Mission of the Republic of Korea to ASEAN

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ASSOCIATION OF SOUTHEAST ASIAN NATIONS

The 2nd ASEAN-ROK Health Webinar

on

Health Financing for Universal Health Coverage

Wednesday, 30 November 2022

14:00~16:10(GMT +7)

The 2nd Health Webinar on Health Financing for Universal Health Coverage Wednesday, 30 November 2022

Time	Program	page
14:00-14:10	**Welcoming Remarks** - Hee-seog Kwon, Ambassador of the Republic of Korea to ASEAN - Ekkaphab Phanthavong, Deputy Secretary-General of ASEAN for ASEAN Socio-Cultural Community	
14:10-14:30	Keynote Speech: Sustainable Health Financing for Universal Health Coverage - Soonman Kwon, Professor and Former Dean of the School of Public Health, Seoul National University	**1**
14:30-15:35	**Presentations:** More Money for Health - Jaeyong Bae, Head, Center for Health Care Research, Korea Institute for Health and Social Affairs - Somtanuek Chotchoungchatchai, Researcher, International Health Policy Programme, Thailand (ASEAN Health Cluster 3 Country Coordinator for Thailand) More Health for Money - Wankyo Chung, Professor, School of Public Health, Seoul National University - Ackhmad Afflazir, Project Management Officer, Health Policy Agency, Ministry of Health, Republic of Indonesia	**13** **27** **37** **46**
15:35-16:10	**Roundtable** - Facilitated by Su-Jin Kim, Research Fellow, Korea Institute for Health and Social Affairs	**59**

Mission of the Republic of Korea to ASEAN

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Keynote Speech: Sustainable Health Financing for Universal Health Coverage

Soonman Kwon

Professor and Former Dean of the School of Public Health, Seoul National University

The 2nd ASEAN-ROK Health Webinar
on
Health Financing for
Universal Health Coverage

Sustainable Health Financing for UHC

30 November, 2022

Soonman KWON, Ph.D.

Professor/Former Dean
School of Public Health, Seoul National University

Former Chief of Health Sector Group
Asian Development Bank (ADB)

Challenges for Public Financing in a Pandemic

- Decrease in government revenue
- Increased need: health care, economic rescue funding, social safety
- Increase in debt financing: long-term negative effect
  e.g., Gross public debt levels are likely to rise to over 60% of GDP in Asia (Tandon, et al., World Bank, 2020)
- Non-increase or decrease in donor support
- Different degrees of vulnerability: dependence on tourism, external funding, open economy

Key Tasks in Public Financing for Health

- Prioritize and mobilize more public funding for health sector
- Swift and flexibility: re-prioritization
- Maximize efficiency in spending: to improve fiscal space

1. Key Lessons from COVID-19

Investment into strengthening **health systems and UHC** is a fundamental solution for the preparedness and response to a pandemic

- Reinforcing the importance of HC and health system
- Not introduce additional vertical (funding) programs, targeting a pandemic

Pandemic as even stronger case for **Investment in Health** (including common goods for health)

- Interconnectedness of health and economy

1. Key Lessons (continued)

Effective targeting and protecting of the **vulnerable**: elderly, poor, migrant workers, residents in vulnerable environments (urban slums)

- Pay attention to Catastrophic health expenditure, Impoverishment due to illness, Unmet need
- Targeting approach along with UHC

Governance: **multi-sectoral cooperation** of public and private sectors, central and local governments, and across different ministries and sectors

- Coordination among central, provincial, local governments
- Pandemic as a social crisis: poverty, unemployment, education, social care in addition to health care
- Impacts on human (capital) development

2. Way Forward: Use COVID-19 experience as an Opportunity for UHC

1) Resource Generation and Funding

Increased funding and investment in health

PFM (Public Financial Management) reform, flexibility, engagement with MoF (budget formulation and execution)

Enhance pooling, unified benefits and data system

- Pooling across funds
- Pooling of insurance contribution and budget

Health taxes: behavioral change, LT effects on health gains can be progressive, Controversy over ear-marking

