Research Article

Health Financing Reforms for Moving towards Universal Health Coverage in the Western Pacific Region

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CONTENTS

Introduction
Health Financing Landscape
Lessons Learned
Ongoing and Future Directions
References

Abstract—This article provides an overview of health financing reforms across countries in the Western Pacific Region as progress is made toward universal health coverage (UHC). Moving toward UHC requires a strong health system with sustainable financing, which countries strive to achieve through various approaches appropriate to their country contexts. Great efforts have been made by financing reforms through resource mobilization, risk pooling, resource allocation, and strategic purchasing. Overall governance of health financing systems has improved within the context of service delivery and budget reforms. But there are still challenges and ongoing needs to continue expanding health financing mechanisms equitably and efficiently, improving stewardship and accountability, strengthening the transition to domestic financing, and enabling evidence-informed priority setting and benefits design processes. Asian countries are rapidly developing and moving to more prepaid financing mechanisms with government subsidies to reduce relatively high out-of-pocket expenses, while facing implementation challenges in the governance and expansion of social health insurance. The Pacific island countries, on the other hand, face stagnating economic growth and rely on government financing, with some countries receiving significant external funding, making it important to have strong stewardship and public financing systems in place. The way forward calls for continuing to strengthen the evidence generation and monitoring function to assess country progress, reorienting primary health care as the foundation of the health sector to ensure that continuity of care is affordable and accountable, and leveraging the private sector to contribute to an equitable and efficient health system.

INTRODUCTION

Universal health coverage (UHC)—all people obtaining the health services they need without suffering financial hardship
when paying for them—is one of the targets under the Sustainable Development Goals (SDGs) and a founding platform for achieving other health-related SDGs. Moving toward UHC will require strong health systems that are well governed and sustainably financed. Each country is finding its own set of health financing reforms to move toward UHC. For many countries this will require more sustainable health financing of its health system, including strengthened domestic health financing and equitable, efficient use of available resources to achieve effective results.

Over the past decade, many countries in the Western Pacific Region have launched health financing reforms to accelerate progress toward UHC. The region covers 37 countries and areas in East Asia, Southeast Asia, and the Pacific islands. It is diverse, in terms of countries’ varying historical, social-political, demographic, geographic, and economic contexts. Though many countries are undergoing changes in their disease patterns and populations, there are also rapid socioeconomic developments and increasing expectations from citizens to access better quality health services. In particular, several Asian countries have accelerated their movement toward UHC through high political commitment and their health-sector reforms, which have oftentimes been triggered by pressing health financing issues and the need to strengthen the foundations of primary health care. The rapidly changing contexts present opportunities but also challenges, including sustaining the gains made from progress made toward the Millennium Development Goals and other priority public health programs, while addressing new and emergent challenges such as noncommunicable diseases (NCDs), accelerated aging of populations, and health security risks such as disease outbreaks and natural disasters.

Other challenges and issues in the region include high out-of-pocket (OOP) health payments in East and Southeast Asian countries, reduced external funding in several Asian countries with rapid economic development and Pacific island countries, fragmented funding flows, increasing decentralization, greater engagement with the private sector, urbanization, migration, and persistent inequities in health outcomes and access to health services. These are interconnected with the broader reforms related to service delivery, budget, and public management. High-income countries in the region, such as Japan, the Republic of Korea, Australia, Singapore, and New Zealand, also face mounting pressures to address the financial sustainability of their health systems, including cost control measures and adoption of new medicines and technologies. With over 85% of deaths caused by NCDs, the majority of the world’s disease outbreaks and natural disasters occurring in this region, and unprecedented accelerated aging, this region is faced with some of the most pressing and diverse challenges of our time.1-3

Primary health care is central to the health-sector reforms in both Asian and Pacific island countries. In the Pacific, in addition to the NCD crisis and persistent health security risks such as outbreaks and natural disasters, there is the need to transform the way in which services are delivered to communities, with a focus on improving priority-setting mechanisms and efficiency in how resources are allocated. In fact, the Pacific island countries have renewed their “Healthy Islands” vision, with primary health care as the overarching strategy for moving toward UHC.4 However, unlike in several Asian countries, economic development in some countries in the Pacific is stagnating, with continued reliance on external funding for health, which can be volatile over time.5

In light of these complexities, countries have taken various financing policy reforms and actions to accelerate UHC. More recently, support to countries has focused on interlinked actions toward UHC, taking a whole-of-systems approach across health and disease programs to improve health systems quality, equity, efficiency, accountability, sustainability, and resilience.6,7 A whole-of-systems approach takes into consideration the dynamic nature of the different components of a health system whereby actions can affect the entire health system.

