



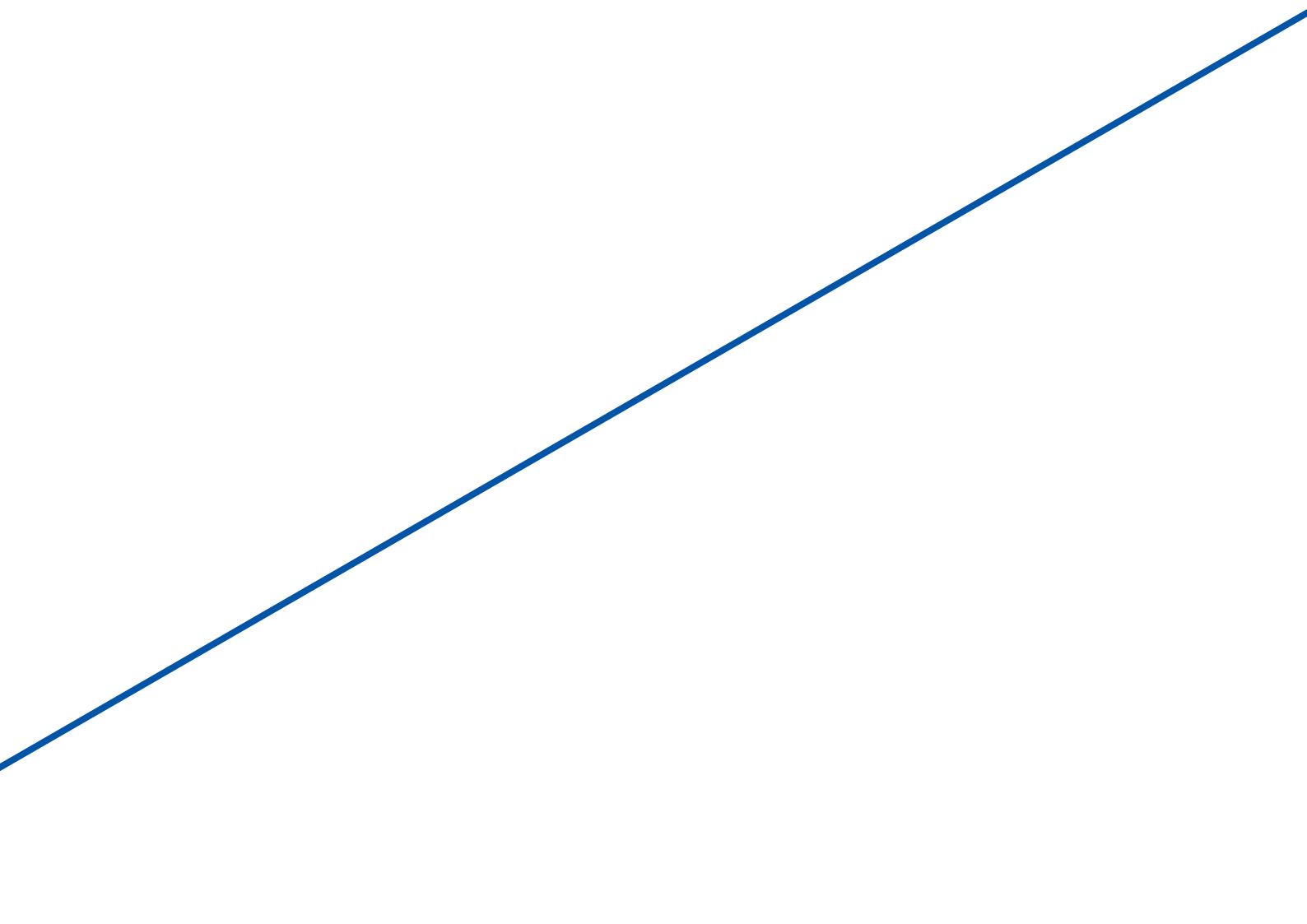
International
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► Extending social health protection: Accelerating progress towards Universal Health Coverage in Asia and the Pacific



► **Extending social health protection:
Accelerating progress towards
Universal Health Coverage
in Asia and the Pacific**

International Labour Organization



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► Abstract

Demand for adequate social health protection systems is high. Access to quality health care without hardship is a central guarantee of a social protection floor, a stepping stone to realize the human rights to health and social security and a necessary condition to achieve the Sustainable Development Goals (SDGs), especially universal social protection and universal health coverage. Changing demographics, evolutions in the world of work and health as well as economic and environmental shocks call for social health protection systems able to innovate and find sustainable pathways towards universal coverage. This includes coverage of workers in all forms of employment and their families, and involves supporting the transition from the informal to the formal economy.

This publication provides important insights to practitioners on concrete ways to adapt and extend social health protection, including through adapted design features building on the principles laid out in ILO standards (in particular, the Medical Care Recommendation, 1944 (No. 69), the Social Security (Minimum Standards) Convention, 1952 (No. 102), the Medical Care and Sickness Benefits Convention, 1969 (No. 130), the Medical Care and Sickness Benefits Recommendation, 1969 (No. 134) as well as the Social Protection Floors Recommendation, 2012 (No. 202)). Drawing on examples from Asia and the Pacific, this publication sheds light on the role of social health protection as a transformative policy contributing to effective access to health care without financial hardship in a way that fosters redistribution and solidarity.

Key words: social health protection, social protection, universal health coverage, health financing, Asia, Pacific, universal social protection, social health insurance, national health service, health care, COVID-19, informal economy.



► Foreword

The Global Call to Action adopted by the International Labour Conference in June 2021 reaffirms the centrality of social protection at the core of a human-centered recovery from the COVID-19 pandemic to avoid the long-term scarring of economies and societies. More broadly, the pandemic has demonstrated the stabilizing effect of well-functioning social protection systems on the economy and their essential role in supporting prevention measures and providing immediate protection against impoverishment and rising inequalities, while contributing to inclusive economic growth and social cohesion. The pandemic has also starkly revealed the absolute necessity of social health protection to protect people's health and ensure income security in times of sickness. During the pandemic, robust social health protection systems have enabled people to receive the life-saving care they need when sick without financial hardship, and to protect their income through sickness benefits. In countries where such systems are deficient, ad hoc and temporary measures had to be implemented to assist those who were not covered by social health protection systems to access free COVID-19 treatment, vaccines and obtain an income while unable to work.

It is now time to move from emergency responses into universal, comprehensive, adequate and sustainable social health protection systems to uphold the human rights to health and social security. Only legally anchored and coordinated responses will allow us to reach the objectives set out in the 2030 Agenda, most notably universal social protection systems, including floors (target 1.3) and universal health coverage (target 3.8) by 2030.

Despite laudable progress over the past decades, those rights are not yet a reality for all in Asia and the Pacific. The region has the highest number of people and percentage of the population who face impoverishment due to out-of-pocket health spending. Furthermore, inequalities in coverage and access to services are still pronounced both across and within countries. Gaps in coverage disproportionately affect the most vulnerable and jeopardize the social contract. To address these challenges, more attention must be paid to the range of services guaranteed and to limiting out-of-pocket spending. High-level commitment by member States to assume primary responsibility for the design, implementation and financing of social health protection is essential to address these issues and prevent impoverishment due to sickness and care-seeking. Such efforts must be informed by other key principles, including collective financing, broad risk-pooling and rights-based entitlements.

Amidst the on-going COVID-19 pandemic, demand for adequate social health protection is high on the global agenda, and the Asia and the Pacific region is no exception. Access to social health protection is essential for decent work and sustained economic recovery, and it is more than ever needed to enhance social cohesion and social justice. It is a moral imperative and essential for a future grounded in solidarity between people, communities, nations and across generations.

This report aims to accompany constituents and other stakeholders in their journey towards universal health coverage. It is based on the acknowledgement that our challenges are interconnected and that addressing them requires exchanges of experience and knowledge across countries of the Asia and the Pacific region and beyond, based on shared values of global solidarity, for prosperity and for peace.

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Many of the country profiles were developed with CONNECT¹, a pioneering multi-stakeholder network of public institutions and non-profit organizations in the Asia and the Pacific region working together to bridge gaps in social health protection. Its mandate is to strengthen the capacity of countries in the region to develop and implement strong, sustainable and comprehensive social health protection policies, strategies and systems to reach universal health coverage. As a regional centre of excellence, it aims to provide joint research opportunities, deliver short and long-term training and support advocacy and awareness-raising efforts in the region. To increase regional capacity and knowledge on social health protection, the network promotes South-South cooperation initiatives to complement on-going national efforts and support existing national policies.

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¹ <https://connectshp.com/>

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► Abbreviations and acronyms

AEHI	Advanced Elderly Health Insurance	ICLS	International Conference of Labour Statisticians
ASEAN	Association of Southeast Asian Nations	IDR	Indonesian Rupiah
B\$	Brunei Dollar	ILO	International Labour Organization
BDT	Bangladeshi Taka	JKN	Jaminan Kesehatan Nasional
CBHI	Community-based health insurance	KRW	Korean Won
CHE	Current health expenditure	Lao PDR	Lao People's Democratic Republic
CHI	Citizens' Health Insurance	LAK	Lao Kip
CMI	Catastrophic Medical Insurance	LKR	Sri Lankan Rupee
CNY	Chinese Yuan	LTCI	Long Term Care Insurance
COVID-19	Coronavirus Disease 19	MFA	Medical Financial Assistance for the Poor
CSMBS	Civil Servant Medical Benefit Scheme	MHLW	Ministry of Health, Labour and Welfare
DOTS	Directly Observed Therapy Short Course	MLSW	Ministry of Labour and Social Welfare
DRG	Diagnosis-related group	MNT	Mongolian Tugrug
EL	Employer liability	MOH	Ministry of Health
ESCAP	Economic and Social Commission for Asia and the Pacific	MOHFW	Ministry of Health and Family Welfare
FFS	Fee-for-service	MOHW	Ministry of Health and Welfare
FMNCH	Free Maternal Neonatal and Child Health	MOPH	Ministry of Public Health
GCC	Gulf Cooperation Council	MSEs	Micro and small enterprises
GDP	Gross Domestic Product	MYR	Malaysian Ringgit
GGE	General government expenditure	NC	Non-contributory scheme
HEF	Health Equity Fund	NCD	Non-communicable disease
HIB	Health Insurance Board	NGO	Non-governmental organization
HIRA	Health Insurance Review and Assessment Service	NHI	National Health Insurance

NHSO	National Health Security Office	UN	United Nations
NSPC	National Social Protection Council	UNDP	United Nations Development Programme
NSSF	National Social Security Fund	UNFPA	United Nations Population Fund
OECD	Organisation for Economic Co-operation and Development	URRBMI	Urban Rural Resident Basic Medical Insurance
OOP	Out-of-pocket	USP 2030	Universal Social Protection 2030
OSH	Occupational safety and health	US\$	United States Dollar
PHC	Primary health care	VND	Viet Nam Dong
PHP	Philippine Peso	VSS	Viet Nam Social Security
PKR	Pakistani Rupee	WHO	World Health Organization
PPP	Purchasing Power Parity		
PVHI	Private voluntary health insurance		
RMNCH	Reproductive, Maternal New Born and Child Health		
SAARC	South Asia Association for Regional Cooperation		
SCI	Service Coverage Index		
SDGs	Sustainable Development Goals		
SHI	Social health insurance		
SHP	Social health protection		
SI	Social insurance		
SSB	Social Security Board		
SSK	Shasthyo Shuroksha Karmasuch		
SSO	Social Security office		
SSS	Social Security Scheme		
TB	Tuberculosis		
UCS	Universal Coverage Scheme		
UEBMI	Urban Employee Basic Medical insurance		
UHC	Universal Health Coverage		

► Executive summary

Along with income security, access to health care without hardship is at the core of comprehensive social protection systems. Rooted in international human rights instruments and international social security standards, social health protection (SHP) provides a rights-based framework towards the policy objectives and Sustainable Development Goals (SDGs) of universal social protection (USP) and universal health coverage (UHC).

This publication analyses and compiles experiences from countries in Asia and the Pacific in their efforts to build universal SHP systems that are resilient, effective, inclusive, adequate and sustainable over the long term. It aims to shed light on the role of SHP as a transformative policy tool contributing to effective access to health care without financial hardship. This report highlights progress made, challenges encountered and remaining coverage gaps, and explores their root causes. The information gathered provides insights for practitioners and policy-makers on concrete ways to design, extend, adapt and implement SHP systems and policies. It also constitutes a basis for fostering learning and exchanges of experiences across countries.

This report recalls the rationale for extending SHP. First, it offers a rights-based approach to UHC. Second, it provides a platform for health and social policies to work together and maximize both operational synergies and opportunities to mobilize public resources on a joint agenda. Third, it is a worthy investment. Returns include health and income security, which directly contribute to well-being and productive capacities at the individual, household, community, societal and global levels.

The research for this publication started in late 2019. Since then, the COVID-19 pandemic has further revealed the devastating consequences of SHP gaps for individuals and societies alike. It has also increased public demand for adequate SHP. In this context, the publication constitutes a timely and vital input to support all concerned stakeholders on recovery strategies. A human-centred recovery from the current health and economic crisis is possible. It involves taking the 'high-road' towards USP. This means building on the progress made in extending coverage and enhancing institutional capacities that are highlighted throughout this publication. This would enable societies to move towards an inclusive recovery that addresses the deep structural inequalities that have obstructed progress towards social justice for too long, including in Asia and the Pacific region where half of the world's population lives.

The publication is comprised of two parts. The first part provides a comparative analysis of SHP in Asia and the Pacific across the dimensions of coverage, adequacy, institutional efficiency and financing arrangements. The second part is composed of 21 country profiles showing the diversity of contexts, paths and policy choices to reach universal coverage.

Coverage

Over the past decades, many countries in Asia and the Pacific have rapidly expanded SHP coverage. Despite laudable progress, the effective realization of the human rights to health and social security is not yet a reality for all. More than three-quarters of the population is legally covered in the area of health protection, which still leaves around 950 million people excluded from legal entitlements. Effective protection is lower than legal coverage due to a lack of awareness of rights and practical difficulties and impediments to access. Only 63.4 per cent of the population is protected by a health care scheme, leaving about 1.6 billion people wholly unprotected. Such aggregated figures further hide inequalities within and across countries. This situation is compounded by coverage gaps for sickness cash benefits. In fact, less than half of the region's work force enjoys legal entitlement to income security when sick.

Gaps in coverage disproportionately affect women and men who have unstable or irregular employment and incomes, are under-employed and part-time workers, in self-employment and/or in the informal economy, as well as migrant workers and their families. They particularly affect those whose incomes depend on agriculture or domestic work. This situation jeopardizes the inclusiveness of SHP systems. Countries that have achieved remarkable progress have enshrined SHP entitlements in their legal



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frameworks and taken progressive steps towards universal coverage, using public funding to ensure significant coverage of hard-to-reach groups of their populations.

Adequacy

Many countries have made significant progress in terms of increasing population SHP coverage, but the adequacy of benefits provided remains a challenge. The adequacy of benefits implies they are sufficiently comprehensive, of high quality and provide a sufficient level of financial protection, as defined in international social security standards. Three main factors determine adequacy. First, despite recent reforms, many countries remain focused on curative care and do not sufficiently include prevention measures. They also need to make adjustments to the needs of a changing demography. This means countries need to adapt both their guaranteed benefit packages and the focus of service delivery on the ground. Second, high levels of out-of-pocket expenditure (OOP) are pervasive, in part driven by the increased costs of care due to new technologies, population ageing and a growing financial and societal burden of chronic diseases. The high levels of OOP expenditures are also driven by a growing middle class that is demanding services and protection of higher quality, particularly from private providers. Lastly, high population coverage does not necessarily translate into equitable access to services and health outcomes. This relates to the distribution and quality of facilities and services. Significant efforts have been made to make health services and related infrastructure geographically available and accessible. Still, the issue of adequate distribution of services and retention of a skilled health workforce remains of concern, in addition to disruptions in medical supply chains. Moreover, the regulation of private provision of health care is still at a nascent stage in most low- and middle-income countries in the region. This affects the quality of health care services and highlights that purchasing

them in pluralistic health systems requires strong stewardship and regulatory capacity on the part of the State, most notably for MOHs.

Institutional arrangements and coordination

Both coverage and adequacy can be enhanced if strong institutions and efficient scheme design and administration are in place. For example, ensuring coverage for workers in all forms of employment and their families requires proactive adaptation of institutional processes to extend protection to currently uncovered categories of the population. Similarly, the rise of the private health sector in several countries creates new expectations from the population and results in either higher OOPs health spending, as mentioned earlier, or in a greater financial burden on SHP systems. This situation sheds light on the importance of enhancing the purchasing function of SHP institutions and improving the quality of public health facilities.

Importantly, the equity objective pursued by SHP systems requires the efficient pooling of risks and financial resources. Broad risk-pooling is best ensured by the reduction of fragmentation, which at the same time is supportive of a greater strategic purchasing power and administrative efficiency. A number of countries in the region have made efforts to consolidate SHP schemes. Some have designed single risk pools from the onset, others merged their existing schemes and some kept different risk pools – but are managing them by a single-payer agency, progressively aligning the design of their different schemes or implementing compensation mechanisms across pools. Financing sources are, therefore, less of a predictor of institutional arrangements.

Indeed, institutional arrangements need to foster greater coordination with the broader social protection system. The rationale for such coordination is three-fold. First, income insecurity and poverty are both social determinants of health. Indeed, they are strongly correlated with poor access to health care services and relatively poorer health outcomes. Access to adequate child benefits, old age pensions or disability benefits provide the necessary income security to live a dignified life, while empowering those who receive them, facilitating their access to health care and better addressing the social determinants of health.

Second, a person's health status affects their capacity to fully engage in the labour market. Conversely, poor health can jeopardize income security. Adequate cash benefits are essential to guarantee income security when health is affected – in the case of maternity, illness, employment injury or occupational diseases as well as in old-age. Sickness cash benefits, in particular, play an essential role in guaranteeing income security and preventing the spread of communicable diseases, as the COVID-19 pandemic has demonstrated.

Third, where long-term care, child care or social care services are not available, the burden of caring for a sick or dependent relative usually falls on family members, often women, depriving them of the opportunity to fully engage in income-generating activities.

For these reasons, health care benefits need to be closely coordinated with cash benefits and social care within comprehensive social protection systems to respond to population needs, leverage administrative systems and maximize the socio-economic impacts of social policies. To ensure continuity of coverage throughout the lifecycle, operational linkages across different types of benefits (health, family, old age) and between contributory and non-contributory benefits are necessary. This involves the design and implementation of an organizational set-up allowing common functions (registration and inspection, for example) as well as management tools (coordinated database) to be shared across contingencies, under the umbrella of enabling cross-sectoral policies.

Financing

More public resources are needed to make solidarity in financing a reality. Under-funding or unpredictable funding remain a major barrier to expanding coverage and enhancing adequacy.

Embedding entitlements in the legal framework and ensuring meaningful participation and social dialogue are key features of an enabling framework for sustained resource mobilization and allocation.

Public domestic revenues remain the main source of funding for SHP in the region. Only a few countries rely on external aid to support a large share of their health expenditure. Some countries have transitioned out of dependency on external support to finance health care from domestically-generated resources in the last decades. Sometimes challenges were encountered, including pervasive gaps in the accessibility of services for specific conditions that were previously vertically funded. Similarly, private health insurance plays a small role. It is mostly used to provide supplementary or complementary benefits for those who can afford it, and is therefore not seen as a tool to extend coverage.

Most countries use a mix of taxes and social security contributions to finance SHP. Financing arrangements are not a predictor of systems performance and the traditional distinction between tax-financed and social security schemes has lost its relevance amidst hybrid schemes. Examples of success and failure exist for both financing models. Performance in terms of coverage, adequacy and equity are above all conditioned by three main factors. First, compliance with the principles set forth by international social security standards throughout the design and institutional arrangements for SHP coverage. Second, the adequacy of public financing, often the result of high-level political commitment. And third, the capacities to operate SHP systems in a cost-effective manner, including linkages with broader contributory and non-contributory social protection schemes.

Tax financing has been identified as a means to raise revenues for SHP. However, the size of the informal economy largely influences the tax base for progressive taxation measures and constrains revenue collection. Therefore, many governments have resorted to consumption taxes of various types, including earmarked health taxes on consumer products that are harmful for health. While taxes on consumer goods are an important source of revenue and health taxes in particular have some proven benefits with regards to prevention (by changing behaviours), some consumer taxes can be regressive. Therefore, the adequate financing mix for SHP needs to be balanced and considered within the overall fiscal framework of a country to ensure it fosters solidarity in financing.

The way forward

Country trajectories in the region show that there is no one-size-fits-all solution to make SHP a reality for all. Success has more to do with political and societal commitments and the application of guiding principles in line with international social security standards than with specific financing or institutional models.

While this holds true, to a certain extent, countries face common challenges. At the essence of SHP are the principles of solidarity and equity, with the idea that everyone, rich or poor, should have access to the same provision of health care. In practice, the offer of health services has increased, especially in the private health sector, and SHP policies are lagging behind. Those who can afford it tend to access health care outside of SHP systems. Dual systems develop and fuel rising inequalities. Torn between the imperatives of equity and cost containment, it is becoming increasingly difficult for SHP policies to keep everyone in the same boat. A renewed commitment based on broad risk pooling and solidarity in financing is needed to reinforce the social contract that make societies whole.

A strong focus of SHP systems, often reflecting health systems more broadly, remains on curative care. Investing in prevention and primary care is an urgent priority to meet the needs of populations increasingly affected by non-communicable diseases (NCDs) and health security issues. Furthermore, adopting a primary health care (PHC) approach and addressing the social determinants of health and well-being is a cross-sectoral goal. It further requires raising the profile of health and care workers to secure their close coordination, availability and quality of services they provide, now and in the future. SHP and social protection systems as a whole should support this much needed shift. Doing so requires overcoming tremendous silos between health, employment and social protection policies. At the intersection of health and social policies, SHP institutions are exceptionally placed to play a central role

in this process. This can mobilize a greater share of public resources and contribute to redistribution in a mutually reinforcing way.

Investing in robust rights-based SHP systems is urgently needed. Less than nine years remain to achieve the 2030 Agenda and the COVID-19 pandemic is pushing many countries further off-track. Prioritizing public investments to guarantee access to health care without hardship, including as part of nationally-defined social protection floors, is central to delivering on the promise of the 2030 Agenda and to leave no one behind. Shifting gears towards achieving the SDGs by 2030 is essential to enable people and societies to address the profound transformations that are associated with demographic, epidemiologic, technological and climate changes. By making progress on the promise to achieve USP and UHC by 2030, and by protecting and promoting human rights, States can strengthen the social contract. This will also better ensure preparedness for future crises, including the risks arising from pandemics, climate change, natural resource depletion and environmental degradation.

The dashboard on the following pages provides an overview of the key statistics and selected design features of the SHP systems in 21 countries in the Asia and the Pacific region against key guiding principles provided by ILO standards.

► Dashboard on social health protection system design and results against key guiding principles from ILO standards

	BGD	BRN	KHM	CHN	FJI	IND	IDN	JPN	LAO
Type of care									
Population legally covered for social health protection (%)									
Population effectively protected by a social health protection scheme (%)	N/A	N/A			N/A				
Percentage of labour force aged 15+ years covered by sickness cash benefits (%)									
Solidarity in financing									
Out-of-pocket expenditure as percentage of current health expenditure (CHE) (%)	73.9	4.9	57.5	35.8	14.2	62.7	34.9	12.8	48.8
Risk pooling for the whole population	Yes	Yes	No ⁵	No ⁵	Yes	No ⁵	Yes	No ⁵	Yes
Diversity in financing sources (taxes and social security contributions)	Taxes ⁸	Taxes ⁸	Mix	Mix	Taxes ⁸	Mix	Mix	Mix	Mix
Mix = social security contributions + taxes									
Adequacy and predictability of benefits									
UHC service coverage index: Coverage of essential health services (range 1-100, SDG 3.8.1)	48	81	60	79	64	55	57	83	51
Skilled health staff density per 10,000	7.4	82.6	10.9	59.7	37.8	28.5	15.5	136.1	14.3
Application of user fees & co-payments (main public schemes)	Yes ²	No	No	Yes	Yes ²	Yes	No	Yes ³	Yes

	MYS	MNG	MMR	NPL	PAK	PHL	SGP	KOR	LKA	THA	TLS	VNM
												
	N/A								N/A		N/A	
		ND									ND	
6	35.1	32.4	76.5	50.8	56.2	53.9	31	32.5	50.7	11	7.1	44.9
s	Yes	Yes ⁶	No ⁵	No ⁵	No ⁵	Yes	Yes ⁶	No ⁷	No ⁵	No ⁵	Yes	Yes
k	Taxes ⁸	Mix	Mix	Mix	Mix	Mix	Mix	Mix	Taxes ⁸	Mix	Taxes ⁸	Mix
	73	62	61	48	45	61	86	86	66	80	52	75
5	56.6	72.6	15.0	26.4	14.8	ND	94.0	92.2	36.8	27.6	15.1	22.6
3	Yes ²	Yes	Yes	Yes	Yes	Yes ³	Yes	Yes	No	Yes ²	Yes ²	Yes ³

	BGD	BRN	KHM	CHN	FJI	IND	IDN	JPN	LAO
Proportion of population spending more than 10% of household consumption of income on out-of-pocket health care expenditure (%)	24.7	ND	15.3	19.7	0.8	17.3	2.7	4.4	3.1
Non-discrimination, gender equality and responsiveness to special needs									
Financing of maternity cash benefits EL = employer liability NC = non-contributory scheme SI = social insurance	EL	NC / EL	SI / EL	SI / EL	EL	SI / EL	EL	SI / EL	SI / EL
Percentage of women giving birth receiving maternity cash benefits (%)								ND	
Pre- and post-natal care and delivery covered without co-payments	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes
Coverage of temporary migrant workers subject to separate mechanisms and/or employer's liability	No	Yes	No	No	No	No	Yes	No	No
Primary responsibility of the State									
Domestic general government health expenditure (GGHE-D) as percentage of gross domestic product (GDP) (%)	0.4	2.3	1.3	3	2.3	1	1.4	9.2	0.1
Purchasing: Publicly managed & administered schemes acts as main purchaser	Single ⁸	Single	Multiple	Multiple	Single	Multiple ⁸	Single	Multiple	Single
Provision: Predominance of public provision, including for higher levels of care	No	Yes	Yes	Yes	Yes	No	Yes	No	Yes
Entitlements to benefits prescribed by national law									
Benefit package guaranteed by law (main public schemes) Mix = Implicit and explicit depending on scheme	Implicit	Implicit	Explicit	Explicit	Implicit	Mix	Explicit	Explicit	Explicit

CO	MYS	MNG	MMR	NPL	PAK	PHL	SGP	KOR	LKA	THA	TLS	VNM
	0.7	2.4	14.4	10.7	4.5	6.3	9	21.8	5.4	2.2	2.9	9.4
EL	EL	SI / NC	SI / EL	EL	SI / EL	SI / EL	NC / EL	SI / EL	EL	SI / EL	SI / EL	SI / EL
		ND			ND			ND			ND	
s	Yes	Yes	No	No	Yes	No ³	No	No	Yes	Yes	Yes	No ³
o	Yes	No	No	No	No	No	Yes	No	No	Yes	No	No
9	1.9	2.2	0.7	1.5	1.1	1.4	2.3	4.4	1.5	2.9	2.6	2.7
gle	Single	Multiple	Multiple	Multiple	Multiple ⁸	Single	Multiple	Single	Multiple	Multiple	Single	Single
s	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No
icit ¹	Implicit	Explicit	Explicit	Explicit	Mix	Explicit	Explicit	Explicit ¹	Mix	Explicit	Implicit	Explicit ¹

	BGD	BRN	KHM	CHN	FJI	IND	IDN	JPN	LAO
Equity in access and leaving no one behind									
Births attended by skilled health personnel (%) (SDG indicator 3.1.2)									
Measles immunization coverage among one-year-olds (%)		ND		ND	ND			ND	
Tuberculosis treatment coverage (%)									
Estimated antiretroviral therapy coverage among people living with HIV (%)	ND	ND		ND				ND	
Social inclusion, including of persons in the informal economy									
Workers in all types of employment are legally covered for social health protection	Yes	Yes	Yes ⁴	Yes	Yes	No	Yes	Yes	Yes
Tripartite participation with representative organizations of employers and workers									
Tripartite representation in governance body (where applicable)	N/A ¹⁰	N/A ¹⁰	Yes	Yes	N/A ¹⁰	Yes	Yes	Yes	Yes

Notes:

1. A combination of a positive list and a list of exclusion is used
2. Fees are limited and/or regulated
3. Vulnerable groups are exempted

4. Voluntary affiliation

5. Fragmented risk pools for different populations
6. Fragmented risk pools for different levels of risk
7. Fragmented risk pools but with redistribution
8. Purchasing largely private through out-of-pocket

Legend:

BGD - Bangladesh; BRN - Brunei Darussalam; KHM - Cambodia; CHN - China; FJI - Fiji; IND - India; IDN - Indonesia; JPN - Japan; LAO - Lao PDR; MYS - Malaysia; THA - Thailand; TLS - Timor-Leste; and VNM - Viet Nam.

Out-of-pocket expenditure as percentage of current health expenditure (CHE) (%)		UHC service coverage index: Coverage of essential health services (range 1-100, SDG 3.8.1)		Proportion of population spending more than 10% of household consumption of income on out-of-pocket health care expenditure (%)	
	> 50		> 80		> 10
	20-49		60-79		5-9
	<20		<60		<5

N/A - Not applicable

ND - No data

Sources: Adapted from ILO World Social Protection Database, based on the Social Security Inquiry (SSI) and ISSA/SSA; WHO Global Health Observatory

	MYS	MNG	MMR	NPL	PAK	PHL	SGP	KOR	LKA	THA	TLS	VNM
	ND						ND	ND	ND			
			ND					ND				
	Yes	Yes	No	Yes ⁴	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	N/A ¹⁰	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A ¹⁰	Yes

on groups
care
n mechanisms
cket expenditure

9. A component of SDG target 3c, indicator Indicator 3.c.1: Health worker density and distribution, reported following thresholds: World Health Report (2006): 22.8; ILO (2010): 41.2; WHO/United States Agency for International Development (2013): 59.4.
10. Not applicable to National Health Service systems

Malaysia; MNG - Mongolia; MMR - Myanmar; NPL - Nepal; PAK - Pakistan; PHL - Philippines; SGP - Singapore; KOR - Republic of Korea; LKA - Sri Lanka; THA

Domestic general government health expenditure (GGHE-D) as percentage of gross domestic product (GDP) (%)	Skilled health staff density per 10,000
> 5	> 59.4
3-5	22.8-41.1
< 3	< 22.8

; Global Health Expenditure Database; WHO and World Bank (2020).



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Introduction

Access to universal social protection, one of the four pillars ³ of the Decent Work Agenda promoting social justice, is crucial for the prevention and reduction of poverty, inequalities and social exclusion. As an automatic stabilizer, social protection also constitutes an effective crisis response measure, enabling access to health care and income security support stabilizing aggregate demand. Thus, it increases resilience against future shocks and helps achieve faster recoveries towards inclusive growth and development.

The COVID-19 pandemic has revealed important gaps in social health protection (SHP). It has increased the public demand for adequate SHP by revealing the devastating consequences of coverage and adequacy gaps for individuals and societies alike. Those who are unable to get the treatment required to recover from COVID-19, to access vaccines or to quarantine do not only endanger themselves but also others, thereby undermining public health efforts to contain the virus. In response, governments around the world introduced emergency measures to ensure timely access to health care, to roll out vaccination programmes and to provide sickness benefits for their populations, including by extending their reach, improving their adequacy and facilitating their delivery.

Moving forward, it is crucial to reflect on the lessons learned during the COVID-19 crisis, including the depth of existing gaps and solutions used to reduce such gaps, and build the required steps towards universal comprehensive, adequate and sustainable social protection systems. Such systems must include specifically universal effective access to affordable health care services and adequate sickness

³ Together with full and productive employment, rights at work and the promotion of social dialogue.

benefits for all, with a particular focus on those unprotected and in vulnerable situations. The pandemic underscored the importance for governments to invest in building national social protection systems and for their sustained action and political commitment. SHP, anchored in international human rights instruments and social security standards, provides a rights-based framework towards the policy objective and Sustainable Development Goal (SDG) target of Universal Health Coverage (UHC) (Dorjsuren, Tessier, and Ron, forthcoming).

This publication compiles experiences from countries in Asia and the Pacific, in their efforts to build universal SHP systems that are resilient, effective, inclusive, adequate and sustainable over the long term. The information gathered in this compendium provides insights for practitioners and policy-makers on concrete ways to design, extend, adapt and implement SHP systems and policies. This publication aims to shed light on the role of SHP as a transformative policy tool contributing to redistribution and effective access to health care without financial hardship.

Social health protection: a concept rooted in the human rights framework

Social health protection provides a rights-based pathway towards the goal of UHC. As an integral component of comprehensive social protection systems, SHP designates a series of public or publicly organized and mandated private measures to achieve (ILO 2008a):

- i. effective access to quality health care without hardship; and
- ii. income security to compensate for lost earnings in case of sickness.

The lack of affordable quality health care risks contributing to both poor health and impoverishment, with a greater impact on the most vulnerable. For this reason, the principle of universality of coverage was underlined in social security standards early on.

In 1944, the ILO Medical Care Recommendation (No. 69) introduced the principle of universality, setting out that health care services should cover all members of the community, “whether or not they are gainfully occupied”. The right to health was subsequently formally enunciated in the Constitution of the World Health Organization (WHO) in 1946 and by human rights instruments. Namely, the Universal Declaration of Human Rights, 1948, includes health and security ⁴ as part of the right to an adequate standard of living, stipulating that:

“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control” (Article 25).

The International Covenant on Economic, Social and Cultural Rights, 1966, in its Article 12, further recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. ⁵ In addition, it requires States that are party to the Covenant to take steps for achieving this right, including actions on child health, environmental and occupational health, prevention and control of disease and the creation of conditions which would assure to all medical services and medical attention in the event of sickness. The right to health is an inclusive right, which is not limited to timely access to appropriate health care, but also extends to the underlying determinants of health (access to safe drinking water and adequate sanitation; an adequate supply of safe food, nutrition and housing; healthy working and environmental conditions; and access to health-related education and information).

The human rights to health and social security are mutually supportive and understood as an obligation to guarantee universal effective access to adequate protection (UN Economic and Social Council 2019).⁶ SHP is rooted in this framework and represents the optimal mechanism to substantiate these human

⁴ The right to social security is also referred to in Article 22 of the Universal Declaration of Human Rights.

⁵ The rights to social security and an adequate standard of living are referred to in Articles 9 and 11.

⁶ UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment No. 19: The right to social security (Art. 9 of the Covenant), 4 February 2008, E/C.12/GC/19, available at: <https://www.refworld.org/docid/47b17b5b39c.html>

rights (ILO 2020a). Therefore, international social security standards developed a normative corpus with detailed guidance on the principles that should guide the establishment of SHP systems as well as minimum levels of protection countries should attain, in particular through the Social Security (Minimum Standards) Convention, 1952 (No. 102), the Medical Care and Sickness Benefits Convention No. 130 (1969) and associated Recommendation 134 (1969), and the Maternity Protection Convention, No. 183 (2000) (see Box 1).

► Box 1. Relevant international human rights instruments and social security standards

- ILO Medical Care Recommendation, 1944 (No. 69)
- Universal Declaration of Human Rights, 1948, Articles 22 and 25
- ILO Social Security (Minimum Standards) Convention, 1952 (No. 102), Part II
- International Convention on the Elimination of All Forms of Racial Discrimination, 1965, Article 5 (e) (iv)
- International Covenant on Economic, Social and Cultural Rights, 1966, Articles 9, 11 and 12
- ILO Medical Care and Sickness Benefits Convention, 1969 (No. 130) and Recommendation, 1969, (No. 134)
- Convention on the Elimination of All Forms of Discrimination against Women, 1979 arts. 11 (1) (e) and (f), (2) (b) and (d), 12 and 14 (2) (b) and (c)
- Convention on the Rights of the Child, 1989, Articles 24 and 26
- International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 1990, Articles 28, 43 (e) and 45 (c)
- ILO Maternity Protection Convention, 2000 (No. 183)
- Convention on the Rights of Persons with Disabilities, 2006, Articles 25 and 28
- ILO Social Protection Floors Recommendation, 2012 (No. 202).

Strategy for the extension of adequate coverage

Following the 2007–2008 economic crisis, it became even more evident that social protection, including in the area of health care, needed to be universalized to cushion the multi-dimensional effects of cyclical crises in an interconnected world with a globalized economy. In 2008, ILO constituents adopted the Declaration on Social Justice for a Fair Globalization, which put forth social protection as one of the four objectives of the Decent Work Agenda. With this push, ILO constituents further discussed the need to adopt a new standard that would provide guidance on strategies towards the universal extension of social protection.

The ILO Social Protection Floors Recommendation, 2012 (No. 202) was subsequently adopted by the International Labour Conference and recognized effective access to essential health care as the first of four basic social security guarantees constituting national social protection floors that should be made a universal reality as a matter of priority (ILO 2021a; 2019a; 2017). Acknowledging this important step forward in forging an international consensus around UHC, the United Nations General Assembly adopted a Resolution on Global Health and Foreign Policy in 2012, which underlines “the importance of universal coverage in national health systems, especially through primary health care and social protection mechanisms, including nationally determined social protection floors”.

International social security standards recognize the diversity of national circumstances. Therefore, they offer an approach to the extension of coverage, whereby Member States should not only guarantee internationally agreed minimum levels of protection to all in the short run (horizontal extension), but also ensure that they progressively reach higher levels of protection as soon as their national circumstances

allow (vertical dimension). This two-dimensional strategy aims at fostering the sustainability of the redistributive role of social protection systems and securing that life contingencies are collectively managed risks, and a core part of the cement that ensures social cohesion within societies.

Convention No. 102 establishes minimum levels of protection and promotes a comprehensive approach to social protection, including access to health care, as one of the nine contingencies covered. This comprehensive approach aims to ensure that life risks are collectively shared within society. Therefore, it is an important tool to address not only access to health care services without hardship, but also to provide at least minimum income security, which in turn addresses some of the key social determinants of health. Figure 1 provides an overview of the nine contingencies and the nature of the minimum set of benefits they involve.

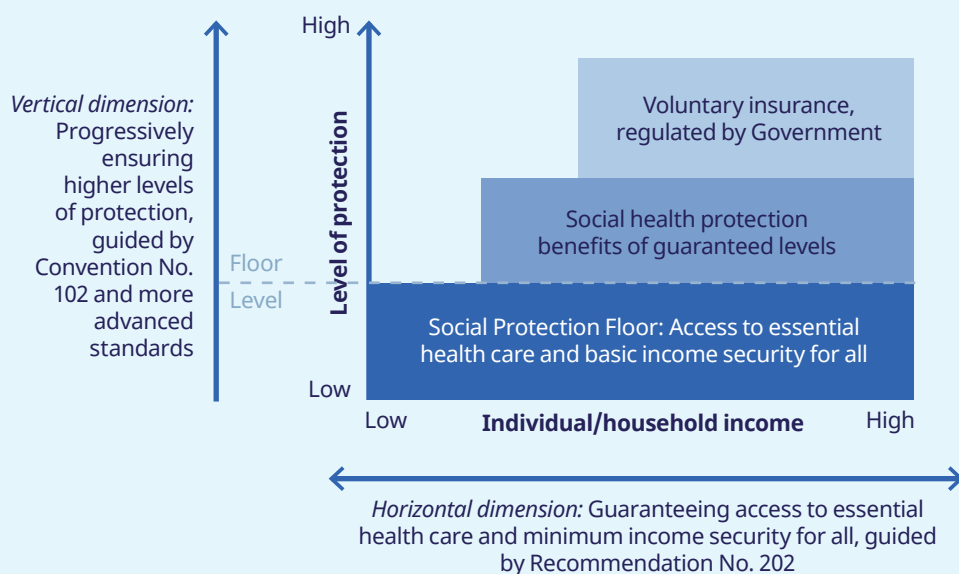
► **Figure 1. Comprehensive social protection coverage: a framework to consider health and some of its social determinants along the life cycle**

Contingency	Access to health care without hardship	Income security
Health care	Comprehensive health care, including maternity care and long-term care	
Child and family support		Income support
Sickness		Income support
Maternity	Maternity care	Income support
Disability		Income support
Unemployment		Income support
Employment injury / occupational disease	Medical care services, including rehabilitation	Income support
Old age		Income support
Death		Income support

Source: Authors, based on Convention No. 102.

As mentioned earlier, the two-dimensional strategy for the extension of coverage comprises two dimensions, as illustrated by Figure 2. The horizontal extension of coverage aims to cover the entire population across four basic guarantees, including health care as per ILO Social Protection Floors Recommendation, 2012 (No. 202) (ILO 2021a; 2017; 2019a). The vertical extension of coverage aims to progressively improve benefit adequacy, ensuring higher levels of protection. ILO standards establish a minimum level of benefit to be guaranteed by law. The benefit level for health care encompasses two dimensions (i) the range of services effectively accessible; and (ii) the financial protection against the costs of such services. The minimum requirements for each of these two dimensions are detailed in Box 2.

► Figure 2. Bi-dimensional strategy for the extension of coverage



Source: Adapted from ILO (2012).

► Box 2. Adequate health benefits

Range of services effectively accessible

While social protection floors should include the provision, at a minimum, of “essential health care” as defined nationally, including free prenatal and postnatal care, countries should progressively move towards greater protection for all. This is reflected in Convention No. 102 and Convention No. 130 which require the provision in national law of a comprehensive range of services.

In terms of benefit package, the relevant conventions and recommendations promote the provision of a comprehensive package of services with the view to maintaining, restoring or improving the health of protected persons. This encompasses at a minimum, access to preventive and curative care, including ambulatory and hospitalization services, with necessary treatments. Recommendation No. 134 goes beyond standards prescribed in Convention No. 130 by adding the need to include necessary supply of medical aid as well as services for convalescents. To be considered adequate, in line with ILO standards and human rights compliance monitoring mechanisms, health services need to meet the criteria of availability, accessibility, acceptability and quality (Recommendation No. 202, paragraph 5a) (OHCHR 2021). Criteria to ensure adequacy of health services comprise (OHCHR 2021):

- **Availability:** Functioning public health and health care facilities, goods and services, as well as programmes, have to be available in sufficient quantity.
- **Accessibility:** This includes four dimensions: (i) non-discrimination: health facilities, goods and services must be accessible to all, (ii) physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, (iii) economic accessibility (affordability): health facilities, goods and services must be affordable for all and (iv) information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues.
- **Acceptability:** All health facilities, goods and services must be respectful of medical ethics and culturally appropriate.
- **Quality:** Health facilities, goods and services must also be scientifically and medically appropriate and of good quality.

Financial protection

ILO instruments stipulate that health care should be accessed “without hardship”. Out-of-pocket payments should not be a primary source for financing health care systems. The rules regarding cost-sharing must be designed to avoid hardship, with limited co-payments and free maternity care. A qualifying period can be applied, but should be limited to avoid hardship.

Source: ILO (2021b).

A similar approach guides the extension of coverage for sickness benefits. ILO standards include income security to compensate for earnings loss due to sickness, quarantine, care-seeking or caring for a sick dependent through publicly-led measures (ILO 2020b). Sickness benefits are provided in the form of periodical cash benefits, which guarantee that the opportunity cost of seeking care does not act as an incentive to forgo care, force people back into work before they are fully recovered, or in the case of communicable diseases, act as a disincentive preventing isolation, and thus putting others at risk of infection. The core contents of the ILO instruments related to medical care, sickness and maternity benefits are summarized in Annex 2.

While international social security standards recognize the diversity of financing and institutional arrangements that countries can put in place to achieve the minimum levels of protection they set forth, they also provide a set of guiding principles that such arrangements should reflect. Table 1 lays out the practical implications of some of the key SHP principles (ILO 2020a).

► Table 1. ILO guiding principles for social health protection systems

Principle	Explanation
Universality of protection	Health and social security are human rights and as such, should be guaranteed to all persons, leaving no one behind.
Diversity of approaches and progressive realization	Diverse arrangements can exist for the financing, purchasing and provision of health care as long as they respect the guiding principles. Progressive realization recognizes that not all governments can mobilize the needed resources to comply immediately with international standards. It requires governments to take effective measures to gradually establish, as a matter of priority, a USP floor by mobilizing the maximum of available resources and continue to increase available resources to guarantee the higher levels of health and social security to as many people as possible as quickly as possible, while refraining from retrogressive measures.
Risk-sharing and solidarity in financing	Collectively financed mechanisms to cover the costs of health care, maternity and sickness are promoted because they generate positive redistributive effects and transfer the financial and labour market risks onto society rather than individuals.
Overall and primary responsibility of the State	The State is responsible to respect, protect and fulfil the right to health and social security in line with international human rights. ILO standards impose on the State the overall and primarily responsibility for the proper administration of health care, maternity and sickness schemes and the due provision of these benefits. This includes ensuring the financial sustainability, revenue collection, pooling and purchasing of health services as well as health service provision.
Adequacy of benefits	Both medical care (including maternity care) and cash sickness and maternity benefits need to be adequate and meet the needs of all persons in terms of the range, scope and quality of the benefits provided, as well as financial protection in line with the minimum benchmarks set out in international standards. Specific criteria related to health care include accessibility, availability, acceptability and good quality.
Predictability of benefits	The national legal framework establishes the benefits and ensures necessary financial resources are secured so that benefits and services are delivered in the prescribed situations and conditions.
Non-discrimination, gender equality and social inclusion	Design of SHP systems should ensure non-discrimination, gender equality and responsiveness to special needs.
Fiscal and economic sustainability with regards to social justice and equity	The SHP system has the capacity to bear the costs of its operation in the country context, while ensuring equity and is regulated through a comprehensive accountability framework.
Participation, social dialogue and accountability	Governance structures include tripartite representation and dialogue with protected persons and employers, consultation mechanisms with other relevant and representative organizations of persons concerned as well as efficient and accessible complaint and appeal procedures within accountability framework.
Integration within comprehensive social protection systems	SHP should be an integral part of coordinated, coherent and comprehensive social protection systems.

Social health protection and the Sustainable Development Goals

Social health protection is central to reaching the objective of UHC, which underlines the importance of financial protection and effective access to health care services. The Sustainable Development Goals (SDGs) framework integrates these dimensions with two complementary goals on UHC (SDG 3.8) and USP systems, including floors (SDG 1.3) – which are intimately interlinked, as priority measures to allow people to lead healthy and dignified lives, which is at the centre of sustainable development and social justice (ILO 2017). Both contribute to the goal of ending poverty.

Extending SHP to all is also key to achieving the targets of SDG 8 on sustained, inclusive and sustainable economic growth, full and productive employment and decent work, as attaining these objectives require a healthy workforce. Hence, social protection is a core part of a human-centred approach to the future of work (ILO 2019b). Ill-health and the inability to obtain medical care – due to financial, geographical, social or other barriers – negatively impact workforce productivity. The lack of financial protection in case of sickness undermines the capacity of households to invest in productive assets and pushes them into poverty. Indirectly, SHP also supports achievement of other SDGs, such as SDG 5.4 on gender equality and SDG 10.4 on social protection policies and greater equality.

In September 2019, the United Nations General Assembly adopted a Political Declaration on UHC reinforcing its commitment to achieving health-related SDGs (UN General Assembly 2019). In the framework of the sustainable development agenda, UHC is defined as ensuring that all people can access the promotion, preventive, curative, rehabilitation and palliative health care services they need without facing financial hardship (WHO and World Bank 2017). SHP provides a rights-based approach towards this objective. In June 2021, the conclusions adopted by the International Labour Conference on the occasion of the second recurrent discussion on social protection (social security) re-emphasized the fundamental role of the SHP principles.

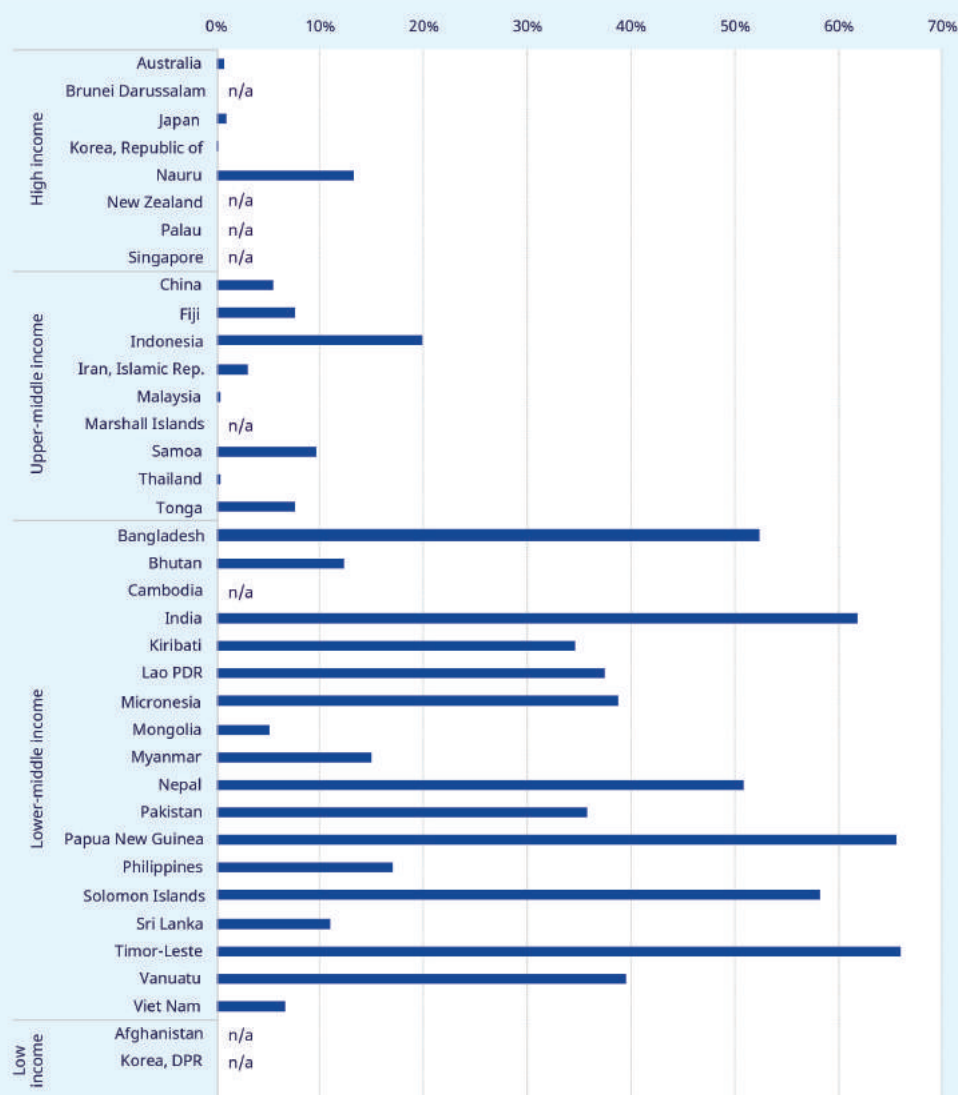
Asia and the Pacific

Diverse realities

The Asia and the Pacific region includes 36 ILO Member States and territories representing diverse socio-economic contexts, as illustrated by Figure 3. Together, these countries and territories cover more than 50 per cent of the world's population (UN 2019). The urban share of population ranges from just 18.6 per cent in Sri Lanka to 100 per cent in Singapore. These countries are made up of diverse economic classifications, including one lower-income economy, 16 lower middle-income economies, 11 upper middle-income economies and seven high-income economies (World Bank n.d. a).⁷ The proportion of the population living in poverty varies substantially across countries. More than one-third of the population in Bangladesh, Lao PDR and Pakistan live on less than 3.20 United States Dollars (US\$) a day (2011 PPP), while in Malaysia, Maldives, Republic of Korea and Thailand less than 1 per cent do (World Bank n.d. b).

⁷ No income classification is available for the Cook Islands.

► **Figure 3. Share of the population living on less than US\$3.20 a day (2011 PPP), countries and territories in the Asia and the Pacific region, by income group**



Source: Adapted from World Bank Data.

Labour force structure varies dramatically across these countries, with the share of employment in agriculture ranging from 0.7 per cent in Singapore to 64.5 per cent in Nepal (ILO n.d. b). For the countries reporting statistics, the share of non-agricultural employment outside the formal sector varies from 4.3 to 65.5 per cent (ILO n.d. b). Population mobility is high in the Asia and the Pacific region. Within three ASEAN member nations (Brunei Darussalam, Malaysia and Singapore), migrants account for more than 10 per cent of total population. Twelve of the 36 countries have in-migrant populations exceeding one million people, while 17 of these countries have more than one million citizens living as immigrants in other countries (UN Population Division 2020).

There is also substantial variation in demographics and health among these countries and territories. Life expectancy ranges from 66.9 years (Myanmar) to 84.2 years (Japan) (World Bank n.d. a). More than one-third of the population in Japan is aged 60 or older, while in 10 of the countries, the share of older

persons in the total population is less than 10 per cent (UN 2019). Furthermore, it is estimated that by 2050, one-in-four people in the region will be over 60 years old (UNESCAP 2017).

Women in reproductive age represent approximately one-quarter of the population in all of these countries. However, differing fertility rates and effective access to maternal and child health care leads to wide disparities in maternal mortality ratios (from five maternal deaths per 100,000 live births in Japan to 250 in Myanmar) (WHO et al. 2019) and child mortality (from 2.5 per 1,000 live births in Japan to 67.2 in Pakistan) (UN Inter-agency Group for Child Mortality Estimation n.d.). Demographic changes further impact on family structures and household composition, of relevance to social protection systems. Other mega trends affecting the region and the way social protection systems need to be designed are urbanization, technological progress, natural disasters and climate change (UNESCAP and ILO 2020).

Non-communicable disease (NCD) as a share of total deaths ranges from 55 per cent (Pakistan) to 90 per cent (China), and as a share of burden of disease measured in disability adjusted life years, ranges from 44 per cent (Pakistan) to 85 per cent (Japan and China). Cancer, one of the most financially burdensome diseases to treat, accounts for 10 per cent of deaths in India, but 32 per cent in the Republic of Korea (IHME 2021). Communicable diseases, particularly those associated with poverty and stigma like HIV and tuberculosis, account for varying disease burdens across these countries. Eight countries in the region (China, India, Indonesia, Myanmar, Pakistan, the Philippines, Thailand and Viet Nam) are estimated to have more than 100,000 people living with HIV/AIDS and are considered to have a high disease burden (UNAIDS 2021). In addition, nine countries in the region (the eight listed earlier as well as Bangladesh) had more than 100,000 new TB cases in 2019, while the region as a whole accounts for two-thirds of the estimated global incidence of TB (WHO 2020a).

Although the social protection agenda is gaining traction in most countries in the region, policies and results vary considerably. In the region, only 44 per cent of the population is covered by at least one social protection cash benefit, from 6 per cent in Cambodia and Myanmar to 100 per cent in Australia, New Zealand and Singapore (ILO n.d. b). Total social protection expenditures as a share of GDP (including domestic general government health expenditures) range from 0.9 per cent in Pakistan to 25.3 per cent in Japan (ILO n.d. a). Out of the 60 ratifications of Convention No. 102, only one ratification comes from the Asia and Pacific region. Moreover, none of the countries in the region has ratified Convention No. 130 or Convention No. 183.

Regional commitments to social health protection

ESCAP Resolution 77/1, adopted at the ESCAP Commission 77th Session in April 2021, re-emphasized the need to make progress towards USP, including health, as part of the COVID-19 recovery in Asia and the Pacific. The resolution was adopted at a time when the high-level commitment of countries in the region is particularly crucial to transform the emergency responses taken to tackle the COVID-19 crisis into sustainable, comprehensive, adequate and USP systems.

The Association of Southeast Asian Nations (ASEAN) committed to the extension of SHP through the ASEAN Declaration on Strengthening Social Protection and the Regional Framework and Action Plan to Implement the ASEAN Declaration on Strengthening Social Protection (ASEAN Secretariat 2018). The principles and goals of social protection laid out in ILO standards and the SDG framework are reflected in these documents. While the stated goal is to enhance the well-being, welfare and livelihoods of people throughout their life cycle, particular emphasis is placed on the poor and other vulnerable groups, including persons with disabilities, the elderly, youth, women, children, undernourished, victims of disasters and migrant workers. Key strategies for achieving the ASEAN social protection goals include capacity building, resource mobilization, multi-sectoral responses, communications and coordination, and monitoring and evaluation systems (including benchmarking). They are to be implemented in accordance with domestic laws and policies, nationally-defined social protection and national priorities, and adapted to the different contexts of ASEAN Member States. While respecting national differences in priorities and resources, the action plan nevertheless encourages moving towards common minimum standards, portability and sharing of experience among ASEAN Member States to enhance regional integration.

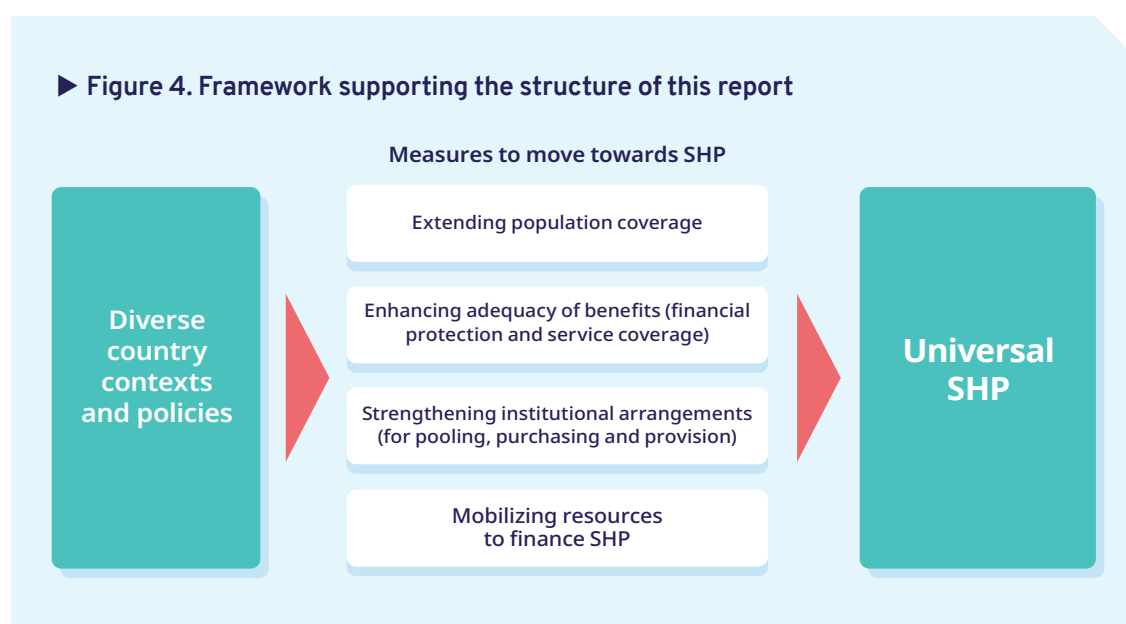
The South Asia Association for Regional Cooperation (SAARC) issued the Kathmandu Declaration in 2014 (SAARC 2014). The declaration recognizes the importance of achieving UHC and other important areas requiring improvement within the region, endorses the 2012 Malé Resolution on Regional Health Issues and urges continued progress in areas of communicable disease control. On social protection, the declaration acknowledged the special needs of the elderly, women, children, differently-abled persons, the unemployed and persons working at hazardous sites and agreed to support countries in specifically developing and strengthening social protection schemes and to share best practices.

Objective, methodology, structure of the report

National social protection systems and SHP policies and programmes, in particular, must adapt to diverse socio-economic realities, while being responsive to demographic and epidemiological changes.

There is no unique way to achieve universal SHP. This publication aims to understand how different countries and SHP systems progressively achieve expansion in coverage and adequacy and answer the following questions: how is coverage extended to different groups of the population? How is a benefit package guaranteed and expanded over time? What measures are in place to limit out-of-pocket spending? How are resources pooled to ensure solidarity? How are services purchased to ensure they are good value for money and meet the health care needs of the population? What measures are in place to ensure quality medical services are available, accessible and acceptable to all? And underlying all of this, how are resources mobilized to achieve SHP? The report highlights progress, challenges and remaining coverage gaps and explores their root causes.

This report is structured around these key questions, with the aim to present practical approaches to institutional arrangements and resource mobilization that have contributed to extend coverage and adequacy of SHP in the Asia and the Pacific region. To facilitate learning from the diverse experiences of Asia and the Pacific countries on their journeys towards ensuring universal SHP, this report is framed around four building blocks that need to be put in place and progressively achieved. Because of the diverse socio-economic and political contexts and histories of social protection systems in different countries, the measures and approaches used vary, as does the pace of achievement of different dimensions of SHP (see Figure 4).



Source: Authors

The first part of the report is comprised of four chapters structured according to those blocks, using country experience to illustrate diverse approaches to achieve a common goal. The report further includes a second part with 21 country profiles providing an overview of national SHP systems' designs and results. The 21 countries are: Bangladesh, Brunei Darussalam, Cambodia, China, Fiji, India, Indonesia, Japan, Lao PDR, Malaysia, Mongolia, Myanmar, Nepal, Pakistan, the Philippines, Republic of Korea, Singapore, Sri Lanka, Thailand, Timor-Leste and Viet Nam.⁸ Unless otherwise specified, the country examples provided throughout the first part of the document are sourced from the country profiles, where full references can be found.



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⁸ Bhutan, the Democratic People's Republic of North Korea, Nauru, Niue and the Federated States of Micronesia are not ILO Member States. Among ILO Member States, data access issues prevented compilation of country profiles for Afghanistan, Australia, Cook Islands, Islamic Republic of Iran, Kiribati, Maldives, Marshall Islands, New Zealand, Palau Islands, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu.

Part 1

Comparative analysis



Chapter 1. Extending population coverage and leaving no one behind

Key messages

- Over the past decades, a majority of countries in Asia and the Pacific have rapidly expanded SHP coverage and several have reached universal or quasi-universal coverage, such as Indonesia, the Philippines and Thailand.
- Despite laudable progress, the effective realization of the right to SHP is not yet a reality for all. In the Asia and the Pacific region, 77.8 per cent of the population is legally covered for health care, leaving approximately 950 million people excluded from legal entitlements.
- Further, the ILO estimates that only 63.4 per cent of the population is effectively protected by a health care scheme, while the remaining 36.6 per cent or around 1.6 billion people are left unprotected. While it largely correlates with legal coverage, effective protection is lower due to lack of awareness of rights and practical difficulties in access, including affordability. The regional average also hides inequalities within and across countries.
- This situation is compounded by gaps in legal coverage for cash sickness benefits. While data on effective coverage for sickness cash benefits is not available, only 43 per cent of the labour force in the region is legally entitled to income security in case of sickness (via sickness benefits or employer liability), 10 percentage points below the world's average.
- The lack of protection leaves people vulnerable to ill health, exposing them to a risk of impoverishment. This is of particular concern at a time of growing inequalities and where needs to access health care services are exacerbated by the COVID-19 pandemic.
- Gaps in coverage disproportionately affect women and men working in the informal economy and their families as well as international and in some countries domestic migrants, which jeopardizes the inclusiveness of SHP systems.

Leaving no one behind supposes that a monitoring system is in place to assess the implementation of laws, follow progress in coverage expansion, identify uncovered groups and support the development and implementation of strategies to cover them. Monitoring SHP progress requires the consideration of population coverage and adequacy of benefits (such as the range of health services covered and the extent of financial protection), both in law and in practice (see Chapter 2). The SDG framework fostered additional data collection efforts and provides new proxies for the measurements of such dimensions relating to effective coverage (WHO and World Bank 2020). Nevertheless, more and better data is needed, particularly on legal coverage, public awareness and quality of care, which are still poorly or unsystematically captured (Kruk et al. 2018). Legal and effective coverage for health care benefits is presented in Table 2 alongside the three dimensions of coverage put forth by the UHC framework. The complexity and inter-dependency of these dimensions, as well as the lack of systematic data collection, make SHP coverage challenging to monitor. Performing well in one dimension does not automatically translate into good performance in the other.

► Table 2. Dimensions of coverage and adequacy for health care benefits

	Legal	Effective
Population coverage	Share of the population identified in the Law as entitled to health protection (i.e. comprehensive benefit package without hardship).	The share of the population effectively protected by a scheme which translates their legal entitlements into practice (i.e. affiliation to scheme, rights holders' awareness on their entitlements, etc.).
Service coverage	Benefit package provided for in the legislation.	The extent to which people effectively access and utilize health services meeting the criteria of availability, accessibility, acceptability and quality.
Financial protection	Share of the costs of health services covered, and hence not borne by individuals, as defined in the legislation.	The extent to which the costs of care are effectively borne by collective mechanisms and its corollary - what remains a financial burden for the household.

Source: Authors.

For sickness and maternity cash benefits, legal coverage encompasses both the share of the population in active age entitled to such benefits by law as well as the prescribed level of benefit. Effective coverage encompasses the share of the population in need effectively protected and/or benefiting in case of occurrence of the protected contingency.

This chapter first explores the dimension of population coverage, both in the law and in practice. It first provides an overview of the newly-available data on legal and effective population coverage.⁹ Then, the trajectories of countries in their journeys towards extension of coverage are highlighted, as well as the remaining challenges to expand coverage. The dimensions that relate to the adequacy of coverage (service coverage and financial protection) are explored in Chapter 2.

► 1.1. Progress in expanding population coverage

This section provides an overview of population coverage in law and in practice. The main focus of this section is on access to health care without hardship, considering that sickness cash benefits are currently under-developed in the region. While this holds true, this section presents the scarce data available on income security, in case of both sickness and maternity, considering their great complementarity with health care.

⁹ The data presented in this report on legal coverage and protected persons is collected by the ILO World Social Protection database and published for the first time.

1.1.1. Legal coverage

Given the importance of legal frameworks to guarantee people's rights to health and social security, bridging the current data gap on this dimension should be a priority.

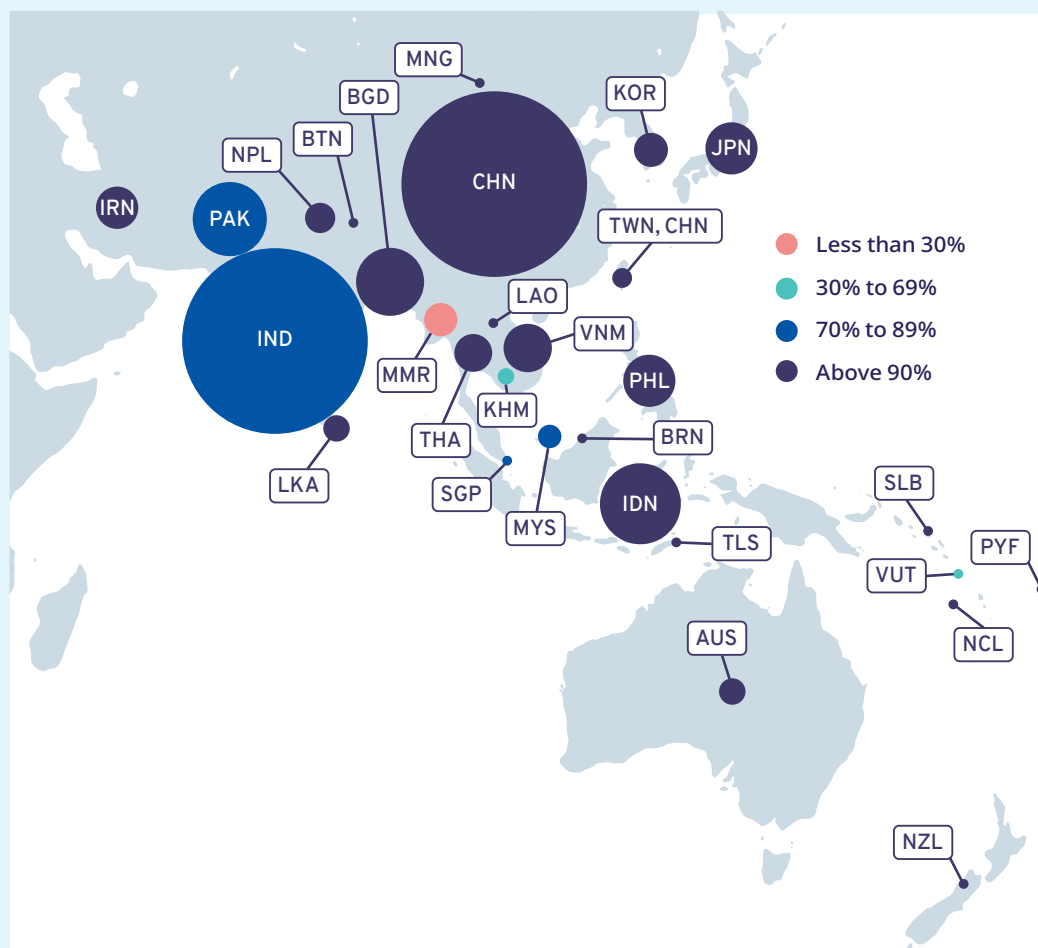
Health care

Based on a review of the legal framework for 28 countries and four territories in the region, it is possible to estimate the share of the population legally covered for health care. Legal coverage is understood as entitlements embedded in the law defining a population, a benefit package and a level of financial protection. An estimated 77.8 per cent of the region's population is legally covered for health care, as illustrated in Figure 5. While many countries have taken a first step to secure legal entitlements for all, some coverage gaps remain. Those who remain unprotected by law often work in the informal economy or rely on it for their livelihoods (dependent spouse, children or older parents, for example), such as in Cambodia and Myanmar. Some gaps in legal coverage also concern migrants, especially those with temporary work permits. In some countries, while their health coverage is an employer's liability, commonly they are not included in the scope of main SHP schemes, such as in Brunei Darussalam, Malaysia and Singapore. In Indonesia, Japan, Mongolia, Republic of Korea, Sri Lanka, Thailand and Viet Nam, legal coverage extends to both permanent and temporary residents.

Laws mandating coverage of households rather than individuals contribute to ensure effective protection against poverty risks (since poverty is a multi-dimensional phenomenon at household level) and are conducive to coverage extension. Enrolment at the household level is a good practice as it facilitates broader coverage, and avoids discriminatory exclusion of specific members in households that may not otherwise be considered a priority (women, older persons). Schemes automatically covering the family, dependents or household are the norm in a few countries, such as Japan, Nepal (HIB) and the Philippines. In other countries, household-based coverage is possible, but not mandatory. In some countries, coverage is on an individual basis only. In Cambodia and Myanmar, formally-employed workers are mandatorily covered but not their families, which further deepens already important coverage gaps.

In view of this situation, reforms are being considered in Myanmar (SSB) to expand mandatory legal coverage to the household. In other countries, household members may be covered by different schemes. For example in Viet Nam, dependents of workers who are mandatorily registered with VSS are not automatically covered. However, the State does subsidize contributions to the SHI scheme for all children under age six and for persons aged 80 years and above with some other vulnerable groups. School children are enrolled as individuals through partial subsidies for their contributions and those collected through schools. For other categories of household members, the regulations encourage membership through declining marginal contributions for each additional family member enrolled.

► **Figure 5. Share of the population legally covered for health care benefits, countries and territories in Asia and the Pacific, latest year available**



Note: The size of the bubbles indicate the country's population size. Review of national legislation conducted in 2020 and 2021.

Legend:

Countries: AUS – Australia; BGD – Bangladesh; BTN – Bhutan; BRN – Brunei Darussalam; CHN – China; FJI – Fiji; IDN – Indonesia; IND – India; IRN – Islamic Republic of Iran; JPN – Japan; KHM – Cambodia; KIR – Kiribati; KOR – Korea, Republic of; LAO – Lao PDR; LKA – Sri Lanka; MMR – Myanmar; MNG – Mongolia; MYS – Malaysia; NPL – Nepal; NZL – New Zealand; PAK – Pakistan; PHL – Philippines; SGP – Singapore; SLB – Solomon Islands; THA – Thailand; TLS – Timor-Leste; VNM – Viet Nam; VUT – Vanuatu.

Territories: NCL – New Caledonia; PYF – French Polynesia; TWN – Taiwan, China; WLF – Wallis and Futuna.

Sources: Adapted from ILO World Social Protection Database, based on the SSI; ILOSTAT; national sources.

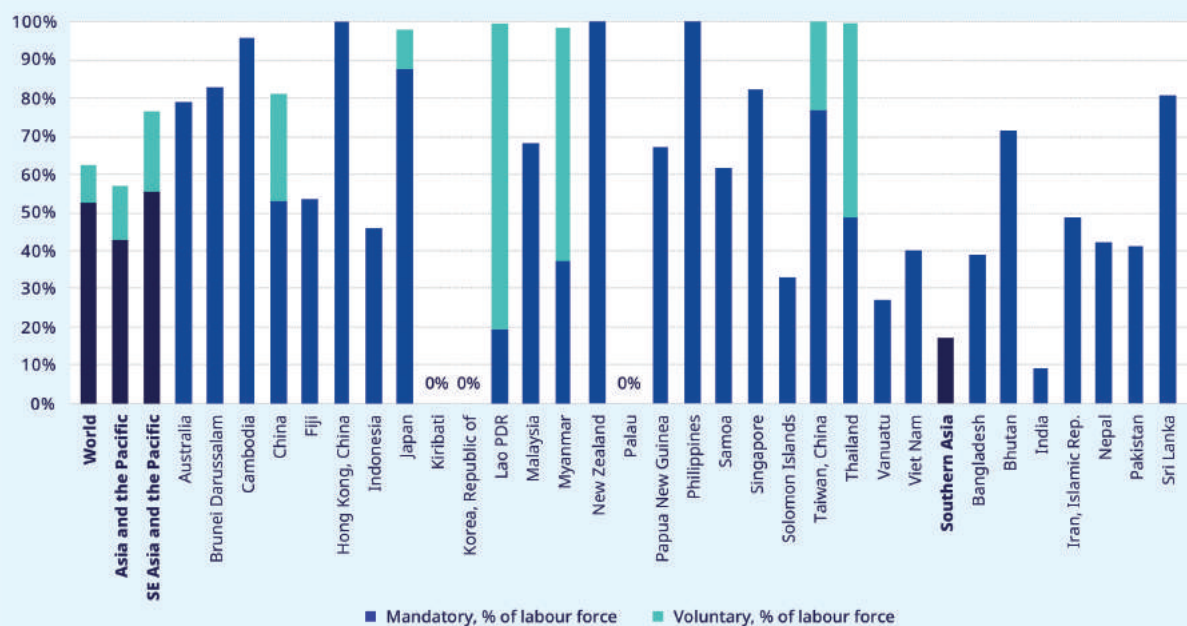
Income security in case of sickness and maternity

The COVID-19 crisis has demonstrated the importance of income security during ill health, including quarantine (ILO 2020c). Sickness benefits are crucial for physical recovery, but also to limit the spread of contagious disease and address health-related poverty. While data is not available on the coverage of cash sickness benefits alone, the ILO estimates that 43 per cent of the labour force in the Asia and the Pacific region, representing 26.3 per cent of the working-age population, is legally entitled to some income security via mandatory mechanisms, either paid sick leave through an employer's liability,¹⁰

¹⁰ As far as ILO social security standards are concerned, these mechanisms are not considered as they do not comply with the principles established therein - notably financing through contributions, taxes or a combination of both (Article 71 of Convention 102).

sickness benefits (provided by social insurance or assistance) or a combination of both mechanisms (Figure 6) (ILO 2021b). This leaves more than one-in-two workers without legal protection.

► **Figure 6. Percentage of persons in labour force protected by law in case of loss of income during sickness, countries and territories in Asia and the Pacific, latest available year**



Sources: Adapted from ILO World Social Protection Database, based on the SSI; ISSA/SSA Social Security Programmes throughout the world; ILOSTAT; national sources.

Most countries in the Asia and the Pacific region have legal provisions for paid sick leave through employer's liability or sickness benefits, or a combination of both, for at least one category of workers. These mechanisms are often limited to some categories of workers, which explains the low share of the labour force protected by law. Some 13 countries out of the 32, for which data is available, rely exclusively on employer's liability to compensate for the loss of income during sickness, such as Bangladesh, Brunei Darussalam, Fiji, Malaysia and Sri Lanka. Some countries combine employer's liability (often for a limited period, such as the first few days or week or sick leave) with social insurance benefits, such as Japan, the Philippines and Viet Nam (see Table 3).

► **Table 3. Income security in case of ill-health, legal protection by type of scheme, latest available year**

Type of scheme	# of countries and territories
Social insurance only or with employer liability	13
Non-contributory scheme only or with employer liability	3
Employer liability only	13
No statutory periodic cash benefits	3
No data	10

Source: Adapted from ILO, World Social Protection Database, based on the SSI; ISSA/SSA, Social Security Programmes Throughout the World; ILOSTAT; national sources.

Similarly, 13 countries rely on employer's liability schemes rather than collectively financed mechanisms for maternity cash benefits to provide income security during maternity leave. Legal entitlements may not apply to all categories of workers, such as temporary or self-employed ones. Therefore, less than two-thirds of the female labour force is legally covered by a social insurance or social assistance scheme for maternity (ILO 2021b). The absence of maternity cash benefits, before and after childbirth, forces many women to interrupt or reduce their participation in paid employment to bear or rear a child, or to keep working into the very late stages of pregnancy and/or to return to work prematurely, thereby exposing themselves and their children to significant health risks. This often translates into increased economic vulnerability at a time of increased household expenditures related to pregnancy and birth. This risk is compounded by the lack of adequate SHP for medical care, resulting in high OOP health spending.

The way cash benefits are financed is not neutral and has an impact on effective coverage and discrimination at the workplace. Employer liability systems tend to exclude workers from legal and effective coverage. As such, coverage is limited by definition to salaried work only (self-employed being their own employer), often also excluding specific categories of employees, such as casual workers and those paid hourly wages. Solidarity in financing is further limited as individual enterprises are left to bear the costs of workers' sickness and maternity. This may lead to discrimination in recruitment against individuals with declared medical conditions or pregnancy. In the case of maternity, this can also have a negative impact on the hiring of women. Especially small enterprises may struggle with the financial implications and therefore have an incentive to employ workers in forms of employment not subject to statutory sick leave or not employ reproductive-aged women (ILO 2020b).

Where maternity and sick leave are an employer's liability, workers may feel a pressure not to take such leave, causing delays in seeking care and possible aggravation of medical conditions – resulting in increased costs of care, risks of employment injury and the spread of communicable diseases to colleagues and clients. Likewise, women facing complications in their pregnancy may try to work until delivery or return to work after giving birth against medical advice, reinforcing health issues for the mother and infant.

Sickness and maternity cash benefits that are collectively financed by way of contributions, taxation or a combination of both, offer a more robust and equitable way to provide income security in case of ill-health or maternity, respectively. Schemes collectively financed, therefore, include non-contributory schemes that tend to provide at least a basic level of income security or social insurance schemes that fully or partially replace earnings during sickness, the final stages of pregnancy and after childbirth.

Even when sickness cash benefits are available, such protection is not always adequate as the benefit level, duration and eligibility criteria – such as contributory and waiting periods – may create gaps in protection.

1.1.2. Effective protection and awareness of entitlements

While legal anchorage of entitlements is crucial, it is often not sufficient for individuals to access health services when they need them without financial hardship, as well as sickness and maternity benefits. This section provides an overview of the situation in the Asia and the Pacific region with respect to this important dimension of coverage, for both health care and related cash benefits.

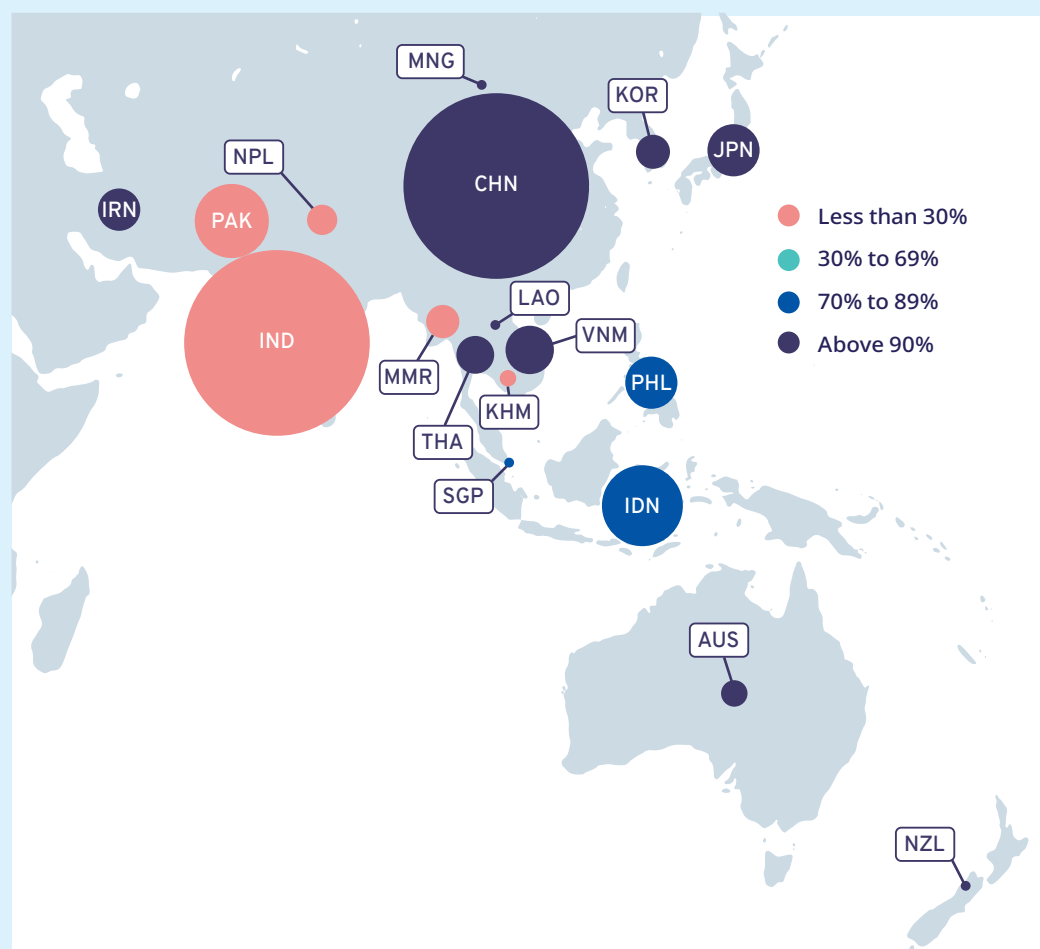
Health care

Effective protection requires that people are aware of their legal entitlements and modalities to access them. A correlated proxy indicator to measure effective protection is the percentage of population protected by a health care scheme (see Annex 1 for more details on the notion of protected persons). The ILO estimates, based on countries for which data is available, estimates that 63.4 per cent of the region's population is protected (see Figure 7). In China, Japan, Lao PDR, Republic of Korea, Thailand and Viet Nam, more than 90 per cent of the respective populations is protected. Indonesia and the Philippines are progressively moving in the same direction, with 70 to 90 per cent of their populations protected. However, countries such as Cambodia, India or Pakistan show greater coverage gaps with less than 30 per cent of their respective populations covered.

Generally, low legal coverage is strongly associated with low proportions of the population effectively protected by a health care scheme. Conversely, high legal coverage does not guarantee high proportions of the population is effectively protected. Countries with low legal coverage – like Cambodia, Myanmar and India – have lower proportions of their populations protected by SHP. At the same time, some countries with high legal coverage, like Indonesia or Nepal, have low shares of their populations effectively protected by a scheme. Mongolia and Viet Nam are moving closer to achieving high levels for both.

Gaps between legal and effective protection are determined by a range of factors. Limited awareness of entitlements and complicated procedures to access benefits largely determine such gaps, in addition to remoteness and, for specific groups stigma and/or criminalization. Specific population groups tend to be disproportionately affected by these coverage gaps, even when legally entitled to protection. For example, workers in the informal economy and their families, migrant workers and people who are criminalized in some countries – such as undocumented migrants, men who have sex with men or sex workers – tend not to be aware of their rights or forgo them for fear of repercussions.

► **Figure 7. Share of the population protected for health care, protected persons, countries and territories in Asia and the Pacific, 2020 or latest year available**



Note: The size of the bubbles indicate the country's population size. Only countries with available data are displayed. Based on data collected for 18 countries and territories representing 92 per cent of the region's population, representing the best estimate of people protected by a health care scheme for their primary coverage. Mechanisms include national health insurance; social health insurance mandated by the State (including subsidized coverage for the poor); national health care services guaranteed without user fees or with small co-payments; and other programmes (user fee waivers, vouchers, etc.). In all, 44 schemes for primary coverage were identified and included. To avoid overlaps, only public or publicly-mandated, privately-administered PHC schemes were included. Supplementary and voluntary public and private programmes were not included.

Legend: AUS – Australia; CHN – China; IDN – Indonesia; IND – India; IRN – Islamic Republic of Iran; JPN – Japan; KHM – Cambodia; KOR – Korea, Republic of; LAO – Lao PDR; MMR – Myanmar; MNG – Mongolia; NPL – Nepal; NZL – New Zealand; PAK – Pakistan; PHL – Philippines; SGP – Singapore; THA – Thailand; VNM – Viet Nam.

Sources: Adapted from ILO Social Security Inquiry; OECD Health Statistics 2020; national administrative data published in official reports; information from regular national surveys of target populations on awareness on rights.

Sickness and maternity cash benefits

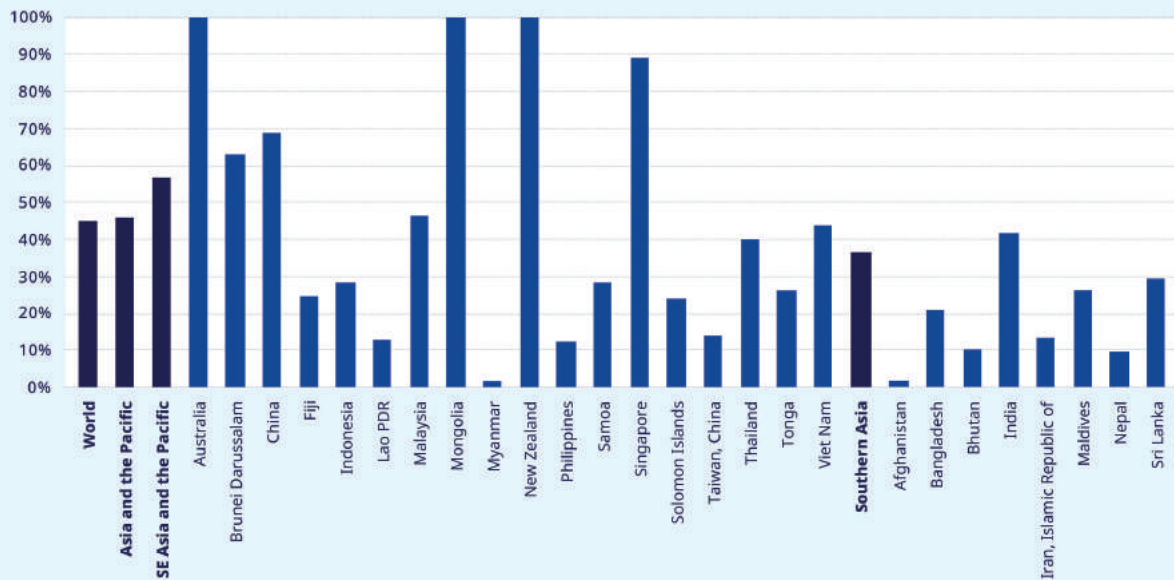
Despite the importance of sickness cash benefits, the shortage of data prevents the monitoring of effective coverage. This data gap must be addressed as a priority, especially in light of the importance of such benefits within the COVID-19 crisis. The fact that many countries took measures to provide emergency sickness cash benefit coverage to large portions of their populations, illustrates important gaps in both legal and effective protection (see Box 3).

► **Box 3. Examples of sickness benefit measures taken in the context of the COVID-19 crisis**

- Japan extended access to cash sickness benefits to persons who are in quarantine or diagnosed with the coronavirus. It simultaneously waved the requirement for obtaining a medical certificate (ISSA 2020).
- Some countries have waived waiting periods. Australia eliminated the ordinary one-week waiting period for income support, including sickness allowance (Australian Government 2020).
- In the Philippines, the PhilHealth COVID-19 package included an isolation package that provided financial support (14,000 Philippine Pesos – PHP) (US\$273.6) for persons under investigation in quarantine (PhilHealth 2020).
- In Viet Nam, infected individuals quarantined outside of their home were entitled to a daily food allowance of 60,000 Viet Nam Dong (VND) (US\$2.59), while those quarantined at home received VND40,000/US\$1.72.
- Singapore announced that the government would pay employers of workers in quarantine \$100 Singapore Dollars (SGD) (US\$68.5) per day throughout the duration of their quarantine. The benefit was extended to self-employed workers (Singapore Ministry of Manpower 2020).

Despite some progress in legal coverage, large gaps remain in providing effective coverage for maternity cash benefits in most countries. Only 45.9 per cent of women in reproductive age are protected in case of loss of income during maternity in Asia and the Pacific (ILO 2021b), slightly above the world average of 44.9 per cent (Figure 8). With the exception of Mongolia, most middle- and lower-income countries in the region still have low levels of effective protection for maternity cash benefits. This is particularly true in countries where informal work accounts for a high share of employment and coverage is mandated through a combination of employer liability and social insurance mechanisms.

► **Figure 8. Maternity cash benefits, effective coverage: Percentage of women protected in case of loss of income during maternity, countries and territories in Asia and the Pacific, 2020 or latest available year**



Sources: Adapted from ILO World Social Protection Database, based on the SSI; ILOSTAT; national sources.

As highlighted throughout this section, there are pervasive gaps in population coverage, despite rapid progress in coverage expansion over the past decades, especially for health care benefits. Understanding the trajectories of countries can provide useful lessons on the extension of SHP coverage. The next section explores the strategies that countries have developed to close coverage gaps, focusing on health care benefits where the most prominent progress has been made.

► 1.2. Closing coverage gaps and leaving no one behind

As illustrated in the previous section, the Asia and Pacific region has seen remarkable progress in legal and effective protection of health care benefits over the past few decades. Some middle-income countries with sizeable populations took definite steps to guarantee universal coverage and saw the share of effectively protected persons grow rapidly, such as China, Indonesia, Lao PDR, the Philippines and Thailand.

While trajectories vary across countries, there is a trend to increase population coverage and progressively provide protection to more population groups. Institutional and financing arrangements differ across countries. However, results in terms of population coverage do not seem to be explained by such choices, but rather by the social mobilization and demand for coverage expansion which have consequently resulted in necessary government allocations to expand coverage.

This section provides an overview of the trajectories adopted by countries to build their SHP systems and explores some approaches taken to close coverage gaps and improve inclusiveness of hard-to-reach populations.

1.2.1. A diversity of trajectories

The expansion of population coverage has followed diverse trajectories across different countries. Most countries established a foundation of universal basic population-based health interventions – such as immunization, mass prophylaxis or tobacco control programmes – funded by the government budget. Beyond this foundation, the financing, institutional and administrative arrangements chosen by countries to extent coverage to individual-based interventions vary greatly. The level of coherence and integration of SHP policies, as well as priorities on the overall health system building blocks also greatly varies. Schematically, four types of trajectories and groups of countries can be identified:

- Some countries – such as Brunei Darussalam, Fiji, Malaysia and Sri Lanka – equipped themselves with a free or affordable national health service accessible to all citizens (and non-nationals, often under different conditions). These countries, therefore, invested heavily in the expansion of the public network of health care providers as the vector for the extension of SHP. As such, they have been successful in expanding equitable coverage of a number of primary care services, and especially as it relates to maternal and child health. With time and as their income rises, these countries are faced with a growing private health sector which remains mostly outside the SHP framework and drives out-of-pocket spending. Much like most middle-income countries in the region, a growing middle class demands a wide range of services (including new technologies and elective interventions), but also ease of access (geographic proximity, absence of waiting times) in step with emerging preferences for private providers. This poses a challenge as the SHP systems built to guarantee financial protection against the cost of health care in these countries was not based on a pluralistic health system. Therefore, the increase in demand for and effective access to private provision outside of the SHP system engenders increased in OOP health spending, which the system needs to tackle along with maintaining equity, while those services are not or less accessed by lower-income households.
- Other countries built compulsory contributory social health insurance schemes which they progressively expanded towards universal coverage of social health insurance schemes, such as China, Indonesia, Japan, Lao PDR, the Philippines, Republic of Korea, Thailand and Viet Nam. In most cases, countries classified populations into different groups and applied various financing, institutional and operational strategies to cover them with progressively more comprehensive benefits packages. Historically, many of these schemes were initially limited to civil servants and/or employees in the formal private sector as it was easier to identify and register beneficiaries as well as enforce compliance with contributions. As employees were often organized into workers movements, they were more likely to have their voices heard to make their rights to health a reality. Some of the earliest schemes limited to workers in formal employment are found in Japan (1922), India (1952) and Myanmar (1954), while others have only been set up recently such as in Viet Nam (1992), the Philippines (1995), Nepal (2013) and Cambodia (2017). Not all were subsequently expanded to the entire population. Countries that are the most successful in expanding coverage to the vulnerable provide partial or full subsidies of their social security contributions. This is done either within existing schemes to strengthen risk-pooling (for instance JKN in Indonesia, CHI in Japan, NHI in Lao PDR, PhilHealth in the Philippines, VSS in Viet Nam, Medical Aid Programme in Republic of Korea) or by setting up separate subsidized (partially or fully) schemes to cover groups not already covered (Universal Coverage Scheme (UCS) in Thailand).
- A group of countries opted for a mix of financing and institutional arrangements to expand coverage for different levels of care, such as Mongolia and Singapore. In these countries, the governments expanded the package of PHC services provided for free or affordable in public facilities. This translates into important investments in expanding public provision of services, while expanding social health insurance to cover higher levels of care.
- Some countries have yet to make a clear choice towards universal coverage and concrete modalities to get there, leaving large portions of the population uncovered legally or in practice,

such as Bangladesh, Cambodia, India, Myanmar, Nepal, and Pakistan. In those countries, under-investment in the public provision of care coupled with fragmented financing mechanisms and an absence of legal universal entitlements to SHP have led to pluralistic and highly commercialized health systems and corollary inequity in access. While Bangladesh, India, Myanmar and Nepal all have a national health services which offer free, affordable services to the population, in practice user fees are not always well regulated or effectively enforced. Additionally, most health services are privately-provided, affecting OOP health spending levels as well as equity in the quality of services received. In some of these countries, like India and Myanmar, this system has co-existed with social health insurance schemes for the formal private sector as well as separate schemes for civil servants, which partially use and have built their own network of service provision, but which do not fully meet the needs of their target populations. In many of these countries, efforts have been made to cover the poor, putting in place new and separate programmes, often based on means-tests or proxy means-tests. This is the case in Cambodia, India and Pakistan. While those schemes provide much needed financial protection and have had success in improving utilization, the means-testing mechanisms are prone to significant exclusion errors. Therefore, in most of these countries there are important coverage gaps, mainly populated by workers in the informal economy and their families as well as hard-to-reach and vulnerable groups that fail to meet eligibility for the means-tested schemes. In view of this situation some countries, despite the wealth of evidence underlining the limited effectiveness of this approach, have put in place additional voluntary mechanisms to expand population coverage through community-based insurance (Bangladesh) or voluntary affiliation to existing contributory schemes.

As diverse strategies have been applied to extending population coverage, the following section will explore the ways in which countries have tried to close coverage gaps.

1.2.2. Strategies to cover the poor and the “missing middle”

The poor and vulnerable, including those in the informal economy, have been at the centre of strategies to close coverage gaps, often with different measures. While substantial investment has been made to secure access for the poorest as well as for organized sectors, workers in the informal economy and their families often fall between the cracks and are therefore referred to as the “missing middle”.

Covering people living in poverty

Protecting the poorest within society against the cost of accessing care was identified early on as a priority by most countries in this study. Indeed, the consequences of catastrophic health spending is disproportionately higher among households living in poverty compared to higher income households. Additionally, good health is a pre-requisite for workforce productivity and critical for the poorest to effectively access opportunities to improve their livelihoods.

Countries have used different mechanisms to extend coverage to the poor, and have applied different definitions of this group according to national circumstances. Schematically, one can distinguish two main approaches: 1) expanding existing mechanisms to the poor 2) developing new parallel schemes to cover them. In addition, some countries have not prioritized extending SHP to these groups in an adequate manner. In practice, given the under-investment in their national health services, high informal co-payments are reported (for example, Myanmar) or public providers represents only a minority part of service provision, de facto accessed only by the poorest who may still have restricted access due to geographical remoteness (for example, Bangladesh).

Some countries expanded coverage of existing mechanisms (social health insurance or national health services) to the poor at no cost for them (with full contribution subsidies or user fee waivers). Covering the poor under the same system used for the entire population provides opportunities for better redistribution through larger financial and risk-pooling and limits discrimination against the poor at the point of care. This approach was adopted by JKN in Indonesia, Republic of Korea's Medical Aid Programme, Lao PDR's NHI, PhilHealth in the Philippines and Viet Nam's VSS. These countries have integrated coverage of the poor into existing SHP mechanisms by providing fully subsidized contributions for this category and sometimes for other categories of the population identified as vulnerable. Thailand adopted a strategy

of universal coverage by providing fully subsidized coverage through a dedicated scheme to all who are not covered by any other SHP scheme. This way, though a new scheme was created, clearly from the onset it was to complement the existing ones towards universality. The UCS scheme includes not only the poor, but other groups such as workers in the informal economy, and as people's situations change, they move from one scheme to another without creating coverage gaps. Several countries with national health services have also succeeded in paying special attention to the needs of the poor and are exempt of cost-sharing (Brunei Darussalam, Malaysia and Sri Lanka). In Mongolia, co-payments for primary health services were abolished in 2006, with the government taking over responsibility for financing PHC services and provided them free to the entire population. This ensured full coverage of these services to the poor and workers in informal employment.

Other countries created separate targeted schemes specifically to cover the poor. As such, the use of poverty-targeting mechanisms is seen as a way to limit the cost of those programmes and ensure strict allocation to the poorest in society. However, the choice to limit eligibility to the poorest often reflects an understanding that the redistribution role of the State should be limited and defined rather narrowly, rather than from a sense of SHP being a human right and all members of society sharing the risk in solidarity. A number of countries designed and implemented schemes specifically for the poor, such as Cambodia's HEF, India's PM-JAY, or Pakistan's Sehat Sahulat and Bait-ul-Mal programmes. While such schemes have undoubtedly contributed a long way to improving the situation of the poor and expanded coverage in a way that aims to put the most vulnerable first, they often leave the country with a number of coverage gaps and are sometimes based on fragile grounds for the following reasons:

- Proxy means-tests and flawed administrative procedures to establish eligibility to those programmes often leave room for exclusion errors, meaning that many of the poor remain actually uncovered in practice (see Box 4 and Chapter 3).
- Many of these programmes still have limited coverage and often have different benefit package and/or financial protection levels for the poor, reinforcing inequalities (see Chapter 2). Further, this fragmentation creates little or no ownership from the general population, which is unlikely to demand a higher level of benefits. Therefore, political support and financial commitment may erode over time, threatening adequacy and sustainability (see Chapter 3).
- If there is no integration with other schemes to ensure the whole population has a coverage mechanism, whether or not it falls into the "poor" category, then coverage gaps will remain and usually the "missing middle" – people in the informal economy who are not eligible for those programmes – tend to remain uncovered.

► Box 4. Means-tested schemes

A scheme that provides benefits upon proof of need and targets certain categories of persons or households whose means fall below a certain threshold, often referred to as social assistance schemes.

A means test is used to assess whether the individual's or household's own resources (income and/or assets) are below a defined threshold to determine whether the applicants are eligible for a benefit at all and if so, what level benefit will be provided.

In some countries, proxy means tests are used; that is, eligibility is determined without actually assessing income or assets, on the basis of other household characteristics (proxies) that are deemed more easily observable.

Means-tested schemes may also include entitlement conditions and obligations, such as work requirements, participation in health check-ups or (for children) school attendance.

Source: ILO (2021b)

Extending coverage to workers in the informal economy and their families

In this context, countries remain highly concerned about the lack of population coverage for workers in the informal economy and their families, the “missing middle”. The term “informal economy” refers to all economic activities by workers and economic units that are – in law or in practice – not covered or insufficiently covered by formal arrangements (ILO Transition from the Informal to the Formal Economy Recommendation, 2015 (No. 204), para 2(a)). It is a broad term which encompasses a diversity of realities and work arrangements in practice. It is inclusive of the informal sector and informal employment, as the respective definitions do not completely overlap (see Box 5).

Though it has reduced over time in many countries, informal employment represents a high share of total employment in many Asia and the Pacific countries (Figure 9). Social protection coverage is one criteria, amongst others, used to define formal employment (alongside subject to national labour legislation and income taxation, see Box 5). At the same time, expanding social protection coverage to households who rely on the informal economy for their livelihood can be challenging. Often they are not eligible for subsidies and face either legal barriers, practical difficulties or both in accessing schemes initially designed for salaried workers in the formal sector.

► Box 5. Defining the informal sector and informal employment

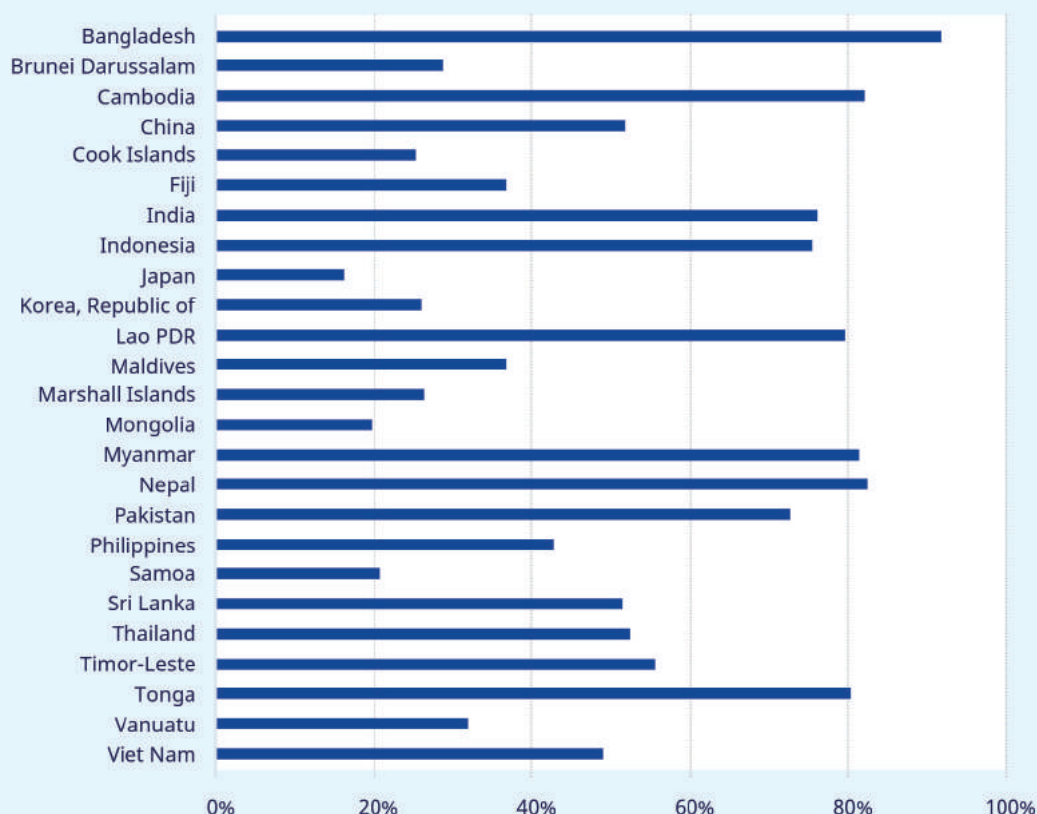
The term “informal sector” designates units engaged in the production of goods or services with the primary objective of generating employment and incomes to the persons concerned. Such units are unincorporated enterprises not constituted as separate entities independently of their owners, as defined at the 15th International Conference of Labour Statisticians (ICLS).¹¹ Typically, they operate at a low level of organization, on a small scale and with little or no division of labour and capital as factors of production. Therefore, many micro and small enterprises (MSEs), including operating in the rural economy, are in the Informal sector (ILO 2021c). In some countries, such MSEs are not or only partially included in the scope of labour and social protection legislation. Similarly, they often face practical difficulties to comply with tax, labour and social security legislations due to their limited administrative and financial capacities. In many cases, neither the employers nor the workers in MSEs are covered by social protection systems (ILO 2021d).

The term “informal employment” is defined in terms of the employment relationship and protections associated with the job of the worker (Husmanns 2004).¹² Informal employment refers to working arrangements that are *de facto* or *de jure* not subject to national labour legislation, income taxation or entitlement to social protection or certain other employment benefits (advance notice of dismissal, severance pay, paid annual or sick leave). Workers in informal employment are defined as those who work in informal jobs, whether carried out in formal sector enterprises, informal sector enterprises, or households. It can encompass diverse realities when it comes to status in employment: employees holding informal jobs, employers and own-account workers employed in their own informal sector enterprises, members of informal producers’ cooperatives, contributing family workers in formal or informal sector enterprises and own-account workers engaged in the production of goods for own end use by their household (based on 17th ICLS). Although not everyone in the informal economy is poor, a significant proportion of the poor are in the informal economy.

¹¹ Resolution concerning statistics of employment in the informal sector, adopted by the Fifteenth International Conference of Labour Statisticians (January 1993), available at: http://ilo.org/wcmsp5/groups/public/---dgreports/---stat/documents/normativeinstrument/wcms_087484.pdf

¹² ILO Guidelines concerning a statistical definition of informal employment, available at: http://ilo.org/global/statistics-and-databases/standards-and-guidelines/guidelines-adopted-by-international-conferences-of-labour-statisticians/WCMS_087622/lang--en/index.htm

► **Figure 9. Informal employment as a share of total employment, selected countries and territories in Asia and the Pacific, latest available year**



Note: Data is for 2016 or later except for China (2014), Japan (2010) and Timor-Leste (2013).
Sources: Adapted from ILOSTAT; ILO (forthcoming a).

In some countries, workers, their families and their employers in some sectors of activity (for example, agriculture) or below a certain size of business unit (for example, 10-50 workers) are not included in the legal provisions of any SHP mechanisms. In India for example, the federal level provides legal coverage to several categories of workers in establishment above a certain threshold, the PM-JAY scheme covers people below the poverty line. More than half of people are not legally covered by any scheme, mostly in the self-employed, employed in small businesses or informal economy categories. In Cambodia, the Health Equity Fund covers the poor and the NSSF scheme covers waged workers in the formal sector. Access is conditioned by business registration, hence effectively excluding those working in non-registered economic units. Cambodia is trying to extend the NSSF scheme for the formal sector to companies as small as having two employees, and the HEF scheme to some specific categories of workers currently in informal employment. Still, narrow eligibility criteria for the latter and a passive enrolment strategy resulted in low coverage. Both countries are envisaging new laws to close the gap.

Voluntary registration, overall, has proven an ineffective mechanism to expand coverage, typically resulting in low take up and, when coupled with fragmented risk pools, it can further jeopardize the financial sustainability of such schemes as it exposes them to adverse selection. Mandatory coverage is more conducive to higher coverage. However, it shows little success in the absence of subsidies considering that contributory capacity and regularity may be lower for workers who are in employment situations prone to informality (see Box 6). In Mongolia, the Law on Health Insurance stipulates that SHI coverage is mandatory for all citizens and stateless persons irrespective of their form of employment

and whether they are unemployed or self-employed, and is voluntary only for foreigners. After a mass enrolment campaign, population coverage peaked at 90 per cent during 2011–2014. However, it has been difficult to maintain this level of coverage in part due to difficulties in retaining coverage among self-employed and unemployed people. Many had previously been covered, but subsequently dropped out due to the lack of administrative support.

► Box 6. Subsidies in Lao PDR

Providing free access to health care to the poor and vulnerable has been a long-standing priority for the Government of Lao PDR, which established several programmes to strengthen the Lao population's financial health protection. Established in 2004, under the management of the Ministry of Health, the Health Equity Fund (HEF) provided coverage to the poor and vulnerable, with full subsidies. In parallel, non-poor workers and their family members dependent of informal employment could be covered through the government-implemented CBHI scheme. In 2010, the Free Maternal Neonatal and Child Health (FMNCH) policy was implemented, contributing greatly to improving health services utilization. However, after years of implementation, affiliation to CBHI remained below 10 per cent and OOP health spending remained at high level for the entire population. In 2012, the government engaged the merging of CBHI, HEF, FMNCH with health insurance schemes dedicated to the formal sector (SASS and SSO) into a single National Health Insurance scheme. In recognition of the difficulties inherent in extending coverage to informal economy workers through voluntary health insurance, a further step was taken in 2017 when the government adopted a predominantly tax-based financing model: the NHI now covers on a non-contributory basis all those who are not affiliated to SASS or SSO, hereby replacing contributions from informal economy workers with full public subsidies directly transferred to the NHI Fund. These public subsidies led to rapid coverage expansion nationwide, bringing the coverage rate up to 94 per cent in 2021. While co-payments apply at the point of services, members identified as poor, pregnant women, children under-five and monks, are all exempted.

Source: Refer to the Lao People's Democratic country profile in part two of this publication.

Even when legal barriers are lifted, effectively expanding contributory coverage can be challenging when administrative, financial and geographic barriers remain. Indonesia's JKN scheme, PhilHealth in the Philippines or more recently the Health Insurance Board of Nepal are examples. In Indonesia, only 13.6 per cent of JKN members are registered under the non-salaried worker segment, even though 60 per cent of the labour force is self-employed.

Policy responses differ depending on the nature of the informal economy in each country and a contextualized analysis is necessary to identify the drivers and bottlenecks for the transition to the formal economy (ILO 2021c). Such a transition is highly desirable to support people's right to decent employment, which in turn impacts their health (see Box 7). In this respect, some countries in the region wished to use social health insurance coverage as one of the measures to promote formalization, and see progressivity in social security contributions, taxation and government subsidies allocation as a way to foster social solidarity and fiscal justice.

► Box 7. Health impacts of informal employment

Workers in the informal economy often engage in the most hazardous jobs, conditions and circumstances across all economic sectors, including agriculture, industry and services. The necessary awareness, technical means and resources to implement OSH measures are often lacking (Kawakami 2006). Preventive measures, in the form of OSH management systems and a general safety culture, to reduce risks at work often do not reach the informal economy (ILO 2021e). High exposure to risks combined with low coverage of social protection place most informal economy workers in a very vulnerable situation. As they do not benefit from labour protections, they are often subject to working conditions that can have adverse impacts on their health and well-being, such as long working hours. For instance, a recent analysis by the ILO and the WHO concluded that working long hours impacts on the burden of ischemic heart disease and stroke globally (Pega et al. 2021). In this context, countries need to create and enabling environment for a transition from the informal economy to the formal economy.

Japan, Republic of Korea and Singapore have also succeeded in covering the “missing middle” through a combination of subsidies to the contribution for certain groups with lower contributory capacity, while also enforcing compliance with compulsory contributory schemes. In the Republic of Korea, the NHI collects contributions, complemented by government subsidies for the self-employed. Through the enactment of the Special Act for the Financial Stability of NHI (2002), government subsidies increased from 28 to 50 per cent of total revenues of the self-employed fund, which was financed from increased tobacco taxes. In Japan, the Citizens Health Insurance (CHI) is financed through contributions and subsidies from general government revenues, with public subsidies set at 50 per cent of the total CHI budget and funded from central and prefectural governments. In Singapore, the 2015 Medishield Life Scheme Act extending coverage of the scheme to all citizens and permanent residents regardless of employment status, subsidizing participation for low- and middle-income households and transforming it to reach nearly universal population coverage (97 per cent of citizens and permanent residents).

Increasing information and awareness of the importance of SHP and benefits is important, but not sufficient to fill coverage gaps. Political commitment and accountability for coverage expansion play a crucial role. It is essential to drive necessary legal reforms, but also to mobilize sustainable financial resources required for subsidies and keep institutions accountable to achieve results.

Strong political commitment resulted in a significant extension of coverage to workers in the informal economy and their families in China, through the residence-based scheme URRBMI (former URBMI and NRCMS). Success factors include government subsidies, commitment and promotion of the scheme, for example including population coverage rates in the performance indicators of government. Similarly, Viet Nam has used performance indicators on provincial population coverage rates to hold provinces accountable for finding ways to extend coverage.

All countries that have achieved high levels of coverage have done so by allocating sufficient resources to the respective SHP system, either through national health services or as social security contribution subsidies to social health insurance schemes. Thailand decided to cover all its population not otherwise covered by contributory schemes through a non-contributory scheme, the UCS, irrespective of resources. Lao PDR is using the same approach in the National Health Insurance scheme.

1.2.3. Measures to improve inclusiveness and leave no one behind

While many countries have made substantial progress to expand coverage over the past decades, and even when legal coverage has been expanded to all, issues of inclusiveness of SHP systems remain in practice. In this respect, special attention needs to be paid to gender equality, accessibility to persons with disabilities and long-term health conditions, ethnic minorities, people residing in remote or disadvantaged

areas, migrant workers as well as responsiveness to the needs of older persons. Specific measures to extend coverage to those groups feature in this section, while strategies to deepen service coverage and/or increase financial protection are covered in Chapter 2.

Gender responsiveness

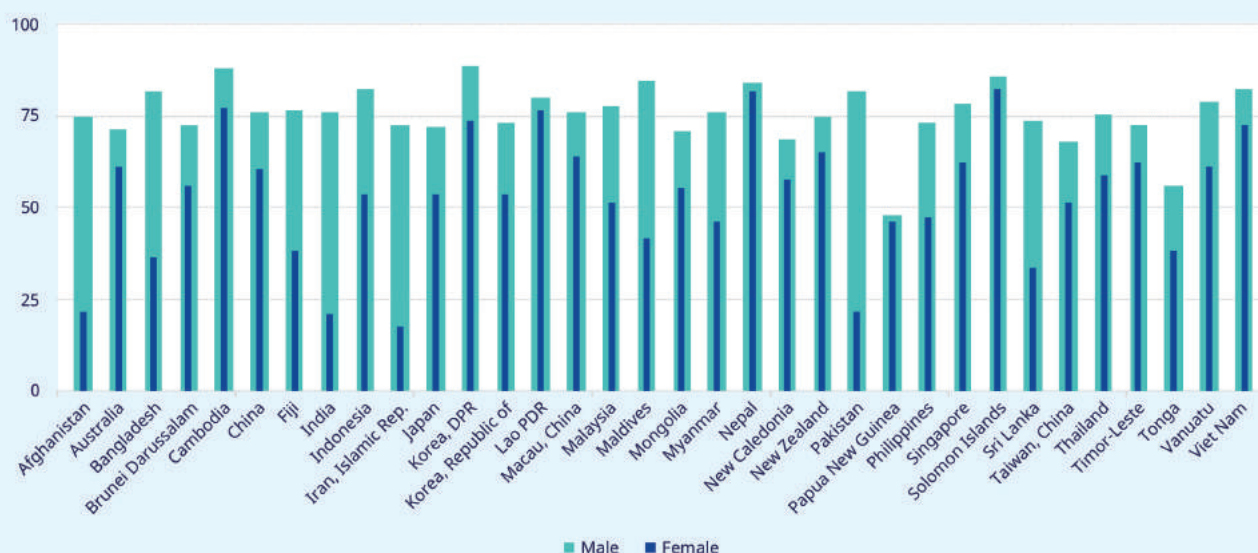
Social health protection-focussed legal and regulatory frameworks usually provide entitlements to women and men without gender criteria, yet gender inequalities in labour market participation, employment patterns and other socio-demographic and socio-economic factors may lead to unequal outcomes. In addition, gaps remain in terms of responsiveness to women's specific needs. As highlighted in the first section of this chapter, less than half of women in working age in the region have their income protected in case of maternity. Likewise, the adequacy of maternity care benefits and especially the level of financial protection has not been prioritized equally across countries (see Chapter 2). For instance, countries like Brunei Darussalam and Malaysia place high priority on free maternity care, while delivery remains a source of OOP health spending in other countries. Similarly, specific health and social care services may be needed to tackle violence and harassment against women, as underlined by the Violence and Harassment Convention, 2019 (No. 190).

Aside from a few exceptions, such as Nepal and Viet Nam, women's participation in the labour force remains relatively low in the region. In addition, employed women tend to be over-represented in more vulnerable forms of employment. This may create gaps in effective coverage when access to SHP systems is related to employment without adequate measures to subsidize contributions of low-income workers. Where these are available, women may be over-represented in schemes targeting the poor, which often have lower levels of protection. Ultimately, these gaps in coverage negatively affect women's ability to fully take part in the labour market, foster a more balanced share of domestic and family responsibilities, and access equal economic opportunities with men.



Most countries prioritize resource allocations to maternal health care and include maternal and child health in their SHP schemes. However, specific analysis is still needed at country level to measure gaps in effective access, but also to assess whether benefit packages are designed in a way that address women's special needs – for reproductive health or specific cancer treatments, for instance. Measures of potential inequities in health care utilization and expenditures among women and men are also needed together with qualitative studies on gender-based discriminatory practices at the points of services. Similarly, addressing men's reproductive health needs can play a key role in transforming stereotyped masculinity. This can reinforce a culture of care sharing, starting by recognizing the role of the father in antenatal, childbirth, postnatal and child health care. This can foster non-violence at home, work and in society.

► **Figure 10. Labour force participation rate by gender, countries and territories in Asia and the Pacific, 2019**



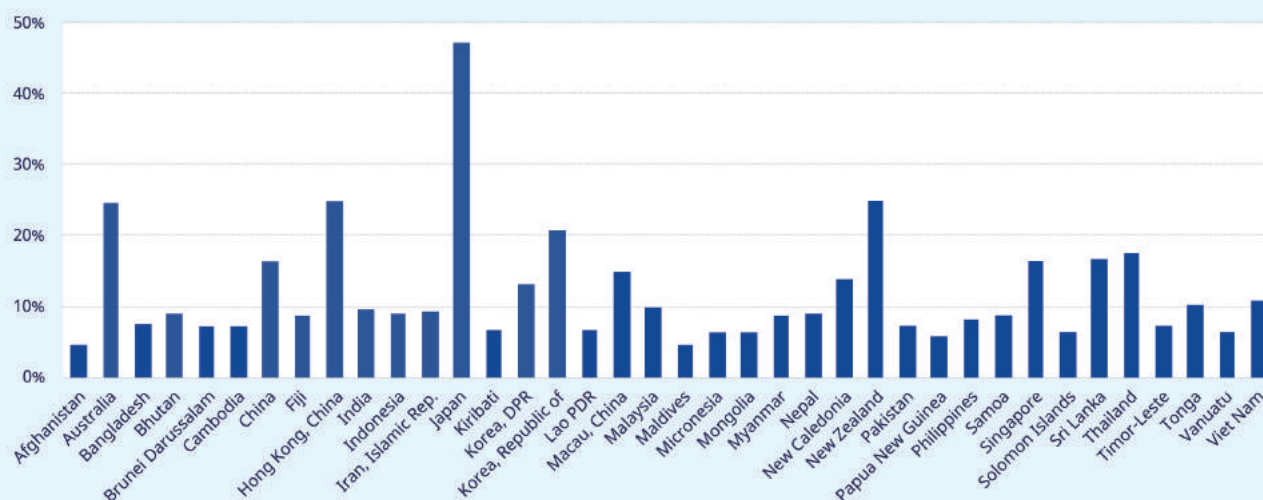
Note: ILO modelled estimates, November 2020.
Source: Adapted from ILOSTAT.

Looking forward in the region, it is not possible to elude the focus that countries will need to place on an ageing population, where women are disproportionately represented. For instance, gender-specific contributions charged for Singapore's ElderShield scheme place a higher financial burden on women, who already shoulder most of the family and domestic responsibilities during their working age. In this context, it is important to maintain the principle of solidarity in line with international social security standards.

Older persons

Along with major progress in health outcomes, the population of the Asia and the Pacific region is undergoing profound and rapid changes. Countries are experiencing significant increases in life expectancy – with an overall average of 73.4 years at birth. Life expectancy for the whole population across the region's low- and lower-middle countries and territories reached 69.9 years on average in 2019, and 76.9 years in upper-middle and high-income countries. Developing countries are ageing at a faster speed than developed ones, and the ageing process has started at an earlier stage of their development, putting them under strong pressure to address issues associated with ageing in a limited time, and with limited resources (UNESCAP 2017).

► **Figure 11. Percentage of persons aged 65 or above relative to the working-age population, countries and territories in Asia and the Pacific, latest available year**



Source: Adapted from World Bank Data.

Along with this progress and declining fertility rates, the proportion of older persons is increasing at an unprecedented pace, although the timing and pace of this transition varies across countries in the region. The age dependency ratio (see Figure 11) illustrates the major socio-economic challenges a number of countries in the Asia and the Pacific region already face.

The provision of SHP is not exempt from the consequences of aging societies: increasing costs of care, decreasing government revenues emanating from income taxes and the dire shortage of skilled long-term care workers are some of the acute challenges policy-makers are increasingly facing.

Most countries pool the health care risks of older persons with other age groups through social health insurance systems in place – such as in the Philippines, Thailand and Viet Nam, while often also subsidizing their participation in the schemes. However, coverage has been limited to medical care and has yet to integrate social care as part of the benefits covered. The long-term care needs of older persons is yet to be adequately addressed by many systems (see Chapter 2).

Countries already facing major demographic impacts of population aging – including Japan, the Republic of Korea and Singapore – have introduced specific social insurance schemes to cover the risks of older persons requiring long-term care. Such schemes cover a variety of services which help meet both the medical and non-medical needs of people who cannot care for themselves for long periods due to disabilities resulting from old age. Such schemes are financed through a combination of contributions from workers, employers and pensioners, medical savings and government subsidies.

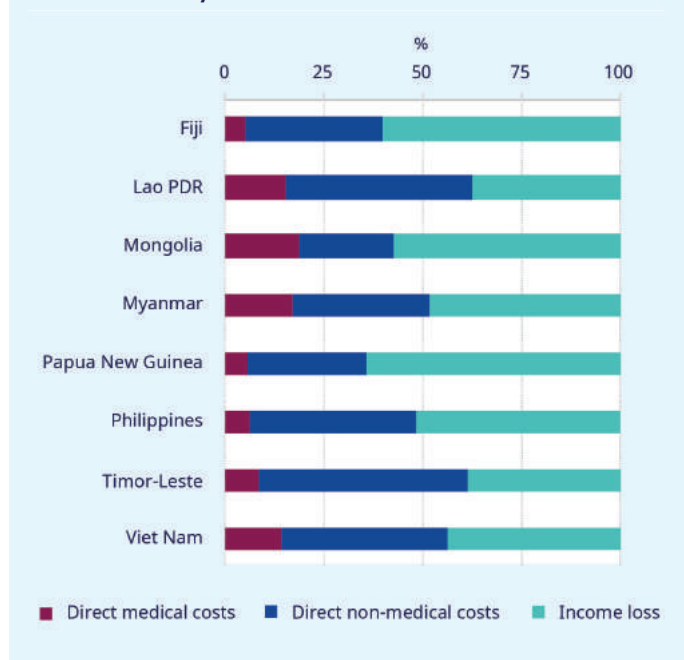
People living with disabilities and long-term illnesses

People with disabilities tend to use more health services on average compared to the broader population, partly because they require the same range of general health services as well as additional services specific to their disability (specific medicine, assistive devices and rehabilitation). However, people with disabilities often suffer poorer health status, experience greater barriers to receiving care and are more likely to face catastrophic health expenditures than persons without disabilities. Moreover, the former also incur higher health OOPs health spending as well as more challenges to work and increased income losses due to time spent seeking care. The latter is also true of people living with long-term or chronic diseases

such as HIV or tuberculosis, who may additionally face practical barriers of access related to discrimination and, for some key populations, criminalization.

Several countries conducted TB patient cost surveys that further highlighted the financial burden of the disease, even when the costs of diagnosis and treatment are fully covered by national TB programmes, due to income losses and non-medical costs of care (transportation, for instance) (Lönnroth et al. 2020). The absence or limited coverage of adequate sickness and disability benefits in the region further reinforces these trends (ILO 2020b).

