Emerging Challenges in Implementing Universal Health Coverage in Asia

by

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Abstract

As countries in Asia converge on the goal of universal health coverage (UHC), some common challenges are emerging. One is how to ensure coverage of the informal sector so as to make UHC truly universal; a second is how to design a benefit package that is responsive and appropriate to current health challenges, yet fiscally sustainable; and a third is how to ensure “supply-side readiness”, i.e. the availability and quality of services, which is a necessary condition for translating coverage into improvements in health outcomes. Using examples from the Asia region, this paper discusses these three challenges and how they are being addressed.

On the first challenge, two promising approaches emerge: using general revenues to fully cover the informal sector, or employing a combination of tax subsidies, non-financial incentives and contributory requirements. The former can produce fast results, but places pressure on government budgets and may induce informality, while the latter will require a strong administrative mandate and systems to track the ability-to-pay. With respect to benefit packages, we find considerable variation in the nature and rigor of processes underlying the selection and updating of the services included. Also, in general, packages do not yet focus sufficiently on NCDs and related preventive outpatient care. Finally, there are large variations and inequities in the supply-side readiness, in terms of availability of infrastructure, equipment, essential drugs and staffing, to deliver on the promises of UHC. Health worker competencies are also a constraint.

While the UHC challenges are common, experience in overcoming these challenges is varied and many of the successes appear to be highly context-specific. This implies that researchers and
policymakers need to rigorously, and regularly, assess different approaches, and share these findings across countries in Asia – and across the world.

**Keywords:**

Asia; universal health coverage; informal sector; health insurance; health financing; benefit package; health care; quality

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**Research highlights**

- Among countries pursuing UHC goals, a common set of new challenges are emerging
- Covering informal workers: partial premium subsidies and outreach is insufficient
- Defining/updating benefit packages: clear processes are needed, especially for NCDs
- Ensuring supply-side readiness: service availability is insufficient and inequitable
- Success is context-specific; testing of approaches and knowledge-sharing is needed
Introduction

The number of low- and middle-income countries aspiring to achieve universal health coverage (UHC) has been increasing over the last two decades (Garrett 2009). Within the last five years, however, the articulation of these shared aspirations has become markedly louder and stronger. Since 2011, there have been four global resolutions endorsing UHC: the World Health Assembly Resolution on Sustainable Health Financing Structures and Universal Coverage in 2011 (WHA 2011), the Mexico City Political Declaration on Universal Health Coverage in 2012 (WHO 2012), the Bangkok Statement on Universal Coverage in 2012 (PMAC 2012), and the UN General Assembly Resolution in support of UHC in 2012 (UN General Assembly 2012). UHC now appears in the short list of proposed Sustainable Development Goals (United Nations 2015) and looks likely to emerge as the unifying central goal for the health sector in the post-2015 period (United Nations 2013; Vega 2013; WHO 2015).

Even though the paths that countries are taking to UHC are different, there is increasing convergence on what the UHC goal is: ensuring that all people have access to needed health services without risking financial impoverishment (WHO/World Bank Group 2013). Moreover, in many countries, including those in East Asia, attaining UHC is now an explicit policy objective that is described in country health strategies and operationalized in implementation plans. This reflects governments’ commitment to good health through developing health policies that are responsive to people’s demands for more comprehensive and affordable care, and to delivering on these policies by ensuring the availability of quality services on the ground. The commitment to UHC also places equity concerns front and center: it seeks to address persistent inequalities in
health outcomes and access to care, and to provide financial protection to the more than 100 million people who are impoverished by out-of-pocket spending annually (WHO 2010). This is tied to a broader social and economic rationale for investing in health: good health also improves educational outcomes and workforce productivity, over the long-run promoting economic development (Jamison, Summers, Alleyne et al. 2013).