Most urgent is the need for governments to closely collaborate within and across the health sector to move forward the UHC agenda for health financing. This agenda calls for improved financial protection and sustainable financing for the health system and relies on joint work across ministries of health, finance, labor and social welfare, transport, urban planning and other sectors to address the changing health demands in the region, such as increasing NCDs and disease outbreaks. These health financing reforms are important to better support the desired changes in service delivery and serve as lessons learned for countries embarking on similar challenges and approaches.

This article provides an overview of the health financing challenges and reforms in the Western Pacific Region over the past decade. It then outlines the lessons learned and health financing policy implications in Asia and Pacific island countries. Lastly, the article highlights the ongoing and future directions for countries at different stages of their health financing system development.

HEALTH FINANCING LANDSCAPE

Countries in the region have been introducing health financing policies that advance UHC, which has served as the foundation for health-related SDGs. The baseline assessment
of UHC and SDG indicators, including service coverage index and financial protection, shows variation across countries from less than 50% to 80% in service coverage index and nearly 0% to 4.8% the proportion of the population incurring large expenditures in health when paying for health services (Figure 1). The service coverage index consists of an index of 16 tracer indicators across four major areas: reproductive, maternal, neonatal, and child health; communicable diseases; NCDs; and service capacity and access. The financial protection indicator is defined as the proportion of the population incurring OOP health expenditures more than 25% of the total household expenditure. Of the countries with available data in the region, the average service coverage index is 75% and the population incurring large expenditures is 1.6%. From Figure 1, three groups of countries are identified: those with high service coverage index and low financial protection, those that have low service coverage and low financial protection, and those with high service coverage and high financial protection. Countries moving from lower-middle to upper-middle income, such as China, may increase access to services but also experience an increase in OOP health expenditures, which may affect financial protection, during this transition. The data serve as a baseline to monitor progress for countries, although more than half of the countries in the region do not have both indicators, due to lack of access to data sets and difficulties in collecting data.

Achieving financial protection is critical to progress toward UHC, because whatever services that are made available and delivered should be accessible and affordable to everyone based on health need. Countries in the region, for the most part, have increased health service utilization, with several improving financial protection. However, overall, the region has the most households incurring high health expenditures as part of their total household expenditures compared to all of the other regions in the world. It also has the largest increase in millions of households incurring large health expenditures from 2000 to 2010 (Figure 2). Several studies have been undertaken to estimate the incidence of catastrophic and impoverishing health expenditures going beyond the UHC-SDG indicator definition to incorporate the capacity to pay considering subsistence expenditures. They have also examined the trends of catastrophic and impoverishing health expenditures over time and their determinants. Some of the main drivers of catastrophic and impoverishing health expenditures are OOP health payments for medicines and/or having an older or chronically ill person in the household.

![Baseline UHC Indicators for Service Coverage Index and Financial Protection](image)

**FIGURE 1.** Baseline UHC Indicators for Service Coverage Index and Financial Protection. The service coverage index is a composite index of 16 tracer indicators measuring the coverage of essential health services across the following: reproductive, maternal, newborn, and child health (family planning demand met by modern methods, antenatal care, child immunizations, and care-seeking behavior for child pneumonia); communicable diseases (tuberculosis detection and treatment, HIV antiviral treatment, at-risk population sleeping under bednets, and access to improved sanitation), NCDs (prevalence of normal blood pressure, mean fasting glucose, cervical cancer screening once data are available, and nonsmoking adult population); and service capacity and access (hospital bed density, health worker density, facilities with essential medicines list once data are available, and International Health Regulations core capacity). The financial protection indicator is defined as the proportion of the population incurring OOP health expenditures more than 25% of total household expenditure. Source: Universal Health Coverage Data Portal.
Health service utilization has also increased in several countries during the same time. Studies have shown that utilization and catastrophic health expenditures increase among the wealthier quintiles, implying that the poor may give up treatment, resulting in unmet need.

Though there have been limited data to measure financial protection and, in some instances, service coverage, much progress has been made in the past 20 years in tracking health expenditures and building capacity in countries to institutionalize the production and use of health expenditure data in their health financing policy development, with over 15 countries in the region routinely tracking health expenditures. Within the past decade, over ten countries, including China, the Federated States of Micronesia, Malaysia, the Republic of Korea, Tonga, Vanuatu, and Viet Nam, in the Western Pacific Region have increased their current health expenditure as a share of gross domestic product (GDP). Though the absolute value of current health expenditure increased during this period for some countries, such as Cambodia and Lao PDR, the GDP has grown at an even faster rate than current health expenditure. A majority of the countries in the region have public financing as a share of GDP ranging from 2% to 6%, with a wider range in Pacific island countries, with some reaching more than 13% given the significant external funding.