► **Figure 12. Snapshot of cost distribution (percentage of total incurred costs) from patient cost surveys conducted under the WHO Global Tuberculosis Programme, selected countries in Asia and the Pacific, latest available year**



Source: Adapted from WHO (2020a).

In view of those challenges, coverage for medical care of people with disabilities are prioritized in some countries through subsidized participation in SHI schemes or alternative SHP mechanisms, such as in China or Pakistan, where various supplementary schemes provide support for medical and social care for people with disabilities. Japan, Republic of Korea and Singapore have included benefits to people with disabilities in their long-term care schemes.

Overall, social protection has a critical role to play in covering the diverse costs that persons with disabilities and long-term health conditions face and in tackling the diversity of barriers undermining their access to health care and income support alike (ILO, forthcoming b).

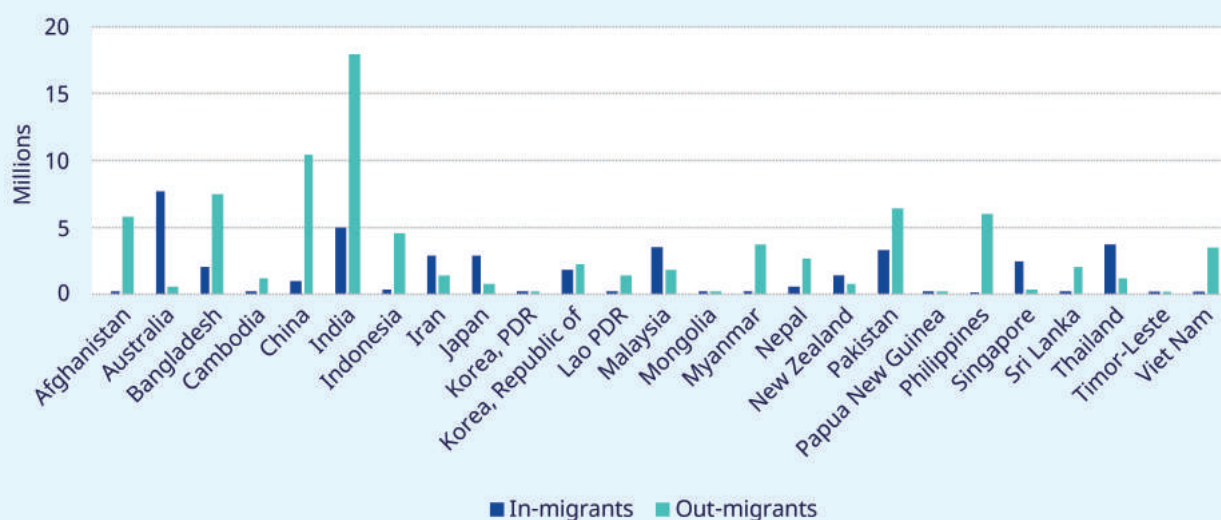
Migrants

Internal migration within respective countries in the region, due to rural-urban transitions as well as conflicts, is a key trend to help understand existing SHP coverage gaps. Indeed, in some countries urban and rural populations may be covered by different SHP schemes. It could be de facto due to different employment structures – for example, in India schemes for the formally employed tend to mostly cover urban populations. It could also be by design, for example in Bangladesh the management of national health services is under different ministries and financial allocations, while in China when there were two separate schemes. As portability of benefits is not always considered in the design of such schemes, internal migrants often face difficulties in effectively accessing health care services without hardship and other social protection benefits. For example, the household registration system in Mongolia or requirements to apply for fee exemptions in Fiji have created barriers to accessing SHP entitlements for internal migrants.

The remainder of this section will discuss more in-depth issues related to the coverage of international migrants. Nine countries constitute the main destination countries for migrants in the Asia and the Pacific region, with more than two million in-migrants each (Australia, Bangladesh, India, Islamic Republic of Iran, Japan, Malaysia, Pakistan, Singapore, and Thailand) (Figure 13). Some countries may not have a large absolute number of migrants, but compared to national populations, migrants account for more than 10 per cent of the total populations in each of 10 countries (Australia, Brunei Darussalam, Cook Islands, Malaysia, Maldives, Nauru, New Zealand, Niue, Palau and Singapore). Additionally, Bangladesh, India, Islamic Republic of Iran, Malaysia, Pakistan and Thailand are major destination countries for refugees from conflicts in Afghanistan and Myanmar.

The Gulf Cooperation Council (GCC) region is an important destination for migrants from the Asia and the Pacific region, particularly for nationals from Bangladesh, India, Indonesia, Myanmar, Nepal, Pakistan, the Philippines and Sri Lanka. Countries with a large number of out-migrants (more than two million) include Afghanistan, Bangladesh, China, India, Indonesia, Myanmar, Nepal, Pakistan, the Philippines, Republic of Korea and Viet Nam (Figure 13).

► **Figure 13. International in- and out-migrant stocks, selected countries and territories in Asia and the Pacific, 2020**



Note: Only includes countries with populations of one million or more. For out-migrants, the figure indicates their country of origin. For in-migrants, the figure indicates the country of destination.

Source: Adapted from UN Population Division (2020).

Coverage varies across international migrant groups, with undocumented migrants or refugees often facing financial and other barriers to access health services. Documented migrant workers and permanent residents were found to be better integrated into national schemes and policies. SHP for international migrant workers includes policies of origin countries to protect their citizens when they work and live abroad, policies of destination countries to protect migrants living and working on their territory as well as multi-lateral and bilateral policies.

ILO standards promote bilateral and multi-lateral social security agreements to ensure equality of treatment and facilitate portability of social protection benefits across borders (ILO 2008b). In the Asia and the Pacific region, multi-lateral agreements have yet to be adopted, though it is important to note that social protection is being discussed within ASEAN (Olivier 2018). Several countries have active bilateral social security agreements, mostly outside the region (with countries in Europe, in particular), but also to

a lesser extent within the region (India, Malaysia and Thailand). While such instruments are the best legal guarantee for the portability of social security benefits, a number focus exclusively on long-term benefits (old age or disability pensions) and exclude short-term ones, such as access to health care, sickness and maternity benefits (Van Panhuys, Kazi-Aoul, and Binette 2017).

Some countries have made the choice to include migrants within their SHP system at par with nationals. Japan and the Republic of Korea require that foreign residents register with national health insurance schemes.

Other countries cover foreign nationals through separate measures. Within this category, the type of measures vary greatly as does the success in terms of coverage and adequacy for migrants. Thailand opted for the creation of a dedicated public social insurance scheme accessible to undocumented and documented migrants who do not fall under categories covered by the mandatory SSO scheme. The country stands out for its special efforts to increase coverage across migrant populations through expanding this specific contributory scheme coverage to dependents, undocumented migrants and making efforts to deal with social and language barriers to accessing health services (see Box 8).

Brunei Darussalam, Malaysia and Singapore opted to cover only permanent residents at par with nationals, while temporary migrant workers can access the National Health Service with higher user fees. In these countries, health care coverage of migrant workers on temporary work permits is an employer's liability or the employer is required to purchase a private health insurance policy with basic coverage.

For example, Singapore's policy requires employers to buy basic commercial health insurance to obtain work permits for foreign workers, but self-employed on employment passes do not have this requirement. A similar situation is often faced by migrant workers on temporary work permits in GCC countries. This creates gaps in access and financial protection alike since health care costs and overall living standards are high in these countries and migrant workers are at the lower end of the wage spectrum. The COVID-19 pandemic shed light on these coverage gaps and a number of countries took specific measures of inclusion as a response to the crisis (ILO 2020d).

Confronted with these situations, a number of countries with important out-migrant populations decided to put in place measures to secure coverage of their nationals abroad and to ensure they can contribute to coverage of dependents left home. Overseas Filipino workers are covered by the compulsory health insurance programme of PhilHealth. In addition, the Philippines has set up Overseas Filipinos Resource Centres in several countries, trained staff and created procedural guidelines to deal with health issues of migrant workers (UNDP 2015).

Social health protection for refugees is a challenging issue in many countries, particularly when the number of refugees is large, when they have faced significant physical and mental trauma and when the host country has limited resources to meet its own population's needs (ILO and UNHCR 2020). Within the Asia and the Pacific region, a large number of refugees have fled Afghanistan and Myanmar and are hosted in Bangladesh, Malaysia, Pakistan and Thailand. None of these four countries is a party to

► Box 8. Protection of workers organized by origin (the Philippines) or destination (Thailand) country

The Philippines

The Philippines is a major migrant worker-sending country within the ASEAN region. The Migrant Workers and Overseas Filipinos Act 1995 (RA 8042) and amendment in Republic Act (RA) No. 10022 provide the legal basis for SHP among overseas Filipino workers and their families left in the Philippines. Specific measures to protect the right to health include the extension of portable health insurance to migrant workers, implementation of multi-sectoral training schemes to enhance the capacity of overseas labour officers dealing with migrant health issues and the creation of procedural guides for overseas welfare officers in managing overseas foreign workers living with HIV deported from host countries with travel-related restrictions. Additionally, RA 10022 stipulates the responsibility of recruitment and manning agencies to shoulder the social health insurance coverage of each migrant worker deployed, establishment of a replacement and monitoring centre for returning Filipinos, and an Overseas Filipinos Resource Centre in countries where there are large concentrations of Filipino migrant workers.

Source: UNDP (2015).

Thailand

Thailand is the primary host country for low-skilled migrant workers from three neighbouring countries within the ASEAN region. Migrant employment is governed by the Labour Protection Act 1998, which focuses on working conditions, benefits and labour welfare. As a WHO Member State, the country is committed to the WHO Resolution on the Health of Migrants, adopted at the 61st World Health Assembly in 2008, which recognizes increased health risks for groups of migrants and calls for the promotion of migrant-sensitive health policies and equitable access to health promotion, disease prevention and care. Many migrant workers are eligible for coverage under the Social Security Scheme for those in formal private employment. Other workers, undocumented migrants and dependents are eligible under the compulsory Migrant Health Insurance Scheme with a reasonable level of contribution (U\$67 per year). Other migrant health strategies include provision of quality services in relevant languages, increased participation of migrant communities and improved training for relevant health personnel involved in the provision of health care to migrants in Thailand.

Source: UNDP (2015).

the 1951 UN Refugee Convention, although the governments do cooperate with UN agencies, local and international NGOs to provide basic health services to refugee populations. Nevertheless, refugees face significant barriers to access, use and afford health care services (Sarker et al. 2020).

Undocumented migrants are likely to face additional access barriers. These are not limited to financial access, but also administrative barriers. Registration procedures may be a deterrent to access benefits for undocumented populations. Challenges pertaining to lack of ID or fear of being 'visible' as an undocumented migrant remain important barriers, even when this group has legal entitlements.

Ethnic minorities and geographically remote populations

Most countries provide the same legal entitlements to the entire citizen population without discrimination based on geographic location or ethnicity. While this is true, gaps in coverage remain in practice.

Extending coverage to people living in geographically remote areas or islands is more difficult to achieve than for other regions because of distance to health facilities and social protection administration as well as gaps in awareness on their entitlements. SHP coverage of ethnic minority peoples, many of whom live in remote and disadvantaged regions, may be further complicated by language and cultural barriers or discrimination in enrolling for coverage or when using services. For example, Dalit and Janajati women in Nepal experienced discrimination when seeking health care, thus reducing acceptability and accessibility. Discrimination against the Rohingya minority in Myanmar has limited its access to government-funded and provided health care services.

Some countries have special provisions in SHP regulations to enhance access among ethnic minority people or residents of disadvantaged areas, such as Viet Nam's full subsidization of SHI contributions and exemptions from co-payments for ethnic minority people and residents of disadvantaged areas. Pakistan also has a scheme (Bait-ul-Mal) to ensure some coverage for vulnerable groups, including ethnic minorities, not covered by other schemes. In Thailand, while all Thai nationals not otherwise covered are entitled to the UCS scheme, the requirements to provide a national ID cannot be met by some marginalized groups, including ethnic minorities living in northern parts of the country.

As this chapter highlighted, population coverage is an important dimension to expand effective access to health care without hardship as well as sickness and maternity cash benefits. While this holds true, the adequacy of such coverage is equally important and will be explored in the following chapter.



Chapter 2. Ensuring adequacy of benefits

Key messages

- While many countries in the Asia and the Pacific region have made promising progress in terms of population coverage, the adequacy of such benefits remains a challenge. This is particularly the case when it comes to the following dimensions:
 - The comprehensiveness of benefits covered: despite many recent reforms, the PHC approach to service delivery promoted by the Alma-Ata Declaration, adopted at the International Conference on Primary Health Care in 1978, is still not a reality. Prevention and promotion interventions could be strengthened by adjusting benefit packages and service provision to the needs of a changing demography.
 - The level of financial protection effectively enjoyed by covered populations may not be adequate due to limitations in benefit packages, official levels of financial protection set too low, lack of effective compliance with regulated cost-sharing arrangements, pervasive informal payments as well as limitations in the designated network of service providers.
- Some countries exempt maternal or child health care services from co-payments – such as Lao PDR, Malaysia, Republic of Korea and Viet Nam – in line with ILO standards. This approach has been successful in improving access and outcomes.
- Similarly, coverage of long-term care is an important challenge and one that is increasingly considered by policy-makers in Asia and the Pacific region. This is especially the case when countries experience important demographic changes and rapid population ageing, in particular. In this context, some countries have adopted measures to cover the needs of older persons. Japan, Republic of Korea and Singapore created dedicated long-term care schemes to help reduce the financial burden on households. Several countries subsidize social health insurance contributions for older persons, such as Japan (AEHI) and Viet Nam (contributions of persons aged 80 and older).
- Solutions to overcome geographic barriers of access have included mobile health clinics (Brunei Darussalam, Mongolia), air-lifting patients from remote areas (Brunei Darussalam), payment for overseas care (Fiji and Timor-Leste) and support for transportation costs.

While population coverage is often the main focus of policy-makers, SHP also needs to be adequate to contribute to the policy objectives of UHC and USP. Adequacy of coverage encompasses two complementary dimensions both in the law and in practice. Firstly, the range of services covered ought to be comprehensive and meet the criteria of availability, adaptability, acceptability and quality. Secondly, the share of the cost of accessing such services borne by collectively-financed mechanisms needs to be high enough to avoid shifting the financial burden of care onto the individual, effectively protect income and prevent impoverishment. In this chapter, the status of these dimensions in Asia and the Pacific are explored, first looking at design features on the scope of benefits and their provision, and then analyzing effective coverage based on existing data on access and utilization.

► 2.1. Expanding the range of services covered

How each country defines the range of health care interventions that will be covered by SHP is a priority-setting exercise to a large extent and the result of numerous trade-offs. The process of defining such entitlements differs from one country to the next, with wide variations in: the use of evidence on the effectiveness and cost-effectiveness of interventions, the level of participation and consultation with relevant stakeholders and the degree to which such entitlements are actually available on the ground and of sufficient quality.

A comprehensive analysis of the range of services covered requires an examination of: (1) which services are covered as per benefit packages defined by laws, as well as (2) the service provision aspects that encompass design features of the SHP system, including types of providers covered and the conditions to access (referral systems and gate-keeping mechanisms). The sections 2.1.1 and 2.1.2 explore these two aspects. Further, the extent to which this translates into practice will be addressed in section 2.1.3, using the available evidence and particularly data collected to monitor SDG 3 on health and well-being for all.

2.1.1. Designing comprehensive benefit packages

Universal health coverage means that all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care (WHO 2021). Social health protection systems contribute to this goal when they are in line with ILO standards and in particular, provide a legal guarantee for accessing a comprehensive and adequate range of medical care services that are collectively financed.

ILO standards call for States to provide social protection to cover health care interventions needed to “maintain, restore or improve” the health of the protected persons and their ability to work and to attend to their personal needs (Convention No. 102). As equally recalled in Medical Care Recommendation, 1944 (No. 69), the range of services covered should be comprehensive and include preventive and curative interventions. According to Recommendation No. 202, among the guarantees that should be secured through national social protection floors, States should ensure access to a set of goods and services that constitute essential health care, including maternity care. The determination of scope of essential health care should be defined through a national dialogue process, with due regard to the principles of availability, accessibility, acceptability and quality and be regularly revised to ensure they remain sufficient to ensure a life with dignity.

States should also seek to provide higher levels of protection as soon as possible and to as many persons as possible using guidance provided by Convention No. 102 and more advanced standards, notably Convention No. 130.

Convention No. 102 provides guidance regarding a minimum package of health care which should include general practitioners' services to provide a basic package of PHC services. Moreover, it should include reproductive, maternal new born and child health (RMNCH) services, including antenatal care, confinement, postnatal care and hospitalization if required, specialist and hospital care and essential prescription pharmaceuticals, to be complemented by dental care and medical rehabilitation (including prosthetic and orthopaedic devices). The responsibility of national authorities is not only to regulate such entitlements, but also ensure that provided services meet the criteria of availability, adaptability, acceptability and quality.

ILO standards stipulate that institutions responsible for SHP shall make a proactive effort to encourage protected populations to utilize population health interventions and more generally promotion and prevention services. This is in line with the vision promoted by the WHO on service delivery. Indeed, PHC was early on identified as a central function and a fundamental approach to the delivery of health care (see Box 9). While this is true, in practice adopting such an approach often requires important shifts in health systems and a strong stewardship and regulatory power from the side of MoHs. The PHC function remains incomplete in many countries (WHO 2019a).

► Box 9. Primary Health Care approach

The Alma-Ata Declaration adopted at the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978, states that:

“Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process.”

Traditionally, service delivery was analyzed or compartmentalized between different levels of care (primary, secondary, tertiary care) depending on the level of specialization, the type of clinician and technology used, as well as type of interventions, depending on whether they were population-based or individual-based (Starfield 1994). The PHC approach is meant to break silos and ensure that people can access people-centered, comprehensive, integrated, first contact care within their community (WHO 2008). The World Health Report, 2008 and Astana Declaration 2018 further reiterated that there is evidence that this approach is both most effective and cost-effective. In addition, the PHC approach fully acknowledges the need to coordinate with actors outside the health sector, including work places, through mainstreaming a Health in All Policies approach, with a view to addressing the social determinants of health. From this perspective, it is an approach supportive of the realization of human rights to health and social security and it should guide the effective access to essential health care in line with ILO Recommendation No. 202.

Since the PHC approach remains incomplete in many countries, the traditional distinction between levels of care is used in the following analysis of guaranteed benefit packages in the region. The following analysis follows the way most benefit packages are formulated in practice, in the form of positive and negative lists as well as implicit baskets when applicable. Hence, the analysis is organized by levels of care and type of interventions, including population health, individual-based primary care, secondary and tertiary care, rehabilitation, mental health care, long-term care and other services. It is clear that a PHC approach would aim to break silos between these types of interventions and encompass several of them.

Overall, a number of countries have succeeded in providing a comprehensive benefits package across all levels of care, including Brunei Darussalam, Indonesia, Japan, Lao PDR, Malaysia, Mongolia, Sri Lanka, Thailand and Viet Nam. Other countries exclude key components of care from SHP coverage, such as outpatient specialist care (not covered by the Philippines' PhilHealth or India's PM-JAY/Wellness clinics) or outpatient services (not covered by China's URRBMI), medical imaging, consultation and education for prevention of chronic diseases (excluded from NHI in Republic of Korea). Additionally, specific services are often excluded from the benefits packages, such as dental and optometry care (excluded from NSSF in Cambodia, China, Lao PDR, Viet Nam), substance abuse care (Cambodia NSSF, Thailand's SSS and Viet Nam VSS), or catastrophic diseases involving oncology, organ transplants, cardiology interventions or hemodialysis. In other countries – like Bangladesh, Cambodia, Fiji, Myanmar, Nepal, Pakistan and Timor-Leste – regulations and national plans intend to provide comprehensive benefit packages. However, in practice fragmentation, limited allocation of resources, low quality of services in some areas or lack of oversight led to programmes falling short (see Section 2.1.2). Some countries

may not limit services per se, but the application of ceilings, deductibles or high co-payments serve as de facto limitations on the ability to avail services in the benefit package (see Section 2.2.1).

Some countries, while covering the same interventions to all protected persons, may offer supplementary features to ones who contribute. For example, in Indonesia, although the JKN scheme provides a unique, broad benefit package to all members, it provides certain groups a higher level of amenities through different class wards. While all JKN members can obtain the same clinical services, salaried workers are entitled to Class 1 or 2 wards, subsidized members can only access Class 3 wards and informal economy members can access services in all wards depending on the contribution paid.

Population health

According to the WHO, Public Health consists in “an organized effort by society, primarily through its public institutions, to improve, promote, protect and restore the health of the population through collective action. It includes services such as health situation analysis, health surveillance, health promotion, prevention, infectious disease control, environmental protection and sanitation, disaster and health emergency preparedness and response, and occupational health, among other” (WHO 2011).

Population health interventions can include health promotion campaigns or detection, prevention and responses to infectious diseases, which have traditionally been offered as part of vertical disease programmes. The specific services included in population health vary across countries, but legal coverage is generally universal because of the collective nature of these interventions, making them public goods (Cichon et al. 1999). Specific policies and regulations defining entitlements to population health include vertical health programme scope or explicit lists of services that are the responsibility of the State to provide, finance or both. In the Philippines, the new UHC law provides a clear space for population health and defines both its contours and its financing and institutional arrangements for delivery. The law further provides a clear framework for the articulation of population-based health interventions and individual-based health interventions.

However, in many countries, these service packages are not always explicitly provided in the legal framework. This situation sometimes mirrors overall low priority and funding dedicated to population health as well as promotion and prevention, more generally. In countries where policies are in place to define this package, people may not be aware of services they are entitled to use. These limitations are particularly important to note due to likely impacts on SHP responsiveness in the near future, as population health interventions are essential to cope with the changing burden of diseases, with NCDs on the rise and requiring, alongside other measures, important lifetime changes (Afshari et al. 2020).

Similarly, policies on prevention of certain risk factors, such as occupational hazards for example, and policies on SHP are not necessarily designed in a coordinated fashion. This leaves room for improvements in the way that SHP institutions and policies approach investments in prevention and population health interventions delivered in the workplace and the community.

Primary care

Different countries provide entitlements for individual-based primary care in different ways. In many countries, the components of benefit packages related to primary care services provided to individuals, whether funded by the State budget or covered by social health insurance, are explicitly defined through positive lists, such as in Bangladesh, Mongolia, Sri Lanka, Timor-Leste and Viet Nam. Efforts are sometimes made to expand entitlements to primary care to a greater share of the population. Indeed, because primary care services are usually cheaper than higher levels of care, their inclusion in benefit packages guaranteed for free or affordable have sometimes been limited. For example, historically, PhilHealth included primary care benefits only for indigents and sponsored members, leaving the remainder of the protected population to pay for such services out-of-pocket. However, with the new UHC Law, the Konsulta package was introduced¹³ providing a defined primary

¹³ PhilHealth Circular 2020-0020 Governing Policies of PhilHealth Konsultasyong Sulit At Tama (PhilHealth Konsulta) Package: Expansion Of The Primary Care Benefit To Cover All Filipinos.

care benefit package for all Filipinos.¹⁴ Similarly, Singapore made efforts towards including primary care in its SHP framework, first by allowing people to use their individual medical savings account for some outpatient interventions, and then by introducing the Community Health Assist Scheme (CHAS) in 2000.¹⁵

Prevention, early diagnosis and treatment of diseases such as TB, HIV and malaria, have traditionally been covered by vertical disease-specific control programmes, sometimes supported by donor-funding. Entitlements to prevention, diagnosis and treatment were not always embedded in the legal framework or included in the benefit package covered by SHP systems. In designing these policies, it was thought that concentrating on a few well-focused interventions was an effective way to maximize the effects and time responses of available resources rather than waiting for changes in the health system so delivery of better services would be viable (Atun et al. 2008). The rapid spread of those diseases and their burdens on countries were strong push factors to take quick action, sometimes with impressive results on disease control.

Over time, several countries have incorporated treatment of these diseases into SHP benefit packages, and some have also found ways to maintain the health promotion and disease prevention programmes. Indonesia, the Philippines and Thailand include TB and HIV treatments, while Viet Nam's integrated HIV treatment and is working on covering TB treatment as well. Thailand maintains funding for individual prevention and promotion activities through specific budget allocations to the National Health Security Office for all citizens. The Philippines has a special TB-DOTs package in the PhilHealth scheme, which comprehensively covers diagnostic exams, consultation services, drugs, health education and counseling during treatment. While important progress has been made in integrating diagnosis and treatment of communicable diseases in benefits packages, patients can still suffer from income loss and the absence of appropriate sickness cash benefits.

Primary care for NCDs is receiving increased attention in benefit package design, particularly due to the growing concerns about population aging and increasing financial burdens. In Republic of Korea, the National Health Insurance Package includes screening and preventive checkups for colon, breast and liver cancer. In Malaysia, the implicit package of the national health service provides health and mental health screening for adults, including cervical and breast cancer screening. Additionally, Malaysia's Peka B40 programme supports low-income groups with NCD-related health care such as screening, subsidized medical devices, and travel allowances. Bangladesh has plans to include outpatient coverage for selected diseases, including diabetes and high blood pressure in its SSK scheme, which currently covers low-income individuals in a few pilot districts. However, adding specific diseases or services to the benefits package is only part of the needed response. In addition, countries will need to apply multi-sectoral NCD prevention strategies to control risk factors, such as tobacco use, harmful alcohol use, unhealthy diet, lack of physical exercise, environmental pollution, exposure to hazards in the workplace, but also broader social determinants of health which will also require coordination with the wider social protection system.

RMNCH services

RMNCH services have often been prioritized in legal coverage, in line with ILO instruments where free maternal care is commanded. While RMNCH services are included in general primary care service packages in most countries, some have placed higher priority on ensuring more comprehensive policies that guarantee coverage of mothers and children and included complicated births. The Philippines' Safe Motherhood programme includes both investments to strengthen the quality and scope of services as well as sustainable financing through PhilHealth. It covers all women about to give birth nationwide (see Section 2.2.1).

¹⁴ Involving no co-payments for the designated package of services if obtained in a public facility and capped co-payments when patients avail of the package in private facilities.

¹⁵ Providing subsidies for primary care services, with means testing to determine the level of subsidy.

Specialized outpatient and inpatient care

Due to the high costs of care and subsequent financial barriers they constitute, specialized outpatient and inpatient care must be covered from SHP systems. This is essential to eliminate health-related impoverishment. Conversely, coverage of secondary and tertiary care only is problematic if primary levels of care are financed through OOP health spending. Indeed, this provides an incentive for people to delay care and is, therefore, not cost-effective.

Most countries in the region have some form of legal entitlements to these services. Entitlements are defined either positively (Bangladesh's SSK, Fiji national health system, Indonesia's JKN, Mongolia's SHI, Myanmar's SSB, Pakistan's Sehat Sahulat scheme, PhilHealth) or both positively and negatively (Cambodia's NSSF and HEF, China's former UEBMI, URRBMI, all of Japan's medical benefit schemes, Republic of Korea's NHI, Lao PDR's NHI and NSSF, Thailand's CSMB, SSS and UCS, Viet Nam's VSS). The scope of packages varies from a comprehensive range of services – in Japan more than 5,000 medical and dental services and 17,000 types of drugs are covered – to a limited number of specific diseases or service items. Negative lists vary across countries, excluding from SHP coverage items each nation considers non-essential. As countries have progressively expanded service coverage in practice, negative lists have tended to contain fewer exclusions.

Some countries have a relatively uniform package for all (Japan, Indonesia, Lao PDR, Mongolia, the Philippines, Republic of Korea, Singapore and Viet Nam). Japan and Thailand, despite having multiple schemes, have managed to align them to achieve a relatively uniformly defined benefit package. Some countries have different service packages or levels of cost coverage when it comes to secondary and tertiary care for different population groups, leading to disparities in legal coverage. For instance, in China, the URRBMI scheme for residents, in comparison to the UEBMI scheme for employed individuals, had a narrower benefit package with outpatient and inpatient coverage mainly only for catastrophic diseases, but not general outpatient services.

Among countries whose main mechanism to ensure SHP is a national health service system, Fiji has an explicit benefits package defined in the Public Hospitals and Dispensaries Act 1955, while in Malaysia and Sri Lanka, an implicit package is understood. Myanmar's Essential Package of Health Services and Nepal's Free Health Care Programme involve government subsidies to public providers, but are not yet guaranteed by law.

Pharmaceuticals

In line with ILO standards, SHP mechanisms include pharmaceuticals in many Asia and the Pacific countries, often with priority given to coverage of a national essential medicines list (Cambodia's NSSF and HEF, China's UEBMI, Japan, Lao PDR's NHI, Mongolia's SHI, Sri Lanka in public facilities, Thailand for all four schemes and Viet Nam's VSS). Some countries have supplementary programmes to increase access to medicines. In Fiji, medicines are provided for free or at subsidized costs at public providers. In addition, a Free Medicines Programme was initiated to improve access to essential pharmaceutical products for lower-income households, who can access medicines prescribed by a licensed medical practitioner from government facilities and selected retail pharmacies. Similarly, in Malaysia patients using drugs, consumables and devices not offered at subsidized prices by public facilities can request payment from the Medical Relief Fund and low-income patients can obtain subsidized pharmaceuticals for NCDs from PeKa B40. In Nepal, a free drug list is offered as part of the Free Health Care Programme, originally covering just 40 drugs, but with plans to expand to 93 drugs. In the Philippines, the new UHC Law ensures funding to cover 120 primary care drugs, a policy response to high OOP health spending on pharmaceuticals.

It is important to note that drugs make up for a sizeable share of public health spending (Kaplan et al. 2012; Ozawa et al. 2019). Providing legal entitlements to free or affordable drugs necessarily entails having a national essential drugs list, which meets the criteria set at a global level (WHO 2019b). Strategies to further pass regulations to secure drugs that are effective, safe and available at a fair price are needed to contain costs and ensure public collective funding is best used.

Long-Term care

When people get older or live with disabilities and are not able to perform daily living activities, access to long-term care becomes essential to live a life in dignity. Such care comes with a cost, consisting of the physical, financial as well as psychosocial hardships of caring for a loved one. Such care can come in different shapes and forms, should encompass health and social care, and should ideally allow ageing for as long as possible. Faced with a rapidly-ageing population, many countries have progressively developed a strong awareness of the growing health, social and economic challenges associated with long-term care.

In the Asia and the Pacific region, there exists a mix of systems to respond to the need to provide care for the elderly, including statutory systems such as long-term care insurance or mandatory family care provision, or non-statutory systems like voluntary family care provision and community-based support models. Guarantees to access long-term care without hardship for all in need is, however, seldom embedded in law.

Family care is the default mechanism to ensure long-term care for older persons in much of Asia. Some countries – such as China, India, Nepal, Sri Lanka and Viet Nam – have legislation that mandates the family's responsibility to care for older persons. However, the reliance on unpaid family caregivers, often women, in many Asia and the Pacific countries places an undue burden on households whose elderly members have lost their ability to take care of themselves, rather than spreading the risk across all of society through social protection mechanisms (ILO 2018). To help alleviate that burden, some countries have adopted policies that provide some recognition of the caregiving role, such as tax incentives in India, Malaysia and the Philippines. Even when the family does not face financial hardship in caring for their loved ones, it may not have the right skills or may face psychosocial distress. To help overcome this problem and encourage family caregiving, governments in some countries have established policies that provide support services, such as counselling in Islamic Republic of Iran, India and Sri Lanka and education and training for informal carers and care professionals in China, Democratic People's Republic of Korea, Fiji, India, Islamic Republic of Iran, Myanmar, Sri Lanka and Viet Nam. Fiji explicitly addresses support for older women caregivers (UNFPA 2017).

The poverty risk for older persons (and their families) when they become dependent is significant. Covering the costs of needed care out-of-pocket is harder at a stage of life when revenues decrease. This is all the more of a concern in Asia and the Pacific when income security at old age is not fully realized. Indeed, more than a quarter of older persons above statutory retirement age in Asia and the Pacific do not receive a pension, and only a third of the working age population is currently contributing to a pension scheme. While non-contributory pensions exist in a number of countries, their level is much lower than contributory pension and is meant to cover the most basic needs (ILO 2021b).

Japan, Republic of Korea and Singapore have developed formal long-term care social insurance schemes embedded in the legal framework. Important features of these schemes are they are mandatory, partially contributory (from pensions or contributions of older workers), and partially subsidized from the State budget. These schemes have usually adopted positive lists to define in-kind benefits and/or provide cash benefits. For example, in Japan, Long-Term Care Insurance (LTCI) covers non-medical services for eligible beneficiaries including home care, day care, respite care, services at long-term care facilities, equipment such as wheelchairs, assistive devices, home improvement and maintenance rehabilitation services. Community-based preventive services are also included.

The Republic of Korea's LTCI also defines a positive benefit package, including home care services such as bathing, day and night care, nursing for elderly family members and assistance with household activities, institutional care, financial support to purchase assistive devices and in some cases, cash benefits for family caregivers. Through the ElderShield package, Singapore provides cash payments to eligible beneficiaries to help cover the costs of long-term non-medical care, without a defined package. It should be noted that when ranges of services are not defined and cash benefits are provided leaving the beneficiary to find ways to seek services they need on the market, such schemes provide little direct incentive towards service providers. From this perspective, such legal entitlements are not

comprehensive and need to be complemented by an over-arching approach to healthy ageing and LTC, including regulation of LTC health and social service providers.

In many countries, regardless of legal entitlements provided to the person in need of LTC, there are issues with the regulation of LTC services provision, especially for social care provided at home. In countries with a high contingent of domestic migrant workers, this issue cannot be disentangled from the overall working conditions, training and social protection coverage of those workers (ILO 2016; Yeoh, Goh, and Wee 2020).

When the benefit package is designed, a designated network of health care providers is usually identified to provide it. This choice is crucial as it determines, to a large extent, which benefit package will be effectively accessible to the protected persons when in need. This is explored in the following section.

2.1.2. Network of service providers and modalities to access services

The definition of the network of services providers and modalities to access services are part of the design features of SHP systems. The way they are designed, often in the legislation, conditions effective access to health care services. This section provides an overview of the types of providers used in SHP policies, their geographical distribution as well as their organization in terms of the pathway to care.

Public and private provision in health systems

Health systems in the Asia and the Pacific region vary substantially in terms of public and private provision (for profit and non-for profit), which has important implications for SHP system design.

In some countries, public provision remains dominant and private providers account for a relatively small share of all services provided. For example in Viet Nam, a majority of inpatient and outpatient care is provided in public hospitals (General Statistics Office 2019). In Thailand, public providers also dominate the system (WHO 2015a). In Malaysia, 70.6 per cent of all admissions in 2016 were in public hospitals. In Sri Lanka, 95–96 per cent of inpatient admissions were in public hospitals, but about half of outpatient services were in private providers. In Indonesia, private hospitals include those run by NGOs and for-profit corporations, but overall private beds are out-numbered by public beds. In some countries, SHI schemes run their own networks of health care providers, such as in India and Myanmar.

In other countries in the region, the respective health systems are pluralistic and the majority of health care service provision is through the private sector. In Cambodia, more than 75 per cent of rural patients used the private sector as their first point of contact for health services. In India, private provision is also dominant, accounting for 58 per cent of hospitals in the country and 81 per cent of doctors. Private services remain the main source of health care for 70 per cent of urban households and 63 per cent of rural households (Thayyil and Jeeja 2013; International Institute for Population Sciences and Macro International 2007). In Pakistan, 70 per cent of health services are delivered by the private sector, while in Japan 85 per cent of health care providers are privately-owned and operate on a non-for-profit basis. The Republic of Korea's health system is also dominated by private providers. In Bangladesh, private provision consists of a mix of governmental, for-profit private, non-for-profit private and NGO service providers, serving different segments of the population.

Designated networks of health care providers

Designated networks of health care service providers that are available, accessible, acceptable and of sufficient quality are crucial to achievement of SHP goals. If not available, people may seek care outside of the designated network and pay OOP health spending, hindering the objective of financial protection or simply forgo health care, to the detriment of their health status.

The designated network of service providers can encompass the diversity of providers in a country or be limited to certain types of providers.

- In Brunei Darussalam, Fiji, Lao PDR, Malaysia and Sri Lanka, SHP mechanisms in place cover public health care providers, with some minor exceptions in case of emergencies, for example.
- In some countries, private facilities are integrated as part of the network of providers with the purpose of addressing gaps in the public system. Some SHP systems covering mainly public providers do make exceptions to cover private providers in certain cases upon referral, ensuring public services have a gate-keeping role (Brunei Darussalam, Fiji, Malaysia and Sri Lanka). In Brunei Darussalam, services in designated private facilities are covered if a public facility refers the patient. In Fiji, special arrangements are made for highly specialized services not available in the public system, either through an overseas referral programme or inviting specialists to come from overseas to provide services in the country's facilities. Fiji is also considering ways to contract general practitioners as primary care was identified as an important source of OOP health spending and of limitations in geographical access. In Thailand, SSS covers private services in cases of emergency or some referrals. In some instances, dedicated funds were set-up to cover expenditures occurred in the private system, upon specific conditions. In Malaysia, patients needing services not available in the public facilities can request funds from the Medical Relief Fund to pay for services in private facilities upon referral. In Sri Lanka, the government does not use public funds to pay for private services, however, some supplementary schemes like the President's Fund and Agrahara scheme enable limited payment of private services.
- In countries with more developed private health sectors, SHP mechanisms tend to cover public and private providers and are subject to increasing political pressure to do so with a view to improving adequacy of coverage, such as in China, Indonesia, Japan, Republic of Korea, Singapore and Thailand. In the Republic of Korea, all private facilities are obligated to participate in the NHI by law and therefore the entire spectrum of public and private providers are part of the designated network, from which people can avail themselves of SHP entitlements.

In some countries, the private for-profit health sector is small but growing to serve the increasing demands for services among the better off, often funded by voluntary private health insurance. In Malaysia, for-profit and ultra-modern facilities are being built to respond to demand from a rising middle- and upper-income class. These facilities are attractive employers, therefore attracting health staff and cater to the highest wealth quintiles who can afford high user fees or private health insurance premiums. In Sri Lanka, almost half of total OOP health spending are incurred by the richest households in private facilities. In Viet Nam, use of private services is highly regressive, and often financed by private health insurance or OOP spending from those who can afford to pay. Development of this for-profit private health sector in parallel to existing SHP mechanisms can create dual health care systems, where the wealthy fund their own use of higher cost services, while the rest of the population is left to use under-funded public services with declining quality due to a lack of social solidarity in financing.

Most health systems in the region are, to some extent, pluralistic and the development of poorly regulated for-profit provision poses challenges to SHP. While it is important to secure physical access and ensure people do not become impoverished through accessing health care services, it is equally vital to ensure the system is financially sustainable over time and based on equity and solidarity (see Chapter 3). This also requires the strengthening of regulations of for-profit provision and to pay special attention to the contractual relationship in a comprehensive way, including conditions of empanelment, quality requirement, frequency of contract revisions and adoption of provider payment methods conducive to quality and limit risks of cost escalations and moral hazards (see Chapter 3).

Geographic distribution of providers

The design of the network of health care providers must take into account the distribution of the population across the territory. In some countries, the SHP system is based on a limited network

of empanelled or owned facilities which do not fully reflect the distribution of the population and cause geographic gaps in coverage. For example, in India the ESIS and CGHS schemes have their own networks of providers with uneven coverage across geographic areas, which adversely affects service coverage for people residing in areas with fewer in-network providers. It poses further issues for migrant workers whose dependents remain in rural areas. In the Philippines, while a widespread network of public and private facilities exists, it remains fragmented across levels and in some regions the lack of accredited facilities means patients cannot benefit from services covered by PhilHealth in their locality (see Chapter 3).

The ways in which geographic barriers limit effective access and utilization of services is further explored in Section 2.1.3.

Referral systems and gate-keeping

The designated network of providers usually encompass rules on how the system can be navigated by patients. Such rules should be supportive of the PHC approach and ensure that first-contact care orientates patients towards higher levels of care when necessary. Such referral systems where the primary level of care plays a gate-keeping role fosters a rational use of health care interventions.

Components of formal referral systems exist in many countries in the region to improve services and control costs. Registration of patients is the process of assigning individual patients to primary care providers, which encourages health facilities to take responsibility for individuals in their panels. For people, it creates a first point of contact for most health needs, integrating preventive and curative care services close to home. The gate-keeping function can help guide patients to an appropriate provider when their needs extend beyond primary care.

Ensuring that patients can conveniently access effective essential health care services close to home at low cost combined with appropriate use of specialist and hospital services is an important strategy for SHP systems, and a key component of the PHC approach to service delivery long advocated by the WHO. One good example of an effective referral system is Malaysia's PeKa B40 chronic disease management programme, which provides referral letters to help patients access higher-level government facilities when needed.

The registration and referral system exists in many countries – such as China, Fiji, India's CGHS, Lao PDR, Mongolia, Singapore and Thailand – although not all countries are using this to ensure greater integration and continuity of care for the population. In Lao PDR, the referral system is often ineffective due to the lack of a gate-keeping function at primary care providers. In Mongolia, family and Soum health centres are intended to perform a gate-keeping role by referring patients to secondary and tertiary facilities, however, self-referrals and high rates of inappropriate admissions within hospitals remains a major challenge.

A number of Asia and the Pacific countries lack patient registration and referral systems to help navigate the health care system (see Chapter 3). The lack of gate-keeping in Bangladesh results in patients with minor ailments presenting for treatment to higher-level facilities directly, overburdening higher level facilities. In the Philippines, no referral system is in place. However, the new UHC law envisions setting up health care provider networks with primary care providers as initial contact points to facilitate referrals. This is expected to reduce long waiting times that currently prevent patients from getting timely care. Sri Lanka lacks a formal referral system or gate-keeping mechanism to allow Sri Lankans freedom of choice, including bypassing primary level facilities in favour of secondary and tertiary care facilities. This leads to inequality as people in more remote or disadvantaged areas face geographic barriers to access higher level services. It also means that secondary and tertiary care facilities must also provide primary care services, which creates inefficiencies in resource allocation.

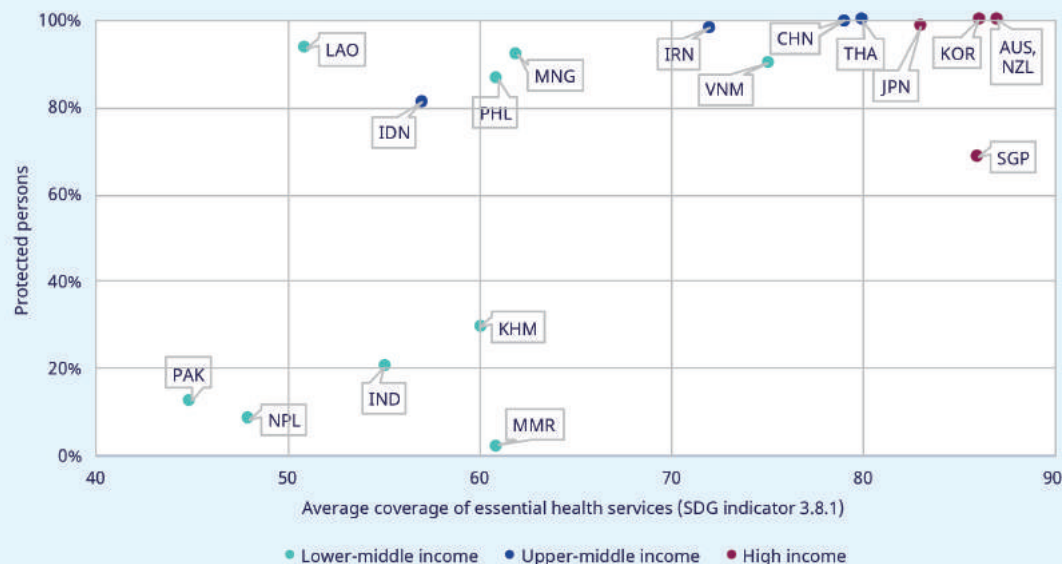
Patient registration, referral mechanisms and a strong gate-keeping function are conducive to rational use of resources and cost containment. At the same time, it is important to avoid designs that are too rigid. For instance, the choice of a primary care provider with whom patients feel comfortable is often reported as an important determinant of perception of quality care (Campbell, Roland, and Buetow 2000).

2.1.3. Effective access and utilization

There may be discrepancies between what people are entitled to by law, their affiliation to a scheme and what they really access in practice. In this respect, there is no standardized monitoring system with comparable data across countries to paint an accurate picture of how the range of services people effectively access and use reflects their legal entitlements, and to what extent these fully meet the criteria of availability, adaptability, acceptability and quality. Reasons for this include the cost of such monitoring and the lack of consensus on how to measure these dimensions, among others. While this holds true, considerable progress was made and a wealth of data collected through the SDG target 3 framework, allowing for analysis on the state of effective access and utilization.

The target indicator for SDG 3.8.1 is the UHC Service Coverage Index a composite measure of health services (see Statistical annex). It shows substantial variation across countries in the Asia and the Pacific region (Figure 14). Higher-income countries tend to have achieved a higher level of effective coverage with a SCI rating of more than 80, although they still face gaps in service coverage. Some upper middle-income countries (China and Thailand) and even a lower middle-income country (Viet Nam) have achieved relatively high effective service coverage levels despite their lower national incomes, suggesting that carefully designed SHP policies can contribute to overcome limited resources. Unsurprisingly, countries with a high share of protected persons (Figure 7 in Chapter 1) also tend to have more effective access and utilization of health care services. Here, again, countries' income levels are strongly correlated with service access performance.

► **Figure 14. Relationship between the share of the population protected by a health care scheme and the essential Service Coverage Index (SDG indicator 3.8.1), countries and territories in Asia and the Pacific, latest year available**



Note: The Service Coverage Index is a measure of SDG indicator 3.8.1, which combines 16 tracer indicators of service coverage into a single summary measure, and is reported on a unitless scale of 0 to 100. Data on the Service Coverage Index is from 2017.

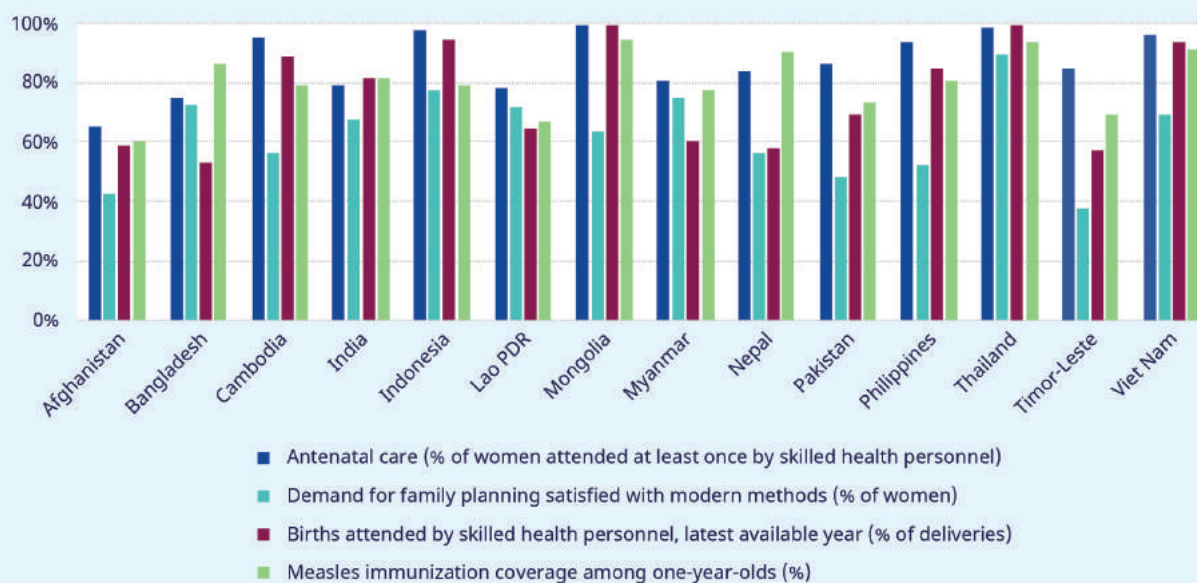
Legend: AUS - Australia; CHN - China; IDN - Indonesia; IND - India; IRN - Islamic Republic of Iran; JPN - Japan; KHM - Cambodia; KOR - Korea, Republic of; LAO - Lao PDR; MMR - Myanmar; MNG - Mongolia; NPL - Nepal; NZL - New Zealand; PAK - Pakistan; PHL - Philippines; SGP - Singapore; THA - Thailand; VNM - Viet Nam.

Sources: Adapted from ILO World Social Protection Database; WHO Global Health Observatory.

Access to RMNCH services

An important component of the SDG 3.8.1 index is RMNCH services. Coverage of RMNCH services is a high priority and a high-return investment in terms of health gains, but effective coverage varies substantially across and within countries and components of service coverage. While it is relatively high and stable in high-income countries of the region, performance varies across the remainder, with some achieving relatively high effective coverage for most RMNCH indicators (Mongolia, Sri Lanka, Thailand, Tonga), while others perform poorly on all indicators (Afghanistan, Bangladesh, Lao PDR, Myanmar, Papua New Guinea and Timor-Leste). Most countries display uneven performance, with high effective coverage of some components and lower coverage of others, such as the Philippines, with high antenatal and postnatal care coverage, but lower rates of skilled birth attendance. This suggests that attention to specific components can achieve high levels of effective coverage, but can also lead to uneven service delivery for RMNCH care. While this is true, some countries have made impressive progress to improve maternal and child health, such as Pakistan (see Box 10).

► **Figure 15. Unequal advances in service coverage for RMNCH services, selected countries in Asia and the Pacific, 2012 or latest year available**



Note: Only countries with complete data on all four RMNCH indicators, from 2012 or more recently, are included.

Source: Adapted from WHO Global Health Observatory.

► **Box 10. Progress in maternal and child health in Pakistan**

As illustrated by the below table, substantial progress was made when it comes to maternal and child health. This progress was greater for the poorest quintile, suggesting investments were made with a redistribution effect. The analysis shows that, for the listed health indicators, the poorest Q1 population saw greater improvements from 2013–2018 than the wealthiest Q5 population, lending some support to the equalizing effect of Pakistan's policies.

Comparison of evolution of national health indicators by wealth quintile

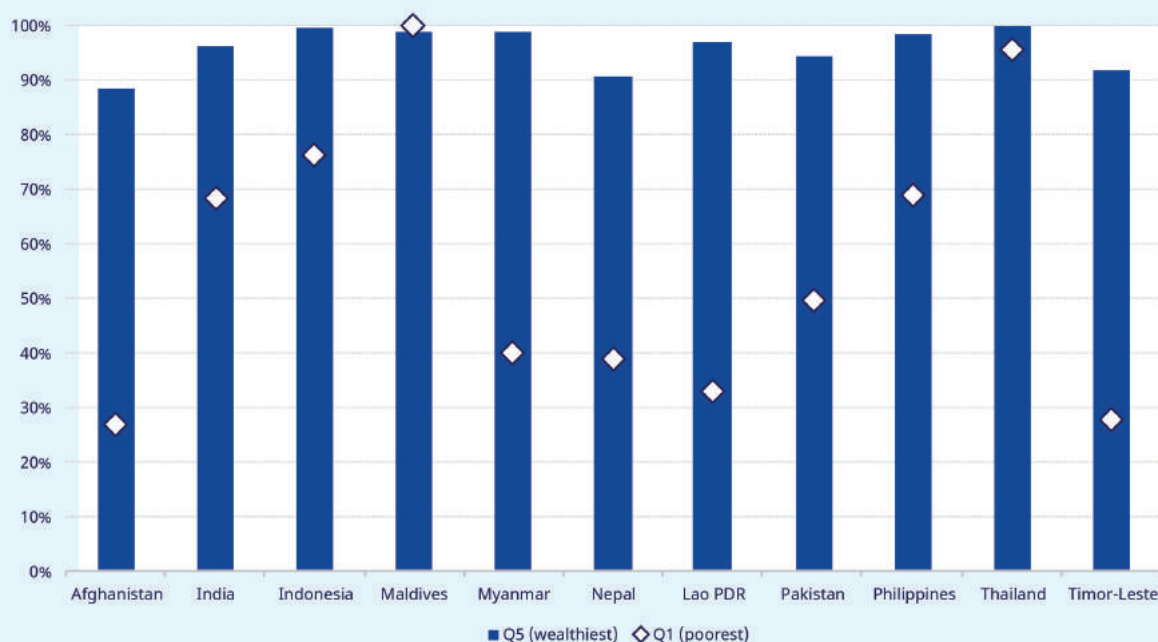
Indicator	Q1			Q5			DID*
	2013	2018	Change	2013	2018	Change	ΔQ1- ΔQ5
Under-5 mortality rate (per 1,000 live births)	119	100	-19	48	56	8	-27
Infant mortality rate (per 1,000 live births)	90	76	-14	44	53	9	-23
Antenatal care (any skilled personnel) (% of women with a birth)	53.6	67.7	14.1	96.9	98	1.1	13
Assistance during delivery (any skilled personnel) (% of births)	34	49.8	15.8	85.8	93.9	8.1	7.7
Problems in accessing health care (getting money for treatment) (% of women)	54.3	45.7	-8.6	9.2	11.1	1.9	-10.5

*Difference-in-differences.

Source: Adapted from World Bank Data.

National averages can reveal large socio-economic disparities in service access and utilization. Figure 16 shows that in almost all countries represented, women in the highest income quintile are more likely to have a skilled birth attendant at their delivery than women in the lowest one. The Maldives has achieved a high degree of equity, with women in the richest and poorest quintiles nearly equally having skilled health personnel assisting them at birth. However, in Afghanistan, Myanmar, Nepal, Pakistan and Timor-Leste, the socio-economic disparity is stark, while only 30–50 per cent of poor women had skilled health personnel attend their births, among the wealthiest quintile the share is about 90 per cent or higher. This is highly reflective of the limited population coverage and adequacy of legal entitlements in those countries highlighted in the above sections of this report. It is also reflective of the need to reduce financial barriers to access (see Section 2.2). Women's health outcomes remain much better in some countries where coverage of effective maternal care services is high, such as China, Malaysia, Sri Lanka, Thailand and Viet Nam. This further highlights the importance of adopting gender-sensitive SHP policies.

► **Figure 16. Inequities in access to maternal health care services: percentage of live births attended by skilled health personnel by wealth quintile, countries in Asia and the Pacific with data for 2015 or later**



Note: Only countries with available data from 2015 or more recently are included.

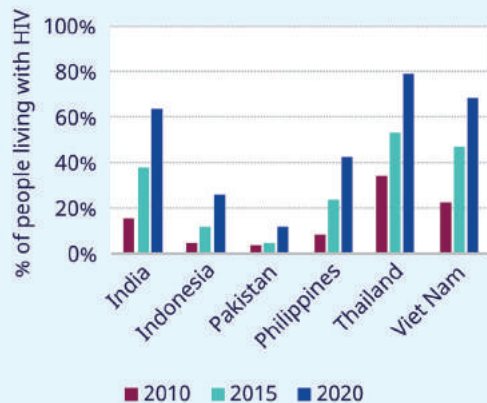
Source: Adapted from WHO Global Health Observatory.

Access to other services

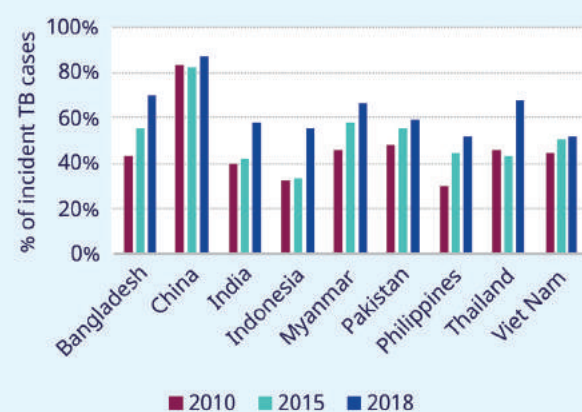
Another important component of the SDG 3.8.1 index concerns infectious diseases control. TB and HIV treatments are part of the indicators used to make up the index. In the region, all countries with a high burden of HIV or TB have made progress in expanding access to care. The expansion in access to care has been particularly pronounced for HIV services. Whereas in 2010 only a fraction of people living with HIV received antiretroviral therapy in high-burden countries, by 2020 the rate is more than 40 per cent in the majority of them (Figure 17). While expanding the SHP package to cover HIV and TB, Viet Nam has been focusing on how to ensure VSS registration of people with these diseases. The scheme expects the health promotion and disease prevention activities to continue to be covered by direct government budget allocations to preventive medicine facilities. While some countries have been successful in embedding HIV and TB prevention, diagnostic and treatment into their SHP schemes, the availability of services in practice can remain a challenge, as for example in Indonesia, as illustrated in Figure 17.

► **Figure 17. HIV and TB treatment in high-burden countries and territories in Asia and the Pacific, latest available year**

(a) Evolution of people living with HIV currently receiving antiretroviral therapy



(b) Evolution of incident TB cases detected and successfully treated



Note: Only countries with an incidence of at least 100,000 for the respective disease are shown.

Sources: Author calculations based on WHO (2020a); WHO Global Health Observatory; UNAIDS (2021).

While the SDG 3.8.1 index also encompasses indicators on NCDs, more effort is needed to achieve a systematic collection of such data (Lozano et al. 2020). It is especially pertinent in Asia and the Pacific where the burden of disease is largely affected by demographic and economic trends that reinforce the rise of NCDs (GBD 2019 Diseases and Injuries Collaborators 2020; GBD 2019 Risk Factors Collaborators 2020).

Availability of health care services

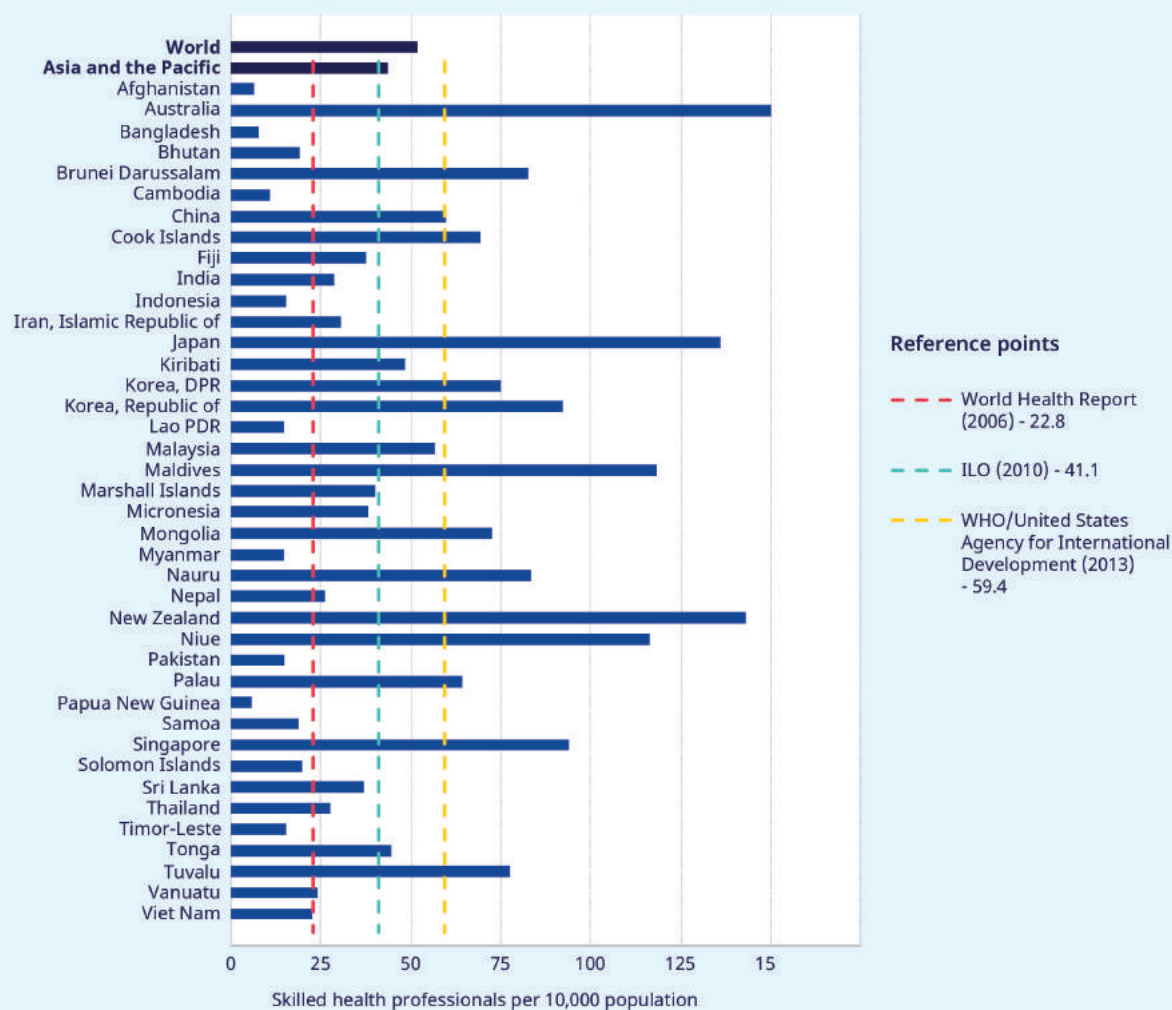
Effective access to services is partially determined by the availability of a skilled workforce in sufficient quantity with the necessary physical infrastructure, equipment and supplies.

Health workforce

Access to quality health services critically depends on features of the health workforce, including the number of workers, skills mix, competency, distribution and productivity.

Figure 18 shows the density of health workers in Asia and the Pacific countries. The number of doctors per 1,000 population tends to be relatively high in the higher-income countries in East Asia, Australia, New Zealand, and Singapore. The density of doctors is very low in many Pacific Island countries and in the South-East and South Asian countries. There are exceptions, with the density of doctors being relatively high (more than 10 per 10,000 people) in some middle-income countries including Brunei Darussalam, China, Cook Islands, Malaysia, the Maldives, Mongolia, Nauru and Palau. Many lower and middle-income countries with a low density of doctors compensate by having a high ratio of nurses to doctors, particularly in Pacific Island countries. In contrast, China, DPR Korea, Mongolia, several South-East and many South Asian countries have less than two nurses for every doctor. Overall, there is evidence of a shortfall in health personnel, as illustrated in Figure 18, as 14 countries in the region still have a density below the threshold proposed by the World Health Report 2006 and 22 below the one featured in the ILO World Social Security Report in 2010, which was just passed by the regional average.

► **Figure 18. Availability of medical doctors and nurses, countries and territories in Asia and the Pacific, latest year available**



Note: More details on the use of these reference points can be found at <https://www.who.int/workforcealliance/knowledge/resources/GHWA-a-universal-truth-report.pdf>.

Source: Adapted from WHO Global Health Observatory.

Investments are also needed to ensure that health workers are adequately protected and supported to perform their duties and that all categories of workers in the health sector have adequate working conditions in line with ILO Nursing Personnel Convention, 1977 (No. 149) and other international labour standards, such as ILO Recommendation No. 69. It is all the more important that the health sector is also rich in employment. In this respect, opportunities still need to be seized. Overall, it is estimated there will be a global shortfall of 18 million health workers by 2030, which will primarily affect low- and lower middle-income countries (High-Level Commission on Health Employment and Economic Growth 2017). Further, a shortfall of 5.7 million nurses (WHO 2020b Buchan, Shaffer, and Catton 2018), and 1.1 million sexual, reproductive, maternal, newborn and adolescent specialist health workers, with the largest shortage in midwives—900,000 by 2030 (UNFPA 2021)—were projected before the COVID-19 pandemic. Recent reports suggest that the pandemic is likely to further exacerbate the health and care workforce shortage as many health and care workers are leaving or intending to leave the profession due to exhaustion, heavy workloads and insufficient resourcing (International Council of Nurses 2021).

Health and care workers are the backbone of every health system. Therefore, strong and sustainable investments in the health and care workforce and in decent working conditions are essential. Investing in the sector can also benefit gender equality as most health staff – especially in midwifery, nursing and personal care cadres – are women and youth. For instance, in Sri Lanka 68 per cent of personal care workers are female, while this proportion is 71 per cent in Thailand as estimated by the ILO-OECD-WHO Working for Health Programme. Securing good working conditions is equally important for the safety of patients and partially conditions the quality of care delivered (WHO 2020c)

In Fiji, health workforce shortages have occurred due to out-migration, with the government in response increasing salaries to retain qualified health workers. In Japan, unfavourable employment conditions are blamed for discouraging certified care workers from pursuing long-term careers. Uneven geographic distribution of health care providers and health sector workers remains a problem in many countries.

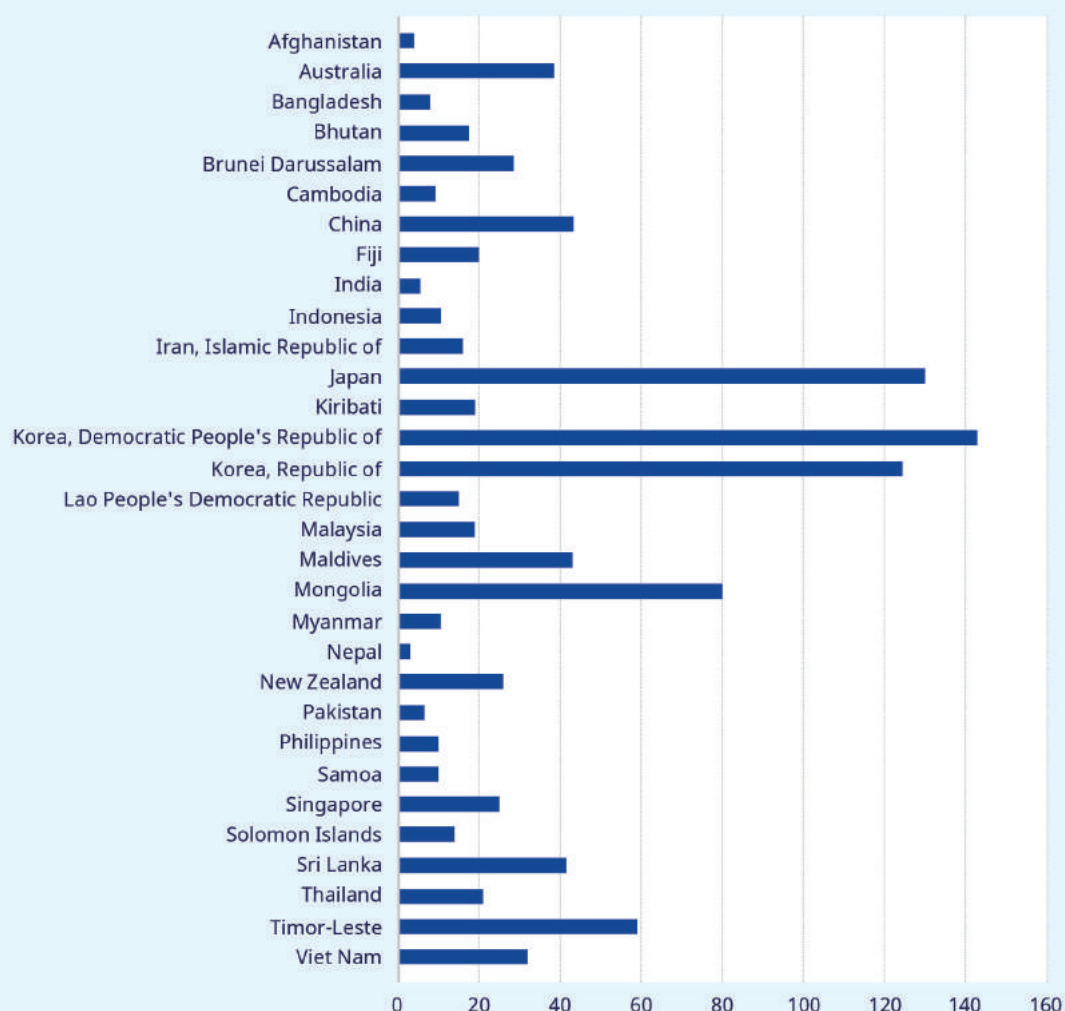
Urban PHC clinics in Mongolia face difficulties in meeting demands from the rising number of patients due to rural-to-urban migration over the last decade. In rural regions, primary care clinics face problems due to a weaker supply of qualified medical personnel, attributed to insufficient PHC financing. In Thailand, requirements for health professionals to start careers in the public health sector have contributed to avoiding shortages. Some countries, such as Bangladesh and Pakistan, have expanded the cadre of health workers to extend coverage of RMNCH services in public and non-profit health sectors. While such measures have had successful health outcomes, the employment status and working conditions of these community health workers as well as of personal care workers more broadly tend to remain precarious, jeopardizing retention and quality of service.

Infrastructure

The expansion and maintenance of infrastructure is the foundation of a robust health system able to provide services near to the population, in rural and urban areas. In addition to human resources, availability of infrastructure is a core determinant of access.

Together with health centres, hospitals play an important role in service provision. Hospitals generally account for the largest share of health care expenditure in the overall health systems. Capacity of the hospital sector is assessed by the number of hospital beds per 10,000 population (Figure 19). While the appropriate number of hospital beds depends on criteria such as demographics, average length of stay, admission rates and bed occupancy rates, regional comparisons shed light on the status of available infrastructure. Bed density in East Asia tends to be high compared to other regions, reaching more than one bed per 100 population in Japan, Republic of Korea and Korea DPR. In contrast, the stock of beds is less than one per 1,000 population in Afghanistan, Bangladesh, Cambodia, India, Nepal, Pakistan and the Philippines. These large disparities indicate substantial differences in the resources invested in hospital care across countries.

► Figure 19. Hospital bed density (per 10,000 population), selected countries



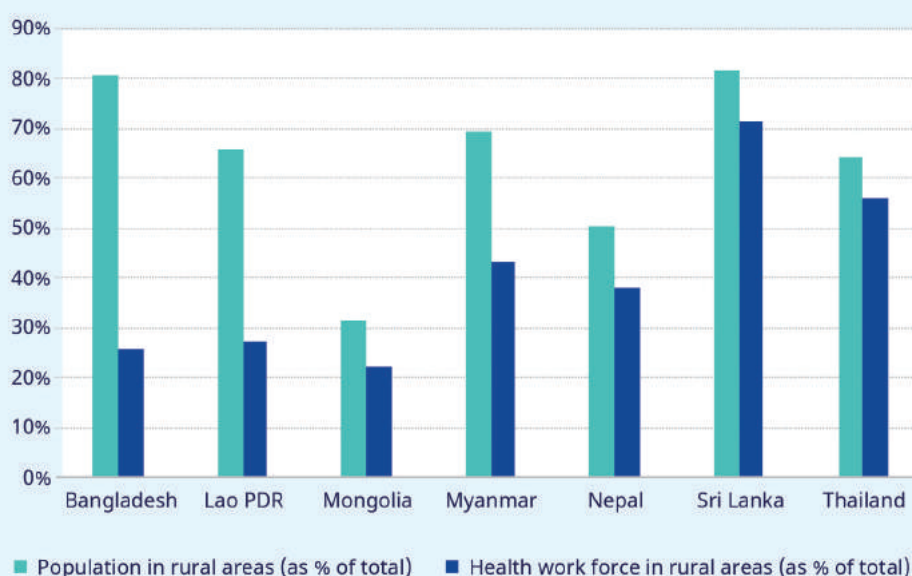
Sources: Adapted from WHO Global Health Observatory; OECD and WHO (2020).

Investments in physical facilities have been made in several countries. China invested heavily in building and renovating primary care facilities and procuring equipment, expanding training and continuing medical education. In the Philippines, the Health Facility Enhancement Programme involved targeted government investments in strengthening buildings and equipment in disadvantaged areas where insufficient PhilHealth accredited facilities were available. In some countries, the solution implemented to overcome inadequate public health infrastructure has been to mobilize private investment. In Indonesia and Singapore, the private health sector grew rapidly. In Viet Nam, the expansion of equipment and high-class wards in public facilities has been mainly implemented through use of private capital investments, with a profit motive. These kinds of investments do not always serve equity objectives. Investments are often made in urban areas only. Additionally, private facilities tend to charge higher fees to pay profits to investors, and are not able to provide the same value for money as public facilities.

Unequal geographical distribution of human resources and infrastructure

Despite significant health sector investments in past decades, important geographical gaps in coverage remain between urban and rural areas or between more remote and less remote regions (Figure 20). Gaps in certain regions may consist of a complete lack of facilities, or underfunded facilities with a significant shortage of skilled health workers, drugs and devices.

► **Figure 20. Inequalities in availability of health workers in urban and rural areas, selected countries in Asia and the Pacific, latest year available**



Sources: Adapted from ILO Labour Force Surveys; ILO-OECD-WHO Working for Health Programme.

In Fiji, six out of 15 provinces have a shortfall in health workers compared to national norms due to international migration or to urban areas. Indonesia and the Philippines lack available health infrastructure and health workers in rural and less developed areas, resulting in patients incurring high transport costs to access services.

In Lao PDR, the poor and ethnic minorities living in rural and remote areas face considerable geographic barriers to access care, while some facilities lack basic medicines and equipment. In Myanmar, all public facilities face insufficient service readiness caused by a lack of inputs and shortage of medical staff due to decades of insufficient funding, a situation worse in rural and remote regions where services and medical supplies are limited or simply unavailable. Nepal is another country with large urban-rural imbalances in service coverage, with only 34 per cent of Nepalese households having access to medical facilities within 30 minutes of their house. Timor-Leste, although with a wide network of publicly-provided health services, faces regional and urban/rural inequalities in allocation of medical professionals, medical facilities and equipment. People are burdened with high transportation costs to seek better quality care in urban areas.

Fragmented pooling mechanisms can also lead to geographic inequalities in coverage. Japan faces uneven geographical distribution of PHC resources due to its fragmented pooling mechanism, with gaps mainly in smaller municipalities with modest funding bases. Pakistan's highly decentralized health

system also results in uneven budget allocations to public health facilities in urban and rural areas and across provinces, resulting in shortages of drugs and trained staff.

Service quality

The availability and distribution of infrastructure, human resources, drugs and medical supplies impact on the quality of health care services.

Good quality is one criteria that must be met by health care services as part of SHP guarantees. It is understood by ILO standards in line with the definition provided in the framework of the human right to health: “Health facilities, goods and services must be scientifically- and medically-appropriate, and in good working condition.” Therefore, health care services should be effective, safe and responsible to meet people’s needs. This means that health care providers should deliver evidence-based health care services to those who need them, avoid harm to people for whom the care is intended and respond to individual preferences, needs and values (WHO 2018). SHP is enhanced if patients trust the clinical effectiveness of services and if they are satisfied with how they are treated by health workers.

Quality of care is essential to ensure that health services are able to protect or restore health. Attention must be paid to proper investments in quality of services, including adequate infrastructure and equipment in the dedicated network of providers, and especially in public facilities. Indeed, deficiencies in provision can push people to use other providers and forgo financial protection. Therefore, ensuring quality of services provided through SHP is important to avoid patients seeking care outside the designated network and facing adverse financial effects on their household.

While this holds true, there is no consensus on ways to monitor and measure quality in a systematic and comparable fashion, across all the dimensions of quality (Kruk et al. 2018). In practice, accreditation is the most commonly used external mechanism for standards-based quality improvements in health care (see Chapter 3). In the Asia and the Pacific region, many countries have set up accreditation systems (Australia, Indonesia, Japan, Malaysia, Mongolia, New Zealand, the Philippines, Republic of Korea, Singapore, and Thailand) (WHO 2003). Additionally, strategic purchasing is used to improve service quality and overall health systems performance (see Chapter 3).

Securing access to essential health care services to maintain and restore health as well as progressively expand the range of services is a key objective of SHP systems. An equally important goal is to ensure such access does not cause financial hardship and that populations are protected against the impoverishing impact of health care costs. The following section explores the ways in which countries in Asia and the Pacific have made progress in securing such protection in law and in practice.

► 2.2. Securing financial protection

Adequate financial protection is achieved when access to health services does not adversely affect living standards and expose people to financial hardship. In this respect, ILO standards provide guidance on minimum levels of financial protection against both the costs of health care services and the loss of income due to sickness or seeking care. This section first examines the status of legal coverage and policies affecting financial protection in the Asia and the Pacific region, before looking at catastrophic spending and impoverishment due to out-of-pocket health spending.



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2.2.1. Legal coverage and policies affecting financial protection

ILO standards provide guidance on both:

- The level of cost coverage, stipulating that maternity care should be free and that co-payment should be limited and, if they exist, the rules concerning such cost sharing shall be so designed to avoid hardship and not prejudice the effectiveness of medical and social protection.
- The level of income support for people who cannot work as a result of sickness, quarantine, care-seeking or caring for a dependent.

Legal coverage should be assessed against these benchmarks, but it is important to note that information on the level of financial protection awarded by the law and related public policies is not systematically collected in Asia and the Pacific in a comparable manner across countries (and for all countries). Due to this lack of data, the analysis only covers financial protection for health care benefits and not income support.

Policies for cost coverage and co-payments

Policies relating to co-payment and various cost-sharing modalities conditioning access to services, lead to out-of-pocket spending and can undermine financial protection if they are set too high. Co-payments or user fees are often imposed to reduce patient moral hazards ¹⁶, but are often imposed in structural adjustment policies to contain social and health spending.

Co-payment may be initially designed to create a disincentive to abusive use of health care services so to keep the overall health spending within available resources. However, they may have adverse effects on access to services and financial protection, particularly for those with lower incomes. ILO standards

¹⁶ To avoid increased health consumption when users are not the ones covering the costs of the service.

stipulate they should not be used as a mechanism to fund the health sector. Co-payment and user fees can take several forms (see Box 11).

► **Box 11. Direct payment, formal cost-sharing and informal payments**

Out-of-pocket expenditure can take the form of direct payments, formal cost-sharing or informal payments.

- **Direct payment** refers to the full price of services, not covered by any form of protection
- **Formal cost-sharing** includes user fees and co-payment:
 - **User fees or charges** can be constituted of any possible combination of fees from registration, consultation, drugs and medical supplies, treatment, hospitalization, delivery fees, laboratory tests or other health services provided in public or publicly subsidized sectors (Qin et al. 2019) – usually not reflecting the full cost of services.
 - **Co-payments** are a fixed payment defined in an insurance policy and paid by the insured person each time a medical service is accessed. Co-payments can form part of the total payment for a health good or service or they can comprise 100 per cent of the cost (Dogget 2014). It can take the form of a percentage of the cost, deductibles, ceilings, maximum number of days, sessions or cases
- **Informal payment** refers to all payments in cash or in-kind made voluntarily or not by the user, to health care providers, outside of official payment mechanisms.

Co-payments may be a nominal fixed amount, such as in Bangladesh, Fiji and Malaysia's outpatient services in public facilities where user fees are regulated. Some SHI schemes also impose fixed co-payments, like Lao PDR's NHI and Thailand's MHIS scheme, which have fixed co-payments for outpatient care depending on facility levels and co-payments for high-cost surgery and treatment. Alternatively, some countries impose co-insurance as a percentage of the charges for services: China, Japan 30 per cent, Republic of Korea 20 per cent for inpatients and 30–60 per cent for outpatients depending on facility levels, Mongolia has co-payments of 10–15 per cent depending on facility levels, Singapore's Medishield Life scheme imposes co-payments of 3–10 per cent depending on the intervention, while the CHAS scheme has a co-payment of 15 per cent before patients are allowed to use Medisave to make co-payments.

Deductibles and ceilings are implemented by several countries. They are typical features of private insurance designed at limiting the liability of the insurer, not in line with ILO principles. In some countries, a deductible is imposed, where the patient would pay out-of-pocket up to a certain amount before availing themselves of health benefits (China, Republic of Korea and Singapore).

Similar to commercial health insurance funds, ceilings or caps are sometimes imposed. Once patients reach the cap, they are obliged to pay any additional amounts out-of-pocket, for example India's PM-JAY has a ceiling on inpatient care. Mongolia has a benefit ceiling of 2 million Mongolian Tugrug (MNT) per year (equivalent to U\$710). Nepal's HIB and SSF schemes impose ceilings on benefits. The HIB ceiling is MNT100,000, but this can be increased by family members transferring benefits to each other. Pakistan's Sehat Sahulat imposes annual limits on financial coverage, with the ceilings varying across provinces. This allows people the option of requesting assistance from the Bait-ul-Mal programme to pay up to a certain amount above the benefit ceiling.

Policies vary widely across the region, with countries' rules and practices classified as follows:

- No or very low official cost-sharing mechanisms by design (Brunei Darussalam, Indonesia and Timor-Leste). For example, Brunei Darussalam only imposes a small registration fee.
- Cost sharing for a limited number of items (Lao PDR's NSSF imposes co-payment with caps on coverage for a short list of high cost procedures, Fiji has a fixed rate co-payment for items listed in the law, Mongolia's PHC requires patients pay for pharmaceuticals, Sri Lanka does not cover contraceptive commodities, Thailand has ceilings on dental, maternity care and hemodialysis).
- Cost sharing as a standard practice at all levels of care, implemented as co-payments, such as Japan's different SHP schemes, Lao PDR (NHI for workers in the informal economy), the Philippines, Republic of Korea and Viet Nam.
- Co-payments only if the patient uses a specific set of facilities (Myanmar's SSB scheme when using non-SSB facilities) or by-pass the referral system.
- Cost-sharing arrangements can vary depending on population groups. In some countries, the level of user fees or co-payments for non-citizens is higher than among citizens either within the same scheme (Malaysia) or through different schemes (Singapore, Thailand).

Importantly, a number of countries are applying co-payment exemptions or complementary coverage for the poorest to remove financial barriers to access (Viet Nam has a 20 per cent co-payment for most people, but no co-payment for the poor and a 5 per cent co-payment for some other vulnerable groups. Lao PDR exempts members of poor households, pregnant women, children under-five and monks from co-payments. China has a complementary scheme (MFA) to pay co-payments for low-income people. In the Republic of Korea, the lowest income group is entirely exempted from co-payments, while the second poorest has a 50 per cent reduction in co-payments.

Cost-sharing for maternity care

ILO standards stipulate that maternity care should not be subject to co-payments. This is rooted in three important findings from international practice (Frota et al. 2020):

- Timely maternity care accessed at early stages and without delay is an efficient and highly impactful investment in terms of health outcomes. Prenatal visits and surveillance have yielded significant results in reducing complications and associated costs. By meeting women's health needs without delay, health systems can avoid having to provide at least some of the more intensive (and more expensive) care at a later stage. Postpartum care ensures prompt recovery and early identification and management of problems and contributes to health promotion, including infant immunization and advice on breastfeeding. Those, in return, facilitate the full recovery of women's capacity to work, alongside maternity benefits during maternity leave.
- The benefit to cost relation of the investment in maternal health protection is high for the health system and beyond. The probability of using the services is generally limited to a small number of events during a woman's lifetime, for a limited period, which limits the cost of maternal health packages per individual compared to compensation offered in the case of other social risks (sickness, injury or old age, for example). Furthermore, maternal and child health interventions are shown to be particularly cost-effective (Memirie et al. 2019).
- Ensuring the highest level of financial protection is crucial to improve effective access to maternity care for all. In this respect, the ILO minimum standards recommend that maternal care be at no charge for women. It is important to keep in mind that women may face greater challenges than men when having to make payments upfront to health facilities. They may not have the same weight in decision-making regarding resource allocation in the household, which adds to a lesser financial capacity.

While ILO standards give high priority to financial protection for maternity care, countries in Asia and the Pacific have made different levels of commitment when it comes to providing entitlements in this respect. Maternity care, in particular delivery, remains costly in many places (see Box 12).

► Box 12. Different strategies to secure free maternity care

Some countries exempt maternal or child health care services from co-payments, such as Lao PDR, Malaysia, Republic of Korea and Viet Nam. In Malaysia, the majority of maternal health services are exempted from user fees that apply to use of other services provided by the public health care system. Success in RMNCH health outcomes for Malaysia are attributed in part to this policy. A similar strategy has been adopted in Brunei Darussalam with comparable success.

Similarly in the Philippines, the Safe Motherhood initiative has been successful at ensuring availability of services and ensuring PhilHealth coverage for RMNCH services. Under this programme, all women about to give birth are automatically enrolled in PhilHealth through point-of-care enrolment at the health facility. Some are eligible for government subsidies for their contributions (indigents), but others are expected to pay contributions equal to those of informal economy workers (if not already covered). The value of benefits exceeds the contribution amount, which facilitates enrolment and compliance with contribution payments.¹⁷

Some countries have put in place co-payment exemptions for specific groups. Often policies to exempt or further reduce co-payment amounts for RMNCH care are embedded within broader exemption policies. Japan has a lower co-payment rate of 20 per cent for school children, the elderly aged 70–74 years, and 10 per cent for lower-income older people in AEHI. The Republic of Korea has a medical aid programme with a graduated co-payment schedule, the Healthy Life Maintenance Aid Programme provides a cash benefit that can be used for co-payments and Co-payment Exemption Programme for vulnerable beneficiaries defined in policy, such as patients with rare and incurable diseases, homeless patients without family, disaster victims, adopted children aged below 18. Lao PDR's NHI scheme exempts village heads, pregnant women, children under-five and monks from co-payments, while Malaysia has co-payment (user fee) exemptions for maternity care and outpatient treatment for infants and inpatient care for persons suffering from certain infectious diseases, the registered poor, people with disabilities and the elderly. In Viet Nam, children benefit from free coverage until the age of seven.

Some countries have put in place additional cash support programmes. Maternal Health Voucher Schemes in Bangladesh and Myanmar have been designed to ensure lower-income mothers and children receive the most essential RMNCH services, but the policy is not nationwide. This has led to improvements in RMNCH indicators and reductions in OOP health spending. However, it has led to a substantial increase in C-section delivery in Bangladesh. In Singapore, efforts were made to include complicated deliveries within the benefit package of MediShield Life in 2019, though it remains subject to co-payments (Central Provident Fund Board of Singapore 2018). With a view to ensure a greater ability of families to cover health and other costs related to childbirth, the CPF put in place a cash payment for newborns. The impact of this situation is compounded with the limitations of maternity leave provided as an employer's liability.

Co-payments link to the gate-keeping function of primary care

Some countries impose higher co-payments when a person bypasses the primary care level to seek care directly at a higher level. This is designed to encourage people to seek primary care first, reducing use of expensive specialist services when they are not needed. This is in line with evidence that primary care is a more effective first contact than specialist services (Starfield 1994).

¹⁷ PhilHealth Circular 025-2015 on Social Health Insurance Coverage and Benefits for Women about to Give Birth (Revision 2).

In China, India's CGHS scheme, Singapore and Thailand, referrals are required for people to get financial protection when using secondary and tertiary care. In India's ESIS, a strict gate-keeping and referral system is in place for patient use of private facilities, as a measure to ensure cost control.

Despite these measures, bypassing of PHC services remains common. The perceived poor quality of primary care facilities leads many patients to self-refer for primary care to higher levels, even though they must pay the full cost out-of-pocket for higher-level outpatient care without a referral. This makes referral systems more of a barrier to financial protection than a facilitator of service coverage. In Myanmar, people covered by the SSB are expected to access secondary and tertiary care services through a referral system from SSB clinics. But, even with referrals, reimbursement is cumbersome giving little advantage to those following formal referral requirements. Japan does not have a strict referral system, but patients who choose to access large hospitals without a referral from a primary care specialist may be required to pay an additional fee. Currently, this is an inadequate incentive and the over utilization of specialist services is attributed to the lack of an effective gate-keeping system.

These examples reveal that more needs to be done to reinforce the PHC function in the region to foster quality and a rational use of health services. This is all the more crucial that it is at that level that coordination is best made with social care and other social protection programmes (WHO 2008).

Other design features impacting financial protection

Qualifying periods may be imposed, limiting financial protection for a defined period of time. While ILO standards recognize that such periods may exist if deemed necessary to preclude abuse, this has often little justification in contexts where mandatory coverage for all prevents adverse selection. Thailand's MHIS for migrants requires a three-month waiting period before members can access benefits. In Viet Nam's VSS scheme, certain member types have a waiting period of 30 days. In the Philippines, priority for RMNCH coverage is evident in the removal of the qualifying period for mothers about to give birth, who can enroll immediately at point of service and use their coverage to ensure safe motherhood.

In some countries, policies explicitly allow providers to charge a higher co-payment for wards and beds with more amenities. An additional practice impacting financial protection is balance billing (see Chapter 3), where facilities can charge patients the difference between bill totals and payments they receive from SHP schemes.

Lastly, the level of financial protection granted by SHP is only valid within the designated network of service providers. As mentioned previously, when this network is not sized to the needs of the population and when the services provided do not meet the criteria of availability, acceptability, adaptability and good quality, people tend to seek care outside of the designated network of service providers and are not financially protected (see Section 2.1.3). These design considerations all affect the level of financial protection people can enjoy in practice, as explored in the following section.

2.2.2. Effective protection against health care costs

Effective and comprehensive monitoring of financial protection allowing for direct comparisons between legal entitlements and effective financial protection in a comparable manner within and across countries is not available. Rather, most countries produce and analyze data on out-of-pocket payments on health based on national surveys conducted periodically.

On this basis, it is possible to know, at the level of a country: i) the proportion of OOP expenditures within the overall expenses on health of the country, and ii) how many households are pushed into poverty because of such payments. The latter has been included within the SDG framework under target indicator 3.8.2. It is worth noting that these indicators are not perfect measures of financial protection, but rather of the lack thereof (see Box 13).

► Box 13. Limitations in monitoring effective financial protection and way forward

Monitoring of financial protection requires detailed data: this includes the magnitude of OOP expenditures, but also who is spending and on which services. Data should allow direct comparisons between legal and effective coverage. In practice, few SHP systems monitor such data and analyse it to this level of detail.

Acknowledging the enormous efforts in data collection and analysis made by countries over the past decades, it is worth noting those indicators are not perfect monitoring tools on financial protection, but rather on lack thereof.

Furthermore, while indicators of catastrophic health spending reflect gaps in financial protection, they do not provide information on the types of services accessed (essential or elective) and the status of people who access them (covered or not). The same limitation applies to the monitoring of OOP expenditures. Therefore, it is important to contextualize the analysis to get to the root cause(s) of such high incidences. More systematic country research is needed, for instance, analyzing high OOP expenditures and poor health outcomes/services by wealth quintiles, geographies, gender and SHP status, and identifying the role of induced demand from the poorly regulated private sector.

Source: Authors.

Causes of low effective financial protection

Data and experiences from the Asia and the Pacific region show how high levels of OOP can still occur, even when population and service coverage are high. Factors include:

- Gaps in population coverage (see Chapter 1).
- Gaps in service provision (see Chapter 2, Section 2.1): This can be caused by unequal geographical distribution of service coverage, effective or perceived low quality of care, inadequate number of designated service providers. Limited availability or acceptability of the designated service providers included in the SHP system causes people to seek care without financial protection or to incur transportation costs. In Cambodia, the perception of inferior service quality in the public sector impacts financial protection, even among the population protected by HEF. With more than 75 per cent of rural patients using the private sector as their first provider choice, the policy prohibiting the HEF to reimburse private facilities adversely affects financial protection.
- Limited benefits package: ILO standards recommend to regularly revise and progressively expand the range of health interventions covered. When this is not done, at some point the benefit package stops being adequate and people are not financially protected for a large share of services they use. For example, in Mongolia pharmaceutical costs contribute substantially to high OOP payments as pharmaceuticals are not covered as part of the PHC benefit package.
- Cost-sharing: As seen in the previous section, some SHP policies include by design a share of the cost of care to be borne by households. Therefore, cost sharing should be avoided when possible and limited to avoid hardship.
- Informal payments: The provider may be unwilling to comply with regulations on co-payments, user fees and charge additional informal payments. This is a crucial point for attention of policy-makers and institutions responsible for SHP as this type of practice, in addition to hindering protection, also impacts people's trust in institutions and health services. This further diminishes their willingness to support, politically and financially, SHP and public investment in the health system more broadly. Informal payments are common in a number of countries and are used by people as a way to secure access, availability or higher quality of service. These

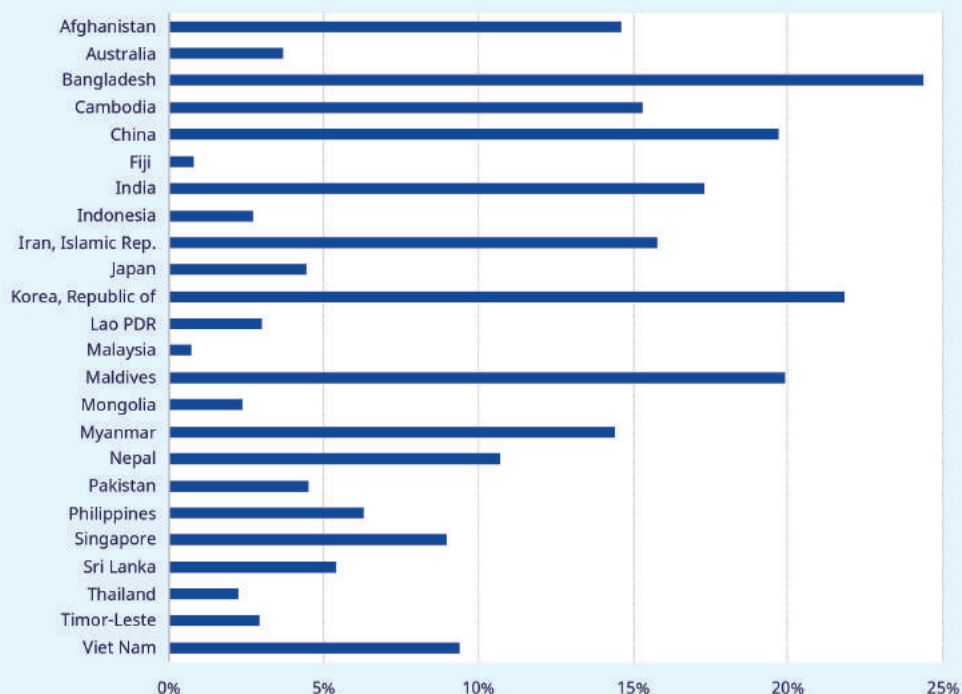
payments might be triggered by health personnel or more rarely voluntarily proposed by patients as a way of showing gratitude or thankfulness – often for deliveries or surgeries. Such practices are reported in many countries (Pourtaieb et al. 2020; Schaaf and Topp 2019). In China, SHI coverage increases the probability of patients making informal payments to doctors in an attempt to pursue cost savings (through SHI) and quality of care (informal payments) (Liu, Bao, and He 2020).

Level of catastrophic health spending in the Asia and the Pacific region

The share of population pushed below the poverty line due to health spending is an important marker of coverage gap impacts on poverty. Catastrophic spending¹⁸ can adversely affect households anywhere across income distribution levels, but it disproportionately affects low-income households.

Overall, the region is characterized by a diversity of situations when it comes to catastrophic health expenditures (Figure 21). Only Fiji and Malaysia achieved incidences of catastrophic health spending below 1.5 per cent. Countries with extremely high incidences of catastrophic spending (>20 per cent) are Bangladesh and Republic of Korea, while the two most populous countries in Asia and the world, China and India, also have very high incidences of catastrophic spending.

► **Figure 21. SDG 3.8.2 Incidences of catastrophic health spending (at more than 10 per cent of household income or consumption), selected countries and territories in Asia and the Pacific, latest available year**



Note: The most recent value available per country is reported, ranging from 2004–2018.

Source: Adapted from WHO Global Health Observatory.

¹⁸ Catastrophic spending is a commonly used indicator on the poverty risk created by health spending on households. Indicator 3.8.2: Proportion of population with large household expenditures on health as a share of total household expenditure or income is one of the indicators of SDG Target 3.8. It is assessed as the proportion of the population living in households where out-of-pocket health spending exceeds 10–25 per cent of household income or consumption.

Though this phenomenon affects all regions, global comparisons show that the share of the population pushed below a relative poverty line of 60 per cent of median income or consumption in the latest year by household health expenditures is highest in Asia and the Pacific (3.2 per cent) (WHO n.d a). This amounts to 135 million people throughout the Asia and the Pacific region.

Relationship between out-of-pocket expenditures and catastrophic health expenditures

The share of OOP expenditures in total CHE is often used to paint a picture of the recourse countries take to individual responsibility for the cost of care. However, it provides little information on the nature of those payments and who in society makes them. Low OOP expenditures can be the result of low population access and low utilization of needed health services caused by financial and geographic barriers.

Conversely, high average levels of OOP expenditures do not necessarily translate into impoverishment, when high OOP expenditures is driven by high-income households choosing expensive private services and/or elective procedures (see Box 14). Therefore, OOP expenditures analysis must be complemented by contextual analysis, including on catastrophic expenditures.

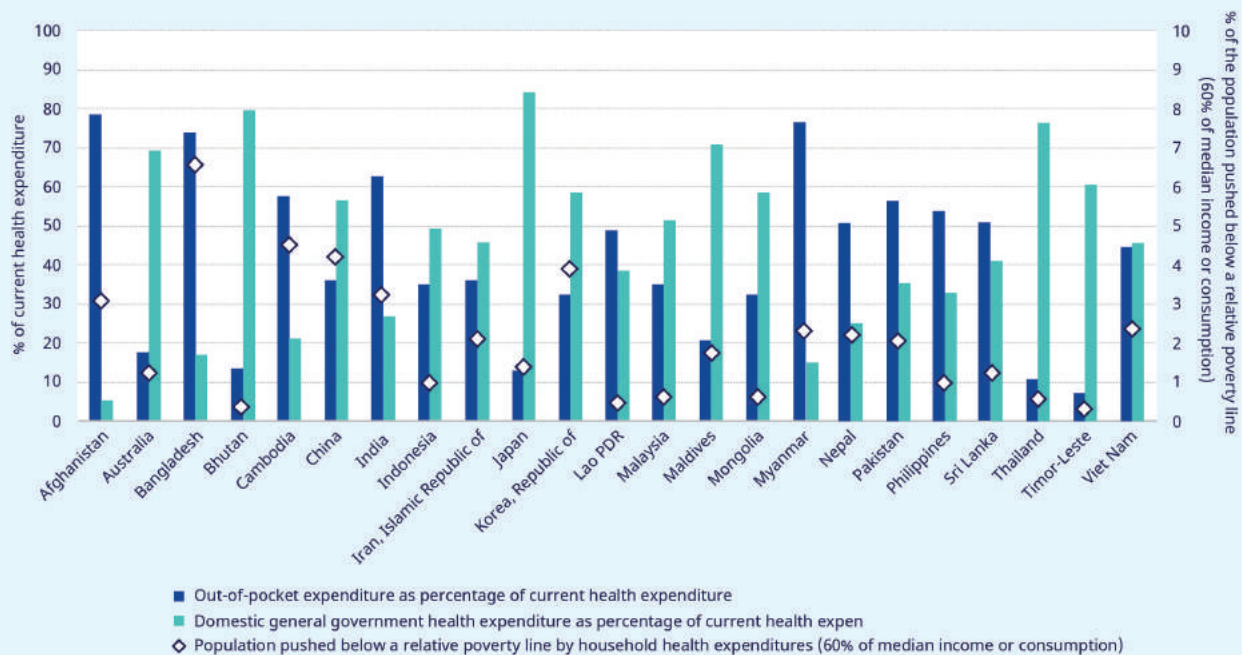
Figure 22 shows that high OOP expenditures are often, but not always, associated with high impoverishment or catastrophic health expenditures, depending where OOP expenditures is concentrated and what it is spent on.¹⁹ However, it is notable that four of the countries experiencing relatively high shares of impoverishment due to health spending (exceeding 3 per cent) are Afghanistan, Bangladesh, Cambodia and India. These countries are also reliant on OOP expenditures to fund health care.



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¹⁹ The poverty line used for this analysis is equivalent to 60 per cent of each country's median household per-capita income.

► **Figure 22. Share of general government and OOP expenditure in total health expenditure, and percentage of population pushed below a relative poverty line (60 per cent of income or consumption), selected countries and territories in Asia and the Pacific, latest available year**



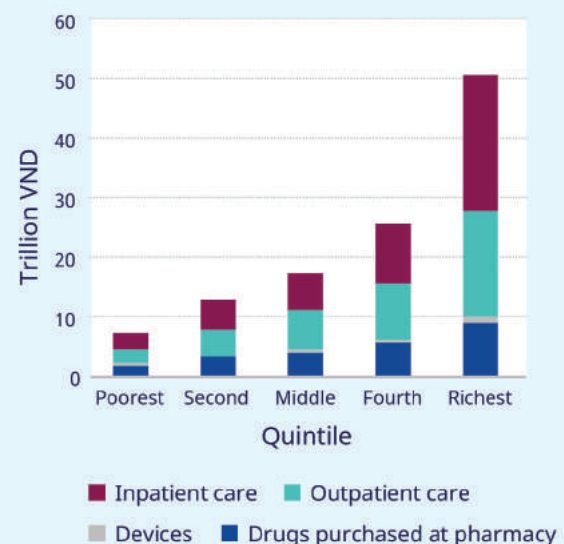
Note: Data on expenditures as share of CHE is for 2018. Data on impoverishing spending on health is from 2010 or later, the most recent value available per country is reported.

Source: Adapted from WHO Global Health Expenditure Database.

► **Box 14. Understanding Viet Nam's high out-of-pocket spending**

In Viet Nam, health spending is concentrated among the better-off. The richest 20 per cent of the population spends more than five-fold the amount spent by the poorest 20 per cent, and nearly double that of the second-richest quintile. Growth in OOP health spending has also been increasing faster among higher-income households, who spend disproportionately on inpatient care compared to other living standard quintiles. Examination of health care service utilization across quintiles indicates that the poor use fewer and lower-level public health care services compared to better-off groups who rely more heavily on costlier public hospital care and private services. Because OOP health spending is concentrated among the highest quintile group, absolute spending rarely exceeds the threshold of 10 per cent of household consumption to push these households below the poverty line.

► **Figure 23. Level of OOP spending on health by income quintiles in Viet Nam, 2016**



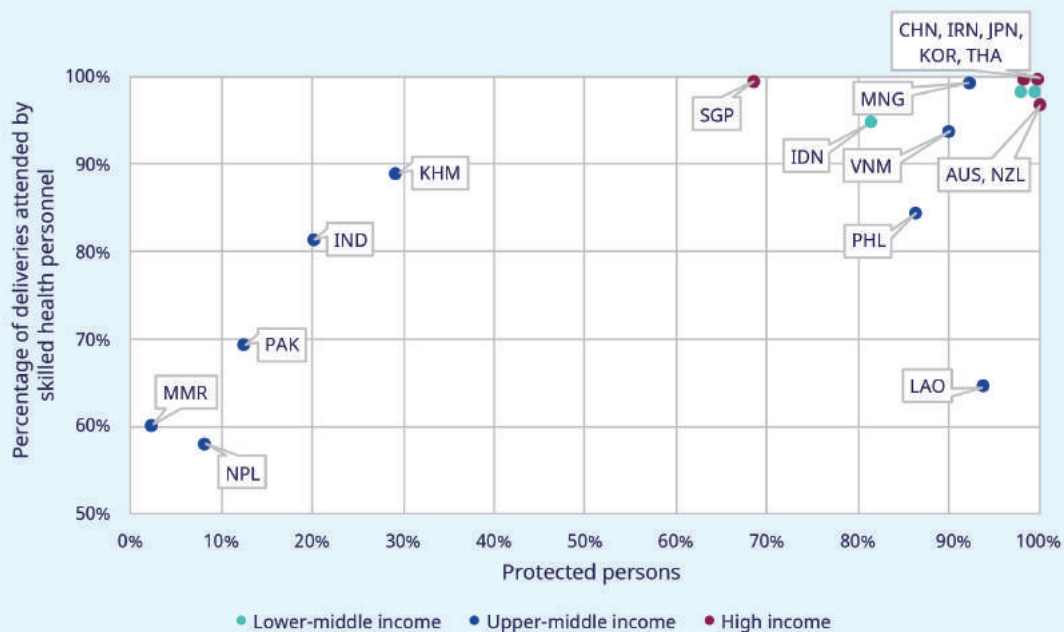
Source: Adapted from Teo et al. (2019).

Effective financial protection: the example of skilled birth attendance

High levels of skilled birth attendance have been used for international comparisons on system performance due to the usually high sensitivity to income inequalities and financial barriers to access. Globally, in high-income and upper middle-income countries, more than 90 per cent of deliveries are attended by skilled health personnel and occur in a health facility. Several lower middle-income countries in the region have achieved effective service coverage for skilled birth attendance by setting low or no cost-sharing in their respective SHP mechanism. Therefore, it is not surprising that a high correlation can be found between the share of protected persons (see Chapter 1) and deliveries attended by skilled health personnel, regardless of country income group.



► **Figure 24. Comparison between the percentage of deliveries attended by skilled health personnel and the share of the population protected by a health care scheme (protected persons), selected countries and territories in Asia and the Pacific, latest available year**



Legend: AUS - Australia; CHN - China; IDN - Indonesia; IND - India; IRN - Islamic Republic of Iran; JPN - Japan; KHM - Cambodia; KOR - Korea, Republic of; LAO - Lao PDR; MMR - Myanmar; MNG - Mongolia; NPL - Nepal; NZL - New Zealand; PAK - Pakistan; PHL - Philippines; SGP - Singapore; THA - Thailand; VNM - Viet Nam.

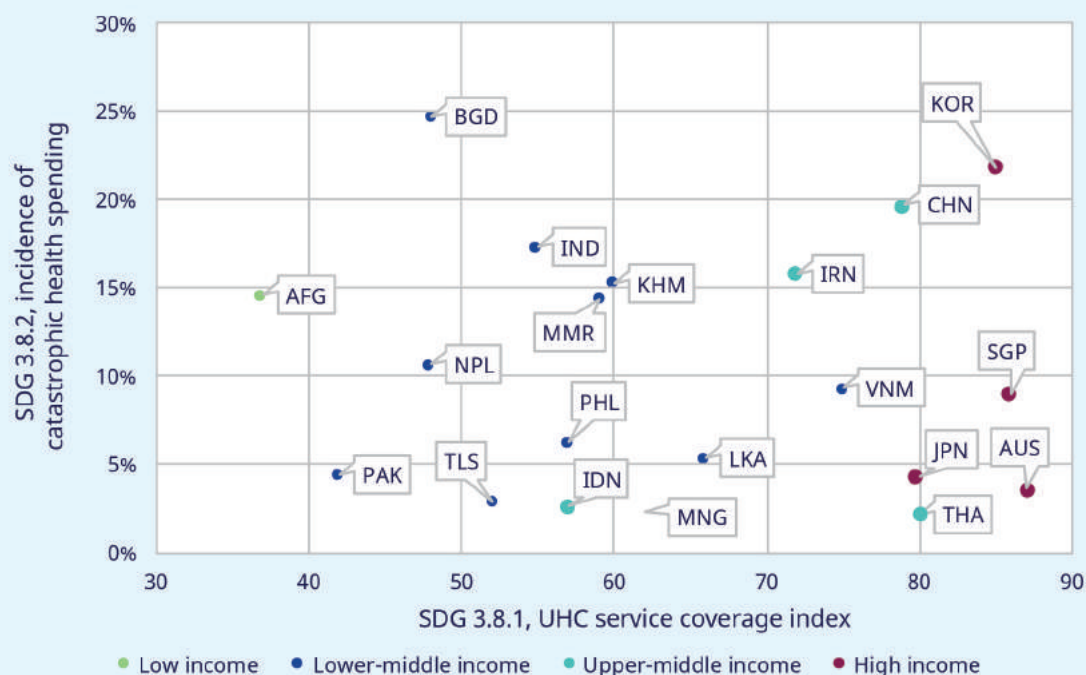
Sources: Adapted from ILO Social Security Inquiry (SSI); information from regular national surveys of target populations on awareness on rights; OECD Health Statistics 2020; national administrative data published in official reports; WHO Global Health Observatory.

Balancing service coverage and financial protection

Countries often need to combine the objectives of gradually moving towards universal population coverage, with the need to increase the scope of service coverage and financial protection. While these two objectives are complementary, their relationship is not always free of trade-offs. Figure 25 illustrates these challenges, with four groups of countries emerging:

- Countries that have reached high service access and use as well as financial protection against catastrophic expenditure, which are high-income countries with the exception of Thailand and Viet Nam.
- Countries that have reached high service access and use, but need to progress on financial protection against catastrophic expenditure, such as China, Republic of Korea and Islamic Republic of Iran.
- Countries that maintained low levels of catastrophic expenditure, but with low levels of service access and use, such as Indonesia, Mongolia, Sri Lanka, Pakistan, the Philippines and Timor-Leste (though the positions on the plot may also be linked to services being so expensive that financial barriers simply prevent access).
- Countries that expanded service access, but without financial protection against catastrophic expenditure, such as Bangladesh, Cambodia, India, Myanmar and Nepal.

► **Figure 25. Comparison between SDG 3.8.1 and SDG 3.8.2, selected countries and territories in Asia and the Pacific, latest year available**



Legend: AUS - Australia; CHN - China; IDN - Indonesia; IND - India; IRN - Islamic Republic of Iran; JPN - Japan; KHM - Cambodia; KOR - Korea, Republic of; LAO - Lao PDR; MMR - Myanmar; MNG - Mongolia; NPL - Nepal; NZL - New Zealand; PAK - Pakistan; PHL - Philippines; SGP - Singapore; THA - Thailand; VNM - Viet Nam.

Note: Data on SDG 3.8.1 index is from 2017. Data on SDG 3.8.2 ranges from 2010–2018, latest year available is shown.

Source: Adapted from WHO Global Health Observatory.

Some of the root causes of limited financial protection or effective access to health care services are not embedded in policy nor legal design. Rather, they may originate in the implementation of said design and hold the potential to be addressed through efficient institutional and financing arrangements, which will be further explored in the following chapters 3 and 4.

Chapter 3. Creating institutional arrangements that foster equity and effective access to quality services

Key messages

- Both coverage and adequacy can be increased, if strong institutions based on tripartite governance and efficient scheme design and administration are in place. The objectives of equity and effective access pursued by SHP systems need to be at the centre of institutional arrangements and administrative systems. For example, extending coverage to informal economy workers and their families requires proactive adaptation of institutional processes to their needs and specificities, alongside subsidies.
- Efforts to extend universal protection through comprehensive benefit packages, but without adequate public funding, have led to dual systems in many Asia and the Pacific countries. The rise of the private health sector creates new expectations from national populations and results in either higher OOP health spending or greater financial burdens on SHP systems. This situation sheds light on the importance of enhancing the purchasing function of, and to improve the quality of, public health facilities.
- To ensure SHP systems are equitable and play a redistribution role, broad risk-pooling is needed. The latter is supportive of strategic purchasing power and administrative efficiency. A number of countries in the region have broad risk pools, either from the design stage of their system or through progressive efforts to consolidate schemes, by putting in place single-payer agencies and reducing fragmentation.
- Purchasing health care services in pluralistic health systems requires strong stewardship and a regulatory role for the respective Ministry of Health to guarantee safety and effectiveness across public and private provision of health care services.

The pursuit of equity and effective access to quality health services is at the foundation of all SHP systems. Achieving this objective requires consideration of a number of dimensions across the health and social protection sectors. This chapter will explore the governance of SHP systems and how it relates to the overall health system, before looking at administrative arrangements that foster inclusiveness. Lastly, the purchasing function and its influence on the quality of services and cost containment will be addressed.

► 3.1. Governance, stewardship and participation

The principles of primary responsibility of the State and participatory governance are enshrined in ILO social security standards and echoed in the health sector through, among others, the Alma-Ata Declaration on Primary Health Care.

This section explores the diversity of governance structures and participatory mechanisms involving social partners adopted by SHP systems in the region. It further assesses the level of integration within the broader social protection framework of respective countries.

3.1.1. Governance structures

Social health protection often goes beyond the mandate of a single line ministry or agency. While this holds true, two elements are of crucial importance to the overall governance of the SHP system: i) the stewardship of the Ministry of Health over the health system (encompassing both public and private provision) and ii) the governance arrangement of bodies specifically in charge of pooling risk and purchasing health care.

Stewardship over the health system

The Ministry of Health plays a crucial role in overall stewardship of the health system and its six building blocks (WHO 2000).²⁰ These building blocks largely underpin the ability of a country to provide effective SHP benefits where health services meet the criteria of availability, acceptability, adaptability and good quality. The MOH performs essential functions such as licensing health care providers, setting quality standards and guidelines, monitoring health system performance, devising medical training standards, and planning across the six health system building blocks. The central role of the MOH as a regulator over the health system as a whole, as well as a provider for public service delivery, has not always been given enough prominence in the region. Strong MOH capacities and leadership are required to ensure effective regulation of the health sector, to secure safety and quality of services, to protect public health as a public good, and to guarantee that health does not become a commodity.

In many Asia and the Pacific countries, the Ministry of Health allocates budget and organizes the provision of health care services in public facilities. The day-to-day operation of public health care facilities are sometimes devolved to local levels and in such cases, the MOH plays an important oversight role.

For instance, in the Philippines, the Department of Health is a regulatory authority with responsibility for developing policies and ensuring access to health care services. It directly runs public health programmes, but most financing and service provision is the responsibility of local government units. In Viet Nam, preventive health care services are directly provided by the provincial Centres for Disease Control. In Pakistan, planning and fund allocation were devolved to provincial health departments. A new Ministry of National Health Services, Regulations and Coordination was set up to provide an oversight role. In Japan and Republic of Korea, the MOH focuses on health system governance, and is less involved in direct service provision.

Importantly, the MOH is also particularly involved in the design, implementation, and governance of health financing policies, including through its oversight role in the management board of autonomous SHP institutions when they exist.

²⁰ According to the WHO, the six building blocks of health systems are: leadership and governance, service delivery, health system financing, health workforce, medical products, vaccines and technologies and health information systems.

Governance of social health protection institutions

In many countries in the region, governments have set up autonomous SHP institutions or embedded SHP within existing social security institutions. Such institutions are characterized by their role in pooling risks, administering the scheme(s) and purchasing health services. They usually enjoy a certain level of financial and administrative autonomy and act under the oversight of one or several line ministries. They often include the participation of beneficiaries and, when applicable, contributors, in particular social partners.

In the Philippines, PhilHealth was established as an autonomous public institution and is attached to the Department of Health for policy coordination, guidance and is responsible for running the National Health Insurance Programme. PhilHealth's functions are quite comprehensive, including collecting contributions and government transfers, processing claims, defining provider payment mechanisms, accrediting providers, creating benefits packages and reimbursing health providers. In Viet Nam, the MOH makes SHI policy, including benefit package design, setting contribution rates, setting health care provider tariffs, provider payment policy design, facility quality assessment, while Viet Nam Social Security (VSS) is mainly responsible for collecting contributions, managing the funds and paying providers based on MOH policies. In Mongolia, the National Health Insurance Council is responsible for managing the SHI scheme, including regulating payment methods, collecting contributions, defining contract guidelines and cost-sharing rules and managing the Health Insurance Fund.

In many instances, autonomous SHP institutions have a board with representation from several line ministries. For example, in many countries, social health insurance or national health insurance schemes are administered or regulated by the Ministry of Labour as part of a broader social insurance portfolio covering cash benefits for old age, maternity. This is the case with Cambodia's NSSF schemes and India's ESIS, administered by a quasi-autonomous body under the Ministry of Labour. In Lao PDR, the Ministry of Labour and Social Welfare (MLSW) has historically run the NSSF schemes, but the NHI under the Ministry of Health has integrated NSSF schemes into a single NHI. Hence, the MLSW now has a more limited role in SHI. In addition, the Ministry of Finance plays a strong role in social assistance schemes and/or in National Health Service systems because of its responsibility to allocate State budget transfers. The Ministry of Finance may also play an important oversight role, such as in Sri Lanka's Employees' Trust Fund health care scheme, or in Nepal's Employee Provident Fund health care scheme.

3.1.2. Representation and participation

ILO standards provide guidance on social protection principles on good governance (see Box 15). In particular, core principles underline the need to ensure effective social dialogue and participation. SHP must not be the sole matter of technocrats and political representatives, but rather be based on governance structures that provide a voice to the intended final beneficiaries of such policies. This includes tripartite governance with government, workers and employers as well as other relevant representative organizations of persons concerned. In the case of SHP, those may encompass associations of patients, representatives of different population groups, representatives of contributors in contributory schemes. This principle of participation and active social dialogue has been present in international social security standards since initial developments at the beginning of the twentieth century and were further reaffirmed in policy declarations in various sectors, including the Alma-Ata Declaration. As outlined in the declaration, people have the right and duty to participate individually and collectively in the planning and implementation of their health care. This helps to ensure that policy decisions reflect the priorities and needs of the population.

► **Box 15. Social protection and good governance: Key principles set out in ILO Recommendation No. 202 on Social Protection Floors**

- Tripartite participation with representative organizations of employers and workers
- Efficiency and accessibility of complaint and appeal procedures
- Regular monitoring of implementation, and periodic evaluation
- Full respect for collective bargaining and freedom of association for all workers
- Transparent, accountable and sound financial management and administration
- Financial, fiscal and economic sustainability with due regard to social justice and equity
- Coherence with social, economic and employment policies
- Coherence across institutions responsible for delivery of social protection.

Social health insurance schemes in the Asia and the Pacific region are generally overseen by tripartite representation in their management boards. This includes, for instance, the NSSF governance board in Cambodia, the ESIS Board Standing Committee and Medical Benefits Council in India, Mongolia's National Health Insurance Council and the Central Provident Fund Board in Singapore. While this is an important step towards effective social dialogue, often a proactive effort is necessary to ensure governance mechanisms effectively encompass the entire spectrum of protected persons and that their representatives have the capacities to meaningfully participate to governance decisions.

The Republic of Korea and Thailand stood out for their emphasis on citizen participation in SHP decision-making. In the Republic of Korea, public participation in decision-making on social health insurance is fostered through a platform called the Citizen Council for Health Insurance. It was launched in 2010 to increase patients' inputs to priority settings and issues, such as the extension of the NHI benefit package. In Thailand, the National Health Act is considered the first Thai law to foster public participation in health policy formulation and agenda setting, providing a platform for stakeholders from all sectors to participate in development of health policies and strategies.

Other countries have broader engagement frameworks to secure participation in policy-making, which eventually influence decisions on SHP. The Mongolia Law on Development Policy and Planning introduced a multi-stakeholder process for policy-making, which has the potential to create more opportunities for Mongolian society to better influence health care provision in accordance to its needs. Viet Nam adopted a Law on Promulgation of Legislative Documents, which provides opportunities for citizens to provide feedback during law development.

3.1.3. Integration within comprehensive social protection systems

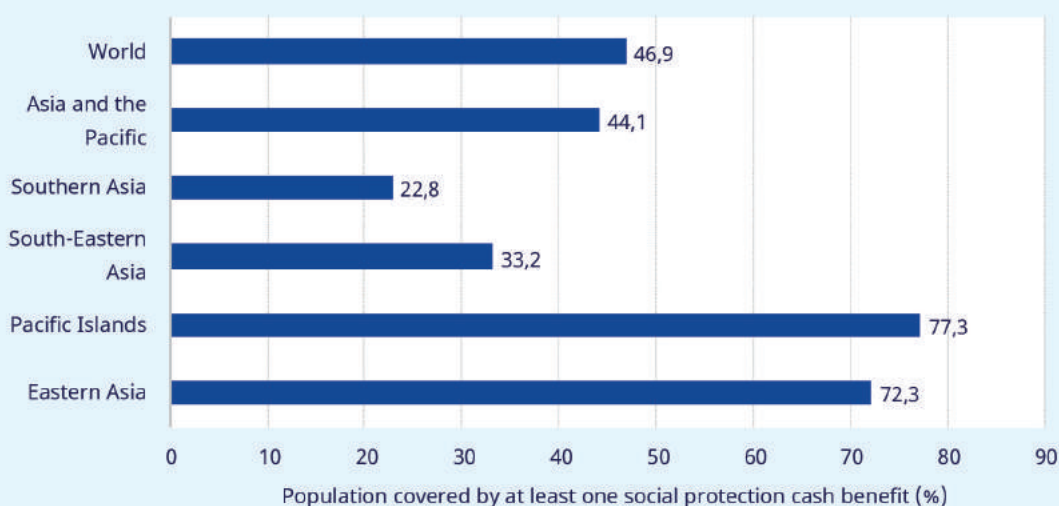
Integration of SHP schemes with the broader social protection system at institutional and policy levels bears great potential to foster essential linkages across social protection benefits, yielding important advantages.

- First, coordination of policies, administration and delivery of social protection benefits facilitate access to comprehensive protection for beneficiaries, throughout the life-cycle. The guarantee of income security through sickness, maternity, unemployment or old-age benefits is indeed fundamental to address the social determinants of health. Income security allows people to maintain their living standards throughout sickness episodes, which contribute to maintain or restore their health through adequate nutrition, decent housing and clean living environment. In turn, access to health care without hardship also contributes to maintain households' income protection levels.

- Second, such coordination facilitates the extension of coverage. In particular, the use of common identification and eligibility systems across social assistance programmes and SHP schemes eases comprehensive coverage. Several countries are coordinating their operations to cover vulnerable groups and improving efficiency through integrated processes. In Cambodia, Indonesia, Republic of Korea, Malaysia, Singapore and Viet Nam, the same mechanism is used for identification of social assistance programme beneficiaries for multiple social protection programmes, reducing duplicate workloads (see Section 3.2.2).
- Third, integration of social protection systems allows for the achievement of synergies and economies of scale in the administration of social protection. Common functions such as members' enrolment, contribution collections, customer service and support functions (human resources, finances) can be consolidated, hence gaining efficiencies in administration. Oversight bodies, such as various national social security boards, can ensure balance in different schemes and the non-fungibility of the funds. Mongolia and Viet Nam achieved administrative efficiencies with systems where a unique social security agency is implementing a range of social protection benefits, under the oversight of line ministries.

Coordination across the entire social protection system is needed to foster extensions of coverage and should be a priority in light of existing coverage gaps. Indeed, as illustrated by SDG target 1.3.1, less than half of the population in Asia and the Pacific is covered for at least one social protection cash benefit, as illustrated by Figure 26.

► **Figure 26. SDG indicator 1.3.1: Percentage of population in Asia and the Pacific covered by at least one social protection cash benefit (effective coverage), 2020 or latest available year**



Note: See Annex 2 of the World Social Protection Report 2020–2022 for methodological explanation. Global and regional aggregates are weighted by relevant population groups.

Source: Adapted from ILO World Social Protection Database, based on the SSI; ILOSTAT; national sources.

Achieving such coordination requires high-level oversight and specific inter-ministerial coordination mechanisms. In Cambodia, the National Social Protection Council, constituted by 11 ministries, plays a coordination role to expand coverage and improve existing social protection schemes. In Pakistan, a new Ministry of Social Protection and Poverty Alleviation has been set up to address fragmentation of social protection.

Despite these efforts, coordination and collaboration between health and social sectors is often impeded by inadequate policies, administrative bureaucracy, lack of formalized collaboration framework, divergent objectives and organizational cultures. From the perspective of the beneficiary, this may translate into fragmented and inadequate benefits. It also creates a duplication of efforts and related costs to deal with administrative processes such as registration, payment of contributions and a grievance and appeals mechanism, adding complexity to access benefits. The next section will explore the efforts made by countries to improve the administrative processes of their SHP systems, including in coordination with the broader social protection system.

► 3.2. Broad risk-pooling and inclusive administrative processes

While participation is a core principle of social health protection, in Asia and the Pacific it is sometimes hindered by the fragmentation of such systems, whereby different population groups are covered by different mechanisms or simply left out – by design or in practice. ILO standards are results-based and therefore non-prescriptive when it comes to the specifics of institutional arrangements each country may choose to administer SHP. While this is true, such arrangements need to be designed in a way that complies with core principles and ILO standards that promote broad risk-pooling with the objective of securing equity in access and to foster solidarity in financing across the entire population of a country.

