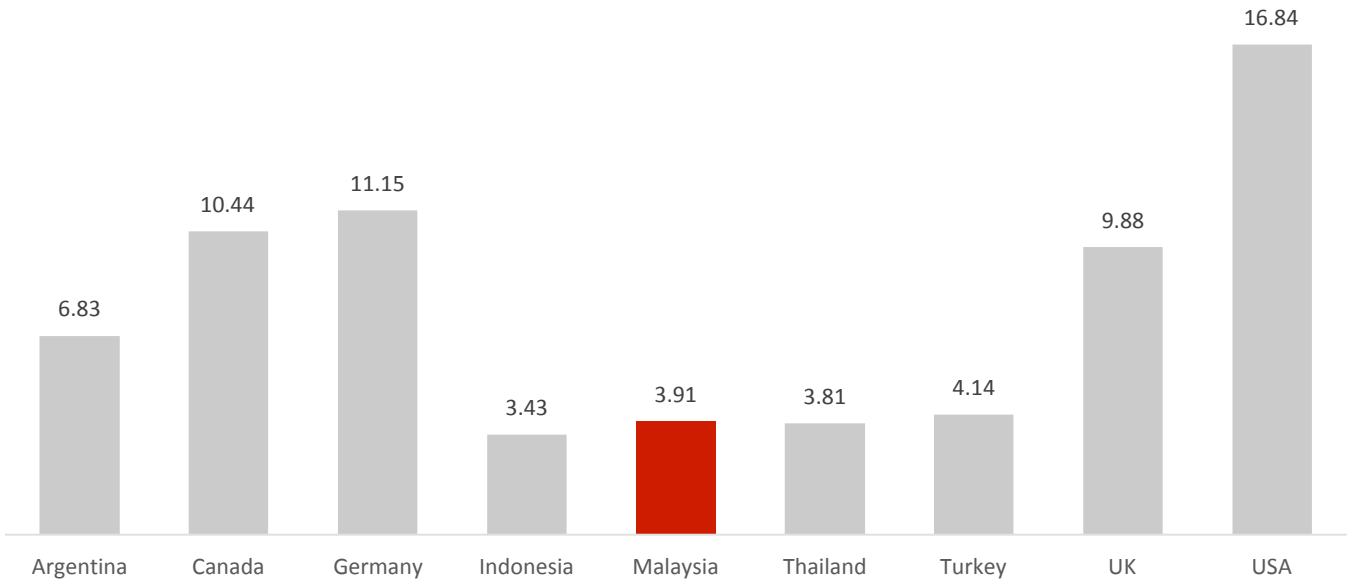
- Private health insurance
  - Late 1990s: negligible proportion, Current: 8%
  - Premiums based on individual risks
    - Not equitable, no cross-subsidization
  - Moral hazards, adverse selection (including the exclusion of pre-existing conditions)
  - Not single payer, weak negotiating purchasing power vis-à-vis health care providers
  - Premiums subject to upward cost pressures, not *sustainable*

Issues/Challenges

- Overall health system:
  - Increasing costs
    - Increasing non-communicable disease (NCD) disease burden
    - Aging demography
    - Upward pressure from expanding private health insurance
  - Increasing polarisation between public and private
  - Threatens principles of equity, access, UHC

