

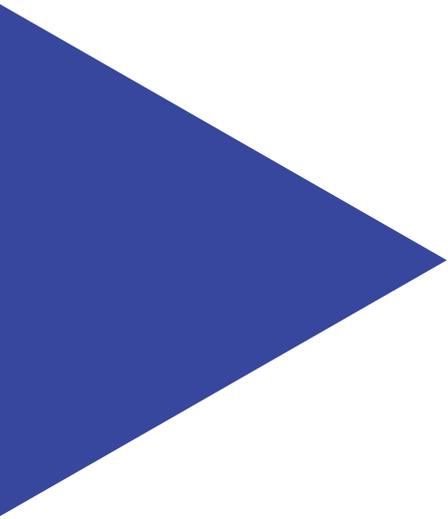


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► *Selected Extracts*

**Extending Social Health Protection:
Accelerating progress towards
universal health coverage in Asia
and the Pacific**



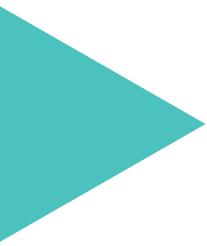




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**Extending Social Health Protection:
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universal health coverage in Asia
and the Pacific**





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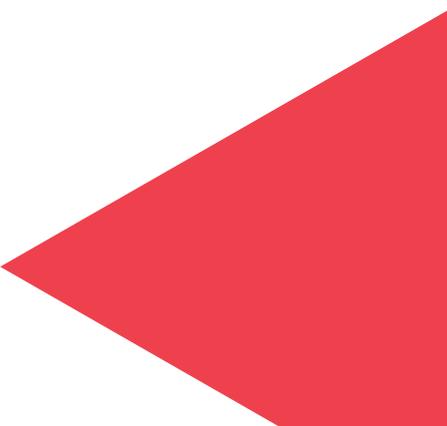
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Preface

The lack of affordable quality health care and income security in case of sickness for the majority of the world's population constitutes an important poverty risk with threat of pushing the most vulnerable further behind. Each year 100 million people slide into poverty after paying for their medical care and 800 million people spend at least 10 per cent of their household budgets to pay for health care. This situation is due to insufficient or absent social health protection (SHP) coverage, which affects more prominently the poor.

With the adoption of the Sustainable Development Goals (especially targets 1.3 and 3.8), and guidance from International Labour Standards (in particular, Conventions No. 102 and 130 as well as Recommendation No. 202), countries are increasingly taking steps to reach universality of SHP coverage. Against this backdrop, the ILO has developed an Asia compendium, *Extending Social Health Protection: Accelerating progress towards Universal health Coverage in Asia and the Pacific (2021)*. In India, the ILO project, 'Technical support to ESIS for improving and expanding access to health care services in India – A transition to formality' (henceforth, the project), supported by the Bill and Melinda Gates Foundation, has been contributing to this effort. The present document is a selection of extracts from this compendium. It documents country experiences and lessons learned on the extension of legal and effective coverage of SHP, both in terms of scope (population coverage) and adequacy of the benefits (service covered, level of financial protection). The countries covered in this document are India, Indonesia, Lao PDR, Nepal, Mongolia, Philippines, and Viet Nam.

The country profiles in the present document take a holistic approach, providing an overview of the historical developments of national social health protection schemes; a detailed analysis of their current design in terms of financing, governance, population coverage, and benefits adequacy; an analysis of empirical evidence on their successes in key aspects including population coverage, utilization, and quality of services; and developments planned for the near future.

This resource document has been prepared by the ILO project team backstopped by ILO Country Office in India with the support of the Social Protection Department at the ILO Headquarters. We hope this contributes to the Decent Work agenda and improved social health protection for workers of India.

Dagmar Walter

Director,
ILO DWT for South Asia and Country Office for India



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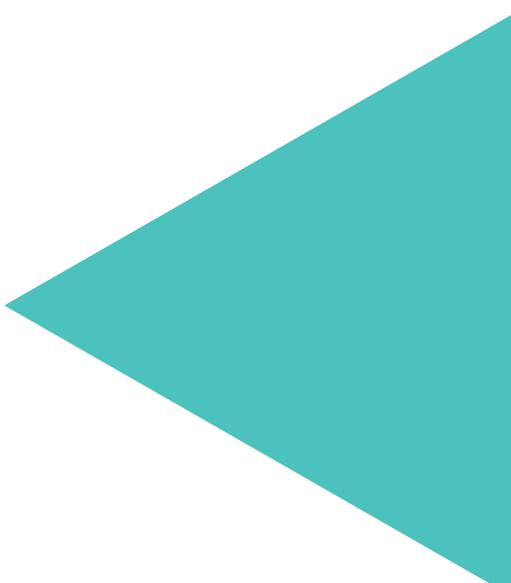
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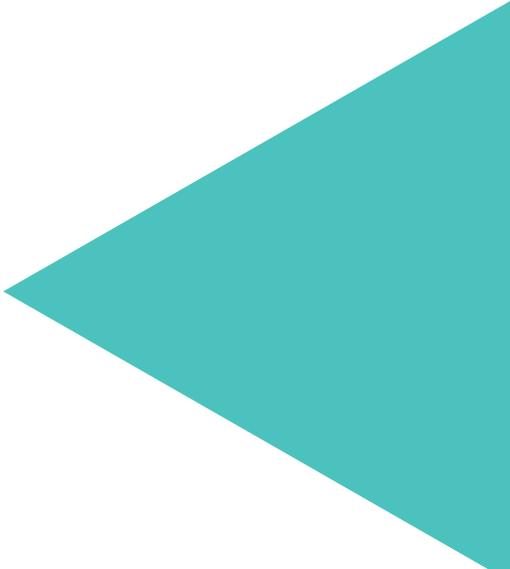
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Abbreviations

ADB	Asian Development Bank
CBHI	Community-Based Health Insurance
CGHS	Central Government Health Scheme
CHE	Current Health Expenditure
DJSN	Dewan Jaminan Sosial Nasional
DRG	Diagnosis Related Group
DTKS	Data Terpadu Kesejahteraan Sosial
EPF	Employees' Provident Fund
ESIS	Employees' State Insurance Scheme
EAG	Empowered Action Group
FHCP	Free Health Care Policy
GoV	Government of Viet Nam
HCFP	Health Care Fund for the Poor
HEF	Health Equity Fund
HIGA	Health Insurance General Agency
HIB	Health Insurance Board
HIL	Health Insurance Law
HIV	Human Immunodeficiency Virus
HCPN	Health Care Provider Network
HWC	Health and Wellness Centre
ISSC	Integrated Social Security Card
ILO	International Labour Organization
IHD	Ischemic Heart Disease
JKN	Jaminan Kesehatan Nasional



MDR	Member Data Record
MLSW	Ministry of Labour and Social Welfare
MNCH	Maternal, Newborn and Child Health
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
MOLISA	Ministry of Labour, Invalids and Social Affairs
NCD	Non-Communicable Diseases
NHIB	National Health Insurance Bureau
NSSF	National Social Security Fund
OOP	Out-of-Pocket Payments
PHC	Primary Health Care
PM-JAY	Pradhan Mantri Jan Arogya Yojana
PMAM	Pradhan Mantri Arogya Mitra
RSBY	Rashtriya Swasthya Bima Yojana
SECC	Socio-Economic and Caste Census
SHC	Soum Health Center
SHP	Social Health Protection
SASS	State Authority for Social Security
SSGO	State Social Security General Office
SSF	Social Security Fund
TB	Tuberculosis
THE	Total Health Expenditure
UHC	Universal Health Coverage
VSS	Viet Nam Social Security



▶ Social Health Protection in INDIA

Authors: Maulik Chokshi, Jaidev Singh Anand
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▶ Introduction

Since the early days of its independence, India has recognized the benefits of ensuring comprehensive health care coverage for its population. As such, several official committees, expert groups and policy documents have reiterated the need for ensuring accessibility and availability of health care, and the country has taken incremental steps to establish and expand social health protection. This has been achieved across various targeted population groups through a range of mandatory social health insurance schemes, targeting industry workers, civil servants and low-income households, respectively. Despite advances made through these schemes, the social health protection system in India remains fragmented, with concerns expressed around the ability of schemes to provide effective coverage to beneficiaries. Moreover, such fragmentation has resulted in varying standards of quality of clinical care and levels of access, with implications for the efficiency of the system at large.

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► History

Social health protection schemes in India have been operating since the country's independence in 1947. With limited economic resources at hand, the Government initiated a targeted roll-out of social health protection measures. Initially the entire population was entitled to affordable health care in public facilities through the national health service run by the Ministry of Health and Family Welfare (MOHFW), though the reach of this system remained limited in practice. Acknowledging the need for expansion, the Employees' State Insurance Scheme (ESIS) was launched in 1952 to cover factory workers and their families earning up to a certain income level. This was soon followed by the establishment of the Central Government Health Scheme (CGHS) in 1954, which aims to cover central government employees and their families. Both of these schemes are contributory and viewed as a means of alleviating the financial burden from the national health service to some degree. In 1997, the Railway Employee Scheme was established, and there are also smaller contributory schemes run by public sector enterprises, government departments and sectoral welfare boards. Furthermore, a gradual opening of foreign investment in insurance products and increased economic liberalization led to the introduction of private health insurance markets.

From 2008 onwards, several states in India, acknowledging health care as an increasing financial burden on households, launched various health protection schemes which mainly provided coverage for costly inpatient services. At central level, the Government of India also acknowledged the need for such a scheme and launched the non-contributory Rashtriya Swasthya Bima Yojana (RSBY) scheme in April 2008, which covered families below the poverty line up to a certain financial threshold, mostly for inpatient and costly outpatient care (Karan, Yip and Mahal 2017). After close to 10 years of implementation, the RSBY scheme was remodelled as PM-JAY, which consists of two inter-linked components: Health and Wellness Centres (HWCs), which aim to provide universal access to primary health care (PHC) and Pradhan Mantri Jan Arogya Yojana (PM-JAY), which covers secondary and tertiary health services. The scheme increased the financial ceiling for

inpatient services by more than ten times that of RSBY, and managed to consolidate the majority of smaller schemes run by state governments at the provincial level. This has facilitated the development of a large and common social health protection scheme, which aims to cover 500 million individuals across the country.

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► Design

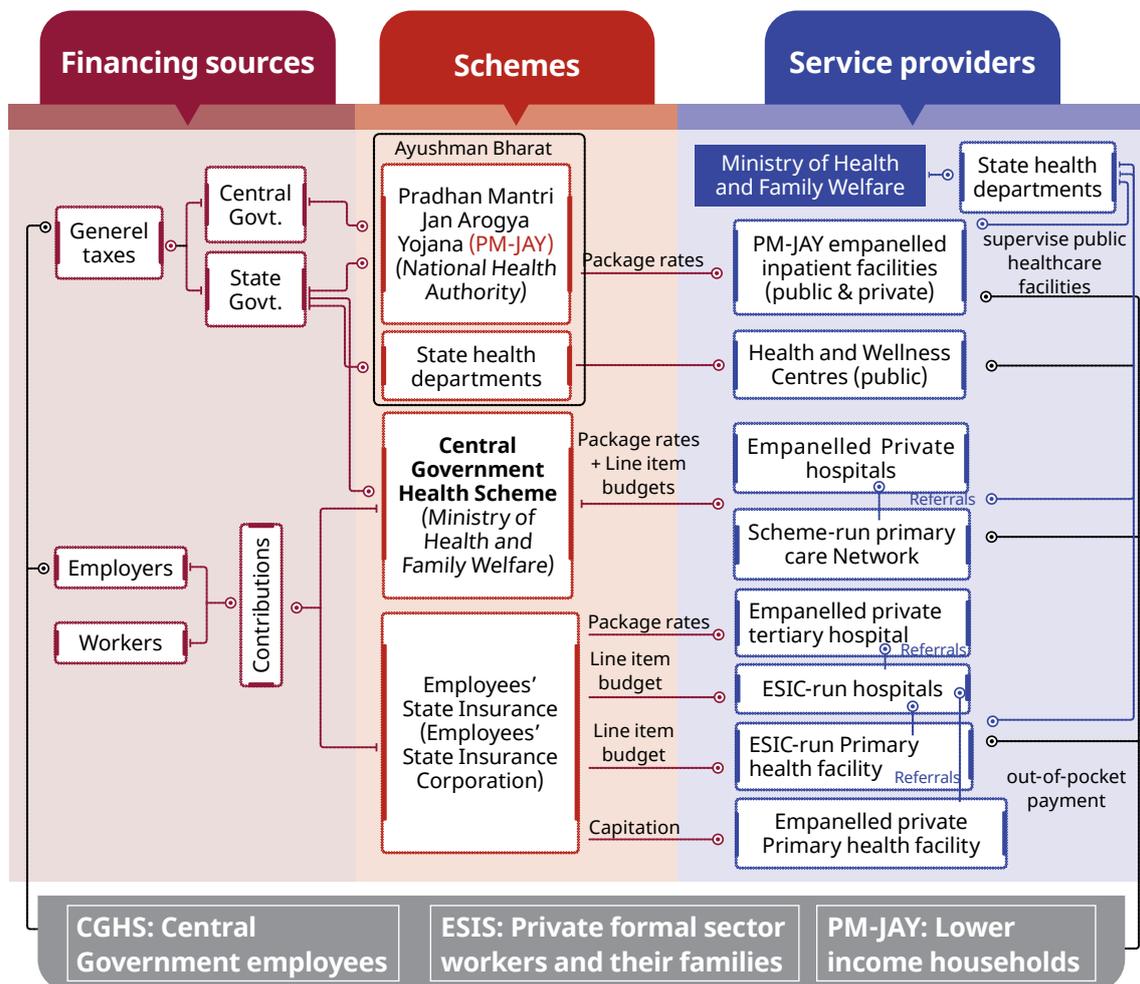
Financing

Financing remains highly fragmented in India. Although public facilities receive general budget allocations from central and state governments and several contributory and non-contributory schemes exist, a large proportion of health expenditure in India is comprised of out-of-pocket (OOP) payments. According to the latest available data, OOP payments by households accounted for 62 per cent of health expenditures in 2017, while domestic general government health expenditure accounted for 27 per cent, and 10 per cent was attributed to other private sources (WHO n.d.).

The non-contributory PM-JAY scheme is financed predominantly through shared resources from central and state governments for supporting low-income households, mainly covering hospital level care. However, for outpatient care, a large proportion of financing is paid for directly by households, the costs of which are driven in large part by drugs and diagnostics (NHA Technical Secretariat 2019).

Figure 1.1 below schematically illustrates the structure of the overall system and the relevant financial flows.

Figure 1.1: Structure and financial flows of the social health protection system in India.



Governance

Parallel governance structures exist to oversee social health protection in India. The Employees' State Insurance Corporation (ESIC) is an autonomous body under the Ministry of Labour that oversees the implementation of Employees' State Insurance Scheme (ESIS). Policy level governance of ESIS falls under the oversight of three major committees, namely the ESIC, the Standing Committee and the Medical Benefits Council. In addition to government and ESIC representatives, these structures also include the participation of employer and employee representatives from covered industries and sectors. Representatives of insured workers and registered enterprises are involved in the overall stewardship of the scheme, as well as in major policy decisions affecting the structure and operations of the ESIS.

The CGHS is governed by a dedicated department under the MOHFW, while the Railway scheme is governed by the Ministry of Railways. In the case of PM-JAY, the National Health Authority (NHA) takes on a stewardship role, providing necessary guidelines and policy decisions that inform the evolution of the scheme. Public facilities and health service provision is stewarded by the MOHFW, though the majority of responsibility vis-à-vis governance and oversight is the purview of state health departments. While the MOHFW can provide guidelines, public health service provision in India is constitutionally decentralised, falling under the mandate of individual state governments.

CGHS and ESIS have both set up dedicated grievance redressal mechanisms to ensure transparency and accountability. Moreover, ESIS has mechanisms in place for ensuring accountability among providers through the use of regular monitoring processes, such as facility visits and reviews. In addition to these monitoring visits, a vigilance unit is in place at the ESIC headquarters to ensure that providers and ESIS officials are held accountable in the event of any transgressions. PM-JAY has also instituted a detailed transparency and accountability mechanism through a grievance redressal system with a chain of command that goes down to the

CGHS and ESIS have both set up dedicated grievance redressal mechanisms to ensure transparency and accountability. Moreover, ESIS has mechanisms in place for ensuring accountability among providers through the use of regular monitoring processes, such as facility visits and reviews

district level. The scheme has also implemented anti-fraud units at Central and State level to ensure that providers and other PM-JAY officials are held accountable for their actions. Detailed medical and facility audits are also undertaken to monitor and oversee functioning and performance of empanelled hospitals.

Legal coverage and eligibility

The social health protection schemes in India are targeted in terms of their beneficiary coverage and are predominantly mandatory for the defined target beneficiaries of each scheme, the scope of which has mostly been limited to the formal sector and the poor. While CGHS covers central government employees (targeting 3 million beneficiaries), the ESIS covers lower-income workers in non-seasonal enterprises, shops and establishments (targeting 135 million beneficiaries), with recent efforts to expand to the informal sector. Notably, through the new Social Security Code passed in 2020, the scope of coverage for ESIS has been expanded to cover some new categories of informal workers.

¹ The Constitution of India 1949 (amended 2020), available at: https://legislative.gov.in/sites/default/files/COI_1.pdf

PM-JAY aims to cover 500 million beneficiaries, the majority of whom are lower-income households as defined by the Socio-Economic and Caste Census (SECC) of 2011. While the scheme is not mandatory, individuals and households that are listed under the SECC 2011 are automatically enrolled into the scheme and can be enrolled at facilities directly after verification of their eligibility.

Benefits

Benefits provided under each scheme vary. CGHS and ESIS aim to provide comprehensive health coverage, though the degree to which they effectively manage to do so is not clear. Maternity services are included under both CGHS and ESIS, together with other National Programme services such as treatment for HIV and tuberculosis, family welfare and immunization. In comparison, PM-JAY is more limited in the benefits it offers in terms of inpatient services. While pre- and post-hospitalization services are part of the package, unlike the other two schemes, PM-JAY does not include primary and general outpatient services.

Provision of benefits and services

CGHS and ESIS differ in the network of providers they utilize to deliver services to their beneficiaries. However, neither CGHS or ESIS implement a provider-purchaser split for the majority of service provision. CGHS provides primary care through its own network of clinics (through line item budgeting) across selected cities in India. Inpatient services under CGHS are provided by a network of private hospitals empanelled under the scheme, and package rates have been established over time. However, the modes and frequency of formal costing or structured revision of these packages is unclear. A strict referral system is in place to regulate traffic of in-patients to secondary and tertiary public and private empanelled providers.

ESIS also provides primary care predominantly through its own network of facilities based on line item budgets, and some private primary care provision is paid through capitation payments. Similarly, inpatient care is provided through own its internal network of facilities as well as through a pool of empanelled public and private providers.

This internal network is managed and run directly by ESIC in some locations (model hospitals) and by state governments in other cases. In the case of specialized procedures (Super Specialty Treatment) and in areas where ESIS's own network is not present, ESIS leverages a network of empanelled private facilities (comprising 1500 facilities), wherein rates are on par with current CGHS rates. Referrals from primary to inpatient care are in place in principle, though the degree to which this gatekeeping system is effective is uncertain. However, there is a strict referral system in the case of utilization at private facilities to help ensure cost control.

In the case of PM-JAY, there is a clear purchaser-provider split, as public and private facilities are empanelled based on pre-defined criteria, with similar governance oversight and monitoring in place. Package rates were arrived at through expert consultations prior to the launch of the scheme, though it has often been claimed by the private sector that the rates provided tend to under-estimate the cost of provision in the private sector (Press Trust of India 2019).

India's social health protection schemes are all working towards developing robust IT and digital solutions to improve their access and performance. While information on CGHS remains limited, ESIS has developed an integrated IT reform through the initiative, Project Panchdeep, which implements various dedicated modules to address issues of inter-facility connectivity, patient medical records, data management and so on (ESIC 2020). PM-JAY has also been instrumental in pushing for a digitized social health protection ecosystem wherein all aspects of scheme functioning, including beneficiary identification, transaction management and fraud detection are undertaken through elaborate IT modules devised for specific purposes.

► Results

Coverage

The social health protection landscape of India is made up of many fragmented efforts to cover specific population groups. Through the CGHS, ESIS and PM-JAY schemes, combined with several smaller schemes run by public sector units, it is estimated that close to half of the Indian population should be covered to some extent for utilization of health services (albeit in a fragmented manner) in the coming years. Among the contributory social health insurance schemes in India, the CGHS, ESIS and Railway schemes are among the largest in terms of coverage. The PM-JAY, on the other hand, is the largest non-contributory, tax-financed scheme.

At the federal level, ESIS and PM-JAY are the largest schemes in terms of coverage. ESIS covers 135,700,000 workers and their families, and PM-JAY covered 126,300,000 beneficiaries in 2020, representing about 10 per cent of the population, with rapid expansion towards meeting its 500 million target. Within PM-JAY specifically, there is limited dynamism vis-à-vis ensuring effective coverage of potential beneficiaries due to the use of a retrospective database, which may not reflect changes in household economic conditions. Therefore, it is likely that several households who may have fallen down the economic gradient and are eligible for PM-JAY are excluded due to the reference database deployed for coverage.

While India has made great strides in expanding population coverage of health services, there remains a lot to be done in terms of further expanding scope and depth of coverage. With regard to the former, it is noteworthy that despite the large number of persons covered under each scheme, more than half of India's population still remains unaffiliated to a social health protection scheme. This is especially prevalent among the informally employed and self-employed, though policy discussions are underway as to how to reach this "missing middle" group.

Adequacy of benefits/ financial protection

As previously noted, sources of revenues for health in India are highly fragmented, with the largest share of health expenditures (around 62 per cent) comprised of OOP payments paid directly by households. Prior to the advent of PM-JAY, risk pooling was very low, with less than 35 per cent of the population participating in a risk pooling scheme and less than 10 per cent covered by a functioning risk pooling mechanism that provides effective protection against catastrophic events (NITI Aayog 2019). The high level of OOP expenditures reflects this lack of risk pooling, and the absence of a single monopsonic purchaser defining input and outcomes. This deficiency means that providers tend to have the upper hand vis-à-vis price setting and determining the level and quantum of care provided, with profit maximization prioritised, and non-coverage of post-hospitalisation care being the norm.

Each pool acts as a health service purchaser, and with this level of fragmentation, every pool has limited leverage with providers. With few exceptions, both public and private schemes in India use less effective provider payment mechanisms, with line item budgets predominating in the public sector and fee-for-service prevalent in the private sector. Limited leverage and the lack of performance/output-based payment mechanisms severely hamper the capacity of these pools to act as strategic purchasers. As a consequence, they behave mostly as passive payers. Ultimately, this situation impedes financial protection of beneficiaries.

