Governance Functions to Accelerate Progress toward Universal Health Coverage (UHC) in the Asia-Pacific Region

Eng-Kiong Yeoh, Cathryn Johnston*, Patsy Yuen Kwan Chau, Nicole Kiang, Pamela Tin, and Jaymond Tang

Jockey Club School of Public Health and Primary Care, The Chinese University of Hong Kong, Hong Kong, China

Our Hong Kong Foundation, Hong Kong, China

Abstract—Many countries in the Asia-Pacific region have committed to universal health coverage (UHC), which is reflected in both their political commitment and the governance actions they have taken in steering their health systems toward the goals of universal access to care and protection from financial hardship. Countries throughout the region are at different stages of development and have different political and governance contexts, which in turn shape how they pursue governance for UHC. This article reviews the governance functions deployed in the Asia-Pacific and finds that, in many, governance reforms adapting their health systems toward greater regulation, accountability, oversight, and stewardship of the health system have been part of their wider move toward UHC. Countries have not followed a set pattern, but shared aspects include establishing UHC as a goal in national policy making and priority setting; the creation of new roles and/or new institutions within the health system; establishing systems of monitoring and evaluation; and putting in place mechanisms to facilitate collaboration and ensure greater accountability. The relationship between governance and UHC in the Asia-Pacific region is found to be complex, negotiated, and shaped by a number of factors in both the internal and external environment, including broader governance arrangements in the public sector (institutional changes and decentralization are particularly prominent factors) and the ability of governments to implement policies and steer the health system.

INTRODUCTION

Around the world, universal health coverage (UHC) has been adopted as a goal, incorporating many long-held aspirations of health systems—such as greater equity, accessibility, affordability, and sustainability—which countries have been
working toward prior to the explicit articulation and adoption of UHC. Defined by the World Health Organization (WHO) as a way to ensure that “all people obtain the health services they need without suffering financial hardship when paying for them,” (p. 113) UHC is generally considered across three areas: the population covered, range of services made available, and extent of financial protection.

Following on from the 2005 World Health Assembly resolution supporting UHC, the 2010 Health Systems Financing— The Path to Universal Coverage report, and in the context of global economic growth and development, UHC has been gaining momentum around the world.

The importance of governance as a key determinant of economic growth, social advancement, and overall development is increasingly recognized, as is the importance of health systems governance for achieving health-specific goals, including attainment of UHC. Significant gains have been made by many countries toward this goal. Many countries in the Asia-Pacific are strengthening their health systems with a view to increasing quality, efficiency, equity, accountability, sustainability, and resilience, as well as acting to bolster financial protections, improve health system stewardship, and access to health care.

Understanding the various mechanisms that countries have used in their efforts to attain these outcomes will provide valuable information for countries actively pursuing a range of development goals, including UHC.

Goverance and leadership are critical components for moving closer to the goal of UHC, cutting across elements of both health services and health systems performance, shaping how the elements of the health system interact, and ensuring that each aspect of the health system operates well. And yet, though leadership and governance are considered to be the most important functions of government with respect to the health system, because they embody the substantive and procedural policy instruments and levers to better coordinate and shape the interactions of the other functional components of the health system, they are also widely considered to be both complex and poorly understood.

In its broad sense, governance refers to the “the actions and means adopted by a society to promote collective action and deliver collective solutions in pursuit of common goals, p. 6.” It considers how power is distributed between institutions (public and private), the exercising of authority (for example, political, economic, or administrative authority), as well as the various means, rules, and institutions by which citizens or groups “articulate their interest, mediate their differences and exercise their legal rights and obligations.”

(p. 14.) Various authors identify different key functions of governance, though they tend to cluster around a core set of concepts: the ability to make plans and set priorities, the ability to generate intelligence and/or monitor system performance, and accountability arrangements.

The concept of health systems governance is relatively new, with no firm consensus in the literature as to how it should be defined or measured. We have taken the WHO’s definition: “leadership and governance involves ensuring that strategic policy frameworks exist and are combined with effective oversight, coalitions building, regulation, attention to system-design, and accountability.”

Goverance functions are understood to describe “the specific efforts and process that are applied to steer the system.”

**METHODOLOGY**

This review aims to synthesize, describe, and summarize the governance functions deployed by countries in the Asia-Pacific region to facilitate implementation of UHC policies as they steer their health systems toward UHC. In doing so we contribute to knowledge synthesis in a highly complex, still developing and evolving domain of governance functions of health systems and their effect on contributing to health system goals, for which there is very limited related literature. We were originally commissioned to conduct a review of governance pathways to UHC in the Asia-Pacific region by the Western Pacific Region Office of the WHO. Upon conducting our search, however, we found little concrete information regarding governance pathways and, as a result, we adjusted our focus to how governance functions facilitated implementation of UHC policies. We were guided by the WHO’s governance for UHC framework, given in the Health Systems Governance for Universal Health Coverage: Action Plan, which was compiled on the basis of a review of governance literature and represents a synthesis of key concepts and can be used to develop questions to assess health system performance. The following five key governance functions are identified in the plan and used in this article: (1) formulating policy and strategic plans; (2) generating intelligence; (3) putting in place levers or tools for implementing policy; (4) collaboration and coalition building; and (5) ensuring accountability (see Table 1).

Data reported in this article were collected from published literature, reports, and grey literature. Online searches of electronic databases (EMB Reviews, Embase, Global Health, Inspec, Medline, Ovid Nursing, PsycINFO, Social Work Abstracts,
Reports available from official websites of international organizations including the WHO, United Nations, the Organization for Economic Cooperation and Development, and Asia Pacific Observatory on Health Systems and Policies were also searched. Additional searches of PubMed and Google Scholar using the search terms were carried out. Documents referred from the WHO Western Pacific Region and reference lists of selected articles were manually screened.