3.2.1. Broadening risk-pooling, overcoming fragmentation

Broad risk-pooling provides a means for redistribution of resources from the wealthier and healthier to the poorer and sicker and across generations, based on the values of solidarity and social justice. Equity is strengthened if people are required to contribute based on their ability to pay and can benefit based on medical needs. Similarly, broad risk-pooling is best achieved when coverage is mandatory and people do not have the possibility to opt-out. Indeed, opt-out options reduce risk sharing and usually foster milk-skimming behaviours in the private health insurance market (see Chapter 4). In addition, risk-pooling is supportive of greater administrative efficiency and strategic purchasing power, which lead to economies of scale and better management of scarce financial resources. This section will explore the diversity of trajectories taken by countries in the region as well as some of the underlying constraints to achieving broad risk-pooling.

A diversity of trajectories in risk-pooling

Countries in Asia and the Pacific have followed different trajectories. Many countries have moved or are implementing policy changes to achieve greater consolidation of risk pools. Countries such as China, Indonesia, Mongolia, the Philippines and Viet Nam have progressively consolidated risk pools, often but not always associated with a single purchaser function to manage the relationship with health service providers. This has been highly successful in the Republic of Korea and is starting in China with the merging of schemes under URRBMI. Indonesia, Lao PDR and Viet Nam have succeeded in consolidating multiple SHI programmes into a single pool and single-payer schemes. Japan's residence-based schemes are also being consolidated at prefecture, rather than municipality level to ensure a larger risk pool and reduce administrative costs.



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Other countries still have fragmented risk pools. In some contexts, such risk pools are well coordinated and secure the coverage of the entire population, such as in Thailand. However, sometimes they are associated with key coverage gaps, such as in Cambodia or India. Some countries have made progress towards consolidation, but retain a separate risk pool for the armed forces (Lao PDR, Viet Nam), or civil servants with the intention of ensuring higher benefit levels for often under-paid civil servants without cross-subsidizing other groups. Use of medical savings is an extreme example of fragmentation of risk-pooling to individual households, diminishing the potential for redistribution and inequality reduction of the overall system. In Singapore, the Medisave scheme consists of individual medical savings accounts, which constitute individual pools for each person or household.

Historically, fragmentation has often been driven by government financial constraints. Typically, this would result in support initially only being provided to households living below a certain income threshold, or starting with groups viewed as able to self-finance, typically companies of 10–50 workers or more in the formal private sector or civil servants. Expansion of the risk pool, especially on a non-contributory basis, is often the theatre of passionate policy debates for which political leadership is essential. Resistance on what is deemed politically acceptable by the overall population often explains the existence and persistence over time of fragmented risk pools. For example, the fact that temporary migrant workers are still technically outside of the SHP systems in Brunei Darussalam, Malaysia and Singapore, where they are covered through separate private pools, is the consequence of divergence of interests across different groups rather than a technical issue.

Similarly, resistance to merge funds established for the poor is often driven by equity concerns related to negative cross-subsidization, whereby public funds dedicated to the poor would benefit the non-poor due to lower utilizations of care by the poor. Similarly, there is often political resistance to merging social health insurance schemes due to fears of losing benefit adequacy by the different groups of contributors.

Fragmentation and decentralization

Fragmentation has been driven in some contexts by the legitimate need to strike a balance between central and local responsibilities. Decentralization plays a role in the fragmentation of risk pools in some countries. For example, in Bangladesh urban and rural area public service provision is financed via two different channels and managed by various ministries, which creates de facto different risk pools. In India, while some risk-pooling mechanisms exist at the federal level, they are fragmented and further add to the fact that several Indian States have taken leadership in creating respective risk-pooling mechanisms. In countries where internal mobility is on the rise, pools that are geographically fragmented can become a barrier to effective financial protection unless portability of benefits is guaranteed nationwide. Solutions exist to overcome fragmentation in decentralized systems, such as equalization payments between localities. Adequate balance often needs to be found between functions that are best centralized (such as pooling of risk) and ones best decentralized to provide some flexibility in resource allocation adapted to local health needs.

Fragmentation of risk pools and coverage gaps

In countries where fragmentation is coupled with a lack of commitment to cover the entire population with large groups not legally covered, the creation of targeted schemes with separate risk pools for the poor holds several caveats.

Despite the significant cost of poverty-targeting exercises and increasing levels of sophistication, the accurate identification of those living in poverty or other forms of deprivation remains elusive. This is particularly the case in contexts where poverty is widespread and dynamic. The resulting exclusion errors deprive poor households of support. In Cambodia, for instance, a large share of people issued with health equity cards are not actually below the poverty line, while many poor people are not given entitlements to coverage. In India, use of a retrospective database to identify poor households to participate in PM-JAY leads to targeting errors as the database may not fully reflect recent changes in household economic conditions. This makes it likely that households who may have fallen down the economic gradient and are eligible for PM-JAY, end up being excluded.

As highlighted in Chapter 1, such risk pools exclusively for the poor tend to create stigma and be subject to poorer quality services if provider payment methods are not aligned with other schemes. They can also be subject to discontinuity when changes in government priorities occur and not garner support from the rest of the population, resulting in low public demand for increased benefits.

Forward looking strategies

Despite difficulties in eliminating fragmentation in some systems, adverse consequences can be mitigated through effective coordination and alignment of entitlements. Thailand has yet to succeed in merging its four SHP schemes (CSMBS, MHIS, SSO and UCS). Nevertheless, efforts have been made to harmonize and coordinate between the schemes in terms of benefits packages, information systems and payment methods. This ensures that universal coverage without duplication is possible, even with fragmented pools. There has been some progress through integrating emergency medical services to ensure patients covered under any of the 3 statutory schemes for citizens are able to access any public or private hospital free of charge in case of emergency. Additionally, health promotion and disease prevention services are uniformly handled by the UCS for the whole population. Japan has achieved virtual uniformity in service coverage through the national fee schedule set by the Ministry of Health, Labour and Welfare (MHLW) that applies to all SHI plans and for public assistance to the poor, through strict enforcement of prohibitions on extra billing and balance billing of services (see Section 3.3).

While the breadth of pooling has an impact on coverage expansion and equity, it is not the only factor. As underlined in Chapter 1, many countries have made impressive progress in coverage, especially with regards to legal coverage and effective protection. However, pockets of uncovered populations remain, with administrative hurdles often a key factor. Making SHP inclusive in practice often involves adapting administrative processes and improving client orientation. In addition, as underlined in ILO

Recommendation No. 202, high-quality public services that enhance the delivery of SHP should be a core principle that fosters efficiency in use of collective resources.

3.2.2. Towards administrative processes that foster inclusiveness

The absence of broad risk-pooling translates into high levels of fragmentation in some SHP systems in Asia and the Pacific. This situation inhibits access for protected populations and efficiency in operations. Different schemes across population groups or scopes of services lead to duplication of organizational structures to perform the same tasks, such as for registration, collection of revenues, grievance mechanisms, payments to providers, payments of benefits and overall administrative support functions (human resources and accounting, for example). In Cambodia, fragmentation of functions between NSSF and HEF schemes exist as claims processing is done separately and with different case-based classification and payment rates, even though they are paying the same facilities. Nepal runs various overlapping schemes, while Sri Lanka has numerous different supplementary contributory schemes managed by various entities. Uncoordinated administrative systems can also cause confusion among the population regarding which scheme to join and the respective rights and responsibilities. This section explores innovations in administration that foster inclusiveness of SHP across its main processes.

Awareness, identification, affiliation and registration

Leaving no one behind means that everyone is accounted for in the SHP system. Nevertheless, in many countries, administrative barriers still hinder enrolment. Some lapses in coverage result from registration difficulties (migrants in Thailand), insufficiently facilitated re-enrolment (Indonesia) or operational gaps leading to temporary interruptions in coverage (time gap to re-enroll poor households at the end of each civil year in Viet Nam). An important part of effective administrative processes, therefore, is to ensure that universality of coverage is translated in practice by the proper identification and awareness of all covered. In this respect, countries in Asia and the Pacific have adopted several types of measures to foster awareness, facilitate identification and affiliation when applicable.

Nepal has put in place special measures to facilitate enrolment. Its HIB scheme has enrolment assistants who work as volunteers, with female community health volunteers prioritized to be enrolment assistants. Enrolment assistants communicate with the population to enhance enrolment in the subsidized scheme run by HIB. Other countries have run awareness-raising campaigns to increase people's awareness of their rights and relative administrative procedures. Pakistan runs awareness-raising campaigns to communicate people's rights under Sehat Sahulat, while Lao PDR's NHIB ensures minorities can access information on conditions of access and entitlements by providing radio messages translated into local languages. In Viet Nam, VSS relies on a network of agents, such as the Post Office and Trade Unions, and a customer care centre to disseminate information on benefits and enrolment. Initially, when Thailand started its UCS scheme it also used community workers to raise awareness, an approach it still takes with the migrant scheme.

Moreover, automatic enrolment through integration of health information and civil registration systems shows great potential to support population coverage. Electronic registration through use of unique ID numbers or centralized databases has facilitated enrolment of members in various countries (see Box 16).

► Box 16. Using national identification in social health protection

Several countries in Asia and the Pacific have made use of national identification systems to expand SHP registration. While the potential gains and simplicity of use for protected persons are impressive, it is important that such systems take into consideration the confidentiality of such information and potential gaps in identification (ISSA 2016).

Thailand has been recognized for its use of new technologies for the rapid expansion of health protection to all Thai citizens. The use of unique identification numbers and Thai civil registration databases have enabled and facilitated the rapid enrolment of beneficiaries and improved the beneficiary registries of all its schemes, helping to ensure people do not fall through the cracks in terms of SHP coverage.

However, migrants still find it challenging to register and access benefits in the SSS and MHIS programmes due to heavy administrative burdens and legal intricacies of the national verification process and ambiguities with respect to where they can access compulsory health check-ups required for registration. Similarly, in Brunei Darussalam and Malaysia presenting a national ID card or a permanent resident's card allows subsidized user fees or no user fees to apply. In Pakistan, several enrolment procedures were piloted by Sehat Sahulat, including electronic registration using ID card numbers for authentication and eligibility checks prior to issuance of membership cards at district card distribution centres.

Countries have used synergies with the broader social protection system to expand affiliation in SHP schemes. Synergies with social assistance are leveraged in several countries. Cambodia's ID Poor system issues equity cards to households determined to be poor, which are then used to help access HEF benefits and other social benefits. Automatic enrolment is facilitated through integration of census data. Pakistan relies on results of the Benazir Income Support Programme (BISP) census to issue Sehat Insaf cards, and beneficiary enrolment centres were made available in all districts. In India, enrolment in PM-JAY is automatic based on results of the Socio-Economic Caste Census, but can also be done directly at facilities after eligibility is checked.

Nepal (HIB scheme) and Viet Nam (SHI) automatically affiliate the low-income population registered in government social assistance or poverty alleviation programmes. In the Philippines, the National Household Targeting Survey for Poverty Reduction is used to target the poor and near-poor for PhilHealth contribution subsidies. In Malaysia, the BSH register is utilized as an eligibility requirement in the PeKa B40 and the MySalam programmes. In Singapore, entitlements to CHAS is automatic through a single public assistance card used by a broad range of social assistance schemes to identify beneficiaries.

Contributions and revenue collection

When SHP schemes are partially or fully contributory, collection is an important administrative function. It can easily be automated for formal sector workers when contributions are collected by the employer via the payroll. With this set-up, collecting contributions across the full spectrum of contributory social protection programmes generates efficiency gains. In Viet Nam, the payment of contributions is coordinated across benefits and, additionally, contributions to health care benefits are harvested automatically from members from sickness, maternity or unemployment benefits.

When contribution collection processes are too complex or the contribution level is inadequate, compliance remains an issue. This can create disincentives for companies to transition from the informal to the formal economy, in the absence of subsidies (see Box 7 in Chapter 1). In response, a concerted effort between social security, labour and tax authorities is needed, as illustrated in Box 17.

► **Box 17. Leveraging technologies to facilitate formalization, tax and social contribution compliance**

In the region, a number of countries are leveraging technology in governance and service delivery to improve tax compliance, registration of businesses and enrolment with social security institutions.

- Formalization of economic units is facilitated by streamlined business registration processes and online registration services. This is the case in Australia with a single online portal, marketed through social media to increase visibility and China's Electronic Business Licence System to enable digital registry of enterprises.
- Technologies also serve labour inspections and are expected to lead to increased transparency, facilitated monitoring, follow-ups and improvements in data collection and processing to boost compliance. Examples include the Gender Sensitive Labour Inspection System portal and database in Pakistan.
- Mongolia's Social Insurance Mobile App facilitates access to social insurance and monitoring of contribution payments, while Viet Nam VSS recently launched its unique VSS-ID. In Indonesia, BPJS Employment is collaborating with Go-Jek, a ride app, to facilitate the enrolment of Go-Jek partner riders through technology-based platforms.
- The Republic of Korea and the Philippines have introduced online systems for tax operations since 2001, and a majority of countries in the region have developed online portals to facilitate the declaration and payment of taxes. Other initiatives aim to ease access to information related to taxation and facilitate online declarations, to encourage registration and compliance. For instance, a number of applications were developed to facilitate taxpayers' tax declarations, such as GDT Live Chat Mobile App and Tax Calendar in Cambodia.

Source: Adapted from Bhattarai (2018).

Collecting contributions from workers who are self-employed, employed in MSEs or in sectors not subject to mandatory registration with the SHP system requires adapting the levels, periodicity and payment procedures. Indeed, these actors may have some contributory capacity, but are often not regular or predictable. Additionally, automated procedures are more challenging to embed due to the large number of units and diversity.

Nevertheless, many social protection systems attempt to introduce adapted procedures, in coordination with tax authorities (see Box 14) or independently. In Viet Nam, contributions from people classified in the "households category" – mostly workers in the informal economy – are set at a flat rate calculated as a percentage of the base salary. The contribution rate then decreases for each additional dependent. Contributors in this category can choose to pay contributions quarterly, semi-annually or annually.

Rolling out network agents close the community is often necessary to bring SHP processes closer to grassroots recipients. In Indonesia, the Kader JKN partnership programme aims to facilitate access to the JKN scheme for workers and other individuals neither in the formal sector nor identified as eligible for full contribution subsidy. Kader JKN agents mainly perform outreach and communication, enrolment of new members, collection of contributions, scheme transfers and handling of complaints. When it comes to collection of contributions, Kader JKN agents facilitate online payment of contributions through online banking payment points. To build trust, they reside in the target communities. Within one year's implementation, the programme had 2,000 agents who managed two million members. Contribution collection rates among target groups increased by around 14 per cent.

PhilHealth launched an iGroup programme for enrolment and contribution collections for businesses, associations and groups of workers not otherwise automatically registered. Workers can enter into collective insurance agreements with PhilHealth through a registered organized group. Organized groups (with at least 30 members) – such as micro-finance institutions, cooperatives, associations, banks and NGOs – assume registration, collection and communication activities with members. To incentivize participation in the programme, iGroup partners receive incentives such as contribution discounts depending on the size of the group.

New technologies are promising to support the adaptation of payment schedules and reduce the cost of contribution collections. Indonesia's JKN aims to harness new technologies and further develop Mobile JKN, a mobile application that allows members to register, pay monthly contributions, submit complaints and access information on their own. It also plans to introduce an auto-payment mechanism using e-wallet accounts to facilitate members' payments without bank accounts. In the Philippines, PhilHealth has facilitated online payment of contributions through the introduction of Moneygment, an independent mobile application that serves as a contribution payment tool for self-employed individuals, small- to medium-sized enterprises, overseas foreign workers and those without bank accounts.

Claim management and third-party payment mechanisms

Third-party payer arrangements, in which the purchasing agency pays the providers directly on behalf of patients rather than requiring patients pay and get reimbursed, are essential to remove financial barriers to health services. In case such mechanisms are not in place, patients may need to borrow money or sell assets to meet health costs, or decide to forgo care altogether. The absence of third-party payments does not only constitute a financial barrier, but can also create administrative obstacles to access as it implies making a claim, and inefficiencies in administering individual claims. This requires the patient is fully cognizant of the claim process, can print or photocopy required documents or is digital-literate, which may not be the case for more vulnerable people, minorities, people with low education or older persons. It is important to note that third-party payment mechanisms do not apply to cost-sharing arrangements, whereby co-payments or user fees apply. In some countries, there are mechanisms to cover such costs if they are too high for the patient (see Chapter 2, Section 2.2), such as in China's Catastrophic Medical Insurance, Republic of Korea's NHI or Singapore's MediFund.

Third-party payer arrangements are the rule in many countries in the region. Claim management is at the heart of the relationship between health facilities and the payer agency, in which information systems to manage claims have become central. Nepal recently introduced the open source software openIMIS at HIB, which is used on provider and purchaser sides to manage claims, feedback and reporting. All parties involved in administering the scheme access the software. In Thailand, the adoption of a single national information and communications technology infrastructure has supported and enhanced claim submissions and management, facilitating effective capitation and diagnosis-related group (DRG) payments. Since 2017 in Viet Nam, a comprehensive electronic claims review system has been operational, facilitating reforms in provider payments and with potential to contribute substantially to improvements in quality and efficiency of health services.

To increase interoperability of information systems used by health facilities, payer agencies and social protection programmes, several countries have turned to comprehensive digital solutions. To overcome the lack of digital connectivity between complementary schemes, Cambodia's National Social Protection Council (NSPC) recently established an Information, Communication and Technology Working Group to adopt a digital strategy and advance planning and implementation of a demonstration project linking the NSSF Health Social Protection Information System with the Patient Management Registration System.

Delegation of administrative functions to third parties

Some countries delegate part of the administration of their SHP schemes to third-party administrators. Implementation modalities vary. In India, the PM-JAY scheme resorts to third-party administrators in each State that take charge of enrolment and claim management. Similarly in Pakistan, the Sehat Sahulat scheme delegates claims checking to a third-party administrator. While delegating administrative tasks to an external party can seem like a solution that saves resources and avoids building heavy internal

administrative capacities, it is important to note that the oversight required for such delegation to work efficiently and in line with the public service mission of the scheme remains a challenge. A good illustration that out-sourcing is not necessarily the best administrative option was recently highlighted in Singapore, where ElderShield was administered by three private insurers appointed by the MOH (Singapore Ministry of Health 2020). However, in 2019, the MOH successfully reached an agreement with ElderShield insurers for the government to take over the administration of the ElderShield scheme from 2021 onwards with a view to improve equity.

Grievance, complaints and satisfaction mechanisms

Handling complaints and ensuring operational grievance mechanisms play an important role in making access to SHP a reality and holding institutions accountable. Systems must be in place to ensure that people “have a right of appeal in case of refusal of the benefit or complaint as to its quality or quantity”.²¹ Moreover, measuring and managing satisfaction allows institutions to identify the drivers of satisfaction or dissatisfaction, which can then be used strategically to enhance the quality and effectiveness of services and trust among the population. This requires adoption of a people-centred approach.

National SHP system investment in grievance and satisfaction mechanisms also contribute to enhance trust and confidence in the health and social security system among the population. As such, it increases timely use of benefits to allow for achievement of optimal social outcomes. Traditional approaches to gathering feedback include complaint boxes or hotlines. However, these are passive tools and limited in their scope and reach. They may not represent the voices of more vulnerable groups and tend to be focused on answering queries rather than assessing satisfaction with various dimensions of health care and social security services. New technologies show potential to facilitate submission of members’ complaints on health and social security services. Countries have developed applications to facilitate such processes, usually serving a broader purpose. For instance, Indonesia’s above-mentioned Mobile JKN allows members to submit complaints, among other features.

Information technology has also been used to strengthen quality of care and service provision. In some countries, the same institution regulates, purchase and provides health care services. This results in little competition among providers to promote greater quality of care, and without a strong complaints and feedback mechanism, public accountability and responsiveness to people’s needs can be limited. Brunei Darussalam developed MOHCares, a mobile application that allows the general public to provide feedback on services and issues concerning the MOH, thus strengthening the MOH’s capacity to accept, monitor and respond to feedback from patients. Fiji has also developed a feedback mechanism on the MHMS website to encourage the public to register any complaints. Singapore’s mobile application “Health Buddy App” enables patients to address queries, in addition to providing information on the nearest general practitioner or clinic, manage appointments, view queue updates, place medicine orders and pay medical bills. Such initiatives aim to improve the quality of health services perceived by the protected population. The next section will further explore how purchasing policies can also play a role in this respect.

► 3.3. Shaping quality of service through efficient purchasing policies

A key function of SHP institutions is to purchase health services on behalf of the population it protects. Purchasing refers to the allocation of pooled funds to providers that deliver health care goods and services to the protected population, as per the defined benefit package. Broad risk-pooling is the basis for creating a strong purchasing function as it gives weight to the purchaser.

²¹ Social Security (Minimum Standards) Convention, 1952 (No. 102), article 70.

However, the extent and nature of the health care provider network, the ways providers are remunerated and further allocate resources internally are equally important. This activity must be done strategically with a view to secure both access to quality services and efficient use of financial resources. A key task of the purchasing agency is to determine how to buy services, including the design of provider payments, setting levels of payments, terms of contracts and establishing mechanisms to monitor and enforce compliance (Mathauer et al. 2019). Payments made to providers must be linked to their performance and the health needs of the covered population to achieve greater efficiency, equitable resource distribution and control over expenditure growth. This section explores the institutional arrangements for purchasing in the region, the ways in which countries select and monitor their networks of providers as well as how they remunerate them for the services they offer to protected populations.

3.3.1. Purchaser-provider split

In some countries, the purchasing function is autonomous from the provision function, while in others it is not. The purchaser-provider split entails that the purchasing and providing functions are separated and often managed by different entities. In such contexts, the relationship between the purchasing agent and service provider is regulated through contracts. The purchaser-provider split aims to avoid conflicts of interest that exist when one entity both purchases and provides services. While this holds true, splitting the two functions necessarily adds some level of administrative burden for both purchaser and provider(s). In some contexts, the provider-purchaser split was necessary to include private providers in the network, which together with contractual incentives, was expected to improve service delivery, cost containment, efficiency, quality and responsiveness to patients' needs.

In most countries where the Ministry of Health is responsible for the direct provision of health services and its full financing with very limited or no user fees, it is usually the same institution that assumes both purchasing and providing functions, such as Brunei Darussalam, Fiji, Malaysia and Sri Lanka. A similar situation occurs when social health insurance institutions manage their own facilities, as seen in India and Myanmar. In such cases, it is still possible to somehow "autonomize" internally each function to foster performance. Although not automatic, the purchaser-provider split is more frequent in social health insurance systems and social assistance schemes where an autonomous purchasing agency is established. In countries with pluralistic health systems with a strong imbalance towards private provision, the government must often include private providers within SHP and de facto implements a system with a purchaser-provider split.

Many countries in the region have separated the purchasing and provisions functions or are moving towards fully implementing such a split. Some countries have already made or nearly made complete purchaser-provider splits, such as China, Indonesia, Japan, the Philippines, Republic of Korea and Thailand. In these countries, the purchasing agency is independent from the agency operating health facilities, and contracts with public and/or private providers. In Japan, there is a strict split between purchaser and provider functions. The service items and prices are uniformly set by the MHLW for all SHI plans and all providers and purchaser-provider relationships are regulated by contracts. In Mongolia, the purchaser-provider split exists for specialist and inpatient care, where public and private providers are contracted and paid to provide services. Singapore also has designed its system to have a purchaser-provider split in its various SHP schemes (MediShield, Medisave, ElderShield, MediFund), in addition to direct public hospital subsidies. In Thailand, the National Health Security Act in 2002 introduced the implementation of a purchaser-provider split by establishing the National Health Security Office (NHSO) as a purchasing agency to contract health care providers to provide health services for its beneficiaries, moving away from the previous budget allocation from the central Ministry of Public Health (MOPH) to health care providers. The CSMBS and SSS schemes also purchase services from competing facilities and do not directly own and operate facilities.

A few countries have made an incomplete purchaser-provider split. For example, in Viet Nam, the purchaser-provider split for curative care services is well established since responsibility for operating the SHI was transferred from the MOH to Viet Nam Social Security Agency in 2002. VSS was set up as an autonomous purchasing agency to contract with public and private providers to purchase services on behalf of patients. However, for preventive medicine and public health services, the government

still directly funds and provides services through public facilities, although government contracting of private services is also possible. The MOH still directly operates about 40 of its own hospitals and directly controls the benefit package design, rate setting and provider payment policy.

Although numerous countries have not implemented the purchaser-provider split, they have made efforts to ensure a more autonomous purchasing function (see Box 18). In Cambodia, the HEF is run directly by the MOH, however the claims review is implemented by the Payment Certification Agency (PCA), which was established to review and verify payment and audit claims received from all public facilities for the HEF. The PCA is also responsible for monitoring and assessing the quality of health services used by HEF beneficiaries. In Myanmar, the SSB has introduced reforms to implement a virtual internal purchaser-provider split to progressively move towards a full split (see Box 19).

► Box 18. Purchasing function in the Republic of Korea

In the Republic of Korea, the Ministry of Health and Welfare (MOHW) has delegated administration of NHI to two entities, the NHIS and Health Insurance Review and Assessment Service (HIRA). Although both are accountable to the MOH, they operate autonomously. The NHIS is responsible for managing beneficiaries, collecting contributions and paying health care providers. HIRA is responsible for health care evaluations, claims reviews, handling issues related to purchasing such as benefits coverage and payment system design. This institutional arrangement overcomes the conflict of interest of the SHI system being run by the MOH.

HIRA is already harnessing the power of big data to better perform purchasing. With an extensive data warehouse, it manages digital information from claims reviews, allowing to inform policies towards greater cost control. Such policies include health technology assessment, pharmaceutical price negotiation, fraud detection and improvements in effectiveness of health interventions (HIRA n.d.).

In countries with several SHP mechanisms covering different population groups or levels of care, a split of purchasing and provision functions may be implemented in some schemes, but not in others. This situation weakens the purchasing function overall.

A key example is India, where the CGHS scheme is run by a dedicated department under the Ministry of Health and Family Welfare (MOHFW), the PM-JAY scheme is managed by the National Health Authority – a separate MOHFW office with full functional autonomy, while the ESIS scheme is run by an entity under the Ministry of Labour and the Railway scheme is overseen by the Ministry of Railways. In Sri Lanka, the State pays for and provides health services to a majority of the population without a purchaser-provider split. However, the various supplementary insurance programmes, like ETF and Agrahara, are all designed with a purchaser-provider split and do not own or operate their own facilities. Instead, they only cover a small share of the population and health financing.

► Box 19. Myanmar SSB's progressive move towards a provider-purchaser split

In Myanmar, there is no purchaser-provider split for the two main SHP schemes. The Ministry of Health and Sports allocates funds and operates public health care facilities to provide the essential health services package, while the Social Security Board (SSB) scheme collects contributions to fund and provide services in its own network of health facilities. Comprised of 96 SSB clinics, three workers' hospitals and 58 enterprise clinics, they are all financed through direct budget allocations. However the SSB, that provides coverage to workers in private formal employment, intends to reform the purchasing function. Acknowledging the absence a provider-purchaser split and the geographic limitation of its health facilities network, the SSB adopted a two-pronged strategy: i) contracting private facilities to provide outpatient services, using different contract modalities and provider payments with capitation and fee-for-service and ii) initiating an internal market model to progressively transition towards a full split, capitalizing on the experience gained in contracting private facilities. Currently at the preliminary steps, the model will re-organize responsibilities within the SSB governance structure to separate the purchasing and provision functions into distinct departments and implementing a virtual contracting of health facilities, with strategic purchasing.

Source: Refer to Myanmar country profile in part two of this publication.

3.3.2. Accreditation and empanelment

Regardless of the way the purchasing function is structured, it is necessary to define a dedicated network of service providers. It is crucial that such a network provides effective and safe interventions. As mentioned in Chapter 2, the extent of the identified network of health care providers largely determines the effectiveness of SHP in practice. If this network is too limited in terms of range of services available, geographical accessibility or cultural acceptability, it is unlikely people will effectively enjoy their right to SHP. Therefore, the choice of providers (public, private-commercial and private non-for-profit) and their respective regulations are crucial features that need to be considered carefully.

Countries are often guided in their choice by licensing and accreditation programmes put in place by the Ministry of Health. Furthermore, when the purchasing and provision functions are conducted by two different institutions, it is necessary they enter into a contract often referred to as an "empanelment process".

This section provides an overview of the ways SHP systems have made use of accreditation and empanelment processes in the region. It further explores issues that relate specifically to such processes applied to the for-profit health sector.

A variety of pathways to empanel and accredit health care providers

Measures utilized to improve the quality of care include accreditation programmes. In most countries in the Asia and the Pacific region that have reached quasi-universal population coverage, public health care service providers represent the majority of health care provision as part of SHP.

In many such countries, certain private providers have also been included in the network with some specific requirements, such as the need to be properly licensed by the Ministry of Health. This is the case in Japan, Republic of Korea, Malaysia, the Philippines, Sri Lanka and Viet Nam. By creating networks of accredited and empanelled providers, health systems can signal to patients that the covered facilities meet quality requirements.

This mechanism is effectively used in the Philippines, where each service package has clear accreditation requirements to ensure that any facility, public or private, that is paid for provides a specific service



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package that has met all necessary conditions. In the Philippines, PhilHealth only pays accredited facilities, but to overcome the problem of remote areas having fewer accredited facilities, government investment in public health care facilities is targeted at areas with low densities of accredited facilities in the Health Facility Enhancement Programme. Bangladesh's Maternal Health Voucher Scheme requires accreditation of providers as a way to gain families' trust to use such services, contributing the positive effects of this programme. It is also looking to introduce formal accreditation for the SSK scheme to maintain the quality of public and private providers.

Not all countries rely on accreditation, yet many have quality criteria or scopes of service capability for empanelling providers into their SHP schemes, such as the ESIS and CGHS schemes in India and the VSS scheme in Viet Nam. Since 2017, the Korea Institute for Health Care accreditation has been evaluating health care facilities nationwide using 129 criteria. In Pakistan, public and private services purchased under Sehat Sahulat are delivered through empanelled hospitals that have met hospital empanelment criteria, covering health facility equipment, management of health staff, clinical practice, laboratory services, pharmacy and client rights.

Some countries have accreditation standards, but have not applied them as part of the empanelment mechanism. Japan has a specialized, non-profit entity that provides accreditation to hospitals, yet it is not mandatory and uptake is limited. However, as patients become more discerning and demand higher-quality services, it will be in the interest of hospitals to get accredited to facilitate competition based on quality. In Viet Nam, though no official accreditation agency exists, in addition to licensing the MOH conducts annual quality checks on hospitals using a standard set of 86 quality criteria. It also has a system for benchmarking commune health station service readiness. However, neither of these quality assurance systems are used in purchasing arrangements, and facilities with low scores are still allowed to receive VSS payments for services.

While some countries do not require accreditation of public providers, measures to accredit private providers are in place or being considered. In Malaysia, incremental changes were introduced to regulate the role of private providers of health services, including a national quality assurance programme. Brunei Darussalam does not accredit public providers, but requests private providers be accredited. Indonesia's JKN requires facility accreditation for private facilities, but not public facilities.

Several countries have concerns about the quality of health care services covered under SHP mechanisms, but do not currently have accreditation standards. Cambodia lacks a quality assurance mechanism for private providers, a cause for concern when SHP schemes consider contracting such providers. Recognizing this challenge, Cambodia's draft Law on Administration of Health Services aims to ensure safety and promote quality of health care services in public and private health facilities at all levels. It includes the establishment of a national accreditation system and requirements that NSSF and HEF schemes only contract accredited providers.

Empanelment of private providers: cost containment and equity considerations

In most countries in the region, health care systems are pluralistic, meaning there is a mix of public and private provision of health care services. In countries where the public network of health care service providers delivers the majority of care, private providers are included on a referral basis only for interventions not available in public facilities, for example the case in Brunei Darussalam and Malaysia.

The balance between public and private provision varies greatly between each country, with some having the majority of service provision in the private sector. When this is the case, it is difficult for Governments to envisage focusing SHP benefits only on public providers. While this is true, in many such countries the strength of the private health sector is often a reflection of the lack of investments in the public health sector and the relative weakness of the MOH's stewardship function. In such circumstances, the MOH may also face difficulties imposing its regulatory and oversight role on private facilities, creating a risk of poor quality, safety and suitability to be part of any SHP mechanism. In countries such as Bangladesh, India and Nepal, many people from especially in the lowest income quintiles seek care with traditional health care providers, who may not be recognized by the authorities. Therefore, improving financial protection and access encompasses an important regulatory dimension (Negi and Abdul Azeez 2021; Thorsen and Pouliot 2016; Haque et al. 2018).

While the accreditation and further empanelment of private providers may be desirable in some contexts, especially to expand geographic access and rapidly scale-up the offer of primary care, impacts must be considered. Equity and financial sustainability constitutes a core issue, particularly in resource-constrained countries, as private for-profit facilities tend to charge higher prices than public providers. Indeed, the latter usually benefit from public subsidies and do not need to generate profits. In countries with large private health care sectors, SHP schemes often need to find a way to pay public and private services, while maintaining equity in access to benefits through the use of publicly-pooled funds. This is essential to safeguard solidarity and willingness to continue contributing into SHP schemes.

Several inclusion modalities of private providers exist. Some countries apply different payment levels and modalities, while other countries and schemes empanel private facilities on the same basis and with the same payment method as for public providers. A common approach is 'balance billing', whereby the scheme applies a unique payment schedule to public and private facilities, leaving it to private facilities to charge additional direct payments from patients (see Box 20).

► **Box 20. Balance billing**

Singapore's Medisave and Medishield Life cover public and private providers. Insured members who wish to seek care in private facilities must access the same benefit paid by the scheme in public facilities, but will end up paying higher OOP payments in private facilities. When using private services or higher-class wards in public hospitals, the Medishield scheme will only cover a percentage of the daily ward and treatment costs, surgical procedures and devices. Patients choosing to use the higher class or private services would need to pay the balance out-of-pocket or by enrolling in supplementary private health insurance (Central Provident Fund and Singapore Ministry of Health 2015).

Viet Nam's NHI covers public and private providers. VSS payments to private providers are made based on the same price schedule as for public providers, and any excess charges are balance-billed to patients who choose to use such private services. Services in public facilities that use equipment obtained through private investment are also permitted to charge higher rates to recover investment costs, but such services are treated the same as private services and patients are billed the balance. Both extra billing (for items not covered in the health insurance package) and balance billing (for items charged at higher rates in private facilities or private wards of public hospitals) are widespread as part of the hospital autonomy policy that pushes hospitals to achieve full cost recovery in revenues from service delivery, leading to high out-of-pocket health care payments.

In the Philippines, balance billing is the norm for PhilHealth members who use public and private facilities. Hospitals are allowed to set their own fees, are reimbursed by PhilHealth based on package rates, and charge patients to compensate the difference between hospital fees and PhilHealth rates. In contrast, in Japan, the same fee schedule is used for all providers, public and private, while private providers are only permitted to operate on a not-for-profit basis and prohibitions on balance billing are strictly enforced to avoid a dual health system and ensure SHP.

When recourse to private providers is a choice made by wealthier households, balance billing may not lead to poverty or may be covered by voluntary private health insurance. However, in several Asia and the Pacific countries, high OOP health spending are also attributed to payments made by lower-income households to private providers. Some countries put in place specific measures to ensure financial protection to the most vulnerable. In the Philippines, balance billing is prohibited for indigent and sponsored members to overcome the adverse effects on financial protection. Additionally, in the new Konsulta primary care scheme a cap applies on the total balance billing allowed in a year.

National efforts to extend USP through comprehensive benefit packages, but with inadequate public funding, have led to dual systems in many Asia and the Pacific countries. In some countries, essential public health care services covered by SHP schemes provide a good level of basic service coverage that contributes to improving health of the population. However, with the apparition of a growing middle-class, wealthier members of society are demanding higher levels of amenities. They are willing to pay out-of-pocket or pay high private health insurance premiums to obtain higher-end services (Fiji, Malaysia, Sri Lanka and Viet Nam). In Cambodia, even though the HEF scheme covering low-income households does not cover private providers, 76 per cent of rural low-income people reported they first sought health care in the past 30 days with a private provider (Kolesar et al. 2019). Fiji also does not pay private services from public sources, with a few minor exceptions. However, most OOP health spending are associated with using private services, especially for primary care. In order to broaden access to services, the government planned a new policy to make private general practitioners free of charge at the point

of service as well as incentives to general practitioners to settle directly in non-urban areas. Funding was meant to come from a dedicated trust fund of the government (Irava 2015).

The progressive development of this dual system brings the risk of reducing solidarity and sustainability of SHP systems in place. In many countries, the actual availability and quality of services and drugs in the basic health package is inadequate, pushing even poorer members of society to seek care or purchase drugs in the private sector, leading to heavy financial burdens as these services are not covered by SHP schemes.

SHP systems can significantly contribute to provide incentives and directions to the architecture of health service delivery through channelling demand for such services towards specific types of providers. Similarly, the way providers are paid can influence their behaviour.

3.3.3. Provider payment methods

Achievement of universal protection requires mobilizing adequate funding and pooling of these funds to share risks among the population, as explored in the previous sections. It equally requires efficient mechanisms to determine how these funds are best used to incentivize access, quality and efficiency of health care services and limit moral hazards.²²

The different types of provider payment mechanisms in health care are described in Table 4.

► Table 4. Provider payment methods

Provider Payment Mechanisms	Definition
Global budget	Prospective payment where health care providers are given a set amount of money to deliver an agreed-upon set of services. In this setting, providers have total flexibility on how they allocate this funding internally.
Line-item budget	Prospective payment where providers receive a given amount of money already allocated to specific items. The budget is not flexible, and expenditure must follow the defined line-items, unless the provider has the prior authorization from the purchaser.
Fee-for-service (FFS)	Retrospective activity-based payment. The provider receives a reimbursement for each individual service provided
Capitation (per capita)	Providers receive a fixed amount of money to provide agreed services for each registered individual over a fixed period. It is received prior to service delivery.
Per diem	Health care providers are paid a fixed amount for given services per day.
Case-based (e.g., diagnosis-related groups (DRGs))	Providers are paid a fixed amount per case such as for each diagnosis, admission, or discharge.
Pay for performance	Providers are paid on the condition that they meet certain performance thresholds based on predetermined measures.

Source: Adapted from Kazungu et al. (2018).

²² Moral hazard refers to the risk that when individuals bear none or only a small share of their medical care costs, they are likely to consume more health services.

Each mechanism entails different types of incentives, for instance:

- Case-based payments incentivize increasing the number of admissions, but also reductions in inputs to care. It can lead to improvements in efficiency of the input mix and reduce lengths of stay.
- Capitation and global budget are associated with under provision of services and excess referrals to other providers, but can also improve efficiency of the input mix.
- Fee-for-service (FFS) payments are associated with an increased number of services provided. FFS payments with a fixed fee schedule can lead to reduced inputs (greater efficiency) per service or FFS payments with no fixed fee schedule can lead to increased use of inputs and inefficiency.
- Per diem payments tend to increase the length of stay, admissions and bed capacity, but also reduce inputs per hospital day.
- Line-item budgets lead to under provision of services and excess referrals to other providers, increased inputs and little incentive to improve efficiency of the input mix. In particular, they provide an incentive to spend all remaining funds by the end of the budget year (Langenbrunner, Cashin, and O'Dougherty 2009).

Most countries use a combination of provider payment mechanisms to maximize their advantages and mitigate risks. Often, a mix of prospective and retrospective payment methods is used. Some systems provide an advance payment to health facilities – subject to later adjustments with the submissions of claims. Advance payment is often conducive to more revenue predictability at facility level. In contrast, retrospective payments may lead to payment delays, leaving health facilities vulnerable to financing gaps.

Capitation

Capitation payments are used in several countries, primarily to cover outpatient service packages. To be effective, capitation payments generally require setting a uniform package of services and requiring patients to use such services at the facility where they are registered for PHC. High-income countries using capitation payments tend to blend them with a pay-for-performance mechanism to counteract the adverse incentives of capitation towards quality. Indonesia's JKN scheme pays capitation for a PHC package covering 155 common diagnoses. In Lao PDR, capitation is used to pay for outpatient services. In Mongolia, privately-run family health centres in urban areas and public Soum health centres in rural areas are paid by capitation to deliver basic primary care (Joint Learning Network et al. 2015). In Thailand, the UCS and CSMBS pay for outpatient care on a capitation basis. The SSS scheme is unusual in that it uses capitation for inpatient and outpatient care for those required to register at and use only one health care facility. Personal preventive and promotive health care services are paid by the UCS for all the Thai population using capitation. Viet Nam is introducing capitation payments for outpatient care. However, the payment mechanism design does not follow basic principles, such as defining a uniform package of services or diseases covered by the capitation payment or requiring that people use services at the facility where they enrol for PHC. Hence, the incentives are not the same as most capitation payment mechanisms.

Fee-for-service

Fee-for-service payments are used in some countries as the main form of provider payment. To achieve cost control with this form of payment requires substantial investment in establishing regulations on conditions for when individual services or drugs can be used and constant adjustment of prices in response to under- or over-use of services. It is challenging to impose such rules when the risk pool is small. In Japan, most providers are paid on a FFS basis with service lists and prices uniformly defined by the fee schedule set by the MHLW. The MHLW has a detailed rule book to define when a service or other input for care is appropriate or not, which acts as a supply-side cost control. In Republic of Korea, most payments to hospitals are also made on a FFS basis, with a large number of mechanisms in place to control prices and assess appropriateness of use of inputs for care to control costs. In the Philippines, FFS is used by hospitals to determine the charges for inpatient admissions, part of which is paid by PhilHealth on all its case rates basis and the balance paid out-of-pocket by patients, except for

indigent and sponsored members who are entitled to the no-balance billing policy. In Viet Nam, FFS is the predominant method of payment from VSS to providers for inpatient and outpatient services, but efforts are underway to replace FFS with prospective payment mechanisms.

FFS payments are often a complementary payment mechanism for certain types of services. In Indonesia, the JKN scheme pays FFS for high-cost specialist services beyond the capitation package, but not requiring hospitalization. Malaysia's PeKa B40 scheme pays private providers on a pre-negotiated FFS basis, while public providers are paid through a benefit-in-kind mechanism, since public facilities are not allowed to retain funding. In Singapore, Medishield Life pays FFS for selected costly outpatient treatments, such as dialysis and chemotherapy for cancer and CHAS pays FFS for specific outpatient services (Singapore Ministry of Health 2021). In Sri Lanka, the various small-scale supplementary insurance schemes generally reimburse patients for costs incurred when using health services, and those services are paid on a FFS basis. In Thailand, in the CSMBs scheme, outpatient care is paid based on FFS, in the UCS a few high-cost services are reimbursed on a FFS basis, such as for bone marrow transplants. In the SSS, some care services such as dialysis and RMNCH, are reimbursed by FFS on top of capitation payments (WHO 2015a).

Line-item budgets

Line-item budgets are used in many countries that do not have a split between provider and purchaser. However, they do not incentivize efficiency or quality of care unless additional measures are implemented, such as complementary pay-for-performance incentives. In Fiji, public hospitals and clinics are paid through line-item budgets (human resources, services, capital investments and pharmaceuticals). A majority of health workers are employed by the Ministry of Health and Medical Services (MHMS) or other government facilities and are paid a fixed salary not dependent on performance. In India, the CGHS uses line-item budgeting to fund its own network of primary care clinics. ESIS uses line-item budgeting to pay its network of primary care facilities and inpatient facilities (own facilities or those run by State governments), however it also uses capitation and package payments. Health and Wellness Centres provide primary care services to PM-JAY members paid directly by the Ministry of Health and Family Welfare. In Malaysia, public health facilities are paid through line-item budgets. In Mongolia, at least half of all public provider revenues come through government budget payments of a line-item budget, although the amounts vary for different level facilities. Mongolia's PHC facilities are reported to use more than two-thirds of their funding for salaries and operating costs, leaving only a small proportion left for improving actual quality of care and services. Sri Lanka's public health care services are resourced through a line-item budget for hospital or groups of facilities for lower-level units.

Global budgets

Global budgets are used in many countries, primarily for public health care providers. Brunei Darussalam uses global budgets to pay its public providers as well as private providers in the case of referrals when a public facility is not able to provide needed services. Myanmar's SSB scheme finances its own clinic through direct budget allocation. Viet Nam's public preventive health care providers are generally remunerated with a global budget based on payroll and historical operating costs. In Nepal, the Free Health care Programme allocates State budget to different administrative levels of government based on population. In Singapore, a block budget is provided to public facilities as a first layer of subsidization for accessing health services.

Case-based payments

Case-based payments are used in some countries, mainly for inpatient care, but with substantial variations in how the cases are defined. The DRG system is a sub-type of case-based payments, in which the cases are classified into diagnosis-related groups, which are determined largely on the basis of clinical codes (diagnosis and procedure). Case-based payments involve payment for a bundle or package of services. In some countries, only a subset of packages is paid on a case basis. For effective cost controls, case-based payments generally also involve some caps, such as a global budget or caps on volumes of

services. Using case-based tariffs for bundles of services provides similar incentives as FFS payments to increase admissions (see Box 21).

► Box 21. Case-based payments in selected countries

In Bangladesh, the pilot SSK scheme uses the DRG system. It involves lump sum payments for pre-defined service packages. However, the lump sums are calculated by SSK to enable hospitals to maintain the same levels of service provision and use the surplus to improve quality. The pilot scheme also uses case-based payments for specialist doctors and diagnostic centres.

In Cambodia, the NSSF and HEF schemes reimburse facilities on a case-based basis for inpatient and outpatient services. However, these two schemes use somewhat different case-based classifications, with different payment rates. Indonesia's JKN scheme pays for inpatient care on a DRG basis (INA-CBG) with DRG tariffs varying by hospital levels and regions. Mongolia uses a similar method and DRG accounts for a third of public and private facility revenues. Thailand's UCS combines DRG with a global budget for inpatient care. In Lao PDR, case-based payments are utilized for inpatient services in district, provincial and regional hospitals. In Nepal, case-based remuneration is made for inpatient care and hospital admissions in HIB and SSF schemes, with cases not classified by DRG, but by various types of medical and surgical procedures. In Singapore's Medishield Life, public and private facilities are paid using case-based payments for hospitals covering inpatient, day surgery and some outpatient care.

China moved away from the fee-for-service (FFS) payment mechanism as it was associated with over-payment for drugs and costly high-tech diagnostic tests and under-payment for less costly, basic services such as consultations. Starting in 2009, China transitioned first to a global budget payment system and then in 2017, the full implementation of a DRG-based payment system nationwide. Early evidence suggests that changes in provider payment mechanisms have had positive effects on provider behaviour.

Japan's unique case-based payment mechanism consists of a diagnosis procedure combination and a *per diem* payment system, whereby a flat-rate per diem fee is paid, but the amount varies by diagnosis and procedure groups and also decreases as the length of stay increases.

Sources: Refer to respective country profiles in part two of this publication.

Pay-for-performance

Pay-for-performance incentives can be important to counteract disincentives for quality in some provider payment mechanisms, particularly capitation payments, but do not appear to be widely used in the Asia and the Pacific region. In the Philippines, Philhealth's new Konsulta package includes a blended capitation payment, with the capitation amount dependent on the percentage of registered patients for which the facility actually has a patient encounter. It requires that in the initial patient encounter, a fixed set of information items, is collected on patient history and risk factors. It also requires that a certain percentage of encounters involve laboratory services, drug dispensing and for all patients screened positive for NCDs they receive monthly drug dispensing. Japan's payment system also includes a mechanism to pay a higher fee to hospitals for performance. Regional offices of the MHLW inspect facilities for compliance with performance targets, such as hospitals with higher nurse staffing ratios or for physicians who provide patient education in a systematic manner to those with diabetes and other lifestyle diseases.

The effectiveness of strategies using provider payment methods to shape provider behaviour can be reduced by the co-existence of several uncoordinated and unaligned SHP mechanisms targeting the same providers. Indeed, in many countries with fragmented risk pools, schemes tend to have different strategies when it comes to paying providers, even when they contract the same providers. In India, CGHS pays empanelled inpatient providers through package rates. ESIS contracts a network of empanelled private facilities to provide specialist procedures and pays them package rates similar to CGHS. PM-JAY only covers inpatient care and pays based on pre-determined package rates.

Efficient and inclusive SHP systems have strong institutions, are based on broad risk-pooling, manage modern administrative processes and adopt strategic purchasing methods. While this holds true, it is only possible when such systems are sufficiently funded. The following chapter provides insights on the strategies adopted by countries in Asia and the Pacific to mobilize resources for SHP.



Chapter 4. Financing Social Health Protection

Key messages

- Under-funding and unpredictable funding remain major barriers to expanding coverage and enhancing adequacy. Enhanced public resources, in terms of quality and volume, are necessary to make solidarity in financing a reality, backed by comprehensive legal frameworks developed through social dialogue to ensure sustainable systems amidst changing political priorities.
- Social security contributions continue to constitute an important source of financing for SHP in many countries, providing predictable and progressive earmarked sources of funds. However, social security contributions need to be complemented by other sources of revenues to ensure solidarity with groups with limited contributory capacity, such as the poor.
- Securing a solid financing mix requires proactive efforts to ease the transition from the informal to formal economy. Formalization of the informal economy would increase the collection of social security contributions, but also broaden the tax base. Indeed, while tax financing is identified as a means to raise revenues for SHP, the size of the informal economy largely influences the tax base for progressive taxation measures and constrains revenue collection.
- Many governments have decided to use consumption taxes, including earmarked health taxes on consumer products that are harmful to health. Taxes on consumer goods are an important source of revenue and need to be considered within the overall fiscal framework of a country to ensure progressive taxation and effective redistribution of resources.
- Reliance on out-of-pocket spending and private health insurance reduces social solidarity and maintains inequities in accessing health care and financing the system. Private health insurance plays a small role in health financing in the region and is mostly used to provide supplementary or complementary benefits for those who can afford it. It is, therefore, neither seen nor appropriate as a tool to extend coverage.
- A number of countries in the region have transitioned out of external aid dependency for health financing in the last decades, as many saw their income levels rise and eligibility to external aid decrease. This transition entails some challenges, including pervasive gaps in accessibility of services for the specific health conditions that were previously vertically funded.

This chapter examines trends in SHP financing in the Asia and the Pacific region. It further explores the various pathways that have successfully ensured adequate resource mobilization, with a view to providing orientation to countries that will need to increase financing to achieve the goal of UHC.

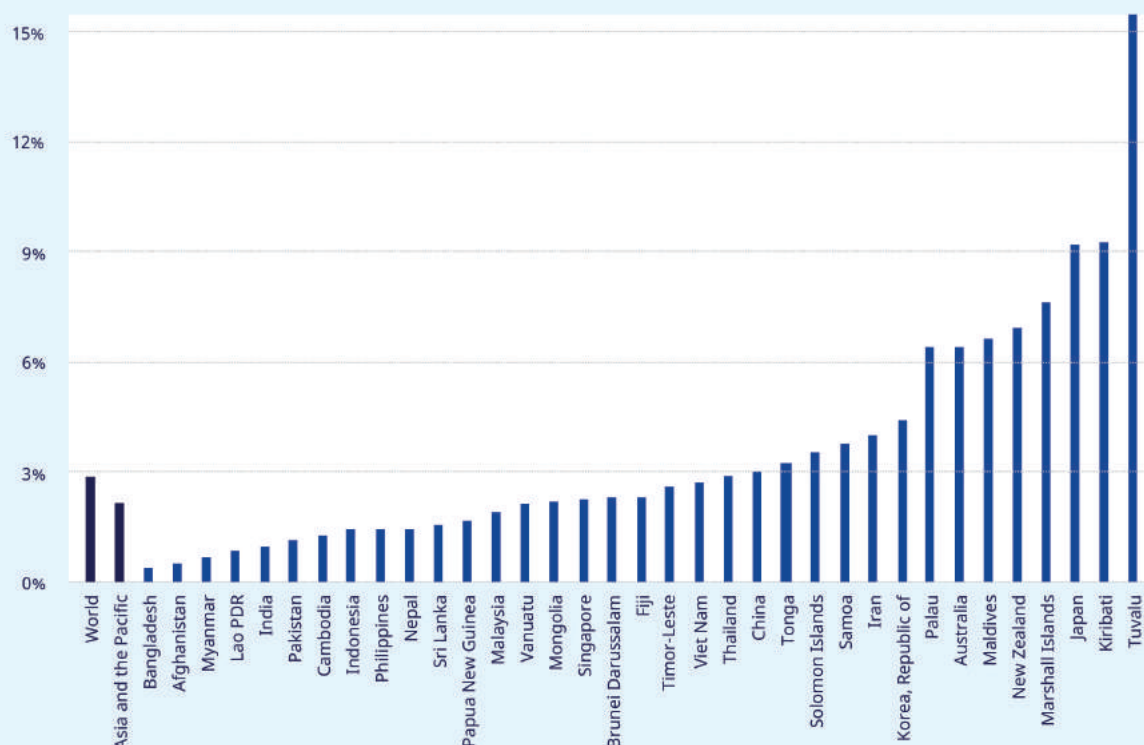
► 4.1. Increasing public resources: a necessity

4.1.1. Essential role of public funding

Trends in public expenditure

Government health expenditure as a share of GDP is an important indicator that reflects, to some extent²³, the prioritization of health in a country (Savedoff 2003) (see Figure 27). In the region, the governments of 20 countries spend less than 5 per cent of GDP on health, including six countries where this proportion is lower than 3 per cent. This suggests that the financing of health expenditure has, in most cases, largely shifted onto patients and their families and is therefore highly regressive (see Figure 29).

► Figure 27. Domestic general government health expenditure, percentage of GDP, countries and territories in Asia and the Pacific, 2018



Note: No data available for the Cook Islands.

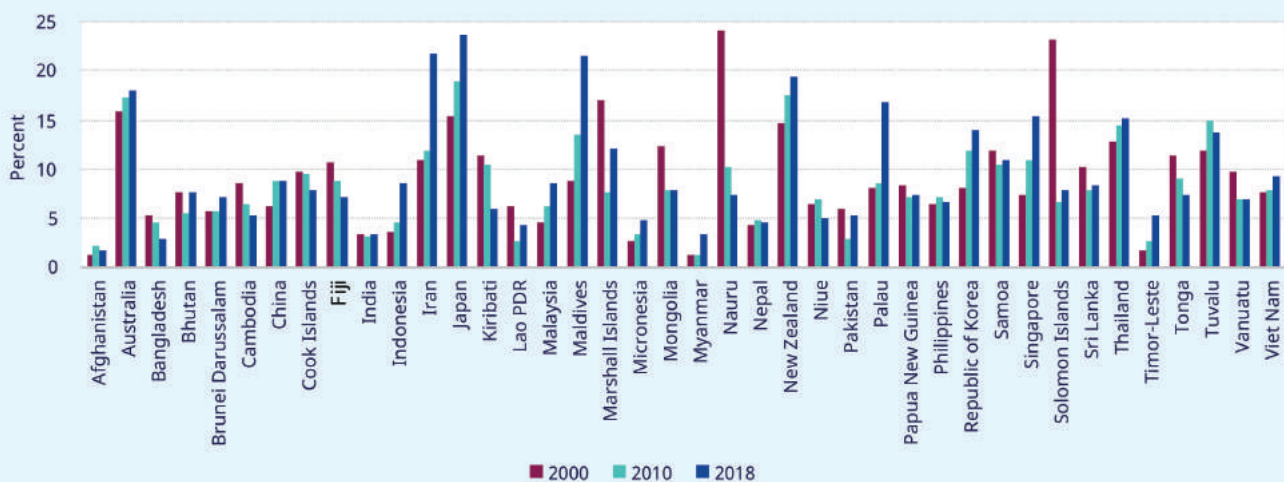
Source: Adapted from WHO Global Health Observatory.

²³ While the threshold of 5 per cent of GDP is often referred to as a reasonable amount for government to allocate to health spending, the appropriate level of spending depends on many factors, such as the epidemiological profile, the desired level of health status, the effectiveness of health inputs purchased at existing prices as well as the relative value and cost of other demands on social resources.

Changes that occurred leading to increased prioritization of health in general government expenditure in some countries are often multidimensional. Historical trajectories help to understand weaknesses in the current funding mechanisms that keep countries at low and stagnant levels of public spending.

Ensuring adequate public funding for SHP requires sustainability and predictability of funding sources. Figure 28 shows the countries that have seen the most severe declines in health's share of government expenditure including Bangladesh, Cambodia and Fiji with declines between 2000–2018. In Fiji, there was a decline in domestic government health spending compared to GDP, even though tax revenue mobilization has increased dramatically in recent years. Mongolia saw a decline in government health spending from 2000–2010 with no recovery back to previous levels. The country has faced substantial fluctuations in allocation of public resources for health. While PHC initially was covered under NHI, in 2006 the government committed to providing free PHC funded by the government budget. However, between 2012–2017, the share of State funding allocated to PHC fell from nearly 25 per cent of government health expenditure in 2005 to under 16 per cent in 2016. These declines indicate a lack of sustainability of health financing sources and explain why many line ministries in charge of SHP have requested earmarked resources be included in the financing mix.

► **Figure 28. Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE), countries and territories in Asia and the Pacific, 2000, 2010 and 2018**



Note: Values for Afghanistan and Timor-Leste were not available for 2000. Instead, data for 2002–2003, respectively, were used.

Source: Adapted from WHO Global Health Expenditure Database.

Importance of public spending in national health expenditure

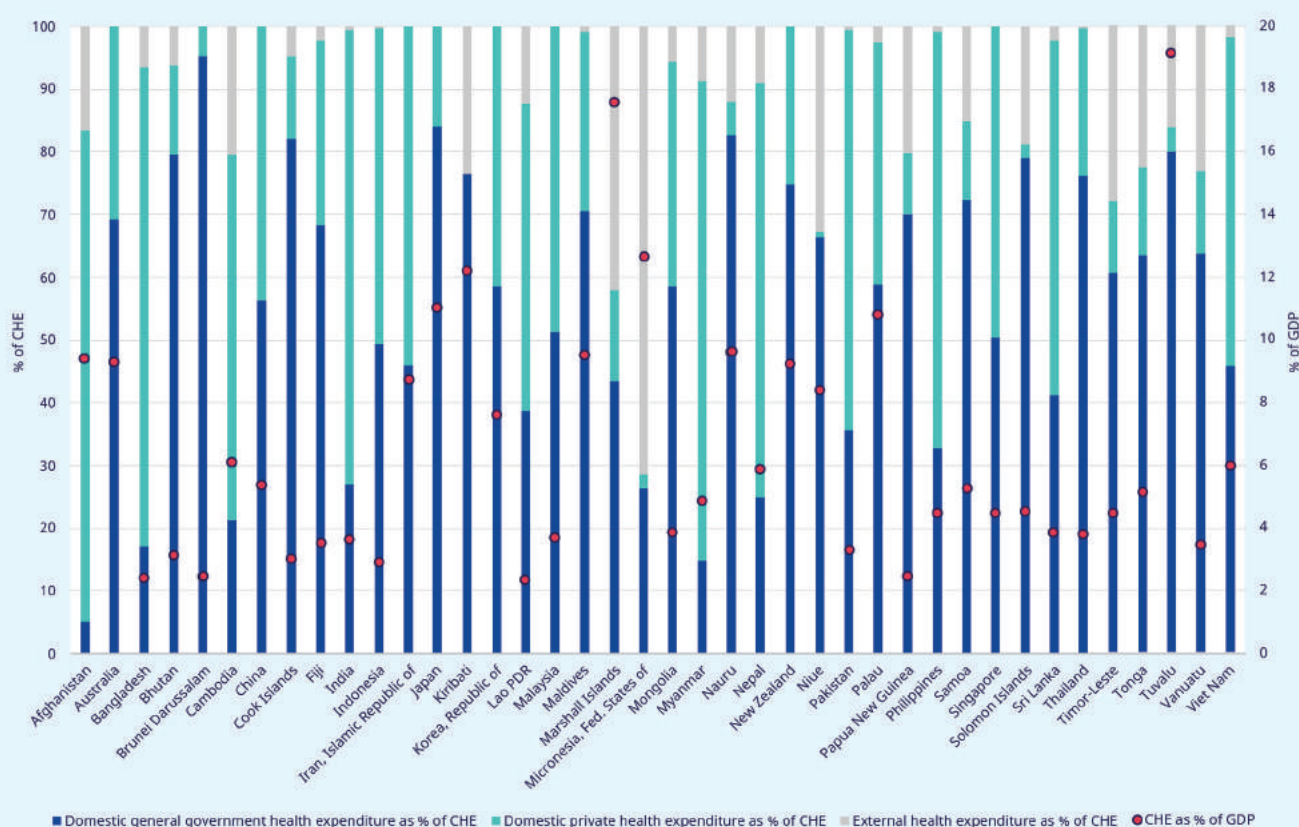
Public spending is considered the most appropriate source of funding in line with the principles of solidarity in financing and the overall and primary responsibility of the State embedded in ILO Convention No. 102, Recommendations No. 69 and 202. The relative share of public spending in national health expenditure is a reflection of the collective efforts towards expanding health coverage. The amount of resources allocated to health as a share of GDP also reveals the degree of priority a population is giving to the health sector (see Figure 29).

Public spending accounts for more than half of current health expenditure in 25 out of 40 Asia and the Pacific countries with information available (Figure 29). Within South-East Asia, only five (Brunei Darussalam, Malaysia, Singapore, Thailand and Timor-Leste) of the 11 countries rely on public spending

for more than half of their current health expenditure. In South Asia, the only countries with the public share of current health expenditure exceeding 50 per cent are Bhutan and the Maldives.

Public resources raised domestically are often complemented by external resources in low-income countries. In this respect, ILO standards recognize the important role of international cooperation and solidarity in the establishment of SHP systems in countries that are particularly resource constrained. However, as countries reach middle-income status, external financing sources tend to decline – leaving domestic funding to ensure sustainability. In the region, an important share of health expenditure is generated from external sources in small Pacific Islands as well as countries affected by conflicts in the past decades, such as Cambodia and Timor-Leste. Two countries, the Federated States of Micronesia and the Marshall Islands, rely heavily on external assistance to achieve a high share of GDP spent on health.

► **Figure 29. Composition of current health expenditure (CHE) and as a percentage of GDP, countries and territories in Asia and the Pacific, 2018**



Source: Adapted from WHO Global Health Expenditure database.

Private health expenditures include OOP expenditures by households as well as private health insurance contracted on a voluntary basis. If used as the main mechanism for financing health services, OOP expenditures can lead to substantial financial burdens on households and inequality in access. There is a large variation in the share of OOP health expenditures in current health expenditure (CHE) in the region, ranging from 0.1 per cent in Kiribati to 78.4 per cent in Afghanistan. Overall, for the 35 countries with available data for 2018, OOP expenditures accounted for less than 21 per cent of CHE in nearly half (17) of them, while for the remaining countries the rate exceeded 30 per cent. Some countries spend a high share of GDP on health through a heavy burden on private sources of health financing, including Afghanistan, Cambodia, Islamic Republic of Iran and Republic of Korea. Most countries were identified as not having taken a clear political commitment towards universal coverage, as highlighted in Section 2.2.1 with an over-reliance on private health expenditure. Private health insurance plays a small role, as explored in Section 4.1.2.

4.1.2. Limited role of private health insurance

Private health insurance contracted on a voluntary basis plays a small role in health expenditure in the region, whether of a commercial nature or not.

Commercial insurance

There are several distinguishing features of private voluntary health insurance that inhibit its ability to contribute to equity or effective financial protection. The financial contributions are generally individually risk-rated premiums, meaning the amounts to be paid depend on people's health status and identified risks rather than their ability to pay. 'Cream skimming'²⁴ is common. Hence, older persons or people with pre-existing conditions are generally not eligible to purchase private insurance policies or must do so at a high cost. Premiums also tend to be high because private insurers are generally for-profit enterprises that have shareholders and their performance is measured by generated profits. To reduce risks of adverse selection, waiting periods are often applied before members can access services. As a result, private voluntary health insurance tends to be purchased mainly by the wealthiest and healthiest groups of the population. Private health insurance may also lead to higher costs of care when they adopt provider payment methods and levels less efficient than public mechanisms with broad risk pools.

Private voluntary health insurance is mostly used to provide supplementary or complementary benefits for those who can afford it. As such, it is not generally seen as a tool to extend primary coverage. Demand for and coverage of private health insurance is growing as people's incomes increase in step with a desire to access private services with more amenities that are not covered by SHP, such as shorter waiting times, choice of doctor or private rooms. Rising demand for PVHI can also sometimes be a signal of inadequacy in the benefit package offered by the SHP system, underlining the importance of periodic reviews and progressive expansion of the benefit packages as countries grow economically and technologically. For example, in the Republic of Korea a majority of Koreans (87 per cent) resort to private health insurance for supplementary and complementary coverage from the NHI plan, driven by the high co-payments associated with the NHI. While inpatient care has co-payments of only 20 per cent, outpatient care co-payments vary between 30–60 per cent.

Although private insurance can fill these gaps, it is not a redistribution mechanism. Therefore, it does not foster solidarity and equity and can contribute to reinforcing inequities in access.

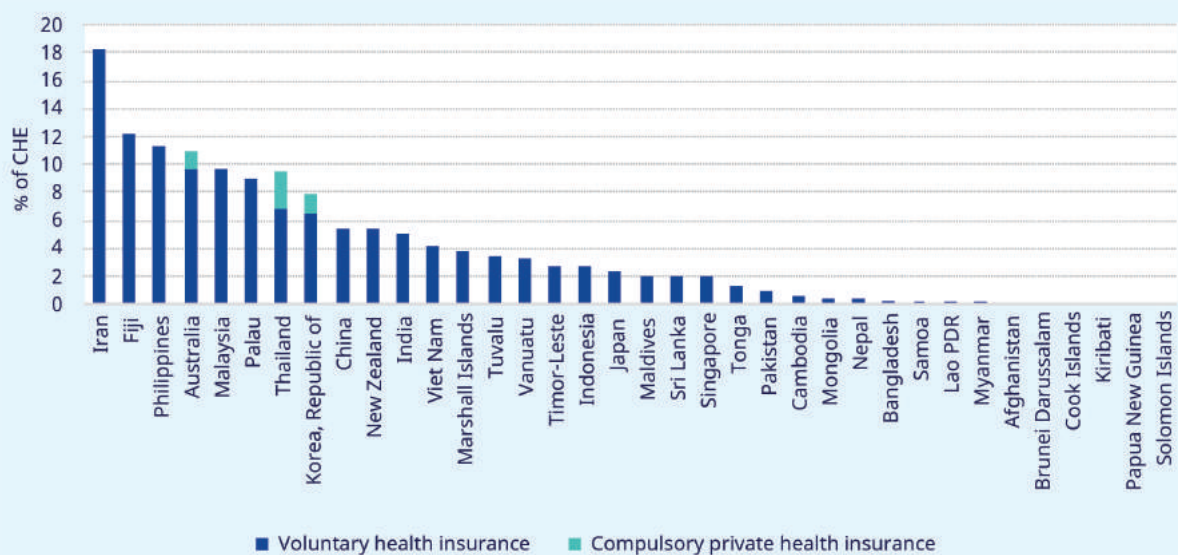
In this context, government oversight is necessary to guarantee consumer protection. Strong regulations are also needed to ensure that members are not allowed to opt out from the national system, which would be detrimental to public risk-pooling mechanisms.

Overall, private health insurance plays a small role in health financing in the region. Very few Asia and the Pacific countries have compulsory private health insurance requirements. These tend to mainly apply

²⁴ The practice of selecting customers based on their good health status or low health risk profiles to enhance the profitability of the insurance company.

to migrant workers, including in Malaysia and Singapore. Private health insurance accounts for less than 3 per cent of current health expenditure in Australia, Singapore and Thailand. Nine Asia and the Pacific countries indicate no PVHI contributions to current health expenditure, while 10 other countries indicated PVHI accounting for less than 2 per cent of current health expenditure (Pettigrew and Mathauer 2016). In only three countries (Fiji, Islamic Republic of Iran and the Philippines), PVHI accounted for more than 10 per cent of CHE (Figure 30).

► **Figure 30. Voluntary health insurance as a share of current health expenditure, countries and territories in Asia and the Pacific, 2018 or latest year available**



Source: Adapted from WHO Global Health Expenditure Database.

Community-based health insurance

Community-Based Health Insurance (CBHI) is usually characterized by voluntary affiliation, members' financial contributions with risk pooling defined, organized and managed at the community level or among a small group of individuals. It is usually not for profit. Some countries in the region have implemented various CBHI models, often publicly mandated and implemented or supported by NGOs.

In most cases, CBHI schemes were meant to fill a gap in national SHP systems and enabled unprotected individuals or households, mostly with limited income and dependent on informal employment, to access financial protection in case of illnesses or maternity. However, such schemes have not succeeded in expanding coverage in countries where not integrated in the SHP system and carried the risk themselves, mostly due to two inherent design flaws. Firstly, those schemes were voluntary in nature and exposed to the risk of adverse selection and to an immense awareness-raising task with little public support. Secondly, pooling risk at community level is inefficient as it does not allow a proper diversification of risks to be financially sustainable, and further presents limited redistributive potential and leads to fragmentation, which poses equity concerns. Impacts on financial protection have yet to be demonstrated, particularly in South Asia (Bhageerathy, Nair, and Bhaskaran 2017).

While this holds true, some countries have made good use of CBHI as action-oriented research and piloting and transformed their CBHI or absorbed it into national SHP systems. For instance, in Lao PDR, the MOH-run CBHI has been reformed and absorbed by the MOH's National Health Insurance scheme. Cambodia's experience in running CBHI in selected provinces for many years helped gather knowledge

and develop management tools which were then transferred to the government, and particularly supported the National Social Security Fund to extend coverage to garment factory workers.

In this respect, CBHI schemes helped strengthen local governance and fostered a culture of SHP, building strong foundations for developing national health protection systems. Bridging CBHI schemes and the respective national system is essential to move towards a universal SHP system, anchored in laws, and based on broad risk pooling (Carrin 2003).

Despite a trend towards increasing public spending, private expenditure on health – including OOP expenditures from households still represents an important share of health expenditure. This suggests that gaps in SHP need to be addressed urgently with the mobilization of additional resources.

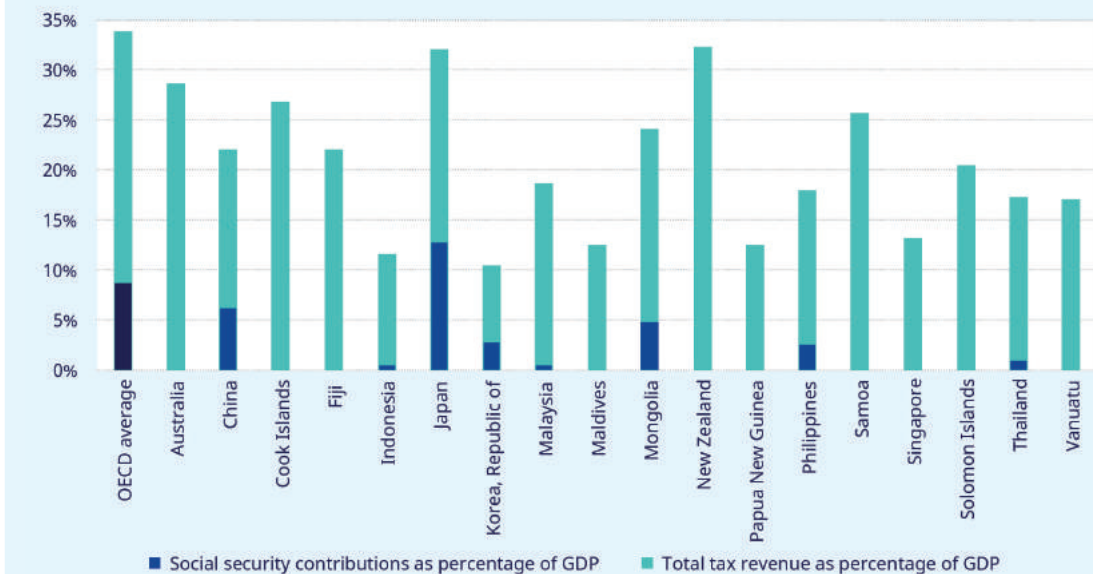
► 4.2. Strategies for resource mobilization

Arguments that SHP is unaffordable are becoming less and less compelling in low- and middle-income countries. In fact, countries cannot afford not to have SHP, and must invest in robust and shock responsive social protection systems to accompany an equitable economic recovery path from COVID-19. As incomes rise, resources are available and politics, laws and institutions need to adapt to ensure these resources are allocated to meet national commitments to provide adequate SHP coverage, particularly by increasing the fiscal space. Indeed, the fiscal space is defined as “the resources available as a result of the active exploration and utilization of all possible revenue sources by a government” (Ortiz, Cummins, and Karunaneth 2015). There are many ways to create fiscal space for SHP, and a mix of financing options are usually explored. Strategies devised by institutions in charge of SHP can focus on raising earmarked resources via the expansion of social insurance coverage and contributory revenues or the establishment of health taxes. They can also focus on increasing non-earmarked tax revenues and advocate for prioritization of health as well as other ways of mobilizing more resources, including improving efficiency, eliminating illicit financial flows and increasing aid and transfers. The next sections will explore how countries have made use of these opportunities to increase the amount of public resources available for SHP.

4.2.1. Political will drives fiscal space mobilization

As discussed in the previous section, domestic revenues provide the most sustainable source of funding for SHP. In most countries, including in the Asia and the Pacific region, taxes and social security contributions are the main sources of public finance, particularly as foreign aid is declining. On average, the tax-to-GDP ratio – which calculation include social contributions – increased from around 15 per cent during 1990–2009 to around 22 per cent during 2010–2014. Despite much progress, low- and middle-income countries in Asia and the Pacific collect lower proportions of their GDPs from public revenues than OECD countries.

► **Figure 31. Social security contributions and tax revenue as a share of GDP, countries and territories in Asia and the Pacific with available data, 2019**



Note: Only countries with data available are shown. Values for 2019 were unavailable for Australia, Japan and the OECD average. Instead, values for 2018 were used.

Source: Author calculations based on OECD (2021).

With strong political will, raising public revenues is not out of reach. Appropriate fiscal reforms are necessary not only to increase the ratio, but also to reduce income inequalities by improving progressivity (see Box 22). This requires decreasing reliance on indirect taxes, which are most often regressive in nature and to enforce direct taxation. Several middle-income countries have successfully mobilized public resources to extend SHP coverage to their populations in a sustainable fashion embedded in law. In 2014, Indonesia's national social health insurance scheme JKN consolidated all previously fragmented SHI schemes and assistance programmes at national and provincial levels after citizens brought legal action to hold the government accountable to implement the 2004 Law on the National Social Security System. Viet Nam also consolidated fragmented schemes and made commitments to government subsidies for the contributions of vulnerable groups in the Health Insurance Law as a way to increase public financing of health services.

► Box 22. Political will drives fiscal space mobilization

Thailand relies heavily on government budget to fund the Civil Servant Medical Benefit Scheme and the UCS for a large part of the population. Thailand was able to ensure government annual allocations for the UCS through passage of the National Health Security Act (2002), which achieved efficiency gains by consolidating funding from existing schemes (Medical Welfare Scheme and Voluntary Health Card Scheme) into the UCS and applying provider payments and other measures that ensured efficiency in health service delivery.

In March 2009, the Central Committee of the Communist Party of China and the State Council issued a guiding policy document, Deepening the Health System Reform, aiming to achieve UHC by 2020. This event launched comprehensive health system reforms to extend social health insurance coverage and promote universal access to health services. To facilitate these reforms, government expenditure on health tripled between 2009–2017 and the SHP landscape in China has witnessed significant improvements through enhanced subsidies for vulnerable groups and the consolidation of schemes for rural and urban residents.

In Japan, the Ministry of Finance has played a major role in securing funding for Japan's SHP, with involvement from the early stage of the Ministry in the insurance system design process in the 1920s to ensure SHP's financial sustainability. The ministry contributed to further shape reform and to introduce policies that led to UHC, particularly by assuring availability and sustainability of the financial resources necessary to keep the promises of providing health benefits. A key aspect was the determinant role of the Ministry of Finance to set a global budget for public health insurance, and later to earmark consumption tax revenue to social security expenses, including health, to secure the sustainability of its social security system (Aso 2017).

Among the options available, earmarked revenues play an important role in financing SHP. The arguments for and against earmarking are numerous. Earmarking policies may vary according to the country contexts, political priorities and budget processes to ensure positive results. Fiscal and public financial management impacts of earmarked revenues for SHP must be carefully analyzed. However, earmarking enables MOHs and social security institutions to benefit from stable revenues. It protects institutions from the risk of insufficient allocation in case policy and budget process are not well aligned or competing political interests are at play, and participate to increased accountability. Earmarking revenues in the form of social security contributions and health taxes contributes to these objectives. At the same time, a financing mix remains necessary to ensure SHP systems have sufficiently diversified revenues to guarantee their sustainability and equity.

4.2.2. Raising earmarked revenues from social security contributions

Social security contributions are explicitly earmarked to cover health spending and alleviate the burden of health care costs for households by redistributing and pooling. Social security contributions to SHP schemes are earmarked nominal financial contributions made to a dedicated fund or institution which enjoys autonomy for the administration of those funds under participatory governance. Social security contributions may be collected from workers, employers and government and are calculated in such a way that each individual pays according to their capacity to contribute, while entitlements to benefits are equal for all covered in line with the principle of solidarity in financing. They are redistributive in nature in that they allow transfers from employers to workers, and from the healthy to the sick or unable to work, and across generations. Social security contributions, as per guidance provided by ILO standards, should be set in a way that ensures equity and solidarity, and therefore be progressive.

Historically, models of financing to guarantee access to health care without hardship were commonly referred to as the Bismarck and the Beveridge models, in reference to the national models of financing chosen by Germany and the United Kingdom. Distinct features that usually distinguished these two models were essentially the source of funding and the way services were procured either through direct provision or contracting providers. In the Bismarck model, employers, workers and the government made mandatory contributions to a social health insurance scheme under participatory governance, which funded access to public and private health care providers for the covered population (workers, pensioners and their families). In the Beveridge model, access to free or largely subsidized health services was guaranteed for the whole population within a network of providers directly financed and managed by the MOH. This distinction does not fit the reality of financing and institutional arrangements adopted in most countries, including in the Asia and the Pacific region. Further, the distinctions that some may have made between those two models has been a poor predictor of outcomes in terms of effective and adequate SHP.

National efforts to extend coverage have led a majority of countries resorting to a financing mix combining revenues from social security contributions and taxes (general and earmarked). For instance, in China, Indonesia, Japan, Mongolia, the Philippines, Republic of Korea, Thailand and Viet Nam all have systems financed with a diversity of funding sources. Similarly, the distinction between the Bismarck and Beveridge models does not hold when it comes to institutional arrangements, as many countries with models based only on tax-financed free public provision have started purchasing from private facilities (Brunei Darussalam and Malaysia) and conversely some countries' SHI remains largely limited to their own facilities (ESIC in India and SSB in Myanmar).

In practice, the combination of social security and tax revenues in the financing mix can take several forms, for example:

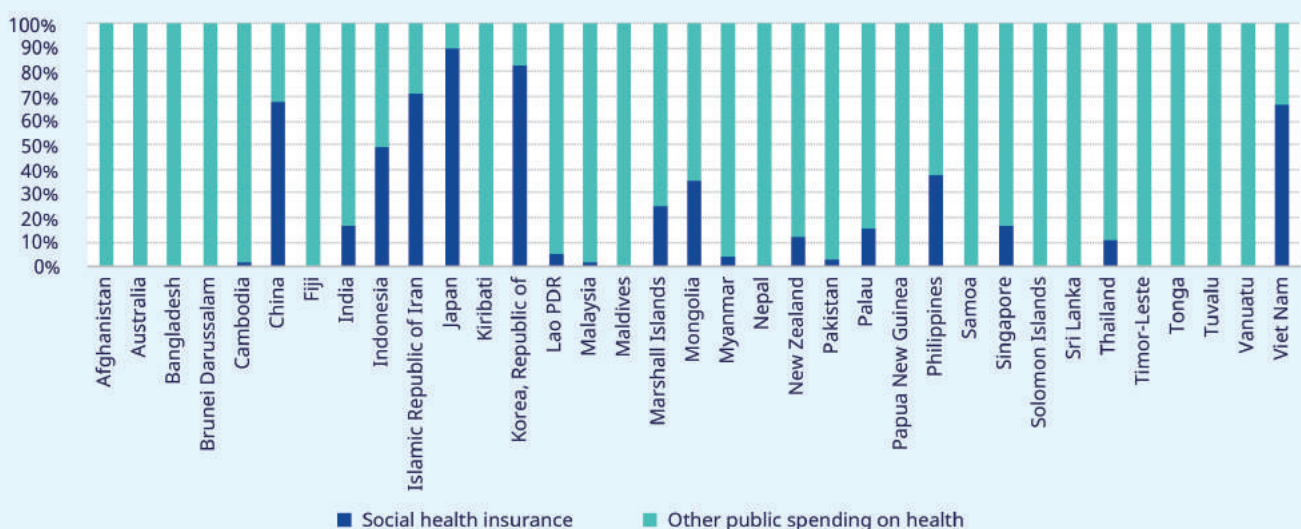
- Tax revenues are used to provide either population-based interventions or the entire primary level of care, while social security contributions are used to finance higher levels of care. In Viet Nam, disease prevention services and health promotion are financed by taxes to mostly public preventive service providers. In Mongolia, taxes fund public and private providers for PHC services. Singapore provides partial tax-financed supply-side subsidies for health services in public hospitals with the amounts depending on means testing of users.
- Tax revenues and social security contributions are used to cover different cost items. For example, many countries use social security contributions to pay for service utilization, while using taxes to provide supply-side subsidies to cover certain cost items, such as human resources or capital costs. For example, Mongolia and the Philippines provide line-item budgets to cover certain costs at public hospitals. In Thailand, the State budget subsidizes payrolls in public hospitals. In Viet Nam, capital costs of public hospitals are often subsidized by the State budget.
- Tax revenues are used to subsidize the social security contributions of specific categories of the population. In Viet Nam, partial subsidies are provided to war veterans and full subsidies are provided to children under-six, among others.
- A contributory system is in place with some level of co-payment, while tax revenues are used to cover co-payments for the poorest and most vulnerable or specific groups, for example China's Catastrophic Medical Insurance (CMI) and MFA.

As a predictable source of revenue, social security contributions play an important role in financing SHP. Similarly, they contribute to the financial sustainability of SHP systems in many countries, as illustrated in Figure 31. In practice, in the Asia and the Pacific region, social security contributions are diverse:

- Countries with small proportions of informal employment – such as Japan, Republic of Korea and Singapore – all have strong contributory schemes that rely on compulsory contributions from workers and employers. Despite having larger shares of informal employment, some middle-income countries, such as China and Viet Nam, strongly rely on social contributions. In Viet Nam, social security contributions represented 47.9 per cent of total revenues of the national health insurance scheme in 2020, which were generated by employers and workers in formal employment representing only 20.2 per cent of the total population protected.

- In some countries, the government fully covers the cost of social security contributions with tax revenues for specific categories of population that cannot contribute (for instance, in Indonesia, Japan, the Philippines and Viet Nam) and/or for whom the contribution collection cost-to-revenue ratio is deemed too low to be worth it (for instance, Thailand).
- In some countries, governments put in place either a unique or a schedule of fixed contribution amounts destined to the self-employed, for which the government itself covers the equivalent of the employer's share of the contribution from tax revenues. Experiences where the government does not match this individual contribution have proven relatively unsuccessful to expand, as it can be unaffordable for the self-employed as they must pay both worker and employer contribution amounts. Fixed amount contributions are sometimes the only practical option, but they are also less progressive which reduces their redistributory effect.

► **Figure 32. Social health insurance as a share of public spending on health, countries and territories in Asia and the Pacific with available data, 2018**



Note: No data available for the Cook Islands. Public spending on health constitutes of government financing arrangements and social health insurance.
Source: Adapted from WHO Global Health Expenditure Database.

In many countries, social health insurance schemes collect mandatory contributions from workers and employers automatically from the payroll. While this is extremely convenient for the managing authority, the efficiency of contribution collections is often limited to the formal economy, which complies with tax regulations and is a more costly exercise when it comes to expanding coverage to smaller business units (see Chapter 3). Similarly, while this financing stream secures a significant volume of revenues relatively easily, it is also vulnerable to fluctuations in the job market and contractions in employment.

Ways to overcome these challenges associated with extension of coverage exist and include a vast spectrum of actions. Social security contributions are linked to legal entitlements and one main strategy for extension includes expansion of legal coverage, by identifying gaps and undertaking necessary legal reforms. A government must then ensure its effective implementation to ensure coverage becomes effective. Simplification of administrative procedures, improving compliance through a mix of enrolment and contributions controls and labour and social security inspections are essential, as explored in Chapter 3. All these strategies must go hand-in-hand with efforts to transition from the informal to formal economy (see Section 3.3.4).

Sustainability and adequate levels of financing for equitable SHP calls for a diversity of financing sources, with recourse to a financing mix allying taxes and social security contributions, but also exploring new sources of revenues and ways to generate efficiency gains for decreasing reliance on external funding and out-of-pocket expenditures.

4.2.3. Raising earmarked revenues from health taxes

Financing for extension of SHP is being achieved through a diversity of financing sources in the region, including newer funding sources within the financing mix. Several countries have resorted to earmarking certain consumption taxes for health care, with substantial attention paid to what is known in the region as “sin taxes”. Those taxes are a type of excise tax that targets goods and services that are harmful to health, specifically alcohol, tobacco, sugar (or sweetened beverages) and gambling. These taxes are often applied not only to generate revenues, but also to discourage harmful consumption. For example, the Philippines has mobilized a substantial amount of additional government health funding to further extend SHP coverage in all three dimensions through public health taxes consisting of excise taxes imposed on the consumption of tobacco and alcohol, aiming to reduce consumption, raise additional revenue and improve population health. This started with the 2012 Sin Tax Law, which assigned 85 per cent of sin tax revenues to the health sector. Funding was increased further with the 2019 Tobacco Tax Law and allocated to the goal of UHC through the 2019 UHC Law. This approach was also successfully applied in the Republic of Korea to extend NHI coverage for workers not otherwise covered, through contribution subsidies funded by tobacco taxes.



Countries vary in the way they allocate revenue raised from tobacco and other health taxes. Most allocate a set percentage of the tax to health, such as Mongolia (2 per cent), Republic of Korea (54 per cent) and the Philippines (85 per cent in 2012). Thailand and Viet Nam charge a surcharge on top of the excise tax value, which is earmarked in Thailand to fund the Thai Health Promotion Foundation and in Viet Nam for tobacco control activities (Law on Tobacco Control).

Health taxes hold potential for generating a diversified source of revenue for health and SHP in particular. It remains a financing source that holds untapped potential in the region since excise taxes on tobacco in many countries in the Asia and the Pacific region remain below the level of 75 per cent recommended by the WHO Framework Convention on Tobacco Control (WHO 2015b). However, it is important to consider them within the overall taxation system to ensure fiscal justice and financial sustainability:

- First, health taxes are an interesting tool in their double function. They generate revenues, but first and foremost have a public health purpose related to behaviour change. This means that when the expected behaviour change will occur, the revenues from those taxes will decrease over time, unless tax rates increase. For example, after the 'sin taxes' on tobacco were introduced in the Philippines in 2012, smoking rates reduced by 25 per cent. As consumption dropped, so did tax revenues and subsequently the tax rate was raised again and overall revenues continued to increase (Mendoza 2020). For this reason, they are best used as part of a broader financing mix.
- Second, health taxes need to be designed carefully to secure their alignment with the principles of solidarity in financing and equity. Indeed, since tobacco, alcohol and poor quality foods are often consumed by low- and middle-income households and represent a larger share of their consumption basket than for high-income earners, heavily taxing such products can be viewed as regressive. It is crucial to ensure that the scope and level of those taxes does not place an inequitable burden on lower-income households or reinforce tax systems already based almost exclusively on consumption taxes targeted at households, which tend to be regressive.

Other countries have put in place earmarked resources through dedicated funding streams or shares of specific tax revenues. In Malaysia, the MySalam scheme – which provides sickness cash benefits in case of hospitalization or critical illness for the population in the lowest income quintile, is supported by a trust fund donated as seed money from a private holding company. Fiji has also used a trust fund created based on revenues from a levy, which is utilized to incentivize general practitioners in underserved communities.

4.2.4. Efficiency gains

Strategies towards efficiency

When public funds for SHP are limited and coverage is incomplete, another essential strategy is to increase efficiency to get greater value for money. Evidence suggests that a significant share of health spending could be spent more efficiently. In OECD countries, up to one-fifth of health spending could be better used (OECD 2017). This commonly materializes in practices such as unnecessary admissions or C-Sections, treatment of simple diseases at tertiary hospitals when they could be addressed at primary level or unnecessary drug prescriptions. Therefore, there is potential for greater access to effective services within the existing envelope allocated to SHP.

More strategic purchasing, including shifting from line-item budgets or fee-for-service towards prospective payment mechanisms, and efficient procurement of pharmaceuticals also bear potential to generate greater value for money (see Chapter 3). Thailand's success in extending coverage to the entire population with its UCS was feasible because measures were in place to ensure that the funds would be used effectively. This included DRG and capitation payments as well as health technology assessment and price negotiation measures. Such efforts kept prices down and avoided introducing excessively expensive technologies into the service package. This further benefited the contributory scheme under SSO, which adopted similar practices.

Reducing fragmentation and duplication of SHP schemes and aligning coverage parameters can also help to achieve greater efficiency (see Chapter 3). The modernization of administration through business process streamlining also contributes to lower administrative costs. Sri Lanka's public delivery system is highly cost efficient in global comparison. This has been achieved through an organizational and management structure that has: i) used managerial methods to drive and incentivize cost efficiency, ii) kept government health workers' salaries relatively low, with doctors' wages kept below market rates by allowing them rights to private practice, iii) used global tender and centralized procurement of drugs to maintain very low unit costs for supplies and iv) used global budgets at national and facility levels to restrain cost growth. The managerial approach depends on intensive and constant supervision and accountability of managers at all levels, considerable peer learning, professionalization of medical management, and extensive de facto managerial autonomy granted to institutional managers, which belies a de jure lack of facility autonomy (Dalpatadu et al. 2016).

Efficiency gains are all the more needed that over time health spending continues to increase (Cichon et al. 1999). Globally, increased demand for care is led by multiple factors. These include the constant development over the past decades of medical knowledge and health technologies. To ensure only effective interventions are included in SHP benefit packages, it is important that countries develop and use health care technology assessments. Other factors drive health spending. Notably, demographic trends – starting with population growth and ageing, play a role. Similarly, the changing burden of diseases related to demography, economics and changing life-styles is a key factor. The latter is increasingly associated with high-fat and sugar diets resulting in obesity and increases in non-communicable chronic diseases, such as cardiovascular disease, some cancers and respiratory illnesses.

The economic case for health promotion and disease prevention

Health promotion empowers people to improve and increase control over their health, through population-based activities that usually focus on addressing behavioural risk factors, such as diet and physical inactivity, mental health, injury prevention and sexual health. Disease prevention helps detect or prevent serious diseases and medical problems, hence lessen chances they appear or become serious. It includes population-based and individual-based interventions such as immunization programmes, nutritional and food supplementation, evidence-based screening programmes for early detection of disease. Collectively, health promotion and disease prevention aim to protect, promote and maintain health and well-being and to reduce the risk of diseases, disabilities and death. They contribute to address social determinants and health inequity.

Not only do these interventions contribute to the achievement of the right to health and have a strong legitimacy from a human perspective, there is also an economic case for action. Keeping people healthy and minimizing the burden of diseases helps to keep the cost of care low, but also lower overall economic costs resulting from a lack of intervention. For instance, WHO-UNDP research shows that one million people die of tobacco-related diseases in China every year and that smoking-related diseases are on-track to kill another 200 million lives in China in this century, and will result in decreased economic productivity and will push tens of millions of people into poverty (WHO 2017).

Multiple strong evidence of the cost-effectiveness of prevention exist for tobacco and alcohol control, quality of people's diets, promotion of physical activities, particularly when targeting the adult population and individuals at higher risk, prevention of traffic accidents or tackling environmental chemical hazards. A combination of interventions is likely to generate additional health benefits, while still remaining cost-effective (WHO 2015c).

A combination of measures involving fiscal policies, regulation and improved access to information on health are needed and should be part of a broader strategy to create fiscal space.

4.2.5. External financing

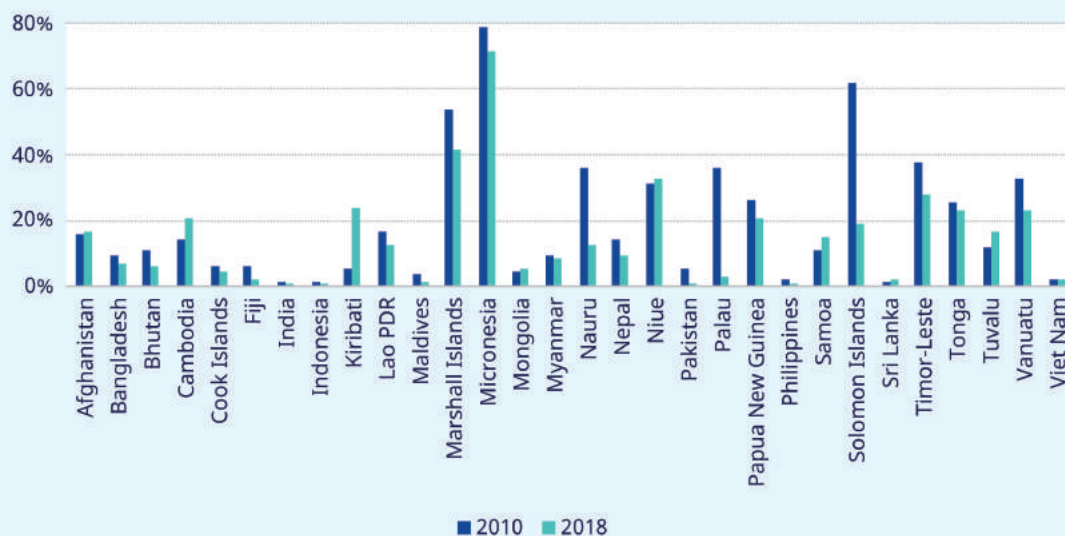
External funding has played an important role in financing population-based health programmes, such as vertical disease control programmes and immunizations over the past decades, especially in

low-income countries. In particular, it has played a crucial role in containing infectious diseases through timely delivery of much needed prevention, detection and treatment free of charge to the patient. Vertical funding mechanisms also allowed, via pooled mechanisms for purchasing at global level, a lower cost of expensive drugs and devices for low- and middle-income countries, therefore improving health spending efficiency. However, such funding is reliant on changing international priorities. Therefore, is not considered a sustainable form of financing, but rather an opportunity to support countries temporarily as they progressively mobilize the necessary resources to finance such programmes with their own resources. A number of countries have transitioned out of external aid dependency in the last decades and their experiences may provide helpful lessons for other countries.

Challenges in the transition process include pervasive gaps in accessibility of services for specific diseases that were previously vertically funded, and risk of leaving large groups of vulnerable individuals previously dependent on external funding uncovered. The transition may be particularly challenging for key populations living with HIV/AIDs, who often experience multi-dimensional deprivations and even criminalization, and for whom highly specialized and sensitized vertical programmes have managed to ensure outreach and effectiveness. Integration of these groups into mainstream SHP may require active efforts of inclusiveness and outreach from government-led institutions and will most likely involve partnering with community-based organizations closest to them (ILO, forthcoming b).

External funding as a share of CHE has been declining in most countries in the Asia and the Pacific region (Figure 33). Nevertheless, it still contributes a high share of CHE in most middle-income Pacific Island countries, and remains above 10 per cent of CHE in Afghanistan, Cambodia, Lao PDR and Timor-Leste. The latter two are heavily dependent on external assistance for vertical disease programmes. Several countries in the region have been able to transition away from donor dependence for vertical disease control programmes by incorporating such diseases (HIV, TB) into the SHP package (Indonesia, the Philippines, Thailand and Viet Nam). In Lao PDR, careful planning and gradual integration of these programmes into the overall SHP architecture will allow it to adjust to the donor transition, using savings from eliminating parallel administrative structures to boost the resources available for service delivery.

► **Figure 33. Trends in external health expenditure as percentage of CHE, countries and territories in Asia and the Pacific for which data is available, 2010 and 2018**



Source: Adapted from WHO Global Health Expenditure Database.

In Timor-Leste, the transition will be more challenging due to the limited domestic revenue raising with large amounts of resources to cover the gaps when donors withdraw.

In Cambodia, external assistance is integrated with government funds and used to purchase health services for poor and vulnerable groups through a unique Health Equity and Quality Improvement Programme (H-EQIP) (see Box 23). Bangladesh has been using a “Sector Wide Approach” (SWAp) to reduce its dependence on external assistance through a pooled funding mechanism from multiple international donors, with contributions made directly into a government account at the central bank and subsequently distributed by the government to implementing agencies through regular budgetary channels. The funding mechanism has been noted to reduce duplication and bring greater control over funds to the government.

► **Box 23. Cambodia’s pooling of external assistance and government counterpart funds (H-EQIP)**

The Health Equity and Quality Improvement Programme (H-EQIP) is a five-year (May 2016–June 2021) US\$180.2 million pooled funding arrangement between selected development partners and the Cambodian Government (US\$94.2 million counterpart funding) (World Bank 2018). The programme aims to improve access to quality health services for targeted population groups through use of a nationwide performance-based financing programme to enhance quality. It also seeks to improve financial protection against (further) impoverishment due to out-of-pocket health expenditure by financially and technically supporting the Health Equity Fund and associated structures. They were established to provide free access to health care for the poorest, reimbursing public health providers the user fees for eligible poor people.

Social health protection programmes can count on some earmarked resources from domestic and, sometimes, external sources in most countries in the region. Countries can also make efforts to improve the efficiency of their spending. Still, a balanced financing mix will require some revenues to be allocated from the general government budget and therefore will require looking at increasing fiscal space more broadly.

4.2.6. Raising unearmarked revenues through tax base expansion and securing the prioritization of health

Widening the tax base through formalization

Many low- and middle-income countries in the Asia and the Pacific region have high rates of informal employment (Figure 9 in Chapter 1), reaching more than 80 per cent in countries like Bangladesh, Cambodia, India, Indonesia, Lao PDR, Nepal and Pakistan. In such countries, mobilizing funding through social security contributions can be challenging. At the same time, raising funds through taxation is also difficult, as the size of the informal economy largely influences the tax base for progressive taxation measures on individual and corporate income. Hence, the same countries that have high rates of informal employment also tend to have limited ability to mobilize public resources through taxation.

Supporting the formalization of the economy is a necessity to ensure decent work for all and equity, but also a prerequisite to broaden taxes on profits and income (see Box 24). ILO recommendation 204 on the Transition from the Informal to the Formal Economy outlines strategies and policies countries can develop to support this path. Formalization of the economy is a long-term process requiring a complex mix of well-coordinated interventions. Assessment and diagnostics of factors, characteristic causes and circumstances of informality form the basis of developing and implementing a legislative and regulatory

framework to address informality, based of tripartite consultations. This must be accompanied by the formulation and implementation of national employment policies promoting decent, productive jobs. A combination of preventive measures and incentives for compliance, law enforcement and effective sanctions, to address tax evasion and avoidance of social security contributions, labour laws and regulations is necessary to facilitate the effective and timely transition from the informal to the formal economy. Such administrative measures are explored in Chapter 3.

► **Box 24. Importance of collective financing and plurality of financing sources to guarantee SHP for all, in the context of the Future of Work**

In recent years, the world of work has undergone dramatic changes due to technological advances, urbanization, migration and climate change, which have been accelerated by the COVID-19 pandemic. Although technological advances and new opportunities for environmentally-friendly industries are creating new jobs, many of those who lose employment lack the necessary skills to get new jobs in these growing industries. Many of these new job opportunities consist of forms of self-employment lacking access to social protection. These trends impede the formalization of employment to ensure decent work conditions, which include social protection, not only in lower-income economies with a large informal economy, but also in high-income economies where the gig/platform economy is growing. Large populations of young people in some countries and aging populations in others create tensions in labour markets and social protection systems. Recognizing these challenges and unfinished development agendas, international actors/entities have begun imagining a new and improved future for the world of work that not only responds to the inevitable changes in the labour market, but also strives to improve the quality of working lives, leaving no one behind.

The future of work agenda includes increasing investment in people's capabilities, with USP, from birth to old age being one of its key components. The ILO Centenary Declaration for the Future of Work adopted in 2019 declared that Member States must direct efforts to develop and enhance social protection systems, which are adequate, sustainable and adapted to the developments in the world of work, protecting workers and taking into account the need to create sustainable enterprises (ILO 2019b). The large size and even growth of the informal economy, including digital platform work, leaves large shares of the population with inadequate coverage to protect themselves from life contingencies. In this context, ILO promotes mechanisms reliant on collective solidarity-based financing and a plurality of financing sources to secure their sustainability.

Introducing other taxes

The introduction of taxes on sectors not previously taxed can provide additional revenues to finance SHP, or social investments as a whole.

More countries are considering introducing financial sector tax schemes, including financial transaction taxes, defined as *"a small tax levied on various types of financial instruments such as shares, bonds, foreign currency transactions, derivatives (futures, forwards, swaps and options), and bank debits and credits, and other types of banking services"* (Ortiz, Cummins, and Karunaneth 2015). Countries in Asia and the Pacific are no exception, with examples including the Securities Transaction Tax in India and Republic of Korea, stamp duty in China, Malaysia, Singapore and Thailand and a transfer tax in the Philippines (Dowd 2020). The potential for raising resources from the financial sector remains largely untapped in the majority of countries in the Asia and the Pacific region.

Property taxes are common place in OECD countries, but represent a small share of GDP in most developing countries. They offer a stable source of income, are difficult to evade and do not penalize the poorest, as the property tax burden usually falls on middle- or high-income households. In Asia, property taxations have been introduced in countries such as Cambodia, China, Singapore and Viet Nam (Ortiz et al. 2019).

Taxation on natural resources and extractive industries channelled to social spending offers additional revenue streams. Brunei Darussalam and Timor-Leste currently rely mainly on oil and gas revenues to fully subsidize their health services. Such revenues may be volatile (reliant on global market price fluctuations) or erode over time (based on non-renewable natural resources) and need to be complemented by more stable sources.

Other innovative taxes on sectors not previously taxed include environment protection taxes and lottery taxes. Viet Nam introduced the first in 2011 and the second in 2017, the year following the removal of the Business License Tax. Based on calculations from the State budget in 2019, both respectively represented 6 and 3 per cent of total direct and indirect taxes (Viet Nam Ministry of Finance 2019).

Tackling corruption, tax evasion and illicit financial flows through international and regional collaboration

Reducing tax evasion and combatting illicit transactions are among strategies that have recently gained renewed attention, given the importance and tremendous potential to expand the tax base if addressed. In addition to mechanisms countries can put in place to facilitate compliance with tax payment at national level (see Chapter 3), international and regional collaboration is needed. Through the 2015 Addis Ababa Action Agenda, countries committed to implement measures to combat corruption, tax evasion and illicit financial flows, including money laundering through strengthened national regulations and increased international cooperation (UN 2015). It emphasizes the importance of inclusive cooperation and dialogue among national tax authorities.

In Asia, the Study Group on Asian Tax Administration and Research (SGATAR) aims to provide “a platform to enhance the performance of tax administrations in the Asia-Pacific region by promoting collaboration and communication among member tax administrations” (SGATAR 2021). Other regional cooperation frameworks on taxation in Asia and the Pacific include the ASEAN Forum on Taxation, the Pacific Islands Tax Administrators’ Association (PITAA), and the South Asian Association for Regional Cooperation (SAARC).

A more accommodating macroeconomic framework

Governments can use both fiscal and monetary policies to create and maintain social protection and health sector investments. Fiscal policy comprises government revenues and expenditure as discussed earlier in this section, and monetary policy deals with money supply and interest rates. As noted by Ortiz et al, “with macro-prudential regulations on capital flows and the supporting role of public provision of social goods (health care, education), countries can accommodate moderate inflation and budget deficits. Ultimately, this means that inflation and deficit thresholds are policy choices. Thus< governments have some room for manoeuvre to design monetary and fiscal policies to generate employment and social protection” (Ortiz et al. 2019). In this respect, it is important to note that, several countries in the region had inflation rates below 1 per cent (Samoa, Thailand, Tonga) or negative (Brunei Darussalam, Lao PDR, Timor-Leste) in 2016 (IMF 2017).

In addition to earmarked revenues, the availability of greater resources in general government revenues would make expanding SHP feasible, but still requires prioritization of spending on health.

Priorization of the health sector

Increased public resources may not benefit the health sector unless policies give high priority to health and laws are in place. Ensuring that policy-makers prioritize health in public resource allocations is facilitated when legislation stipulates explicit entitlements related to SHP. Indonesia, Lao PDR, the

Philippines, Thailand and Viet Nam have all set concrete UHC goals in laws and regulations, which are then used to justify State budget funding requests (see Box 25). This includes the UHC Law in the Philippines setting concrete goals to expand population and service coverage and increase financial protection. The Health Insurance Law in Viet Nam stipulates that population groups receive government subsidies for their contribution amounts. The Thai Health Security Law since 2003 and the Indonesian Law on the National Social Security System and Law No. 24 on the Social Security Administrative Body, also evidence these governments' commitment to achieve UHC.

► **Box 25. Thailand: Reallocating military expenditures for the Universal Coverage Scheme**

The 1997–1998 Asian Financial Crisis severely hit the Thai economy and its society. With the backing of the 1997 Constitution, civil society calls to address neglected social policies led the government to adopt the Universal Coverage Scheme in 2001. Given that approximately a third of the population was excluded from health coverage at that time, most of whom belonged to the informal agricultural sector without regular income, achieving universal coverage through contributory schemes alone was not possible, as it needed budget support. Most of the funding for the UCS was financed through reduced spending on defense (from 25 per cent of total expenditures in the 1970s to 15 per cent during the 2000s and to 7.62 per cent in 2015) and lower debt service payments. The government included the UCS as part of a more general fiscal stimulus plan. Other measures increased the amount of money in the hands of people with a high propensity to spend, including the creation of a People's Bank, a debt moratorium for farmers and a village fund.

Source: Adapted from Ortiz, Cummins, and Karunaneth (2015)



Way forward

COVID-19 has acted as a wake-up call for SHP systems in the Asia and the Pacific region and the world more broadly, further revealing pre-existing gaps in coverage, comprehensiveness and adequacy of protection. Those who are unable to access vaccines, gain the treatment they need to recover from COVID-19 or to quarantine not only endanger themselves but also others, thereby undermining public health efforts to contain the virus. Importantly, the need for integration and comprehensiveness of social protection systems has been highlighted throughout the pandemic, with millions of households in acute need of access to health care and income security. The crisis has revealed stark inequalities in access to SHP, both in terms of health care and sickness cash benefits, across and within countries, and for workers in different forms of employment and their families.

The COVID-19 crisis has provided a tragic illustration of the prescient dictum that “poverty anywhere is a threat to prosperity everywhere” (ILO Declaration of Philadelphia, 1944), as we are all only as safe as the most vulnerable among us. In response, governments around the world have introduced emergency measures to ensure timely access to health care, to roll out vaccination programmes and provide sickness and other cash benefits for their populations, including by extending their reach, improving their adequacy and facilitating their delivery. Moving forward, it is crucial to transform the emergency responses adopted to tackle the pandemic into sustainable, comprehensive, adequate USP systems. Such systems must include specifically universal and effective access to affordable health care services and adequate sickness benefits for all, with a particular focus on those unprotected and in vulnerable situations.

A human-centred recovery from the current health and economic crisis is possible and involves taking the high road towards USP. An important and urgently needed component of the high-road approach involves universal access to comprehensive, adapted and sustainable SHP systems that provide an adequate range of services and financial protection for all, throughout the entire life course and in response to covariate shocks (ILO 2021b). Building on the progress in coverage and institutional capacities highlighted throughout this publication, an inclusive recovery will need to address the deep structural inequalities that have obstructed progress towards social justice for too long, including in Asia and the Pacific where half of the world’s population lives.

Extension in duration and quality of life will come from scientific breakthroughs in health technology, effective and equitable access to health care without hardship. But it will also come from actively addressing the social determinants of ill-health along the life cycle. The compounded effects of deprivations people experience throughout their lives, in terms of lack of access to appropriate health care and periods of income insecurity and poverty, impact their health status. Comprehensive social protection encompasses both access to health care and measures to secure income security in case of sickness, maternity, old age, unemployment, disability, loss of primary income earners, work accidents or disease, and support of families and children to prevent poverty and ensure an adequate standard of living. Only with this broad range of benefits and services, can comprehensive USP play a key role in addressing the social determinants of health.

Such breakthroughs can only contribute to improvements in health outcomes if they are broadly shared between rich and poor, women and men, low- and high-income countries, and across generations. Indeed, with life expectancy rising – assuming the impact of COVID-19 is reversed, populations are ageing rapidly in low- and middle-income countries, yet the additional years of life gained are not necessarily healthy ones. Older people in such countries carry a greater disease burden than those in high-income countries, pushed by cardiovascular diseases as well as sensory, respiratory and infectious disorders (GBD 2019 Diseases and Injuries Collaborators 2020). SHP schemes and more broadly social protection and health systems need to be prepared to cater to the needs of a growing number of older persons who have lost some level of autonomy. With rapid ageing, there is a growing need for long-term care services that are provided in a way that is respectful of the dignity of older persons and supportive of

ageing in place. To ensure equity, it is also essential that the cost of such services be born collectively. As was stated by the International Labour Conference in June 2021, long-term care needs to be considered an integral part of social protection systems and decent working conditions for workers in the care economy needs to be secured.²⁵ This should also be considered an investment with significant returns, as it is an employment-intensive and growing sector of the economy, which must comply with decent work standards. Some countries in Asia and the Pacific are leading the way to address the long-term care needs of their populations and can provide useful insights to ones that envisage new policies in this respect.

Investing in robust and adaptable rights-based SHP systems is urgently needed. The clock is ticking, with fewer than nine years remaining to achieve the 2030 Agenda, including targets 1.3 and 3.8.

Prioritizing public investments to guarantee access to health care without hardship, as part of nationally-defined social protection floors, is key to delivering on the promises of the 2030 agenda, to leave no one behind and to unleash “high human development – high growth” patterns. Achieving the 2030 agenda goals also requires reflection in the design of social health protection policies, their implementation, monitoring and evaluation the perspectives and needs of the users they serve, hence with the active participation of representatives of users, workers’ and employers’ organizations. Shifting gears towards achieving the SDGs by 2030 is essential to enable people and societies to address the profound transformations that are associated with demographic, epidemiologic, technological and climate changes. By making progress towards realizing the promise of achieving USP and UHC by 2030, and by protecting and promoting human rights, States can strengthen the social contract. This will also better ensure preparedness for future crises, including the risks arising from climate change, natural resource depletion and environmental degradation. To this purpose, ratification and implementation of Conventions No. 102, 130 and 183 should be placed high on national agendas. Ratifying social security conventions demonstrates a commitment to realizing the human rights to social security and health.

The pandemic has demonstrated the centrality of the objectives of USP and UHC, the enormous gains from making them a policy priority, and the risks associated with the failure to do so. Expansion of SHP should be seen as an investment. A just transition of our economies towards a more digital, greener, fairer and human-centred future of work requires reinvigorated SHP systems closely coordinated with the health and social care sectors, that can help people navigate transitions and seize new opportunities, while supporting those left behind.

If there is a silver lining to the crisis triggered by the COVID-19 pandemic, it is the renewed recognition for the need to strengthen health and social policies. In this context, countries have a unique policy window to reinforce their SHP systems to achieve universal coverage and increase access to quality health services, to be better prepared for future crises and ultimately ensure a socially just future. Decisive policy action is needed to close gaps in SHP and adapt systems to changing conditions of both people and the planet. Such a high-road strategy needs to build on the broad support from governments, social partners, civil society, health and care sector workforces, patients and other stakeholders.

²⁵ Resolution Concerning the Second Recurrent Discussion on Social Protection (Social Security), adopted by the International Labour Conference 109th Session (ILC.109/Resolution III), available at: https://www.ilo.org/wcmsp5/groups/public/-/ed_norm/-/relconf/documents/meetingdocument/wcms_806099.pdf

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Part 2

Country profiles

21 country profiles providing an overview of national social health protection systems' design and results are presented in the following section. The 21 countries are: Bangladesh, Brunei Darussalam, Cambodia, China, Fiji, India, Indonesia, Japan, Lao PDR, Malaysia, Mongolia, Myanmar, Nepal, Pakistan, the Philippines, Republic of Korea, Singapore, Sri Lanka, Thailand, Timor-Leste and Viet Nam.

Bhutan, the Democratic People's Republic of North Korea, Nauru, Niue and the Federated States of Micronesia are not ILO Member States. Among ILO Member States, data access problems prevented compilation of country profiles for Afghanistan, Australia, Cook Islands, the Islamic Republic of Iran, Kiribati, Maldives, Marshall Islands, New Zealand, Palau Islands, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu.





▶ Bangladesh

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This profile was prepared by Sven Engels and Lou Tessier with the support of Henrik Axelson and Nga Leopold (ILO). It benefited from the review, inputs and quality assurance of Syed Abdul Hamid (Institute of Health Economics, University of Dhaka, Bangladesh).

▶ 1. Introduction

Since the establishment of Bangladesh's first Constitution in 1972, the improvement of health care and nutrition has been established as a priority, with the state primarily responsible for ensuring the provision of health services as a basic necessity.²⁶ The statutory public health system therefore provides all citizens with a range of services, with only nominal user fees charged to patients. In practice, however, the system is struggling to provide adequate levels of care, with many sick people being left untreated (WHO 2015). Private facilities have mostly filled the gaps, resulting in a high share of out-of-pocket (OOP) health spending, and hence limited financial protection for the population.

To date, national development policies have not given sufficient weight to the health sector, resulting in few systematic improvements. Consequently, both the allocation and the level of government expenditure on health is low relative to the services promised, accounting for just 5.4 per cent of the overall government budget and

0.95 per cent of GDP. Despite these challenges, the government aims to achieve full universal health coverage (UHC) by 2030. This would require public spending on health to substantially increase, which currently accounts for only 17 per cent of cumulative spending on health. In addition, the large share of the informal economy in Bangladesh will require tailored revenue raising mechanisms to ensure the financial sustainability of the social health protection system.

▶ 2. Context

The current health system in Bangladesh developed from a system of government-owned and government-funded health care services, which was primarily established during British colonial rule. In recent decades, the public health sector has undergone several changes, including the introduction of a sector-wide approach and an essential service package for primary health care. The National Health Policy 2011 articulated several goals, including increasing the health

²⁶ Bangladesh Constitution of 1972, reinstated in 1986, with amendments through 2014, available at: https://www.constituteproject.org/constitution/Bangladesh_2014.pdf?lang=en

budget every year, ensuring free treatment for the poor through the provision of health cards, and introducing social health insurance for formal sector employees, and for other population groups in the long term (Bangladesh Ministry of Health and Family Welfare 2011a). The 7th Five-Year-Plan (2016–2020) promoted the piloting of risk-pooling mechanisms such as social health insurance, and the implementation of the national Health Care Financing Strategy (General Economics Division 2015). These issues have also been emphasized in the 8th Five-Year-Plan (2020–2025), which has focused primarily on addressing COVID-19 and other infectious diseases.

Long-term efforts to strengthen the Bangladeshi public health system are set out in the Health Financing Strategy 2012–2032, which aims to reduce OOP expenditures from 64 per cent to 32 per cent between 2012–2032; increase government expenditure from 26 per cent to 30 per cent; reduce the share of external funding from 8 per cent to 5 per cent (all three indicators are relative to total health expenditure); and increase social protection coverage from less than 1 per cent to 32 per cent (Health Economics Unit 2012).

To realize these goals, in addition to the national health service, a number of schemes are being piloted by the government, often through official development assistance. Specifically, Shasthyo Shuroksha Karmasuchi (SSK), a government-financed and administered social health protection scheme that targets the population below the poverty line, was launched in 2016 (Islam, Akhter, and Islam 2018). Furthermore, the Maternal Health Voucher Scheme (MHVS), a non-contributory demand side financing scheme covering 53 upazilas (sub-districts), was launched as a pilot scheme in 2007 (Ahmed, Begum, and Smith 2019). To address a lack of social health protection schemes available for government employees in Bangladesh (Molla and Chi 2017), a government-employee contributory scheme is also being designed (Rahman et al. 2018), and several initiatives are being implemented in the garment industry. Some community-based health insurance (CBHI) schemes have also been implemented, without achieving considerable pooling (Islam, Akhter, and Islam 2018). All of these schemes are currently implemented at a very small scale, and are consequently not discussed in this profile, which focuses on the National Health Service.

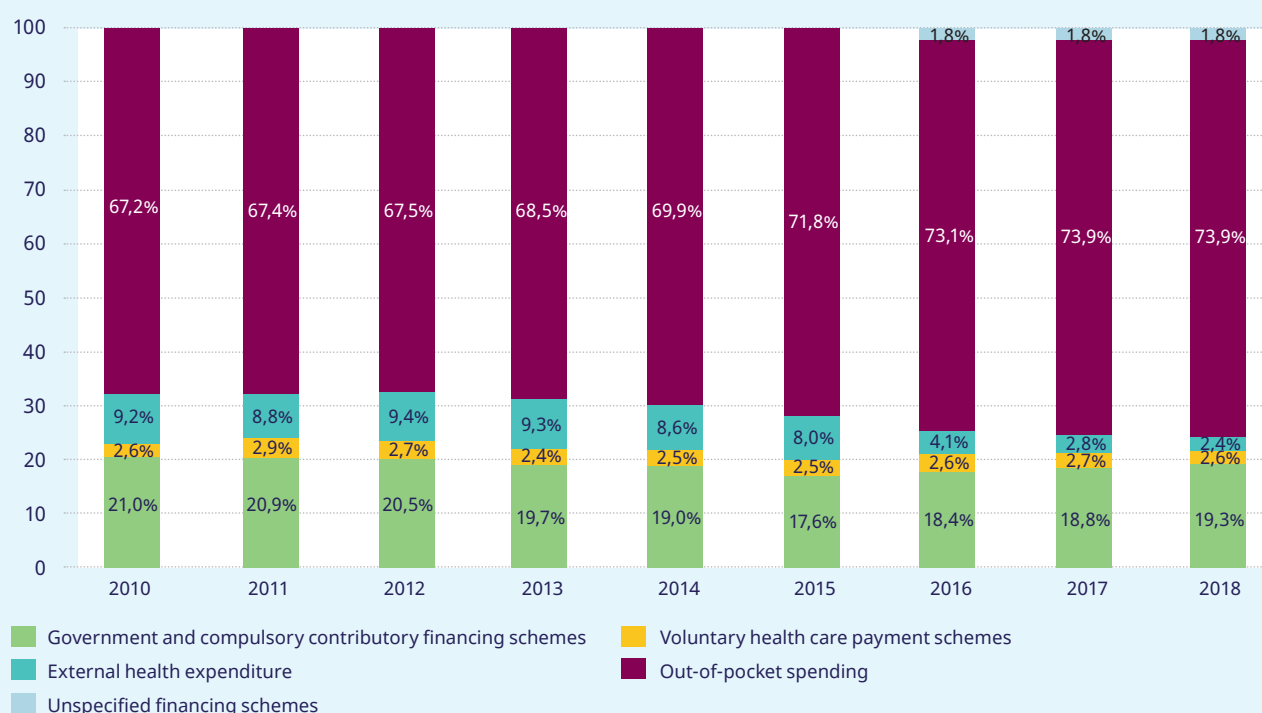
► 3. Design of the social health protection system

- Financing

In 2018, per capita spending on health was US\$41.9, equal to 2.34 per cent of GDP (WHO n.d.). Although government expenditure on health care has increased nominally in recent years, its share in overall health spending continues to decline (Mustafa et al. 2018). OOP expenditures accounted for 73.9 per cent of current health expenditure in 2018, while government schemes and compulsory contributory health care financing schemes accounted for 17 per cent, external health expenditure accounted for 6.8 per cent, and voluntary health care payment schemes accounted for 2.3 per cent (WHO n.d.). Notably, there are no dedicated tax sources for the public health system. Recurrent expenses of the Ministry of Health and Family Welfare (MOHFW) are primarily funded through general government revenues, while development budgets are used predominantly for investments and technical assistance (Mustafa et al. 2018).

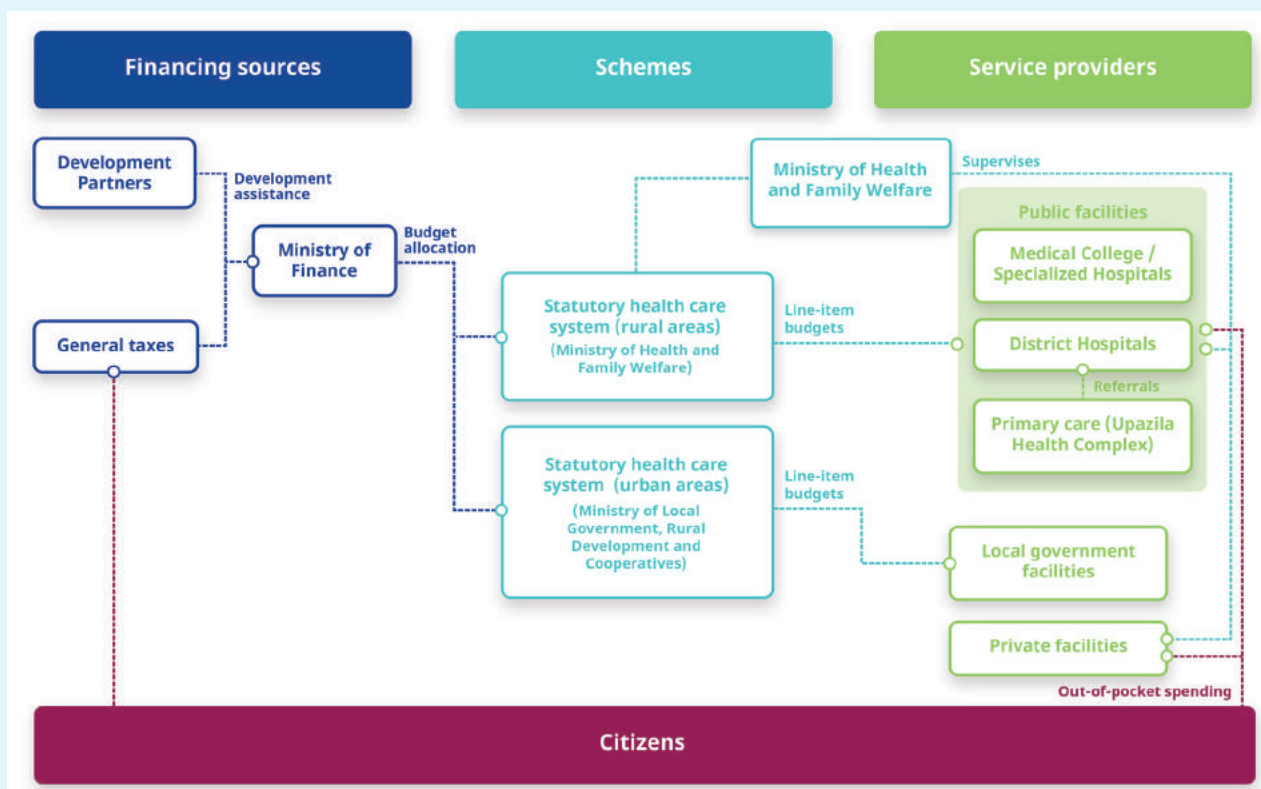
As part of the “Sector Wide Approach” (SWA) implemented in Bangladesh in 1998, several international donors participate in a health sector programme, which involves a pooled funding mechanism (OECD 2006). The participating development partners provide sector-wide support, with contributions made directly into a government account at the central bank and subsequently distributed by the government to implementing agencies through regular budgetary channels. This funding mechanism has been noted to reduce duplication and allow the government to exercise greater control over funds (WHO 2015).

► Figure 1. Analysis of total health expenditure in Bangladesh



Source: Adapted from WHO Global Health Expenditure Database.

► Figure 2. Overview of main financial flows of the social health protection system in Bangladesh



Source: Authors

- Governance

The public health system in Bangladesh is highly centralized. The MOHFW is responsible for all institution-based health care delivery in the country and manages the public system of general health, family planning and nutrition services in rural areas throughout the country. According to the City Corporation Act 2009 and the Municipality Act 2010, local government institutions (LGIs) take formal responsibility for primary health care in urban areas.