As countries in Asia advance along their respective paths to UHC, a number of common challenges are emerging. This paper explores three of them. First is the challenge of making universal health coverage truly universal: while formal sector workers are easily covered by payroll deductions, and the poorest are often covered through government subsidies, the big challenge is to expand coverage to non-poor informal sector workers, the so-called “missing middle”. Second is the challenge of defining a common benefit package that is appropriate to the disease burden, represents good value for money and is socially acceptable. Third is the challenge of closing the gap between legal entitlements and citizens’ actual ability to benefit from health services through ensuring supply-side readiness, i.e. the availability of quality health services within sufficiently close geographic proximity. These three challenges are illustrated by examples from East Asia, especially the larger countries of China, Indonesia, Philippines, Thailand and Vietnam. Ethical approval was not required for this research because the authors did not collect new, or analyze previously collected, human subjects data; the research relies solely on existing and publically-available literature.
Covering the informal sector

Among the countries that are taking a social health insurance path to UHC, it seems that a common pattern of coverage is emerging. Relatively comprehensive coverage of civil servants and the formal sector is fairly easily attained through payroll deductions (whether in the form of earmarked contributions to health insurance schemes or income tax) and complemented by the inclusion of the poor through government subsidies. This has been the pattern in Vietnam, Indonesia, and the Philippines, for example. However, it has typically resulted in a “missing middle”, made up mostly of informal workers and their families. Covering this group is proving challenging.

The negative statistical relationship between GDP per capita and the proportion of the labor force in informal employment (Bitrán 2013) makes it easy to assume that the high economic growth experienced in the region over the last decade will translate into more formal sector jobs, creating a strong tax base from which to fund UHC. Indeed, in the decade ending 2011, the elasticity of employment to output has been quite high, at 0.33 in Thailand, 0.3 in China and 0.22 in the Philippines (Hanusch 2013). Yet, the nature and quality of the jobs created is often part-time, short-term and/or contractual, and labor market informality is not only high by global standards, but has proven very persistent over time (World Bank 2014). This implies that there is likely to be limited ability to raise public revenue from income- and labor-related taxes.

Beyond mandating, and enforcing through legal action, contributions from the informal sector (which may not be feasible), there are two basic approaches to extend coverage to this group: (i) encourage contributions from the informal sector through financial and/or non-financial incentives
and information campaigns, or (ii) use general tax revenues to cover not only the poor, but also the informal sector.

Vietnam used premium subsidies of 70 percent to finance its recent health insurance coverage expansion (Tangcharoensathien, Patcharanarumol, Ir et al. 2011). The Philippines used a system of discretionary local government subsidies for the enrollment of the near-poor until 2012 before extending a full insurance subsidy to the near-poor in 2014 (Bredenkamp and Buisman 2015). China almost completely (at 85 percent) subsidizes the premiums of the rural population (Yip and Hsiao 2008) and contributes 60 percent (on average, with adjustments for income) on behalf of urban non-working populations (Liang and Langenbrunner 2013). Similarly, health insurance schemes in the higher-income countries of Japan, South Korea, and Taiwan provide a partial subsidy to informal sector workers (Kwon 2011).

Premium subsidies are not the only policy intervention that has been tried to increase enrollment; other interventions have included education about the concept of health risks, information campaigns about the schemes, assistance with the actual enrollment process, and the introduction of more convenient ways to pay premiums, for example, using convenience stores or mobile phones. Still, success often remains elusive. In experiments in Vietnam (which involved a combination of a 25 percent subsidy and provision of an information kit) and Philippines (where the intervention was a 50 percent enrollment subsidy, provision of an information kit and SMS reminders to enroll), for example, these packages resulted in enrollment increases of only 1 and 5 percentage points respectively (Wagstaff, Nguyen, Dao et al. 2014; Capuno, Kraft and Quimbo et al. 2014). Interestingly, in the Philippines experiment, a follow-up intervention which added
assistance with filing out insurance forms and mailing them resulted in as much as a 36.5 percentage point increase. In China, the setting of enrollment targets for local government officials helped to raise enrollment rates (Liang and Langenbrunner 2013), while in Korea a mix of enrollment mandates and effective tracking of income and property has increased the administrative pressure to enroll (Jeong 2010). In Indonesia, which aims to fully cover its 70 million unenrolled informal sector workers by 2019, the government has initiated pilots to identify what works best. However, early results suggest subsidies, education, information and convenience will likely not make a large difference to enrolment among rural informal workers, with only a limited take-up among the urban informal sector (J-PAL 2015).

