

THEMATIC PAPER

ACCELERATING PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE FOR WOMEN AND CHILDREN IN SOUTH ASIA, EAST ASIA AND THE PACIFIC

Allison Beattie, Robert Yates, Douglas Noble



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ACRONYMS

ADB	African Development Bank
GDP	Gross domestic product
HITAP	Health Intervention and Technology Assessment Program (Thailand)
JKN	Jaminan Kesehatan Nasional
MDGs	Millennium Development Goals
MHLW	Ministry of Health, Labour and Welfare (Japan)
MNCH	Maternal, Newborn and Child Health
NCDs	Non-communicable diseases
OOP	Out of pocket
PHE	Public health expenditure
PNG	Papua New Guinea
SARS	Severe acute respiratory syndrome
SHI	Social health insurance
SDGs	Sustainable development goals
THE	Total health expenditure
UHC	Universal health coverage
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
WASH	Water, sanitation and hygiene
WHO	World Health Organization
WPRO	Western Pacific Regional Office (WHO)

EXECUTIVE SUMMARY

In pursuing Universal Health Coverage (UHC), countries aim to extend coverage of quality health services to all people and to protect them from the risk of financial hardship when paying for them. Achieving a UHC system is as much a political process as a technical one. More and more countries are moving towards publicly financed health care systems that cover the whole population for essential health services, enabling them to reduce preventable illness and death, particularly in women and children. Using public financing, countries can allocate resources equitably to respond to their burden of disease, optimise health outcomes, boost economic growth and strengthen accountability to citizens. Article 24 of the Convention on the Rights of the Child and Sustainable Development Goal three can be advanced through UHC.

Removing both direct and indirect barriers to health care contributes to improving access to essential services, reducing one of the main causes of household impoverishment. Investing in health delivers excellent economic returns and helps to deliver fundamental rights, including the right to health. For example, reducing preventable maternal and child deaths would save an estimated \$7 billion in health care costs globally. In addition, preventable deaths in women and children lead to an estimated \$15 billion in lost productivity each year. More than 40% of such deaths occur in Asia and the Pacific.¹ Growing evidence suggests that poor health status in infancy can predispose adults to non-communicable diseases in later life.² Children are among the most vulnerable in any population. In protecting people from health shocks UHC is indispensable for achievement of individual health security and, therefore, collective health and human security.

UHC is a journey (rather than a destination) and requires

a strong, equitable and accessible primary health care system. Although each country will need to develop its own path towards UHC, the most successful share common attributes: (i) they organise and deliver comprehensive, integrated health services making these accessible to all; (ii) they remove financial and other barriers, especially direct payments for health; (iii) their health financing systems are dominated by public financing; (iv) they have large risk pools to ensure sustainable cross-subsidy between the healthy and wealthy and the sick and the poor; and, (v) their governments use public financing to cover the informal sector and households living on or below the poverty line.

Most countries spend well under 4% for public expenditure on health (or indeed 3%) with some notable exceptions. The higher the public health expenditure as a share of total health expenditure, the more control a country will have over how it can allocate resources equitably. Although decisions about what services will be covered by UHC schemes have important technical components (for example, identifying cost-effectiveness, value for money, and health impacts for individuals and populations), the politics of priority setting are equally important. Without independent or at least transparent priority-setting processes, priorities are set through individual preferences rather than through decisions led by evidence about what produces the best health results for the population.

All countries can make progress wherever they are on the UHC journey. This paper reviews lessons learned from across Asia and the Pacific using a literature review and interviews with key informants to identify best practices, challenges and opportunities to further advance UHC. The paper culminates in ten lessons learned and ten policy recommendations:

TEN LESSONS LEARNED		
Laying the groundwork: Designing a pro-poor strategy based on progressive universalism	Moving the process forward: UHC System Design & Implementation	
1. UHC is a political process from the start 2. Primary health care first 3. Strengthen quality and sustainable coverage through investing in health systems 4. Address the social and economic determinants of health	5. Raising funds: public financing is crucial 6. Increase pooling and reduce fragmentation 7. Priority setting is a political process 8. Engage the private sector to support UHC	9. Make UHC a long-term investment 10. Build accountability to citizens through transparent progress tracking and monitoring

1. Partnership for Maternal, Newborn and Child Health (2009), Investing in Maternal, Newborn and Child Health: The Case for Asia and the Pacific, World Health Organization, Geneva, 2009.
 2. De Boo, H. A. and Harding, J. E. (2006), The developmental origins of adult disease (Barker) hypothesis. Australian and New Zealand Journal of Obstetrics and Gynaecology, 46: 4–14. doi:10.1111/j.1479-828X.2006.00506.x

TEN POLICY RECOMMENDATIONS

1. Make UHC a 'whole of government' decision linked to nation-building and achieving citizen development;
2. Engage political actors including the head of state, parliamentarians, administrators and powerful interest groups across the political and social spectrum;
3. Engage beyond health to strengthen the critical drivers of UHC systems such as tax collection and budget management;
4. Invest in good quality accessible primary health care as the foundation of UHC and a precondition for success;
5. Be willing to develop differentiated strategies and to pay more to address equity and remove barriers to access for the poorest;
6. Countries spending less than 3% of GDP in public expenditure should commit to increase funding by 0.3%/year;
7. Combine funds from all sources to create the largest pool of resources possible to maximise cross-subsidisation;
8. Establish a transparent priority-setting process to determine what should be included in the UHC package;
9. Engage the private sector through strengthened regulation, negotiated payment systems, and partnership;
10. Strengthen accountability through developing and monitoring clear, explicit and measureable targets.

Reaching the poorest and most marginalised is challenging and programmatically difficult. Countries can draw on these lessons and best practices to shape their own journeys, making adjustments and adaptations as they build experience. The groundwork for UHC needs to be laid carefully so that service provision is able to meet

health needs irrespective of where the funding comes from. If services are not accessed by all the people who need them, when they need them, it is not UHC. Children are especially vulnerable. UHC is an effective strategy for advancing the right to health of children, which countries have agreed to guarantee.





SECTION 1

Introduction

Across the world, expenditure on health is tracking upwards. This is hardly surprising; as populations age they need more health care, technology is improving and more people live in closer proximity to better health services. Expectations are rising among citizens and populations, especially in middle-income countries and emerging economies, many of which are in Asia and the Pacific regions. And while overall expenditure goes up, the share of out-of-pocket payments by individuals is overall trending downwards.³ More and more countries are moving towards publicly financed health care systems that cover the whole population for essential health services, reducing preventable illness and death, particularly in women and children. Deaths in children are always tragic and almost always preventable. In addition to the emotional distress

a death causes, there are cost implications – to families, communities and the national economy. Premature deaths have a disproportionate effect and can inhibit economic growth. For every 10% gained in life expectancy, economies can expect a boost of 0.3% to 0.4% in annual growth.⁴ Eliminating preventable child mortality is vital to increasing national life expectancy.

Policy-makers from the Asia and Pacific regions will gather in Kuala Lumpur in November for the three-yearly High-Level Meeting aimed at discussing how to advance the rights and needs of children. This paper aims to support those discussions by helping to situate the benefits and challenges of universal health coverage (UHC), as a policy instrument, into the regional context. It will complement

3. Trend Tables: WHO Moving to UHC doc 2016

4. WHO, Investing in health: A Summary of the Findings of the Commission on Macroeconomics and Health, WHO, Geneva, 2001.

the two other thematic areas of focus in the 2016 High-Level Meeting, which include equitable social protection and the elimination of violence against children. Poor health or a premature death in a breadwinner or primary caregiver can reduce income and create expenses in the household that can lead to children being removed from school and sent out to work. This cements intergenerational cycles of poverty, preventing social and economic development among the poorest. By improving health and reducing the economic burden caused by sickness (both in terms of the direct cost of care and the indirect cost of lost income), UHC is an important driver of household well-being, boosting economic and social security and creating a very powerful safety net. Household resources previously spent on preventable health conditions can be redirected to investments in housing, education and the family economy. With better access to reproductive health, couples can plan their families, and have the number of children they decide they can afford. Universal access to quality health services is thus an important driver of well-being and development, affecting the lives of children and their families in a range of ways.

Most countries in the world are moving towards governance systems that are more accountable to citizens. The lack of equity in human development – for example between the rich and poor, men and women, urban and rural populations – is increasingly less tolerated by electorates. In many countries, the burgeoning population of young people – the electorate of tomorrow – has rapidly rising expectations. Despite challenges associated with economic fluctuations, internal migration, climate change and other issues, the aspirations of a broader range of groups in society are shaping politics (and budget allocations).

In this context, UHC can be an opportunity, if delivered the right way, to meet one of the strongest needs of populations everywhere.⁵ It provides an opportunity for political authorities to shift resources in ways that reduce inequity and genuinely close the inclusion gap. Funding health services in ways that meet the needs of all people can accelerate development and helps enable every individual to reach their potential. Despite costing more to national governments in the short term, the costs to societies overall are often less and UHC pays back its initial debt to national economic growth in multiples. For example, the Lancet Commission on Investing in Health in 2013 found that the economic benefits of achieving a grand convergence of global health outcomes for infectious diseases and for maternal and child health would outweigh the costs by a factor of between nine and 20 over 20 years from 2015 to 2035.⁶ In country after country, where it has been well thought out and delivered, UHC has acted as a means to sustainable nation-building.

There is a huge wealth of technical and policy material on UHC, particularly in Asia, and the rate of production has

increased since UHC was formalised as a Sustainable Development Goal (SDG) target (see Section 3). Many of these technical papers have been developed through multi-country research conducted over a long period of time. This paper does not attempt to repeat existing research. Instead, it aims to synthesize the best available evidence, combined with analysis, to inform political decision-makers by identifying critical lessons emerging from the region, and to suggest ten policy recommendations.

Section 2 of this paper explains the basics of UHC, including its benefits and essential ingredients, synthesising the current situation in Asia and the Pacific regions. Data for comparison has been used from recognised international sources, although we are aware that sometimes more recent national surveys will offer different estimates. Section 3 examines the global and regional policy context for health (and UHC) including the SDGs, the new global health agenda and rising concerns about global health security. Section 4 summarises the main lessons learned from countries' experience with UHC so far and includes examples and short case studies from the region. This section concludes with a summary of the determinants of success and barriers to progress. Section 5, finally, sets out policy recommendations and next steps.



5. See, for example, World Bank. 2005. Dying for change: Poor people's experience of health and ill-health. Washington, DC: World Bank. <http://documents.worldbank.org/curated/en/2005/12/6114408/dying-change-poor-peoples-experience-health-ill-health>

6. DT Jamieson, LH Summers et al. "Global Health 2013: A World Converging within a generation", The Lancet, Vol 382; Issue 9908; 1898-1955, 2013



SECTION 2

What is UHC and why does it matter for women's and children's health?

UHC DEFINED

UHC is a simple concept defined by the WHO as a means to ensuring that “all people obtain the health services they need without suffering financial hardship when paying for them”.^{7 8} UHC thus combines two benefits: firstly, everybody is covered by a package of good quality health services; secondly, UHC provides financial protection from health care costs.^{9 10} Several critical elements underpin UHC including:

- An efficient, resilient health system
- Affordable care and a system of financing health care that doesn't impoverish users
- Access to essential medicines and technologies
- Health workers who are motivated, and sufficient in number and skills
- Efficient, functional administrative and governance arrangements
- Transparency in tracking progress and achieving equity

Achieving UHC requires countries to advance health services in three distinct ways. Firstly, the proportion of the population covered should extend to encompass all people in a country (universal population coverage).

7. World Health Organization, What is Universal Health Coverage? [online], available at: www.who.int/features/qa/universal_health_coverage/en/ (accessed 26 March 2016).

8. Adopted as a resolution at the 2005 World Health Assembly. In 2012, the United Nations General Assembly adopted a resolution on global health and foreign policy that called for action towards UHC. The World Bank and WHO have selected UHC as a key objective to address both the right to health and extreme poverty.

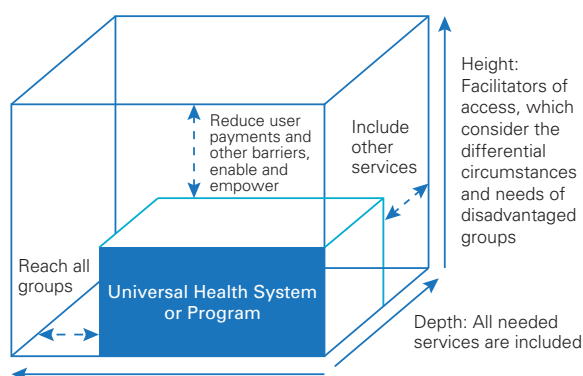
9. Robert Yates (2015), Commonwealth paper 2015.

10. Financial protection covers both the direct or indirect costs of accessing health services as well as the more severe catastrophic expenditure which is classified as spending over 40% of the annual household income on health.

Secondly, the range of services covered by UHC policies should expand as resources permit, including sufficient investment in essential public health functions. Services must also be accessible and be of adequate quality to be effective. And, thirdly, the proportion of the financing required to deliver services should be increasingly drawn from pooled funds raised through compulsory prepayment mechanisms, including general or specific taxation or public social insurance. Figure 1 illustrates how expansion of all three dimensions will advance UHC in all directions.

FIGURE 1: THE THREE DIMENSIONS OF UHC WITH EQUITY¹¹

UHC with equity (all groups with need achieve effective coverage)



Source Figure 1: Adapted from www.causehealth.be

Breadth: Health system cover all population groups

THE BENEFITS OF UHC

UHC has increasingly become the focus of the global health agenda.¹² In 2010, the WHO World Health Report focused on the pathway to UHC, setting out how countries could arrange their health financing systems to pay for it. Since then, more than 70 countries have sought out WHO assistance to move forward with their own strategies.¹³ In 2012, Margaret Chan called UHC, “the single most powerful concept that public health has to offer”.^{14 15}

Adopting and sustaining a UHC system is thus as much a political process as a technical one. Although there are

important elements around getting the system right, UHC begins with and is sustained by the commitment of political decision-makers, often in response to citizen demand, to ensure that the whole population can access the quality of health services they need without the risk of financial hardship.¹⁶ Choosing how to advance universal coverage is different in each country context but countries that have made progress with UHC have experienced a range of benefits. Evidence and examples (both global and from Asia and the Pacific regions) are summarised in the table below.

TABLE 1: THE MULTIPLE BENEFITS OF UHC

Health benefits	Broad health coverage leads “to better access to necessary care and improved population health, with the largest gains accruing to poorer people.” ¹⁷ A study by Imperial College, London found that a 10% increase in pooled government health spending led to a reduction of almost eight deaths per 1000 children under five. When truly universal, health coverage improves outcomes fastest among the poorest and most marginalised districts, supporting equity and reducing or eliminating disparities within populations. ¹⁸ Health coverage should include essential public health services including prevention and promotion, investments in public goods such as clean air, and in the main determinants of health, including water and sanitation, the non-communicable disease risk factors such as tobacco, and in nutrition.
Health system benefits	Reaching all citizens with services requires a system that extends to all geographical parts of the country, is staffed, equipped, managed and able to meet needs. UHC can act as a driver of and incentive to sustaining investments aimed at strengthening health systems, overcoming bottlenecks and, in particular, improving the availability and performance of health care workers and essential medicines and supplies. In protecting people from shocks UHC is indispensable for achievement of individual health security and therefore collective health and human security.

11. An observation about the cube is that it appears to downplay the importance public health services/ functions, and services that support individual and collective health security. While we have not attempted to re-design the cube, we concur that these broader services and functions should be included.

12. Bristol, Nellie “Global Action toward Universal Health Coverage”, Center for Strategic and International Studies, Washington DC, 2014.

13. Margaret Chan “Opening remarks at the WHO/ WB Ministerial-level meeting on UHC” from Bristol (2014) p6

14. Margaret Chan, Universal Coverage is the Ultimate Expression of Fairness. Acceptance speech at the 65th World Health Assembly; Geneva, Switzerland; May 23 2012. Chan quote -re election speech

15. UN Declaration on UHC (2012)

16. The term ‘health services’ in this paper will draw on the WHO definition and include promotion, prevention, treatment and rehabilitation including services aimed at individuals (curative, vaccination) and public health services aimed at populations and including international health regulations.

17. R Moreno-Serra and P Smith, “Does progress towards universal health coverage improve population health?”, The Lancet, Vol 380; 917-23.2012.

18. J Gruber, N Hendren and RM Townsend, “The great equalizer: Health Care Access and Infant Mortality in Thailand” American Economic Journal: Applied Economics, Vol 6, No. 1, 91-107; 2014.

Economic benefits	Healthier populations support economic growth while unhealthy populations, particularly those afflicted with preventable diseases, can slow down and even stall economic growth. With use of 'value life years' to estimate the economic benefits, over the period 2015–35 these benefits would exceed costs by a factor of about nine to 20 for infectious diseases and for maternal and child health, making the investment highly attractive. ¹⁹ Households protected from financial hardship due to medical expenses are less likely to slip into poverty. They are less vulnerable. And they earn more. Investments in a package of micronutrients in children increases their incomes as adults by 11 % per year ²⁰ . The converse is also true: a leading cause of impoverishment across the world is medical and health-related costs and it is estimated that every year 100 million households fall into poverty because of medical and health expenses ²¹ . Some governments have successfully used increases in social services, including health coverage, as a counterweight to less popular reforms such as removing subsidies on fuel or some foodstuffs. ²²
Political benefits	As a political process, UHC requires strong redistributive policies and actions by the state as well as transparent processes for allocation of resources for competing needs across different interest groups. Many politicians have found that extending health coverage to underserved areas is a popular policy and attracts support. It builds universalism and solidarity across social groups in society, acting as a force to unite rather than divide groups. UHC helps countries achieve their international commitments to fulfilling citizen rights to health and other progressive social policies, including advancing gender equality.
Helping to meet the child's right to health	Article 24 of the Convention on the Rights of the Child (a Convention signed by all countries in the Asia and Pacific regions) can be advanced through UHC in several ways. By covering the whole population, governments, as duty bearers, take steps to guarantee the right to health of citizens. The elimination of financial barriers contributes to improving access to health services. The package of services covered by UHC can advance many of the Convention's requirements, including care at birth, interventions to prevent diseases, nutrition counselling to parents and the protection from harmful practices.

Sources: Yates, R "Accelerating Progress towards Universal Health Coverage in the Commonwealth", The Commonwealth, London, 2015; UNICEF data bank; WHO, "Anchoring universal health coverage in the right to health: What difference would it make?" Policy Brief, World Health Organization, Geneva, 2015; The Convention on the Rights of the Child: <http://www.ohchr.org/en/professionalinterest/pages/crc.aspx>

WHY IS UHC IMPORTANT TO WOMEN'S AND CHILDREN'S HEALTH?

Reducing preventable maternal and child deaths would save an estimated \$7 billion in health care costs globally. In addition, preventable deaths in women and children lead to an estimated \$15 billion in lost productivity each year. More than 40% of such deaths occur in Asia and the Pacific.²³ Growing evidence suggests that health status in infancy can predispose adults to non-communicable diseases (NCDs) in later life.²⁴ Children are among the most vulnerable in any population. Where parents have to pay upfront for life-saving care, there may be delays in seeking medical help for a sick child, especially if household assets need to be sold to raise funds. Add to this a perception that the quality of care is poor or other access barriers such as transport costs and it is easy to see how many parents, while wanting to do the best for their children, lack confidence in their health care systems, or cannot access services for various reasons, including lack of funds.

Between 30% and 50% of Asia's economic growth between 1960 and 1995 can be attributed to favourable demographic and health changes, leading to reduced infant and child mortality, subsequent fertility decline, changing dependency ratios and improvements in reproductive health.²⁵ Every \$1 spent on family planning and birth spacing saves \$4 or more on addressing the complications of unplanned pregnancies, which contribute disproportionately to maternal and infant mortality. This excludes the increased productivity of women in the labour market and the value of their contribution to GDP. Extending family planning to all women who want it would reduce unintended pregnancies by more than two-thirds globally (from 75 million to 22 million per year). Through the consequent delays in first births, and by spacing births and limiting the total number of births, healthy years of life lost among women and their newborns would be reduced by 60%.²⁶

19. DT Jamieson, LH Summers et al. "Global Health 2013: A World Converging within a generation", The Lancet, Vol 382; Issue 9908; 1898-1955, 2013 [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)62105-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)62105-4/fulltext)

20. Hoddinott, J., Alderman, H., Behrman, J. R., Haddad, L. and Horton, S. (2013), The economic rationale for investing in stunting reduction. *Maternal & Child Nutrition*, 9: 69–82. doi: 10.1111/mcn.12080

21. DB Evans, R Elovainio and G Humphreys "The World Health Report: Health Systems Financing- The Path to Universal Coverage, World Health Organization, Geneva, 2010

22. R Yates, "Recycling fuel subsidies as health subsidies", *Bulletin of the World Health Organisation*, Vol 92; 547-547A, 2014.

23. Partnership for Maternal, Newborn and Child Health (2009), Investing in Maternal, Newborn and Child Health: The Case for Asia and the Pacific, World Health Organization, Geneva, 2009.

24. De Boo, H. A. and Harding, J. E. (2006), The developmental origins of adult disease (Barker) hypothesis. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 46: 4–14. doi:10.1111/j.1479-828X.2006.00506.x

25. Partnership for Maternal, Newborn and Child Health (2009), Investing in Maternal, Newborn and Child Health: The Case for Asia and the Pacific, World Health Organization, Geneva, 2009.

26. Singh S et al., Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health, New York: Guttmacher Institute and United Nations Population Fund, 2009.

Women tend to spend their income on their families, including their children's education and health. Increasing public spending on health can reduce the financial burden on mothers and is one of the best investments in early childhood development. Combined with nutrition and early stimulation interventions, preventive and curative health services are essential for building cognitive capacity in children.²⁷ This represents one of the foundations of individual and national development.

All people need health services at some point. When a family member's life is at risk, and if household assets have to be spent to access vital health care, then the decision to seek care is affected by concerns about resources and, for the poorest, will require difficult trade-offs with other essentials such as food, education, or agricultural inputs. All too often, this equation results in impoverishment and/or a premature death. When Margaret Chan talks about "a powerful concept", she is, in part, suggesting that UHC can resolve the need for this trade-off and help balance the equation, especially for the poorest. Every \$1 invested in reducing stunting in children returns in the order of \$18. Improving nutritional knowledge and providing a package of care in pregnancy that includes micronutrients and salt iodisation, can help to mitigate against the effects of infections, including diarrheal disease, preventing some forms of malnutrition.



WHERE ARE ASIA AND PACIFIC COUNTRIES ON THE UHC JOURNEY?

Situation analysis

Across the Asia and Pacific region, countries are at very different stages of their UHC journeys. Each of the UHC dimensions – population coverage, quality and package of services offered, and the proportion of costs covered or financial protection achieved – is discussed, with a synthesis of current data in the Asia and Pacific region.

Extending Coverage

Universal coverage aims to ensure that all people are reached with essential health services and that everyone has financial protection from health care costs. Coverage of the population can be difficult to achieve and in many countries actual population coverage lags behind²⁸. Geographic distribution can make some communities hard to reach while migration patterns, cultural and language barriers, and a range of other factors, affect access to services. Administrative regulations requiring personal identification or evidence of registration (proving 'the right' to receive services based on nationality or place of abode) can be a major barrier to coverage. In some countries, resident citizens may be covered but migrant workers are

not, which effectively diminishes coverage significantly and weakens public health outcomes. In some countries, these may be internal migrants living in urban slum areas but who are classified as transient and thus excluded^{29 30}. For many basic health services – especially those that prevent, detect and treat transmissible diseases – it is much more effective from a public health perspective to aim for full coverage regardless of an individual's status in a country.

In the Asia and the Pacific region, countries are at different stages in their efforts to reach whole populations with full equity. This was recently demonstrated in a paper reviewing progress in providing effective health coverage for mothers and children in eight countries in South Asia, which showed variable performance in service coverage and financial protection.³¹ Even where services are offered, the reality may be limited or sub-optimal utilisation or attendance for a number of complex reasons (see Lesson 2 in section 4). For example, Figure 2 shows the distribution of antenatal visits by wealth quintile for the countries where equity data were available.