- Legal coverage and eligibility

In principle, the national health service covers all citizens, and public health facilities are accessible to all citizens irrespective of social status, race or religion.

- Benefits

The MOHFW published its most recent essential health service package (ESP) in 2016. It defines the minimum set of services that must be provided by public facilities to meet a certain level, and lists some additional services that may be provided by facilities if their infrastructure allows for it (Bangladesh Ministry of Health and Family Welfare 2016). The ESP covers interventions for five core service areas: (i) maternal, neonatal, child and adolescent health care; (ii) family planning; (iii) nutrition; (iv) communicable diseases; and (v) non-communicable diseases. In addition, some “common conditions” are covered, including eye, ear and skin conditions, dental care, emergency treatment, and geriatric care. In terms of non-clinical support services, the ESP includes laboratory, radiology and pharmacy services. Drugs listed on the Essential Drug List, as well as medical supplies should in theory be provided free of cost to patients, though supplies are limited.

- Provision of benefits and services

All public health facilities in the country provide care through the statutory health system. By law, public facilities provide services with a nominal user fee charged to the patient.²⁷ Specifically, 10 Bangladeshi Taka (BDT), equivalent to US\$0.12, is charged for outpatient visits (Mustafa et al. 2018). In wards, hospital beds are provided for free, but users may opt to pay an extra BDT150 per day for a shared room, or BDT600 for a private room. Basic primary care is provided at the ward level (by community clinics) or at the union level (by union sub-centres, union health centres and family welfare centres). Comprehensive primary care is provided at the upazila level at upazila health

facilities. Secondary care is provided at upazila health complexes, district hospitals and general hospitals. Lastly, tertiary care is provided by medical college hospitals and specialized institute hospitals. However, there is no structured referral system, and patients with minor ailments may present for treatment at higher-level facilities directly (WHO 2015).

Over the years, budget allocation for primary care facilities has been undertaken centrally by the MOHFW, using indicators such as the number of inpatient beds, bed days and allocated staff size (Evans, Grant, and Pharm 2017). However, since 2019 the Medical and Surgical Requisite (MSR) budget has been allocated based on outpatient visits, number of beds, bed days and bed utilization rate. The 3rd Health, Population and Nutrition Sector Development Programme acknowledged the need for budget allocations based on more relevant data, such as the extent of poverty, disease incidence, population, and local topography (Bangladesh Ministry of Health and Family Welfare 2011b). These needs are also highlighted in the 4th Health, Population and Nutrition Sector Programme (HPNSP) 2017–2022.

Private health care provision represents the largest share of health care services in the country, with over 70 per cent of health facilities and 62 per cent of hospital beds in the country classified as private as of 2019 (Bangladesh Ministry of Health and Family Welfare 2020). The private health provision sector is implemented by a strong and well-organized not-for-profit sector led by NGOs focusing on primary care, as well as a fast-growing for-profit sector concentrated in curative care in urban areas (Rahman 2020). Detailed statistics on the number of NGO-led facilities compared to for-profit facilities are unavailable. However, birth registries from 2018 indicate that 8.5 per cent of all deliveries took place at NGO hospitals, 21.1 per cent were at other private facilities, and the remaining 70.4 per cent were at government facilities (Bangladesh Ministry of Health and Family Welfare 2020). It is, however, likely that these rates differ between types of health service.

²⁷ Details of hospital user fees published by the Ministry of Health and Family Welfare, available at: http://hospitaldghs.gov.bd/wp-content/uploads/2019/11/Hospital_User_Fees.pdf

► 4. Results

- Coverage

The statutory public health system was established in order to fulfil the government's responsibility to provide health services to the whole population. Although the design of the system (including the services covered and eligibility criteria) is comprehensive, as a result of significant inequalities in the geographical distribution of public facilities, the Bangladeshi health care system has been unable to provide effective financial health protection to all citizens. The WHO's "UHC service coverage index" assigned a score of 48 (out of 100) to Bangladesh in 2017. While this is two points above the score received in 2015, the government is unlikely to reach its own target of 80 by 2025 and 100 by 2030, unless larger reforms of the public health sector are enacted (Government of Bangladesh 2020).

- Adequacy of benefits/financial protection

At 73.9 per cent, the level of OOP spending in Bangladesh is among the highest in the world, indicative of the limited financial protection provided by the national health system (Ahmed, Begum, and Smith 2019). Government social health protection schemes, of which the statutory health system is the main component, covered less than a fifth of all health expenditure in recent years (refer to figure 1). The increasing reliance on OOP spending indicates that access to health services is not equal across the population, meaning that improvements in health outcomes (discussed below) may not necessarily hold for all population groups.

Over the years, income inequality linked to OOP spending on health care has increased (Molla and Chi 2017). A study of the projected achievement of UHC indicators by 2030 found that wealth-based inequities in access to antenatal care, postnatal care, delivery care, adequate sanitation and care seeking for pneumonia, which are already considerable, are projected to persist for all indicators (Rahman et al. 2018). The same study estimated that the incidence of catastrophic health expenditure would increase from 17 per cent to 20 per cent between 2015 to 2030. During the same period, the study predicted that

impoverishment would increase from 4 to 9 per cent (Rahman et al. 2018).

These challenges are particularly acute for workers in the informal economy, most of whom lack job security, social and legal protection. Workers in the informal economy represent 85.1 per cent of the labour force in Bangladesh, accounting for an estimated 51.7 million people in 2017 (Oliveira Cruz, Islam, and Nuruzzaman 2019). This group is more likely to work in hazardous and exploitative environments, with greater vulnerability to loss of income when ill. Informal economy workers are also less likely to seek formal health services, and more likely resort to informal health providers or self-medication through pharmacies and drug sellers compared with workers in the formal economy. Although medical supplies and essential drugs should be provided free of cost, facility supplies of drugs are often inadequate (WHO 2015). As a result, patients often have to purchase drugs from private pharmacies out of pocket. Additionally, there is evidence that in some facilities, unofficial fees are charged (Killingsworth et al. 1999), and there is a degree of socioeconomic inequity in the utilization of services at public facilities, with influential individuals able to access services more easily.

- Responsiveness to population needs

o Availability and accessibility

Since independence, Bangladesh has made concerted efforts to expand the geographical coverage of health services to rural areas, with an important share of public resources allocated to rural facilities, and health cadres dedicated to mitigating the lack of skilled health professionals in rural areas. Despite these efforts, human resource challenges remain a constraint to equitable service provision, with only 6.73 physicians, 2.26 community and domiciliary health workers, and 0.029 dentists per 10,000 people reported in 2019 (Bangladesh Ministry of Health and Family Welfare 2020). The majority of secondary and tertiary hospitals are concentrated in urban areas, though MOHFW-operated primary health facilities are scarce. As such, most LGIs have not fulfilled their assigned responsibility of providing primary care in urban areas. Due to these access barriers and geographical disparities, several studies have identified inequities in health indicators across social, economic and demographic dimensions in Bangladesh, including gender, economic status

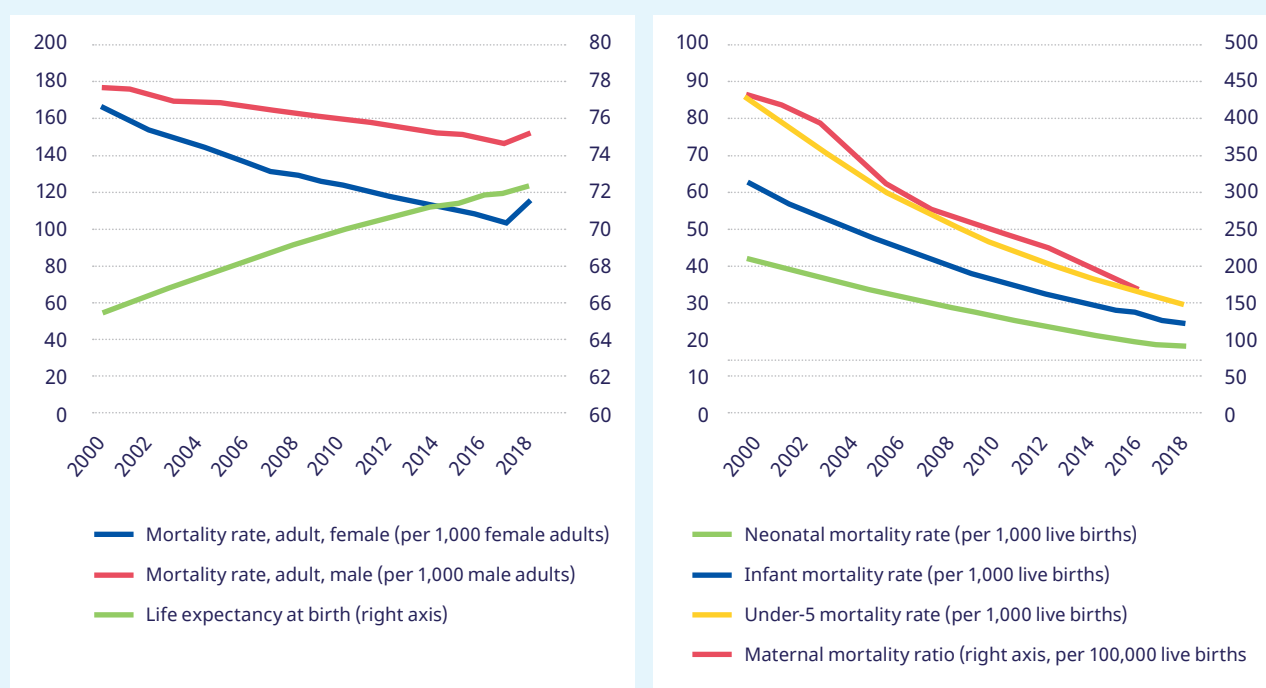
and education level (Joarder, Chaudhury, and Mannan 2019; Hamid et al. 2014).

o Quality and acceptability

Insufficient staffing of the public health system in Bangladesh has led to large numbers of vacant posts in all tiers of the health system, which significantly impacts quality of care at all levels. Limited infrastructure, combined with limited capacity of medical workers compounds this. As noted above, primary care in urban areas is largely neglected due to the fact that responsibility to provide care falls on LGIs, despite the fact that more than 80 per cent of funding for health is allocated to MOHFW. With the exception of child immunization, preventative care in Bangladesh is notably lacking, due to the fact that the public health system is focused primarily on curative care. These deficiencies are driven in part by the fact that the public health sector has insufficient capacity to efficiently spend allocated budgets. Another factor affecting quality of care is the fact that hospitals' organograms are outdated and unresponsive to modern demands.

Despite challenges related to quality and scope of services, Bangladesh has seen improvements in its health indicators over the past decades, especially when it comes to maternal, newborn and child health (MNCH). Figure 3 shows that the mortality rate of adults (aged between 15 to 60) has reduced for both males and females, although progress has been less pronounced for males. Correspondingly, life expectancy at birth increased from 65 in 2000 to 72 in 2018. An analysis of MNCH indicators suggests that the positive trend in overall health outcomes is persisting, with significant reductions to child and neonatal mortality as well as maternal mortality. The relatively strong improvements of MNCH indicators may result from combined efforts of the public and not-for-profit health sectors, which expanded the number of health cadres providing prevention and follow-up services. Targeted demand-side initiatives, such as the aforementioned MHVS scheme, may also have had a positive impact in this regard.

► Figure 3. Bangladesh health system outcomes (left: general outcomes; right: MNCH outcomes)



Source: Adapted from World Bank World Development Indicators.

► 5. Way forward

For Bangladesh to achieve its target of full and effective UHC by 2030, major reforms must be made to the public health system in a short amount of time. These efforts will need to be accompanied by a significant amount of additional government investment in health to reinforce the supply and quality of public health care provision. To ensure sustainable financing for health, methods to raise revenues for social health protection, with a view to urgently reduce OOP levels, would need to be established, including through greater allocation of general revenues to health, as well as new earmarked revenues. In light of this need, addressing informality will be key to expanding the tax base in Bangladesh. A gradual move away from input-based line-item payment systems and towards outcome-based payment systems may also aid in reducing health system inefficiencies.

Covering a portion of the cost of the health care services that are predominantly provided in the private sector will also be necessary. In this respect, evaluating the success and applicability of pilot projects for the whole country will be a useful first step, after which, successful pilots could be incorporated into the statutory health care system at National level, thereby expanding effective coverage and strengthening social health protection in Bangladesh.

protection. Notably, an estimated 51.7 million people, or 85.1 per cent of the national labour force made their living in the informal economy in 2017.

- The development of the social health protection system has not been sufficient to achieve UHC in Bangladesh due to limited infrastructure, as well as a lack of qualified medical workers. Focus should be placed on strengthening health care delivery, improving quality of care and tackling inequalities in access to care.
- Targeted social protection mechanisms have shown some promise in increasing access to health care and utilization of essential health services for specific population groups. For example, the MHVS, a non-contributory financing scheme covering maternal health, and providing cash incentives to pregnant mothers to promote safe deliveries, has contributed to improved utilization and reduced OOP for the services covered. However, issues relating to the design of the scheme, such as payment methods, has led some facilities to provide services that may be medically unnecessary, such as C-Section operations, in order to receive higher payments.

► 6. Main lessons learned

- Although a comprehensive tax-funded health system exists on paper, in practice, its utilization and effectiveness are insufficient to guarantee health coverage without hardship. An administrative structure in which urban and rural facilities are managed by different ministries with unequal budgets, further complicates coverage expansion.
- The large proportion of the Bangladeshi population working in the informal economy, which significantly limits the tax base, poses a significant challenge to raising the revenues needed to guarantee the right to social health

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▶ Brunei Darussalam

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This profile was prepared by Sven Engels and Lou Tessier with the support of Henrik Axelson and Nga Leopold (ILO). It benefited from the review, inputs and quality assurance of Pg Dr Khairol Asmilee bin Pg Hj Sabtu and Naedawati Morsidi (Ministry of Health, Brunei Darussalam).

▶ 1. Introduction

A small island nation with the second highest GDP in South East Asia, Brunei Darussalam had a population of just 437,483 in 2019 (World Bank n.d.) all of whom are provided with free health care through a public network of health facilities. Financed directly by the government, funding for health care is primarily raised through the sale of natural resources. Through the public health care system, citizens are provided with a comprehensive range of services, and all services offered at public facilities—from prevention and primary health care to tertiary hospital care—are fully covered. As a result of comprehensive service and population coverage, combined with the proximity of health care facilities to residents thanks to the country's small land mass, utilization of health services is high. As such, the country performs strongly in various health indicators. However, the health budget as a percentage of GDP, at 1.9 per cent, is below the rates seen in other high-income countries; within the OECD, countries spent an average of 8.8 per cent of GDP on health from 2015–2019 (OECD 2021). Given the remarkable health outcomes achieved in Brunei Darussalam, it seems that the country has a relatively efficient health financing

model compared to other high-income countries. Nonetheless, the health system's reliance on revenues from natural resource extraction may pose sustainability challenges in the future.

▶ 2. Context

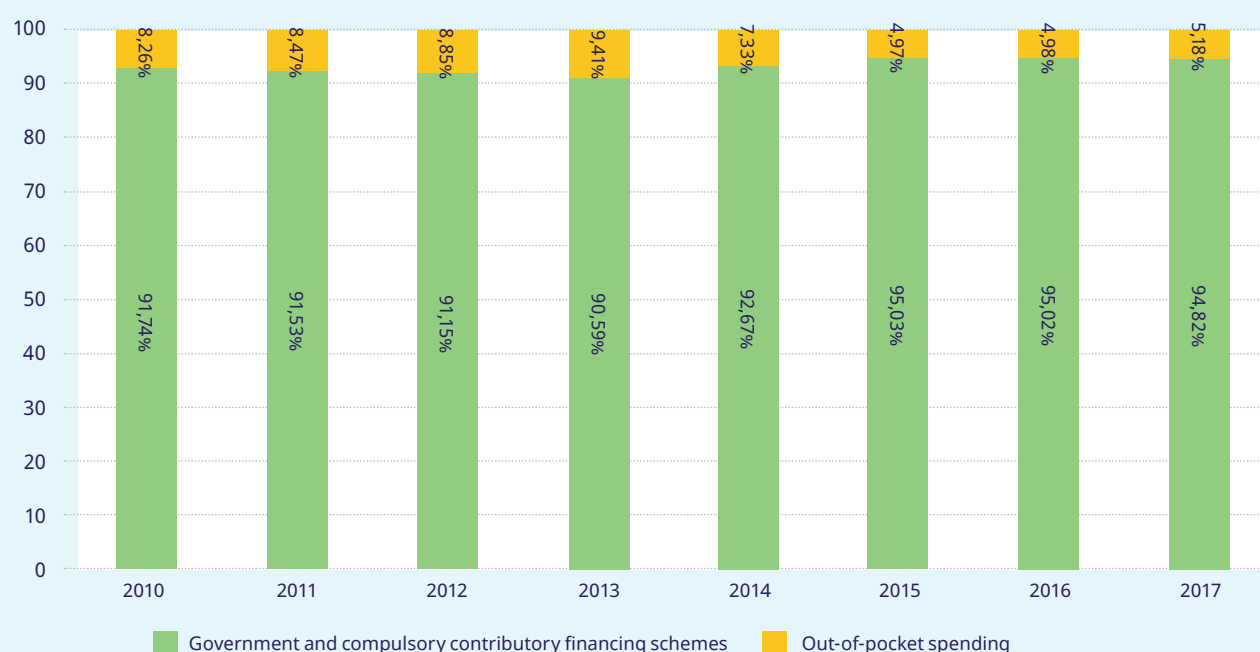
Brunei Darussalam gained its independence from Britain in 1984. In the same year, Raja Isteri Pengiran Anak Saleha (RIPAS) Hospital—currently the largest hospital in Brunei Darussalam—was founded to accommodate the nation's growing medical and health needs (Brunei Ministry of Health 2020). However, universal health protection in the country had been enshrined long before Independence, with Brunei Darussalam instituting universal health care for its citizens in 1958 (Tant 2014). Presently, the country provides free health care for all using publicly funded and provided health services.

As an overarching strategic document, the national long-term development plan entitled *Wawasan Brunei 2035* (or Brunei Vision 2035), was introduced in 2007. The plan outlined sustainable development goals to promote a dynamic and

Total per capita spending on health was US\$671 in 2017, equal to 2.4 per cent of GDP. In the same year, government schemes accounted for 94.8 per cent of current health expenditure (CHE), while out-of-pocket (OOP) spending accounted for

the remaining 5.2 per cent (figure 2). The health budget accounted for 8.8 per cent of the total national budget and around 1.9 per cent of GDP for the financial year 2017–2018.

► Figure 2. Current health expenditure by financing scheme and mechanism



Note: Government and compulsory financing schemes only refer to the tax-financed national health system.

Source: Adapted from WHO Global Health Expenditure Database.

- Governance

The health system is managed by the MOH (Younas and Yafar 2017) under the leadership of the Minister of Health and a Permanent Secretary. There are also two deputy permanent secretaries, one of whom is responsible for technical and professional issues, while the other is responsible for administration and finance matters. The Department of Health Services at the MOH is responsible for providing public health services throughout the country (Brunei Ministry of Health 2017). Meanwhile, the Brunei Medical Board regulates health care practices by medical practitioners and dentists in Brunei Darussalam (Hoang et al. 2014). As health care services are mainly provided and managed by

the government, health care quality is controlled primarily through regulation and registration of medical practitioners in the country. In 2017, the Allied Health Professions of Brunei Darussalam Order²⁹ was introduced to regulate a diverse group of allied health professions.

- Legal coverage and eligibility

All Brunei Darussalam citizens are entitled to free government-financed health care, though foreigners are not covered by this system (Younas and Yafar 2017).

- Benefits

Brunei Darussalam has a comprehensive benefit package. All services offered at public facilities,

²⁹ Available at: <http://www.moh.gov.bn/Image%20Gallery/AHPBD%20Order%202017.pdf>

from prevention and primary health care to tertiary hospital care, are fully covered through the national health system (Myint et al. 2019).³⁰

- Provision of benefits and services

The network of health care facilities in Brunei Darussalam includes public facilities, army facilities and private facilities. Free health care services for all are only available at public facilities, for which patients are not required to make co-payments. Accreditation is not required for public providers in Brunei Darussalam (Myint et al. 2019). The network has two levels of health facilities: health centres/clinics (for primary outpatient care and dental services) and hospitals (for secondary and tertiary care). Notably, to reach out to remote populations, Brunei Darussalam also has mobile health clinics and flying medical teams (using helicopters) in cases of emergency (Brunei Ministry of Health 2017). Care at private hospitals is covered for Brunei Darussalam citizens if they are referred to a private hospital by a public facility (Tant 2014), though limited information is available on how the referral system works.

► 4. Results

- Coverage

As noted, Brunei Darussalam has been successful in maintaining universal health coverage (UHC) since 1958, through the equitable provision of free health care to all its citizens.

- Adequacy of benefits/financial protection

Owing to the provision of free public health care services, OOP payments in the country are very low, at only 5.18 per cent of total current health spending, indicating a high level of financial protection provided by the country's social health protection system.

- Responsiveness to population needs

- o Availability and accessibility

As there are no financial barriers to seeking care, health care in Brunei Darussalam is readily available and accessible. As a result, health care utilization is expected to closely correspond to the

medical needs of the country. However, a study of health systems survey data found that health care utilization in Brunei Darussalam varies by ethnicity, residence, health status and income, suggesting some access barriers may exist for certain groups (Tant 2014). Chinese households were significantly less likely to utilize public health facilities and significantly more likely to seek care from private providers than other ethnic groups, while indigenous groups were less likely to seek care from private providers. Income was found to be positively associated with health expenditure and the use of private providers. The study concluded that, while a well-funded universal health care system (as is present in Brunei Darussalam) can reduce access and utilization inequalities, substantial financial resources alone do not guarantee equity among rural and minority populations.

- o Quality and acceptability

Brunei Darussalam has succeeded in providing high quality services through its national health care system. Should any quality issues arise, the general public are able to provide comments, complaints, and recommendations for services and issues concerning the MOH, through the mobile application, MOHcares (Brunei Ministry of Health n.d.). The app is a useful tool to strengthen the capacity of MOH to accept, monitor and respond to feedback from patients.

Recent evidence suggests that high quality maternal and child health services, including vaccination and antenatal care, have significantly contributed to low maternal mortality ratios and low child mortality rates (United Nations General Assembly 2019). Since the 1960s, the maternal mortality ratio has shown a marked decline from 487.2 to 0.0 per 100,000 live births in the 1990s. In 2017, only four maternal deaths were recorded across the country. In the same year, almost 100 per cent of births were delivered at hospitals or with the attendance of skilled health professionals (Brunei Ministry of Health 2017). The under-five mortality rate and infant mortality rate have also seen significant improvements over time, with current rates at about a third of those in the 1970s.

³⁰ It was not possible to obtain a full list of services provided.

► 5. Way forward

Brunei Darussalam's health care system has led to strong improvements in health indicators and a high level of financial protection for its citizens. However, the existence of a degree of utilization disparities between ethnic groups suggests that UHC efforts should incorporate measures to understand and address barriers to health care among minority communities (Tant 2014).

Moving forward, ensuring the sustainability of the health system will be a key challenge for the country, due to the system's reliance on government subsidies, primarily from the sale of oil and other natural resources (Haji Saim 2010). Should government funding become limited in the future, for example due to a strong decline in economic activity resulting from reduced revenues from natural resource extraction, the health sector may struggle to meet this shortfall in funding through other sources.

► 6. Main lessons learned

- The national health service has positively contributed to the achievement of significant health outcomes. Evidence suggests that the provision of free, high-quality maternal and child health services, including vaccination and antenatal care, has significantly contributed to low maternal mortality ratios and low child mortality rates (United Nations General Assembly 2019).
- The availability of free national health services has contributed to low levels of inequity in accessing care in Brunei Darussalam, with studies finding that inequity in health care utilization by ethnicity, residence, health status and income, although present, are relatively low (Tant 2014).
- Given its impressive health outcomes, Brunei Darussalam's health system can be considered efficient. For the financial year 2017/2018, the health budget accounted for only 1.9 per cent of GDP, which is lower than other high-income countries.

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► Cambodia

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► 1. Introduction

Cambodia has experienced more than two decades of solid economic growth, at an average rate of 7.7 per cent from 1995–2017 (World Bank 2021). With a GDP per capita of US\$1,643.12 in 2019 and a GDP growth rate sustained above 5 per cent over the past 10 years, Cambodia was reclassified from a low-income to a lower middle-income country in 2016 (World Bank n.d.). However, in 2014, around 13.5 per cent of Cambodia's population were living below the poverty line, and the country faces significant wealth inequality. To address this, efforts to improve social protection have been forthcoming. Specifically, in 2017, the government launched the National Social Protection Policy Framework (NSPPF) for the period 2016–2025 to prevent and reduce poverty, vulnerability and inequality by strengthening and expanding social security and social assistance.

In tandem with these developments, Cambodia has significantly improved several key health outcomes and achieved high coverage of maternal and child health services (Mathauer, Dale, and Meessen 2017). However, with a growing private for-profit health provider sector, out-of-pocket (OOP) expenditures represented 60 per cent of health expenditure in 2017, indicating that a

significant proportion of the poor and vulnerable population in Cambodia lack social health protection. Improving Cambodia's health system along a pro-poor path continues to be a critical challenge, particularly with regard to quality of care and coverage. An increased prevalence of non-communicable diseases (NCDs), together with an aging population and increasing urbanization pose challenges to the structure and delivery model of the existing health system in Cambodia (Cambodia Ministry of Health 2016). As such, the extension of social health protection towards Universal Health Coverage (UHC) is among the government's key strategies to achieve sustainable economic growth and reduce poverty and vulnerability. Specifically, Cambodia's health strategy aims to increase coverage to 50 per cent of the population by 2020 and the National Strategic Development Plan 2019–2023 targets "65 per cent of the population [to be] covered by social health protection systems by 2023" (Cambodia Ministry of Health 2016).

► 2. Context

The progress of the social health protection framework in Cambodia is part of the broader development of comprehensive social protection

policies, which began with the enactment of the Labour Code in 1997, granting maternity and sickness cash benefits. A major milestone in the development of the social health protection system in Cambodia was the first pilot of the Health Equity Fund (HEF) in the early 2000s. The Ministry of Health officially launched the HEF scheme in 2006 to cover the poor, and rolled it out in several provinces, progressively reaching nationwide coverage in 2015. In parallel, between 2005 and 2016, various models of community-based health insurance were piloted.

In 2008, the National Social Security Fund (NSSF) was created, and almost a decade later, in 2017, the government launched social health insurance schemes for private sector workers through the NSSF (NSSF-F) and for active and retired civil servants (NSSF-C), alongside the implementation of Prakas (proclamation) 404. Issued by the Ministry of Economy and Finance (MOEF), the Ministry of Health (MOH) and the Ministry of Labour and Vocational Training (MOLVT), this joint legal directive extended coverage to some informal workers defined as part-time, seasonal and casual workers through the HEF. In the same year (2017), the government adopted the National Social Protection Policy Framework (2016–2025), which provides a medium-term roadmap focusing on two main pillars: social assistance and social Security, including health. This was followed by the enactment of a new Social Security Law in 2019.

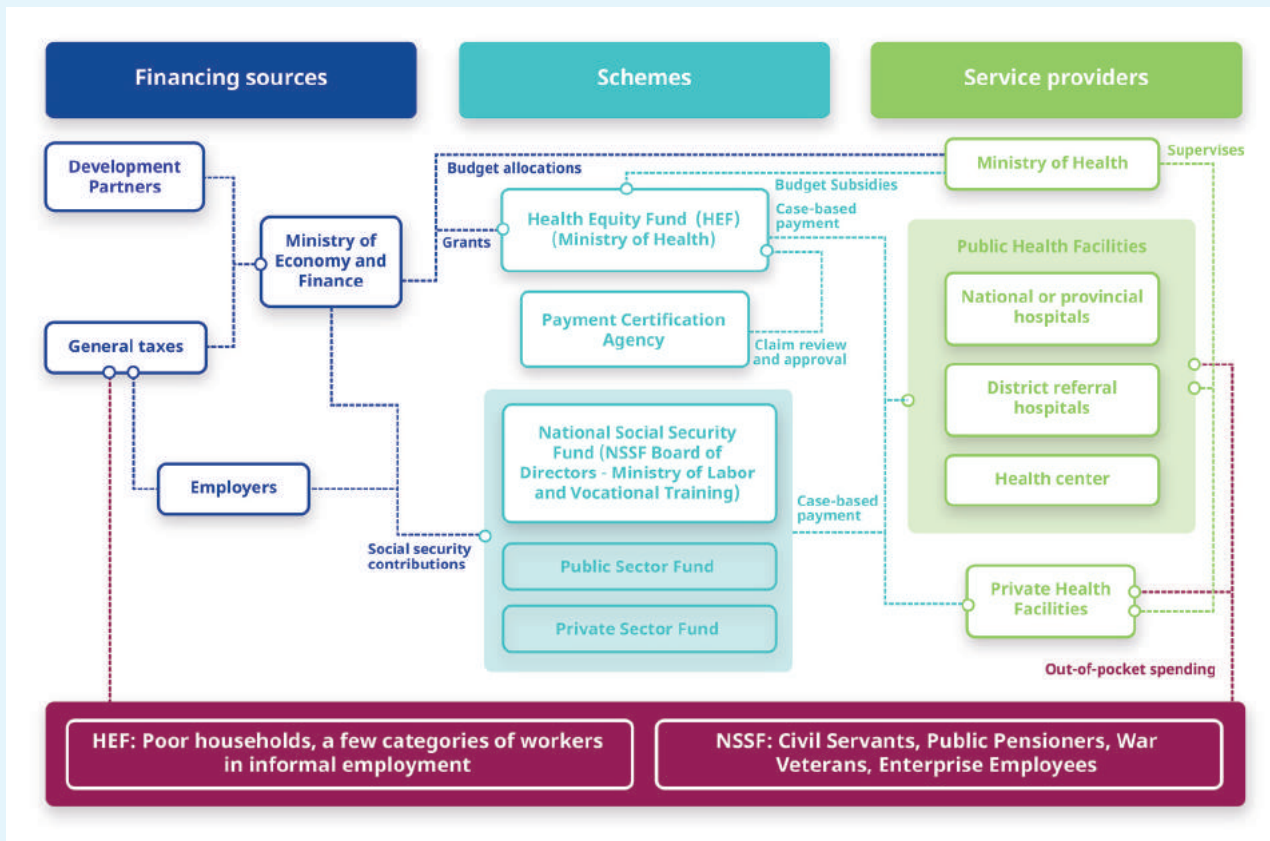
Unlike the NSSF schemes, the HEF scheme is non-contributory. Financing comes from development partners' grants and from general taxes, which are allocated through the MOEF. The Health Equity and Quality Improvement Project (H-EQIP) finances up to US\$6 million per year in user-fee reimbursements for health services provided to poor beneficiaries, and the balance is paid from the national budget. In 2019, total user-fee reimbursement exceeded US\$18.4 million.

► 3. Design of the social health protection system

- Financing

The revenues of the scheme for private sector workers (NSSF-F) are collected directly from employers, and the contribution rate for formal private sector workers is set at 2.6 per cent of the employee's salary, paid entirely by the employer. The monthly contribution calculation is capped at 1.2 million Cambodian Riel (KHR), or approximately US\$300. The contribution rate for the civil servants' scheme (NSSF-C) is set at one per cent of the member's salary, which is paid by the MOEF to the NSSF-C.

► Figure 1. Overview of main financial flows of the social health protection system in Cambodia



Source: Authors

- Governance

The social health insurance schemes for civil servants (NSSF-C) and for private sector employees (NSSF-F) are managed by NSSF, with technical oversight from the MOLVT. Since the new Social Security Law was enacted in 2019, the NSSF governance board has been comprised of the Minister of the MLVT (Chair) and representatives from the MOEF, the MOH, the Ministry of Civil Service, the Ministry of Social Affairs, and the Council of Ministers. Veteran and Youth groups are also represented, along with two representatives from employers' federations, two representatives from trade unions and the NSSF Director General.

The MOH manages the HEF for poor households and its extension via the informal workers' scheme, through the Department of Planning and Health Information (DPHI), and the Department of Budget and Finance. The governance of the

HEF is overseen by Health Financing Steering Committees (HFSC) at provincial and district levels, chaired by the vice-governors of respective localities. The HFSC for Phnom Penh is the final referral point for any decisions or problems that cannot be resolved at a lower level. The Payment Certification Agency (PCA) monitors and assesses HEF utilization and Service Delivery Grants implementation, identifies issues and recommends solutions. In addition to monitoring and assessing the quality of health services used by HEF beneficiaries, the Payment Certification Agency (PCA) was established to review and verify payment and audit claims received from all public facilities.

The National Social Protection Council (NSPC) and its Executive Committee have a critical decision-making, stewardship, oversight and coordination role to expand coverage and improve existing social protection schemes. The council works

to accelerate progress on priority areas while ensuring optimal performance and efficiency of all social health protection schemes. The Minister of Economy and Finance chairs the Council, which is constituted by ten other Ministers including the Minister of Health and the Minister of Labour and Vocational Training. The same ministries also have high-level representation on the Executive Committee of the Council.

- Legal Coverage and eligibility

Eligibility for the NSSF-F scheme is restricted to workers who are registered with the NSSF as formal private sector employees. Initially, companies with fewer than eight workers were not eligible to register with the NSSF, but this has now been extended to all enterprises regardless of their size. Membership for the NSSF-C scheme is limited to individual civil servants and retirees. NSSF members are covered on an individual basis without consideration of dependents. Enrolment is mandatory for both NSSF-F and NSSF-C schemes.

HEF is targeted to poor households, as well as people living with HIV/AIDS. In addition, some groups of informal workers whose registration is undertaken by NSSF are eligible for HEF in line with Prakas 404. These workers are defined as individuals with an employment contract for work not exceeding eight hours a week, including part-time, casual or seasonal work.

To identify beneficiaries of the HEF determined as poor, a nationwide ID Poor system is applied, and the government issues an equity card to identified households. The identification system combines proxy means testing using observable household characteristics and assets, and community-based targeting. This system is complemented with a post-identification system, enabling enrolment at the point of service delivery. The identification of eligible HEF beneficiaries is evolving with different identification strategies (ex-ante, ex-post, and more recently, on-demand). Initially, the identification criteria varied among various NGOs and development partners, but in 2005, the Ministry of Planning developed a uniform assessment to capture the poorest households.

The identification of poor households in Cambodia is implemented in yearly rounds, covering one-third of the country every year. To facilitate enrolment among the new poor between rounds and improve efficiency of the process, in 2020 the Ministry of Planning rolled out its On-Demand Identification (OD-ID) system. This system is operationalized by commune councils using mobile tablets.

- Benefits

The benefits packages for the NSSF-C and NSSF-F schemes are very similar. Both include outpatient and inpatient care; maternity-related care; child general medicine; family planning; medium surgical intervention; and transport (referral and corpse). Rehabilitation, a daily allowance and a room with air conditioning are also included, and the NSSF provides cash benefits to replace income in cases of illness and maternity. There is a negative list of exclusions in addition to this positive list.³¹ Reimbursement of drug costs³² is limited to pharmaceuticals included on the essential drug list published by the MOH. The NSSF benefit package specifically excludes reimbursement for public health services offered free of charge to the patient in line with Article 4 of Prakas No. 109. This includes treatment for HIV, tuberculosis, malaria and vaccination services.

The HEF includes 36 “medical service packages” which are reimbursed by the HEF. Benefits cover inpatient admission, outpatient consultations, emergency care, preventive services, physiotherapy and rehabilitation. The service packages include consultations, diagnostic tests and medicines on the essential drug list, which are provided based on availability. Additionally, a transportation allowance is offered for referred cases, delivery/attempted delivery and post-abortion care. A funeral grant is also provided for referred cases. Services excluded from the HEF benefit packages include oncology, organ transplants, cosmetic surgery and infertility treatments.

³¹ Excluded services include: dental care; sex change operations and care; organ transplants; artificial insemination; self-treatment; plastic surgery; artificial vision devices and laser vision surgery; treatments for drug abuse; infertility treatment; eye implant surgery; coronary and heart surgery; hemodialysis; and general health check-ups.

³² The NSSF reimbursements are case fees—fixed fees payable for predefined “cases” of care reflecting the type of medical treatment and cost category; different rates apply for different types of service providers. In addition to case fees, a selected list of treatments and diagnostic procedures considered to be high cost will be reimbursed separately on a fee-for-service basis but subject to a cap or maximum amount per case.

- Provision of benefits and services

Public facilities are the backbone of the network for all schemes. In addition to all public providers, the NSSF also contracts selected private health facilities to facilitate access to reproductive and maternity services, given that 68 per cent of its members are women. Presently, the NSSF contracts around 90 private providers to improve access, particularly nearby manufacturing areas where public services may be limited. Most facilities contracted by the NSSF are concentrated in Phnom Penh. To access NSSF services, there are no user-fees at the point of service provision, and no waiting periods, co-payments, ceilings or deductibles. There is no referral system or incentive to seek care at primary level first.

Similarly, for the HEF, eligible beneficiaries do not pay at the point of service provision and there are no waiting periods or other criteria before eligible households can avail of medical benefits. There is no waiting period to access benefits and the scheme reimburses public health facilities for user fees normally paid by the patient (Mathauer, Dale, and Meessen 2017). Although there is no strictly enforced referral system to access different levels of care, there is an incentive for beneficiaries to access care at primary level first if they wish to be eligible for transportation allowance.

The HEF and NSSF insurance schemes use somewhat different case-based classifications with different payment rates. The overall payment by the HEF for medical services to each individual facility is subject to change based on the quality-of-care score; the score is determined quarterly for each hospital and semi-annually for each health centre, based on (1) the quarterly quality enhancement score and (2) patient dossier and health register reviews (Jain and Srey 2020). Currently, the purchaser-provider split is not complete, as the PCA co-locates with and operates under the technical supervision of the MOH. Additionally, the PCA does not actually make payments to facilities, but it approves them before payments are made by the MOH. The NSSF also reimburses public facilities on a case-based basis but the rates are not reviewed on a regular basis. Furthermore, as noted above, the NSSF has started purchasing care from the private sector with a view to extend the network of providers available to protected persons.

The fragmentation of (and within) the current schemes creates inefficiencies, leads to unnecessary duplication of efforts and limits

purchasing power. For example, parallel systems used by NSSF and HEF reimburse (mostly) the same health facilities; moreover, these systems are not digitally connected. There are several interconnected issues which need to be addressed, including: the current reliance on manual claims submission processes through the H-SPIS; reliance on a paper-based system at many facilities for the HEF; a lack of interoperability between the two claims systems, causing duplication of work at the health facility level; and the operational capacity and constraints of institutions managing claims and payments for each scheme. Health system efficiency can be improved by leveraging, aligning and linking the strengths from various existing system elements. Specifically, the claims processing for the NSSF and HEF schemes are managed separately through the H-SPIS and the Patient Management and Registration System (PMRS), respectively. If unaddressed, fragmentation within the social health protection sector will only become further entrenched with time.

► 4. Results

- Coverage

Despite sustained efforts to expand coverage, the majority of the Cambodian population remains uncovered. Prior to COVID-19, enrolment in the NSSF-F and NSSF-C schemes was intensifying (Kolesar et al. 2020). Since the launch of the two schemes for workers, as of 2020, the NSSF registered 11,326 enterprises/establishments with 2,141,030 workers (1,418,165 females) (NSSF 2020). This accounts for 13.0 per cent of the total population and 23.4 per cent of the labour force. Around 11,000 enterprises are currently registered, with approximately 1.25 million employees enrolled in the NSSF-F scheme. Current membership of the NSSF-C scheme is about 430,000. Inclusion of dependents (for example, dependent spouses, children under 18 years of age, parents, and older adults residing in the household) could potentially increase coverage by 4.77 million people: 4.25 million under the NSSF-F scheme, and 523,000 under the NSSF-C (Kolesar et al. 2020). At present, because contributions are paid solely by the employer, the administrative and logistical obligation of contribution collection is minimal. However, extending benefits or

coverage to dependents of the contributory schemes would require increasing contributions and/or introducing a contribution from the workers, which may be an obstacle to necessary reforms.

As for the HEF scheme, at the end of November 2020, a total of 701,290 households were enrolled, raising the total number of individual beneficiaries to 2,785,847 or approximately 16.7 per cent of the total population. More recently, service statistics suggest that the HEF extension scheme for informal workers and selected populations covered 131,755 members as of 2020 (NSFF 2020). Using Cambodia Socio-Economic Surveys data and administrative statistics, the total population that can be legally covered under the HEF extensions is estimated to be about 817,000. Low enrolment in the scheme can be attributed to a passive enrolment with no promotion of the scheme among the public. Coverage of households with an ID Poor card in the bottom decile is much higher than among those in the top decile, suggesting some favourable results from the targeting process (Shrestha 2020). However, evidence also suggests there are exclusion and inclusion errors related to the ID Poor targeting system, which restricts health care access among poor Cambodians, with only 56 per cent of those in the poorest decile included and 7 per cent of the richest also included (Shrestha 2020). As noted above, the ID Poor registered HEF beneficiaries presently comprise about 16.7 per cent of the population. This is less than the proportion in the first quintile (20 per cent), but higher than the (2019) official national poverty rate of 12.5 per cent.³³

A considerable percentage of the vulnerable and near poor population (second and third wealth quintile households) are not covered by social health protection schemes. Despite efforts to expand social health protection coverage in recent years, over 54 per cent of the population currently has no legal social health protection coverage, and about 16 per cent of the population who are legally covered are not yet effectively enrolled. According to estimates from the MOH, the combination of all social health protection schemes effectively covers about five million Cambodians, which is less than a third of the population (27.6 per cent in 2018). Relatively narrow eligibility criteria (for example, the exclusion of dependents under NSSF schemes and poverty targeting under the

HEF), and difficulties in enrolment are explanatory factors. In addition, recent coverage expansion to some informal workers leaves significant gaps, since the HEF extension scheme for informal workers and selected populations is limited to specific categories of work (Kolesar et al. 2020).

The expansion of existing schemes (NSSF and HEF) provides an adequate pathway to cover the “missing middle”. It would require expansion of legal coverage to dependents of workers already covered under NSSF schemes and to the near poor (including second and third wealth quintiles) in the informal economy, on a mandatory basis to substantially reduce the coverage gap. Including dependents of formally employed workers could rapidly increase coverage by about 3.38 million for the NSSF-F scheme and 523,000 for the NSSF-C scheme (Kolesar et al. 2020). Extending HEF coverage to the near-poor would allow for the provision of financial health protection to around 5.7 million financially vulnerable persons who rely predominantly on the informal economy for their livelihoods but are not classified as poor, and therefore not covered by the HEF.

- o Adequacy of benefits/financial protection

Cambodia ranks among the world’s top 10 countries in terms of OOP health spending, with OOP payments for health services at 60 per cent of total health expenditure in 2017 (World Bank 2017). This has a disproportionate impact on the poor and vulnerable, with evidence indicating that lower-income households are at the greatest risk of impoverishment due to health spending (Fernandes Antunes et al. 2018). Empirical evidence suggests that a one-size-fits-all approach to individual monthly health care contributions among the lower three quintiles has limited potential for revenue generation, especially considering collection costs (Kolesar et al. 2020). This indicates the need for more public resources to be made available to protect poor and vulnerable population groups.

While the HEF aims to provide free access to health care among the poor, there is a lack of evidence demonstrating higher utilization of public services among the poor (Kolesar et al. 2019), with a very high proportion (54–86 per cent) of HEF beneficiaries seeking care in the private sector. Similarly, 75 per cent of rural patients have been found to use the private sector as

³³ The previous rate (from 2013) was 13.5 per cent.

their first provider choice. This trend is driven by a perception of inferior service quality in the public sector. As HEF does not reimburse services provided in the private sector, financial protection is limited in such cases. Notably, research suggests that 24.5 per cent of HEF beneficiaries borrow money with interest to pay for medical expenses, compared to 12.5 per cent of non-HEF members (Ir et al. 2019).

- Responsiveness to population needs
 - o Availability and accessibility

Low-utilization of cost-effective health services and a shortage of providers, especially in rural areas, point to limited accessibility and availability of health care in Cambodia, with available services failing to meet the emerging needs of the population. Adequate access to services is limited by a lack of clinical expertise and pharmaceutical availability. Services are also constrained by the availability of medicines within public facilities. Presently, only 15 predetermined items from the National Essential Drug List are monitored for stock-out.

- o Acceptability and quality

There are many challenges affecting the quality and acceptability of health services in Cambodia, including the lack of an accreditation system and no systematic assessment of the quality of health care, especially in the private sector. This is compounded by a lack of harmonization and coordination between private and public health services. As previously noted, the perception of inferior service quality in the public sector is commonly cited as the reason for high private sector utilization in Cambodia.³⁴ Although recent information on patient satisfaction is limited, a 2012 national health care services client satisfaction survey of the public sector found dissatisfaction in several areas, including “attentiveness of health-facility staff, cleanliness of facilities and communication on diagnosis and prevention” (Peou and Depasse 2012). Patients typically view public facilities as being too far, requiring long waiting times and lacking in efficiency and hospitality (Basu et al. 2012; World Bank 2014). Despite these challenges, a study also

found that health care users reported trusting public providers’ skills and abilities as well as the referral system (Ozawa and Walker 2011). To gain a clearer picture of health care quality, in 2019, Cambodia scaled-up its health care quality monitoring system to the national level for the public sector, considering three dimensions of assessment, namely structure, process and outcome.³⁵

► 5. Way forward

Since 2000, Cambodia has significantly improved several key health outcomes, including achieving a major reduction in maternal and child mortality (UNICEF 2019). However, looking forward, Cambodia is entering into a period of demographic and epidemiological transition. The aging population and increasing prevalence of non-communicable diseases puts increasing pressure on the national health system and will undoubtedly impact on the country’s health indicators. Enhancing social health protection will contribute to reduced vulnerability, increased household productivity and benefit the long-term economic prospects of Cambodia.

To this end, efforts to expand the NSSF are underway, focusing on enrolment of formally employed workers in new business units, and primarily concerning higher income households, since the effort so far has mostly focused on low-paid garment factory workers. The government is also interested in exploring the option of extending SHP to dependents and piloting new procedures to facilitate the affiliation of tuk-tuk drivers and domestic workers in the capital city (GRET 2019). However, without a single risk pool or at least a solidarity mechanism between the different risk pools, these efforts are unlikely to foster equity. Efforts are also needed to consolidate the current pension schemes, and launch a pension for the elderly poor to guarantee much needed income security for older persons, who tend to experience greater morbidity. The focus of expansion efforts should be placed on

³⁴ More than three out four rural patients (75.7 per cent) use the private sector as their first point of contact for either curative or preventive health services (Kolesar et al. 2019).

³⁵ “Structure” assesses management, financing, staff, infrastructure, interpersonal communication and equipment using direct observation, record review and checklists; “Process” assesses technical competency and interaction between patients and providers using vignettes; and “Outcome” assesses patient perception of quality through patient interviews using a standardized tool (Fritzsche and Peabody 2018).

rural areas, where access to health care is more limited.

In addition to enhancing protection among vulnerable groups, the reduction of OOP spending, and the improvement of health care quality are among the primary challenges for Cambodia. As noted above, in 2019, Cambodia scaled-up its health care quality monitoring system to the national level. However, there are still significant challenges relating to quality of care, and the issue has been identified as the most pressing imperative for health-system strengthening in Cambodia (Annear et al. 2016; Pheakdey et al. 2020). To address the issue of quality of services, a Law on Administration of Health Services has been drafted “to ensure and promote quality of health care services provided by health facilities to ensure health and safety of clients”. The law is expected to apply to both public and private health facilities at all levels. When promulgated, the law will establish a national accreditation system (Pheakdey et al. 2020). Although voluntary, the idea is that accreditation will be required in order for facilities to be contracted by the NSSF and HEF schemes.

► 6. Main lessons learned

- Strategies to cover the “missing middle” must be taken up early on when developing social health protection systems so that population gaps are addressed progressively. Despite the existing NSSF and HEF schemes, the vast majority of the population remain uncovered. Expanding population coverage through existing schemes systems can provide an adequate pathway to cover the “missing middle”. The expansion of legal coverage to dependents of workers already covered under NSSF schemes, and the extension of HEF coverage to the near poor in the informal economy on a mandatory basis would substantially reduce coverage gaps. In addition, some adjustments will be needed to ensure coverage of informal self-employed workers, as current registration procedures require employers to register their workers.
- While Cambodia has made significant progress in reducing impoverishment

and catastrophic health care expenses, a continued focus on financial risk protection is needed. There is evidence that the HEF is not currently eliminating OOP costs among the poorest (Kolesar et al. 2019). As low utilization of public health care providers contributes to this issue, increased utilization of public facilities would likely improve technical efficiency while reducing OOP spending.

- The fragmentation of (and within) the current schemes leads to unnecessary duplications of efforts, inefficiencies, and limited purchasing power. To address these issues and ensure equity, the focus is slowly shifting towards progressively aligning and harmonizing the design and implementation of the NSSF and HEF schemes.
- Strategic purchasing to incentivize quality service provision and enhance value for money can start with a simple approach. A first step is to establish quarterly performance assessments of quality with selected facilities, and once the design of system is fully operational and accepted by both parties, the linkage of health facility quality scores to actual reimbursement payments to providers can be implemented and rolled out. This approach could then be optimized by increasing reimbursement rates upon the score achieved.

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► China

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► 1. Introduction

Since China initiated economic reforms in 1978, GDP growth has averaged almost 10 per cent a year (World Bank 2021b). Today, China is an upper middle-income country, and the world's second largest economy, with a GDP per capita of approximately US\$10,500 in 2020 (World Bank n.d.). According to latest World Bank data from 2016, 0.6 per cent of the population lived under the international poverty line of less than US\$1.90 a day (World Bank 2021a). In February 2021, President Xi Jinping announced that China had eradicated extreme poverty, with nearly 100 million people lifted out of poverty over an eight-year period. However, in recent years, growth has slowed due to structural constraints, including a declining labour force, reduced productivity and diminishing returns on investment. Moreover, while income inequality has improved substantially over the last decade, it remains relatively high.

Demographic changes in China have led to health challenges related to urbanization and industrialization, population ageing, non-communicable diseases, and life style and environmental risk factors (WHO 2015).

To address these challenges, in 2009, the government launched comprehensive health system reforms to extend social health insurance coverage and promote universal access to health services (Meng et al. 2019). These reforms presented goals, priorities and strategies to improve access to affordable and equitable health care and essential medicines (Wang et al. 2019), and re-affirmed the government's role in the health system. Despite substantial progress in this area, the health system in China remains complex and somewhat fragmented, which is exacerbated by high population density and diversity across regions. Furthermore, despite noteworthy decreases in out-of-pocket (OOP) spending and increased subsidies for the poor and vulnerable, catastrophic health expenditure remains a challenge.

To bolster efforts to achieve Universal Health Coverage (UHC), in 2016, China issued the 13th five-year plan for health reform, setting forth the policy priorities and strategies for health reform for the following five years. In the same year, the Chinese Government announced the "Healthy China 2030" agenda in an effort to provide universal health security for all citizens by 2030 (Zhao et al. 2019). Concerted efforts have also been initiated to improve the financial efficiency, effectiveness and sustainability of the overall

health system, strengthen primary care and improve public hospitals (Meng et al. 2019).

► 2. Context

In the 1980s and 1990s, the provision of social health protection in China was characterized by low population coverage and limited overall financial protection. OOP payments reached 60.1 per cent of current health expenditure in 2000, with government general health expenditure representing only 22 per cent of current health expenditures (WHO n.d.). To facilitate reforms initiated in 2009, government expenditure on health tripled from 2009 to 2017, alongside enhanced subsidies for vulnerable groups and the consolidation of schemes for rural and urban residents (World Bank 2021b).

Reforms have driven efforts to extend coverage to the entire population through China's existing health protection schemes: Urban Employee Basic Medical insurance (UEBMI), which was launched in 1998; the New Rural Cooperative Medical Scheme (NRCMS), initiated in 2003; and Urban Resident Basic Medical Insurance (URBMI), which was first implemented in 2007. The NRCMS and URBMI schemes for rural and urban residents were merged in some regions from 2016, which was extended nationally in 2018 to form the Urban Rural Resident Basic Medical Insurance (URRBMI), implemented under the National Health Care Security Administration (NHSA). Since 2019, the unified nationwide basic medical insurance scheme for urban and rural residents (URRBMI) has been fully implemented, replacing the previous URBMI and NRCMS schemes. The consolidation was initiated in order to unify coverage, pooling mechanisms, benefits, reimbursement rates and fund management (Pan, Xu, and Meng 2016).

In addition to URRBMI and UEBMI, two supplementary schemes are in place to cover catastrophic costs: Catastrophic Medical

Insurance (CMI), which was first piloted in 2012 and then implemented nationally in 2015 for rural and urban residents (only a very few areas covered employees); and Medical Financial Assistance for the Poor (MFA), launched in 2003 in rural areas, expanded to urban areas in 2005, and has now unified coverage in urban and rural areas.

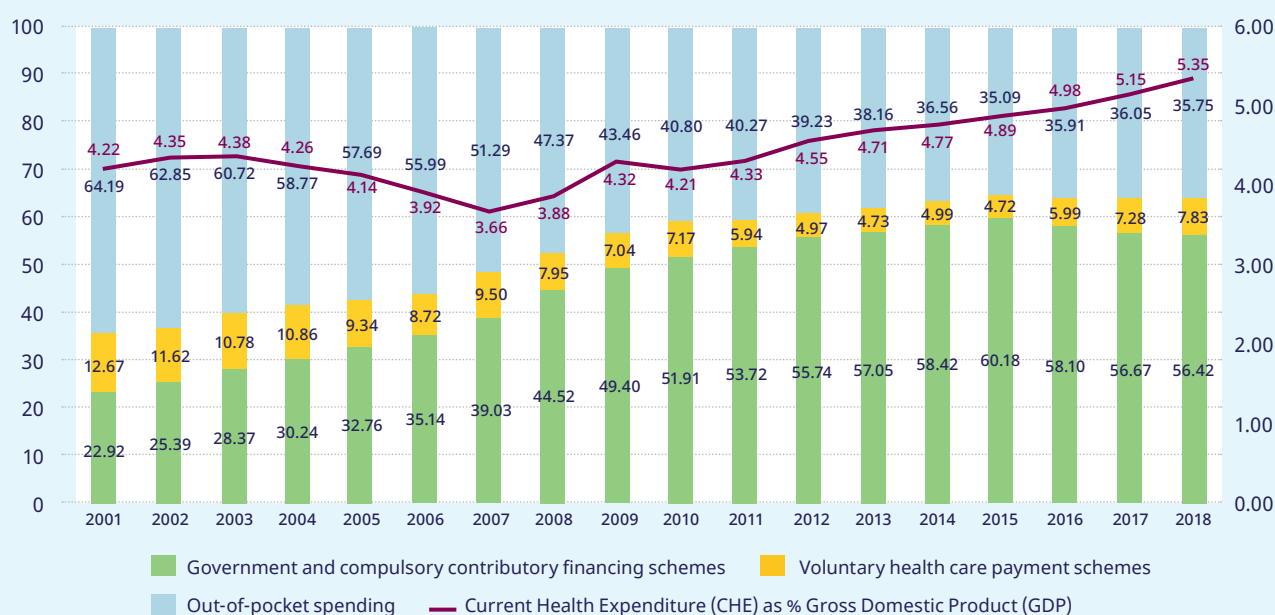
► 3. Design of the social health protection system

- Financing

The expansion of the health insurance schemes was accompanied by an increase in public investment into the health system, which served to significantly reduce OOP spending. Today, China's health system is primarily financed by general taxation, social health insurance contributions, OOP payments, and private insurance premiums (Zhao et al. 2018). In 2018, per capita spending on health was US\$500.5, equal to 5.34 per cent of GDP (WHO n.d.). In the same year, government schemes and compulsory contributory health care financing schemes accounted for 57.95 per cent of health expenditure, OOP spending accounted for 35.07 per cent, and voluntary health care payment schemes accounted for 6.98 per cent, with total spending on social health insurance accounting for 38.46 per cent of health expenditure (WHO n.d.). In 2020, the total income of the national basic medical insurance funds (including maternity insurance), accounted for approximately 2.4 per cent of the year's GDP.³⁶

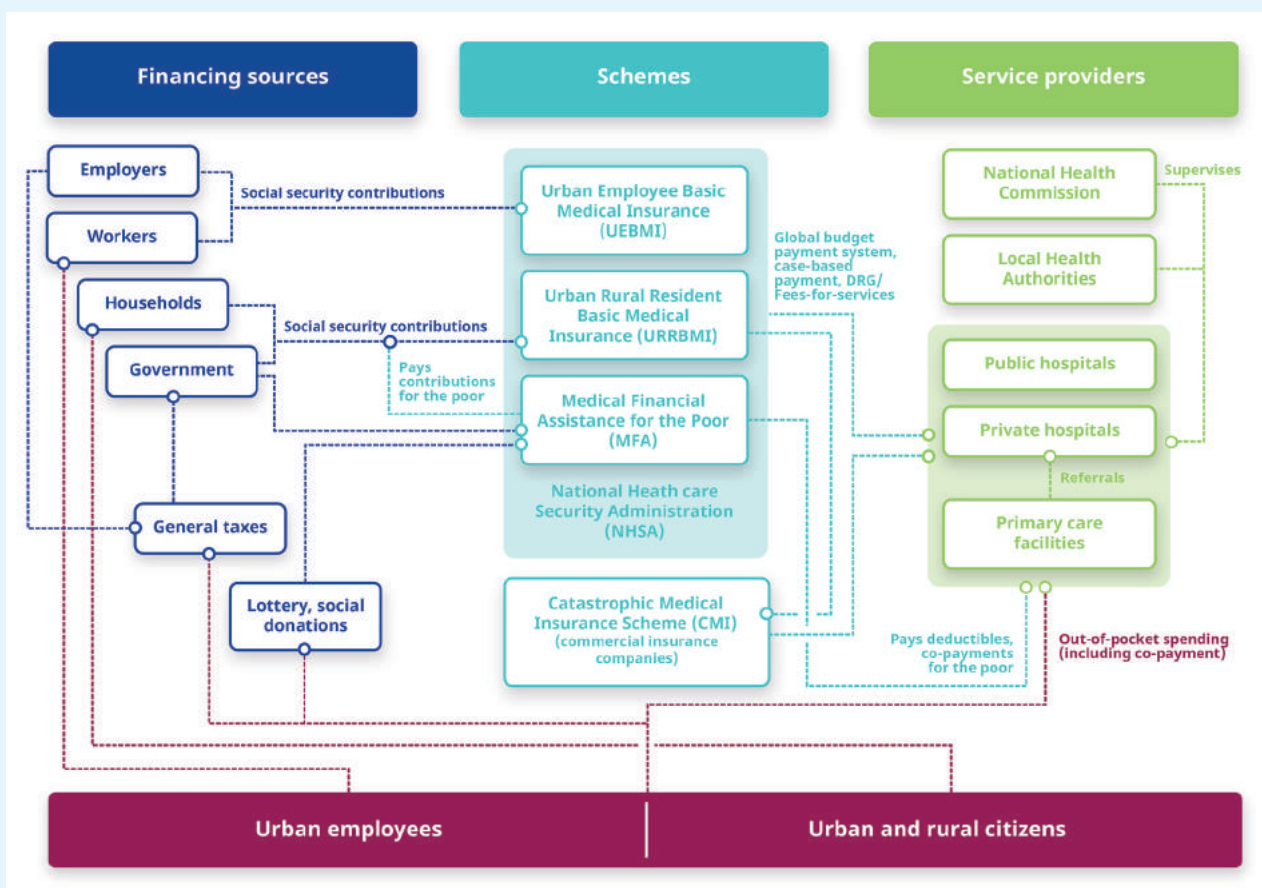
³⁶ Information (in Mandarin) sourced from 2020 data available on official NHSA website, available at: http://www.nhsa.gov.cn/art/2021/6/8/art_7_5232.html.

► Figure 1. Current health expenditure in China by financing scheme



Source: Adapted from WHO Global Health Expenditure Database.

► Figure 2. Overview of main financial flows of the social health protection system in China



Source: Authors.

The UEBMI scheme for urban employees is financed by employers and employees through payroll contributions and from the local government (Zhao et al. 2019). Contributions are collected on a monthly basis. Employers are responsible for transferring contributions to UEBMI. The specific contribution rate is decided by local governments, but generally, the employer contributes about 6 per cent of the salary and the employee contributes around 2 per cent (Xu et al. 2018). In 2014, employers contributed 64 per cent and employees contributed 36 per cent of UEBMI revenues (Liu, Vorthers, and Hong 2017). The total expenditures of UEBMI amounted to 1.782 trillion Chinese Yuan (CNY), equal to around US\$253.3 billion, in 2018 (National Bureau of Statistics of China 2020).

In contrast, contributions for the URRBMI scheme for urban and rural residents are financed by individuals and central and local governments, and has been harmonized within localities since the merger, with no distinction between urban and rural areas. In 2021, NHSA set the average per capita contribution of URRBMI at no less than CNY900 (US\$139.6) and the per capita financial subsidy at no less than CNY580 (US\$90.0), with individual contributions up to CNY320 (US\$49.6). According to regulations, the central treasury provides subsidies to local governments in stages, granting subsidies at 80 per cent and 60 per cent for western and central regions respectively, and subsidizing provinces in the eastern region in accordance with a certain percentage (much lower than the first two).³⁷

Contributions to URRBMI are collected annually, and the contribution standard is a minimum, with local governments authorised to adapt it according to their own financial situation and for different population groups. In 2021, the contribution standard of URRBMI in Beijing is CNY1,970 (US\$305.5) per person for children and students (with a government subsidy of CNY1,645 or US\$255.1); CNY2,790 (US\$432.7) per person for residents of working age (with a government subsidy of CNY2,210 or US\$342.8); and CNY4,600 (US\$713.5) per person for residents over 60 (with a government subsidy of CNY4,260 or US\$660.7).³⁸

According to the 2019 National Medical Security Development Statistical Bulletin published by NHSA, the per capita funding for URRBMI in 2019 was CNY781 (US\$121.1) with the per capita government subsidy at CNY546 (US\$84.7).³⁹

As for the two supplementary assistance schemes, the CMI scheme for catastrophic expenses is financed by funds from the URRBMI (CNY36 or US\$5.81 per year per capita, or 0.2 per cent of average income) (Dou, Wang, and Ying 2018). Local health care security bureaus can decide to increase the amount allocated from URRBMI fund. The MFA scheme for the poor on the other hand is primarily financed by the government, welfare lotteries, and social donations (Fang et al. 2019).

- Governance

The Social Insurance Law of 2010, formally enacted in July 2011, was the first comprehensive social insurance law in China (ILO 2016). The law defines the basic framework and principles of the social insurance system (Casale and Zhu 2013). Along with medical care, it also provides for old-age pension, employment injury, unemployment and maternity benefits. When enacted, it provided the legal basis for UEBMI, URBMI and NRCMS. Its last amendment in 2018 provides a legal basis for the combined implementation of maternity insurance and UEBMI. The Law of the People's Republic of China on the Promotion of Basic Medical and Health Care, which came into effect in June 2020, clearly stipulates that citizens have rights and obligations to participate in basic medical insurance according to the law. It also specifies financing arrangements, including the fact that basic medical service fees shall be paid primarily by the basic medical insurance funds and individuals (Chapter VII, article 82). Furthermore, it outlines the responsibility of employers and staff members to pay basic medical insurance contributions for employees in accordance with the provisions issued by the state. Urban and rural residents must pay basic medical insurance premiums in accordance with the provisions.

In addition to laws, the establishment and reform of China's medical insurance system relies heavily

³⁷ Information (in Mandarin) sourced from 2020 data available on official NHSA website, available at: http://www.nhsa.gov.cn/art/2021/6/8/art_7_5232.html.

³⁸ In line with the Notice of the Beijing Municipal Medical Security Bureau and the Beijing Municipal Finance Bureau on Adjusting the Funding Standards and Related Policies of the Basic Medical Insurance for Urban and Rural Residents in 2021, available (in Mandarin) at: http://yj.beijing.gov.cn/zwgk/2020_zcwj/202010/t20201012_2108344.html.

³⁹ Information (in Mandarin) sourced from 2019 data on NHSA (National Healthcare Security Administration) website, available at: http://www.nhsa.gov.cn/art/2020/6/24/art_7_3268.html.

on departmental regulations. UEBMI follows the Decision of the State Council on Establishing the Urban Employees' Basic Medical Insurance System issued in 1998. The most important basis for the establishment of URRBMI is the Opinions of the State Council on Integrating the Basic Medical Insurance Systems for Urban and Rural Residents, issued in 2016. CMI was established in accordance with the Opinions of the General Office of the State Council on Comprehensively Implementing Critical Illness Insurance for Urban and Rural Residents, implemented in 2015.

Before the establishment of the NHSA, the management responsibilities of the medical security system were scattered among multiple ministries. Specifically, UEBMI and the former URBMI were managed by the Ministry of Human Resources and Social Security; the former NRCMS was the responsibility of the Health and Family Planning Commission, which is now called the National Health Commission. Following the establishment of NHSA in 2018, all functions related to medical security have been integrated into this agency. NHSA is in charge of both policy formulation and fund supervision of UEBMI and URRBMI. MFA is now also managed by NHSA, but was previously overseen and implemented by the Ministry of Civil Affairs (MOCA) and its local counterpart agencies (WHO 2015). However, the actual operation of funds is mostly undertaken by municipal health care security bureaus and a few county-level health care security bureaus. China has committed to raising the fund management level to the provincial level during the 14th Five-Year Plan period.

CMI on the other hand is managed by commercial insurance companies, which have been selected by the government through a tendering process (Dou, Wang, and Ying 2018). CMI is currently provided by 16 commercial insurance companies (Li and Jiang 2017). The scheme operates under two models: (i) the “handle agent model”, whereby local governments pay an annual administration fee of 1–5 per cent of fund volume (not formal data) from the government fiscal income, with the government essentially purchasing CMI management services from

health insurance schemes; and (ii) the “organize” model, whereby governments provide CMI funds to private health insurance schemes and set profit rates in the contract, sharing profits (money from CMI funds) and risks between CMI and private health insurance schemes.

- Legal Coverage and eligibility

When initially established, eligibility for UEBMI depended on employment status and household registration type, and only covered employees and retirees formally employed in urban areas, on a mandatory basis. Both employees in informal employment (also known as flexible employees in China) and migrant workers could not benefit from the UEBMI. However, with the improvement of the flexible employment system⁴⁰ and the reform of the household registration system,⁴¹ workers in informal employment and the self-employed can now choose to independently enrol either in the UEBMI or URRBMI. Furthermore, with the exception of a few very large cities (such as Beijing), migrant workers enrolling in UEBMI are no longer subject to household registration restrictions. Enrolment is undertaken on an individual basis, and family members are not covered by the scheme (Xu et al. 2018).

In addition to workers in informal employment and the self-employed (who can choose to enrol in one of two of the basic schemes), URRBMI covers all non-working residents in both urban and rural areas. This includes pre-school children, students, the disabled, elderly people without pensions, and the unemployed. From the perspective of departmental regulations, enrolment is voluntary, but in practice, more emphasis is placed on universal coverage or a universal enrolment plan.⁴² Beneficiaries enrol on an individual basis.

Regarding the two supplementary schemes, CMI provides additional protection to rural and urban residents enrolled in URRBMI with critical illnesses, and those who incur OOP expenses that are higher than the average disposable income per capita. More than a billion people in China were eligible to receive benefits from the CMI in 2017. Individuals who are not able to afford the contribution rates for social health insurance

⁴⁰ See Guiding Opinions of the General Office of the Ministry of Labour and Social Security on the Participation of Basic Medical Insurance by Urban Flexible Employment, 2003; and Guiding Opinions of the Ministry of Human Resources and Social Security, the National Development and Reform Commission, the Ministry of Transport, and Other Ministries and Commissions on Protecting the Labour Rights and Interests of Workers Employed in New Forms, 2021.

⁴¹ See Opinions of the State Council on Further Promotion of Reform of the Household Registration System, 2014.

⁴² The State Council of the People's Republic of China. 2017. available at: http://www.gov.cn/zhuanti/2017-03/07/content_5174479.htm.

schemes or who cannot cover their co-payments – based on levels defined by region – are eligible for MFA. The scheme focuses specifically on the poor, low-income patients with severe illnesses, persons with severe disabilities and senior citizens from low-income families (The Commonwealth Fund 2020). Eligibility for assistance is related solely to the income and medical expenses of beneficiaries, regardless of their registration with URRBMI or UEBMI.

- Benefits

UEBMI benefits are defined positively, covering outpatient and inpatient services, and services at designated pharmacies. The scope and standard of basic medical services of UEBMI are regulated by a national basic medical insurance drug list, a list of diagnostic and therapeutic terms, medical service standards, and related management measures. Some emergency dental services and optometry services are covered, but most of these services are generally financed through OOP payments (The Commonwealth Fund 2020). Home care and hospice care are also excluded from the benefit package, as well as daily necessities and equipment such as wheelchairs (WHO 2015). The adjusted *National Basic Medical Insurance, Work Injury Insurance and Maternity Insurance Drug Catalog* (2020) defines the drugs covered by the insurance schemes. It includes a balanced mix of Western and Chinese medicines (1,426 are Western medicines and 1,374 are Chinese patent medicines).

Through the UEBMI scheme, benefit policies for outpatient services and inpatient services are set separately. Before 2021, outpatient expenses were usually paid by personal accounts⁴³ or in cash, and were directly paid by the fund only in a few areas (such as Beijing and Shanghai). This policy has been under reform since 2021, with the intention of reducing the size of personal accounts and paying outpatient expenses by the fund. As for inpatient services, in principle, the UEBMI deductible is controlled at about 10 per cent of the average annual salary of local employees, which was CNY400–1,200 (US\$59–178) in 2017 (Xu et al. 2018). Expenses below the deductible are paid from the personal account or in cash.

The UEBMI schemes apply deductibles, co-payments, and ceilings as cost-sharing mechanisms, with cost-sharing applied to “eligible medical expenditure,” including delivery. Insured patients pay their co-payment to the health facility after a visit, while the remaining cost is invoiced by the health providers to the scheme. Basic medical services at outpatient facilities, hospital admissions, and services at pharmacies authorized by UEBMI are eligible for immediate reimbursement through the beneficiary’s insurance card (WHO 2015).

The ceiling amount is six times the average annual wage of local employees (Hu et al. 2019). A nominal reimbursement ratio is currently set by the pooling area (usually by municipal area), ranging between 60–95 per cent in different areas. The reimbursement ratio is also based on the hospital level – the higher the hospital level, the lower the reimbursement ratio. In 2019, the nominal reimbursement ratio for inpatient services under UEBMI reached 85.8 per cent; first, second, and third-level hospitals reached 89.3 per cent, 87.2 per cent, and 85.0 per cent, respectively; and the actual reimbursement ratio for inpatient care under UEBMI was 75.6 per cent.⁴⁴ Excess costs can be insured by commercial insurance companies or the MFA.

URRBMI benefits are also defined positively. The list for basic medical services of URRBMI is slightly different from that of UEBMI, including inpatient and outpatient services but not designated pharmacies. The scope and standard of basic medical services under URRBMI follows the same lists of drugs, diagnostic and therapeutic terms, medical service standards, and related management measures. Similar to the UEBMI, most dental and optometry services, as well as home care, hospice care, daily necessities and wheelchairs are excluded (WHO 2015).

The biggest difference in benefit design between the UEBMI and URRBMI is that the latter does not include personal accounts, so both outpatient and inpatient expenses under URRBMI are paid by the fund or in cash. As is the case for the UEBMI, URRBMI applies deductibles, co-payments and ceilings as cost-sharing mechanisms, and cost

⁴³ When the UEBMI scheme was established, it imitated the mode of the basic pension insurance scheme and adopted a partly-funded system, with a pooled fund and personal accounts. The personal account fund is composed of all personal contributions and about 30 per cent of employers’ contributions. Personal account funds can only be used to pay for eligible medical expenditures, usually including general outpatient expenses, drug purchase expenses at designated pharmacies, and other OOP expenses.

⁴⁴ Information (in Mandarin) sourced from 2019 data on NHA (National Healthcare Security Administration) website, available at: http://www.nhsa.gov.cn/art/2020/6/24/art_7_3268.html.

sharing is applied to the same eligible medical expenditures as UEBMI. The specific standards of cost-sharing are determined by the pooling areas, which causes large regional differences.

With the exception of some cities with high benefit levels (Beijing, Shanghai and Shenzhen for example), the fund's payment for outpatient expenses is very low, with annual ceilings ranging from CNY100–400 (US\$15.5–62.1). As for inpatient services, the deductible varies between areas and increases with the level of the hospitals. For example, in the western city, Chongqing, the deductible for first, second, and third-level hospitals is CNY100 (US\$15.5), CNY200 (US\$31.0) and CNY800 (US\$124.2), respectively; in the Eastern City, Beijing, the deductible for first, second, and third-level hospitals is CNY300 (US\$46.6), CNY800 (US\$124.2), and CNY1,300 (US\$201.8) respectively; and in the central city, Harbin, the deductible for first, second, and third-level hospitals is CNY240 (US\$37.2), CNY480 (US\$74.5), and CNY720 (US\$111.7) respectively. Expenses below the deductible are paid in cash.

According to central unified requirements, in principle, the ceiling amount for URRBMI combined with CMI should reach around six times the per capita disposable income of local residents. A nominal reimbursement ratio is also set by the pooling area (usually municipal area), ranging between 45 per cent and 90 per cent in different areas. Again, the reimbursement ratio is also based on the hospital level. In 2019, the average nominal reimbursement ratio for inpatient services under URRBMI reached 68.8 per cent, first, second, and third-level hospitals reached 77.5 per cent, 72.1 per cent, and 63.6 per cent respectively, and the actual reimbursement ratio for inpatient care under URRBMI was 59.7 per cent.⁴⁵ Excess costs can be insured by commercial insurance companies, CMI or MFA.

Defined positively, CMI benefits include any services resulting in health expenditure exceeding the beneficiary's individual income from the previous year (WHO 2015). CMI also applies deductibles, co-payments, and ceilings as cost-sharing mechanisms, and cost sharing is applied to the same eligible medical expenditures as UEBMI and URRBMI. In principle, the CMI deductibles should not be higher than 50 per cent of the per capita disposable income of residents in the pooling area for the

previous year. Subsistence allowance recipients and extremely poor people are exempt from deductibles, and for regions that do not have the conditions, deductibles should not exceed 5 per cent of the per capita disposable income of residents in the pooling area during the previous year, with exemption gradually being explored. For low-income family members and severely ill patients from poor families, deductibles are set at about 10 per cent and 25 per cent of the per capita disposable income of residents in the pooling area in the previous year, respectively. The nominal reimbursement ratio for CMI should not be less than 60 per cent. The ceilings of CMI are determined by the pooling area, and are not subject to national unified restrictions.

MFA provides additional protection by financing contributions to the social health insurance schemes, individual deductibles and co-payments and reimbursing OOP payments for the poorest portion of the population, after receiving reimbursement from one of the basic social health insurance schemes (The Commonwealth Fund 2020). The scheme prioritizes inpatient care expenses, and the specific benefit package is determined by the locality (usually at the county level).

- Provision of benefits and services

A network of contracted public and private health providers and pharmacies provides services to UEBMI and URRBMI members. Members can also use out-of-network health services (even across provinces), but they have to pay higher co-payments to do so (The Commonwealth Fund 2020). Contracting is delegated to the pooling area. In 2018, there were 33,009 hospitals, 34,997 community health service centres, 36,441 township health centres, 622,001 village health clinics, and 18,033 specialized public health institutions (National Bureau of Statistics of China 2020). Following the 13th Five-Year Plan for Economic and Social development (2016–2020), the government sought to reform the referral system as part of broader health policy reforms. According to the referral reform policy, patients are encouraged to seek care at primary health facilities. If they go directly to secondary and tertiary hospitals without a referral, the reimbursement rate is lower than it is for the provision of services at primary health facilities. In addition to increasing government health

⁴⁵ Information (in Mandarin) sourced from 2019 data on NHSA (National Healthcare Security Administration) website, available at: http://www.nhsa.gov.cn/art/2020/6/24/art_7_3268.html.

expenditure, reforms have promoted the development of the private health sector through policies allowing private health facilities to enter more areas of service provision (WHO 2015).

The fee-for-service (FFS) approach has historically been the main provider payment mechanism in China, which has led to over-payment for drugs, costly high-tech diagnostic tests, and under-payment for less costly basic services, such as consultations (Dou, Wang, and Ying 2018). In 2009, the government decided to replace FFS with other provider payment mechanisms such as the global budget payment system (GBPS) and case-based payments, which have been implemented in most provinces. In 2017, the government decided to fully implement a payment system based on diagnostic related group payments (DRGs) and to further reduce the use of FFS, signaling the implementation of provider payment reform nationwide (Dou, Wang, and Ying 2018). Early evidence suggests that changes in provider payment mechanisms have had positive effects on provider behaviour (Yang and Wu 2017). In 2020, NHSA also promoted a local version of China's case-based payment reform called the Diagnosis-Intervention Packet (DIP) which has now been piloted in more than 70 cities.

economy can now choose to enrol in UEBMI or URRBMI.

Today, the social health insurance participation rate in China has stabilized at more than 95 per cent, with the two basic medical insurance schemes covering more than 1,361.31 million people, among which 75.6 per cent are covered by URRBMI (which constitutes the largest scheme) and 24.4 per cent are covered by UEBMI.⁴⁶ Within UEBMI, employees and retirees comprise 73.8 per cent and 26.2 per cent of the insured, respectively. Employees are primarily from enterprises (67.7 per cent), while government employees represent 18.5 per cent of the UEBMI membership, and workers in flexible employment account for 13.8 per cent. Within URRBMI, adults, school students and children, and college students account for 73.8 per cent; 24.2 per cent and 2.0 per cent of membership, respectively.

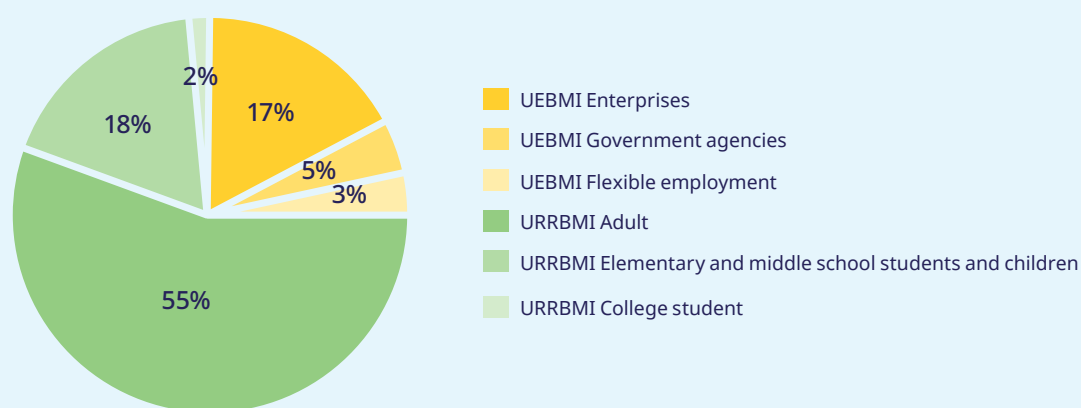
► 4. Results

- Coverage

Extension of population coverage has been made possible over the years through considerable government subsidies to the urban and rural resident schemes, which are now combined into the URRBMI. The former URBMI and NRCMS schemes both contributed to significantly extending coverage of workers in the informal economy, supported by government subsidies and strong encouragement for this population group to join the schemes. As noted above, workers in the informal

⁴⁶ Information (in Mandarin) sourced from 2020 data available on official NHSA website, available at: http://www.nhsa.gov.cn/art/2021/6/8/art_7_5232.html.

► Figure 3. Composition of UEBMI and URRBMI membership



Source: Author of NHSA reports.

Population coverage of the UEBMI increased in 2020, with the number of employees and retirees covered rising by 15.3 million or 4.6 per cent compared to 2019. As a result of population ageing, the employee-retiree ratio has been continually decreasing over the years, with three employees for every one retiree in 2012 compared to 2.82 in 2020. The membership of the URRBMI seems to have been impacted by the pandemic, with a drop of 0.8 per cent compared to 2019, equivalent to almost 10 million people.

As for the supplementary schemes, in 2015, CMI benefits were claimed by 11 million people, who received benefits of more than US\$4.3 billion (H. Li and Jiang 2017). In 2020, the MFA spent CNY54.69 billion (US\$8.49 billion), accounting for 0.05 per cent of GDP and 0.22 per cent of the national general public budget expenditure, which subsidized basic medical insurance for 99.84 million people (6.9 per cent of the total population) and provided outpatient and inpatient assistance to 84.04 million people (5.82 per cent of the total population).⁴⁷ In 2020, the total spent on hospitalization assistance and outpatient assistance through the scheme was CNY1,056 (US\$163.9) and CNY93 (US\$14.4), respectively.

- Adequacy of benefits/financial protection

The expansion of social health insurance coverage in China has significantly reduced OOP expenditures as a share of current health expenditure, which decreased from 64 per cent in 2001 to 36 per cent in 2018 (WHO n.d.) and is projected to decrease further to 25 per cent by 2030 (Fu et al. 2018). However, catastrophic expenditures still place a heavy burden on vulnerable households. Notably, OOP expenses for URRBMI members are higher and more likely to lead to catastrophic health spending than for those enrolled in UEBMI (Fang et al. 2019). In 2013, OOP expenditure per inpatient admission represented 33 per cent and 30 per cent of the annual disposable income for population groups covered by NRCMS and URBMI (now consolidated into URRBMI), respectively (Fang et al. 2019). A recent study found that social health insurance status increases the probability of patients making informal payments to doctors in China, with some variation between population groups and between social health insurance and private health insurance (Liu, Bao, and He 2020). The authors of the study suggested that the pursuit of both cost savings and quality of care may drive patients to make informal payments.

⁴⁷ Information (in Mandarin) sourced from 2020 data available on official NHSA website, available at: http://www.nhsa.gov.cn/art/2021/6/8/art_7_5232.html.

The CMI and MFA schemes have been effective in supplementing the basic social health insurance schemes and provided extra financial protection to a range of vulnerable groups. Specifically, CMI reduced the average proportion of OOP expenses after reimbursement from basic social health schemes by about 10 per cent, and in 2017, through MFA, 4 per cent of the population received subsidies to pay for their social health insurance premiums. However, as noted above, despite government efforts to provide additional financial protection through these supplementary schemes, catastrophic health spending among the poor is still an issue for many households; to exacerbate this, the prevalence of the Fee for Service payment approach has resulted in cost escalation (Yang and Wu 2017).

- Responsiveness to population needs

- o Availability and Accessibility

The expansion of social health insurance schemes in China has improved access to health care, and reforms have contributed to decreasing inequity in population health (Liu, Vortherms, and Hong 2017). In particular, evidence suggests that the integration of the previously separate rural and urban schemes has reduced inequity in reimbursements between high-income and low-income populations, with the consolidated URRBMI scheme contributing 37.5 per cent to reducing inequality in inpatient service utilization (Myint et al. 2019). However, so far, the integration of NRCMS and URBMI schemes seems to have had no noteworthy effects on the probability of unmet hospitalization needs (Zhao et al. 2019). Despite consolidation efforts, fragmentation of health insurance schemes and differences in their financial mechanisms and funding sources remain, with variations in benefit packages and reimbursement rates resulting in barriers to equal health care access (Li et al. 2017). For example, rural enrollees have more limited benefit packages and lower reimbursement rates than members of the urban scheme, which leads to discrepancies in access to health care and financial protection between rural and urban populations.

Nonetheless, over the years, the proportion of individuals who reported a need for hospital admission but did not seek inpatient care has decreased, declining from 29.6 per cent in 2003 to 17.1 per cent in 2013 (Liu, Vortherms, and Hong 2017). The average number of outpatient visits per capita increased from 1.7 in 2003 to 5.9 in 2017, increasing by 3.6 percentage points for

former NRCMS members and 7–13 percentage points for former URBMI members (now URRBMI members). For UEBMI members, the probability of outpatient treatment increased by 12.6 per cent (Liu, Vortherms, and Hong 2017). Despite this overall increase in health care utilization over the years, there is some evidence to suggest that certain groups lack access to household registration, which prevents them from claiming full citizenship rights, including social welfare and formal identity documents (Vortherms 2019). However, with the reform of the household registration system noted above (most cities no longer restrict household registration), this situation has significantly improved in recent years.

- o Quality and acceptability

In line with 2009 reforms, China has invested considerable public funds in strengthening health services, including building and renovating primary health care (PHC) facilities, procuring equipment, expanding public health services, and strengthening training and continuing medical education (Fang et al. 2019). However, increasing the quality of PHC in China remains a challenge. This has been attributed in part to limited capacity among PHC providers as a result of insufficient training opportunities; notably, in 2010, only 5.6 per cent of doctors in township health centres had a formal medical education (five years of medical school), which increased to 10 per cent in 2017 (Meng et al. 2019).

Limited capacity of PHC practitioners has been cited as a common reason for patients to bypass PHC institutions when they require care, and despite efforts to address this, evidence suggests that outpatient visits to PHC institutions have notably declined over the years (Li et al. 2020). Further shortfalls contributing to this issue include a lack of integration between clinical care and the public health service, as well as between different health sectors, and deficient continuity of care throughout the system as a whole; to compound these challenges, the widespread fee-for-service model incentivises unnecessary testing and treatments (Li et al. 2020). However, evidence suggests that provider payment reforms have reduced costs and the irrational use of drugs and antibiotics, which suggests some improvements to quality of care (Liu, Vortherms, and Hong 2017).

Despite PHC deficiencies, a 2015 study found that overall satisfaction with tertiary health care

in China is reasonably high (Sun et al. 2017). The areas with the highest satisfaction rates were diagnosis and treatment for outpatient care and nursing care for inpatient care. Outpatients were least satisfied with long waiting times, while inpatients were least satisfied with the food. The patient-doctor relationship was the strongest predictor of overall satisfaction (Sun et al. 2017). An earlier National Health Attitudes Survey (2012–2013) found that the population groups most likely to be satisfied with health services were older people, those in better health, people who have social health insurance, and those who feel that their insurance is adequate for their needs (Duckett and Munro 2016). With regards to rural medical services, according to a 2019 study, overall satisfaction scores averaged 3.61 out of 5 for outpatients and 3.80 out of 5 for inpatients (Liu and Mao 2019). Patients were most satisfied with medical service attitude and illness explanation and least satisfied with waiting times and medical expenses. Satisfaction with medical technology and trust in physicians were identified as the strongest predictors of patients' satisfaction with rural medical services (Liu and Mao 2019).

► 5. Way forward

By expanding social health insurance schemes and reaching near universal population coverage, China has been successful in improving access to health services and reducing OOP spending. However, as noted above, many challenges remain related to the quality of PCH and the fragmented delivery and financing of China's health insurance schemes. Facilitating a well-coordinated and integrated health system with a focus on primary care is therefore greatly needed to strengthen the health system in China and achieve better health outcomes (Meng et al. 2019). Building the capacity of the health workforce is key to this endeavour. As such, government efforts should continue to focus on incentives to attract and retain qualified health professionals in the PHC system (Li et al. 2020).

Reducing OOP spending for urban un-employed persons, the self-employed and rural populations is also crucial. This will require the eventual consolidation of the entire social health insurance system to integrate risk-pooling levels and equalize benefit packages through increased government funding (Fang et al. 2019). To this

end, the NHSA has been working to reduce the difference in benefits between schemes and regions, and began to gradually implement a nationally unified list of medical insurance benefits in 2021. The goal is to eliminate regional differences within each scheme as much as possible and reduce the differences between the two main schemes after three years. More broadly, in June 2021, the NHSA started soliciting public comments on the Draft of the Medical Security Law, which is expected to fill the gaps in China's medical security laws and address medical security reform and development.

To better meet the needs of vulnerable populations, increased funding should be more effectively targeted to the poor. This can be achieved by connecting benefit eligibility to household disposable income as opposed to an absolute threshold; it has also been proposed that medical aid should be extended to cover those who incur catastrophic health expenses after catastrophic medical insurance reimbursements, and OOP expenses for the extremely poor should be capped (Fang et al. 2019). To ensure that such measures are sustainable, further steps must be taken to increase health system efficiency, strengthen primary care, and control provider behaviour through payment system reforms (Fang et al. 2019).

► 6. Main lessons learned

- Government subsidies have contributed to high population coverage through China's social health protection schemes, with population coverage reaching 97 per cent in 2017. This is reinforced by a high level of government commitment to universal coverage at an early stage, which has been institutionalized through the inclusion of coverage rates in the performance indicators of governments at each level into annual health care reform assessment indicators.
- High population coverage is not sufficient to provide adequate protection. A narrow benefit package and low reimbursement rates (except in the case of the urban employee scheme), high deductibles and co-payments, and limited portability of benefits

for rural-to-urban migrants have resulted in low effective coverage and limited financial protection for members of social health insurance schemes. Furthermore, the decentralized policy decision-making power is causing significant variations between medical insurance policies and posing equity issues. Since 2021, the NHSA has been initiating reforms to promote the gradual unification of the financing and benefit policies of all pooling areas.

- Portability of social health insurance benefits is fundamental to providing adequate financial protection. Reviews of administrative rules can be changed to allow this portability. In the early stages of NRCMS, migrants from rural areas who benefited from rural social health insurance could not transfer their benefits to the urban employee and resident schemes, nor could they use their benefits outside their area of origin, which reduced utilization and financial protection among migrants. After a new round of health care reforms, the problem has been addressed step by step at provincial level. Since 2017, all the regions have been covered through a national system to ensure medical expenses can be settled where they are incurred.

- Fee-for-service, which has historically been the main provider payment mechanism in China, is not optimum in term of cost-control; It has led to increased use of drugs and costly high-tech diagnostic tests, and reduced use of less costly, basic services, which has driven cost escalation and inappropriate treatments. In a context high pressure to contain costs, the initiation of provider payment reforms in 2009, along with the implementation of a case-based payment system, has had positive effects on provider behaviour. Furthermore, since its establishment, the NHSA has actively promoted the centralized procurement of medicines and consumables, including price negotiations for costly medicines. This has led to a substantial drop in the cost of medicines, representing a shift from the passive purchasing practices employed in the early days of medical insurance, to the promotion of the strategic purchasing role of medical insurance.



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► 1. Introduction

In the Republic of Fiji, an upper middle-income country with an approximate population of 896,000 in 2020 (World Bank n.d.), the right to health is enshrined in the Constitution. Legally, the state “must take reasonable measures within its available resources to achieve the progressive realization of the right of every person to health, and to the conditions and facilities necessary to good health, and to health care services, including reproductive health care”.⁴⁸ The State’s responsibility for social health protection is reflected in the architecture and financing of the health system in Fiji, which relies primarily on government revenues to provide essential health services for free or at a low cost to all residents (WHO 2011). The Ministry of Health and Medical Services (MHMS) has recently adopted a Strategic Plan (2020–2025) outlining a strategy to achieve universal health coverage (UHC), and provide the quality of health services necessary to ensure health for all (Fiji Ministry of Health and Medical Services 2019).

However, Fiji is facing challenges in the effective provision of services. In 2017, the health service coverage index for Fiji was only 64, compared to the average health service coverage index of 75

among upper-middle income countries. This has been attributed primarily to weak management of non-communicable diseases (NCDs). Furthermore, while health services in Fiji are provided for free or at low cost for all residents, a low level of funding and allocative inefficiencies hinder effective coverage for all. The geography of Fiji, as well as social and cultural factors also impede access to services, which ultimately impacts utilization. As a result, life expectancy among the Fijian population is lower than in many Pacific Islands (67 in Fiji compared with 70, 71 and 73 in Vanuatu, Tonga and Samoa, respectively), which suggests that the capacity of the national health care system to deliver effective services remains limited (WHO n.d. a).

To address these challenges, the Strategic Plan (2020–2025) envisages a broader “collaboration with partners for a more efficient, innovative and higher-quality health system” (Fiji Ministry of Health and Medical Services 2019). Moving forward, the MHMS intends to pursue “whole-of-government” and “whole-of-society” approaches to national policy and legislative interventions to address risk factors and social determinants of poor health outcomes.

⁴⁸ Constitution of the Republic of Fiji, article 38 (1).

► 2. Context

Fiji inherited its health system from the British colonial administration. It provides social health protection to its population through tax-funded services. In the late 1990s, the Government of Fiji attempted to decentralize its health system through the creation of geographical divisional structures. This involved a transfer of considerable power and responsibility to these structures, coupled with the development of stronger institutional and managerial capacity (WHO 2016). However, due to political instability and a lack of support from central management, the reform was largely unsuccessful. In the late 2000s, the health system was partially recentralized, although divisional structures remained in place in the form of Divisional Health Offices. Decentralization efforts were renewed in 2009 in the subdivision of Suva (Fiji's capital), and the process of reforms is currently ongoing, with a focus on promoting primary health services, including prevention.

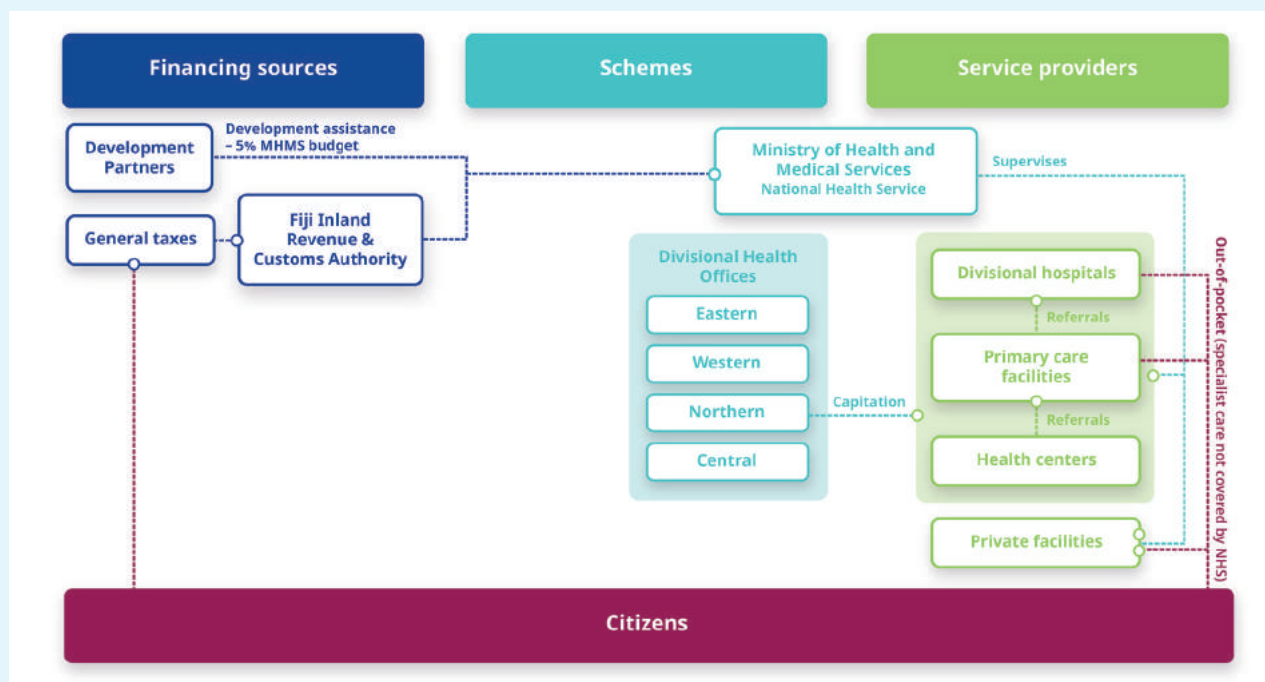
► 3. Design of the social health protection system

- Financing

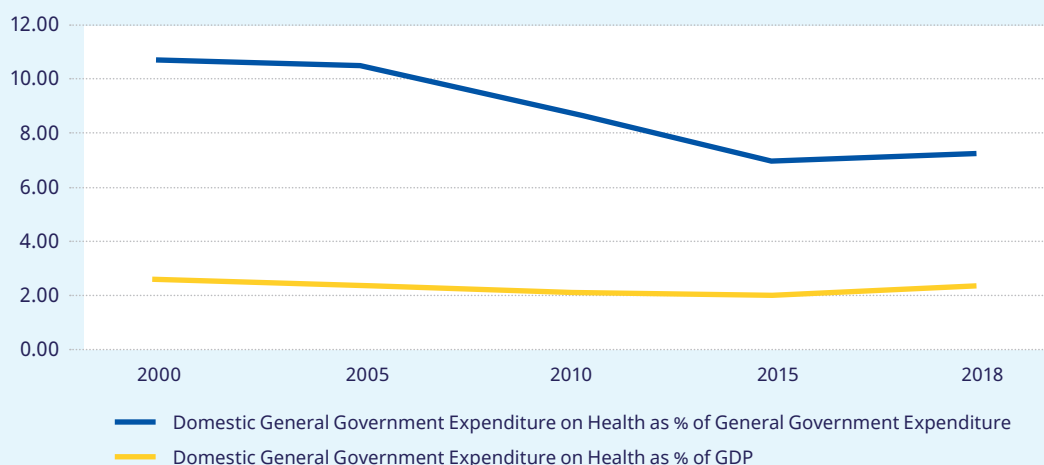
Access to health services is predominantly funded by the Government budget. Between 2000 and 2018, domestic general government expenditure on health increased by more than 2.7 times in absolute terms. However, there has been a decrease in relative terms, reducing from around 2.6 per cent of GDP in 2000 to around 2.3 per cent of GDP in 2018 (WHO n.d. a). The share of domestic general government spending on health as a share of general government spending also decreased from 10.6 per cent to 7.2 per cent over the same period (WHO n.d. a), indicative of low prioritization of health in the general budget. Nonetheless, tax revenue mobilization has increased drastically in the last few years, rising from 19 to 24 per cent between 2010 and 2018 (Kubasta et al. 2020). This has created additional fiscal space to be mobilized for social spending.

The financing flows of the health protection system are schematically presented in figure 1.

► Figure 1. Overview of main financial flows of the social health protection system in Fiji



► **Figure 2. Domestic General Government Expenditure on Health, 2000 to 2018**



Source: Adapted from WHO Global Health Expenditure Database.

- Governance

Fiji has a decentralized health system of integrated primary, secondary and tertiary care managed by the MHMS. The system is administered through four Divisional Health Offices (DHOs), each responsible for one of the four regions: Eastern, Western, Northern and Central. The DHOs are led by Division Medical Officers (DMOs), who manage a network of sub-divisional hospitals, health centres and nursing stations (WHO 2011). DMOs are responsible for developing their own business plans and enjoy considerable financial authority to ensure more effective resource distribution at local level (Gilbert et al. 2019).

The Minister of Health is responsible for administering the work of the health system, and reports directly to Parliament. The MHMS coordinates and supervises the work of DHOs, sets standards, regulates the provision of services and manages financial planning for the overall health system. Much of the work of the MHMS is undertaken through Fiji Medical and Dental Councils. The two Councils can register or deregister the licence of health care practitioners in the country, as well as issue codes of practice and professional guidelines, investigate complaints, and take disciplinary actions.

- Legal coverage and eligibility

The government funded national health service is a universal scheme that provides coverage to the entire population of Fiji (WHO 2014; 2011). The Public Hospitals and Dispensaries Act of 1955 stipulates the provision of services to both Fiji citizens and foreigners, meaning that legal coverage extends to all residents of Fiji.

- Benefits

The health services offered by the public sector include both primary level services offered by primary health care facilities and in-patient and out-patient services offered at clinics and hospitals (WHO 2011). The latter include general medical services, specialist referral services, sub-specialist referral services and high-cost complex referral services (WHO 2011). The general package of services is defined in the Public Hospitals and Dispensaries Act of 1955. Among the specialized services included in the package are general diagnostics (including radiography, X-ray scans, ultrasound and ECG) and common dental care services. The Act established a zero-cost policy for a range of general medical treatments and diagnostic procedures for children.

Medicines are either provided for free or at a subsidized cost. In addition, since 2015, the Government of Fiji has run the Free Medicines Programme initiative which aims at improving access to essential pharmaceutical products for lower-income households (Fiji Ministry of Health and Medical Services 2014). Under

the programme, all eligible Fijians can access medicines prescribed by a licensed medical practitioner free of charge from any government hospital pharmacy, dispensary or selected private retail pharmacy. To become eligible, a patient needs to demonstrate that s/he has an annual income of less than 20,000 Fijian Dollars (FJD) and is required to provide a Tax Identification Number or Social Welfare Number (Fiji Ministry of Health and Medical Services 2014).

On the whole, public services in Fiji are mostly geared towards curative care. However, the MHMS runs a range of primary level programmes aimed at health promotion to achieve better health outcomes and to contain increases in curative care costs. For example, a Wellness Unit was established in 2012 to help reduce the negative effect of NCDs on the Fijian population through provision of wellness services (Fiji Ministry of Health and Medical Services 2019).

- Provision of benefits and services

Most of the health facilities in Fiji are public. According to the MHMS, in 2016, there were 207 government health facilities, including 97 nursing stations, 86 health centres, 19 sub-divisional and three divisional hospitals, as well as two specialized hospitals (Fiji Ministry of Health and Medical Services 2016). Financing and providing the majority of services, the Government acts as both purchaser and provider (WHO 2014). Public hospitals and clinics receive funding from the MHMS on the basis of line-item budgets (human resources, services, capital investments, purchase of pharmaceuticals and so on) (WHO 2014).

Providers within the national public health system are organized into primary, secondary, and tertiary levels. In principle, primary health care practitioners (community health workers and nurses) act as the first point of contact within the health system, with a referral system as follows:

- Community health workers and nursing stations are the first point of contact, and refer patients to higher-level health facilities. They are tasked with delivering the most basic health services and preventive care (including immunization).
- A more comprehensive primary health care package is delivered at health centres, which serve larger populations and areas, and have more personnel and equipment.

- Secondary care is provided by sub-divisional hospitals, which have much greater diagnostic capacity and offer a range of in-patient and out-patient services.
- Finally, the most advanced and specialized care is offered by the country's divisional hospitals, which are the largest hospitals in the country and act as national domestic referral centres (Asante et al. 2017).

The private health sector has expanded in recent decades, but remains smaller than the public sector, with nearly all of the private providers in the country concentrated in urban areas. Currently, there are four private hospitals that have a comparatively low bed capacity. This includes the recently established Children's Heart Hospital. However, there is a considerable number of private practitioner clinics, estimated to number around 160.⁴⁹ These clinics are largely day clinics and provide general outpatient services (Asante et al. 2017).

Co-payments are in place to access some specific health care services and certain medicines. These are detailed in a special annex to the law (Schedule 1), which was last updated in 2013. These co-payments are charged at a fixed rate, depending on the type of in-patient or out-patient service provided. However, in accordance with Regulation 49 of the Act, these co-payments only apply to patients seeking services at public hospitals who were referred by a private health care provider.

► 4. Results

- Coverage

As previously noted, all Fiji residents (both nationals and foreigners) are entitled by law to access health services without hardship. According to news reports, in August 2018, there were 31,000 beneficiaries of the Free Medicine Programme (DEPTFO News 2018), which corresponds to around 3.5 per cent of the Fijian population. Regarding the rights of migrants in Fiji, who were estimated to account for around 1.5 per cent of the country's population in 2017 (WHO 2018), with around 600 refugees in Fiji in 2019 (UNHCR 2020), gaps may exist. While the Public

⁴⁹ Information sourced from telephone Interview with the President of the Fiji College of General Practitioners.

Hospitals and Dispensaries Act of 1955 does not distinguish between regular and irregular residents, it is not clear whether access for migrants is determined by their status. It is likely that undocumented migrants face challenges in accessing certain procedures. For example, challenges could arise for undocumented migrants in applying for exemption from fees that are charged for specific services, which require the completion of a form signed by a local authority, in accordance with the Regulation 20 (3) of the Public Hospitals and Dispensaries Act.

- Adequacy of benefits/financial protection

Overall, the Fijian social health protection system provides a good degree of financial protection. As outlined above, most consultations, admissions, and laboratory and radiological examinations are provided for free at public health facilities (Asante et al. 2017; Irava 2015; WHO 2011). WHO assessments suggest that the population of Fiji is not exposed to the risk of expenditures related to informal/illicit payments to health care providers (WHO 2014).

As a result, out-of-pocket (OOP) spending remains at a low level, representing 14 per cent of health expenditure in 2018. However, this figure should be interpreted with caution due to potentially low utilization of public health services. It was estimated that only around 3 per cent of OOP health spending was related to the use of public health services in 2015 (Irava 2015), with most OOP payments resulting from the use of private health services. Overall, research confirms that government health funding in Fiji is pro-poor, favouring lower-income households (Asante et al. 2017). Indeed, around 61 per cent of public spending for nursing stations and 26 per cent of spending for government hospital inpatient care were directed to services provided to the poorest 20 per cent of the population (Asante et al. 2017).

- Responsiveness to population needs
 - o Availability and accessibility

According to a survey conducted in 2017 in collaboration with the Fiji Bureau of statistics, only 70 per cent of men and 60 per cent of women reported having received some form of health care when they last required treatment (Fisk and Crawford 2017). This may be due to geographic and social factors that adversely affect conditions for accessing health benefits in

Fiji. For example, there is evidence that patients from remote communities need to travel long distances to receive diagnosis and treatment, which is particularly challenging for patients with chronic conditions (Fisk and Crawford 2017; WHO 2016; 2014). Additionally, certain population groups face social barriers to accessing services due to stigma, cultural norms, poorly-informed social perceptions and lack of public dialogue (Pūras 2019; WHO 2011). Specifically, it has been found that discriminatory attitudes among health care workers impede access to maternity and family planning services for women in certain communities and areas (Pūras 2019). Notably, a 2017 survey involving 325 women in Suva found that fewer than half of the participants had a good level of knowledge of family planning (Lincoln, Mohammadnezhad, and Khan 2018). Based on findings from a 2017 study conducted with the Fiji Bureau of Statistics, gender-based inequalities were also evidenced in relation to a range of other health issues (Fisk and Crawford 2017).

Persons with disabilities also face challenges in accessing health services in Fiji. Health infrastructure and medical care are often not tailored to people with special needs, such as those with communication disabilities (Hopf and McLeod 2015) and persons with psychosocial, cognitive and learning disabilities (Pūras 2019). In certain cases, patients have to rely on support provided by civil society organisations and charities, as there is a significant gap in services for persons with disabilities delivered by the health system (Pūras 2019).

In terms of the availability of health personnel, a 2017 study found that six out of 15 provinces in Fiji fall short of the recommended threshold of 2.3 health workers per 1,000 people (Wiseman et al. 2017). This issue is partly due to the outbound migration of the health workforce and re-location to urban areas (WHO 2011). For example, in 2006, the combined number of Fiji-born health practitioners in New Zealand and Australia was greater than the total number of public doctors in Fiji (W Irava and Prasad 2012). There are also some inequalities in the distribution of the workforce within the country, but these have been found to be less acute than in many other low- and middle-income countries.

- o Quality and acceptability

Issues related to quality stem from the lack of a qualified health workforce in Fiji, which affects the capacity of the system to deliver services in

a timely manner. The majority of health workers are employed by the MHMS or other government institutions and the Government pays out fixed salaries which are not dependent on performance (WHO 2014). This has been highlighted as an issue by some observers as a practice that is not conducive to improving efficiency or quality (Rannan-Eliya, Irava, and Saleem 2013). However, separating purchasing from provision (including some degree of autonomy for providers and the adoption of strategic payment) is difficult to implement, as it would require substantial technical capacity and resources to effectively develop, manage and monitor, both at facility and management level, which Fiji has not yet attained (Rannan-Eliya, Irava, and Saleem 2013).

A global overview of health care access and quality published in 2018 ranked Fiji at 131 out of 195, indicating that the country performed below the international average (Fullman et al. 2018). Perceived low level of quality of some public services has led to an increase in the utilization of private services (Wayne Irava 2015; Singh 2011; WHO 2016; 2011). To address quality concerns, on its official website, the MHMS encourages the public to register any complaints "as close as possible to the source of the issue" by following the complaint process at a given health facility (Fiji Ministry of Health and Medical Services 2020). The website also has a generic form that can be used to send a complaint or leave feedback electronically. The Fiji Human Rights Commission also has a dedicated service on its website to allow for the submission of complaints on any issues related to human rights, including the right to health (Fiji Human Rights and Anti-Discrimination Commission n.d.).

In the context of the high burden of NCDs in Fiji, the allocation of funding and distribution of services do not match the levels necessary to improve the quality and availability of services, leading to a failure to respond effectively to the increasing health care needs of the Fijian population (Asante et al. 2017; Negin, Roberts, and Lingam 2010; WHO 2011). For example, in 2015, about 62 per cent of government spending on health in Fiji was allocated to hospital services, whereas only around 18 per cent was allocated to primary care facilities (such as nursing stations and health centres), and 7 per cent was allocated to providers of preventive care (authors calculations based on Fiji Ministry of Health National Health Accounts from 2017).

Overall, the provision of health services remains underfunded, with an insufficient number of qualified personnel and insufficient scale of outreach and health promotion activities (Negin, Roberts, and Lingam 2010). Despite the existence of a referral system, a 2011 WHO assessment concluded that the gate-keeping system in Fiji is not well-defined and that patients can bypass the primary level, in practice (WHO 2011). The weak gate-keeping function of primary-level care may further negate efforts to promote healthier lifestyles through primary health care interventions at community level.

Moreover, the Fiji health system has been found to be vulnerable to medicine shortages (Walker et al. 2017). For example, in March 2020, public health facilities ran out of stock of major drug used for blood pressure control that was included in the Free Medicines Scheme list (Deo 2020). The lack of high quality medical services is partly mitigated by the existence of special overseas referral programmes (for example, to Australia, New Zealand and India) based on eligibility criteria and visits by individual specialists and teams sponsored by government, donors and charitable organizations (Fiji Ministry of Health and Medical Services 2014).

► 5. Way forward

While the Republic of Fiji already provides comprehensive legal social health protection coverage to its citizens, further efforts are needed to boost the utilization of services and improve effective coverage. Increasing and rationalizing funding, as well as improving efficiency in spending towards primary level of services, will be key to sustain access for all. Accordingly, the Government has acknowledged the existence of funding gaps which impede the right to social health protection. As such, in 2015, a proposal was endorsed to increase total government health expenditure to at least 5 per cent of GDP with the express aim of expanding access to quality services (Asante et al. 2017). However, as highlighted above, further efforts are needed. One possible solution being considered for mobilizing additional resources for health is the introduction of earmarked taxes on products that are known to adversely impact health. Notably, in Fiji, taxes on tobacco remain below the WHO-recommended level and

the prevalence of tobacco consumption is high, estimated at 22 per cent (WHO 2018).

Broadening access to services also remains a priority in Fiji. In 2018, the Government announced that the population would gain access to private general practitioners (GPs) by making them free of charge at the point of service. The new policy, when finalized, is expected to include incentivising GPs to settle directly in Fijian communities, including in peri-urban areas, towns, local communities and rural and remote parts of the country. In order to fund this initiative, the Government has chosen to set up a dedicated trust fund. As the legislative basis of this initiative, Act No. 30 of 13 July 2018 amends the Fiji National Levy Order 1988, with half of the levy collected on employers being earmarked “for the purpose of facilitating public access to private medical services.” However, it remains unclear which payment mechanism will be used for private practitioners, and how the use of funds will be balanced between private and public providers.

The issue of health workforce shortages is reflected in the MHMS Strategic Plan 2020–2025 (Fiji Ministry of Health and Medical Services 2019). The Government of Fiji has taken steps to tackle this by mitigating outbound health workers’ migration, and attempts have been made to retain qualified health workers by increasing their salaries (Pūras 2019). A migration of the workforce from the public to the private health sector has been observed in the past, with the share of professionals employed in the private practice reaching 25 per cent of the total medical workforce in 2008 (Negin, Roberts, and Lingam 2010).

To address pharmaceutical shortages, a more effective procurement mechanism needs to be established, informed by better stock forecasting and supply tracking mechanisms (Walker et al. 2017). Up until now, FMI medicines were supplied to private retailers for free by the Government. However, the Government is now considering reforming the Free Medicines Initiative, whereby private pharmacies would have to procure the medicines on the FMI list from the central warehouse themselves, and charge a dispensing fee to the Government ex-post. This poses a potential threat to the financial sustainability of the scheme.

► 6. Main lessons learned

- Ensuring adequate quality of health services is crucial to improving effective coverage. Low quality of public health services at primary level is partly due to underfunding and allocative inefficiency. Negative perceptions among the population encourage bypassing the primary level and directly accessing expensive secondary and tertiary services, as well as using private health services.
- Social health protection strategies must incorporate responses to social and financial barriers to access. The health care system in Fiji has achieved a degree of vertical equity in financing and is predominantly pro-poor. Despite the policy of free services at the point of entry, health access is hindered for certain population groups, due to discriminatory practices of providers and financial barriers related to transportation and accommodation costs. These obstacles should be addressed as part of national expansion of social health protection efforts.
- Financing strategies of the social health protection system must rely on sustainable domestic funding sources. Because the social health protection system is highly dependent on government general budget allocations, the low prioritization of health as part of the general budget has had a direct detrimental impact on access to health. Moving forward, strategies including the introduction of earmarked resources appears as promising stable source of funding, with potential to partially fill the funding gap.

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► India

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► 1. Introduction

Since the early days of its independence, India has recognized the benefits of ensuring comprehensive health care coverage for its population. As such, several official committees, expert groups and policy documents have reiterated the need for ensuring accessibility and availability of health care, and the country has taken incremental steps to establish and expand social health protection. This has been achieved across various targeted population groups through a range of mandatory social health insurance schemes, targeting industry workers, civil servants and low-income households, respectively. Despite advances made through these schemes, the social health protection system in India remains fragmented, with concerns expressed around the ability of schemes to provide effective coverage to beneficiaries. Moreover, such fragmentation has resulted in varying standards of quality of clinical care and levels of access, with implications for the efficiency of the system at large.

► 2. Context

Social health protection schemes in India have been operating since the country's independence in 1947. With limited economic resources to hand, the Government initiated a targeted roll-out of social health protection measures. Initially the entire population was entitled to affordable health care in public facilities through the national health service run by the Ministry of Health and Family Welfare (MOHFW), though the reach of this system remained limited in practice. Acknowledging the need for expansion, the Employees' State Insurance Scheme (ESIS) was launched in 1952 to cover factory workers and their families up to a certain income level. This was soon followed by the establishment of the Central Government Health Scheme (CGHS) in 1954, which aims to cover central government employees and their families. Both of these schemes are contributory and viewed as a means of alleviating the financial burden from the national health service to some degree. In 1997, the Railway Employee Scheme was established, and there are also smaller contributory schemes run by public sector enterprises, government departments and sectoral welfare boards. Furthermore, a gradual opening of foreign

investment in insurance products and increased economic liberalization led to the introduction of private health insurance markets.

From 2008 onwards, several states in India, acknowledging health care as an increasing financial burden on households, launched various health protection schemes which mainly provided coverage for costly inpatient services. At central level, the Government of India also acknowledged the need for such a scheme and launched the non-contributory Rashtrya Swasthya Bima Yojana (RSBY) scheme in April 2008, which covered families below the poverty line up to a certain financial threshold, mostly for inpatient and costly outpatient care (Karan, Yip, and Mahal 2017). After close to 10 years of implementation, the RSBY scheme was remodelled as PM-JAY, which consists of two inter-linked components: Health and Wellness Centres (HWCs), which aim to provide universal access to primary health care (PHC) and Pradhan Mantri Jan Arogya Yojana (PM-JAY), which covers secondary and tertiary health services. The scheme increased the financial ceiling for inpatient services by more than ten times that of RSBY, and managed to consolidate the majority of smaller schemes run by state governments at the provincial level. This has facilitated the development of a large and common social health protection scheme, which aims to cover 500 million individuals across the country.

► 3. Design of the social health protection system

- Financing

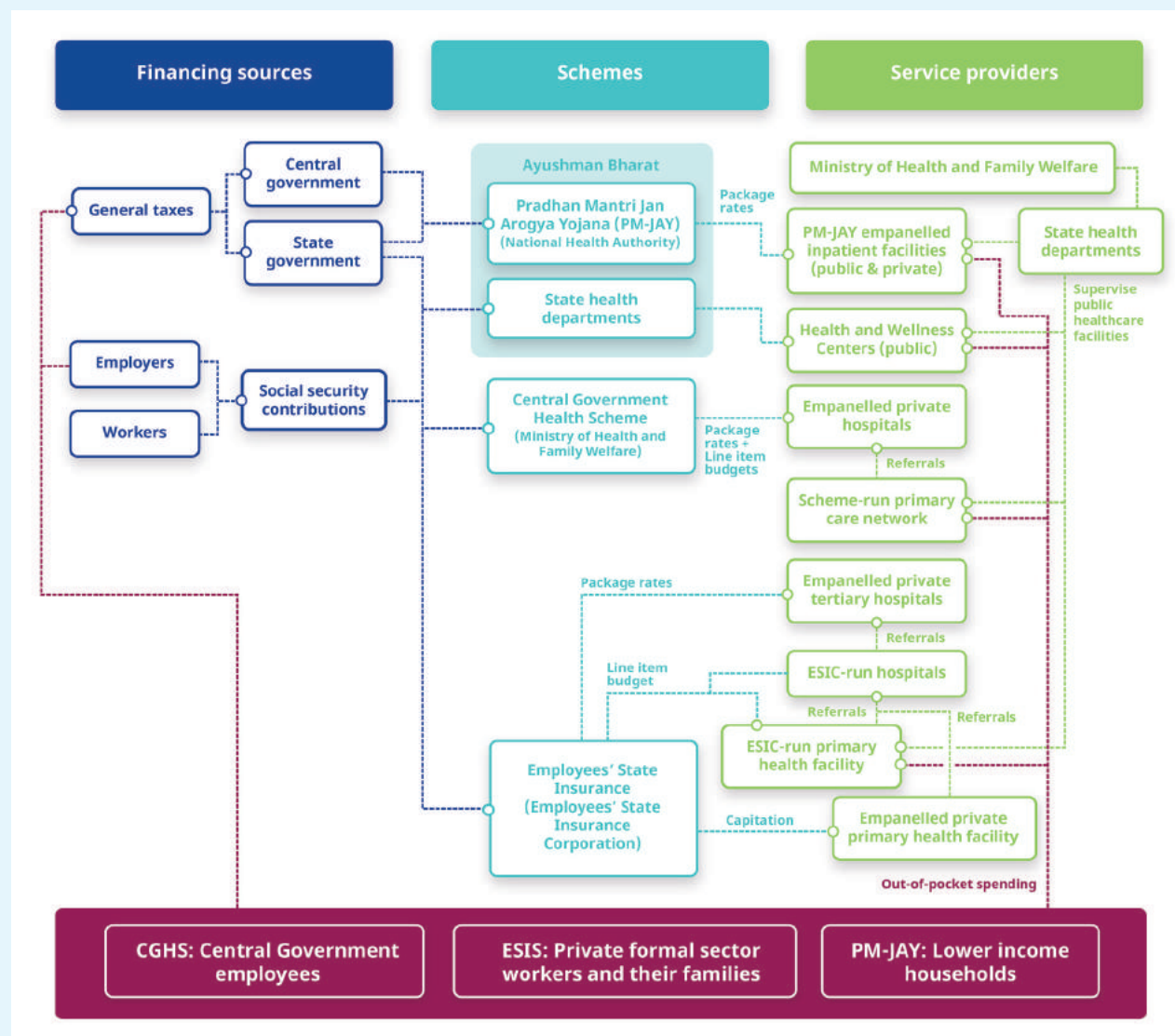
Financing remains highly fragmented in India. Although public facilities receive general budget allocations from central and state governments and several contributory and non-contributory schemes exist, a large proportion of health expenditure in India is comprised of out-of-pocket (OOP) payments. According to the latest available data, OOP payments by households accounted for 62 per cent of health expenditures in 2017, while domestic general government health expenditure accounted for 27 per cent, and 10 per cent was attributed to other private sources (WHO n.d.).

The non-contributory PM-JAY scheme is financed predominantly through shared resources from central and state governments for supporting low-income households, mainly covering hospital level care. However, for outpatient care, a large proportion of financing is paid for directly by households, the costs of which are driven in large part by drugs and diagnostics (NHA Technical Secretariat 2019).

Figure 1 below schematically illustrates the structure of the overall system and the relevant financial flows.



► Figure 1. Overview of main financial flows of the social health protection system in India



Source: Authors.

- Governance

Parallel governance structures exist to oversee social health protection in India. The Employees' State Insurance Corporation (ESIC) is an autonomous body under the Ministry of Labour that oversees the implementation of Employees' State Insurance Scheme (ESIS). Policy level governance of ESIS falls under the oversight of three major committees, namely the ESIC, the Standing Committee and the Medical Benefits Council. In addition to government and ESIC representatives, these structures also include the participation of employer and employee

representatives from covered industries and sectors. Representatives of insured workers and registered enterprises are involved in the overall stewardship of the scheme, as well as major policy decisions affecting the structure and operations of the ESIS.

The CGHS is governed by a dedicated department under the MOHFW, while the Railway scheme is governed by the Ministry of Railways. In the case of PM-JAY, the National Health Authority (NHA) takes on a stewardship role, providing necessary guidelines and policy decisions that inform the evolution of the scheme. Public facilities and

health service provision is stewarded by the MOHFW, though the majority of responsibility vis-à-vis governance and oversight is the purview of state health departments. While the MOHFW can provide guidelines, public health service provision in India is constitutionally decentralized, falling under the mandate of individual state governments.⁵⁰

CGHS and ESIS have both set up dedicated grievance redressal mechanisms to ensure transparency and accountability. Moreover, ESIS has mechanisms in place for ensuring accountability among providers through use of regular monitoring processes, such as facility visits and reviews. In addition to these monitoring visits, a vigilance unit is in place at the ESIC headquarters to ensure that providers and ESIS officials are held accountable in the event of any transgressions. PM-JAY has also instituted a detailed transparency and accountability mechanism through a grievance redressal system with a chain of command that goes down to the district level. The scheme has also implemented anti-fraud units at Central and State level to ensure that providers and other PM-JAY officials are held accountable for their actions. Detailed medical and facility audits are also undertaken to monitor and oversee functioning and performance of empanelled hospitals.

- Legal coverage and eligibility

The social health protection schemes in India are targeted in terms of their beneficiary coverage and are predominantly mandatory for the defined target beneficiaries of each scheme, the scope of which have been mostly limited to the formal sector and the poor. While CGHS covers central government employees (targeting 3 million beneficiaries), the ESIS covers lower-income workers in non-seasonal enterprises, shops and establishments (targeting 135 million beneficiaries), with recent efforts to expand to the informal sector. Notably, through the new Social Security Code passed in 2020, the scope of coverage for ESIS has been expanded to cover some new categories of informal workers.

PM-JAY aims to cover 500 million beneficiaries, the majority of whom are lower-income households as defined by the Socio-Economic Caste Census (SECC) of 2011. While the scheme is not mandatory, individuals and households that are listed under the SECC 2011 are automatically enrolled into the

scheme and can be enrolled at facilities directly after verification of their eligibility.

- Benefits

Benefits provided under each scheme vary. CGHS and ESIS aim to provide comprehensive health coverage, though the degree to which they effectively manage to do so is not clear. Maternity services are included under both CGHS and ESIS, together with other National Programme services such as treatment for HIV and tuberculosis, family welfare and immunization. In comparison, PM-JAY is more limited in the benefits it offers in terms of inpatient services. While pre- and post-hospitalization services are part of the package, unlike the other two schemes, PM-JAY does not include primary and general outpatient services.

- Provision of benefits and services

CGHS and ESIS differ in the network of providers they utilize to deliver services to their beneficiaries. However, neither CGHS or ESIS implement a provider-purchaser split for the majority of service provision. CGHS provides primary care through its own network of clinics (through line-item budgeting) across selected cities in India. Inpatient services under CGHS are provided by a network of private hospitals empanelled under the scheme, and package rates have been established over time. However, the modes and frequency of formal costing or structured revision of these packages is unclear. A strict referral system is in place to regulate traffic of in-patients to secondary and tertiary public and private empanelled providers.