In addition, the levels of financial protection offered by the existing schemes vary. In the case of PM-JAY, there has been a significant improvement in this regard compared to the previously implemented RSBY scheme, but some design elements traditionally associated with private commercial insurance (such as ceilings) persist (Dror and Vellakkal 2012). While ESIS offers high levels of cost coverage, in practice, beneficiaries have reported that financial protection is greater in

ESIS facilities, while contracted facilities, especially those in the private sector, tend to charge more. Lastly while efforts have been made to reduce financial barriers to maternity protection, delivery in particular remains costly for most women in India. With financial barriers tending to have a gendered impact, efforts are needed to improve awareness and entitlements to RMNCH (Mohanty et al. 2020).

Responsiveness to population needs

Availability and accessibility

Improving access to services in India remains a challenge (Ranga and Panda 2014). Overall, the fact that each scheme has its own provider network, does not result in optimal access for beneficiaries. Challenges in accessibility are evidenced by the very low levels of utilization witnessed across facilities under ESIS (0.37 outpatient visits per beneficiary as of 2017-18, compared with 5 per beneficiary in China) (ESIC 2018). This challenge may well relate to the lower number of beds and physicians available per capita, with ESIS providing only 0.6 doctors per 10,000 beneficiaries compared to an Indian average of approximately seven (computed by authors from ESIC Annual Reports). Furthermore, beneficiaries have reported that, while family members working in urban areas have access to ESIS or empanelled facilities, geographical access is much more limited for family members in rural areas, which is a very common situation among industrial workers. This concern was raised by the results of ESIS beneficiary surveys (Verma et al. 2013). As for PM-JAY, empanelment and retention of private facilities remain challenging due to limited availability and involvement of facilities, which obstructs access to care.

There have also been concerns expressed around administrative barriers to accessing care, as evidenced by the beneficiary survey conducted by ESIS. These concerns relate to the ability of employers and employees to comply with the reportedly work-intensive, administratively challenging registration requirements and reimbursement procedures (issues that are currently being resolved as part of ESIS's transition to a more digitized process framework). Beneficiaries participating in the ESIS survey also reported gaps in knowledge of their benefits and

how to avail of them in some cases. As a means of addressing this, ESIS undertakes a host of activities to increase awareness of the scheme among beneficiaries. This includes outreach and media campaigns (online and offline) as well as information provided at ESIS facilities. PM-JAY also carries out a large variety of communication and awareness activities for the scheme. In addition to using public sector front line-worker cadres to disseminate information on PM-JAY, the scheme also uses media campaigns, and has designated Pradhan Mantri Arogya Mitra (PMAM), who serve as provider-level facilitators to inform beneficiaries of scheme details, and navigate them through the process of utilizing covered services. However, communication and awareness activities under CGHS remain limited.

Quality and acceptability

Some recurrent challenges in providing social health protection in India relate to quality of services (Central Bureau of Health Intelligence 2019). Concerns have been expressed regarding the lack of comprehensiveness of the schemes, namely the exclusive focus on inpatient services under PM-JAY, and concerns about adequate accessibility to and quality of health services offered under the formal sector schemes. Furthermore, over-prescription of drugs, especially antibiotics, as well as overtreatment (such as unnecessary injections) are rampant in both public and private sectors, and appear to be worse in rural settings and among private providers. Issues including supplier-induced demand for drugs and care, and a lack of standard treatment practices create an environment in which over-prescription and unnecessary treatments flourish.

To compound this problem clinical protocols or guidelines are generally absent or unavailable, and even when they are available, non-compliance with diagnostic and therapeutic standards is high (Karan et al. 2019; Rao et al. 2011). This not only impacts the quality of services provided but also increases spending on health, including OOP spending among households and costs of the SHP schemes. While MOHFW efforts to increase regulation of private provision have been made, it remains difficult to control the majority of health care provision in India; the existence of many informal providers makes effective regulation of the sector particularly challenging (Kasthuri 2018; Roy 2021)

▶ Main lessons learned

- ▶ To achieve the commitment of the National Health Policy of 2017 to increase government health expenditure as a percentage of GDP to 2.5 per cent by 2025, the Indian Government needs to take bolder steps towards increasing public funding of the health sector and improving health care service quality and access. The increased allocation of 1.8 per cent of GDP to health in line with the most recent budget announcement is commendable in light of the limited availability of fiscal space resulting from the economic impacts of the ongoing pandemic. However, there is a need to ensure sustained commitment to the health sector in the years ahead. Ensuring health as a central policy goal will help to ameliorate chronic issues around service quality, utilization and the high OOP financial burden faced by Indian households.
 - ▶ Strong governance is crucial to enabling universal health coverage and achieving progressive realization of effective social health protection. Solid regulation, supervision, accountability and enforcement mechanisms at all levels are urgently needed to address the insufficient performance of the system and to facilitate the expansion of existing social health protection schemes so that they can effectively protect the population from the financial risks related to ill health.
 - ▶ A rights-based approach needs to be prioritized. Currently, the PM-JAY Scheme and many other publicly funded schemes have only limited legal grounding and are insufficiently institutionalized, which could explain the weak regulation and enforcement of the benefits provided under these schemes.
 - ▶ A solid social health protection system, which is an intrinsic feature of comprehensive social protection, can contribute to improving health outcomes while reducing the risk of impoverishment linked to catastrophic health care expenditures. This, in turn, contributes to increased economic productivity and national income. While different health protection options exist in India, there is considerable scope to expand upon ongoing efforts by increasing risk pooling across these multiple schemes. Reducing the fragmentation across pools and/or adopting common design features across pools would ensure: (i) greater leverage for price setting by a single purchaser; (ii) a uniform benefit package in the interests of equity; (iii) standardized quality of care tied to appropriate financial incentives; and (iv) increased access to care for the population in an equitable manner.
-

▶▶ **The Indian Government needs to take bolder steps towards increasing public funding of the health sector and improving health care service quality and access.**

► Way forward

Several changes are afoot in terms of increasing coordination between social health protection schemes and streamlining their operations. Most recently, ESIS and PM-JAY have agreed to align and share their respective networks of health service providers to enable greater access for beneficiaries of both the schemes, resulting in an overall increase in access to services (FE Bureau 2021). The need to expand health coverage to the missing middle in India and adopt a more universal approach to social health protection has also been widely acknowledged, as exemplified by the National Health Policy 2017. This may pave way for a potential convergence or even a merger of multiple pools to ensure uniform access and greater efficiency in purchasing decisions and governance flows. Better channelling of resources into formal risk pools (governed and operated by institutional purchasers), and better integration of such pools (through an aligned set of regulatory rules and/or a merger) would greatly increase leverage over providers, as well as facilitate the development of provider payment innovations. This development will be essential for setting incentives for provider integration and consolidation (NITI Aayog 2019).

While no specific laws have been conceived to promote progress towards universal coverage, other important legal precursors are in place, the implementation of which will influence the degree to which India can transition towards universal health coverage. Specifically, the pan-India implementation of the Clinical Establishment Act will help to regulate private sectors vis-à-vis their allocation of funds for infrastructure under the National Infrastructure Pipeline (NIP), outlined in the latest budget. However, a lot more investment will be required to truly bridge access and availability gaps (Roy 2021). Some key policy level steps are required to advance social health protection and improve efficiency and effectiveness of existing schemes, as follows:

1. Develop a vision and its implementation pathway to universalize social health protection coverage.
2. Streamline risk pooling and strategic purchasing to de-fragment financial flows and build a pathway for expanding financial coverage for all.
3. Organize the mixed health care delivery system into an accountable, affordable, high-quality system aligned with public objectives.
4. Reimagine India's digital health landscape and improve availability of data, including analysis of existing data for clinical, epidemiological, financial and administrative improvement.

In addition to these measures, there is a need for social health protection schemes to adopt a greater focus on preventive and primary care, in addition to inpatient services. This is particularly important given that the prevalence of non-communicable diseases (NCDs) such as diabetes and stroke have substantially increased as drivers of mortality in the last decade. Moreover, ischemic heart disease (IHD) continues to prevail as the most significant burden of disease, with a substantial increase in its proportionate contribution to mortality (Dandona et al. 2017). All of these conditions could be handled and managed at the primary care level, through which active engagement with the community in prevention, management and treatment of risk factors would contain disease progression.

In addition to the clinical burden of NCDs, they also place a large economic burden on the country. It is estimated that, due to five NCDs alone, India will suffer an economic loss of US\$4.58 trillion between 2012 and 2030, accounting for nearly double India's GDP in 2016 (Bloom et al. 2014). Despite a nationwide shift toward NCD treatment, in some

states, especially those in the Empowered Action Group (EAG), the rapid increase in the prevalence of NCDs is coupled with an unfinished agenda in infectious diseases and maternal, newborn and child health conditions. In this context, in addition to the focus needed to curb the NCD-related burden, it is important that efforts are made to sustain and improve maternal and child health outcomes.

Another important demographic consideration for the future is the ageing population of India. While a “demographic dividend” in India has been touted, declining fertility rates and an increase in life

expectancy will result in an older population within a decade or two, which will require a substantially larger share of available health care resources. Today, 9 per cent of the population, accounting for over 116 million adults, are 60 years or older; by 2050, the population share of this age group will grow to 19 per cent. Furthermore, the proportion of adults aged 80 and over is projected to triple to 3 per cent by 2050, putting an additional strain on health protection schemes and the system at large to cater to the health needs of this large population group (Agarwal et al. 2016).



► Table of statistical indicators

Table 1.1: Statistical indicators: India

Indicator	Value	Year
Number of inhabitants	1,380,004,000	2020
GDP per capita	2009.98	2018
GDP growth (%)	6.8	2018
Life expectancy at birth	69.4	2015–2020
Proportion of informal employment in non-agricultural employment - Harmonized series (%)	88.6	2018
Poverty rate (Poverty headcount ratio at US\$3.20 a day (2011 PPP) (% of population))	60	2011
Poverty rate (Poverty headcount ratio at \$1.90 a day (2011 PPP) (% of population))	13.4	2015
Total Health Expenditure (THE) as a % of GDP	4	2017
Domestic General Government Health Expenditure as % Gross Domestic Product	1	2017
Domestic General Government Health Expenditure as % of THE	27	2017
International public health expenditure (aid) as % of THE	NA	
Out-of-Pocket Spending as % of THE	62	2017
Current Primary Health Care expenditure as % of Current Health Expenditure	44	2016
Social Health Protection legal coverage, in % of the population	NA	
% of the total population affiliated to a scheme (protected persons) (should be equal to the sum of inventory of schemes)	Approx. 480 million (Estimated)	Various years
Health service coverage index (SDG 3.8.1)	55	2017
Utilization of health care services disaggregated by IP/OP care (if available)	NA	
Antenatal care coverage – at least 4 visits	51.2	2010–2016
Proportion of births attended by skilled health personnel (SDG 3.1.2)	81%	2016
Maternal mortality ratio (per 100 000 live births)	145	2017
Under 5 mortality ratio (SDG 3.2.1)	36.6	2018
SDG 3.8.2 – Incidence of catastrophic health spending - at more than 10 per cent of total income or consumption	17.33	2011
SDG 3.8.2 – Incidence of catastrophic health spending - at more than 25 per cent of total income or consumption	3.9	2011
SDG 1.1.1 – Impoverishment due to health spending (Population pushed into below the \$3.2 a day poverty line due to health spending) (%)	4.44	2011

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▶ Social Health Protection in INDONESIA

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▶ Introduction

With the enactment of the 2004 Law on the National Social Security System and the Law No. 24 of 2011 on the Social Security Administrative Body, the Government of Indonesia has made a strong commitment to achieving universal health coverage (UHC). In 2012, the National Social Security Board, Dewan Jaminan Sosial Nasional (DJSN), and the Ministry of Health laid out a road map to an integrated social health protection (SHP) system and the establishment of a Social Security Administrative Body for Health (BPJS Kesehatan). In 2014, all previously fragmented health schemes were merged into a single-payer system, to be managed by BPJS Kesehatan. The national health insurance scheme, Jaminan Kesehatan Nasional (JKN) is currently one of the largest single-payer systems in the world, with around 223 million members as of 2020. Since its implementation, it extended social health insurance coverage to more than 82 per cent of the total population. However, the last mile towards universality has proved to be a significant challenge, particularly with regard to ensuring coverage for workers in the informal economy and their families.

▶▶ The national health insurance scheme, Jaminan Kesehatan Nasional (JKN) is currently one of the largest single-payer systems in the world, with around 223 million members as of 2020. Since its implementation, it extended social health insurance coverage to more than 82 per cent of the total population.

► History

The social health insurance system in Indonesia has evolved and has seen significant reforms. The oldest social health insurance scheme, Askes, started in 1968 provided coverage for certain population groups, namely civil servants, military and police personnel, retired government workers, veterans and their families. In 1992, the social insurance scheme Jamsostek (covering health, old-age and work injury) was set up for employees of private companies (with more than ten employees and paying salaries greater than IDR 1 million (USD 71) per month per employee). However, coverage of these schemes was continuously low at 7% and 5% of the population in 2013, respectively (JKN 2019).

In 2005, the Jamkesmas scheme was launched to provide coverage for the poor and near-poor. It covered more than 76 million people in 2013 (32.2% of the total population) that could access health services at public primary healthcare facilities and selected public hospitals with no co-payment. While the scheme was successful in increasing utilization and reducing catastrophic expenditure, significant supply-side constraints and inequities in the availability of services persisted (Harimurti et al. 2013).

In 2014, Indonesia's national social health insurance scheme, JKN, consolidated all previously fragmented social health insurance schemes and assistance programmes at national and provincial levels, after citizens brought legal actions to hold the government accountable to implement the 2004 law on the National Social Security System. The merger of Indonesia's SHP system and move to a single-payer system have allowed for significant coverage extension. The scheme is compulsory for all residents, including foreigners who have been working in the country for at least six months. JKN is funded by member contributions and government subsidies for the poorest 40 per cent of the population. The scheme covers around 223 million members as of 2020 (BPJS 2020).

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► Design

Financing

While domestic public health expenditure has steadily increased since the introduction of JKN, standing at 48% of current health expenditure (CHE) in 2017, OOP payments, paid directly by households to public and private service providers, accounted for more than a third of total health expenditure. Domestic public expenditure comprises both general government revenues (36% of total health expenditure) and social health insurance contributions (representing respectively 13% of total health expenditure in 2017) (PPJK 2018). The remaining health expenditure is made up of private health expenditure (16% of CHE) and OOP (34% of CHE).

The JKN is financed by central and local government revenues and social security contributions. For salaried workers, 4% of their monthly payroll is paid by the employer and 1% by the workers, while non-salaried workers (informal sector) and non-workers pay a fixed contribution based on their choice of inpatient ward class² (BPJS 2020).

Governance

The JKN scheme is implemented and managed by the BPJS Kesehatan – a not-for-profit trust fund, legally independent entity directly controlled by the President of Indonesia. Under the supervision of MoH, BPJS Kesehatan is responsible for the enrolment of beneficiaries, collection of contributions, management of claims, processing of payments to healthcare providers, and administering contracts with providers. The National Social Security Board, Dewan Jaminan Sosial Nasional (DJSN), was established as an autonomous and tripartite board with 15 members by the President of Indonesia. It formulates social and health protection policies and oversees the performance of BPJS Kesehatan. As an independent body, it reports to the President

of Indonesia. However, in terms of administration and budget, it is located under the Coordinating Ministry for Human Development and Cultural Affairs (Prabhakaran et al. 2019).

Coverage

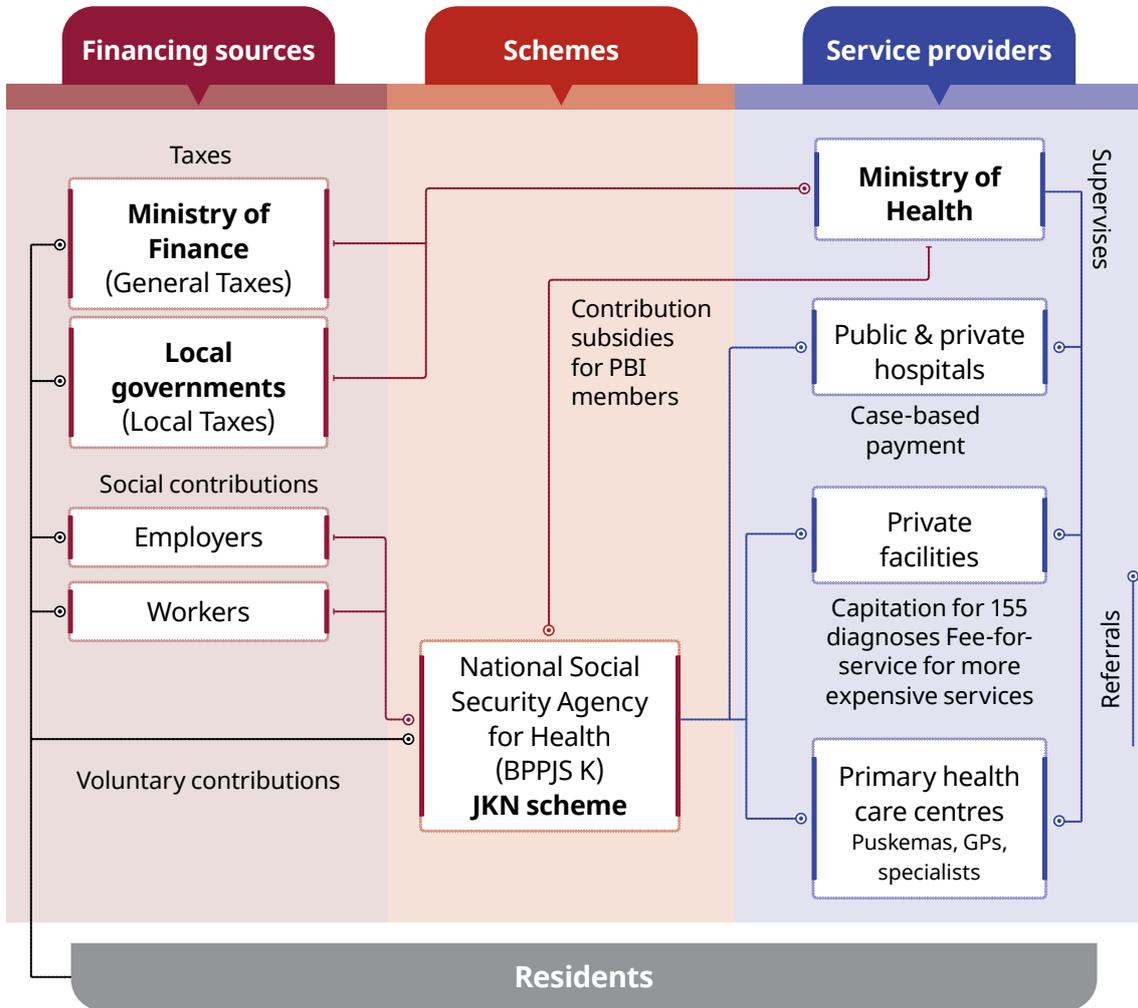
Registration to the JKN scheme is compulsory for all residents, including foreigners who have been working in the country for a minimum of six months. The main categories covered by the scheme include: i) salaried workers whose contributions are shared with employers, ii) non-salaried workers and non-workers who pay a flat contribution and iii) poor and vulnerable population (40% with the lowest income) whose contributions are fully subsidized. Coverage for dependents is possible for all member categories. As differentiated deadlines were set for implementing mandatory coverage, in practice for some population groups (such as informal economy workers) registration remains voluntary. As of 2020, JKN covered 223 million members (equivalent to 82% of the total population), compared to 133,420,000 people covered in 2014 (BPJS 2020).

Benefits

Currently, the JKN scheme provides a unique, broad benefits package to all members. Other differences persist, for instance, the ward type where members' access to services differs between membership groups, but not the services covered. Salaried workers are entitled to Class 1 or 2 wards, subsidized members can access only Class 3 wards and informal economy members can access services in all wards depending on the contribution paid. However, the number of available health care facilities varies among regions, leading to inequitable outcomes with respect to access to health care.

² According to the Presidential Regulation 82/2019, there are different monthly contributions for workers in the informal economy based on ward level: I – IDR 42,000; II – IDR 110,000; and III – IDR 160,000.

Figure 2.1: Financing flows



Note: **PBI APBN:** Subsidized segment (national level, based on the unified database); **PPU BU:** Formal private sector; **PBI APBD:** Subsidized segment (local level, transferred from Jamkesda); **PPU P:** Public sector workers; **PBPU:** Informal sector workers

Members of JKN are entitled to comprehensive coverage of health promotion; preventive, curative, and rehabilitative medicine services; medically indicated laboratory tests, drugs, and supplies; and ambulance services for referrals (Prabhakaran et al., 2019). The establishment of the JKN was also used as an opportunity to include both HIV and tuberculosis (TB) diagnostic and treatment services in the benefit package, while those were managed vertically outside the social

health insurance system before (Health Policy Plus 2018). The policy reform opened an avenue for greater integration of HIV and TB in this respect.

Provision of services

The BPJS facilities network includes 27,075 public and accredited private facilities registered with BPJS Kesehatan as of 2020. As of 2017, 60 per cent

out of all BPJS Kesehatan contracted facilities were private, and the private health sector grew faster than the public one (Gani and Budiharsana 2019). Primary health care (PHC) facilities typically provide outpatient services only, including consultations, medications, and some diagnostic testing and screening (Gani and Budiharsana 2019). More complex services and most inpatient services are only available at the hospital level (Agustina et al. 2019). JKN members are initially registered at the PHC of their choice, usually, one that is close to where they live based on the address on their e-ID card. For some subsidized members, the choice of PHC may have been decided based on the district as it is based on DTKS. In line with international good practices, patients are covered only for specialist care after a primary care provider has given them an appropriate referral (Agustina et al., 2019).

Under the JKN scheme, there are three types of provider payment methods: capitation for primary health care for 155 diagnoses, fee-for-service for high-cost services not paid by capitation for more onerous interventions, and case-based payment rates (INA-CBG) for hospital services that vary by hospital level and region (Prabhakaran et al., 2019).

Communication & awareness

Given the size of Indonesia, the distances between people's homes and BPJS Kesehatan offices are often considerable, making it difficult for people to access the offices to receive information on the scheme and enrol. Opportunity costs (in terms of working time loss) can be a particular challenge for self-employed workers. A particularly noteworthy initiative in this context is the Kader JKN partnership programme which aims to facilitate access to social health insurance for informal economy workers and other individuals through selected members from the closest communities. The Kader JKN agents mainly perform four functions: outreach and communication; enrolment of new members; a collection of contributions and their transfer to the scheme; and handling of complaints. Candidates must fulfil certain criteria (e.g., domicile near the area of the target group, registration for online banking) to qualify as Kader JKN agents. While BPJS acknowledges that

there are potential risks in ensuring appropriate accountability and control mechanisms in such a programme, the programme increased the contribution collection rate by about 14 per cent from 2017 to 2018, thanks to a total of 2,000 active agents who managed two million members (Nguyen and Cunha 2019). Moving forward, BPJS Kesehatan aims to harness new technologies and further develop Mobile JKN, a mobile application that allows members to register, pay monthly contributions, submit complaints and access information.

Under the JKN scheme, there are three types of provider payment methods: capitation for primary health care for 155 diagnoses, fee-for-service for high-cost services not paid by capitation for more onerous interventions, and case-based payment rates (INA-CBG) for hospital services that vary by hospital level and region (Prabhakaran et al., 2019).