27. Remarks by World Bank Group President Jim Yong Kim at the Early Childhood Development Event at the World Bank-IMF Spring Meetings Apr 14 2016

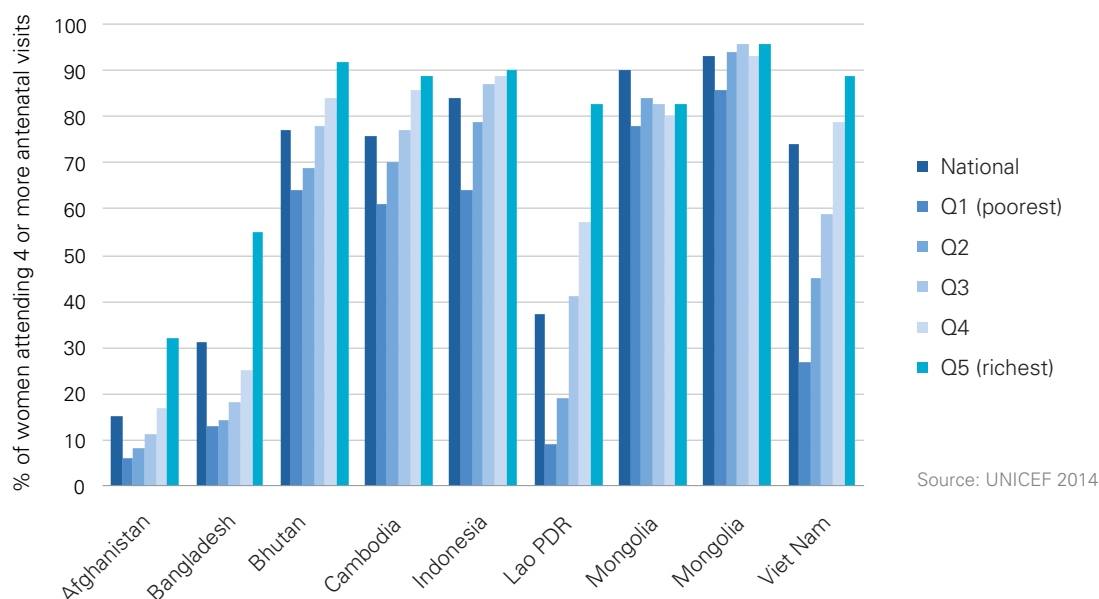
28. See for example, W Soors, J de Man, et al. "Towards universal coverage in the majority world: Transversal findings & lessons learnt, a summary" Institute of Tropical Medicine (ITM, Antwerp), 2015.

29. K Afsana and SS Wahid, "Health care for poor people in the urban slums of Bangladesh", *Lancet*, Vol 382, Dec 21/29; 2013.

30. See for example, W Soors, J de Man, et al. "Towards universal coverage in the majority world: Transversal findings & lessons learnt, a summary" Institute of Tropical Medicine (ITM, Antwerp), 2015.

31. Scammell K, Noble DJ, Rasanathan K, et al. A landscape analysis of universal health coverage for mothers and children in South Asia. *BMJ Global Health* 2016;1:e000017.doi:10.1136/bmjgh-2015-000017

FIGURE 2: PERCENTAGE OF WOMEN ATTENDING FOUR OR MORE ANTENATAL VISITS (2014)

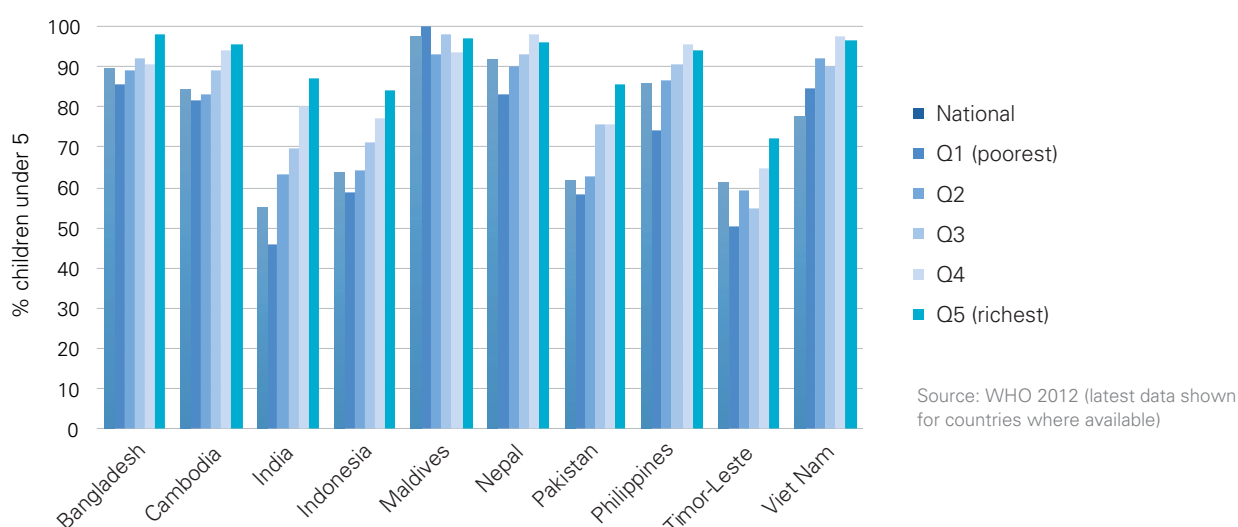


Thailand and Mongolia, both well advanced in their UHC journeys, reach women across the social spectrum at high rates. Bhutan, Cambodia, Lao PDR and Viet Nam are able to reach some women but coverage decreases with socio-economic status. In Afghanistan and Bangladesh, where there are still ongoing challenges with equity, services are not used particularly well even by the highest socio-economic groups, especially when repeat visits are required.

For immunisation services, the coverage rate in many countries is generally higher although still variable

within and between populations (Figure 3). Timor-Leste, Indonesia, India and Pakistan are striving to achieve majority coverage of children while other countries such as Bangladesh, Maldives, Nepal, Viet Nam, Cambodia and to some extent, the Philippines, have much higher rates of coverage for children's vaccination services. This may be due to several factors. Vaccinations are often delivered very close to the community, through special campaigns accompanied by more pro-active community engagement. Funding for vaccination services is one of the most reliable through the Global Vaccine Alliance and almost everywhere they are delivered free of charge.

FIGURE 3: IMMUNISATION RATES (DTP3) AMONG CHILDREN UNDER FIVE BY WEALTH QUINTILE (2012)

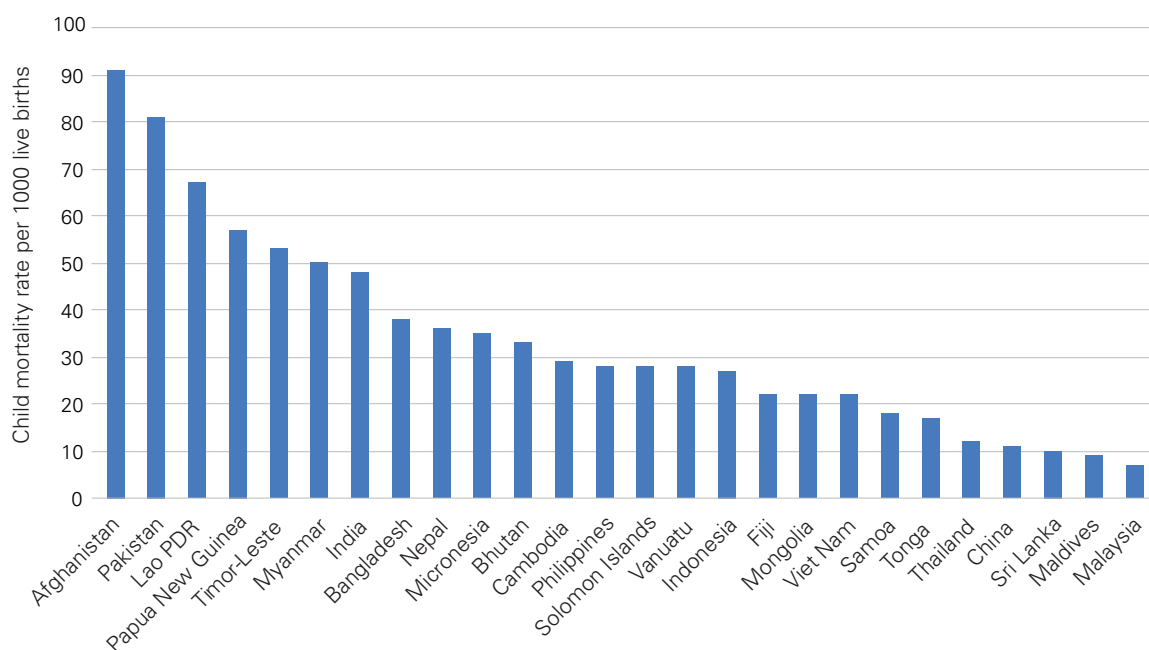


Extending Services

Extending the range of services covered by UHC is a persistent challenge in all countries. There are never enough resources to fund all the health services that people can consume. Priority setting and decision-making about who should be covered for what services depends on several factors, including the burden of disease, quality, resources

available and, crucially, political negotiation. Using child mortality rates as a proxy for burden of disease, Figure 4 shows the current status in Asia and Pacific countries. Many countries in the region are still working towards extending the most cost-effective health interventions to their whole populations.

FIGURE 4: CHILD MORTALITY RATES (2015)



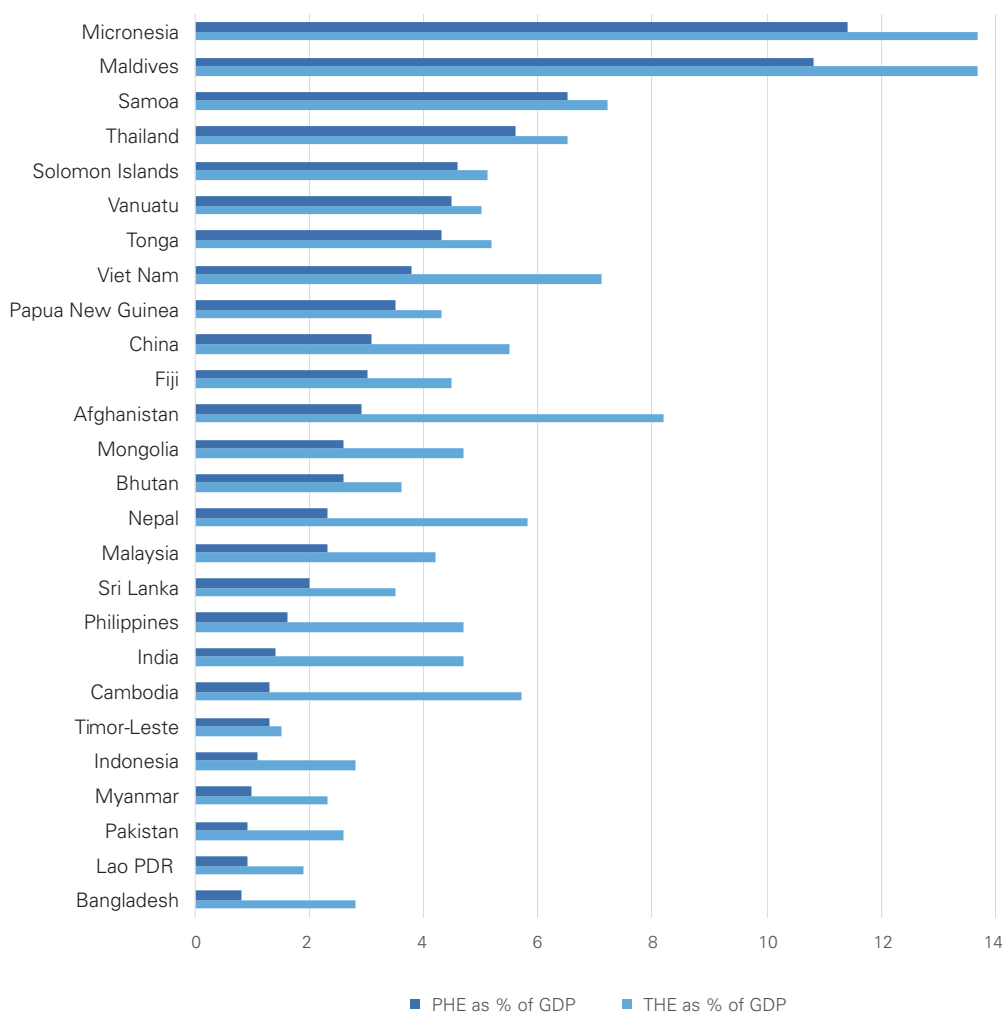
Source: World Bank data 2015



Clearly the resource envelope is important in determining which services should be covered. The Lancet Commission on Investing in Health (2013) shows that as economies grow, countries that increase their public health expenditure (PHE) to more than three percent of GDP can make faster progress reducing health outcome disparities and provide a basic package of care (and four percent of GDP is even better).³² Resources available for health come either from public mechanisms (tax funding, social insurance and external aid) or through private mechanisms such as private insurance schemes, direct out-of-pocket (OOP) payments and some limited use of personal health savings accounts. Total health expenditure (THE) calculates spending on health from all sources of financing, including public and private sources. Figure 5 shows the total and public health spending in Asia and the Pacific, expressed as a percentage of GDP.

32. Lancet Commission on Investing in Health, 2013: <http://globalhealth2035.org>

FIGURE 5: TOTAL HEALTH EXPENDITURE (THE) AND PUBLIC HEALTH EXPENDITURE (PHE) IN ASIA AND PACIFIC COUNTRIES (2014)



Source: World Bank data 2014

Most countries spend well under 4% for public expenditure on health (or indeed 3%) with some notable exceptions. The higher the PHE as a share of THE, the more control a country will have over how it can allocate resources equitably to respond to its burden of disease.

Although decisions about what services will be covered by UHC schemes have important technical components (for example, identifying cost-effectiveness, value for money, and health impacts for individuals and populations), the politics of priority setting are equally important. As a recent working group on priority setting observed, it is difficult for politicians and policy-makers not to respond to interest groups and the (increasing) demands of wealthy populations, who tend to want specialist care in new hospitals. Without a transparent process, “cost-effective health interventions are often the opportunity cost of that response when priorities are not explicitly set”, which leads to sub-optimal use of resources for health.³³ Without independent or at least transparent priority-setting

processes, priorities are set through individual preferences rather than through decisions led by evidence about what produces the best health results for the population.



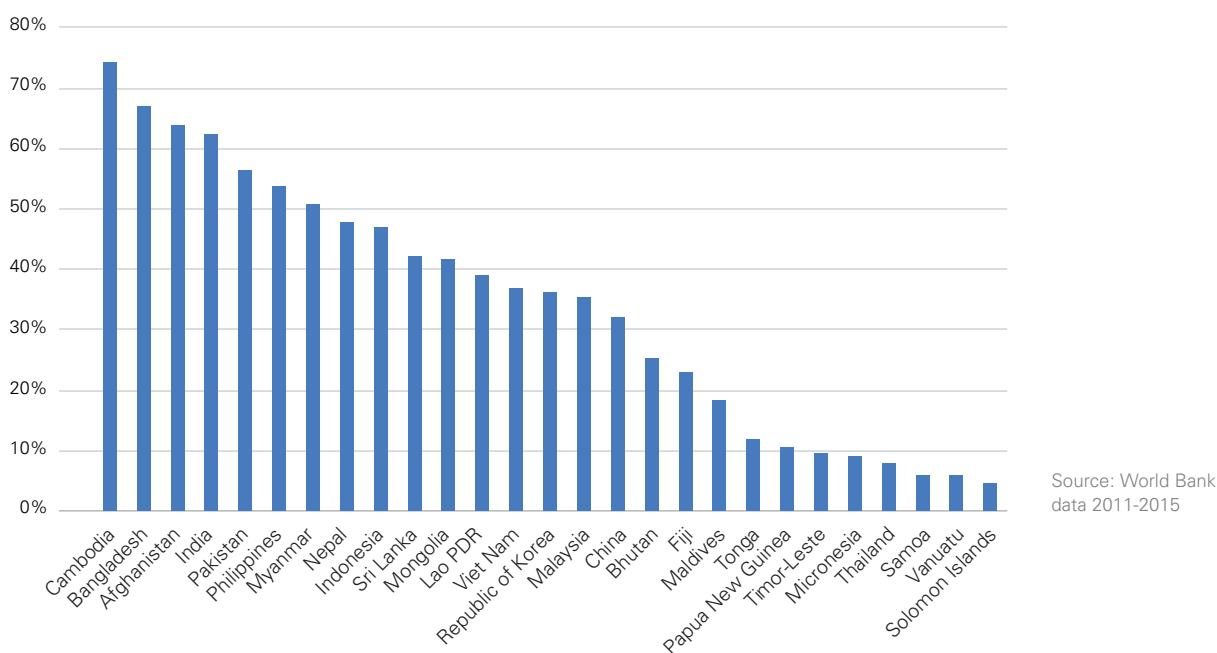
33. A Glassman and K Chalkidou, Priority-setting in health: Building institutions for smarter public spending. A report of the Center for Global Development's Priority-Setting Institutions for Global Health Working Group. Center for Global Development, Washington DC, 2012. p. x.

Extending Financial Risk Protection

A critical feature of UHC is that it should provide financial risk protection. The direct costs of health care can be catastrophic for households and the poorest are often the hardest hit because they are least able to afford services. Looking at figure 5 again, the difference between PHE and THE represents private voluntary financing either directly to service providers or to voluntary private health insurance.

The greater the difference, the greater the financial burden on individual households. To extend financial risk protection, countries need to reduce or eliminate direct payments at the time of service delivery. Figure 6 shows this burden in a different way, illustrating the very high reliance on OOP payments in some countries.³⁴

FIGURE 6: OOP EXPENDITURE AS A PROPORTION OF TOTAL HEALTH EXPENDITURE IN ASIA AND PACIFIC COUNTRIES (2015)



RISKS AND HAZARDS

Despite sound evidence and a favourable policy environment, the road to UHC can be problematic, particularly in overcoming opposition from vested interest groups such as those who benefit or profit from the status quo and are opposed to changes. On the other hand, although it is politically attractive to promise far-reaching reforms, for politicians to do so without a clear plan of action can result in confusion, or worse, investment in an approach that is flawed or unworkable. Hasty decisions about what kind of UHC system to adopt can be financially as well as politically costly. For example, the UHC journey can go off track when it focuses on expanding access to a wider range of higher-quality health services for a limited group in society such as the urban employed, rather than focusing on improving health outcomes for all based on need (equity).

Some of the most common hazards include focusing on setting up the system itself and distributing health cards that create entitlement to services, without also ensuring that the care meant to be delivered is available, accessible

and of good quality. In this case, people may get a health card but they are not actually better off in terms of their health outcomes.³⁵ Another common challenge is failing to negotiate with private sector partners, health workers, unions and other powerful groups who may lose out in some way from a UHC system and may actively oppose reforms. These groups need careful handling and attention to ensure they become supporters not spoilers.

So what should countries do? What are the critical policy lessons for those countries moving forward with UHC? Using evidence and experience from the Asia and Pacific region, we have identified the most important lessons and policy recommendations to support political decision-making. The regional and global context for health in Asia and the Pacific generally, and for UHC in particular, offers both useful insights and challenges going forward. Before examining the lessons learned about UHC, the next section will sketch out the global and regional context within which efforts to design and deliver UHC are being shaped.

34. The figure does not reflect the distribution of the OOP burden and, for example, masks some important omissions or inequities such as the socioeconomic groups most affected.

35. WHO and the World Bank, (2015) First Tracking Report on UHC, Geneva, WHO, 2015.



SECTION 3

The Context for UHC in Asia and the Pacific

The newly launched SDGs illustrate that, for all countries in the region (and indeed, the world), health will be one priority of many in the coming years. Health consistently ranks high on the list of citizen concerns,³⁶ but for governments it is only one of many pressing priorities. The

new global development agenda (the SDGs) and associated instruments such as the Addis Ababa Action Agenda on financing for development,³⁷ aim to help countries identify, focus on, and increasingly finance their own priorities.

THE SDGS: AN INTEGRATED APPROACH

The SDGs, taken collectively, set out a vision for a world where children get the right start in life and can grow in a safe, secure and nurturing environment to achieve their full potential (Annex 3). The SDGs are multifaceted and reflect complexity; the 17 goals collectively aim to end poverty,

promote well-being and protect the planet, and will require sustained political commitment over their full lifetime. Goal 3 is dedicated to health: “Ensure healthy lives and promote well-being for all at all ages”. Its nine targets and four means of implementation (figure 7) aim to expand

36. See, for example, World Bank. 2005. Dying for change: Poor people's experience of health and ill-health. Washington, DC: World Bank. <http://documents.worldbank.org/curated/en/2005/12/6114408/dying-change-poor-peoples-experience-health-ill-health>

37. See the Addis Ababa Action Agenda: http://www.un.org/esa/ffd/wp-content/uploads/2015/08/AAAA_Outcome.pdf

and build momentum from the Millennium Development Goals (MDGs) to eliminate preventable deaths and confront other priority or growing health risks. The means of implementation address the main health systems building blocks: health workers, access to medicines and commodities, sustainable financing, and others.

Target 3.8, pulled out in the top of figure 7 sets out the ambition to “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services, medicines and vaccines for all”, thus making UHC a target for every country. UHC is a target in the SDGs because it is also considered a vital

component of ending poverty and promoting well-being.

Despite having its own target, national policies to promote UHC could be boosted by a number of other targets in other (non-health) goals – for example, targets 8.5 and 8.6 aim to increase productive employment, which will (among other benefits) increase the tax base and therefore help raise public financing for health. It is worth taking a longer look at all the detailed SDG targets to consider how targets can be made to work together. UHC will help boost the achievement of other targets as well, through improving health and protecting households from impoverishment. They therefore reinforce each other.

FIGURE 7: GOAL 3 AND ITS TARGETS

SDG3: ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING FOR ALL AT ALL AGES		
TARGET 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services, medicines and vaccines for all		
MDG UNFINISHED AND EXPANDED AGENDA	NEW SDG3 TARGETS	SDG3 MEANS OF IMPLEMENTATION TARGETS
3.1 Reduce maternal mortality 3.2 End preventable newborn and child deaths 3.3 End the epidemics of HIV, TB, malaria and NTD and combat hepatitis, water borne and other communicable diseases 3.7 Ensure universal access to sexual and reproductive health care services	3.4 Reduce mortality from NCD and promote mental health 3.5 Strengthen prevention and treatment of substance abuse 3.6 Halve global deaths and injuries from road traffic accidents 3.9 Reduce deaths from hazardous chemicals and air, water and soil pollution and contamination	3.a Strengthen implementation of framework convention on tobacco control 3.b Provide access to medicines and vaccines for all, support R&D of vaccines and medicines for all 3.c Increase health financing and health workforce in developing countries 3.d Strengthen capacity for early warning, risk reduction and management of health risks
Interactions with economic, other social and environmental SDGs and SDG 17 on means of implementation		

Source: WHO SEARO 2016

Looking at figure 7, it is clear that health investments and outcomes will be affected by several other goals that will support health outcomes directly and indirectly. For example, nutrition underpins health across the whole of life and is a vital determinant of health. Water and sanitation, energy, poverty reduction and education have direct links to health. But there are other targets that will also have an impact on the ability of the health sector to function and to deliver services of sufficient quality to all who need them. As discussed in Lesson 5, for example, the ability to raise sufficient revenue for health service provision is affected by goal 8 (sustainable employment and economic growth). Goal 16 (Promote peaceful and inclusive societies for sustainable development, provide access to justice for all

and build effective, accountable and inclusive institutions at all levels) includes providing every person with a legal identity (target 16.9), and public access to information and services (target 16.10). Goal 10 aims to build equity within and between societies, including through trade agreements. The means of delivery of 10a includes implementation of the TRIPS agreement and affects the availability of some generic medicines.³⁸

The economic case for investing in women’s, children’s and adolescents’ health prepared as part of the Lancet Commission on Investing in Health 2013 demonstrates how these investments in the health of women, adolescents and children provide returns of many times

38. The World Trade Organization TRIPS agreement is here: https://www.wto.org/english/tratop_e/trips_e/intel2_e.htm



over.³⁹ The development of a list of cost-effective essential interventions that together can safeguard life and promote health in women, children and adolescents continues to aid priority setting.⁴⁰⁻⁴¹ These essential interventions lie at the centre of a new global strategy for women's, children's and adolescents' health.⁴² The Strategy supports countries aiming to deliver the targets in Goal 3, specifically those to reduce preventable mortality, and focuses on equity, leaving no one behind, the most vulnerable in conflict and humanitarian settings, and building resilient health systems.