ESIS also provides primary care predominantly through its own network of facilities based on line-item budgets, and some private primary care provision is paid through capitation payment. Similarly, inpatient care is provided through own its internal network of facilities as well as through a pool of empanelled public and private providers. This internal network is managed and run directly by ESIC in some locations (model hospitals) and by state governments in other cases. In the case of specialized procedures (Super Specialty Treatment) and in areas where ESIS's own network is not present, ESIS leverages a network of empanelled private facilities (comprising 1500 facilities), wherein rates are on par with current CGHS rates. Referrals from primary to inpatient care are in place in principle, though the degree

⁵⁰ The Constitution of India 1949 (amended 2020), available at: https://legislative.gov.in/sites/default/files/COI_1.pdf

to which this gate-keeping system is effective is uncertain. However, there is a strict referral system in the case of utilization at private facilities to help ensure cost control.

In the case of PM-JAY, there is a clear purchaser-provider split, as public and private facilities are empanelled based on pre-defined criteria, with similar governance oversight and monitoring in place. Package rates were arrived at through expert consultations prior to the launch of the scheme, though it has often been claimed by the private sector that the rates provided tend to under-estimate the cost of provision in the private sector (Press Trust of India 2019).

India's social health protection schemes are all working towards developing robust IT and digital solutions to improve access and performance. While information on CGHS is limited, ESIS has developed an integrated IT reform through the initiative, Project Panchadeep, which implements various dedicated modules to address issues of inter-facility connectivity, patient medical records, data management and so on (ESIC 2020). PM-JAY has also been instrumental in pushing for a digitized social health protection eco-system wherein all aspects of scheme functioning, including beneficiary identification, transaction management and fraud detection are undertaken through elaborate IT modules devised for specific purposes.

► 4. Results

- Coverage

The social health protection landscape of India is made up of many fragmented efforts to cover specific population groups. Through the CGHS, ESIS and PM-JAY schemes, combined with several smaller schemes run by public sector units, it is estimated that close to half of the Indian population should be covered to some extent for utilization of health services (albeit in a fragmented manner) in the coming years. Among the contributory social health insurance schemes in India, the CGHS, ESIS and Railway schemes are among the largest in terms of coverage. The PM-JAY on the other hand is the largest non-contributory, tax-financed scheme.

At the federal level, ESIS and PM-JAY are the largest schemes in terms of coverage. ESIS

covers 135,700,000 workers and their families, and PM-JAY covered 126,300,000 beneficiaries in 2020, representing about 10 per cent of the population, with rapid expansion towards its 500 million target. Within PM-JAY specifically, there is limited dynamism vis-à-vis ensuring effective coverage of potential beneficiaries due to the use of a retrospective database, which may not reflect changes in household economic conditions. Therefore, it is likely that several households who may have fallen down the economic gradient and are eligible for PM-JAY are excluded due to the reference database deployed for coverage.

While India has made great strides in expanding population coverage of health services, there remains a lot to be done in terms of further expanding scope and depth of coverage. With regard to the former, it is noteworthy that despite the large number of persons covered under each scheme, more than half of India's population still remains unaffiliated to a social health protection scheme. This is especially prevalent among the informally employed and self-employed, though policy discussions are underway as to how to reach this "missing middle" group.

- Adequacy of benefits/financial protection

As previously noted, sources of revenues for health in India are highly fragmented, with the largest share of health expenditures (around 62 per cent) comprised of OOP payments paid directly by households. Prior to the advent of PM-JAY, risk pooling was very low, with less than 35 per cent of the population participating in a risk pooling scheme and less than 10 per cent covered by a functioning risk pooling mechanism that provides effective protection against catastrophic events (NITI Aayog 2019). The high level of OOP expenditures reflects this lack of risk pooling, and the absence of a single monopsonic purchaser defining input and outcomes. This deficiency means that providers tend to have the upper hand vis-à-vis price setting and determining the level and quantum of care provided, with profit maximization prioritized, and non-coverage of post-hospitalization care the norm.

Each pool acts as a health service purchaser, and with this level of fragmentation, every pool has limited leverage with providers. With few exceptions, both public and private schemes in India use less effective provider payment mechanisms, with line-item budgets predominating in the public sector and fee-for-service prevalent in the private sector. Limited

leverage and the lack of performance/output-based payment mechanisms severely hamper the capacity of these pools to act as strategic purchasers. As a consequence, they behave mostly as passive payers. Ultimately, this situation impedes financial protection of beneficiaries.

In addition, the levels of financial protection offered by the existing schemes vary. In the case of PM-JAY, there has been a significant improvement in this regard compared to the previously implemented RSBY scheme, but some design elements traditionally associated with private commercial insurance (such as ceilings), persist (Dror and Vellakkal 2012). While ESIS offers high levels of cost coverage, in practice, beneficiaries have reported that financial protection is greater in ESIS facilities, while contracted facilities, especially those in the private sector, tend to charge more. Lastly while efforts have been made to reduce financial barriers to maternity protection, delivery in particular remains costly for most women in India. With financial barriers tending to have a gendered impact, efforts are needed to improve awareness and entitlements to RMNCH (Mohanty et al. 2020).

- Responsiveness to population needs
 - o Availability and accessibility

Improving access to services in India remains a challenge (Ranga and Panda 2014). Overall, the fact that each scheme has its own provider network, does not result in optimal access for beneficiaries. Challenges in accessibility are evidenced by the very low levels of utilization witnessed across facilities under ESIS (0.37 outpatient visits per beneficiary as of 2017-18, compared with 5 per beneficiary in China) (ESIC 2018). This challenge may well relate to the lower number of beds and physicians available per capita, with ESIS providing only 0.6 doctors per 10,000 beneficiaries compared to an Indian average of approximately seven (computed by authors from ESIC Annual Reports). Furthermore, beneficiaries have reported that, while family members working in urban areas have access to ESIS or empanelled facilities, geographical access is much more limited for family members in rural areas, which is a very common situation among industrial workers. This was a concern raised by the results of ESIS beneficiary surveys (Verma et al. 2013). As for PM-JAY, empanelment and retention of private facilities remains challenging due to limited availability and involvement of facilities, which obstructs access to care.

There have also been concerns expressed around administrative barriers to accessing care, as evidenced by the beneficiary survey conducted by ESIS. These concerns relate to the ability of employers and employees to comply with the reportedly work-intensive, administratively challenging registration requirements and reimbursement procedures (issues that are currently being resolved as part of ESIS's transition to a more digitized process framework). Beneficiaries participating in the ESIS survey also reported gaps in knowledge of their benefits and how to avail of them in some cases. As a means of addressing this, ESIS undertakes a host of activities to increase awareness of the scheme among beneficiaries. This includes outreach and media campaigns (online and offline) as well as information provided at ESIS facilities. PM-JAY also carries out a large variety of communication and awareness activities for the scheme. In addition to using public sector front line-worker cadres to disseminate information on PM-JAY, the scheme also uses media campaigns, and has designated Pradhan Mantri Aarogya Mitras (PMAMs), who serve as provider level facilitators to inform beneficiaries of scheme details, and navigate them through the process of utilizing covered services. However, communication and awareness activities under CGHS remain limited.

- o Quality and acceptability

Some recurrent challenges in providing social health protection in India relate to quality of services (Central Bureau of Health Intelligence 2019). Concerns have been expressed regarding the lack of comprehensiveness of the schemes, namely the exclusive focus on inpatient services under PM-JAY, and concerns about adequate accessibility to and quality of health services offered under the formal sector schemes. Furthermore, over-prescription of drugs, especially antibiotics, as well as overtreatment (such as unnecessary injections) are rampant in both public and private sectors, and appear to be worse in rural settings and among private providers. Issues including supplier-induced demand for drugs and care, and a lack of standard treatment practices create an environment in which over-prescription and unnecessary treatments flourish.

To compound this, clinical protocols or guidelines are generally absent or unavailable, and even when they are available, non-compliance with diagnostic and therapeutic standards is high (Karan et al. 2019; Rao et al. 2011). This not only

impacts the quality of services provided, it also increases spending on health, including OOP spending among households and costs of the SHP schemes. While MOHFW efforts to increase regulation of private provision have been made, it remains difficult to control the majority of health care provision in India; the existence of many informal providers makes effective regulation of the sector particularly challenging (Kasthuri 2018; Roy 2021).

► 5. Way forward

Several changes are afoot in terms of increasing coordination between social health protection schemes and streamlining their operations. Most recently, ESIS and PM-JAY have agreed to align and share their respective networks of health service providers to enable greater access for beneficiaries of both the schemes, resulting in an overall increase in access to services (FE Bureau 2021). The need to expand health coverage to the “missing middle” in India and adopt a more universal approach to social health protection has also been widely acknowledged, as exemplified by the National Health Policy 2017. This may pave way for a potential convergence or even a merger of multiple pools to ensure uniform access and greater efficiency in purchasing decisions and governance flows. Better channelling of resources into formal risk pools (governed and operated by institutional purchasers), and better integration of such pools (through an aligned set of regulatory rules and/or a merger) would greatly increase leverage over providers, as well as facilitate the development of provider payment innovations. This development will be essential for setting incentives for provider integration and consolidation (NITI Aayog 2019).

While no specific laws have been conceived to promote progress towards universal coverage, other important legal precursors are in place, the implementation of which will influence the degree to which India can transition towards universal health coverage. Specifically, the pan-India implementation of the Clinical Establishment Act will help to regulate private sectors vis-à-vis their allocation of funds for infrastructure under the National Infrastructure Pipeline (NIP), outlined in the latest budget. However, a lot more investment will be required to truly bridge access and availability gaps (Roy 2021). Some key

policy level steps are required to advance social health protection and improve efficiency and effectiveness of existing schemes, as follows:

- i) Develop a vision and its implementation pathway to universalize social health protection coverage;
- ii) Streamline risk pooling and strategic purchasing to de-fragment financial flows and build a pathway for expanding financial coverage for all;
- iii) Organize the mixed health care delivery system into an accountable, affordable, high-quality system aligned with public objectives;
- iv) Reimagine India’s digital health landscape and improve availability of data, including analysis of existing data for clinical, epidemiological, financial and administrative improvement.

In addition to these measures, there is a need for social health protection schemes to adopt a greater focus on preventive and primary care, in addition to inpatient services. This is particularly important given that the prevalence of non-communicable diseases (NCDs) such as diabetes and stroke have substantially increased as drivers of mortality in the last decade. Moreover, ischemic heart disease (IHD) continues to prevail as the most significant burden of disease, with a substantial increase in its proportionate contribution to mortality (Dandona et al. 2017). All of these conditions could be handled and managed at the primary care level, through which active engagement with the community in prevention, management and treatment of risk factors would contain disease progression.

In addition to the clinical burden of NCDs, they also place a large economic burden on the country. It is estimated that, due to five NCDs alone, India will suffer an economic loss of US\$4.58 trillion between 2012 and 2030, accounting for nearly double India’s GDP in 2016 (Bloom et al. 2014). Despite a nationwide shift toward NCD treatment, in some states, especially those in the Empowered Action Group (EAG), the rapid increase in the prevalence of NCDs is coupled with an unfinished agenda in infectious diseases and maternal newborn and child health conditions. In this context, in addition to the focus needed to curb the NCD-related burden, it is important that efforts are made to sustain and improve maternal and child health outcomes.

Another important demographic consideration for the future is the ageing population of India. While a “demographic dividend” in India has been touted, declining fertility rates and an increase in life expectancy will result in an older population within a decade or two, which will require a substantially larger share of available health care resources. Today, 9 per cent of the population, accounting for over 116 million adults, are 60 years or older; by 2050, the population share of this age group will grow to 19 per cent. Furthermore, the proportion of adults aged 80 and over is projected to triple to 3 per cent by 2050, putting an additional strain on health protection schemes and the system at large to cater to the health needs of this large population group (Agarwal et al. 2016).

► 6. Main lessons learned

- To achieve the commitment of the National Health Policy of 2017 to increase government health expenditure as a percentage of GDP to 2.5 per cent by 2025, the Indian Government needs to take bolder steps towards increasing public funding of the health sector and improving health care service quality and access. The increased allocation to health of 1.8 per cent of GDP in line with the most recent budget announcement is commendable in light of the limited availability of fiscal space resulting from the economic impacts of the ongoing pandemic. However, there is a need to ensure sustained commitment to the health sector in the years ahead. Ensuring health as a central policy goal will help to ameliorate chronic issues around service quality, utilization and the high OOP financial burden faced by Indian households.
- Strong governance is crucial to enabling universal health coverage and achieving progressive realization of effective social health protection. Solid regulation, supervision, accountability and enforcement mechanisms at all levels are urgently needed to address the insufficient performance of the system and to facilitate the expansion of existing social health protection schemes so that they can effectively protect the population from the financial risks related to ill health.
- A rights-based approach needs to be prioritized. Currently, the PM-JAY Scheme and many other publicly funded schemes have only limited legal grounding and are insufficiently institutionalized, which could explain the weak regulation and enforcement of the benefits provided under these schemes.
- A solid social health protection system, which is an intrinsic feature of comprehensive social protection, can contribute to improving health outcomes while reducing the risk of impoverishment linked to catastrophic health care expenditures. This in turn contributes to increased economic productivity and national income. While different health protection options exist in India, there is considerable scope to expand upon ongoing efforts by increasing risk pooling across these multiple schemes. Reducing the fragmentation across pools and/or adopting common design features across pools would ensure: (i) greater leverage for price setting by a single purchaser; (ii) a uniform benefit package in the interests of equity; (iii) standardized quality of care tied to appropriate financial incentives; and (iv) increased access to care for the population in an equitable manner.

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► Indonesia

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► 1. Introduction

With the enactment of the 2004 Law on the National Social Security System and Law No. 24 of 2011 on the Social Security Administrative Body, the Government of Indonesia has made a strong commitment to achieving universal health coverage (UHC). In 2012, the National Social Security Board, Dewan Jaminan Sosial Nasional (DJSN) and the Ministry of Health (MOH) laid out a road map towards an integrated social health protection (SHP) system and the establishment of a Social Security Administrative Body for Health, known as BPJS Kesehatan. Prior to 2014, a range of fragmented health protection schemes existed, which were eventually merged into a single-payer system, known as Jaminan Kesehatan Nasional (JKN), managed by BPJS Kesehatan. Currently, the JKN national health insurance scheme is one of the largest single payer systems in the world, with around 223 million members as of 2020. Since its implementation, it extended social health insurance coverage to more than 82 per cent of the total population in Indonesia. However, the last mile towards universality is proving to be a significant challenge, particularly with regard to ensuring coverage for workers in the informal economy and their families. Due to inequitable access to health care, increased health care utilization has not yet translated into significant

improvements of health outcomes. For example, the maternal mortality ratio remains high, decreasing from 199 deaths per 100,000 live births in 2014 to 177 deaths per 100,000 live births in 2017 (WHO 2018). Furthermore, the under-five mortality ratio increased from 19.1 in 2014 to 25 in 2017.

► 2. Context

The social health protection system in Indonesia has evolved over time and seen significant reforms. The oldest social health insurance scheme, Askes, was established in 1968 to provide coverage for civil servants, military and police personnel, retired government workers, and veterans and their families. In 1992, the social insurance scheme, Jamsostek (covering health, old-age and work injury), was set up for employees of private companies with more than ten employees and paying salaries greater than 1 million Indonesian Rupiah (IDR) (approximately US\$71) per month per employee. However, coverage of these two schemes was continuously low covering just 7 per cent and 5 per cent of the population in 2013, respectively (Director General for Poverty Alleviation 2019).

In 2005, a scheme called Jamkesmas was established to provide coverage for the poor

and near-poor, which covered more than 76 million people in 2013 (32.2 per cent of the total population). Beneficiaries could access health services at public primary health care facilities and selected public hospitals with no co-payments. While the scheme was successful in increasing utilization and reducing catastrophic expenditures, significant supply-side constraints and inequities in the availability of services persisted (Harimurti et al. 2013).

In 2014, the establishment of Indonesia's national social health insurance scheme (JKN) consolidated all previously fragmented social health insurance schemes and assistance programmes at national and provincial levels. This resulted from citizens taking legal action to hold the Government accountable to implement the 2004 law on the National Social Security System. The merger of Indonesia's social health protection schemes and transition to a single-payer system has allowed for significant coverage extension.

► 3. Design of the social health protection system

- Financing

The JKN scheme is financed by central and local government revenues to provide subsidies for the poorest 40 per cent of the population. It is also funded by social security contributions from workers and employers. For salaried workers, 4 per cent of their monthly payroll is paid by the employer and 1 per cent by themselves, while non-salaried workers (informal sector) and non-workers pay a fixed contribution based on their choice of inpatient ward class (BPJS 2020).⁵¹

Domestic public health expenditure has steadily increased since the introduction of JKN, standing at 48 per cent of current health expenditure (CHE) in 2017. Within domestic public expenditure, general government revenues and social health insurance contributions represented 36 per cent and 13 per cent of CHE respectively in 2017

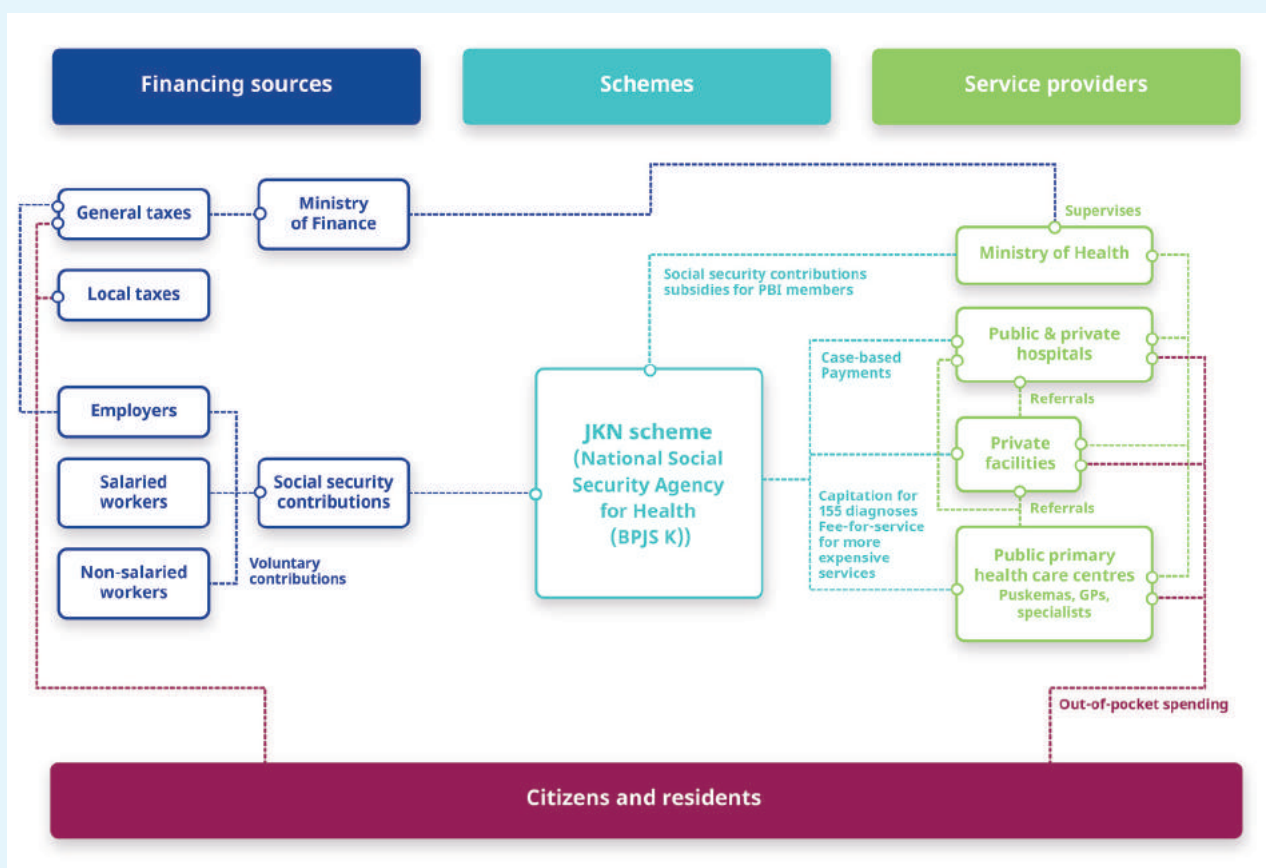
(PPJK 2018). The remaining proportion of health expenditure is comprised of private health expenditure (16 per cent of CHE) and out-of-pocket (OOP) expenditures (34 per cent of CHE).



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⁵¹ According to the Presidential Regulation 82/2019, there are different monthly contributions for workers in the informal economy based on ward level: I – IDR42,000; II – IDR110,000; and III – IDR160,000.

► Figure 1. Overview of main financial flows of the social health protection system in Indonesia



Note:

PBI APBN: Subsidized segment (national level, based on unified database)

PPU BU: Formal private sector

PBI APBD: Subsidized segment (local level, transferred from Jamkesda)

PPU P: Public sector workers

PBPU: Informal sector workers

Source: Authors.

- Governance

The JKN scheme is implemented and managed by the BPJS Kesehatan – a not-for-profit trust fund, and legally independent entity directly controlled by the President of Indonesia. Under the supervision of the MOH, BPJS Kesehatan is responsible for the enrolment of beneficiaries, the collection of contributions, claims management, processing of payments to health care providers, and administering of contracts with providers. The National Social Security Board, Dewan Jaminan Sosial Nasional (DJSN), was established by the President of Indonesia as an autonomous and tripartite board with 15 members. It formulates social and health protection

policies and oversees and monitors the performance of BPJS Kesehatan. As an independent body, it reports to the President of Indonesia. However, in terms of administration and budget, it is located under the Coordinating Ministry for Human Development and Cultural Affairs (Prabhakaran et al. 2019).

- Legal coverage and eligibility

Registration to the JKN scheme is compulsory for all residents, including foreigners who have been working in the country for a minimum of six months. The main categories of beneficiaries covered by the scheme include: (i) salaried workers whose contributions are shared with

employers; (ii) non-salaried workers and non-workers who pay a flat contribution; and (iii) poor and vulnerable population groups (the poorest 40 per cent of the population) whose contributions are fully subsidized. Coverage for dependents is possible for all member categories. As differentiated deadlines were set for implementing mandatory coverage, for some population groups (such as informal economy workers), registration remains voluntarily in practice.

- Benefits

The JKN scheme provides a unique, broad benefit package to all members. Some differences in the benefit package exist, depending on the type of ward where members access services or depending on different membership groups, but there are no differences in the services covered. Salaried workers are entitled to Class 1 or 2 wards, subsidized members can only access Class 3 wards, and informal economy members can access services in all wards depending on the contribution paid. All JKN members benefit from comprehensive coverage of health promotion; preventive, curative, and rehabilitative medicine services; medically indicated laboratory tests, drugs and supplies; and ambulance services for referrals (Prabhakaran et al. 2019). The establishment of the JKN was used as an opportunity to include both HIV and tuberculosis diagnostic and treatment services in the benefit package, which were previously managed vertically outside the social health insurance system (Prabhakaran et al. 2018). The only exclusions include services in health facilities that are not empaneled or contingencies already covered by other programmes, such as employment injury and traffic accidents.

- Provision of benefits and services

As of 2020, the BPJS registered network of facilities includes 27,075 public and accredited private facilities. In 2017, 60 per cent out of all BPJS Kesehatan contracted facilities were private, with the private health sector growing faster than the public sector (Gani and Budiharsana 2019). Primary health care (PHC) facilities typically provide outpatient services only, including consultations, the provision of medications and some diagnostic testing and screening (Gani and Budiharsana 2019). More

complex services and most inpatient services are only available at the hospital level (Agustina et al. 2019). Patients are only covered for specialist care after a primary care provider has referred them (Agustina et al. 2019).

JKN members are initially registered at the PHC facility of their choice, which is usually a facility that is close to where they live, based on the address on their electronic ID card. For some beneficiaries with subsidized membership, the choice of PHC facility may have been decided based on the district, as their enrolment is linked with their identification through the social assistance programme, National Social Welfare Integrated Data.

Under the JKN scheme, there are three types of provider payment methods: capitation for primary health care for 155 diagnoses; fee-for-service for high-cost services not paid by capitation for more onerous interventions; and case-based payment rates (INA-CBG) for hospital services that vary by hospital level and region (Prabhakaran et al. 2019).

► 4. Results

- Coverage

JKN has achieved legal coverage of the entire resident population, and since its introduction, effective coverage has also continuously improved, particularly among the poor. As of 2020, the population at the lower end of the income stream, whose contributions are fully subsidized, made up around 60 per cent of all JKN members.⁵² As of 2020, JKN covered 223 million members (equivalent to 82 per cent of the total population), which rose from 133,420,000 persons covered in 2014 (BPJS 2020).

However, there remain challenges to the extension of effective coverage, particularly for those working in the informal economy, otherwise known as the “missing middle”. Only 13.6 per cent of all members are registered under the non-salaried worker segment, although around 60 per cent of the labour force in Indonesia is self-employed (Badan Pusat

⁵² The PBI is intended to cover approximately the bottom 40 per cent of the Indonesian population, which is much higher than the 9.7 per cent of the population who are below the official poverty line (TNP2K 2018).

Statistik 2019). Many of these workers may not be poor enough to qualify for subsidies, but they may also not be able to pay regular contributions independently. Even when informal workers are enrolled, irregular collection of contributions results in coverage gaps.

- Adequacy of benefits/financial protection

Although some progress has been made with regard to financial protection since the introduction of JKN, OOP spending remains relatively high at 32 per cent of CHE in 2018, with an estimated 2.71 per cent of Indonesian households facing catastrophic health care expenditures during the same year. This could be partly attributed to the existence of informal payments directly paid by patients to health providers in order to avoid long waiting times or to buy medicines that are not listed on the medicine list of the JKN (GIZ 2018; OECD 2019). The high share of OOP payments is also believed to result from limited geographical accessibility of health care facilities, particularly in rural and remote areas, which forces many people to visit facilities not contracted by BPJS and pay directly for their medical care (Health Policy Plus 2018). Additional, transportation costs increase when patients need to access facilities further away from their homes, resulting in additional non-medical costs of accessing care.

- Responsiveness to population needs
 - o Accessibility and availability

The introduction of JKN, a single-payer system with a unified benefit package, has increased access to both outpatient and inpatient care, leading to a rise in utilization rates (Health Policy Plus 2018). Notably, JKN steadily increased the number of service providers contracted, resulting in an increase of 23 per cent between 2015 and 2018. However, the geographical distribution of facilities remains uneven (Gani and Budiharsana 2019). Inequalities in utilization rates between urban and rural areas, as well as across socio-economic quintiles persist, with the number of available health care facilities varying between regions, and a lack of available health infrastructure and health workers in rural and underprivileged areas. As noted above, this means that high transportation costs can be incurred through seeking medical care (Agustina et al. 2019).

Moreover, the distances between people's homes and BPJS Kesehatan offices are often considerable, which makes it difficult for people to access offices to receive information on the scheme and enrol. Opportunity costs (in terms of working time loss) can also be an additional barrier, particularly for self-employed workers. A particularly noteworthy initiative in this context is the Kader JKN partnership programme which aims to facilitate access to social health insurance for informal economy workers and other individuals through selected members from the closest communities. Kader JKN agents perform four functions: outreach and communication; enrolment of new members; collection of contributions and their transfer to the scheme; and handling of complaints. Candidates must fulfil certain criteria (such as domicile near area of target group or registration for online banking) to qualify as a Kader JKN agent. While BPJS acknowledges that there are potential risks in ensuring appropriate accountability and control mechanisms in such a programme, the initiative increased the contribution collection rate by around 14 per cent from 2017 to 2018, thanks to a total of 2,000 active agents who managed two million members (Nguyen and De Cunha 2019).

- o Quality and acceptability

A key challenge for the Indonesian system is to ensure access to quality health services in an equitable manner. Currently, the lack of health care facilities and the inequitable quality of services across provinces limits access to the broad benefit package offered by JKN (Gani and Budiharsana 2019). Limited quality of health care services is strongly linked to under-staffed and poorly equipped health care facilities in Indonesia. With regard to investments in infrastructure, in 2019, 233 districts had a minimum of one accredited public general hospital, compared with the target of 477 set by the MOH; and 350 sub-districts had at least one accredited PHC facility, compared with the MOH target of 5,600. Notably, fewer than 70 per cent of these centres were deemed to be in good condition and had access to tap water (Fauzia and Dita 2018). Furthermore, the number of doctors per 1000 people has remained stagnant since the introduction of JKN, standing at a very low ratio of 0.378 doctors per 1,000 people (WHO n.d.).

In 2018, only about half of the community based health posts were properly staffed, which remains an important challenge to meet the needs of the population (Gani and Budiharsana 2019). Similarly, health sector assessments have highlighted a bias towards the greater financing of individual health interventions (financed by JKN) rather than whole population interventions (financed by the general budget), the latter of which are key to the eradication or systemic prevention of diseases such as tuberculosis, HIV and water-borne diseases (Gani and Budiharsana 2019). While the JKN benefit package does include essential preventative care, the changing burden of diseases in Indonesia, with non-communicable diseases on the rise, suggests the need for a stronger focus in this area. In this context, care provided in the community is of the utmost importance (Gani and Budiharsana 2019).

► 5. Way forward

According to the DJSN and MOH road map, Indonesia should have achieved UHC by 2019. While much progress has been achieved since the introduction of JKN, significant remaining challenges include ensuring effective access to quality care and reaching out to the “missing middle”. The implementation of Mobile JKN — a mobile application that allows members to register, pay monthly contributions, submit complaints and access information — is among measures to address these challenges. Plans are also in place to introduce an auto-payment mechanism using e-wallet accounts which facilitate payments and ensure regular payment for members without bank accounts. Based on the national ID system, BPJS Kesehatan also plans to strengthen its collaboration with the Ministry of Interior to better identify informal economy workers whose participation could be supported with government subsidies.

In terms of fostering harmonization, the integration of social health protection schemes at administrative and policy levels has fostered linkages with the broader social protection system. Indonesia has made progress towards developing an information system underpinning the social protection system, creating a single targeting mechanism for all social assistance programmes, namely National Social Welfare

Integrated Data. An integrated social protection information system of this nature has the potential to ensure a more equitable, responsive and inclusive distribution of resources while increasing efficiency and effectiveness to better serve the population.

► 6. Main lessons learned

- The integration of various health insurance schemes into JKN was key to accelerating the extension of coverage in Indonesia. The creation of JKN helped to reduce fragmentation within the social health protection system by introducing a unique benefits package and a single risk pool. Through the integration of several social health protection schemes and the provision of subsidies for vulnerable population groups, the Government managed to scale up the new solidarity-based scheme in a short period of time and extend coverage to 82 per cent of the total population.
- A rights-based approach is essential for the operationalization of the scheme and ensuring effective access. Progress in social health protection coverage was achieved through political commitment generated through pressure from civil society. The merger of Indonesia’s SHP system was initiated after citizens took legal action to hold the Government accountable to implement the 2004 law on the National Social Security System. The law stipulates that benefits should be uniform for all members (Global Financing Facility and World Bank 2019).
- Institutional integration is necessary, but insufficient to guarantee equity. Considerable inequities between geographical regions and socioeconomic groups remain with regard to utilization of health services. The entitlement to a broad benefit package needs to be accompanied by its implementation in practice, especially with regard to increased investments in health care infrastructure and equipment. Increasing the number of qualified health workers across regions is equally important to ensure a more

equitable, responsive and inclusive distribution of human resources. It is also key to facilitating active outreach efforts to ensure equal information across all socioeconomic groups and geographical locations about rights to social health protection and how to access the scheme.

- More efforts are needed to effectively guarantee financial protection. Despite the rapid extension of JKN, as well as its comprehensive benefits package, OOP payments remain high in Indonesia, at 32 per cent of CHE in 2018. This can be explained by limitations of the network of contracted health care providers. Lack of accessibility to health care facilities, particularly in rural and remote areas, forces many people to visit non-contracted BPJS facilities and pay directly for their medical care. Additionally, a high level of informal payments can be requested by medical facilities or professionals. Moreover, the growth in the private health sector contributed to an increase in overall expenditure and the relatively high level of OOP.
- Based on Law No. 40/2004, JKN is mandatory for all. However, the Social

Health Insurance Roadmap (2012–2019) foresaw mandatory affiliation increasing gradually, based on the size of participating enterprises. The remaining challenges for JKN is to extend health coverage to workers in the informal economy, demonstrating that voluntary affiliation did not lead to significant increases in coverage, which confirms other international experiences. Particularly when awareness of social health protection is low and contributory capacities are limited, voluntary affiliation seldom yields successful results. Including workers in the informal economy in the mandatory scheme, adapted to their contributory capacities, would not only ensure better protection, it would also contribute to sustainable and equitable financing through a larger risk pool.



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► 1. Introduction

A high-income country with the world's third largest economy and a predominantly urban population of over 126 million (UN 2019), Japan is renowned for its highly developed social health protection system (Ikegami 2019), which encompasses four compulsory, contributory social health insurance (SHI) schemes: an employment-based scheme called Employee's Health Insurance; a residence-based scheme called Citizens' Health Insurance for those not employed, self-employed, and retirees; a contributory Health Insurance for Advanced Elderly scheme that covers all adults who are 75 years and older; and an age-based long-term care insurance scheme. All schemes provide a similar comprehensive set of benefits, which is determined and approved by the National Government (The Commonwealth Fund 2020; Sakamoto et al. 2018; JHPN 2015).

Thanks to the country's strong social health protection system, with the right to lead a healthy and culturally fulfilling life enshrined in the Constitution of Japan (JHPN 2015), the country achieved the milestone of Universal Health Coverage (UHC) in 1961 (Ikegami 2019). There are nonetheless challenges in implementing effective social health protection. Today, the demands of a rapidly aging population

are putting a strain on the health care system in Japan, with health expenditure rising from 7.2 per cent of GDP in 2000 to almost 11 per cent in 2017 (WHO n.d.). This increase has resulted in part from the lack of GDP growth in Japan for the past 30 years, which has been a hurdle for the mobilization of additional resources for health.

► 2. Context

The country's journey towards UHC began with the introduction of the Health Insurance Act in 1922, following which, Japan's first social health insurance scheme, Employee's Health Insurance (EHI) was implemented in 1927 (Ikegami 2019). The scheme initially only targeted manual labourers in factories and mines (who composed around 3 per cent of the total population). However, from the 1930s onwards the Government began to gradually expand its coverage to include formal employees in other sectors and eventually certain categories of part-time workers (Ikegami 2019). In 1938, the coverage provided under the scheme was supplemented by Residence based Citizens' Health Insurance (CHI), following the adoption of the Citizens' Health Insurance Law, through which social health insurance plans for farmers and informal workers were introduced. The new

law encouraged municipalities to establish CHI plans and enrol those living in their jurisdiction who were not covered by employment-based schemes. Although this led to a significant increase in coverage, some households remained uncovered and certain municipalities (such as Tokyo) did not establish health insurance schemes. Furthermore, even when such schemes were implemented, enrolment was not mandatory.

To address coverage gaps, several significant health insurance laws were passed in the second half of the 20th century, expanding the coverage of both the employment-based and the residence-based schemes. Among these is the Seamen's Insurance Act of 1940, which provided coverage to maritime workers. The most important legal advancement was the implementation of the new Community Health Insurance Law in 1958. Milestone amendments were made which mandated municipalities to establish CHI plans and made enrolment mandatory for all those not covered by the employment-based schemes, including foreigners. This led to a rapid growth in the number of enrollees, and the achievement of UHC by the early 1960s (Sakamoto et al. 2018). Decades later, in order to meet with the health and social needs of Japan's aging society, a new social insurance scheme was introduced in 2000 to cover long-term care (LTC) needs. To further reduce the financial burden on the CHI scheme, a separate insurance plan for the elderly population was introduced in 2006, known as health insurance for advanced elderly (AEHI).

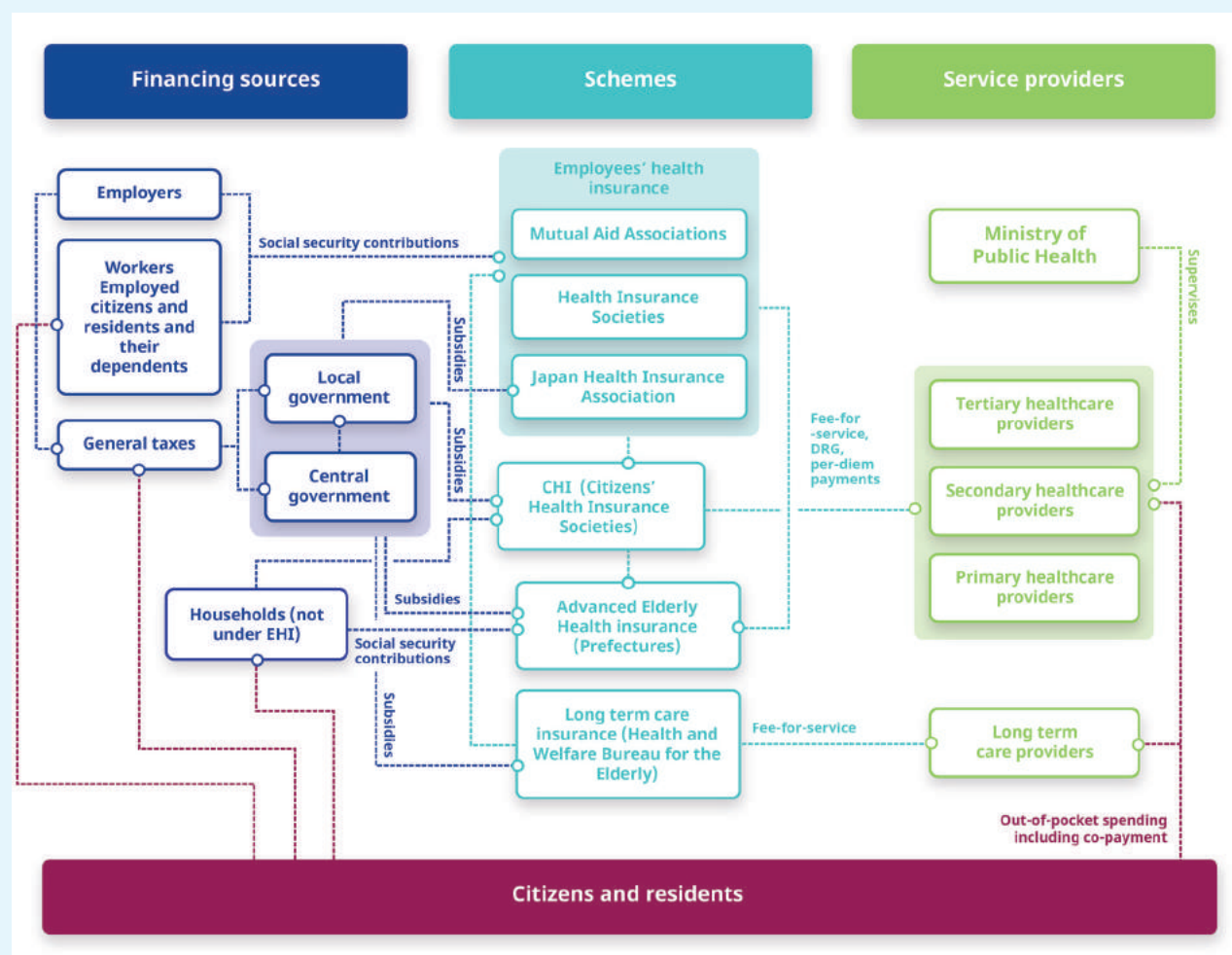
► 3. Design of the social health protection system

- Financing

Until 2010, Japan's public health care spending as a share of GDP was below the OECD average; however, it is now one of the highest among OECD countries (Sakamoto et al. 2018), in part due to the inclusion of LTC expenditures. The health system is funded by contributions from the insured, as well as co-payments, which are made on varying rates based on the type of insurance and the socio-demographic characteristics of the insured. Public funding is mobilized to finance a proportion of health care expenses, and support schemes that have an inadequate financial basis, as well as to subsidize contributions for the elderly population. Government at all three administrative levels contribute to financing the system, but the major contribution comes from the National Government, while prefectural and municipal governments provide a smaller share.



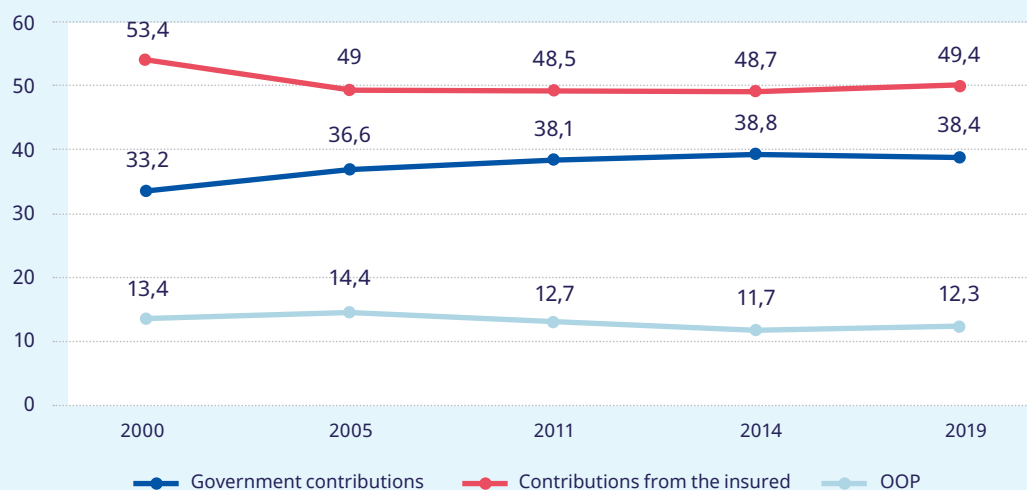
► Figure 1. Overview of main financial flows of the social health protection system in Japan



Source: Authors.

Currently, the largest share of funding comes from contributions, followed by government spending, and out-of-pocket (OOP) spending. However, the share of insurance contributions has been gradually decreasing over the years, due in part to the aging of the population and resulting decrease in the number of full-time workers contributing to the employee scheme. There have also been decreases in OOP spending, thanks to the gradual strengthening of financial protection policies, especially for the elderly. In parallel, the share of tax-funded resources has increased proportionally, resulting in a growing financial strain, which is currently at the centre of Japan's national social health protection concerns.

► Figure 2. Health expenditure by Source (2000–2019)



Source: Adapted from Sakamoto et al. (2018), based on from the Ministry of Labour, Health and Welfare.

Revenues for the country's four SHI schemes are sourced as follows:

Employee's Health Insurance (kenkō hoken)

EHI plans are financed by contributions from employers and employees, but the Japan Health Insurance Association (JHIA) receives government subsidies as a proportion of total expenditures; Mutual Aid Associations (MAAs) and Health Insurance Societies (HISs), on the other hand, are financed exclusively by contributions (Sakamoto et al. 2018).⁵³ Contributions, which are deducted from employee paychecks, reflect the health expenditures of their enrollees and the amount contributed to old age health care costs (Sakamoto et al. 2018; JPS n.d.). On average, the contribution rate for salaried workers is around 10 per cent of their total compensation, but this differs for each plan (Sakamoto et al. 2018; JPS n.d.). Employers must pay at least half of the insurance contribution, with the proportion differing for each plan. The ratio is decided by the employer and the employees, as defined by the governing board of the plan, in line with article 161 of the Health Insurance Act.

Citizens' Health Insurance (kokumin-kenkō-hoken)

CHI is financed through contributions and subsidies from general government revenues. Public subsidies are set at 50 per cent of the total CHI budget, and come from central and prefectural governments. CHI also receives some funds from the HIS, JHIA, and MAA to subsidize enrollees aged 65 to 74 covered under the CHI plans (JHPN 2015). Contribution rates are set by Citizens' Health Insurance Societies and municipal authorities, and vary considerably from municipality to municipality (Sakamoto et al. 2018). Contribution rates are calculated for each member based on personal income and the by-laws set in each municipality—such as income level of the enrolled household, the number of those enrolled in each household and predicted medical costs (Sakamoto et al. 2018). Calculated rates are then allocated on a per-household basis (SCH 2020). Overall, contribution rates range from around 7.3 to 15.9 per cent of total household income (Sakamoto et al. 2018) and are capped at amounts based on a beneficiary's age and income (The Commonwealth Fund 2020). Contributions to the CHI scheme are usually collected on a monthly basis and paid by the head of a household (JHI 2019), through banks or other financial institutions, post offices, convenience stores, at city or branch offices, or through automatic debits (SCH 2020). For

⁵³ For details on the JHIA, MAAs and HISs, see the "governance" section below.

individuals aged 70–74, contributions can be deducted directly from their pensions.

Pursuant to article 77 of the Citizens' Health Insurance Act, insurance payments can be reduced for persons in special circumstances. Accordingly, a person can apply for: (1) a contribution reduction programme, which allows for a reduction of the per-capita based charge if his/her household's income falls below a certain level or the person becomes involuntarily unemployed; or (2) a contribution exemption programme, which allows for exemption under extraordinary circumstances, such as natural disasters or serious illnesses (SCH 2020).

Advanced Elderly Health Insurance Scheme (Koki Koreisya)

The AEHI scheme is financed from the public budget (accounting for around 50 per cent of total funding), member contributions (accounting for around 10 per cent) and funds from the EHI and NHI schemes, which take the form of fiscal adjustment and total around 40 per cent of AEHI funding (Sakamoto et al. 2018; JHPN 2015). The National Government contributes around two thirds of all public funds, while prefectural and municipal governments contribute the remaining third (Sakamoto et al. 2018). The amount paid by the enrollee depends on their income. As is the case for CHI, lower-income members and members in special circumstances can apply for a reduction of contributions or an exemption. Contributions for AEHI are usually collected on a monthly basis through direct deductions from members' pension payments or through bank transfers or automated payment orders (Japan Ministry of Health, Labour and Welfare 2012).

Long-Term Care Insurance (Kaigo Hoken)

Around half of the LTCI budget is funded from tax revenues, and the remaining half is funded from contributions (Sakamoto et al. 2018). The contribution rate differs for each municipality and reflects its LTCI expenditures. Around two-fifths of contributions are funded by premiums levied from persons aged 65 and over who reside in the municipality, and around three-fifths is funded by the premiums from those aged 40–64, which is levied together with their health insurance by the same insurer. The premium level is revised every three years according to estimated expenditures, and the amount levied is allocated to the municipality's LTCI. Monthly LTCI contributions are usually deducted from

pensions, or from wages for those employed and their dependents. For the self-employed and their dependents, contributions are levied together with other health insurance contributions (through account transfer, payment slip and so on).

Beneficiaries can benefit from a reduction of mandatory contribution amounts under specific circumstances—for example in cases whereby the insured has experienced a sharp decrease in income compared to previous year (City of Sapporo 2020). As for funding from taxes, 5 per cent of the total is allocated to municipalities that have a higher proportion of residents aged 75 and over and those that have a significant number of enrollees with low incomes. This allocation method is in place to ensure that factors that increase the contribution rate, such as age composition and income level, are adjusted, while at the same time placing fiscal responsibility on the municipality, as the insurer.

- Governance

The administrative structure in Japan is decentralized, with many important functions, including health protection, transferred to the country's local municipal authorities. For health insurance schemes, the Central Social Insurance Council under the Ministry of Health, Labour and Welfare (MHLW) sets and revises the fee schedule, which includes pharmaceuticals and devices. The Council has a multi-partite composition, comprised of payer representatives (employees and employers), provider representatives and relevant experts (The Commonwealth Fund 2020). The specific governance structures for each scheme are as follows:

Employee's Health Insurance (kenkô hoken)

EHI is comprised of three sub-schemes administered through different entities, all of which are governed by the Health Insurance Act No. 70 of 1922, the Seafarer's Insurance Law No. 73 of 1939, the Public Employees Mutual Aid Association Act No. 152 of 1962, and their subsequent amendments. The entities administering the three sub-schemes include Health Insurance Societies (HISs), which are established by large businesses to provide coverage for their employees; the Japan Health Insurance Association (JHIA), which enrolls employees of small to medium sized companies;

and Mutual Aid Associations (MAAs) which provide coverage to public sector employees. There were 1409 HISs in Japan in 2016 (Sakamoto et al. 2018). The Health Insurance Act mandates that both employers and employees are represented in the governance bodies of the HIS and JHIA (Article 17 and article 21, respectively). MAAs are mandated by the Public Employees Mutual Aid Association Act and administered by Management Councils, which are monitored by the Federation of the National Public Service Personnel of MAAs. In 2016, there were 85 MAAs throughout Japan (Sakamoto et al. 2018).

Citizens' Health Insurance (kokumin-kenkō-hoken)

CHI was revised by the Citizens' Health Insurance Act No. 192 which was implemented in 1959. The scheme, for which the municipal government is the insurer, is administered by Citizens' Health Insurance Societies (CHISs) organized by the 1,716 municipal governments which are responsible for setting and collecting contributions and registering beneficiaries. However, high-level oversight of the scheme, including some limited pooling of funds and overseeing service delivery is undertaken by prefectural governments (The Commonwealth Fund 2020). In addition, there are 164 CHI societies that enrol the self-employed in the same occupation, such as barbers and construction workers. Each CHIS has a unique constitution and society council, with their own society directors and auditors. The CHI Council is composed of representatives of insured enrollees, providers and members.

Health Insurance for Advanced Elderly (Koki Koreisya)

The AEHI scheme is regulated by the Elderly Health Care Security Act and administered at prefectural level through regional alliances of municipalities for medical care of the advanced elderly established in each of the 47 prefectures (Sakamoto et al. 2018; Takeda Health Insurance Society 2015). The governing committee is similar to that of the CHI. Alliances are responsible for the provision of AEHI, including setting contribution rates (which are uniform within the prefecture) and monitoring payments made for medical costs (Japan Ministry of Health, Labour and Welfare 2012). Municipal governments assist alliances and prefectures with technical matters and collect contributions. These alliances were established because prefectural governments

did not want the responsibility of running the programme.

Long-Term Care Insurance (Kaigo Hoken)

The LTCI system is governed by the Long-Term Care Insurance Act No.123 of 1997. LTCI is administered by municipalities, which set premiums, undertake contracting and coordinate service providers. The Health and Welfare Bureau for the Elderly under the MHLW oversees the implementation of the scheme by providing basic guidance and offering assistance related to planning, information collection and implementation (Sakamoto et al. 2018). The LTCI council has essentially the same composition as that of CHI at the municipal level, except for the fact that provider representatives are made up of LTC providers (both institutional and community level), and the nurse association also has a seat. "Public interest" is usually represented by academics.

- Legal coverage and Eligibility

Enrolment in an SHI scheme is mandatory for all Japanese nationals, as well as for foreigners officially residing in Japan. Specific eligibility requirements apply to each scheme, as follows:

Employee's Health Insurance (kenkō hoken)

To be eligible for affiliation with EHI, a person must be working full time at a company that has five or more regular employees. Some part-time employees are also included (JPS n.d.). Public-sector employees and maritime workers are separately covered. EHI also covers dependents residing in Japan if the dependent is financially supported by the insured and/or has an annual income below a certain level, earns less than the annual income of the insured or, in certain circumstances, less than the total financial support provided by the insured (JPS n.d.).

Citizens' Health Insurance (kokumin-kenkō-hoken)

Enrollees are comprised of the self-employed, unemployed, their dependents and retirees under 75 years of age. Any person, regardless of nationality, becomes eligible for the CHI scheme on the day that they obtain official residency status in Japan, and lose eligibility upon leaving the country or enrolling in another health insurance scheme.

Health insurance for advanced elderly (Koki Koreisya)

The AEHI scheme covers all persons, including foreign residents, aged 75 and over, regardless of their employment status and with no distinction made between the main contributor and dependents (Sakamoto et al. 2018; JHPN 2015). Individuals aged from 64 to 75 with certain disabilities are also covered by the scheme.

Long-Term Care Insurance (Kaigo Hoken)

All persons with formal resident status aged 40 and over are eligible for LTCI coverage and must pay contributions alongside contributions to one of the three SHI schemes (JHPN n.d.). Insured persons are divided into two categories: Category I is composed of those aged 65 and over who have unconditional rights to LTCI benefits, and category II is composed of those aged 40–64 experiencing age-related conditions such as stroke or Alzheimer's (Sakamoto et al. 2018; JHPN n.d.).

- Benefits

With the exception of LTCI, virtually all of the benefit services that are covered by the SHI plans and public assistance schemes are uniform in terms of service coverage and prices set. Over 5,000 medical and dental services and 17,000 drugs are listed in the MHLW fee schedule (Sakamoto et al. 2018). The fee schedule defines each item in detail and also sets the conditions of billing for each. For example, the fee for a first consultation may be billed only if the patient had not made a visit within the last 29 days or the doctor had not scheduled the next visit. The fee schedule is biennially revised by the MHLW following recommendations from the Central Social Insurance Medical Council⁵⁴. Services listed include the following:

- hospital and clinic outpatient care services
- hospital and clinic inpatient care services
- primary and specialist services
- mental health care services
- therapy services provided by physiotherapists, occupational therapists and speech therapists
- most dental care services

- home care services provided by medical institutions such as visits made by physicians, nurses and therapists
- hospice care in all settings
- approved prescription drugs and materials such as artificial joints and stents

Treatments that are not included in the scope of the benefits include some forms of dietary treatments and medical treatment using advanced medical care techniques which have been approved for testing by the MHLW. These services may be delivered if the medical facility has obtained prior approval from the MHLW and the patient consents. When delivering the service, the medical facility must gather data on its efficacy and safety. Once the new technique is proven to be effective and safe, it is listed in the fee schedule. Health prevention and screening services are not listed in the fee schedule and their inclusion is determined by the health insurance plan, though the MHLW sets the basic requirements.

Long-Term Care Insurance (Kaigo Hoken)

The broad categories of benefits covered by LTCI are home care, day care, respite care, services at LTC facilities, equipment such as wheelchairs, assistive devices and home improvement such as ramps, and maintenance rehabilitation services (Sakamoto et al. 2018). Community-based preventative services are also included. The monetary amount of benefits provided to a beneficiary is determined according to the results of an assessment that evaluates a person's physical capacity and cognitive status, following which, the applicant is assigned one of seven levels of assistance, or declared as ineligible (Sakamoto et al. 2018; JHPN n.d.). The assessment is conducted using a standardized methodology that uses a questionnaire with 74 items to measure daily living activities and behaviours (Sakamoto et al. 2018) as well as further cognitive and behavioural questions. The results of the 74 assessment items are fed into a computer programme which sorts the applicant into one of the 7 levels of eligibility (or ineligibility). The results are reviewed by a Needs Assessment Review Committee established in each municipality, which reviews the statements made by the assessor and the opinion form completed by the attending doctor (Sakamoto et

⁵⁴ The Central Council deliberates and submits its conclusions to the Minister of HLW. The Minister then publishes the revised fee schedule in the official bulletin. The revision is then enforced from April 1, at the beginning of the fiscal year.

al. 2018). Those eligible then select a certified care manager, assigned by the insurer, who develops a care plan and coordinates service provision (Sakamoto et al. 2018; JHPN n.d.). Re-assessment is conducted every five years, or following a request due to a change in circumstances (JHPN n.d.).

There are ceilings on the amount of benefits that can be received from LTCI, determined by eligibility level (JHPN n.d.). If the beneficiary wishes to purchase more services, they can do so by paying out-of-pocket. Should the monthly co-payment exceed the amount set by their income level, the beneficiary may apply to have the amount exceeded reimbursed. In doing so, the co-payment for health insurance may also be taken into consideration. Low-income individuals may apply for additional exemptions (JHPN n.d.).

- Provision of benefits and services

Individuals enrolled in all of the statutory health insurance schemes can receive care from any medical provider (JHPN 2015). However, in exceptional circumstances, or for services listed in special programmes, services may have to be sought from designated providers (The Commonwealth Fund 2020). For example, patients with one of the 306 “difficult-to-treat” diseases must receive services from designated providers if they want to benefit from lower co-payment rates.

There were 8,442 hospitals, 101,529 clinics, and 68,940 dental clinics in the country in 2016, most of which were privately owned, with only about 15 per cent owned by the Government or government-affiliated entities (Sakamoto et al. 2018). LTC services are almost wholly delivered by the private sector, which has greatly expanded following the implementation of LTCI. For-profit providers are prohibited from participating in health care provision under the three main schemes, but are permitted to provide care under the LTCI scheme.

There is no strict referral system in Japan, and patients can access secondary and tertiary care facilities directly without a referral from a primary care specialist (Kato et al. 2019). Although guidelines require presentation of a referral letter upon a visit to a large hospital, patients can access services by paying an additional fee if they do not have a referral (Usui and Yamauchi 2019; JHI 2019; JHPN 2015). All patients enrolled in one of the SHI schemes (including LTCI) must pay

co-payments when they receive health services (Sakamoto et al. 2018), with the exception of those on special programmes, such as those for victims of the atomic bomb. Those on public assistance are not enrolled in SHI and have all their costs covered.

The co-payment rate is generally set at 30 per cent of the service cost, while the remaining 70 per cent is covered by the insurance. For most enrollees of AEHI, the co-payment rate is 10 per cent, but for those with higher incomes, the rate is increased to 20 or 30 per cent (Sakamoto et al. 2018; Japan Ministry of Health, Labour and Welfare 2012). However, certain population groups have a lower co-payment rate. In particular, under school-age children and individuals between 70 and 74 years of age (unless they have an income at the same level as that of a working person) are charged a co-payment rate of 20 per cent or less (The Commonwealth Fund 2020; Sakamoto et al. 2018; JHPN 2015). For pre-school children aged below 7, the co-payment rate is 20 per cent. However, virtually all municipalities have expanded the age range and the co-payment rate.

There is no pre-determined waiting period for newly enrolled members before they can start benefiting from EHI coverage. Coverage for the eligible employee and his/her dependents begins on the first day of active work, as long as the enrolment procedure is completed within 30 days after being enrolled. For the community-based plans, they are enrolled in the CHI of their new residence. Both the EHI and CHI plans are legally required to start offering benefits immediately after enrolment.

Before accessing services, all patients must present a valid SHI card, which is accepted by over 99 per cent of health care facilities (JHI 2019). Persons aged from 70 to 74 also receive an Elderly Recipient Certificate (elderly benefits card) which may allow them to pay lower co-payments (SCH 2020). When accessing services from providers that do not accept SHI cards, or if a patient does not have a card when they receive the service, they must pay out-of-pocket for all medical expenses and then ask for reimbursement (JHI 2019). However, some providers may be willing to wait for the patient to show the SHI card. Patients must present their cards at the beginning of each calendar month. If a patient seeks care from a provider that does not accept SHI cards (which include services

from a health care provider outside of Japan), s/he has to pay the full cost of treatment and then seek reimbursement from his/her respective SHI insurer. In such cases, detailed documentation has to be provided, including an invoice and a doctor's certificate. The amount reimbursed in such cases is equivalent to that if the same services had been delivered in Japan.

There is a strict split of purchaser and provider functions in Japan. The service item and the price are uniformly defined by the fee schedule set by the MHLW, which applies for all SHI plans and public assistance programmes. The extra-billing and balance billing of services are strictly regulated. Most providers are paid on a fee-for-service basis but there are also some per-case and fixed monthly payments (The Commonwealth Fund 2020). Providers submit claims for reimbursement to the clearing houses at the beginning of every calendar month for the services delivered in the past month. The claims of patients enrolled in employment-based plans are submitted to Claims Review and Reimbursement Organizations (CRROs). For all other SHI plans, the claims are submitted to CHI organizations for review (Sakamoto et al. 2018). Before billing the plans, the claims undergo a review process by clinicians who are employed on a sessional basis (working about five days a month). Payment will be denied for any items which have been inappropriately billed. Compliance with billing conditions is inspected by the regional office of the MHLW. If medical records do not confirm compliance with the conditions of billing, then the provider is ordered to check the claims made in the past six or twelve months and return the amount that was inappropriately billed. The biennial revisions of fees and the conditions of billing of each item is fiercely contested when the MHLW negotiates with provider groups such as the Japan Medical Association (Ikegami 2019).

The fee schedule is established at national level and acts as a supply-side cost control measure (Sakamoto et al. 2018). In 2006, a diagnosis procedure combination per-diem payment system (DPC/PDPS) was established, in which a flat-rate per-diem fee based on the diagnostic and procedure group is made. The per-diem rate decreases as the length of stay increases. Each DPC sets three length-of-stay periods based on historical data. For example, the first period is set based on the number of days that the 25th percentile patient was discharged. These periods

are individually revised for each DPC group based on performance (Ishii 2012). All of the claim data is recorded and stored in a national database, which aggregates information from all claims (Sakamoto et al. 2018).

► 4. Results

- Coverage

All those officially residing in Japan are covered by one of the statutory health insurance schemes. In terms of population coverage, EHI is the largest scheme, covering 55 per cent of the population in 2020, which is equal to 69 million people (Japan Ministry of Health, Labour and Welfare 2012). The CHI scheme covers 30 million people, or 24.2 per cent of the population – a figure which increased in the 1990s and the early 2000s due to increases in the number of unemployed persons (mainly attributed to the elderly after retirement), which put the scheme under a significant strain (Sakamoto et al. 2018). The introduction of AEHI led to the reduction of those covered by the CHI. In 2020, AEHI covered around 17.7 million individuals or 14.1 per cent of the population, with membership expected to increase as the number of the elderly persons in Japan continues to rise (Japan Ministry of Health, Labour and Welfare 2012). The number of elderly people requiring LTCI benefits is also on the rise, having increased from 2.2 million to nearly 5.7 million.

- Adequacy of benefits/financial protection

For all four schemes, the aforementioned range of exemptions or lower-co-payment rates helps to ensure better protection for vulnerable and disadvantaged categories of the population. Specifically, there are legal provisions for a postponement of and a partial or full exemption from co-payments for individuals who find themselves in difficult circumstances, and government subsidies for individuals with chronic diseases, disabilities or mental illnesses. Furthermore, those on public assistance programmes have the full costs of services covered. The fact that providers are paid at the same rate by the same fee schedule means that all are entitled to and receive the same quality and quantity of service.

There are thresholds on monthly and yearly OOP payment amounts, which vary based on the beneficiary's age and income; if the threshold is surpassed, the co-payment rate becomes 1 per cent for the amount surpassed (The Commonwealth Fund 2020; Sakamoto et al. 2018). This principle also applies if the annual combined health care and LTCI co-payments surpass the threshold (The Commonwealth Fund 2020). As a result, OOP private spending on health in Japan has remained relatively low compared with other OECD and high-income countries (WHO n.d.). This has resulted in Japan having the lowest risk of impoverishment from health care globally (Harvard Medical School 2020). However, the standard co-payment rate of 30 per cent for Japan's three main schemes is higher than rates in many other high-income countries (Shimazaki 2013).

However, a significant disparity has been observed between the EHI and CHI schemes, with CHI beneficiaries allocating a higher proportion of their annual income to OOP medical expenses than EHI beneficiaries. Furthermore, CHI contribution rates tend to be higher, despite the fact that the average annual income of CHI enrollees, many of whom are unemployed, partially employed or retired, is considerably lower than that of EHI members (Kido and Tsukamoto 2020). As such, CHI beneficiaries face greater financial risks, and are more likely to face difficulties in paying their health insurance contributions. Should they not pay, they will not be able to use their insurance until they have paid off all past premium contributions (Kido and Tsukamoto 2020). As a result of these challenges, it is believed that over 1 per cent of the Japanese nationals who are eligible for coverage are unprotected (Sakamoto et al. 2018). Another challenge in this regard is the exclusion of undocumented migrants from the coverage of the statutory schemes, which renders this group highly vulnerable to impoverishment from health expenditures.

Observers have also pointed to the possibility of greater financial risks for AEHIS beneficiaries compared to those covered by EHI, due to significantly higher average annual expenses among elderly members and higher premium rates (Kido and Tsukamoto 2020). Moreover, long-term care needs of the elderly tend to increase, while their incomes tend to decrease. While the LTCI scheme has shifted the financial burden of care-giving for the elderly from

individual households to society, concerns have been raised about the capacity of the LTCI to compensate families for their opportunity costs (Sakamoto et al. 2018).

- Responsiveness to population needs
 - o Availability and accessibility

In general, services in Japan are available at affordable prices almost anywhere in the country (Sakamoto et al. 2018), which positively contributes to service utilization and equitable access to health care. However, as noted above, Japanese regulations have led to an exclusion of undocumented migrants (especially women and victims of trafficking) from social protection (SMJ 2010), which has contributed to an estimated 4 million people who live in Japan with limited or no access to health insurance (Kido and Tsukamoto 2020). On the other end of the spectrum, for those who are eligible for coverage, it has been observed that the high service availability and the comprehensive coverage offered by Japan's statutory health insurance schemes can lead to over-utilization in some cases, which has been partly linked to the absence of an effective gate-keeping system.

Some studies indicate that access to primary care remains an issue in Japan due to uneven geographical distribution (Kato et al. 2019). Certain prefectures were observed to have significantly fewer physicians than others, and the distribution of public hospitals was found to be uneven (Zhang and Oyama 2016). This is exacerbated as more workers and households move to larger cities in Japan, leaving many municipalities with a much smaller funding base (Sakamoto et al. 2018). Overall, according to latest estimates, Japan has 2.4 physicians per 1,000 people, which is higher than the global average (1.6), but lower than the average among high-income countries (3.1). On the other hand, the number of nurses and midwives (12.2) and the number of hospital beds (12.9) are both higher than the global average and the average among high-income countries (World Bank n.d.).

Regarding the availability of LTC, the introduction of LTCI has driven growth in this area, with the number of personnel engaged in LTC provision in Japan increasing more than threefold between 2000 and 2012 (OECD 2015). In 2011, there were over 2.5 million doctors, nurses, and other medical professionals engaged in the provision of LTC and over 2 million care workers (UNESCAP

2015), which is expected to increase to over 7.2 million by 2025. However, it has been noted that many LTC professionals face unfavourable employment conditions, which discourages certified care workers from pursuing LTC careers (Sakamoto et al. 2018). It has been projected that this could lead to a shortage of 300,000 LTC staff by 2025, and there is also evidence of a shortage of LTC facilities, especially in urban areas (JHPN n.d.).

o Acceptability and quality

Article 30-3 of The Medical Care Act No. 205 of 1948 obliges the MHLW to ensure a system that efficiently delivers good quality and appropriate medical care. As such, facilities in Japan are generally well-equipped and have advanced diagnostic tools and specialized facilities, although providers in some remote areas have been reported to face difficulties in this area (Sakamoto et al. 2018). To ensure quality remains high, prefectural governments carry out inspections of hospitals on an annual basis and the Government incentivizes voluntary reporting of quality-related indicators by hospitals on their websites (The Commonwealth Fund 2020). Furthermore Japan has a specialized, non-profit entity that provides accreditation to hospitals, though this is not mandatory and uptake is limited. The greatest driving force for improving quality is the payment system. For example, the fee schedule sets higher hospital fees if the hospital has higher nurse staffing ratios and the ratio of registered nurses to all nursing staff is 70 per cent or higher. Furthermore, physicians are paid an extra amount if they provide education in a systematic manner as defined by the fee schedule for patients with diabetes and other lifestyle diseases.

Evidence indicates that attention to the quality of health care has increased among the Japanese public in recent decades, and there has been greater demand for disclosure of information by health care providers (Matsuda 2019). A study based on data from Nationwide Patient Experience Surveys found that general patient satisfaction increased from 53.7 per cent to 64.7 per cent between 1996 and 2011 among inpatients, and from 48.1 per cent to 50.4 per cent among outpatients (Kawashima et al. 2015). A 2003 study concluded that waiting times in Japan were low compared to most other OECD countries (Siciliani and Hurst 2003). Waiting lists for services are not an issue in Japan, but

the length of time that patients must wait after arriving at a health facility has been noted. A 2018 survey indicates that 47 per cent of respondents perceived waiting times at hospitals be too long (Statista 2021), and an earlier informal survey in one hospital estimated the average waiting time to see a doctor after arriving at the reception counter to be around 2 hours (Fujitsu Journal 2014). One reason for long waiting times can be attributed to the fact that Japanese patients prefer to go directly to hospitals, even when their health needs can be met by a primary health care provider (OECD 2015). This has been interpreted by some observers as a potential factor limiting the efficiency of the overall health care system (Kato et al. 2019).

Regarding LTC, the ability for users to choose and change their providers, along with the fee schedule requirements to maintain staffing levels in facilities and the qualifications of staff in community care have been major factors in maintaining quality. However, some studies have pointed to the lack of quality assurance mechanisms for LTC services (Yamamoto-Mitani et al. 2018). Furthermore, high staff turnover, inadequate skill development and inexperience among care workers has been noted as a set of challenges resulting from low wages, short-term contracts and unfavourable working conditions (Sakamoto et al. 2018). Aside from keeping the wages of workers low, other efforts of LTC providers to cut costs are likely to be affecting the quality of services.

► 5. Way forward

As evidenced by Japan's positive health outcomes, equitable population coverage, broad benefits package and high availability and quality of services, the health protection system in Japan is among the most developed in the world. Nonetheless, challenges remain. Moving forward, ensuring financial sustainability and efficiency in the context of diminishing revenue, without reducing the financial protection of the system, remains a priority for Japan. The development and institutionalization of new services tailored towards the needs of the rapidly ageing population may create opportunities for the optimization of care provision as well generating new income sources through

employment creation (ILO 2017). However, it is likely that structural changes to the existing health insurance system might also be needed. Between 2012 and 2018, there has been a trend towards consolidation, with the gradual transfer of fiscal management of residence-based schemes from municipalities to prefectures, although the premium contribution rate continues to be set by each municipality. Further consolidation could be envisaged to create a unified scheme with unified administration to improve risk pooling capacity and decrease operation costs.

To improve the system's functioning on the ground, the MHLW is currently leading a national initiative to strengthen medical education, increase the availability of primary care providers and to promote consultations with general physicians prior to visits to secondary and tertiary health care facilities (Usui and Yamauchi 2019). Furthermore, the Government is currently planning to establish a community-based integrated care system to ensure the provision of health care, nursing care, prevention, housing and livelihood support for those in need of LTC (Iwagami and Tamiya 2019). Notably, the MHLW has proposed the provision of incentives for LTC personnel, in addition to outsourcing some types of care to the community, promoting the development of the foreign workforce, and re-orientating LTC services to support the independence of the elderly (JHPN n.d.). However, for reforms to have effect, the fee schedules of the SHI and the LTCI schemes must be revised.

- A fragmented health insurance system creates long-term financial vulnerabilities and weaknesses. In Japan, the large number of residence-based health insurance plans and the separation between employment-based and residence-based schemes results in financial imbalances, which has been further exacerbated by demographic and social changes. Japan has attempted to address this by introducing cross-subsidies and fiscal adjustment measures, increasing government financing of struggling schemes, and creating new schemes to re-adjust the distribution of financial burdens.
- Countries with aging populations need to plan early for health care cost reduction measures through the adoption of innovative health delivery and promotion mechanisms. Despite Japan's developed and well-financed health protection system, growing health care costs linked to aging pose a challenge. To contain rising health expenditures, preventive health care policies need to be developed and enacted (potentially with the use of new technologies) before the problem manifests itself.

► 6. Main lessons learned

- Establishing effective health protection policy requires coherent and coordinated action to advance across population coverage, service coverage and cost coverage. In Japan, high population coverage is effectively combined with extensive financial protection measures to mitigate costs for patients, and a comprehensive health benefits package that is ensured through a uniform fee schedule. The fee schedule is the primary mechanism for promoting efficiency and equity.

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▶ The Republic of Korea

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▶ 1. Introduction

The Republic of Korea is a high-income country with a population of approximately 51.71 million. The country has achieved excellent health outcomes, exceeding OECD averages. For example, in 2017, life expectancy reached an average of 82.7 compared to the OECD average of 80.7, and the infant mortality rate was 2.8 deaths per 1,000 births in 2017, exceeding the OECD average of 3.8. These achievements have been facilitated by a strong social health protection system, developed on the principles of universality, social inclusion and non-discrimination, in line with the ILO's ten social protection principles. Notably, the country achieved Universal Health Coverage (UHC) in 1989, just 12 years after mandatory National Health Insurance (NHI) was introduced in 1977. However, financial protection remains a concern, with high out-of-pocket (OOP) expenditures a burden for households. In order to guarantee the right to full and affordable health care, especially for the underprivileged, the Government of the Republic of Korea has defined the goal of expanding the coverage ratio of the NHI scheme to 70 per cent of medical expenses by 2023. Known as MoonJae

In-Care or "Moon Care", the reform is defined by the Comprehensive National Health Insurance Plan (2019–2023).

▶ 2. Context

Since 1977, following the amendment of the Health Insurance Law, the Republic of Korea has experienced rapid changes to the social health protection landscape, with legal reforms marking the beginning of compulsory health insurance for the population (Do, Oh and Lee 2014). NHI was established through the Compulsory Health Insurance Act, and initially consisted of a contributory plan for employees in businesses with 500 or more workers, including their dependents (Na and Kwon 2015; National Health Insurance Service 2019). The Medical Aid Programme (MAP), a government funded assistance programme targeted at the poor, was established shortly after, in 1979, through the Medical Protection Act (Kim 2017). In the same year, the NHI system enrolled civil servants and private schools. Over the years, NHI membership was progressively expanded to the entire

population, with the self-employed from rural areas added to the system in 1988. Finally, in 1989 the self-employed from urban areas were included in the system. Since the early 2000s, the system has functioned as a single-payer scheme with the National Health Insurance Service (NHIS) as the main insurer (Kwon, Lee and Kim 2015; Sohn and Jung 2016).

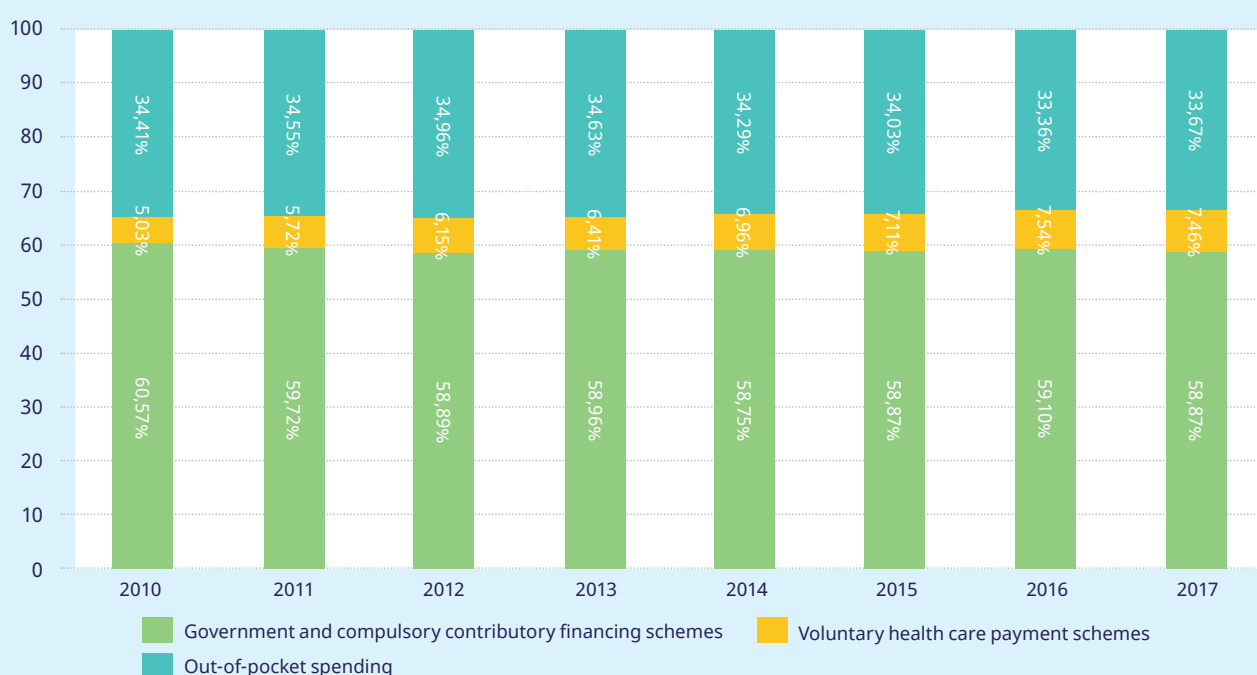
In 2008, to respond to the challenges of a rapidly aging population, the Long-Term Care Insurance (LTCI) scheme was launched, creating a new source for provision and utilization of medical and social care for the elderly in the Republic of Korea (Cheng et al. 2018). The scheme is one of five social security schemes introduced by the Government.⁵⁵ The purpose of LTCI is to simplify and improve access to nursing and home care services for the elderly population (Shin 2014). Through the implementation of these three complementary and coordinated schemes (NHI, MAP and LTCI), comprehensive health protection coverage is now provided to the entire population.

► 3. Design of the social health protection system

- Financing

Republic of Korea's total health expenditures are currently equivalent to 8.1 per cent of GDP. In 2017, per capita spending on health was US\$2,283, and in the same year, current health expenditure was 7.60 per cent of GDP (WHO n.d.). The government-financed and compulsory contributory health care schemes (NHI, MAP and LTCI) account for 58.9 per cent of health expenditure, OOP expenditures account for 33.7 per cent and voluntary health care payment schemes account for 7.5 per cent (WHO n.d.). While MAP only covers 3 per cent of the population, its accounts for 16.9 per cent of total NHI expenditure (Yoo et al. 2016). As demonstrated by figure 1 below, this distribution

► Figure 1. Current health expenditure by financing scheme



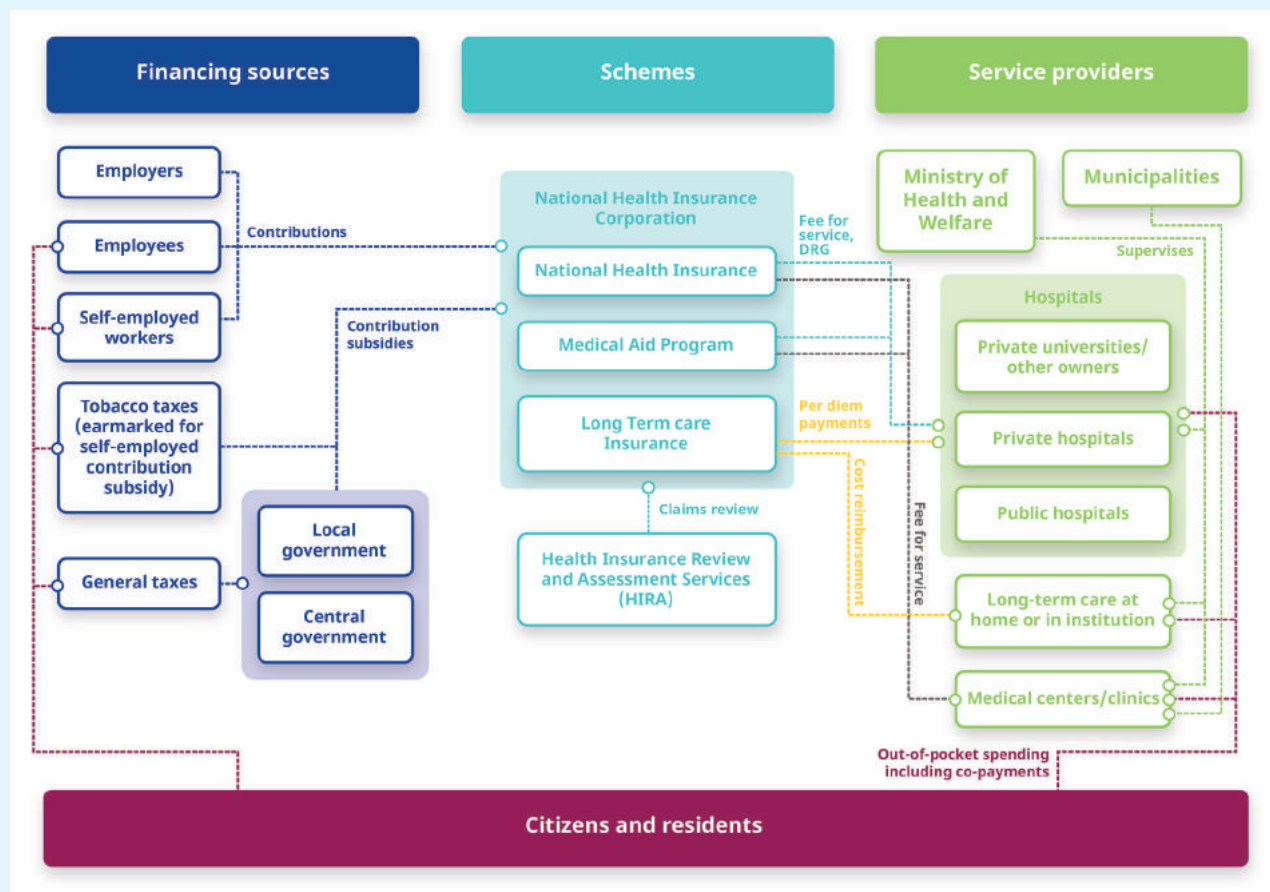
Source: Adapted from WHO Global Health Expenditure Database.

⁵⁵ Republic of Korea has implemented four social insurance schemes: National Pension, National Health Insurance, Employment Insurance and the National Basic Livelihood Security System. Long Term Care is considered the fifth scheme (Lee 2015).

of financing sources has remained stable since 2010.

Figure 2 summarises the health financing flows of the social health protection system in the Republic of Korea.

► Figure 2. Overview of main financial flows of the social health protection system in the Republic of Korea



Source: Authors.

NHI is the single insurer and purchaser of health care services, and is financed by contributions, government subsidies and tobacco tax (Lee and Lee 2019). In 2019, 86.3 per cent of NHI funding was sourced from social insurance contributions, 11.4 per cent from government subsidies and 2.3 per cent from other sources (Republic of Korea Ministry of Health and Welfare 2019, 648–49). In the same year, the monthly contribution rate was 6.5 per cent – an increase from 5.1 per cent in 2008 (Shim and Hur 2019). Contributions are shared equally between the employee and the employer and contributions of self-employed members are calculated based on their total

wealth (income and value of their property) using a scoring system (Kwon, Lee and Kim 2015; Lee et al. 2019; Shim and Hur 2019). There is a monthly income ceiling of 78.1 million Korean won (KRW) (approximately US\$63,741) for NHI (Social Security Administration 2016).

Besides contributions, the NHI also depends on government subsidies for the self-employed (Lee et al. 2019). Through the enactment of the Special Act for the Financial Stability of National Health Insurance, established in 2002, government subsidies increased from 28 per cent to 50 per cent of total revenues. Increased government subsidies were financed from increased tobacco

taxes in 2002 (Na and Kwon 2015).⁵⁶ In 2019, tobacco tax represented 3.1 per cent of total government subsidies.

There are several full and partial exemptions to contributions. A 50 per cent reduction of contributions applies to the insured working in remote islands or areas, the insured working overseas without any dependents in the country, and beneficiaries working abroad with dependents living in the country. Reduction of the contribution rate applies to the insured aged 65 or older and beneficiaries registered as living with a disability, the self-employed, the insured living in farming or fishing villages, single-parent families, single women over 55 and orphans. Reduction rates range between 10 to 30 per cent. Exemptions from contributions are applied to Koreans working abroad without any dependents in the country, persons serving a jail sentence and persons in the military (National Health Insurance Service 2019).

The MAP is jointly funded by the central government (80 per cent) and local governments (20 per cent) (Lee and Lee 2019) and the contribution payment is made by the Government on behalf of the insured (Type 1 and Type 2 plans).

The financing model of the LTCI scheme is similar to that of the NHI (Shin 2014). The LTCI is funded by long-term care social insurance contributions paid by active workers and employers, in addition to government subsidies (Park 2015). The Government funds about 20 per cent of the annual budget for the scheme. The contribution rate is calculated as a share of the NHI contribution and is paid together with contributions to the NHI. In 2019, LTCI comprised 8.5 per cent of NHI contributions.

- Governance

The NHI scheme is placed under the overall leadership of the Ministry of Health and Welfare (MOHW). The MOHW has delegated the administration of the NHI to two entities: the National Health Insurance Service (NHIS) and the Health Insurance Review and Assessment Service (HIRA). The NHIS is accountable to the MOHW and is responsible for managing beneficiaries, collecting contributions and paying

health care providers. It carries out the following functions: (i) administration of insurance benefits; (ii) preventive programmes; (iii) payment of insurance benefit costs; (iv) fund management and; (v) collection of contributions for all social security programmes.⁵⁷ The HIRA on the other hand is responsible for health care evaluation, claims review and handling issues related to purchasing, such as benefits coverage and payment system design (Kwon, Lee and Kim 2015; Na and Kwon 2015).

The Board of Directors of the NHIS, as mandated by the National Health Insurance Act, is comprised of the President, executive directors, representatives of labour unions, employer associations, civic groups, consumer groups, agriculture groups, senior citizens' associations and government officials representing the MOHW, the Ministry of Strategy and Finance and the Ministry of Personnel Management (National Health Insurance Service 2019). Public participation in decision-making on social health insurance is enabled through a platform called the Citizen Council for Health Insurance, which was launched in 2010 to increase patients' inputs to priority setting and issues such as the extension of the NHI benefit package (Kwon, Lee and Kim 2015).

The LTCI scheme, which was introduced based on article 1 of the Act on Long Term Care Insurance for Senior Citizens, is also managed and regulated by the NHIS (National Health Insurance Service 2019). The Long-Term Care Committee is placed under the oversight of the Minister of Health and Welfare. The Committee is comprised of 16 to 22 members, with the Chairperson appointed by the Minister of Health and Welfare. Other members include representatives of employees' and employers' associations, non-governmental organizations, long-term institutions and representatives of the academic community. The Committee makes decisions regarding long-term care benefits and contributions, manages and assesses contributions and deals with all essential matters concerning the functioning of the scheme.

⁵⁶ In 2012, the government also introduced financial support for Employment Insurance and National Pension contribution for firms with fewer than 10 workers. In 2018, government subsidies to insurance contribution amounted to US\$774 million (Shim and Hur 2019).

⁵⁷ Government of the Republic of Korea, National Health Insurance Law of 2011, available at: https://elaw.klri.re.kr/eng_mobile/viewer.do?hseq=53994&type=new&key=

- Legal Coverage and eligibility

Any member of the population living in the country has a right to NHI coverage. Affiliation is mandatory, with no possibility to opt out (Kwon, Lee and Kim 2015). The republic of Korea's single-payer insurance system presupposes every citizen to be enrolled in the NHI or the MAP, depending on their income levels and criteria set by the Government (see below). Koreans residing overseas have a right to be insured based on article 19 of the National Health Insurance Act (National Health Insurance Service 2019). According to the National Health Insurance Law, foreigners residing in the Republic of Korea for six months or longer are required to contribute to the NHIS, and non-working foreign residents can contribute on a voluntary basis.⁵⁸

Enrolment in the NHI scheme can be undertaken on an individual or a household basis. The social health insurance system encourages family-based membership if the income of dependents is below a certain level. Dependents include spouses, children and other members of the family or household of the insured member paying the contribution. Enrolment of the employed and the self-employed is completed through online submission of the appropriate form to the NHIS (Kwon, Lee and Kim 2015; National Health Insurance Service 2019). It is the employer's responsibility to enrol employees with the NHI.

Persons with low incomes are entitled to enrol in the MAP, and membership criteria is set and revised annually by the MOHW. Beneficiaries of the National Basic Livelihood Security System (NBLSS) and households making less than 40 per cent of the median income in the Republic of Korea qualify for medical aid (Moon and Moon 2020). Eligible persons need to submit their application in order to become a beneficiary. The MAP is divided into Type 1 and Type 2 medical aid. Type 1 medical beneficiaries make up 57 per cent of all members and include: households with without the ability to work; patients with rare and incurable diseases; shelter residents receiving benefits from the NBLSS; homeless patients without family or any support; disaster victims; family members of those who have been injured or who have died while helping others; adoptive children below 18; men and women of national merit; Living Human Treasures; and refugees

from North Korea. Type 2 beneficiaries account for 43 per cent of all scheme members (Moon and Moon 2020) and include all other individuals and households who do not fall under any of the Type 1 categories, but receive NBLSS benefits (The Republic of Korea Ministry of Health and Welfare 2019).

Affiliation to the LTCI scheme is mandatory for individuals aged 65 or over and those below 65 with debilitating conditions (Kang, Park and Lee 2012). Those who are younger than 65 and suffering from illnesses such as dementia might also be affiliated (Park 2015). Eligibility for LTCI is determined by a trained NHIS assessor. One of the main criteria for inclusion is the inability of the senior citizen to live on his or her own for longer than six months. An assessment of the person's physical and mental status is made irrespective of their financial status or family support, and eligibility is revaluated once a year (Park 2015). Not all elderly people with care-related needs are covered by the scheme. As such, central and local governments have introduced several smaller programmes for older people with a mild disability or living on their own (Jun Choi 2015). Enrolment is possible for an individual but not for a household. However, family members supporting the beneficiary receive financial support from the NHIS (National Health Insurance Service 2019).

- Benefits

The NHI and the MAP have the same benefit package. This unique benefit package consists of benefits in cash and benefits in kind. Benefits received in kind include diagnosis, tests, treatments, medical supplies, treatments, surgeries, preventive care, rehabilitation, hospitalization, nursing, transportation and health check-ups, including blood tests (Kim 2019). Cancer check-ups are also included, with the patient bearing 10 per cent of the screening cost and the NHIS bearing 90 per cent of the cost. Benefits in cash include reimbursement if the medical cost exceeds the co-payment ceiling, reimbursement of medical devices for people with disabilities, and delivery expenses. NHIS reimburses the full amount (National Health Insurance Service 2019) in cases where the beneficiary or his/her dependent receive treatment for disease, injury or childbirth from other institutions providing similar services to

⁵⁸ Government of the Republic of Korea, National Health Insurance Law of 2011, available at: https://elaw.klri.re.kr/eng_mobile/viewer.do?hseq=53994&type=new&key=

hospitals—for example, clinics that are permitted to offer in-patient services, as defined under the decree of the MOHW, or the home, in cases of emergency home births.

The benefit package is based on a positive list, with some exclusions. The HIRA determines services to be reimbursed by the NHIS. It is estimated that about 21 per cent of services within the health system are not covered by NHI, including medical imaging, dermatology services, and medical consultation and education for the prevention of chronic diseases (Kwon, Lee and Kim 2015; Do 2013). Cosmetic treatment intervention and dermatology services are not included in the benefits package, with the exception of reconstructive surgery for face burns, which is covered by the NHI (National Health Insurance Service 2019). Screening and preventive check-ups for certain diseases like colon, breast and liver cancer are available only to the members of a certain age, between 40 to 50 years of age and over (National Health Insurance Service 2019). Moreover, limitations in the benefit package include a benefit ceiling of 90 days of utilization per year.

Treatments for which effectiveness has not been proven by the National Evidence-based Health care Collaborating Agency (NECA) are also not covered (Mauna Kea Technologies 2018). NECA contributes to policy and decision-making related to the benefit package by generating evidence on the clinical effectiveness and cost-effectiveness of health services, technologies and health products (Kwon, Lee and Kim 2015). Members of the NHI can purchase additional private health insurance on a voluntary basis to cover benefits not covered by the NHI (Lee and Lee 2019).

LTCI provides a unique benefit package, defined positively, and includes home care services, including bathing, day and night care, nursing elderly family members and providing assistance with household services institutional care and, in exceptional cases, cash benefits (Lee 2015). A family member who supports beneficiaries can receive supportive cash benefits from the NHIS. LTCI also provides financial support to purchase necessary equipment that provides assistance in daily and physical activities for those who have difficulties carrying out their daily routines due to physical or cognitive decline (National Health Insurance Service 2020). Cash benefits are also

provided on a case-by-case basis to older persons living in remote areas with no access to in-kind benefits (Jun Choi 2015).

- Provision of benefits and services

The NHI purchases health care services from public and private service providers. Benefits provided by the NHI are equally available to all citizens, since they can use all the treatments in any public or private hospital covered by the NHI scheme. All private facilities have the obligation to participate in the NHI (Kwon, Lee and Kim 2015). The NHI is the central purchaser of health care services. For both the NHI and the MAP, the MOHW is responsible for direct payment to health care providers, which is done in the same way for all members, regardless of whether they are enrolled in the NHI or the MAP.

Depending on the services provided, reimbursement of providers is undertaken by the NHIS through fee-for-service and Diagnosis-Related Groups (DRGs). Public and private hospitals and clinics are mainly reimbursed through fee-for-service payment (Kwon, Lee and Kim 2015). DRGs were introduced in 2013 to pay for inpatient services for seven diseases (Lee 2015; Na and Kwon 2015). Payments are thoroughly examined by the HIRA, which evaluates and decides whether or not reimbursement is appropriate (Lee et al. 2019).

For the LTCI scheme, a purchaser-provider split is implemented. Each institution files a claim for reimbursement of costs incurred from the provision of benefits under the LTCI programme, and the claim is filed with the NHIS. When the NHIS receives a claim for reimbursement of costs of either home care or institutional care, it reviews the claim and proceeds with payment to the provider. The beneficiary's co-payment is deducted from the expenses.⁵⁹ Hospitals participating in the LTCI programme are paid based on per diem payments, differentiated by 17 disease categories (Kwon, Lee and Kim 2015).

The NHI implements a co-payment system in order to prevent over-utilization (see Table 2). In cases where costs of health services are split between the NHI and the patient, the patient may bear his or her part of the cost through several forms of payment, including deductibles, co-insurance, a ceiling system, co-payment and indemnity (Sohn and Jung 2016).

⁵⁹ Government of the Republic of Korea, National Health Insurance Law of 2011, available at: https://elaw.klri.re.kr/eng_mobile/viewer.do?hseq=53994&type=new&key=

► **Table 1. Co-payments across different levels of care**

Type of care	Type of facility	Co-payment
Inpatient	All hospitals	20% of total treatment cost (registered cancer patients 5% and registered rare/incurable disease patients 10%)
Outpatient	Tertiary hospital	60% of total treatment cost and other expenses
	General hospital	50% (Dong district) and 45% (Eup and Myeon districts) of total expenses
	Hospital	40% (Dong District) and 35% (Eup and Myeon Districts) of total expenses
	Clinic	30% of total care benefit expenses
	Pharmacy	30% of total care benefit expenses

Source: Adapted from National Health Insurance Service (2019).

Beneficiaries of the MAP have been required to make co-payments since 2007 (Yoo et al. 2016) with a gradual co-payment schedule based on the level of care and beneficiary classification (type 1 or 2) (Moon and Moon 2020). However, the Healthy Life Maintenance Aid Programme and Co-payment Exemptions Programme were introduced by the Government to better meet the medical needs of beneficiaries. Through the Healthy Life Maintenance Aid Programme, the Government provides US\$6.00 per month to each type 1 beneficiary via a virtual health savings account. This money can be used for co-payments of outpatient services. If more than US\$2.00 remains, it can be converted into cash once a year. This policy does not apply for inpatient services, which are provided at no cost to beneficiaries. The Co-payment Exemptions Programme is targeted towards type 1 category beneficiaries, such as pregnant women, homeless persons, persons under 18 years of age, patients with organ transplants and patients with rare incurable diseases (Yoo et al. 2016).

Beneficiaries of the LTCI scheme are required to co-pay 15 per cent of the costs of in-home services and 20 per cent of institutional services (Park 2015). The poorest group is entirely exempt from co-payments, while the second poorest is exempt from paying 50 per cent of the co-payment (Won 2013).

► 4. Results

- Coverage

In December 2019, there were 52.8 million people covered (100 per cent of the population), of which 97.2 per cent were covered by the NHI and 2.8 per cent were covered by the MAP (HIRA and NHIS 2020, 54;82). The fact that the Republic of Korea attained full population coverage within 12 years of the launch of the NHI scheme is a noteworthy success story, particularly considering that in 1977, when the NHI was first implemented, only 8.8 per cent of the total population was covered.

- Adequacy of benefits/financial protection

The rate of OOP payments in the Republic of Korea is considered high for an OECD country (Na and Kwon 2015; WHO n.d.). Evidence suggests that OOP payments are partly driven by private providers inducing demand for new treatments and technologies which are not proven to be cost-effective and therefore not fully covered by NHIS (Kwon, Lee and Kim 2015). The proportion of the population spending more than 25 per cent of household consumption or income on health expenditures was 3.8 per cent in 2015. Some studies have found that poor households

have lower rates of catastrophic expenditure than those that are better off. This may seem like an equitable outcome, but in reality, it is simply the result of poor individuals forgoing the use of health services to avoid having to make high OOP payments (World Bank n.d.; Lee 2015)

- Responsiveness to population needs
 - o Availability and Accessibility

The Republic of Korea's health system is characterized by well-trained medical staff and advanced medical equipment. In 2017, there were 2.3 doctors, 6.9 nurses/midwives, and 12.8 hospital beds per 1,000 people. Although the Republic of Korea's health system is one of the most developed in the world, not all Koreans have the same access. Disparities in access to health services and facilities exist between urban and rural populations due to uneven geographical distribution of health workers and facilities (Cho 2013). For instance, in 2016, the average number of beds per 1,000 people was 6.1, with the highest number of beds in Jeonju region (9.9 beds) and the lowest in Seongnam region (3.4 beds) (The Republic of Korea Ministry of Health and Welfare et al. 2017). A survey conducted in 2018 found that 26 per cent of respondents perceived that access to treatment was a major issue of the health system (Ipsos 2018).

- o Quality and acceptability

With life expectancy in the Republic of Korea having increased tremendously over the years, rising from 55.4 in 1960 to 83.2 in 2019 (World Bank n.d.), there is evidence to indicate the positive effect of NHI on health outcomes. Notably, the wide availability of cancer screening programmes financed by the NHI scheme potentially contributed to lower cancer mortality and improved survival rates (Kwon, Lee and Kim 2015). Specifically, the survival rate increased from 41.2 per cent for cancer patients diagnosed between 1993–1995, to 70.7 per cent for cancer patients diagnosed from 2011–2015 (Jung et al. 2018).

When it comes to patient satisfaction with services, a 2011 MOHW survey found that 63.9 per cent of respondents were “satisfied” with the health system's performance (Kwon, Lee and Kim 2015). Another study found that Koreans are generally satisfied with access to health care services, and that satisfaction was higher in the capital than in smaller cities (Park et al. 2016). One study measuring satisfaction with the NHI

found that 28.3 per cent of the general public expressed satisfaction with the NHI system and 21.4 per cent expressed dissatisfaction, with the public expressing greater overall satisfaction than physicians (Kim, Park and Hahm 2012). In 2017, approximately 40,000 individuals in the Republic of Korea visited 204 clinics and reported that they were highly satisfied with the service provision and the rapport they had built with doctors (Kang et al. 2019).

The efficient coordination of long-term care remains an important undertaking in the Republic of Korea (Jeon and Kwon 2017; Won 2013), with several studies undertaken in recent years to assess the quality of long-term care provision. A survey conducted by the MOHW in 2014 found that 89.1 per cent of beneficiaries' families were satisfied with the long-term care programme, and 90.5 per cent stated that it reduced their family's financial burden (Jun Choi 2015).

Since 2017, the Korea Institute for Health Care Accreditation has been using 129 criteria to evaluate health care facilities across the country and accredit those that meet the required standards (Shin 2017). The Korean health system has been ranked among the world's best in terms of quality, survival rates, new technology and other quality indicators (OECD 2015). This results in part from the Committee for New Health Technology Assessment, which has the mandate to contribute to quality improvement, and evaluate the safety and effectiveness of medical procedures and diagnostics. The HIRA is also responsible for quality assurance through claim reviews, assessment of appropriateness of health care, technical support to benefit packages, and the design of the provider payment system (National Health Insurance Service 2019).

► 5. Way forward

Through successive reforms to consolidate a system with multiple payers into a single system, the health insurance system in the Republic of Korea has matured quickly in a relatively short period of time. Today, the country's health system is one of the most developed in the world, characterized by universal coverage, impressive health outcomes and state of the art medical services. However, challenges remain, especially in relation to the extension of financial protection,

with OOP expenditures remaining high and placing a burden on low-income families. In addition, falling birth rates and a steep rise in the elderly population require specific types of care, which poses a challenge to the long-term financing of the country's health insurance system. The proportion of the population aged 65 and over is projected to increase from 15.7 per cent in 2020 to 24.1 per cent by 2030.

In order to tackle these challenges and achieve more comprehensive health insurance coverage to increase financial protection offered by NHI, the Government launched the "Moon Jae-in Care" policy (Lee et al. 2019). The main objective of this policy is to increase financial protection by reducing non-reimbursable services, setting maximum deductibles and expanding emergency financial assistance. The comprehensive National Health Insurance Plan (2019–2023), which is designed to deliver Moon Jae-in Care, has five main components: (1) reducing medical costs by strengthening health insurance coverage; (2) constructing a comprehensive health care system that incorporates the community level; (3) strengthening primary health care and operating supportive health insurance fees; (4) providing reasonable and appropriate medical cost compensation; and (5) maintaining cumulative reserves to promote sustainable health insurance and address challenges arising from an aging population. The implementation of this plan will be at the heart of sustaining achievements to date in the context of rapid demographic shifts and epidemiological changes to public health.

to a negatively defined benefit package; reducing non-reimbursable services; setting a ceiling on OOP payments; the inclusion of health promotion and disease prevention through various health check-ups; covering Long-term care; and a gradual decrease of co-payments, particularly for chronic diseases.

- Health promotion and disease prevention are well integrated into NHI, contributing to better health outcomes overall for the population. High priority is placed on disease prevention, as exemplified by a damages lawsuit filed by the NHI against major tobacco firms. Although the NHI was not successful in this case, efforts are maintained to publicize the harmful effects of smoking and raise awareness about the issue.
- The NHI scheme is an example of the progressive realization of an integrated system, with the consolidation of various payers into a single scheme. Efficiency in administration has also been enhanced over the years, in part due to the unified collection of major social insurance fees (National Health Insurance, National Pension, Unemployment Insurance and Workers' Compensation).

► 6. Main lessons learned

- The Republic of Korea's achievement of UHC through NHI was reached rapidly in comparison to other high-income countries. Main success factors include the embedding of rights into law, compulsory coverage, progressive expansion of membership and benefits, and the provision of subsidies for those unable to afford contributions.
- The attractiveness of benefits, including high quality of care, played a major role in achieving UHC. The benefit package was progressively expanded through various policies, including: moving from a positive

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► Lao People's Democratic Republic

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► 1. Introduction

In less than a decade, the Lao People's Democratic Republic has made remarkable progress towards Universal Health Coverage (UHC) by expanding social health protection to a large proportion of its population. To date, more than 90 per cent population coverage has been achieved. The rapid expansion of social health protection in the country is the result of a strong political commitment to achieving UHC and its financing modalities. The Lao Health Sector Reform Strategy for the period 2013–2025 was introduced in 2013 to set out a roadmap to achieve UHC by 2025, with a consequent increase in domestic spending on health (WHO 2017). In its Eighth Health Sector Development Plan (Lao People's Democratic Republic Ministry of Health 2016), the Government of Lao People's Democratic Republic outlined its aim to achieve UHC by 2025 and set the target of achieving 80 per cent population coverage by 2020. The Plan also sought to address cultural, financial and geographical access barriers encountered by vulnerable groups in accessing health care to promote a more equitable health system (WHO 2017). Subsequently, in 2017, the Ministry of Health (MOH) and the National Health Insurance

Bureau (NHIB) introduced the National Health Insurance (NHI) Strategy 2017–2020 (Lao People's Democratic Republic Ministry of Health 2017) to provide a clear vision and logical framework for the development of a unified National Health Insurance scheme. Finally, the Law on Health Insurance was promulgated in 2018, which became the first law on social health protection in the country, creating a legal framework for NHI. On this basis, the health protection system, which previously comprised various schemes, is currently being streamlined into a single NHI scheme.

► 2. Context

The very first pre-paid pooled fund in the Lao People's Democratic Republic was introduced in 1995 to cover government employees and their dependents through the State Authority for Social Security (SASS) scheme. In 2001, social health protection coverage was extended to private employees and their dependents via the establishment of the Social Security Organization (SSO) scheme. Both schemes were managed through the National Social Security Fund (NSSF) under the Ministry of Labour and Social

Welfare (MLSW). In 2002, social health protection was further extended to informal economy workers through the voluntary and contributory Community-Based Health Insurance (CBHI) scheme. In 2004, the fully subsidized Health Equity Fund (HEF) was established under the management of the MOH to provide coverage to the poor and vulnerable. However, population coverage of the CBHI remained limited, with low enrolment rates, mostly due to the voluntary nature of the scheme and a lack of subsidies. Targeting errors of the HEF also posed challenges to the extension of social health protection to the poor and vulnerable. Consequently, only 10.8 per cent of the population was covered by a social health protection scheme in 2008 (Phetpasak, unpublished).

In 2010, a policy of Free Maternal Neonatal and Child Health (FMNCH) services was implemented, which contributed greatly to improving health services utilisation. However, informal payments and out-of-pocket (OOP) payments remained very high, which limited financial protection for intended beneficiaries of the policy (ILO 2019). In recognition of the difficulties inherent in extending coverage to informal economy workers through voluntary health insurance, in 2012, the aforementioned NHI fund was created under Decree 470/PM. The Decree not only provided the foundation for integrating all MOH and MLSW schemes into a single NHI scheme, but also introduced the provision of a 50 per cent subsidy for contributions from workers in informal employment.

The implementation of the integrated NHI scheme, merged with the pre-existing schemes under the MOH (CBHI, HEF and FMNCH) was set in motion in 2016 and rapidly rolled out to all provinces in 2017. At the time of writing, the only region not included in the NHI scheme is the Capital of Vientiane, where protection for workers in informal employment is provided through CBHI and FMNCH (ILO 2019). To further extend coverage, in 2017, along with the merger of the MOH schemes, the Government decided to adopt a tax-based financing model, which replaced contributions from informal economy workers with full public subsidies directly transferred to the NHI Fund. These public subsidies led to rapid coverage expansion nationwide, bringing the coverage rate up to 80 per cent in 2018 – two years earlier than the target set by the MOH in the NHI strategy (ILO 2019). As part of the second step of the merging, which aimed to integrate NSSF

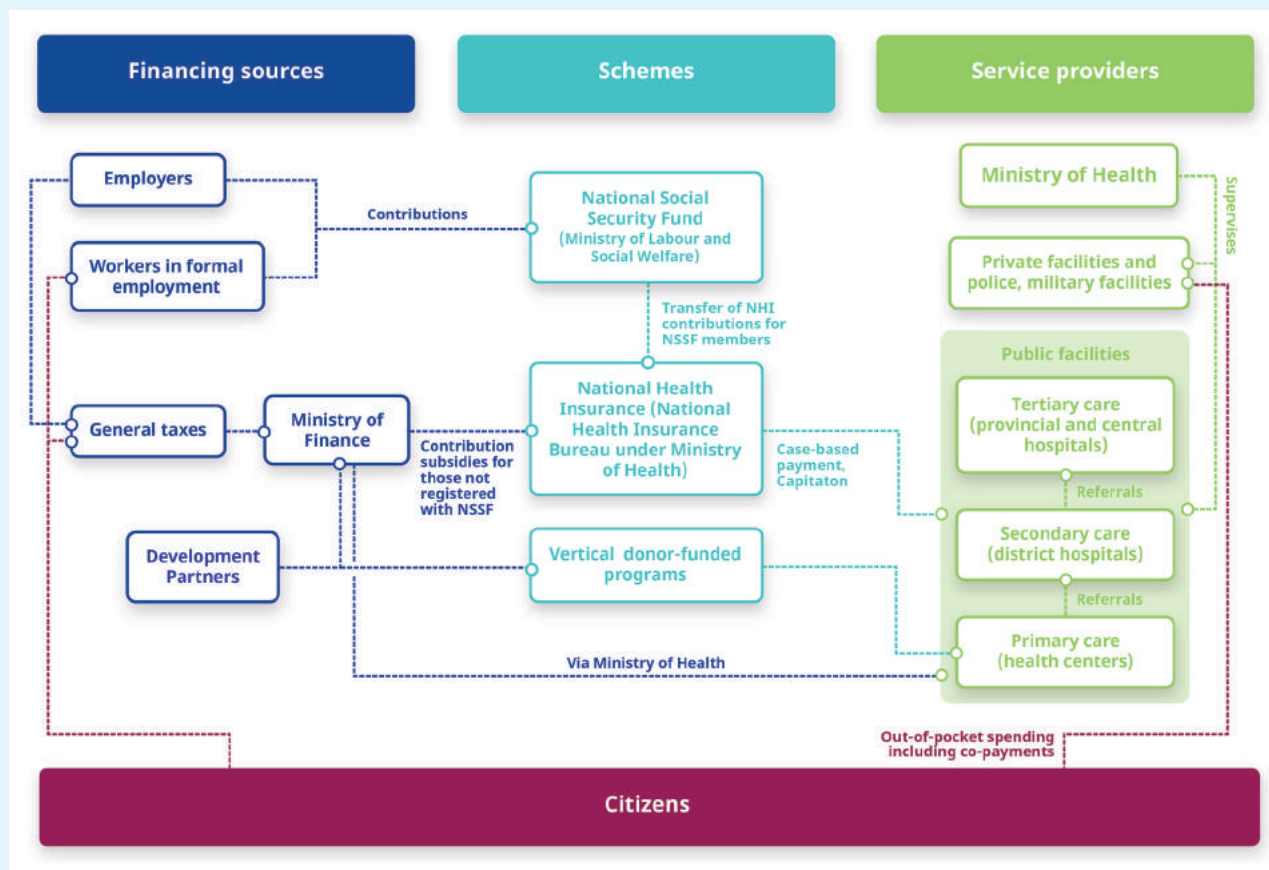
schemes into the NHI Scheme, a pilot merger in Sekong and Vientiane provinces was initiated in October 2018. The nation-wide roll-out of the newly consolidated scheme was implemented in July 2019, covering all provinces except Vientiane Capital. The police scheme is also intended to be integrated into the NHI scheme, while the army scheme will maintain separate arrangements.

► 3. Design of the social health protection system

- Financing

The NHI is now a predominantly tax-financed health insurance scheme, with contributions from formally employed workers constituting a small share of the total revenues of the scheme. Health benefit contributions to the NSSF amount to 4 per cent of insurable salary, equally split between employers and employees. The NSSF transfers 1.25 per cent of the total social security contributions collected to the NHIB. In addition to taxes and member contributions, the scheme is intended to be financed by other sources of funding, such as grants, the tobacco control fund and other related funds (Law on Health Insurance of 2018, article 40). With the exception of Vientiane Capital, all sources of funding are now pooled into the NHI fund, which is used for to pay providers. Figure 1 below illustrates the financing flows of the NHI in Lao People's Democratic Republic.

► Figure 1. Overview of main financial flows of the social health protection system in Lao People's Democratic Republic



Source: Authors.

In 2017, government health expenditure accounted for 35.1 per cent of total current health expenditure in Lao People's Democratic Republic, while international sources (including aid and grants) accounted for 16.7 per cent. In the same year, OOP payments remained a dominant source of health financing, representing 46.2 per cent of total current health expenditure (WHO n.d.).

- Governance

The implementation of the NHI scheme is based on Decree 470/PM,⁶⁰ which was issued to provide the legal basis for the creation of a single NHI fund. The Law on Health Insurance was enacted in 2019, and further defines the principles, rules

and measures regarding the management of national health insurance activity. The objective of the Law is to guarantee the scheme's effective and efficient implementation, "aiming to ensure that Lao citizens are covered by health insurance and shall access universally to equitable health care services".⁶¹ In addition, the Law on Social Security was amended in 2018 to define social security principles and rules, protecting the rights and interests of social security fund members and their families. Since then, the Lao People's Democratic Republic has introduced additional strategic documents to guide and support the achievement of UHC.

⁶⁰ Decree 470/PM on National Health Insurance Fund of 2012, available at: <file:///C:/Users/admin/AppData/Local/Temp/433970.pdf>

⁶¹ Law on Health Insurance of 2018, article 1.

The NHI fund is implemented under the leadership of the MOH. It is managed by the National Health Insurance Management Committee (NHI Management Committee) and its Secretariat, the National Health Insurance Bureau (NHIB). The NHI Management Committee is comprised of Management Committees at central, provincial and district levels wherein the NHIB at each respective level serves as its secretariat. The NHIB at the central level is a department of the MOH, in charge of all NHI management functions. According to the National Health Insurance Strategy 2017–2020, the NHIB is tasked with fulfilling nine main operational functions to provide effective coverage: stewardship, revenue collection and pooling, financial management, interface with the public, administration, strategic purchasing, technical support, verification and monitoring and evaluation (Lao People's Democratic Republic Ministry of Health 2017). Provincial and district offices are set up nationwide for the daily implementation of the scheme.

- Legal coverage and eligibility

The NHI scheme is inclusive, in that “all Lao citizens regardless of sex, age, ethnicity, race, religion and social-economic status shall have the right to enrol in a health insurance scheme”, as stipulated in the Law on Health Insurance. NHI enrolment for workers in formal employment – both public and private – is compulsory via NSSF membership. However, there are no registration mechanisms in place for the rest of the population, including for the self-employed and informal economy workers, who gain access to NHI services by showing an ID card at public health facilities. Enrolment to the NSSF is family-based, with the same health benefits entitlements extended to the contributing member's spouse and children.

- Benefits

All NHI members are entitled to a relatively comprehensive benefits package covering most health services in the public sector and at each level of care. The package is regulated by the Law on Health Insurance, using a combination of both negative and positive definitions. Through the negative definition, the package excludes aesthetic/cosmetic services, VIP room services (private), services used at private or overseas facilities and health services which are based on personal demands. It also excludes health services already covered by a third party

or other vertical programmes (for example, those that provide treatment for leprosy, HIV/AIDS, tuberculosis or malaria). Using a positive definition, the Law on Health Insurance also provides the legal foundation for the consequent introduction of under-law regulations on a list of essential drugs and medical supplies, as well as price caps on services covered by NHI.

While the harmonization of benefits is a priority, there are still some differences in the benefits provided to members who register through the NSSF or directly to the NHI. Table 1 compares the differences between NHI and NSSF benefit exclusions. As noted, the NHI benefit package for the general population is broader, as it covers many NSSF exemptions such as heart surgery, dialysis, thalassemia treatment and chemotherapy.

► **Table 1. NHI and NSSF Benefit Package exclusions**

NHI exclusions	NSSF exclusions
1. Services requested by patients: VIP rooms, additional services, repair surgery, cosmetic surgery, artificial teeth, sterilization, glasses and contact lenses; 2. Services used in private facilities or overseas health care facilities; 3. Health care services covered by vertical programmes; 4. Health care services covered by other personal liabilities (for example, injuries caused by traffic accidents will be covered by the party responsible for the accident or by accident insurance, and injuries caused by dog bites will be covered by the dog owner); 5. Transportation costs to and from health care facilities.	1. Health care services covered by government vertical programmes (for example, TB, HIV, malaria and leprosy); 2. Heart surgery; 3. Dialysis (not more than 5 sessions); 4. Thalassemia; 5. Chemotherapy; 6. Glasses or intraocular lenses (except for work injuries or occupational diseases); 7. Dental prosthesis, except for work injuries; 8. All medicines related to the treatment of HIV/AIDS; 9. Annual health check-ups; 10. Sex reassignment surgery, artificial breeding, sterilization and plastic surgery.

Sources: Adapted from MOH NHI implementation guideline, No. 0263/NHIB; 2016 Social Security Law implementation guideline, No. 2751/MoLSW, dated 24 July 2015.

Co-payments apply at the point of service, except for those identified as poor by village/district authorities, pregnant women, children under five and monks, all of whom are fully exempt from co-payments. Although the Law on Health Insurance stipulates that the uninsured must comply with the co-payment policies, this provision has not yet been enforced.

- Provision of benefits and services

NHI members can access treatment at all public health facilities in all provinces where NHI is rolled out. Public health services in the Lao People's Democratic Republic are delivered through a network of health centres, and district, provincial, central and specialized hospitals. In addition, the military and police sectors also provide health care services for their own employees and their families, as well as parts of the local community. Today, an increasing number of private clinics and hospitals are becoming a prevalent part of the health service delivery network (WHO 2018). Within the NHI network, there are currently three levels of health care services:

- (i) Primary health care services (health centres);
- (ii) Secondary health care services (district/ community hospitals);

- (iii) High level health care services (provincial and regional hospitals).

There is a referral system in place, but it is not very effective (World Bank 2017) due to the lack of a gate-keeping function at primary health care facilities (Akkhavong et al. 2014). In cases where provincial hospitals cannot treat a patient, they will send them to a central hospital. In such cases, third party payment does not apply, meaning that the patient will have to make a claim after treatment for reimbursement from the NHI Office. At the time of writing, only one private hospital (Xaymangkorn hospital) in Udomxay is contracted with NHIB and part of the NHI network.

The NHI scheme uses a mix of payment mechanisms. Capitation is the payment method for outpatient services, while the case-based method is used for inpatient services (World Bank 2017). The case-based method is used to pay for the free provision of maternity care services and inpatient care for children under five, which is free-of-charge for patients, whereas capitation is used to pay for outpatient care (World Bank 2017). Payment mechanisms at different levels of care are summarized in Table 2 below.

► **Table 2. NHI provider payment mechanism**

Patient co-payment	Health centre	District hospital	Provincial hospital	Regional hospital
Outpatient	Capitation	Capitation	Capitation	Capitation
Admission		Case-based payment	Case-based payment	Case-based payment

Source: Author based on information provided by NHIB.

Presently, there is an emerging purchaser-provider split, whereby the NHI Fund is the purchaser and contracted NHI facilities are service providers. Both are placed under the leadership of the MOH. A third-party payment mechanism applies for all NHI members. As noted above, the only exception is at central hospital level, where referred patients need to pay first and submit a claim to the NHI Office to be reimbursed.

When seeking care, direct co-payments apply to NHI members, with the exception of members who registered through the NSSF and members of poor households identified by their village heads, as well as pregnant women, children under 5 and monks. The co-payment amount varies depending on the level of care, as follows:

- Health centres (outpatient and inpatient): 5,000 Lao Kip (LAK) (approximately US\$0.55) per visit or admission
- District hospitals (outpatient): LAK10,000 (US\$1.10) per visit
- Central hospitals (outpatient): LAK20,000 (US\$2.20) per visit
- Provincial and regional hospitals (outpatient): LAK15,000 (US\$1.60) per visit.

“High-cost surgery and treatment” requires much higher co-payments from non-NSSF members, while a specific schedule of provider payments applies for NSSF members seeking high-cost treatment, as summarized in the table below.

► **Table 3. Co-payments for high-cost cases and risk adjusted capitation for chronic diseases for NSSF members**

Co-payments for high-cost surgery or treatment for hospitals or members	Risk adjusted capitation for chronic disease of LAK10,000 per member per year
1. Brain surgery: LAK1,500,000 per surgery; 2. Orthopedic surgery with steel implants: 50 per cent of total cost; 3. CT scan, MRI or mammogram: 50 per cent of total cost; 4. Road accidents (in case of hospitalization): not more than LAK1,000,000 per admission; 5. Transportation cost for serious cases: 50 per cent of total cost/time based on the actual receipts; 6. Chemotherapy not exceeding 6 sessions per year: members pay 50 per cent of total cost but this should not exceed LAK5,000,000 per session; 7. Haemodialysis not exceeding 5 sessions or renal cleaning fee for patients not over LAK4,000,000.	- o Cardiovascular; - o High blood pressure; - o Diabetes; - o Hyperthyroidism; - o Hepatitis; - o Renal failure; - o Gout.

Source: Author based on information included in a 2018 MoU between LSSO and NHI.

► 4. Results

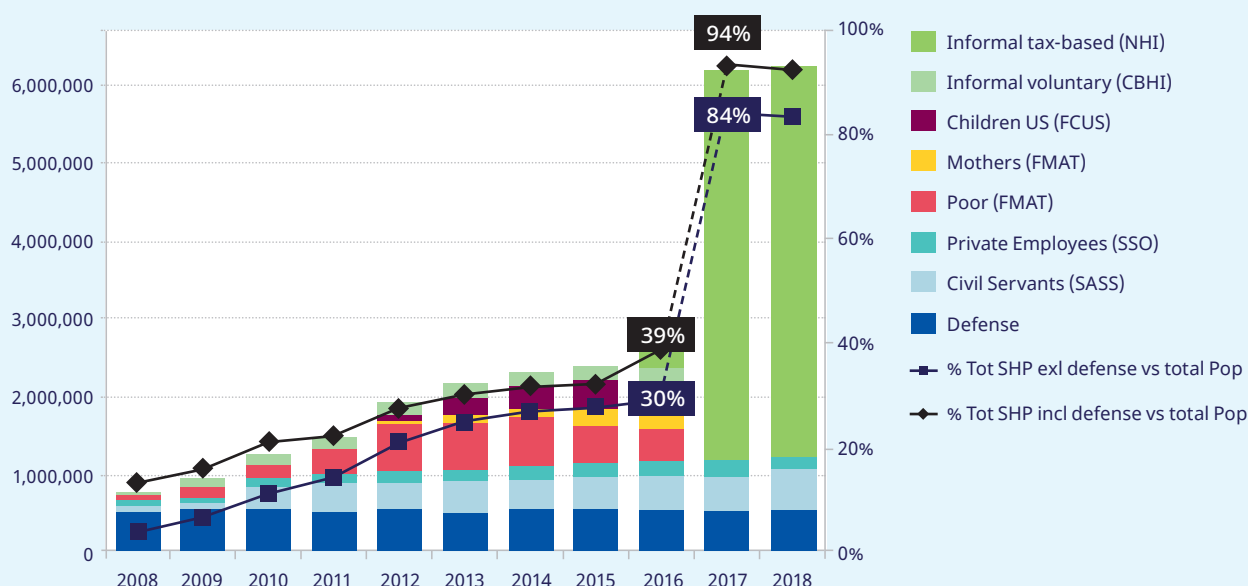
- Coverage

Owing to the introduction of public subsidies to finance the participation of poor households and workers in the informal economy in the

NHI scheme, social health protection coverage in the Lao People's Democratic Republic has increased remarkably, reaching 94.3 per cent of the population in 2020 (National Health Insurance Bureau 2020). The coverage rate has been maintained at this level since then.

In 2018, the NHI covered 75 per cent of the population through tax subsidies, while SASS,

► Figure 2. Social health protection coverage in Lao People's Democratic Republic, 2008-2018



Note: FCUS, FMAT, HEF, CBHI except VTC merged into NHI

Source: Adapted from Phetpasak (unpublished).

SSO and the scheme for police and military forces covered 7 per cent, 3 per cent and 8 per cent of the population, respectively. As previously noted, the unified NHI scheme has not been implemented in Vientiane Capital yet. The CBHI (the MOH's voluntary scheme for workers in the informal economy) and Free Maternal and Child Health (FMCH) programmes still exist in Vientiane Capital, covering around 2 per cent of the total population in 2019.

This high level of coverage has been achieved in just one year, from 2016 to 2017, during which time the population coverage expanded exponentially from 31 per cent to 91 per cent. The remarkable coverage expansion in the country has been facilitated by increased budget allocation to subsidize enrolment of informal workers and

the poor and vulnerable into social health protection schemes. However, challenges remain in maintaining this coverage rate. Inadequate and erratic budget allocation by the Ministry of Finance has been observed recently, posing a major threat to the financial sustainability of the NHI and transferring financial risk to health facilities. This may have significant implications for the continuation of contribution subsidization and level of protection provided to workers in the informal economy, as well as the poor and the vulnerable.

