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Review of National Commitments to Reducing Health Inequalities in Asia: Content Analysis of Policy Documents

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Abstract

The purpose of this paper is to summarize the experiences of Asian countries in formulating and implementing pro equity policies in the financing and delivery of their health care services. The study is based on the content analysis of health policy documents from the 15 Equitap countries in Asia namely Bangladesh, China, Hong Kong SAR, India, Indonesia, Japan, Korea, Kyrgyz Republic, Malaysia, Mongolia, Nepal, Philippines, Sri Lanka, Taiwan and Thailand. These countries comprise a wide range of diversity, not only in levels of economic development but also in terms of health systems financing and policy

Individual country collaborators were asked to collected government documents for review for statements of how the government was formulating and implementing policies concerning equity. Key domains were placed on a matrix, which was used to analyze policy documents from each country both in terms of policy formulation and implementation.

The common health policy objectives mentioned in the policy documents reviewed were improving the quality and effectiveness of health care services, improving its efficiency, improving access to health care particularly for the poor and reducing health inequalities. With respect to equity objective, policy statements were further analysed to reflect whether the focus was primarily on equity, equality and pro-poor policies. Analysis of the policy documents revealed both the definition used in the policy documents and the extent to which equity as a policy objective was made explicit varied between countries. In most countries, equity was defined in terms of access. In high-income territories the policy objective with respect to equity was "all have access to good quality care whereas it was minimal standards available to all in the low income countries. The strategies frequently mentioned in the policy documents to reduce health inequalities were improving access/coverage to health services, and giving priorities to improving health of the poor.

The policy implications of the findings are discussed and suggestions made. Our review suggests that Asian countries are committed to reducing health inequalities and are attempting to meet this objective in innovative ways.

Key words: Policy analysis, policy documents, Asia, health inequalities, equity.

1. Introduction

In 1978, the member states of the World Health Organization (WHO) accepted Primary Health Care (PHC) as their national health policy (WHO/UNICEF, 1978). Shifting the view of health improvements from the bio-medical paradigm to a paradigm focusing on social, economic and political determinants of health, PHC highlighted equity of health care as a basic principle. Since 1978, keeping equity on the policy agenda has not been easy. In an environment of financial constraints and political insecurity, many have suggested that PHC and its demand for equity are not realistic policy goals (Carpenter, 2000).

Severe economic hardship in number of economies and ideological shift to new public management had resulted in introducing market mechanisms within the health sector with the aim of improving the efficiency of the health system (Twaddle, 1996). Since the World Bank's publication "Financing Health Services in Developing Countries" (World Bank, 1987) equity and pro poor policies were neglected and the emphasis was on efficiency as measured in terms of cost–effectiveness. The World Bank's 1993 Report "Investing in Health" (World Bank, 1993) recommended the concept of essential package of services based on cost-effectiveness was a further blow to PHC, equity and pro-poor policies. Not only did the report not mention PHC but also it focused on a revamping of service delivery with efficiency and effectiveness rather than equity as major policy goals. Following this trend the WHO (2000) report on health systems was viewed by many as a move away from PHC and the health for all (WHO, 2000).

However, in recent years, reducing health inequalities through pro-poor policies has found a new support and impetus. Experiences have suggested that without addressing questions of resource distribution and problems of poverty, economic growth and security are severely threatened. The World Bank recognized this threat in its 2001-2002 Report "Attacking Poverty" (World Bank, 2000). The World Health Organization in its 2003 report highlights equity as key to health development and called for a revitalization of PHC (WHO, 2003). A number of bilateral donors including DfiD, EU, Rockerfeller, Ford Foundation too are committed to pro-poor policies. The recent millennium development goals (MDGs) by the UN millennium summit in September 2000 reflect commitment by the international community to pro- poor policies. Thus addressing health inequalities and pro poor policies are important issues on the current global agenda.

With this renewed concern for equity and poverty reduction on the international agenda the issue is whether this commitment to reducing health inequalities is also reflected at the national level. It is well known that the choice of policies influences the health status of the population (Whitehead et al. 2001). If health policies are aimed at reducing health inequalities then it would be essential that these are explicitly stated in the respective national policy documents. Analysing the contents of such national health policy documents with respect to equity objectives would be the first step.

This study is a part of the Equitap project, which aims to systematically assess equity in national health systems in Asia in terms of financing, utilisation, spending and health status. Besides microanalysis of equity, a key component was undertaking policy analysis of equity. Three studies were conducted using the policy analysis framework presented in Figure 1. Policy formulation and implementation takes place at various levels in the system. Understanding policy documents reveals the intent with respect to reducing health inequalities. The gap between the intent in the documents and its translation into effective implementation can be a major obstacle. In addition, policy documents often give no clear indications of opportunity costs and trade-offs between objectives. Eliciting views from the policy makers was aimed at addressing this concern. Finally, this leaves us with eliciting the views of the general public who play an important role as payers and users of the health services. Little comparative work has been done to assess views of policy makers and that of public in the region. Thus, besides the present study which analysed the policy documents, the other two studies under this policy component aimed to assess the views of policy makers (Bhatia, 2005a) and the general public (Bhatia, 2005b) with respect to health systems issues generally and health inequalities in specific (see Figure l). All these three pillars in the policy analysis framework are analysed in the context of the respective health systems.

For the present study, all 15 countries under the Equitap project were included in the study. These countries are: Bangladesh, Peoples Republic of China, Hong Kong (a special economic zone of the Peoples' Republic of China), India, Indonesia, Japan, South Korea, Kyrgzstan, Malaysia, Mongolia, Nepal, Philippines, Sri Lanka, Taiwan and Thailand. The purpose of this paper is to summarize the experiences of these countries in formulating and implementing pro equity policies in the financing and delivery of their health care services. Two key objectives were to (i) To understand the extent to which, health inequalities are a concern in the national policy documents, and (ii) What policies address these issues? In order to meet the above objectives we describe health policy in relation to equity in these countries; compare approaches to equity by developing an analytical framework; and identify common themes and issues emerging from these approaches.

The paper is structured as follows. The next section is devoted to the concept of equity followed by the brief profile of the countries included in Section 3. Section 4 then presents the findings, which are discussed in Section 5. Finally, the paper ends with policy recommendations and a conclusion.

2.0 Concept of Equity

Equity is regarded as an important policy objective in the health care field by researchers and policymakers alike. Research on equity, particularly among economists has been hampered by the view that research on equity is necessarily normative in character. Increasingly it is recognised that while the definition of equity is indeed normative, questions of whether equity, defined in a specific sense has been achieved, or has increased or tends to be higher in one setting relative to another belongs in positive economics research (Wagstaff and Van Doorslaer 2000). This, along with the growing importance of equity in international and national political

debates may underlie the increase in research on equity. In general, empirical research on equity has focussed on four key dimensions: (i) equity in health status, (ii) equity in the delivery of health care, (iii) equity in financing of health care, and (iv) equity in terms of risk protection.

In the context of health, equity has multiple meanings, for few of which there is universal agreement. It can also be applied to a variety of measures or objects of interest. Wagstaff and van Doorslaer (2000) contains a comprehensive discussion of the concept of equity in health economics, key points from which are summarised below.

Two dominant theories of justice found in the philosophy literature in the context of medical care are the libertarian and Marxist/egalitarian approaches (Donabedian 1971). Libertarians are concerned with ensuring that minimum standards are achieved. Egalitarians' main concern is with ensuring that health care is financed according to ability to pay, everyone enjoys the same access to health care and care is allocated on the basis of need with the objective of promoting equality of health. Recent empirical work on equity in health care largely reflects that relatively pro-egalitarian bias among policymakers (Wagstaff and Van Doorslaer 2000). This characterisation based on the distinction between libertarian and egalitarian perspectives of equity nevertheless leaves unanswered questions about what concepts such as *access* and *need* really mean, the relevant definitions for the four dimensions of equity mentioned above and the compatibility of the various interpretations of equity.

The term access is widely used to mean "receipt of treatment" both in policy statements and the academic literature (Wagstaff and Van Doorslaer 2000). Le Grand (1982) and Mooney (1983) have pointed out that while "access" refers to the opportunities available to people, "treatment" refers to whether or not people actually received them. An improved definition of access would therefore take into account the time and money costs incurred in obtaining health care. Under this definition however, if two people face the same time and money costs, they would be interpreted as having equal access regardless of their incomes. Yet another alternative proposed by Olsen and Rogers (1991) is to define access as the maximum attainable level of consumption of medical care, given incomes, time and money prices associated with receiving medical care.

"Need" for health care is often controlled for when measuring or assessing access as defined above. In most of the empirical literature 'need' is regarded as ill-health. The "equal treatment for equal need" principle is usually applied, implying that people who are relatively sicker than others ought to receive proportionally more health care. A definition of need that is based on current health is incomplete (Culyer and Wagstaff 1993). Firstly, need for medical care can only apply when medical care is available that can improve health. Secondly, need is an instrumental concept and one that ought to permit the non-ill to also need it, as in the case of preventive health care. An alternative definition of need proposed by Culyer and Wagstaff (1993) is the "minimum amount of resources required to exhaust capacity to benefit". An assessment of need will therefore involve an assessment of the amount of expenditures required to reduce the capacity to benefit to zero. In practice, need is often measured using indicators of current health status.