The global agenda is thus in place to support countries to put children at the heart of their efforts to advance universal coverage. The tools, policy processes and funding platforms to accelerate health outcomes for women, children and adolescents are evidence-based, developed through consensus and aligned. Taken together, they can support national policies and domestic commitments to support political commitments to UHC.⁴³

UHC AND GLOBAL HEALTH SECURITY

The Asia and Pacific regions have been the source of disease outbreaks such as severe acute respiratory syndrome (SARS), avian influenza and others. Following on from the Ebola outbreak in West Africa and Zika in South and Central America, there are growing concerns about the urgent need to strengthen global health security. As Heymann and colleagues emphasised in a special package on Global Health Security in the *Lancet*,⁴⁴ "Collective health security is the sum of individual health security, and compels global action to provide individuals in all countries with access to essential health care."

The threat of antimicrobial resistance has exacerbated these concerns further. It is now one of WHO's top priorities and is exacerbated by private OOP health financing.⁴⁵ Many practitioners and policy-makers have observed that

UHC has an important role to play in global health security efforts in three distinct ways.⁴⁶ Firstly, through its concern for reaching all people with quality health services, UHC can help ensure that credible public health measures are in place and that health services are available and functional, including motivated health workers capable of detecting and responding effectively to diseases that have the potential to become emergencies.⁴⁷⁻⁴⁸ Secondly, in building a strong frontline health system, UHC contributes to a nation's resilience and its ability to withstand and recover from shocks, including natural disasters and epidemics. Thirdly, in establishing access to health services based on need rather than ability to pay, UHC helps to ensure rational health care decisions unaffected by perverse incentives (for example, physicians' profiting from drug sales) that can lead to inappropriate prescribing.⁴⁹

39. The PMNCH Knowledge Brief 24: The Economic Benefits of Investing in Women's and Children's Health, 2013: http://www.who.int/pmnch/knowledge/publications/summaries/knowledge_summaries_24_economic_case/en/ and Knowledge Brief 28: The Investment Framework for Women's and Children's Health, 2013: <http://www.who.int/pmnch/knowledge/publications/summaries/ks28.pdf>

40. Essential interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health, PMNCH, WHO and the Aga Khan Foundation, 2011. http://www.who.int/pmnch/topics/part_publications/essential_interventions_18_01_2012.pdf?ua=1

41. A two-year investigation into the success factors most likely to determine health outcomes in women and children was also conducted and is reported here: <http://www.who.int/pmnch/knowledge/publications/successfactors/en/>

42. Survive, Thrive and Transform: The Global Strategy for Women's, Children's and Adolescents' Health 2015-2030 <http://www.everywomaneverychild.org/global-strategy-2>

43. See also the Addis Ababa Action Agenda on development finance, 2015. <http://www.un.org/esa/ffd/ffd3/press-release/countries-reach-historic-agreement.html>

44. See for example, DL Heymann et al. "Global Health Security: The Wider Lessons from the West African viral diseases epidemic", *The Lancet*; Vol 383, 9980: 1884-1901, 2015.

45. Alsan, Marcella et al. (2016) Out-of-pocket health expenditures and antimicrobial resistance in low-income and middle-income countries: an economic analysis *The Lancet Infectious Diseases*, Volume 15, Issue 10, 1203-1210 [http://www.thelancet.com/journals/laninf/article/PIIS1473-3099\(15\)00149-8/fulltext](http://www.thelancet.com/journals/laninf/article/PIIS1473-3099(15)00149-8/fulltext)

46. J Kutzin and S Sparkes "Health systems strengthening, universal health coverage, health security and resilience" *Bulletin of the World Health Organization*, Vol 94; 2: 2016.

47. Yates, R., "Accelerating Progress towards Universal Health Coverage in the Commonwealth", *The Commonwealth*, London, 2015

48. WHO Regional Office for the Western Pacific, "Universal Health Coverage: Moving towards better health", WHO Regional Office for the Western Pacific, Manila, draft November 2015.

49. Alsan, (2016).



SECTION 4

Ten UHC Lessons from Asia and the Pacific

We undertook a literature search and conducted more than 30 interviews with policy-makers, practitioners and academics from a large proportion of the South Asia, and Asia and Pacific Regions. The methodology is briefly described in the annexes.⁵⁰ The bibliography identifies the literature consulted. Wherever possible, evidence from

interviews has been triangulated with examples from the literature or with country data. Out of this process, we picked out the most commonly occurring themes from across countries and identified ten lessons for political decision-makers focused on achieving or expanding UHC, listed in Table 2.

50. For a full description of the methodology, see the UHC Inception Report.

TABLE 2: UHC POLICY LESSONS FROM ASIA AND THE PACIFIC

Laying the groundwork: Designing a pro-poor strategy based on progressive universalism	Moving the process forward: UHC System Design & Implementation	Taking the long view: Adaptability, accountability and tracking
<ol style="list-style-type: none"> 1. UHC is a political process from the start 2. Primary health care first 3. Strengthen quality by investing in health systems 4. Address the social and economic determinants of health 	<ol style="list-style-type: none"> 5. Raising funds: public financing is crucial 6. Increase pooling and reduce fragmentation 7. Priority setting is a political process 8. Engage the private sector to support UHC 	<ol style="list-style-type: none"> 9. Make UHC is a long-term investment 10. Build accountability to citizens through transparent progress tracking and monitoring

LESSON 1: UHC IS A POLITICAL PROCESS FROM THE START

The Asia and Pacific Region, like other regions, has demonstrated that the health and broader government reforms required to deliver UHC are inherently political processes. UHC can generate huge benefits for some groups in society but can have significant costs for other groups. This in turn can result in considerable political costs and benefits (in terms of political popularity) for governments and political leaders overseeing these reform processes.

Given the high political stakes involved, it is not surprising that UHC reforms in the region have often been led by the head of state (for example, Prime Minister Hayato Ikeda in Japan (1963), President Park in Republic of Korea (1977), and most recently President Jokowi in Indonesia (from 2014).



In particular, fulfilling the equity principle underlying UHC (that healthy and wealthy people subsidise services for the poor, vulnerable and sick) requires a strong role for the state in establishing and governing a progressive health financing system (see also lessons 5 and 6).

The beneficiaries of these subsidies previously lacked health coverage and often see the politicians who introduce accessible health care as national heroes. This has been the case in Thailand.

The rise in the popularity of President Jokowi (see below) in Indonesia, while Governor of Jakarta, was in no small part due to his launching a similar UHC initiative in the nation's capital (known as the KJS health programme). In a poll in March 2014 (three months before the Presidential election), 57% of people surveyed in Jakarta attributed his popularity to the KJS health programme.

However, compelling privileged groups to join socialized health financing systems often generates political opposition in powerful segments of society, such as among the wealthy elite, in richer districts and states, among the urban middle class, civil servants, insurance companies, private health providers and some sections of the medical profession. In recent years some of these interest groups have been seen to oppose pro-poor public UHC reforms and instead promote private systems that do not benefit everyone.^{51 52}

Overcoming this resistance to build and sustain an equitable health financing system requires considerable political commitment and strong leadership, as has been demonstrated most recently by President Obama in the United States, as well as by the Asia Pacific leaders

51. Chandra S Union Budget 2015: More tax benefits on health insurance required: Max Bupa Money control website 12 February 2015 available at: http://www.moneycontrol.com/news/insurance/union-budget-2015-more-tax-benefitshealth-insurance-required-max-bupa_1300778.html?utm_source=ref_article

52. The Nation news article: Health Insurance being Pushed by NRC 28 August 2015 Available at: <http://www.nationmultimedia.com/webmobile/national/Health-insurance-being-pushed-by-NRC-30265351.html>

53. Ikegami N., editor (2014) Universal Health Coverage for Inclusive and Sustainable Development - Lessons from Japan The World Bank 2014, Available at: http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2014/10/10/000442464_2014101010104230/Rendered/PDF/911630PUB0Box30see0also0888620Sep25.pdf

identified above. Yet, the recent American experience shows the power of vested interest groups, highlighting the need for a groundswell of evidence and opinion before reform is possible. The case for UHC is political, technical, economic and moral. All parts have to be addressed comprehensively to achieve the change necessary.

Increasingly, regional political leaders have recognised that the potential political benefits in securing UHC are worth this investment of political capital. Furthermore, it is striking how many analyses of large-scale UHC programmes in Asia have cited political reasons as the main motivation behind these reforms. This was the case in Japan in 1963 and Republic of Korea in 1977 when incumbent governments launched popular UHC reforms in an attempt to stave off

the threat of opposition parties vying for power.⁵³ Also in Nepal, parties campaigning for universal free health care won power in the country's first general election since it became a Republic after its civil war in 2008.⁵⁴ The former Chinese Minister of Health was also explicit in recognizing that China's recent large-scale reforms were largely a political response to the population's growing dissatisfaction with low coverage rates.⁵⁵

Across Asia and the Pacific, political leaders have recognised that by bringing accessible health care to the masses, successful UHC reforms are extremely popular and can be a potent political tool to help win and sustain power.

LESSON 2: CLOSING PRIMARY HEALTH CARE GAPS IS A FOUNDATION FOR UHC

Overwhelmingly, through the literature review and from the interviews, the evidence is clear that countries wishing to make rapid progress towards UHC should prioritise primary health care, including prevention and health promotion as a first step. Primary health care services are situated closest to most people geographically. Well structured, efficient primary health services can meet most of the health needs

of most of the population, most of the time. The benefits include:

- a rapid reduction in preventable illness and death
- reaching people who need services the most
- reducing disparities and inequities in health
- providing citizens with basic services they value
- ensuring the most health for the resources available

BOX A: SRI LANKA - A UHC SUCCESS STORY SECURED AND SUSTAINED BY POLITICAL PRESSURE

Sri Lanka has a health system that has been heralded as a UHC success story and was one of the countries identified in the 1982 report "Good Health at Low Cost".

In a 2009, a World Bank Working Paper (Sri Lanka "Good Practice" in Extending Health Coverage) by Rannan-Eliya and Sikurajapathy highlighted the importance of political factors in driving the country's UHC reforms. In particular, they cite the transition to a competitive democracy as the primary factor that brought UHC to the island's population and the reason has been sustained to this day:

"The introduction of democratic politics forced successive governments to continuously expand free public health services into rural areas where voters wanted the same standards established earlier for the urban population. Once democracy had served to establish a widely dispersed government health infrastructure, accessible by all, it then acted to ensure its survival under often difficult, fiscal conditions.

Subsequently, successful market-oriented and reform-minded governments in Sri Lanka have generally understood that the cost of adequate public sector health services accessible to the poor was a small fiscal price to pay for the political support that they engender to enable other more important economic reforms."

This example follows a pattern seen in other Asia and Pacific countries such as Japan where, once established, UHC takes firm hold in the political landscape and the expectation of the electorate (citizens) is that successive political leaders and parties will defend and enhance the health services and health coverage.

Source: Ranna-Eliya R and Sikurajapathy L (2009) Sri Lanka: Good Practice in Expanding Health Care Coverage, Institute for Health Policy Research Studies, Series 3, The World Bank

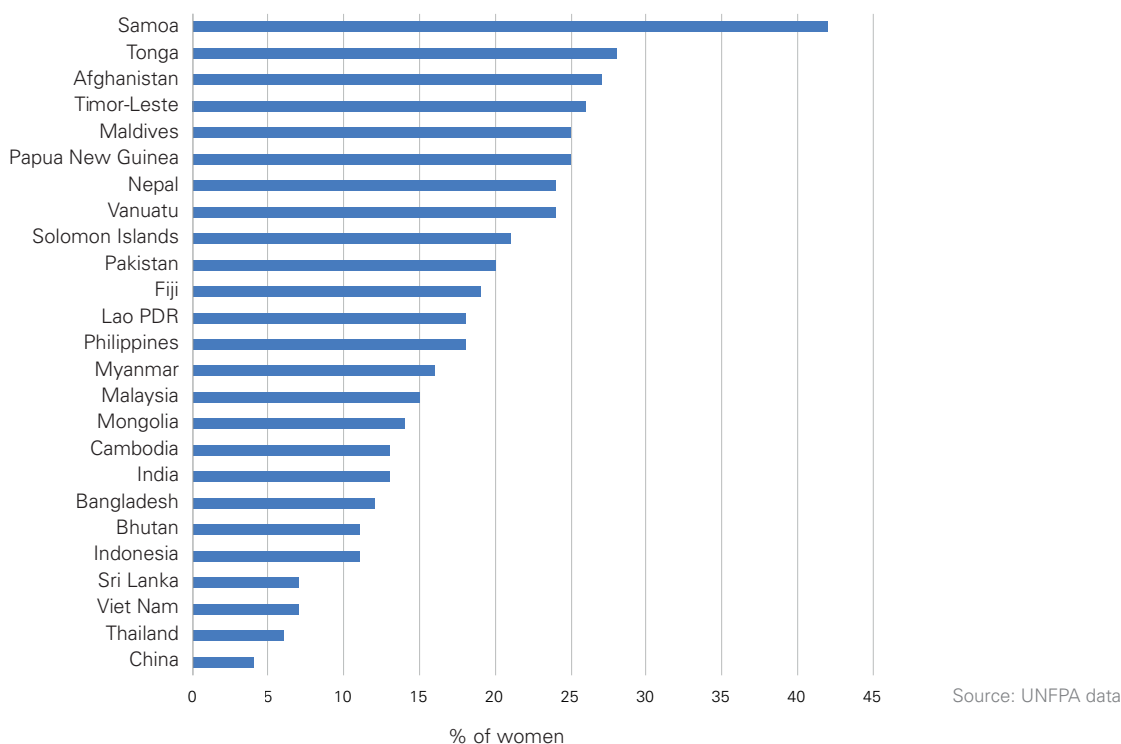
54. Nepal's Story: Understanding improvements in maternal health, (2014) Engel J, Glennie J, Shiva Raj Adhikari, Bhattarai SW, Prasai DP and Samuels F, ODI, Oxford <https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/8624.pdf>

55. Cheng TM (2008) China's Latest Health Reforms: A Conversation With Chinese Health Minister Chen Zhu Health Affairs July 2008 vol. 27 no. 4 1103-1110 Available from: <http://content.healthaffairs.org/content/27/4/1103.full>

The ability of countries to meet their citizens' basic health needs varies across the region, as illustrated by the extent of unmet need for family planning, one of the most important and high-impact health services. As Figure 8

shows, countries with comprehensive primary health care systems tend to be more successful at meeting women's need for family planning services.

FIGURE 8: PERCENTAGE OF WOMEN WITH UNMET NEED⁵⁶ FOR FAMILY PLANNING USING MODERN METHODS (2015)



Without a comprehensive primary health care approach through which proven, cost-effective and life-saving services can be made available to all, countries will be unable to ensure the services promised by UHC commitments are actually accessible to citizens and the risk will be to exacerbate inequity further. For example, where purposeful investment in primary health care is lacking, it is easy for resources to be diverted to tertiary hospitals where spending on expensive medicines, costly specialist staff and complex procedures and diagnostic testing can rapidly consume all available funds.⁵⁷ In this regard, some countries are unable to ensure even the most basic services to all citizens and yet they are increasing public expenditure on tertiary care such as heart surgery, complex cancer treatment and other specialist services⁵⁸.

Other countries have been more focused on closing

primary health care gaps. Thailand, for example, chose to invest in primary health care services over a sustained period of time before shifting to a formalised UHC system.⁵⁹ The Thai Universal Coverage Scheme, when it was launched in 2001, covered the costs of basic services for the poor and informal sectors. Sustained investment in building up these services prior to launching the so-called 30-Baht scheme ensured there was little gap between the newly announced government policy and the availability of services in practice.⁶⁰ Sri Lanka, Mongolia, China, Nepal and other countries have also invested in primary health care as part of their long-term plan to deliver UHC.

Ensuring sufficient public funding is channelled to primary health care, especially for hard-to-reach communities, can be helped by strengthening priority-setting approaches (Lesson 7).

56. Unmet need refers to women who have articulated a desire to use contraceptive services but are unable to access them.

57. For example, see the case study of India's RSBY in: Oxfam, Universal Health Coverage: Why health insurance schemes are leaving the poor behind. Oxfam Briefing Paper 176, 9 October 2013

58. Glassman and Chalkidou (2012).

59. Oxfam (2013), Universal Health Coverage: Why health insurance schemes are leaving the poor behind, Oxfam Briefing Paper 176, Oxford, 2013.

60. Evans TG et al "Thailand's Universal Coverage Scheme Successes and Challenges – An Independent assessment of the first 10 years (2001-2011)", 2012 Nonthaburi, Thailand: Health Insurance System Research Office

Removing barriers to access

Engaging communities and removing barriers to access is part of strengthening the primary health care approach. Countries can develop UHC systems that eliminate the financial barriers to access. But other access barriers need to be addressed as well. A common mistake in developing UHC systems is failing to consider and address the barriers people face in addition to the direct financial costs. Without addressing other barriers, removing financial constraints will not, alone, deliver the desired result. These include:

- perceptions about poor quality of local services
- language and cultural barriers

- lack of appropriate services for needs (for example, for adolescents)
- indirect costs of accessing care (transport, child care)
- poor community engagement or low participation in health services

Some of these barriers can be addressed through strengthening health services (Lesson 3) while others, such as the indirect costs of accessing care, are less easy to resolve and may involve other social protection measures such as cash transfers.

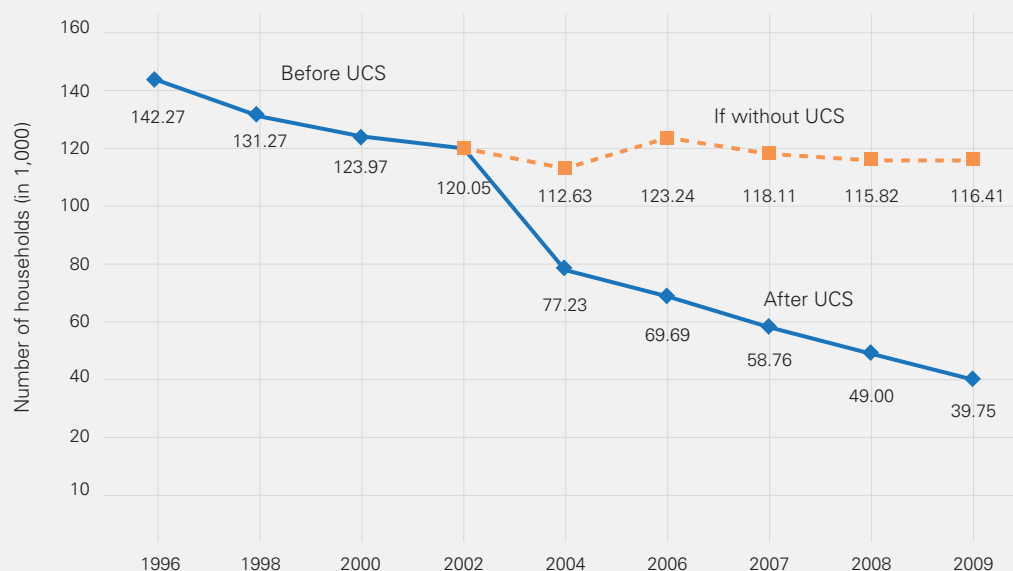
BOX B: REDUCING CATASTROPHIC AND IMPOVERISHING HEALTH EXPENDITURE IN THAILAND

The 2010 World Health Report demonstrated the catastrophic effects of paying directly for health care - with nearly 150 million people worldwide suffering financial hardship and 100 million being pushed below the poverty line as a result of OOP payments. Avoiding financial losses associated with unaffordable, and sometimes sudden, health care expenditure can help households stabilize disposable incomes and enable them to spend more money on other goods and services, which can improve the welfare and future prospects of the family.

An independent review of the first ten years of Thailand's Universal Coverage Scheme (UCS) shows a dramatic reduction in the proportion of OOP health expenditure and falls in catastrophic health expenditure and impoverishment due health care costs. Between 1996 and 2008 the incidence of catastrophic health care expenditure among the poorest quintile of UCS members fell from 6.8% to 2.8%.

Furthermore, the incidence of non-poor households falling below the poverty line because of health care costs fell from 2.71% in 2000 to 0.49% in 2009. The review calculated that the comprehensive benefit package provided by the UCS and the reduced level of OOP expenditure protected a cumulative total of 292,000 households from health-related impoverishment between 2004 and 2009. This is equivalent to the area between the two lines in the figure:

FIGURE B: NUMBER OF HOUSEHOLDS PROTECTED FROM HEALTH IMPOVERISHMENT IN THAILAND 1996-2009



Sources: Evans TG et al "Thailand's Universal Coverage Scheme Successes and Challenges – An Independent assessment of the first 10 years (2001-2011)", 2012 Nonthaburi, Thailand: Health Insurance System Research Office

LESSON 3: IMPROVE QUALITY OF CARE through sustained health systems strengthening

Quality improvement was identified as one of the main barriers to progress in both the literature review and the interviews. For many countries, the risk is that universal coverage is enacted or decreed and perhaps there are health cards distributed and entitlements are determined. But the coverage extended is for services that are simply not there in practice and cannot in fact be accessed by those who are 'entitled' to use them.⁶¹

Quality of care is vital for a number of reasons:

- If the services are not considered good quality, people won't use them, making the system inefficient and ineffective (demand side issues);
- Quality of care drives value for money across the system (ultimately, poor quality is a waste of money and a waste of political capital);
- Quality of care assurance is vital for long-term UHC.

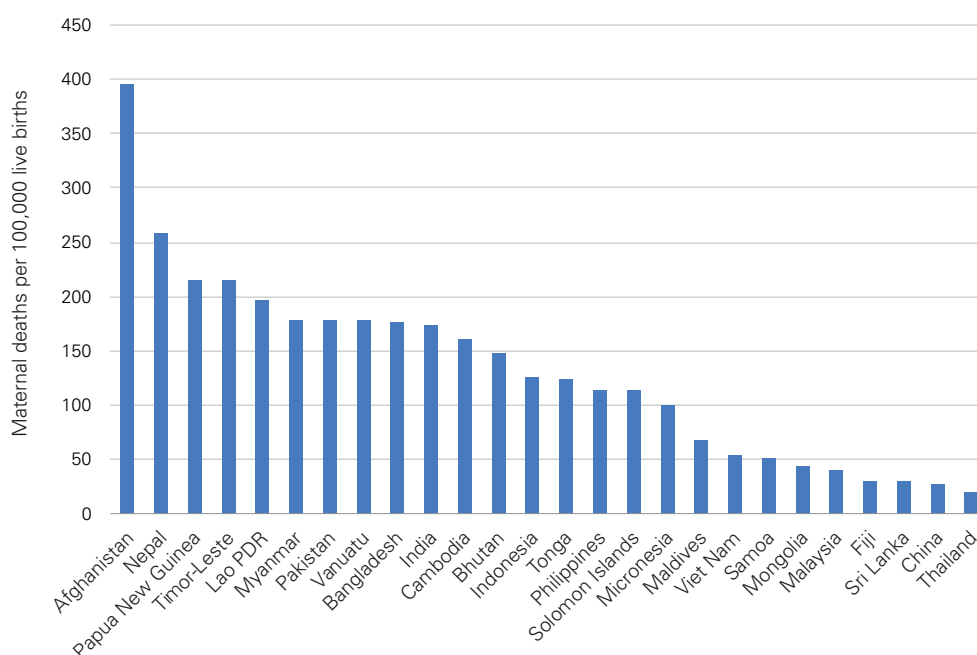
Although it is very hard to measure – and countries use their own approaches and standards rather than a common

scale – quality is generally thought to encompass several defining features:

- Protects patient safety
- Effective
- People-centred
- Integrated services

Perceived quality is what patients think about the quality of care they receive and it is judged by the experience of attending health services. Are drugs available? Are health staff on duty, respectful and courteous? Are the required services available?⁶² Using standards of care – for example, the list of essential services for women's, children's and adolescents' health identified in the Global Strategy – health systems quality can be linked to the capacity to deliver essential services in ways that meet user expectations. Indonesia has identified poor supply-side readiness leading to low perceptions of quality as a problem and as it moves forward with UHC, aims to invest in strengthening basic services.⁶³

FIGURE 9: MATERNAL MORTALITY RATIO IN ASIA AND THE PACIFIC (2015)



Source: World Bank data 2015

Maternal health services are often seen as a good test for system quality because they need a combination of demand side elements (decision to attend, trust in the services, ability to reach services) and supply side elements (trained staff who can act quickly, capacity to refer, equipment, drugs and commodities, transport and communication). All these elements have to be available together, everywhere

in the health system, in order to ensure that a woman gets the care she needs. Figure 9 shows the maternal mortality ratios in countries across the Asia Pacific region. Some of the countries more advanced in their UHC journeys have lower mortality while those still getting underway tend to show higher ratios.