Financial Resource for UHC

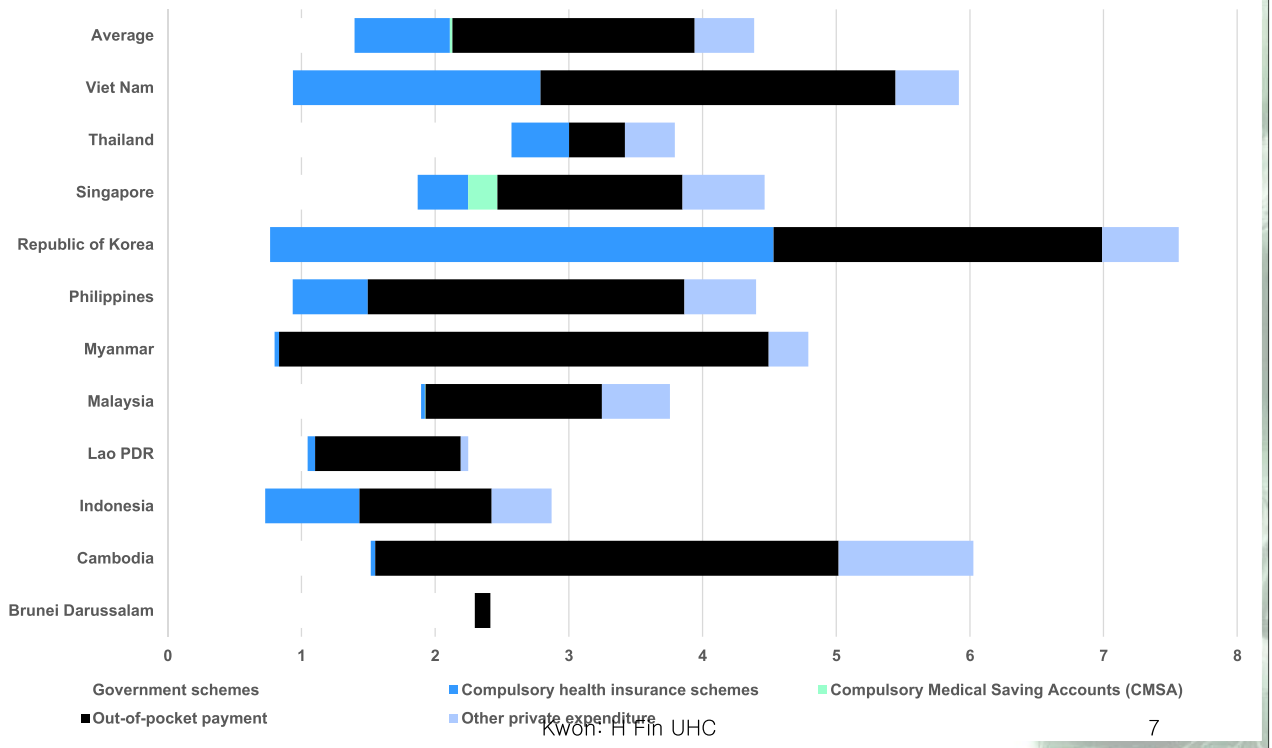
Mandatory public financing

- Principle of social solidarity
- Income-based contribution (progressive or proportional payment) is not possible in voluntary financing

Health care financing as a means to achieve the goal of UHC: Putting various (public) sources of revenue in a big **pool** for effective **purchasing** of health care for people

- Contribution: Korea, Taiwan, Vietnam
- General revenue: Malaysia, Thailand, India
- Government subsidy for insurance contribution of the vulnerable: Indonesia, Vietnam, Philippines, China
- Earmarked consumption tax (Ghana), earmarked non-wage income tax (France, Taiwan, Korea)

Total Health Expenditure (2018) (Public-Private Mix and % of GDP)



Source: Global Health Expenditure Database [http://apps.who.int/nha/database]

2. Way Forward: Use COVID-19 experience as an Opportunity for UHC

2) Improve Efficiency

Strengthen **strategic purchasing**

- Align financing and delivery, including effective contracting with private providers
- Streamline service delivery, continuum of care
- Quality of care
- Governance and accountability

Benefits package to include essential medicines

Decisions on Service/Benefits Coverage

UHC does not mean covering every service
- Need priority setting for essential services, How?

Should institutionalize a transparent process to determine service/benefits coverage based on

- Evidence: economic evaluation (e.g., cost effectiveness), reduce political manipulation

- Social value judgement: ethical consideration
  -> High-level committees with the participation of stakeholders, Deliberation with citizen participation

-> Need Accountability and fairness in decision (policy) process on service coverage

2) Improve Efficiency (continued)

Strengthen Primary Care

- Ageing, NCDs, Care coordination in community care
- Essential package
- Capacity, Trust: vicious or virtuous circle?

Provider payment systems: provider incentives and behaviour

- capitation and case-based payment

Supply chain: medicines, devices

Innovative service delivery, e.g., digital health

2. Way Forward: Use COVID-19 experience as an Opportunity for UHC

3) Political Economy of Reform

Political Economy of reform

- Oppositions to reform by vested interests: Pharmaceutical industry, Health care providers enjoy status quo with high OOP pay and demand inducement
- Role of MoF

Three streams for successful agenda setting and policy (John Kingdon)

- Problem: seriousness, awareness, idea
- Policy: good policy solution for UHC, considering context
- Politics: political leadership, strategy, political support

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SOONMAN KWON

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Thirty years of national health insurance in South Korea: lessons for achieving universal health care coverage