► Results

Population coverage

JKN has achieved legal coverage of the entire resident population and since its introduction, effective affiliation coverage has also continuously improved, particularly among the poor. As of 2020, the population at the lower end of the income stream, whose contributions are fully subsidized, makes up around 60 per cent of all JKN members³. There remain challenges to the extension of effective coverage, particularly to those working in the informal economy (the “missing middle”). Only 13.6% of all members are registered under the non-salaried worker segment, although around 60% of the labour force is self-employed (Statistics Indonesia 2018). Many of these workers may not be poor enough to qualify for subsidies, but they may also not be able to pay regular contributions on their own. In fact, three-quarters of the top 60% of the income distribution work informally (OECD, 2019). Even when they are enrolled, irregular collection of contributions results in coverage gaps.

Financial protection

Although some progress was made with regard to financial protection since the introduction of the JKN, out-of-pocket spending remains quite high at 32 per cent of the current total health expenditure in 2018, while around 2.71 per cent of Indonesian households suffered from catastrophic healthcare expenditure the same year. Possible explanations for the high out-of-pocket payments in Indonesia include the existence of informal payments directly paid by patients to health providers to avoid long waiting times or to buy medicines that are not listed on the medicine list of the JKN (GIZ 2018; OECD 2019). In addition, the high share of OOP is believed to be the result of limited geographical

accessibility of health care facilities, particularly in rural and remote areas, which forces many people to visit facilities not contracted by BPJS and pay directly for their medical care (Health Policy Plus and TNP2K 2018). Alternatively, their transportation costs increase (non-medical costs of accessing care). JKN steadily increased the number of service providers contracted (an increase of 23% between 2015 and 2018 for instance), but the geographical distribution remains uneven (Gani and Budiharsana 2019).

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³ The PBI is intended to cover roughly the bottom 40% of the Indonesian population, which is much higher than the 9.7% of the population who are below the official poverty line (TNP2K 2018).

Benefit package

The JKN benefit package is rather broad, covering health promotion, preventive, curative, and rehabilitative medicine services with few exclusions – the latter being services in health facilities that are not empaneled or contingencies already covered by other programmes, such as employment injury and traffic accidents. However, in practice, the lack of health care facilities and the inequitable quality of services across provinces limit access to the broad benefits package offered by JKN (Gani and Budiharsana 2019).

While the benefits package does include essential preventative care, the changing burden of diseases in Indonesia, with NCDs on the rise, prompts for a stringer focus in this respect. In this context, care provided in the community is of utmost importance and the fact that in 2018 only about half of the community-based health posts were properly staffed remains an important challenge to meet the needs of the population (Gani and Budiharsana 2019). Similarly, health sector assessments have suggested a bias towards the greater financing of individual health interventions (financed by JKN) rather than population ones (financed by the general budget), which are key in the eradication or systemic prevention of some diseases (such as tuberculosis, HIV, but also water-borne diseases) (Gani and Budiharsana 2019).

Utilization

Overall, the introduction of the single-payer system (JKN) with a unified benefit package has increased the utilization of both outpatient and inpatient care (Health Policy Plus and TNP2K 2018). This has not translated into significant improvements in health outcomes, for example, the maternal mortality ratio remains high, decreasing from 199 deaths per 100,000 live births in 2014 to still 177 deaths per 100,000 live births in 2017 (WHO, 2018). The under-five mortality ratio has increased from 19.1 in 2014 to 25 in 2017. In addition, inequalities persist in utilization rates between urban and rural areas as well as across socioeconomic quintiles, largely driven by the lack of available health infrastructure and health workers in rural and underprivileged areas and/or high transportation costs incurred through seeking medical care (Agustina et al. 2019).

Quality

A key challenge in the Indonesian system is to ensure equitable access to quality health services. The lack of quality is strongly linked to poorly staffed and equipped health care facilities. With regard to investments in infrastructure, in 2019, 233 districts had the minimum of one accredited public general hospital, compared with the 477 MoH target, 350 sub-districts had at least one accredited primary healthcare facility, compared with the 5,600 MoH target and less than 70% of these centres were deemed in good condition and had access to tap water (Zen and Dita 2018). Furthermore, the number of doctors per 1,000 people has remained stagnant since the introduction of JKN, standing at a very low ratio of 0.378 doctors per 1,000 people (WHO, 2017).

▶▶ In this context, care provided in the community is of utmost importance and the fact that in 2018 only about half of the community-based health posts were properly staffed remains an important challenge to meet the needs of the population (Gani and Budiharsana 2019).

► Main lessons learned

The integration of various health insurance schemes into JKN was key to accelerate the extension of coverage in Indonesia. The creation of the JKN helped to reduce fragmentation within the social health protection system by introducing a unique benefits package and a single risk pool. Through the integration of several SHP schemes and the provision of subsidies for vulnerable population groups, the government managed to scale up the new solidarity-based scheme quickly and extend coverage to 82 per cent of the total population.

A rights-based approach is essential for the operationalization of the scheme and effective access. Progress in social health protection coverage was achieved through political commitment, generated through pressure from civil society. The merger of Indonesia's SHP system was initiated after citizens brought legal actions to hold the government accountable to implement the 2004 law on the National Social Security System, which stipulated that benefits should be uniform for all members (Global Financing Facility and World Bank 2019).

Institutional integration is necessary but is insufficient to guarantee equity. Considerable inequities across geographical locations and socioeconomic groups remain in terms of the utilization of health services. The entitlement to a broad benefits package needs to be accompanied by its implementation in practice, especially with regard to increased investments in health care infrastructure and equipment, and active outreach efforts to ensure equal information across all socioeconomic groups and geographical locations about their rights and how to access the scheme.

More efforts are needed to effectively guarantee financial protection. Despite the rapid extension of JKN as well as its comprehensive benefits package, out-of-pocket (OOP) payments remain high in Indonesia, at 32% of current health expenditure in 2018. This can be explained by the limitations of the network of contracted health care providers. Lack of accessibility to health care

facilities, particularly in rural and remote areas, forces many people to visit non-contracted BPJS facilities and pay directly for their medical care. Additionally, high level of informal payments can be requested by medical facilities or professionals. Lastly, the growth in the private health sector contributes to the increase in overall expenditure and the relatively high level of OOP.

Based on Law No. 40/2004, JKN is mandatory for all. However, the Social Health Insurance Roadmap, 2012-2019 foresaw a gradual mandatory affiliation based on the size of the enterprises. **The remaining challenges of JKN to extend health coverage to workers in the informal economy show that voluntary affiliation did not lead to significant increases in coverage, confirming other national experiences across the world.** Especially when people's awareness of SHP and contributory capacities are limited, voluntary affiliation seldom encounters success. Including workers in the informal economy in the mandatory schemes, adapted to their contributory capacities, would not only be important in terms of ensuring better protection but also contribute to sustainable and equitable financing through a larger risk pool.

►► Despite the rapid extension of JKN as well as its comprehensive benefits package, out-of-pocket (OOP) payments remain high in Indonesia, at 32% of current health expenditure in 2018.

► Way forward

According to the DJSN and MoH road map, Indonesia should have achieved UHC by 2019. While much progress has been achieved since the introduction of the single-payer system JKN, the key challenges include ensuring effective access to quality care and reaching out to the missing middle. Among other measures, Mobile JKN plans to introduce an auto-payment mechanism using e-wallet accounts that facilitate payments and ensure regular payment for members without bank accounts. Based on the national ID system, BPJS Kesehatan also plans to strengthen its collaboration with the Ministry of Interior to better identify informal economy workers whose participation could be supported with government subsidies.

The integration of SHP schemes at the administrative and policy levels has also fostered linkages with the broader social protection system. Indonesia has made progress towards developing an information system underpinning the social protection system, by creating a single targeting mechanism for all social assistance programmes, namely Data Terpadu Kesejahteraan Sosial (DTKS). Such an integrated social protection information system can ensure a more equitable, responsive

and inclusive distribution of resources while also increasing efficiency and effectiveness and better serve the population.

The integration of several SHP schemes into JKN has brought Indonesia closer to its goal of achieving UHC. The allocation of subsidies to the coverage of vulnerable population groups with limited contributory capacities is particularly noteworthy. In the years to come, it will, however, be crucial to run the last mile and get to 100% population coverage to leave no one behind. Of crucial importance will be to increase the number of qualified health staff across regions to ensure a more equitable, responsive and inclusive distribution of human resources. Similarly, investments in health infrastructure are necessary to ensure the availability of PHC facilities across all regions to improve access and quality of health services. In this perspective, adopting minimum service standards to enhance the quality of health care, and increase efficiency and effectiveness can be a valuable step forward. Lastly, raising awareness among the entire population on their entitlements remain central to a well-functioning social health protection system.



► Table of statistical indicators

Table 2.1: Statistical indicators: Indonesia

Dimension	Sub-Dimension	Indicator	Latest available year	
Context	Population	Number of inhabitants	270,625,567	2019
	Population	GDP per capita (current USD)	3,894	2018
	Growth and employment	GDP growth (%)	5.17	2018
	Population	Life expectancy at birth	71.28	2017
	Growth and employment	% of workers in informal employment out of total employment	85.6	2018
	Growth and employment	Poverty rate (national poverty line)	9.88	2018
Expenditure	Expenditure	Total Health Expenditure (THE) as a % of GDP	3	2017
	Government expenditure	Domestic General Government Health Expenditure as % Gross Domestic Product	1.4	2017
	Government expenditure	Domestic General Government Health Expenditure as % of THE	48.4	2017
	International aid	International public health expenditure (aid) as % of THE	0.5	2017
	OOP	Out-of-pocket spending as % of THE	32	2018
	PHC	Current primary health care expenditure as % of Current Health Expenditure	N/A	N/A
Legal coverage	Legal coverage	Social Health Protection legal coverage, in % of the population	100%	2020
Effective coverage	Population coverage	% of the total population affiliated to a scheme (protected persons)	82%	2020
	Service coverage	Health service coverage index (SDG 3.8.1)	57	2017
	Service coverage	Utilization of health care services disaggregated by IP/OP care	N/A	N/A
	Service coverage	Antenatal care coverage – at least 4 visits	N/A	N/A
	Service coverage	The proportion of births attended by skilled health personnel (SDG 3.1.2)	N/A	N/A
	Service coverage	Maternal mortality ratio (SDG 3.1.1)	177	2017
	Service coverage	Under 5 mortality ratio (SDG 3.2.1)	25	2018
	Financial protection	SDG 3.8.2 – Incidence of catastrophic health spending - at more than 10 per cent of total income or consumption (%)	2.71	2018
	Financial protection	SDG 3.8.2 – Incidence of catastrophic health spending - at more than 25 per cent of total income or consumption (%)	0.51	2018
	Financial protection	SDG 1.1.1 – Impoverishment due to health spending (Population pushed into below the \$1.9 a day poverty line due to health spending) (%)	0.31	2015

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▶ Social Health Protection in LAO PDR

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▶ Introduction

In less than a decade, Lao PDR has made remarkable progress towards Universal Health Coverage (UHC) by expanding social health protection to the Country's vast population.

The Lao Health Sector Reform Strategy (2013-2025) was formulated in 2013 to set out a roadmap towards UHC by 2025 with a consequent increase in domestic spending on health (WHO, 2017). In its Eighth Health Sector Development Plan (Ministry of Health, 2016), Lao PDR set a target to achieve Universal Health Coverage by 2025 and set the target of 80% population coverage by 2020. The Plan also sought to address cultural, financial and geographical access barriers encountered by vulnerable groups in accessing healthcare towards a more equitable health system (WHO, 2017). Later in 2017, the Ministry of Health (MOH) and the National Health Insurance Bureau (NHIB)

introduced the NHI Strategy 2017-2020 (Ministry of Health, 2017a) to provide a clear vision and logical framework for the development of a unified National Health Insurance scheme. Finally, the Law on Health Insurance was promulgated in 2018 and became the first law on social health protection in the country, creating a legal framework for the NHI.

On this basis, the country is currently transitioning into a single national health insurance system, covering more than 92% of its population. The rapid expansion of social health protection is the result of political commitment to achieving UHC and its financing modalities.

► History

The very first pre-paid pooled fund in Lao PDR was introduced in 1995 to cover government employees and their dependents through the State Authority for Social Security (SASS) scheme. In 2001, Social health protection coverage was extended to private employees and their dependents via the establishment of the Social Security Organisation (SSO) scheme. Both schemes were managed in the National Social Security Fund (NSSF) under the Ministry of Labour and Social Welfare (MLSW). After the 2000s, health protection was further extended to informal economy workers through the voluntary and contributory Community-Based Health Insurance (CBHI, since 2002), and to the poor and vulnerable via the introduction of the fully subsidized Health Equity Fund (HEF, since 2004), under the management of the Ministry of Health. However, the population coverage for the CBHI remained rather limited, with low enrolment rates mostly due to the voluntary feature and lack of subsidies. Targeting errors of the HEF also posed challenges to the extension of social health protection to the poor and vulnerable. Consequently, only 10.8% of the population was covered by a social health protection scheme in 2008 (Ministry of Health, 2017b)

In 2010, the policy of Free Maternal Neonatal and Child Health (FMNCH) services was implemented and it contributed greatly to improving health services utilisation. However, informal payments and out-of-pocket payments remained very high, which limited the financial protection for the intended beneficiaries (ILO, 2019). Realising the difficulty in extending coverage to informal economy workers through voluntary health insurance, in 2012, the National Health Insurance (NHI) Fund was created under Decree 470/PM. The decree not only integrated all MOH and MLSW schemes into a single scheme but also introduced the provision of 50% subsidies to the contributions for workers in informal employment.

The implementation of the NHI scheme started in 2016 with the merging of the schemes under the MOH only (CBHI, HEF, and FMNCH). NHI was rapidly



rolled out to all provinces in Lao PDR in 2017. At the time of writing this report, only Vientiane capital is not included in the NHI scheme and it provides protection to the workers in informal employment through CBHI and FMNCH (ILO, 2019). In extending coverage to the uncovered, along with the merger of MOH schemes, in 2017 the government decided to adopt a tax-based financing model, which replaced contributions of informal economy workers with full public subsidies directly transferred to the NHI Fund for informal economy workers and the poor and vulnerable. These public subsidies led to a rapid expansion of nationwide coverage, in which the coverage rate reached 80% in 2018, two years ahead of the target set by the MOH in the NHI strategy (ILO, 2019). As the second step of merging of schemes, which aimed at consolidating NSSF schemes with the NHI Scheme, a pilot in the provinces of Vientiane and Sekong started in October 2018. The nationwide roll-out started in July 2019 and covered all the provinces except in Vientiane capital.

► Financing of health systems in Lao PDR

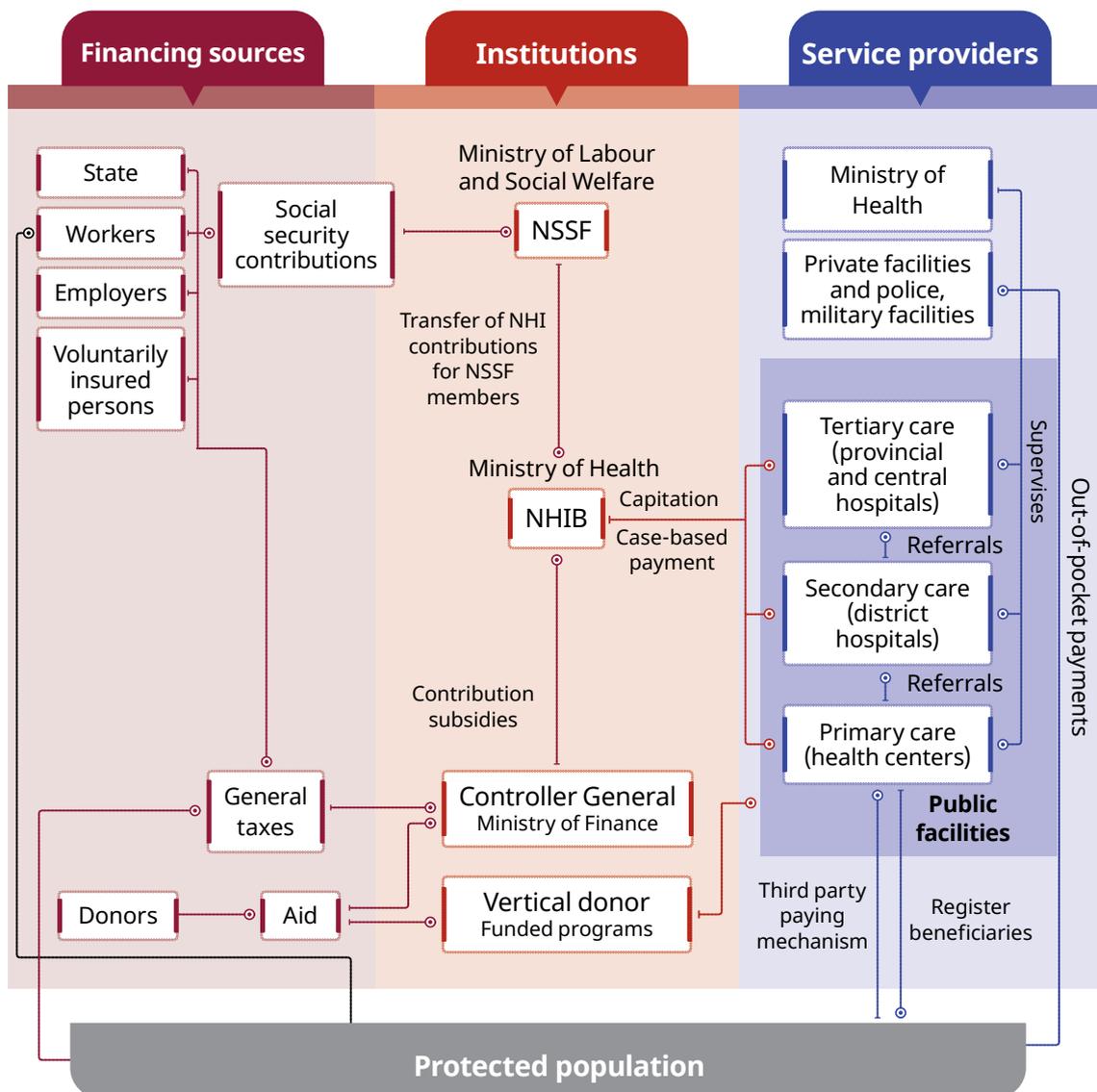
In 2017, government health expenditure accounted for 35.1% of total current health expenditure, while this share for international sources (aid/grant) was 16.7%. In the same year, out-of-pocket payments remained a dominant source of health financing, representing 46.2% of total current health expenditure (WHO, 2020).

The NHI is now predominantly tax-financed health insurance, where contributions from workers employed in the formal sector constitute a small

share of the total revenues of the NHI Scheme. In addition to taxes and member's contributions, the scheme is meant to be financed by other sources of funding such as grants, tobacco control funds and other related funds (Article 40, Law on Health Insurance 2018).

Figure 3.1 illustrates the financing flows of the NHI in Lao PDR. As suggested, except Vientiane capital all sources of funding are now pooled into the NHI fund under NHIB, which is used to pay providers.

Figure 3.1: National health insurance flows in Lao PDR



Source: Authors

► Design

Governance

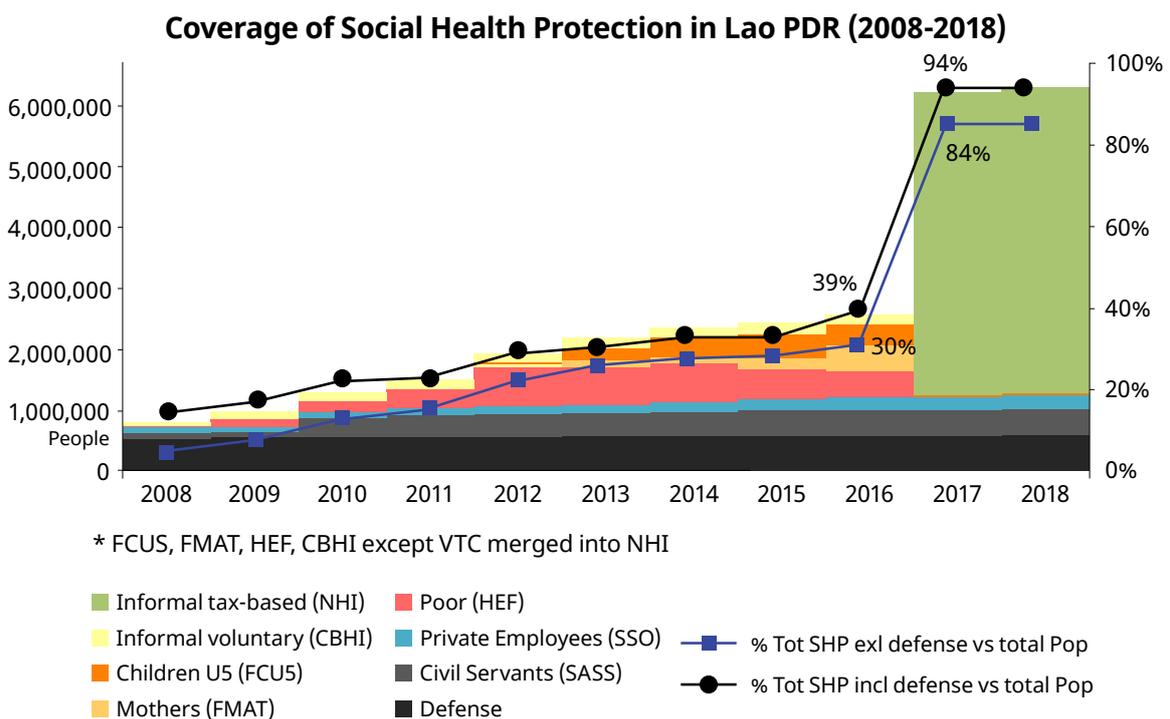
The National Health Insurance fund (NHI) is placed under the leadership of the Ministry of Health. It is managed by the National Health Insurance Management Committee (NHI Management Committee) and its Secretariat - the National Health Insurance Bureau (NHIB). NHI Management Committee is an apex body that comprises members of Management Committees at central, provincial and district levels wherein NHIB at each respective level serves as its secretariat. NHIB at the central level is a department of the Ministry of Health (MOH), in charge of all NHI functions for the entire population. According to the National Health Insurance Strategy 2017 – 2020, NHIB has to fulfil nine main operational functions to provide effective coverage: stewardship, revenue collection and pooling, financial management, interface with the public, administration, strategic purchasing, technical support, verification, and monitoring and evaluation (Ministry of Health, 2017a). Provincial and District offices are set up nationwide for daily implementation of the scheme.

The implementation of the NHI is based on Decree 470/PM (Government of Lao PDR, 2012) that was issued to provide the legal basis for the creation of a single National Health Insurance (NHI) Fund. In addition, the Law on Social Security was amended in 2018 to define social security principles and rules, protecting the rights and interests of social security fund members and their families. Since then, Lao PDR has introduced additional legal and strategic documents to guide and support the achievement of UHC.

Coverage

Owing to the introduction of the public subsidies to finance the participation of poor households and workers in the informal economy in the NHI scheme, social health protection coverage in Lao PDR has increased remarkably and reached 94.3% of the population in 2018 (according to government sources). The coverage rate has maintained this level since then.