61. N Bristol, Global Action toward Universal Health Coverage" Center for Strategic and International Studies, Washington DC, January 2014

62. World Bank. 2005. Dying for change: Poor people's experience of health and ill-health. Washington, DC: World Bank. <http://documents.worldbank.org/curated/en/2005/12/6114408/dying-change-poor-peoples-experience-health-ill-health>

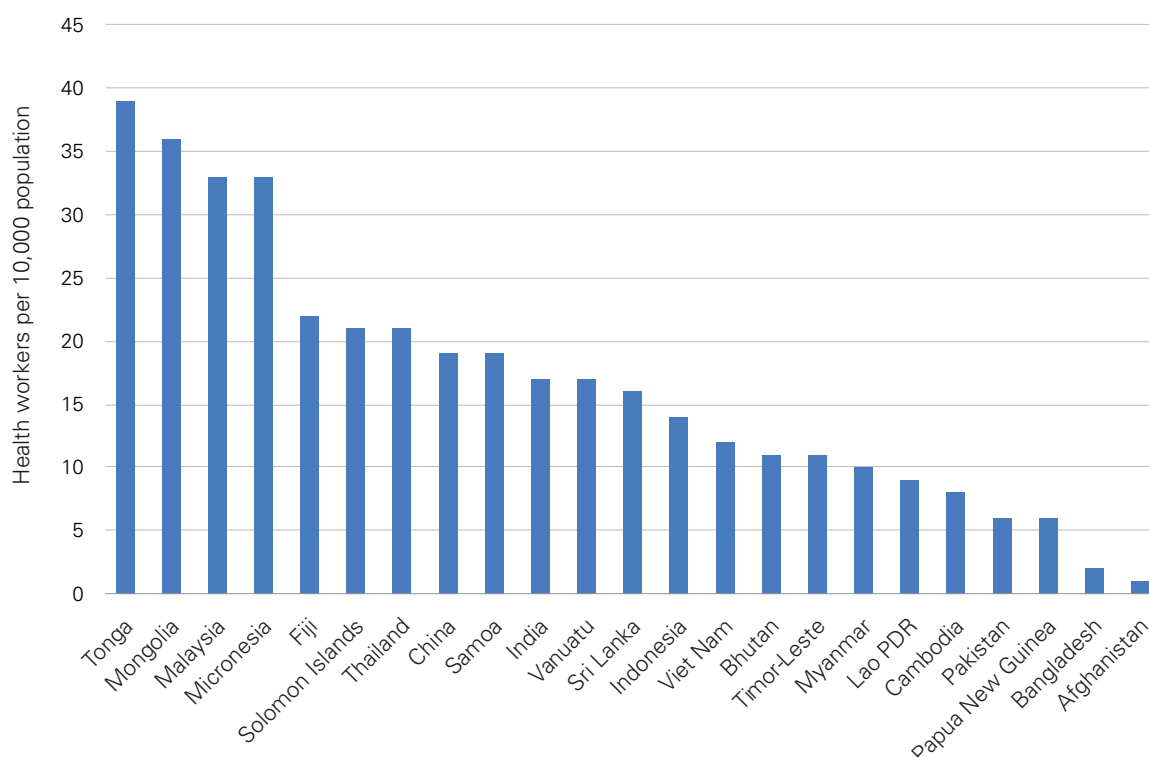
63. C Bredenkamp, T Evans et. al. "Emerging Challenges in Implementing Universal Health Coverage in Asia", Social Science and Medicine, July 2015

a. Health workers

Coverage of services has to translate into utilisation in practice. One of the main determinants of quality service delivery is the availability of motivated, trained health care workers. When asked about their perceptions of quality, patients cite the attitude of health workers as one of the most important indicators to them. Common barriers to an effective, well-functioning workforce include insufficient numbers of nurses and doctors, poor training, irrational deployment and distribution, a lack of supportive

supervision, poor remuneration and/or in-service benefits including inadequate housing, opaque promotion opportunities and weak performance management.⁶⁴ WHO recommends 23 health workers (doctors, nurses and midwives) per 10,000 population.⁶⁵ Looking at figure 10 and 11, it is clear that many countries in the Asia and Pacific region fall well below the threshold needed to reach the majority of the population.

FIGURE 10: NURSES AND MIDWIVES PER 10,000 POPULATION (2013)



Source: World Bank data 2010-2013

For most countries, ensuring the right health staff are in the right place is a significant challenge. In addition, a global health worker shortage leads to constant movement of health staff within and between countries. The way that health staff are deployed is determined – to a great extent – by the infrastructure and service capacity in a country. For example, in Bangladesh, there are more primary health care centres in rural areas and more hospitals in urban areas, which leads to more demand for physicians and nurses in urban areas and community health workers and paramedics in rural areas. A related driver of this tendency is that training facilities are mainly in urban areas, where most students also originate, as the requisite science

classes are largely unavailable in rural schools. Bangladesh has embarked on a comprehensive, long-term programme to train and build the skills of rural community health workers, especially as skilled birth attendants.⁶⁶ So far, along with other targeted interventions, the training is showing promise and health outcomes are improving in Bangladesh. For example, under-five mortality has almost halved since 2000.⁶⁷ Continued education, linked at an institutional level to supervision, and at an individual level to renewed practice licenses, and incentives such as promotion opportunities have been used to support health worker quality in various settings.

64. Wendy Holmes and Maya Goldstein, "Being treated like a human being": Attitudes and behaviours of reproductive and maternal health care providers, August 2012: https://www.burnet.edu.au/system/asset/file/1408/Holmes_et_al_attitudes_review_sept2_final.pdf

65. World Health Organization: www.who.int/workforcealliance/knowledge/en/

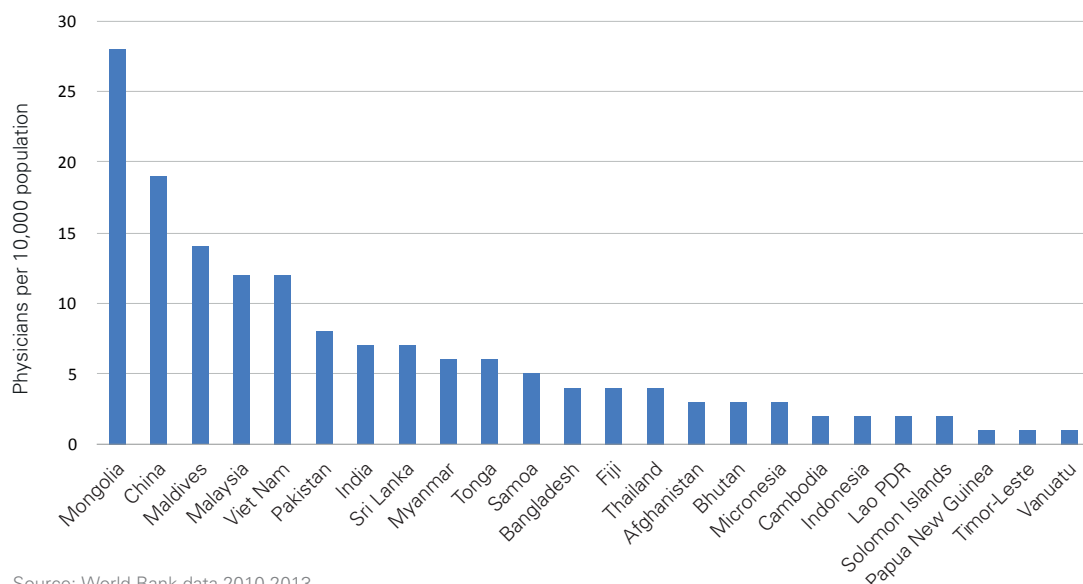
66. Global Conference on Universal Health Coverage for Inclusive and sustainable growth, Lessons from 11 Country case studies: A Global Synthesis. Government of Japan, World Bank, December 2013, Tokyo.

67. A Adams, A Rabbani et al. Explaining equity gains in child survival in Bangladesh: scale, speed and selectivity in health and development, Lancet Series on Bangladesh, Vol 382, Dec 14 2013, 2027- 2037.

In its 11-country study of UHC, the World Bank identified human resources for health as one of three critical areas that could improve success along with political economy and health financing. To overcome human resource-driven inequities in the health system, it suggested that countries

“consider flexible career paths and non-traditional points of entry, especially those aimed at health workers from rural and underserved communities, in order to complement existing modes of health-care worker education and deployment...”⁶⁸

FIGURE 11: PHYSICIANS PER 10,000 POPULATION (2013)



Source: World Bank data 2010-2013



68. M Reich, J Harris et al “Moving towards universal health coverage: lessons from 11 country studies”, The Lancet Online August 21 2015, corrected version first published on January 8 2016.

b. Access to medicines and commodities

Medicines and commodities are a vital part of any health care system, with many complexities and facets, including costs, safety, quality, availability, prescribing habits and patient compliance. As one of the major cost drivers of THE, pharmaceuticals management is prone to significant inefficiencies. In fact, in its list of the ten main causes of health system inefficiency,⁶⁹ WHO cites pharmaceuticals in the top three spots:

- Underuse of generics
- Use of substandard and counterfeit medicines
- Inappropriate and ineffective use of medicines.

Within the health system, “medicines are a major driver of quality, safety, equity, and cost of care.”⁷⁰ Along with respectful, trained and available health workers, access to the right medicines and treatment is a second important contributor to patient satisfaction and quality perceptions.⁷¹

There are a range of health system drivers that determine availability of medicines and diagnostic procedures, including information systems, supply chain management capacity, health worker prescribing habits, medicine procurement policies and others. Underpinning the availability of medicines and health commodities to end users are complex policy, governance, regulatory, technical and logistical challenges driven by a systems’ perspective: who gets access to medicines and diagnostics? And who decides? In those countries not yet well advanced with a UHC approach, even in public sector delivery settings, people in countries across Asia and the Pacific report having to pay for medicines, materials, and tests in order to secure the treatment they need.⁷² Perhaps more than in any other aspect of health care delivery, this is the area that is most susceptible to perverse incentives and profit-making motives on the one hand and financial hardship, impoverishment and lack of access on the other.

BOX C: CONTROLLING THE RISE OF NCDs: ACCESS TO QUALITY-ASSURED MEDICINES AND COMMODITIES IS VITAL TO SUCCESS.

Of the 35 million annual deaths from NCDs, 18 million occur in women and a large share of these in women still in their most productive years. One in seven pregnancies is affected by gestational diabetes mellitus. And 86% of the annual 266,000 cervical cancer deaths occur in low- and middle-income countries. Cardiovascular disease is the number one killer of women globally.

Women in low- and middle-income countries are much more likely to die from an NCD than women elsewhere, as they are less likely to be able to access the health care they need to preserve and prolong their lives. The barriers to access include, for many, the cost of regular, usually quite inexpensive generic medicines that can help keep diseases such as high blood pressure, type 2 diabetes and high cholesterol under control, and which enable affected adults to continue working and supporting their families, extending their quality and length of life.

As the number of people across Asia and the Pacific affected with NCDs continues to rise rapidly, the challenges for governments will be to reduce their citizens’ vulnerability to NCDs using a range of instruments such as taxation on some commodities that increase risk (tobacco, alcohol, sugar). But for those already affected, the challenge will be to reduce the resulting economic, social, and health burden. Removing the barriers to accessing vital health services, including affordable quality medicines, lies at the heart of this effort.

Sources:

a. NCD Alliance, 2011. Non-communicable Diseases: A Priority for Women’s Health and Development. http://www.who.int/pmnch/topics/maternal/2011_women_ncd_report.pdf.pdf

b. WHO, Effective management of medicines: Report of the South-East Asia Regional Consultation Bangkok, Thailand, 23–26 April 2013

c. Building demand through community engagement

Engaging citizens in the design, delivery and monitoring of the services that affect them increases the likelihood of those services being relevant, appropriate, valued and used. Community engagement may be time-consuming and often requires local service providers and policy-

makers to relinquish a top-down approach to health service delivery. However, its benefits are well documented and, when done well, it can make the difference between marginalization from services and access and utilization of services. This is because when citizens are able to help

69. N Bristol, “Global Action toward Universal Health Coverage” Center for Strategic and International Studies, Washington DC, January 2014.

70. Anita K Wagner, Jonathan D Quick and Dennis Ross-Degnan, Quality use of medicines within universal health coverage: challenges and opportunities, BMC Health Services Research, BMC series, 2014; 14:357 DOI: 10.1186/1472-6963-14-357

71. See, for example, Muhammed Muazzam Hussain, Mohammed Mojammel Hussain Raihan, Patients’ Satisfaction with Public Health Care Services in Bangladesh: Some Critical Issues, Malaysian Journal of Medical and Biological Research, Vol 2 (2); 2015, Issue 5.

72. WHO SEARO, Regional Workshop on Strengthening Quantification and Procurement of Essential Medicines. Report of a regional workshop. New Delhi, India, 10–12 June 2014

design their own services, they are more likely to use them and will work harder to ensure the services function. Communities will help shape services to be suitable to local needs and everyone will learn more about each other and the problems they are trying to solve. Thorough community engagement helps identify marginalized groups

and supports better access to services for those groups by addressing specific local barriers. Community engagement increases trust and helps hold service providers to account, building transparency and creating more interest in problem solving and community development.⁷³

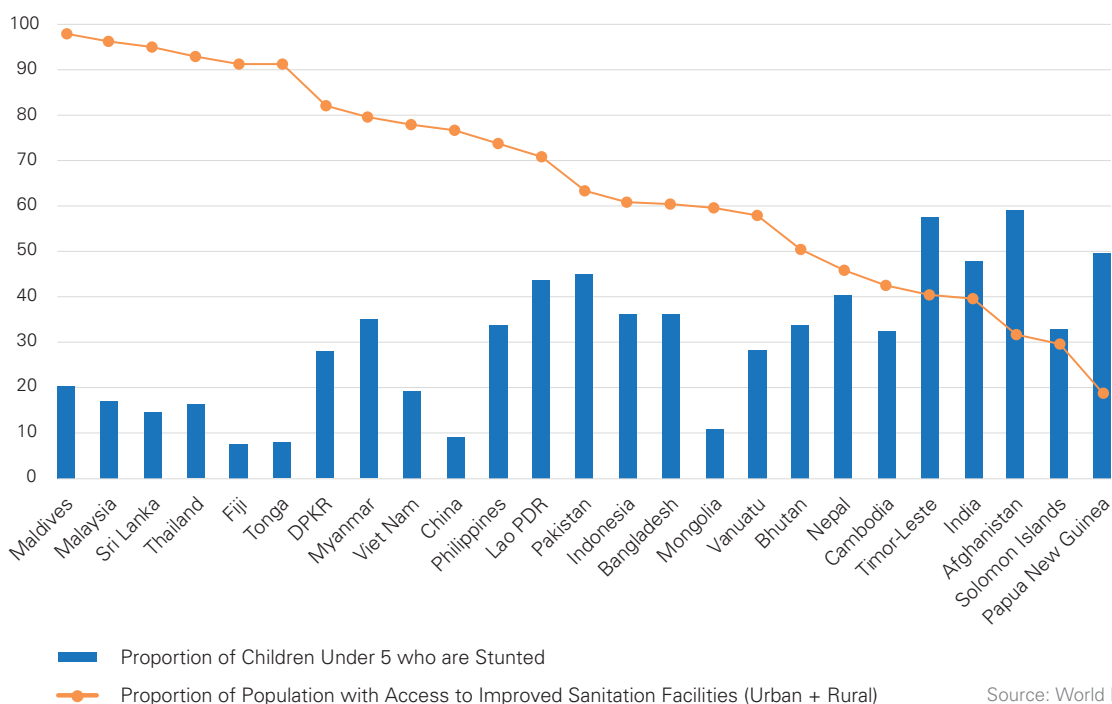
LESSON 4: MAKE PROGRESS WITH SOCIAL AND ECONOMIC DETERMINANTS OF HEALTH

Although health services can save lives and some, such as vaccinations and reproductive health services, promote good health and prevent a range of health problems, there are a number of important contributors to health in children and adults that lie outside the health sector's direct authority. Nutrition, for example, underpins health to such an extent that it is linked to 45% of child deaths.⁷⁴ Water, sanitation and hygiene; gender empowerment; household income (poverty); quality of housing; infrastructure and education, especially for girls and women, all drive health outcomes. The urban environment, labour laws and practices, climate change mitigation, child protection policies and other policies affect health.⁷⁵

While health services can protect health and save lives,

they do not, alone, engender health. Countries and states that have made the most progress in improving the social and economic determinants of health can also demonstrate the best health outcomes. For example, Sri Lanka has adopted a multi-dimensional rural development approach and the result of 30 years of sustained investment is less urban-rural disparity, greater equality of health across different segments of society and an integrated concern for equity that has become an accepted element of its approach to UHC. Thailand, Malaysia, Maldives and Fiji have also made significant progress in addressing some of the social and economic determinants of better health. For example, figure 12 shows the association between water and sanitation investments with reduced stunting in children under 5.

FIGURE 12: ACCESS TO SANITATION AND PROPORTION OF CHILDREN UNDER FIVE WHO ARE STUNTED IN ASIA PACIFIC COUNTRIES (2015)



Source: World Bank data 2015

73. Bassler, A. et al., "Developing Effective Citizen Engagement: A How-to Guide for Community Leaders." Center for Rural America, 2008.

74. WHO Fact Sheet: <http://www.who.int/mediacentre/factsheets/fs178/en/>

75. Institute for Health Metrics and Evaluation: <http://www.healthdata.org> accessed 2 May 2015. Data aggregated to the level of the Asia and Pacific region shows that for the whole of society, the most prevalent risks are already those associated with non-communicable diseases. For the under-fives, nutrition, diarrhoeal diseases, vaccine preventable diseases, lower respiratory infections (from infections and air pollution) and prematurity are the major causes of illness. Across all of society, addressing life-style, economic and social determinants and public goods (air quality) will be important to securing better health for all.

BOX D: ELIMINATING FEMALE DISADVANTAGE IN BANGLADESH

Since Independence, Bangladesh has focused – among many of its challenges – on progressing gender equality and eliminating several forms of female disadvantage. This has taken many forms. Efforts have included expanding education to girls and the number of girls now exceeds boys. Women have been encouraged to join the workforce, including to deliver services of particular value to girls and women such as teaching, nursing and community work, especially the distribution of family planning products. Women have joined the industrial economy in very large numbers as well. Access to a regular income has created a virtuous cycle for households as funds are used to improve children’s nutrition, health and education.

Eliminating preventable maternal and child deaths is another field of action where much progress has been made through targeted efforts. These efforts have included the use of women’s agency, innovations, community engagement for social cooperation and specifically extending the reach of health initiatives aimed at improving maternal and child health. These initiatives have had the largest impact on the poorest women and are equity enhancing.

As Amartya Sen points out, “...women’s agency has contributed greatly to the advancement of the lives and freedoms of all – men, women, and children. The unlocking of the power of women’s active role in the society and in the economy has been an extremely productive mover for Bangladesh.”^a

Bangladesh’s long-term focus on women’s empowerment, greater gender parity and a deliberate focus on equity have played an important role in improving maternal and child health outcomes and supports economic growth and security.^b

There is still a long way to go – for example, the poorest women receive less antenatal care (only 48% of the poorest women in 2011 had four antenatal visits compared to 93% of the wealthiest) and many deliver without skilled birth attendants (12% of the poorest women in 2011 compared to 64% of the wealthiest). This gap is reflected in a high maternal death rate (170 per 100,000 live births). But this case study illustrates that sustained targeted efforts pay off and that women’s empowerment has benefits for all of society. Among children, there is near parity between girls and boys and much less disparity by socio-economic status in access to vaccinations, health care services for acute conditions and oral rehydration therapy. However, child mortality in under five boys at 44/1000 live births in 2013 was higher than girls (38/1000 live births).^c

Sources:

a. Sen, Amartya “What’s happening in Bangladesh”, *Lancet*, Vol 382, 14 December 2013 p1966-1968. (quotation from p.1967);

b. A Adams, A Rabbani et. al. Explaining equity gains in child survival in Bangladesh: scale, speed and selectivity in health and development, *Lancet Series on Bangladesh*, Vol 382, Dec 14 2013, 2027- 2037.

c. UNICEF data 2013 http://www.unicef.org/infobycountry/bangladesh_bangladesh_statistics.html

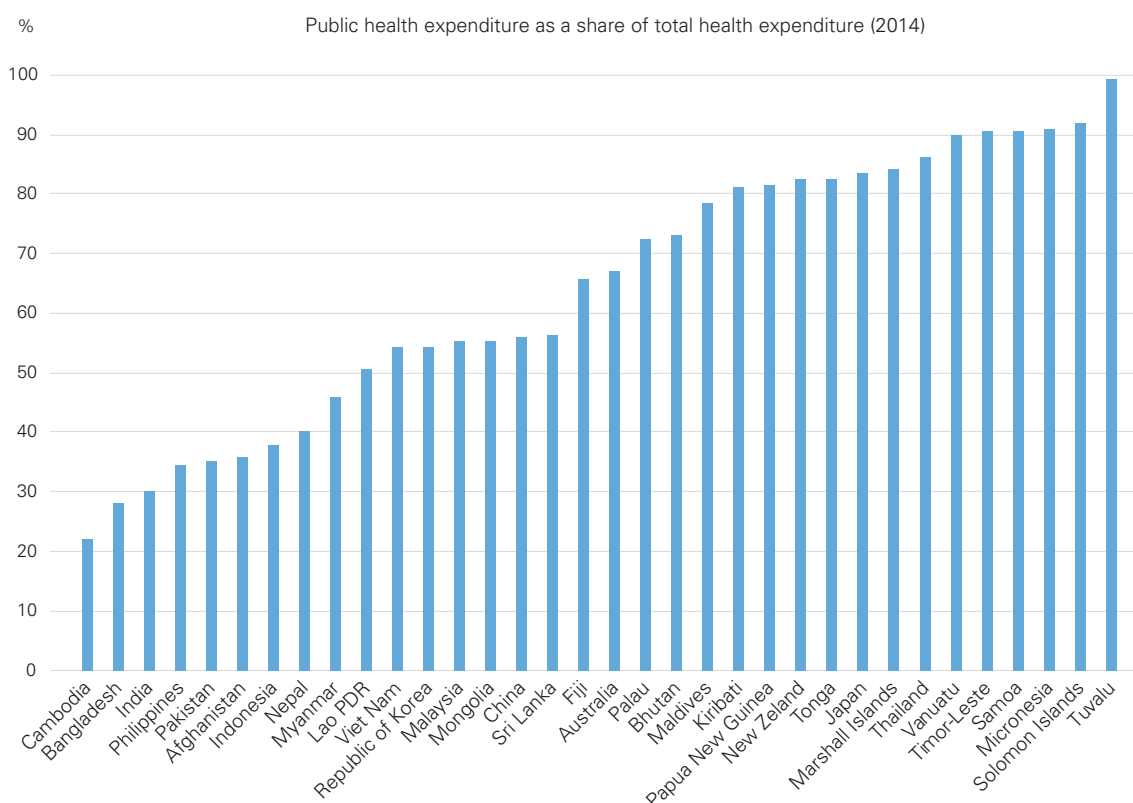


LESSON 5: RAISING FUNDS: PUBLIC FINANCING IS CRITICAL

As countries in Asia and the Pacific have become wealthier, they have moved towards UHC with a tendency for their health financing systems to develop in similar ways. Firstly, as their economies have grown, they have spent more on health as a share of their GDP, indicating a growing societal demand for health services. In common with the rest of the world, high-income countries in the region now spend around 9% to 15% of their GDP on health, middle-income countries between 5% and 9% and low-income countries less than 5%.