Assessments of equity in health status or equity in the delivery of health care invariably make references to three interpretations of equity: equality of access, allocation according to need, equality of health. However, access is only one of many factors that influence the receipt of medical care (Mooney 1983) and many do not necessarily produce an allocation according to need or equality of health. Culyer and Wagstaff (Culyer and Wagstaff 1993) investigated the outcomes associated with allocation according to need, with need measured using the three definitions described above. They found that allocation according to need does not necessarily result in equality in health or promote it for that matter. There is therefore very little consensus in the literature as to which equity principle is most appropriate for assessing equity in the delivery of health care. Sen (1992) has added another dimension to this by arguing that good health is an important element of a person's functioning and flourishing; if people have the opportunity to achieve this functioning and yet choose not to do so, the inequalities in health that arise are not deemed to be unjust. What is considered unjust is in inequality in the opportunity to achieve those functioning. Most of the empirical work to date on equity in the delivery of health care has defined access as the use of health care conditional upon need.

Assessments of equity in the finance of health care have invariably taken as their starting point the premise that health care out to be financed according to ability to pay. One dimension of this is vertical equity, in that persons or households with unequal ability to pay make appropriately dissimilar payments for health care; another dimension is horizontal equity, in that persons or households with the same ability to pay make the same contribution (Wagstaff and Van Doorslaer 2000). Empirical work on equity in health care financing, both in OECD countries and the developing world has largely been concerned with vertical equity, or the progressivity of different financing mechanisms.

Adequate assessment of the fairness of health care financing in any given setting must also consider the extent to which the potentially catastrophic financial burden of illness is distributed across individuals and the extent to which society's aggregate resources are redistributed in an attempt to lessen the financial burden on more vulnerable individuals. In the empirical literature, minimum standards approaches have considered the degree to which health care payments, particularly out-of-pocket payments exceed a pre-specified proportion of pre-payment income, or drive households into poverty. Equity in risk protection may be assessed in terms of the proportion of poor households that is impoverished as a consequence of health care payments or incurs catastrophic health care payments in relation to their annual household income. To the extent that public subsidies for health care are a means of protecting poor households from the financial consequences of illness, assessment of the degree to which health subsidies actually reaches the poor is also relevant for examining equity in risk protection. Benefit incidence studies have focused on the distribution of government subsidies for health care and the extent to which they help reduce income inequalities between socio-economic groups.

3.0 Profile of Study Countries

All the 15 Equitap territories participated in this study: Bangladesh, China, Hong Kong SAR, India, Indonesia, Japan, Korea, Kyrgyz Republic, Malaysia, Mongolia, Nepal, Philippines, Sri Lanka, Taiwan and Thailand. These countries comprise a wide range of diversity, not only in levels of economic development (Annex 1 Table 1), but also in terms of health systems financing and policy (Annex 1 Table 2). As other components of the Equitap study have shown these are associated with substantial variations in performance with respect to different dimensions of equity.

Japan, Taiwan and Korea are high-income developed economies with health care financing mainly based on social health insurance. To a large extent these countries do well in terms of equity in financing, protection against catastrophic medical expenses and health care use, with varying involvement of privately-provided health sector, funded through a national health insurance system operated by the government.

The other group of countries are Hong Kong; Sri Lanka and Malaysia, which are tax funded with dominant pubic supply system. Although Hong Kong is a high income country like Japan/Taiwan, their health systems are financed and organised quite differently. Hong Kong's health care system consist of a dominant general revenue-financed, hospital dominated public sector, which provides most inpatient care, alongside a largely ambulatory-based private sector which dominates in outpatient care provision. Although user charges are levied in the public sector, these are quite minimal in relation to average incomes, and empirical findings elsewhere in the Equitap study indicate that no households experience catastrophic medical expenses, and that government spending is the most targeted to the poor of any of the systems examined. Although Sri Lanka and Malaysia are not high income countries these too have strong public supply systems with good health status indicators.

Of the other countries in this analysis, social health insurance financing is found only in Mongolia, China, Thailand, Krygyz, Philippines and Indonesia. Of these, only in Mongolia and Thailand can these insurance systems be described as being universal in coverage of all income groups, although Philippines is expanding efforts to increase coverage through insurance. In both these countries, public sector facilities charge user fees, but the public insurance system covers most of these costs, and a higher proportion in the case of inpatient services. In China and Indonesia on the other hand, social insurance systems cover only a small proportion of the population, essentially in urban areas only. In rural areas, public facilities are the main source of health care provision in these two countries, and such facilities rely to varying extent on user fees, for which most of the rural population do not have insurance coverage. In general, amongst these social insurance-dominated countries, only Mongolia and Thailand are found to do well in actual equity performance, achieving high levels of protection of households against catastrophic expenses, and a less skewed targeting of government health care spending to the rich than occurs in China and Indonesia. Interestingly, it should be noted in passing that of this group of countries, China and Mongolia both share a common history of communist rule, although Mongolia switched to multiparty democracy in 1990.

The remaining countries of Bangladesh, India, Nepal and Sri Lanka have no significant social or private insurance financing. This has much to do with their common history of exposure to British imperialism (Nepal was not a colony but was a protectorate, and their generally low income. These countries rely essentially on general-revenue financing of public sector health services, with a parallel private sector funded by out-of-pocket payments. Sri Lanka has essentially no user charges in its public sector, Punjab (India) has modest levels and Nepal has substantial charges in its public hospital sector. Of this group of countries, only Sri Lanka does well in terms of effective targeting of government health spending to the poor (even though official policy does not explicitly target), and protection of households against catastrophic medical expenditures. Bangladesh and Nepal do quite poorly in these respects, and Punjab (India) somewhere in between. It should be noted that this variation in health systems equity is associated with significant health status outcomes, with Sri Lanka doing significantly better than the global average in terms of population health status with respect to its income level, whilst the others are only average performers.

4.0 Methodology

The study is based on the content analysis of health policy documents from the 15 Equitap countries in Asia. Individual country collaborators were asked to collected government documents for review for statements of how the government was formulating and implementing policies concerning equity. It was not considered necessary to have a cut off date for the policy documents, but majority of these documents were recent and reflect the latest policy statement in these nations.

The long term objective of studies on equity aims to show the impact of health policies on health status. In a study to examine the impact of PHC policies (a wider remit) in sub-Saharan Africa Dugbatey (1999) found this was a difficult task. One problem was the lack of data, particularly a systematic collection of data that investigates the specific links between policy and outcome. In addition there is the empirical problem of establishing an association between policies and health outcomes within a specific time frame. Dugbatey developed a comparative framework that took verbatim policy quotes and paraphrases from policy documents then developed a ranking system based of the perceived fit between respective policies and the instituted programs. This level focused on outcome measures and how they related to health status. He illustrated the analytical framework by using four case studies.

For this study, only policy documents available were analysed. It was therefore not possible to do such an extensive analysis. Nor was it possible to propose any type of ranking. Instead, domains were developed to describe and compare policy formulation and intended implementation using verbatim and/or paraphrasing quotes from the available documents. The domains were identified after reviewing all the available documents and selecting umbrella headings for common concerns. The domains fell into either the categories of policy formulation or implementation. However, as the policy formulation and implementation is influenced by the ideology of the respective country, ideology with respect to equity was explicitly looked for in the policy documents. These are described below.

Ideology

Ideology reflects the political and often economic view about how health services are to be delivered. For some countries, this view is a rather radical change from the post war formulation of health and education services provided free to all individuals by the State. The economic shock of oil price inflation in the 1970s and the subsequent economic repercussions in following decades has brought to the fore the New Public Management (NPM) (Kaul, 1997). The NPM calls for a reduction of State involvement in service delivery and a wider private/public partnership. These core principles form the basis for much of the present day health system reforms. They serve to refocus the policy orientation of States such as India and Kyrgzstan whose ideology was rooted in State socialism.

Formulation

There are three domains identified for description concerning equity policies. These are equity, equality, and explicitly pro-poor policies. Policies described in the equality box are those concerned with equal resource distribution; those described as equity are those developed to compensate for unfair and avoidable disparities. Pro poor policies are those that concern formulation of policy that specific address the needs and concerns of the lowest socio-economic population in the country. These people are often defined in terms of whether they are below the poverty line. However, in many countries, such as Bangladesh, Indonesia, Nepal and Sri Lanka, women have been identified as a sub-group that need specific attention and gender equity policies appear in these documents. The designation of women as a target group reflects the research that women are less educated, are household heads and thus the major economic support of the household, and are more economically exploited. These characteristics place women at greater health risks than males. According to Gwatkin, pro-poor policies are primarily concerned with improving the health of the poor and not reducing the differences between the rich and the poor (Gwatkin, 2002).

Implementation

There were also four domains identified to describe policy implementation. These are financing, delivery of services, health outcomes and barriers to implementation. Financing focuses on the way in which programs for addressing equity will be supported monetarily. Countries might choose social insurance, progressive taxation with earmarked health funds, forced savings by those in employment to pay for the years when they receive pensions and/or fee for service with exemption policies. Policy evidence here describes how each of the policies formulated will be financed. Delivery describes how the services will focus on providing and preserving services for those most in need. It identifies services provided to specific groups including gender related services. It identifies what services are to be available to whom. Health outcomes identify the proposed health improvements for which policy strives. This domain is one of the more difficult to describe as the policy documents do not provide much specific information in this area.