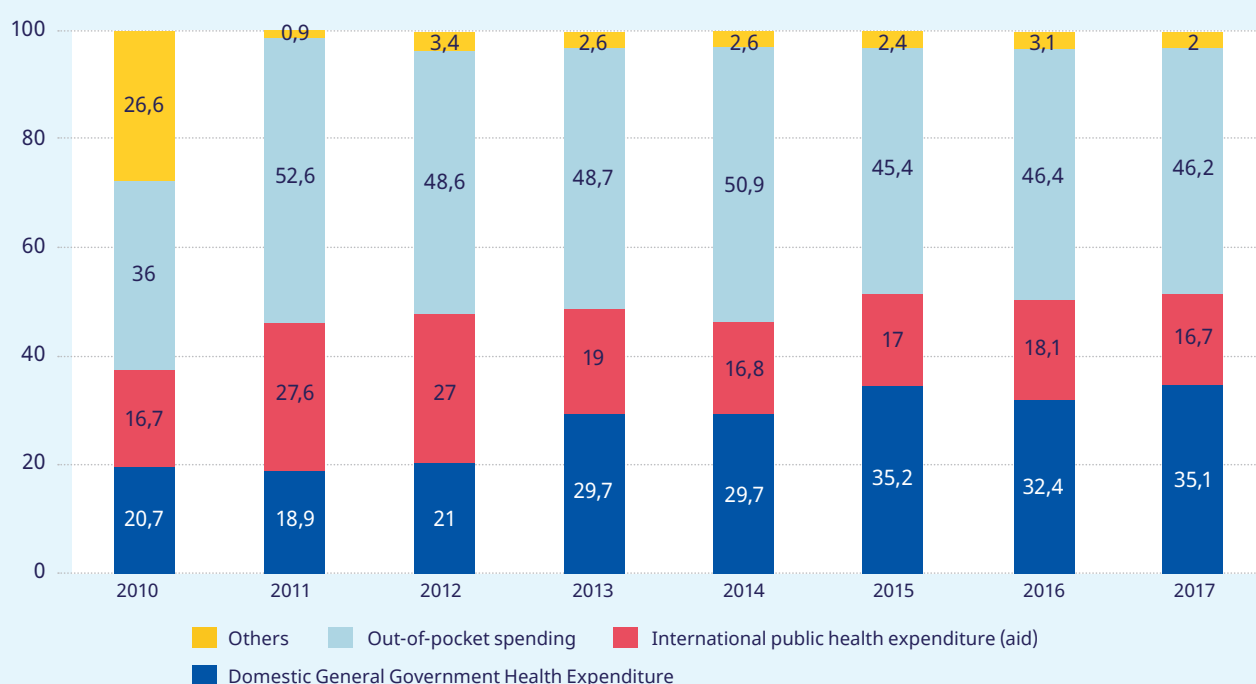
- Adequacy of benefits/financial protection

Despite the comprehensive benefits package and the low co-payment amount, the financial

protection capacity of the NHI remains limited, as reflected in the high rate of OOP payments in the country. Albeit on a downward trend, OOP expenditure as a proportion of total health expenditure is very high, at 46.2 per cent in 2017

(WHO n.d.). Informal direct payments remain significant at facility level, which limits financial protection for the NHI beneficiaries (ILO 2019).

► **Figure 3. Health expenditure structure in Lao People's Democratic Republic (as % of total health expenditure), 2010–2017**



Source: Adapted from WHO Global Health Expenditure Database.

- Responsiveness to population needs
 - o Availability and Accessibility

Even though the NHI benefits package is relatively generous in design, the provision of benefits is hindered by a lack of supply-side readiness (World Bank 2017). This is manifested in a lack of basic amenities and equipment, limited diagnostic capability and the absence of basic medicines at health centres and district hospitals, which include primary and secondary facilities (WHO 2018).

In 2017, the number of doctors and nurses, and midwives per 10,000 inhabitants in Lao People's Democratic Republic was 3.7 and 12.6, respectively. In the same year, health service

coverage index (SDG 3.8.1) reached 51 units (WHO n.d.), in which the indicator of service capacity and access was relatively low, at 35 units (WHO 2019b).

Although the country's network of health care facilities covers 93 per cent of the population within a 90-minute walking distance (Akkhavong et al. 2014), there remain financial and physical barriers to accessing health care for NHI members, especially among the poor and the vulnerable, and ethnic minority groups living in rural and remote areas. Significant inequalities in health care utilization and health outcomes persist across socioeconomic quintiles, ethnic groups and geographic locations (ILO 2019; Nagpal et al. 2019). For example, it has been

found that “distance to the nearest health care facility” and “ethnicity” are the most significant predictors of the immunization rate in the country (Mobasser et al. 2016).

o Acceptability and Quality

In general, quality of care remains a challenge with regard to health care delivery at public facilities, especially at primary and secondary levels (health care centres and district hospitals). The shortage of qualified health workers in primary and secondary health facilities, which is caused by a shortage and mal-distribution of health workers, contributes to worsening the quality of care at these two levels (World Bank 2017).

However, in terms of maternal care services, skilled birth attendance increased significantly, from 37.5 per cent in 2011 to 64.4 per cent in 2017 (Lao Statistics Bureau 2018), with an overall increase in utilization of maternal services of over the last 10 years. This has translated into significant improvements in health outcomes. Specifically, the maternal mortality ratio, measured as the number of deaths per 100,000 live births, plunged from 272 in 2011 to 185 in 2017 (WHO n.d.). In addition, the under-five mortality ratio decreased from 58.9 to 47.3 per 1,000 live births between 2013 and 2018 (WHO n.d.). Despite these positive trends, in general, utilization of health care services in the Lao People’s Democratic Republic remains relatively low. Specifically, utilization rates among NHI members for outpatient and inpatient care are only 53.9 per cent and 5.6 per cent, respectively (ILO 2019). Health care utilization among NSSF members is much higher than that of NHI members. According to the NSSF, utilization rates among NSSF members in 2017 were estimated at 97 per cent for outpatient care, 20 per cent for emergency care and 7 per cent for inpatient care.

► 5. Way forward

Despite the impressive pace of advancement towards UHC in the Lao People’s Democratic Republic, challenges remain. The MOH is developing a new NHI strategy for the period 2021–2026, in which enhancing financial sustainability and decreasing OOP payments are among the top priorities to maintain the coverage rate achieved so far and provide

better financial protection. Addressing the budget deficit requires a thorough fiscal space analysis and fiscal restructuring, which will require concerted government efforts and a strong political commitment. To enhance population coverage, the NHI Bureau plans to roll out the NHI scheme in Vientiane Capital and is considering various design options (within the constraints of the limited budget available). Capacity strengthening, particularly at provincial and district levels, and the modernization of the administration of the NHI scheme are also among top priorities. Among the administrative reforms needed, the MOH is considering the development of a fully functional Management Information System, operational nationwide and providing real time information, as an essential tool to strengthen the efficiency of administration and responsiveness to members’ needs.

► 6. Main lessons learned

- Voluntary contributory health insurance is neither an efficient nor a sustainable option for covering informal economy workers in low-and middle-income countries, especially in the context of widespread poverty and limited understanding of insurance.
- Substantial government funding is essential to fully or partially subsidize enrolment into social health protection schemes for workers in informal employment, as well as the poor and the vulnerable, providing almost “automatic” solutions to address population coverage gaps.
- To sustain the current policies and financing arrangements, it is essential to define domestic resources, taking into account the contributory capacities of different population groups., and the variety of means available to create fiscal space. Such methods may include (individually or in combination) effective enforcement of tax and contribution obligations, reprioritizing expenditure, or a broader and sufficiently progressive revenue base.

- A comprehensive benefit package with minimal co-payments is not sufficient to provide sound financial protection. Health care services must be accessible and of sufficient quality, with strict control over unofficial payments at the point of service. Without supply-side readiness, increasing NHI enrolment is not sufficient to guarantee effective and equitable access. Strengthening health care supply, especially at primary level, tackling the shortage and mal-distribution of qualified medical workers, and addressing social, economic and financial barriers to accessing health care are necessary, alongside a comprehensive NHI policy.
- Integrating multiple schemes to increase risk and financial pooling for better redistribution is achievable through strong political will and good inter-ministerial collaboration, with a common vision for universal social health protection.



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▶ Malaysia

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▶ 1. Introduction

Malaysia has achieved broad access to health services at all levels of care, and relatively effective financial protection against catastrophic health spending, especially for the poor, with a modest level of government expenditure on health. Improvements in utilization and health outcomes since the 1960s have been achieved over the years, with spending on health services ranging from 2.0 per cent to 4.0 per cent of GDP (WHO 2000). Between 1990–2020, life expectancy at birth increased significantly (Malaysia Department of Statistics 2020c; Yu, Whynes, and Sach 2008). Malaysia's child mortality rates are comparable to high-income countries, with under-five mortality reducing by over 75 per cent and infant mortality by 70 per cent from 1965–1990. Infant mortality fell a further 62 per cent from 1990–2005 (Jarrah 2018; Yu, Whynes, and Sach 2008). Today, a rising burden of non-communicable diseases (NCDs), alongside population ageing, are the leading causes of illness and disability in Malaysia, though communicable diseases such as tuberculosis and (to a lesser extent) HIV/AIDS, are among the leading causes of death (Noor, Muzafar, and Khalidi 2020).

The main provider of health services in Malaysia is the national health care service under the Ministry of Health (MOH), which provides universal coverage to the population. Services in public facilities are tax-financed and are either free or subject to a small regulated user fee. In addition to the national health care service, over the past three decades, the private provision of health services has expanded, and out-of-pocket (OOP) spending has subsequently increased. With a view to improve financial protection, especially for marginalized populations, the Malaysian Government launched two programmes to complement the national health care service. Firstly, the Medical Relief Fund is in place, which provides financial assistance to fully or partially cover the costs of medical equipment and certain consumables which are not part of the implicit benefit package in MOH facilities. Secondly, the PeKa B40 scheme is implemented, which focuses on supporting low-income groups with NCD-related health care. In addition, the Ministry of Finance launched the MySalam scheme, which provides sickness cash benefits in cases of hospitalization or critical illness for persons in the lowest income quintiles.

► 2. Context

Malaysia inherited its national health care service system from British colonial rule, with services predominantly provided in urban areas. Upon independence in 1957, health care services were expanded, especially for the poor and rural population, enabling Malaysia to achieve broad access to health services at all levels of care, and relatively effective financial protection against catastrophic health expenses for the poor. Since the 1980s, the Malaysian health system has transformed from a health system composed mostly of public facilities to one that also includes a large private sector, with the Government encouraging private investment and delegating health system activities such as drug distribution and hospital support services to private actors. To regulate the role of private providers in health service provision, Incremental policy changes were introduced,⁶² including fees (Quek 2014).

The Fees (Medical) Order of 1982 regulated user fees for patients in government health facilities. The private sector (medical clinics, dental clinics and hospitals) is regulated under the Private Health Care Facilities and Services Act 1998, but this legislation was not enforced until the promulgation of 2006 Regulations, and was further amended by the Private Healthcare Facilities and Services (Private Hospitals and other Private Health care Facilities) (Amendment) Order of 2013, which includes user fee levels in its scope (Jaafar et al. 2012). The Private Health Care Facilities and Services Act requires Managed Care Organizations (MCOs) to register and provide information to the MOH. MCOs manage private health insurance coverage, which accounts for a very small share of health expenditure.

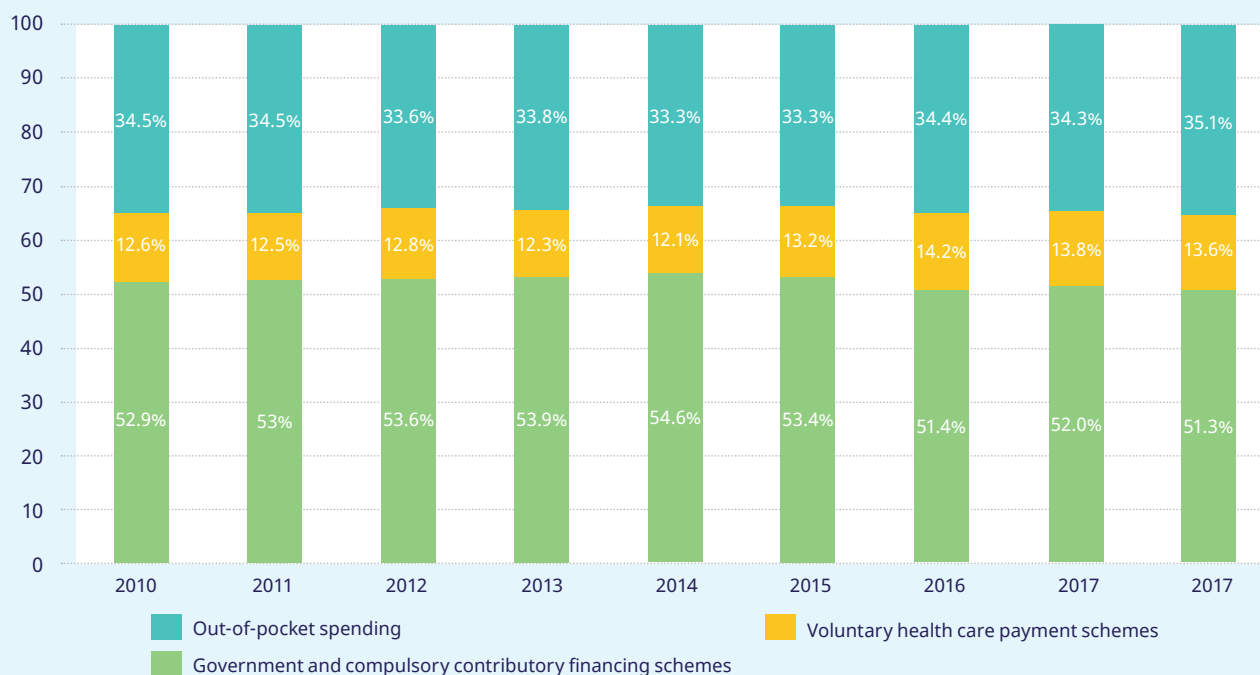
► 3. Design of the social health protection system

- Financing

Government health expenditure represented less than 2 per cent of GDP in 2018 (Croke et al. 2019; WHO n.d.). A significant proportion of health spending is funded through OOP payments (services at private facilities, as well as the small user fees charged at public facilities), private health insurance (representing around 7 per cent of current health expenditure), individual withdrawals from the Employee Provident Fund, and (in the case of occupational diseases and injuries) by the Social Security Organization (SOC SO) (Zainuddin et al. 2019). The share of income spent by households on health is relatively stable across wealth quintiles, with the highest proportion in the upper quintile.

⁶² Private Health Care Facilities and Services Act, 1998 and Regulations, 2006, amended by the Private Health care Facilities and Services (Private Hospitals and other Private Health care Facilities) (Amendment) Order of 2013.

► Figure 1. Health expenditure in Malaysia, 2010-2018



Source: Adapted from WHO Global Health Expenditure Database.

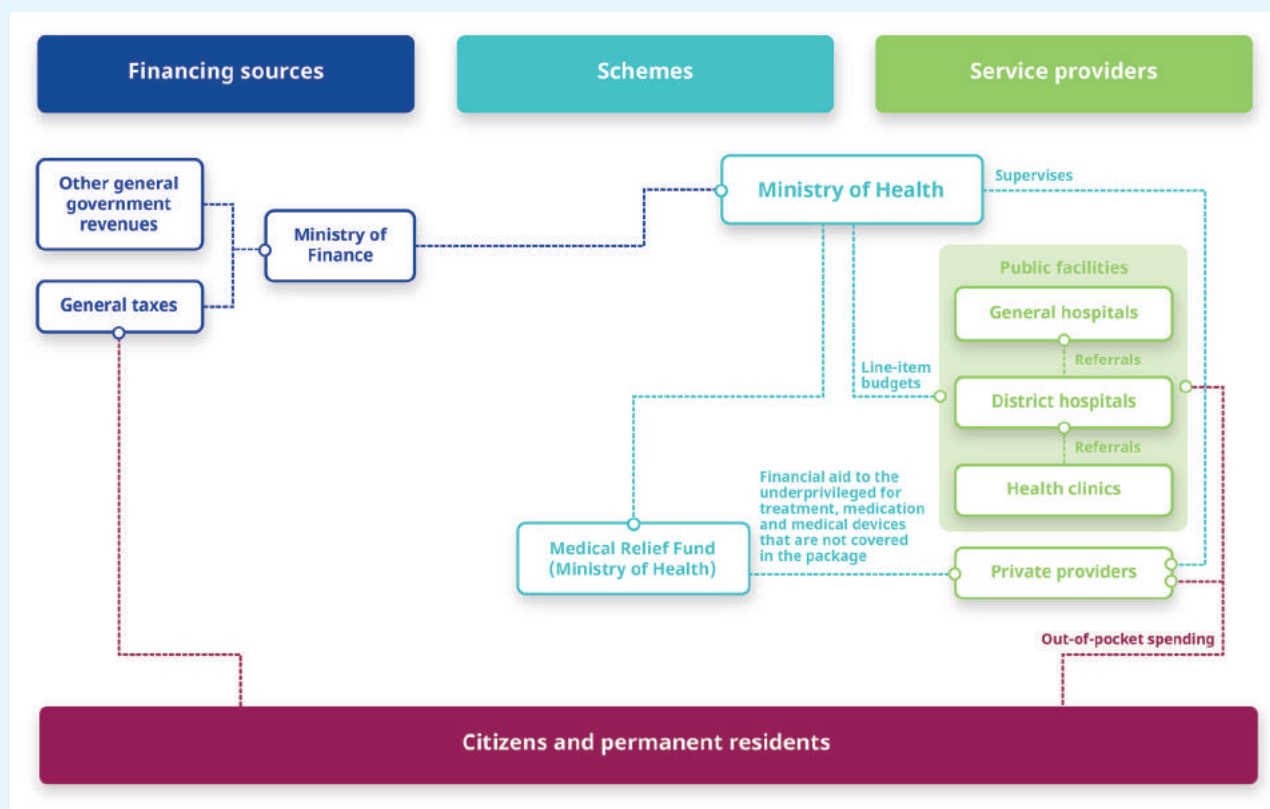
The national health care service and the Medical Relief Fund are financed by general taxes (direct and indirect) and non-tax revenues collected by the federal government and allocated to the MOH. The allocation of funds by the Treasury to the MOH is based on past spending combined with possible additional funds determined by estimated rises in the Consumer Price Index and projected needs by the MOH. The Treasury also provides additional funds for specific purposes, such as disease outbreaks (Jaafar et al. 2012). Total MOH revenue amounted to 745.8 million Malaysian Ringgit (MYR) in 2018, equivalent to US\$171.3 million (Malaysia Ministry of Health 2018). The much smaller PeKa B40 scheme, which focuses on NCD-related health care ⁶³ for low-income individuals is non-contributory and financed directly through the general government budget.

provided in private facilities are primarily financed via OOP payments, corporate arrangements and, to a lesser extent, private health insurance. Voluntary prepayment arrangements represented 13.6 per cent of current health expenditure in 2018 and this share has slightly increased over the past decade. Expenditure from such schemes is mostly geared towards private hospital costs.

Figure 2 below provides an overview of the main financial flows of the system. Health care services

⁶³ The scheme focuses on 4 specific benefits:
 1. Health screening
 2. Health aid (assistance for purchase of selected medical equipment)
 3. Cash incentives for completing cancer treatment
 4. Transport incentives

► Figure 2. Overview of main financial flows of the social health protection system in Malaysia



Notes for figure 2:

1. Care at private providers is primarily paid through OOP expenses, although some private insurance schemes exist. In addition, the second account of the EPF can be withdrawn for specific health expenses.
2. Medical care related to occupational diseases and injuries is managed by SOCSO.
3. The recently introduced MySalam programme offers cash sickness benefits to the B40 category in case of hospitalization or critical disease. MySalam is a form of insurance based on Islamic laws known as "takaful".⁶⁴

Source: Authors.

- Governance

The MOH is the primary funder, provider and regulator of health services, and provides most of the country's health services (70.6 per cent of all admissions in 2016) (Malaysia Ministry of Health 2017). The national health service is organized at three levels: federal, state and district (Jarrah 2018). Policy-making, regulation and planning functions are centralized at the MOH. Health is primarily the responsibility of the federal Government, although state governments also

play a role, especially in public health, through state health departments and district health offices (Atun et al. 2016). State health departments are organized in the same way as the central MOH's structure for each of the technical programmes. State and district hospitals are managed by state health departments. District health offices manage district-level public health, oversee regulatory, management and pharmacy functions, provide collective health services, and are responsible for critical service delivery units, including health centres and mobile clinics. The

⁶⁴ MySalam is non-contributory. The initial seed funding of MYR2 billion (US\$459 million) for the mySalam trust fund was provided by Great Eastern Holdings Limited. The Government plans to increase the size of the trust fund over time with additional contributions from Great Eastern Holdings, other insurance companies and other financing sources (mySalam 2020).

MOH attempts to involve community groups in promoting population health, and community leaders are also appointed to advisory panels and/or boards of health clinics and hospitals (Jaafar et al. 2012).

PeKa B40 is administered by ProtectHealth Corporation, a not-for-profit entity established under the MOH. The MySalam scheme is operated by a takaful operator officially licensed under the Islamic Financial Service Act 2013. This is currently the Great Eastern Takaful Berhad, although other takaful operators may be appointed to administer the scheme in the future (mySalam 2020).

The Malaysian Social Protection Council (MySPC) is in place to address coordination between social protection schemes with representation from MOH, EPF and SOCSO. The SOCSO Board also provides an informal platform to facilitate coordination with the broader social protection system, since it includes representatives from different ministries including the MOH and other stakeholders, including employer and insured persons representatives (Social Security Organization 2021).⁶⁵

- Legal coverage and eligibility

The entire population is eligible to access the national health care service. Malaysian citizenship or permanent residency is required to benefit from the subsidized system. Non-nationals who are not permanent residents, among whom include migrant workers on temporary work permits, can access public health services, but they do not benefit from financial protection and need to pay higher user fees for services (Ng 2019).⁶⁶ A subset of the migrant population is required by law to enrol into the Foreign Workers Hospitalization and Surgical Insurance scheme.

The MOH Medical Relief Fund (Tabung Bantuan Perubatan), which provides full or partial financial assistance to cover costs of medical treatments and drugs that are not available in government health facilities, determines eligibility on a case-by-case basis. The PeKa B40 and MySalam schemes both target the low-income population registered in the Bantuan Sara Hidup (BSH) programme, recently renamed Bantuan Prihatin Rakyat — a social assistance programme established by the Government in

2019. Eligibility for the BSH is performed through income tax data. The BSH register provides a platform to offer a coordinated set of social protection benefits (both health-related and income support) to the lower end of the wealth quintiles in Malaysia. The centralized registry is used by several social assistance programmes with a view to boost redistribution and reduce poverty and inequality. The PeKa B40 scheme is open for all BSH-registered individuals above 40 years of age, who must additionally undergo a health screening. Citizens of at least 40 years of age, and below the 40th percentile for household income in the country, as well as their spouses, are covered under the scheme. The MySalam scheme is more restrictive: BSH-registered individuals are eligible from the age of 18 if married, or 40 up to the age of 65, if single.

- Benefits

The national health care service system offers comprehensive services ranging from preventive and primary health care to tertiary hospital care (Jaafar et al. 2012). Preventive services offered include health screening for adult men and women, mental health screening for adult men and women, cervical cancer screening through pap smears, early detection of breast cancer through clinical breast examination and mammogram screening for women at high risk (Atun et al. 2016). Maternal health services include prenatal, antenatal and postnatal care (Malaysia Federal Government 2020). Long-term care is not covered, but the Government promotes an inter-sectoral and community-based approach to help the elderly living at home.

The Medical Relief Fund covers costs of drugs that are not supplied by government hospitals but registered with the National Bureau of pharmaceuticals, and costs of purchasing medical and rehabilitation equipment that is not provided by government hospitals (Malaysia Ministry of Health 2020a; Mybenefitsnews 2018).

PeKa B40, which focuses on NCDs, has a set benefit package including health screening, subsidized medical devices, and travel allowance. In addition, those receiving cancer treatment are provided with a cash incentive of MYR1,000 (US\$250) upon completion of their treatment

⁶⁵ Employees' Social Security Act 1969, act 4, available at: <https://www.ilo.org/dyn/travail/docs/1626/Employees%27%20Social%20Security%20Act%201969%20-%20www.agc.gov.my.pdf>

⁶⁶ For example, while Malaysian citizens are charged MYR1.00 (US\$0.25) for outpatient care at a health clinic, non-citizens are charged MYR40.00 (US\$10) for the same service.

at MOH hospitals (Malaysia Ministry of Health 2020b).

MySalam provides cash support to cover indirect patient costs associated with hospitalization, offering a one-time MYR8,000 (US\$1,850) payment upon diagnosis of one of 45 critical illnesses, as well as MYR50 (US\$11.50) for daily hospitalization costs for up to a maximum of MYR700 (US\$161) a year. This scheme was created because of the absence of a social protection scheme for sickness benefits in Malaysia, where only employer liability to cover paid sick leave for formal workers is in place.

- Provision of benefits and services

National health services are predominantly provided in public facilities. For devices, drugs and consumables that are not offered at subsidized prices by the network of public facilities under the implicit benefit package, patients can make a request to the Medical Relief Fund on a case-by-case basis. In 2018, the public health system consisted of 1,000 health clinics, 1,791 community clinics and 90 maternal and child health clinics. Malaysia also has a range of mobile clinics and provides services to 109 areas in the interior of Sarawak through the Flying Doctor Service. Private providers are mostly excluded from the network of providers under the national health care service system, except under the Medical Relief Fund in exceptional circumstances as mentioned above. The MOH engages in some contracting with the private sector to reduce waiting times in public facilities and to provide services not available in MOH facilities. Public health facilities and providers are paid through line-item budgets (Jarrah 2018). The MOH also purchases limited volumes of outsourced, mostly non-medical support services (Jaafar et al. 2012).

There are small co-payments for services provided in public facilities regulated by law, with exemptions for specific health care services in ante and postnatal care for mothers, outpatient treatment for infants, and inpatient care for persons suffering from certain infectious diseases, the registered poor, persons with disabilities and the elderly (Ng 2015). Malaysian citizens and permanent residents pay MYR1.00 (US\$0.30) for a general outpatient consultation and MYR5.00 (US\$1.50) for a specialist consultation. In comparison, non-citizens without permanent residency status pay user fees of MYR40.00 (US\$9.50) for a general outpatient

consultation and MYR60.00 (US\$18.00) for specialist consultations.

PeKa B40 covers services at most government health facilities and at any private clinic that is registered with PeKa B40. All health clinics under MOH are automatically enrolled in the scheme. Around two thirds of registered clinics and laboratories performing screening services are private (Bernama 2020). Should further treatment or examination be required, private doctors will issue a PeKa B40 referral letter for a relevant government health facility (Ministry of Health 2020b). Under the programme, private providers are paid on a pre-negotiated fee-for-service basis while public providers are paid through a benefit-in-kind mechanism, due to public financial management rules which do not allow public facilities to retain funding.

► 4. Results

- Coverage

The population of Malaysia enjoys universal legal coverage through its subsidized public health care system, with three social assistance programmes in place to provide supplementary financial support to targeted population groups. However, gaps and challenges remain in relation to access and equitability, which limits effective coverage. Notably, the exclusion of those without Malaysian citizenship or permanent residency from the subsidized health system may prevent meaningful coverage of this group, who make up a large share of the population. In 2019, 9.7 per cent of Malaysia's population were classified as non-citizens and in 2017 the majority of non-nationals were migrant workers without permanent residency (World Bank 2020; Malaysia Department of Statistics 2020b). Although a migrant-specific requirement is in place for employers to provide basic private accident insurance coverage for hospitalization and surgery at public hospitals, user fees for outpatient visits, charged at the higher non-citizen rate, are not covered.

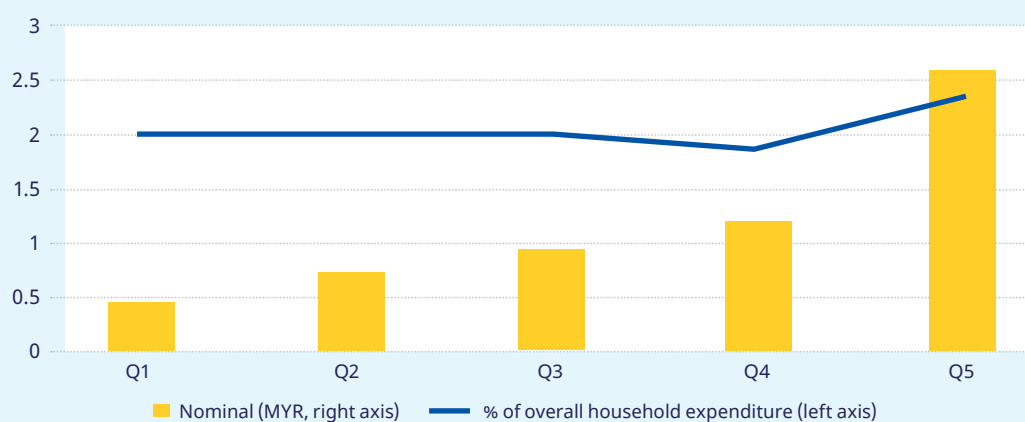
Furthermore, in relation to the PeKa B40 and MySalam schemes, there is some anecdotal evidence that the BSH register, which is used as an eligibility check for these and other social assistance schemes, may be subject to some

inclusion and exclusion errors, potentially resulting in coverage gaps among those eligible for support. This is due to the system's reliance on income tax data, which can often be incomplete or incorrect. Notably, in 2020, several Members of Parliament were surprised to have been sent cash handouts under the BSH scheme, with some returning their checks due to the fact that their income should place them above the means threshold (Arumugam 2020). As a result, many workers in the informal economy and their families, constituting the "missing middle", benefit only minimally from the existing social protection system. Although the BSH scheme has a wide scope, potentially covering up to 40 per cent of the population (in relation to the broader social protection system), the limited depth of the coverage offered has resulted in only a modest effect on overall inequality (World Bank 2018).

- Adequacy of benefits/financial protection

Incidences of catastrophic expenditure and impoverishment due to health care spending are relatively low (Atun et al. 2016). Although OOP spending is higher than in most high-income countries, it tends to be concentrated in Malaysia's richest households and is progressive in that its share of household budget increases with income. The poorest 60 per cent of the population account for only 20 per cent of OOP spending, while the richest 20 per cent account for 59 per cent of OOP spending (Rannan-Eliya et al. 2016). This pattern correlates with the growth of privately provided health services, which fall outside of the scope of the national health care service.

► **Figure 3. Monthly household expenditure on health (by wealth quintiles, 2019)**



Source: Adapted from Malaysia Department of Statistics (2020a, 101).

Notably, public facilities cannot refuse services to people who cannot pay (Jaafar et al. 2012). As outlined above, for devices, drugs and consumables that are not offered at subsidized price by the network of public facilities under the implicit benefit package, patients can make a request to the Medical Relief Fund on a case-by-case basis, or receive financial assistance from the PeKa B40. Through the Medical Relief Fund, MOH disbursed MYR469.8 million (US\$107.9 million), equivalent to about 1.8 per cent of government health spending, in financial support to 54,288 eligible patients receiving treatment at the National Heart Institute, in addition to other

forms of financial assistance, such as subsidies for haemodialysis or NGO support (Malaysia Ministry of Health 2018). In addition, MySalam offers income replacement in case of sickness. These three schemes can be viewed as attempts to adapt financial protection to the changing burden of disease. Such protection will be especially important for patients suffering from long-term, chronic or non-communicable diseases.

However, there remains some evidence that not all patients are provided with sufficient financial protection from health care costs. A study from 2017 found that the mean annual OOP spending

for ischemic heart disease in Malaysia was MYR3,045 (US\$761). About 16 per cent of affected patients suffered from catastrophic health spending,⁶⁷ 29.2 per cent were unable to pay for medical bills, 25 per cent accessed savings to cope with spending on basic items, 16.5 per cent reduced their monthly food consumption, 12.5 per cent were unable to pay utility bills, and 9.0 per cent borrowed money to finance spending on basic items (Sukeri, Mirzaei, and Jan 2017). Similarly, a 2014 study found that the societal cost of treating tuberculosis was US\$916.4 per patient, of which 79.4 per cent constituted patient costs for transportation, time away from work and so on (Atif et al. 2014). At the same time, broader coverage of patient costs associated with long-term treatments may introduce pressures on the overall health system's affordability. For example, a 2019 study found that the costs of hypoglycaemia for type II diabetes patients constitute 0.5 per cent of the total MOH budget (Aljunid et al. 2019).

On the whole, financial protection for health expenditures related to long-term care in Malaysia is limited, which is particularly concerning given currently restrictive eligibility criteria for the broader social assistance programme, EPF, which is in place to provide income security for the elderly. There are particular concerns that EPF savings, intended to help Malaysians who worked in the private sector through old age, may not be sufficient.⁶⁸ A study in 2016 found that only 22 per cent of the 54-year old active EPF contributors had MYR196,800 or more in their savings (corresponding to MYR820, or US\$200 a month at current life expectancies) (Aiman 2019). This is a challenge that is likely to become increasingly prevalent within an ageing society, and it is not a gender-neutral issue, given that women live longer and also tend to have fewer opportunities to contribute to the pension system during active age.

As previously highlighted, the higher fees applied by the national health service providers for non-nationals who do not have permanent residency can be prohibitive for marginalized non-citizens seeking health care, such as low-skilled migrant workers and refugees. Accordingly, studies looking at the affordability of health care for migrants in Malaysia have found shortcomings in the financial protection offered to them. Notably,

some migrants reported that their employers may initially pay for clinic visits, but that the costs are later deducted from their salaries (Loganathan et al. 2019).

- Responsiveness to population needs
 - o Availability and accessibility

The higher co-payment fees required of migrants constitutes a significant barrier of access for non-citizens. Furthermore, as Malaysia does not officially recognize refugee status and requires citizens to report the presence of undocumented foreigners to the police, refugees face exceptional challenges in accessing health care (Malaysiakini 2020). There are also persistent inequities in access to health care and health outcomes related to ethnicity and socioeconomic status. For example, while overall health outcomes have been improving in Malaysia, the life expectancy of Chinese Malaysian males has consistently been several years higher than for Bumiputera Malaysian males since the 1980s. Meanwhile, life expectancy for ethnic Indian Malaysian males is two years lower than for Bumiputera Malaysian males, and, although the size of this gap has reduced over time, it has persisted since the 1980s (Atun et al. 2016).

In terms of utilization of health services among the population as a whole, the number of inpatient visits per capita per year decreased from 0.03 in 2000 to 0.02 in 2016, and the number of outpatient visits per capita per year decreased from 7.24 in 2000 to 5.01 in 2016 (IHME n.d.). In 2016, 29.4 per cent of all admissions were at private hospitals (Malaysia Ministry of Health 2017). This dual system of public and private service providers with a largely regressive financing stream for the private share of provided services poses a threat to equity in access; in turn this may decrease the buy-in of the upper-middle class to the tax-financed national health care service in the long run, to the benefit of privately-run and financed systems.

In terms of geographical availability of services, health facilities in Malaysia tend to be accessible, with the distribution of rural health services in Malaysia based on the size, need and population of the various districts and states (Ahmad 2019). However, in practice, there are significant inequities in the deployment of health facilities

⁶⁷ OOP spending exceeding 40 per cent of household non-food expenditures.

⁶⁸ Public sector employees have the option to contribute to the EPF, but before 1991 they had a separate pension system.

and health workers in rural, mountainous, and remote regions and there remain inequities in access. Specifically, 92 per cent of the urban population live within three kilometers of a health facility, compared with only 69 per cent of the rural population (Quek 2014). Furthermore, not all health facilities in rural areas are manned with adequately trained staff. They are usually managed by a rural health nurse, with sporadic visits (ranging from weekly to monthly) visits from a medical assistant or a doctor (Quek 2014). However, Malaysia's network of mobile health services and the Flying Doctor Service attempts to address inequities in access by delivering services in remote and hard-to-reach areas (Malaysia Ministry of Health 2018).

- o Quality and acceptability

Practically all births (99.4 per cent) were attended by skilled health staff in 2015 (World Bank n.d.). As such, Malaysia's experience in reducing maternal mortality has been used to provide lessons to other developing countries, with researchers noting that the removal of financial barriers was a crucial step in achieving such reductions (Pathmanathan et al. 2003). This is reflected in the country's disease burden, with maternal and neonatal disorders falling from the third leading cause of premature deaths in 1990 to ninth place in 2017 (Noor, Muzafar, and Khalidi 2020).

In terms of patient feedback on quality of care and services, Malaysia does not have an independent complaints procedure available to the public such as an ombudsman (Jaafar et al. 2012). However, the National Health and Morbidity Survey (Malaysia Ministry of Health 2018) measures patient satisfaction, and indicates high levels of satisfaction with both public and private health services. Aspects of the system that people are less satisfied with include process-related quality (such as waiting times, availability of a private room or choice of doctor) in the public sector, and the cost of services in the private sector (Atun et al. 2016). Furthermore, shortages of some types of specialists at public facilities may result in long waiting times (Jaafar et al. 2012), and limited opening hours are also a source of dissatisfaction (Atun et al. 2016).

As per the Private Health Care Facilities and Services Act of 1998, private facilities are part of the national quality assurance programme (Yu, Whynes, and Sach 2008). The network of is composed of both for-profit and non-profit institutions, the former of which are ultra-modern

facilities where client satisfaction is driven by the demands of a rising upper-middle class (Aliman and Mohamad 2016). Such facilities are attractive to employers and cater for the highest wealth quintiles who can afford high user fees or private health insurance premiums. As noted above, this has implications for equity in access. While price discrimination is practiced by some non-profit health providers, it is challenging to implement this in practice given the increasing competition from for-profit providers (Barracough 1997; Yu, Whynes, and Sach 2008).

► 5. Way forward

Particular challenges for the future of Malaysia's social health protection system concern its adaptation to an ageing society, with an expected rise in the burden of NCDs and demand for long-term care services, for which the current national health care service remains poorly equipped. Furthermore, issues of access to income security in old age are likely to increase barriers of access to health care for older persons, as financial protection is already identified as an important determinant of care seeking behavior (Yunis et al. 2017). In addition, the dual system of service provision coupled with increases in income inequality may lead to more individuals opting to pay out-of-pocket for care at private facilities, which risks drawing staff and knowledge away from the national health care service towards better-paying private facilities. To make recommendations to the Government for a more robust social protection framework more broadly, Malaysia's Employee Provident Fund (EPF) has been working with the SOCSO under the Ministry of Human Resources to revive the National Social Well-being Blueprint (KWSP 2018).

The COVID-19 pandemic is a stark reminder of the interlinkages between individual and societal health. The historic approach of the Malaysian public health system, in which care for citizens and specific diseases is prioritized, may be less suitable under increasing public demand for social health protection, and changing perceptions of the issue. Broadening health care access to the migrant population, which has grown both in nominal and relative terms in the last decade (Malaysia Department of Statistics 2020b), will likely become increasingly crucial to preventing

the import and spread of communicable diseases in the country.

► 6. Main lessons learned

- The Malaysian health care system, comprised of a subsidized national health service directly providing care with small regulated user fees to the population, has led to broad access to health care services for the population.
- The majority of maternal health services are exempt from user fees and are provided at no cost to patients. This is identified as an important factor in Malaysia's success with regard to maternal and child health outcomes. Indeed, over 99 per cent of all births are attended by skilled health staff, and Malaysia's child mortality rates are comparable to high-income countries.
- With the expansion of the private health sector in the 1990s, OOP spending rose, which prompted the Government to explore solutions to improve financial protection. Nonetheless, the dual system poses a threat to equity. For example, higher-income individuals may prefer private facilities over the national health care system, increasing the competition for skilled medical staff.
- Recently-developed social health protection schemes focused on low-income groups have contributed to reasonable levels of equity in health care use and spending, although a focus on official tax records for income classification may exclude a proportion of the vulnerable population.
- Not all patients are provided with sufficient financial protection from health care costs. A focus on providing social protection exclusively to citizens means that non-citizens who are not permanent residents are faced with higher user fees for most health services, and many of them rely on private insurance schemes.
- Rising life expectancy and increasing household incomes are driving the need for publicly-funded NCD care, long-term care services and income security for older women and men.



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► Mongolia

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► 1. Introduction

A middle-income country with a population of just over 3 million, Mongolia has experienced significant economic growth since its transition to a market-oriented economy in 1990, with the country's GDP more than tripling since 1991. This growth has been accompanied by substantial improvements in the provision of public health care services. Specifically, the right to "health protection and to obtain medical financial protection provided. These challenges are particularly acute in remote regions and among the most vulnerable, including nomadic households who comprise around one quarter of the Mongolian population (Higara, Uochi, and Doyle 2020). In particular, herders, who make up 19.5 per cent the population and account for three in five of the rural poor depend solely on their livestock for income (Higara, Uochi, and Doyle 2020; National Statistical Office 2018). This places them at high risk of slipping into poverty due to catastrophic health expenditures. To address these challenges, the Government is pursuing Universal Health Coverage (UHC) as a national priority, as reflected in both the State Policy on Health (2017–2026) and the Long-Term Strategy for the Development of Health Insurance (2013–2022).

► 2. Context

Prior to Mongolia's economic transition to a market economy in 1990, the country's health system was based on the Semashko model, characterized by a centralized publicly owned health system, which provided free essential health services to the population (Sheiman, Shishkin, and Shevsky 2018). However, the system's effective functioning stalled towards the 1990s with the withdrawal of Soviet Union funding. To address this, the Government introduced user fees for accessing health care, which contributed to decreased health service utilization and caused negative fluctuations in health indicators throughout the 1990s. In response, the Government began to decentralize the health care system, with increased emphasis on primary care (Asian Development Bank 2008). To generate additional resources for the health sector, a compulsory SHI scheme was introduced in 1994, precipitating a transition from a fully-integrated model to a contracting model with a purchaser-provider split. At the time, the Government fully subsidized insurance contributions for low income and vulnerable population groups, but in the late 1990s, these subsidies were reduced to limit scheme's reliance

on governmental funding (Bayarsaikhan, Kwon, and Chimeddagva 2016).

Following initial shocks to the health care system resulting from economic transition, in 2005, the Government adopted the landmark Health Sector Strategic Master Plan 2005–2015. The plan encompassed a commitment to “improve the health status of all the people of Mongolia, especially mothers and children, through implementing a sector wide approach and providing responsive and equitable pro-poor, client-centered and quality services” (Mongolia Ministry of Population Development and Social Protection 2013). As a result, Mongolia’s Health financing landscape began to benefit from increased public funding, promoting the development of a more equitable and pro-poor health system.

In 2006, co-payments for primary health services were abolished, and the Government took sole responsibility for financing PHC in line with amendments to the Health Insurance Law. These services were removed from the SHI package, and became part of a range of cost-free services. Today, tax funded PHC services and SHI scheme are the two central mechanisms for providing social health protection (SHP) to the Mongolian population. The dual structure of the health protection mechanism is derived from the broader structure of the social security system in Mongolia, which comprises both contributory social insurance schemes and a social welfare scheme financed from government revenues.

► 3. Design of the social health protection system

- Financing

PHC services are provided to the entire population on a non-contributory basis and are fully funded by the government general revenue. Financing of SHI on the other hand comprises a combination of government

subsidies, co-payments and salary contributions of affiliated employees and employers. In line with resolutions issued by the Health Insurance General Agency (HIGA),⁶⁹ contributing employers and employees each pay 2 per cent of the concerned employee’s monthly salary, with the Government contributing as the employer for state employees. Contributions are also required from self-employed and unemployed persons, students, foreigners, and other categories of the population at a rate of at least 1 per cent of the average minimum wage. In 2011, the Government re-introduced SHI subsidies for vulnerable groups (Asian Development Bank 2013). According to HIGA resolutions, these categories include: children under the age of 18, pensioners, low-income citizens, parents caring for a child who is younger than 2 years of age (or 3 years of age in the case of twins), military personnel, and prisoners. Nomadic populations in Mongolia no longer benefit from these subsidies. It was estimated that in 2014, subsidized population categories accounted for about 60 per cent of all insured persons (Bayarsaikhan, Kwon, and Chimeddagva 2016).

It is the responsibility of employers in the formal sector to pay and transfer SHI contributions (along with other social insurance contributions) from their employees’ monthly salaries to the State Social Security General Office (SSIGO). SSIGO performs the collection function, and is then split into different social insurance funds, implemented through the Health Insurance General Agency (HIGA) in the case of Health Insurance. For self-employed persons, the frequency of payments may vary and for workers in the informal economy, such as nomads, payments are made on a quarterly or yearly basis based on their seasonal income and the nature of their employment, in line with individual payment agreements made at HIGA branch offices.

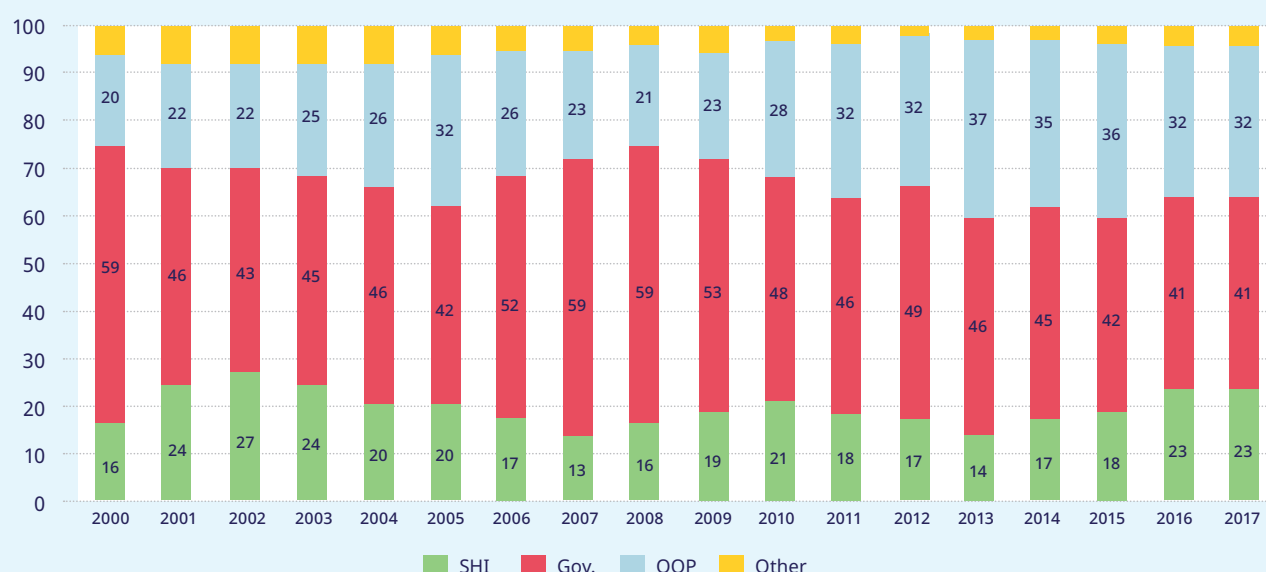
Overall, financial resources dedicated to health care have remained at around 4 per cent of GDP during the majority of the past decade. The Government has consistently committed between 6 to 8 per cent of its total spending to the health system since 2010, and government health expenditure per capita grew steadily from 2000 to 2012, reaching US\$102.3 per capita.

⁶⁹ HIGA issued a number of resolutions related to financing of SHI following legal amendments introduced in 2020. The series of resolutions, together with other HIGA resolutions from 2019–2021, can be found (in Mongolian) on the official HIGA website, available at: <http://www.emd.gov.mn/%d1%8d%d1%80%d1%85-%d0%b7%d2%af%d0%b9%d0%bd-%d0%b0%d0%ba%d1%82/eronhii-gazriin-dargiin-tushaal/>

However, between 2012 and 2017, this figure declined by 9.8 per cent (WHO n.d. a). Notably, the share of state funding allocated to PHC has decreased from nearly 25 per cent of the total government health expenditure in 2005 to under

16 per cent in 2016 (WHO 2017). Today, the main sources of funds for the health system include government funds, SHI revenues, and direct out-of-pocket (OOP) payments.

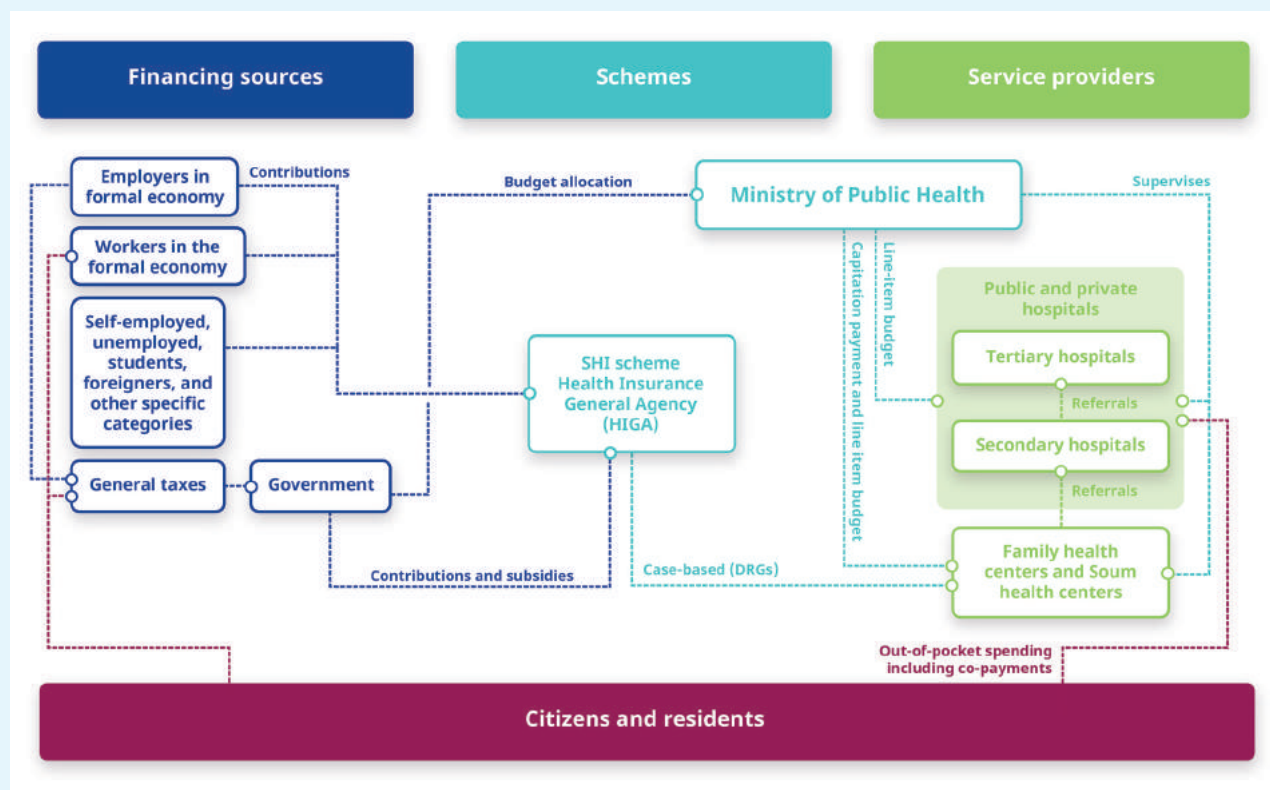
► **Figure 1. Evolution of the share of the different financing sources in the composition of the current health expenditure**



Source: Adapted from WHO Global Health Expenditure Database.

Since 2008, a decline in the government share of Current Health Expenditure is apparent, compensated for by an increase of OOP expenditures and pooled resources under the SHI scheme. As a result, Mongolia has a considerably high level of OOP health expenditure, which currently exceeds the average in the East Asia and Pacific region by nearly 23 per cent, although it remains lower than the average among lower-middle income countries globally. Figure 2 below indicates the funding flows for the health protection system.

► Figure 2. Overview of main financial flows of the social health protection system in Mongolia



Source: Authors.

- Governance

The social health protection (SHP) system in Mongolia is based on a well-established legal framework. The provision of PHC is mandated by the Law on Health of 2011, which defines the types of medical care to be financed from the government budget through article 24.6; and the Law on Medical Care and Services of 2016, which outlines expenses for these services. The Ministry of Health (MOH) is tasked with developing national-level policies and guidelines and overseeing implementation by provincial ("Aimag") and capital city health departments and facilities (WHO 2017). Article 11.2.3 of the Law on Health empowers local level governors "to organize the involvement of business entities, organizations, and citizens in public activities in the field of protection and promotion of health". In addition, it gives the power to citizen representatives at Aimag, district (Soum), and lower levels to "ensure joint participation of governmental and

non-governmental organizations and citizens in measures to protect and promote the health of the population of the territory under their jurisdiction and coordinate their activities" (Article 10.1.4).

The SHI scheme is implemented under the governance of the Law on Health Insurance of 1994 and its subsequent amendments. The law defines the principles and scope of the health insurance policy, while also regulating interactions between the state, service providers, and citizens. SHI is centrally regulated, with the MOH functioning as the standard-setting agency, under which the government implementing agency, HIGA, is responsible for managing the scheme. HIGA is supervised by the National Health Insurance Council (NHIC) — a tripartite body that reports to the Parliament of Mongolia and is in charge of regulating payment methods, collecting contributions, defining contract guidelines and cost-sharing rules, and managing the Health

Insurance Fund (IRIM and Conseil Santé 2018). HIGA selects, signs purchasing contracts and pays public and private service providers, which helps to ensure a purchaser-provider split (IRIM and Conseil Santé 2018).

- Legal coverage and eligibility

By law, all citizens are entitled to free PHC services. The State Policy on Health stipulates universality and non-discrimination as integral components of its guiding principles by specifically stating that health care services should be provided in an “equitable and inclusive manner regardless of the citizen’s health status, type of disease, place of residence, age, gender, education, sexual orientation, origin, language and cultural difference”.⁷⁰

SHI is an inclusive scheme that aims to cover all of the Mongolian population. According to articles 4.2–4.3 of the Law on Health Insurance of 1994, SHI coverage is mandatory for all citizens and stateless persons whether they are employed in the formal or informal sector, unemployed or self-employed. For foreigners, enrolment to the scheme is voluntary.

- Benefits

Tax-funded primary health services are defined based on a positive list under the Law on Medical Care and Services 2016 (article 17). These services are available to all citizens seeking care at Family Health Centres (FHCs), which are based in urban areas, and Soum Health Centres (SHCs) which are concentrated in rural areas. Available services include public health services; emergency medical care and ambulance services; obstetric and maternal care and health care during disasters and communicable disease outbreaks. PHC services available in rural areas tend to be slightly broader than in urban areas, as they need to accommodate for health care needs in areas where no secondary and tertiary health facilities are available. In general, the package corresponds to PHC as defined under the Alma-Ata Declaration of 1978, including immunization (WHO 2017). The cost of medicines is fully borne by patients,⁷¹ unless they are covered by SHI.

The SHI benefit package complements tax funded PCH services. Services available to insured persons are the same for all members, regardless of the contribution amount paid. General categories of secondary and tertiary services covered by the SHI scheme are defined positively in accordance with the Law on Health Insurance (Article 9.1) and include the following:

- Inpatient services;
- Outpatient/ambulatory services, follow up, diagnostics and treatment;
- Palliative care for cancer and other illnesses;
- Traditional care, rehabilitative and sanatorium services;
- Some high-cost medical services and required medical tools;
- Pharmaceuticals (included in the essential drug list approved by the NHIC) prescribed by medical doctors at FHCs, SHCs, Aimag and district clinics, and other medicines available and subsidized prices;
- Certain kinds of artificial tubes, prosthetics and orthopaedic implants for rehabilitative care;
- Some rehabilitative, home and day care services provided by FHCs, SHCs and village health centres, and diagnostic tests;
- Day care for cancer chemotherapy and radiotherapy;
- Treatment of associated diseases preceding the 37th week of pregnancy and post-natal period;
- Prevention, early detection and routine diagnostic tests defined by the NHIC.

According to HIGA resolutions issued in 2020,⁷² the ceiling on the benefit amount that an insured person can receive under SHI is set at around 2,000,000 Mongolian tögrög (MNT) per year, which is equivalent to around US\$710. However, individuals may transfer their own benefit to another family member (Bayarsaikhan, Kwon, and Chimeddagva 2016).

⁷⁰ Resolution of the Government of Mongolia, 2017 (No. 24).

⁷¹ Except for “drugs for diseases that require lengthy treatment and palliative care” and “drugs for children with disabilities under 16 years of age”, in which case costs will be paid by the Government (article 24.6).

⁷² Available (in Mongolian) at: <http://www.emd.gov.mn/%d1%8d%d1%80%d1%85-%d0%b7%d2%af%d0%b9%d0%bd-%d0%b0%d0%ba%d1%82/eronhii-gazriin-dargiin-tushaal/>

- Provision of benefits and services

As noted above, PHC in urban areas is provided by FHCs — private organizations fully funded by the Government budget (Dorjdagva et al. 2017), and in rural areas, PHC is delivered at SHCs, which are owned by local governments (Audibert, Guillon, and Mathonnat 2018). No co-payments are required to access PHC services. FHCs and SHCs are intended to perform a gate-keeping role by referring patients to secondary and tertiary facilities, which include both public and private facilities, though the latter predominate.⁷³ Secondary and tertiary health care providers in Mongolia are concentrated at district and city levels, comprising district health centres, general hospitals, city-level specialised centres, aimag general hospitals, regional treatment centres, specialized centres, and state hospitals (IRIM and Conseil Santé 2018). To access secondary and tertiary care services and apply for SHI benefits, individuals typically have to be referred by primary health care practitioners though self-referrals, meaning that high rates of inappropriate admissions within hospitals at this level are commonplace (Jigjidsuren et al. 2019). Upon accessing SHI benefits, affiliated patients are required to make co-payments that are charged at a flat rate of 10–15 per cent depending on the level of the facility at which the services are provided (Dorjdagva et al. 2016). Insured persons are provided with magnetic insurance cards (Bayarsaikhan, Kwon, and Chimeddagva 2016).

Line-item budgets, case-based hospital payments and fee-for-service for direct payments are the three types of payment methods currently being used in Mongolia. This mix of payment systems applies with large variation at each level of the health care system, including at the individual provider level. At least 50 per cent of all revenue for the majority of public providers is allocated through a line-item budget payment system, although this system represents only 12 per cent of total revenue for some tertiary providers. On average, DRG payments represent around 30 per cent of revenues received by both public and private hospitals, and fee-for-service comprises a fairly minimal share of total revenue for all public providers, usually accounting for less than 5 per cent to a maximum of 10 per cent of revenue for a single provider. At PHC level, FHCs receive 100 per cent of their revenue

through such payments, SHCs are paid through a mix of mechanisms, while SHI resorts to case-based payment using Diagnosis Related Groups (DRGs) (Joint Learning Network et al. 2015). The Health Insurance Fund acts as third party payer and reimburses pharmacies for discounted sales of essential medicines to insured persons when prescribed by SHC and FHC physicians (WHO 2017).

► 4. Results

- Coverage

Because all citizens are entitled to free PHC by law, legal coverage stands at around 99 per cent of the population, excluding international migrants (UN 2019). In 2014, a total of 218 FHCs provided PHC services for approximately two million individuals in urban areas (Dorjdagva et al. 2017), and currently, there are over 330 SHCs providing services for their areas of operation in rural areas (Jigjidsuren et al. 2019). Coverage for secondary and tertiary care provided through the SHI scheme is lower. Directly after its introduction in 1994, the scheme achieved a high affiliation rate. However, after subsidies were reduced in the late 1990s, the affiliation rate substantially declined (Bayarsaikhan, Kwon, and Chimeddagva 2016), which was further compounded by increasingly prevalent rural to urban migration. This trend led to an increase in the number of poor and unregistered people in cities facing challenges in accessing in health care due to a lack of civil residential status. SHI membership peaked again from 2011–2014, reaching over 90 per cent after the government launched mass enrolment campaigns (Bayarsaikhan, Kwon, and Chimeddagva 2016). Unfortunately, the government has struggled to maintain this progress in subsequent years. Based on the latest data available from 2016, SHI coverage in Mongolia stands at around 76 per cent (IRIM and Conseil Santé 2018). This decline can be attributed in part to challenges in maintaining adequate coverage among the self-employed, unemployed persons and remote and disadvantaged populations, due to dropouts, insufficient administrative support, and internal migration. Very low population density further

⁷³ Based on data from 2014, there were 869 public and private providers contracted through SHI – 100 public and 769 private (Bayarsaikhan, Kwon, and Chimeddagva 2016).

complicates the coverage of herders who live in remote rural areas of the country (Dorjdagva et al. 2017).

- Adequacy of benefits

The provision of tax funded PHC and the expansion of SHI have significantly improved the financial protection of the population against catastrophic and impoverishing health expenditures. Nonetheless, there are limits to which the existing system is able to shield its users from financial risks. Although no co-payments are required when accessing primary health services, the cost of medicines is fully borne by patients unless they are covered by the SHI, which can result in a high degree of financial vulnerability. Even when subsidized through SHI, the price of medication can be prohibitive for many population groups. Moreover, the practice of self-medication is quite prevalent in Mongolia (IRIM and Conseil Santé 2018), which means that people often seek to purchase drugs from pharmacies without prescriptions, thus forgoing the benefit of subsidised prices and incurring greater health care costs. Estimates from 2011 indicate that pharmaceuticals represented 94 per cent of OOP payments among the very poor in Mongolia (Tsilajav et al. 2017).

Comprising 32 per cent of total national health expenditures in 2017, OOP payments pose a significant challenge, with estimates suggesting that approximately 20,000 people in Mongolia are forced into poverty due to health care expenditures (Dorjdagva et al. 2016). In addition to pharmaceutical costs, Mongolia's relatively high OOP expenditure rate can be attributed to co-payments for accessing tertiary and secondary health services under SHI. Because co-payment rates are flat for all population groups (between 10–15 per cent), including vulnerable populations, this creates inequalities in access and negatively impacts health care utilization; it has also been noted that the contribution rate of 1 per cent of the average minimum wage for the self-employed is likely too high for many categories among this group (IRIM and Conseil Santé 2018).

- Responsiveness to population needs

- o Availability and accessibility

The introduction of state-funded PHC has yielded some positive results in improving access to health among the poor and the vulnerable in

Mongolia. Studies show that low-income groups are much more likely to use PHC, regardless of their health care needs, while higher income groups access secondary and tertiary health care more frequently (Dorjdagva et al. 2016). In particular, in urban areas, FHCs often serve as the major (and often the only accessible) health care provider for low income households (Dorjdagva et al. 2017). However, in the case of SHCs in rural regions, some patients have to travel long distances (50 kilometres and more) in order to access PHC services. Because secondary and tertiary health care providers in Mongolia are concentrated primarily at district and city levels, this compounds limited service availability for many rural population groups, which leads to indirect financial costs, resulting from transportation and accommodation expenses, and time spent on travel. It is worth noting that a large share of the rural population in Mongolia are herders, who move every season and settle for prolonged periods in remote areas where no infrastructure is available.

Mongolia has a comparatively high density of hospital beds, which is greater than the average among the lower-middle income countries, as well as the global average (WHO n.d. b). However, geographical distribution is uneven. Notably, a study from 2017 study calculated that the mean number of hospital beds per 1,000 km in rural regions was over 61 times less than the mean in suburban regions and nearly 304 times less than in Mongolia's capital (Erdenee et al. 2017). Even in areas where health infrastructure is plentiful, the civil registration requirement for individuals to benefit from state welfare benefits and health insurance prevents many unregistered individuals in urban areas from receiving essential health services (Asian Development Bank 2008; Gan-Yadam et al. 2013; Lhamsuren et al. 2012). Unregistered populations can constitute up to 20 per cent of city or district populations, which is driven by high levels of internal migration and complex registration procedures (Asian Development Bank 2008; Lhamsuren et al. 2012). These barriers, combined with the aforementioned requirement of co-payments to access tertiary and secondary care, result in inequality in service utilization which can lead to greater financial losses for vulnerable groups at a later stage (Dorjdagva et al. 2017).

- o Quality and acceptability

Although the quality and scope of health services provided by the health care system has

improved in recent decades (WHO 2017), PHC facilities in Mongolia face significant shortages of equipment and medicines, and have limited diagnostic capacity (Jigjidsuren et al. 2019). The capacity of FHCs in particular do not meet the demands of the increasing number of patients in these facilities, due to rising levels of rural-to-urban migration over the last decade. This intensifies pressure on FHC health care personnel, who tend to cater for over 2 times more patients than SHC personnel (WHO 2017). Secondary and tertiary level hospitals and clinics also experience shortages of equipment and medicines (Jigjidsuren et al. 2019), though there is currently little reliable information on the quality of the health services provided by the private sector (Bayarsaikhan, Kwon, and Chimeddagva 2016; IRIM and Conseil Santé 2018).

Overall, Mongolia has a comparatively large number of health workers. Latest WHO estimates indicate that there are nearly 2.9 physicians per 1,000 patients, which is greater than the average among lower-middle income countries (Higara, Uochi, and Doyle 2020). However, the number of nurses is quite low (Jigjidsuren et al. 2019). In rural regions in particular, SHC facilities face a weaker supply of qualified specialized medical personnel. These deficiencies stem primarily from insufficient PHC financing. In 2017, primary health facilities used over two thirds of their funding for salaries and operating costs, while only a small proportion remained for improving actual quality of care and services (IRIM and Conseil Santé 2018).

As such, public perceptions of the quality of primary care are generally negative, which has been cited as a major contributing factor to a high prevalence of self-medication and self-referrals within district and tertiary level hospitals in Mongolia (IRIM and Conseil Santé 2018; Jigjidsuren et al. 2019). This is a significant challenge, as it results in higher health care costs and increased OOP spending due to the fact that self-referred patients cannot benefit from SHI protection (Dorjdagva et al. 2016). There is also evidence that perceptions of the quality of tertiary level services are also relatively low. One survey conducted between 2014 and 2015 in three tertiary level state hospitals in Ulaanbaatar found the overall satisfaction with health services among patients to be just over 60 per cent (Batbaatar et al. 2016).

The MOH mandates client satisfaction surveys to be conducted on an annual basis, in line with Decree No.135 (4 May 2006) of the Minister of Health on the Approval of the Code of Ethics for Medical Staff and the Charter of Ethics committee, which emphasises respect for patient rights in health services. However, it has been found that the results of such surveys are inadequately used for substantive actions (WHO 2017). A 2018 technical report prepared by the Independent Research Institute of Mongolia and Conseil Santé concluded that, overall, the services provided in the health sector were “not client-friendly” in terms of the providers’ attitudes and health-setting environments (IRIM and Conseil Santé 2018). Notably, one study observed a negative association between FHC visits and disability status (Dorjdagva et al. 2017).

► 5. Way forward

Despite vast improvements to Mongolia’s SHP system over the years, the aforementioned challenges impede progress towards sustainable, equitable and efficient health protection. In light of the impacts of the COVID-19 pandemic, ensuring equitable access to adequate quality health care has never been more important. To accelerate progress in this area, the State Policy on Health (2017–2026), adopted through the Resolution of the Government of Mongolia No. 24 of 2017, stipulates a commitment to improving availability, accessibility and quality of services, by setting a range of defined targets to be achieved by 2026. These targets include: a reduction of the share of OOP payments to 25 per cent of the total health expenditure; an increase of the share of health sector financing to 5 per cent of GDP; and an increase of the average life expectancy in Mongolia to 74 years.

In order to achieve these targets, health financing, health sector management, organization and transparency, as well as new technologies for information management have been identified as key priority areas to address (IRIM and Conseil Santé 2018). If fully implemented, this approach should help decrease the disparities between SHI financing sources. The digitization of health information and improvement of the relevant registries

could also help reduce the mis-targeting of government subsidies, which has previously been identified as a pressing challenge (Asian Development Bank 2013). The World Bank and the Government of Mongolia have already started working on establishing health information platforms throughout the country to facilitate the management and monitoring of health systems, in particular through the implementation of the E-Health Project 2015–2020 (World Bank and Mongolia Ministry of Health 2019). A broader effort to create integrated information platforms to easily and securely store, transfer, and combine individual civil and health data could yield a wide range of benefits to both patients and service providers.

In terms of governance, continuing decentralization efforts hold promise towards improving the system's resilience, as the delegation of power to local authorities may enable a more efficient use of resources (WHO 2018). These efforts may be reinforced by steps towards improving the participation of different stakeholders in the design of health policies and plans. For example, the Law on Development Policy and Planning has introduced a multi-stakeholder process for policy-making, which has the potential to create more opportunities for Mongolian society to better influence health care provision in accordance to its needs. More broadly, the ratification of the ILO Convention No. 102 on medical care, sickness, and maternity could be an important step towards improving the existing social health protection system, as it would help to harmonize national laws and practices with existing international standards and guidelines, thereby improving the system's performance.

To enhance coverage and sustainability of the SHI scheme, activities prescribed by the Long-Term Strategy for the Development of Health Insurance 2013–2022, if fully implemented, have the potential to stimulate necessary improvements. These include mobilizing additional resources for SHI funding; improving the government subsidy targeting mechanism; improving the efficiency and quality of the health services offered; and conducting continuous social marketing activities in order to increase understanding and knowledge of health insurance among the population. With regard to PHC specifically, the Government is currently making efforts to address the physical constraints related to accessing SHCs by

introducing mobile health units. For example, two trains have been equipped to serve as "mobile hospitals" providing basic diagnostics and preventive care (Batchimeg 2019).

► 6. Main lessons learned

- The case of the Mongolian SHP system illustrates a successful combination of tax funded primary health care and coverage provided through SHI. The mix of financing mechanisms ensures continuity of coverage, and hence continuum of care, throughout the health system. The financial participation of the population through contributions makes SHP more affordable to the government, which can allocate its limited financial resources to provide quality primary health care and support the most vulnerable.
- In Mongolia, the fluctuation of policies on SHI contribution subsidies, including the introduction, removal and then reintroduction of subsidies, has impacted enrolment rates and in turn financial protection. This illustrates the crucial need for consistency in social health protection policies and continuity in government financial allocation in the form of SHI contribution subsidies to enable coverage of groups of the population with low contributory capacity.

Mongolia is facing a triple challenge: not only is it the most sparsely populated country in the world, but the country has a large nomadic population spread over large areas. This makes the provision of public services expensive, and complicates the ability to reach out to populations in need. With only 40 per cent of Mongolian herders participating in the health insurance scheme (National Statistical Office 2018), specific strategies are needed. The government is endeavouring to adjust the health protection system to cover these groups through the provision of subsidies for low-income earners, and by enhancing the flexibility of contribution mechanisms in terms of timing and frequency of payments.

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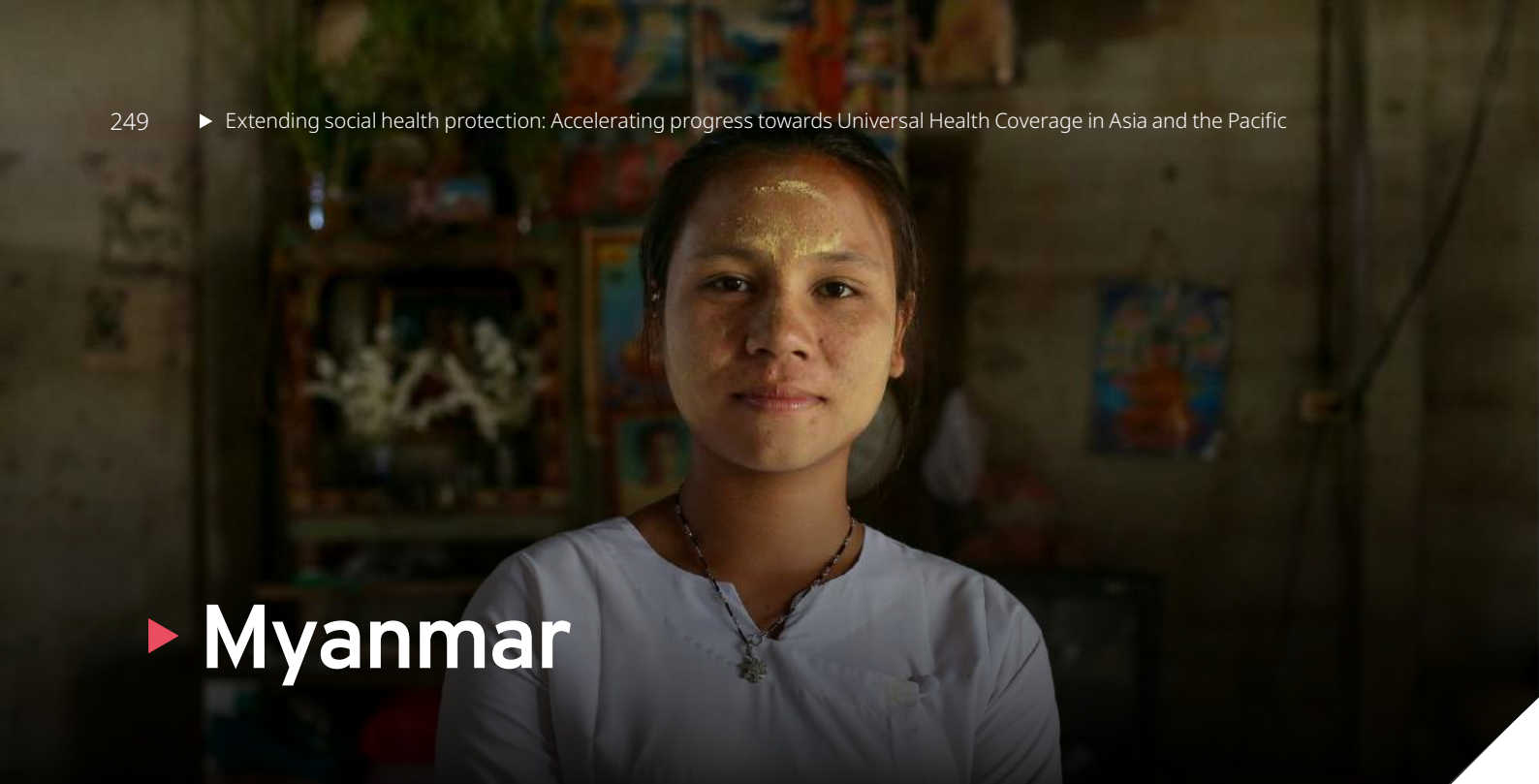
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► Myanmar

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(Written before the military coup of 1 February 2021).

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► 1. Introduction

As a country in transition, Myanmar has been striving to improve its development outcomes and overcome a past characterized by authoritarian rule. The country's overarching development framework is laid out in the Myanmar Sustainable Development Plan 2018–2030 (Myanmar Ministry of Planning and Finance 2018), in which social protection has been outlined as a priority. One of the country's social development strategies is to “expand an adaptive and systems-based social safety net and extend social protection services throughout the life cycle” (Myanmar Ministry of Planning and Finance 2018, p45). The health sector policy framework is outlined in the National Health Plan (NHP) 2017–2021 (Myanmar Ministry of Health and Sports 2016), which aims to strengthen the country's health system and move towards Universal Health Coverage (UHC) by 2030 through the implementation of pro-poor health protection policies. In addition to the provision of a range of tax financed public health services to the population, social health protection in Myanmar is delivered through the Social Security Board (SSB) which administers the

National Health and Social Care insurance scheme and provides insurance and income security to contributing workers.

Efforts to strengthen Myanmar's social health protection system are ongoing, and tangible progress has been made over the years. Alongside steady increases in health spending, life expectancy rose from an average of 56 in the year 1990, to 66 in 2016. Moreover, in line with regional trends, the country has experienced notable declines in maternal and child mortality rates and a marked decrease in the prevalence of malaria, tuberculosis, HIV/AIDS and other communicable diseases. However, with out-of-pocket (OOP) health expenditure in Myanmar among the highest in the region, significant challenges remain. To sustain and accelerate momentum in the context of emerging health challenges, enhanced investment in social health protection and the health system as a whole is needed.

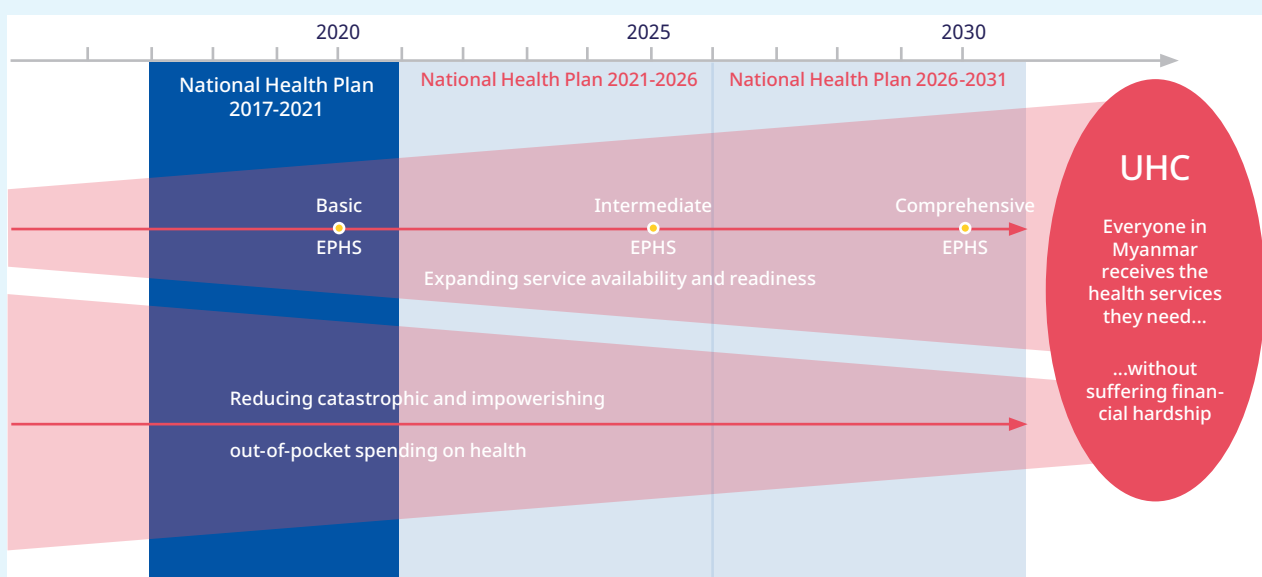
► 2. Context

The health system in Myanmar has evolved in accordance with political regime changes. Following the independence of Myanmar in 1948, the country followed a publicly financed services model, wherein government taxation and international assistance were major sources of health financing. Health care services were then nationalized and expanded to rural areas under the one-party ruling of the Burma Socialist Programme Party, in power from 1962–1988 (Sein et al. 2014). During this time, primary health care was implemented and set as a priority. However, health care during this period remained under-resourced and mismanaged (Sein et al. 2014). Due to a lack of government investment in the health sector in the late 1980s and mid-1990s under the military Government of Burma (otherwise known as the State Peace and Development Council), from 1988–2011, there were major health financing reforms which encouraged households to assume greater responsibility for their own health care. Fee-for-service hospital rooms and wards were introduced in all government hospitals, and user fees were charged for selected

medicines and services. These mid-1990s reforms resulted in a significant increase in the proportion of OOP financing for health care.

Today, Myanmar's social health protection system builds from two existing mechanisms: (i) the tax-funded health care system meant to be free for all (non-contributory) and; (ii) the contributory social health insurance scheme managed by the Social Security Board (SSB). The SSB Health and Social Care scheme (hereafter the SSB scheme) is the only social health insurance scheme in the country. In line with the National Health Plan 2017–2021, the Government envisions providing a Basic Essential Package of Health Services (EPHS) to the entire population, while increasing financial protection. The Basic EPHS emphasizes the critical role of primary health care and the delivery of essential services and interventions at township level and below. The National Health Plan envisages a stepwise approach, progressively expanding service availability and readiness until a comprehensive EPHS is attained. The goal is to reduce catastrophic and impoverishing OOP spending on health, and to achieve UHC by 2030.

► Figure 1. National Health Plan strategy



Source: Adapted from Myanmar Ministry of Health and Sports (2016).

► 3. Design of the social health protection system

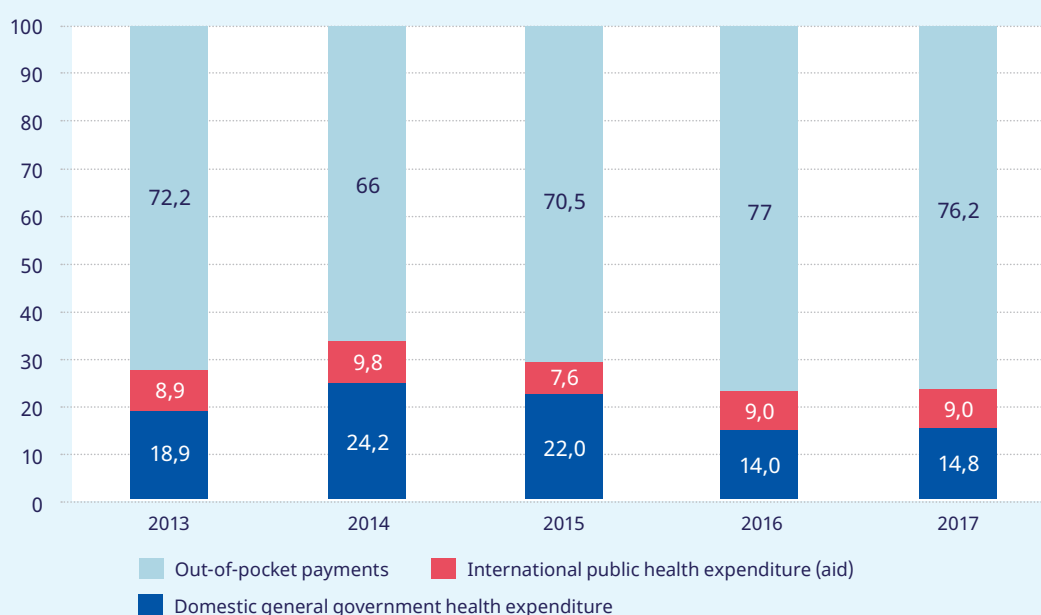
- Financing

Since Myanmar's transition to a civilian government in 2011, investments in the health sector have increased (Han et al. 2018). Budget allocation for health grew from less than 3 per cent during 2011–2012 to 8 per cent in 2015 (Myanmar Ministry of Health and Sports 2019). However, investment in health in Myanmar remains low compared to other countries of the same income level. Myanmar's total health expenditure was 3.6 trillion kyat in 2015, equal to 70,100 kyat or US\$54 per capita, which is less than

half of the US\$136 average among lower middle-income countries (Myanmar Ministry of Health and Sports 2019). Current health expenditure in 2018 accounted for just under 5.0 per cent of GDP (World Bank n.d.). Despite increased investments in health care, Myanmar's health system is still under-funded.

Due to limited government funding for health as well as limited health insurance coverage, OOP payments remain the dominant source of health financing in Myanmar. OOP spending by households accounted for 76.2 per cent of health expenditure in 2017. In 2015, 14.4 per cent of households incurred catastrophic spending (at the threshold of health spending totalling more than 10 per cent of total household consumption) (WHO n.d.). Figure 2 below illustrates the share of health care financing sources that comprised the total health expenditure for the period 2013–2017.

► Figure 2. Health financing sources as a percentage of total health expenditure from 2013–2017



Source: Adapted from WHO Global Health Expenditure Database.

In 2017, tax revenue accounted for around 21 per cent of total health expenditure, while the SSB health insurance scheme only accounted for 0.42 per cent. The main revenue source of the SSB takes the form of contributions paid by registered employees and their employers. The health contribution rate to the SSB is 4 per cent,

which is split as follows: 2 per cent of the salary from the worker and 2 per cent from the employer (if the insured person is less than 60 years old at the time of registration). If the insured is 60 years of age or older, the rate is 2.5 per cent each from the worker and the employer.⁷⁴ The employer also contributes an additional 1 per cent

⁷⁴ In accordance with The Myanmar Ministry of Labour, Employment and Social Security Social Security Rules of 2014, available at: <https://www.mol.gov.mm/en/wp-content/uploads/2016/10/The-Social-Security-Rules-E.pdf>

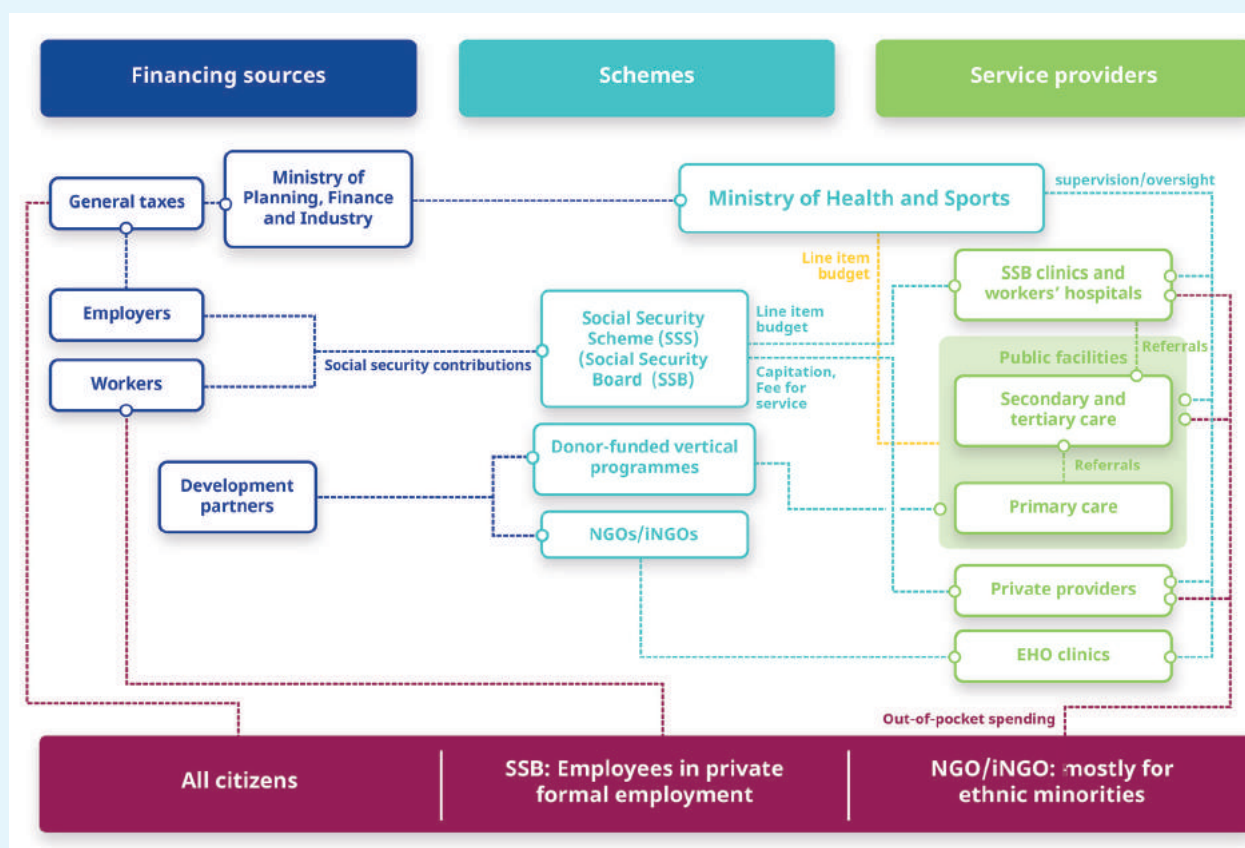
of the worker's salary to the employment injury insurance scheme. A worker's salary is defined as consisting of: (i) basic salary or basic wages; (ii) subsistence allowance; (iii) overtime wages; and (iv) other monthly additional payments paid to the worker by the employer. Cash benefits such as sickness benefits, maternity benefits, temporary disability benefits, permanent disability benefits and unemployment benefits are not counted as insurable salary. Contributions to the SSB are collected through a payroll deduction, and the employer is responsible for deducting the employee contribution from payroll and remitting it to the SSB.

Several vertical funding pools are distributed through different ministries and agencies, with most pooled funds sourced from tax revenues and managed by the Ministry of Health and Sports (MOHS) (Teo and Cain 2018). Pooled funds for health in Myanmar (both the SSB health fund and other tax funded and donor funded pools) are small and fragmented, which limits the

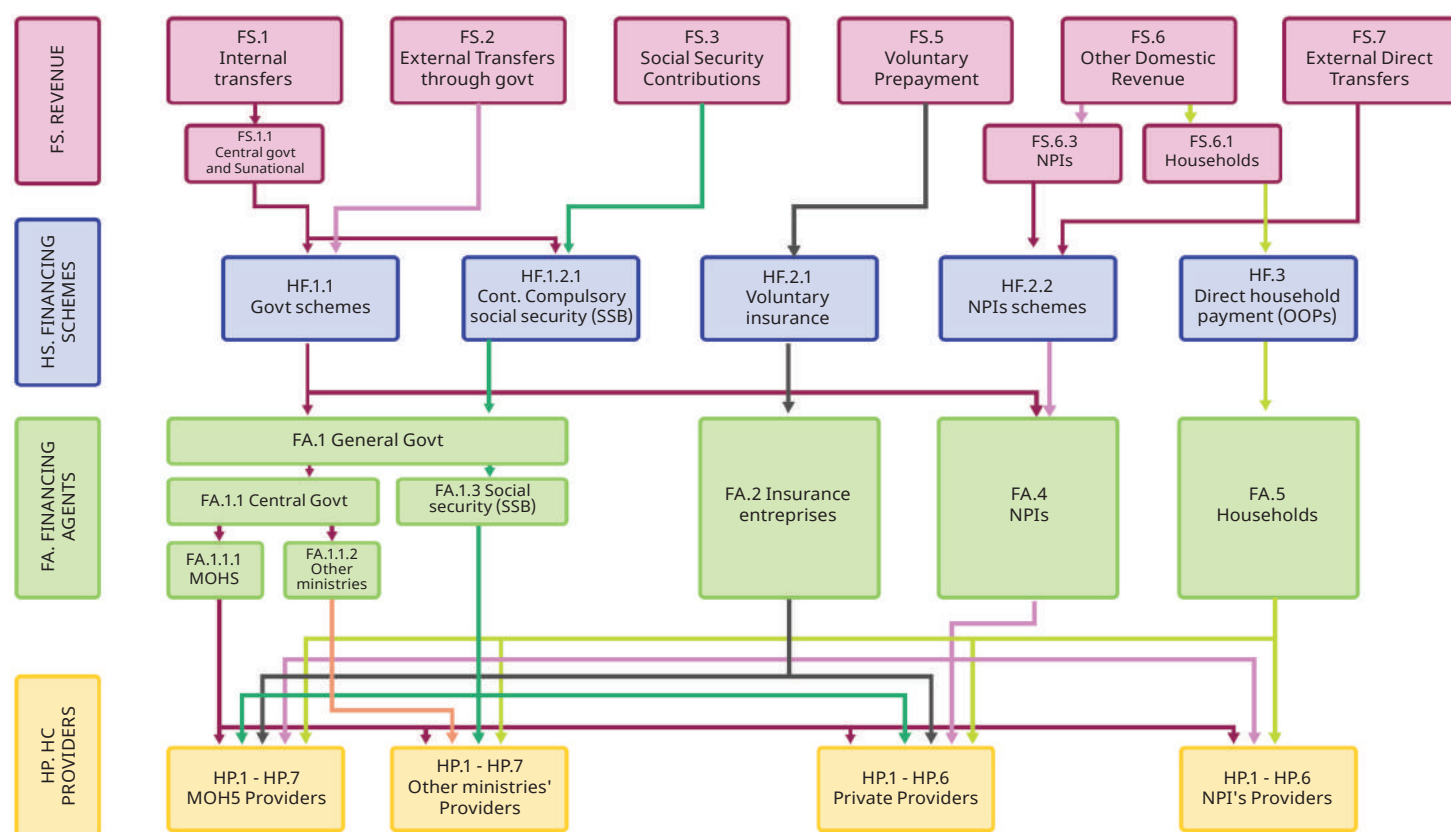
redistributive capacity of the health financing system. Currently, multiple financing agents, including the MOHS, other related ministries, the SSB and NGOs (including Ethnic Health Organizations), purchase health services on behalf of different sub-populations in Myanmar. The same service provider could therefore be receiving multiple sources of revenue from different programmes (for example, maternal and reproductive health programmes, nutrition programmes and so forth). This fragmentation negatively affects the efficiency of the system, which is already facing financial constraints. The prepaid or pooled share of total health spending in Myanmar in 2014 was 23 per cent, compared to an average of 76 per cent in low and middle-countries in East Asia.

Figure 3 summarises the financing flows of the social health protection system in Myanmar.

► Figure 3. Overview of main financial flows of the social health protection system in Myanmar



► Figure 4. Financing flows in Myanmar Health Accounts 2016–2018



Source: Adapted from Myanmar Ministry of Health and Sports (2020, 3).

The MOHS finances public facilities through budget line-items for redistribution among different sub-line-items (Myanmar Ministry of Health and Sports 2019). The budget lines are generally rigid, and although funding passes through regions, states and townships, sub-national entities have no authority to reallocate the funds. Public finance arrangements for budget allocation to the health sector lead to inequities and inefficiencies in resource utilization and in health service delivery (Teo and Cain 2018). Insufficient resources to provide free health care, including funding, equipment, commodities and staff, limit the ability of providers to deliver free services of sufficient quality. In addition to low levels of government financing, budget execution is poor, including under-spending, over-spending and poor budget accuracy. This is symptomatic of broader challenges in the public financial management system, which in turn affects health service delivery (Teo and Cain 2018).

Addressing these issues by extending access to an essential package of health services to the entire population while increasing financial protection is the main goal of the National Health Plan 2017–2021. In late 2019, the Strategic Directions for Financing UHC in Myanmar (Myanmar Ministry of Health and Sports 2019) outlined how resources will be mobilized to finance progress towards UHC and how risk pooling mechanisms will be strengthened to increase affordability of care and address barriers to accessing care, especially among the poor and vulnerable.

- Governance

Health policies are developed by the Ministry of Health and Sports. The SSB health insurance scheme is governed by the Social Security Law of 2012, adopted by the Assembly of the Union of Myanmar. The law builds on the 1954 Social Security Act (No. LXVII), and aims to expand

mandatory and voluntary coverage. The SSB manages the overall implementation of the 2012 Social Security Law and related Social Security Rules of 2014.

The SSB is supervised by the Ministry of Labour, Immigration and Population (MOLIP), and overseen by a Tripartite Board, chaired by MOLIP. The National SSB provides guidance and manages any disputes related to the 2012 Social Security Law. The Social Security Appellate Tribunal hears appeals against decisions of the regional or state social security office. The Medical Advisory Board, formed by the SSB, provides advice on implementing the medical duties of the SSB.⁷⁵

- Legal coverage and eligibility

The right to free access to public health services is not embedded into the legal system. SSB Registration is compulsory for businesses with a minimum of five workers and voluntary for the self-employed and companies with fewer than five workers. This applies to formal private sector enterprises and state-owned enterprises, as well as government enterprises which generate revenues, in accordance with the 2012 Social Security Law. Dependents are not covered by the SSB.

- Benefits

The public health system provides promotive, preventive, curative and rehabilitative services, including traditional medicine, which, in theory, are subject to small user fees according to the fee-schedule established by health facilities. In reality, patients often have to pay informal user-fees or purchase medical supplies from private pharmacies. Prices are not necessarily determined in advance, and the total amount of OOP spending is often unpredictable for the patient.

The Social Security Law 2012 specifies the SSB medical scheme benefits. The package is relatively extensive, covering out-patient and in-patient care, medicines, laboratory tests and transportation costs in cases of referral outside urban areas. In addition, medical care is provided for the first year of a new born's life (Tessier and Guillebert 2015). The SSB benefit package for medical care is the same for all SSB beneficiaries.

As part of the scheme, the SSB also provides access to sickness benefits, maternity and paternity benefits, family benefits (including

assistance in the occurrence of natural disasters), disability benefits, funeral grants and survivors' cash benefits, in accordance with the Social Security Law. Employment injury insurance is provided through a separate scheme, and an unemployment insurance scheme is currently under development.

As mandated by the Social Security Law of 2012, any insured person has the right to access medical care and obtain a medical certificate if they are registered and have paid contributions. Sickness cash benefits can only be claimed for those who have been registered for at least six months and paid four months' worth of contributions prior to the first commencing day of sickness. The insured have the right to obtain maternity cash benefits provided they have paid six months of contributions and were registered with the social security office at least 12 months before the commencement of maternity leave (or miscarriage).

- Provision of benefits and services

The public health system comprises a network of facilities at all levels, including specialized hospitals, with a total of 11,726 facilities, comprised of 1,177 hospitals and 10,549 rural and urban health centres. The SSB scheme provides free health care for SSB beneficiaries, without co-payment, through its own health facilities, which include 96 SSB clinics, 3 workers' hospitals and 58 enterprise clinics. Workers' hospitals and SSB clinics are concentrated in urban areas, consistent with the distribution of insured workers (Sakunphanit et al. unpublished). Workers registered with the SSB and who make regular contributions may access secondary, tertiary and outpatient services in SSB hospitals through a referral system from SSB clinics (Sakunphanit et al. unpublished). SSB members are also entitled to seek care in public facilities and selected private facilities. In such cases, co-payment applies to all insured workers and are implemented in line with a sliding scale. The SSB is currently piloting the contracting of private facilities to provide outpatient services to test a purchaser-provider split (PPS) mechanism. The SSB finances its own clinics through direct budget allocation. In the case of private facilities, different contract modalities are used. Capitation has been tested in Kachin, Southern Shan and Tanintharyi, while fee-for-service has been tested in the Yangon region for outpatient care (Sakunphanit et al. unpublished).

⁷⁵ The social security Law 2012, available at: <https://www.mol.gov.mm/en/wp-content/uploads/2016/10/Social-Security-Law-2012-E.pdf>

► 4. Results

- Coverage

In theory, the entire population is entitled to free tax funded health care in public facilities. However, while a range of public services is already accessible to the entire population of Myanmar in line with the National Health Plan, the EPHS is not yet defined and not yet embedded within law (Teo and Cain 2018). Due to limited supply-side availability and quality, the benefits package of the public health system is rather limited and unpredictable. Overall, the readiness of public health care facilities to deliver essential health services remains very limited, due to years of chronic underinvestment in the health sector.

On the contributory side, the SSB is intended to cover 8 million formal sector workers, which is equal to 15 per cent of the total population of Myanmar. According to SSB administrative data, currently, the SSB covers about 1.4 million workers and 34,000 companies, which is only equal to 17.5 per cent of the target group. About 4,000 workers have registered on a voluntary basis. While the law provides for coverage of dependents, this measure has not yet been implemented. This low coverage rate is mainly due to a lack of enforcement of the scheme.

- Adequacy of benefits/financial protection

Among the general population (excluding insured SSB beneficiaries), financial protection is limited due to low government spending on health and the lack of a clear definition of free health care services, combined with the absence of a legal framework for the provision of free services (Teo and Cain 2018). The current tax funded health services available do not protect uninsured persons from falling into poverty as a result of health care payments. Interventions to provide financial protection, for example through trust funds for poor patients, were introduced in the mid-1990s but were not effective (Sein et al. 2014).

As a result, OOP payments in Myanmar are alarmingly high, accounting for 76.2 per cent of total health expenditure in 2017, which is one of the highest rates in the world. In a recent study, the issue of catastrophic health care expenditure in Myanmar was highlighted and evidenced through various indicators and thresholds of catastrophic health care spending (Myint, Pavlova, and Groot

2019b). According to a study that drew from the Myanmar Demographic and Health Survey 2016, around 2 per cent of non-poor households were pushed into poverty due to OOP payments for health care (Han et al. 2018). As noted above, only a small portion of the population is benefiting from the SSB social health insurance scheme, meaning that coverage of workers remains limited. This is due to the limited mandate of the SSB (most public service officials are not covered) and partial implementation of the Law (dependents are not yet covered). Those covered by the SSB face limited access to health facilities due to the limited network of health care providers and low quality of services under the scheme. This leads many SSB-insured patients to opt for services outside of the scheme, even though they have to pay out-of-pocket (Myint, Pavlova, and Groot 2019a).

SSB beneficiaries are therefore not exempt from the impact of OOP spending. A recent survey conducted in the three most industrialized townships in Myanmar (Yangon, Mandalay and Bago) show that more than 90 per cent of surveyed SSB members had to pay out-of-pocket when seeking care because they used services outside the SSB system (Myint, Pavlova, and Groot 2019a). The survey also found that around 13.7 per cent of surveyed respondents who were uncovered by the SSB had to borrow money to pay for health care services or medicines, compared with 12.7 per cent of SSB beneficiaries. 2 per cent of persons not enrolled in SSB and 3.6 per cent of SSB beneficiaries had to sell their assets to cover medical costs associated with their most recent experience of illness or injury (Myint, Pavlova, and Groot 2019a).

While SSB beneficiaries still incur OOP spending, they nonetheless benefit from better financial risk protection than those not insured through SSB, despite the fact that the coverage and utilization rate is low. Indeed, evidence shows that, among those who pay out-of-pocket, SSB members are paying up to eight times less than the general population. As noted, the share of respondents among the general population who needed to borrow money or sell assets to cover health care expenditures is similar to the proportion of surveyed SSB beneficiaries. However, both the mean amount of money borrowed and the mean amount of money gained from sold assets to cover health care expenditure among SSB beneficiaries is significantly lower than that of the General population (five times lower and one and a half times lower, respectively) (Myint, Pavlova, and Groot 2019a).

- Responsiveness to population needs
 - o Availability and Accessibility

Despite the Essential Health Care package policy, services and medical supplies provided by public facilities are often limited, unavailable and unpredictable. Limited access is particularly problematic in rural areas and hard-to-reach regions due to a lack of resources and infrastructure, and gaps in access to and utilization of health care services are noticeable across geographic regions (Sein et al. 2014; Teo and Cain 2018). Inequalities across income groups are also evident, as the richest quintiles benefit from better health care access and utilization (Han et al. 2018; Sein et al. 2014; Teo and Cain 2018).

Primary care services are more readily available at SSB clinics and at workers' Hospitals for secondary level care. However, the number of SSB clinics and workers' hospitals is too limited to ensure equitable access for all registered members across geographic regions; the need to travel a long distance to reach SSB clinics and workers' hospitals, combined with inconvenient opening hours are additional barriers to health care access (Tessier and Guillebert 2015). In light of this limited access, the utilization of health care services is determined by many other factors besides care needs (Sein et al. 2014). In addition to geographic barriers, perceived quality of care and medical costs are the most important determinants of health care utilization (Myint, Pavlova, and Groot 2019a), suggesting that there are both physical and financial barriers to access in Myanmar. Such factors may lead SSB beneficiaries to opt for a nearby clinic over an SSB facility which would have provided them with free health care (Myint, Pavlova, and Groot 2019a).

- o Acceptability and Quality

Due to the historical dominance of socialist ideologies and autocracy in Myanmar, citizens have not traditionally been accustomed to participating in their own care, with health policies predominantly implemented from the top-down. However, alongside increasing calls for transparency and accountability in government, there are growing expectations among citizens on their entitlements (Sein et al. 2014). Despite this shift, the quality of care in Myanmar remains somewhat limited, with patients often receiving incomplete care in public facilities, which is a direct consequence of consistently insufficient funding (Teo and Cain 2018). As a result, all public facilities face inadequacy of service readiness,

caused by a lack of inputs and a shortage of medical staff (Tessier and Guillebert 2015). Another consequence of insufficient funding is manifested in concerns over the perceived quality of medicines used at public facilities, which leads many people to resort to private pharmacies when seeking care (Tessier and Guillebert 2015).

SSB members are generally dissatisfied with the quality of care received at SSB facilities due to concerns over the quality of drugs used, inconvenient opening hours, long waiting times and cumbersome reimbursement processes in the case of referrals (Tessier and Guillebert 2015). Despite this, there is no motivation to improve the quality of care in either public or SSB facilities due to a range of system-level inefficiencies. For example, the budgets of public hospitals and SSB facilities are not linked to effective service provision or patient satisfaction. According to research supported by the ILO Vision Zero Fund, given the lack of a provider-purchaser split, there is no incentive for quality improvements among service providers because there is no direct link between service delivery (outputs) and what is paid for (inputs) (ILO 2019). The study also found that the lack of equipment and resources at public and SSB facilities may dampen motivation for innovation among medical staff.

► 5. Way forward

With health outcomes in Myanmar lagging behind regional averages, a population facing high risks of health-related impoverishment, and persisting health inequities, the need to design and implement comprehensive health reforms is urgently needed. Success in improving the overall health status of the population requires the implementation of combined strategies to strengthen the overall health system and improve financial risk protection. Today, after years of under-investment in health care, the Government of Myanmar is accelerating reforms towards the achievement of UHC. To achieve this, mobilizing financial resources for the health sector to address limited health care access and poor quality of care in Myanmar is key.

The National Health Plan recognizes the urgent priority of strengthening overall health systems. To do so, more public investment in health is needed, which is challenging given the impact of the global pandemic on the macro-fiscal

environment. Based on the latest statistics, the public share of total health spending is only 23.0 per cent, or about 1.1 per cent of GDP, which is among the lowest shares compared to countries at a similar level of development (Teo and Cain 2018). Prioritization of the health sector in the Government budget or allocation of additional resources to the health sector (earmarked taxes) are among the political decisions to be made to ensure increased fiscal space for health. As a first step, the Health Financing Strategy identifies complementary strategies for resource mobilization, including “increasing Government allocation to Health, introduction of sin taxes, expanding contributions collection to all formal sector workers and improving budget utilization”.

To achieve better pooling and more strategic purchasing, the Government is looking into addressing the fragmentation of funding flows to improve the efficiency of the whole health system. Policy directions to progress towards UHC were laid out in the “Strategic Directions for Financing Universal Health Coverage in Myanmar” document, formulated in 2019. The strategy initiates the development of a vision and identifies options for establishing a strategic purchasing function in the public sector (Teo and Cain 2018). Presently, the MOHS is planning to realize this vision by establishing a semi-autonomous agency to purchase health services from accredited state and non-state health providers (Myanmar Ministry of Health and Sports 2019). A key intermediate step is to ensure that the purchasing entity has a sustainable source of revenue, systems and staff needed to manage and track expenditures (Teo and Cain 2018). In the meantime, a number of pilots are on-going to test various payment mechanisms with private facilities.

Expanding population coverage is another key priority moving forward. The establishment of a strategic purchasing agency is expected to bring coherence across various social health protection instruments, to provide better financial protection to the entire population of Myanmar and improve health equity. In May 2020, the MOHS proposed a draft National Health Insurance Law in this direction. Scenarios outlined include the provision of public subsidies to cover poor and vulnerable households. In parallel, the SSB has set in motion efforts to expand coverage of its health and medical schemes to dependents, and an actuarial assessment has been initiated, which is expected to lead to a decision to expand coverage in 2021.

► 6. Main lessons learned

- Institutional arrangements are not good predictors of the performance of social health protection systems. Neither the tax funded health system nor the SSB scheme have been able to reduce the financial burden currently on the shoulders of households in Myanmar. This is due to low government spending, poor quality of care, gaps in the legal framework and inadequate implementation of policies. Addressing these issues in an integrated manner is essential to the provision of universal health protection.
- Currently, the SSB health Insurance scheme seems to provide better financial protection than the tax funded system. However, coverage of the SSB is very low, and SSB members still incur health costs. Indeed, despite a comprehensive benefit package without co-payments, limited access to SSB facilities translates into OOP expenditures, indebtedness and obligations to sell assets among beneficiaries.
- Successful implementation of the social health protection system requires major investments to strengthen health systems. In Myanmar, limited quality of care caused by inadequate funding, a lack of physical infrastructure, limited qualified human resources and other system-level inefficiencies are detrimental to the successful implementation of both contributory and non-contributory social health protection mechanisms, and hinder the achievement of UHC.
- Strong inter-ministerial collaboration with active participation of social partners is needed to further advance the reforms in preparation, and ensure the rapid development of a comprehensive social health protection system, to the benefit of the entire population. The existing policy framework is conducive to the development of a comprehensive social health protection system and the attainment of UHC in Myanmar. Translating this into practice requires a sustained and resolute political commitment at the highest level.

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► Nepal

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This profile was prepared by Christine Lohse (GIZ and ILO) with the support of Nita Neupane, Quynh Nguyen and Lou Tessier (ILO), and benefited from the review, inputs and quality assurance of Vishnu Prasad Sapkota (Institute of Medicine, Tribhuvan University).

► 1. Introduction

The 2009 and 2015 constitutions of Nepal have laid the foundations of the country's path towards Universal Health Coverage (UHC), with the goal of UHC institutionalized through the Health Sector Strategy (2015–2020), which emphasizes the importance of supporting vulnerable groups. In order to achieve this goal, a programme of free basic health care (FHCP) has been implemented, alongside three social health insurance schemes, namely the Health Insurance Board (HIB), the Social Security Fund (SSF) and the Employee Provident Fund (EPF). Despite these efforts, the coexistence of various schemes has led to fragmentation and inefficiency (Nepal Ministry of Health and Population 2018; Sharma, Aryal, and Thapa 2018). As a consequence, a burden of high out-of-pocket (OOP) payments constitutes a major challenge in ensuring access to health services for all.

► 2. Context

A large number of public health programmes have been implemented over the years to increase access to health care services in Nepal. Such programmes include Ama Surakshya (a programme targeting expectant mothers to promote institutional deliveries), community-based integrated management of neonatal and childhood illness, as well community-based health insurance schemes and projects promoted by the government and private initiatives. Notably, the aforementioned Free Health Care Programme (FHCP) ⁷⁶ was introduced through the Free Health Care Policy between 2006 and 2009, in four phases: targeted free care, universal free care, free primary health care and free hospital care. The Employee Provident Fund (EPF) medical scheme for civil servants was later established in 2013, in line with the Employee Provident Fund Act, 2019 (1962).

The National Health Policy 2014 and the National Health Sector Strategy (2015–2020), together with a number of regulations, such as the Health

⁷⁶ A further development can be observed here: the Constitution and the Strategy now use the terminology “Basic Health Services”—intended to unite the previous programme and the vertical schemes. The corresponding Basic Health Service Package has not yet been endorsed.

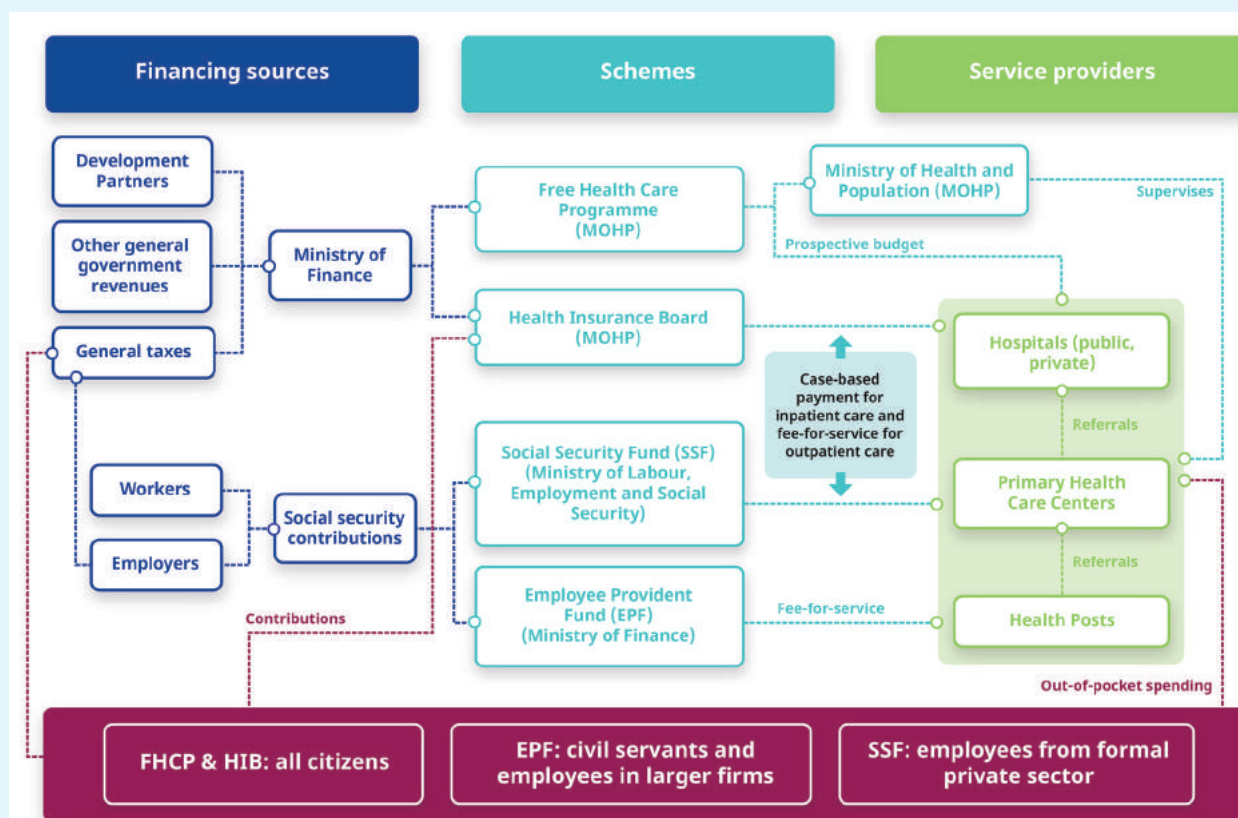
Insurance Regulation 2075, have served as the basis to lead interventions towards UHC, and develop a national health insurance system (Dahal et al. 2017). Building on these efforts, the Social Health Security Development Committee, from which today's Health Insurance Board (HIB) emerged, was founded in 2015, eventually constituting Nepal's national health insurance scheme. This was initially focused on the poor and the informal sector, but is now intended to cover the entire population. Parallel to the introduction of the HIB national health insurance scheme, a further social protection mechanism, known as the Social Security Fund (SSF), targeting the formal sector, was initiated under the Contribution Based Social Security Act 2017 (2074). A Medical and Health Protection Scheme and a Maternity Protection Scheme were stipulated under the sixth chapter of the Act, as part of the SSF. The Public Health Service Act was later implemented in 2018, through which the right of every citizen to receive high quality health care was emphasized.

► 3. Design of the social health protection system

- Financing

In general, a rough distinction can be made between four funding sources within the Nepalese health system, including budgets calculated prospectively by the state (financed by taxes and donations from development partners), social security contributions and OOP expenditures. The latter, which comprised 57.8 per cent of health expenditures in 2017, account for the largest share of funding, and are paid directly to health facilities.

► Figure 1. Overview of main financial flows of the social health protection system in Nepal



As Figure 1 shows, with the exception of the FHCP, the schemes are *inter alia* financed by contributions. The SSF and EPF schemes receive income-related payments from employers and employees, while HIB charges a uniform fixed contribution per household and receives tax-funded contributions from the government budget to subsidize coverage for the poor.

- Governance

Administratively, the schemes are managed by autonomous institutions under the responsibility of different ministries, without an overall coordination mechanism in place at the time of writing. However, the need for coordination between HIB and SSF was anticipated, which is reflected in the initially planned composition of the HIB Board, outlined in the National Health Insurance Policy 2013. According to this policy, a representative of the SSF should be nominated on the Board. However, the current composition of the Board does not currently reflect this initial intent.

The HIB and FHCP are both under the responsibility of the Ministry of Health and Population (MOHP). The HIB was constituted as an autonomous institution under the responsibility of the MOHP, though the institution is still in the process of building this autonomy. SSF on the other hand was established as a “separate entity”, which means that the SSF Board includes wider representation of interest groups, including the executive director and representatives of the government, employers and employees.

EPF, under the responsibility of the Ministry of Finance, is composed of two previously separate funds: Sainik Drabya Kosh (Army Provident Fund) and the Nijamati Provident Fund (NPF) for civil servants working in Kathmandu. The Board of the EPF is the most important decision-making body governing the scheme. Members are nominated by the government and representatives of government, banks, financial institutions and other bodies. No available information was found on the participation of workers and employers in the board.

- Legal coverage and eligibility

Based on the legal coverage of each scheme, overlapping target group definitions can be identified. In terms of the legally established target groups of FHCP and HIB, both schemes are intended to cover all citizens on a mandatory basis, and they both define particularly

vulnerable groups who receive special attention, though both systems use different methods of identification. In the case of the HIB, contributions for vulnerable population groups are fully subsidized by the government, which identifies eligible beneficiaries through the national poor-targeting process.

With regard to the SSF, in principle, the scheme covers all employees (including those from the informal sector and the self-employed) and enrolment is mandatory. However, in reality, only employers and employees from the formal private sector have registered so far (Niti Foundation 2019).

Within the EPF, civil servants are automatically covered. Moreover, employees of institutions with more than 10 permanent employees have the option to join. In 2015, the insurance scheme was opened to self-employed persons. Unlike the HIB and SSF, the EPF only covers employees and not their dependents, with the exception of maternal health.

- Benefits

Basic free health care services are provided through FHCP in all public facilities. Vulnerable persons not only receive free essential health care services through FHCP, but also emergency services and inpatient and outpatient treatment in public facilities. For other groups, supplementary services are covered by “social health protection arrangements”, namely SSF, EPF and HIB. HIB and SSF are characterized by ceilings that limit the maximum amount of benefits available to beneficiaries. In addition to medical care services, SSF also offers cash benefits, for example, in the event of maternity. A list of explicitly excluded benefits is also available for HIB and SSF – for example, neither of the schemes cover treatments related to plastic surgery.

The benefit packages offered by all existing schemes are intended to be extended over time. The experience of the Free Drug List of the FHCP illustrates the demand for this expansion. When first implemented, 40 drugs were included in this list, which was not sufficient to treat patients with various common diseases. For example, amclox (ampicillin and cloxacillin), third generation antibiotics (agithromycin) and anti-hypertensive and anti-diabetes drugs were missing. As such, the list was extended to 70 drugs. Media sources have indicated that the number of drugs on the

list is set to increase further to 93 (Poudel 2019; Prasai 2013; Singh et al. 2017).

- Provision of benefits and services

Facilities in Nepal are differentiated by level, including local facilities (health posts, community health units, urban health promotion centres and primary hospitals), provincial facilities (secondary hospitals) and federal level facilities (tertiary hospitals). Basic health services such as preventive and curative measures are mainly offered at health posts. In primary health centres, which are comparatively better equipped, beds for births are also provided. The most advanced and comprehensive treatments are provided at secondary and tertiary level hospitals. This range of facilities is complemented by an increasing number of private providers (Kullabs 2020; Nepal Ministry of Health and Population 2019). Out of a total of 316 providers, 249 are public and 67 are private. Both public and private care providers are regulated by the MOHP.

When accessing care, HIB members have to follow a referral mechanism. Their first point of contact is the nearest primary health care centre or hospital, from which the patient is directed to another hospital, if necessary. Only public health facilities are eligible as first point of contact facilities. If a contract has been concluded with a private clinic, private clinics can also be consulted when making a referral. This process does not have to be followed in cases of emergency treatment (Social Health Security Development Committee 2017b). A cashless system has been implemented so that the patient only has to present their card received when registering, and the service provider checks whether there is still sufficient credit for the treatment in question.

Contracted private and public health care providers are paid for services through fee-for-service and case-based payments. In most cases, the schemes reimburse the providers directly, through a third payer mechanism. For HIB and SSF, fee-for-service applies for outpatient services, and case-based remuneration applies for inpatient care and hospital admissions. As for the EPF, service providers are paid through fee-for-service. With regard to FHCP, the MOHP pays prospective defined and population-based budgets to various administrative government levels.

- Implementation/administration

To assist the registration process for the HIB scheme, enrolment assistants (EAs) (one EA per 1,000 families) work on a voluntary basis in their municipalities. The selection of EAs is based on the Guidelines for Selection of Enrolment Assistants (second amendment) 2074 BS, which stipulates that female community health volunteers are to be prioritized for selection. To further support registration, as well as renewal, claim management, feedback and reporting, the open-source software insurance management tool, openIMIS, was introduced alongside the HIB. The tool, which plays a key role in the provision and administration of health insurance, can be accessed by all relevant parties both within and outside the HIB system, including EAs, enrolment officers, district managers, claim reviewers and health care providers (Social Health Security Development Committee 2017a). This tool not only assists in the context of routine activities, but also serves a function at a higher level. Notably, its implementation during the design phase of the HIB helped to sharpen decisions and has facilitated a rapid expansion of affiliation (Grainger 2018).

► 4. Results

- Coverage

Compared to coverage targets, affiliation rates to each of the schemes are relatively low. As of June 2019, there were 509,540 households covered by HIB and 1.68 million affiliated persons (Health Insurance Board 2019). With 20 million considered as eligible for the scheme, only 8.4 per cent of the coverage target has been achieved. As of April 2021, HIB was reported to cover about 12.8 per cent of the total population (3.8 million). However, this figure does not take into account the drop-out rate, which, according to national sources, stands at 30 per cent. This encompasses affiliated persons who have decided not to renew their social health insurance membership after one year, which reduces the number of effectively protected persons. As for SSF, registration began during the fiscal year 2019/20, which led to the coverage of 147,643 registered workers (about 1 per cent of the population) and 12,157 employers by the end of 2019. With regard to EPF, as of 2018, 600,000 insured persons out of a target group of 700,000 were insured under the scheme.

The overlapping target groups of the schemes has led to inefficient parallel systems, causing confusion among the population regarding entitlements, which contributes to overall limited coverage. For example, when SSF was introduced, which was made mandatory, its interaction with EPF was not clearly defined or regulated. Finally, the Ministry of Labour, Employment and Social Security (MOLESS) announced that the decision on which scheme to register with would be made individually by the insured, which somewhat contradicts the objectives of mandatory coverage and broad risk pooling (Poudel 2019). Similarly, while in the initial stages of discussions on the Health Insurance Law, it was foreseen that all formally employed persons would be affiliated under HIB on a mandatory basis, but this was never implemented in practice. The initial idea of a single pool, with two relatively secured sources of funding (from mandatory social contributions from the formally employed on the one hand and from government contribution subsidies for the poor on the other) would have left the institution with some room to concentrate on innovative solutions for the “missing middle”, particularly informal economy workers. However, this has not materialized in practice, leading to coverage gaps and exposing the scheme to adverse selection.

- Adequacy of benefits/financial protection

The proportion of OOP payments as a share of health expenditures in Nepal is very high, comprising almost 58 per cent, with an increasing trend since the year 2000, and a significant jump since 2006. This has been attributed to an increasing use of privately provided health services. Although various government measures to provide free health care in public facilities have facilitated better access, the increasing market share of poorly regulated private facilities has led to a corresponding increase in OOPs (Gupta and Chowdhury 2014). This is reflected in the share of OOP payment flows to private hospitals, which was reported at 13.2 per cent for the year 2011/12 and 16 per cent for the year 2015/16 (Nepal Ministry of Health and Population 2019; Nepal Ministry of Health and Population and Nepal Health Sector Support Programme 2018). This trend is exacerbated by the limited coverage offered by Nepal’s social health insurance mechanisms. Accordingly, the incidence of catastrophic health spending at more than 10 per cent of total income or consumption was experienced by 10.71 per cent of the total population.

Shortly after the introduction of HIB, it became clear that the scope of benefits did not meet the needs of the population. For example, there has been criticism that the imposed ceiling for a family is not sufficient to cover the treatment of one family member. For this reason, HIB adjusted the benefit package accordingly and increased the ceiling from 50,000 to 100,000 Nepalese Rupee (The Kathmandu Post 2018). Despite this increase, the ceiling still limits the financial protection provided by the scheme.

- Responsiveness to population needs
 - o Availability and accessibility

The health sector in Nepal is characterized by significant urban/rural disparities (Mehata et al. 2017; Pandey et al. 2013), which has contributed to the fact that only 34 per cent of Nepalese households have access to medical facilities within 30 minutes of their house (Mehata et al. 2012). This not only limits the attractiveness of social health insurance, but also the feasibility of visiting a doctor. Reimbursement of travel costs has been proposed as a solution to reduce the financial burden of a visit to the doctor, in recognition that the actual cost of care may be less of a barrier than other non-medical costs (Mishra et al. 2015). In this context, the absence of sickness benefit coverage for most of the population is an additional factor constraining access to care in times of need.

In addition to geographical barriers, the social inequalities inherited from the caste system, although officially abolished in Nepal, continue to act as a significant obstacle to accessing health care. This is evidenced by the Nepal Demographic and Health Survey 2011, which demonstrated a marked difference in utilization rates between different ethnic groups, particularly in relation to disadvantaged members of minority groups, namely Dalit and Janajati women. A 2015 study attempting to identify underlying factors in this context highlighted barriers that women experience in accessing services, including lack of awareness that the facility or services exist, being too busy to attend, poor services, embarrassment, disrespectful care, and financial issues (Milne et al. 2015). It remains to be seen whether such obstacles can be eliminated through targeted communication strategies in connection with the establishment of federal structures. More broadly, this issue calls for concerted action within the social protection

system as a whole to address gender and other social inequalities.