Secondly, the composition of their health financing systems has changed, with the share of public financing (from general taxation and social health insurance) growing over time and replacing private voluntary financing (mostly in the form of OOP health financing). This is demonstrated across the region today where private financing dominates in low- and lower-middle-income countries, whereas in higher-income countries public financing is dominant.

FIGURE 13: PHE AS A SHARE OF THE (2014)



Source: World Bank data 2014

These health financing trends were first described in a 2012 paper by Savedoff et al entitled "Transitions on Health Financing and Policies for Universal Health Coverage". These authors argued that whereas economic growth was the main driver of increasing overall health spending, it was political pressure from populations that led governments

to enact legislation to give public financing a dominant role. In effect, populations and politicians have realised that only publicly governed health financing systems can enforce the cross-subsidies required from the rich to the poor and the healthy to the sick, which are necessary to achieve UHC.



BOX E: CHINA REDISCOVERS THE IMPORTANCE OF PUBLIC HEALTH FINANCING FOR UHC

China, with the world's largest population, has demonstrated dramatic shifts in its health financing policies in the last seventy years. During the 1960s and 70s, its publicly financed health system was heralded as being very efficient and equitable, especially in providing universal PHC through its famous "bare-foot doctors". China was another country singled out as a UHC success story in the 1982 report "Good Health at Low Cost".^a

However, in the 1980s and 1990s, as China liberalised and privatised most of its economy, it also allowed private financing to assume a dominant role in the health sector. By 2003 China was spending 4.8% of its GDP on health services with 3.1% GDP being in the form of private financing (65% of total expenditure) – mostly OOP spending. As a result of this high burden of OOP financing, hundreds of millions of the Chinese population lacked effective health coverage and in 2003 surveys showed that only 30% of the population was covered by any form of health insurance.^b

As well as leading to a deterioration of some health indicators and increased impoverishment due to health costs, this situation also led to acts of violence against health workers and health facilities that had denied people care or demanded excessive payments.

Largely in response to this mounting pressure, the Government of the Republic of China announced major health financing reforms in 2009 which involved huge increases in tax financing (\$160 Billion over 3 years) to subsidise the nation's four health insurance schemes. In effect, China re-socialised its health financing system and by 2011 health insurance coverage recovered to an astonishing 96% of the population.

World Bank data for 2014 now shows that the Chinese health system is again predominantly (56%) publicly financed.

In a 2008 interview whilst these policies were being finalised, the former Minister of Health Dr Chen Zhu acknowledged the political motivation behind these reforms: promising that "everyone shall enjoy basic medical and health care services" and that this was a requirement in "building a harmonious society".^c

Sources:

a. Halstead S, Walsh J, and Warren K Good health at low cost. Rockefeller Foundation, Bellagio; 1985

b. Meng, Qun et al. Trends in access to health services and financial protection in China between 2003 and 2011: a cross-sectional study The Lancet 2012, Volume 379, Issue 9818, 805 – 814

c. Cheng TM China's Latest Health Reforms: A Conversation With Chinese Health Minister Chen Zhu Health Affairs July 2008 vol. 27 no. 4 1103-1110 Available from: <http://content.healthaffairs.org/content/27/4/1103.full>

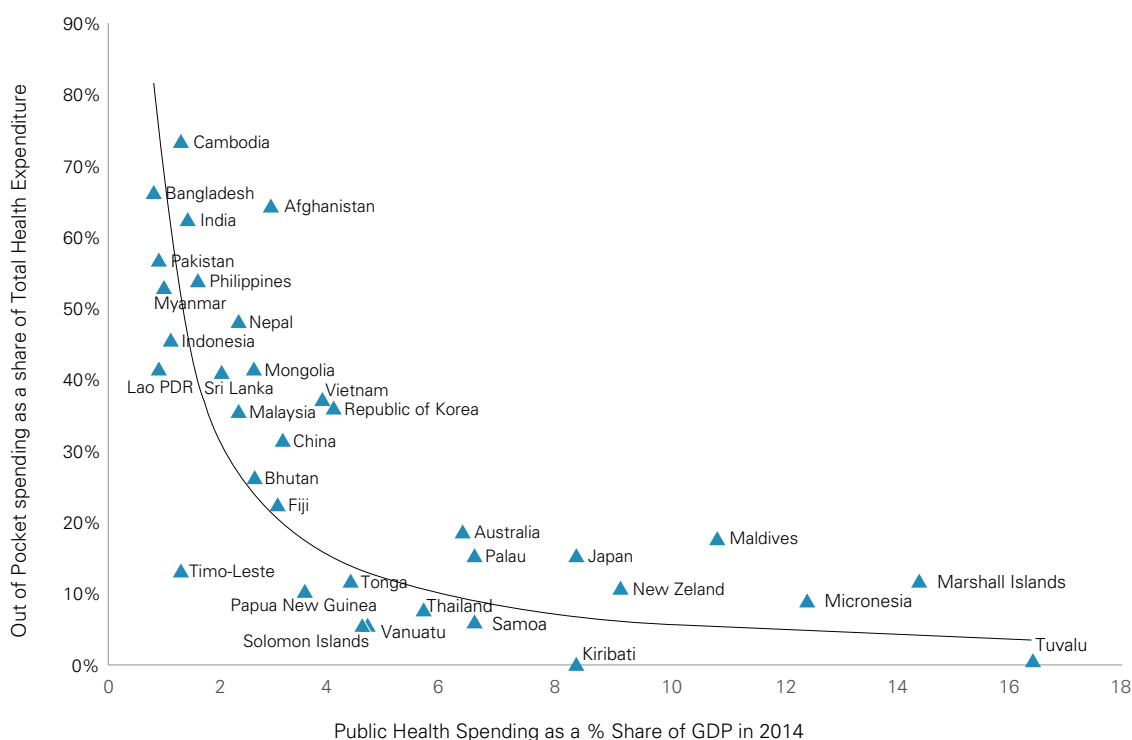
Politically driven financing transitions have been evident across Asia and the Pacific over the last few decades, with many countries socialising their health financing systems quite rapidly – for example Japan (1963), Republic of Korea (1977), Thailand (2001), Nepal (2008) China (2009) and Indonesia (2014). These financing transitions have had, and continue to have, a profound impact on the ability of Asian and Pacific countries to deliver UHC. Firstly, and most obviously, large increases in public funding have given countries the financial resources to increase the availability and quality of health services to the extent that there are sufficient services for everyone.

But, also important for achieving UHC, increasing public financing in the region has reduced the burden on households having to finance health services out of their own pockets. This is illustrated in the graph below, where it shows that in countries spending more than 3% of their GDP of public financing in 2014, OOP spending was less than 20% of THE. This is important because WHO has shown that below this level (20%), OOP spending generally tends to be less catastrophic and impoverishing in nature.⁷⁶

The clear policy message from this chart is that if countries want to reduce financial hardship to levels consistent with the UHC goal, they should seek to spend at least 3% of their GDP in public health spending.



FIGURE 14: PUBLIC HEALTH FINANCING REPLACING OOP EXPENDITURE IN ASIA AND THE PACIFIC (2014)



Source: World Bank data 2014

76. WHO and the World Bank Tracking Universal Health Coverage First Global Monitoring Report 2015, Available at: http://apps.who.int/iris/bitstream/10665/174536/1/9789241564977_eng.pdf

LESSON 6: POOL FUNDS TO INCREASE EFFICIENCY AND EQUITY

Moving away from financing a health system through direct OOP payments requires introducing or strengthening forms of prepayment and the pooling of health funds to protect people against the financial risk of paying for services. As WHO argued in its seminal World Health Report of 2010 (Health Systems Financing – The Path to Universal Coverage)⁷⁷:

“The most effective way to deal with the financial risk of paying for health services is to share it, and the more people who share, the better the protection”

When it comes to pooling pre-paid health resources, WHO argues there is “strength in numbers” and it is better to consolidate small risk pools into larger pools covering ever increasing proportions of the population. This is because larger pools tend to be more efficient because administration costs are spread more widely and they also have greater capacity for cross-subsidization across different population groups.

In creating these pools it is important to emphasise again that only publicly governed risk pools, where contributions are compulsory and progressive (related to people’s ability to pay) can meet the equity requirements for UHC.⁷⁸ Private voluntary insurance schemes don’t achieve this outcome because there is an incentive for members to exclude high-need people in society and for richer or healthier members to refuse to pay higher contributions. Those less likely to use health services tend not to join, which limits cross-subsidisation. As one of the leading authors of the Lancet Commission’s Investing in Health Commission said in 2013, “the path to UHC cannot work with reliance on voluntary private insurance”.

These are all lessons emerging from countries in the Asia Pacific Region as their health financing systems evolve into ones compatible with achieving UHC. As countries increase pooling of pre-paid resources most are doing so using the two main public financing mechanisms – general taxation and compulsory social health insurance contributions. Across the region the role of private health insurance – both commercial, for-profit health insurance and community health insurance is quite limited and if anything is diminishing in importance.

It is also interesting to note that with a few exceptions (e.g. Sri Lanka and Bhutan where virtually all pooled health

financing is sourced from tax financing), most countries in the region are using a combination of these mechanisms. For example, Thailand’s civil service and formal sector insurance schemes are financed through compulsory statutory health insurance (SHI) contributions whereas its Universal Coverage Scheme for the informal sector is funded from general taxation. Likewise, China’s New Rural Medical Scheme (covering over 800 million people) is partly funded by compulsory household contributions but also heavily subsidised (more than 90%) by general taxation. The old European dichotomy between tax-financed and social insurance systems (often referred to as Beveridge vs Bismarck) is therefore not really relevant in Asia and the Pacific, where these hybrid systems are developing.

In following the principle of “strength in numbers,” some countries in the region are trying to reduce fragmentation in their health financing systems by merging existing health insurance schemes. Here the intention has been to improve efficiency and increase equity by facilitating greater cross-subsidisation of the poor and vulnerable by richer and healthier groups in society. For this to occur it is necessary for household contributions to remain progressive but for benefits packages to be standardised across all members, irrespective of how much people contribute. Not surprisingly, merging schemes in this way can face political opposition from privileged groups concerned about higher costs and dilution of their health benefits. This has been the case in Thailand, which has made only tentative steps towards merging its three distinct health insurance schemes in the last decade due to political opposition from richer members of society.⁷⁹ Evidence from other countries like Sri Lanka suggests that single large funding pools lead to faster results.⁸⁰

As WHO argues in the 2010 World Health Report, experience from around the world suggests that a single pool (often referred to as a single-payer system) offers several advantages, including greater efficiency and a maximum capacity for cross-subsidization. However, moving towards this goal represents a tricky political balancing act for governments to ensure the system delivers health outcomes for the poor while ensuring the rich and middle classes remain broadly supportive.

One country in the region which appears to be determined to achieve this goal is Indonesia, which if successful will create the biggest single-payer health system in the world.

77. WHO, World Health Report 2010: Health Systems Financing – the Path to Universal Coverage. WHO, Geneva, 2010.

78. In some countries, contributions would have to be made from public funding on behalf of large poor populations or informal workforces. One such example is India and the discussions about making a basic package of care available to all could only be achieved if contributory funding

79. W Soors, J de Man, et al. “Towards universal coverage in the majority world: Transversal findings & lessons learnt, a summary” Institute of Tropical Medicine (ITM, Antwerp), 2015.

80. Interventions to strengthen equity are discussed in: UHC: Why health insurance schemes are leaving the poor behind, Oxfam, 2013.

BOX F: INDONESIA IS CREATING THE BIGGEST SINGLE-PAYER HEALTH SYSTEM IN THE WORLD

At the turn of the decade, Indonesia's health financing system had evolved into a system common to many middle-income countries, with separate insurance schemes covering civil servants and formal sector workers and people below the poverty line, and pregnant women covered by separate tax-financed schemes. However, around half the population (approximately 125 million people mostly in the informal sector) lacked effective health coverage and were therefore constantly at risk of incurring high health care costs.

The Government of Indonesia responded to the uncovered population and in 2014 launched extensive health financing reforms with the specific intention of reaching full population coverage by 2019. Unusually, this involved creating a single-payer system (the JKN) from the outset, requiring civil servants and formal sector workers to make progressive compulsory contributions while the premiums for the poor were paid by the government from tax revenues. However, differences remain in the benefit packages received by these groups with wealthier contributors entitled to higher levels of inpatient services. Another complexity involves integrating local insurance schemes at a sub-national level that flourished due to the political interventions of locally elected governors and district heads before the launch of JKN. To date it would appear that the JKN is doing little to tackle the inequitable distribution of health services across the country, as 80% of doctors continue to practice on just two islands (Java and Sumatra) and public debate about the JKN focuses on building and equipping tertiary hospitals as opposed to investing in district-level primary care services.

Also, in the absence of effective enforcement mechanisms, membership for previously uncovered people, in reality, has been voluntary rather than compulsory. This has led to the phenomenon of "adverse selection" whereby only high-need people in the informal sector have tended to join voluntarily. This has jeopardised the financial viability of the JKN, which has built up large deficits, and also meant that population coverage targets have not been met. Also, with public health financing in Indonesia still only amounting to 1.2% GDP in 2014, there are concerns about financial sustainability and specifically that the JKN is underfunded for the task of reaching full population coverage by 2019.

Despite these setbacks, with current membership exceeding 150 million Indonesia can justifiably claim that it has already created the biggest single-payer health system in the world.

Sources:

a. The Economist Intelligence Unit (Jan 2015), Universal healthcare coverage in Indonesia: One year on, January 2015

b. WHO South East Asia Regional Office (2015) Universal Health Coverage and Health Care Financing, Indonesia. <http://www.searo.who.int/indonesia/topics/hs-uhc/en/>

LESSON 7: PRIORITY SETTING FOR EQUITY IS A POLITICAL PROCESS

Priority setting is the process of deciding what health services should be covered under UHC, and who should benefit and when. Priority setting is an inherently political process and is almost always controversial since it leads to choices about who in society will benefit from public resources (and therefore, also who will not). However, it is also the case that if countries used cost-effectiveness analysis to re-allocate available health funding to equity-enhancing health interventions, many more lives could be saved.

As identified in section 3, there are a range of priority-setting tools available to support decision-making.^{81 82} Others include Disease Control Priorities⁸³ and the Lancet

Child Survival Series,⁸⁴ which identifies the most cost-effective interventions to save children's lives. Others in the series focus on neonatal, maternal and, most recently, adolescent health. Few countries in the Asia and Pacific region have explicit or dedicated priority-setting processes or institutions. China, for example, uses local decision-making approaches. Recently, however, China used the *Lives Saved Tool*⁸⁵ to identify explicit national priorities as part of the development of a national child survival strategy. The process identified 24 evidence-based interventions that together would help reduce under-five mortality most efficiently. A selection of these have been incorporated into the 13th Five-Year Health Plan.

81. For example, referenced in section 3 was a widely distributed aid: Essential interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health, PMNCH, WHO and the Aga Khan Foundation, 2011. http://www.who.int/pmnch/topics/part_publications/essential_interventions_18_01_2012.pdf?ua=1

82. Chalkidou K, Glassman, A, Priority setting for achieving UHC, Bull World Health Organ 2016;94:462–467 | doi: <http://dx.doi.org/10.2471/BLT.15.155721>

83. Disease Control Priorities is on its third edition. The RMNCAH Priorities volume has recently been revised and can be accessed here: <http://dcp-3.org/pmnch>

84. The Lancet Child Survival Series can be accessed here: <http://www.thelancet.com/series/child-survival>

85. The Lives Saved Tool helps countries estimate and compare the impact of different interventions on lives saved. <http://www.livesavedtool.org>

In the Philippines, since 2012, the national insurer PhilHealth has started developing an explicit priority setting process including a standardized set of criteria to determine coverage decisions. In addition, PhilHealth, in partnership with the Department of Health and other stakeholders, intends to use Health Technology Assessment to further guide decisions on inclusions of health interventions in the benefit packages. Philhealth currently offers a wide package of services covering primary, secondary and some tertiary care, including cover for catastrophic illness such as cancer (although co-payments are required for some of these services and many people don't access services).⁸⁶

Viet Nam intends to develop an explicit approach to assessment, having been requested by its National Assembly to do so.⁸⁷ Sri Lanka uses a responsive system and priorities have been set largely by the changing needs of the population, which have been shifting from diseases of poverty to non-communicable conditions. Thailand has taken a different path, investing in formal health technology assessments done through the Health Intervention and Technology Assessment Program (see Box G) to support investment decisions.

Priority setting thus needs to ensure that the package of benefits addresses the main conditions affecting the poorest people. The main causes of impoverishment



should also be covered, such as repeated prescriptions to treat or manage NCDs over time. This approach is especially important for children's well-being. All too often, an adult family member, perhaps even the main breadwinner, has health needs such as diabetes or heart disease, that require household expenditure to such a degree that children are taken out of school to fund fees or to support the family economy. Thinking about the well-being of children, therefore, means thinking about the well-being of the household as well. Ensuring that the full continuum of care is covered under UHC is also a useful tool to attract support from a broad spectrum of society; so that everyone will see how they might benefit.

BOX G: THE HEALTH INTERVENTION AND TECHNOLOGY ASSESSMENT PROGRAM (HITAP)

Thailand increased its health budget by 40% between 2003 and 2006 following the establishment of its universal coverage scheme in 2001. To support priority setting and to shape the spending of its growing budget, the Ministry of Health created HITAP in 2007, making it an autonomous agency. Using available evidence and drawing on Thai social norms and preferences, cost-effectiveness analysis and other approaches, HITAP assesses health interventions, procedures, commodities and technologies to make recommendations about what should be included in the basic package of care.

Representatives from four different groups of stakeholders including health professionals, academics, patient groups and civil society organisations are appointed to sit on a panel overseeing intervention prioritisation. Although the panel has some flexibility in its process, it mainly assesses interventions against six criteria:

- Size of population affected
- Severity of the disease
- Effectiveness of the health intervention
- Variation in practice
- Economic impact on household expenditure
- Equity/ ethical and social implications

In 2010, HITAP's budget was 0.007% of Thailand's THE. Its work has the potential, however, to save the Thai health system millions. For example, one study and associated recommendations on preventing cervical cancer had the potential to save \$6 million. Another assessment advising a shift to a newer antiretroviral therapy estimated that it would avert 100 paediatric infections and save \$2.6 million per child over a lifetime in HIV/AIDS-related health and social care. As a separate autonomous agency with wide representation, HITAP can more easily maintain a neutral role in identifying the most cost-effective interventions to be covered by the Thai UHC system.

Source: Adapted from Glassman and Chalkidou 2010

86. WHO and the World Bank, First UNC Tracking Report (Bringing UHC into Focus), WHO, Geneva, 2015.
87. Bredenkamp, (2015).

What works best to address equity?

As set out in Section 2, UHC has multiple dimensions (population coverage, service coverage, financial protection). Few countries can afford to immediately fund a full package of services to all citizens and the vast majority take incremental steps over time.⁸⁸ One of the early decisions to be taken in working towards UHC,

therefore, is whether to prioritise coverage of people with a basic package of care or to extend the quality and range of services to be offered to a more limited group, such as the formally employed. Table 3 shows some of the advantages and limitations of each approach.

TABLE 3: PRIORITISING POPULATION COVERAGE VS PACKAGE OF SERVICES

	Advantages/ benefits	Limitations/ challenges
Prioritise population coverage	<ul style="list-style-type: none"> • Prioritising populations ensures that the 'universal' part of UHC is achieved first. • It creates a strong justification for funding and delivering basic primary health care services to all as a first priority • It introduces from the start (and helps to normalise) the important concept of cross-subsidy which is vital to UHC: the healthy and wealthy subsidise the sick and the poor. 	<ul style="list-style-type: none"> • Reaching the whole population can be very difficult and requires sustained investments in basic health infrastructure • Maintaining broad social and political commitment during a period of PHC system strengthening can be challenging if wealthier segments of society feel they are paying for but not benefitting from UHC investments.
Prioritise range of quality services	<ul style="list-style-type: none"> • Those who bear the heavier cost burden can immediately see the benefits in terms of more access to a wider range of better quality services. This can build support for publicly funded health care. • Funding quality services for the middle class or formally employed tends to be valued by these groups who could otherwise be 'spoilers' or try to disrupt progress to UHC. 	<ul style="list-style-type: none"> • Increasing the range of services to a privileged group will widen inequity and create more health disparities. The objectives of UHC including the higher ambitions around nation-building, can only be achieved if everyone is covered for at least a basic package of care. • The path to UHC in all settings requires measures to address equity and these become harder to introduce the longer the delay.

Another policy option a country can adopt is to aim for high levels of population coverage and service benefit packages but combine this with lower levels of financial protection. This is an approach being followed at least implicitly by China and the Philippines. Both these countries are now reporting health insurance coverage rates in excess of 90% and benefit packages that include a wide range of services, including specialist hospital care. However, the existence of relatively high levels of co-payments for these services raises questions about the depth of this coverage. For example, in the Philippines, despite recent rises in the health budget, OOP expenditure remains more than half of THE.⁸⁹

Coverage of the whole population with a defined range of services leads to improved population outcomes and lower inequalities than covering a narrow group of citizens with more and better quality services.⁹⁰ It promotes equity and embeds the principles of cross-subsidy from the start⁹¹. However, there are challenges in deciding what should be included in a package of care given limited resource envelopes and expanding health needs (and demand).

As Kutzin argues in a recent paper in the World Health Bulletin: "Universal means universal. The appropriate unit of analysis when planning or analysing reforms is the entire population. How a particular financing scheme affects its members is not of interest per se; what matters is how the scheme influences UHC goals at the level of the entire population."⁹²

Progress towards achieving equity in many health systems across Asia and the Pacific is uneven, as Figure 15 shows. Infant mortality rates vary considerably both within and between countries.⁹³

On a practical and economic level, preventable diseases and health conditions cause a drain on the country's resources. Besides the moral argument, in financial terms it is more cost-effective to prevent disease and ill health. Countries aiming to move to UHC should work as quickly as possible to reduce the occurrence of preventable health conditions, especially among the poorest, as a means to ensuring available resources are used as cost-effectively as possible.

88. David Stuckler, Andrea B Feigl, Sanjay Basu, Martin McKee "The political economy of universal health coverage", First Global Symposium on Health Systems Research, Montreux, 2010.

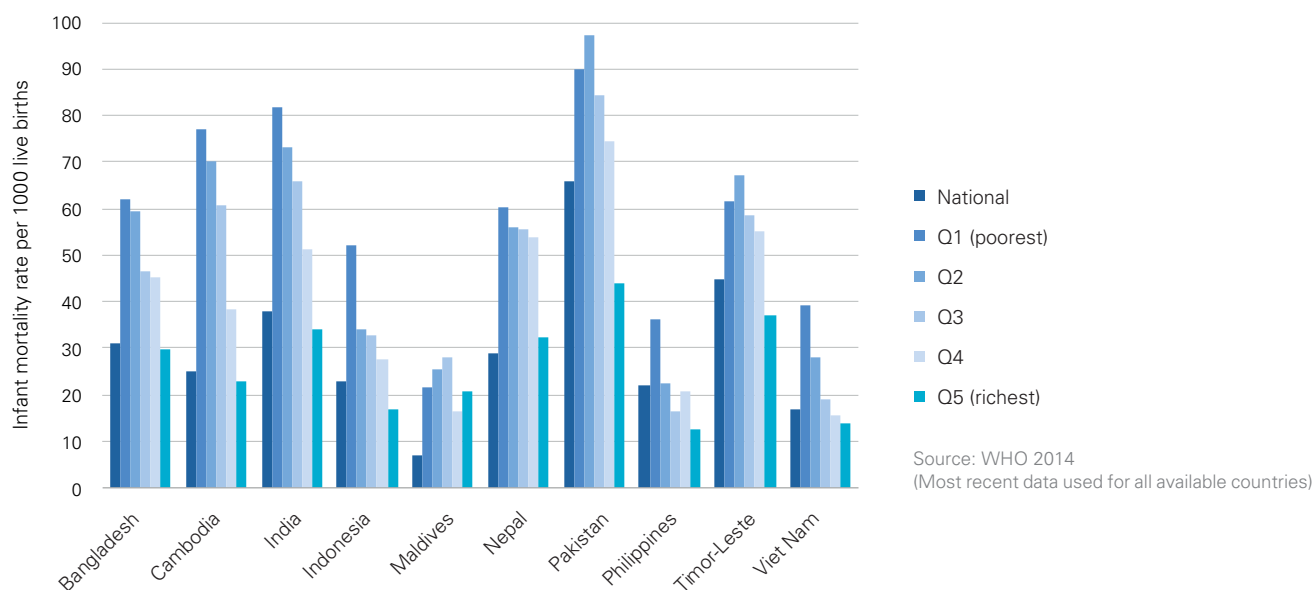
89. UNICEF 2015 UNICEF's strategic engagement with the national health insurance program PHILHEALTH in the Philippines: an effective approach towards health systems strengthening

90. Kutzin J Anything goes on the path to universal health coverage? No. Bulletin of the World Health Organization 2012;90:867-868. doi: 10.2471/BLT.12.113654

91. Oxfam, Universal Health Coverage: Why health insurance schemes are leaving the poor behind. Oxfam Briefing Paper 176, 9 October 2013.