Barriers describe what might hinder policy implementation. Prominent among the barriers is the simple lack of money to implement proposed programs. The domain here gives figures on health expenditures at present for most countries and identifies

other factors described in documents that will hinder equity issues from being addressed.

The domains, described above, were placed on a matrix with formulation domains listed in the left side and the implementation domains across the top. This matrix was used to analyze policy documents from each country by describing the policy formulation and implementation (**See Table 1**). It was difficult to decide which policies and statements follow in the equity, equality or pro-poor categories. Therefore, it may be noted that although these are presented in different compartments, to a large extent these policy statements are interrelated with one another.

Limitations

The inclusion criterion for data review was the availability of documents collected by researchers in each of the participating countries. The first limitation was the availability of documents. It may be noted that the study is based on health policy documents, which were supplied by country collaborators. In general, documents that were not from the Ministry of Health were not included in this review. Similarly, documents from other sources including international organisations were excluded, as aim was to get national intent/ commitment. A second limitation is that the documents provided were those published in English. This raises a number of problems. It might be that the translations do not properly reflect the intent of the policy. In addition, it might be that important documents have not been reviewed because there is no English translation. Despite these limitations, it is of some comfort to note that these documents are shared in the translation with the international organizations such as WHO. They provide the data on which international discussion and analysis are made. A third limitation is that the information provided in the documents does not allow each of the domains in the matrix to be filled in. For example, not all countries have pro-poor policies nor do all documents provide information about health outcomes. In addition, the information provided often could be placed in one or another domain. It could be debated at length of whether a financing issue was an issue of equity or equality. However, in the overall scheme that the issue was explicitly addressed is more critical than which box it was placed.

5.0 Findings

A total of 49 policy documents were reviewed from these 15 countries. The country break-up of the documents reviewed is presented in **Table 2** and the list of documents reviewed is in **Annex 2.** The documents reviewed represented a range varying from constitutional documents, Acts and Byelaws to national policy documents and national 5-year plans and programme. Although there was variation from group of countries, essentially all the country documents expressed either implicit or explicit concerns to equity issue. In some countries equity statements were just mentioned in these documents whereas these were made explicit and fully described especially in high income countries. The detailed statements with respect to equity, equality and pro-poor policies are presented in **Table 3.** From these descriptions the major issues for equity were identified. A summary of the findings for country groups is presented in **Box 1**. These findings are presented below. The review of the 15 case studies

allows us to see some emerging themes and patterns and are discussed in the next section.

Health Policy Objectives

As the stated policy objectives would to a large extent influence the formulation and implementation of policies by the countries, the first question to address was "What are the health policy objectives in these countries and the extent to which equity is mentioned as a policy objective in these documents. The common health policy objectives mentioned in the policy documents reviewed were improving the quality and effectiveness of health care services, improving its efficiency, improving access to health care particularly for the poor and reducing health inequalities.

With respect to equity objective, policy statements were further analysed to reflect whether the focus was primarily on equity, equality and pro-poor policies. The summary of the policy statements on equity, equality and pro-poor policies are presented in the Box 1 below. It can be seen from **Box 1** that examples of policy statements on equity, equality and pro-poor policies can be found across countries irrespective of their level of development. With respect to equity statements the emphasis was on "fairness" in financing and delivery of health care. For example, equitable contribution based on ability to pay was mentioned in Korea, whereas equitable access to health care based on needs in Hong Kong and India. With respect to equality statements, there was clear distinction between high income territories and low income countries with weak health systems. Whereas access to good quality care to all appears to be the common in high income territories (e.g. Hongkong, Korea), the emphasis in tax funded weak health care systems countries is on minimal standards of care available to all (e.g. India, Nepal). In formulation of their health policies, govts in low income countries have attempted to define a package of essential heath care (basic/minimal package). Finally, pro-poor statements included shifting resources to primary health care (Krygyz, India), exemptions from user fee policy to poor (Bangladesh), insurance premiums adjusted/subsidised for the poor (Korea, Taiwan), safety nets for financially vulnerable (Hong Kong). Recognising that poor are mainly in the rural areas, with limited access (rather inequalities in access due to unequal geographical distribution of government health services) to health facilities in general and government facilities in specific, many policy documents defined priority groups based on this rural: urban divide. This was seen more commonly in countries like India, Indonesia, Nepal, Sri Lanka, Bangladesh, etc than Hong Kong, Japan, Taiwan and Korea. Similarly, many policy documents also acknowledged women, children, elderly, and disabled to be in a disadvantaged position should be considered as a priority group. Finally, those belonging to lower socio-economic groups were also mentioned in the policy documents as group to be targeted. Thus it is apparent that improving access to health care particularly for the poor are common statements in number of countries

Box 1. Summary of equity, inequalities and pro-poor statements in policy documents

Equity statements	
Country Korea	Social health insurance reform: more equitable contribution based on the ability to pay
Hong Kong	Everyone should have equitable access to quality health care for comparable needs
Thailand	Ensure every citizen possesses health insurance with quality, coverage and fairness
Indonesia	To maintain and enhance quality, equitable and affordable health services
India	Principle objective of new health policy to reduce inequities and allow disadvantaged sections of society a fairer access to public health services
Sri Lanka	Network of health institutions and facilities including GPs at Divisional Level within easy reach of people based on peoples' needs.
Equality statements	
Taiwan	Provide equal access to health care for all citizens
Sri Lanka	Minimum standards of care irrespective of class, creed, economic status, age, gender, etc. will be established
Indonesia	To provide quality health services to all Indonesian people, including the poor.
Nepal	Essential Health Care Services at the district, will be available to 90% of the population living within 30 mins travel time
Philippines	Universal coverage of health through SHI and aims to reduce out-of pocket expenditures
Thailand	Universal coverage through health insurance; every person has equal access to quality health services
Mongolia	Government pays for full drug costs for catastrophic or prolonged illness regardless of ability to pay; discounts on essential drug prices,
Malaysia	To enforce legislation to ensure affordable health care
Pro-poor statements	

Korea	Insurance premiums adjusted for those with low or no income. Government pays support for low-income patients suffering from rare and incurable diseases; Medical Assistance Programme pays for health services for the poor
Taiwan	Health insurance coverage will be extended to the economically disadvantaged group and the government will fully or substantially subsidize the premiums for the low-income people to assure their accessibility to medical care.
Hong Kong	: Safety nets for financially vulnerable :
Bangladesh	User fee policy, with exemption for the poor and the disabled; To ensure basic/essential health services are available particularly to the poor communities
India	Increased allocation for primary health sector
Kyrgyz:	Shift from system of reliance on hospitals to development of primary health care services

6.0 Discussion

As seen above, countries in the Asian region do have policies to address health inequalities. The study findings, strategies for improving access and barriers to effective implementation of these policies are discussed below.

Policy objectives and Findings

Some of the issues with respect to policy objectives are discussed below. First, both the definition used in the policy documents and the extent to which equity as a policy objective was made explicit varied between countries. In most countries, equity was defined in terms of access. In high income territories the policy objective with respect to equity was "all have access to good quality care whereas it was minimal standards available to all in the low income countries. Some of the equity objectives were explicitly mentioned in some documents whereas these were implicit in others. Second, it appears that the equity objectives are being dominated be effectiveness/efficiency objectives. For example, equity is defined as "access to effective care" or "access to good quality care" rather than equitable access per se! Thirdly, it is apparent that one of the key issue is the trade-off between improving overall health of the population vs. reducing health inequalities[1]. Given the resource constraints, trade of between equity vs. efficiency goals is inevitable. Although most health care systems aim towards universal coverage, in practice, many systems aim at brining medical care received by the poor up to a minimal standard rather than at promoting equality of access. In a study by Lindbladh et al. (1998), the authors concluded that equality in health is not a policy objective because it is thought to be equitable. Instead it is believed to be an efficient way to maximize public health (the common good), on the assumption that you get more health per dollar by aiming at the health of the poor.

[1] See Bhatia et al. (2005a).

Fourthly, policy objectives in terms of equity are not clearly stated. For example, it is observed that govts in many low-income countries are attempting to provide basic minimum level of health care. However, what is a minimal level of health care? This is not clear from the policy documents. Similarly, statements like “everyone has right to have access to health care services” are frequently mentioned in the documents but what access means is not clear. It may be noted that from an egalitarian perspective, equity requires reduction of all unjust and avoidable disparities and not just ensuring minimum standards for all. It appears that many countries are struggling in between as a compromise between egalitarian vs. libertarian view. Fifthly, health objectives should be stated in distributional terms. In all the countries, the health objectives were stated in terms of the population in general and not specific to the worst off. The problem with such an approach is clearly discussed by Gwatkin (2000) that such targets could be achieved by not benefiting the poor at all or even by increasing health inequalities. To ensure that inequalities are removed through improving the health of the poor, targets specific to the poor would need to be set. Finally, there was no mention of vertical equity in any of the policy documents. According to Mooney and Jan (1997), it is essential countries with marked health differentials between groups do have policy statements addressing vertical equity. Given the large health differentials between groups in number of Asian countries, one would expect explicit mention of policy statements on vertical equity in the policy document. However, statements on vertical equity were lacking in most documents.