Figure 3.2: Social health protection coverage in Lao PDR, 2008- 2018



Source: Ministry of Health, 2019

In total, NHI covered 75% of the population through tax subsidies, while SASS, SSO and the scheme for police and military forces covered 7%, 3% and 8%, respectively of the population in 2018.

The unified NHI has not been implemented in Vientiane Capital yet. CBHI (MOH's voluntary scheme for workers in the informal economy) and Free Maternal and Child Health (FMCH) programme still exist in Vientiane Capital, covering around 2% of the total population in 2019.

Membership eligibility criteria

The NHI scheme is inclusive, wherein “all Lao citizens regardless of sex, age, ethnicity, race, religion and social-economic status shall have the right to enroll in health insurance scheme”, as stipulated on the Law on Health Insurance.

NHI enrolment for workers in formal employment is compulsory via NSSF membership while there are no registration mechanisms for the rest of the population, including for the self-employed and informal economy workers, who get access to NHI insured services by showing an ID card at public health facilities.

Benefits

All NHI members are entitled to a benefits package that is rather comprehensive, covering

most health services in the public sector and at each level of care. The package is regulated by the Law on Health Insurance using a combination of both negative and positive definitions. In the negative definition, the package excludes aesthetic/cosmetic services, VIP room services (private), used at private or overseas facilities, and health services which are personal demands. It also excludes health services already covered by a third party or other vertical programmes (e.g., those that provide treatment for leprosy, HIV/AIDS, tuberculosis, malaria etc.). Using a positive definition, the Law on Health Insurance also provides the legal foundation for the consequent introduction of under-law regulations on a list of essential drugs and medical supplies as well as price caps on those services covered by NHI. NHI members can access treatment at all public health facilities in provinces where NHI is rolled out.

While the harmonization of benefits is a priority, there are still some differences in the benefits provided to members who register through the NSSF and the others. Table 3.1 compares the difference in NHI and NSSF benefit exclusions. As suggested, the NHI benefits package for the general population is broader as it covers many NSSF exemptions such as heart surgery, dialysis, thalassemia treatment, chemotherapy, and so on.

Table 3.1: NHI and NSSF benefit package exclusions

NHI exclusions	NSSF exclusions
<ol style="list-style-type: none"> Services requested by patients: VIP rooms, additional services, repair surgery, cosmetic surgery, artificial teeth, sterilization, glasses and contact lenses Services used in private facilities or overseas healthcare facilities Healthcare services covered by vertical programmes Healthcare services covered by other personal liabilities (e.g., injuries caused by traffic accidents will be covered by accident makers or accident insurance; injuries caused by dog bites will be covered by the dog owner) Transportation costs to and from healthcare facilities 	<ol style="list-style-type: none"> Healthcare services covered by government vertical programmes (TB, HIV, malaria, leprosy) Heart surgery Dialysis (not over than five times) Thalassemia Chemotherapy Glasses or intraocular lens (except work injuries or occupational diseases) Dental prosthesis except for work injuries All medicines related to the treatment of HIV/AIDS Annual health check-ups Sex reassignment surgery, artificial breeding, sterilization and plastic surgery

Financial protection

A third-party payment mechanism applies for all NHI members. The only exception is the Central Hospitals level, where referred patients need to pay first and submit a reimbursement claim to the NHI Office.

When seeking care, direct co-payments apply to NHI members, with the exceptions of members who registered through the NSSF, and Members of poor households identified by their village heads; pregnant women, children under five, and monks.

Co-payment amount depends on the level of care as follows:

- ▶ Health centres (outpatient and inpatient): LAK 5000 (approximately USD 0.55) per visit or admission.
- ▶ District hospitals (outpatient): LAK 10,000 (USD 1.10) per visit.
- ▶ Central hospitals (outpatient): LAK 20,000 (USD 2.20) per visit.
- ▶ Provincial and regional hospitals (outpatient): LAK 15,000 (USD 1.60) per visit.

“High-cost surgery and treatment” requires much higher co-payment from non-NSSF members, while a specific schedule of provider payments applies for NSSF members seeking high-cost treatment, as summarized in the table below.

Table 3.2: Co-payment for the high-cost case and risk-adjusted capitation for chronic diseases for NSSF members

Co-payment for high-cost surgery or treatment to hospitals or members.	Risk-adjusted capitation for chronic disease of 10,000 Kips per member per year.
<ol style="list-style-type: none"> 1. Brain surgery: 1,500,000 Kips per time; 2. Orthopedic surgery with steel implants: 50% of total cost; 3. CT scan, MRI, Mammogram: 50% of total cost; 4. Road accidents (in case of hospitalization): not more than 1,000,000 Kips per time; 5. Transportation cost for serious patients: 50% of total cost/time based on the actual receipts; 6. Chemotherapy not more than 6 times per year: Members pay 50% of the total cost but should not exceed 5,000,000 Kips per time; 7. Haemodialysis not over than 5 times or renal cleaning fee for patients not over than 4,000,000 Kips. 	<ul style="list-style-type: none"> ▶ Cardiovascular; ▶ High blood pressure; ▶ Diabetes; ▶ Hyperthyroidism; ▶ Hepatitis; ▶ Renal failure; and ▶ Gout

Source: Compilation Based on National Insurance Funds implementation guideline (National Health Insurance Bureau, 2016)

Network of healthcare facilities

Public health services in Lao PDR are delivered through a network of health centres, districts, provincial, central, and specialized hospitals. In addition, the military and police sectors also provide healthcare services for their own employees, their families, and parts of the local community. An increasing number of private clinics and hospitals are becoming a recognizable part of the health service delivery network in Lao PDR (WHO, 2018). Within the NHIS network, there are currently three levels of health care services:

- i. Primary health care services (health centres);
- ii. Secondary health care services (district/ community hospitals);
- iii. High-level health care services (provincial and regional hospitals);

Advanced health care services, the highest level of care provided at central hospitals and specialized centres are in Vientiane capital and hence not yet included in the NHI system. At the time of writing, only one private hospital (Xaymangkorn hospital) in Udomxay is contracted with NHIB and part of the NHI network. However, in case provincial hospitals cannot treat a patient, the latter will be

sent to the central hospital. Third-party payment does not apply, meaning that the patient will have to claim afterwards to get reimbursed by the NHI Office.

There is a referral system in place but it is not very effective (The World Bank, 2017) due to the lack of the gate-keeping function of primary health care facilities (Akkhavong et al., 2014).

Provider payment mechanisms

The NHI scheme uses a mix of payment mechanisms. Capitation is the payment method for outpatient services while the case-based method is used for inpatient services (The World Bank, 2017). The case-based method is used to pay for the free provision of maternity care services. Whereas, capitation and case-based method are respectively used to pay for outpatient and inpatient care for children under five – which are also free-of-charge for patients (The World Bank, 2017). Payment mechanisms at different levels of care are summarised in Table 3.3.

Presently, there is an embryo of purchaser-provider split where NHI Fund is the purchaser and contracted NHI facilities are service providers. Both are placed under the leadership of the Ministry of Health.

Table 3.3: NHI provider payment mechanism

Patient co-payment	Health centre	District hospital	Provincial hospital	Regional hospital
Outpatient	Capitation	Capitation	Capitation	Capitation
Admission		Case-based payment	Case-based payment	Case-based payment

Source: Authors

► Results

Coverage

The remarkable coverage expansion in Lao PDR has been enabled by the increased budget allocation to subsidize the enrolment into social health protection schemes of workers in informal employment as well as the poor and the vulnerable. In just one year from 2016 to 2017, population coverage of social health protection has expanded exponentially from 31% to 91%.

However, challenges remain in maintaining this coverage rate. Inadequate and erratic budget allocation by the Ministry of Finance has been observed recently, posing a major threat to the financial sustainability of the NHI and transferring financial risk to health facilities. This may have important implications for the continuation of contribution subsidization, and the level of protection provided to workers in the informal economy as well as the poor, and the vulnerable.

Utilization

There has been an increase in the utilisation of maternal care services over the last ten years. Between 2011 and 2017, skilled birth attendance increased significantly, from 37.5% in 2011 to 64.4% in 2017 (Lao Statistics Bureau, 2018). This translated into significant improvements in outcomes, such as maternal mortality ratio and early childhood mortality ratio. In particular, the maternal mortality ratio, measured as the number of deaths per 100,000 live births, plunged from 272 in 2011 to 185 in 2017 (WHO, 2020). The under-five mortality ratio decreased from 58.9 to 47.3 per 1,000 live births between 2013 and 2018 (WHO, 2020). However, in general, utilization of healthcare services in Lao PDR remains relatively low as the utilisation rates of NHI members for out-patient care and in-patient care are only 53.9% and 5.6%, respectively (ILO, 2019). Healthcare utilization among NSSF members is much higher than that of NHI members. According to NSSF, utilization rates of NSSF members in 2017 were estimated at 97%

►► The maternal mortality ratio, measured as the number of deaths per 100,000 live births, plunged from 272 in 2011 to 185 in 2017. The under-five mortality ratio decreased from 58.9 to 47.3 per 1,000 live births between 2013 and 2018.

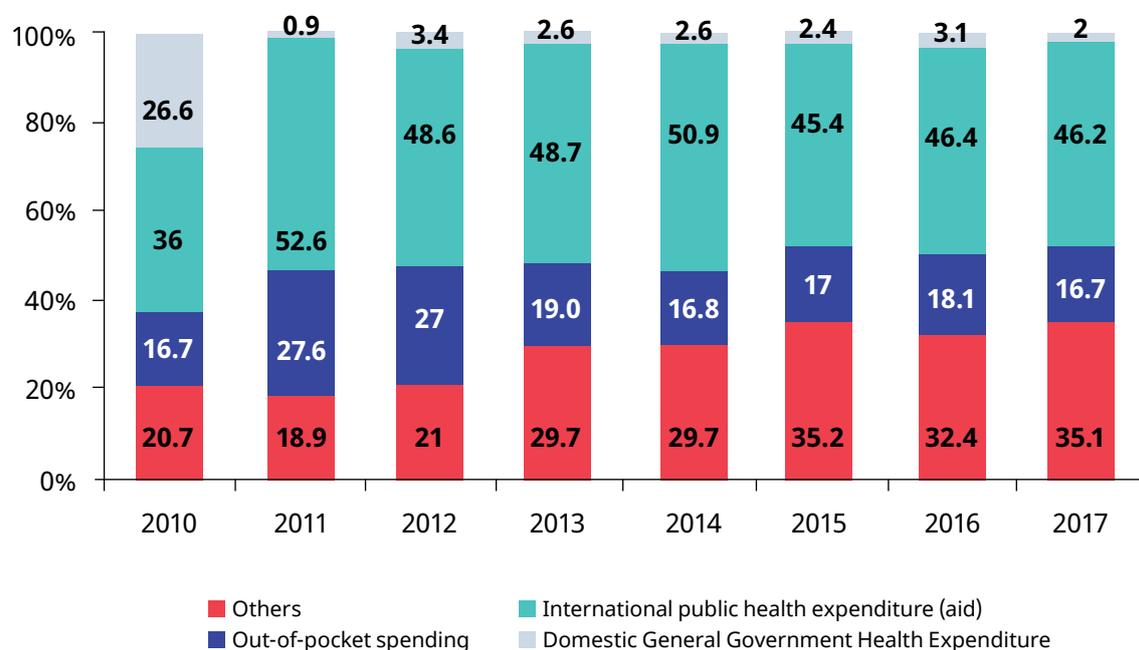
for outpatient care, 20% for emergency care and 7% for inpatient care.

Notably, significant inequalities in healthcare utilisation and outcomes persist across socioeconomic quintiles, ethnic groups and geographic locations (ILO, 2019; Nagpal et al., 2019).

Adequate levels of benefit

Financial protection

Despite the comprehensive benefits package and the low co-payment amount, the financial protection of NHI remains limited, as reflected in high out-of-pocket payments. Albeit on a downward trend, OOP expenditure as a proportion of total health expenditure remains very high, at 46.2% in 2017 (WHO, 2020). Informal direct payments remain significant at the facility level, which limits the financial protection for the NHI beneficiaries (ILO, 2019).

Figure 3.3: Health expenditure structure in Lao PDR (as % of total health expenditure), 2010-2017

Source: WHO (2020)

Responsiveness to population needs

Availability and Accessibility

Even though the NHI benefits package is rather generous in design, the provision of benefits is hindered by the lack of supply-side readiness (The World Bank, 2017), manifested in the lack of basic amenities and equipment, limited diagnostic capability, and absence of basic medicines at health centres and district hospitals, that is primary and secondary facilities (WHO, 2018).

In 2017, the number of doctors and nurses/midwives per 10,000 inhabitants in Lao PDR was at 3,726 and 12,643, respectively. In the same year, the health service coverage index (SDG 3.8.1) reached 51 units (WHO, 2020), in which the indicator of service capacity and access was relatively low, at 35 units (WHO, 2019).

Although the country's network of healthcare facilities covers 93% of the population within a

90-minute walking distance (Akkhavong et al., 2014), there remain financial and physical barriers in accessing healthcare encountered by NHI members, especially the poor and the vulnerable, and ethnic minority groups living in rural and remote areas. These barriers are manifested in the finding that distance to the nearest healthcare facility and ethnicity are the most significant predictors of immunization rate in Lao PDR (Mobasser et al., 2016).

Acceptability and Quality

In general, quality of care remains a challenge in healthcare delivery at public facilities, especially at primary and secondary levels (healthcare centres and district hospitals). The shortage of qualified health workers in primary and secondary health facilities, which is caused by the shortage and mal-distribution of health workers, contributes to worsening the quality of care at these two levels (The World Bank, 2017).

▶ Main lessons learned

- ▶ Voluntary contributory health insurance is neither an efficient nor a sustainable option for covering informal economy workers in low-and middle-income countries, especially in the context of widespread poverty, and limited perception and understanding of insurance.
- ▶ Substantial Government funding is indeed essential to fully or partially subsidize the enrolment into social health protection schemes of workers in informal employment as well as the poor and the vulnerable.
- ▶ A comprehensive benefits package, with small co-payment, is not sufficient to provide sound financial protection. Health

care services must be accessible and of sufficient quality, with strict control over unofficial payments at the point of service. Without supply-side readiness, increasing NHI enrolment is not sufficient to guarantee effective and equitable access. Therefore, the focus should also be placed on strengthening the healthcare supply, especially at the primary level, tackling the shortage and mal-distribution of qualified medical workers, as well as addressing social, economic and financial barriers to accessing healthcare.

▶ Way forward

Extension of the NHI to all provinces, including Vientiane Capital. The NHI Bureau plans to roll out the scheme in 2021, in order to cover the remaining provinces that are not benefiting from the scheme yet.

The MOH is soon to develop a new NHI strategy for the period 2021-2026. Financial sustainability as well as decreasing out-of-pocket payments are likely to be among the top priorities to maintain the coverage rate achieved so far and provide better financial protection. Addressing the budget deficit requires a thorough fiscal

space analysis and fiscal restructuring, which in turn will need concerted government efforts and commitment.

A modernization of the administration of the NHI is slowly starting, with the assessment of the information systems in place. A fully functional MIS, operational nationwide and providing real-time information, is indeed essential to strengthen the efficiency of the administration and to remain responsive to members' needs.

► Table of statistical indicators

Table 3.4: Statistical indicators: Lao PDR

Indicator	Latest available year	
Number of inhabitants	7,169,456	2019
GDP per capita (current USD)	2,542.49	2018
GDP growth (%)	6.25	2018
Life expectancy at birth	67.277	2017
% of workers in informal employment out of total employment	NA	NA
Poverty rate (national poverty line)	23.2	2013
Total Health Expenditure (THE) as % of GDP	2.5	2017
Domestic General Government Health Expenditure as % of GDP	0.9	2017
Domestic General Government Health Expenditure as % of Total Health Expenditure (THE)	35.1	2017
International public health expenditure (aid) as % of Total Health Expenditure (THE)	16.7	2017
Out-of-pocket spending as % of THE	46.2	2017
Current primary health care expenditure as % of Current Health Expenditure	NA	NA
Social Health Protection legal coverage, in % of the population	NA	NA
% of the total population affiliated to a scheme (protected persons) (should be equal to the sum of inventory of schemes)	92%	2017
Health service coverage index (SDG 3.8.1)	51	2017
Utilization of health care services disaggregated by IP/OP care	NA	NA
Antenatal care coverage – at least 4 visits	62.2	2017
Proportion of births attended by skilled health personnel (SDG 3.1.2)	64.4	2017
Maternal mortality ratio (SDG 3.1.1)	185	2017
Under 5 mortality ratio (SDG 3.2.1)	47.3	2018
SDG 3.8.2 – Incidence of catastrophic health spending - at more than 10 per cent of total income or consumption (%)	2.98%	2007
SDG 3.8.2 – Incidence of catastrophic health spending - at more than 25 per cent of total income or consumption (%)	0.26%	2007
SDG 1.1.1 – Impoverishment due to health spending (Population pushed into below the \$1.9 a day poverty line due to health spending) (%)	0.4%	2007

Source: The World Bank (2020); United Nations Population Division (2020); Lao Consumption and Expenditure Survey 2012/13

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► Social Health Protection in MONGOLIA

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► Introduction

A middle-income country with a population of slightly over 3 million, Mongolia has experienced significant economic growth since it transitioned to a market-oriented economy in 1990, with the country's GDP more than tripling since 1991. This growth has been accompanied by substantial improvements in the provision of public services such as healthcare and education. Following initial shocks to the healthcare system resulting from economic transition, in 2005, the Government adopted the landmark Health Sector Strategic Master Plan 2005-2015. The plan encompassed a commitment to “improve the health status of all the people of Mongolia, especially mothers and children, through implementing a sector-wide approach and providing responsive and equitable pro-poor, client-centered and quality services” [Resolution of the Government of Mongolia No. 72 of April 2005].

Mongolia has since witnessed an observable improvement in health outcomes, with significant reductions in maternal and child mortality (World Bank, 2020a). To achieve equitable health outcomes,

the Government is pursuing Universal Health Coverage (UHC) as a national priority, as reflected in both the State Policy on Health (2017-2026) and the Long-Term Strategy for the Development of Health Insurance (2013-2022). The right to “health protection and to obtain medical care” is enshrined in the Constitution of Mongolia (Article 16.6). Through state funded Primary Health Care (PHC), and the country's mandatory Social Health Insurance (SHI) scheme, access to health services in Mongolia has significantly improved. However, challenges related to the accessibility and quality of health services and financial health protection remain. These challenges are particularly acute in remote regions and among the most vulnerable, including nomadic households who comprise around one quarter of the Mongolian population (World Bank 2020b). In particular, herders, who make up 19.5 per cent the population (National Statistics Office 2018) and account for three in five of the rural poor (World Bank 2020b) depend solely on their livestock for income. This places them at high risk of slipping into poverty due to catastrophic health expenditures.

► Financing of health systems

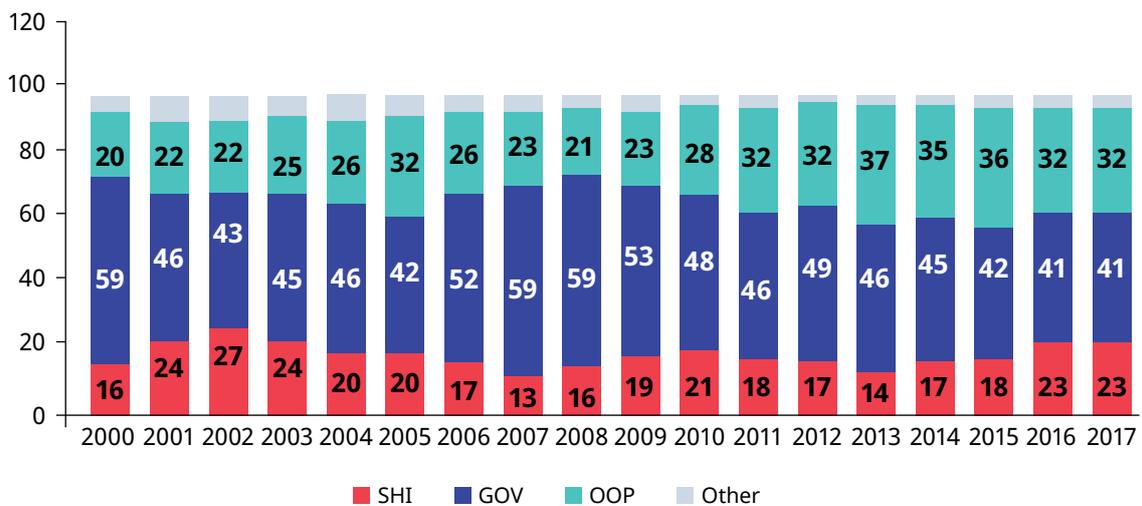
Prior to Mongolia’s economic transition to a market economy in 1990, the country’s health system was based on the Semashko model, characterized by a centralized publicly owned health system, which provided free essential health services to the population (Sheiman et al, 2018). However, the system’s effective functioning got stalled towards the 1990s with the withdrawal of Soviet Union funding. To address this concern, the Government introduced user fees for accessing healthcare, which contributed to decreased health service utilization and caused negative fluctuations in health indicators throughout the 1990s. In response, the Government began to decentralize the healthcare system, with increased emphasis on Primary Care (ADB, 2008). To generate additional resources for the health sector, a compulsory SHI scheme was introduced in 1994, precipitating a transition from a fully integrated model to a contracting model with a purchaser-provider relationship. At the same time, the government

fully subsidized insurance contributions for low-income and vulnerable population groups, but in the late 1990s, these subsidies were reduced to limit the scheme’s reliance on governmental funding (Bayarsaikhan et al., 2016).

In the late 2000s, Mongolia’s Health financing landscape began to benefit from increased public funding, promoting the development of a more equitable and pro-poor health system. In line with the adoption of the Health Sector Strategic Master Plan (2005-2015), co-payments for primary health services were abolished in 2006, and the government took sole responsibility for financing PHC [Law of 20 July 2006 on Amendments to the Health Insurance Law]. These services were removed from the SHI package and became part of a range of cost-free services.