Out-of-pocket health payments as a share of current health expenditure range from 30% to 40%. The countries in the Western Pacific Region have yet to reach the stage of countries in other regions achieving lower OOP health payments and higher domestic government health expenditure, such as Europe, the Americas, and the Eastern Mediterranean. A comparison of Asian countries over time shows a general pattern of increasing domestic government health expenditure as a percentage of GDP and lowering OOP health expenditures as a percentage of current health expenditures as countries moved from lower-middle to upper-middle income status from 2000 to 2015, with the exception of a few countries (Figure 3). Most of the high-income countries, including Brunei Darussalam, the Republic of Korea, Japan, New Zealand, and Australia, have also increased domestic government health expenditures as a share of GDP during this time period. The same trend is not necessarily seen in Pacific island countries, where volatility in the macrofiscal context has led to some countries having higher OOP health expenditures as a percentage of current health expenditures or reduced domestic government health expenditures as a share of GDP (Figure 4). For the most part, countries that have higher domestic government health expenditures as a share of GDP also have higher health outcomes. However, this is not always the case, with some exceptions, such as Singapore and Hong Kong.

There are three major types of health financing in the region—public funds, external funds, and OOP health payments. Public financing is in the form of taxation or compulsory, contributory health insurance, with many countries having a mixed public financing system (notably, China, Japan, Mongolia, the Philippines, the Republic of Korea, and Viet Nam).

As a part of their health-sector reforms, China, Mongolia, the Philippines, and Viet Nam all have recent revisions or are
undergoing revisions in their social health insurance laws and/or major changes in the governance of their social health insurance systems. In 2018, China established a new State Health Insurance Administration at the central level that will manage the three major health insurance schemes, which are also being harmonized, along with other major functions. China has also been embarking on major provider payment reform through piloting in selected provinces. \(^{19-23}\) Mongolia, the Philippines, and Viet Nam have recently revised their health insurance laws with attempts to increase tax revenues and contribution rates, better define who pays for what services, and improve coverage to vulnerable and poor populations. \(^{24-26}\)

The population coverage of national health insurance in several Asian countries has jumped considerably within the past decade, particularly in China, with coverage over 95%, the Philippines at 93%, and Viet Nam at 87%. Their acceleration of population coverage reflects the similar achievements of high-income Asian countries, such as Japan and the Republic of Korea, which reached a high level of population coverage in a relatively shorter time span compared to the time frame in European countries. \(^{27}\) In Japan and the Republic of Korea, strong political will and

\[\begin{align*}
\text{FIGURE 3. Health Expenditure Indicators in Asia in 2000 and 2016. Note: Each bubble represents one country; the size of each bubble represents the GDP per capita of that country. Source: World Health Organization.}^{18}\end{align*}\]
mandatory enrollment in social health insurance was the foundation for increasing population coverage, along with the rapid expansion of Japan’s employee-based and community-based social health insurance and Republic of Korea’s economic growth. However, there is much need to strengthen the prepayment mechanisms and function of health insurance agencies because only 10% to 15% of health expenditures in middle-income countries are from social health insurance. In the region, Asian countries have greater expenditures through prepayment mechanisms as they move from lower-middle to high income status (Figure 5), highlighting the importance of prepaid funds and reducing OOP health expenditures.

**FIGURE 4.** Health Expenditure Indicators in the Pacific in 2000 and 2016. Note: Each bubble represents one country; the size of each bubble represents the GDP per capita of that country. FSM=Federated States of Micronesia, PNG=Papua New Guinea, and SOL=Solomon Islands. Source: World Health Organization.

18 Chu et al.: Health Financing Reforms for Moving towards UHC in The Western Pacific Region
FIGURE 5. Composition of Current Health Expenditures by Health Financing Schemes in Asian Countries in the Western Pacific Region (2016). Note: Health expenditures by health financing schemes are shown as percentages of total current health expenditures. Government schemes refer to automatic, noncontributory schemes for all of the population or specific subgroups defined by law or government regulation. Compulsory contributory schemes include social health insurance, compulsory private health insurance, and compulsory medical savings accounts. Voluntary health insurance covers primary and supplementary voluntary health insurance, coverage through nonprofit institutions, and enterprise financing schemes. Out-of-pocket is direct payment by the user at the point of service, not including reimbursements through other schemes. “Other” refers to nonresident schemes. Source: World Health Organization.