**Function 1: Formulating Policy and Strategic Plans**

Countries throughout the Asia-Pacific have adopted pro-UHC policies and strategic plans and many have explicitly expressed their aspiration to progress toward UHC. Some incorporate UHC directly into their national plans, and others have implemented functionally pro-UHC policies (for example, expanding financial coverage or access to services) without explicitly acknowledging UHC as their ultimate aim. In Myanmar, the government has endorsed the National Health Plan 2017–2021, formulating a three-phase plan to achieve UHC by 2030, aiming to increase access, equity, and financial protection; Vietnam has set out a Master Plan for UHC, setting targets to increase coverage levels and reduce out-of-pocket (OOP) expenses by 2020; Malaysia set achieving universal access to quality health care as a national goal in the 11th Malaysia Plan; and China’s 2009 Health Reform Plan lays out key reform priorities to establish UHC.

Though some countries throughout the region have enacted policies supporting UHC goals in all of its dimensions, others have thus far prioritized particular aspects (for example, service coverage or financial coverage). Though Pacific island countries have committed to ensuring service delivery is based on UHC principles as part of the “Healthy Islands Vision” and the 2015 Yanuca Island Declaration, different approaches have been used in acting on these commitments. Fiji has endorsed increased government spending to expand access to health services for the poor. Papua New Guinea’s Department of Health has worked with provinces to develop annual health service plans, informed by facility audits, covering services in health facilities including aid posts, rural health centers, and hospitals. The Solomon Islands have developed their pre-existing Role Delineation Policy (2011) in response to the national commitment to UHC made in 2013. As a result, the health system was reclassified from five to four levels, and the Ministry of Health and Medical Services undertook development of integrated service delivery packages,

| Governance Function | Explanation |
|---------------------|-------------|
| Formulating policy and strategic plans | Development, implementation, and review of national health policies, strategies, and plans; national governance strategies and plans |
| Generating intelligence | Generating and using data on financial catastrophe and impoverishment; health budgets and expenditure; donor commitments and disbursements |
| Putting in place levers or tools for implementing policy | Design of health system organizational structures and their roles, powers, and responsibilities; design of regulation; standard setting; incentives; enforcement and sanctions |
| Collaboration and coalition building | Including across sectors and with external partners |
| Ensuring accountability | Putting in place governance structures, rules, and processes for health-sector organizations; mechanisms for independent oversight, monitoring, review, and audit; transparent availability and publication of policies, regulations, plans, reports, accounts, etc.; and openness to scrutiny by political representatives and civil society. |

**TABLE 1. Governance Functions**

Source: World Health Organization. Health systems governance for Universal Health Coverage: action plan.

Scopus, Academic Search Ultimate) were conducted to identify peer-reviewed literature, using the search terms “universal health coverage,” “governance,” “pathways,” and their synonyms. Countries listed in the WHO Western Pacific and South-East Asia regions were also included in the search terms, and our search was limited to articles published between 2010 and 2017. The search generated 3,987 articles; after duplications were removed, 2,605 were eligible for screening, following which 468 were included for full-text review. Articles were then allocated between team members, who simultaneously abstracted information on all governance functions. Each reviewer extracted study characteristics related to key governance actions and policy tools, pathways, and country. Information was consolidated and reviewed by members of the team to make sure that data were captured accurately. Any discrepancies were discussed to ensure consistency.
specifying essential services, staffing, equipment, and infrastructure at each level of the health system, in collaboration with development partners.\textsuperscript{5,24,27}

One broad public-sector governance reform pursued by a number of countries across the region has been decentralization, with success in some cases in improving efficiency, stakeholder participation, and accountability.\textsuperscript{3,28–30} However, decentralization has also been a major governance challenge for implementing UHC reforms, shaping and constraining the external environment in which governments and other health systems actors can make and enact policy. In Vietnam, though central decision making has facilitated formulating UHC reforms, decentralization coupled with a lack of alignment between UHC reforms and broader government strategies has constrained progress, particularly around the reduction in OOP expenditure and expansion of coverage. Benefits of decentralization have been unequal and favor urban populations.\textsuperscript{2,31} In China, the high responsibility placed on subnational governments to generate funding and carry out service provision, coupled with poor accountability between subnational and central governments, has produced inequity and limits the ability of the central government to ensure compliance with reforms.\textsuperscript{2,7}

Broader changes in governance like decentralization have also shaped the structure and role of organizations. In Fiji, decentralization has been attempted multiple times with limited success. The present policy of deconcentration of outpatient services from hospitals to peripheral health centers in Suva has resulted in greater service capacity but has not had the anticipated results of transferring administrative or decision-making power, with decision making remaining largely centralized.\textsuperscript{32,33} This presents an interesting contrast with Thailand, where centralized governance at the time of UHC reform design enabled the government to effectively plan and implement reforms and where decentralization, though legally mandated and planned, has progressed slowly, due in part to concerns about system fragmentation.\textsuperscript{2,30}

Function 2: Generating Intelligence

Countries throughout the region have set up systems to use intelligence to inform policy. For example, Thailand, Australia, New Zealand, Singapore, Hong Kong SAR (China), the Philippines, China, and Malaysia use health technology assessments (HTAs) to inform policy and decision making.\textsuperscript{34–37} Other countries, including Indonesia, India, and Myanmar, have begun to use HTAs, though in an unstructured and informal way.\textsuperscript{21,34} HTAs have been used to develop the universal health benefit package and the National List of Essential Medicines in Thailand, and the National Health Security Office (NHSO) works with a large group of stakeholders in deliberative processes to foster legitimacy and transparency.\textsuperscript{38,39} In Fiji, the health information system (which collects core public health data and clinical-level data via electronic patient records linked to a national health number) provides information that guides decision making in both clinical and management settings.\textsuperscript{5} The Ministry of Health of Lao People’s Democratic Republic (PDR) began in 2012 to implement a web-based reporting platform to provide timely and accurate data to policy makers and inform decision making, planning, and program implementation. Standardized report forms have been developed, and routine data from health facilities are collected and can be aggregated to district, provincial, and national levels.\textsuperscript{5}