Overall, financial resources dedicated to healthcare have remained at around 4 per cent of GDP during the majority of the past decade. The government

Figure 4.1: Evolution of the share of the different financing sources in the composition of the current health expenditure



Source: Compilation of data from the WHO Global Health Expenditure database

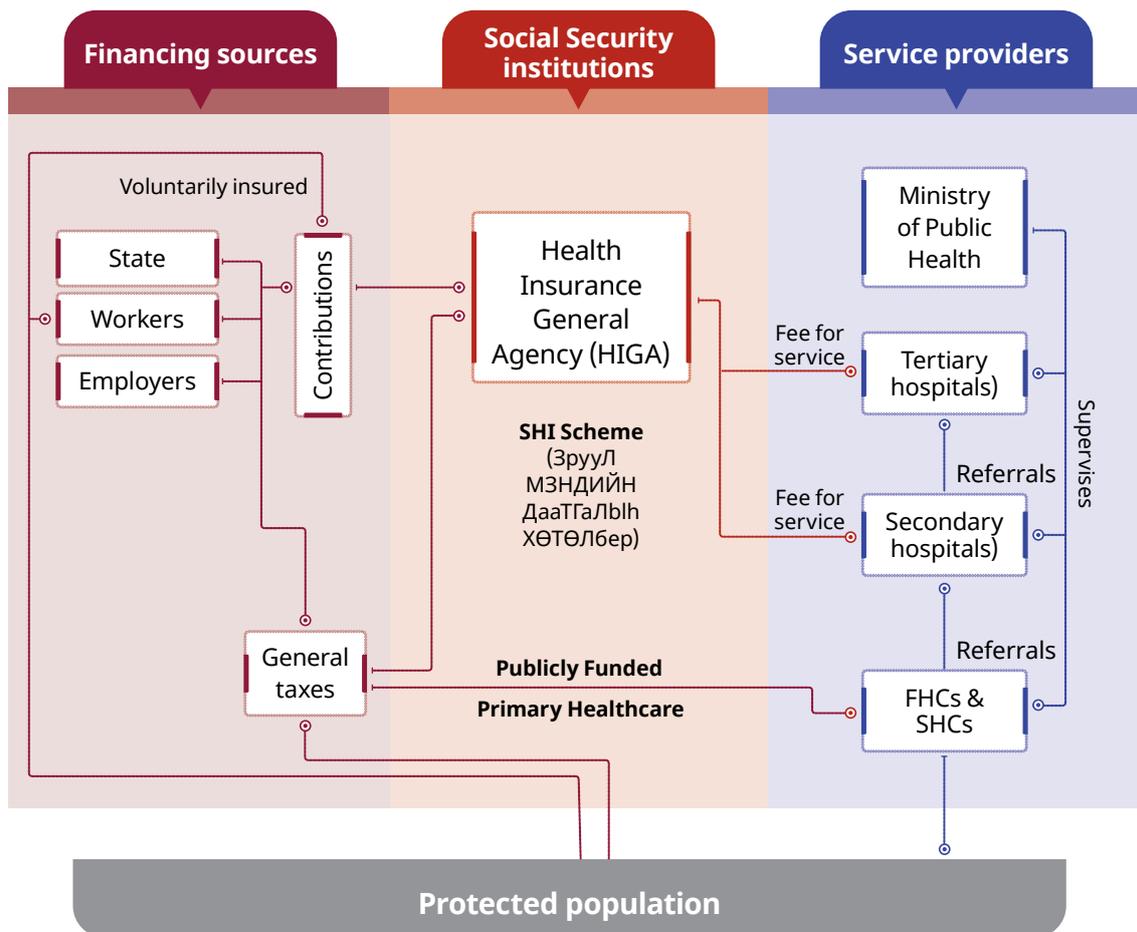
has consistently committed between 6 to 8 per cent of its total spending to the health system since 2010, and Government health expenditure per capita grew steadily from 2000 to 2012, reaching US\$102.3 per capita. However, between 2012 and 2017, this figure declined by 9.8 per cent (WHO, 2020a). Notably, the share of state funding allocated to PHC has decreased from nearly 25 per cent of the total government health expenditure in 2005 to under 16 per cent in 2016 (WHO, 2017).

Today, the main sources of funds for the health system include government funds, SHI revenues, and direct OOP payments.

Since 2008, a decline in the Government share of Current Health Expenditures has been evidenced, compensated for by an increase of OOP expenditures and pooled resources under the SHI scheme. As a result, Mongolia has a considerably high level of OOP health expenditure, which currently exceeds the average in the East Asia & Pacific region by nearly 23 per cent, although it remains lower than the average among lower-middle-income countries globally.

The following figure 4.2 indicates the funding flows for the health protection system.

Figure 4.2: Sources of funding flows for the health protection system in Mangolia



► Social health protection mechanisms

The aforementioned tax-funded PHC services and SHI scheme are the two central mechanisms for providing social health protection (SHP) to the Mongolian population. The dual structure of the health protection mechanism is derived from the broader structure of the social security system in Mongolia, which comprises both contributory social insurance schemes and a social welfare scheme financed from government revenues (ILO, 2016).

Governance

The SHP system in Mongolia is based on a well-established legal framework. The provision of PHC is mandated by the Law on Health of 2011, which defines the types of medical care to be financed from the government budget [Article 24.6] and by the Law on Medical Care and Services of 2016, which outlines expenses for these services. The Ministry of Health is tasked with developing national-level policies and guidelines and overseeing implementation by provincial (“Aimag”) and capital city health departments and facilities (WHO, 2017). The Law on Health empowers local level governors “to organize the involvement of business entities, organizations and citizens in public activities in the field of protection and promotion of health” [Article 11.2.3]. In addition, it gives the power to citizen representatives at Aimag, district (Soum), and lower levels to “ensure joint participation of governmental and non-governmental organizations and citizens in measures to protect and promote the health of the population of the territory under their jurisdiction and coordinate their activities” [Article 10.1.4].

- The SHI scheme is implemented under the governance of the Law on Health Insurance of 1994 and its subsequent amendments. The law defines the principles and scope of the health insurance policy, while regulating interactions between the state, service providers and citizens. SHI

is centrally regulated, with the Ministry of Health functioning as the standard-setting agency, under which the Health Insurance General Agency (HIGA) is responsible for managing the scheme. HIGA, a Government Implementing Agency, is supervised by the National Health Insurance Council (NHIC) - a tripartite body that reports to the Parliament of Mongolia (IRIM & Conseil Santé, 2018). The NHIC is in charge of regulating payment methods, collecting contributions, defining contract guidelines and cost-sharing rules, and managing the Health Insurance Fund (IRIM & Conseil Santé, 2018). HIGA selects, signs purchasing contracts, and pays public and private service providers, which help to ensure a purchaser-provider split (IRIM & Conseil Santé, 2018).

Legal coverage and eligibility

By law, all citizens are entitled to free primary health care. The State Policy on Health also stipulates universality and non-discrimination as integral components of its guiding principles by specifically stating that healthcare services should be provided in an “equitable and inclusive manner regardless of the citizen’s health status, type of disease, place of residence, age, gender, education, sexual orientation, origin, language and cultural difference” [Resolution of the Government of Mongolia, No. 24 of 2017]. To access health services in Mongolia, civil registration is generally required.

SHI is an inclusive scheme that aims to cover all of the Mongolian population. According to the Law on Health Insurance, SHI coverage is mandatory for all citizens and stateless persons whether they are employed in the formal or informal sector, unemployed or self-employed [Articles 4.2-4.3]. For foreigners, the scheme is voluntary.

Benefits

Tax-funded primary health services are defined based on a positive list under the Law on Medical Care and Services 2016 (Article 17). These services are available to all citizens seeking care at Family Health Centers (FHCs), which are based in urban areas and Soum Health Centers (SHCs) which are concentrated in rural areas. Available services include public health services; emergency medical care and ambulance services; obstetric and maternal care and health care during disasters and communicable disease outbreaks. PHC services available in rural areas tend to be slightly broader than in urban areas, as they need to accommodate for healthcare needs in areas where no secondary and tertiary health facilities are available. In general, the package corresponds to PHC as defined under the Alma-Ata Declaration of 1978, including immunization (WHO, 2017). Although no co-payments are required when accessing primary health services, the cost of medicines is fully borne by patients⁴, unless they are covered by SHI.

The SHI benefit package complements tax-funded PCH services. Services available to insured persons are the same for all members, regardless of the amount of contributions paid. General categories of secondary and tertiary services covered by the SHI scheme are defined positively in accordance with the Law on Health Insurance (Article 9.1) and include the following:

- ▶ Inpatient services;
- ▶ Outpatient/ambulatory services, follow up, diagnostics and treatment;
- ▶ Palliative care for cancer and other illnesses;
- ▶ Traditional care, rehabilitative and sanatorium services;
- ▶ Some high-cost medical services and required medical tools;
- ▶ Pharmaceuticals prescribed by medical doctors at FHCs, SHCs, Aimag and district clinics (Note: pharmaceuticals included in the essential drug list approved by the NHIC);
- ▶ Certain kinds of artificial tubes, prosthetics and orthopaedic implants for rehabilitative care;

▶▶ PHC services available in rural areas tend to be slightly broader than in urban areas, as they need to accommodate for healthcare needs in areas where no secondary and tertiary health facilities are available.

- ▶ Some rehabilitative, home and daycare services provided by FHCs, SHCs, and village health centers and diagnostic tests;
- ▶ Daycare for cancer chemotherapy and radiotherapy;
- ▶ Treatment of associated diseases preceding the 37th week of pregnancy and post-natal period.
- ▶ Prevention, early detection and routine diagnostic tests defined by the NHIC.

Prescribed pharmaceuticals included in the NHIC-approved essential drug list are provided under the package and other medicines are available at subsidized prices (Dugee, 2018; Dorjdagva et al., 2016).

Upon accessing SHI benefits, patients are required to make co-payments that are charged at a flat rate of 10-15 per cent depending on the level of the facility at which the services are provided (Dorjdagva et al., 2016). The ceiling on the amount of benefits that an insured person can receive under the SHI is set at around MNT 2,000,000 per year, which is equivalent to around US\$710 (HIGA, 2020). However, individuals may transfer their own benefit to another family member (Bayarsaikhan et al., 2016).

⁴ Except “drugs for diseases that require lengthy treatment and palliative care” and “drugs for children with disabilities under 16 years of age”, in which case costs will be paid by the Government (Article 24.6)

Provision of services/benefits

As noted above, PHC in urban areas is provided by FHCs- private organizations fully funded by the government budget (Dorjdagva et al., 2017), and in rural areas, PHC is delivered at SHCs, which are owned by local governments (Audibert et al., 2018).

FHCs and SHCs are intended to perform a gatekeeping role by referring patients to secondary and tertiary facilities, which include both public and private facilities, though the latter predominate.⁵ Secondary and tertiary healthcare providers in Mongolia are concentrated at district and city levels, comprising district health centres, general hospitals, city-level specialised centres, Aimag general hospitals, regional treatment centres, specialized centres, and state hospitals (IRIM & Conseil Santé, 2018).

To access secondary and tertiary care services and to apply for SHI benefits, individuals typically have to be referred by primary healthcare practitioners, and affiliated persons are provided with magnetic insurance cards (Bayarsaikhan et al., 2016). However, self-referrals and high rates of inappropriate admissions within hospitals at this level are commonplace, which is one of the major challenges faced by the Mongolian health system (Jigjidsuren et al., 2019).

Provider payment mechanisms

Line item budgets, case-based hospital payments, and fee for service for direct payments are the three types of payment methods currently being used in Mongolia.

A mix of payment systems applies with large variation at each level of the health care system, including at the individual provider level. At least 50 per cent of all revenue for the majority of public providers is allocated through a line item budget payment system, although this system represents only 12 per cent of total revenue for some tertiary providers. On average, DRG payments represent around 30 per cent of revenues received by both public and private hospitals, and service fee comprises a fairly minimal share of total revenue for all public providers, usually accounting for less than 5 per cent to a maximum of 10 per cent of revenue for a single provider (ibid). At the PHC level, FHCs receive 100 per cent of their revenue

through such payments, SHCs are paid through a mix of mechanisms, while SHI resorts to case-based payment using Diagnosis Related Group (DRG) (World Bank et al., 2015).

The Health Insurance Fund acts as a third party and reimburses pharmacies for discounted sales of essential medicines to insured people when prescribed by SHC and FHC physicians (WHO, 2017).

Revenues

PHC is provided on a non-contributory basis and fully funded by the government's general revenue.

SHI, on the other hand, is funded by a combination of government subsidies, co-payments, and salary contributions of affiliated employees and employers, each of whom pay 2 per cent of the concerned employee's monthly salary (HIGA, 2020). For state employees, the government contributes as the employer. Contributions are also required from self-employed and unemployed persons, students, foreigners, and other categories of the population at the rate of at least 1 per cent of the average minimum wage (HIGA, 2020). In 2011, the government re-introduced SHI subsidies for vulnerable groups (ADB, 2013). These categories include children under the age of 18. years, pensioners, low-income citizens, parents caring for a child who is younger than 2 years of age (or 3 years of age in the case of twins), military personnel, and prisoners (HIGA, 2020). Nomadic populations in Mongolia no longer benefit from these subsidies. It was estimated that in 2014, subsidised population categories accounted for about 60 per cent of all insured persons (Bayarsaikhan et al., 2016).

It is the responsibility of formal sector employers to pay and transfer SHI contributions (along with other social insurance contributions) from their employees' monthly salaries to the State Social Security General Office (SSSGO). SSSGO performs the collection function and is then split into different social insurance funds, such as HIGA in the case of Health Insurance. For self-employed persons, the frequency of payments may vary and for workers in the informal economy, such as nomads, payments are made on a quarterly or yearly basis based on their seasonal income and the nature of their employment, in line with individual payment agreements made at HIGA branch offices.

⁵ Based on data from 2014, there were 869 public and private providers contracted through SHI – 100 public and 769 private (Bayarsaikhan et al., 2016).

► Results

Coverage

Because all citizens are entitled to free PHC by law, legal coverage stands at around 99 per cent of the population, excluding international migrants (UN, 2019). In 2014, a total of 218 FHCs provided PHC services for approximately 2 million individuals in urban areas (Dorjdagva et al., 2017), and currently, there are over 330 SHCs providing services in their areas of operation in rural areas (Jigjidsuren et al., 2019).

Coverage for secondary and tertiary care provided through the SHI scheme is lower. Directly after its introduction in 1994, the scheme achieved a high affiliation rate. However, after subsidies were reduced in the late 1990s, the affiliation rate substantially declined (Bayarsaikhan et al., 2016), which was further compounded by increasingly prevalent rural to urban migration. This trend led to an increase in the number of poor and unregistered people in cities facing challenges in accessing healthcare due to the lack of civil residential status. SHI membership peaked again in 2011-2014, reaching over 90 per cent after the government launched mass enrolment campaigns (ibid). Unfortunately, the government has struggled to maintain this progress in subsequent years. Based on the latest data available from 2016, SHI coverage in Mongolia stands at around 76 per cent (IRIM & Conseil Santé, 2018). This decline can be attributed in part to challenges in maintaining adequate coverage among the self-employed, unemployed persons and remote and disadvantaged populations, due to dropouts, insufficient administrative support, and internal migration. Very low population density further complicates the coverage of herders who live in remote rural areas of the country (Dorjdagva et al., 2017).

Adequate levels of benefits

Tax-funded Primary Health Care and the expansion of SHI have significantly improved

the financial protection of the population against catastrophic and impoverishing health expenditures. Nonetheless, there are limits to which the existing system can shield its users from financial risks. Although no payments are required when accessing primary health services, the cost of medicines is fully borne by patients, unless they are covered by the SHI, which can result in a high degree of financial vulnerability. Even when subsidised through SHI, the price of medication can be prohibitive for many categories of the population. Moreover, the practice of self-medication is quite prevalent in Mongolia (IRIM & Conseil Santé, 2018), which means that people often seek to purchase drugs from pharmacies without prescriptions, thus forgoing the benefit of subsidised prices and incurring greater healthcare costs. Estimates from 2011 indicate that pharmaceuticals represent 94 per cent of OOP payments among the very poor in Mongolia (Tsolmongerel et al., 2011).

Comprising 32 per cent of total national health expenditures in 2017, OOP payments pose a significant challenge, with estimates suggesting that approximately 20,000 people in Mongolia are forced into poverty due to health care expenditures (Dorjdagva et al., 2016). In addition to pharmaceutical costs, Mongolia's relatively high OOP expenditure rate can be attributed to co-payments for accessing tertiary and secondary health services under SHI. Because co-payment rates are flat for all population groups (between 10-15 per cent), including vulnerable populations, this creates inequalities in access and negatively impacts healthcare utilisation (IRIM & Conseil Santé, 2018). It has also been noted that the contribution rate of 1 per cent of the average minimum wage for the self-employed is likely too high for many categories among this group (IRIM & Conseil Santé 2018).

Responsiveness to population needs

Availability and accessibility

The introduction of the state-funded PHC has yielded some positive results in improving access to health among the poor and the vulnerable in Mongolia. Studies show that low-income groups are much more likely to use PHC, regardless of their healthcare needs, while higher income groups access secondary and tertiary healthcare more frequently (Dorjdagva et al., 2016). In particular, in urban areas, FHCs often serve as the major (and often the only accessible) healthcare provider for low-income households (Dorjdagva et al., 2017). However, in the case of SHCs in rural regions, some patients have to travel long distances (>50 km) in order to access primary health services (ibid). Moreover, because secondary and tertiary healthcare providers in Mongolia are concentrated primarily at district and city levels, this compounds limited service availability for many rural population groups, which leads to indirect financial costs resulting from transportation expenses, time spent on travel and, in certain cases, the need for accommodation. It is worth noting that a large share of the rural population in Mongolia are herders, who move every season and settle for prolonged periods in remote areas where no infrastructure is available (ibid).

Although Mongolia has a comparatively high density of hospital beds, which is greater than the average among the lower-middle-income countries as well as the global average (WHO, 2020b), geographical distribution is uneven. Notably, a study from a 2017 study calculated that the mean number of hospital beds per 1,000 km in rural regions was over 61 times less than the mean in suburban regions and nearly 304 times less than in Mongolia's capital (Erdenee et al., 2017).

Even in areas where health infrastructure is plentiful, the civil registration requirement for individuals to benefit from state welfare benefits and health insurance prevents many unregistered individuals in urban areas from receiving essential health services (Gan-Yadam et al., 2013; Lhamsuren et al., 2012; ADB, 2008). Unregistered populations can constitute up to 20 per cent of city or district populations, which is driven by high levels of

Unregistered populations can constitute up to 20 per cent of city or district populations, which is driven by high levels of internal migration and time-consuming complex registration procedures (Lhamsuren et al., 2012; ADB, 2008). These barriers, combined with the aforementioned requirement of co-payments to access tertiary and secondary care, result in inequality in service utilization that can lead to greater financial losses for vulnerable groups at a later stage (Dorjdagva et al., 2017).

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Acceptability and quality

Although the quality and scope of health services provided by the healthcare system have improved over the past decades (WHO, 2017), PHC facilities in Mongolia face significant shortages of equipment and medicines and have a limited diagnostic capacity (Jigjidsuren et al., 2019). The capacity of

FHCs in particular do not meet the demands of the increasing number of patients in FHCs in Mongolia due to rising levels of rural-to-urban migration over the last decade. This intensifies pressure on FHC healthcare personnel, who tend to cater to patients 2 times more patients than SHC personnel (WHO, 2017).

Overall, Mongolia has a comparatively large number of medical workers. The latest WHO estimates indicate that there are nearly 2.9 physicians per 1,000 patients, which is greater than the average among lower-middle-income countries (WHO, 2020b). However, the number of nurses is quite low (Jigjidsuren et al., 2019). In rural regions, in particular, SHC facilities face weaker supply of qualified specialised medical personnel. These deficiencies stem primarily from insufficient PHC financing. In 2017, primary health facilities used over two-thirds of their funding for salaries and operating costs, while only a small proportion remained for improving actual quality of care and services (IRIM & Conseil Santé, 2018).

As such, public perceptions of the quality of primary care are generally negative, which has been cited as a major contributing factor to a high prevalence of self-medication and self-referrals within district and tertiary level hospitals in Mongolia (Jigjidsuren et al., 2019, IRIM & Conseil Santé, 2018). This is a significant challenge, as it results in higher health care costs and increased OOP spending due to an inability of self-referred patients to benefit from SHI protection (Dorjdagva, 2016).

Secondary and tertiary level hospitals and clinics also experience shortages of equipment and medicines (Jigjidsuren, 2019), though there is currently little reliable information on the quality of the health services provided by the private sector (Bayarsaikhan et al., 2016; IRIM & Conseil Santé, 2018). One survey conducted between 2014 and 2015 in three tertiary level state hospitals in Ulaanbaatar, found the overall satisfaction with health services among patients to be just over 60 per cent (Batbaatar et al., 2016).

Decree No.135 (4 May 2006) of the Minister of Health on the Approval of the Code of Ethics for Medical Staff and the Charter of Ethics committee emphasises respect for patient rights in health services. Accordingly, the Ministry of

Health mandates client satisfaction surveys to be conducted on an annual basis; however, it has been found that their results are inadequately used for substantive actions (WHO, 2013, 2017). A 2018 technical report prepared by the Independent Research Institute of Mongolia and Conseil Santé concluded that the services provided in the health sector were “not client-friendly” in terms of the providers’ attitudes and health-setting environments (IRIM & Conseil Santé, 2018). Notably, one study observed a negative association between FHC visits and disability status (Dorjdagva et al., 2017).

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► Main lessons learned

Lesson 1: The case of the Mongolian health protection system illustrates a successful combination of tax-funded primary health care and coverage provided through Social Health Insurance. The mix of financing mechanisms ensures continuity of coverage – and hence a continuum of care – throughout the healthcare system. The financial participation of the population through contributions makes Social Health Protection more affordable to the Government, which can allocate its limited financial resources to support the most vulnerable.

Lesson 2: In Mongolia, the fluctuation of policies on SHI contribution subsidies, through the introduction, removal and then reintroduction of subsidies has affected enrolment rates, and hence provided financial protection. This illustrates the crucial need for consistency in Social (Health) Protection policies and continuity in Government financial allocation in the form of SHI contribution

subsidies to enable coverage of groups of the population with low contributory capacity.

Lesson 3: Mongolia is facing a triple challenge: Not only is it the most sparsely populated country in the world, but the country has a large nomadic population spread over large areas. This makes the provision of public services expensive and complicates the ability to reach out to populations in need. With only 40 per cent of Mongolian herders participating in the health insurance scheme (NSO 2018), specific strategies are needed. The government is endeavouring to adjust the SHP system to cover these groups through the provision of subsidies for low-income earners, and by enhancing the flexibility of contribution mechanisms in terms of timing and frequency of payments.



► Way forward

Despite vast improvements to Mongolia's SHP system over the years, the aforementioned challenges impede progress towards sustainable, equitable and efficient health protection in Mongolia. In light of the impacts of the COVID-19 pandemic, ensuring equitable access to adequate quality health care has never been more important. To accelerate progress in this area, the State Policy on Health (2017-2026), adopted through the Resolution of the Government of Mongolia No. 24 of 2017, stipulates a commitment to improving availability, accessibility and quality of services, by setting a range of defined targets to be achieved by 2026. These targets include a reduction of the share of OOP payments to 25 per cent of the total healthcare expenditure; an increase of the share of health sector financing to 5 per cent of the GDP; and an increase of the average life expectancy in Mongolia to 74 years.

In order to achieve these targets, health financing, health sector management, organization and transparency, and new technologies for information management have been identified as key priority areas to address (IRIM & Conseil Santé, 2018). If fully implemented, the policy should help decrease the disparities between SHI financing sources. The digitisation of health information and improvement of the relevant registries could also help reduce the mis-targeting of government subsidies, which has previously been identified as a pressing challenge (ADB, 2013). The World Bank and the Government of Mongolia have already started working on establishing health information platforms in the country to facilitate the management and monitoring of health systems, in particular through the implementation of the E-Health Project 2015-2020 (World Bank, 2014). A broader effort to create integrated information platforms to easily and securely store, transfer, and combine individual civil and health data could yield a wide range of benefits to both patients and service providers.