FIGURE 6. Composition of Current Health Expenditures by Health Financing Schemes in Pacific Island Countries in the Western Pacific Region (2016). Note: Health expenditures by health financing schemes are shown as percentages of total current health expenditures. Government schemes refer to automatic, noncontributory schemes for all of the population or specific subgroups defined by law or government regulation. Compulsory contributory schemes include social health insurance, compulsory private health insurance, and compulsory medical savings accounts. Voluntary health insurance covers primary and supplementary voluntary health insurance, coverage through nonprofit institutions, and enterprise financing schemes. Out-of-pocket is direct payment by the user at the point of service, not including reimbursements through other schemes. “Other” refers to nonresident schemes. Health expenditure estimates for Niue, Tuvalu, and Samoa are from 2015 for more completeness. Source: World Health Organization.
Cambodia and Lao PDR are in the early stages of developing their health insurance systems. Cambodia has the Health Equity and Quality Improvement Project, which supports the Health Equity Funds, and is building from the formal sector’s workers injury insurance and launching its National Social Protection Policy Framework 2016–2025, and Lao PDR is continuing to develop its formal-sector and government employee insurance schemes and covering the informal sector through a tax-based national health insurance scheme that will replace community-based health insurance and integrate the health equity funds and free maternal and child health services.30,31

Some countries also have other complementary voluntary schemes, such as private health insurance, as seen in Australia, the Philippines, and the Republic of Korea, with several other countries facing challenges of how to regulate private health insurance. In addition, many countries, such as Cambodia, Lao PDR, Kiribati, Papua New Guinea, Solomon Islands, northern Micronesia islands, and, to a lesser extent, Mongolia and Viet Nam, receive external funds from donors, including from global health initiatives channeled through either government schemes or other mechanisms (Figures 5 and 6). In Pacific island countries, the composition of health expenditures shows that a majority is coming from government and external funds, with social health insurance in a few countries. Though OOP health expenditures are lower compared to Asian countries, there are still geographical and financial barriers to accessing health services, which includes spending on transport costs.

The health financing patterns in the region confirm that countries with higher population coverage have greater prepayment mechanisms and the focusing on voluntary health insurance as a primary health financing mechanism is not a viable, or equitable, option for moving towards UHC. Coupled with the financial protection information, countries with higher prepayment mechanisms also have higher financial protection. But there is an ongoing need to further strengthen the quality and scope of both health expenditure and financial protection information to influence policy dialogue and development.

LESSONS LEARNED

Based on the varied development of health financing systems across Asian and Pacific island countries, lessons learned and policy implications are outlined below across each of the health financing functions with linkages to intermediate objectives of efficiency, equity, accountability, and transparency.32

Mobilization of Resources

Over the past decade, most countries with growing economies have made efforts to increase domestic public spending for health, such as domestic government spending for health as a proportion of general government spending, in their health-sector reforms and are strengthening the engagement and trust between ministries of health and finance. Ministries of health are often faced with questions regarding how effectively they spend their funds, what evidence they have, and what they are doing to improve efficiency. Governments have subsidized heavily access to health services for vulnerable and poor populations and, in some cases, the informal sector. For countries with national health insurance, contribution rates have slowly increased over time. Government subsidies have contributed greatly to expanding coverage of social health insurance.

Countries in the region have used tobacco and alcohol taxation as an increasingly useful fiscal instrument for health to expand their health budgets and are leading in the movement toward implementing taxes on sugar-sweetened beverages. Furthermore, though mobilizing more domestic resources is important, the effective use of public funds can play a role in increasing fiscal space for health.33 Linking the health plan or strategy with clear health objectives and indicators and consideration of budget implications are necessary for priority setting and resource allocation. Having this linkage also strengthens the accountability of the health financing system.

Nearly every country in the region imposes taxation on tobacco and alcohol products. Taxing sugar-sweetened beverages is also rapidly gaining popularity in the region. Taxation of these products can serve as another way to mobilize resources while also inhibiting consumption of harmful products. Earmarking funds is often a political decision rather than purely a financial one. There are advantages and disadvantages to earmarking, the flexibility of which depends on the country’s public financial management system.34 Some countries in the region have earmarked funds for health, such as the Philippines, where a percentage of tobacco and alcohol taxes and gambling revenues is used to subsidize health insurance coverage for poor populations and inpatient care. Though countries have benefited from the health and fiscal implications of tobacco and alcohol taxation, funds generated from economic growth and gained efficiencies continue to be a significant source of increased fiscal space for health.35
Risk Pooling

Risk pooling helps in the redistribution of resources and protects against the individual risk of becoming ill and paying high costs for health services by spreading the risk across the greater population. Pooling enables cross-subsidies from those who are healthy to those who are ill, from the wealthy to the poor, and from the working-age group to the non-working-age group. Having a larger risk pool can enable greater bargaining power in purchasing health services. Countries in the region have set up single, multiple, or fewer large funds with key considerations in each scenario. In countries such as Cambodia, China, and Lao PDR, multiple funds have been organized for different subgroups of the population—for example, government employees, private sector employees, the self-employed, and the poor. Though having a multiple funds system can address the needs of their enrollees in terms of benefit packages and willingness to pay premiums, this can also lead to inequity among the various subgroups. Lao PDR is in the process of introducing a tax-based national health insurance scheme that will replace community-based health insurance and integrate the health equity funds and free maternal and child health services.