Despite these disparities, among the Nepalese population as a whole, an increased rate of utilization of health care services has been observed as a result of the implementation of the FHCP (Suvedi et al. 2012, XV). However, system-wide and current data on the usage rate (especially after the introduction of SHI) could not be found. According to three independent studies exploring the use of health services among the elderly ⁷⁷ (from 2012, 2016 and 2019 respectively), a lack of awareness on entitlements was as an obstacle among this group (Acharya et al. 2019; Gurung, Paudel, and Yadav 2016; Sanjel et al. 2012).

- o Quality and acceptability

The quality of service provision remains a weakness of the Nepalese health care system, as illustrated by the results of the Health Facility Survey, which indicates that less than 1 per cent of health facilities met minimum standards of quality of care at point of delivery in 2015 (Nepal Ministry of Health and Population et al. 2017). In contrast, private providers are perceived to offer higher quality and better equipment. Notably, Nepal's social health insurance schemes do not have quality criteria in place (Prasai 2013).

Low quality of services is driven in part by human resource deficiencies. According to the Service Tracking Survey, the "percentage of sanctioned posts filled" for medical doctors at district hospitals was 56.4 per cent in 2012, and according to the Health Facility Survey, in this indicator stood at 51.9 per cent. This has had negative effects on the effective implementation of the FHCP. The fact that staffing expectations have not been met has been attributed to regulatory inadequacies, whereby improvements were predicted as a result of the implementation of the Health Service Act (Prasai 2013). This issue was addressed in the National Health Sector Strategy (2015–2020) under the title "Rebuilt and strengthened health systems: Infrastructure, HRH management, Procurement and Supply chain management", in which a target value of 0.52 doctors per 1,000 persons was set for the year 2020 (the baseline figure for 2013 was 0.18 doctors per 1,000 persons).

► 5. Way forward

In recent years, many programmes have been implemented and much has been achieved to pave the way towards UHC in Nepal. The fact that HIB prioritizes the extension of coverage to workers in the informal economy is particularly noteworthy. Over the next few years, it will be crucial to raise awareness among the entire population on the benefits of social health protection, and to further develop the existing mechanisms in a coordinated manner. Important principles for the further development of the health care system and strategies to drive progress towards UHC in Nepal were outlined in the National Health Sector Strategy, including the explicit goal to harmonize the various schemes.

A good starting point in this context is the use of a uniform IT system, with work currently underway to enable SSF to use the same system as HIB, namely openIMIS. The existence of a shared database would provide an important basis for evaluations and evidence-based decisions in the future. Not only at the level of health care but also in the area of social protection as a whole, efforts are being made to achieve greater coordination and cooperation. Current work on a National Social Protection Framework, which began in 2010, is one example of these efforts. Motivated by this framework to consolidate the fragmented range of schemes, a National Steering Committee on Social Protection was set up on behalf of the Planning Commission.

Increased utilization of health services and more equitable distribution have also been outlined as key outcomes of the National Health Sector Strategy. Particular focus is placed on access to health services and an expanded service network with a referral system, in an effort to effectively cover the "unreached population". In the NHSS Progress Report 2018–2019, the distribution of doctors trained under a government-financed scholarship in various provinces was cited as a major step forward. Ensuring the provision of high-quality care is also an important factor in widening access and utilization, by encouraging enrolment and reducing dropouts. Although a number of quality-related indicators have already been defined and legislation has been introduced, strengthening the role of strategic purchasing through the provision of financial and

⁷⁷ Limitations of comparability: Different focus regions in terms of urban/rural areas.

non-financial incentives could actively contribute to improving quality through service providers.

accelerated the registration process. In the future, this database will make an important contribution to monitoring, verification and management.

► 6. Main lessons learned

- Subsidization of contributions for vulnerable population groups facilitated a step towards the "universality of protection". The government's decision to subsidize contributions for defined groups of vulnerable households facilitates access to health care and increases the number of those protected by both the FHCP programme and the HIB scheme. However, the participation rate of these population groups, measured in terms of the number of insured persons eligible for contribution subsidies and utilization rates, still appears to be low. Awareness programmes and expansion of the identification process have proven to be key activities in this regard.
 - Overlap between the three parallel public health insurance schemes is an obstacle to extending coverage. The co-existence of the country's three public health insurance schemes not only leads to limited coverage and confusion among the population, but also prevents systemic efficiency gains and limits risk pooling and solidarity in financing. At the national level, the establishment of a coordinating body could help to avoid overlaps.
 - Satisfaction with service provision increases willingness to subscribe to programmes that aim at stimulating demand. Distrust of public service providers has led to a rejection of registration with the public health insurance system. The intended role of HIB as a purchaser, and the introduction of various quality measures could provide the right impetus in this area in future.
 - The interrelated introduction of public health insurance and digital administration through openIMIS has proven to be target-oriented. This not only forced the necessity of concretization during the conceptualization of the entire health insurance setup (programmers needed precise information when programming the IT system), but also simplified and
- Enrolment assistants established in communities have played an important role in reducing knowledge gaps among the population and were able to contribute to an initially high enrolment rate through personal contact.

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► Pakistan

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► 1. Introduction

Pakistan has a public health care system which, in principle, can be accessed by all citizens. However, Pakistan lags behind other countries in the region in terms of health indicators. For example, the probability of dying from cardiovascular disease, cancer, diabetes or chronic respiratory disease between the age of 30 and 70 (SDG 3.4.1) was 29.41 per cent in 2019, which is higher than the corresponding figures for India (21.9 per cent) and Bangladesh (18.9 per cent) (WHO n.d. a). Furthermore, Pakistan's 2019 average of 13 International Health Regulations core capacity scores was 51.04, whereas neighbouring countries, India and Bangladesh, scored 95.28 and 77.75 respectively (WHO n.d. a). These results demonstrate that Pakistan still needs to improve its health outcomes through concerted efforts towards enhancing social health protection for its population.

Currently, there are few prepayment mechanisms in Pakistan (Malik 2015), and low government spending has made it challenging to ensure that public health services provide the required medicines and laboratory equipment for effective

health care delivery at affordable rates. As such, most health services in Pakistan are provided by the private sector (Rabbani and Abbasi 2017). However, government employee schemes run by federal and provincial governments are in place, which are currently the largest social health insurance schemes for those in formal employment. Furthermore, there is currently political will and momentum to improve social health protection, particularly for the poor and those in the informal economy. Notably, the Sehat Sahulat programme was implemented in 2016 to improve access among the poor to quality and affordable medical services, with an ambitious goal to cover a third of Pakistan's current population in the coming years, and gradual efforts towards universal coverage.

► 2. Context

Pakistan's health sector has been evolving since the country's independence from the British Government in 1947 (Meghani, Sehar, and Punjani 2014). The Federal Ministry of Health (MOH) was the main steward and regulator of the

public health sector until it was dissolved in 2011 through the 18th Constitutional Amendment. Simultaneously, all responsibilities for the health sector, including planning and fund allocation, were devolved to provincial health departments (Global Health Workforce Alliance 2021). This made Pakistan the only country in the world at that time without a central structure, such as a ministry or department for health (Nishtar et al. 2013). However, the Ministry of National Regulations and Services was established in April 2012, which later became the Ministry of National Health Services, Regulations and Coordination, as its scope of work was expanded.

As a result of three democratic transitions from 2008 to 2018, health sector reforms are high on the political agenda. Accordingly, several political parties promised “health care for all” in their election manifestos in 2018 (Khalid et al. 2020). The National Health Vision 2016–2025 envisions a health system that provides universal access to quality essential health services without financial burden, with a focus on vulnerable groups (WHO 2018). Ministries and provincial departments of health are committed to increasing public health spending and improving the efficiency of health systems in their geographical domains with a goal to achieve universal health coverage (UHC).

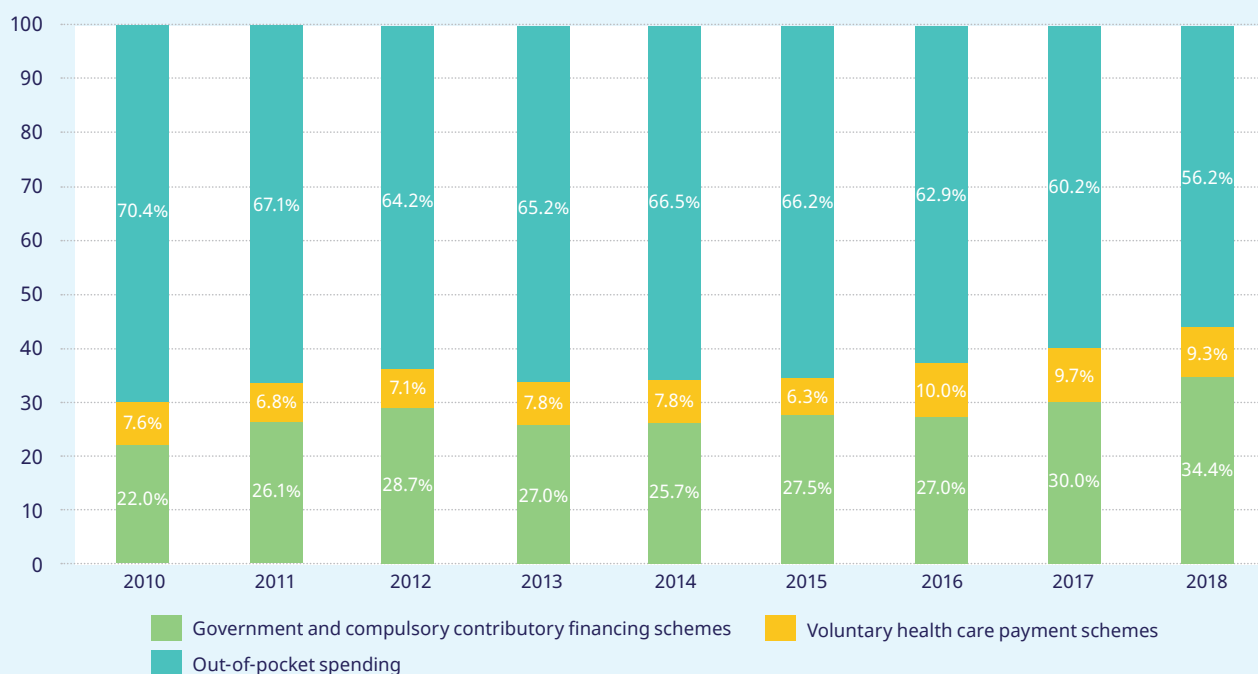
An especially noteworthy development has been the establishment of the Prime Minister’s National Health Programme, later renamed the Sehat Sahulat programme, which was launched in 2016, constituting Pakistan’s first large-scale social health protection scheme (besides than the specific programmes run for government and military employees). Predominantly targeting the poor, the aim is to improve access among vulnerable groups to quality and affordable medical services – including some services offered by private facilities – with the ambitious goal of covering 11 million families in 3–5 years. In addition to this scheme, due to the decentralization of the health system, several provincial social health protection schemes exist. These include the Punjab Employees Social Security Institution (PESSI) in the province of Punjab and the Khyber Pakhtunkhwa Employees Social Security Institution (KP ESSI) in the province of Khyber Pakhtunkhwa.

► 3. Design of the social health protection system

- Financing

In 2018, per capita spending on health in Pakistan was US\$42.87, which was equal to 3.20 per cent of GDP, while out-of-pocket (OOP) spending accounted for 56.24 per cent current health expenditure (CHE), government schemes and compulsory contributory health care financing schemes accounted for 34.42 per cent, and voluntary health care payment schemes accounted for 9.34 per cent (see figure 1).

► Figure 1. Current health expenditure by source of financing



Source: Adapted from WHO Global Health Expenditure Database.

Services provided by the private sector are mainly financed through OOP spending by households, while most public services are financed and delivered through vertical programmes and by provincial authorities. National programmes for family planning and primary health care are funded by the provincial government, while public hospitals receive funding from both the federal and provincial governments (Malik 2015). The Federal Government provides constitutionally mandated transfers to provincial governments for the public health system, primarily sourced from federal taxes. These funds are then shared between provincial health departments, which oversee district headquarters hospitals and district governments, the latter of which are responsible for district-level public health facilities (Asian Development Bank 2019).

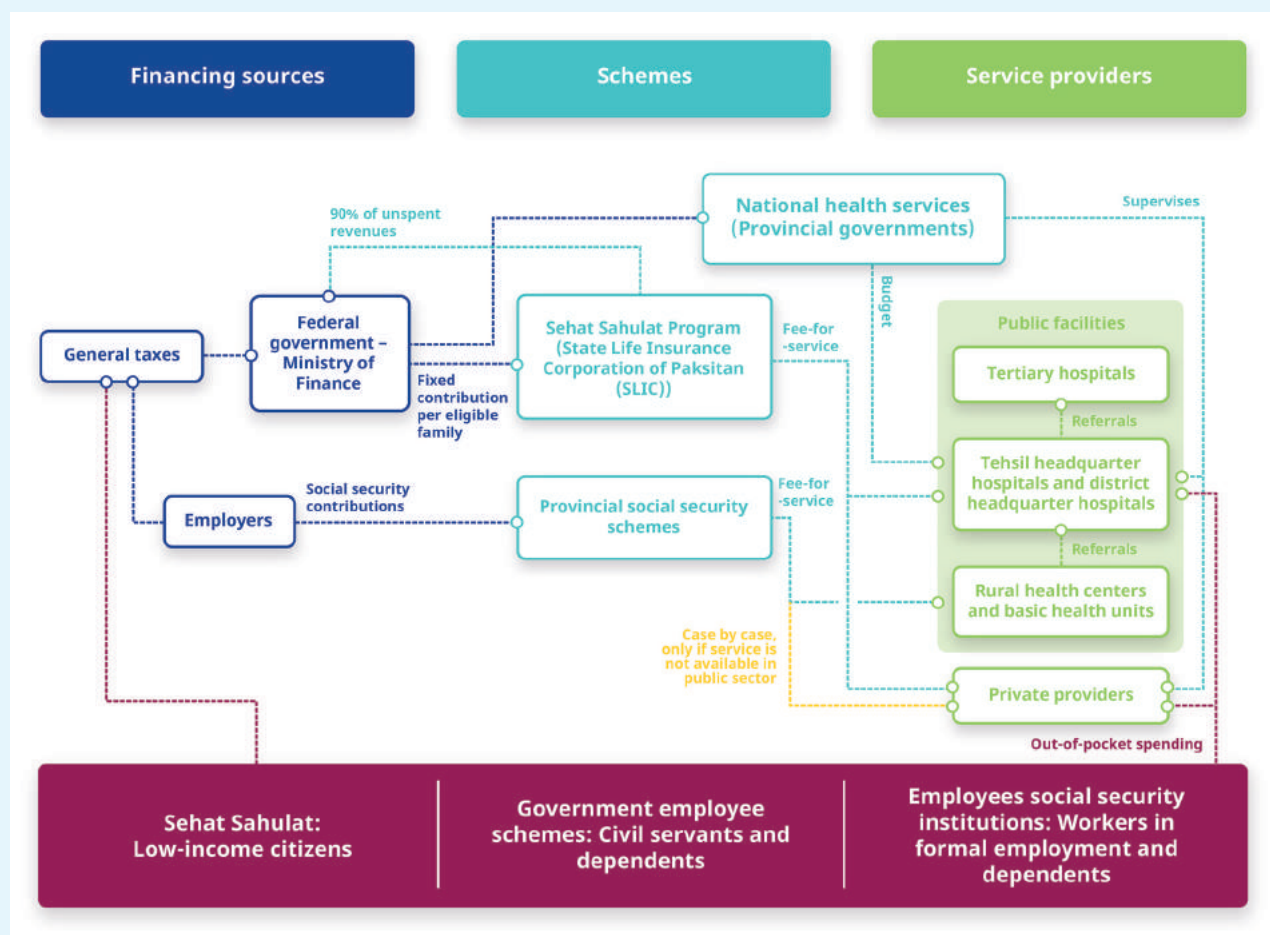
The Sehat Sahulat programme is financed by the government, which pays a fixed contribution per eligible family to the State Life Insurance Corporation of Pakistan (SLIC) (Sehat Sahulat Programme 2021b). 90 per cent of any unspent revenues is refunded to the government at the end of the three-year contract period with

SLIC (Sehat Sahulat Programme 2021b). While the government initially aimed to introduce scheme contributions as eligibility expands, recent expansions in the Northwest Khyber Pakhtunkhwa region and Federal territories have been facilitated on a non-contributory basis; whether contributions will be introduced in the future as planned, remains uncertain (GIZ 2021; Thiede 2017; Sehat Sahulat Programme 2021b). Claims costs per family in 2017 amounted to PKR1,005 (US\$6.20) (Sehat Sahulat Programme 2021b).

The PESSI scheme is funded through employer contributions equal to 6 per cent of covered workers' wages, which is paid directly to the administrative body (PESSI 2018b), and the KP ESSI scheme is funded through employer contributions equal to 7 per cent of the covered workers' wages (Sajid 2016).

Figure 2 provides a visual overview of the national-level social health protection system in Pakistan.

► Figure 2. Overview of main financial flows of the social health protection system in Pakistan



Source: Authors.

- Governance

The Sehat Sahulat Programme was launched in 2016 following approval by the Executive Committee of the National Economic Council (ECNEC) (Ehsan Qazi 2019). The Programme is administered by the State Life Insurance Corporation (SLIC) (Sehat Sahulat Programme 2021b). The SLIC is responsible for enrolment of beneficiaries, contracting of providers, data management, and monitoring and evaluation (Thiede 2017). A third-party administrator (TPA) is appointed through an open tender process. Competing insurance companies submit information on their technical capabilities, as well as financial bids based on their estimates of the costs of future claims and

administration (Sehat Sahulat Programme 2021b). Two separate schemes exist under the umbrella of the Sehat Sahulat Programme, with one scheme funded at the Federal level for beneficiaries in the Federal regions and Punjab province, and another scheme run in Khyber Pakhtunkhwa, funded by the provincial government. The two schemes operate in a similar fashion, with some differences in the benefit packages offered.

PESSI and KP ESSI were both established through the Provincial Employees Social Security Ordinance of 1965, and the latter was based on a recommendation from the ILO (KP ESSI 2021a). The PESSI scheme operates as an autonomous body

administered by the Labour and Human Resource Department of the Government of Punjab province (PESSI 2018b). KP ESSI is governed by a state body headed by the Khyber Pakhtunkhwa's Provincial Minister for Labour, and is reportedly self-sustaining without financial assistance from the Provincial or Federal Government (KP ESSI 2021a).

- Legal coverage and eligibility

The Sehat Sahulat programme predominantly targets the poor. When it was first launched, Sehat Sahulat covered people earning less than US\$2.00 per day living in the provinces of Punjab and Khyber Pakhtunkhwa, as well as those living in Federal regions, namely Islamabad Capital Territory, Azad Kashmir and Gilgit-Baltistan regions. Over the years, the geographical scope of coverage has been gradually expanded. Dr. Faisal Sultan, the Special Assistant to Pakistani Minister of Health, claimed in October 2021 that the scheme has now been extended to the entire country (BR Web Desk 2021). Coverage is family-based, comprising husbands, wives and any unmarried children. In addition, persons with disabilities who are formally registered with the National Database and Registration Authority who hold a computerized national identity card are covered in these regions. Transgender persons are covered country-wide, but must comply with the same registration and identification criteria as persons with disabilities (Sehat Sahulat Programme 2021b).

Eligibility for the scheme is linked to the Benazir Income Support Programme (BISP) – the government's flagship social protection scheme—with the BISP census providing the basis for many of the government's means-tested programmes, including the Sehat Sahulat scheme (Sehat Sahulat Programme 2021b). BISP data are used for the registration of families for issuance of "Sehat Insaf" cards (The Nation 2019). The National Socio-Economic Registry (NSER) of the BISP is used to identify and enroll eligible citizens, each of whom are given a unique identifier number. A Nationwide Poverty Scorecard Survey enables BISP to identify eligible households through proxy means testing, which determines the welfare status of affiliated households on a scale from 0 to 100. Families with a PMT of 35 are eligible for the programme (Sehat Sahulat Programme 2021b). Eligibility for the programme can be checked by sending an SMS with the person's National Identity Card Number to a number provided by Sehat Sahulat (Sehat Sahulat Programme 2021b).

Within the province of Punjab, PESSI covers employees working in industries or commercial establishments who receive monthly wages of no more than 22,000 Pakistani rupee (PKR), equivalent to US\$145 per month (Zafar et al. 2008). Within the province of Khyber Pakhtunkhwa, KP ESSI covers employees of registered companies. Male employees aged 21 and above are eligible, as well as female employees who are unmarried. For both schemes, dependents of eligible employees are covered.

- Benefits

Benefits of the Sehat Sahulat programme are provided through two packages: the priority care package and the secondary care package. There are no exclusions and all pre-existing conditions are covered (Sehat Sahulat Programme 2021a). Each package has an "initial coverage" amount, which is available to all beneficiaries, and an "additional coverage" amount, which can be allocated to families in "life threatening situations and in case of maternity" (Sehat Sahulat Programme 2021a). The following services are included in the priority care package: inpatient services (all medical and surgical procedures); heart diseases (angioplasty/bypass); diabetes mellitus completion; burns; limb saving treatment, implants and prosthesis; end stage kidney diseases/dialysis; chronic infections (hepatitis/HIV/rheumatology); organ failure (liver, kidney, heart and lungs); cancer treatment (chemotherapy, radiotherapy and surgery); and neurosurgical procedures (Sehat Sahulat Programme n.d.). Outpatient care is only covered for a single post-discharge follow-up visit, and beneficiaries are provided with a voucher upon discharge (Asian Development Bank 2019).

Through its secondary care package, the Sehat Sahulat programme provides the following services: inpatient services; emergency treatment requiring admission; maternity services (normal delivery and C-section); maternity consultation for family planning, immunization and nutrition; 4 antenatal check-ups and 1 postnatal check-up; fractures and injuries; post-hospitalization; local transportation costs of PKR1,000 (US\$6.20) up to three times per year; and provision of transport to tertiary care hospitals (Sehat Sahulat Programme 2021b).

Both the PESSI and KP ESSI schemes provide unique benefits packages defined through a positive list. Medical benefits offered through the PESSI scheme include treatment of heart

disease with bypass surgery; CT scans; treatment of breast cancer; dialysis; diagnosis and treatment of gastroenteritis; treatment of hepatitis; prosthetics; diagnosis and treatment of dengue fever; 24-hour ambulance services; and transportation of human remains (PESSI 2018b). Medical benefits offered through the KP ESSI include hospitalization; free medicines if prescribed by associated doctors; dental care related to employment related injuries; angiography, angioplasty and heart surgery; and ambulance services. In addition to medical care, both PESSI and KP ESSI beneficiaries are eligible to receive cash benefits in case of sickness, injury, maternity, disability, survivorship, funeral, and “iddat” (the period of waiting that a woman must observe after the death of her husband or divorce) (PESSI 2018a); (KP ESSI 2021b). For beneficiaries of the PESSI scheme, cash benefits also include free education for insured workers’ children, and undefined financial assistance (PESSI 2018a).

- Provision of benefits and services

Public health facilities account for 30 per cent of total health expenditure, with the remaining 70 per cent accounted for by private providers (Hassan et al. 2017). For the national public health services, there is no formal or explicit method for allocating budgets to public health facilities, and resource allocation is predominantly based on historical spending and political and other influences, with some informal assessment of performance and patient load.

Enrolment of eligible beneficiaries for the Sehat Sahulat programme is conducted by beneficiary enrolment centres available in all districts, with electronic registration possible for those who live far from an enrolment centre. Eligible persons receive a Sehat Sahulat Insaf card from the card distribution centre in his or her district which the member has to use to access treatment at health facilities (Sehat Sahulat Programme 2021a).

Services under the Sehat Sahulat scheme are provided through empaneled hospitals, including both public and private hospitals that have successfully satisfied the Hospital Empanelment Criteria; this includes criteria on health facility equipment, management, health staff, clinical practice, laboratory services,

pharmacy and client rights (GIZ 2019). Benefits are portable between districts and provinces. Hospitals empaneled in Sehat Sahulat include 300 public and private hospitals in 84 districts (Sehat Sahulat Programme 2021a). There were 1,279 public hospitals, 5,527 Basic Health Units (BHUs), 686 Rural Health Centres (RHCs), and 5,671 dispensaries in 2018. In terms of personnel, there were 220,829 registered doctors, 22,595 registered dentists, and 108,474 registered nurses in 2018 (Pakistan Ministry of Finance, 2018). Under the scheme, hospitals are reimbursed after patient claims have been submitted (Sehat Sahulat Programme 2021a). Reimbursement is based on fixed rates agreed between hospitals and insurance companies, with the exception of cancer treatment, which may use a fee-for-service payment model.

PESSI beneficiaries can access medical treatment at official Social Security Hospitals free of charge. E-cards are used to access benefits (PESSI 2021b). Health services or facilities that are not available at Social Security Hospitals may be arranged through other hospitals at no additional cost to patients, even if care is only available abroad (PESSI 2018a). KP ESSI beneficiaries can access medical treatment at the scheme’s medical units and government hospitals, free of charge. KP ESSI has established 35 medical units in Khyber Pakhtunkhwa province: 1 hospital, 1 poly clinic, 12 medicare centres, 12 dispensaries, 1 dental unit and 8 medical posts (KP ESSI 2021c). PESSI and KP ESSI beneficiaries are issued with a social security card which allows them to avail of medical services from Social Security Hospitals (KP ESSI 2021d; Zafar et al. 2008).

► 4. Results

- Coverage

The number of beneficiaries of the Sehat Sahulat programme increased from 2.4 million families in early 2018 to 3.2 million families across 38 districts in October 2018, as reported by the National Database and Registration Authority (Yusufzai 2018).⁷⁸ It is the largest of the publicly governed health care schemes, and includes

⁷⁸ Assuming that families enrolled in the scheme comprise of an average of 6.27 members—a figure used in the study by (GIZ 2019)—the 3.2 million families covered in October 2018 constitute about 20 million individuals, which amounts to slightly less than 10 per cent of Pakistan’s total population in 2018. The goal of 11 million families would translate to 68.97 million individuals, slightly less than a third of Pakistan’s population in 2019.

coverage of care at private facilities. As previously noted, the programme aims to expand coverage to around 11 million families within 3–5 years by increasing the income threshold and extending the programme to all employees of government institutions, including employees of universities and medical institutes (Sehat Sahulat Programme 2021a).

A study conducted in 2019 on the health sector in the Khyber Pakhtunkhwa province found that, of the estimated population of 30.5 million, the estimated number of beneficiaries of the Sehat Sahulat Programme is 19.2 million, accounting for over 60 per cent of the population of the province (Asian Development Bank 2019). In early 2021, the government expressed ambitions to expand the scheme's original target coverage, and offer universal coverage through the scheme nationwide; to this end, coverage in the Federal regions is gradually being expanded (Dawn.com 2020; White-Kaba 2020). Besides Khyber Pakhtunkhwa province, the Sehat Sahulat Programme has been operational in Punjab, Azad Kashmir and one district of Sindh province, namely Tharparkar (BR Web Desk 2021). In addition, there are an estimated 7.84 million beneficiaries covered through schemes for formal workers, though the vast majority of those covered (7.16 million) are employed in the public sector, within the government or the military. Overall, these figures imply that 27.16 million persons in Khyber Pakhtunkhwa province are covered by a health protection scheme, accounting for nearly 90 per cent of its population.

However, there are reports that only a fraction of those officially covered have been able to benefit from the programme. For example, a news article stated that although by September 2020, 5 million families were issued Sehat Insaf cards and thus formally a part of the Sehat Sahulat Programme, in practice only 93,000 were found to have utilized benefits from the programme (Qayyum 2020).

As for the employee schemes, the overall number of secured workers under PESSI is 918,343 while the number of dependents is 5,508,708.⁷⁹ KP ESSI coverage gaps remain high, with an official report published by KP ESSI in 2014 noting that out of the province's 7.3 million total workforce, only 60,000 workers are affiliated with KP ESSI,

with an additional 340,000 dependents (KP ESSI 2014).

- Adequacy of benefits/financial protection

A cycle of ill health and poverty in Pakistan is exacerbated by inadequate financing of the health sector (Arshad et al. 2016). There are limited prepayment mechanisms in place and low government spending has led to high levels of OOP spending by households, which, as noted above, comprised 56.24 per cent current health expenditure in 2018. This places a significant financial burden on poor households. However, the Government has made commitments to expanding financial protection, particularly for health.

- Responsiveness to population needs
 - o Availability and accessibility

There are large disparities between the rich and the poor in terms of access to health services (Kurji et al. 2016). One study undertaken in Baluchistan province found an unusually high level of inequity in the utilization of almost all public health services. In particular, the utilization of services such as post-natal consultation, institutional delivery and tetanus toxoid injections for pregnant women were found to be higher among wealthier segments of the population (Malik and Ashraf 2016).

There are also considerable variations in the resources allocated to urban and rural public health facilities due to fragmented sources of funding. In some localities, most of which are urban areas, the public health system provides a wide range of services, including heart and cancer treatments as well as treatments for other critical illnesses. However, in rural areas, the availability of public care services is lower.

⁷⁹ The official PESSI website reports the number of secured workers and their dependents under the programme for each directorate (PESSI 2020).

Notably, in the province of Khyber Pakhtunkhwa, 1.45 doctors are available per 1,000 people in urban areas, while in rural areas the corresponding figure is only 0.36 (Asian Development Bank 2019). Moreover, there is evidence of gender inequalities in accessing health care, with Pakistan's 2019 CPIA gender equality rating lower than 85 per cent of other countries analyzed, including India, Nepal and Bangladesh.⁸⁰ Women therefore seek care less frequently than men, which has a negative impact on women's health status and general wellbeing (Arshad et al. 2016).

Despite these disparities, an analysis of health statistics by wealth quintiles, represented in table 1 below, suggests that for the listed health indicators, the poorest quintile (Q1) saw greater improvements from 2013 to 2018 than the wealthiest quintile (Q5), lending some support to the equalizing effect of Pakistan's social health protection system. In particular, substantial progress has been made when it comes to maternal and child health, and this progress was more significant for the poorest quintile.

► **Table 1. Comparison of evolution of national health indicators by wealth quintile**

Indicator	Q1			Q5			DID*
	2013	2018	Change	2013	2018	Change	ΔQ1- ΔQ5
Under-5 mortality rate (per 1,000 live births)	119	100	-19	48	56	8	-27
Infant mortality rate (per 1,000 live births)	90	76	-14	44	53	9	-23
Antenatal care (any skilled personnel) (% of women with a birth)	53.6	67.7	14.1	96.9	98	1.1	13
Assistance during delivery (any skilled personnel) (% of births)	34	49.8	15.8	85.8	93.9	8.1	7.7
Problems in accessing health care (getting money for treatment) (% of women)	54.3	45.7	-8.6	9.2	11.1	1.9	-10.5

Note: The first quintile (Q1) comprises the 20 per cent of the population with the least wealth, and the last quintile (Q5) comprises the 20 per cent of the population with the most wealth.

Source: Adapted from World Bank Data.

As exemplified by the evolution of national health indicators noted above, despite facing challenges, Pakistan has a history of strong programmatic interventions that have successfully improved social health protection for its citizens. For example, the Lady Health Worker Programme (LHWP) has been operated throughout the country since 1994, which equips female health workers with the skills to provide essential primary health

services in rural and urban slum communities (WHO 2008). Evaluations of the LHWP have shown that populations served by the programme have significantly better health outcomes than the general population—a strong result considering its focus on rural and marginalized populations (Women Deliver 2016). In addition, several Health Equity Monitor indicators, including neonatal, infant and under-five mortality rates, as well

⁸⁰ CPIA gender equality ratings are assessed on a scale from 1 to 6, with higher scores indicating higher gender equality (World Bank n.d. a).

as immunization coverage for diseases such as measles and polio, have improved for the poorest wealth quintile in the past decade (WHO n.d. a).

o Quality and acceptability

Despite these efforts, in line with resource distribution disparities, there are noteworthy differences in the quality of care offered in urban and rural areas. This, combined with perceptions of private services as superior quality, has caused a large proportion of the population to pay out-of-pocket for care in private facilities, even if such services are available in public facilities. Some studies find that patients have expressed dissatisfaction with services provided by their doctors, including unavailability of specialist doctors, seeing different doctors during each visit, absence of a physical examination, and fear of asking questions (Jalil et al. 2017). However, there are some individual reports of high levels of patient satisfaction with the Sehat Sahulat programme (Hussain 2019; The Nation 2020), although it must be noted that patient satisfaction is not systematically measured and monitored at national level as it is in many countries.

► 5. Way forward

Despite some signs of progress, OOP spending in Pakistan remains high and the social health protection system is fragmented. The multi-sectoral and multi-stakeholder Ehsaas Strategy was launched in 2019 to address fragmentation and enable better coordination between the institutions involved in administering national poverty alleviation and social protection programmes which target the mustahiq (deserving) population. This includes not only health schemes such as the Sehat Sahulat Programme, but broader financial assistance programmes such as Bait-ul-Mal⁸¹ and Zakat.⁸² Ehsaas is intended to bring such schemes and other components of social protection under one division to better serve the community (Government of Pakistan 2019a; ILO 2019). Ehsaas currently encompasses 115 policy actions under

four pillars: (i) making the government system work to create equality; (ii) safety nets for the disadvantaged; (iii) jobs and livelihoods; and iv) human capital development (Government of Pakistan 2019b).

Furthermore, the establishment of a new Ministry of Social Protection/Poverty Alleviation to address fragmentation of social protection mechanisms has been announced. The BISP, Bait-ul-Mal, and Zakat, among others, are to be coordinated by the new ministry (Pakistan Ministry of Finance 2019). Under the overarching Ehsaas framework mentioned above, two of the executing agencies of Poverty Alleviation and Social Safety Division (PASSD), namely Bait-ul-Mal and the Pakistan Poverty Alleviation Fund, signed an MoU to collaborate on strengthening women's economic empowerment and elevating women's roles in society (Benazir Income Support Programme 2019). As noted elsewhere, there is also coordination between SHP schemes and BISP on targeting of beneficiaries.

► 6. Main lessons learned

- Due to under-investment and resulting gaps in affordable access to health care, payments for health care services are primarily comprised of OOP spending, with many health care services provided by private facilities. This has led to significant disparities in access to health care between the rich and the poor.
- Fragmentation of schemes and limited population coverage have reduced the collective impact of social health protection schemes in Pakistan. The Government is addressing fragmentation through improved coordination structures and the launch of a new, large-scale health protection scheme, largely driven by a strong political will to improve access to health care for the poor population.

⁸¹ Through Individual Financial Assistance (IFA) and various support programmes, Bait-ul-Mal supports the poor, widows, destitute women, orphans and disabled persons, providing general assistance, education, medical treatment and rehabilitation, and child support (Bait-ul-Mal 2019).

⁸² Zakat is currently running a range of programmes for the poor which include Guzara Allowance for the chronic poor, marriage grants for poor single women, free treatment for poor patients, and educational stipends for the students of Deeni Madaris and government Institutes (Zakat n.d.).

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▶ The Philippines

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▶ 1. Introduction

Health is recognized as a human right by the 1987 Philippine Constitution, which declares that “the State shall protect and promote the right to health of the people.” To this end, remarkable progress has been made towards the achievement of universal health coverage (UHC) in the Philippines over the last decade. Currently, the national health insurance programme (NHIP), administered by the Philippine Health Insurance Corporation (PhilHealth), covers 85 per cent of the population, including more than 18 million workers in the informal economy and their dependents. Rapid expansion of population coverage was supported by sin tax revenues, demonstrating the important role of collectively financed mechanisms to cover the costs of accessing health care.

Despite impressive progress in terms of population coverage, obstacles related to low quality of care, high out-of-pocket (OOP) spending, limited accessibility of services and low utilization rates

among the poor are currently stalling progress towards UHC. To lay the foundations for the comprehensive reforms necessary to expand financial protection and access to health services for all, the government passed the Universal Health Care law in 2019,⁸³ the implementation of which is expected to respond to the main challenges of the social health protection system.

▶ 2. Context

The Government of the Philippines introduced Medicare, the country’s first mandatory health insurance scheme for public and private sector employees, in 1969, through the Social Security System (SSS) and Government Service Insurance System (GSIS). Just over three decades later, the National Health Insurance Act of 1995 established PhilHealth —the national health insurance organization responsible for the implementation

⁸³ Implemented through the Congress of the Philippines, Republic Act No. 11223 Instituting Universal Health Care for All Filipinos, available at: https://lawphil.net/statutes/repacts/ra2019/ra_11223_2019.html.

of the single-payer fund, NHIP.⁸⁴ This move towards a single pool, with PhilHealth as the main purchaser, has been utilised by the Filipino Government to work towards the expansion of coverage to all segments of the population, including those in the informal economy and other hard-to-reach groups.

Significant milestones include, among others, the introduction of a Sponsored Programme for poor households and a no-balance-billing policy for these households. To facilitate the enrolment of informal economy workers, partnership programmes were launched with Organized Groups and microfinance institutions in 2003 and 2006, respectively. Funded by an increase in taxes on tobacco and alcohol, full subsidies were also extended to the poor and the near-poor in 2012 through the amendment of the National Health Insurance Law. Efforts towards expanding coverage have been furthered through the 2019 Universal Health Care Act, which aims to facilitate automatic enrolment of all citizens onto PhilHealth, enhance financial protection, improve the quality of health facilities (especially in underserved areas), respond to health gaps, and improve health service delivery.

► 3. Design of the social health protection system

- Financing

In 2019, total health expenditure stood at 906 billion Philippine Peso (PHP), equivalent to 4.6 per cent of the national GDP (Philippine Statistics Authority 2020). The main financing sources of the health system include the following: public health expenditure, comprising general government revenues and mandatory social health insurance contributions, accounting for 42 per cent of total health expenditure (THE); voluntary social health insurance contributions, comprising 10.1 per cent of THE; and OOP payments, which account for 47.9 per cent of THE (WHO n.d.).

In December 2019, the Philippines Congress ratified a bill to increase taxes on alcohol, vapes and e-cigarettes (Department of Finance 2019), which has allowed for the creation of additional fiscal space to extend coverage of PhilHealth.⁸⁵ In addition, package 2 of the Comprehensive Tax Reform Programme (CTRP) aims to fill the current funding gap of PHP75 billion (US\$1.47 billion) within the budget for 2020, to facilitate the successful implementation of the UHC Law. This measure is expected to create additional revenues of PHP47.9 billion (US\$939 million) in 2020, which will ensure coverage for over 120 primary care drugs, and the treatment of all conditions at the primary care level.

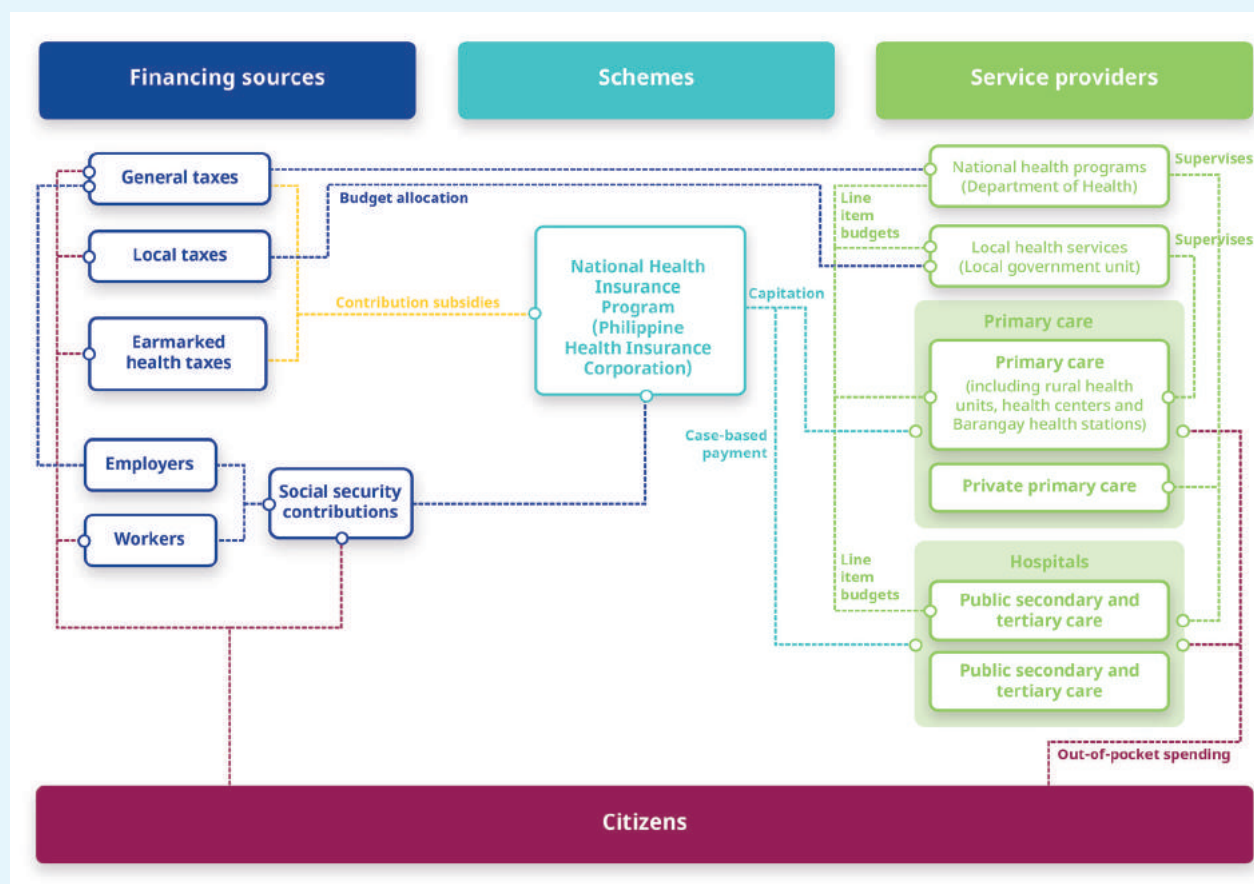
The NHIP is financed by central and local government revenues and social health insurance contributions. Previously, seven categories of members were defined, but this has been simplified by the new UHC Law into two main categories: “direct contributors” (contributors from payroll) and “indirect contributors” (fully subsidized from tax revenues). For direct contributors, 2.75 per cent of a member’s monthly salary is paid by the insured and their employer (where there is one). The salary floor of the contribution is PHP10,000 (US\$195), and the ceiling is PHP50,000 (US\$975). Through the implementation of the UHC Act, it is expected that contribution rates will increase to 5 per cent in 2025. For indirect contributors, contributions are fully subsidized by the government.

Online payment of contributions is possible through PhilHealth online payment options for employers. The Moneygment, an independent mobile application, serves as a contribution payment tool for self-employed individuals, small-to medium-enterprises, overseas Filipino workers and those without bank accounts (Moneygment 2020). It also allows better tracking of total expenses against one’s income through “zero-based budgeting.” Through the application, users can not only pay their PhilHealth contributions but also compute and file their taxes, utility bills, loans and other insurance payments.

⁸⁴ While the Government Service Insurance System (GSIS) and the Social Security System (SSS) are responsible for the pension plans of public and private sector employees, PhilHealth provides health insurance.

⁸⁵ Another benefit of imposing higher excise taxes on sin products and thus increasing their prices is discouraging their consumption. Available information on sin taxes indicates that, at the macro level, public health gains for the poorest population groups resulting from reduced consumption, combined with free health insurance for the poorest, could offset the regressive effect of indirect taxes on households (Kaiser et al. 2016).

► Figure 1. Overview of main financial flows of the social health protection system in the Philippines



Source: Authors.

- Governance

The health system in the Philippines is highly decentralized and fragmented with significant responsibility for health financing and service provision allocated to local government units (LGU). However, it functions under the overall leadership of the Department of Health (DOH) of the Ministry of Health, which is the regulatory authority responsible for developing policies and ensuring access to health care services, as mandated by the National Health Insurance Act of 2013. In addition, the Ministry implements public health programmes to tackle diseases such as HIV/AIDS, tuberculosis (TB) and Malaria, and provides many tertiary health services.

The national health insurance organization, PhilHealth, is a government entity attached to the DOH, which is responsible for administering the NHIP and providing policy coordination and guidance. PhilHealth functions include collecting contributions, processing claims, defining provider payment mechanisms, accrediting providers, creating benefits packages and reimbursing health providers. PhilHealth is governed by its Board of directors, comprising 13 members appointed by the President. Members include representatives from various government departments and agencies (including DOH, Department of Labour and Employment, Department of Finance and Department of budget and management), and representatives

of employers and workers in the private sector (PhilHealth 2017).⁸⁶

- Legal coverage and eligibility

In the past, enrolment was mandatory for all formal sector members, sponsored members and the poor. Workers in the informal economy, including migrant workers, lifetime members,⁸⁷ senior citizens, overseas workers programme (OWP) members and their spouses could enrol on a voluntary basis. Through the new UHC Law, enrolment is mandated for all Filipinos, increasing legal coverage from 98 per cent in 2018 to 100 per cent of the total population, with a goal to progressively realize UHC.⁸⁸ Efforts are ongoing to translate this extended legal coverage into effective coverage in practice.

As noted above, members are divided into direct contributors and indirect contributors. Direct contributors are those who have the capacity to pay contributions and are gainfully employed, whether bound by an employer-employee relationship or self-employed. This includes migrant workers and their dependents and lifetime members (individuals aged 60 years and above who have paid at least 120 monthly contributions to PhilHealth and the former Medicare Programmes). Indirect contributors, who are eligible to receive full subsidies, include poor and sponsored members, senior citizens and persons with disabilities.

- Benefits

Defined through a positive list, the benefit package of the NHIP includes the following services: (i) inpatient benefits; (ii) “Z-benefits package” (which expands the scope of the inpatient benefit package to additional conditions that are especially likely to lead to catastrophic expenditure, such as cancer); (iii) outpatient benefits, including day surgery, radiotherapy, haemodialysis, outpatient blood transfusion, and primary care benefits; (iv) other outpatient treatment packages for HIV/AIDS, malaria, TB, surgical contraception and animal bites, reimbursed through case-based payments; and; (v) the TB Directly Observed Therapy Short Course (DOTS) package. Under the National Safe Motherhood Programme, Filipino women

have full access to health services during their pregnancy and delivery. For all members, the benefits are the same, with the exception of outpatient primary care benefits, which are only available for poor and sponsored beneficiaries.

- Provision of benefits and services

PhilHealth membership registration is required to access benefits, following which each member is provided with a Member Data Record (MDR) and a PhilHealth ID Card, which is also recognized as a means of identification in the Philippines (PhilHealth 2016). In 2014, in response to challenges related to the registration process, the enrolment process was simplified by reducing the requirements for supporting documentation (PhilHealth 2014).

The service delivery system in the Philippines includes hospitals, primary care facilities and other facilities such as maternity care providers, outpatient HIV/Aids Treatment Centres, DOTS package providers and ambulatory surgical clinics. Out of 8,416 health care providers, there are 4,258 government and 4,158 private providers (PhilHealth 2020). Among all accredited hospitals, 60 per cent are private. The delivery of services at various levels of care is highly fragmented, and a referral system is not in place (Dayrit et al. 2018).

In 2019, PhilHealth reimbursed almost PHP97.34 billion to health facilities for their services to patients (PhilHealth 2018). Over the years, several payment mechanisms have been implemented, with fee-for-service used to pay for certain services, and capitation used to pay LGUs for primary care services. Since 2011, PhilHealth has shifted the provider payment mechanism away from a fee-for-service system with benefit ceilings, to case-based rates first for the 23 selected services. This was subsequently expanded in 2014 to cover all inpatient medical and surgical cases. However, in 2019, PhilHealth revealed that 100 per cent of hospital costs covered by its case rate system have either been underpaid or overpaid (Peralta 2020).

The poor and all other members subsidized by the government are exempt from co-payments. For other member categories, a fixed co-payment is set for the outpatient benefits package

⁸⁶ In line with the Congress of the Philippines 2019 Republic Act No. 10932 on strengthen the Anti-Hospital Deposit Law, available at: <https://www.officialgazette.gov.ph/2017/08/03/republic-act-no-10932/>

⁸⁷ This category is comprised of members who have reached the legal age of retirement and have paid at least 120 monthly contributions.

⁸⁸ Republic Act No. 11223.

and for the Z-benefits package (Villaverde et al. 2018). The UHC Law states that no co-payment will be charged for services rendered in basic accommodation. A fixed co-payment can be expected for non-basic or non-ward accommodation, regulated by the DOH and PhilHealth. This means patients will know what to expect in terms of their OOP expenditures.⁸⁹

► 4. Results

- Coverage

Through the implementation of a rights-based approach, with support from sin tax revenues, social health insurance coverage has gradually expanded over the years, leading to high population coverage in the Philippines. Specifically, PhilHealth increased its effective population coverage from 73 per cent in 2007 (64.6 million members, including dependents) to 85 per cent of the total population in 2020 (93.3 million beneficiaries), and acts as a single payer at national level. Direct contributors comprise 59 million beneficiaries, and indirect contributors account for 34 million beneficiaries (PhilHealth 2020). Notably, PhilHealth successfully extended coverage to more than 18 million workers in the informal economy and their dependents through adapted mechanisms. However, further efforts are needed to achieve UHC. To do so, it is necessary to eliminate barriers to effective coverage, particularly among workers in the informal economy and migrant workers, who do not seem to be covered in the new UHC law. Many of these workers may not be poor enough to qualify for government subsidies, but they may also not be able to pay regular PhilHealth contributions independently.

- Adequacy of benefits/ financial protection

In 2019, 47.9 per cent of THE was comprised of OOP payments, and the incidence of catastrophic spending stood at 6.3 per cent (Philippine Statistics Authority 2020; WHO and World Bank 2019), which more than doubled from 2.8 per cent in 2000 (WHO and World Bank 2019). The lack of PhilHealth coverage of medicines, and

the high cost of drugs, medicines, laboratory and diagnostics have been identified as the main drivers behind the high OOP rate (PhilHealth, 2018). Limited financial protection for members related to limitations in the benefit package and co-payment levels may affect utilization, though there is some evidence that utilization is higher for members than for non-members (Gouda et al. 2016).

In 2018, the benefit payments- to-contribution collection ratio was low for all member groups, except for poor and sponsored members. This is most likely due to the no-balance-billing (NBB) policy, which stipulates that no other fees or expenses shall be charged to or paid for above PhilHealth's package rate, which is applicable only to poor and sponsored members. Evidence suggests that even with this measure, the enforcement of the NBB policy may need to be more stringent to ensure financial protection of the most vulnerable. It would also need to be expanded, since the NBB Programme only covers confinements in basic or ward accommodation (Dayrit et al. 2018).

- Responsiveness to population needs
 - o Availability and accessibility

Inpatient care, deliveries, catastrophic coverage and ambulatory surgeries are available for NHIP members, but the scope of PhilHealth benefits is largely focused on inpatient care, with outpatient benefits still not provided as a universal entitlement. Moreover, there are a limited number of health facilities and staff shortages persist, especially in geographically disadvantaged areas. To compound this, a large share of the population is unaware of their entitlements or unable to access their benefits. In particular, certain challenges have been observed regarding the PhilHealth registration process, including the time and money needed to submit required documentation, which has prevented many families from accessing PhilHealth benefits.

These challenges translate into relatively low utilization rates in the Philippines, particularly among the poor (Dayrit et al. 2018). However, evidence reveals the positive impact of health insurance coverage in increasing utilization. A recent study demonstrated that PhilHealth membership increases the likelihood of outpatient services utilization by 6–6.5 percentage

⁸⁹ Republic Act No. 11223.

points for adults, and 4.7–8.1 percentage points for children below 15 years of age (Balamiento 2018). According to the same study, the probability of accessing inpatient care among adults increased by 4.1–8.2 percentage points among poor PhilHealth members compared to non-members. Overall, the study found that the impact of PhilHealth affiliation is greater for children below 15 years of age than for adults. With regard to delivery services, a 2016 study revealed moderate wealth-based disparities in access to institutional delivery (Hodge et al. 2016). However, the likelihood of facility-based delivery for women who are insured through the PhilHealth subsidized coverage programme is 5–10 per cent higher than for those without insurance. This impact is more pronounced among poor women in rural areas, where insurance increases the likelihood of facility based delivery by 9–11 per cent (Gouda et al. 2016).

- o Quality and acceptability

Inadequate quality of health services is a significant challenge facing the health system in the Philippines. A survey among women aged 15–49 revealed that 12.6 per cent of women in urban areas and 8.4 per cent of women in rural areas decided not to deliver a baby in a health facility because of poor quality service and lack of trust in the system (Philippine Statistics Authority and ICF 2017). In addition to a shortage of facilities and qualified staff, one of the key constraints to quality improvement is the absence of an efficient referral system. This prevents patients from navigating the health system effectively and can increase waiting times for patients, preventing them from benefiting from timely care.

► 5. Way forward

The Philippines has made remarkable progress towards UHC by extending social health insurance coverage to large parts of the population. The allocation of subsidies financed through sin taxes to cover vulnerable groups with low contributory capacities is particularly noteworthy. Similarly, the existence of a central purchaser managing all of the different entry points into the system represents an effort towards increased equity, and provides an opportunity for impactful purchasing

strategies. However, the financial burden of OOP expenditures and impoverishing health expenditures remain problematic, comprising almost 50 per cent of THE, despite the achievement of high population coverage. Ensuring adequacy of benefits with a comprehensive benefit package, including primary care, is of essence in this context. In addition, increased investments in health infrastructure and efforts to enhance quality, availability and accessibility of the system are required.

The UHC Law of 2019 sets an ambitious reform agenda towards a system that guarantees equitable access to quality and affordable health care and financial protection for all, and envisages providing all citizens with a benefit package that includes a more comprehensive range of outpatient services (PhilHealth 2019). Specifically, the law stipulates structural changes in health financing, service delivery and governance, and aims to facilitate innovative financing streams for population-based and individual-based interventions. With a view to address fragmentation in the system, the law has mandated the establishment of province- or city-wide health care provider networks (HCPNs), starting with 33 selected pilot provinces. Lessons learnt will be used by DOH and PhilHealth to support the eventual rollout of the law. Moving forward, in line with the new law, the role of DOH will be more focused on regulation, policy development, standard setting and implementation guidance at the local level, while PhilHealth's role as national purchaser of services will be strengthened. DOH and LGUs will be responsible for population-based interventions and health services, such as immunization and health promotion programmes, while PhilHealth will finance individual-based health services.

To prevent duplication of diagnostic procedures and improve overall quality of care, the UHC law mandates the establishment of a primary care network of public and private providers to serve as initial contact points and facilitate two-way referrals (Dayrit et al. 2018). In a move to further promote quality improvements, the UHC Law and Implementing Rules and Regulations instruct PhilHealth to shift to paying providers using performance-based, prospective payments based on disease or diagnosis related groupings and develop different payment mechanisms that give due consideration to service quality, efficiency

and equity.⁹⁰ Currently, there is a lack of effective auditing processes to ensure transparency of reimbursement of providers, which reduces value for money.

► 6. Main lessons learned

- Gradual expansion of social health insurance coverage, including to workers in the informal economy, through a rights-based approach has led to high health protection coverage in the Philippines. PhilHealth has successfully extended coverage to more than 18 million workers in the informal economy and their dependents through adapted financing and administrative mechanisms. The expansion of population coverage has been supported by sin tax revenues, demonstrating the important role that such taxes can play in efforts to move towards UHC.
- Despite broad population coverage, the burden of OOP health expenditures remains high for Filipino households, underlying the need to now prioritize benefit adequacy. The fact that impoverishing health expenditures remain high demonstrates that universal legal population coverage alone is not enough to provide financial protection. Effective coverage through a broad benefits package and limited co-payments is essential to move towards adequacy of benefits in line with international social security standards.
- Low PhilHealth share of THE, comprising only 17 per cent, prevents comprehensive coverage. This is mostly due to issues with effective coverage of the benefit package and underutilization of health services among poor members. Expanding the scope of benefits for vulnerable groups would ensure both higher PhilHealth funding of health facilities and broader risk pooling across the nation. Although it has increased greatly over the years, a higher share of THE would enable PhilHealth to provide enhanced financial protection

for its members. In addition to providing more financing for health, the recently introduced UHC Law aims to deliver more value for money by reducing inefficiencies through consolidation of the system and strengthened governance.

- PhilHealth introduced the TB DOTS outpatient benefit package to deal with the burden of TB, which has illustrated the importance of comprehensive outpatient care coverage and provides an interesting example of integrating of formerly vertically-funded programmes. Accredited TB-DOTS centres (public and private) were strategically conceptualized by the Philippine Coalition Against Tuberculosis and PhilHealth to help finance detection and treatment of TB cases by PhilHealth. Only accredited facilities providing TB-DOTS treatment are eligible to receive reimbursement from PhilHealth. By 2020, 20 per cent of all PhilHealth accredited facilities provided the TB-DOTS package (PhilHealth 2020). This initiative highlights the importance of integrating the benefit package and building partnerships between the social health protection system and the broader health system.

⁹⁰ Implementing Rules and Regulations of Republic Act No. 11223.

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► Singapore

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► 1. Introduction

Singapore has achieved excellent health outcomes for its population and one of the highest life expectancies in the world (84.9 years), while spending a modest 4–5 per cent of GDP on health care. Singapore adopts a “mixed payer” social health protection model which is built around four central philosophies: the importance of personal motivation, targeted subsidies, a strong survival motif, and the use of market mechanisms to drive efficiency. This has resulted in a mix of several health protection instruments, including a national health care service financed by taxes and user fees, a public universal health insurance scheme for high medical costs (MediShield Life), a saving scheme structured in individual accounts (MediSave) and two public schemes to cover vulnerable households for the costs of inpatient care (MediFund) and primary care (CHAS). An additional scheme is in place for long-term care for the elderly (ElderShield).

The recent and progressive introduction of a number of rights-based schemes has resulted

in an increase in public spending on health and a subsequent decrease in out-of-pocket (OOP) payments, improving affordability of care for Singaporean citizens and permanent residents. Today, the population almost universally benefits from the social health protection programmes in place, and with a rapidly ageing population, Singapore stands out in its recent efforts to provide and finance long-term care in an integrated fashion. However, broad risk pooling across the population and solidarity in financing is limited, and programmes remain scattered for a small population. This creates issues of equity in access to care and difficulties for users to navigate a complex system. Furthermore, narrow entitlement criteria based on migration status, employment status or stringent means testing, limit both benefit adequacy and risk pooling.

► 2. Context

During British colonial rule, Singapore had a national health service whereby health care

provided by public facilities was fully subsidized by the government budget. Post-independence, the Singaporean health system developed further with the introduction of the National Health Plan in 1983. The Plan presented the government's health development strategies, including affordable care and meeting the demands of the population (Haseltine 2013). The national health service, which provided free services at public facilities for all, was deemed unsuitable by the government, who felt it was wasteful, and did not incentivize individuals to focus on their own health, leading to high health care costs and overconsumption.

In response, the government sought to shift some of the burden of health care from the state to the individual (for example, through co-payments), citing the importance of personal motivation and individual responsibility for a productive economy. In addition, Singapore's Government advocated for the power of markets to drive efficiency in the health sector, while seeking to retain government control over key issues, using the market as a policy tool only when deemed appropriate (Lim 2013). Accordingly, the government replaced the national health service model with a system which places responsibility on each individual for their own health and other life contingencies, with the family positioned as the first line of support, followed by government-led interventions as a last resort (Phua 2006; Teo et al. 2003).

Indicative of this shift, in 1984, after the Central Provident Fund Act of 1953 was revised, MediSave was created—a scheme based on individual saving accounts which are contributed to by employers and workers on a mandatory basis, and can be topped up by the government.⁹¹ At the time of the release of the National Health Plan, the use of a savings account model was criticized by some in the medical community who underlined the responsibility of the state to cover medical expenses rather than individuals, and highlighted issues affecting the chronically ill (History SG 2019).

The National health service and MediSave alone were found to be insufficient to cover impoverishing OOP health expenses, which prompted the creation of additional schemes. A public health insurance scheme known as MediShield (now known as Medishield Life), was

created under the Central Provident Fund (CPF) in 1990, with a view to cover hospital bills and selected outpatient interventions in both public and private health facilities. Contributions to this scheme are taken out of the MediSave account and subsidized for low-income groups.

In 1993, the government published a White Paper entitled “Affordable Health Care”, which aimed to promote the accessibility of basic medical services available to all citizens, regardless of their income (Haseltine 2013; Singapore Ministry of Health 1993). In the same year, the Medical Endowment Fund (MediFund) was introduced under the CPF, and its periodic replenishment was eventually embedded in the Medical and Elderly Care Endowment Schemes Act of 2000.⁹² MediFund can be used for similar interventions covered by MediShield Life on a case by case basis, if both MediSave and MediShield Life have been exhausted and the patient is still unable to afford the remainder of the bill (The Commonwealth Fund 2020). MediFund therefore serves as the ultimate resort for indigent citizens.

In 2000, the Community Health Assist Scheme (CHAS), which subsidizes access to primary health care, was created under the Ministry of Health in an attempt to ensure affordability of the entire spectrum of care. Shortly after, in 2002, a long-term care scheme named ElderShield was created under the MOH in response to the demographic reality of an ageing population.

To address coverage gaps among the migrant population, in 2008, the Ministry of Manpower introduced compulsory private medical insurance for migrant workers on temporary residence permits after the MOH withdrew eligibility for migrants to access the subsidies of the national health service. The following year, the MOH introduced means-testing for subsidies for care provided in public facilities for Singaporeans (Haseltine 2013).

To further extend coverage, in 2015, the MediShield Life Scheme Act was passed, which extended coverage to all citizens and permanent residents regardless of employment status.⁹³ This is now the scheme with the broadest coverage (97 per cent of citizens and permanent residents). Initially, affiliation to MediShield was not compulsory for

⁹¹ Central Provident Fund Act of 1953 (revised 2013), available at: Central Provident Fund Act - Singapore Statutes Online (agc.gov.sg).

⁹² Medical and Elderly Care Endowment Schemes Act of 2000 [revised 2001], chapter 173a, available at: <https://sso.agc.gov.sg/Act/MECESA2000>

⁹³ MediShield Life Scheme Act of 2015, available at: MediShield Life Scheme Act 2015 - Singapore Statutes Online (agc.gov.sg).

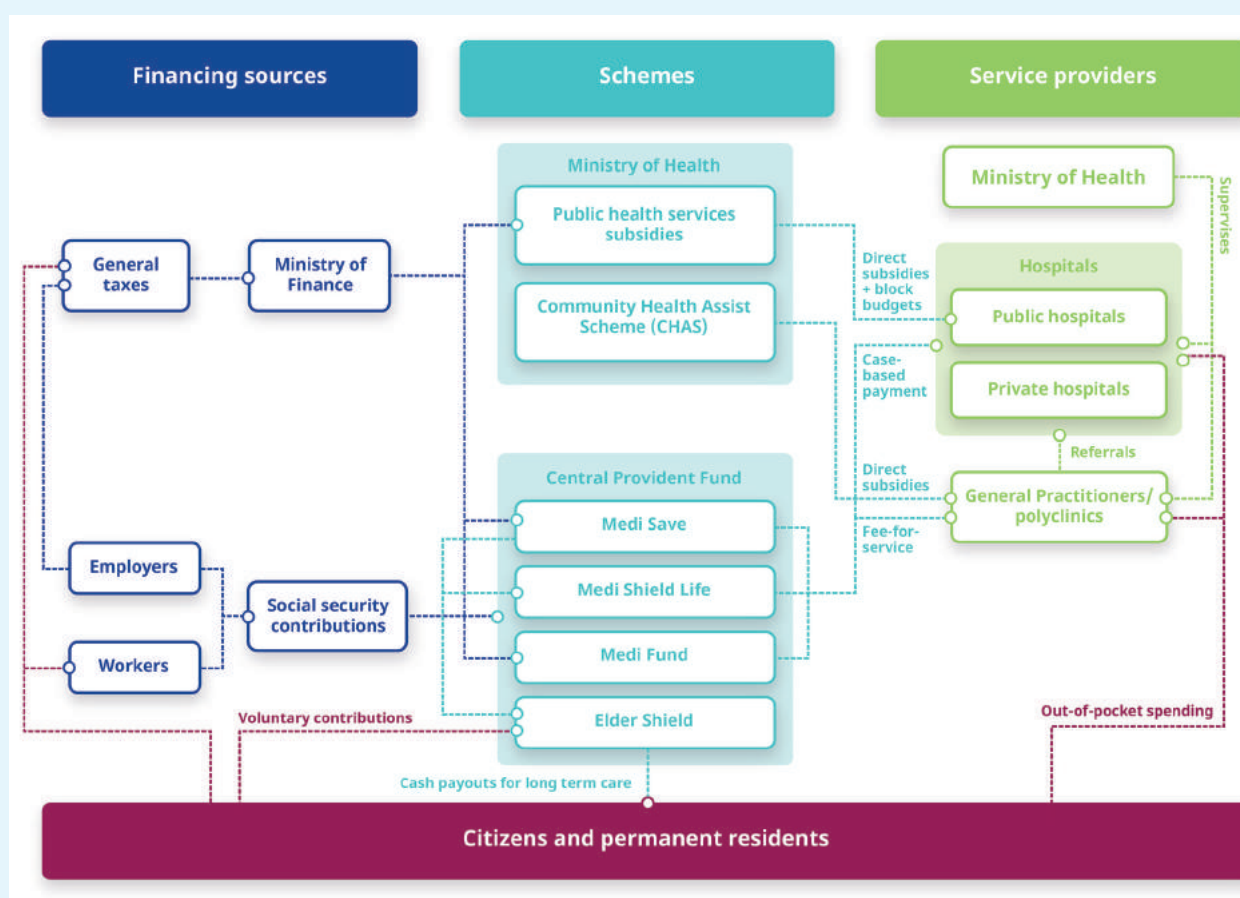
Singaporeans holding private insurance plans. However, as private insurers primarily targeted the young and healthy, the MediShield pool increasingly consisted of higher-risk individuals, leading to an increase in premiums. To combat this, the government launched the Integrated Shield Plan in 2005, in which private insurers can only offer packages that are supplementary to basic MediShield coverage. Today, the government continues to amend and expand health financing schemes as needs on the ground evolve, while firmly maintaining the Singaporean values and political philosophies that have guided its efforts in the past.

► 3. Design of the social health protection system

- Financing

The financing flows between the main schemes are schematically presented in figure 1 below.

► Figure 1. Overview of main financial flows of the social health protection system in Singapore



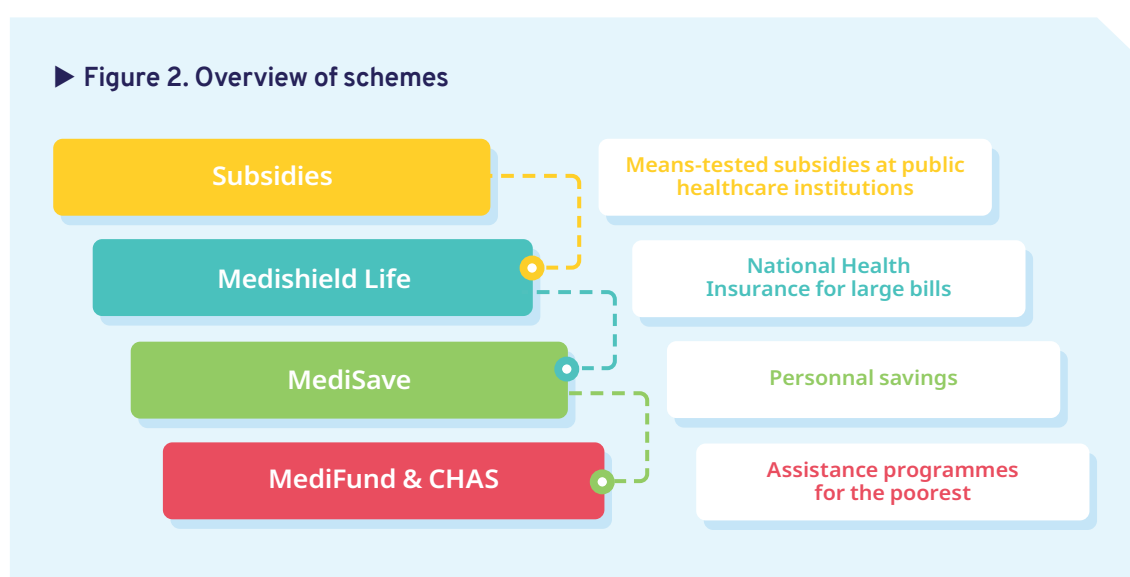
Source: Authors.

MediSave is a receptacle that collects both social contributions from workers and employers, and tax-financed government subsidies. Once placed in MediSave individual accounts, funds can be used to finance MediShield Life contributions (for the household) and ElderShield contributions.

The means-tested subsidies for the public national health service are financed from general taxes, similar to the endowment of the MediFund and the benefits of the CHAS. The public national health service provides a combination of direct

subsidies and a block budget to public health care facilities, while CHAS directly subsidizes patients.

MediSave functions as a saving account to be used to cover health care expenses, and it is not a risk pooling mechanism per se. MediShield Life is an insurance-based scheme focused on high-cost health interventions (primarily hospital-based interventions). Both schemes use a case-based provider payment method for public and private hospitals.



Source: Adapted from Singapore Ministry of Health (2020).

As illustrated by Figure 2, the different schemes are designed to be complementary, and do not overlap. They combine different types of instruments and sources of funding. The system is partially based on collective financing, and partially relies on individual savings. Both MediShield Life and ElderShield establish differential contribution levels depending on personal characteristics such as age or gender. This modus operandi is closer to private insurance premiums than that of social insurance contributions, and therefore may be discriminatory. For example, premiums for women were found to be 23 per cent higher than for men of the same age, allegedly due to higher life expectancies (Gee 2018).

- Governance

The MOH administers the subsidized national health service and the CHAS. As part of the National Health Plan, the CPF manages MediSave, MediShield Life and MediFund under the Central Provident Fund Act (Haseltine 2013). The CPF

Board and six Committees supporting its duties and responsibilities, including the MediShield Life and Insurance Schemes Committee, manage the CPF. Based on tripartism, the CPF Board includes members from the government, along with representatives of employers and workers.

On the whole, the government plays an integral role in the management of health care provision and financing, with private players only allowed to enter the market when the government believes it will improve overall efficiencies (Lim 2013). Notably, the management of Eldershield was initially delegated to three private insurance companies appointed by the MOH. However, the scheme recently underwent a review and the government determined that public management by a central agency would be more efficient and better able to respond to the needs of the population through a change in a number of scheme parameters, with a view to improve equity (Singapore Ministry of Health 2021c). To this end, the Long-Term Care

Bill and CareShield Life was established, through which the scheme will be publicly-governed.⁹⁴

The shift in management of the EldersShield scheme is part of a comprehensive package of policies to address ageing over the past decades. Such policies include the introduction of new regulations for residential and non-residential care, the creation of the Agency for Integrated Care, the enactment of a mandatory re-hiring policy for employers of senior workers as well as the subsidization of foreign domestic workers hiring and skill enhancement (Cheah et al. 2012; Mehta and Vasoo 2008; Nurjono et al. 2018; Nurjono and Vrijhoef 2019; Ortiga et al. 2020; Ow Yong and Cameron 2019; Rozario and Rosetti 2012; Tan et al. 2017).

- Legal coverage and eligibility

All Singaporean citizens and permanent residents are covered through one or more of the social health protection mechanisms, with income status and age used to determine eligibility for certain programmes. Joint eligibility criteria and identification mechanisms are in place which ensures coordination between social assistance programmes and subsidized health schemes. For example, eligibility to the CHAS health scheme for vulnerable groups is determined through a centralized system and access is automatic through a Public Assistance Card. Eligibility criteria for each scheme is detailed below in Table 1.

- Benefits

Most services offered at public health care facilities are subsidized, and the government sets fixed, often subsidized prices for drugs listed on the official standard drug list (Singapore Ministry of Health 2021a). In addition, supplementary financial support may be provided to eligible citizens and permanent residents based on results of a means test. The national health service focuses primarily on acute hospital-based care. For other medical care, including primary care provided in the private sector, compulsory savings accounts managed by the Central Provident Fund (namely MediSave) are in place (Tan et al. 2014). MediSave accounts can be used for medical bills for the entire household. More detailed information on specific benefits offered by each scheme is provided below in table 1.

- Provision of benefits and services

The different government-led schemes have a strong focus on secondary and tertiary care. Before CHAS, access to primary care was subsidized in a network limited to 16 public polyclinics, while the country relied on a network of about 800 private clinics for outpatient care. These private structures provided the vast majority (82 per cent) of primary care services in Singapore, and MediSave was the only mechanism that could be used by patients, until the creation of CHAS for low-income households (Lim 1998).

A referral system is in place, gearing access to subsidies and MediShield Life cover for secondary and tertiary care (Singh Bali and Ramesh 2017). In order to support patients to navigate the health care system, particularly the different layers of financial protection (means-tested subsidies, health insurance, and so on), medical social workers are the key point of contact in public health facilities. They provide patients with advice on their expectations of programmes and services provided, as well as any problems regarding hospital billing and technicalities during admission (SingHealth 2021).

As highlighted in figure 1, a purchaser-provider split exists, though there are several schemes purchasing health care services. The means-tested subsidy system and MediShield Life use modern provider payment methods with a view to control costs, though they mostly concern inpatient care and high-cost outpatient care interventions. Purchasing at primary care level remains driven by the use of MediSave. While policies on long-term care have developed over the past decades, financing schemes and subsidies have mostly adopted an approach whereby the patient receives a cash amount that can be used to pay a wide range of providers rather than establishing centralized payment mechanisms for long-term care providers.

- Transparency and accountability

All of the schemes undergo regular adjustments based on consultations with the protected population. Recently, the MediShield Life parameters were revised and a public consultation was conducted with a view to collect public opinions and feedback on the proposed reform parameters (Singapore Ministry of Health 2020). Notably, after an increase in hospital

⁹⁴ CareShield Life and Long-Term Care Bill No. 24/2019, available at: <https://sso.agc.gov.sg/Bills-Supp/24-2019/Published/20190806?DocDate=20190806>

fees in 2002, increased government regulation led hospitals to become more transparent and provide detailed information on prices and patient

outcomes, which has enhanced transparency and accountability and contributed to a more efficient health system.

► **Table 1. Summary of key design features: coverage, benefit and service provision**

Scheme	Population coverage	Revenue collection	Benefit package	Benefit level	Benefit provision
Subsidized national health service	Citizens and permanent residents	Taxes	Inpatient and outpatient care	10 to 80 per cent of the costs of medical care is subsidized depending on patient's income.	Public facilities, provider payment mix of block budget and subsidies per intervention.
MediShield Life	Citizens and permanent residents	Employer, worker and government contributions (partial and full subsidies for low and middle-income households as well as the elderly).	Coverage for large hospital bills when the patient is hospitalized longer than eight hours, including day surgery, and some outpatient services.	Co-payment levels range from 3 to 10 per cent depending on the intervention. In addition, the scheme has deductibles. ¹	Public and private facilities ² , case-based payment for hospitals and fee-for-service for polyclinics.
MediSave	Citizens and permanent residents	Employer, worker and government deposits	Inpatient and some outpatient interventions are eligible to be paid by MediSave account. Contributions to MediShield Life and ElderShield can also be paid through MediSave	Savings account – the available funds in the account can be used for health interventions for the contributor and their household up to a ceiling withdrawal amount	
MediFund	Low-income citizens	Tax-financed endowment, revenue from fund interests	Complement the subsidized national health service, MediSave and MediShield	Covers remaining co-payments for citizens unable to afford it on a case-by-case basis	
CHAS	Low-income citizens and permanent residents	Taxes	Outpatient care (GPs, dental care and other primary care interventions)	Benefit level depends on type of health intervention and beneficiary income profile. A co-payment of 15 per cent is required before being able to use MediSave to pay the non-subsidized part of the bills	Public and some private primary health care providers.
ElderShield	Dependent citizens and permanent residents	Contributions from beneficiaries / MediSave account	Long-term care	Periodical cash payments of US\$300 or US\$400 per month for up to 5 or 6 years depending on the package	Eligibility: an eligible person requires physical assistance of another person for the Activities of Daily Living (ADL).

Source: Adapted from National Health Insurance Service (2019).

¹ The deductible is fixed and to be paid once per year in case of hospitalization. It ranges from 1,500 Singapore Dollars (US\$1,078) to 3,000 Singapore Dollars (US\$ 2,157) of the claimable amount, depending on age of the beneficiary and type of ward.

² The scheme can be used in both public and private facilities, but the benefit is designed to complement the national health service subsidies in public facilities. Affiliates who wish to seek care in private facilities will get the same level of benefit, but will end up paying higher OOP payments as private facilities are not subsidized. The pro-ration for private provider bills is currently 35 per cent, though lowering it to 25 per cent is under consideration.

► 4. Results

- Coverage

Since its independence, Singapore has provided access to health care services at subsidized costs to all Singaporeans. The national health insurance scheme, MediShield Life, complements the subsidization system with a view to cover remaining user fees in cases of large medical bills. The combination of contributions and tax-financed contribution subsidies ensure broad population coverage of MediShield Life, especially for acute hospital-based care. The scheme initially had many exclusions but progressively became accessible to all citizens and permanent residents. The Central Provident Fund reported the affiliation of 3.908 million persons in 2018, representing 97 per cent of citizens and permanent residents (Singapore Department of Statistics 2021). Significant efforts have been made over time to ensure that the self-employed are included in mandatory coverage.

All the schemes described in table 1 cover citizens and permanent residents, in line with the government's stated priority to provide adequate universal health coverage for all Singaporeans, with transient foreigners and workers left to rely on employers for protection. This excludes coverage of the 1.641 million temporary residents in Singapore, who represented over 28 per cent of the population in 2018 (Singapore Department of Statistics 2021). Temporary residents are mostly migrant workers (1.38 million, representing over a third of the workforce) who are among the most vulnerable workers in Singapore. Under the Employment of Foreign Manpower Act, migrant workers on temporary migration schemes need to be covered for medical care by their employer through a private basic medical care insurance covering high inpatient costs (non-work-related hospitalization or day surgery). There is no risk pooling with the rest of the population, and beyond this basic coverage, employers are liable for uninsured medical expenses, leading to inequities in coverage. The fact that temporary migrant workers remain excluded from the scope of social health protection coverage, combined with the fact that they tend to be concentrated in low or intermediate skilled jobs, reinforces unfavourable perceptions and attitudes towards migrants that encourage discriminatory practices (UN Women and ILO 2019).

- Adequacy of benefits/ financial protection

While efforts to improve the affordability of care have yielded some results, OOP payments on health care still represent over a third of current health expenditure, as illustrated by graph 1 below (WHO n.d.). Substantial government subsidies, which in 2017 amounted to 314 million Singapore Dollars (US\$222 million), and the existence of multiple schemes covering a wide range of services (from primary health care to long-term care), remain insufficient to effectively provide adequate financial protection, especially for the most vulnerable. For instance, there is evidence that affordability is an issue for people suffering from co-morbidities in old age and lower-income groups, and studies have highlighted that many citizens feel that the current health care financing system provides insufficient "peace of mind" (Asher and Nandy 2008; Tan et al. 2019). However, in terms of tackling increasing OOP payments related to old age health and care needs, the ElderShield long-term care scheme, which provides periodical cash payments in cases of severe disability, provides an interesting experience for the rest of the region.

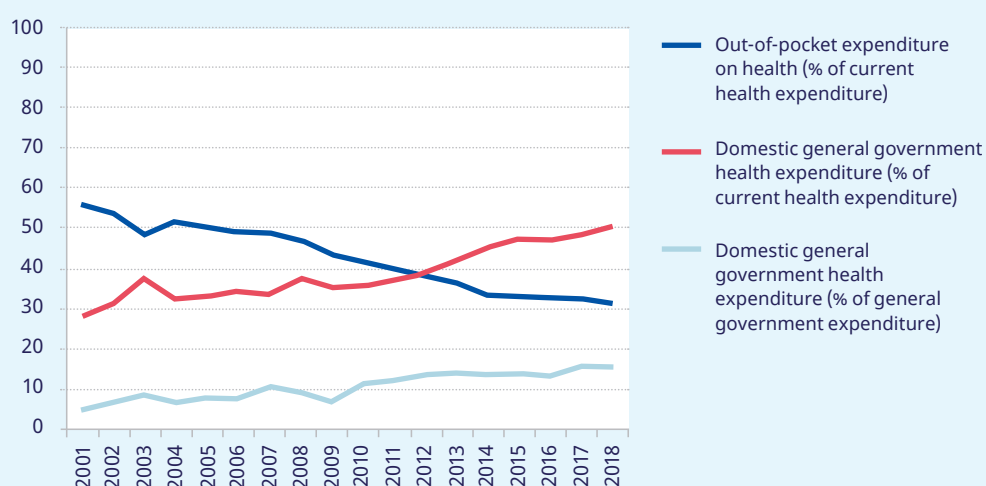
The implementation of CHAS significantly enhanced financial protection for primary health care in Singapore, highlighting the limitations of focusing exclusively on hospitalization to tackle impoverishing health expenses. As for MediSave, while this was initially presented as a mechanism that would reduce moral hazard, the effectiveness of using a medical savings account as a cost containment tool has been called into question (Hsiao 1995). In addition to the individual saving accounts, contributions to MediShield Life and ElderShield based on the age and gender of contributors are features based on individual risks rather than a solidarity-based system through a single risk pool. These coexist with schemes subsidized on a means-test basis and financed through other approaches, sometimes allocated on a case-by-case basis rather than from a risk pool, which decreases the redistribution and inequality reduction potential of the system as a whole. The ways in which eligibility for means-tested public programmes is determined have been criticized for being narrow and reliant on traditional solidarity mechanisms within the household, which may no longer be as organic as they used to be (Asher and Nandy 2008; Chia et al. 2008; Smith et al. 2015; Yahya 2015).

Another limitation of the system which reduces financial protection for the population is the

fact that Singapore's social protection model is premised on employment and jobs to enable self-reliance. As a result, Singapore does not provide legal entitlements to sickness and maternity benefits to ensure income security during such contingencies. Instead, it relies on an employer's liability, similar to the case of health coverage for temporary migrant workers (Chow 1985). This system remains difficult to enforce and places a financial burden that some employers are not able to sustain, especially in the context of the global pandemic (Addati 2015; ILO 2020;

ISSA 2020). This situation reinforces the possible adverse financial effects of sickness and maternity for the Singaporean population. To compound the limitations of providing maternity leave as an employer's liability, maternity care remains subject to co-payments, although efforts were made to include complicated deliveries within the package of MediShield Life in 2019 (Central Provident Fund Board 2018). To ensure that families are more able to cover health and other costs related to childbirth, the CPF put in place a cash payment for new-borns.

► **Figure 3. Evolution of OOP and public expenditure on health in Singapore, 2001–2018**



Source: Adapted from WHO Global Health Expenditure Database.

- Responsiveness to population needs
 - o Availability and accessibility

The mixed system of funding in place has enhanced widespread access to health services for the Singaporean population. However, the high costs of non-subsidized high health care in Singapore act as a significant access barrier to health care services for migrant workers. This inequity in access to health care services has been underscored by the COVID-19 pandemic (Goh et al. 2020; Rajaraman et al. 2020).

In terms of availability of services, the number of hospital beds in Singapore was 2.4 per 1,000 people in 2015, which is below the OECD average. Nonetheless, since 1960, hospital beds doubled in Singapore, with the sharpest increase seen

in the private sector, increasing by 370 per cent (Singapore & more in numbers 2019).

The mobile application, "Health Buddy App", is a noteworthy feature of the system which enhances accessibility for the population, enabling patients to access health information and services at any time through their personal profile (SingHealth 2021). Using the application, patients can find their nearest GP or clinic, manage appointments, view queue updates, place medicine orders and pay medical bills.

- Quality and acceptability

The MOH and its statutory boards are responsible for regulating the quality of Singapore's health care system. All health facilities such as hospitals, medical centres, community health centres, nursing homes, clinics (including dental clinics),

and clinical laboratories are required to apply for a licence under the Private Hospitals & Medical Clinics (PHMC) Act/Regulations. Moreover, MOH monitors the performance of the health care system against a large number of indicators, several of which rival levels encountered in OECD countries. Notably, waiting times for admission to wards were recorded as under 3 hours in 2019; waiting times for registration and admission at polyclinics were below 20 minutes in 2019; and the number of health personnel (24 doctors per 10,000 people) is more than double the WHO recommended minimum (Singapore Ministry of Health 2021b).

According to a survey undertaken by the MOH³ with the participation of more than 12,000 patients, the number of patients who rated services provided at public hospitals as good or excellent increased from 79 per cent in 2014 to 86 per cent in 2015. The share of patients who found services to be affordable increased from 69 per cent in 2014 to 72 per cent in 2015. Due to the high bed occupancy in public hospitals, the biggest gap between expectations and satisfaction was the waiting time for a bed at the emergency unit (Khalik 2016).

► 5. Way forward

Despite broad population coverage, challenges are emerging related to Singapore's increasingly older population, the rise in non-communicable diseases and conditions which require long-term care, as well as growing concerns among young voters and the elderly about rising health care costs and inequity. In response, the Singapore Government has expressed a desire to create a more holistic, inclusive, and universal health care system by bridging the gaps of the current model (Lim 2017). Recent reforms in this direction are progressively broadening risk pooling and reducing reliance on personal savings to finance health care.

One such reform is the extension of the MediShield Life social health insurance scheme to all citizens and permanent residents regardless of employment status or contributory capacity. In addition, the further revision of parameters to

abolish the exclusion of preconditions, and more recently, the transfer of the ElderShield scheme to the public sector, accompanied by a broader scope of coverage, contribute to these efforts. In parallel, the introduction of CHAS, the relaxing of some of the rules of MediShield and MediSave to include more outpatient interventions, and the creation of the agency for integrated care, represent efforts towards a better balance between primary, secondary and tertiary care.

However, as revealed by the COVID-19 crisis, efforts still need to be made to reduce inequality. To this end, coverage of migrant workers is to be expanded further as a result of pressures from civil society, trade unions and the research community. In addition to this, more and better data on multi-dimensional poverty and inequality in Singapore would support monitoring the extension of social health protection and its impact. Indeed, while Singapore has a wealth of publicly available data, it remains challenging to find official evidence and analysis on poverty and inequality (Smith et al. 2015).

► 6. Main lessons learned

- The development of legal entitlements and legal reforms were instrumental to the extension of coverage. Recent efforts to extend coverage focused on the development of the legal framework to create mandatory affiliation for citizens and permanent residents to MediShield Life, which reached 97 per cent of its target group. Efforts were also made to embed long-term care entitlements in the law.
- While population coverage is near universal, benefit adequacy, risk pooling and solidarity in financing encounter limitations due to the number and type of programmes adopted as well as the principles and beliefs upon which the programmes are built. Although there is no overlap between the schemes, the Singaporean principle of "many helping hands" has led to a situation in which there are many different programmes to cover a rather small population. In addition, the principle of self-reliance, the use of individual medical saving accounts,

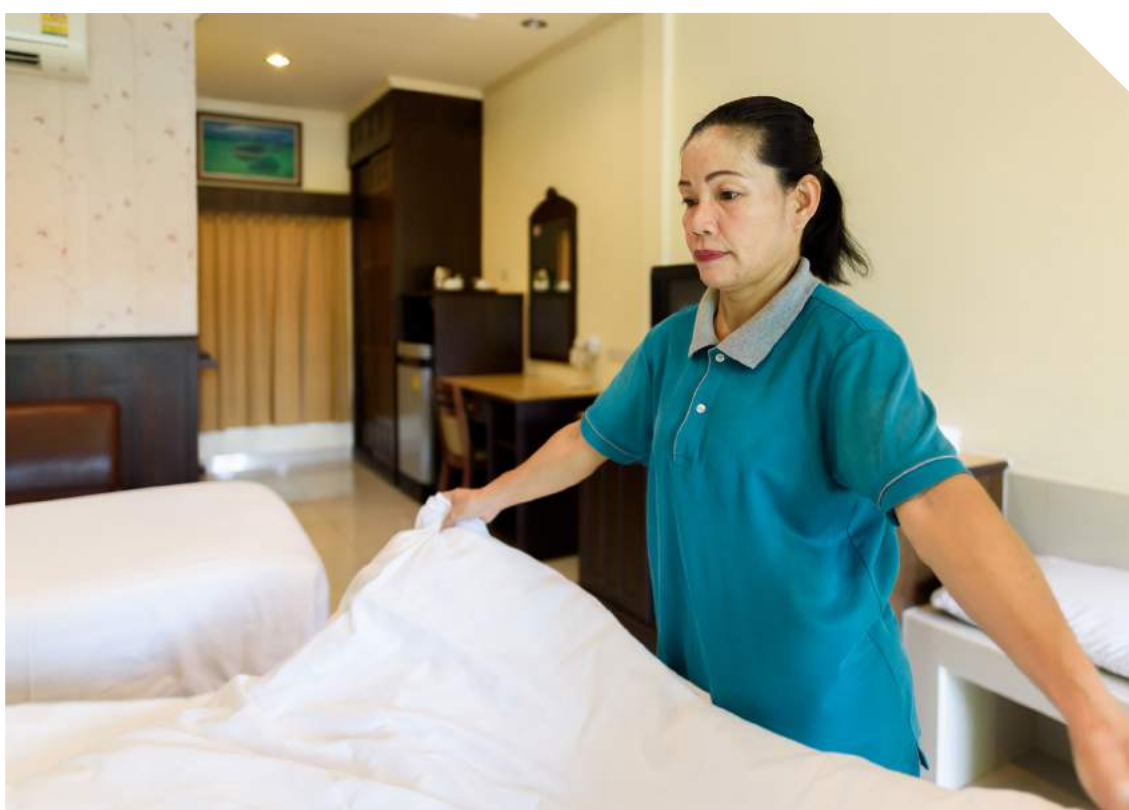
³ This survey was discontinued and today it is unclear what the tracking mechanisms are.

the limitation of the scope of risk pooling mechanisms for secondary and tertiary care, and the exclusion of temporary residents limit equity in access to care and create adverse incentives for the use of primary care. Narrow eligibility criteria for means-tested services and programmes further limits the equity of the system.

- Although the different social protection mechanisms in Singapore are complementary and do not overlap, the system remains highly fragmented in terms of the number of schemes with respect to the relatively small population of Singapore, which reduces efficiency. As it has been noted, international experience suggests that the presence of multiple health schemes purchasing services “is technically much more complex than a system with a single purchaser and involves higher transaction and administrative costs” (Thomson and Jeurissen 2017, 12).
- The reliance on employer liability for some contingencies and/or population groups has been exposed by the COVID-19 crisis as

a weakness of the social protection system. While paid sick leave and maternity leave have a replacement rate of 100 per cent, these are an employer’s liability, and there is no risk pooling mechanism in place (Social Security Administration 2016). Similarly, employers of migrant workers on temporary residence permits are responsible for their health expenses. Exclusive reliance on employer’s liability schemes tends to create inequities in access to social protection benefits related to employment status, and are generally unsustainable during times of crisis.

- With a rapidly ageing population, Singapore identified long-term care as a contingency in its own right early on. The Singapore experience reveals that innovative financing methods such as the Eldercare scheme should be accompanied by efforts to integrate care and regulate LTC providers. In this context, the role and value of migrant workers ought to be recognized, which may lead to improving both public perceptions and skills over time.



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► Sri Lanka

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► 1. Introduction

Sri Lanka has made remarkable progress towards Universal Health Coverage (UHC) over the years, through a social health protection system that evolved as a result of fundamental political changes initiated in the 1920s and 1930s. Sri Lanka's health care system can be characterized by a predominantly tax-funded public system, providing health care services to the population free at the point of use, which is supplemented by a fee-for-service private sector. The government's efforts have focused on the supply side to ensure publicly financed health care services for all through an equitable, efficient and low-cost public delivery system (Rannan-Eliya and Sikurajapathy 2009). At the same time, the system facilitates and depends on significant private provision. This private provision meets a substantial proportion of overall demand, allowing limited government spending to effectively cover the poor, and keeping the cost of public provision low.

This pragmatic mixed system has allowed the country to achieve exceptional health outcomes – better than any country at its income level, particularly with regard to the maternal and child health agenda and infectious disease control, with relatively good levels of financial protection.

In recent years, Sri Lanka has also demonstrated progress in tackling the challenges associated with an ageing population and increasingly prevalent non-communicable diseases (NCDs). Sri Lanka is known for having achieved such results without major health financing reforms. However, the system is not without its problems. It is characterized by low levels of public spending (less than 2 per cent of GDP), which results in considerable dissatisfaction among middle-income Sri Lankans, who tend to prefer private services. As a result, there is pressure on politicians to enact reforms, but such change proves challenging in light of existing fiscal and political economy constraints.

► 2. Context

Sri Lanka has provided universal, free public health care services for the whole population since 1951, when user fees were abolished (Rannan-Eliya and Sikurajapathy 2009), but it has also enabled people to use private services as they so wish. The development and characteristics of Sri Lanka's approach to social health protection was driven by two critical events during the 1930s. Firstly, in 1931, government powers were transferred from the British colonial government to a local

legislature elected through universal franchise, which ensured that future governments had to take into account preferences of all voters on key social policies. Secondly, from 1934–1935, the island was struck by an unprecedented malaria epidemic that infected almost the whole population. The epidemic devastated rural areas, prompting the realization that charitable and market approaches to social protection were not adequate, which catalysed the requirement of direct state intervention to provide hospital care. Prioritization of the government health budget for allocation to hospitals and inpatient provision was reinforced by voters, and the approach of tax-financed, public provision of hospital services was institutionalized as the country's social health protection mechanism in 1947 by the Commission on Social Services (Commission on Social Services 1947).

In parallel with the provision of public health services, the provision of private services has also been advanced. Despite an extensive range of health care services that are free in practice and widely accessible, funding constraints have led to increasing dissatisfaction with public health services among upper and middle-income Sri Lankans, leading them to seek private services. This has prompted the establishment of a range of employer-financed and private medical benefit schemes. The Employees' Trust Fund (ETF) was established by the government in 1987 to provide coverage for a limited range of services for workers in the formal private sector. Because this excluded middle-income government employees who lack access to private insurance, a government-financed private insurance scheme was introduced in 1997 to cover civil servants. This was later converted into a statutory scheme known as Arahara. In addition to these two schemes, the President's Fund was established in 1978 to provide ad hoc financial assistance for medical treatment to those in need.

► 3. Design of the social health protection system

- Financing

An outstanding feature of the Sri Lanka health system model is the absence of the major health financing reforms that have been pursued in most low-income countries. Specifically, the country has not focused on a demand-side financing approach, there are no conditional cash transfers, very limited health insurance, and no targeting of the poor. In 2018, per capita current expenditure on health was US\$122 or 2.9 per cent of GDP, and public spending constituted 48 per cent of government spending (Amarasinghe et al. 2021). This is relatively low compared to countries of the same income level (Amarasinghe et al. 2018; WHO 2019b). The two major sources of health financing in Sri Lanka are the government budget and out-of-pocket (OOP) payments. In 2018, OOP spending accounted for 43 per cent of health expenditure, government spending accounted for 42 per cent, employer spending accounted for 5 per cent and voluntary health insurance accounted for 4 per cent; international development assistance for health was only a minor health financing source, accounting for less than 1 per cent of health expenditure (Amarasinghe et al. 2021). In the same year, 52 per cent of health spending originated from private sources, 81 per cent of which was paid out-of-pocket, 9 per cent comprised employer benefits, 9 per cent comprised health insurance, and 1 per cent was sourced from the non-profit sector (Amarasinghe et al. 2021).

As shown in Figure 1, the distribution among the three main sources of health financing has been relatively stable over the years, though public and private shares have fluctuated, with a slightly decreasing OOP contribution over the longer term. The public share has increased marginally in recent years, but it is not clear if this is a permanent shift associated with rising incomes, or a temporary fluctuation.

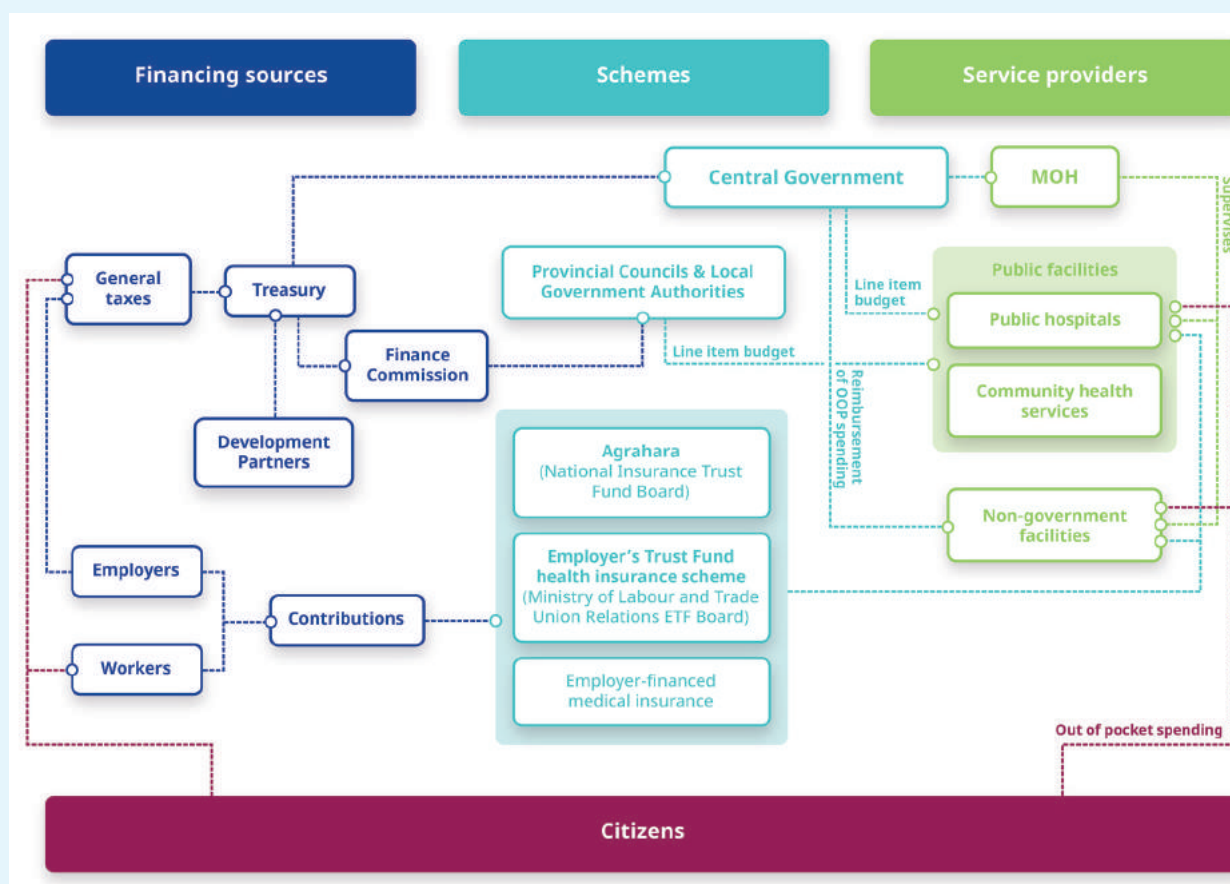
► Figure 1. Current health expenditure by source of financing in Sri Lanka, 1990–2018



Source: Adapted from Amarasinghe et al. (2021).

Figure 2 illustrates the flow of funds in the Sri Lankan health system (both public and private).

► Figure 2. Overview of main financial flows of the social health protection system in Sri Lanka



Source: Adapted from Amarasinghe et al. (2018).

Health facilities are resourced through a line-item budget at the level of hospitals or groups of facilities in the case of lower-level units, while some staffing costs and most medical supplies are financed by higher level budgets at provincial and national levels. Resource allocations are essentially input-based and not directly related to performance. However, gradual shifts in funding allocations have occurred in response to changes in patient demand, with a reallocation of financing and human resources towards secondary and tertiary facilities in recent decades, reflecting public preferences. Public funds are allocated to the central health ministry as part of the central government budget allocation, while provincial governments are financed primarily through the Finance Commission using block or criteria-based grants (Amarasinghe et al. 2018).

Government spending on public facilities and services is central to overall financing flows, whereas the contribution of government health insurance and reimbursement schemes, namely Agraphara and ETF is minimal (Amarasinghe et al. 2021). Specifically Agraphara, the insurance scheme that covers civil servants, accounts for 0.8 per cent of overall health financing, the President's Fund accounts for 0.3 per cent and the ETF accounts for 0.04 per cent. Employer financed medical benefit schemes account for 5 per cent of current expenditure on health, and commercial private medical insurance, which is mostly employer-financed group insurance for employees, accounts for 4 per cent.

Employer schemes typically reimburse workers for using private providers, or directly provide them with medical services. In recent years, the trend has been for employers to shift from directly managing such schemes to paying for group medical insurance schemes, whereby insurance firms manage the administration and payment of claims. Employer-financed group medical insurance accounts for 80 per cent of all private medical insurance, since high costs resulting from adverse selection effects reduces uptake of individual private medical insurance. Owing to typical insurance market failure, private medical insurance has withdrawn from the outpatient market, and generally only covers inpatient and specialist medical services, making no meaningful contribution to financing primary care services.

The ETF is financed by contributions to the fund, comprising 3 per cent of an employee's monthly salary, which is paid by employers. For the self-employed and migrant workers, who pay their own

contributions, the minimum monthly contribution is 500 Sri Lankan Rupee (LKR), amounting to approximately US\$2.65, and LKR1,000 (US\$ 5.30), respectively. For the Agraphara scheme, contributions are paid by the government as the employer of beneficiaries. In 2018, LKR4,017 million (US\$22.0 million), was collected in contributions, while LKR4,033 million (US\$22.1 million) was paid out to reimburse benefit claims under the Agraphara insurance scheme (National Insurance Trust Fund Board 2018). This represents less than 1 per cent of total health spending in the country. Given government fiscal constraints, it is unlikely that Agraphara will increase this contribution to health financing. The President's Fund is financed by revenues from the Development Lotteries Board and public donations (President's Fund, 2020a). It represented only 0.3 per cent of Current Health Expenditures in 2018 (Amarasinghe et al. 2021).

- Governance

Government health services

Government health care services are managed and provided by the Ministry of Health (MOH) and the nine provincial Departments of Health (DOHs) (Rannan-Eliya and Sikurajapathy 2009).

Agraphara

Agraphara was originally established as a government-financed, private medical insurance policy, but it has since been converted into a statutory scheme (Sri Lanka Ministry of Finance 2019). Since January 2006, the scheme has been managed by the National Insurance Trust Fund Board under the National Insurance Trust Fund (NITF), which operates under the oversight by the Ministry of Finance (Karunaratna et al. 2019).

Employees' Trust Fund (ETF)

The ETF was established through Act No. 46 of 1980 to manage the implementation of the fund with oversight by the Ministry of Labour (ILO Country office for Sri Lanka and the Maldives 2016). Oversight has since shifted to the Ministry of Finance, Economy and Policy Development. The ETF Board is a semi-governmental institution (Employees' Trust Fund Board 2018), with tripartite representation. The board is responsible for the collection of contributions, investment of funds, maintenance of individual accounts, issuance of member balance statements, enforcement of the Act by tracking non-compliant employers, and the

enrolment of self-employed persons (ILO Country office for Sri Lanka and the Maldives 2016).

The President's Fund

The President's Fund is a social assistance programme introduced under Act No.7 (President's Fund 2020a). Services provided by the fund are approved by the Board of Governors of the Fund, which is responsible for issuing grants to children of low-income families who have attained certain distinctions in school (President's Fund 2020a).

- Legal coverage and eligibility

Government health services

Sri Lanka provides free public health care services for the whole population. Non-citizens, including migrant labourers, can also access health services for free, although no specific policy on this exists.

Agrahara

As a compulsory scheme, all public sector employees, pensionable public sector employees and their dependents are enrolled by default into the Agrahara scheme.

Employees' Trust Fund (ETF)

ETF covers workers in formal employment, including private sector employees and public sector employees who are not entitled to the Agrahara scheme. Enrolment is mandatory, with the exception of specific categories of workers. Exemptions include religious, social or charitable institutions employing fewer than ten employees, institutions training juvenile offenders, orphans or persons who are destitute, deaf or blind, and businesses where only family members are employed. The self-employed and migrant workers can join this scheme voluntarily and pay for their own contributions (ILO Country office for Sri Lanka and the Maldives 2016).

The President's Fund

To be eligible for social assistance through the President's Fund, beneficiaries must satisfy all of the following conditions: (i) the monthly income of the family, including the patient, spouse and unmarried children, must not exceed LKR150,000 (US\$835) (President's Fund 2020a); (ii) he/she is ineligible to obtain an amount equivalent to 50 per cent or more of the total cost incurred for surgery/treatment from any other institution (including insurance coverage, medical schemes or welfare schemes); and (iii) if the beneficiary is a retiree,

s/he should be ineligible for Agrahara Insurance benefits.

- Benefits

Government health services

In principle, all services provided at public facilities are free-of-charge, with the exception of fees charged for contraceptive commodities. However, in practice, owing to financial constraints, public sector patients may be directed to private pharmacies and diagnostic services to obtain medicines and laboratory tests if these are not available in the public facility. In general, the Government does not use public funds to pay for or subsidize private services, and government doctors are not allowed to use public facilities for their off-duty private practice. The only exceptions are some very limited financing of private services by the President's Fund and the Agrahara insurance scheme.

The range of preventive health care services which are provided free-of-charge is relatively comprehensive, ranging from ante-natal and post-natal care, child growth monitoring, immunization, family planning, health promotion, nutrition counselling, communicable disease prevention, school and environmental health, food safety, and any health issues related to disaster management. The curative care network offers a comprehensive list of services, defined implicitly, which includes cosmetic surgery, oncology drugs (such as Herceptin and cardiac angioplasty) and cardiac transplants. However, these expensive services are often limited in availability and access is restricted by waiting lists.

Agrahara

Agrahara mainly covers a list of inpatient care services. In the early stages of the scheme, outpatient care was reimbursed, but this was discontinued due to excessive claims, paralleling the collapse of coverage in the private medical insurance market. Today, only spectacles and hearing aids are reimbursed as outpatient services (Karunaratna et al. 2019). Agrahara covers both public (non-fee levying) and private (fee levying) hospitals (Karunaratna et al. 2019), with no co-payments. However, in practice the Government has minimized the fiscal costs by use of reimbursement ceilings and burdensome administrative procedures that have reduced claims. In 2016, the scheme was upgraded to provide more benefits to retired public sector employees until the end of life (National Insurance

Trust Fund Board 2016). In the same year, two additional options called the Gold and Silver packages were introduced, allowing beneficiaries to upgrade their benefits package voluntarily by paying a top-up contribution.

Employees' Trust Fund (ETF)

The ETF provides financial assistance for a very limited list of health services. It provides coverage through the Shramasuwa Rekawarana Hospitalization medical scheme. Members are eligible to claim costs related to hospitalization treatment up to a maximum amount of LKR25,000 (US\$132) per year, and LKR500 (US\$2.63) per day of treatment as an in-patient in a government hospital for up to 10 days. This is conditional upon continuous contribution to the ETF for five years, and the length of hospitalization, which should be at least 48 hours. In addition, ETF also provides financial protection up to a certain predetermined amount on an ad-hoc basis for serious illnesses that require hospitalization and surgery. Procedures covered are limited to heart surgery, intra-ocular lens transplants and kidney transplants (ILO Country office for Sri Lanka and the Maldives 2016). The ETF also provides non-health benefits, including automatic life insurance cover for active members, disability benefits, housing loans at concessionary rates and scholarships and grants for children of active or disabled members who are unable to work anymore (ILO Country office for Sri Lanka and the Maldives 2016).

The President's Fund

The President's Fund covers medical expenses for specific diseases only, defined through an explicit list. This includes heart surgery, kidney disease, cancer, brain surgery, orthopedic implants, spinal disease, bone marrow transplant, liver disease, eye surgery and hearing aids (President's Fund 2020b). President's Fund beneficiaries must apply for reimbursement on an ad-hoc basis after seeking care at public hospitals and approved private and foreign hospitals. To apply for reimbursement through the President's Fund, the application must be submitted within 30 days from the date of discharge, and the surgery or treatment must have been performed in a hospital approved by the Fund.

- Provision of benefits and services

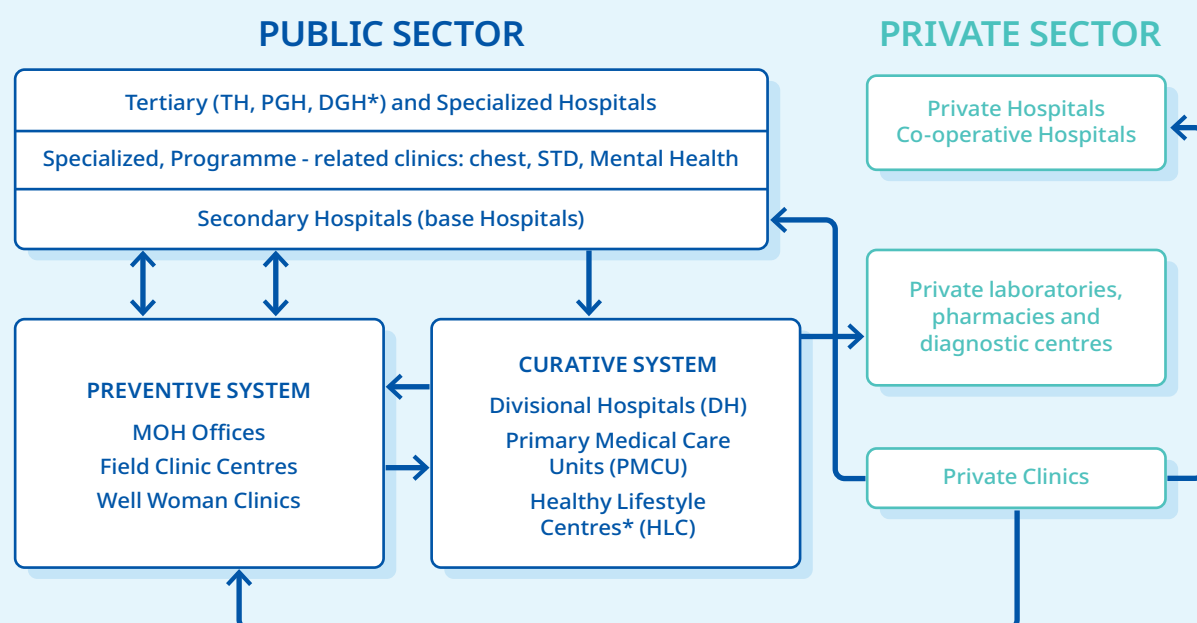
Government services are provided through a well-organized network of facilities across the country under the management of local medical offices.

The Government health system has three levels of care (primary, secondary and tertiary care), in which primary care is divided into preventive and curative functions. The clear separation between preventive and curative service provision at the local level is a unique feature of the system. Although there have always been some formal rules requiring referral between the different levels, in practice, there is no referral system or gate-keeping mechanism, allowing Sri Lankans full freedom of choice to visit any public facility on the island and to bypass their nearest primary level facilities in favour of secondary and tertiary care facilities if they wish to (Smith 2018; WHO 2017). This reflects the emphasis placed on universal access over quality. In practice, almost all tertiary and secondary hospitals also provide primary care through their general outpatient clinics, but access to specialist clinics in these hospitals is accessible only via referral through general outpatient clinics.

Public health facilities are mainly financed through line-item budgets, which are not performance based, and management of public facilities is hierarchical and led by doctors. There is no purchaser-provider split, and financing and provision of services are fully integrated within the public system, at central and provincial levels. There are no co-payments and limited informal payments requested from patients in public facilities, although fees are charged for family planning commodities. Beneficiaries of the ETF can use public and approved private providers and, in some cases, they can use providers abroad.

The private sector is staffed mostly by government doctors engaging in private practice outside official hours. This is most significant in the outpatient sector, where private provision accounts for half of all visits, but is limited in the inpatient sector where private hospitals account for only 4–5 per cent of inpatient visits, largely owing to the OOP cost of care.

► Figure 3. Network of health care providers in Sri Lanka



Source: Adapted from Ministry of Health, Nutrition and Indigenous Medicine (2019).

► 4. Results

- Coverage

As previously noted, Sri Lanka provides free public health care services for the whole population, supplemented with the option of private services to enhance the level of coverage for beneficiaries of insurance schemes. Overall, employer-financed medical benefit schemes and private medical insurance schemes cover about 10 per cent of the population, mostly comprised of formal sector workers and their dependents. However, they do not provide meaningful coverage of the poor, the chronically ill or the elderly, who would most benefit from improved health care financing. In 2018, there were around 82,416 employers in the scheme and there were 14.6 million ETF accounts, though 12.0 million accounts were inactive, leaving only 2.6 million active members (Employees' Trust Fund Board 2018). In 2018, there were 183,688 ETF claims for reimbursement, but these accounted for less than 0.1 per cent of total financing; as such, the ETF makes a negligible contribution to social health protection. The Agrahara scheme covered approximately 850,000 people in 2016

(National Insurance Trust Fund Board 2016), and the President's Fund covered around 7,752 beneficiaries in 2017 (President's Fund 2020c).

- Adequacy of benefits/ financial protection

While OOP payments remain very high as a share of financing, at 42 per cent of current health expenditure in 2018, Sri Lanka experiences a low incidence of catastrophic health spending, which stood at 0.4 per cent in 2015. This is due to the fact that almost half of total OOP expenditures are incurred by the richest households in private facilities, while forced spending among the poor is minimal. In fact, the share of total OOP expenditures only appears high due to the low level of public health spending and the high cost-efficiency of the system. The actual level of OOP spending is in fact relatively low (less than 1.4 per cent of GDP) compared to other countries in the region (Smith 2018). Therefore, despite a high OOP share, Sri Lanka performs well in terms of providing financial protection to those who need it most, with a situation comparable to that in Malaysia (Rannan-Eliya et al. 2016). However, low levels of public financing does result in gaps in provision, which not only affects

the supply of medicines and lab tests, but also those who require treatment for chronic diseases. OOP expenditures on medicines and lab tests accounted for about 61 per cent of total OOP spending in 2018 (Amarasinghe et al. 2021), and a proportion of this was related to public sector consultations.

- Responsiveness to population needs
 - o Availability and accessibility

The public system is able to provide Sri Lankans with high volumes of health services at reasonable levels of clinical quality and at low cost, in such a way that prevents income inequalities in access to most services. The health care network in Sri Lanka is extensive, with the co-existence of both public and private providers, which positively contributes to the accessibility of health care services. Indeed, the country has a dense network of health facilities. Most Sri Lankans live within three kilometres of a health facility, approximately 93 per cent of the population lives within 15 kilometres from the nearest hospital and the average distance between households and maternity clinics is just 2.5 kilometres. The provision of widely accessible public health care services is reinforced by a relatively high population density (Smith 2018). Furthermore, despite potential disadvantages, the lack of enforcement of a referral system prevents inequalities in access that would arise if people living in disadvantaged areas could only access services in their immediate vicinity.

This relatively high level of access is indicated by several metrics. In the case of critical preventive services, coverage rates for essential immunizations are typically 98–99 per cent, which is higher than the OECD average. As for curative care, doctor consultations averaged 7.7 per capita in 2018, which was higher than the OECD average of 6.8 in 2017. Easy access to hospitals is reflected by very high hospital discharge rates, which reached 34.5 per 100 capita in 2018, compared with an OECD average of 15.4 in 2017.

In general, the average Sri Lankan, including Sri Lankans living below the poverty line, make more frequent use of physicians and hospitals than the average citizen of other South and South-East Asian countries, with the single exception of Singapore. These high levels of health care use translate into low levels of unmet need. According to preliminary results from the Sri Lanka Health and Ageing Survey 2019, which is comparable to the European Union (EU) survey to track unmet need, 5.3 per cent of Sri Lankans had experienced

unmet needs for medical care (Institute for Health Policy, unpublished). This can be compared with an EU average of 2.6 per cent in 2016, 0.3 per cent in Germany and 5.5 per cent in Italy. Sri Lankan survey respondents attributed unmet needs in the past 12 months to financial costs, travel barriers or waiting times.

It is worth noting that, at lower-level public hospitals, there are significant variations in available services, though public tertiary hospitals generally provide most of the services they have been assigned to provide (Sri Lanka Ministry of Health, Nutrition and Indigenous Medicine 2019). However, not all services are readily available, as there can be significant waiting lists or limited availability of the required specialized human resources, equipment and drugs for certain services (Smith 2018). Ten of the 48 essential medicines were available in more than 95 per cent of facilities, while another ten medicines were available in less than 50 per cent of the facilities. These shortages are officially managed by providing some public sector patients with prescriptions which they can take to private pharmacies.

- o Quality and acceptability

In general, public services do relatively well in providing extensive preventative and curative services for the population. Intensive use of modern medical services has been a key driver of Sri Lanka's impressive health outcomes for several decades, ranging from child health and maternal outcomes to the elimination of malaria (Amarasiri de Silva et al. 2001; Caldwell et al. 1989; Rannan-Eliya and Sikurajapathy 2009). A critical factor in this is the relatively high quality of clinical care provided in both public and private sectors. Available evidence indicates that public sector services often provide better quality of care than equivalent private services, and that overall quality levels compare favourably with other developing countries (Rannan-Eliya et al. 2015).

However, the limited availability of human resources, equipment and drugs required for certain specialized services at public facilities, such as angioplasty for coronary artery disease, potentially hinders the system's responsiveness to population needs, particularly in relation to NCDs, for which medications and diagnostic services are essential inputs. As previously noted, general financial constraints in the public sector have led wealthier patients to opt for private facilities, but it is not necessarily the case that this results in

pro-rich inequities in quality of care, including for the management of chronic NCDs. In fact, recent data collected by the Sri Lanka Ageing Survey 2019 indicates a skewed, pro-poor use of specialist services for NCD care because of the availability of such services in the public sector.

Generally, there are high levels of public support for public sector health services, with high levels of satisfaction, although dissatisfaction increases with income level (Bhatia et al., 2009; Rannan-Eliya and de Mel 1997). Although management reforms have continued to generate large increases in operating efficiency, the failure to increase government spending as a share of national income results in shortfalls in consumer quality of free public services. Health policy has implicitly focused on driving continuous productivity improvements to minimize public sector costs and improve targeting of the limited public spending by focusing on maximizing physical access and clinical quality. This has taken precedence at the expense of consumer aspects of quality such as waiting times, doctor choice, minimal amenities and crowding, which tend to matter more to higher-income Sri Lankans.

Quality issues resulting from low levels of government health spending can be attributed to a political economy that gives voice to better-off Sri Lankans and economic interests opposed to increased taxation. This has resulted in a stable compromise, whereby the Government delivers an extensive range of health care services that are free in practice and widely accessible, but, due to funding constraints, are not sufficient to provide upper-income Sri Lankans with the level of non-clinical quality that they would like. Consequently, they prefer to opt for private services, which provide comparable or lower levels of clinical quality compared to the public sector (Rannan-Eliya et al. 2015). However, middle-income patients who prefer private services are often dissatisfied by the cost of private care, which leads to considerable dissatisfaction within the top two income quintiles. Nonetheless, most Sri Lankan voters express high levels of satisfaction with and support for public health services.

► 5. Way forward

Sri Lanka's approach has proven remarkably resilient to shocks and demonstrated a strong

ability to learn and adapt to new challenges while minimizing costs. Evidence indicates that the health system is coping well with the cost pressures from population ageing and epidemiological transition, and that it is incrementally adjusting service provision and quality to meet the increasing burden of NCDs. The system does well in maximizing health outcomes and financial risk protection, and experiences of comparable mixed systems indicate that the overall system has the capacity to meet the needs of the population as the country develops.

However, Sri Lanka's population is ageing relatively rapidly compared with most other countries at a similar income level. This will result in upward cost pressures in the health system, with challenges likely to arise in the resourcing of long-term care (LTC). Currently, Sri Lanka has no financing mechanisms to pay for LTC (Asian Development Bank 2019), which in developed economies, now accounts for 2–4 per cent of GDP. However, the Sri Lankan health system has proven to be quite resilient to cost pressures, with overall volumes and quality of care actually increasing in the past two decades, despite health spending falling as a share of GDP. Repeated analyses have concluded that Sri Lanka's ability to constantly reduce unit costs through productivity improvements may enable Sri Lanka to substantially mitigate cost pressures arising from ageing and to maintain overall health care costs at a level substantially lower than other countries of a similar income level (Rannan-Eliya 2008; Rannan-Eliya et al. unpublished).

While the health system successfully addressed the maternal and child health agenda, additional investment will be needed to address the changing health needs of the population to prevent and respond to the increasing burden of NCDs. This would include addressing human resource constraints and availability of NCD diagnosis and treatment, particularly at outpatient level. However, system performance in managing NCDs is relatively good compared to other developing countries, with recent evidence indicating comparatively high levels of diagnosis and control of diabetes, as well as rapid reductions in age-specific cardiovascular disease mortality, which is beginning to close the gap with developed nations (Sri Lanka Ministry of Health and Harvard TH Chan School of Public Health 2016). Organizational and clinical governance reforms may well be needed too, but these promising signs suggest that the current system still has capacity to improve

performance with additional investment, and to incrementally adapt services and strategies.

Overall, increased resources for health are needed, but the Government first needs to create additional fiscal space. The main constraint on government spending for the last four decades has been a tax policy that has continuously shrunk the tax base, with general revenue tax mobilization reaching a low of 12 per cent of GDP in 2019. Tax cuts in late 2019, combined with the impact of COVID-19, are projected to reduce revenue to 9 per cent of GDP in 2020 (Central Bank of Sri Lanka 2019). This level of tax mobilization is far lower than other countries at the same income level. Taxes have also shifted towards reliance on indirect taxes (VAT); however, in the 2019 budget, these were also cut. Generating additional resources by raising corporate and personal income tax rates and widening the tax base is needed. However, this requires a fundamental rethinking of tax and economic growth strategies to align them more closely with public preferences in favour of increased taxation, especially increased direct taxation, to pay for public services (Rannan-Eliya 2020).

As previously noted, Sri Lanka's approach to social health protection represents a compromise between the political pressures from its poorer voters for universal access and risk protection, and the opposition from wealthier voters and economic interests to increased taxation to pay for coverage of the non-wealthy. This compromise critically depends on continuing to collect taxes from the wealthy but using differences in consumer quality to persuade them to voluntarily opt out of free, tax-funded public services and self-pay for private services. The introduction of insurance schemes covering the non-poor would likely damage this balance and hurt the poor by undermining willingness of higher-income Sri Lankans to continue paying taxes for services that they opt out of. Any social health insurance scheme would therefore have to be universal in coverage, since the creation of two public tiers that provides subsidized access to private providers for better-off voters would be opposed by most of the population. Such opposition could threaten stability in the country.

Any new insurance-financed public scheme which subsidizes access to the private services that middle-income voters prefer to use would inevitably cost more than the current public system and would have to be financed either through increased taxation or new social

insurance contributions. Since poorer voters have access to free services, they will not be able or willing to contribute to any new insurance scheme. While middle-income voters may express support for paying into an insurance scheme to assist in paying for private services, it is not likely that they will support making additional contributions to a scheme to pay for poorer Sri Lankans to obtain the same access to subsidized private care.

For these reasons, there is likely to be a continued cycle of proposals to introduce insurance mechanisms, and interest by some development partners in supporting such proposals, followed by failure to implement them. Without substantial increases in taxes or mandatory contributions, the most feasible changes would involve more modest increases in taxation or contributions to extend public financing to partially cover private providers. However, with growing fiscal deficits and continuing declines in tax collection, even such modest changes are currently unfeasible.