92. Kutzin, J. Health financing for universal coverage and health system performance: concepts and implications for policy Bulletin of the World Health Organization 2013;91:602-611. doi: <http://dx.doi.org/10.2471/BLT.12.113985> [PDF] <http://t.co/vWD6wBBkyu>

FIGURE 15: INFANT MORTALITY RATE PER 1000 LIVE BIRTHS IN ASIA AND THE PACIFIC (2014)



LESSON 8: ENGAGE THE PRIVATE SECTOR TO SUPPORT UHC

Across Asia and the Pacific, the majority of outpatient health services are delivered by private health providers, although in most countries inpatient care is still mainly delivered in public-sector hospitals.⁹⁴ Private providers are a fact of the health care landscape and include traditional and alternative health practitioners, private generalists and specialists, and pharmacists, not to mention laboratories, diagnostic centres, specialist treatment facilities and a whole range of corollary and support services.

The challenge for countries moving towards UHC is to find ways to engage the private sector, including private health care providers, maximizing their potential to increase the coverage and reach of basic services to all people while minimizing their incentives to over-supply and over-charge for services. As noted in Lesson 5, relying on market forces to finance health for all (for example, by financing health through voluntary, private or commercial insurers) cannot successfully deliver UHC. Indeed, the more countries focus on the 'universal' component of UHC, the more heavily the government will have to be involved in financing care (See also Box H). Public financing is the surest and the best way to successful UHC. However, there is much more scope to deliver services through a mixture of public and private providers and there are many ways in which the private sector can and should be engaged in the UHC journey.



93. The SDG target for 2030 is fewer than 12 neonatal deaths per 1000 live births and fewer than 25 under-five deaths per 1000 live births. Tracking indicators include neonatal, infant and child mortality rates.
94. See A Wagstaff, (2013) World Bank blog post here for a discussion on data quality and reliability. <http://blogs.worldbank.org/developmenttalk/what-exactly-public-private-mix-health-care>

BOX H: “MARKET FAILURES” IN THE HEALTH SECTOR

- Health-related services include public goods such as public sewerage, clean air and water supply systems that the market could not fully supply.
- Services such as immunization have positive externalities in that one individual's consumption confers benefits on others in terms of herd immunity. Decisions based only on individual needs are likely to result in suboptimal funding.
- Markets tend to under-insure against major health expenditure because they cannot control costs effectively. There is little incentive for a healthy person to join an insurance scheme.
- Markets may not adequately reflect the greater willingness of the population to finance basic health care over other non-health goods and services.
- Markets can worsen health inequities.
- Markets for goods and services that embody expert knowledge produce ‘information asymmetry’ between providers and clients that can make clients vulnerable to abuse of provider power and unable to make decisions about what health care they need.

Source: Gerald Bloom, Claire Champion et al (2008), Making Health Markets Work Better for Poor People: Improving Provider Performance, Institute of Development Studies and Future Health Systems Consortium, 2008

There is a vast body of literature about the private sector and its multifaceted roles in health. From our research, key informants tended to concentrate on one crucial dimension of private sector engagement and that is its stewardship as part of the journey towards UHC:

1. Private sector regulation requires strong governance

One of the main challenges for health authorities across Asia (and globally) is to regulate private providers. Regulation underpins safety, quality of care, minimum standards and legal controls. In some settings, private providers may not be obliged to register, be licensed or be subjected to regular inspection or professional accreditation processes. This weakens the rights of patients and makes it difficult to track and incorporate providers into a UHC scheme, to strengthen standards and quality of care, to ensure legal compliance and to monitor results.

2. Powerful lobbies (doctors, pharmaceutical companies)

Private sector groups can form powerful lobbies which can act for or against major reforms. Doctors, for example, can resist public reforms aimed at capping their pay or changing their working patterns, including their ability to pursue private practice within a public sector setting. Pharmaceutical companies can mount very powerful lobbies to protect their market share and their profits. Tertiary hospitals can often attract the lion's share of available health resources, whether public or private.

Engaging with powerful interests in the course of developing UHC plans is vital.

3. Extending coverage through private providers

Large employers can be an important ally in the journey towards UHC. For example, in countries engaged in natural resource extraction, concession holders can be required to deliver health services to employees and their families or surrounding communities that are in line with national policy with or without additional public funding.⁹⁵ In many cases, for example Papua New Guinea (PNG), some concession holders deliver health services to their employees only. There may be scope to extend these to whole communities but this requires negotiation skills on the part of governments and often legislation and associated policies.

It is important to recognise the flexibilities, strengths and potential of the private sector to support UHC objectives. In Indonesia, for example, as the commitment to publicly financed health services grew so quickly, the private sector was able to rapidly scale up to help meet demand. In several countries, most health providers are private (See Box I, for example) and they form the backbone of the primary health care system as well as much specialist care. However, in these mature systems, public sector regulation of private delivery is well developed and includes negotiated payment scales, licensing, audit and results tracking.

95. For example, among private resource extraction companies in Papua New Guinea. See, for example, Carmichael, H., Mola, G., Amos, L., Wemin, J., Majumdar, P., and Matheson, D. (2015), The Mid-term review and Joint Assessment of the Papua New Guinea National Health Plan 2011-2020, Papua New Guinea, 2015.

BOX I: JAPAN'S UHC SYSTEM OF PUBLICLY FINANCED PRIVATE PROVIDERS

Whereas it is now recognised that compulsory public financing is preferable to private voluntary financing in reaching UHC, the picture with respect to service provision is not so clear. Some successful UHC systems in the region rely predominantly on public providers (e.g. China and Bhutan). But others use predominantly private providers (e.g. Japan and Republic of Korea) and many use a mix of public and private providers (e.g. Thailand and Malaysia).

Japan is a good example of a publicly financed UHC system where the vast majority of health care providers are in the private sector. So whereas 83% of THE originates from public sources (mostly social insurance contributions) when it comes to service provision the private sector dominates, accounting for 82% of hospitals and 72% of hospital beds. Furthermore, at primary care level virtually all clinics are solo private practices run by doctors.

A World Bank book published in 2014 describes how this system evolved and how it has produced a very efficient and equitable UHC system. In particular, one of the key policy lessons to emerge from Japan has been the government's ability to contain costs through tight regulation of the prices it pays private providers for services. This has been achieved by creating a highly organised and centralised purchasing function governed by the Ministry of Health, Labour and Welfare (MHLW), who every year define the statutory services to be provided and set prices for these services. The fee schedule is nationally uniform, and applied to all SHI programmes and virtually all providers. It sets not only the price of each service, drug, or medical device but also the conditions (for example, patient diagnosis and service standards) under which providers are allowed to bill. In some instances, in responding to technical advances, the MHLW has substantially reduced prices paid for some procedures, for example with respect to MRI scans.

In order to ensure financial protection for the population, charging patients above the prices set by the fee schedule (balanced billing) is strictly prohibited and tightly enforced.

As there will always be an incentive for profit-maximising private providers to oversupply services and seek additional payments, Japan's experiences illustrate how it is possible to curb these behaviours if countries invest in regulation and enforcement systems.

Source: Ikegami N., editor (2014) Universal Health Coverage for Inclusive and Sustainable Development - Lessons from Japan The World Bank 2014, Available at: http://www-wds.worldbank.org/external/default/WDSPContentServer/WDSP/IB/2014/10/10/000442464_20141010104230/Rendered/PDF/911630PUB0Box30see0also0888620Sep25.pdf



LESSON 9: MAKE UHC A LONG-TERM PROPOSITION

From political will to sustained political action, UHC is a *progressive or dynamic process rather than a once-and-for-all solution that can be “achieved”*.⁹⁶ Although one political party may seize an opportunity to launch UHC, ultimately, a UHC system has to be seen as a national goal, belonging to all and one that needs sustained, enduring, cross-party, intergenerational commitment⁹⁷. In Japan, Republic of Korea, Sri Lanka, Thailand and other countries with well-developed UHC systems, populations have come to expect UHC as their right and politicians stand on platforms that include how – not whether – they will protect and advance that right.⁹⁸ Reaching this ‘tipping point’ on the UHC journey seems to be an important milestone. And a vital one if the system is to become resilient in the face of some inevitable challenges. Some of these challenges

being experienced now in mature national health systems – for example in Japan, the United Kingdom, and Germany are discussed below. Countries can plan ahead for these and learn lessons from elsewhere. As a dynamic process, UHC will need to contend with:

a. Demographic changes: The paradox of good population health and strong health care systems is that people live longer and require more health care as they age. In Japan, for example, over 80% of hospital beds are occupied by older people.⁹⁹ Dependency ratios change over time as well. As fertility declines, countries can benefit from a ‘demographic dividend’, which boosts economic growth.¹⁰⁰ Ultimately, slowing population growth leads to a smaller working population (and tax base). UHC systems adapt to these changes by investing in reducing preventable diseases and health conditions, introducing efficiencies (for example in medicines procurement), ensuring rigorous priority setting (through transparent health technology assessment processes), changing provider payment systems (for example through capitation), and using smart technology (e-health measures, for example).

b. The ebb and flow of national economic growth can stall UHC: Budgetary pressures can threaten the expansion of UHC and lead to a stalled journey. In PNG, for example, the recent economic downturn has (temporarily) slowed ambitious health care reforms.¹⁰¹

c. Population health needs change constantly in a range of ways: Demands on health services change in both predictable and less foreseeable ways. The growth in NCDs can be anticipated everywhere for example, as well as the expanded needs of ageing populations. Other demands on health services and infrastructure include newly emerging diseases (for example SARS and avian influenza), old diseases adapting to new environments (Zika, Ebola), the health impacts of climate change (spread of mosquito-borne diseases), the health impacts of rapid economic development (air pollution in urban areas, for example), and resilience in the face of natural disasters (for example storms and earthquakes).

d. Migration: Populations move from rural to urban areas, and between as well as within countries. Health services need to move with them. Not only are migrants more likely to need health services (especially public health measures and interventions to support population health), and sanitation and hygiene, but maintaining the resilience and adaptability of the health systems will require services to be adaptable and accessible to those who need them (rather than just those who live in the ‘right’ location or are administratively eligible).



96. J Kutzin and S Sparkes “Health systems strengthening, universal health coverage, health security and resilience” Bulletin of the World Health Organization, Vol 94; 2: 2016

97. Stuckler (2010)

98. Ikegami (2014)

99. Ikegami (2014)

100. For an explanation of the Demographic Dividend, see for example, Population Reference Bureau, <http://www.prb.org/Publications/Articles/2012/demographic-dividend-factsheet.aspx>

101. Carmichael, H., Mola, G., Amos, L., Wemin, J., Majumdar, P., and Matheson, D. (2015), The Mid-term review and Joint Assessment of the Papua New Guinea National Health Plan 2011-2020, Papua New Guinea, 2015.

LESSON 10: BUILD ACCOUNTABILITY through transparent progress tracking and monitoring

The UHC journey is unique to each country. Maintaining momentum towards the achievement of UHC goals will require timely and reliable data, the willingness to undertake course correction at periodic intervals and a strong sense of accountability to citizens. Open and transparent accountability helps policy-makers maintain commitment and focus. It helps to ensure resources are used as intended. And it supports citizen empowerment to track progress and provide feedback, deepening citizen engagement.

Most countries that have made progress with UHC also have good data collection and analysis at the heart of their systems, founded on a health management information system. For example, since 2012 the Lao People's Democratic Republic has been working to achieve first the MDGs and then UHC by 2025. The Ministry of Health is implementing the District Health Information System, which provides policy- and decision-makers with real-time aggregated data at district, provincial and national levels.¹⁰²

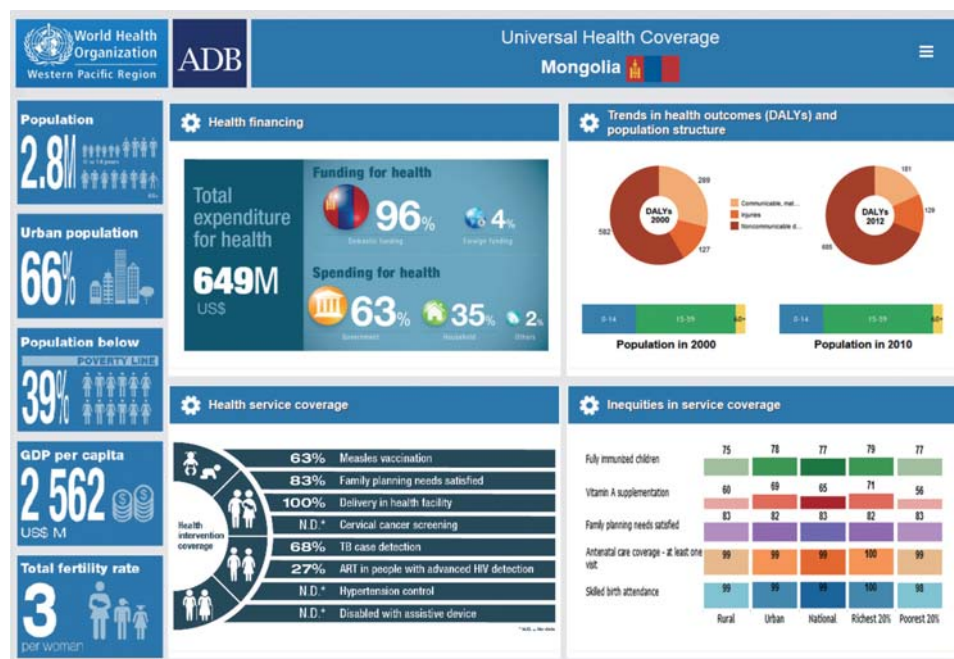
The right amount of up-to-date and reliable data is the starting point for accountability. China has relied very heavily on information systems to target service coverage, track progress and monitor results. China uses three main information gathering approaches: household surveys that track populations and their health needs and demand for services; health accounts to gather detailed information on

health financing, and routine health information systems to monitor the supply of care.¹⁰³

But more than data alone is needed. Countries need to be able to track and respond to the progress they are making in real terms against the three dimensions of UHC. For example, it is not enough to say that a service is free at the point of delivery and therefore UHC “has been achieved” at least for that service. As we have seen clearly in earlier lessons, access barriers prevent service utilisation even when it might be available and free at the point of use. People may not know they need a service (for example, those with undiagnosed HIV), or they may not have funds to pay indirect costs such as transport or child care. They may feel the quality of the service is inadequate or they may face language or other barriers. Young people may feel apprehensive about being welcome to use services; employed people may not be able to get to the services during working hours. Making a service available is certainly an important step forward but in itself, may not be enough to achieve real, verifiable universal coverage.

Working with the Asian Development Bank, the WHO Western Pacific Regional Office has developed a “UHC Dashboard” that helps countries track their progress with the main elements of UHC: population coverage, quality health care delivery, population equity, and financial protection. An example for Mongolia is shown in Figure 16.

FIGURE 16: THE ADB - WPRO DASHBOARD SHOWING AN EXAMPLE FROM MONGOLIA



Source: Susan Roth, Mark Landry and Jane Parry (2015) “UNIVERSAL HEALTH COVERAGE BY DESIGN ICT-enabled solutions are the future of equitable, quality health care and resilient health systems”, ADB Briefs No. 36, Asian Development Bank, Manila

102. WHO Western Pacific Regional Office “Universal Health Coverage: Moving towards Better Health”, Manila, Philippines, November 2015.

103. World Health Organization and the World Bank, “Tracking universal health coverage: first global monitoring report”. Geneva, Switzerland, WHO, 2015

TABLE 4: UHC - SUMMARY OF THE DETERMINANTS OF SUCCESS AND THE BARRIERS TO PROGRESS

Features of successful UHC journeys	Identifiable barriers to progress
<ul style="list-style-type: none"> • Framed as nation-building • Long-term political commitment • Strong citizen demand • Broad coalition of interests come together • Full coverage of quality primary health care in place • Sufficient public financing • Compulsory prepayment by users • Sustained investment in quality • Transparent accountability • UHC is approached as an evolving journey rather than a destination • Long-term vision 	<ul style="list-style-type: none"> • Vested interests • A low or narrow tax base • Insufficient government expenditure • Payments are voluntary • Fragmentation of pooled funds • Diversion of health funds to tertiary services • A high burden of preventable illness • Access barriers: utilisation of services by those who need them is poor • Large sections of the population are left out (e.g. the informal sector) • Administrative and bureaucratic failures: funds unused or used inefficiently • Wasted resources and ultimately, wasted political capital





SECTION 5

Ten UHC policy recommendations

Based on the current state of play in Asia and the Pacific, the lessons gleaned from best practice and the views of policy-makers and practitioners, the next steps and policy recommendations arising from this paper have been identified and are set out below.

1. Make UHC a ‘whole of government’ decision linked to nation-building and achieving citizen development.

There is rarely a perfect time to launch a major public reform, so integrating UHC into a larger political discourse will build support (and tolerance) with the incremental changes needed to sustain progress. UHC has often been launched in the aftermath of a national crisis as a means of nation-building accompanied by a narrative linking UHC to the delivery of citizens’ rights, and as an important mechanism to unite the nation through shared expectations. By using its authority to ensure equitable access to health resources, the government is meeting its

responsibility as a duty bearer to guarantee the rights of its people.

2. Engage political actors including the head of state, parliamentarians, administrators and powerful interest groups across the political and social spectrum.

UHC reforms typically create winners and losers. It is important to undertake political economy analysis early and often to ensure that

- the system develops and remains appropriate for the country’s circumstances, approach to decentralised administration, regulatory capacity and budget;
- political leaders understand and appreciate the political benefits and costs of different policy options, in particular the merits of reaching full population coverage;
- those who are more likely to perceive themselves as losing out are engaged early to ensure they do not become spoilers;

- public commitment is enhanced.¹⁰⁴

3. Engage beyond health to strengthen the critical drivers of UHC systems.

While health system investments are important to delivering on UHC, other national systems are vital as well.

- Supporting efforts to make tax collection more efficient and effective will benefit health (and UHC).
- Strengthening capacity at sub-national level to plan, budget, use and account for resources will support delivery.
- Extending infrastructure to underserved areas (including roads, electricity, water, education etc.) supports the development of poorer communities and enhances health, reducing the underlying causes of illness.
- Engage other ministries and sectors to increase access to WASH, education, nutrition and other interventions that have health impacts.

4. Good quality, accessible primary health care is the foundation of UHC.

Ensuring quality primary health care, accessible to all who need it, will reduce the burden of preventable diseases on services, promotes equity and is more efficient and cost-effective. Countries aiming to achieve progress with UHC should start by investing in primary health care and health systems strengthening that is especially focused on the basics: trained, motivated health workers and reliable access to quality medicines and commodities. Removing access barriers to primary health care for the poor, vulnerable, marginalised and excluded is vital to making equitable progress with UHC. Most countries should start with a phased approach, prioritising a basic package of services for women, newborns, children and adolescents that can be expanded gradually over time.

5. Be willing to pay more to address equity.

Reaching the poorest and most marginalised children can take longer, be more challenging and cost more per capita. People in rural communities may live farther apart. They may have language, cultural, faith-based, or other barriers to access. Overcoming these barriers may require proactive engagement by health authorities, more time and – in some circumstances – more resources. But unless the most vulnerable people are included, UHC will not reach its equity objectives.

6. Commit more public financing to UHC.

Build and sustain an adequate level of pooled public funds as the predominant financing mechanism for the health system through:

- Incremental growth in allocation of GDP to health. Countries should aim to spend at least 3% of GDP in public expenditure on health and health care¹⁰⁵ and should aim to increase spending by at least 0.3% per year, starting in 2017 until they reach at least that level of spending.

- Take steps to improve health system absorptive capacity, expand public health infrastructure, strengthen supply chain management and address the HR gaps.
- Reducing OOP payments and extending financial risk protection is vital to success.
- Increasing revenue from alternative sources (e.g. through additional taxes on some commodities such as alcohol, tobacco, sugar etc. – the so-called ‘sin’ taxes)
- Using public funding to pay for the informal sector and the poor to ensure they are covered.

7. Create the largest pool of resources possible.

Reduce fragmentation at the pooling level, especially so that funds collected through multiple channels are pooled for use across the whole system. The larger the pool of resources, the easier it is to ensure financial protection for all. Larger pools make better use of the principals of cross-subsidisation between the wealthy and healthy and the sick and the poor. They also more easily allow redistribution for equity between different sub-national regions.

8. Establish a transparent priority-setting process.

Priority setting is challenging and yet vital to ensuring that the package of services covered by UHC adds up to the most cost-effective use of resources to deliver optimal health outcomes for the whole of society. Setting up an explicit priority-setting process that will identify what should be covered using explicit criteria can help reduce political pressure, make decisions more transparent, and strengthen the value for money to be achieved from health resources. Transparent and inclusive/participatory prioritisation involving civil society can build confidence in the health system, including among the marginalised.

9. Engage the private sector: regulation, payment systems, partnership.

Private sector participation in health is a fact in most countries and in some, the majority of health care providers are private. Private providers can be powerful allies in extending UHC to the underserved, including private for-profit and not-for profit partners. Often, however, they see the shift to universalism as potentially encroaching on their preferred ways of working. There are several levels on which UHC policy-makers should engage private actors:

- As providers of care. Public purchasing of privately delivered health services requires minimum standards and regulatory capacity, and sometimes new payment models such as capitation arrangements agreed through what can be tough negotiations;
- Systems to support data collection from private providers;
- Where UHC shifts pharmaceutical procurement approaches, there may need to be negotiations and strong government commitment to the best practices associated with supply chain management, including the use of generics, buying in bulk etc.;
- As sub-contractors of services (catering, cleaning), contract negotiation.

¹⁰⁴. Stuckler (2010)

¹⁰⁵. This target is suggested in the Lancet Commission on Investing in Health, 2013

10. Strengthen accountability through developing and monitoring transparent, explicit and measureable targets.

These should be announced and tracked/monitored, and services should be held to account for progress towards achieving them. Vision is a necessary but not sufficient start to UHC and without clear goals, targets, and accountability mechanisms, progress can stall. Investments in data analysis, evidence and active monitoring are therefore vital. Targets should include those that capture

- Health outcomes (so, reflect real access and results);

- Health service coverage rates (e.g. immunisations, deliveries in health units, outpatient rates disaggregated in appropriate ways, such as by sex, wealth quintile or geography);
- System elements linked to quality, equity, performance, and user satisfaction;
- Key measures of financing including at least:
 - THE and PHE as a share of GDP;
 - OOP expenditure;
 - Proportion of the population protected from financial hardship due to health costs.

CONCLUDING REMARKS

Each country's UHC journey will be different: there is no blueprint. However, this policy review suggests that there are some important determinants of success.