The benefits of moving toward a more integrated system and merging risk pools, such as a single health insurance fund, can be seen in Mongolia, the Philippines, and the Republic of Korea, where nationwide subsidies across subgroups can be implemented and there is a uniform benefit package and lower administrative costs. However, this can also lead to perverse cross-subsidization in which the poorer rural provinces subsidize the richer, more urban provinces, as in the case of Viet Nam, where health service utilization is lower in rural areas. Countries such as Mongolia and the Philippines are still trying to increase the effectiveness of having a single health insurance fund and improve coordination with the government budget and other funding streams. The single fund can have greater bargaining power in purchasing better quality services from providers if managed effectively and pooled together with the government budget.

Resource Allocation and Strategic Purchasing

How resources are allocated and health services are purchased underpin the linkage between health financing and service delivery. Key decisions to be made include what services to purchase, who the purchasers and providers are, how providers are paid and at what price, and how these decisions on budget allocations and reimbursements are made. Several low- and middle-income Asian countries in the region allocate budget based on historical trends (Table 1), with some adjustments based on geography, economic development, and health needs at the provincial level. The purchaser can be a combination of the Ministry of Health, health insurance agencies, and/or other private financing schemes. A selected few countries, such as the Republic of Korea, have a single purchaser system that is separate from the Ministry of Health. Though having a purchaser–provider split can avoid conflicts of interest and achieve better quality services more efficiently, coordination and alignment between ministries of health and health financing policies are still needed between the purchasers and providers.

Common provider payment mechanisms include line item budgeting, fee-for-service, and case-based payments. Countries such as Cambodia, China, and Lao PDR are moving toward performance-based financing. China is also developing and piloting a diagnostic-related group payment system for hospital care in selected areas. The budget structure is important, with program-based budgeting being another development in broader health financing and budget reforms that countries are undertaking, such as in Cambodia and Mongolia, where ministries of health are the first to pilot the transition toward program-based budgeting.

In Mongolia, for example, the priority is on primary health care for both spending from government budget and health insurance funds. Though the Ministry of Health is piloting a project to link a small part of its budget to health policy objectives, the health insurance funds are specifically allocated to be used for four major areas of health interventions—rehabilitation, home-based care, day care, and diagnostics—as outlined by the health insurance law. How to define and pay for primary health care within the framework for these four major areas and how to fund for efficient and effective interventions are some of the ongoing challenges.

ONGOING AND FUTURE DIRECTIONS

The varied health financing situations of Asian and Pacific island countries in the Western Pacific Region show that there is no one standard set of health financing policies to move toward UHC. Though the region has experienced steady economic growth in Asian countries, this growth has been limited in Pacific island countries. Even economic development, however, does not automatically translate to larger health budgets. Several ongoing and future directions in health financing reforms in the region in terms of expanding health financing mechanisms, improving stewardship and accountability, transitioning toward strengthened domestic financing, and establishing evidence-informed priority setting and benefits design are highlighted in this section.
| Country      | What Is Being Purchased?                                                                 | Who Are the Purchasers/ Fund Holders? | Who Are the Providers? | How Are Allocations/ Reimbursements Decided? | How Are They Paid?                                      |
|--------------|----------------------------------------------------------------------------------------|---------------------------------------|------------------------|---------------------------------------------|--------------------------------------------------------|
| Brunei       | Implicit package                                                                       | Ministry of Health                    | Public facilities      | Budget allocation based on historical trends | Line item budget                                        |
| Cambodia     | Government subsidies for public health functions                                       | Ministry of Health                    | Public facilities      | Budget allocation based on historical trends | Line item budget FFS Move toward program-based budgeting |
|              | National Social Security Fund                                                           | Ministry of Health                    | Private facilities     | Move toward program-based budgeting          | Service delivery grant Performance-linked grants       |
|              | Health Equity Fund and service delivery grants                                         | CBHI                                  |                        |                                             |                                                        |
| China        | Government subsidies for public health functions                                       | Ministry of Health                    | Mainly public facilities (high autonomy at the hospital level) | Varies by province Efforts to harmonize across schemes | FFS Case-based payment Global budget                   |
|              | Three health insurance scheme packages: Urban Residents Basic Medical Insurance, Urban Employee Basic Medical Insurance, and New Rural Cooperative Medical Scheme | Ministry of Health                    |                        |                                             |                                                        |
|              | Contribution by members and employers for the formal sector for government employees and private sector employees | Ministry of Health (NHIB, Ministry of Health (NIHI, CBHI, HEF)) |                        |                                             |                                                        |
|              | Contribution by members and employers for the formal sector for government employees and private sector employees | NSSF (Ministry of Labor and Social Welfare) (formal-sector schemes) |                        |                                             |                                                        |
| Lao PDR      | Government subsidies for covering the informal sector through a tax-based national health insurance scheme that will gradually replace the CBHI scheme and integrate HEF and free MCH services | Ministry of Health                    | Mainly public facilities | Budget based on historical trends for salary, investment, equipment | NSSF: fixed capitation for all services, risk-adjusted capitation for chronic disease and cost sharing for high-cost services |
|              | Contribution by members and employers for the formal sector for government employees and private sector employees | NHIB, Ministry of Health (NIHI, CBHI, HEF) |                        | NSSF: based on costing studies and approved by the board of the NSSF | NHIB (NIHI, CBHI, HEF): capitation for outpatient, case based for inpatient and delivery |
|              | Mainly negatively defined benefit package (except for free MCH services)               | NSSF (Ministry of Labor and Social Welfare) (formal-sector schemes) |                        | NHB: based on costing studies and approved by the National Health Insurance Management Committee | Free MCH services: case based |
|              | Including transport and food allowance for the poor and free MCH services              |                                        |                        | Government policy on free MCH services        |                                                        |
| Malaysia     | Implicit package                                                                       | Ministry of Health                    | Public facilities      | Budget based on historical trends            | Public: global budget based on historical trends Private: FFS Line item budget Capitation Case-based payment |
| Mongolia     | Primary care by government budget                                                      | Ministry of Health                    | Public facilities      | Budget based on historical trends            |                                                        |
|              | Social health insurance package (since 2018 also includes certain primary care services) | Health Insurance General Agency     | A few private facilities (tertiary level) |                                             |                                                        |