Ideology

The results of the content analysis of the policy documents must not be viewed in isolation but within the overall ideology for these countries. One pattern that can be observed in this domain is the historical shift from state responsibility for the provision of free and universal health care to a reduction of state responsibility. There are many reasons for this shift including a change in the global political environment and the wider and rapid communications networks now available. However, the major impetus of this shift must be attributed to reduction of available resources in relation to growing and increasingly demanding citizens of the state. As the need for hard rationing decisions, accountability and efficiency becomes more pressing, alternatives that decrease state responsibility and funding are being sought. In all countries under review, the reduction of the state's involvement in health care and a restatement in policy of a reformulated policy that places more burden of care and cost on the patient is a repeated pattern.

Under the influence of new public management and structural reforms, policies legitimise market based inequalities with emphasis on willingness to pay (WTP) for health care, legitimise user fees, and restrict public spending on health care are commonly employed. With shrinking public sector resources, it is not surprising that most countries in Asia have an expanding private sector. One suggestion of dealing with the crisis, made by the World Bank and increasingly followed in donor rhetoric, is to focus public sector resources on the poor and primary health care services. For example, both Indonesia and Nepal recognize the need to shift the emphasis from curative care to a preventive/promotive orientation reducing the costs of health care provision. In Indonesia the government has adopted the pursuit of a "healthy paradigm" where allocation is being shifted from curative and rehabilitative care. In

Nepal, focus is on shifting resources from a curative sector to support an under resourced public health sector.

There are number of issues with respect to equity if governments focus public sector resources on the poor and leave the rest of the population to seek curative care from the private sector based on willingness to pay. Besides leading to fragmentation of services this approach would also result in poor services for the poor. As the middle-class opts out of public services there will be less resources with which to maintain a service for the poor, and the poor have little political voice with which they can defend their interests and increase budgetary allocations. In addition, as the private sector is based mainly on out of pocket payments, it is naturally inequitable as the ability of the rich to pay is greater than that of the poor (Mooney, 2000). It is argued that private sector takes the burden off the state and leaves more for the poor. However, as discussed by Mooney (2000), it may be more equitable for making the rich pay more in taxation for the public health system instead. Similarly, number of policy documents mention providing incentives to the private sector (and insurance). According to Mooney (2000) such subsidies benefit the rich and have no justification on equity grounds. Finally, such a shift from pubic sector to private sector would need a strong and responsive private sector on the one hand and a government sector which has the capacity to regulate the private sector effectively. However, government in several countries has not been able to ensure efficient and effective private care provision. In Bangladesh, the Philippines and Nepal discussion about these problems is seen in the policy documents. In all these countries, regulation of the private sector is a main concern. In Hong Kong, the government also is shifting focus to preventive programs but the private sector is strong and able to provide regulated care for those who can pay.

One of the impacts of the health sector reforms has been increased contributions by the individuals to health care either in the form of direct fees for service, co-payments for service and/or health insurance schemes. Fee for service in many countries is essentially out of pocket payments (OPP). While this course of action efficiently raises revenue it tends to discriminate against the poor. In Malaysia, where WHO ranked the country very high in terms of OPP, (Malaysia recorded 43.4% OPP,) the government defended its position by saying health insurance for the employed and provision of public sector health services through taxation ameliorated the projected impact of OPP expenses. However, other countries with high OPP have acknowledged the problem. In Thailand households pay nearly half of all health expenditures. OPPs are also high in the Kyrgyz Republic. Number of studies have argued the negative impact of user fees for health care in developing countries (Gilson, 1997; Whitehead et al. 2001). However, very few policy documents explicitly attempted to address this issue.

Many governments do have in place exemption policies that allow free curative care for those who can prove real need. However, weak infrastructures and lack of accountability often means that the target population does not receive what is intended by law. Several countries identify those living in rural areas as people with specific needs. However, this policy does not discriminate between the rural dwellers who are a bit better off than those in absolute poverty. In addition, the policies do not address the needs of the urban poor. In countries without strong regulation and good

administrative infrastructures to process individual claims for compensation, pro-poor policies tend to remain on paper. In addition, in some countries in the region, the commitment to service to the poor is badly hampered by lack of funding and staff.

One major argument for improving the efficiency of delivery of health services in terms of both efficiency and equity was to decentralize decision-making including financial allocations from the central to the lower administrative units. It was argued that decentralization was promoted as a way of responding to local situations to make health care more efficient and effective. There is a mixed record of success in decentralizing health care systems. (Kolehmaninen-Aitkin, R. 1999). The difficulties of such approaches are illustrated in the case of the Republic of the Philippines. Reviews highlight that devolution has meant services are inaccessible in some parts of the country. These parts are those which were already underserved. In addition, devolution has meant, contrary to expectation, central government spending has increased. At the local level, fragmentation of health delivery facilities and local health financing has created a barrier to both efficient delivery and focus on needs of the poor. Other examples are found in the cases of Korea, Sri Lanka and Nepal where urban areas, better served than rural areas due to resource allocation and infrastructure, command more resources than their poor countryside neighbors. With respect to decentralisation, the key issue is even if addressing health inequalities is on the policy agenda for the centre, but given the widespread wave of decentralisation across countries in Asia, is this still a concern at local level? Do national priorities influence local policy agenda is an area for future research.

Strategies for improving access to health care services

All countries have a pattern that sees them committed to equity and to providing some type of safety net for those most in need. Although to a varying degree, all struggle in the context of shrinking resources, increasing expensive health care and population expectations for improved quality of life. Governments in all case studies are committed to seeking a basic provision of health care in which all citizens are guaranteed universal coverage. Most often this is expressed in the development of a good public health system becomes the basis of prevention and health promotion. The commitment to curative care varies. Where there is a strong presence of private sector, more and more governments in these countries seek to use this private sector to provide curative care for those who can pay. Where the sector is weak or non-existent alternatives are sought. The most popular alternative is the search to develop some type of health insurance that is a form of pre-payment against future illness. At a basic level, this might be buying health cards, as in Indonesia and Thailand, where rural poor pay in advance for treatment. On a more complex level, national governments in the region are seeking to spread the cost of care by compulsory payments either through employment or other categories of contribution to ensure a steady and predictable contribution. All countries are seeking mechanism to ensure those who cannot pay still have care.

The need to allocate resources based on needs and a shift in resources towards primary health care is reflected in number of policy documents. Policy documents of number of countries like India, Nepal, Bangladesh, and Sri Lanka clearly mention increased allocation of resources to primary health care as an important strategy for reducing health inequalities. The focus being strengthening rural health infrastructure,

increasing health staff allocation mainly through provision of incentives to doctors in rural areas, and improving quality of services, etc. The assumption being that increased availability of govt health facilities and manpower would improve the access to these services by the rural poor. It seems proximity and improved quality appears to be important factors in improving access by the rural poor. However, there is enough evidence to suggest that the rich benefit more from the existing government health services. If this is the case, then further expansion of facilities/scaling up without any changes may have limited impact on the health of the poor. However, additional resources are mandatory. Such a shift in presence of a cost-containment strategy would be extremely difficult. Assuming that additional resources are committed resulting in strengthening of PHCs, it is logical that more people will utilise these services. This will result in more referrals made to higher level facilities and hospitals, which therefore would need further strengthening and resources. Hence strengthening PHCs at the cost of hospitals may not be an effective long-term strategy.

Unlike rich countries, which have universal coverage, an approach commonly adopted by many low-income countries to improve access to health services is targeting. The rationale for the poor countries to opt for targeting is given the resource constraints how best to improve the health of the poor. By targeting resources to the poor in order for them to benefit from it, this approach intends to reduce existing health inequalities in the system. Some of the common targeting strategies observed in the documents of number of countries are geographical targeting to rural areas, increase allocation to PHC, targeting of diseases affecting the poor like malaria, TB etc. For example, the shift of resources more to rural areas and more to basic health services (primary health care) is a common feature in health policy documents of number of countries. By focusing on the poor, targeting strategies aim at reducing socio-economic and regional disparities in the provision and access to health services. The question however is to what extent are these targeting strategies effective in practice?

Barriers/Factors constraining access

Although equity has been an official priority in the health policy of all members of WHO since 1978, pursuing equity has met with great problems. These problems can be categorized under two headings--financing and capacity. Financing focuses most often in the tension between equity and efficiency. Capacity focuses on weaknesses in both institutional and human resource capacities.

For most governments, general taxes are the basis for the provision of health care for the public. The most efficient way of collecting taxes is to create a standard formula for income tax and direct taxes. However, this is problematic in countries where records for earned income are scarce and often inaccurate and where direct taxes applied uniformly penalize the poor. In addition, taxes can be difficult to collect and can be liable to diversion by officials. An example of the problems is reflected in the implementation policy in Thailand. The overall tax system in Thailand is regressive contributing to greater inequality. In addition, taxes on consumption help the high-income earners and penalize low-income earners. Thailand is now pursuing a system of direct taxation where progressive income tax and proportional on tax on non wage earners could help reduce imbalances. However, this approach does not attack poverty directly.