In terms of governance, continuing decentralization efforts hold promise towards improving the system's resilience as the delegation of power to local authorities may enable more efficient use of resources (WHO, 2018). These efforts can be reinforced by steps towards improving the participation of different stakeholders in the design of health policies and plans. For example, the Law on Development Policy and Planning has introduced a multi-stakeholder process for policy-making, which has the potential to create more opportunities for Mongolian society to better influence healthcare provision in accordance with its needs. More broadly, the ratification of the ILO Convention No. 102 on medical care, sickness, and maternity could be an important milestone towards improving the existing SHP system as it would help to harmonize national laws and practices with existing international standards and guidelines, thereby improving the system's performance.

To enhance coverage and sustainability of the SHI scheme, activities prescribed by the Long-Term Strategy for the Development of Health Insurance 2013-2022, if fully implemented, have the potential to stimulate necessary improvements, such as mobilizing additional resources for SHI funding, improving the government subsidy targeting mechanism, improving the efficiency and quality of the health services offered, and conducting continuous social marketing activities in order to increase understanding and knowledge of health insurance among the population. With regard to PHC, the Government is currently making efforts to address the physical constraints related to accessing SHCs by introducing mobile health units. For example, two trains have been equipped to serve as "Mobile Hospitals" providing basic diagnostics and preventive care (Batchimeg, 2019).

► Table of statistical indicators

Table 4.1: Statistical indicators: Mongolia

Indicator	Value	Year
Number of inhabitants	3,278,000	2020
GDP per capita	4121.7	2018
GDP growth (%)	7.23	2018
Life expectancy at birth	69.55	2015-2020
% of workers in informal employment out of total employment	31.4	2019
Poverty rate (Poverty headcount ratio at US\$3.20 a day (2011 PPP) (% of population))	5.6	2018
Poverty rate (Poverty headcount ratio at US\$1.90 a day (2011 PPP) (% of population))	0.5	2018
Total Health Expenditure (THE) as a % of GDP	4.4	2016
Domestic General Government Health Expenditure as % Gross Domestic Product	2	2017
Domestic General Government Health Expenditure as % of THE	62	2017
International public health expenditure (aid) as % of THE		
Out-of-pocket spending as % of THE	32	2017
Current primary health care expenditure as % of Current Health Expenditure	NA	
Social Health Protection legal coverage, in % of the population	76 *	2016
% of the total population affiliated to a scheme (protected persons) (should be equal to the sum of inventory of schemes)	76 *	2016
Health service coverage index (SDG 3.8.1)	62	2017
Utilization of health care services disaggregated by IP/OP care (if available)	NA	
Antenatal care coverage – at least 4 visits	89.6	2011-2013
The proportion of births attended by skilled health personnel (SDG 3.1.2)	99.3	2018
Maternal mortality ratio (per 100 000 live births) (SDG 3.1.1)	45	2017
Under 5 mortality ratio (SDG 3.2.1)	16.3	2018
SDG 3.8.2 – Incidence of catastrophic health spending - at more than 10 per cent of total income or consumption	2.36	2014
SDG 3.8.2 – Incidence of catastrophic health spending - at more than 25 per cent of total income or consumption	0.45	2014
SDG 1.1.1 – Impoverishment due to health spending (Population pushed into below the \$3.2 a day poverty line due to health spending) (%)	0.37	2014

* **Note:** Social health insurance only

Source: compilation of data from World Bank, 2020; UN, 2019; ILO, 2020; WHO, 2020a; WHO, 2020b; and UN Inter-Agency Group for Child Mortality Estimation, 2020

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▶ Social Health Protection in NEPAL

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▶ Introduction

In Nepal, the two Constitutions from the years 2009 and 2015 constitute the foundation to move towards Universal Health Coverage (UHC). The goal of UHC was concretized in the Health Sector Strategy whereby the importance of supporting vulnerable groups was emphasized. In order to achieve this goal, universal Free Health Care Policy (FHCP) and various social health insurance schemes have been implemented in recent years. These include the Health Insurance Board (HIB), the Social Security Fund (SSF) and the Employees' Provident Fund (EPF). Although this has facilitated the extension of protection to the population, the coexistence of the three different schemes leads to fragmentation and inefficiency in the system. As a consequence, high out-of-pocket (OOP) expense remains a major challenge in ensuring access to services to all.

▶▶ The goal of UHC was concretized in the Health Sector Strategy whereby the importance of supporting vulnerable groups was emphasized. In order to achieve this goal, universal Free Health Care Policy (FHCP) and various social health insurance schemes have been implemented in recent years.

► History

In the past, a large number of public health programmes, with the goal of offering free care, were implemented in Nepal. Thus, service-specific programmes such as Aama Surakshya or community-based integrated management of neonatal and childhood illnesses as well as insurance-related projects were implemented. These included community-based health insurance promoted by the government and private initiatives, the **Free Health Care Programme**⁷ (Free Healthcare Policy) as well as the Medical Scheme of **Employees' Provident Fund** (launched 2013, Employees' Provident Fund Act, 2019 (1962), 13th Amendment).

Despite these efforts, no adequate universal protection for the population could be ensured. OOP remained high and the fragmentation of the system has made targeted care difficult (Ministry of Health and Population 2018b; Sharma, Aryal, and Thapa 2018). The National Health Policy (2014) and the National Health Sector Strategy (2015-2020), together with several regulations such as the Health Insurance Regulation No. 2075 serve as the basis to lead interventions towards UHC and subsequently a national health insurance system (Dahal et al. 2017). Building on this, the Social Health Security Development Committee from which today's **Health Insurance Board** emerged, was formed in 2015, constituting the national health insurance. Parallel to the introduction of this (meant to cover the entire population but initially focussing on the poor and the informal sector) social health insurance, a further Social Protection Platform (**Social Security Fund**) targeting the formal sector was initiated under the Contribution Based Social Security Act 2017 (2074) (Social Security Act). With regard to health,

a "Medical and Health Protection Scheme" and a "Maternity Protection Scheme" were stipulated under the sixth chapter.

The latest regulation was issued in 2018. Under the title "Public Health Service Act 2018", the right of every citizen to receive high-quality health care was emphasized.

► Service-specific programmes included community-based health insurance promoted by the government and private initiatives, the Free Health Care Programme⁵ (Free Healthcare Policy) as well as the Medical Scheme of Employees' Provident Fund (Employees' Provident Fund Act, 2019 (1962), 13th Amendment)

⁷ Currently, a further development can be observed here. The Constitution and the Strategy now refer to the terminology "Basic Health Services" - intended to unite the previous programmes and the vertical schemes. The corresponding Basic Health Service Package is apparently not yet endorsed.

► Design

Financing

In general, a rough distinction can be made between four funding sources in the Nepalese Health System: Budgets calculated prospectively by the state (financed by taxes and donations from the development partners), social security contributions and OOP. OOP that constituted 57.8% in 2017 and paid directly to the health facilities account for the largest share.

Figure 5.1 shows that the schemes are inter alia financed by contributions, in addition to FHCP. SSF and EPF receive income-related payments from employers and employees, while HIB charges a uniform fixed contribution per household and receives tax-funded contributions from the Government budget to subsidize coverage for the poor.

Governance

Administratively, the schemes are managed by autonomous institutions under the responsibility of different ministries – without an appropriate coordination mechanism. However, the need for coordination between HIB and SSF was anticipated, as shown by the initially planned composition of the Health Insurance Board in the National Health Insurance Policy 2013. Accordingly, a representative of the SSF should also be represented on the Board. However, the current composition of the Board does not reflect the initial intent.

HIB has been constituted as an autonomous institution under the responsibility of the Ministry of Health and Population (MoHP). Still, the institution is in the process of building this autonomy. Conversely, SSF was established as a “separate entity”. The associated SSF Board has a wider representation of interest groups (executive director and representatives of the government, employer and employee).

Coverage

When it comes to the legally established target groups of FHCP and HIB, two parallels can be drawn. Both these schemes intend to cover all citizens and define vulnerable groups of people who receive special attention. In FHCP, vulnerable persons receive not only essential health care services but also emergency, in- and out-patient services in public facilities. At HIB, contributions of vulnerable population groups, identified through the official poor-targeting process of the government, are fully subsidised by the government. It should be noted, however, that both systems use different methods and characteristics for identification.

In June 2019, 509,540 households were covered by HIB (contributions payable per family) and 1.68 million people were affiliated.⁸ Considering 20 million as eligible population, the target population coverage stood at 8.4 per cent. By April 2021, it covers about 12.8% of the total population (3.8 million). However, this figure does not take into account the drop-out rate. In other words, a high number of affiliated persons who have decided not to renew their social health insurance cover after one year reduces the number of effectively protected. According to Government sources, the drop-out rate is at 30%.

SSF covers all employees (including those from the informal sector and the self-employed). However, in reality, only employers and employees from the formal private sector have registered so far (Niti Foundation 2019). The registration has only started during the fiscal year 2019/20, with figures of about 147,643 registered workers (about 1% of the population) and 12,157 employers by end of 2019.

Within EPF, civil servants are automatically covered. Moreover, employees of institutions with more than ten permanent employees have the option to join. In 2015, the insurance was opened

⁸ https://hib.gov.np/public/uploads/shares/notice_hib/health_insurance_report_2075-76.pdf?fbclid=IwAR23Dvj3Youh6LOmNT2HCX0D3tS69Z46GyN9r1XW9z67_3xoZFWqHMJSntM

to self-employed persons. By 2018, about 600,000 insured persons out of a target group of 700,000 were insured under this scheme. Contrary to HIB, SSF (with the of exception maternity health) and EPF cover only employees and not their dependents/ families.

Benefits

Basic health services are provided through FHCP in all public facilities. Supplementary services are covered by “social health protection arrangements” (meaning SSF, EPF and HIB). HIB and SSF are characterized by ceilings that limit the maximum amount of benefits and therefore improve financial protection. In addition to medical care services, SSF also offers cash benefits, especially in the event of maternity. A list of explicitly excluded benefits is also available for HIB and SSF - for example, both schemes do not cover treatments for plastic surgery.

Provision of services

The contracted private and public health care providers are paid for services through fee-for-service and case-based payments. In most of the cases, the schemes reimburse the providers directly under the third payer mechanism. For HIB and SSF, fee-for-service applies for OPD services and case-based payments for inpatient care and hospital admissions. However, the case types are not classified as DRG. These are simply the various types of medical and surgical procedures. In the EPF, service providers are paid by a fee for service.

The MoHP acts with regard to the FHCP by paying prospectively defined and population-based budgets to different administrative government levels.

Affiliation/Registration

Within the HIB scheme, the main actors for direct communication in the field and the registration process are the so-called Enrollment Assistants (one EA per 1,000 families), who work on a voluntary basis in their municipalities for HIB. Decisive for the selection of the EA are the Guidelines for Selection of Enrolment Assistants (Second Amendment), 2074 BS. According to these

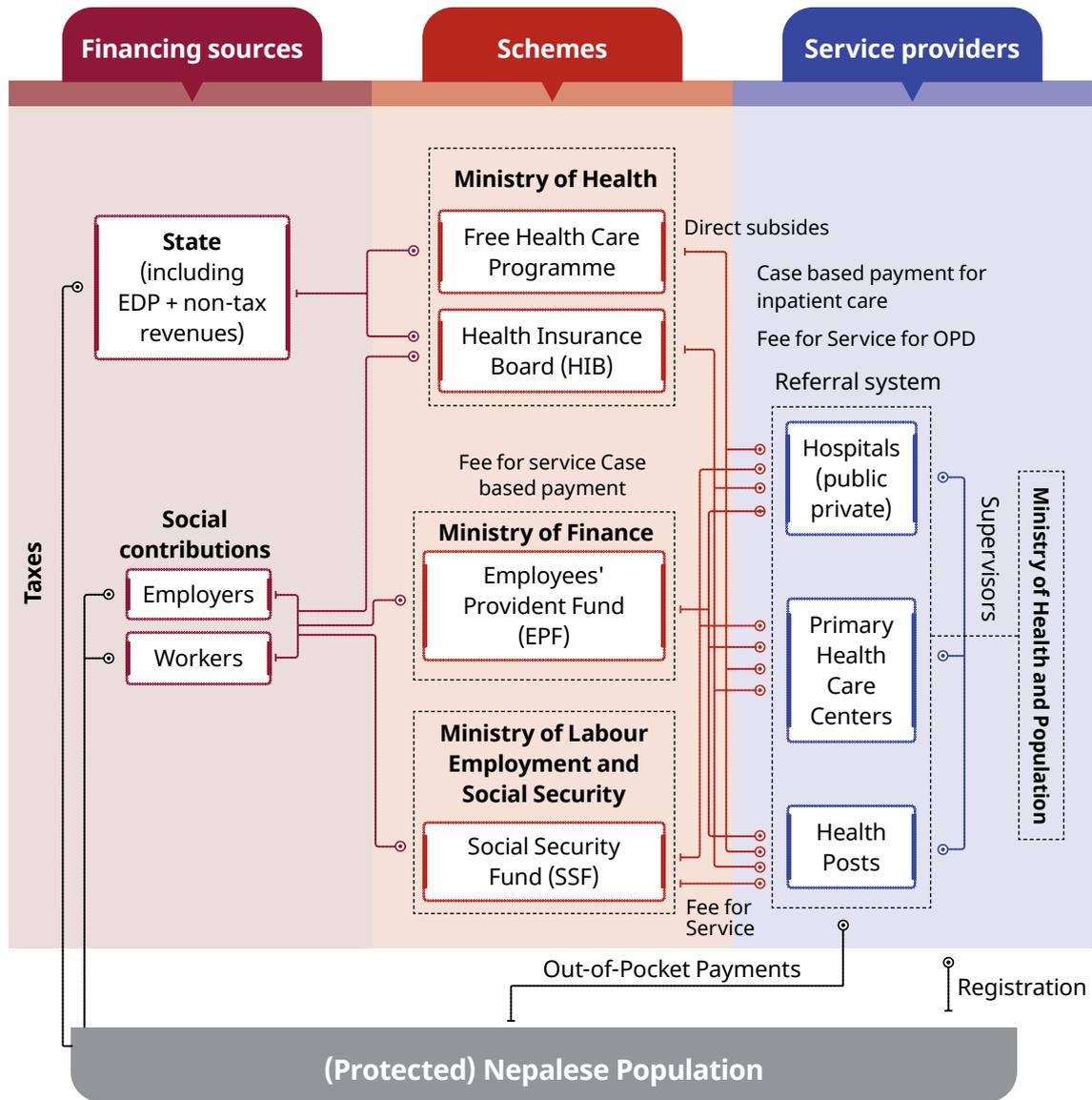
Supplementary services are covered by “social health protection arrangements” (meaning SSF, EPF and HIB). HIB and SSF are characterized by ceilings that limit the maximum amount of benefits and therefore improve financial protection.

guidelines, Female Community Health Volunteers (FCHV) are to be selected on priority.

IT system

Together with the national health insurance (HIB), the open-source Insurance Management Information System (openIMIS) was also introduced. It is a health insurance management tool that can be used for registration, renewal, claim management, feedback and reporting. Due to its wide range of applications, it can be assigned a key position in the administration of health insurance. The system can be accessed by all relevant parties inside and outside HIB: Enrolment Assistants, Enrolment Officers, District Managers, Claim Reviewers and Health Care Providers (Social Health Security Development Committee 2017). However, this tool is of particular importance not only in the context of routine activities but also at a higher level. Thus, the implementation in the design phase of the HIB has helped to sharpen decisions. This digital solution has facilitated a rapid expansion of affiliation (Grainger 2018).

Figure 5.1: Source of mobilising resources for SHP in Nepal



► Results

Coverage

Based on the legal coverage of the three schemes, partially overlapping target group definitions can be identified. As a result, this not only leads to inefficient parallel systems but also causes confusion among the population and has overall limited coverage. For example, at the beginning of the introduction of SSF (the Government made enrolment mandatory), it was not clearly regulated how the interaction with EPF is intended. Finally, the Ministry of Labour, Employment and Social Security (MoLESS) announced that the decision could be made individually by the insured person, which de facto provides a choice somewhat in contradiction with the objectives of mandatory coverage and broad risk pooling (Poudel 2019). Similarly, while in the initial stages of the Health Insurance Law discussion it was foreseen that all formally employed would be affiliated under HIB on a mandatory basis, this never concretized in practice. The initial idea of a single pool, with two relatively secured sources of funding (from mandatory social contributions from the formally employed on the one hand and from Government contribution subsidies for the poor on the other), would have left the institution with some room to concentrate on innovative solutions for the missing middle – the informal economy. Rather, the current situation is challenging and exposes the scheme to adverse selection.

Financial protection

At almost 58%, OOP expenses constitute a very high proportion of health expenditure in Nepal, with an increasing trend since the year 2000. After 2006, a significant jump can be observed. While the population share with household health expenditures greater than 10% of their total expenditure (SDG 3.8.2) has decreased since 2010, it still stands at a high level at 10.71%.

In the literature, the increasing use of privately provided health services is often cited as a reason. For example, it is stated that although various government measures in the area of free health care in public facilities have permitted better access, the increasing market share of poorly regulated private facilities has led to a corresponding increase in OOPs (Gupta and Chowdhury 2014). This can

be illustrated by the share of OOP payments made to the private hospitals: 13.2% for the year 2011/12 and 16% for the year 2015/16 (Ministry of Health and Population 2019; 2018a). The different social health insurance mechanisms' limited population coverage impedes countering this trend. Accordingly, the incidence of catastrophic health spending at more than 10 per cent of total income or consumption was at 10.71% of the total population.

Shortly after the introduction of the national health insurance (HIB), it became clear that the scope of benefits did not meet the needs of the population. For example, there has been criticism that the imposed ceiling for a family is not sufficient to cover the treatment of one family member. For this reason, HIB's managers adjusted the benefits package accordingly and they, inter-alia, increased the ceiling from 50,000 to 100,000 (The Kathmandu Post 2018). This type of design with ceiling is usually a feature used by private insurance schemes to limit their liability and not by social health insurance programmes in the rest of the world, still a similar design is encountered in India on a large scale as well as in Bangladesh in a pilot phase. This type of design feature limits the financial protection effectively awarded by the scheme.

Utilisation

Utilisation of health services was together defined with equitable distribution as one outcome of the NHSS. Particular focus is placed on access to health services (focus: "unreached population") and an expanded service network with a referral system. In the Progress Report 2018/2019, this chapter describes the distribution of doctors trained under a government-financed scholarship in provinces as a major step forward.

An increased utilization rate is cited in particular in connection with the introduction of the Free Health Care Programme (Suvedi et al., 2012, p. XV). System-wide and current data on the usage rate, especially after the introduction of SHI could not be found.

For this reason, three independent studies (in the years 2012, 2016 and 2019) were selected to investigate the use of health services by the older

population.⁹ The analysis showed no fundamental changes (chronological ascending order: 68%, 84.4% (urban area), 70%) among the elderly. All three studies highlighted the lack of awareness of entitlements as an obstacle (Acharya et al., 2019; Gurung et al., 2016; Sanjel et al., 2012).

Benefits

The benefits package offered by all existing mechanisms is meant to be extended over time and there is a social demand for it, as illustrated by the experience of the Free Drug List of the Free Health Care Programme. In the beginning, 40 drugs were included in this list. However, it turned out that this list was not sufficient to treat patients with various common diseases. For example, amclox (ampicillin and cloxacillin), third-generation antibiotics (agithromycin) and anti-hypertensive and anti-diabetes drugs were classified as missing. Based on this criticism, the list was extended to 70 drugs. With regard to the new basic package, the media have already indicated that the number is set to increase further to 93 (Poudel 2019; Prasai 2013; Singh et al. 2017).

Quality

The quality of service provision remains a weak point in the Nepalese health care system, as revealed by the results of the Health Facility Survey with regard to the indicator for achieving minimum standards (% of health facilities meeting minimum standards of quality of care at the point of delivery). According to these results, less than one per cent of public health facilities met the standards in 2015 (Ministry of Health and Population 2017). In contrast, private providers are perceived to offer higher quality and better equipment. In addition, currently, the different social health insurance schemes do not have quality criteria in place (Prasai 2013).

Availability

The use of human resources is indispensable for the provision of services and thus for the achievement of UHC. In this context, "% of sanctioned posts filled" can be used as an indicator. According to the Service Tracking Survey, this value was 56.4% in 2012 for medical doctors at district hospitals. Subsequently, negative effects on the implementation of the Free Health Care Programme are reported. This

is attributed to inadequacies in the regulatory area, whereby improvements are predicted as a result of the Health Service Act coming into force (Prasai 2013). The fact that these expectations could not be met is shown by the Health Facility Survey, in which this indicator stood at 51.9%. This topic was also pursued in the National Health Sector Strategy 2015-20 (NHSS) under the title "Rebuilt and strengthened health systems: Infrastructure, HRH management, Procurement and Supply chain management". A target value of 0.52 for the indicator "Doctors per 1,000 population" would be set for the year 2020 (Baseline 2013: 0.18).

Accessibility

The Nepalese situation is characterized by significant urban/rural imbalances (Mehata et al. 2017; Pandey et al. 2013), which has an impact on health care. This is why only 34% of Nepalese households have access to medical facilities within 30 minutes of their house (Mehata et al. 2013). This limits not only the attractiveness of social health insurance but also the actual feasibility of visiting a doctor. Several studies state that the reimbursement of travel costs as a proposed solution to at least cushion the financial burden of a visit to the doctor since the actual cost of care might be less of a barrier than other non-medical costs (Mishra et al. 2015). In this respect, the absence of sickness benefit coverage for most of the population is an additional factor that limits access to timely care.

In addition to geographical barriers, the social inequalities inherited from the caste system officially abolished in Nepal also play an important role when it comes to access to health care. For example, in the Nepal Demographic and Health Survey 2011, a clear difference in the rate of use between different ethnic groups was found, according to which Dalit and Jan Jati (tribal) women were disadvantaged as members of ethnic minority groups. A 2014 study tried to identify underlying factors in this context. In concrete terms, lack of knowledge and trust, use and preference of traditional healing methods, limited decision-making powers of women and humiliation experienced by service providers were listed as barriers. It remains to be seen whether deficits can be eliminated, especially through targeted communication strategies in connection with the establishment of federal structures. More broadly, this calls for concerted action within the social protection system as a whole to address gender and other social inequalities.

⁹ Limitations of comparability: Different focus regions in terms of urban/rural areas.