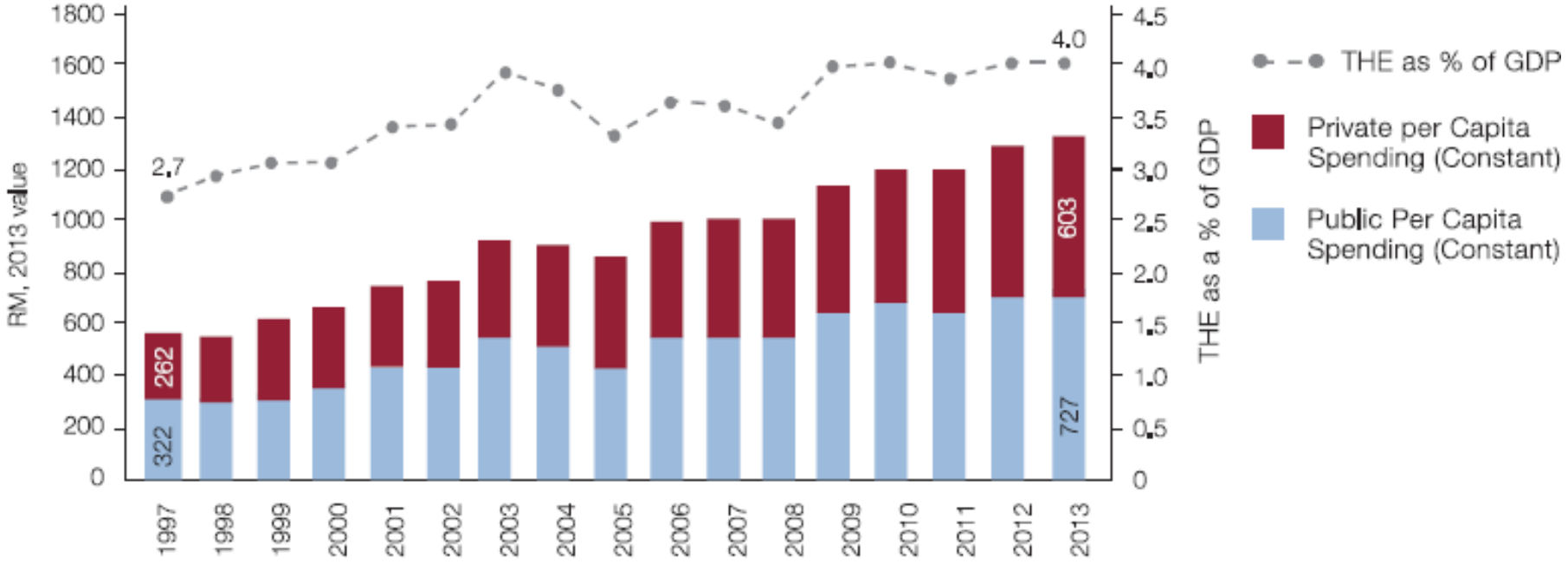
Options: What can be done?

Current health expenditures as % of GDP, 2015



Increase public health expenditure

Figure 62. Total Health Expenditure and per Capita Spending in Malaysia, 1997–2013



Data Source: Malaysian National Health Accounts (System of Health Accounts Framework 2013)

Question

- Retain tax-based financing or transition to social health insurance?

Social Health Insurance

- Primarily paid by wage-based contributions from employees and employers
  - Like a payroll tax
  - Unlike risk-rated private insurance
- Compulsory (private insurance is voluntary)
- Self-employed pays a flat rate
- Government pays for the poor, indigent

Social Health Insurance

- Cross-subsidization, social solidarity, UHC
- Variations in different countries
  - Progressivity, financial equity
    - Depends on how premiums are structured
    - Not achieved in many countries with SHI
  - Financial risk protection
    - Depends on range of benefits
  - Equitable access
    - Depends on co-payments

Social Health Insurance

- Evolved in countries with long history of workers' mutual assistance and sickness funds
  - Industrialization, economic growth
- Coverage in formal employment sector
  - Can have adverse effects—employers shift from formal to casual employment
- Difficult to cover non-poor informal sector workers (non-enrolment, evasion)

Social Health Insurance

- Adds an additional layer of administration and management (for enrolment, collection, coverage, benefits, payments)
- Tends to escalate costs and requires strong administrative controls

World Bank Study by Wagstaff

- Tax funded health system more equitable, cost-effective than SHI
- SHI replacing tax financing will *increase* per capita health spending by 3–4% without corresponding improvement in health outcomes
- Formal sector employment share likely to be reduced by 8-10% as employers casualise employment contracts to avoid employer SHI obligations
- Social Health Insurance regressive in most contexts

Feasibility of SHI in Malaysia

- Will it automatically lead to increased health funds? How will MoF respond?
- Will the public accept another 'tax'?
  - Successive social health insurance schemes proposed over the last 30 years
- Do we have the legal framework, and the technical, intellectual and operational resources needed?