A much easier and quicker approach to achieve high levels of coverage among the informal sector is to link coverage with citizenship or national residence, and to enroll the whole (as opposed to only the poor) informal population using general government revenues. Thailand embarked on this path and saw coverage rates improve significantly and relatively quickly (Li, Yu, Butler et al. 2011; Tangcharoensathien et al. 2011; Limwattananon, Neelsen, O’Donnell et al. 2014). Many other countries, including China, Korea and Taiwan, also rely on general revenues to cover the informal sector (Annear, Comrie-Thompson and Dayal 2015). This approach can also be more equitable than social health insurance; the latter is often regressive because of maximum ceilings on contributions that are typically imposed even when contributions are set proportional to income (Kwon 2009). However, sole reliance on a tax-financing approach to reaching this group can have an immediate and long-term negative budgetary impact and may not be an option in countries with relatively low tax mobilization. It might also induce an increase in informality if employers and/or workers choose to stay (or to switch to) informal arrangements to avoid paying the mandatory
contributions associated with formal employment (see, for example, Wagstaff and Manachotphong 2012).

The “best” policy package of subsidies and other interventions remains unclear. Experimentation continues and despite, and in part because of, the diversity of experience across the region, systemic solutions to this challenging problem have not yet been identified.

**Deciding which benefits to include in the package and how to update it**

Without a clear, rational process for defining and updating the benefit package what happens in practice is that thousands of discrete, and unpredictable, “rationing decisions” take place between client and provider at the point of service (Wong and Bitran 1999). These decisions are unlikely to result in either an efficient or an equitable distribution of health services and resources. Moreover, many benefit packages are somewhat out of date, having originally been designed when infectious diseases accounted for the majority of the overall burden of disease (Cotlear, Nagpal, Smith et al., in press). Today, in selecting services to include in the benefit package, consideration needs to be given to the increased share of non-communicable diseases (NCDs) in the burden of disease (IHME and World Bank 2013), as well as rapidly ageing populations, advances in medical technology, hospital-centric health systems, and the demands of a growing middle class (Somanathan, Bredenkamp and Pambudi et al. 2015), all of which will not only increase the demand for new services, but also exert upward fiscal pressure. Additional choices in benefit package design include whether to have a single benefit package for all or different
packages for different population groups, and what share of the cost of services in the benefit package should be financed by copayments. Countries which have chosen social health insurance as the primary means of achieving UHC also face the challenge of “who pays for what”, especially when it comes to public health: which services should be financed as part of the insurance package and which should be financed directly by Ministries of Health?

The myriad considerations involved in designing benefit packages (see, for example, Busse 2013), the technical skills needed and the fact that the content of benefit packages is often a political decision, results in considerable variation in the types of services included in the package.

In China, the local authorities decide on the scope of benefit packages based on local needs and available resources, but their capacity to cost out and determine the benefit package is limited (Liang and Langenbrunner 2013), and in practice the range of services offered is not clearly defined. The benefit package reflects more the types of curative services that providers would need to be reimbursed for rather than the preventive and promotive services it should contain in order to improve overall population health and financial well-being. Also, the limited coverage of outpatient services, critical to preventing and/or managing non-communicable diseases, may have led to increased financial risk (Hou, Van de Poel and Van Doorslaer et al. 2014). In fact, overall coverage remains relatively shallow, both in terms of services offered and depth of coverage.
In Indonesia, since 2014 when the different central insurance schemes were merged under a single umbrella scheme, the benefit package has been equalized across all employment and population groups. It is also very comprehensive with only minimal specific exclusions (like cosmetic treatments, alternative medicine, and fertility treatment) and beneficiaries are also entitled to all drugs in the national drug formulary without copayment (Harimurti, Pambudi, Pigazzini et al. 2013). However, the lack of exclusions mean that the formal benefit package is *de facto* constrained by the ability to deliver it – something that will be taken up in the next section. The Ministry of Health and the *Badan Penyelenggara Jaminan Sosial* (BPJS) national insurance scheme determine and update the benefit package, but there are not yet clear objective processes to do so (Cotlear, Nagpal and Smith et al., in press).