▶ Main lessons learned

- ▶ **Subsidization of contributions for vulnerable population groups was a step towards the “universality of protection”.** The government’s decision to subsidize contributions for defined groups of vulnerable households facilitates access to health care and increases the number of people protected in both the FHCP programme and the HIB scheme. However, the participation rate of these population groups - measured in terms of the number of insured persons eligible to contribution subsidies and utilization rates - still appears to be low. Awareness programmes and expansion of the identification process proved to be key activities.
 - ▶ **Overlap of three parallel existing public health insurance schemes is an obstacle to extend coverage.** The co-existence of the different public health insurance schemes not only leads to limited coverage and confusion on the side of the population but also prevents systemic efficiency gains and limits risk pooling and solidarity in financing. At the national social protection level, the establishment of a coordinating body could avoid overlaps.
 - ▶ **Satisfaction with the service provision increases the willingness to subscribe to programmes that aim at stimulating demand.** Distrust of the public service providers led to a rejection of registration in the public health insurance system. The intended role of HIB as a purchaser and the introduction of various quality measures could provide the right impetus in this area in the future.
 - ▶ **The interrelated introduction of public health insurance and IT systems (health insurance administration systems) proved to be target-oriented.** This not only forced the necessity of concretization during the conceptualization of the entire health insurance setup (programmers needed precise information when programming the IT system) but also simplified and accelerated the registration process. In the future, this database can make an important contribution to monitoring, verification and controlling.
 - ▶ **Enrolment assistants in mission to reduce information deficits in the population.** Inadequate knowledge can be a barrier to enrolling in a public health insurance scheme. The so-called Enrolment Assistants established in the neighbourhood were able to contribute to an initially high enrolment rate through personal contact.
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- ▶ Satisfaction with the service provision increases the willingness to subscribe to programmes that aim at stimulating demand. Distrust of the public service providers led to a rejection of registration in the public health insurance system.

► Way forward

Important principles for further development of the health care system and thus for UHC are laid down in the national health sector strategy. These include the explicit desire to harmonize various schemes. A good starting point in this context is also the use of a uniform IT system. From this point of view, it is positive that work is currently underway to enable SSF to use the same system as HIB. The database thus obtained can be an important basis for evaluations and evidence-based decisions in the future.

Not only at the level of health care but also in the area of social protection as a whole, efforts are underway to achieve greater coordination and cooperation. The work on a National Social Protection Framework, which began in 2010, is one example. Motivated by this framework to consolidate the fragmented range of schemes, a National Steering Committee on Social Protection was set up on behalf of the Planning Commission.

It has been shown that high-quality care is also an important factor in making any programme aiming at stimulating demand more attractive (thus increasing enrolment rates and reducing drop-out rates). Although several quality-related indicators have already been defined and legislation has been introduced, a strengthened role of strategic purchasing could be helpful. Through financial and non-financial incentives, they could actively contribute to improving the service provider side.

In summary, it can be concluded that a lot has been implemented and achieved in the UHC area, particularly in recent years. The fact that HIB initially addressed the informal sector is particularly noteworthy. In the next few years, it will be crucial to raise awareness among the entire population and to bundle and further develop the existing approaches in a coordinated manner.



► Table of statistical indicators

Table 5.1: Statistical indicators: Nepal

Dimension	Sub-Dimension	Indicator (latest available year)	Latest available year
Context	Population	Number of inhabitants (2019)	28,608,715
	Population	GDP per capita (2018)	1034
	Growth and employment	GDP growth in % (2018)	6.66%
	Population	Life expectancy at birth (2018)	70.48
	Growth and employment	% of workers in informal employment out of total employment (2018)	77.62
	Growth and employment	Poverty rate in % (2010)	25.2%
Expenditure	Expenditure	Total Health Expenditure (THE) as a % of GDP (2017)	5.55
	Government expenditure	Domestic General Government Health Expenditure as % Gross Domestic Product (2017)	1.2
	Government expenditure	Domestic General Government Health Expenditure as % of THE (2017)	22.34
	International aid	International public health expenditure (aid) as % of THE Budget of MoHP (Budget FY 2019/20)	21
	OOP	Out-of-pocket spending as % of THE (2017)	57.80
	PHC	Current primary health care expenditure as % of Total Health Expenditure (2017)	49.06%
Legal coverage	Legal coverage	Social Health Protection legal coverage, in % of the population (2019)	99%
Effective coverage	Population coverage	% of the total population affiliated to a scheme (protected persons) (should be equal to the sum of inventory of schemes)	11
	Service coverage	Health service coverage index (SDG 3.8.1) (2017)	48
	Service coverage	Utilization of health care services disaggregated by IP/OP care (if available)	NA
	Service coverage	Antenatal care coverage – at least 4 visits (2016)	69.4
	Service coverage	The proportion of births attended by skilled health personnel (SDG 3.1.2) (2016)	58
	Service coverage	Maternal mortality ratio (SDG 3.1.1) (2017)	186
	Service coverage	Under 5 mortality ratio (SDG 3.2.1) (2018)	32.2
	Financial protection	SDG 3.8.2 – Incidence of catastrophic health spending - at more than 10 per cent of total income or consumption (2014)	10.71
	Financial protection	SDG 3.8.2 – Incidence of catastrophic health spending - at more than 25 per cent of total income or consumption (2014)	2.41
	Financial protection	SDG 1.1.1 – Impoverishment due to health spending (2019)	28.5

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► Social Health Protection in PHILIPPINES

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► Introduction

Health is recognized as a human right by the 1987 Philippine Constitution, which declares that “the State shall protect and promote the right to health of the people”. In the last decade, remarkable progress was made towards the achievement of universal health coverage (UHC) in the Philippines. Currently, the national health insurance programme of the country, administered by the Philippine Health Insurance Corporation (PhilHealth), covers 85% of the population, including more than 18 million workers in the informal economy and their dependents. In particular, the rapid expansion of population coverage was supported by sin tax revenues, showing the important role of collectively financed mechanisms to cover the costs of accessing health care. With the new UHC law in 2019, the Government laid the foundation for comprehensive reforms necessary to expand financial protection and access to health services for all.

►► The rapid expansion of population coverage was supported by sin tax revenues, showing the important role of collectively financed mechanisms to cover the costs of accessing health care.

► History

The Filipino government introduced its first mandatory health insurance scheme (Medicare) for public and private sector employees in 1969. The National Health Insurance Act of 1995 established the national health insurance organization, PhilHealth, for the implementation of the national health insurance program (NHIP). Since then, the Filipino Government has continuously worked towards the expansion of coverage to all segments of the population, including those in the informal economy and other hard-to-reach groups. Significant milestones include the introduction of the sponsored programme for poor households and a no-balanced-billing policy for these households as well as the launch of partnership programmes with Organized Groups in 2003 and microfinance institutions in 2006 to facilitate the enrolment of informal economy workers. Funded by an increase in the sin tax on tobacco and alcohol, full subsidies were also extended to the poor and the near-poor population in 2012 through an amendment of the National Health Insurance Law.

Efforts towards expanding coverage continued with the UHC Act, which was signed into law in 2019. The main features of this reform aim to respond to the current challenges of the system: automatic enrolment of all citizens to PhilHealth; enhancing financial protection; improvement of health facilities, especially in underserved areas; responding to the gap in health workers and improving health service delivery.

►► The National Health Insurance Act of 1995 established the national health insurance organization, PhilHealth, for the implementation of the national health insurance program (NHIP). Since then, the Filipino Government has continuously worked towards the expansion of coverage to all segments of the population, including those in the informal economy and other hard-to-reach groups.

► Design

Financing

In 2019, total health expenditure stood at PHP 906 billion, equivalent to 4.6% of the national GDP.¹⁰ The main financing sources of the health system include public health expenditure, comprising general government revenues and mandatory social health insurance contributions (42% of THE), voluntary social health insurance contributions (10.1% of THE) and OOP (47.9% of THE) (WHO 2020a).

Increased government revenues from sin taxes on tobacco and alcohol allowed the creation of additional fiscal space to extend the coverage of PhilHealth.¹¹ In December 2019, the Philippines Congress ratified the bill on the increase of excise taxes on alcohol, vapes, and e-cigarettes (Department of Finance 2019). This Package 2+ of the Comprehensive Tax Reform Program (CTRP) aims to fill the PHP 75 billion (USD 1.47 billion) funding gap within the budget for 2020, required for the successful implementation of the UHC Law. This measure is expected to result in PHP 47.9 billion (US\$939 million) of additional revenues in 2020. The additional funding will ensure coverage for over 120 primary care drugs, all conditions at the primary care level.

The NHIP is financed by central and local government revenues and social health insurance contributions. Instead of seven categories of members as previously, the new UCH Law simplifies it into two main categories of insured persons: “direct contributors” (contributors from payroll) and “indirect contributors” (fully subsidized from tax revenues).¹² For direct contributors, 2.75% of their monthly payroll is jointly paid by themselves

► In December 2019, the Philippines Congress ratified the bill on the increase of excise taxes on alcohol, vapes, and e-cigarettes (Department of Finance 2019). This Package 2+ of the Comprehensive Tax Reform Program (CTRP) aims to fill the PHP 75 billion (USD 1.47 billion) funding gap within the budget for 2020, required for the successful implementation of the UHC Law.

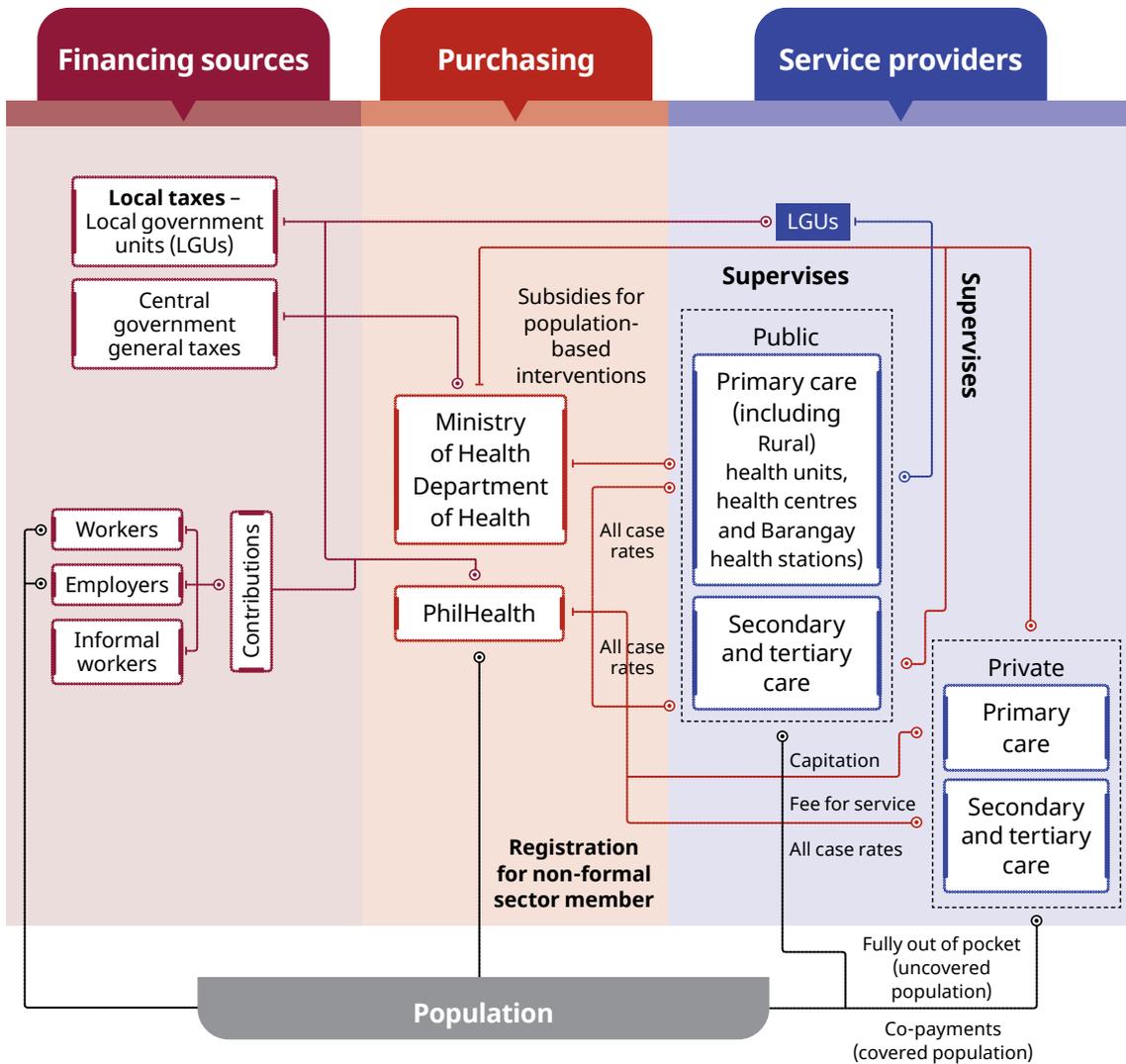
and their employer (where there is one). The salary floor of the contribution is PHP 10,000 (US\$ 195) and the ceiling is PHP 50,000. The UHC Act foresees the increase of contribution rates to 5% by 2025. For indirect contributors, such as indigent and sponsored members, senior citizens and persons with disabilities, contributions are fully subsidized by the government.

¹⁰ <https://psa.gov.ph/pnha-press-release/node/163258>

¹¹ Another benefit of imposing higher excise taxes on sin products, thus increasing their prices is discouraging their consumption among all consumers. Available information on sin taxes indicates that, at the macro level public health gains for the poorest population due to reduced consumption, combined with free health insurance for the poorest, could offset the regressive effect on households of indirect taxes like sin taxes (Kaiser, Bredenkamp, and Iglesias 2016).

¹² Direct contributors refer to those who have the capacity to pay contributions, are gainfully employed and are bound by an employer-employee relationship, or are self-earning, migrant workers, including their qualified dependents, and lifetime members (i.e., individuals aged 60 years and above who have paid at least 120 monthly contributions with PhilHealth and the former Medicare Programs of SSS and GSIS). Those that receive full subsidies include indigent and sponsored members.

Figure 6.1: Financing flows for SHP in the Philippines



Governance

The health system in the Philippines is under the overall leadership of the Department of Health (DOH), which is the regulatory authority responsible for developing policies and ensuring access to healthcare services, as mandated by the National Health Insurance Act of 2013. In addition, it implements public health programmes, such as HIV/AIDS, TB and Malaria, and provides many tertiary health services. The national health insurance organization PhilHealth

is a government corporation attached to the Department of Health for policy coordination and guidance, and is responsible for administering the NHIP. The functions of PhilHealth are collecting contributions, processing claims, defining provider payment mechanisms, accrediting providers, creating benefits packages, and reimbursing health providers. PhilHealth is governed by its Board of directors. All 13 members of the Board are appointed by the President and include representation from other government

departments and agencies (DOH, DOLE, DOF, DBM), and representatives of employers and workers in the private sector (Government of the Philippines 2017; PhilHealth 2017). The health system is highly decentralized and fragmented with significant responsibility for health financing and service provision allocated to the local government units (LGU).

According to the new UHC law, the role of DOH will be focused more on regulation, policy development, standard-setting and guiding implementation at the local level, while PhilHealth's role as a national purchaser of services will be strengthened. The DOH and LGUs will be responsible for population-based interventions and health services (e.g., immunization programs and health promotion programs), while PhilHealth will finance individual-based health services.

Coverage

PhilHealth increased its population coverage from 73% in 2007 (64.6 million members including dependents) to 85% of the total population in 2020 (93.3 million beneficiaries). Direct contributors count 59 million beneficiaries, and indirect contributors count 34 million beneficiaries (PhilHealth 2020). However, a large share of the population is unaware or unable to access their benefits (see below).

In the past, enrolment was mandatory for all formal sector members, sponsored members, and the indigent. Workers in the informal economy members, including migrant workers, lifetime members, senior citizens, OWP members and their spouses enrol on a voluntary basis. With the changes introduced by the new UHC Law, the goal is to automatically enrol all Filipinos in the NHIP, thereby progressively realizing universal health coverage (Congress of the Philippines 2018a).

Benefits

Currently, the benefits package includes the following services (positive list): i) inpatient benefits, ii) Z-benefits package which expands the scope and depth of the inpatient benefit package to additional conditions, such as cancer, that are especially prone to leading to catastrophic expenditure, iii) outpatient benefits: day surgery,

 **PhilHealth Board members, appointed by the President, include representatives from other government departments and agencies (DOH, DOLE, DOF, DBM), and representatives of employers and workers in the private sector.**

radiotherapy, hemodialysis, outpatient blood transfusion, primary care benefits, iv) other outpatient treatment packages for HIV/AIDS, malaria, tuberculosis, surgical contraception and animal bites reimbursed through case-based payments, and v) tuberculosis (TB) DOTS package (PhilHealth, 2019). Under the National Safe Motherhood Programme, Filipino women have full access to health services during their pregnancy and delivery. The benefits are the same for all member categories, except for the outpatient primary care benefits that are available only for indigent and sponsored beneficiaries. The new UHC law foresees to provide all citizens a benefits package that includes comprehensive outpatient services.

Provision of services/benefits

The service delivery system in the Philippines includes hospitals, primary care facilities and other facilities such as maternity care providers, outpatient HIV/Aids Treatment Centers, DOTS package providers and ambulatory surgical clinics. Out of 8,416 health care providers, there are 4,258 government and 4,158 private providers (PhilHealth 2020). Among all accredited hospitals, 60% are from the private sector. The delivery of services at various levels of care is highly fragmented. A referral system is not in place, which is one of the major constraints to quality care (Dayrit et al., 2018). To reduce fragmentation in service delivery, the new UHC law, therefore,

mandates the setup of health care provider networks (HCPNs) organized within the province- or city-wide health systems, and the establishment of a primary care network of public and private providers that serve as an initial contact point and facilitate two-way referrals.

Affiliation/Registration process

Once PhilHealth Membership Registration is completed, each new member is given a PhilHealth ID Card and the Member Data Record (MDR). Each member of PhilHealth is entitled to a PhilHealth ID Card which is also recognized as a means of identification in the Philippines (PhilHealth 2016). However, certain challenges have been observed regarding the PhilHealth registration process, such as the time and money needed to submit required documentation, thus many families were

unable to access PhilHealth benefits. In 2014, the enrolment process was simplified by reducing the requirements for supporting documentation (PhilHealth 2014).

Use of digital technologies

Online payment of contribution is possible through PhilHealth online payment options for employers. The Moneygment, an independent mobile application, serves as a contribution payment tool for self-employed individuals, small to medium enterprises, OFWs, and those without bank accounts (Moneygment 2020). It also allows better tracking of total expenses against one's income through "zero-based budgeting." Through the application, users can not only pay their PhilHealth contributions but also compute and file their taxes, utility bills, loans and other insurance payments.



► Results

Population coverage

Gradual expansion of social health insurance coverage, including to workers in the informal economy, through a rights-based approach, has led to high coverage in the Philippines. PhilHealth successfully extended coverage to more than 18 million workers in the informal economy and their dependents through adapted mechanisms. The expansion of population coverage was supported by sin tax revenues, suggesting important role of taxes in supporting efforts to move towards universal social protection coverage and more specifically UHC. With the introduction of the automatic enrolment of all Filipinos through the new UHC Law, legal coverage increased from 98% in 2018 to 100% of the total population. However, more efforts are needed to ensure that there are no barriers to effective coverage, particularly among workers in the informal economy and migrant workers who do not seem to be covered in the new law. Many of these workers may not be poor enough to qualify for the government subsidies, but they may also not be able to pay regular PhilHealth contributions on their own.

Financial protection

In 2019, about 47.9% of total health expenditure came from OOP, while the incidence of catastrophic spending stood at 6.3% (WHO and World Bank 2019).¹³ The limited financial protection of members is also reflected in the low benefits-to-contribution ratio. For example, for employees in the private sector, benefits payment stood at PHP 20.3 billion versus PHP 50.4 billion contribution payment. The lack of PhilHealth coverage of medicines, and the high cost of drugs and medicines as well as laboratory and diagnostics were identified as the main drivers behind the high OOP (PhilHealth, 2018). In 2018, benefits payment to contribution collection was lower for all member groups, except for indigent

and sponsored members. This is most likely due to the no-balance-billing (NBB) policy applicable only for indigent and sponsored members, which stipulates that no other fees or expenses shall be charged to or paid for by the members above PhilHealth's package rate. Evidence suggests that even with this measure, the enforcement of the NBB may need to be more stringent to ensure financial protection of the most vulnerable and it would need to be expanded since the NBB Programme covers only confinements in basic or ward accommodation (Dayrit et al. 2018a).

The new law is expected to significantly reduce the high OOPs for health. According to the new UHC Law, population-based health services will be provided free of charge, financed by the government through the DOH (Congress of the Philippines 2018a). In addition, no co-payment will be charged for services rendered in basic accommodation and a fixed co-payment can be expected for amenities in public hospitals, regulated by the DOH and PhilHealth (Congress of the Philippines, 2018a).

Benefits package

PhilHealth beneficiaries have access to a package of services, including inpatient care, catastrophic coverage, ambulatory surgeries and deliveries. However, the scope of PhilHealth benefits is still largely focused on inpatient care, with outpatient benefits not a universal entitlement. A noteworthy policy is PhilHealth's introduction of the TB DOTS outpatient benefit package to deal with the burden of tuberculosis. Accredited TB-DOTS centres (public and private) were strategically conceptualized by the Philippine Coalition Against Tuberculosis and PhilHealth to help finance the detection and treatment of TB cases by PhilHealth. Only accredited facilities providing TB-DOTS treatment are eligible to receive reimbursement from PhilHealth. By 2020, 20% of all PhilHealth accredited facilities provide the TB DOTS package

¹³ <https://psa.gov.ph/pnha-press-release/node/163258>

(PhilHealth, 2020). This initiative highlights the importance of integrating benefit package and building partnerships between the social health protection system and the broader health system.

In 2019, PhilHealth reimbursed almost PHP 97.34 billion to health facilities for their services to the patients (PhilHealth 2018). There were several payment mechanisms in the Philippine social health insurance system. Fee-for-service was used to pay for certain services, while capitation was used to pay LGUs for primary care services. Starting in 2011, PhilHealth has decided to shift the provider payment mechanism away from a fee-for-service system with benefit ceilings to case-based rates, first for the 23 case rates and subsequently expanded in 2014 to cover all inpatient medical and surgical cases. However, in 2019, PhilHealth revealed that 100 percent of hospital costs covered by its case rate system have either been underpaid or overpaid.¹⁴ There is a lack of effective auditing processes to ensure transparency of reimbursement of providers, which reduces value for money. The UHC Law and Implementing Rules and Regulations instruct PhilHealth to shift to paying providers using performance-based, prospective payments based on disease or Diagnosis related group and develop different payment mechanisms that give due consideration to service quality, efficiency and equity (Department of Health 2019; Congress of the Philippines 2018c).

Utilization

In general, utilization of hospital services in the Philippines among the poor remains low (Dayrit et al., 2018). One study found that the likelihood of facility-based delivery for women who are insured through the PhilHealth subsidized coverage program is 5-10% higher than for those without insurance. The impact is slightly more pronounced in rural areas with poor women, where insurance leads to a 9-11% higher likelihood of facility-based delivery (Gouda et al. 2016). Another study on utilization in the Philippines from 2016 found moderate wealth-based disparities in institutional delivery (Hodge et al. 2016).

A recent study showed the membership in PhilHealth increases the likelihood of outpatient

▲▲ A survey among women aged 15-49 years showed that 12.6% of women in urban areas and 8.4% in rural areas decided not to deliver a baby in a health facility because of the poor quality service and lack of trust (Philippine Statistics Authority 2017).

services utilization by 6-6.5 percentage points for adults and 4.7-8.1 percentage points for children below 15 years (Balamiento 2018). The probability of inpatient care among adults, increased by 4.1-8.2 percentage points among PhilHealth indigent members compared to non-members, according to the same study. The effect of PhilHealth membership is higher for children below 15 years old than adults (Balamiento 2018).