There are other examples of where tax revenues have failed to allow policy formulation on equity in health care to be successfully implemented. India has policy to provide universal coverage for comprehensive PHC services but has neither the money nor capacity to do so. Japan seeks universal health care coverage but at this time sees over 1/3 of the health budget being spent on those over 70 years old. Korea, with an aging population, also has difficulty in providing its objective of a lifetime health maintenance program for all its citizens. Perhaps the most extreme example is that of the Krygyz Republic where independence from the Soviet Union has seen both reduced purchasing power of its currency and a radically reduced allocation of the government to health care. The contradiction between commitment to equity and the ability to pursue this policy due to lack of money is most striking here.

Prepayment has been highlighted by WHO (2000) as the most effective means of insuring stable, on-going financial support for health care. Some type of health insurance is the most common form. Most countries under review are seeking to build and support some type of health insurance scheme that will provide consistent and predictable revenue for government health care with explicit targeting of the poor and vulnerable. In the case of India, Korea, Sri Lanka, and Thailand women have been identified as populations that need special concern. The countries with strong financial bases including Hong Kong, Japan, Korea have universal health coverage and are seeking to support this policy in the future by establishing compulsory savings schemes for health care. These schemes are mandatory but have provisions for those who cannot pay either in contributions to the scheme or in terms of the care required. India is investigating establishing a social insurance scheme. In Sri Lanka, the government is establishing a "health earmark tax" for funds to support government health services, a modified version of health insurance. Malaysia is the one country that does not refer to an insurance scheme for universal coverage.

Capacity constraints

Lack of capacity to implement policies with equity concerns is the second problem of pursuing equity. Capacity weakness is seen both in terms of administrative infrastructure and human resources. In the context of the former, Sri Lanka illustrates an archetype. According to the policy documents, the health services lack proper planning, meeting ad hoc demands rather than needs. They respond to political exigencies. They are compartmentalized without any exchange or communications between departments. There are other examples of administrative weaknesses. In Nepal, there is no efficient and effective referral system and essential components of preventive health services are either not available or not carried out as defined by the policy. In Korea, there is not a sufficient infrastructure to establish a new medical fee payment system to gain more money for government health insurance schemes. Malaysia lacks the capacity to introduce a cost-sharing scheme. Japan lacks the capacity to control medicine use and cost. The Philippines has difficulty in implementing decentralized policies as the Local Government Agencies lack the capacity to support these reforms.

A major problem is to ensure efficiency in the administration of these schemes. In India, in an attempt to develop an accountability system for health staff, a community-monitoring program is being developed. Hong Kong also is trying to establish a

community model where all welfare services including private provision will be consolidated and monitored at the community level.

A striking example of infrastructure weakness is found in the Kyrgyz Republic. The remnants of Soviet control have left the country with a reliance on hospitals, too many staff and a poor system for managing the existing resources. In addition at the primary health care level, facilities lack drugs and disposable equipment. As a result, too many people are referred to a deteriorating hospital structure. This situation undermines both equity and efficiency in health care.

Another example of weak infrastructure is illustrated in the area of regulation. Nepal faces a rapidly expanding private sector with few laws to guide the provision of care. With devolution in the Philippines, rigid regulation has meant it is very difficult for facilities to meet these standards. There are regulatory gaps in the control of outpatient facilities that give consultations, diagnostics, laboratory and regulatory services. In addition, the government needs to make rules to govern an expanding private sector. In Korea, there are reported problems in ensuring efficiency in the administration of the National Health Insurance. There is also a poor community level service provision that cannot meet the demands on the services at this level.

In the context of capacity in terms of human resources a major concern is staff availability. Some countries basically lack to staff to carryout their projected policies. Both Nepal and Malaysia state lack of staff is a problem. Another aspect of staff availability is deployment of existing health personnel. In the past, in most countries, doctors provided first contact for any illness. However, due to reduced numbers of doctors and preference of doctors for urban deployment, the provision of doctors' consultation at the first contact is being examined. The Philippines emphasizes the problem of doctor availability documenting that 43% of doctors in this country are working in the Metro Manila area. Both Hong and India are examining the use of lower level staff to be deployed at the first contact level. The other side of this same coin is illustrated in the case of the Kyrgyz Republic. Here, as the result of the historical inheritance of Soviet Union policies, there are too many staff who are both underutilized and underpaid. As a result, the available human resources are very poorly used.

Another area of obvious weakness is the lack of staff capacities to implement health policies. This situation is mainly due to lack of training and experience. Bangladesh highlights the weak planning and management capabilities of staff. This situation is also emphasized by the government of Nepal where the central planning does not allow staff to accurately reflect health needs of the population. In addition, Nepal lacks technical staff. In the area of service delivery, Indonesia states the need to retrain staff to work in promotive rather than only curative situations and to learn how to function in a decentralized system where decisions are made at the local level. Sri Lanka lacks staff to run the National Drug Quality Assurance Laboratory.

In terms of equity, weak capacity denies adequate capacities to address the problems of those with greater needs. Poor planning capabilities, a drifting preference for better resourced urban areas over poor rural areas, a concentration of health staff in less challenging environments and an inability to enforce rules and regulations that benefit the poor are the result. Countries struggle not only with lack of finances but also with

the need for more training and more experience to strengthen the infrastructure and improve staff performance. Reviews of case studies such as the Kyrgyz Republic suggest this will not be an easy task. A major reason is that expectations by planners, health personnel and patients not only skills of professionals will need to be re-oriented. The time line for the former is far greater than for the later.

6.0 Recommendations

If equity is a serious concern in the Asian region, it should be explicitly stated in policy documents as a central objective rather than being implicit or submerged under the objectives of effectiveness or efficiency. In addition, health objectives should be stated in distributional terms. In none of the countries did the policies mention equity-oriented targets. Depending upon the country context, health inequality targets related to infant mortality, maternal mortality, life expectancy, etc. could be developed. The aim is to narrow the widening gap between the population as a whole and those who are poor in terms of health benefits. This will help focus the direction of policy makers towards health inequalities and health of the poor!

It is apparent that in terms of financing payment should be related to ability to pay (ATP) and not use of medical facilities and that access to health care on need. Efforts to be made to allocate resources according to some definition of "need" rather that distribution of population (per cap). It is essential that any such resource allocation formulae include health outcomes particularly linked with health inequalities. This would ensure greater allocation of resources towards poor and giving priorities to diseases affecting the poor. The objective of all the formulae is to distribute resources for provision 'fairly'.

There is a need for further research to assess set of interventions, which would translate equity policy goals into specific strategies. Some options presented in the documents were related to promoting public private mix, reducing geographical disparities in allocation of resources (e.g. allocate resources to underserved population, shift expenditure to PHC and redistribute health personnel); to improving access (increase in government spending on health, universal access to essential care, decrease user fees, exempt poor, etc.). However, there is lack of evidence on what policy interventions reduce inequalities in health. Measure progress/monitor to provide guidance to policies and programmes.

In this era of decentralisation on the one hand and globalisation on the other, if reducing health inequalities is a priority, appropriate action is needed not only at national level but also at local and international levels. A good starting point would be to disaggregate national health stats to explain regional and local variations. The role of international organisations could be to provide leadership, evidence base on what works, WTO and trade policies, etc. We need to move beyond statements of belief in health equity towards a clearer identification of who is responsible for what. The international community can have a high level of influence, but given the multiplicity of donors and their differing agendas and priorities in such fragmented states, it may be difficult to ensure that they coordinate with one another and contribute to establishing a policy framework.

7.0 Conclusion

As policy statements are statement of intent, it is possible that these intentions are not matched with actual implementation in reality. Hence unless matched with strong commitment and resources, expectations of what the desired policy may achieve may not be met. One of the limitations of this study is that implementation has not been addressed in the study. There is sufficient evidence to suggest that even where there are strong policies in place, implementation of these policies is weak.

To answer the question "is reducing health inequalities a concern in Asian region", this study looked at national policy documents from 15 countries in the region. As there was huge variation between countries based on their financing system and the state of the public health system. It was observed that in many countries the primary concern is increasing effectiveness and efficiency and assume that poor will like everyone else benefit from increased effectiveness and efficiency. Even if targeting towards poor, it's aimed at maximising health gain rather than reaching poor. Where concerns for poor rose in documents but more rhetoric as no clear policies aimed at meeting their needs. There is a tendency to continue to pursue policies that may increase health inequalities. Mackintosh poses the simple question in relation to the UK and Eastern and Southern Africa - why should we expect more equitable health policies when the economic context is one of deepening inequality (Mackintosh, 2001)? We suspect this is useful to keep in mind when we are trying to get past donor and government rhetoric on targeting resources towards the poor. Most of these countries have adopted are moving towards market economies and in doing so conflict between equity efficiency objectives is obvious.