In the Philippines, the benefit package provided by the national insurer, PhilHealth, is explicit and has expanded rapidly in recent years, complemented by public health programs that are financed separately by the Department of Health. The PhilHealth package, which is determined by PhilHealth staff, includes inpatient coverage for a wide range of medical cases and surgical procedures, generous maternity and newborn care benefits, a catastrophic “z-benefit” package (e.g. for certain cancers, kidney dialysis, cardiovascular surgery), as well as a primary care benefit package that was expanded in 2015 to include screening for certain non-communicable diseases and a small medicines benefit (Bredenkamp and Buisman 2015). People formally identified as poor do not have any copayments.

In Vietnam, the Ministry of Health leads the development and updating of benefits packages, with the participation of the Vietnam Social Security (VSS) office and health providers. Clear criteria
for what should be included or excluded have not been established and the technical capacity to undertake health technology assessments to aid in this prioritization is still in its infancy. The benefit package is comprehensive, covering ambulatory and many outpatient services and inpatient services (including advanced diagnostics and treatments such as organ transplants), but does not cover anything that could be considered screening, counselling, or other preventive services. Many of these services are provided by the National Targeted Programs (for immunization, tuberculosis, and malaria, for example), though. The National Assembly has requested a revised Basic Health Service Package financed by health insurance to be issued by 2018 and the Ministry of Health is taking this opportunity to identify means to update it based upon the health needs of the population, objective evidence, and affordability.

Among the countries considered in this paper, the setting and updating of the benefit package in Thailand is arguably best practice; it is one of the few upper middle income countries in the region, and indeed in the world, to carry out formal health technology assessments to set priorities (Tantivess, Teerawattananon and Mills; Glassman and Chalkidou 2012; Mohara, Youngkong, Perez et al. 2012). This has resulted in improved decision-making and has fostered an environment in which the Health Intervention and Technology Assessment Program (HITAP) not only plays a central role in deciding which drugs and vaccines will be included in the benefit package, but has also successfully empowered and incentivized the government to negotiate for reduced drug and vaccine prices (Teerawattananon, Tritasavit, Suchonwanich et al. 2014; Teerawattananon and Tritasavit 2015). Thailand also offers one of the most comprehensive packages for the poor, including high cost medical treatment like kidney and liver transplants. Most importantly, there is convincing evidence that there is a close correlation between the
mandated package and the services that are in reality available to the population (Cotlear, Nagpal and Smith et al., in press), a result of a long-term investment in Thailand of creating technical and political processes that link fiscal envelopes to benefit package design.

The challenges of expanding coverage while also responding to the increased demands for health services means that it will be vital to institutionalize rigorous, objective, transparent and socially acceptable processes to determine, and update, the UHC benefit package. One of the most important considerations in benefit package design is the capacity to deliver on promises made by ensuring skilled human resources, facilities, and services are available at the point of delivery. This challenge is taken up in the next section.

Supply-side readiness

The breadth of the benefit package is one measure of universal health coverage. However, in order to improve health outcomes, the health system’s readiness to actually provide what is promised in the benefit package – with quality and equity – is what ultimately matters. Unfortunately, supply-side readiness to deliver services often lags behind the UHC entitlements described in the benefit package.

In Indonesia, a recent set of studies (World Bank and National Institute of Health Research and Development, Ministry of Health, Indonesia 2014a; World Bank and National Institute of Health Research and Development, Ministry of Health, Indonesia 2014b) illustrates some of the service-readiness challenges. Using nationwide data, the researchers surveyed the availability of the inputs
(human resources, equipment, medicines, etc.) required, according to national and international guidelines, to deliver the services for a set of tracer conditions and diseases (such as maternal health, diabetes, and cardiovascular conditions) included in the UHC benefit package.

One finding was that while the availability of basic equipment is often fairly good, the availability of the inputs which need to be replenished regularly is not. For example, while basic equipment such as blood pressure cuffs (92 percent of health centers) and stethoscopes (99 percent) were readily available, essential medicines (which are typically from recurrent budgets or from user fees) were not. For example, only 7 percent of health centers had injectable magnesium sulphate on hand, while only 45 percent had injectable antibiotics in stock.