(Continued on next page)
Expansion of Health Financing Schemes

The population coverage of many countries has increased due to several factors, including heavy government subsidies to cover the poor, vulnerable, and informal sectors; family-based enrollment (dependents coverage); a strengthened and well-distributed health workforce; and engagement with private providers. Countries in the region where there are large informal sectors struggle to increase population coverage and have started expanding coverage within the formal sector and increasing government funds to cover the poor and vulnerable populations and then providing subsidies to the informal sector to enroll.

There are several implementation issues that have emerged with the expansion of national health insurance, including compliance with mandatory participation, income assessment and collection of contributions, and maintenance of registration systems, particularly when the informal sector is a majority of the population. In middle-income countries, compliance can also be an issue in the formal sector because employers are reluctant to pay half of the contribution for employees. For example, participation in health insurance was only about 50% even for formal-sector workers in Viet Nam. The extension of coverage from the formal sector to the informal sector can still be difficult due to the large informal sector and complications associated with cross-subsidizing from the formal sector, particularly in low- and middle-income countries. Due to these implementation issues, covering the informal sector through social health insurance is quite challenging in low- and middle-income countries, unless the government provides subsidies for the informal sector as well as the poor and vulnerable populations.

Tax-based financing also has its challenges. Mobilization of tax revenues for health through increased priority on health is not an easy task, with weak implementation of funds allocated to health, competing sectors, and continued emphasis on economic growth, particularly in several Asian countries. There exist limitations to tax-based systems that may have achieved good health outcomes with less government spending but experience dissatisfaction with service quality in the public sector, particularly by the nonpoor population. Equitable access to quality health services is of major concern, and determining how well the public service delivery system can serve and/or work together with the private service delivery system to achieve intended outcomes is crucial.

For most countries, health financing systems are usually a mix of tax-based and health insurance funds, and the need for coordination across these streams of financing is critical to advancing UHC. In high-income countries, such as Japan and the Republic of Korea, partial government subsidies are provided to the self-employed for health insurance. Common challenges in these countries include increasing citizen demand for quality health services, long-term financial sustainability of the financing system, continuous improvements in the priority-setting process, benefits design, and provider payment methods. No matter what type of health financing

| Country          | What Is Being Purchased?                                      | Who Are the Purchasers/Fund Holders? | Who Are the Providers?            | How Are Allocations/Reimbursements Decided? | How Are They Paid?                      |
|------------------|----------------------------------------------------------------|-------------------------------------|-----------------------------------|--------------------------------------------|-----------------------------------------|
| The Philippines  | Implicit package linked to government subsidies PhilHealth packages. Hospital care: case-based payment with no balance billing for the poor and co-payment for the rest | Department of Health PhilHealth Local governments | Public facilities Private facilities | Budget based on historical trends PhilHealth sets reimbursement rate | Budget allocation to facilities Case-based payment and FFS for PhilHealth |
| Viet Nam         | Government subsidies for public health functions Social health insurance package | Ministry of Health Viet Nam Social Security | Public facilities (high autonomy at the hospital level, can include private wing) | National fee schedule with ceiling, service price updated most recently in 2016 and 2017 to better reflect full costs | Budget allocation FFS Piloting capitation and case-based payments |

*CBHI = community-based health insurance; HEF = Health Equity Fund; MCH = Maternal and Child Health Services; NHIB = National Health Insurance Bureau; NSSF = National Social Security Fund; FFS = fee-for-service. Source: World Health Organization. 37

TABLE 1. Resource Allocation and Strategic Purchasing for Health Services in Selected Asian Countries*
system a country has, effective government regulation and leadership are mandatory to advance UHC. For example, the effective implementation of social health insurance relies on subsidies for segments of the population, regulation of medicine prices, and the establishment of transparent and participatory decision-making processes.