Quality

A key challenge in the health system is the lack of quality, mainly related to the limited number of health facilities and shortage of staff, especially in geographically disadvantaged areas. A survey among women aged 15-49 years showed that 12.6% of women in urban areas and 8.4% in rural areas decided not to deliver a baby in a health facility because of the poor quality service and lack of trust (Philippine Statistics Authority 2017). One of the constraints to quality improvement is the absence of an efficient referral system. This prevents patients from navigating the health system effectively and can increase waiting times for the patients and prevent them from getting timely care. An effective (and mandatory) referral system, envisaged by the new UHC Law, may prevent duplication of diagnostic procedures and improve the overall quality of care (Dayrit et al., 2018).

¹⁴ <https://www.cnnphilippines.com/news/2020/8/12/philhealth-case-rate-2019.html>

► Main lessons learned

Gradual expansion of social health insurance coverage, including to workers in the informal economy, through a rights-based approach, has led to high health population coverage in the Philippines. PhilHealth has successfully extended coverage to more than 18 million workers in the informal economy and their dependents through adapted financing and administrative mechanisms. The expansion of population coverage was supported by sin tax revenues, suggesting that taxes could play an important role in supporting efforts to move towards universal health coverage.

Despite broad population coverage, the burden of health expenditure remains high for Filipino households underlying the need to consider benefit adequacy. The financial burden of out-of-pocket expenditure and impoverishing health expenditure remains high, reflecting that universal legal population coverage is not enough in itself to provide financial protection. Effective coverage through a broad benefits package and limited co-payments is essential to move towards the adequacy of benefits in line with international social security standards.

Low PhilHealth share of total health expenditure prevents comprehensive coverage. PhilHealth contributes only 17% to the country's total health expenditure, mostly due to issues with effective coverage of the benefits package and underutilization of health services by the indigent members. Expanding the benefit coverage breadth and width for vulnerable groups would ensure both higher PhilHealth funding of health facilities and broader risk pooling across the nation. Although its coverage has expanded greatly over the years, a higher share of total health expenditure would enable PhilHealth to provide higher financial protection for its members. In addition to providing more money for health, the recently introduced UHC Law aims to deliver more health for the money by reducing inefficiencies through consolidation of the system and strengthened governance.

► Accredited TB-DOTS centres (public and private) were strategically conceptualized by the Philippine Coalition Against Tuberculosis and PhilHealth to help finance the detection and treatment of TB cases by PhilHealth. By 2020, 20% of all PhilHealth accredited facilities provide the TB DOTS package (PhilHealth, 2020)

PhilHealth introduced the TB DOTS outpatient benefit package to deal with the burden of tuberculosis that has shown the need for outpatient care coverage and provides an interesting illustration of the integration of formerly vertically-funded programmes. Accredited TB-DOTS centres (public and private) were strategically conceptualized by the Philippine Coalition Against Tuberculosis and PhilHealth to help finance the detection and treatment of TB cases by PhilHealth. By 2020, 20% of all PhilHealth accredited facilities provide the TB DOTS package (PhilHealth, 2020). This initiative highlights the importance of integrating benefit package and building partnerships between the social health protection system and the broader health system.

► Way forward

The Philippines has made remarkable progress towards UHC by extending social health insurance coverage to large parts of the population. The allocation of subsidies to the coverage of vulnerable groups with low contributory capacities and its financing through sin taxes is particularly noteworthy. Similarly, the existence of a central purchaser managing all the different entry points into the system is an effort towards more equity and provides an opportunity for impactful purchasing strategies. However, the financial burden of out-of-pocket expenditure and impoverishing health expenditure remains high at almost 50% of total health expenditure, reflecting that high population coverage is not enough in itself to provide financial protection and that adequacy of benefits, with a comprehensive benefits package including primary care, is of the essence. In addition, increased investments in health infrastructure and efforts to enhance the quality, availability and accessibility of the system are required.

The UHC Law of 2019 sets an ambitious reform agenda towards a system that guarantees equitable access to quality and affordable health care and financial protection for everyone. The law stipulates structural changes in health financing, service delivery, and governance, aiming to address fragmentation in the system. It plans to establish province- or city-wide health systems, starting with 33 selected pilot provinces and articulates in an innovative manner financing streams for population-based and individual-based interventions. The lessons learned will be used by DOH and PhilHealth to support the eventual rollout of the law.

►► The UHC Law of 2019 sets an ambitious reform agenda towards a system that guarantees equitable access to quality and affordable health care and financial protection for everyone. The law stipulates structural changes in health financing, service delivery, and governance, aiming to address fragmentation in the system.

► Table of statistical indicators

Table 6.1: Statistical indicators: Philippines

Dimension	Sub-Dimension	Indicator	Year	
Context	Population	Population	108,116,615	2020
	Growth and employment	GDP per capita (current US\$)	3,103	2018
	Growth and employment	GDP per capita growth (% change per year)	6.24%	2018
	Population	Life expectancy at birth	70.95	2017
	Growth and employment	% of workers in informal employment out of total employment	39%	2017
	Poverty	Poverty headcount ratio at national poverty level (% of the population)	21.6%	2015
Expenditure	Expenditure	Per capita current health expenditure (CHE) (current US\$)	133	2017
	Expenditure	CHE as % of GDP	4.45%	2017
	Government expenditure	Government health expenditure as % GDP	1.41%	2017
	Government expenditure	Government health expenditure as % of CHE	31.91%	2017
	Government expenditure	Government health expenditure as % of total government expenditure	7.12%	2017
	Government expenditure	Government schemes and compulsory contributory health care financing schemes expenditure as % of CHE	35.00%	2017
	Voluntary health expenditure	Voluntary health care payment schemes expenditure as % of CHE	11.95%	2017
	International aid	External health expenditure as % of CHE	2.59%	2017
	OOP	Out-of-pocket spending as % of CHE	53.04%	2017
	PHC	Current primary health care expenditure as % of CHE	51.89%	2016

Dimension	Sub-Dimension	Indicator	Year	
Legal coverage	Legal coverage	Social Health Protection legal coverage, in % of the population	100%	2020
Effective coverage	Population coverage	% of the total population affiliated to a scheme (protected persons)	93.00%	2017
	Service coverage	Health service coverage index (SDG 3.8.1)	57.00	2017
	Service coverage	Number of inpatient visits per capita per year	0.01	2016
	Service coverage	Number of outpatient visits per capita per year	4.86	2016
	Service coverage	Antenatal care coverage – at least 4 visits	86.50%	2017
	Service coverage	Proportion of births attended by skilled health personnel (SDG 3.1.2)	84.40%	2017
	Service coverage	Maternal mortality ratio (SDG 3.1.1)	100	2018
	Service coverage	Under-five mortality rate (SDG 3.2.1)	29	2017
	Financial protection	SDG 3.8.2: Incidence of catastrophic health spending (at more than 10% of total income or consumption)	6.31	2015
	Financial protection	SDG 3.8.2: Incidence of catastrophic health spending (at more than 25% of total income or consumption)	1.41	2015
	Financial protection	Incidence of impoverishment due to out-of-pocket health spending (%) Poverty line: \$1.90 a day (2011 PPP)	0.48	2015
	Financial protection	Incidence of impoverishment due to out-of-pocket health spending (%) Poverty line: \$3.20 a day (2011 PPP)	1.37	2015

Sources: (WHO 2020b), (WHO 2020a), (World Bank 2020), (IHME 2019)

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▶ Social Health Protection in VIET NAM

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▶ Introduction

With the recognition of the right to social security, including health protection and care, in the 2013 Constitution of the Socialist Republic of Viet Nam, the country has reaffirmed the priority of Universal Health Coverage (UHC). Currently, the Government of Viet Nam (GoV) is targeting 90.7 per cent participation in social health insurance by 2020, with 100 per cent coverage of the poor, the elderly and other vulnerable groups.¹⁵

With 25 years of experience in implementing Social Health Insurance (SHI), Viet Nam has made laudable progress towards UHC. However, significant challenges remain in terms of improving the quality of care and the financial sustainability of the scheme. Ensuring an adequate level of financial protection to all remains arduous.

This policy brief documents the evolution of the social health protection mechanisms in Viet Nam over the past decades and draws key learnings

from this experience, while highlighting remaining gaps towards UHC.

SDG 1.3 aims to implement nationally appropriate social protection systems and measures for all, including floors, and by 2030, achieve substantial coverage of the poor and the vulnerable.

Social protection floors (SPFs) guarantee access to essential health care and basic income security for children, persons of working age and older persons. A total of 185 countries have adopted the Social Protection Floors Recommendation, 2012 (No. 202), to achieve universal social protection.

This note presents a successful country experience of expanding social protection.

¹⁵ Decision No. 1167/QĐ-TTg of Prime Minister on amendment of target on HI coverage in the period 2016-2020

► History

Viet Nam enshrined the right to health care and protection for all citizens in its Constitution for the first time in 1992. The same year based on a three years pilot study, the National Viet Nam Health Insurance Programme was introduced. With out-of-pocket spending reaching 70% of total health spending in the early 1990s, the programme's mandate was to facilitate financial access to health care. The scheme provided mandatory coverage for certain population groups, namely civil servants, employees of state-owned enterprises, employees of private companies (with more than 10 employees) and pensioners. The rest of the population could enrol in a separate voluntary scheme.

In 2003, the Health Care Fund for the Poor (HCFP) was set up, using Government revenues to provide social health protection to the poor, ethnic minorities in selected mountainous areas, and all households living in municipalities officially designated as highly disadvantaged.

The first Health Insurance Law (HIL) was adopted in 2008. The law made coverage compulsory for children under 6 years, the elderly, the poor, and near-poor. It provided full subsidies for these groups and ethnic minorities, as well as partial subsidies to near-poor and students. It also integrated the HCFP into the existing health insurance scheme, giving birth to the social health insurance single pool.

The HIL incorporated a roadmap for planning the enrolment of all remaining categories, starting with farmers, workers in agriculture, forestry, fishery sectors and salt producers (included in 2012), and finally the self-employed, family dependents and others (in 2014). In the roadmap ratified by the Prime Minister's Decision 538/QD-TTg in 2013, the coverage target was set to over 80 per cent by 2020. In 2016, in light of the successful achievements in terms of population coverage, the target was revised upwards - 90 per cent by 2020 - through the Prime Minister Decision 1167/QD-TTg on amendment of Health Insurance coverage target 2016-2020.

►► In 2003, the Health Care Fund for the Poor (HCFP) was set up, using Government revenues to provide social health protection to the poor, ethnic minorities in selected mountainous areas, and all households living in municipalities officially designated as highly disadvantaged.

While the HIL 2008 introduced, in principle, a single pool for SHI and HCFP, in practice high fragmentation remained at the provincial level. Confronted with an inefficient health financing system (Barroy, Jarawan, and Bales 2014), the GoV revised the Health Insurance Law in 2014, reinforcing measures to ensure compliance with compulsory enrolment for all.

Since then, the GoV issued a series of legal documents progressively expanding mandatory enrolment to the entire population, now categorized into six groups and 35 different sub-groups (Decree 146/2018/ND-CP). Named after the source of payment of their contributions, the six groups are as follows: Employer/employee; Social Insurance; State Budget; State Budget (partial subsidies); Households; Employees (dependents of military and public security services).

► Design

Governance

The SHI is implemented and managed by the Viet Nam Social Security (VSS), a public service agency. The VSS is also responsible for collecting contributions for all social security benefits,¹⁶ including social health insurance and processing benefit payments.

The Ministry of Health (MOH) has oversight and regulatory function. The Minister of Health is in charge of monitoring and evaluation of SHI and reports on the scheme's performance to the National Assembly of Viet Nam. MOH is also responsible for setting prices of medical services (Oanh and Phuong 2016). In parallel, the Ministry of Labour, Invalids and Social Affairs (MOLISA) is responsible for identifying vulnerable households and establishing lists of poor and near-poor households.

Financing

The GoV support to Social Health Protection was demonstrated through high budgetary allocations to the health sector. In 2016, Domestic Government health expenditure represented 47 per cent of the current health expenditure, and between 8 and 10 per cent of General Government expenditure in the years following the adoption of the HIL 2008.¹⁷ This support was essential to the subsidisation of contributions for the most vulnerable populations.

Benefit package

Currently, the Social Health Insurance (SHI) scheme provides a unique, broad benefits package to all members. This has been, from the start, a major

feature of the scheme. In addition to curative and rehabilitative services, the benefit package covers preventive services including immunization and control and prevention of infectious diseases (AIDS included)¹⁸. In practice, however, access to this broad package is hindered by limited health facilities equipment and low quality of services at the primary level. The set of benefits covered also lacks prioritisation, as its composition does not rely on systematic Health Technology Assessment processes. Fifty-one per cent of the expenditure on selected medicines reimbursed through the SHI is considered to be inappropriate for the specified indications.¹⁹

Provider payment methods

Under the health insurance law, three types of provider payment methods can be applied. These are capitation for primary health care; fee-for-service for all secondary and tertiary hospitals and for referral health services, including high-cost services that are not paid by capitation; and Diagnosis related group (DRG) piloted in a few hospitals. In reality, all providers are paid fee-for-service.

In 2016, the MOH developed new specific guidance on payment, which led to a general decrease in health services' tariffs for VSS providers. Since then, abuses in provider's tariff settings were observed in many places. The VSS now uses an electronic health insurance assessment system, which partly addresses this issue. Indeed, the MOH promoted the application of Information Technology (IT) in health services management, assessment and payment, with the aim of improving administrative procedures. The early deployment

¹⁶ VSS also covers benefits related to maternity, old-age, employment injury, unemployment

¹⁷ However, public resource mobilization is constrained by low tax revenue collection.

¹⁸ In addition to prevention, the scheme covers ART, lab tests required during ART such as virus load and CD4 counting

¹⁹ Kieu T., Health Technology Assessment and Its Application in Viet nam, Value in Health, June 2017

of IT applications has also contributed to avoiding fraud from patients and service providers.

Primary health care

Earlier efforts have focused on strengthening primary care (PHC) in Viet Nam, which led to relatively equitable access to PHC and a pro-poor distribution of benefits at the primary level (World Health Organization 2018b). Specifically, the MOH issued a Circular regulating basic health service packages for grassroots-level health facilities. Accordingly, the basic health service package offered by VSS includes almost 80 technical services for medical examination and treatment and 241 drugs that health stations should provide (including commune and ward health stations, town and equivalent, independent family doctor clinic, civilian army medical station and civilian-military clinics).

Providers' network

As per regulation, the VSS facilities network includes all public facilities and all licensed private facilities registered with VSS. In 2018, out of a total of 2,316 contract providers, 23 per cent were private. This broad network aims to ensure maximal geographical access to providers and gives a choice to the patient. This requires a necessary tradeoff between minimum quality standards, ensuring geographic access to everyone. As a consequence, a number of facilities are included on the list of approved facilities, though while not yet meeting the government licensing requirements.

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► Results

Effective population coverage

As of 31 December 2018, 87.7 per cent of the total population was covered by the SHI, meaning that the target for 2018 was reached.²⁰ These results were achieved because of the great commitment of the Government, VSS and MOH in the past few years, as described earlier.

However, population coverage remains inequitable. The enrolment rates are highest among low- and high-income groups, but persistently low among groups in the middle due to low enrolment of the near poor: the “missing middle” (Somanathan et al. 2014). Even when they are enrolled, irregular collection of contributions from independent and informal workers creates gaps in coverage. Similarly, about 40 per cent of the elderly population, many of whom are poor and live in rural areas, are not covered by SHI (Asian Development Bank 2016). Despite recent progress linked to the Law on Enterprise,²¹ nearly 20% of formal workers are not affiliated to the SHI (General Statistics Office of Viet Nam and International Labour Organization 2016). This is believed to be due to various factors, including weak enforcement measures, collusion between employees and employers in under-reporting monthly salary and paying contributions, and overall lack of knowledge on SHI and its benefits (Matsushima 2014).

Utilisation of services

The extension of SHI coverage had a positive impact on health services utilization, as demonstrated for children under 14, for example. During 2010-2012, the student health insurance programme and free health insurance programme increased the number of health care visits of children by

►► During 2010-2012, the student health insurance programme and free health insurance programme increased the number of health care visits of children by approximately 13.6 and 66.1%, respectively (Nguyen 2016). Utilization rates show very few differences between rural and urban areas, revealing high geographic equity.

approximately 13.6% and 66.1%, respectively (Nguyen 2016). Utilization rates show very few differences between rural and urban areas, revealing high geographic equity.

Yet the better offs use mostly Central and Provincial Hospitals while the poor and near-poor seek care at Community Health Centres and District hospitals first. This can partly be attributed to the perception of low quality of care at the grassroots level. The rich (5th socioeconomic quintile) are also more likely to use certain health services than the poor: in 2013 there were still 23 points difference between the skilled birth attendance rates of the two quintiles (World Health Organization 2018a).

²⁰ GoV target coverage rates in the year (88.1% in 2019 and 90.7% in 2020).

²¹ According to this Law, the companies are responsible for registering employees that contracted for more than 3 months to social insurance.

Risk pooling

Due to lower utilisation of services, the poor and the near-poor accounted for a larger share of revenue than expenditure, in practice subsidizing other groups (Joint Learning Network for Universal Health Coverage 2015).

Viet Nam's SHI is still highly fragmented, with 63 provincial funds, and only marginal equalization is made across these funds through central reserves. Redistribution effects are therefore often regressive, from poorer to richer regions or groups (Barroy, Jarawan and Bales 2014). The consequence is limited risk sharing and reverse cross-subsidisation.

Financial protection

OOP spending dropped from 49 per cent in 2012 to about 44.6 per cent in 2016. However, considering that 87 per cent of the population is covered by the SHI, out-of-pocket spending remains significantly high. Interestingly, recent evidence²² shows that OOP payments are mainly paid by the richest quintiles (48.2 per cent of In-Patient care, 43.8 percent of Out-Patient care) and offered mainly at provincial and central hospitals. The poorest households (lowest quintile) accounted for only 6.2 per cent and 5.8 per cent of total OOP expenditures for in-patient and out-patient care, respectively, mainly at lower levels (commune and districts). This is believed to be the result of effective financial protection (the poorest do benefit from the zero co-payment policy) but could also be a consequence of low access to health services.

Financial sustainability

Revenues of the SHI scheme have increased steadily over the years, especially through the contributions from employers and workers and the state budget for subsidized groups. For instance, contributions from employers and workers in 2016 were almost double their level in 2015. Due to the mixed financing relying on contributions and subsidies, the participation of each group in the total membership is not proportional to the revenues they "generate". For instance, the group of employers and workers accounted for 40 per cent of 2018 total revenues but for only 15.5 per cent of the total population enrolled in the SHI scheme. On the contrary, contributions from households and other groups (including people of working age in informal employment) generated 8.8 per cent of total revenues but 18 percent of the total membership.

The benefits packages in Viet Nam remain generous which increases the burden on SHI spending (Oanh and Phuong 2016). In addition, some hospitals tend to oversupply expensive services, and there are no incentives for cost control or efficiency improvements at the facility level. Yet, some measures have already led to efficiency gains at central level. For example, the MOH and VSS organized a national drug tender, saving hundreds of billions of Vietnamese dong (VND).²³

²² General Statistics Office of Viet nam, Viet Nam Household Living Standards Survey, 2016

²³ <https://vietnamnews.vn/society/419259/first-centralised-drugs-bid-saves-21-million.html#PHQDgzH8w8Kcm9w3.97>

▶ Main lessons learned

- ▶ In Viet Nam, asserting the right to health care and protection in the Constitution and establishing a sound legal basis for UHC facilitated the extension of social health protection coverage.
- ▶ Political commitment was - and still is - extremely important to develop and enforce related laws and regulations and guarantee adequate funding.
- ▶ Legally asserting SHI as mandatory for all was key in achieving nearly 87.7 percent of population coverage in 2018.
- ▶ The Government's pro-poor policies (e.g., subsidisation of the poor's contribution) facilitated the equitable extension of population coverage.
- ▶ Improving enrolment alone is not sufficient to guarantee effective access to all. Efforts should also focus on the adequacy of the benefits provided, looking in particular at strengthening Primary Health Care and improving quality of care at all levels.



► Way forward

While significant progress has been achieved on the way to UHC in Viet Nam recently, some important reforms are being considered to further strengthen efficiency and equity, while reducing OOP spending.

Financial sustainability

The most pressing issue regards the financial sustainability of the scheme. VSS runs on a deficit since 2016. In 2018, 60 out of 63 provinces ran on a deficit, which reached, at national level the equivalent of 17 percent of the scheme's revenues. Revenues from contributions remain low and the financial viability of the scheme is dependent upon the state allocation. In 2017, the state budget contributed to 43.3% of total SHI revenues.²⁴

Management

Responsibilities of both the MoH and VSS are clearly stipulated in regulations, but mechanisms for collaboration are missing and the coordination between the two institutions remains to be strengthened. Differences in management structures and levels of authority between MOH and VSS make communication and collaboration difficult. Measures towards the improvement of SHI governance should include clearer cooperation lines between MOH and VSS, and the strengthening of the rights and responsibilities of VSS in policy decisions affecting the financial sustainability of the scheme.

Purchasing mechanisms

The MOH and the VSS will soon develop a strategy to (i) cover long-term health services to adapt to an ageing society), (ii) continue to expand the list of bidding drugs and (iii) negotiate with firms, pharmaceutical companies, medical equipment and supplies with potential in order to ensure a reasonable and sustainable supply.

More provider payment mechanisms are actively explored. Capitation, case-based payments, and Diagnosis related group have been piloted in some provinces. Building on these experiences, VSS should also attempt to shift from fee-for-service towards more strategic purchasing mechanisms.

IT system

VSS has adopted a modernisation Plan 2016-2020, including important business process re-engineering, HR reforms and the national integration of a Management Information System (MIS) (The World Bank 2017).

The MOH is looking at building a unified information system at the primary care level, which will synchronously manage activities such as prevention, family planning, personal health management, and medical treatment. Promoting the application of information technology in medical examination and treatment will also be a priority, as well as correct social health insurance inspection and use of electronic social health insurance cards, named Integrated Social Security Card (ISSC).

ISSCs should be issued together with the MOLISA by 2020 (Decree 146/2018/ND-CP). The ISSC contains a unique ID for use within the VSS and MOLISA systems, and later linked to the National ID. A central database will provide the basic demographic information for issuing the ISSC. This will reinforce the integration of SHI with other social protection benefits.

While improving the issuance of social health insurance cards, it is necessary to strengthen monitoring and inspection - including reporting on equity - to strictly implement the provisions of the Law.

Altogether these measures are expected to provide the necessary foundation for Viet Nam to achieve its target of covering the entire population by 2025 and provide effective financial health protection to all Vietnamese and residents.

²⁴ VSS, Health insurance policy implementation Department. 2019. Current situation of health insurance policy enforcement in Viet Nam (2008 - 2018) (presentation).

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