Definition of equity used in the policy documents varies between countries and to some extent influence the policies that are formulated. Improving access to health services is important in many policy documents. Not clear how? Criteria? Many mention increase access to vulnerable groups, special groups (MCH). Most policy statements were rhetorical and were not backed with sufficient evidence on how these were to be implemented. Weak conceptualisation of policy needs (not clear which specific groups to focus – poor, children, women is too broad). There was apparent conflict between universal coverage (access) to minimum care vs. pro-poor policies. With minimal care there is risk of maintaining existing inequalities as it ignores current differential levels of access/utilisation. In practice, many systems aim at brining medical care received by the poor up to a minimal standard rather than at promoting equality of access

The strategies frequently mentioned in the policy documents to reduce health inequalities were improving access/coverage to health services, and giving priorities to improving health of the poor. Improving access: introducing Social health insurance, safety net for poor, exemptions for the poor, free health care for all, provision of essential package of services to all, etc. Priorities to poor: safety nets, exemptions, and health cards. Question is to what extent these are effective given the constraints in resources and capacities particularly in some of the low-income countries. Overall, it appears that there is good intention on the part of the governments but it may be unrealistic to strive for equity per se! Policy statements on its own are not sufficient to ensure implementation and achievement of equity objectives. Implementation will be crucial. Success is most likely with strategies that

connect health care reforms with the wider set of public sector reforms and in doing so address the underlying determinants of health inequalities.

Equity has been recognized by international agencies and national governments as a critical objective for the health of the nation and of the international community. There is a growing dialogue among and between governments about the importance of equity to ensure both human rights and a stable, progressive future for all human beings. The challenges equity poses are enormous. Our review suggests that Asian countries are committed to reducing health inequalities and are attempting to meet these challenges in innovative ways.

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Table 1: Matrix used for analysis of policy documents

Statements of: Formulation/Implementation	**Financing**	**Delivery**	**Health Outcomes**	**Barriers**
Country				
Ideology				
Equity				
Equality				
Pro-Poor				

Table 2: No. of policy documents per territory

Equitap collaborators	**Number of documents**
India	*3*
Bangladesh	*2*
Nepal	*7*
SriLanka	*1*
Hong Kong	*5*
Philippines	*2*
Indonesia	*7*
Taiwan	*1*
Thailand	*2*
Japan	*2*
Korea	*1*
Kyrgyzstan	*2*
Mongolia	*5*
China	*1*
Malaysia	*6*
Total	*47*

Table 3: Equity, equality and pro-poor statements from national policy documents

1. Country: *Japan*

Ideology: Universal medical care insurance system through mainly 2 types: National Health Insurance covering self employed, farmers, unemployed and employe health insurance; Government-Managed Health Insurance for mainly small and medium companies.

Barriers: Medical expenditure on people over 70 years takes 1/3 of national health expenditure; drug pricing policy gives incentives to use expensive drugs; R&D drugs with questionable efficacy but generate large profit; patient acceptance of large number of drugs due to lack of information

Policy statements	Financing	Delivery	Health Outcomes
Equity	Long term care premium calculated so burden eased for people with low income and offset by a greater burden for those with high income		
Equality	Long-term care Insurance System combines medical and social welfare through payments used to offset cost in old age; fixed 10% cost of service		
Pro-Poor			

2. Country: *Korea*

Ideology: Comprehensive health promotion programmes from cradle to grave through active and preventive health promotion including disease control, and healt maintenance and rehabilitation programs; welfare benefits for low-income group regarded as the (social) right rather than charity.

Barriers: Primary care at community level not sufficiently provide required services; health care delivery and payment system do not provide lifetime health maintenance; difficulty in ensuring efficiency in administration of National Health Insurance; disparities in health status between urban and rural and different soc classes; coinsurance rate and out of pocket payment affect the poor

Policy statements	Financing	Delivery	Health Outcomes
Equity	Social health insurance reform: more equitable contribution based on the ability to pay		Research done on women's issues on health an welfare to devise policies
Equality	Universal health insurance coverage	Government provides free vaccination for infants	
Pro-Poor	Insurance premiums adjusted for those with low or no income. Government pays support for low-income patients suffering from rare and incurable diseases; Medical Assistance Programme pays for health services for the poor	Senior citizens (over 65) in low income bracket get care in free or low priced health facilities; also get free health check-ups and health education	

3. Country: Taiwan

Ideology: To assure people's access to medical care in the form of service provision to improve or restore their health condition in the events of illness and injurie
childbearing. Appropriately allocate medical resources in prevention, disease curing and rehabilitation. Control total health spending to a reasonable level and mal
efficient use of health resources; and continually enhance quality of care.

Barriers

Policy statements	Financing	Delivery	Health Outcomes
Equity	Payroll tax financed mechanism. Financing burden should be distributed according to ability to pay.	Provide equal access to health care for all citizens.	Provide all citizens with appropriate hea services to promote their health.
Equality		Implement referral system: OPP increases if attend facility without referral; 30% paid by individual if go directly to district hospital; 40% if visit regional hospital outpatients; 50% if visit medical centres.	Major illness and injury, child delivery; preventive health service as defined in a 32; receiving medical care in mountain r and outlying islands.
Pro-Poor	Health insurance coverage will be extended to the economically disadvantaged group and the government will fully or substantially subsidize the premiums for the low-income people to assure their accessibility to medical care. Premium for low income households be calculated according to actualised premium of total number of beneficiaries; will be subsidise 15%for social affairs, 20% from provincial government and 65% from the county		

4 Country: *Hong Kong*

Ideology: Universal coverage

Policy aims to protect citizens from potentially huge financial risks arising from catastrophic or prolonged illness: DOH shift from provision of care to improving
life through strengthening preventive care and developing community care programmes; aims to provide accessible, equitable and quality services to members of
community on the basis of health needs

Barriers: 2001-02 public sector recurrent allocation is 14/7% of total recurrent public expenditure; fee income 2.5% of operating costs; 46% of beds occupied by
65 years; fee structure cannot tell rich from poor

Policy statements	Financing	Delivery	Health Outcomes
Equity	Those with means should bear affordable share of medical expenses: restructuring fees to distribute workload between public and private sector	Everyone should have equitable access to quality health care for comparable needs	

Equality	Health Protection Accounts with mandatory contributions of 1-2% of earnings from age 40-64 to a personal savings account to pay for care after age 65--will use to reimburse care at public sector rates	Expand role for allied health professionals such as nurses; DOH transfer out-patient services to Hospital Authority ; Community based model, joining private and public providers and welfare sector to give comprehensive and integrated service	
Pro-Poor	Safety nets for financially vulnerable	Public funds for services channelled to lower income groups; Out-patient services redesigned into clinics for financially vulnerable and chronically ill who have high financial risk due to long treatment; Health Protection Account will supplemented for those with little savings or no savings due to frequent illness	

5. Country: Malaysia

Ideology: Provision of health care dual system of both public and private sectors. Equity, accessibility and affordability first priority in 8th Five Year Plan.

Barriers: 43.4% of health expenditure is OPP; only 2-3% of fee money contributing to MOH operating expenses Shortages in health human resources in all categ

Policy statements	**Financing**	**Delivery**	**Health Outcomes**
Equity	General taxation largest pre-payment form. To implement a new financing mechanism, which will incorporate cost-sharing features with consumers but with a safety net for those who cannot afford to pay. For example, poor charged less than rich for private outpatient visit as it is subsidised by money raised through taxes; disadvantaged and elderly free of charge	Equitable distribution of accredited facilities and human resources	

Equality	To enforce legislation to ensure affordable health care. Legislation, which specifies user fees levied in government health facilities with exemption for certain, groups or services. Cost sharing to be introduced; 47.3% increase for health in the social sector development budget	To reduce incidence of vaccine preventable diseases- childhood immunisation programme provided free in all government health facilities. Efforts to improve access by increasing number of public health facilities including hospitals and clinics; increasing trained manpower. 95% of health budget spent on going construction and equipping news hospitals and clinics; MOH to take over control of all public health functions; government concentrates on preventive and promotive health; private sector and NGOs concentrate on service delivery.	
Pro-Poor	Free care in government health facility for the destitute		Efforts to focus health sector dev to improve the health status of th population, particularly the low i disadvantaged groups.

6. Country: *Sri Lanka*

Ideology: The government has social responsibility to provide basic health care and a healthy living environment for all. Country's health system to be equitable affordable to all.

Barriers: Presently services don't reach or target underprivileged and poorest of the poor

Policy statements	**Financing**	**Delivery**	**Health Outcomes**
Equity		Network of health institutions and facilities including GPs at Divisional Level within easy reach of people based on peoples' needs. Make family planning services more accessible to community specially in the remote and difficult areas	Improve health of wom identifying all areas, pr institutions related to w work for improvement quality of life
Equality	Increase health sector allocation to 3.5% Mobilise funds through a "health earmark tax"; introducing paying beds in all general hospitals.	Minimum standards of care irrespective of class, creed, economic status, age, gender ,etc. will be established; greater coverage by school health services in all areas Universal coverage of immunisations	
Pro-Poor			

7. Country: *Bangladesh*

Ideology: State to provide essential health care to all and ensure for the least well off.

Barriers: Weak planning and management capabilities; low budget allocation; insignificant participation of private sector

Policy statements	Financing	Delivery	Health Outcom
Equity	Tax and other revenue finance health care. To investigate role of health insurance scheme		
Equality		Essential health and family planning service package at the grass root level through nationwide public service network. Infrastructure and transport to reduce/urban rural disparities; one stop centres to deliver Essential Service Packages	Everyone to get
Pro-Poor	User fee policy, with exemption for the poor and the disabled	To ensure basic/essential health services are available particularly to the poor communities; provide food and nutrition to children and women in poor families	Ensuring primary order to reduce d

8. Country: India

Ideology: A shift from egalitarian towards libertarian views. i.e. State to provide minimum health needs to all and ensure provision for the least well off through e primary health facilities and provisioning essential drugs through central funding. Those who can pay to fend for themselves. Policy of user-charges and private h secondary and tertiary public health care services, for those who can afford to pay.