Another finding was large geographic variation in levels of service readiness. In the case of diabetes, for example, in a quarter of provinces, less than a fifth of health centers could perform basic urine and blood tests; there were also urban-rural differences with almost all health centers in the city of Yogyakarta able to perform these tests, but only a fifth of provinces in Eastern Indonesia able to do so. For non-communicable diseases (NCDs) which, as noted above, are becoming an increasing share of the disease burden, there is particularly wide variation in service readiness. A composite index for NCD service readiness, generated and mapped for each province, shows that those in the east score below 65 percent, while those towards the west perform better (see Figure 1). Generally, wealthier provinces have better service readiness than poorer ones.
In Lao PDR, too, health facility surveys have highlighted a lack of key commodities and equipment, compromising the ability of the national free maternal and child health policy, the flagship health policy of the Lao Government, to deliver on its promises. In six southern provinces, only 2 percent and 10 percent of health centers satisfied all the WHO SARA indicators for antenatal care and basic obstetric care, respectively (Yap, Tandon and Rong 2013).

Beyond looking at service readiness as an ‘input’ to health service provision, i.e. what exists at a health facility, a further dimension is to explore what happens at a health facility. Two important elements need to be considered: provider effort and provider ability (knowledge). A recent study in India using ghost patients, for example, revealed significant shortcomings among both public and private providers in their ability to deal with the most basic health problems (Das, Holla, Das et al. 2012). Correct diagnoses were rare and incorrect treatments were widely prescribed. Adherence to clinical checklists was higher in private than in public clinics. A similar conclusion
of low overall quality of care was reached in China in a study of village clinicians based on adherence to clinical checklists and the rates of correct diagnoses and treatments (Sylvia, Shi, Xue et al. 2014).

In Cambodia, San Joaquin (unpublished results) used standardized vignettes to assess the competencies of public and private providers in the care of five common health problem and found large variation in staff performance – by both facility type and job type. Qualified health professionals performed moderately well in large public and private facilities, but accuracy in the final diagnosis was highly dependent on the type of staff. Health professionals working in smaller consultation rooms and in the informal sector performed significantly less well in making an accurate diagnosis and prescribing the correct treatment. As more than half of primary health visits in the Cambodia occur in such environments (mostly traditional healers and informal drug sellers), the probability of receiving an incorrect diagnosis and/or treatment is high. Competencies for diabetes diagnosis and treatment were particularly low.

Overall, more applied research is needed to generate evidence on service readiness. Expanding and deepening financial protection will not achieve its desired objective of contributing to improved health and equity outcomes if health services are not available and of reasonable quality. There are good measurement instruments available to measure the availability of care, such as the WHO’s Service Availability and Readiness Assessment (SARA) (2012b) and the World Bank’s Service Delivery Indicators (SDI) instrument, as well as validated approaches and protocols to assess the quality of care. If applied systematically, these surveys and approaches would provide
an invaluable analytical input into the design of health policies, programs and investments to achieve universal health coverage.

**Conclusion**

The common challenges that countries face in moving toward UHC are coming into sharper focus, and early research has begun to shed light on relatively better and relatively less effective approaches to addressing these challenges. Still, it seems likely that the solutions to these challenges will be highly context-dependent, inherently path-dependent and will also be shaped by political leadership and administrative capability. For example, contribution-based approaches to enrolling the informal sector into UHC plans did not work very well in Vietnam or the Philippines, but seem to have shown success in China where local political leaders are strongly encouraged to ensure that as many people as possible are enrolled in schemes. In many countries, the extension of coverage to various population groups appears to have outpaced the ability to ensure the equitable provision of quality primary care services to beneficiaries, though, which indicates that the administrative capability to deliver on policy promises is a continuing challenge, leading to a renewed emphasis on supply-side strengthening as an important UHC agenda. We are also learning that the root cause – and ultimate solution – of these challenges is sometimes more political than technical. Countries’ approaches to defining their benefit packages, for example, may reflect the early desire of leaders to provide a full package of health benefits to all citizens, regardless of cost or feasibility, as much as it reflects technical analysis of disease burdens and cost-effectiveness. The solution to successfully overcoming these challenges lies in continuing to
rigorously test and assess new approaches within specific contexts, and also in sharing the findings within and across countries in Asia – and across the world.
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