► 6. Main lessons learned

- Strong outcomes can be achieved without adopting complex financing systems. The performance of a model depends more on good governance, strong political leadership and efficient management.
- It is possible to design pro-poor social health protection without targeting the poor. Sri Lanka's success involved eliminating means testing, removing co-payments and minimizing informal payments at the point of care through the public scheme. Effective universal access to this has been achieved by maintaining an organized, highly distributed, accessible and efficient network of public health facilities. The absence of targeting mechanisms, known for incurring large exclusion errors, and the lack of user charges, which can discourage access by the poor, have reinforced universal access.
- Despite the high share of OOP spending, at around 40 per cent of total health spending, Sri Lanka performs well in terms of financial protection, with a modest incidence of catastrophic health spending and relatively minimal impoverishing OOP spending. This is because OOP spending is largely

concentrated among wealthier populations. By using policies that shift the burden of OOP spending to the better-off, who voluntarily choose to use private services, minimizing OOP spending among those who use free public services, and prioritizing public spending to cover expensive hospital and inpatient care, financial protection has been maximized despite low levels of government spending.

- Mixed systems, like those of Sri Lanka, Malaysia and Hong Kong, are far more stable and resilient to change than casual observers imagine, and they represent a low-cost alternative to the Beveridge and Bismarckian approaches to achieving UHC. This warrants attention from other developing nations with limited financial resources.



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▶ Thailand

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▶ 1. Introduction

When it comes to socio-economic progress and poverty reduction, Thailand is widely considered a success story. Despite being classified as a middle-income country with limited fiscal resources, Thailand's economic growth has allowed for a reduced national poverty headcount ratio of 42.3 per cent in 2000 to 9.9 per cent in 2018. From 1960–1996, Thailand's economy grew at an average annual rate of 7.5 per cent, and after the 1997 financial crisis, the annual growth rate was still 5 per cent. Not only has this growth spurred job creation, helping to pull millions of households out of poverty, it has driven the development of Thailand's health system. In 2002, as a result of increased investment in health delivery system infrastructure, financing reforms, health workforce capacity building, health information system development, and a high level of political commitment, Thailand achieved Universal Health Coverage (UHC). As such, the case of Thailand is often-cited as an international good practice in this area.

In Thailand, the right to health care is anchored in the 2007 Constitution, which stipulates that “a person shall enjoy an equal right to receive appropriate and standard public health service”.⁴ In order to realize this right, three main public health protection schemes are implemented to cover Thailand's population: the government-funded Civil Servant Medical Benefit Scheme (CSMBS) for public employees; the contributory health Social Security Scheme (SSS) for private sector employees; and the most recently implemented Universal Coverage Scheme (UCS), which is a tax-based scheme providing free health care for those not covered by the two other schemes. For migrant workers in Thailand, coverage is provided either through the SSS scheme in the case of regular formal sector migrant workers, or the Migrant Health Insurance Scheme (MHIS) for those working in the informal economy.

In tandem with the development of the social health protection system, health outcomes in Thailand have significantly improved. Specifically, the under 5 mortality rate in Thailand decreased from 37 deaths per 1000 live births in 1990 to 12.2 deaths per 1000 live births in 2016, and the

⁴ Constitution of Thailand, 2007, article 51, available at: https://www.constituteproject.org/constitution/Thailand_2007.pdf

maternal mortality rate also declined, from 42 deaths per 100,000 live births in 1990 to 20 per 100,000 live births in 2015 (WHO 2018a; 2015). However, challenges remain as the country faces similar issues experienced by health care systems in other countries, including financial sustainability obstacles and growing burdens related to population ageing.

► 2. Context

Thailand's strong social health protection system is a product of relatively recent history. Before implementing the UCS scheme in 2002, which is widely perceived as having been instrumental to the achievement of UHC, the country had four health protection schemes. These included the two aforementioned health insurance schemes covering formal sector employees: the CSMBS and the SSS, established in 1980 and 1990, respectively. In addition, the 1975 community-based Medical Welfare Scheme (MWS) managed by the Ministry of Public Health (MOPH) was implemented to exempt the poor from user fees at public health facilities and was later extended to cover the elderly, the poor and other vulnerable groups. However, the programme faced issues related to inefficient financial management and complex funding usage rules (Health Security Office 2003) from underfunding and very little political interest (Mongkhonvanit and Hanvoravongchai 2015). In 1991, the MOPH merged fragmented community health insurance schemes into one programme, namely the Voluntary Health Card Scheme (VHCS), with the objective to cover those not eligible for the other programmes. Through the VHCS, each household with up to five people was able to purchase health insurance for 500 Thai baht (THB) per year. However, due to its voluntary nature and lack of incentives (Mongkhonvanit and Hanvoravongchai 2015), and the wide-spread perception that the quality of care was higher for those who paid the full cost upfront (Satidporn 2020), the scheme proved unsuccessful.

Due to underlying operation issues, mainly with the MWS and VHCS, 30 per cent of the Thai population were still uninsured during this period. This accelerated efforts to create a new health financing scheme by integrating the MWS

and VHCS schemes to launch UCS. Introduced in April 2001, the UCS scheme was initially piloted in six provinces and rolled-out to the rest of the country (with the exception of Bangkok) within seven months. Through the UCS, supported by strong political commitment, adequate budget allocation, active civil society engagement and technical expertise, Thailand managed to expand its health insurance coverage rapidly, covering 76 per cent of its population (47 million) less than 2 years on from its launch (ILO 2016).

► 3. Design of the social health protection system

- Financing

Overall, for the past decade, current health expenditure financing resources have remained at around 3.7 per cent of Thailand's GDP, and since the introduction of UCS, out-of-pocket (OOP) payments have drastically decreased from 33.9 per cent to 11 per cent in 2018 (World Bank n.d.) In tandem, government expenditure per capita has steadily increased, rising from US\$232 per capita, and reaching US\$723 in 2018 (World Bank n.d.).

Thailand's social health protection system is predominantly tax-funded, with the exception of the contributory SSS scheme, which is financed via tripartite financing arrangements, equally shared between employers, employees and the government. The payroll tax contribution to the SSS scheme is set at 1.5 per cent, borne equally by each of the three parties, namely the worker, the employer and the government (WHO 2015). It is the responsibility of the employer to deduct 1.5 per cent of their employee's salary and match the same amount. The government also contributes to the SSS through an annual budget contribution to the Social Security Office (WHO 2015).⁵

The CSMBS on the other hand, is a non-contributory scheme. Since its inception, the scheme has been fully funded by the government budget as a fringe benefit to supplement civil servants' historically low salaries. Despite covering a relatively small proportion of the Thai

⁵ WHO data shows that since the scheme was first launched, the salary threshold to calculate contributions has been fixed at THB15,000 per month and has not been increased since 1991 (WHO 2015).

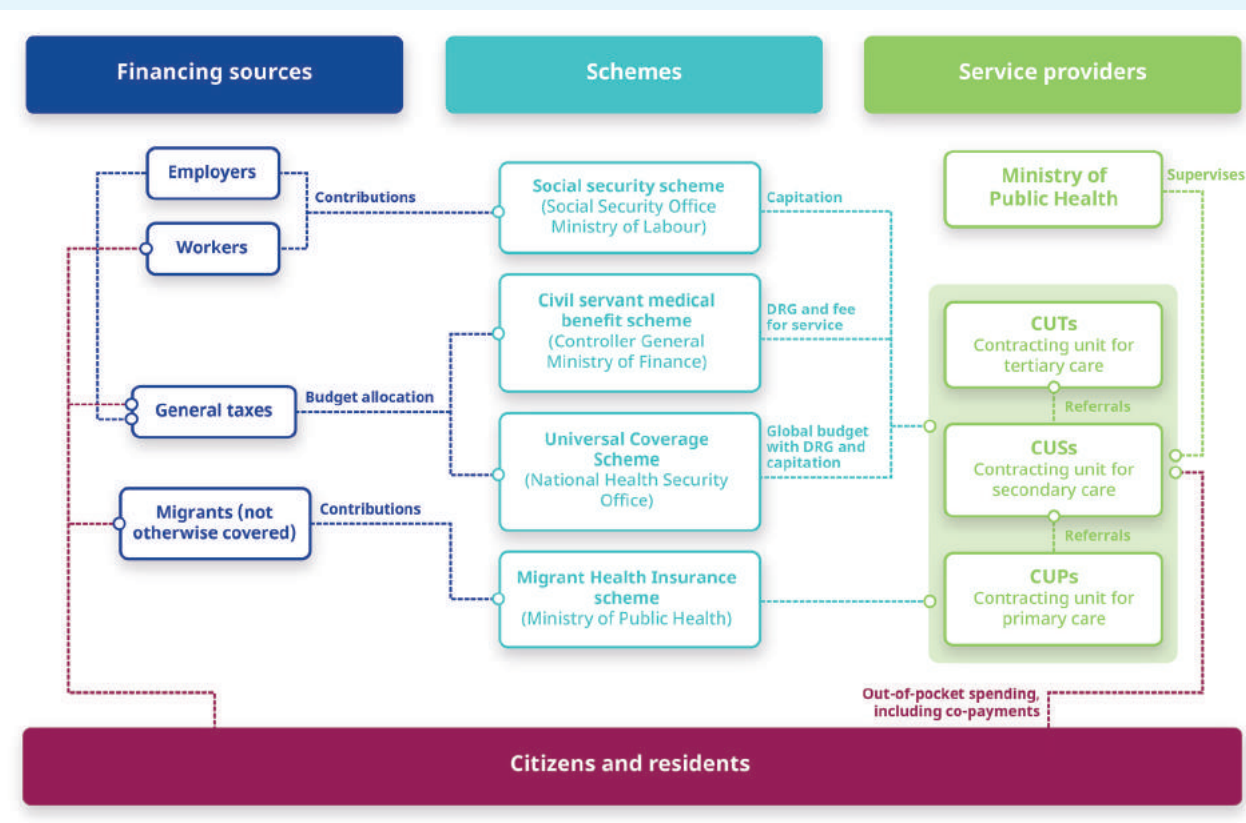
population, the CSMBS is considered the most expensive scheme and its expenditure is rising rapidly, making it four times higher than the other two main schemes (Barber, Lorenzoni, and Ong 2019).

The UCS scheme is tax-financed, characterized by a fixed annual budget, transferred from the government budget to the National Health Security Office (NHSO), based on the number of beneficiaries it covers and the capitation rate per beneficiary (McManus 2012). In addition to rapidly expanding coverage, the creation of UCS led to sweeping reforms of the Thai health financing system. In 2002, the implementation of a purchaser-provider split was introduced through the establishment of the NHSO, which contracts health care providers to provide health services for its beneficiaries. This signalled a move away from the previous model of budget allocation from the central MOPH to health care providers.

Along with the introduction of UCS, Thailand introduced capitation payments, and later on, Diagnostic Related Groups (DRGs), launching another significant reform toward demand-side health care financing and strategic purchasing (Hanvoravongchai 2013).

The MHIS scheme for migrant workers is a contributory scheme and paid out-of-pocket by the worker, with the exception of migrant workers in the fishery sector, where the employer must cover the expenses (IOM 2021). Differential prices apply depending on pre-defined categories of the population. While the standard price of the insurance is a fixed amount (THB3,200 for one year) for adults, the cost of the insurance for children under the age of 7 is lower (THB365). For migrant workers waiting to be covered by the SSS scheme, who are expected to register with MHIS during the three-month waiting period, the cost is THB1,050.

► Figure 1. Overview of main financial flows of the social health protection system in Thailand



- Governance

The Civil Servant Medical Benefit Scheme (CSMBS)

The CSMBS was launched in 1980 through the Royal Decree on the Disbursement of Medical Benefits for Civil Servants, B.E. 2523, last amended in 2007. Additional legal documents for the scheme include the Royal Decree on Medical Benefits, B.E. 2553 (2010), in accordance with the Act on Stipulation of Payment Rules in line with budget, B.E. 2518 (1975). Since its inception, the scheme has been managed by the Comptroller General's Department at the Ministry of Finance (MOF) and governed by an advisory board of 19 members, including member representatives, chaired by the Permanent Secretary of the MOF (WHO 2015).

The health Social Security Scheme (SSS)

The SSS health scheme was legally established in 1990, pursuant to the Social Security Act, B.E. 2533, which also established the Social Security Fund and the Social Security Office (SSO). The Social Security Act includes two different sections: Section 33 for all private sector employees and regular migrant workers; and Section 39, which relates to individuals who have been previously insured under Section 33, paid contributions for no less than 12 months, ceased being employees, and wish to continue being insured (Schmitt, Sakunphanit, and Prasitsiriphol 2013). The SSO, under the Ministry of Labour (MOL), assures the management of the SSS scheme. Its governance body is a tripartite board, chaired by the Permanent Secretary of the MOL, and composed of 15 members, including government, employee and employer representatives (WHO 2015).

Universal Coverage Scheme (UCS)

The UCS scheme was officially institutionalized through the 2002 National Health Security Act, B.E. 2545, which complements Section 51 of the 2007 Constitution of Thailand. The Act is considered the first Thai law to foster public participation in health policy formulation and agenda setting, providing a platform for stakeholders from all relevant sectors to participate in health promotion and the development of conducive policies and strategies (WHO 2017). To manage the scheme, an autonomous public agency known as the NHSO was created. It is governed by the National Health Board (NHSB), which is composed of 30

members (including civil service representatives) and chaired by the Minister of Public Health. Under its legal provisions, the National Health Security Act ⁶ defines health services (section 3) and sets out the NHSO's responsibilities, which include registration of both UCS beneficiaries and service providers under the scheme (Section 6); administration of the scheme's fund (sections 26 and 38); and reimbursement of claims in line with NHSB regulations (sections 7 and 8).

Migrant Health Insurance Scheme (MHIS)

The MHIS, which is also referred to as Compulsory Migrant Health Insurance (CMHI) by the MOL, is managed by the Health Insurance Fund for Foreigners and Foreign Workers under the MOPH. The primary legal basis for the scheme is the Cabinet Resolution of 15 January 2013 and a set of announcements by the MOPH, known as the Health Examination and Health Insurance of Foreign Workers (No. 2) B.E. 2562 (2019) (IOM 2021). The governance and guiding documents for the scheme are few and complex, subject at times to disparate understandings between various government bodies.

- Legal Coverage and eligibility

The Civil Servant Medical Benefit Scheme (CSMBS)

The CSMBS is Thailand's largest public employee health scheme, covering civil servants and their dependents (spouses, up to three children under 20 years of age and parents). It also covers government retirees, military personnel and foreign employees whose wages are paid from the Government budget and whose employment contract does not specify an alternative type of medical coverage (Schmitt, Sakunphanit, and Prasitsiriphol 2013). Some types of public employees are not covered by the scheme, including those working for local governments, state enterprise workers, government employees under temporary or fixed term contracts, and government retirees who opted for a pension lump sum payment (Schmitt, Sakunphanit, and Prasitsiriphol 2013). Such groups are covered by separate public health insurance schemes.

The health Social Security Scheme (SSS)

The SSS scheme covers employees from the private sector and documented migrants employed in the formal sector. Currently, dependents are not

⁶ National Health Security Act B.E. 2545 (A.D. 2002), available at: http://eng.nhso.go.th/view/1/National_Health_Security_Act_B.E.2545/EN-US

covered under the scheme, with the exception of maternity protection for spouses (WHO 2015). Registration is compulsory for private sector employees and regular migrant workers employed in the formal sector in Thailand.

Universal Coverage Scheme (UCS)

As set out under the provision of the Health Security Act, the UCS was created to cover the remaining Thai population not eligible under the CSMBS or SSS schemes, and exclusively covers Thai Nationals. Section 5 of the Health Insurance Act stipulates that “every person” shall be entitled to health services under this Act, and “person” is to be understood a person of Thai nationality who possesses an ID number (Schmitt, Sakunphanit, and Prasitsiriphol 2013).⁷ Beneficiaries of the scheme are identified through the national registry of beneficiaries. This registry was built upon the existing Ministry of Interior Population database and it is shared by the three statutory health protection schemes. As such, the identification of UCS members is made possible by the exclusion of beneficiaries from the two other schemes (ILO 2015).

Migrant Health Insurance Scheme (MHIS)

The MHIS is a voluntary health insurance scheme and covers documented migrants working in the informal economy and their dependents (up to 18 years of age), as well as documented migrant workers working in the formal sector, who are not yet covered by the SSS scheme. As previously noted, since workers eligible under the SSS scheme are not eligible for benefits under the scheme for the first three months of their employment, they are expected to sign up to the MHIS during this period; prior to May 2020, irregular migrant workers could enrol in the scheme, but now only regular migrant workers are eligible (IOM 2021).

There are three main channels for regularized work migration into Thailand: bilateral MoU processes with neighbouring countries (Lao PDR, Cambodia and Myanmar and Viet Nam), the Border Pass employment scheme for seasonal work, and the nationality verification process, undertaken on an ad hoc basis, in Thailand. Migrant workers under any of these categories are eligible to enrol in the MHIS. However, only

workers that have achieved regularized status through the national verification process are allowed to register their dependents. Dependents who enter the country alongside MoU and Border Pass migrant workers have irregular status and cannot register with the MHIS (IOM 2021).

Although the MHIS is a voluntary insurance scheme by law, migrant workers are required to purchase it in order to work in Thailand (IOM 2021). In order to be allowed to proceed with a work permit request, the MOL requires all migrant workers to provide a health check-up report and receipt of enrolment in the MHIS beforehand, making the scheme de facto “compulsory” via the work permit process. This has resulted in the adoption of the informal name, “Compulsory Migrant Health Insurance” by the MOL and related agencies.⁸

- Benefits

Despite varying eligibility requirements and governance and financing structures, the three main schemes (CSMBS, SSS and UCS) offer essentially the same range of benefits. Defined negatively, the benefit packages include general practitioner care, primary care and specialist care, including inpatient and outpatient services at public hospitals. A fee-for-service mechanism based on fee schedules is applied for high-cost health services, such as open-heart surgery, coronary bypass or brain surgery, for example (Schmitt, Sakunphanit, and Prasitsiriphol 2013). The benefit packages also cover pharmaceuticals and medicines on the National List of Essential Medicines (NLEM), including antiretroviral therapy for HIV/AIDS. Drugs not included in the NLEM can also be fully reimbursed if a GP considers them a necessity. Dental care, rehabilitation, delivery, ante natal and post-natal care, long term care, medical devices (270 items) and traditional Thai medicine services or other alternative medicine practices are also provided under the schemes. Preventive health care services and clinic-based health promotion activities are not explicitly part of the benefit packages but are organized by the NHSO, the managing agency of the UCS, through its annual budget for members of all three schemes (WHO 2015). These services, which were initially not included in all the schemes, have been extended to the whole Thai population by UCS.

⁷ Section 5 of the National Health Security Act states that “a Person has the right to Health care” and in order to register for the scheme you need a Thai ID card. Only Thai nationals are entitled to a 13-digit ID card, and Section 52 of the Thai Constitution states that “Thai people are entitled to health care”.

⁸ This information was obtained through informal 2021 interviews undertaken with ILO experts.

There are a range of exclusions, with the following treatments not included in the benefit packages: treatment for psychosis (with the exception of acute attacks); drug addiction treatment; long-term hospitalization (more than 180 days in a year); haemodialysis (except for acute renal failure requiring immediate treatment for no more than 60 days and end-stage of chronic renal failure); cosmetic surgery; experimental treatments; infertility treatments; tissue biopsy for organ transplantation (except for bone marrow and corneal transplantation); non-medically indicated procedures; sex reassignment surgery; reproductive surgery; recovery care; dental surgery services (except for extraction, filling, scaling and dentures at a rate specified by SSO); spectacles; and contact lenses (fully covered by the patient).

Compared to the other schemes, the MHIS benefit package has a slightly less comprehensive range of benefits, and does not include rehabilitation and specialist care.⁹ Official MHIS documents include both a positive and negative list. The positive benefits package under the MHIS includes an annual health check-up; general medical treatment (consultation, diagnosis and treatment); maternity care (delivery and neonatal care); rehabilitation care; dental care (tooth extraction, filling and cleaning); medicines listed in the NLEM; access to child health care (comprising vaccinations for children aged 0–15 years old); and emergency medical treatment. Moreover, antiviral and HIV/AIDS medication, as well as communicable disease prevention services are also covered (IOM 2021). High-cost care is also covered, in line with the conditions set by the Migrant and Mother and Child Health Insurance Administrative Board (MMCHAB). There are exclusions to the benefit package, including various types of surgeries (organ transplant, cosmetic and/or sex reassignment surgeries), drug rehabilitation, psychosis treatment and fertility treatments. Moreover, inpatient care for the same condition/disease exceeding 180 days of treatment is no longer covered, unless there are complications and/or medical conditions.

A 2019 qualitative study found that although the benefits packages are virtually the same, the choices are not. For example, although contributory, SSS beneficiaries have fewer choices of artificial/medical devices/rehabilitation

services compared to the non-contributory schemes. Disparities among the three health insurance schemes have emerged due to differences in purposes, financial resources and management, and payment mechanisms, which has led to different treatments and reactions among health care units for different patients depending on their health insurance scheme (Suksamai, Dhebpanya, and Sangrugsas 2019).

- Provision of benefits and services

The Civil Servant Medical Benefit Scheme (CSMBS)

CSMBS members can choose any public health provider, with no previous registration required (WHO 2015), and in case of emergencies, beneficiaries can go to any private hospital with the requirement of being transferred as soon as possible (Schmitt, Sakunphanit, and Prasitsiriphol 2013). A minimal co-payment is required. In terms of referrals, there are no primary health care gate keeping mechanisms for the scheme (Tangcharoensathien et al. 2018). For inpatient care, two options are available: patients have the choice to go to any facility and pay for the services upfront and be reimbursed retrospectively or register first with a preferred hospital for the scheme, which reimburses the provider directly. The use of retrospective unlimited fee-for-service with no set fee-schedule for both outpatient and inpatient services (including the reimbursement of bills from up-front payments) has been identified as a key factor contributing to the high cost of the scheme.

In 2007, to respond to the increasing cost of the scheme, the CSMBS management unit introduced DRGs to reimburse inpatient services (including maternity care), using the traditional fee-for-service mechanism or outpatient care (Sakunphanit 2008). The CSMBS uses a fee-for-service payment mechanism based on rates applied by all public hospitals. Up until 2007, CSMBS members had to pay an upfront conventional fee-for-service for outpatient care (including rehabilitation). This was replaced by a direct reimbursement to the health care provider on a monthly basis (WHO 2015).

The health Social Security Scheme (SSS)

Unlike the CSMBS scheme, patients under the SSS scheme have to register with a contracted

⁹ The majority of the information in this paragraph is sourced from an unofficial translation of the 2013 MOPH Announcement on Health Check Up and Health Insurance for Migrants, available at: <https://www.usp2030.org/gimi/RessourceDownload.action?ressource.ressourceId=45078>

public or private provider and are only eligible for free care at their registered hospital. The only exception is emergency care – in such cases, a patient insured under the SSS can choose any hospital, even outside the contracted network. In fact, through an integrated Emergency Medical Services (EMS) policy initiative implemented in 2012, patients covered under any of the three statutory health schemes are able to go to any public or private hospital free of charge for the first 72 hours, in case of emergencies (Suriyawongpaisal et al. 2016).

Health services from any registered provider under the SSS are free of charge, without co-payments for any of the services provided in the benefits packages, with “no deductibles, no maximum ceiling of coverage and no extra-billing allowed by health care providers” (WHO 2015). However, there are some notable exceptions with implicit co-payments, as follows: dental care, which includes a reimbursable expense of THB250 per service, with use limited to twice a year; maternal care via a lump sum payment of THB12,000 to cover antenatal treatment, delivery and postnatal care; and haemodialysis, for which a ceiling is set at THB1500 per session and THB3000 per week. In these three instances, co-payments are implicit if the actual payments go beyond the schedule and covered amount (WHO 2017).

In order to gain access to benefits under the SSS scheme, members must have contributed for a minimum period of three months. Those who have contributed for less time are encouraged to enrol on or purchase other insurance schemes to cover for this three-month period. As previously noted, migrant workers eligible for coverage under the SSS scheme are encouraged to enrol in the MHIS scheme (IOM 2021).

Regarding provider payment mechanisms, inclusive capitation is used for both outpatient and inpatient payments, and includes additional adjusted fees for accidents, emergency and high-cost care, with DRG inpatient payment applied only partially for this particular scheme (WHO 2015).

Universal Coverage Scheme (UCS)

Benefits and primary care services for UCS beneficiaries are provided by locally contracted district units, known as “contracting units for

primary care” (CUPs), which are required to set up one primary care unit for every 10,000-15,000 registered beneficiaries (McManus 2012). In urban settings, the UCS scheme also contracts private clinics/hospitals for the provision of ambulatory care. CUPs deliver primary care services and also arrange referrals of patients to secondary and tertiary care services in autonomous hospitals. A strategic objective of the scheme is to foster a culture of proper referrals to hospitals via a more systematic strategy (McManus 2012).

As previously noted, the UCS scheme introduced a major transformation for service delivery through the introduction of a provider-payment split between NHSO as the purchaser, and public and private providers which supply health services to the scheme’s beneficiaries. The scheme is characterized by a capitation payment mechanism for outpatient care and a global budget allocation and DRGs for inpatient care (Schmitt, Sakunphanit, and Prasitsiriphol 2013).

When the scheme was first launched, it was accompanied by a “30 Baht for All Diseases Policy”, which introduced a flat co-payment per consultation with exemption for specific groups of population, and was later eliminated in November 2006, making health care through the scheme free at the point of use. The co-payment was however reinstated on 1 September, 2012 under the Pheu Thai government, but is only charged to patients who need prescription of medicine. If no medicines or drugs are prescribed, the patient is exempt from the TBH30 co-payment. Emergency care, prevention activities and visits to health facilities below the community hospital level are also exempt from co-payments (PHCPI 2018). Moreover, hospitals and clinics can determine under their own discretion additional co-payment exemptions, for example when patients are unable to pay.¹⁰

For both public and private hospitals, a single base rate per relative weight is used. Health promotion and prevention for the whole population is paid primarily through capitation in combination with a fee schedule. Expensive treatments such as chemotherapy, antiretroviral treatment and chemotherapy are paid exclusively on a fee schedule (Tangcharoensathien et al. 2018).

Migrant Health Insurance Scheme (MHIS)

¹⁰ Information from 2012 news article (in Thai), available at: <https://www.posttoday.com/social/general/164465>.

Migrant workers have to register at the public hospital where they had their health check and purchased the health insurance scheme. Once the insurance has been purchased at a specific public hospital, the beneficiary can only access services in that health care facility for the duration of the insurance (1 year) and cannot transfer it to a different facility should they move to a different district (IOM 2021). As well as being limited to accessing medical services at the health facility they initially registered at, members do not have access to private hospitals. However, migrant workers employed in the fishery sector can access health care at registered hospitals in 22 coastal provinces.¹¹

Under the conditions set out in the 2013 MOPH announcement on Health Insurance for Migrants, several referral guidelines are outlined. Specifically, insured workers can be referred from their registered hospital to a second hospital for further treatment. In such cases, full reimbursement of the service provided at the referral hospital will be undertaken at the workers' registered hospital, without exceeding the rates set out by the Health Insurance Group (HIG). Moreover, for inpatient care, reimbursement of referral fees are aligned with the rates set out in the Medical Treatment Costs Guidelines, using DRG criteria. In cases of a referral to a health care provider not registered under the MHIS (such as private or university hospitals), reimbursement for both outpatient and inpatient care follows the same principles as at registered hospitals.

Upon registration to the MHIS scheme, a card is delivered to the insured person which is valid for one year. The card, which is individual and does not cover dependents, is mandatory to access health care services through the scheme. In addition to presenting their card, users must pay a small fee ¹² for each visit (IOM 2021).

► 4. Results

- Coverage

Thailand achieved universal coverage in a very short space of time, demonstrating that UHC is

not solely a reality for high-income countries. As of 2020, 71.2 per cent (47.5 million beneficiaries) of the Thai population was covered by the UCS scheme, 18.9 per cent (12.6 million beneficiaries) was insured under the SSS scheme and 7.7 per cent of the population (5.2 million beneficiaries) was covered by the CSMBS (NHSO, 2020). Of all the schemes, CSMBS covers a high percentage of the elderly population, including both Government pensioners and parents of currently employed civil servants (Jindapol et al. 2014). According to the most recent Thai National Health and Welfare Survey results (2017), 99.2 per cent of the population are covered by one of the health insurance schemes, though this figure does not account for MHIS beneficiaries, irregular migrants and beneficiaries of other micro schemes (Tangcharoensathien et al. 2018).

There is currently no detailed information on the exact numbers of migrant workers insured by each scheme (MHIS and SSS), making it impossible to get an accurate picture of population coverage or ascertain the percentage of eligible migrant workers insured. In 2018, Thailand was home to around 4.9 million non-Thai residents, a substantial increase from 3.7 million in 2014, including an estimated 3.9 million documented and undocumented migrant workers from neighbouring countries (UN 2019). Although Thai nationals and migrants who contribute to the social security system have equal rights to social health protection, it is believed that a significant number of undocumented migrant workers are not covered by the MHIS due to problems of affordability and a lack of information and transparency. Health protection for undocumented migrants therefore remains a challenge, as only migrant workers with valid work permits are fully covered. Accordingly, in September 2019, only 823,420 migrant workers and dependents were enrolled in the MHIS scheme, and in August 2020, the number of workers with active MHIS membership dropped to 510,211 (IOM 2021).

Initially upon its launch in 2002, UCS covered all Thai nationals, including those awaiting proof of Thai nationality (PWTN), who hold a 13-digit ID card. However, entitlement for this group was later terminated as a consequence of the legal interpretation of what constitutes a Thai

¹¹ Information for this and the following paragraph is sourced by authors from an unofficial translation of the 2013 MOPH Announcement on Health Check Up and Health Insurance for Migrants, available at: <https://www.usp2030.org/gimi/RessourceDownload.action?ressource.ressourceId=45078>

¹² The exact amount of the co-payment could not be determined based on sources available to authors.

National (WHO 2015). Consequently, in addition to the exclusion of undocumented migrant workers, there are coverage gaps among some marginalized groups, including those born in the country that failed to obtain legal registration under Thai law, and stateless persons (Schmitt, Sakunphanit, and Prasitsiriphol 2013).

- Adequacy of benefits/financial protection

Through UCS, financial protection drastically increased, allowing more people, especially marginalized and vulnerable populations, to access health services when needed without hardship. This is reinforced by the relatively minimal co-payments and comprehensive benefits packages offered by all the schemes, despite some significant exclusions. As a result, OOP expenditure rates have reduced dramatically over the past decade, dropping to 11 per cent in 2018 (World Bank n.d.). Results based on data from the NSO's annual national household socioeconomic survey (SES) show a significant drop in household health expenditures from 6 per cent (1996) to 2 per cent (2015) at the 10 per cent threshold, and from 1.8 per cent to 0.4 per cent at the 25 per cent threshold (Tangcharoensathien et al. 2020). Before UHC was achieved, catastrophic health expenditures were much higher in rural settings, where most households and UCS beneficiaries reside, but today, the gap between urban and rural settings is virtually non-existent (Tangcharoensathien et al. 2020). To further enhance financial protection in the context of the COVID-19 pandemic, in 2020, Thailand extended health-related financial protection to foreign residents, providing access to the UCEP (Universal Coverage for Emergency Patients) to allow patients to seek COVID-related treatment free-of-charge at public and private hospitals (ILO 2020).

- Responsiveness to population needs
 - o Availability and Accessibility

To enhance accessibility and availability of services in Thailand, geographical barriers have been systematically addressed over the years. Since the 1970s, the Government has continuously invested in the development of health system infrastructure at district level, prioritising rural over urban investment and earmarking funds specifically for rural development. As a consequence, at least one primary health care

centre per sub-district (amounting to 9,762) was built and there are community hospitals in over 90 per cent of districts (Fleck 2014). Moreover, to counter the unequal distribution of human resources and medical practitioner shortages in rural areas, financial incentives were implemented and the provision of community health volunteers—a pioneering programme first implemented in the 1960s—has been promoted and extended. Combining enhanced geographical accessibility and financial protection has allowed for a drastic increase in utilization of health services, including an increase in outpatient visits in urban settings from 29.4 per cent to 41.1 per cent between 1977 and 2006. Skilled birth attendance also drastically rose from 66 per cent (1987) to 99 per cent in 2007 (PHCPI 2018).

Thailand's long history of investment in the creation of health care structures placed the country in a good position to build the local health infrastructure needed for UCS. Indeed, the wide geographical coverage of MOPH owned hospitals and health care units is considered a key foundation of UCS, as it enables beneficiaries, including those living in rural areas, to easily access services (McManus 2012). As such, within 10 years of its implementation, UCS drastically improved access to needed health services for its beneficiaries. However, UCS beneficiaries have very limited or no choice of provider since they are automatically assigned to their local district hospital via their registration document (Hanvoravongchai 2013).

As previously noted, recent years have seen a drop in migrants enrolled in MHIS, which may be indicative of access barriers among this group. Notably, among MHIS-insured migrants, MOPH¹³ records show that in 2019, only 13 per cent of members, accounting for 109,127 migrant workers, made 293,738 hospital visits (IOM 2021). Potential access barriers identified include a lack of compliance from employers, fragmented coordination and management information systems, lengthy and costly administrative processes, and limited awareness of the scheme. Specifically, the second step of the health insurance registration process for migrants, which involves a compulsory health check-up, has proven a challenge due to a lack of clarity and discrepancies within the policy messages of the MOPH on the validity of health checks from private hospitals.

¹³ 2020 data provided by the Division of Health Economics and Health Security.

o Acceptability and Quality

Data suggests a steady increase in the use of outpatient services from the launch of UCS onwards among all health services providers, with a preference for using services at health centre level (41.1 per cent), followed by community hospitals (38.8 per cent) and regional/general hospitals (20.1 per cent) (Prakongsai, Limwattananon, and Tangcharoensathien 2009). However, research shows that the increase in the use of outpatient services at hospital level (community, regional and general) has had a negative impact of the quality of provision, highlighted by an increase in complaints, lawsuits and patient-health provider conflicts at hospitals (Prakongsai, Limwattananon, and Tangcharoensathien 2009).

Furthermore, while Thailand's historical investment in the district health system development in rural areas has allowed for more isolated members of the population to receive services, this has meant that health care services are not as well developed in urban areas, where most CSMBS beneficiaries reside (Tangcharoensathien et al. 2018). This, in turn, has contributed to the lack of a gate keeping function for the CSMBS scheme.

In terms of the quality of awareness raising and availability of information on benefits and rights, there is a lack of awareness of rights under the MHIS scheme, specifically (Mon and Xenos 2015). Although some individuals are satisfied with the services provided through the scheme (including the provision of translators in some provinces), there is a consensus on the lack of clear, organized and available information on the scheme, including its benefits and services covered (IOM 2021).

► 5. Way Forward

Over the past two decades, Thailand's significant efforts to strengthen its social health protection system have enhanced access to health care services across the country and helped to reduce the financial burden and risks associated with poor health. The country's achievement of UHC is a testament to this. However, with Thailand set to become an aged society by 2025, combined with an increasing prevalence of NCDs and challenges resulting from air-pollution and road accidents,¹⁴ the country is facing an increased burden on health care costs. These challenges threaten the long-term financial sustainability of the UCS scheme. National efforts to further develop the health sector in response to these challenges, including ambitions for budgetary and fiscal reforms, are reflected in broad terms in the 12th National Development Plan (2017–2021). Moving forward, enhancing administrative and management efficiency of the public health service system, and improving its fiscal viability has been identified as a key development pathway for Thailand.¹⁵

Specifically, further harmonization of the three public insurance schemes would be needed. Thus far, progress in this area has been slow due to limited political support, resistance from CSMBS members for fear of a loss in benefits, and predominantly public hospitals benefiting from excessive CSMBS claims (WHO 2015). Streamlining of operations by further standardizing common features, such as the benefits package, information system and payment method, could promote harmonization and reduce disparities and inequities in benefits and level of expenditure (McManus 2012).

¹⁴ Due to weak enforcement of road and vehicle safety laws, Thailand has the world's second highest death rate in road accidents, at 36.2 deaths per 100 000 people (WHO 2018b).

¹⁵ Thailand 12th National Development Plan (2017–21).

► 6. Main lessons learned

- Thailand's achievement of UHC provides an internationally recognized example that this milestone is achievable in the face of significant challenges. In particular, Thailand was able to successfully and rapidly extend health protection to the entire Thai population through the UCS scheme in the aftermath of the Asian financial crisis, despite being a middle-income country with limited fiscal resources. Civil society members were crucial for the long-lasting success of the UCS scheme, working tirelessly to convince the public and political figures of the importance of universal coverage. Furthermore, health purchasing power shifted and is no longer centralised with the MOPH. Within a year of the launch of UCS, 75 per cent of the Thai population, who were previously uncovered or partially covered benefited from health insurance coverage.
- Achieving UHC in a very short space of time with low levels of spending through the establishment of a predominately tax-financed system, although laudable, has inevitably led to challenges related to sustainability and funding. With an ageing population, as well as a rise in non-communicable and chronic diseases, health care costs are likely to increase. Furthermore, the relatively high cost of the CSMB scheme and the absence of coverage of dependents of the SSS members pose concerns. This translates into heavy reliance on general tax revenues as the main source for UCS and CSMBs, running the risk of incurring shortfalls, especially during cyclical economic downturns (WHO 2015). Key policy actions require a reconsideration of the level and composition of the financing mix necessary to maintain efficiency and equity of the system.
- Thailand has utilised the use of new technologies to promote the rapid expansion of health protection to all Thai citizens. In particular, the use of a unique identification number (UIN) and the Thai civil registration (CR) databases have contributed to the development of the country's health insurance beneficiary registration system, facilitating the rapid enrolment of beneficiaries. The widespread adoption of provider information and communications technology, and the implementation of national information and communications technology infrastructure has supported and enhanced the reimbursement system.
- Despite the laudable efforts made in Thailand to provide coverage to migrant workers, the challenges faced by migrant workers, who have to register for either the SSS or MHIS, highlight the legal complexities inherent in registering and accessing benefits. Specifically, the administrative burden and legal intricacies of the National Verification (NV) process is an obstacle towards legalising the precarious status of undocumented migrant workers, who are not eligible under the main MHIS scheme.
- There is fragmentation and lack of coherence within the various statutory health insurance schemes for migrants. The MHIS is considered the main scheme for informal migrant workers as opposed to the SSS for formal migrant workers. However, the differences in the design of the MHIS scheme, its voluntary basis, and the lack of a legal framework, make it a less attractive option for workers.

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► Timor-Leste

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► 1. Introduction

A lower middle-income country, in 2018, Timor-Leste had a population of 1,267,975, and in 2014, 40.2 per cent of the population lived below the national poverty line (World Bank 2018). The social protection system in Timor-Leste is comprised of a range of 26 programmes, including broad-based cash transfer schemes, social services to vulnerable groups and free or affordable national health and education services. Presently, the health system in Timor-Leste is predominantly public, with a national health service system implemented by the Ministry of Health (MOH), which covers all Timorese citizens, residents and stateless persons. This is supplemented by a range of additional social health protection schemes and programmes designed to expand health coverage to hard-to-reach populations or target vulnerable population groups.

Health services in Timor-Leste are mainly financed and provided by the Government, and generally, health care in public facilities is free at the point of service, with out-of-pocket payments (OOPs) lower than most countries in the region. However, the low OOP rate is linked to lower utilization of health services compared to other countries in the region. Moreover, the absolute amount

of public health spending is low compared to other countries in East Asia. The country faces a growing need to allocate resources towards health coverage and increase the accessibility and availability of health services, particularly for the country's rural inhabitants, who account for 74 per cent of the population. To address these challenges, in 2011, the Government launched the National Strategic Development Plan (2011–2030) to set ambitious targets towards becoming an upper-middle-income country. A key part of the national strategy is to provide access to health care and financial protection to all citizens (UN et al. 2018).

► 2. Context

After Timor-Leste's independence in May 2002, most of the country's infrastructure was destroyed, including the health system. Specifically, 77 per cent of health facilities were damaged and a significant number of doctors and other health professionals were displaced (Cousins 2019). The United Nations Transitional Administration in East Timor (UNTAET) was established on 25 October 1999 as a United Nations protectorate which aimed to solve the decades-long East Timorese crisis in the area

occupied by the Indonesian military. Since its establishment, UNTAET provided an interim civil administration, directly administering the territory of East Timor, and a peacekeeping mission in the territory of East Timor. This continued until the country's independence following the outcome of the East Timor Special Autonomy Referendum. One year after independence from Indonesia, the Council of Ministers approved the "Health Policy Framework for East Timor" which demonstrated a firm commitment to providing free essential services on the principles of equity, population-wide coverage and financial protection. Since independence, Timor-Leste has invested in training physicians for primary health care by sending students to study in Cuba under a Timor-Leste and Cuba government partnership.

To supplement the national health service which provides health services for free to all Timorese citizens in public health care facilities, the Integrated Community Health Service Programme, Serviço Integrado de Saúde Comunitária (SISCA) commenced in 2008, which provides community-based primary care at the village level (Martins and Trevena 2014). Following this, in 2011, MOH released the National Health Sector Strategic Plan 2011–2030 to provide guidance for the country's health sector to move towards UHC through better access to health services and financial protection (Timor-Leste Ministry of Health 2011). The plan aims to rebuild health facilities, expand community-based health services, increase the number of medical graduates, and launch the health financing strategy and family health service delivery model (WHO 2019).

In line with the plan, in July 2015, the Health in the Family Programme (Saude na Familia) was launched to cover reach hard-to-reach populations by providing basic health care to every household within the country. The programme, modelled on the Cuban system, proactively sends medical teams (comprised of a doctor, midwife and nurse) to every household in the nation, which is considered a transformative primary health care reform in Timor-Leste (Government of Timor-Leste 2017). In the same year, the Vulnerable Patients Programme was introduced to provide financial assistance for vulnerable patients who are transferred to referral hospitals. The programme aims at enabling family members to accompany beneficiaries during the period of hospitalization (UN et al. 2018). The Health Care for National Liberation Combatants Programme was later introduced to finance overseas health

care utilization for National liberation combatants who fought in the independence conflict with Indonesia.

In 2019, the country launched the Health Financing Strategy 2019–2023, which envisions the following four main objectives: "ensure financial protection for the population; increase health funding to cover unmet needs such as coverage of essential services, strengthen hospital care and tackle financial needs associated with non-communicable diseases and others; reduce inequities in resource availability and service utilization across territories and population groups; and improve system-level allocative and technical efficiency" (WHO 2019). Despite these efforts, 2020 was a particularly challenging year for Timor-Leste in terms of progressing social policy. In addition to the COVID-19 situation, the Social Security Reserve Fund (SSRF) was established and its management models were approved. The autonomous fund was created to reinforce the financial sustainability of the system and promote intergenerational solidarity.

► 3. Design of the social health protection system

- Financing

Timor-Leste has a non-contributory national health service system in which health services are publicly financed and provided. The health sector is heavily dependent on external funding through international development assistance for health (DAH), while national government budgets are generally heavily dependent on revenues from oil extraction. However, in the last few years donor health spending has notably declined, and is projected to continue this trend in the medium term. This will place significant pressure on the total health budget, as the MOH will be forced to fund priority health projects previously funded by donors (World Bank 2014).

In 2017, public health care financing schemes accounted for 86.63 per cent of current health expenditure, OOP spending accounted for 8.3 per cent and voluntary health care payment schemes accounted for 5 per cent (WHO n.d. a). The health

sector budget was equal to US\$73 million in 2017, and accounted for only 5.4 per cent of total national budget (Kelly et al. 2019). In the same year, per capita spending on health was US\$83.20, which amounted to 3.88 per cent of GDP (WHO n.d. a).

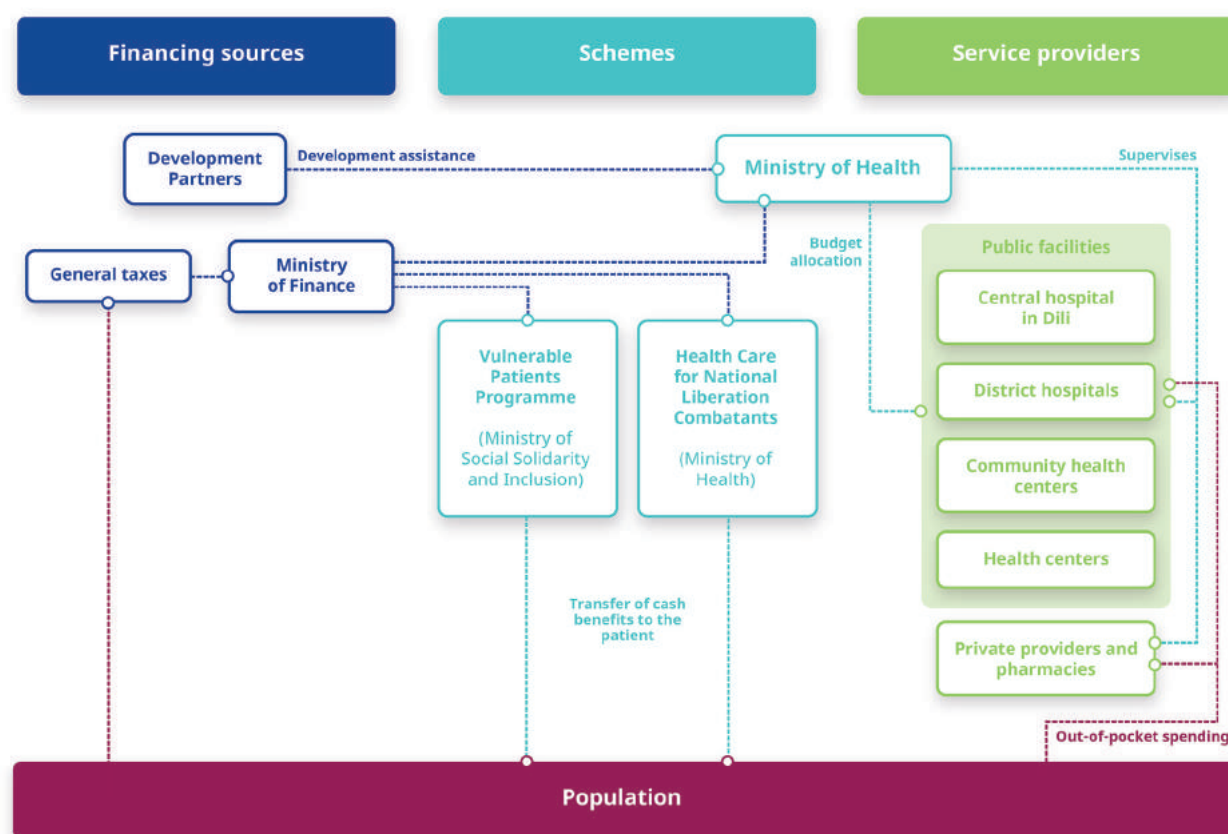
The national health service system is predominantly financed by the general government budget, which is primarily comprised of revenues from the extraction of oil. External financial sources also contribute to strengthening the system, including via vertical programmes. The total budget allocated to hospitals, municipal health services, laboratories and service delivery units in 2015 was estimated at US\$33,945,000 (UN et al. 2018).

The SISCA programme is also entirely financed by the general government budget, though it

does not have a specific budget, because each health centre or hospital, responsible for several villages in its area, uses its operational budget for this programme (UN et al. 2018). Similar to SISCA, the Health in the Family Programme does not have separate budget allocation, which leads to unpredictability of service provision (UN et al. 2018). The vulnerable Patients Programme, which is non-contributory, and the Health Care for National Liberation Combatants Programme are also financed by the national budget. In 2015, the Vulnerable Patient's programme was allocated US\$25,000 and in 2018, the National Liberation Combatants programme was allocated US\$750,000 (UN et al. 2018).

The financing flows of the health protection system are schematically presented in figure 1.

► Figure 1. Overview of main financial flows of the social health protection system in Timor-Leste



- Governance

The Health System Law of 2004 ¹⁶ establishes the legal basis for the national health service system, ensuring health protection through prevention, promotion and treatment activities. According to the law, health policies are defined by the Government, with the MOH proposing, promoting and following up on their execution and coordination, and international health organizations and ministries overseeing related areas. In line with the Health System Law, the national health service system operates under the direction of the MOH and, in each district, under the guidance of the respective district chief of health. Each District Health Service has a District Health Council, to provide support, consultation and coordination for the provision of primary health care.

The SISCA programme operates on the basis of ministerial orders, namely the Organic Law of the VI Constitutional Government and the National Strategy of the Health Sector 2011–2030 (UN et al. 2018). Similar to SISCA, there is no specific legislation to regulate the Health in the Family and the Vulnerable Patients programmes. The Health Care for National Liberation Combatants Programme operates under the National Liberation Combatants' Statute and is implemented by the Ministry of Social Solidarity (MSS), the National Directorate of National Liberation Combatants Affairs, and the Department of Programmes (UN et al. 2018).

- Legal coverage and eligibility

The 2004 Health System Law establishes the legal basis for the national health service system, which covers all Timorese citizens, residents and stateless persons. SISCA targets all the residents of visited communities, with special attention given to children younger than 5 years of age, pregnant women, adolescents of reproductive age, older persons and people with disabilities (UN et al. 2018). The Health in the Family programme targets all Timorese families, especially those in isolated locations. The Vulnerable Patients programme targets vulnerable patients who are transferred to referral hospitals, as well as their families. The Health Care for National Liberation Combatants Programme finances overseas health care utilization for National liberation combatants

who fought in the independence conflict with Indonesia.

- Benefits

The national health service system provides an implicit benefit package defined by law, with publicly funded services free or affordable at the point of service in public facilities, covering a wide range of interventions including specialized and emergency health services, drugs and physical examinations and laboratory tests. The benefit package also includes the possibility for overseas referrals, partly financed by the national health service. User fees are stipulated by article 20 of the Health System Law and the schedule for such fees is jointly approved by the Ministry of Finance and the Ministry of Health. Fees are applied to the following:

- (a) payment of health care provided in a private room or by any other modality that is not provided to users at large
- (b) payment of health care by third parties which are legally or contractually liable, notably health subsystems or insurance companies
- (c) payment of health care provided to people who are not beneficiaries of the National Health Service, where there are no liable third parties
- (d) payment of affordable contributions for health care provision
- (e) payment of charges for other services provided, notably within the scope of sanitary surveillance, or for the use of facilities or equipment
- (f) proceeds from own goods
- (g) proceeds from donations
- (h) proceeds from payments by users or third parties, with respect to infringements of the applicable rules or the fraudulent use of services or materials.

The SISCA programme provides community visits to the population. During community visits, medical teams often provide a free-of-charge set of basic primary care services, including: (i) general health care, including medical consultations, and health and hygiene education; (ii) medical care for children, including birth registration, nutritional assessment and education for parents on healthy practices; and (iii) maternal care, including

¹⁶ Law No. 10/2004 of 24 November 2004 on the Health System, available at: https://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=fr&p_isn=89769&p_country=TL&p_count=70&p_classification=15&p_classcount=11

nutritional assessment, treatment and primary health care education.

The Health in the Family programme carries out home visits in order to identify the health conditions and risk factors of each family, and offers preventive and curative care. In theory, the programme sends a team of health professionals to each household in the country. The following services are included in a home visit: (i) delivery of medicine and dietary supplements based on patients' needs; and (ii) consultation with medical professionals on the personal health of each family member and on healthy habits and disease prevention (UN et al. 2018). The service has a strong educational component and also aims to contribute to the development of a single registration database for health care at all levels.

The Vulnerable Patients programme provides a range of cash benefits depending on the patient's situation, which are paid on a daily, monthly or lump sum basis. The Health Care for National Liberation Combatants pays all costs of health care provided abroad to beneficiaries.

- Provision of benefits and services

Timor-Leste's public health system is decentralized, with three levels of care. Primary health care is provided through a network of health posts, Community Health Centres (CHCs), and the integrated community health services under the SISCAs program. The district-level health system is hierarchical and clustered in three layers: a district health office, CHCs and health posts. The health posts report to CHCs, which in turn report to the district health office (WHO 2016). The public network includes a national hospital in the capital providing tertiary care, five district-level hospitals, a network of 68 CHCs, 280 health posts, and 43 maternity clinics delivering primary health care services (UN et al. 2018). In 2013, the primary level delivered approximately 90 per cent of the outpatient visits, and employed 45 per cent of doctors and 52 per cent of other technical personnel (Cabral et al. 2013).

Non-governmental Organizations (NGOs) also provide a limited number of health services in several parts of the country via vertical programmes/projects, and private medical clinics are operating in Dili and towns in some districts. However, these services are not incorporated into the government-funded system and despite legislation in place, their regulation could be further strengthened. Although many

international NGOs have ceased health work in the country, as of 2010 there were 60 national and international NGOs working with the MOH in areas such as nutrition, maternal, newborn and child health, family planning, delivery of primary care and specialized services, mental health, and interventions for HIV/AIDS (Mercer et al. 2014).

► 4. Results

- Coverage

Although the government-funded national health service in Timor-Leste provides free or affordable health care to the whole population, there are significant gaps in rural areas in particular, due to inaccessibility. In 2017, the overall proportion of the population with access to health services was estimated at 52 per cent (WHO n.d. b; WHO and World Bank 2017).

Several of the complementary social health protection schemes reach a large share of their targeted population, even if they do not offer benefits to a large number of people; specifically, in 2015, SISCAs had 812,870 beneficiaries, representing 68.6 per cent of the total population (UN et al. 2018). In 2015, the Vulnerable Patients Programme covered 400 beneficiary patients (1.7 per cent of all hospitalized individuals) and 200 beneficiary families (0.1 per cent of total households). The Health Care for National Liberation Combatants Programme covered around 52 beneficiaries in 2015. As for the Health in the Family programme, in 2017, the Prime Minister of Timor-Leste reported that, since the launch of the programme on 22 July 2015, medical teams had visited 94 per cent of households and had registered the details of 84 per cent of the population at the individual level (Government of Timor-Leste 2017).

- Adequacy of benefits/ financial protection

OOP payments in Timor-Leste are relatively low compared with other Asia and Pacific countries (Hou and Asante 2016), accounting for only 8.34 per cent of current total health spending in 2017 (WHO n.d. a). However, it is important to highlight that the low level of OOP payments is likely to reflect limited infrastructure and availability of health services rather than low-cost access to

a full range of health services. According to the 2007–2008 Timor-Leste Survey of Living Standards (TLSLS), most of those who incurred OOP spending did so due to utilization of the private sector. Most households (89 per cent) that sought health care reported visiting a public health care provider and only 3 per cent of visits to public providers incurred a payment. Conversely, more than half of patients who went to private providers made a payment to a provider (World Bank 2014). Nonetheless, evidence suggests that catastrophic expenditure in Timor-Leste is moderate, with around 3.5 per cent of the population spending more than 10 per cent of the household budget on health and 1.1 per cent of the population pushed below the poverty line of US\$1.90 per capita per day because of health spending (WHO 2017).

- Responsiveness to population needs

- o Availability and accessibility

Transportation costs are reported to add to patient costs when seeking care, which poses significant barriers to care seeking, with distances to the nearest health facility disproportionately affecting rural and poor populations (World Bank 2018). As such, inequalities in health care access exist between rural and urban regions, which is also reflected in an uneven allocation of medical professionals, medical facilities and equipment. These factors mean that rural households less likely to visit hospitals than urban households (Guinness et al. 2018). In addition, the poorest quintile has been found to be less likely to use more expensive hospital services than other socio-economic groups (Guinness et al. 2018). According to a study that used a representative cross-sectional survey of health care utilization among 1,712 households in Timor-Leste, medical need was found to be the key driver in seeking both primary care and hospital services (Guinness et al. 2018). Overall, evidence suggests that the distribution of health service utilization in Timor-Leste is inequitable, with variations in access to health services between urban and rural, rich and poor, and educated and uneducated populations (WHO 2019). However, over the years, there has been an expansion of public health services catering to urban areas, which effectively improved access in some regions (World Bank 2018).

In addition to individual and contextual constraints, such as income and access to affordable and reliable transportation, utilization is affected by the limited availability of medicines

and trained health workers (Guinness, et al., 2018). In 2010, the Demographic and Health Survey programme (DHS) reported concerns about the availability of health care staff and drugs at facility level, which hinders the range of benefits effectively provided (National Statistics Directorate et al. 2010).

- o Quality and acceptability

Despite limited availability of health staff and drugs, Timor-Leste has progressed rapidly in the area of maternal health, increasing the number of deliveries attended by a skilled health professional. In areas this indicator reached almost 87 per cent in 2016, demonstrating an increase of 27 percentage points compared to 2010 (WHO n.d. b). This is encouraging, and reveals efforts to adapt to the population's needs. However, more efforts are needed to extend such progress to rural areas, and improve child health indicators, which remain below the regional average (World Bank 2018). In addition, there is an insufficient supply of specialized health care services for certain types of diseases (such as mental illness) or for vulnerable groups (such as older persons and persons with disabilities).

Overall, several challenges are faced in ensuring the quality of the services or the in-kind benefits (UN et al. 2018). While a Quality Control Unit exists under the MOH, intermittent or unreliable service provision in public health facilities and lack of human resources, medical supplies and drugs are key constraints leading to poor service delivery (Kelly et al. 2019). To address this, the Strategic Development Plan 2011–2013 proposed that all health posts should have at least one doctor, two nurses and two midwives by 2020 (Government of Timor-Leste, 2011). As a result, the presence of doctors in rural areas has hugely improved, from less than 2 per 1,000 population in 2012 to more than 6 in 2014 (World Bank 2018). Nonetheless, the presence of doctors on the ground does not automatically translate to improved service delivery. Furthermore, women have concerns that they may not be able to be attended by a female health professional, which remains a significant issue to address.

- Coordination

There are limited mechanisms for the coordination of social protection and health policy formulation, implementation, operations, resources or information sharing (UN et al. 2018). This has led to a fragmented system in which

different programmes collect information on potential beneficiaries. Most programmes suffer from a lack of financial and human resources, a lack of mechanisms for quality assurance and monitoring and evaluation, and the late release of funds for operations (UN et al. 2018). These issues often relate to other underlying problems, such as inadequate management and information systems and lack of coordination mechanisms, resulting in limited institutional capacity to better manage, deliver, monitor, and evaluate social protection programmes. In addition, several programmes operate based only on ministerial orders, failing to ensure their long-term continuity or the establishment of rights to beneficiaries (UN et al. 2018).

In relation to the broader social protection system, it is also important to note that in 2016, the Government established the first General Social Security Scheme (Law No. 12/2016), which is mandatory for all workers in the private formal and public sectors, marking a historical transformation in social policy. The new social security system has been built in stages since then, offering provisions for old age, invalidity, maternity, paternity, adoption, death and, in the future, work injury (UN et al. 2018). By 2017, just one year from its implementation, around 70,000 people or 36.6 per cent of the labour force were effectively covered by the scheme. Although not part of the health protection system, the scheme includes benefits which are either directly or closely related to health conditions, such as maternity and old age.

Specifically, the scheme establishes a set of contributory provisions, in cash, that protect workers and their families through different benefits in the following cases: (i) Old age – Pensions, for workers aged 60 years or older, with benefit value based on average wage and length of the contributory career; (ii) Invalidity – Pensions for total and partial invalidity, with benefit value based on average wage and length of the contributory career; (iii) Death – Lump-sum payments, survivor's pensions and reimbursement of funeral expenses in the event of a worker's death, with benefit values varying according to average wage of contributory career; (iv) Maternity or paternity – income substitution benefits for maternity, paternity, adoption, medical risks during pregnancy and pregnancy complications (UN et al. 2018). Given the link between such benefits and health, coordination between this scheme and health protection

policies will therefore be essential moving forward.

► 5. Way forward

As outlined above, the Timorese social protection system is comprised of a range of programmes, including broad-based cash transfer schemes, social services to vulnerable groups, and free or affordable public health services. However, the system is fragmented, resulting in gaps which leave many without coverage or adequate support. Moreover, the country still confronts inequalities with respect to access to health services, which considerably affects rural households and reinforces their vulnerability. To address this, the Government of Timor-Leste is exploring innovative ways to increase health care access in more isolated areas. Rural road infrastructure and public transport development should be a priority in this regard, with support from donor partners through grants. Such improvements would not only help smooth the path to UHC but would also provide benefits to other sectors of the economy (Guinness et al. 2018).

In terms of improving direct service provision, such as improving the quality of essential health care services, recommendations are covered extensively in the National Health Sector Strategic Plan 2011–2030. This plan was designed in line with the Strategic Development Plan 2011–2030, which incorporates health sector goals. It aims to promote human resource development and health infrastructure development, through building hospitals and strengthening administrative capacity (Japan International Cooperation Agency 2012).

The robustness of the system has been put to the test by the COVID-19 crisis, and the investments made in public health infrastructure supported the relative containment of the virus. However, inequities between rural and urban areas in this context persist, with the vaccination roll-out reaching 70 per cent of the population in Dili by October 2021, while only reaching less than half of the overall population (Reuters n.d.; World Bank 2021). The quick political reaction and activation of the MOH plan to contain the pandemic have been effective thus far, and demonstrate the trust the population places in existing public health services.

► 6. Main lessons learned

- Timor-Leste has a national health service system in which health services are provided for free or at an affordable cost at the point of use. Even though government spending on health as a share of total spending is significant, with health services primarily publicly financed and provided, the absolute amount of government health spending is relatively low. As such, the Government faces challenges in securing additional funds for emerging health challenges such as the increase in NCDs.
- Timor-Leste has managed to keep OOP spending on health at a low level, with OOP expenditure accounting for less than 10 per cent of health expenditure in 2017, which is lower than most countries in the region. This contributes to reducing the likelihood of households incurring catastrophic expenditure on health services. However, it is likely that the low level of OOP payments in Timor-Leste partly reflects limited infrastructure, availability and utilization of health services, which is a threat to the achievement of adequacy of benefits.
- Ensuring adequate government funding is necessary for the achievement of UHC in Timor-Leste. Programmes such as SISCA and the Health in the Family Programme suffer from insufficient funding allocation, do not have any budget plan for service delivery and lack supplies. The lack of public funding is reflected in limited infrastructure and lack of health care supplies and equipment, especially at primary care facilities, which negatively affects quality of care at this level. Insufficient public funding is therefore a significant issue, and in light of the fact that a large share of health financing comes from oil revenues dependent on fluctuating international markets, ensuring financial sustainability is also a challenge.
- Limited coordination combined with low institutional and human resource capacity has resulted in a fragmented social health protection system, which has resulted in gaps and left many people left without coverage or adequate support. In addition, social health protection is not well

integrated in the broader social protection system. Most programmes suffer from lack of financial and human resources, lack of mechanisms for quality assurance, limited monitoring and evaluation, and the late release of funds for operations. These issues often relate to other underlying problems, such as inadequate management and information systems and lack of coordination mechanisms, resulting in limited institutional capacity to better manage, deliver, monitor and evaluate social protection programmes.

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▶ Viet Nam

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▶ 1. Introduction

One of the fastest growing economies in Asia, Viet Nam began its transition to a socialist-oriented market economy in 1986, following political and economic reforms known as Doi Moi. Since then, Viet Nam has been transformed from one of the poorest countries in the world to a thriving lower middle-income country. GDP per capita steadily increased from US\$423 in 1986 to US\$2,715 in 2019, and remarkable progress in poverty reduction has been achieved (World Bank n.d.). In tandem with sustained economic growth and substantial declines in poverty, vast progress has been made towards improving the health of the Vietnamese population over the past few decades, with health outcomes advancing alongside rising living standards and improved access to health services (Teo et al. 2019). However, the country faces an increasing burden of non-communicable diseases (NCDs) such as cancers, hypertension, and diabetes, as well as challenges related to a rapidly aging population (Teo et al. 2019).

To promote equitable health outcomes, Viet Nam enshrined the right to health protection for all citizens in its Constitution in 1980 (article 61), which the country is striving to achieve through the implementation of a national social health insurance (SHI) scheme. With the introduction of Viet Nam's Health Insurance Law in 2008, a roadmap towards universal health insurance was planned out ¹⁷ and amendments to this law have made health insurance compulsory for all. ¹⁸ The Government has since exceeded its 2020 target of 90.7 per cent population coverage (Kim Loan 2020) and the new Social Security 5-year plan 2021–2025 has set the ambitious target to achieve SHI coverage of 95 per cent by 2025. Although a high level of coverage has been reached, out-of-pocket (OOP) health spending continues to increase and inequities and coverage gaps persist, particularly among near-poor groups, self-paying households, internal migrants and workers in informal employment, who comprise a large share of the workforce in Viet Nam. These challenges are of particular concern in the context of the impacts of the COVID-19 crisis.

¹⁷ Viet Nam Health Insurance Law 2008, No. 25/2008/QH12.

¹⁸ Viet Nam Health Insurance Law Amendment 2014, No. 46/2014/QH13., article 1.

► 2. Context

Political and economic restructuring in the late 1980s precipitated the end of Viet Nam's previously universal state-funded health system, which operated with limited resources but was free for the entire population. This was accompanied by a sharp cut in government health spending and increased participation of private actors in health care delivery (Ramesh 2013). To compensate for diminished government funding, user fees were introduced during the late 1980s and early 1990s to supplement inadequate state budget supply-side subsidies to public health care facilities. Unfunded exemptions for vulnerable and meritorious groups were ineffective and these policies led to a dramatic increase in OOP payments; in the 1990s, OOP health expenditure accounted for more than 70 per cent of total health spending (Ramesh 2013; Somanathan et al. 2014). To address this, the Government introduced a set of broad national health system reforms throughout the 1990s to improve service coverage, access, use, leadership, health financing and community-level health outcomes, and to reduce hospital overcrowding and costs (London 2008).

In 1992 a contributory SHI scheme for workers in formal employment and pensioners was introduced (Le et al. 2020; ILO 2019; Palmer 2014). Two years later, a voluntary scheme was established for informal economy workers, students and dependents of those in the compulsory scheme (Le et al. 2020). In an effort to protect hard-to-reach populations, the tax-funded Health Care Fund for the Poor was later introduced in 2002 to provide social health protection for the poor, selected ethnic minority groups, and individuals living in the most disadvantaged regions, through payment of SHI contributions or cash reimbursement of health services.¹⁹ In 2005, these efforts were further complemented by the Government mandated provision of tax-funded coverage for all children under 6 years of age.²⁰ Other entitlement programmes were also established to provide financial support for health care for other groups, such as military and public security health services and programmes

implemented by the Ministry of Labour, Invalids and Social Affairs (MOLISA) for persons of merit and social assistance beneficiaries.

In 2008, the first Health Insurance Law was issued, through which all the funds and schemes were consolidated into one national SHI scheme, reliant on a mixed financing system combining tax revenues, contributions and OOP payments. This established a single pool, with the exception of separate funding pools for persons engaged in active military and public security forces. SHI is now the primary vehicle for delivering social health protection in Viet Nam, alongside state funded preventive medicine and public health, which constitutes an essential complementary source of resources. The social security funds for active duty military and police forces, which are pooled separately, have slightly more generous benefits. However, the design of these schemes is aligned with SHI, and claims review and payments are also implemented through the Viet Nam Social Security (VSS) agency.

As SHI has developed, the Government has gradually shifted away from subsidizing curative health care facilities to subsidizing SHI contributions for the poor and the vulnerable. The state budget is still responsible for preventive medicine and public health, but funding for personal services that were formally provided by vertical programmes are gradually being integrated into the SHI system. In 2017, the Central Committee of the Communist Party of Viet Nam set the objective to progress towards universal health coverage (UHC) through universal health insurance, and to guarantee equal rights and obligations in accessing health insurance benefits and services.²¹

¹⁹ Decision 139/2002/QĐ-TTg of 2002 on Health Care for the Poor.

²⁰ Decree 36/2005/ND-CP of March 17, 2005 Detailing the Implementation of a Number of Articles of the Law on Protection, Care and Education of children.

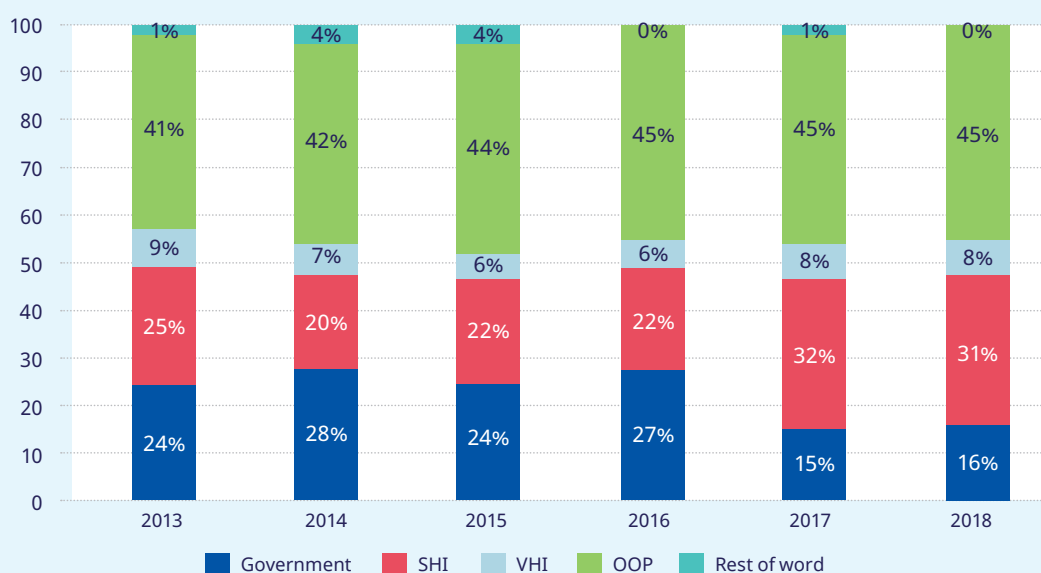
²¹ Resolution 20-NQ/TW of the 2017 Sixth Plenary Session of the 12th Party Central Committee on the Protection, Care and Improvement of People's Health in the New Situation.

► 3. Design of the social health protection system

- Financing

Due to substantial increases in both public and private spending, total spending on health in Viet Nam has increased significantly since 2000, with current health spending accounting for 5.9 per cent of GDP in 2018 (WHO n.d. a).

► Figure 1. Health expenditure structure in Viet Nam (as a percentage of current health expenditure), 2013–2018

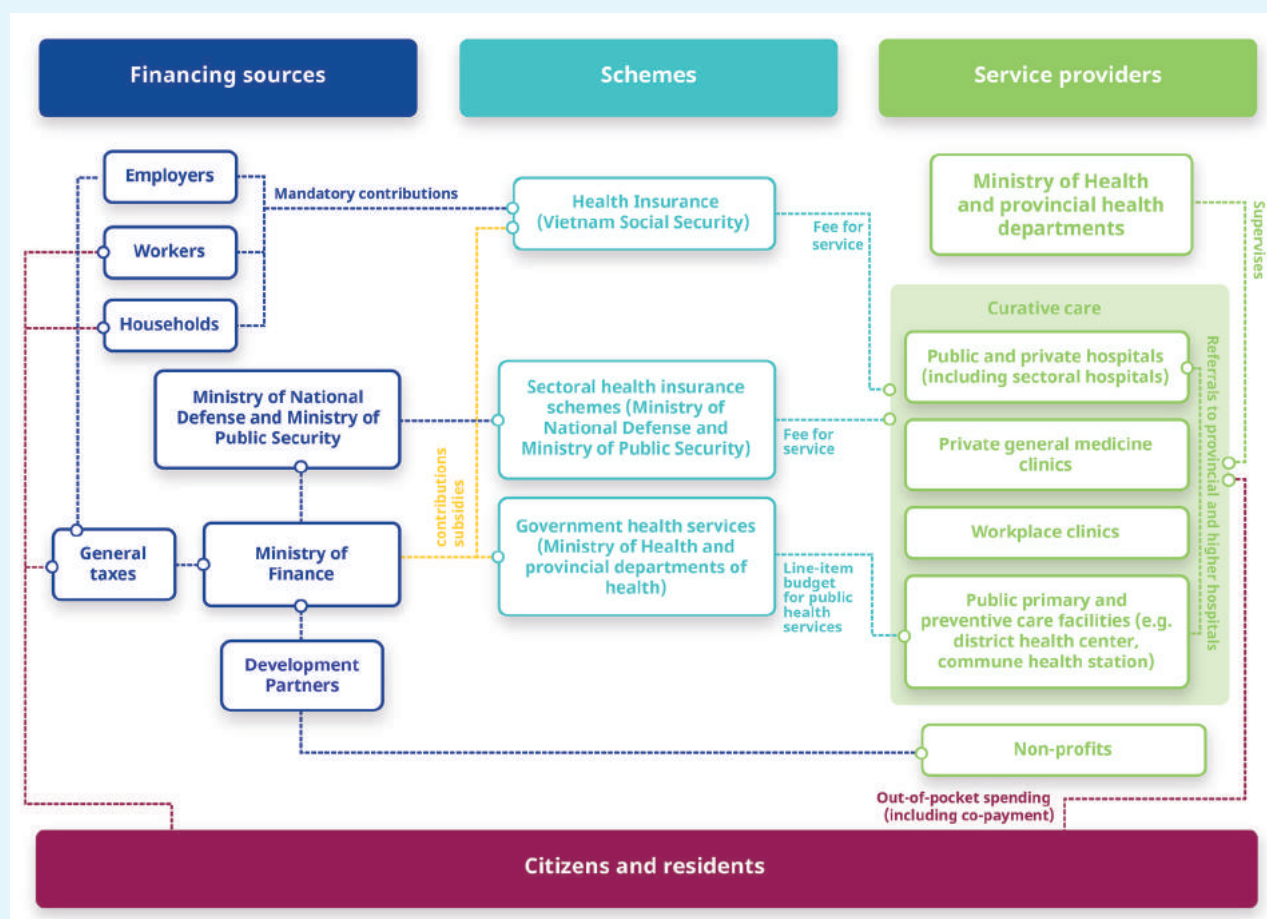


Source: Adapted by author based on presentation by the Viet Nam Ministry of Health at NHA workshop in Hanoi in December 2020 (Viet Nam Ministry of Health, Unpublished).

The structure of sources of current health expenditure have changed substantially over the years. Between 2000 and 2018, OOP spending increased from 37 per cent of current health expenditure to 45 per cent. This large increase in OOP spending began in 2012, alongside a considerable drop in the share of state budget spending from 44 to 29 per cent. This was only slightly compensated by an increase in the share of SHI from 17 to 20 per cent. External financing for health (including funds distributed

by government and direct transfers through non-profits) as a share of current health expenditures also dropped, from 4 per cent in 2000 to 2 per cent in 2018 (WHO n.d. a).

► Figure 2. Overview of main financial flows of the social health protection system in Viet Nam



Source: Authors.

SHI relies on a mixed financing system encompassing both contributory and tax-financed membership, which is somewhat complicated due to the fact that the scheme consolidates many different entitlements funded from multiple sources. The contribution rate is currently set at 4.5 per cent of contracted or civil servant salary (insurable salary), pension, social benefit or base salary,²² depending on the beneficiary group. However, the Health Insurance Law allows the government to increase the rate to a maximum of 6 per cent. A ceiling of 20 times the base salary is imposed for employed member contributions. Contribution rate, funding source and co-payment level are detailed in Table 1

for each population group and memberships categories, as defined in the law.

²² Base salary is a fixed amount used as the base to calculate salaries of government employees and general living costs for a defined period (for example, the base salary is VND1,490,000/month for the period July 2019–December 2020). This base salary is adjusted regularly by the Government. At the time of publication, the base salary had not been revised for the year 2021.

► **Table 1. Summary of key design features: coverage, benefit and service provision**

Population groups and membership categories	Contribution rate	Funding source	Member co-payment level
Group 1: Individuals whose contributions are shared between employers and employees			
- Formal economy workers - Civil servants (excluding active armed forces)	4.5% of insurable salary	Employers contribute 3%; employees contribute 1.5%	20% of eligible treatment charges
Contract-based public officials at commune-level	4.5% of base salary	Employers contribute 3%; employees contribute 1.5%	20% of eligible treatment charges
Group 2: Individuals whose contributions are paid by VSS			
- Pensioners - Current recipients of social insurance benefits including unemployment benefits, disability benefits, paid sick leave, and so on.	4.5% of pension or base salary, or allowance depending on the specific group	VSS pays full amount	5% of eligible treatment charges for pensioners and those on disability benefit. 20% of eligible treatment charges for the rest
Group 3: Individuals whose contributions are fully tax-financed			
Active duty military or police forces	4.5% of insurable salary	State budget pays full amount	0%; coverage includes items required by patients that are not in the service package covered by SHI, with payment from the sectoral social security fund.
Students of military or police training institutions	4.5% of base salary		
- Persons of merit (revolutionaries, war invalids, Agent orange victims, caregivers of war martyred families, and so on) - Social assistance recipients (including elderly aged 80 and older and people with disabilities)	4.5% of base salary	State budget of MOLISA and DOLISA	0% of eligible treatment charges 5% of eligible treatment charges for dependents of revolutionaries
- Members of poor households - Ethnic minority groups living in selected underprivileged regions - Children under the age of six	4.5% of base salary	State budget	0% of eligible treatment charges
- National Assembly and People's Council elected representatives - Organ donors - Foreign students studying in Viet Nam with a Viet Nam Government scholarship - Commune-level officials receiving monthly pensions from state budget - People who exhausted their disability benefits but receive monthly payments from the state budget	4.5% of base salary	State budget For scholarship recipients, contributions are paid by scholarship providers out of the scholarship coverage.	20% of eligible treatment charges
Group 4: Individuals whose contributions are partly subsidized by tax			
Individuals living in near-poor households in poor districts	4.5% of base salary	State budget	5% of eligible treatment charges

Population groups and membership categories	Contribution rate	Funding source	Member co-payment level
Individuals living in near-poor households not in poor districts	4.5% of base salary	30% from individual; 70% from state budget	5% of eligible treatment charges
- School children and college students - Average income agricultural households	4.5% of base salary	70% from household; 30% from state budget	20% of eligible treatment charges
Group 5: Remaining individuals (except dependents of armed forces personnel)			
Individuals not covered in any of the above categories, usually informal economy workers, whose contributions are paid on a family basis	1st household member: 4.5% of base salary. The 2nd, 3rd, 4th household members: respectively 70%, 60%, 50% of the 1st member's contribution rate The 5th member onwards: 40% of the 1st member's contribution rate	Household pays full amount	20% of eligible treatment charges
Group 6: Dependents of armed forces personnel			
Dependents of military, police personnel (parents, spouse, biological and adopted children)	4.5% of base salary	Employer of military, police personnel pays (state budget, service delivery unit or enterprise)	20% of eligible treatment charges

Source: Author based on the Health Insurance Law 2008; Health Insurance Law Amendment 2014; Decree No. 146/2018/ND-CP; and Decree No. 70/2015/ND-CP.

Central and local budgets finance part of the contributions. For partly subsidized groups, local governments can voluntarily top-up the subsidized amount using their local budgets or other resources. According to government sources, 59 out of 63 provinces in Viet Nam provide health insurance subsidy top-ups for individuals from near-poor households, in addition to the 70 per cent subsidy regulated by law. Moreover, many provinces have expanded subsidies to other groups of the population. In particular, SHI insurance for 65–70-year-olds is often fully subsidized by local government budgets, even though the law only mandates free health insurance for people over 80 years of age. Households contribute their share as prescribed by law, and the local or central budget contributes the balance.

Frequency of contribution payment depends on the membership category an individual falls into. Employers are responsible for paying monthly contributions to the SHI Fund on behalf of their employees, along with other social security

contributions. VSS is responsible for paying monthly contributions for pensioners and recipients of social insurance benefits from social insurance funds. Tax-financed contributions are paid quarterly, and informal economy workers who are enrolled on a household basis can choose to pay contributions quarterly, semi-annually or annually.

- Governance

The SHI fund is implemented and managed by VSS which also manages other contributory social protection benefits through an integrated approach, including maternity, old-age pension, employment injury, unemployment, sickness and survivorship. VSS reports to the Ministry of Health (MOH) on the administrative management of the SHI scheme, to MOLISA regarding social insurance, and to the Ministry of Finance (MOF) regarding financial management of social insurance funds, including the SHI fund. MOH has oversight, policy-making and regulatory functions with regard to SHI and reports to the

National Assembly and the Government Office of Viet Nam on the scheme's performance. It is also responsible for setting prices of medical services and regulations surrounding medicine procurement and quality.

Identification of subsidized beneficiaries is the responsibility of multiple government agencies, with MOLISA taking responsibility for identifying vulnerable households and establishing lists of social assistance beneficiaries and persons of merit eligible for subsidized health insurance. The Ministry of Education and Training compiles lists of students, and the Ministry of Public Security and Ministry of National Defence provide lists of their staff and dependents covered by SHI, though they manage insurance cards for active service members separately.

The management of SHI consists of tripartite representation: (i) the Government is represented by the Ministries of Labour, Health, Finance, and Home Affairs, as well as VSS; (ii) employers are represented by the Viet Nam Chamber of Commerce and Industry (VCCI), and; (iii) workers are represented by the Viet Nam General Confederation of Labour (VGCL), the Viet Nam Cooperative Alliance (VCA) and the Viet Nam Farmer's Union.²³

- Legal coverage and Eligibility

SHI is mandatory and intended to cover all residents, regardless of employment status or citizenship, as stipulated in the Health Insurance Law (2008) and its subsequent amendment in 2014. Decree No. 146/ND-CP (2018) classifies the population into six SHI membership categories based on sources of contribution to the scheme, which includes 35 different sub-groups. Decree No. 70/2015/NĐ-CP supplements this with stipulations for active duty armed service members (See Table 1 for details).

Formal economy workers and civil servants working outside the military and police forces must enrol via their employer and must comply with payroll-based contributions, including those with time-limited contracts of three or more months, as well as those without time limits. For recipients of both long-term and short-term social insurance benefits, enrolment is

automatic through the administrative system. Population groups who are fully subsidized by the state budget — including both vulnerable groups (such as members of poor households, children under 6 and persons aged 80 and older), meritorious groups (including revolutionaries, veterans and organ donors) and the armed forces — are enrolled automatically. For certain groups, including school pupils and university students, the near-poor and middle-income farmers, enrolment is also compulsory but only partially subsidized. Active members of the armed forces and dependents of employees in the military and police are covered by contributions solely from their employers. Those who do not fall under any of the above categories are legally obliged to enrol on a household basis using a discounted contribution structure for each additional household member.

- Benefits

All SHI members are entitled to a single and broad set of benefits (ILO 2019; Somanathan et al. 2014) including diagnosis and treatment, rehabilitation, antenatal care, delivery care and, in some situations and for certain groups, medical transport. Following the Health Insurance Law Amendment in 2014, a series of subsequent sub-legal regulations have been introduced to define the SHI benefits package using a positive list approach. In particular, under several MOH policy documents, SHI covers medicines, radioactive substances, technical medical services, medical devices and consumables, which includes traditional and modern medicine methods.²⁴ The MOH has imposed some restrictions on the benefits, such as limiting provision of some services and medicines to tertiary facilities with advanced capacities, limiting some services or drugs to specific diagnoses, or limiting coverage to a small percentage of costs for high-cost items. However, these restrictions are not applied to active service members.

The Health Insurance Law of 2008 and its 2014 amendment also contains some blanket restrictions in the form of a negative list of services not covered by the SHI scheme, which consists of items that are covered by other funding sources (preventive services, contraception, forensic medicine, clinical trials, medical interventions in

²³ Decree No. 01/2016/NĐ-CP prescribes the functions, duties, power and organizational structure of Viet Nam Social Security.

²⁴ Circular No. 43/2013/TT-BYT; Circular No. 50/2014/TT-BYT and other technical medical services approved by the Minister of Health for implementation in medical facilities are not yet listed in these two circulars. This includes both traditional and modern medicine services. Circular No. 30/2018/TT-BYT and 27/2020/TT-BYT stipulates lists of modern and traditional medicines covered by health insurance

times of natural disasters, and prosthetic devices for war victims and people with disabilities), elective services (health check-ups, fertility treatments, foetal screening not related to treatment, abortion, elective aesthetic medicine services and nursing homes) and other services (optometry, hearing aids, mobility devices, medical care and rehabilitation for substance abuse).

In 2017, a basic primary care package was demarcated under Circular No. 39/2017/TT-BYT²⁵ covering curative and rehabilitation care services, medicines covered by SHI at commune level, and primary care, disease prevention and health promotion provided at district health centres or commune-level facilities and covered by state funding.²⁶ The MOH is working on integrating treatment costs for some infectious diseases into the SHI package. Costs of antiretroviral treatment for HIV have been covered since 2019 and COVID-19 treatment was covered in 2020, with work ongoing for tuberculosis. Costs associated with prevention and control of infectious disease are still paid through the state budget (ILO 2019).

- Provision of benefits and services

SHI members can access health care services at one of the many public or licenced private facilities contracted by VSS. The network of registered facilities providing health care services to SHI members includes primary care facilities (such as commune health centres, regional polyclinics,²⁷ district health centres, workplace clinics and some private clinics) and public hospitals (including provincial, central, general and specialized hospitals, traditional medicine hospitals, rehabilitation hospitals, sectoral hospitals and private hospitals). The hierarchical design of the health system and nationwide network of commune health stations has enabled the SHI system to set up a rational referral network and facilitated the integration of preventive medicine and curative care services for insured members. However, the continued underfunding and inadequate quality assurance surveillance of commune-level services, combined with improved transportation networks and rising incomes have led many people to bypass these facilities and seek care directly at higher level facilities without referrals. As a result, the

Health Insurance Law amendment reversed the requirement of commune-level facilities to refer insured patients to the district level for care. This facilitates access to more specialized medical services, but undercuts the integration and coordination of care by a primary care provider at the commune level.

Viet Nam's primary care network, which consists of 11,100 commune-level health stations, 277 regional polyclinics, 710 workplace clinics and a large number of private clinics, reaches every commune in the country, including those in remote areas. All 713 districts have a district health centre providing preventive medicine and public health services, and 666 districts also have a district-level hospital. A total of 47 central and 470 provincial general and specialist hospitals, traditional medicine hospitals, and rehabilitation facilities are run by the Government, compared with a total of around 230 private hospitals (Viet Nam Ministry of Health 2019). VSS automatically covers services provided at commune health centres (with no contract required), and contracts all public sector hospitals and health centres, including a share of private hospitals, to provide insured services to patients. In total, VSS covers all commune level health stations, and contracts more than 2,500 higher level facilities, of which 31 per cent are private (5 per cent of total facilities covered are private) (VCCI and ILO, unpublished). However, few of the large number of private outpatient clinics used widely by the population are contracted by VSS.

To access SHI benefits, most members are required to make co-payments at facility level, the value of which varies depending on a patient's SHI membership category. According to Decree 146/2018/ND-CP certain vulnerable groups (such as children under 6 years of age, the poor, individuals from disadvantaged ethnic minority groups and social assistance recipients), and meritorious groups (revolutionaries, war veterans, active armed forces and family members of certain meritorious groups) do not have to pay any co-payments when seeking care in compliance with the health care facility referral regulations. Pensioners, individuals who are living in near-poor households and family members of certain persons of merit are only required pay a 5 per cent co-payment. For members who do not

²⁵ Viet Nam Ministry of Health Programme 527/CTr-BYT of 2013 to improve quality of medical services at health facilities with the objective of ensuring satisfaction of health insured patients.

²⁶ Viet Nam Ministry of Health Circular No.39/2017/TT-BYT of 2017 Regulating a Basic Health Care Package for Primary Care Facilities

²⁷ In Vietnamese, these are called "Phong kham đa khoa khu vực".

belong to these categories, a co-payment of 20 per cent applies.

Although SHI members are required to register their health insurance cards with a primary care provider, patients can access insured services at other facilities without referral and without additional co-payments in cases of inpatient care at provincial level facilities or below, or outpatient care at other district level facilities or below. However, if the patient seeks inpatient care at a central level facility without a referral, VSS will only pay 40 per cent of the normal coverage rate, with the patient paying the rest as a co-payment. If a patient seeks outpatient care at a provincial or central facility, SHI does not cover the costs of services, except in cases where individuals are permitted to register for care at such facilities. For most member groups, SHI benefits can be accessed right after registration without any waiting period. However, for the near-poor, school pupils, university students and household members, there is a 30-day waiting period. To access SHI benefits, the insured individual is required to show their VSS issued SHI card, or evidence that the card is being processed. Patients who follow the referral line need to present all referral documents together with their SHI card to avoid paying higher co-payments.

A purchaser-provider split is in place, although some purchaser functions, such as determining the benefit package and prices, are still implemented by the MOH, which is also still directly involved in service provision through central medical care facilities. Under the Health Insurance Law, three types of provider payment methods can apply: capitation, fee-for-service and case-based payment. Implementing Decree 146 stipulates that primary outpatient health care will be paid on a capitation basis and fee-for-service payments will apply to services not paid by other methods, but does not specify the scope of services to be paid by case-based payments. Currently, providers are almost exclusively paid on a fee-for-service basis. Widespread balance billing practices, which drive competition among providers to generate revenues rather than reduce costs, combined with policies promoting financial self-reliance among public facilities, complicate the introduction of payment mechanisms other than fee-for-service (Somanathan et al. 2014). The lack of a gate-keeping function at primary care facilities further complicates development of

the capitation payment policy. Work is on-going to develop the capitation and diagnosis-related payment mechanisms.

► 4. Results

- Coverage

Legal coverage in Viet Nam is 100 per cent, as universal health insurance is compulsory by law (article 1, Health Insurance Law Amendment 2014). However a proportion of the population remains uncovered, including undocumented persons. Nonetheless, strong political commitment to achieve UHC in Viet Nam has led to a rapid increase in coverage over the years, from around 71.4 per cent in 2014 to 90.85 per cent by the end of 2020 (VCCI and ILO, unpublished). There is presently no in-depth analysis clearly identifying the remaining 10 per cent of the population who are uncovered. Internal government reports indicate that the majority of the uncovered population are made up of informal economy workers within second and third quintile income groups (Somanathan et al. 2014), as well as students. A recent study found no significant impact of information provision or subsidized contributions to further increase coverage among informal economy workers (Wagstaff et al. 2016).

According to official government sources, in 2018, the coverage rate reached 100 per cent among the poor, disadvantaged ethnic minority persons and social assistance recipients, whose contributions are financed by tax revenues. Furthermore, as a result of generous government subsidies, the coverage rate among the near-poor was also relatively high, at around 95.3 per cent in 2018. High level attention from the Prime Minister's office, including assigning annual coverage rate targets for each province and monitoring achievement, are likely to have contributed to this sustained coverage expansion.²⁸

- Adequacy of benefits/ financial protection

Viet Nam has achieved great progress in reaching out to the poor and the vulnerable through generous SHI subsidies and varied co-payment rates for different membership categories, which

²⁸ Prime Ministerial Decision 1167 dated 28 June 2016 on Adjusting the Targets for Implementing Health Insurance for the Period 2016–2020.

has significantly enhanced financial protection for vulnerable groups. However, the aforementioned co-payment structure only applies to those who comply with the referral system, which many individuals do not adhere to due to concerns over poor quality at the primary level (Le et al. 2018). For outpatient care at central or provincial hospitals, ²⁹ patients who have not been referred are required to pay 100 per cent of the total cost, which significantly increases OOP payments for self-referred patients. Due to recent policy reforms, penalties for by-passing the referral line for inpatient care up to the provincial level have been removed. However, the penalty for by-passing referrals at central facility level is very high, with a 68 per cent co-payment rate, from which the poor, ethnic minority persons living in disadvantaged areas and residents of islands are exempt (article 22, Health Insurance Law Amendment 2014).

Another factor which undermines financial protection for SHI members is underutilization, which has been attributed to a perceived quality gap between premium services care services for those who can afford and are willing to pay out-of-pocket and VSS-contracted services within the same public facilities (Le et al. 2018). This is perpetuated by increasing privatization of public hospitals under a policy of hospital autonomy, which risks limiting financial protection for SHI members in the future.

As a result of these obstacles, OOP payments in Viet Nam are increasing and remain very high, accounting for more than 45 per cent of the country's current health expenditure in 2017, which rose from 37 per cent in 2000. However, this increase in OOP expenditures has been concentrated among higher-income households who can afford premium services (Teo et al. 2019). As a result, despite high OOP spending, there have been substantial improvements in households' financial protection against large health expenditures, with catastrophic expenditure declining over time, from approximately 16 per cent in 2004 to 9.5 per cent in 2016 (Teo et al. 2019). Notably, Viet Nam is among the top five countries in terms of declining impoverishment due to OOP spending, with the rate of impoverishment due to health spending as low as 1.3 per cent (Teo et al. 2019).

- Responsiveness to population needs
 - o Availability and accessibility

The broad network of VSS-contracted facilities noted above ensures patient accessibility to providers and a choice for the patient. Among remote and geographically isolated population groups, village health workers and village birth attendants affiliated with a commune health station contribute greatly to the provision of public health services and first aid for people in rural areas (Le et al. 2018). Despite these favourable conditions, persons living in remote and disadvantaged regions continue to face various socio-economic barriers to access, including long distance to the nearest facility, poor service quality in primary care and lack of affordability (Tran et al. 2016). Furthermore, there is an uneven distribution of human and financial resources between urban and rural regions, which negatively affects equity in health care access (Lieberman and Wagstaff 2009; Somanathan et al. 2014). In particular, commune health stations are significantly under-resourced and underused, which has implications for equity in health care access, especially among those living in remote and disadvantaged areas. (Somanathan et al. 2014). In 2018, survey results indicate that individuals in the poorest quintile had greater access to inpatient care but lower access to outpatient care than those among richer quintiles. However, for both inpatient and outpatient care, the poorest quintile had minimal access to tertiary facilities, relying heavily on district and lower level facilities, while richer quintiles had substantially higher access to tertiary and private health services for both inpatient and outpatient care (General Statistics Office 2019).

- o Acceptability and quality

Even though the SHI benefits package is broad and generous in theory, access to effective primary and secondary health services at facilities close to home is complicated by perceptions of low quality of care due to limited equipment and medicines (ILO, 2019f; Somanathan et al. 2014). Primary care facilities, especially those in rural areas, suffer from insufficient funding and limited capacity among medical staff (Lieberman and Wagstaff 2009; Somanathan et al. 2014; World Bank 2016). In 2017, the number of doctors and nurses/midwives per 10,000 inhabitants in Viet

²⁹ Due to the weak referral system, many tertiary facilities also provide outpatient care and medical services that can be conducted at lower levels of care.

Nam was estimated at 8.28 and 14.46 respectively (WHO n.d. b), which is slightly lower than WHO recommended ratios (WHO 2006).³⁰

Overcrowding and long waiting times are common at provincial and central hospitals (Nguyen and Cheng 2014; Somanathan et al. 2013). As previously noted, self-referrals are commonplace, largely as a result of perceived poor quality of care at primary facilities (Le et al. 2018). To compound this, tertiary facilities have the financial incentive to directly compete with low-level facilities for profit, due to the user fee, hospital autonomy and social mobilization policies initiated in the health sector starting in the 1990s (Barroy et al. 2014; Ramesh 2013); this deepens existing quality disparities between facilities.

Moreover, there is an increasing quality gap between services offered within the same facilities, which has led to a perception of discrimination against SHI users (Dang 2013; Duong 2014; Kim and Vu 2013). At large hospitals, the queue for VSS-contracted services is often longer than that for premium services which are not covered by SHI. Those who use these services can also benefit from better infrastructure, facilities and equipment. Commercial health insurance payments for these premium services exacerbates incentives for public hospitals to prioritize resource allocations to these departments, undermining the solidarity of the SHI system. This divide between two lines of services within public facilities is the result of a decentralization policies that have allowed public service providers to generate and retain revenues to deal with a lack of funding, and low wages for medical staff (Lieberman and Wagstaff 2009; Ramesh 2013). Given the competitive advantage of tertiary facilities over lower-level hospitals in this regard (Barroy et al. 2014), this disparity may be reinforced as public hospitals in Viet Nam become increasingly “private”.

Since 2015, patient satisfaction surveys have been used to measure patients’ opinions on the quality of health care services delivered. A 2014 UNICEF-funded study in Dien Bien, one of the poorest

provinces in Viet Nam, rated patient satisfaction for all services at more than 78 per cent.³¹ Given the poor quality of care at primary level, the high level of satisfaction indicated in these two studies may point to low expectations among those living in disadvantaged areas, or a potential reluctance to voice complaints.

As a result of these challenges, quality of care has recently become central to government efforts to strengthen the health system. Through the implementation of a 2009 programme³² and a 2020 Directive on quality of health services for insured patients,³³ the 2008 Law on Health Insurance has focused attention on the need for a range of measures to improve quality of care and ensure satisfaction of insured patients. The 2009 Law on Examination and Treatment began the institutionalization of certification of health care professionals and licensing of health care facilities to improve quality of care. After results of a pilot in 2013, a set of 83 quality standards were issued in 2016 in an effort to monitor and evaluate hospital structural quality.³⁴

► 5. Way forward

Viet Nam has demonstrated a high level of political commitment to achieving UHC and made substantive progress in expanding SHI coverage. However, challenges remain in terms of ensuring affordable, equitable and quality health care for all. Maintaining and further expanding effective population coverage to the missing 10 per cent of the population will require determining new strategies, which may include extension of state budget-funded subsidies to further support the participation of workers in the informal economy. The implementation of regulations such as Decree 146, allowing provinces to use local budgets to increase subsidies for partially subsidized groups, as well as activities to tackle non-compliance with compulsory contributions among the employed as part of VSS’s 2021–2025

³⁰ The WHO recommended doctor-to-population ratio is 10 per 10,000 people. If combining the total number of medical doctors and nurses/midwives, Viet Nam marginally reached the minimum threshold of 23 doctors, nurses and midwives per 10,000 population that was established by WHO as necessary to deliver essential maternal and child health services.

³¹ Surveyed services included ante-natal care, medical check-up, vaccination, maternal and child care and health promotion via health communication activities.

³² Viet Nam Ministry of Health 2009 Programme 527/CTr-BYT to Improve quality of medical services at health facilities with the objective of ensuring satisfaction of health insured patients.

³³ Viet Nam Ministry of health Directive 25/CT-BYT of 2020 on Continuing to Strengthen Insured Medical Services Quality Management.

³⁴ Viet Nam Ministry of Health Decision 6858/QĐ-BYT of 2016 Issuing the Vietnam Hospital Quality Standards.

five-year plan, are expected to contribute to further coverage expansion.³⁵

Recent years have seen increases in user fees to cost-recovery levels, combined with phasing out supply-side subsidies and pressure on hospitals to increase revenues to cover full operating costs and supplement low civil servant salaries of staff in public hospitals, as part of the policy of hospital autonomy. This has driven rising OOP payments, which is starting to erode the financial protection of SHI coverage. Increasing SHI enrolment is therefore not sufficient to guarantee effective and equitable access.

Another challenge lies in addressing the rising cost of care in the context of a rapidly ageing population, the associated double burden of disease, and rapid diffusion of expensive technologies and medicines without adequate regulations or incentives to avoid overuse. The Health Insurance fund has experienced consecutive years of expenditure exceeding revenues, which needs to be addressed before the depletion of the reserve fund in order to maintain the existing coverage rate and level of benefits, without increasing contribution rates. Cost control, particularly through more strategic purchasing and provider payment reforms, is already part of the SHI scheme reform plans.³⁶ These reforms are expected to enhance efficiency and affordability of what the SHI fund purchases, while ensuring it maintains effectiveness in meeting people's needs. Enhancing effectiveness of the primary health care network, and increasing satisfaction with and trust in primary health care is also needed to ensure greater focus on disease prevention, management and health promotion, which are more appropriately provided at primary care facilities rather than hospitals. This shift will require increased compliance with a rational referral system.

► 6. Main lessons learned

- The enshrinement of the right to health in the Viet Nam Constitution has successfully facilitated the extension of social health protection coverage. Including universal SHI coverage in the Constitution helped to increase its priority level and enhance

government accountability, requiring the Government to implement the required reforms to ensure this constitutional right. It fostered the necessary level of political commitment, which has been crucial to developing and enforcing legislation and guaranteeing adequate funding for UHC. In addition to improvements to the SHI legal framework, Viet Nam's ambition to achieve UHC has been reflected in many political documents and targets. Increased budgetary allocation for health has also been observed.

- The consolidation of various health protection schemes initiated in 2008 was instrumental to creating a single risk-pooling mechanism for financing health care. It has contributed to improving the efficiency of the SHI Fund, and constitutes the necessary foundation for strategic purchasing.
- The Government's pro-poor policies and significant budget allocations have enabled the equitable extension of population coverage. However, middle income households lack coverage and do not benefit from the effective benefits received by poorer groups, which are still substantially lower than middle- and high-income groups. The complex classification of the population into multiple groups and sub-groups to set contribution amounts, and allocating subsidies on the principle of "fairness" may be limited. Achieving UHC will require new strategies, including potentially fully subsidizing the remaining uncovered population, to maintain and further expand coverage.
- Increasing SHI enrolment is not sufficient to guarantee effective and equitable access. Focus should also be placed on strengthening effectiveness and trust in primary health care, enhancing the potential for care coordination through primary care providers, and better integrating disease prevention, health promotion and curative care services through a patient-centred approach, while ensuring appropriate evidence-based care at all levels.

³⁵ Decision 1320/QĐ-BHXH dated 23 October 2020.

³⁶ As per the Five-Year Socio-Economic Development Plan No. 3353/KH-BHXH of Viet Nam Social Security for the Period 2021–2025.

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Annex 1

► Statistical annex

Social protection coverage is a multidimensional concept with at least three dimensions:

Scope. This is measured here by the range (number) and type of social security areas (branches) to which the population of the country has access. Population groups with differing status in the labour market may enjoy different scopes of coverage, and this factor must be taken into account in assessing scope.

Extent. This usually refers to the percentage of persons covered within the whole population or the target group (as defined by, for example, gender, age, income-level or labour market status) by social security measures in each specific area.

Level. This refers to the adequacy of coverage by a specific branch of social security. It may be measured by the level of cash benefits provided, where measurements of benefit levels can be either absolute or relative to selected benchmark values such as previous incomes, average incomes, the poverty line, and so on. For health benefits, it is measured as the extent of health services covered and the level of financial protection (support value) provided for those services. Measures of quality are usually relative and may be objective or subjective – for example, the satisfaction of beneficiaries measured against their expectations.

In measuring coverage, a distinction is made between legal coverage³⁷ and effective coverage in each of the above three dimensions, so as to reflect different dimensions of coverage. Table A1.1 summarizes these various dimensions.

► Table A1.1. Multiple dimensions of coverage: Examples of questions and indicators

Dimension of coverage	Legal coverage	Effective coverage
Scope	Which social security areas are anchored in the national legislation? For a given group of the population: for which social security area(s) is this group covered according to the national legislation?	Which social security areas are actually implemented? For a given group of the population: for which social security areas is this group effectively covered (benefits are actually available)?
Extent	For a given social security area (branch): which categories of the population are covered according to the national legislation? What percentage of the population or labour force is covered according to the national legislation?	For a given social security area (branch): which categories of the population enjoy actual access to benefits in case of need (currently or in the future)? The “beneficiary coverage ratio”: for a given social security area, what percentage of the population affected by the contingency receives benefits or services (e.g. percentage of older persons receiving an old-age pension; percentage of unemployed receiving unemployment benefits)? The “contributor coverage ratio”: for a given social security area, what percentage of the population contributes to the scheme, or is otherwise insured by the scheme, and can thus expect to receive benefits when needed (e.g. percentage of working-age population or of the labour force contributing to a pension scheme)?

³⁷ Legal coverage is sometimes referred to as “statutory coverage”, taking into account that provisions may be rooted in statutory provisions other than laws.

Dimension of coverage	Legal coverage	Effective coverage
		By extension, the “protected person coverage ratio” would include people who – assuming that legislation is unchanged – would be entitled to a health benefit (as a service user, beneficiary, contributor or dependent, depending of the type of national system) or a non-contributory cash benefit in the future, either through a universal scheme, or a means-tested scheme, provided they meet the eligibility criteria.
Level	For a given social security area: what is the level of protection provided according to the national legislation? For cash benefits: what is the prescribed amount or replacement rate according to the national legislation? For health care benefits: what is the prescribed health package and level of co-payment, if any?	For a given social security area: what is the level of protection actually provided (e.g. for cash benefits, average level of benefit as a proportion of median income, minimum wage or poverty line; for health benefits effective utilization of services and level of financial protection (affordability))

Source: Based on ILO, 2010a.

Legal coverage

Estimates of the *scope of legal coverage* usually measure the number of social security areas (branches) by which – according to existing national legislation – a population or its specific groups are covered. The list of the nine branches covered by ILO Convention No. 102 is used as guidance.

Estimates of the *extent of legal coverage* use both information on the groups covered by statutory schemes for a given branch in national legislation and available statistical information quantifying the number of persons concerned at the national level. A population group can be identified as legally covered in a specific social security area (e.g. maternity cash benefits, health care benefits, sickness cash benefits) if the existing legislation sets out that this group is mandatorily covered by social insurance, or that the group will be entitled to specified non-contributory benefits under certain circumstances – for instance, if income falls below a specified threshold or if the person reaches a certain age – or that the group is covered by a national health service. A legal coverage ratio for a given branch of social security is the ratio between the estimated number of people legally covered and – as appropriate – the total population (health care benefits) or labour force (income replacement schemes) in the relevant age bracket. Convention No. 102 allows a ratifying country to provide coverage through social insurance, through universal or means-tested benefits, or a combination of those. The proportion of the population legally covered by social health protection adopts this methodology.

The *level of legal coverage* for specific branches of social security is usually measured for cash benefits by benefit ratios or replacement ratios calculated for specified categories of beneficiaries, using benefit formulas or benefit amounts specified in the legislation. For example, Convention No. 102 sets minimum replacement rates for cash benefits in seven of its nine branches (see tables in Annex III below). It specifies that such minimum rates should apply to a defined “standard” beneficiary meeting qualifying conditions, and be guaranteed at least to those with earnings up to a certain prescribed selected level. For health care benefits, the extent of the prescribed benefit package is necessarily a qualitative indicator against the main components of a comprehensive package as defined in ILO standards, including promotion, preventive, curative and rehabilitative care. The extent of health care providers that can be accessed also needs to be provided for by law. The level of co-payment is measured in percentage of the costs of care left to the patient to cover out-of-pocket.

Effective coverage

Measurements of effective coverage should reflect how the legal provisions are implemented in reality. Effective coverage is usually different from legal coverage (and usually lower) because of non-compliance, problems with enforcement of legal provisions or other deviations of actual policies from the text of the legislation. In order to arrive at a full coverage assessment, measures of legal and effective coverage need to be used in parallel.

Measurements of the scope of *effective coverage* in a country reveal the number of social security areas (branches) for which there is relevant legislation that is actually enforced: that is, whether in all such areas the majority of the population legally covered is also effectively protected (as measured by the extent of effective coverage; see below).

When measuring the extent of effective coverage a distinction has to be made between coverage measured in terms of *protected persons* and in terms of *actual beneficiaries*. Protected persons are those who have benefits guaranteed but are not necessarily currently receiving them – for example, people affiliated to a health care scheme are effectively protected, although they receive the benefit only when they have a specific health need (e.g. immunization, injury, illness, etc.).

The *protected person coverage ratio* includes all people entitled to benefits (both contributory and non-contributory), assuming unchanged legislation. For health benefits, even in contributory schemes, usually the protection granted extends to the dependents of the contributor, hence for health care benefits the protected persons coverage ratio represents the percentage of the population protected by a scheme, regardless of whether they are contributing or not. The proportion of the population protected by social health protection adopts this methodology.³⁸

In respect of *actual beneficiaries*, the beneficiary coverage ratio describes the proportion of the population affected by a certain contingency who actually benefit from the appropriate social protection benefits. This ratio reflects the number of those actually receiving benefits, such as the number of beneficiaries of any maternity cash benefits among all women giving birth. For health care benefits and sickness cash benefits, measurement of the occurrence of such contingency in relation to benefit provision is challenging and there is no consensus on a methodology to reflect such dimensions of coverage.

Measurements of the level of effective coverage would identify the levels of benefits (usually related to certain benchmark amounts or benefit package) actually received by beneficiaries. In the case of health care, SDG indicator 3.8.1 is an index which measures the effective access to a range of health services and infrastructure³⁹ in times of need by a given national population (WHO and World Bank, 2017a). When it comes to the level of financial protection afforded when effectively accessing health services, there is an international consensus on the use of out-of-pocket payments made by households on health care and its poverty impact as a proxy indicator for the lack of financial protection, as reflected in SDG indicator 3.8.2 (WHO and World Bank, 2017a).

When assessing coverage and gaps in coverage, distinctions need to be made between coverage by (1) contributory social insurance; (2) universal schemes covering all residents (or all residents in a given category);⁴⁰ and (3) means-tested schemes potentially covering all those who pass the required test of

³⁸ It represents the best estimate of people protected by a health care scheme for their primary coverage. Mechanisms include national health insurance; social health insurance mandated by the State (including subsidized coverage for the poor); national health care service guaranteed for free or with small co-payments; and other programmes (user fee waivers, vouchers, etc.). 189 schemes for primary coverage were identified and included. To avoid overlaps, only public or publicly-mandated privately administered primary health care schemes were included. Supplementary and voluntary public and private programmes were not included, with the sole exception of the USA (the only country in the world where private health insurance plays a significant role in primary coverage).

Multiple sources were combined for this indicators, including data from ILO Social Security Inquiry and OECD Health Statistics 2020, national administrative data published in official reports, information from regular national surveys of target populations on awareness on rights. Data was collected for 117 countries and territories representing 89 per cent of the world's population.

³⁹ The additional indicators displayed in the report on health service use and availability are sourced from the Global Health Observatory of the World Health Organization (methodology and metadata accessible at: <https://www.who.int/data/gho/>), while indicators on the health work force are calculated using Labour Force Surveys data from the ILO-OECD-WHO Working for Health Programme (<https://working4health.org/>).

⁴⁰ Such schemes are also referred to as categorical schemes.

income and/or assets. In the case of social insurance it makes sense to look at the numbers of those who are actually members of and contributors to such schemes and who thus potentially enjoy – sometimes with their dependants – coverage in the event of any of the contingencies covered by their social insurance. These people fall into a category of persons “protected” in the event of a given contingency. The concept of protected persons may also apply where people are covered by universal or categorical programmes if all residents, or all residents in a given category (e.g. age), are entitled to certain benefits or to free access to social services by law and in practice in the event of the given contingency. It is, however, rather difficult to specify who is in fact effectively protected in the case of benefits granted on the basis of a means test or proxy means test, or conditional cash transfers.

The above measures of extent and level of coverage are specifically applied to certain areas (branches) of social security (and sometimes even only to specific schemes or types of scheme); they do not attempt to provide a generic measure of social security coverage. Ensuring the specificity of coverage indicators by area is essential to arrive at a meaningful analysis and ensure its relevance for policy development. In the case of health care benefits, the level of benefit coverage needs to encompass both the extent of services utilized in practice as well as the financial protection awarded against the costs of health care. SDG indicators 3.8.1 (service coverage) and 3.8.2 (catastrophic expenditure on health) are used as proxies to monitor the level of effective coverage along those two dimensions.

For more details on the methods used for regional estimates as well as sources of expenditure data, please refer to the statistical annex of the World Social Protection Report 2020–2022.

Annex 2

► Minimum requirements in ILO social security standards

ILO social security standards have come to be recognized globally as key references for the design of rights-based, sound and sustainable social protection schemes and systems. They also give meaning and definition to the content of the right to social security as laid down in international human rights instruments (notably the Universal Declaration of Human Rights, 1948, and the International Covenant on Economic, Social and Cultural Rights, 1966), thereby constituting essential tools for the realization of this right and the effective implementation of a rights-based approach to social protection. Guiding ILO policy and technical advice in the field of social protection, ILO social security standards are primarily tools for governments which, in consultation with employers and workers, are seeking to draft and implement social security law, establish administrative and financial governance frameworks, and develop social protection policies. More specifically, these standards serve as key references for:

- the elaboration of national social security extension strategies;
- the development and maintenance of comprehensive national social security systems;
- the design and parametric adjustment of social security schemes;
- the establishment and implementation of effective recourse, enforcement and compliance mechanisms;
- the good governance of social security and improvement of administrative and financial structures;
- the realization of international and regional obligations, and the operationalization of national social protection strategies and action plans; and
- working towards the achievement of the SDGs, particularly Goals 1, 3, 5, 8, 10 and 16.

The ILO's normative social security framework consists of eight up-to-date Conventions and nine Recommendations.⁴¹ The most prominent of these are the Social Security (Minimum Standards) Convention, 1952 (No. 102), and the Social Protection Floors Recommendation, 2012 (No. 202). Other Conventions and Recommendations set higher standards in respect of the different social security branches, or spell out the social security rights of migrant workers. ILO standards establish qualitative and quantitative benchmarks which together determine the minimum standards of social security protection to be provided by social security schemes in certain life contingencies, with regard to:

- the definition of the contingency (what risk or life circumstance must be covered?);
- the individuals protected (who must be covered?);
- the type and level of benefits (what should be provided?);
- any entitlement conditions, including any qualifying period (what should a person do to get the right to a benefit?);

⁴¹ Income Security Recommendation, 1944 (No. 67), Medical Care Recommendation, 1944 (No. 69), Social Security (Minimum Standards) Convention, 1952 (No. 102), Equality of Treatment (Social Security) Convention, 1962 (No. 118), Employment Injury Benefits Convention, 1964 (No. 121) and Recommendation, 1964 (No. 121), Invalidity, Old-Age and Survivors' Benefits Convention, 1967 (No. 128) and Recommendation, 1967 (No. 131), Medical Care and Sickness Benefits Convention, 1969 (No. 130) and Recommendation, 1969 (No. 134), Maintenance of Social Security Rights Convention, 1982 (No. 157) and Recommendation, 1983 (No. 167), Employment Promotion and Protection against Unemployment Convention, 1988 (No. 168) and Recommendation, 1988 (No. 176), Maternity Protection Convention, 2000 (No. 183) and Recommendation, 2000 (No. 191), and Social Protection Floors Recommendation, 2012 (No. 202). These instruments are reproduced in the compendium Building social protection systems: International standards and human rights instruments (ILO, 2021a).

- the duration of benefit and any waiting period (how long must the benefit be paid/provided for, and when must it commence?).

In addition, they set out common rules of collective organization, financing and management of social security, as well as principles for the good governance of national systems. These include:

- the general responsibility of the State for the due provision of benefits and proper administration of social security systems;
- solidarity, collective financing and risk-pooling;
- participatory management of social security schemes;
- guarantee of defined benefits;
- adjustment of pensions in payment to maintain the purchasing power of beneficiaries;
- the right to complain and appeal.

Tables A2.1-A2.3 provide a summary overview of some of the key requirements set out in ILO standards relating to medical care, sickness benefits and maternity protection.

► **Table A2.1. Main requirements: ILO social security standards on medical care**

	Convention No. 102: Minimum standards	ILO Convention No. 130 a and Recommendation No. 134 b: Advanced standards	Recommendation No. 202: Basic protection
What should be covered?	Any ill-health condition, whatever its cause; pregnancy, childbirth and their consequences.	The need for medical care of a curative and preventive nature.	Any condition requiring health care, including maternity.
Who should be covered?	At least: • 50% of all employees, and wives and children; or • categories of the economically active population (forming not less than 20% of all residents, and wives and children); or • 50% of all residents.	C.130: All employees, including apprentices, and their wives and children; or • categories of the active population forming not less than 75% of the whole active population, and their wives and children; or • prescribed class(es) of residents forming not less than 75% of all residents. (Persons already receiving certain social security benefits shall also continue to be protected under prescribed conditions.) R.134: In addition: persons in casual employment and their families, members of employers' families living in their house and working for them, all economically active persons and their families, all residents.	At least all residents and children, subject to the country's existing international obligations.
What should the benefit be?	<i>In case of ill health:</i> general practitioner care, specialist care at hospitals, essential medications and supplies; hospitalization if necessary. <i>In case of pregnancy, childbirth and their consequences:</i> prenatal, childbirth and postnatal care by medical practitioners and qualified midwives; hospitalization if necessary.	C.130: The medical care required by the person's condition, with a view to maintaining, restoring or improving health and ability to work and attend to personal needs, including at least: general practitioner care, specialist care at hospitals, allied care and benefits, essential medical supplies, hospitalization if necessary, dental care and medical rehabilitation. R.134: Also the supply of medical aids (e.g. eyeglasses) and services for convalescence.	Goods and services constituting at least essential health care, including maternity care, meeting accessibility, availability, acceptability and quality criteria; free prenatal and postnatal medical care for the most vulnerable; higher levels of protection should be provided to as many people as possible, as soon as possible.

	Convention No. 102: Minimum standards	ILO Convention No. 130 a and Recommendation No. 134 b: Advanced standards	Recommendation No. 202: Basic protection
What should the benefit duration be?	As long as ill health, or pregnancy and childbirth and their consequences, persist. May be limited to 26 weeks in each case of sickness. Benefit should not be suspended while beneficiary receives sickness benefits or is treated for a disease recognized as requiring prolonged care.	C.130: Throughout the contingency. May be limited to 26 weeks where a beneficiary ceases to belong to the categories of persons protected, unless he/she is already receiving medical care for a disease requiring prolonged care, or as long as he/she is paid a cash sickness benefit. R.134: Throughout the contingency.	As long as required by the health status.
What conditions can be prescribed for entitlement to a benefit?	Qualifying period may be prescribed as necessary to preclude abuse.	C.130: Qualifying period shall be such as not to deprive of the right to benefits persons who normally belong to the category. R.134: Right to benefit should not be subject to qualifying period.	Persons in need of health care should not face hardship and an increased risk of poverty due to financial consequences of accessing essential health care. Should be defined at national level and prescribed by law, applying principles of non-discrimination, responsiveness to special needs and social inclusion, and ensuring the rights and dignity of people.

^a Medical Care and Sickness Benefits Convention, 1969.g1

^b Medical Care and Sickness Benefits Recommendation, 1969.

► Table A2.2. Main requirements: ILO social security standards on sickness benefits

	Convention No. 102: Minimum standards	Convention No. 130 and Recommendation No. 134 : Advanced standards	Recommendation No. 202: Basic protection
What should be covered?	Incapacity to work resulting from illness that results in the suspension of income	C.130: Incapacity to work resulting from sickness and involving suspension of earnings. R.134: Also covers periods of absence from work resulting in loss of earnings due to convalescence, curative or preventive medical care, rehabilitation or quarantine, or due to caring for dependants.	At least basic income security for those who are unable to earn a sufficient income due to sickness.
Who should be protected?	At least: 50% of all employees; or categories of the economically active population (forming not less than 20% of all residents); or all residents with means under a prescribed threshold	C.130: All employees, including apprentices; or • categories of economically active population (forming not less than 75% of whole economically active population); or • all residents with means under prescribed threshold. R.134: Extension to persons in casual employment, members of 'employers' families living in their house and working for them, all economically active persons, all residents.	At least all residents of working age, subject to the country's existing international obligations.
What should the benefit be?	<i>Periodic payments:</i> at least 45% of reference wage.	C.130: Periodic payments: at least 60% of reference wage; in case of death of the beneficiary, benefit for funeral expenses. R.134: Benefit should be 66.66% of reference wage.	Benefits in cash or in kind at a level that ensures at least basic income security, so as to secure effective access to necessary goods and services; prevents or alleviates poverty, vulnerability and social exclusion; and enables life in dignity. Levels should be regularly reviewed.

	Convention No. 102: Minimum standards	Convention No. 130 and Recommendation No. 134 : Advanced standards	Recommendation No. 202: Basic protection
What should the benefit duration be?	As long as the person remains unable to engage in gainful employment due to illness; possible waiting period of max. three days before benefit is paid; benefit duration may be limited to 26 weeks in each case of sickness.	C.130: As long as the person remains unable to engage in gainful employment due to illness; possible waiting period of max. three days before benefit is paid; benefit duration may be limited to 52 weeks in each case of sickness. R.134: Benefit should be paid for full duration of sickness or other contingencies covered.	As long as the incapacity to earn a sufficient income due to sickness remains.
What conditions can be prescribed for entitlement to a benefit?	Qualifying period may be prescribed as necessary to prevent abuse.	C.130: Qualifying period may be prescribed as necessary to prevent abuse.	Should be defined at national level, and prescribed by law, applying principles of non-discrimination, responsiveness to special needs and social inclusion, and ensuring the rights and dignity of people.

► Table A2.3. Main requirements: ILO social security standards on maternity protection

	Convention No. 102: Minimum standards	ILO Convention No. 183a and Recommendation No. 191b: Advanced standards	Recommendation No. 202: Basic protection
What should be covered?	Medical care required by pregnancy, childbirth and their consequences; resulting lost wages.	C.183: Medical care required by pregnancy, childbirth and their consequences; resulting lost wages. R.191: Same as C.183 .	Essential maternity health care. At least basic income security for those who are unable to earn a sufficient income due to maternity.
Who should be protected?	At least: - all women in prescribed classes of employees, which classes constitute not less than 50% of all employees and, for maternity medical benefit, also the wives of men in these classes; or - all women in categories of the economically active population forming not less than 20% of all residents, including, with regard to maternity medical benefit, the wives of men in these classes); or - all women with means under a prescribed threshold.	C.183: All employed women including those in atypical forms of dependent work. R.191: Same as C.183 .	At least all women who are residents, subject to the country's international obligations.

	Convention No. 102: Minimum standards	ILO Convention No. 183a and Recommendation No. 191b: Advanced standards	Recommendation No. 202: Basic protection
What should the benefit be?	<i>Medical benefits:</i> At least: • prenatal, confinement and postnatal care by qualified practitioners; • hospitalization if necessary. With a view to maintaining, restoring or improving the health of the woman protected and her ability to work and to attend to her personal needs. <i>Cash benefits:</i> Periodic payment: at least 45% of the reference wage.	C.183: <i>Medical benefits:</i> At least prenatal, childbirth and postnatal care; hospitalization if necessary. Daily remunerated breaks or reduced hours for breastfeeding. <i>Cash benefits:</i> At least 66.67% of previous earnings; should maintain mother and child in proper conditions of health and a suitable standard of living. Appropriate increases in the levels of cash benefits must be considered periodically. R.191: <i>Medical benefits:</i> Medical maternity care should also comprise pharmaceutical and medical supplies, medically prescribed tests, and dental and surgical care. <i>Cash benefits:</i> Should be raised to the full amount of the woman's previous earnings.	<i>Medical benefits:</i> Goods and services constituting essential maternity health care, meeting criteria of availability, accessibility, acceptability and quality; free prenatal and postnatal medical care should be considered for the most vulnerable. <i>Benefits in cash or in kind:</i> should ensure at least basic income security, so as to secure effective access to necessary goods and services, and be at a level that prevents or alleviates poverty, vulnerability and social exclusion and enables life in dignity. Levels should be regularly reviewed.
What should the benefit duration be?	<i>Medical benefits:</i> Throughout the contingency <i>Cash benefits:</i> At least 12 weeks for cash benefits.	C.183: 14 weeks' maternity leave, including 6 weeks' compulsory leave after childbirth; additional leave before or after maternity leave in cases of illness, complications or risk of complications arising from pregnancy or childbirth. R.191: At least 18 weeks' maternity leave. Extension of the maternity leave in the event of multiple births.	As long as the incapacity to earn a sufficient income remains.
What conditions can be prescribed for entitlement to a benefit?	As considered necessary to preclude abuse.	C.183: Conditions must be met by a large majority of women; those who do not meet conditions are entitled to social assistance. R.191: Same as C.183.	Should be defined at national level and prescribed by law, applying the principles of non-discrimination, responsiveness to special needs and social inclusion, and ensuring the rights and dignity of women.

^a Maternity Protection Convention, 2000.

^b Maternity Protection Recommendation, 2000

Extending social health protection: Accelerating progress towards Universal Health Coverage in Asia and the Pacific

This regional report documents and analyses country experiences and lessons on the extension of social health protection coverage in the Asia and the Pacific region. It provides a detailed account of progress made, challenges encountered and remaining coverage gaps, and explores their root causes. The report highlights the plurality of options available to countries and illustrates the different paths taken towards Universal Health Coverage in the region, whilst also stressing the need for sustained political commitments to social health protection and the rigorous application of international social security standards to make social health protection a reality for all in the Asia and the Pacific region and beyond.

This publication aims to serve as a roadmap for practitioners and policymakers alike for the design, extension and implementation of social health protection systems that are resilient, effective, inclusive, adequate and sustainable. In the context of the COVID-19 pandemic, this report provides concrete insights for all stakeholders to devise inclusive recovery strategies that bring social health protection to the forefront, as part of comprehensive social protection systems.

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