Soonman Kwon*

Accepted 21 June 2008

South Korea introduced mandatory social health insurance for industrial workers in large corporations in 1977, and extended it incrementally to the self-employed until it covered the entire population in 1989. Thirty years of national health insurance in Korea can provide valuable lessons on key issues in health care financing policy which now face many low- and middle-income countries aiming to achieve universal health care coverage, such as: tax versus social health insurance; population and benefit coverage; single scheme versus multiple schemes; purchasing and provider payment method; and the role of politics and political commitment. National health insurance in Korea has been successful in mobilizing resources for health care, rapidly extending population coverage, effectively pooling public and private resources to purchase health care for the entire population, and containing health care expenditure. However, there are also challenges posed by the dominance of private providers paid by fee-for-service, the rapid aging of the population, and the public-private mix related to private health insurance.

Keywords Health care financing, health insurance, universal coverage, Korea

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Sustainable Health Financing for COVID-19 Preparedness and Response in Asia and the Pacific

Soonman KWON[1]† and Eunkyoung KIM[2]

[1]Seoul National University and Korea Health Industry Development Institute (KHIDI) and [2]World Health Organization Lao PDR Country Office

To make health systems more resilient to shocks and crises, it is critical for governments to invest in core health system functions such as financing, service delivery, and governance. Ensuring sufficient resources for health is necessary for basic infrastructure including vaccines; the overall level of health expenditure and the public sources of funding are important. Funding for public health services, including infection prevention and control, surveillance, and information systems, is fundamental to ensure health systems are prepared for and respond to health emergencies. Funding should be made available for a quick and effective response to emergencies, requiring a supportive flexible public financial management system. Moreover, it is essential to mitigate the potential risks of health system collapses through innovative ways, for example, telemedicine, and mobilizing private sector providers. Vulnerable groups who are even more impacted during crises need special attention. Multisectoral cooperation is paramount to health system resilience during pandemic response.

REPUBLIC OF KOREA'S COVID-19 PREPAREDNESS AND RESPONSE

DISCUSSION PAPER NOVEMBER 2020

Soonman Kwon
Hoonsang Lee
Moran Ki
Da Woon Chung
Enis Baris

/

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Kwon: H Fin UHC

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Research Article

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

Annie Chu*,[1], Soonman Kwon[2], and Peter Cowley[1]
[1]Health Policy and Financing Unit, WHO Regional Office of the Western Pacific, Manila, Philippines
[2]Graduate School of Public Health, Seoul National University, Seoul, Republic of Korea

CONTENTS

Kwon: H Fin UHC

Abstract—This article provides an overview of health financing reforms across countries in the Western Pacific Region as progress is made toward universal health coverage (UHC). Moving toward UHC requires a strong health system with sustainable financing, which countries strive to achieve through various approaches appropriate to their country contexts. Great efforts have been made by financing reforms through resource mobilization, risk pooling,

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How and why do countries make Universal Health Care policies? Interplay of country and global factors

Chris Atim[1],
Augustina Koduah[2],
Soonman Kwon[3]

[1]Results for Development, Accra, Ghana
[2]University of Ghana, Accra, Ghana
[3]Seoul National University, Seoul, South Korea

Background An examination of country policy making tends to reveal more complex processes that reflect domestic as well as external pressures and influences. The paper examines the interplay of external and internal, as well as other, factors in universal health care (UHC) decision-making for a select number of countries spanning the income range from low to high income.

Methods After developing a conceptual framework to help identify variables to explore in answering our study questions, we reviewed literature on health policies and policy making, especially around the time of the adoption of relevant policies for a number of UHC reform countries, followed by a narrative review of countries for more in-depth study. For more quantitative data, we consulted databases maintained by international institutions.

Results We found that, for low-income countries (LICs)/lower-middle-income countries (LMICs), the external environment helps set the policy agenda that drives national priorities

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Pathways to DRG-based hospital payment systems in Japan, Korea, and Thailand

Peter Leslie Annear[a], Soonman Kwon[b,*], Luca Lorenzoni[c], Stephen Duckett[d], Dale Huntington[e], John C. Langenbrunner[f], Yuki Murakami[c], Changwoo Shon[b], Ke Xu[g]

[a] Nossal Institute for Global Health, School of Population and Global Health, University of Melbourne, Australia
[b] School of Public Health, Seoul National University, Republic of Korea
[c] OECD, Paris, France
[d] The Grattan Institute, University of Melbourne, Australia
[e] Johnson and Johnson, Singapore
[f] Consultant, USA
[g] World Health Organization, Geneva, Switzerland