**Transition Toward Strengthened Domestic Financing**

Strengthening financing institutions to improve systemwide efficiency involves both allocative and technical efficiency efforts and improved capacities. This entails having more integrated planning and budgeting processes, along with the appropriate reporting and monitoring mechanisms through public financial management systems. It also calls for securing sustainable financing for essential public health services and across health and disease programs using a whole-of-systems approach. As a part of this transition, a few countries have been moving from input- to output-based budgeting and performance-linked financing.41

Though countries are increasing their domestic financing for health overall, several countries in the region, such as Cambodia, Fiji, Lao PDR, Malaysia, Mongolia, the Philippines, and Viet Nam, are facing a decline of external funding from bilateral partners and global health initiatives, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund); Gavi, the Vaccine Alliance; and the US President’s Emergency Plan for AIDS Relief. Though there have been great strides made in limiting the burden of communicable diseases, such as tuberculosis, HIV/AIDS, malaria, and vaccine-preventable diseases, there are still challenges of sustaining such progress while new and emerging challenges arise and ensuring the continuum of care for vulnerable populations when external resources decline.42,43

These global health initiatives enabled a rapid response to disease control but now pose challenges in sustainable financing for public health priorities and how previously vertically financed programs are integrated into the general health system and governed during the transition period.7 With countries having an overall lower disease burden and undergoing service delivery reforms, the business-as-usual model to finance priority disease control models has to change. The challenges include major issues of health financing as well as how to implement changes in service delivery models, procurement and supply management systems, and the way in which human resources are managed. Countries are not expected to completely fill the financing gap left by reduced donor funding; rather, they need to start early in planning for their transitions as a part of their national planning and policy processes and prioritize across programs with common core elements, such as surveillance, procurement, and monitoring, to assess any potential duplications or overlaps from an efficiency standpoint. While countries continue to strengthen the capacities to detect, respond to, and prevent priority diseases, they need to develop a monitoring system for the implementation of their transition plans.

**Stewardship and Accountability**

Collaboration with various partners, such as other government sectors and nonstate actors, has supported essential public health functions in several countries in the region. Improving cooperation and coherence across government sectors is instrumental in meeting public health standards and supporting a country’s efforts toward UHC and the achievement of the SDGs. Social protection policies, such as those related to poverty alleviation programs and for specific vulnerable populations, can include subsidies to enroll in social protection mechanisms and patient support for priority public health services.

Though health financing mechanisms may be in place, it is critical to have supply-side readiness and to be able to use these mechanisms to support quality health service delivery. Several countries in the region have been able to meet population needs through strengthened partnerships with private providers at all levels and particularly in the primary care sector. In particular, the need for equitable, quality health services has sparked countries to consider alternative ways to channel funding for primary health care in both urban and rural areas (China, Mongolia, and Viet Nam). For example, though population-based interventions are funded by state budgets, Mongolia is using health insurance funds to pay for a package of services for primary health care. In addition, as countries undergo health financing reforms to introduce more flexibility in financing and strategic purchasing, increased and managed provider autonomy needs to be realized.44

Government leadership in assuring an accountable health financing system is fundamental to advancing UHC through the effective use of legislative, regulatory, and financial levers to make quality health services available and affordable. An accountable health system has institutionalized processes for decision making that are transparent, participatory, and evidence informed without conflicts of interest. In several countries with more decentralized governance systems, such as in China, Lao PDR, Papua New Guinea, the Philippines, and other Pacific island countries, greater coordination and clarity of roles and functions across the levels of government and agencies are needed to achieve health policy objectives. In addition, as health financing systems evolve, so too should the capacities of government at central and local levels, health insurance agencies as
more independent purchasers of health services, and other related social sectors that also contribute to improved health outcomes. Government capacity is also important to manage various interests of the medical profession, enrollees in different insurance plans, private insurance, pharmaceutical companies, and other stakeholder groups. Countries such as Cambodia, China, and Mongolia have recently had significant changes in governance of health financing systems, specifically with regards to institutional arrangements and consideration of purchaser, provider, and monitoring functions. Though coordination between the Ministry of Health and the health insurance agency is highly conducive for effective implementation of health policies, this also needs to be balanced with appropriate accountability mechanisms and its independence from the Ministry of Health. A more accountable health financing system also reduces the opportunities for financial mismanagement, inefficiencies, and corruption.