Countries throughout the region have established, or are developing, health information and information technology systems to generate information for monitoring, evaluation, and accountability and to support decision making. Financial protection has been a focus domain for most countries for monitoring and evaluation. Data collected from Thailand’s socioeconomic survey are used to estimate the incidence of catastrophic health expenditure.\textsuperscript{40} Similarly, in China, the national health services surveys have been providing information for estimating the overall impoverishment rate.\textsuperscript{41} In Singapore, indicators of access, quality, and affordability of services are regularly tracked and reported to government as part of key performance indicators given to the Ministry of Health.\textsuperscript{42} In the Republic of Korea, the Health Insurance Review and Assessment Agency processes insurance claims, and the claims database is linked with health facilities, enabling the monitoring and evaluation of services and drug utilization.\textsuperscript{5} Other countries have developed systems to monitor specific aspects of their health systems. States in India, including Tamil Nadu, have established information technology systems to track and monitor the delivery of drugs from the manufacturer to the patient.\textsuperscript{29}

Some countries, however, have difficulty generating information. Major barriers include limited resources available to rural health facilities to establish electronic medical records systems, as in the Philippines,\textsuperscript{37} and inconsistent formats of databases and fragmented health information systems that are difficult to integrate, as in Indonesia.\textsuperscript{28}

Countries throughout the region (including Viet Nam, Malaysia, Lao PDR, Cambodia, China, and Mongolia) are developing their capacities for research and analysis via research, health strategy, and policy institutes.\textsuperscript{5} These can be set up and supported in a number of ways; for example, via government decree (Viet Nam), under the umbrella of a national health institute (Malaysia) or ministry of health (Cambodia, Lao PDR, China), via think tanks (China), and in association with universities and other research institutes (China, Mongolia).\textsuperscript{5}
Function 3: Implementing Policy: Levers and Tools

In their efforts to progress toward UHC, countries across the Asia-Pacific have deployed a wide range of tools and policy levers to implement policies across the health sector. These take a number of forms, including regulation and legislation, standard setting, incentives, and organizational design and change. Often action has focused on key functions of health systems, including health financing, health workforce, services and facilities, and medicines and drugs.

Changes to how organizations operate and interact within the health system to support pro-UHC aims and policies have occurred in several countries throughout the region. Some countries have created new roles for existing institutions and/or created new institutions. During Thailand’s implementation of the Universal Coverage Scheme, the Ministry of Public Health shifted roles from provider to having enhanced responsibility for the oversight, management, regulation, and stewardship of the health sector, ceding some of its other responsibilities to semi-autonomous public bodies, including the Thai Health Promotion Foundation, the Healthcare Accreditation Institute, and the NHISO, created to administer the Universal Coverage Scheme.\(^2\) The creation of the National Health Commission established both the structure and processes for stakeholders participation in health policy making. However, interactions between institutions have faced challenges, with the Ministry of Public Health delaying transfer of the health budget to the NHISO and retaining control of salary budgets, in part due to the influence of doctors in senior hospitals.\(^2\) In South Korea, the establishment in 2000 of a single insurance agency, the National Health Insurance Corporation, introduced (along with the separation of prescribing and dispensing roles) major structural changes in the health system, resulting in it becoming more pluralistic, participatory, and democratic, though interest groups (mainly private providers and doctors) frequently resist government reforms.\(^{43,44}\) Tamil Nadu, in India, has created quasigovernmental organizations, such as the Tamil Nadu Medical Services Corporation, to help circumvent slow-moving bureaucratic processes. Action has also been taken to bolster managerial capabilities, via methods including the creation of a dedicated public health management cadre\(^45\) and a system of career progression to attract and retain high-caliber staff.\(^46,47\)

UHC programs increasingly adopt approaches including purchaser–provider split, greater provider autonomy, and greater engagement of private providers, as well as making explicit the roles and responsibilities of actors within the health system, using tools such as benefit packages.\(^48\) Some countries are making use of public–private partnerships (PPPs) to address workforce and service delivery challenges.\(^45–47,49–54\) In Andhra Pradesh, India, the government engages with private providers to improve diagnostic service capabilities.\(^55\)

The creation and implementation of new regulatory systems has also occurred throughout the region. China, with the support of the WHO, has implemented drug price regulation, new essential drug list development, and regulated drug procurement procedures.\(^56\) These support improved value for money, help ensure that primary health facilities (in both urban and rural areas) are only using essential drugs, and encourage the rational use of drugs by local health authorities,\(^57\) though they are undercut by the weak implementation of regulations in the pharmaceutical market and under-qualified staff.\(^58\) The Cheaper and Quality Medicines Act (2008) and the Pharmacy in the Village Program in the Philippines laid the groundwork for regulation of prices and encourage availability of drugs.\(^59\) Conversely, in Cambodia, deregistration is used to control the sale and distribution of substandard products.\(^5\) A lack of comprehensive regulation has hindered some countries in implementing reforms. In Viet Nam, the 2009 Law on Health Insurance neither stipulates compliance-assurance measures nor lays out mechanisms to enforce compliance with mandatory insurance, resulting in low joining rates to the Social Health Insurance scheme.\(^2\)

Countries also regulate their workforces. Though most countries throughout the region have systems of professional registration, certification, and licensing, there are concerns about the ability of some countries to enforce these systems.\(^5\) Australia has transformed its system of health workforce regulation, establishing a national scheme under a single national organization (the Australian Health Practitioner Regulation Agency) and a single legislation framework to manage the annual registration of all registered health practitioners via national regulation standards. It has also developed a National Code of Conduct for unregistered health practitioners, which sets standards for conduct and practice.\(^5\) Indonesia reformed its accreditation process and standardized certification processes to address the problem of unqualified health workers.\(^52\)