Every country can make progress from their current position. All countries, regardless of their economic status, can increase domestic revenue for health by improving tax collection, adjusting tax rates, and introducing new progressive taxes, including taxes on alcohol, tobacco and other commodities. Countries can phase out inappropriate subsidies on goods and services that predominantly benefit the better off (for example, fuel subsidies) and use savings to finance UHC.

Reaching the poorest and most marginalised is challenging and programmatically difficult. Countries should draw on lessons and best practice to shape their own journeys, making adjustments and adaptations as they build experience. The groundwork for UHC needs to be laid carefully so that service provision is able to meet health needs irrespective of where the funding comes from. If services are not accessed by all the people who need them, when they need them, it is not UHC. Children are especially vulnerable. UHC is an effective strategy for advancing the right to health of children, which all countries have agreed to guarantee.

Financing is, of course, a vital component as well, and a UHC system should be designed to meet four criteria:

- Ensure equitable access by removing financial barriers, especially direct payments;
- Prepayment must be compulsory;
- Large risk pools are essential;
- Where people are unable to contribute (for example, they are unemployed or very poor), governments need to pay on their behalf.

Finally, it isn't UHC if it doesn't make progress on delivering the basic ingredients: extending genuine coverage to the whole population; ensuring coverage of a basic package of quality-assured, essential services; and, extending protection from financial hardship due to health care costs, especially to the poorest.



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A Note about Data

Data were sourced from the following data banks. The most recent data available were used unless specified. All data in a single table were drawn from the same source. Data on equity and socioeconomic status were not available for all countries. The authors recognise that other national data sources and surveys sometimes offer different estimates, but for consistency international databases have been used in this report.

World Bank data: <http://data.worldbank.org/>

WHO Global Health Observatory Data: <http://apps.who.int/gho/data/>

WHO Health Expenditure Database and Health System Financing Profiles by Country: <http://apps.who.int/nha/database/Select/Tables/en>

UNICEF data sets: <http://data.unicef.org/>

UNFPA World Population Dashboard: <http://www.unfpa.org/world-population-dashboard>

Countdown to 2015 country data summaries: www.countdown2015mnch.org

ANNEX 1:

WHY INVEST IN WOMEN'S AND CHILDREN'S HEALTH?

Investing in women's and children's health provides an excellent return in both the short and the long term. Healthy families and communities are more productive and happier. Healthy children learn better, are more productive as adults and can look forward to healthier adulthoods. Premature deaths are tragic but they also erode social fabric and communities; they impoverish households and societies and they reduce economic growth. Health is a right and access to health for children is guaranteed in Article 24 of the Convention on the Rights of the Child, to which all countries in Asia and the Pacific have subscribed.

In addition, the absolute economic returns expected from health investments are among the best buys a government can make (see below). Reducing poverty associated with ill health and accessing health care has huge benefits for households (100 million of whom are impoverished every year globally as a result of health-related causes). And there are other economic spin offs, such as reducing out-of-pocket (OOP) health expenditure, which allows households to save less (for unforeseen medical expenses) and spend more in the wider economy. Table 1 in the main report sets out the leading arguments for investing in health through UHC. Recent nutrition evidence underlines the inter-generational case for systematic investments in health and nutrition.

The return on investing in UHC

There is significant evidence from a number of countries that UHC reforms have generated tangible economic benefits for households. For example, an independent review of the first ten years of Thailand's celebrated Universal Coverage Scheme (UCS) shows a dramatic reduction in the proportion of OOP health expenditure and falls in catastrophic health expenditure and impoverishment due to health care costs. Between 1996 and 2008 the incidence of catastrophic¹⁰⁶ health care expenditure amongst the poorest quintile of UCS members fell from 6.8% to 2.8%.¹⁰⁷ Furthermore, the incidence of non-poor households falling below the poverty line because of health care costs fell from 2.71% in 2000 to 0.49% in 2009. The review calculated that the comprehensive benefit package provided by the UCS and the reduced level of OOP expenditure protected a cumulative total of 292,000 households from health-related impoverishment between 2004 and 2009.

Reducing preventable maternal and child mortality

The Lancet Commission on Investing in Health

demonstrated that it would be financially and technically feasible to reduce child and maternal deaths to OECD levels by 2035 (called the convergence in health). Using value life-years to estimate the economic benefits, (reflecting, among other things, income lost through premature death) and over a 20-year period (2015–35), the benefits of investing in women's and children's health to achieve convergence in child and maternal deaths with OECD countries would exceed costs by a factor of about 9–20, making the investment highly attractive. Reducing maternal and child deaths would save an estimated \$7 billion in health care costs globally. In addition, preventable deaths in women and children lead to an estimated \$15 billion in lost productivity each year. More than 40% of such deaths occur in Asia and the Pacific¹⁰⁸.

Demographics, family planning and birth spacing

Between 30% and 50% of Asia's economic growth between 1960 and 1995 can be attributed to favourable demographic and health changes, leading to reduced infant and child mortality, subsequent fertility decline, changing dependency ratios and improvements in reproductive health.¹⁰⁹

Every \$1 spent on family planning and birth spacing saves \$4 or more on addressing the complications of unplanned pregnancies, which contribute disproportionately to maternal and infant mortality. This excludes the increased productivity of women in the labour market and the value of their contribution to GDP. Extending family planning to all women who want it would reduce unintended pregnancies by more than two-thirds globally (from 75 million to 22 million per year). Through the consequent delays in first births, and by spacing births and limiting the total number of births, healthy years of life lost among women and their newborns would be reduced by 60%.¹¹⁰

Nutrition

Every \$1 invested in reducing stunting in children returns in the order of \$18.²

Improving nutritional knowledge and providing a package of care in pregnancy that includes universal salt iodisation, and micronutrient and calcium supplementation to manage severe acute malnutrition, as well as therapeutic zinc supplementation can help to mitigate against the effects of infections, including diarrheal disease, preventing some forms of malnutrition. As adults, well-nourished children earn incomes that rise by 11% per year.¹¹¹ The country-

106. Defined as out-of-pocket expenditure exceeding 10% of total household consumption expenditure

107. Assessment of Thailand's Universal Coverage Scheme – Synthesis Report available here: <http://www.gum.info/en/topics/health-politics-and-trade-unions/development-and-health-determinants/development-and-health-determinants/thailand2019s-universal-coverage-scheme-achievements-and-challenges>

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specific benefit-cost ratios for investments that reduce stunting in 17 high-burden countries range from 3.6 (in Democratic Republic of Congo) to 48 (in Indonesia) and have a median value of 18 (Bangladesh). This means that every \$1 invested in reducing stunting in Bangladesh delivers returns in the order of \$18 and in Indonesia, it is even more.²

Using taxes to reduce NCDs

Today, more than 100 published studies, including evidence from low- and middle-income countries, show how tobacco excise taxes can generate reliable tax revenue and reduce tobacco use. Taxes on tobacco and alcohol can be important quantitatively and qualitatively because they do not have the adverse incentive effects of taxes on capital or labour. A 50% price increase in cigarettes from tax increases in China would prevent 20 million deaths and generate an extra US\$20 billion in revenue annually in the next 50 years. In India, in the same timeframe, a 50% price increase would prevent 4 million deaths and would generate an extra \$2 billion in revenue annually¹¹². The additional tax revenue would decrease over time as consumption patterns are adjusted, but is expected to remain higher than existing levels even after 50 years. Tax increases are also a highly cost-effective approach to reduce total alcohol consumption and the number of episodes of heavy drinking, especially in young people. Young people and low-income populations tend to respond most to price increases on unhealthy foods and beverages, tobacco and alcohol.

NCDs best-buys: \$1.50 per capita in middle-income countries will avert 37% of the cardiovascular and diabetes burdens. WHO estimates that scale-up of the essential clinical package to 80% coverage across all low-income and middle-income countries by 2025 would avert 37% of the global burden of cardiovascular disease and diabetes and 6% of the global cancer burden. To achieve such coverage would cost an average of US\$9.4 billion per year from 2011 to 2025, representing an annual median cost per person of less than \$1 in low-income countries, less than \$1.50 in lower-middle-income countries,

and about \$2.50 in upper-middle-income countries.

The importance of Human Rights and Equity

Health systems reforms should take into account that all countries in the world are signatories to the UN convention on Human Rights, which includes the following right to health and social protection: “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.”¹¹³

These fundamental rights were recently re-affirmed in a UN General Assembly (UNGA) resolution on UHC passed unanimously in December 2012. This resolution also explicitly recognised that inadequate coverage levels at present were compromising the attainment of these rights: “Noting with particular concern that for millions of people the right to the enjoyment of the highest attainable standard of physical and mental health, including access to medicines, remains a distant goal, that especially for children and those living in poverty, the likelihood of achieving this goal is becoming increasingly remote, that millions of people are driven below the poverty line each year because of catastrophic out-of-pocket payments for health care and that excessive out-of-pocket payments can discourage the impoverished from seeking or continuing care.”

To redress this situation the recent UNGA resolution emphasises the importance of achieving universal population coverage, in acknowledging that: “universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population.

112. Lancet Commission on Investing in Health (2013), *Lancet* 2013; 382: 1898–955.

113. Article 25 of the Universal Declaration of Human Rights

ANNEX 2: THE GRAPHS

FIGURE 2: PERCENTAGE OF WOMEN ATTENDING FOUR OR MORE ANTENATAL VISITS (2014)

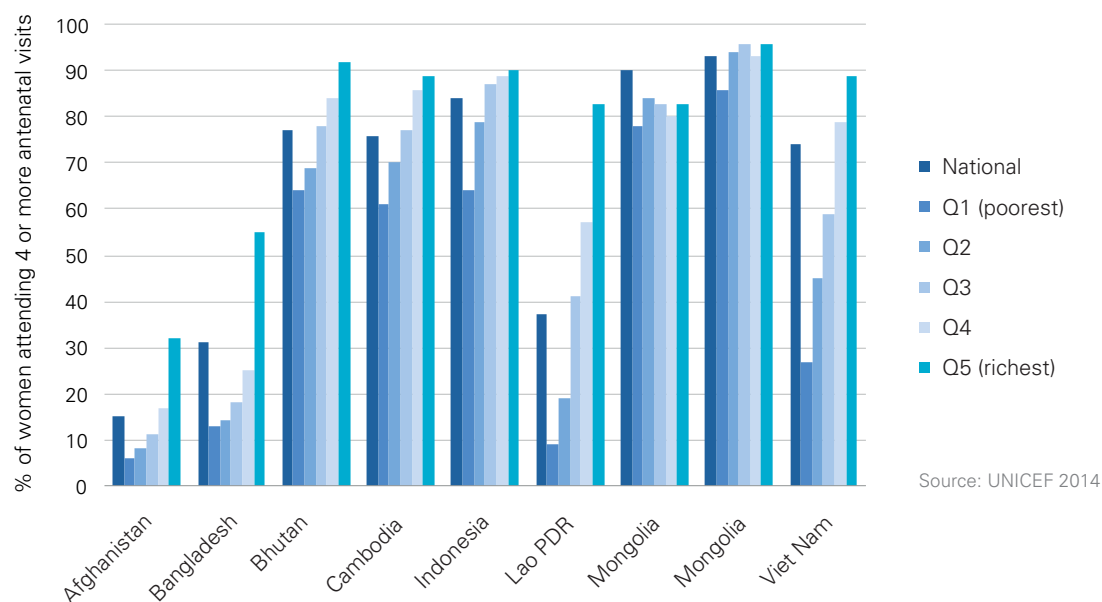


FIGURE 3: IMMUNISATION RATES (DTP3) AMONG CHILDREN UNDER FIVE BY WEALTH QUINTILE (2012)

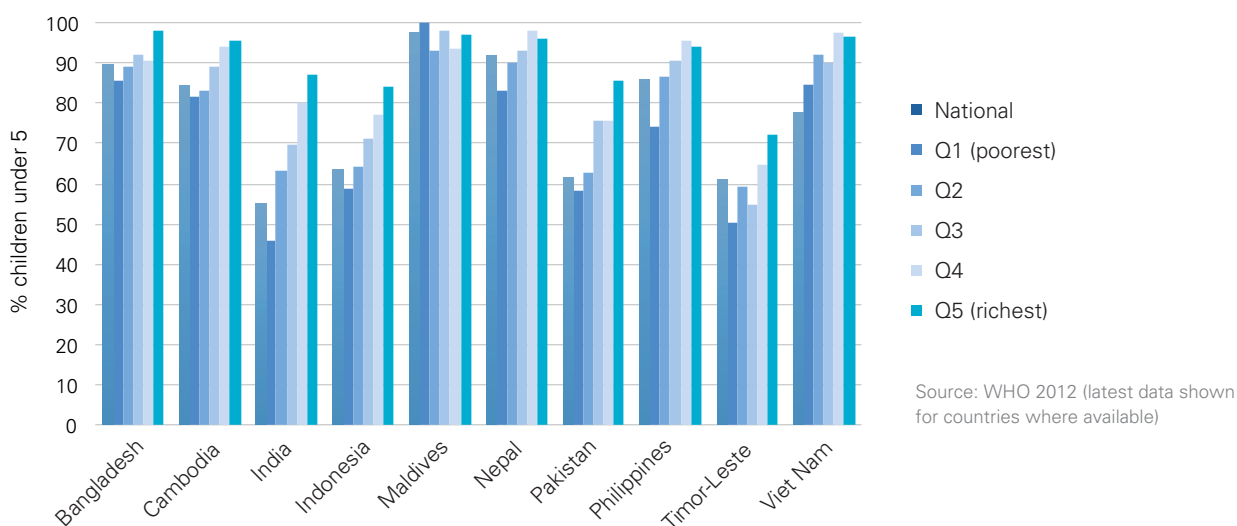
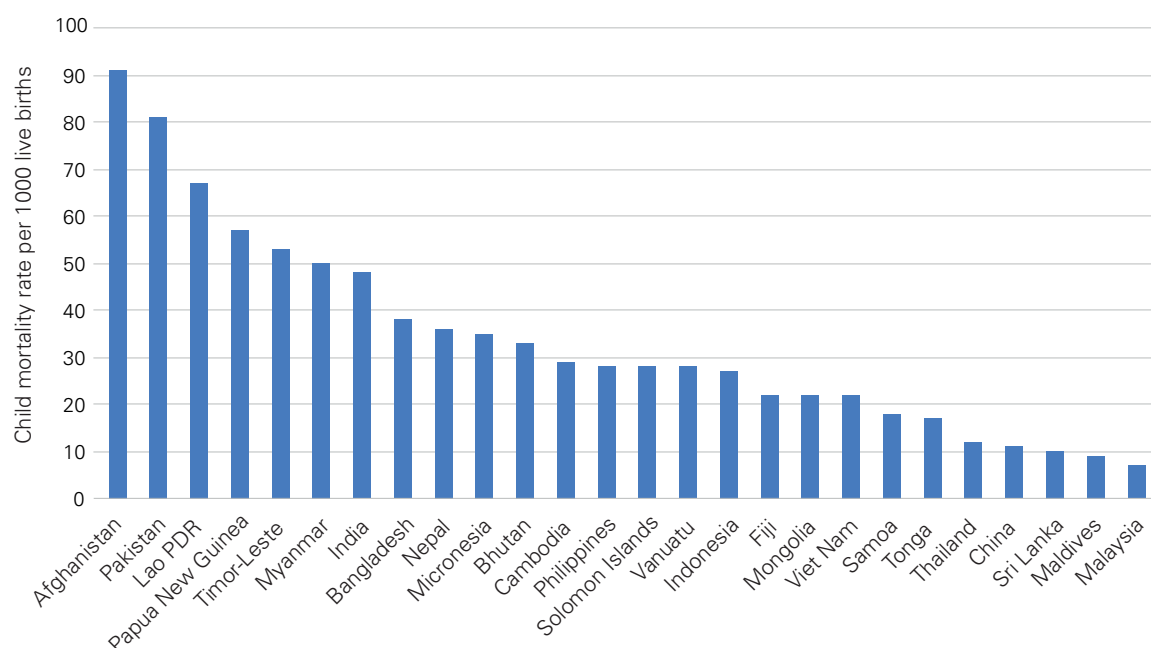
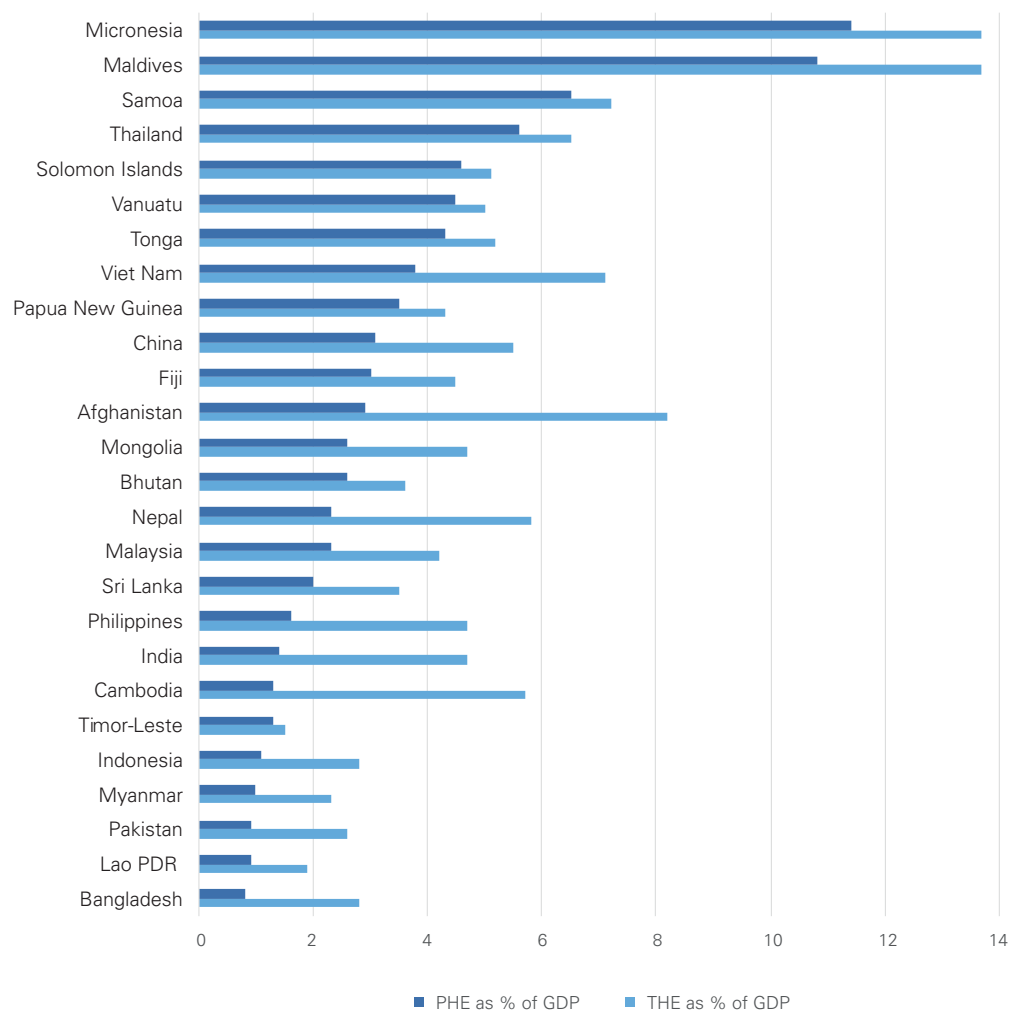


FIGURE 4: CHILD MORTALITY RATES (2015)



Source: World Bank data 2015

FIGURE 5: TOTAL HEALTH EXPENDITURE (THE) AND PUBLIC HEALTH EXPENDITURE (PHE) IN ASIA AND PACIFIC COUNTRIES (2014)



Source: World Bank data 2014

FIGURE 6: OOP EXPENDITURE AS A PROPORTION OF THE IN ASIA AND PACIFIC COUNTRIES (2015)

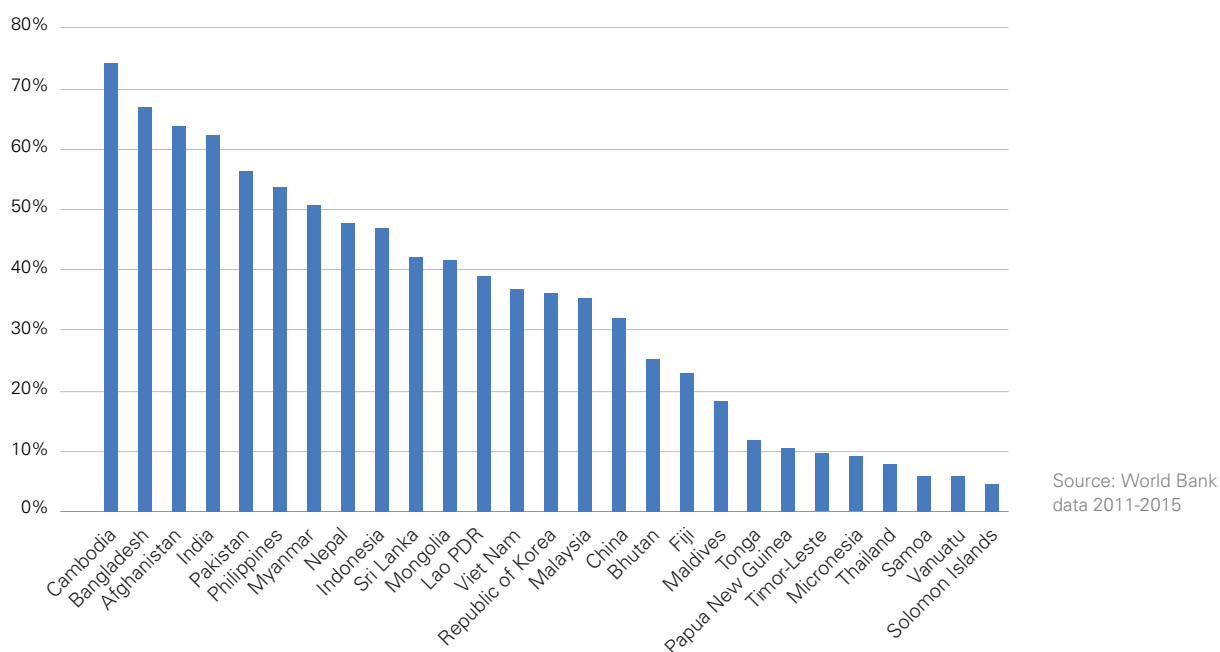
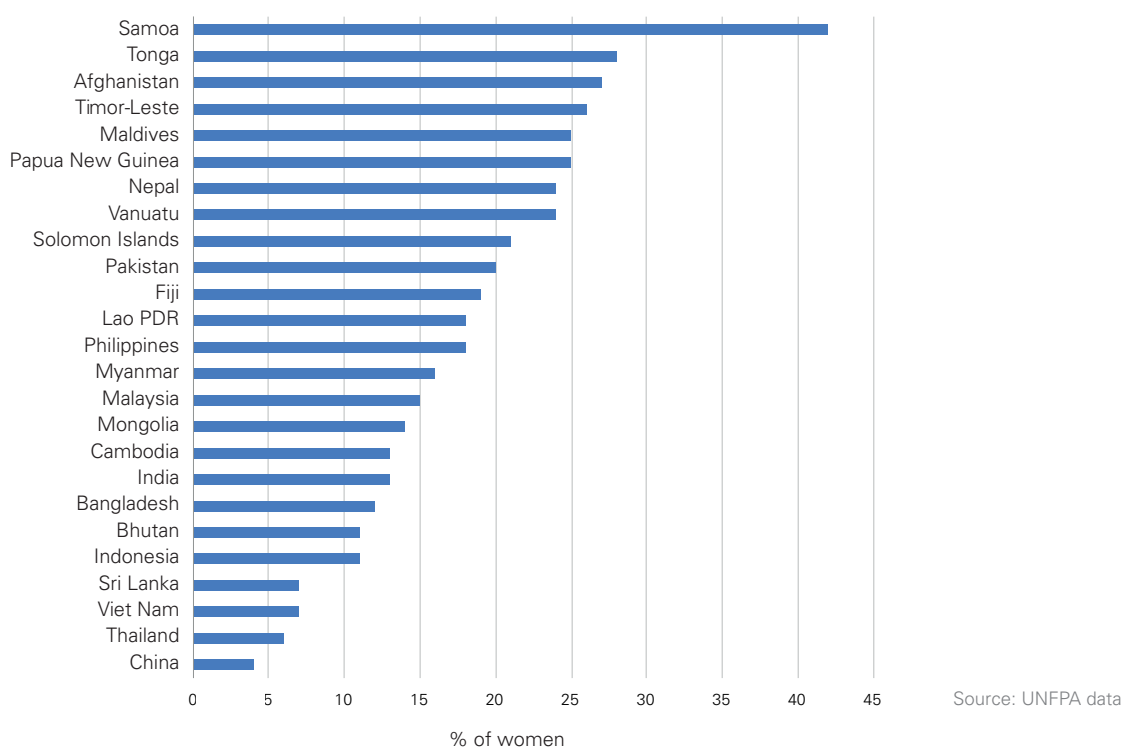
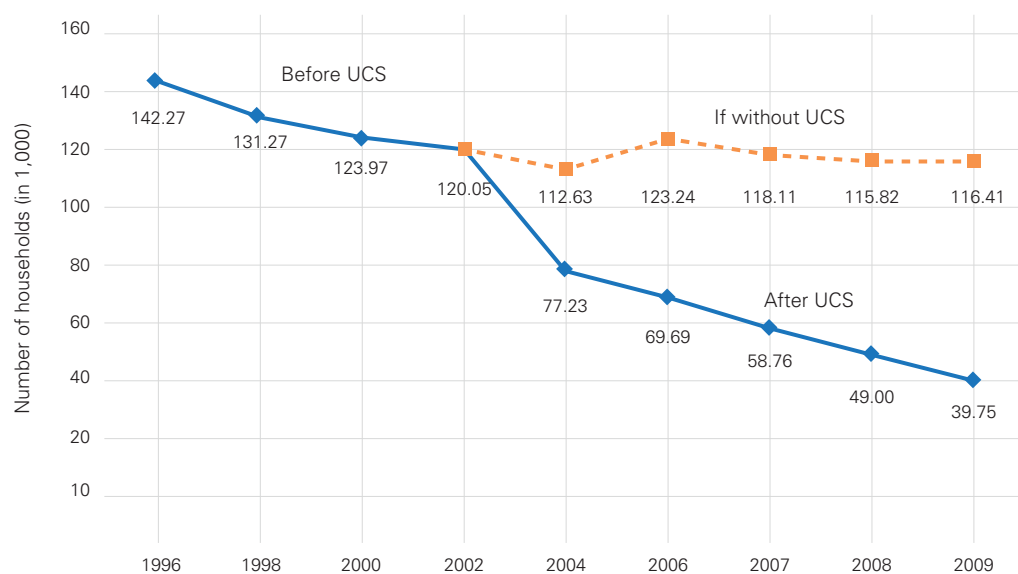