In several Pacific island countries, strengthening stewardship and accountability mechanisms is a main priority, including having donors being on plan (activities included in the government’s operational plans), on budget (development partner activities and contributions to be included in the budget), and on system (using and channeling funds through the government’s financial management system).

Evidence-Informed Priority Setting and Benefits Design

Increasingly, countries in the region are facing complex challenges on how to make the best use of their available resources to improve access to services that are of quality and affordable. Countries have to make difficult choices regarding how to allocate funding given the budget constraints, which affects what services are delivered and their access. This entails dealing with issues of governance, including the evidence used to support these decisions on what services to provide, how they are provided, and the process by which these decisions are made. For example, when designing benefits, cost-effectiveness is used as one of the major factors in the priority setting of interventions; however, there are several additional factors involved, such as social, equitable, ethical, legal, political, budget impact, and implementation considerations. It is also important that vulnerable populations are factored into the prioritization process. This goes beyond health technology assessment and is critical in maintaining accountability of decision makers and health managers for how funds are spent. Furthermore, political processes and economic context remain the underlying factors in how funds are allocated and spent.

Countries in the region have started to develop capacities in linking evidence to the decision-making process that is transparent and participatory. Having multiple stakeholders involved, including representation from the community/patient perspective, is critical in the composition of stakeholders. In the Pacific, high expenditures on overseas tertiary care is an important concern, as well as how decisions are made to allocate budgets for tertiary care, whether through an overseas or domestic system. Countries are to develop a systematic framework for decision making and, beyond this, establish how their service delivery systems will evolve to address the disease burden in the long run. With changing population needs and fiscal contexts, priority setting and resource allocation are critical to sustaining the health gains made and further progressing toward UHC.

Way Forward

Within the past few decades, great strides have been made in poverty alleviation and improved health outcomes in the Western Pacific Region. Though several countries have enjoyed rapid economic development, changing epidemiological and demographic profiles, rising expectations for better health services, and other emerging issues have increased pressure on countries’ health financing systems, which continue to evolve. With the exception of high-income countries in the region, most health financing systems have low financial protection, particularly in Asian countries, because prepayment mechanisms are still being developed and strengthened. In addition, most Pacific island countries face an unstable macroeconomic context and may be highly dependent on external funding.

Though OOP health payments are still a major source of financing in the region, efforts have been made to increase domestic government spending on health and government subsidies to finance health services for poor and vulnerable populations through public prepaid health financing mechanisms. Moving toward UHC cannot be realized without contributions from tax-based funding or government subsidies, particularly when trying to cover the poor, vulnerable populations and large informal sector in middle-income Asian countries. Japan and the Republic of Korea first covered the formal sector and incrementally extended coverage to the informal sector and the poor. Rapid economic development of those countries contributed to the rapid decrease in vulnerable populations to be subsidized.

There is increasing commitment and request for technical support to strengthen the governance of health financing systems in the region. Good governance requires institutional arrangements, clarity in roles and functions of agencies, and use of legislative, regulatory, and financial levers to ensure an accountable health financing system that is able to monitor progress and respond to feedback, not to mention equitable access to health services.
In addition, with primary health care as the foundation of health-sector reforms in countries throughout the region, the role of the service delivery “network”—its entities, functions, management, financing, and services provided—will be critical to establishing continuity of care that is affordable and accountable. Reorienting the service delivery system may be particularly challenging in decentralized contexts and may differ across urban and rural settings. In expanding primary health care, several countries in the region have done this through the engagement of private providers and are developing ways in which private providers and public hospitals exhibiting profit-maximizing behavior can be better harnessed to support public policy objectives. Countries such as China, Mongolia, and Viet Nam are exploring options to finance primary health care through health insurance, but how they define the specific services covered and how to implement such services across public and private providers remains in a piloting phase.

Nevertheless, countries have undertaken various financing reforms to move toward UHC, with much progress in health outcomes and population coverage in the region in an accelerated time frame, such as 40 years for Japan and 12 years for the Republic of Korea. Clearly, there are emerging patterns and key considerations to be taken when strengthening health financing systems to ensure equity, efficiency, and sustainability dimensions. Countries in the region are faced with new and ongoing challenges that put a strain on existing resources and health systems, leading to the need for health financing reforms and more dynamic approaches to sustainability. Though countries are gradually moving toward more prepaid financing mechanisms and reduced OOP health payments, greater efforts need to be made to achieve accessible and affordable quality health services. The governance of the health financing system, including accountability mechanisms, is increasingly important to steer a country toward UHC, monitor progress, and uphold the trust of citizens.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

No potential conflict of interest was reported by the authors.

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