Multiple kinds of incentives are also used to influence the behavior of the health system throughout the region. Thailand has sought to engage the pharmaceutical sector, using strong negotiation and leveraging provider payment systems to increase benefits for the population.\(^52\) Financial incentives (for example, double pay for rural postings) and social incentives (awards, social recognition) have been
deployed to alter workforce capacity, capability, and distribution (for example, rural–urban) and to improve service delivery and accessibility. These include the introduction of quota systems and mandatory or bonded service and financial compensation. For example, in Japan, the Ministry of Health, Labour and Welfare has worked with prefectures, universities, and hospitals to encourage more doctors to work in remote regions via scholarship models in return for work commitments. The financing of health systems also sets up incentives that can both benefit and hinder progress toward UHC. Fee-for-service payment can act as a perverse incentive, encouraging overprovision of services; for example, in China, where overprescription has accompanied the transition from a centralized pharmaceutical supply system to a commercialized one. Hospitals in Viet Nam continue to emphasize profit-making services, despite policies establishing ceilings for fees.

Function 4: Collaboration and Coalition Building
A number of countries in the region have engaged in collaborations with actors both within and outside of government to facilitate implementation of UHC policies. For example, interministerial collaboration has taken place in Thailand, South Korea, and China. China’s 2009 health system reform plan followed four years of consultation and collaboration with stakeholders, including service providers, policy analysts, think tanks, academic institutions, and international organizations. In Cambodia, the Ministry of Health worked with the Department of Drugs and Food to collaborate with a wide range of agencies internal and external to the government, including law enforcement agencies (national and international), nongovernmental organizations, and the WHO to reduce the circulation of poor-quality medicines. This has been supported by the creation of a number of interministerial committees that range across a wide variety of government ministries. However, in some countries, complex institutional arrangements and the multiplicity of institutions and organizations involved in administering and implementing programs (for example, social health insurance) have created difficulties facilitating coordination, as in Viet Nam.

In many countries, international organizations such as World Bank, UNICEF, and WHO are involved in shaping the direction of policy formulation and strategy implementation through providing funding support and capacity building. In particular, some countries (for example, Viet Nam, Myanmar, and Cambodia) work with international organizations in strengthening their health systems.

Efforts to facilitate greater collaboration between the public and private sectors have been undertaken by countries in the region. A number of countries throughout the region have entered into PPPs. Hong Kong SAR’s (China) experience with PPPs suggests that forming collaborative partnerships rests on fostering good stakeholder relationships and involvement and building mutual trust. Other forms of collaboration across sectors in the region include consultation with academics for evidence and expert advice, partnerships with nongovernmental organizations to improve access and quality of care, and public engagement for agenda setting and policy formulation.

Function 5: Accountability
Strengthening accountability is one of the governance functions that helps to ensure that health system objectives and population needs are met and resources are used effectively. There are a number of accountability relationships at play, extending between actors including service providers, health ministries, and legislatures. Each actor has its own “accountability focus” (for example, responsiveness, meeting quality standards, meeting set targets, and meeting public expectations). Accountability can be further categorized into “answerability,” referring to the government’s obligation to provide information on decisions and actions, and “sanctions,” which constitute the “teeth” of accountability and refers to the presence and application of sanctions where allowed.

A number of tools to ensure financial accountability across health system actors are in place throughout the region. For example, audits of cost claims are routinely conducted in countries such as Viet Nam and Thailand in case of any under- or over-reimbursements. In the Republic of Korea, the Health Insurance Review and Assessment Agency provides explicit guidelines and criteria about its review process, which enables more transparency. Thailand conducts reviews of medicines and interventions included in its benefits package, to protect citizens against catastrophic medical expenditures.

Countries put in place regulations and sanctions to facilitate greater performance accountability. Most countries in the region regulate doctors, nurses, and pharmacists, and some regulate allied health professionals and traditional medical practitioners. Regulations are also set up in most countries to license and accredit health facilities in both the public and private sectors. In Thailand, in accordance with the Medical Premises Act 1998, the Medical Registration Division of the Ministry of Health regulates private clinics and hospitals. Noncompliance with licensing standards
results in sanctions, including probation, suspension, and license revocation.29 These arrangements promote accountability by creating a framework of standards and procedures.67

Throughout the region, countries have developed ways to engage civil society and feed community concerns and suggestions back into the policy and decision-making processes. Mechanisms include improving access to information via awareness campaigns, system “report cards” and scorecards, and social audits.48,71 Others include using the judicial system to redress perceived problems, as in Indonesia.65 Countries have also established institutions to facilitate civil engagement. In 2012, the Republic of Korea established the Citizen Committee for Participation, a lay citizens council, to inform priority setting and benefits coverage.72 This occurred after a lengthy period of public requests for expanded benefits coverage (starting in the early 1980s) and following an initial expansion of benefits coverage in 2005. This expansion triggered a series of public debates regarding the criteria by which coverage decisions were made and culminated in the creation of the Citizen Committee, which makes recommendations to the Health Insurance Policy Committee on service priorities. This has been largely successful, with the Citizen Committee participating in revising benefit coverage decisions.72 New Zealand has also institutionalized the participation of civil society in decision making. The New Zealand Public Health and Disability Act 2000 requires the involvement of Māori and other groups in decision making, planning, and delivery of health and disability services. District health groups also consult with community groups regarding their health needs.5

**DISCUSSION**

Countries in the Asia-Pacific region have had varied experiences in using governance functions as they move toward UHC. On the basis of our review, we found that governance functions deployed in the Asia-Pacific region to facilitate progress toward UHC included political commitment; leadership and support from politicians and civil servants; good stakeholder engagement; regulatory, political, and institutional structures to support policy implementation; and systems for monitoring and evaluation. However, countries were also observed to face challenges with respect to governance for UHC, including difficulties creating policies and management strategies that work across rural–urban settings, which affects high-income as well as low-income countries.73 Another common barrier is poor monitoring and evaluation and lack of oversight across a range of factors (for example, health worker performance, working conditions). This is exacerbated by deficiencies in auditing, monitoring, and data gathering.