Barriers Lack of capacity for financing and administration for universal provision of comprehensive PHC services. Large gap in provision of facilities for vulne

Policy statements	Financing	Delivery	Health Outcom
Equity	To reduce interregional and rural urban inequities, NHP proposes increased public health investment with increased allocation for primary health sector and central government funds for essential drugs. Principle objective of new health policy to reduce inequities and allow disadvantaged sections of society a fairer access to public health services. Levy user charges for certain secondary and tertiary services for those who can pay.	Organisational restructuring of public health initiatives to facilitate equitable access. Increased access in deficient areas and upgrading infrastructure in deficient areas. Increase utilisation of public health facilities from <20% to >75% by 2010. Investigate use of nurses and paramedics to provide care in rural and underserved areas;	Improve health s for underprivileg areas.
Equality	Tax financed health care with centre investigating role of social health insurance; increased government spending on health care from 1% to 2% of GDP by 2010.	Essential primary health care, emergency life saving services, services under the National Disease Control Programs and the National Family Welfare Program totally free of cost to all individuals.	Strengthening pr to improve publi equitable basis
Pro-Poor	Increased allocation for primary health sector Improve access to women and other underprivileged groups.	Policy attempts to allow the disadvantaged sections of society a fairer access to public services.	

9. Country: Indonesia

Ideology: State to ensure universal access to health services; decentralisation of achieve equality and justice and upgrading peoples welfare for all people in the R

Barriers: Need to move government involvement to preventive and promotive services from curative and rehabilitative through shifting policy to a "healthy parad development budget

Policy statements	Financing	Delivery	Health Outcomes

Equity	To maintain and enhance quality, equitable and affordable health services.	Population sector responsible for policies on fairness and equality related to gender	
Equality		To provide quality health services to all Indonesian people, including the poor.	
Pro-Poor	Private hospitals must treat the poor without payment when person brings supporting letter; health card issued to poor to entitle them to free services.	Social sector responsible for protection of the poor.	

10. Country: Nepal

Ideology: Health is a human right; government committed to improving health status particularly for the most vulnerable and disadvantaged groups; a health care equitable access to quality health care; work with the private sector.

Barriers Health expenditure is about $10.50 per capita with $7.40 being private OPP of which 70% is spent on drugs. Gov't expenditure including external aid is $ resources from rural to urban secondary and tertiary care with reduction in primary care spending. Resources on curative care; under resourced public health secto and unregulated private sector

Policy statements	**Financing**	**Delivery**
Equity		
Equality	Develop appropriate insurance schemes and regulate schemes and market for private care and NGO provision which will be encouraged	Essential Health Care Services at the district, will be available to 90% of the population living within 30 mins travel time;
Pro-Poor	Pro-poor policy for safety net to stop families falling into poverty by focusing health resource on primary care with special emphasis on remote areas; seek alternative financing to ensure public resources target poor and vulnerable	Essential Health Care Services have systems to ensure poor and vulnerable have priority to access. Emphasis on interventions aimed at improving status of women including safe motherhood programmes in remote rural areas; communities responsible for drug financing schemes including .criteria for exemptions for poor

11. Country: *Philippines*

Ideology: State to ensure universal access to essential services. Reduce OPP through national health insurance

Barriers: Devolution has meant services are inaccessible and inadequate due to weak infrastructure and poor regulation to implement new laws. 43% of doctors w Manila; DOH spends 54% of funds on 50% of the existing hospitals; National Health Insurance low in areas where local financing is limited and administrative in is weak.

Policy statements	**Financing**	**Delivery**	**Health Outcomes**
Equity			
Equality	Universal coverage of health through SHI and aims to reduce out-of pocket expenditures	To ensure delivery of cost-effective services with universal access to essential services by emphasising prevention and reducing hospital costs	
Pro-Poor			Promote equitable distribution care by reducing unfair gaps in delivery system which deprive access to basic health services

12. Country: Thailand

Ideology: Ensure universal coverage; alleviate poverty problem; priority given to equity. Health moved from curative focus to health promotion emphasis

Barriers Household pay nearly half of all health expenditures. Need to gradiate tax so doesn't penalize the poor; emphasize on direct taxation; Poorest spend 10% on health while rich spend 2%.

Policy statements	Financing	Delivery	Health Outcomes
Equity	General tax main source for health care financing.	Ensure every citizen possesses health insurance with quality, coverage and fairness;	Women's potential supported a developed
Equality		Universal coverage through health insurance; every person has equal access to quality health services	
Pro-Poor	Low income card scheme exempts poor from fees at public health facilities provided they are referred	Establishing social safety net to ensure poor and the deprived are ensured access	

13. Country: *China*

Ideology:

Barriers:

Policy statements	Financing	Delivery	Health Outcomes
Equity	5% of Special Fund of Poverty Alleviation is spend on health care in rural areas		
Equality	Increase in health expenditures should be the same as increase in government fiscal expenditures; Basic Medical Insurance compulsory for all urban employees; government regulates price of health services according to average social cost of services	Government builds all public health institutions at all levels and subsidies are shared by all residents	
Pro-Poor	Implement rural medical aid system for poor peasants; and establish new rural cooperative medical system (CMS). Under RMAS, poor peasants are guaranteed medical care including subsidising expensive treatment, through transfer payment. Under CMS, local government pays not less than 10 yuan to those peasants who join the new CSM. Part of relief payment of Ministry of Civil Administration used on medical care for poverty households; medical care given to poor rural areas and rural co-operative Medical System in Western China		

14. Country: Kyrgyztan

Ideology: To improve the health status of the people by ensuring health care reforms which promotes health gain, equity, effective use of resource and cost-effecti
Fairly distribution of costs and benefits both geographically and socially. Health equity aimed at reducing and eliminating difference in health indicators in differe
and between urban and rural areas; move toward market economy approach.

Barriers: Reduction of health budget due to purchasing power of State budget since independence; reduction of allocation from 10-12% of budget to 3.9% in 199
of pocket costs, dependence on hospitals, too many health staff, inefficiency in management of resources

Policy statements	Financing	Delivery	Health Outcomes
Equity	Tax based system and earmarked taxes on goods such as alcohol; user fees with exemptions - co-payment system according to insured/uninsured and other beneficiaries All funds accumulate into one pool and from it providers are funded according to their needs.	Cross-subsiding from healthy to less healthy, from rich to poor.	
Equality	Tax financed health care. Mandatory health insurance fund. Single payer system: pooling Mandatory Health Insurance Fund; free primary care through Family Group Practices; in patient referral with co-payment	Shift from system of reliance on hospitals to development of primary health care services; close rural hospitals, set up referral system	
Pro-Poor	Free referral care for all those exempted		

15. Country: *Mongolia*

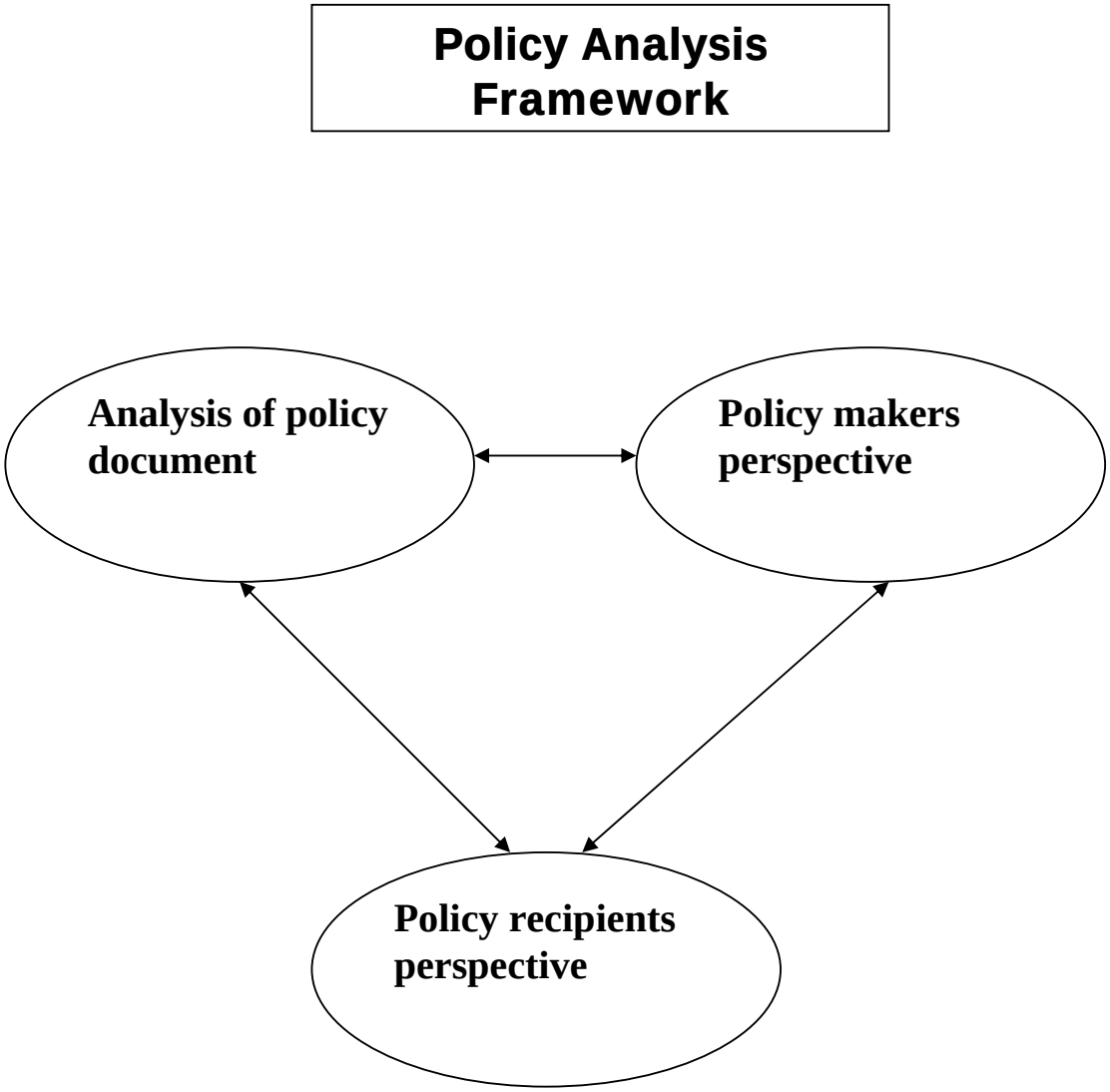
Ideology: State to ensure universal access to health services. Policy aims to ensure equal access to health services regardless of ability to pay, also aims to protect
catastrophes and long term illness; dominant egalitarian view.