FIGURE 8: PERCENTAGE OF WOMEN WITH UNMET NEED FOR FAMILY PLANNING USING MODERN METHODS (2015)

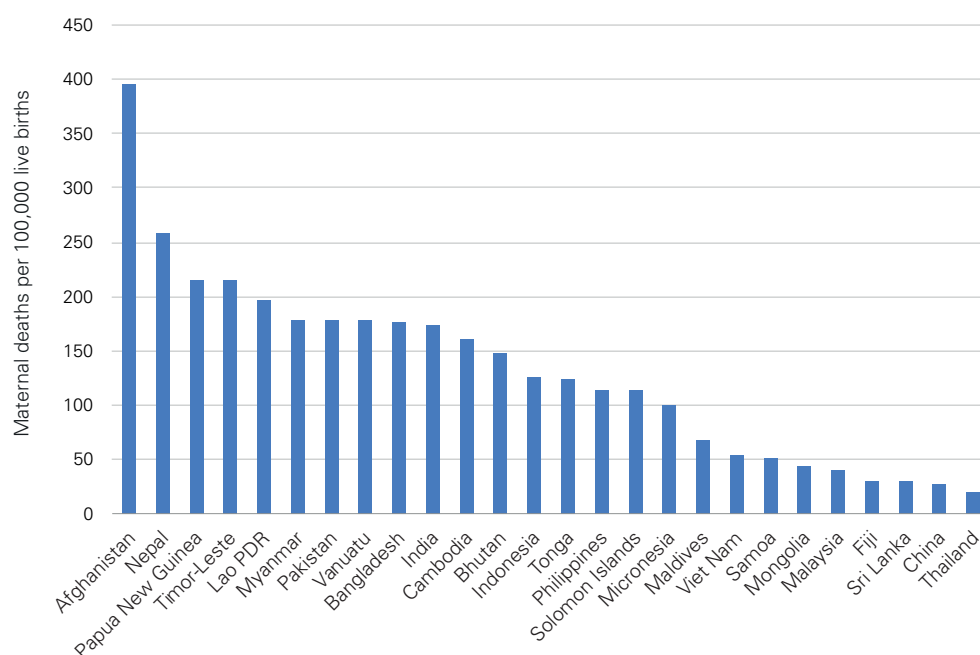


BOX B - TABLE B: NUMBER OF HOUSEHOLDS PROTECTED FROM HEALTH IMPOVERISHMENT IN THAILAND 1996-2009



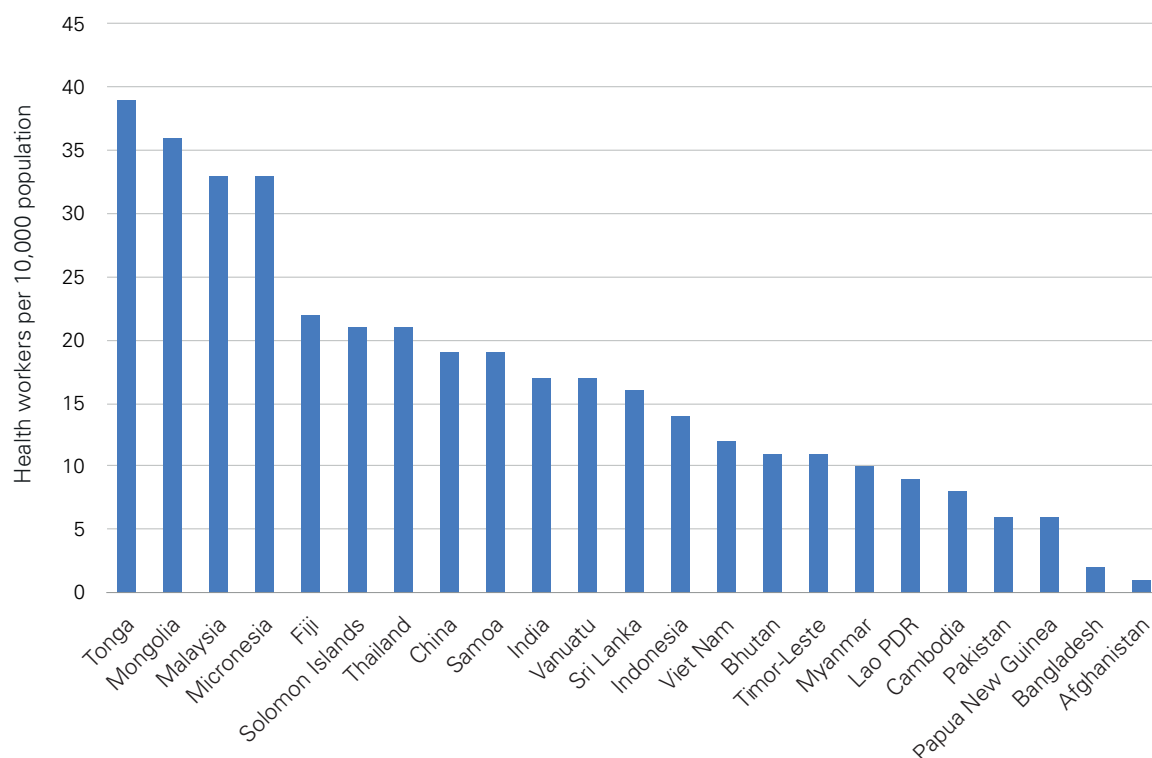
Sources: Evans TG et al "Thailand's Universal Coverage Scheme Successes and Challenges – An Independent assessment of the first 10 years (2001-2011)", 2012 Nonthaburi, Thailand: Health Insurance System Research Office

FIGURE 9: MATERNAL MORTALITY RATIO IN ASIA AND THE PACIFIC (2015)



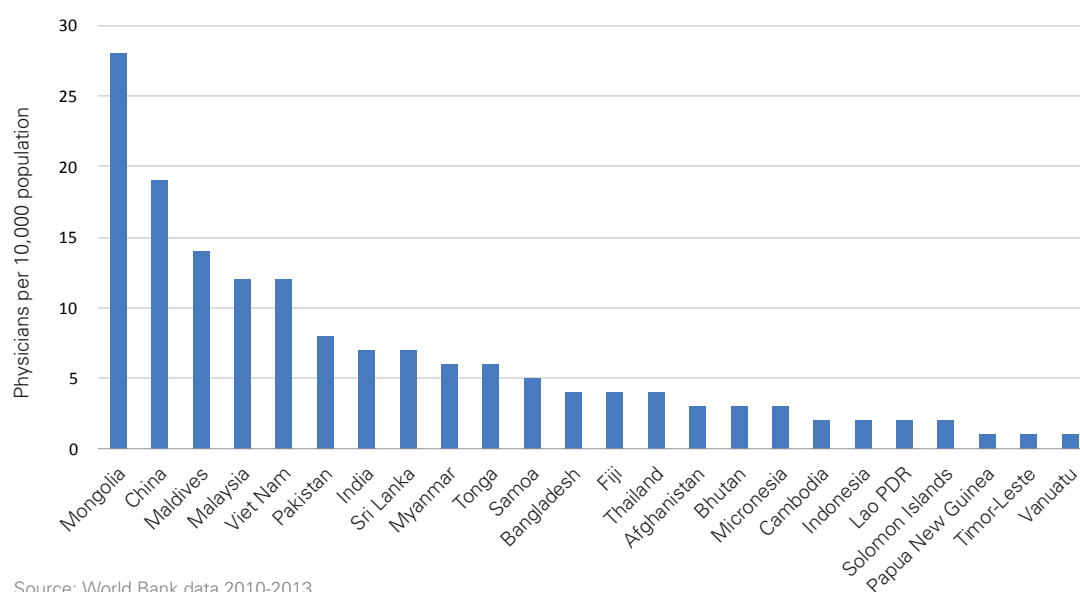
Source: World Bank data 2015

FIGURE 10: NURSES AND MIDWIVES PER 10,000 POPULATION (2013)



Source: World Bank data 2010-2013

FIGURE 11: PHYSICIANS PER 10,000 POPULATION (2013)



Source: World Bank data 2010-2013

FIGURE 12: ACCESS TO SANITATION AND PROPORTION OF CHILDREN UNDER FIVE WHO ARE STUNTED IN ASIA PACIFIC COUNTRIES (2015)

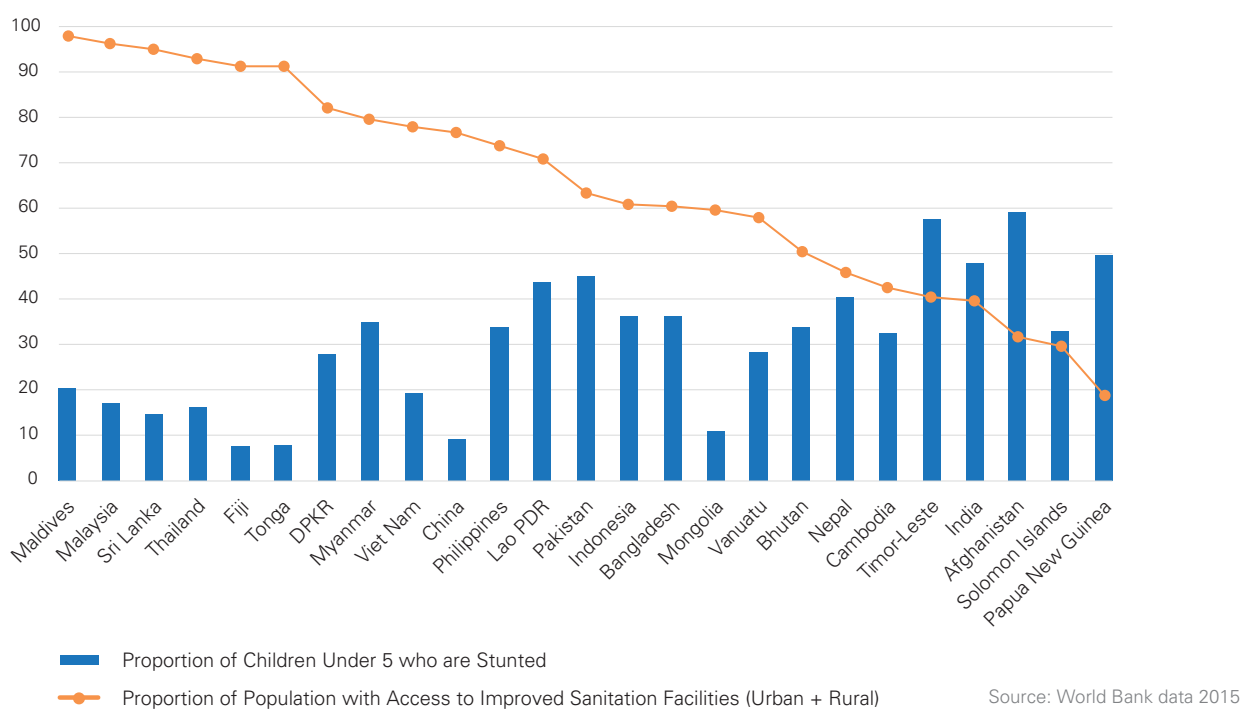
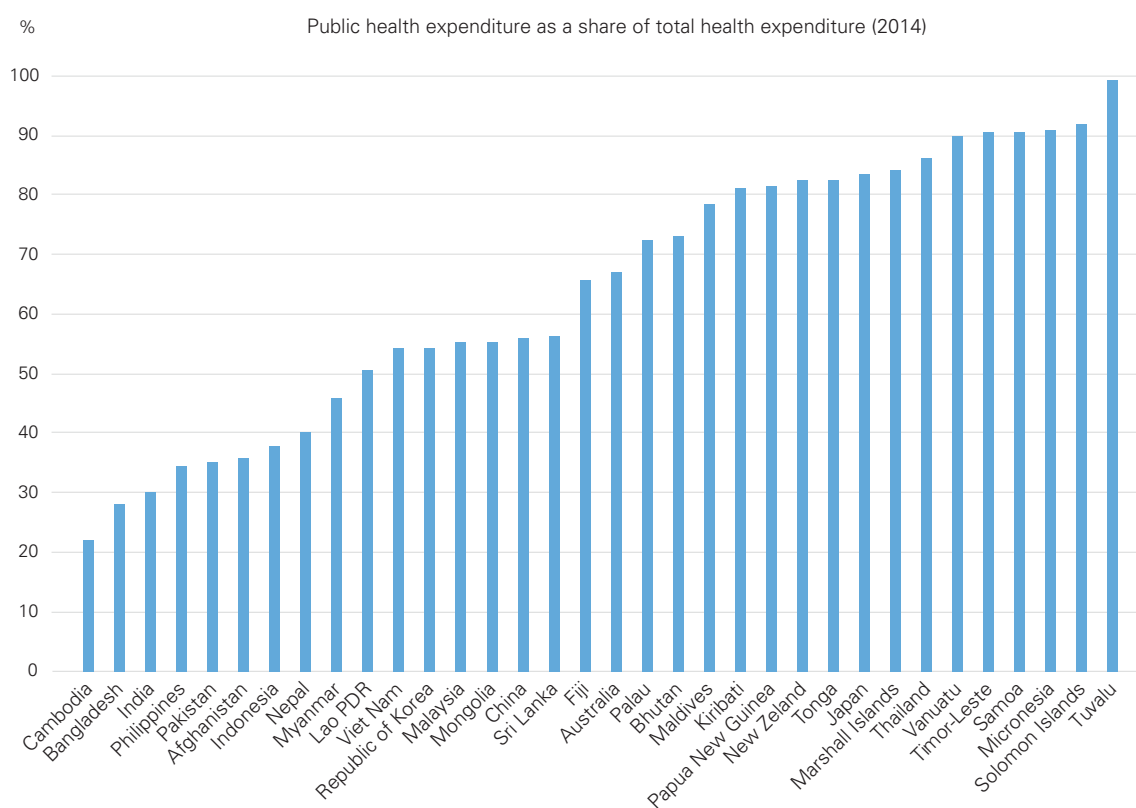
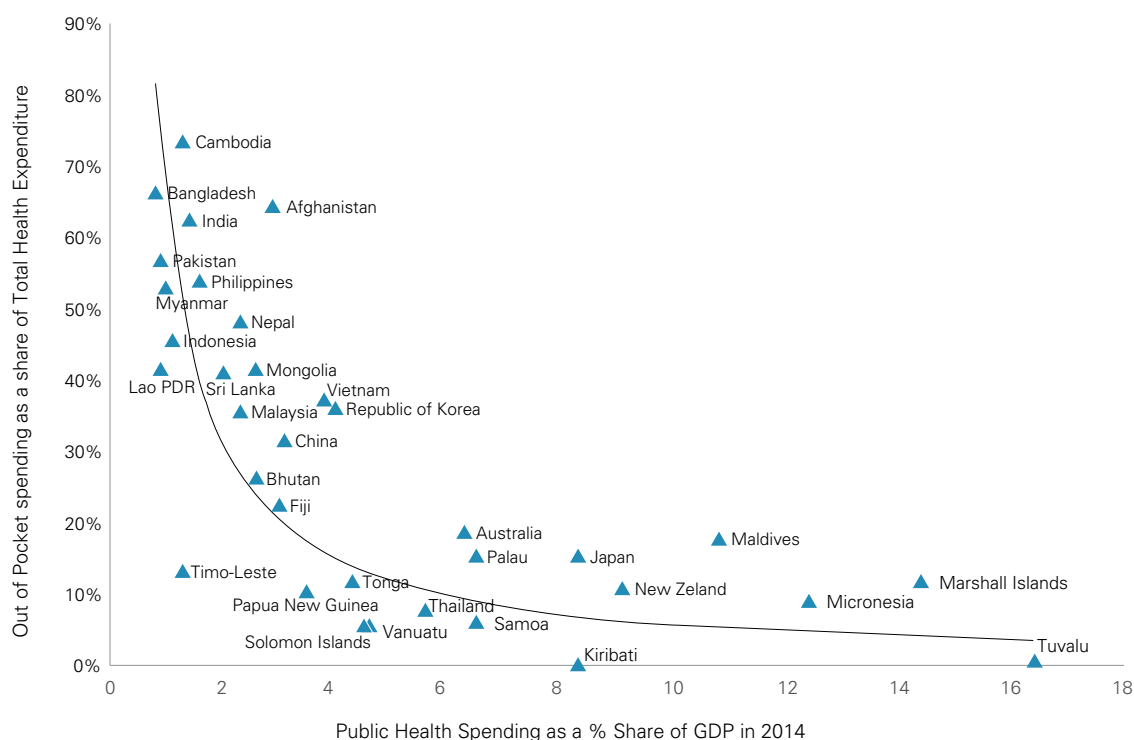


FIGURE 13: PHE AS A SHARE OF THE (2014)



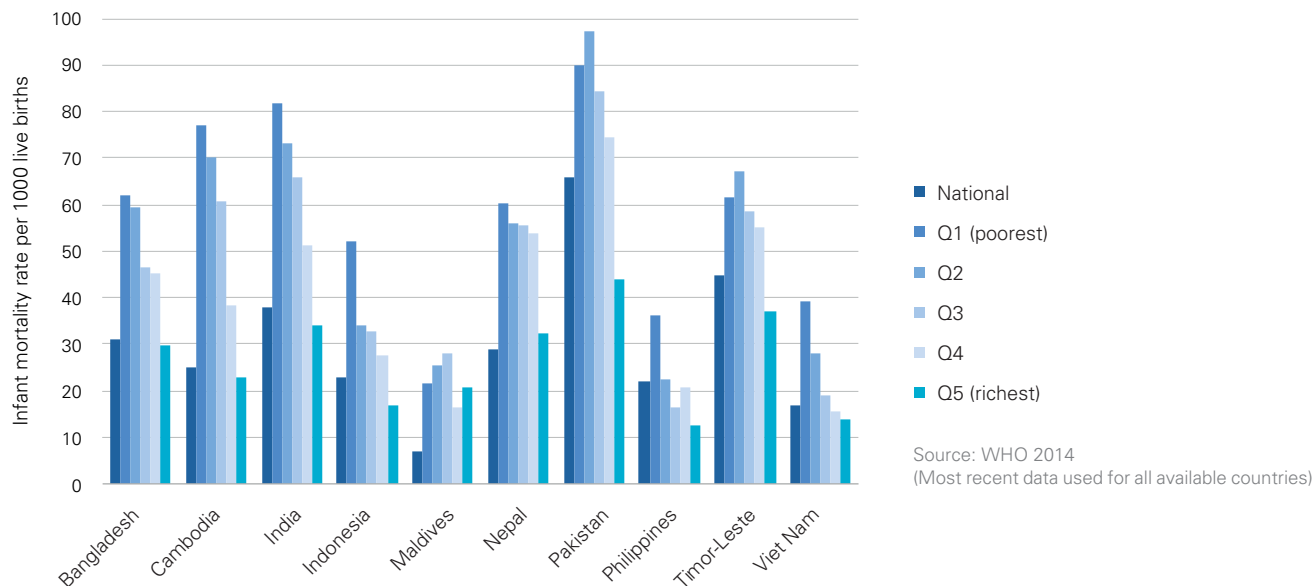
Source: World Bank data 2014

FIGURE 14: PUBLIC HEALTH FINANCING REPLACING OOP EXPENDITURE IN ASIA AND THE PACIFIC (2014)



Source: World Bank data 2014

FIGURE 15: INFANT MORTALITY RATE PER 1000 LIVE BIRTHS IN ASIA AND THE PACIFIC (2014)



ANNEX 3: A NOTE ON METHODOLOGY

Approach

This report reviewed evidence of the state of UHC in Asia and the Pacific regions, highlighting good practice and identifying barriers to progress. The analysis of evidence included an assessment of access to quality essential health services¹¹⁴ for women's and children's health, population coverage, and levels of financial protection with a particular focus on equity.

Overarching research questions and aim:

This analysis was guided by a series of overarching questions:

1. What is the state of UHC in the countries of South Asia, East Asia and the Pacific for women's and children's health (at policy and implementation levels), in particular analysing coverage of Maternal, newborn and child health (MNCH) services?
2. What are the key lessons learned in country experience with UHC?
3. What measures and indicators do countries use to monitor progress in working towards UHC?
4. What health financing policies do countries have in place to support attainment of UHC?
5. What are the main determinants of success and the barriers to progress found in countries across the region in relation to progressing towards UHC?

Research

In answering these overarching questions, the researchers followed a systematic research plan:

1. Undertake an in-depth structured literature search including grey literature.
2. Conduct semi-structured interviews with at least 30 stakeholders across the region.
3. Document key UHC measures including outcomes, service coverage rates and health financing including total health expenditure, public health expenditure, out-of-pocket expenditure, distribution of the disease burden across wealth quintiles where possible, routine health and health systems indicators.
4. Triangulate the evidence emerging from the literature, the interviews, and the data analysis and identify the main themes, evidence for best practice, constraints, barriers to progress and considerations for equity, quality, coverage and sustainability.
5. Describe the main lessons arising from the material and develop appropriate policy recommendations to support countries aiming to advance UHC.

The methodological approach to the thematic paper was based on qualitative analysis triangulating evidence from the literature, from interviews and from data analysis. The researchers used qualitative analysis techniques to identify, triangulate and validate findings and conclusions. Documents were country- and region-specific to the extent possible but some global material was also covered, as well as recent synthesis material. Data sets were those in the public domain and, for consistency, were limited to data available from the World Bank data bank, the WHO global health observatory or UNICEF.

114. 'Essential health services' in this paper is used in the sense covered by the broad WHO definition of health services including promotion, prevention, treatment, rehabilitation and palliation services where relevant to the women's and children's health.



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