At its most fundamental level, committing to and implementing UHC is a political process: the state must be willing and able to mobilize its substantial range of resources and have the capacity to apply the different governance functions to coordinate and shape the interactions of the other components of the health system to work toward UHC goals. Building support for UHC policies and programs will require collaboration with and across multiple sectors and constituents and building coalitions to generate the political capital to overcome vested interests.1,2,74 However, as Savedoff et al. recently noted, “The path to universal health coverage is contingent, emerging from negotiation rather than design.”75 (p. 926) The examples of country experiences given above suggest that this is the case for countries in the Asia-Pacific region as they move toward UHC.

The journey to UHC is highly complex, involving trade-offs regarding who should be covered, the extent of coverage, and the financial protection provided, and involves all five governance functions. Leadership by governments as the stewards of health systems is critical in shaping the inter-related governance functions, developing strategies in the choice of the policy levers and tools, and comprehensive applications of the range of governance functions. The experiences that countries have had, ranging from changes in the financing and payment systems to changing health institutions, are a reflection of this complexity. Though some policies may work for some countries, they do not necessarily work in others, and the context and design of the strategy and policy and how it is implemented will impact outcomes. The example of the success of decentralization in improving efficiency, stakeholder participation, and accountability in a number of countries is contrasted with the inequitable outcome of greater benefits for urban populations due to lack of alignment between UHC reforms and broader government strategies.2,7,31 Moreover, the links between policies related to governance functions and progress toward UHC are conditional on how they are designed and the relationship between them. For example Viet Nam, which has successfully formulated national plans for UHC, set targets, introduced regulation, and directed resources toward expanding service access and financial coverage, has nevertheless not only struggled to meet its targets but continues to
experience high levels of OOP, and health financing is beginning to represent a fiscal burden on the government.\textsuperscript{76}

**CONCLUSION**

All countries approach UHC from their own unique contexts, and for many the drive for UHC and for expanding health coverage and health services has arisen from, and been implemented on the basis of, local concerns and socio-economic circumstances.\textsuperscript{1, 65} Our review found that a number of countries in the Asia-Pacific, as they have moved toward UHC, have sought to establish UHC as a goal in national policy making and priority setting; created new roles and/or new institutions within the health system; established systems of monitoring and evaluation; and put in place mechanisms to facilitate collaboration and ensure greater accountability. These actions are influenced by factors in both the internal and external environments, including broader governance arrangements in the public sector (institutional changes and decentralization are particularly prominent factors) and the ability of governments to implement policies and steer the health system. The governance functions advocated by the WHO provide a useful framework for governments to consider the complex range of factors, in their unique contexts, to formulate strategies and policies across all health system functions and generate the political support needed to incrementally move toward UHC goals.

**LIMITATIONS**

One of the limitations of this study is the lack of available information on UHC reforms in some countries, particularly in the Pacific region. Additionally, much of the information we could identify was drawn from grey literature (which may reflect its own institutional priorities) rather than peer-reviewed literature. Rapid political, economic, and social changes and large regional differences (economic, political, and social) complicate cross-country comparisons. It was a challenge to identify information on the means that countries use to monitor and evaluate the mechanisms by which they implement policies.

**DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST**

This research was originally conducted as part of a study for the WHO: Western Pacific Region on Governance Pathways in the Asia-Pacific Region. The authors declare no conflict of interest.

**ORCID**

Eng-Kiong Yeoh \(\odot\) http://orcid.org/0000-0002-1721-9450

Patsy Yuen Kwan Chau \(\odot\) http://orcid.org/0000-0002-6809-0941

Jaymond Tang \(\odot\) http://orcid.org/0000-0003-1312-1744

**REFERENCES**

1. Bristol N. Global action toward universal health coverage. Washington (DC): CSIS Global Health Policy Centre; 2014.

2. Hort K, Jayasuriya R, Dayal P. The link between UHC reforms and health system governance: lessons from Asia. J Health Organ Manag. 2017;31(3):270–285. doi:10.1108/JHOM-11-2016-0220.

3. Whiting S, Dalipanda T, Postma S, de Lorenzo AJ, Aumua A. Moving towards universal health coverage through the development of integrated service delivery packages for primary health care in the Solomon Islands. Int J Integr Care. 2016;16(1):3. doi:10.5334/ijic.2447.

4. The Organization for Economic Cooperation and Development. Universal health coverage and health outcomes: Final report for the G7 Health Ministerial meeting. Paris; 2016 Jul 22 [accessed 2018 Jun 19]. http://www.oecd.org/els/health-systems/Universal-Health-Coverage-and-Health-Outcomes-OECD-G7-Health-Ministerial-2016.pdf.

5. World Health Organization (WHO) Regional Office for the Western Pacific. Universal health coverage: moving towards better health: action framework for the Western Pacific Region. Manila (Philippines): WHO Regional Office for the Western Pacific; 2016. http://www.who.int/iris/handle/10665/246420.

6. Beattie A, Yates R, Noble DJ. Accelerating progress towards universal health coverage in Asia and Pacific: improving the future for women and children. BMJ Glob Health. 2016;1(Suppl 2):i12–i18. doi:10.1136/bmjgh-2016-000190.

7. World Health Organization, Health Systems Financing - The Path to Universal Coverage. Geneva, Switzerland: World Health Organization; 2010. [Accessed 13 December 2018]. https://www.who.int/whr/2010/en/.