Barriers:

Policy statements	Financing	Delivery	Health Outcomes
Equity	About 60% financed from General tax, 30% from Social Insurance; 10% from OPP; Government pays Health Insurance for about 50% of the population (children under 16;retired people, soldiers); progressive vertical equity. Voluntary health insurance allowed to cover risks above the ceiling health expenditures.	Govt pursues policy to encourage and support private hospitals	Strengthening primary health infrast improve public health outcomes on a basis; more funds toward primary an outpatient care from inpatient servic
Equality	Government pays for full drug costs for catastrophic or prolonged illness regardless of ability to pay; discounts on essential drug prices, differences is paid by Health Insurance fund	Government pursues policy to ensure equal access to health services. Primary care services are free; secondary and tertiary level care has co-payment of 10% and 15% respectively.	Plans to introduce effective financial among hospitals to diminish disparit health

Pro-Poor	Government pays higher capitation payment rate for poor population of which under 40% live in poverty; poor exempt from co-payments on secondary and tertiary level medical care.	Almost all have full access regardless of ability to pay; sufficient number of public health facilities ensures equality on time costs. Number of FGPs established in rural local areas, sufficient number of public health facilities ensuring equality on time cost.	

Figure 1: Framework for Policy Analysis



Annex 1 Table 1: Development indicators, year 2000

Territory	World Bank Income Group	GNI per capita[a]	Population	% urban[b]	Life expectancy[c]
Hong Kong, SAR	high	25920	6,797,000	100	79.82
Taiwan	high	14188	22,276,672	63.25	74.9
Thailand	lower-middle	2010	60,728,000	19.83	68.82
Sri Lanka	lower-middle	850	19,359,000	22.8	73.14
China	lower-middle	840	1,262,460,000	35.79	70.26
Indonesia	low	570	210,421,000	40.99	66.03
Mongolia	low	1,600	2,398,000	57	...
Punjab (India)	low	537	24,324,749	27.66	64.1
Bangladesh	low	370	131,050,000	25	61.19
Japan		35280	22,268,000	79	81
Korea		9,790	47,008,000	82	-
Kyrgyz Republic		280	4,915,000	34	60
Philippines		3390	23,270,000	57	73
Malaysia		1030	76,626,496	59	-
Nepal	low	240	23,043,000	11.85	58.86

Source: World Bank, WDI Tables (http://devdata.worldbank.org/data-query/)
Notes: a.GNI - gross national income, Atlas method (current US$).

a. % of population which is urban.
b. Life expectancy at birth (years).
c. Infant mortality rate per 1000 live births

Table 2: Health care financing mix (percentage of total health expenditure from main sources)

Territory (year)	Public Finance			Private Finance		Other
	General govt. revenue[a]	*Social Insurance*	*All public finance*	*Private Insurance*	*Direct payments*	
Bangladesh (1999)	27.23%	0.00%	27.23%	0.0%	64.64%	8.13%[b]
China (2000)	14.89%	16.52%	31.4%	0.0%	60.35%	8.24%[c]
Hong Kong, SAR (1999-2000)	55.10%	0.00%	55.10%	12.52%	30.79%	1.28%
Indonesia (2001)	23.71%	1.77%	25.48%	6.11%	68.41%	0.00%
Japan	12%	68%	80%	0	18%	2%
Korea	10%	45%	55%	2%	37%	6%
Kyrgyz Republic	44%	5%	49%	0	51%	0
Malaysia	-	-	-	-	-	-
Mongolia			71%		17%	12%
Nepal (1994-5 & 1995-6)[d]	23.50%	0.00%	23.50%	0.00%	75.00%	1.50%[e]
Philippines	29%	9%	38%	56%		4%
Punjab (India) (1995-96)	40.73%	1.30%	42.03%	0.20%	56.41%	1.28%[f]
Sri Lanka (2002)	45.0%	0.00%	45.0%	6.0%	48.0%	1.0%

Taiwan (2000)	9.17%	51.78%	60.95%	8.90%	30.15%	0.00%
Thailand (2000)	56.28%	5.11%	61.39%	5.87%	32.74%	0.00%

Source: National / Domestic / Regional Health Accounts unless stated otherwise. Row totals sum to 100%.

a. Includes revenues from donors / foreign aid.
b. Private enterprise, NGOs and community health insurance.
c. Payments by collective organisations, towns and villages through grass roots governments and rural cooperatives.
d. Public finance data for 1994-5 [HMG/Nepal, 2000 #985], private expenditure data from 1995-6 Nepal Living Standards Survey (Hotchkiss, Rous et al. 1998).
e. Private companies.
f. Revenue from private firms and NGOs for finance of own facilities

Annex 2: List of National Policy Documents

1. India
   National health policy (2002)
   National Population policy (2000)
   Annual report, MOH&FW (2001-2002)

2. Bangladesh
   National health policy (2000)
   National health policies and objectives: Bangladesh Health Bulletin (98-99), August 2001.

3. Nepal
   National Health Policy (1991)
   Policy on drug financing schemes (2000)
   2nd long-term health plan, 1997-2017 (1997)
   Local self-governance Act (1999)
   Health information bulletin (2001)
   Medium term strategic plan (2001)
   Health sector strategy development: An agenda for change (2002)

4. Sri Lanka
   National health development plan (1993)

5. Hong Kong (www.info.gov.hk/hwb/english/consult/index.htm)
   Development of medical services in Hong Kong (1964)
   The further development of medical and health services in Hong Kong (1974)
   Lifelong investment in health. Consultation document on health care reform (2001)
   Improving Hong Kong's health care system: why and for whom? Harvard Report (1999)
   A broader-based tax system for Hong Kong? Consultation document (2001)

6. Philippines (www. doh.gov.ph)
   National objectives for health (1999-2004)
   The health sector reform agenda

7. Indonesia (www.depkes.go.id/English)
   Nevisrv
   Financial management and accountability –deconcentration; Govt. regulation no. 106/2000 dated 10th Nov. (2000)
   Draft law of the Republic of Indonesia regarding governance (1999)

Draft government regulation Number 105 (2000) concerning the region's financial management and accountability.
Equlibrium funds. Government regulation No. 104 (2000).
Health financing
Indonesia republic health minister decision No. 1122 (1994) about health card
Indonesia republic health minister regulation No. 378 about private hospital social function implementation.

8. Taiwan
   National Health Insurance Act (1994)

9. Thailand
   Thai Constitution (2002)
   9th National Economic and Social Development Plan (2002-6)
   9th National Health Development Plan
   Plan 9 of Ministry of Public Health

10. Japan
    Annual report on Health, Labour and Welfare (2000-2001)
    White paper. Annual report on Health and Welfare (1998-1999)

11. Korea
    Health and Welfare Services (2002)

12. Krygyzstan
    MANAS Health Policy Analysis Project, Policy research paper number 12.
    MANAS National programme on health care reforms (1996-2006).

13. Mongolia
    National policy on Public Health
    Health Law
    Government Strategy Plan
    Health Insurance Law
    Policy to be pursued by the state on public health. The presidential office of Mongolia (2001).

14. China
    National Policy Document
    Abstract of equality documents in China.

15. Malaysia
    Enhancing health sector performance initiatives
    Subgroup: Fairness of financial contribution
    The third outline perspective plan (2001-2010)
    Mid-term review of the eight Malaysian plan (2001-2005)
    Eight Malaysian plan (2001-2005)
    Fees Act, 1951: Fees (medical) order 1982.