8. Tang S, Brixii H, Bekedam H. Advancing universal coverage of healthcare in China: translating political will into policy and practice. Int J Health Plann Manage. 2014;29(2):160–174. doi:10.1002/hpm.2207.

9. Barbazza E, Tello JE. A review of health governance: definitions, dimensions and tools to govern. Health Policy. 2014;116(1):1–11. doi:10.1016/j.healthpol.2014.01.007.

10. Siddiqi S, Masud Tl, Nishtar S, Peters DH, Sabri B, Bile KM, Jama MA. Framework for assessing governance of the health system in developing countries: gateway to good governance. Health Policy. 2009;90(1):13–25. doi:10.1016/J.HEALTHPOL.2008.08.005.

11. World Health Organization. Health systems governance for universal health coverage: action plan. Geneva (Switzerland): World Health Organization; 2014. [accessed 2018 May 11]. http://www.who.int/universal_health_coverage/plan_action-hsgov_uhc.pdf
12. Smith PC, Anell A, Busse R, Crivelli L, Healy J, Lindahl AK, Westert G, Kene T. Leadership and governance in seven developed health systems. Health Policy. 2012;106(1):37–49. doi:10.1016/j.healthpol.2011.12.009.

13. Brinkerhoff DW, Bossert TJ. Health governance: principal-agent linkages and health system strengthening. Health Policy Plan. 2014;29(6):685–692. doi:10.1093/heapol/czs132.

14. World Health Organization. Everybody’s Business. Strengthening health systems to improve health outcomes: WHO framework for action. Geneva (Switzerland): World Health Organization; 2007. [accessed 2018 May 11]. https://www.who.int/healthsystems/strategy/everybodys_business.pdf

15. Mikkelsen-Lopez I, Wyss K, de Savigny D. An approach to addressing governance from a health system framework perspective. BMC Int Health Hum Rights. 2011;11:13. doi:10.1186/1472-698X-11-13.

16. Dodgson R, Lee K, Drager N. Global health governance: a conceptual review. Geneva (Switzerland): World Health Organization and London School of Hygiene and Tropical Medicine; 2002. [accessed 2018 May 11]. http://apps.who.int/iris/bitstream/handle/10665/89534/a85727_eng.pdf?sequence=1&isAllowed=y.

17. Regional Committee for Europe. Stewardship/Governance of health systems in the WHO European Region. Copenhagen (Denmark): World Health Organization Regional Office for Europe; 2008 July 28. EUR/RC58/Conf.Doc./4 http://www.euro.who.int/__data/assets/pdf_file/0016/70180/RC58_edoc09.pdf.

18. Greer SL, Mendez CA. Universal health coverage: a political struggle and governance challenge. Am J Public Health. 2015;105(Suppl 5):S637–9. doi:10.2105/AJPH.2015.302733.

19. Global Health Group. Attaining universal health coverage: a research initiative to support evidence-based advocacy and policy-making. Mission E editors. Milano (Italy): Global Health Group, Cergas; 2010. [accessed 2018 May 11]. http://www.pacifichealthsummit.org/downloads/UHC/Attaining%20Universal%20Health%20Coverage%20Researchinitiative%20to%20Support%20Evidence-based%20Advocacy%20and%20Policy-making.PDF.

20. WHO. The world health report 2000: health systems: improving performance. Geneva (Switzerland): The World Health Organization; 2000. [accessed 2018 May 11]. https://www.who.int/whr/2000/en/whr00_en.pdf?ua=1

21. Savedoff WD. Governance in the health sector: a strategy for measuring determinants and performance. Washington (DC): World Bank; 2011. Policy Research working paper no. WPS 5655. [Accessed 2018 May 11]. https://openknowledge.worldbank.org/bitstream/handle/10986/3417/WPS5655.pdf?sequence=1&isAllowed=y.

22. World Bank. Moving toward UHC: Myanmar – national initiatives, key challenges, and the role of collaborative activities. Moving toward UHC. Washington (DC): World Bank Group. 2017. http://documents.worldbank.org/curated/en/99199151348339321/pdf/122045-BRI-Moving-Toward-UHC-series-PUBLIC-WorldBank-UHC-Myanmar-FINAL-Nov30.pdf.

23. Ministry of Health of Viet Nam. Plan for people’s health protection, care and promotion 2016-2020. Hanoi (Viet Nam): Ministry of Health; 2016. No: 139/KH-BYT. [Accessed 2018 May 11]. http://www.euhf.vn/upload/Strategic%20documents/82%20MOH%205-year%20plan%20(Eng).pdf.

24. Economic Planning Unit of Prime Minister’s Department of Malaysia. Eleventh Malaysia Plan 2016-2020. Kuala Lumpur (Malaysia): Economic Planning Unit; 2015. [Accessed 2018 May 11]. http://www.sarawakdga.org.my/wp-content/uploads/2015/09/11th_Malaysian_Plan.pdf

25. WHO Regional Office of Western Pacific Region. Universal health coverage on the journey towards Healthy Islands in the Pacific. Background documents in Twelfth Pacific Health Ministers Meeting, Rarotonga, Cooks Islands; 2017. http://www.wpro.who.int/southpacific/pic_meeting/2017/documents/12thphmm_session02_uhc_16august.pdf.

26. Asante AD, Irava W, Limwattananon S, Hayen A, Martins J, Guinness L, Ataguba JE, Price J, Jan S, Mills A, et al. Financing for universal health coverage in small island states: evidence from the Fiji Islands. BMJ Glob Health. 2017; 2(2):e000200. doi:10.1136/bmjgh-2016-000200.

27. Eleventh Pacific Health Ministers Meeting. 2015 Yanuca Island Declaration on health in Pacific Island countries and territories. WHO Regional Pacific Region (Fiji): Eleventh Pacific Health Ministers Meeting; 2015. [accessed 2018 May 11]. http://www.wpro.who.int/southpacific/pic_meeting/2015/phmmdeclaration2015_english_final_nov3.pdf.

28. World Health Organization. Integrated people-centred health service case study - Role Delination Policy. Solomon Islands (Philippines): World Health Organization; 2016. https://www.integratedcare4people.org/media/files/Solomon_Island_RDP_Case_Study.pdf.

29. Madendradhata Y, Trisnantoro L, Listyadewi S, Soewono P, Matthias T, Harimurti P, Prawira J. The Republic of Indonesia health system review. New Delhi (India): WHO Regional Office for South-East Asia; 2017. Health Systems in Transition Vol.7, No.1.

30. WHO Regional Office for South-East Asia. Strengthening human resource for health in South-East Asia: time for action and commitment. New Delhi (India): WHO Regional Office for South-East Asia; 2015. http://www.who.int/iris/handle/10665/164332.

31. Jongudomsuk P, Srisasalux J. A decade of health-care decentralization in Thailand: what lessons can be drawn? WHO South East Asia J Public Health. 2012;1(3):347–356. doi:10.4103/2224-3151.207031.

32. Ramesh M. Health care reform in Vietnam: chasing shadows. J Contemp Asia. 2013;43(3):399–412. doi:10.1080/00472336.2013.763497.

33. Mohammed J, North N, Ashton T. Decentralisation of health services in Fiji: a decision space analysis. Int J Health Policy Manag. 2016;5(3):173–181. doi:10.15171/ijhpm.2015.199.

34. Mohammed J, Ashton T, North N. Wave upon wave: Fiji’s experiments in decentralizing its health care system. Asia Pac J Public Health. 2016;28(3):223–243. doi:10.1177/1010539516653270.

35. Li R, Hernandez-Villafuerte K, Tows A, Vlad I, Chalkidou K. Mapping priority setting in health in 17 countries across Asia, Latin America, and sub-Saharan Africa. Health Syst &
36. World Bank. Moving toward UHC: Vietnam—national initiatives, key challenges, and the role of collaborative activities. Washington (DC): World Bank Group; 2017. http://documents.worldbank.org/curated/en/464111513160157867/Moving-toward-UHC-Vietnam-national-initiatives-key-challenges-and-the-role-of-collaborative-activities.

37. Sivalal S. Health technology assessment in the Asia Pacific region. Int J Technol Assess Health Care. 2009;25(Suppl 1):196–201. doi:10.1017/S0266462309009631.

38. World Health Organization. Regional Office for the Western Pacific. The Philippines health system review. Manila: WHO Regional Office for the Western Pacific. Health Syst Transit. 2011;1(2):xxii–129.

39. Rasathanath K, Posayanonda T, Birmingham M, Tangcharoensathien V. Innovation and participation for healthy public policy: the First National Health Assembly in Thailand. Health Expect. 2012;15(1):87–96. doi:10.1111/j.1369-7625.2010.00656.x.

40. World Health Organization. Regional Office for the Western Pacific. The Kingdom of Thailand Health System Review. Manila: WHO Regional Office for the Western Pacific. Health Syst Transit. 2015;5(5):xxx–265.

41. Limwattananon S, Tangcharoensathien V, Prakongsai P. Catastrophic and poverty impacts of health payments: results from national household surveys in Thailand. Bull World Health Organ. 2007;85(8):600–606. doi:10.2471/BLT.06.033720.

42. Meng Q, Xu L. Monitoring and evaluating progress toward universal health coverage in China. PLoS Med. 2014;11(9):e1001694. doi:10.1371/journal.pmed.1001694.

43. Boerma T, Eozenou P, Evans D, Evans T, Kiyen MP, Wagstaff A. Monitoring progress towards universal health coverage at country and global levels. PLoS Med. 2014;11(9):e1001731. doi:10.1371/journal.pmed.1001731.

44. Na S, Kwon S. Building systems for universal health coverage in South Korea. Washington (DC): World Bank Group. 2015. HNP Discussion Paper. http://documents.worldbank.org/curated/en/367221468186565282/Building-systems-for-universal-health-coverage-in-South-Korea.

45. Smullen A, Phua KH. Comparing the health care systems of high-performing Asian countries. Asia Pac Policy Stud. 2015;2(2):347–355. doi:10.1002/app5.76.

46. Rao M, Rao KD, Kumar AKS, Chatterjee M, Sundararaman T. Human resources for health in India. Lancet. 2011;377(9765):587–598. doi:10.1016/S0140-6736(10)68880-4.

47. Balabanova D, Mills A, Conteh L, Akkazieva B, Banteyerga H, Dash U, Gilson L, Harmer A, Ibrahimova A, Islam Z, et al. Good health at low cost 25 years on: lessons for the future of health systems strengthening. Lancet. 2013; 381(9883):2118–2133. doi:10.1016/S0140-6736(12)60005-0.

48. Rao M, Godajkar P, Baru R, Bishit R, Mehrotra RP, Dusgupta R, Reddy S, Bajpai V. Draft national health policy 2015; a public health analysis. Econ Polit Wkly. 2015;50(17):94–101.

49. Meng Q, Xu L, Zhang Y, Qian J, Cai M, Gao J, Xu K, Boerma JT, Barber SL. Trends in access to health services and financial protection in China between 2003 and 2011: a cross-sectional study. Lancet. 2012;379(9818):805–814. doi:10.1016/S0140-6736(12)60278-5.

50. Hu D, Zhu W, Fu Y, Zhang M, Zhao Y, Hanson K, Martinez-Alvarez M, Liu X. Development of village doctors in China: financial compensation and health system support. Int J Equity Health. 2017;16(1):9. doi:10.1186/s12939-016-0505-7.

51. Akashi H, Osanai Y, Akashi R. Human resources for health development: toward realizing universal health coverage in Japan. Biosci Trends. 2015;9(5):275–279. doi:10.5582/bst.2015.01125.

52. Tangcharoensathien V, Limwattananon S, Suphanchaimat R, Patcharanarumol W, Sawangdee K, Putthasri W. Health workforce contributions to health system development: a platform for universal health coverage. Bull World Health Organ. 2013;91(11):874–880. doi:10.2471/BLT.13.120774.

53. Reich MR, Harris J, Ikegami N, Maeda A, Cashin C, Araujo EC, Takemi K, Evans TG. Moving towards universal health coverage: lessons from 11 country studies. Lancet. 2016;387(10020):811–816. doi:10.1016/S0140-6736(15)60002-2.

54. Campbell J, Buchan J, Cometto G, David B, Dussault G, Fogstad H, Frontiere I, Lozano R, Nyonator F, Pablos-Méndez A, et al. Human resources for health and universal health coverage: fostering equity and effective coverage. Bull World Health Organ. 2013;91(11):853–863. doi:10.2471/BLT.13.118729.

55. Campbell J. Towards universal health coverage: a health workforce fit for purpose and practice. Bull World Health Organ. 2013;91(11):887–888. doi:10.2471/BLT.13.126698.

56. Ismail M, Hao RK, Jain N, Noh K, Nagpal S, Phuong HT, Seddoh A, Selvavaynagam T, Tomaro J, Tuan KA. Engaging the private sector in primary health care to achieve universal health coverage: advice from implementers, to implementers. In: Thomas C, Makinen M, Blanchet N, Krussell K editors. Joint learning network (JLN) for Universal health coverage primary health care technical initiative. Washington (DC): Results for Development Institute; 2016. p. vii–91. [Accessed 2018 May 11]. http://www.jointlearningnetwork.org/resources/PHC-Engaging-the-private-sector-in-PHC-to-Achieve-UHC.

57. Zhang S, Zhang W, Zhou H, Xu H, Qu Z, Guo M, Wang F, Zhong Y, Gu L, Liang X, et al. How China’s new health reform influences village doctors’ income structure: evidence from a qualitative study in six counties in China. Hum Resour Health. 2015;13:26. doi:10.1186/s12960-015-0019-1.

58. Tang S, Tao J, Bekedam H. Controlling cost escalation of healthcare: making universal health coverage sustainable in China. BMC Public Health. 2012;12(Suppl 1):S8. doi:10.1186/1471-2458-12-S1-S8.

59. Syed-Abdul S, Hsu MH, Iqbal U, Scholl J, Huang CW, Yeoh et al.: Governance Functions to Accelerate Progress toward UHC in the Asia-Pacific Region

60. Tan GH. Diabetes care in the Philippines. Ann Glob Health. 2015;81(6):863–869. doi:10.1016/j.ajoah.2015.10.004.
61. Mao W, Vu H, Xie Z, Chen W, Tang S. Systematic review on irrational use of medicines in China and Vietnam. PLoS One. 2015;10(3):e0117710. doi:10.1371/journal.pone.0117710.

62. Bae EY, Hong JM, Kwon HY, Jang S, Lee HJ, Bae S. Eight-year experience of using HTA in drug reimbursement: South Korea. Health Policy. 2016;120(6):612–620. doi:10.1016/j.healthpol.2016.03.013.

63. Zheng H, de Jong M, Koppenjan J. Applying network theory to policy-making in China: the case of urban health insurance reform. Public Adm. 2010;88(2):398–417. doi:10.1111/j.1467-9299.2010.01822.x.

64. World Bank. Moving towards UHC: Cambodia—national initiatives, key challenges, and the role of collaborative activities. Washington (DC): World Bank Group; 2017. [accessed 2018 May 11]. http://documents.worldbank.org/curated/en/666481513156478339/pdf/122050-BRI-Moving-Toward-UHC-Cambodia-FINAL2-Nov30.pdf

65. Wong EL, Yeoh EK, Chau PY, Yam CH, Cheung AW, Fung H. Accountability and health systems: toward convergence and cooperation for medicines and the health workforce. Geneva (Switzerland): WHO; 2017. [accessed 2018 May 11]. http://www.wpro.who.int/about/regional_committee/68/documents/wpr_rc68_9_annex_medicines_health_workforce.pdf

66. Pisani E, Kok MO, Nugroho K. Indonesia’s road to universal health coverage: a political journey. Health Policy Plan. 2014;1(1):62–71. doi:10.1093/heapol/czw120.

67. WHO Regional Office for Western Pacific Region. Draft - Western Pacific regional action agenda on regulatory strengthening, convergence and cooperation for medicines and the health workforce. Manila (Philippines): WHO Western Pacific Region; 2017. WPR/RC68/9. [Accessed 2018 May 11]. http://www.wpro.who.int/about/regional_committee/68/documents/wpr_rc68_9_annex_medicines_health_workforce.pdf

68. Brinkerhoff DW. Accountability and health systems: toward conceptual clarity and policy relevance. Health Policy Plan. 2004;19(6):371–379. doi:10.1093/heapol/czh052.

69. Phuong HT, Tran TMO. Strategic purchasing for universal health coverage: a critical assessment. Vietnam: Resyst; 2016. Research Brief. https://resyst.ishlt.ac.vn/sites/resyst/files/content/attachments/2018-08-22/Vietnam%20purchasing%20brief.pdf.

70. Tangcharoensathien V, Limwattananon S, Patcharanarumol W, Thammatacharee J, Jongudomsuk P, Sirilik S. Achieving universal health coverage goals in Thailand: the vital role of strategic purchasing. Health Policy Plan. 2015;30(9):1152–1161. doi:10.1093/heapol/czu120.