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ABSTRACT

Countries in Asia are working towards achieving universal health coverage while ensuring improved quality of care. One element is controlling hospital costs through payment reforms. In this paper we review experiences in using Diagnosis Related Groups (DRG) based hospital payments in three Asian countries and ask if there is an Asian way to DRGs. We focus first on technical issues and follow with a discussion of implementation challenges and policy questions. We reviewed the literature and worked as an expert team to investigate existing documentation from Japan, Republic of Korea, and Thailand. We reviewed the design of case-based payment systems, their experience with implementation, evidence about impact on service delivery, and lessons drawn for the Asian region. We found that countries must first establish adequate infrastructure, human resource capacity and information management systems. Capping of volumes and prices is sometimes essential along with a high degree of hospital autonomy. Rather than introduce a complete classification system in one stroke, these countries have phased in DRGs, in some cases with hospitals volunteering to participate as a first step (Korea), and in others using a blend of different units for hospital payment, including length of stay, and fee-for-service (Japan). Case-based payment systems are not a panacea. Their value is dependent on their design and implementation and the capacity of the health system.

Social health insurance development in Mongolia: Opportunities and challenges in moving towards Universal Health Coverage

Dorjsuren Bayarsaikhan, Soonman Kwon and Dashzeveg Chimeddagva

Word Health Organization, Geneva, Switzerland; Seoul National University, Republic of Korea; Macroeconomics and Health, Ulaanbaatar, Mongolia

Abstract Mongolia achieved high population coverage under mandatory health insurance relatively quickly. This fact was viewed by policy- and decision-makers as a central issue for health financing reform in Mongolia. Health insurance brought many new features for health service planning, provision, funding and resource management. Based on initial achievements, health insurance came to be strategically considered as the vehicle for achieving universal coverage. The article analyses developments in Mongolia's health insurance over the last decade along with the core policy dimensions of Universal Health Coverage. It examines various reform approaches and the numerous amendments to laws that have been implemented during this period and discusses new opportunities as well as challenges. The analytical review and findings discussed suggest that Mongolia has a need for evidence-based policy decisions and informed political support, with health insurance backed

Addresses for correspondence: Dorjsuren Bayarsaikhan (correspondence author), Health Economist, Health Financing Policy, Department for Health Systems Governance and Financing, Word Health Organization, avenue Appia 20, 1211 Geneva 27, Switzerland; Email: BayarsaikhanD@who.int. Soonman Kwon, Professor, School of Public Health, Seoul National University, 28 Yonkon-dong, Chongno-gu, Seoul 110-799, Republic of Korea; Email: kwons@snu.ac.kr. Dashzeveg Chimeddagva, Board Chairman, Macroeconomics and Health, Non-governmental Organization, Baga Toiruu, 3/9, Post Office-2783, Ulaanbaatar 15160, Mongolia; Email: chimeddagva@gmail.com.

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ORIGINAL ARTICLE

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The role of national health insurance for achieving UHC in the Philippines: a mixed methods analysis

Konrad Obermann [a], Matthew Jowett [b] and Soonman Kwon [c]

[a]Mannheim Institute for Public Health (MIPH), Heidelberg University, Mannheim, Germany; [b]Department of Health Systems Governance & Financing, World Health Organization, Geneva, Switzerland; [c]School of Public Health, Seoul National University, Gwanak-gu, South Korea

ABSTRACT

Background: Achieving Universal Health Coverage (UHC) has by now become a key health policy goal in many countries and some form of National Health Insurance (NHI) is often used for this. The Philippines has had more than 50 years' experience with social health insurance and in 1995 established PhilHealth, the country's national health insurer.

Objectives: Analyzing the role of the Philippine NHI scheme in moving towards UHC, identifying potential avenues for improvement as well as indicating challenges and areas for further development.

Methods: This paper is based on a mixed methods approach including extensive literature search, data from PhilHealth and other sources, and key informant interviews with staff at PhilHealth, health care providers, and policy experts at national and international level.

Results: Major achievements were the expansion of population coverage using an earmarked revenue source ('Sin Tax'), the introduction of the no-balance-billing to prevent co-payments, and the Health Facilities Enhancement Program to improve quality. The share of PhilHealth in total health expenditures is still only 14%, managing quality and cost of providers remains insufficient, the benefit coverage does not reflect the country's burden of disease, and financial protection for PhilHealth members is low. The UHC bill would provide a massive jump forward as all Filipinos would then be automatically enrolled in and thus entitled to the benefits of PhilHealth.

Conclusions: For expanding a contribution-based NHI beyond formal employment there needs to be a large increase in budget transfers to cover for citizens unable to contribute. The Philippine UHC bill shifts from the idea of contribution leading to entitlement to the idea of citizenship leading to entitlement and can thus be seen as a paradigmatic change in thinking about NHI. There are three areas that we believe are of key importance in developing further NHI: (i) governance, (ii) financial impact, and (iii) strategic purchasing.

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Social health protection in Cambodia: Challenges of policy design and implementation

Soonman Kwon and Lundy Keo

Seoul National University, Republic of Korea;
Independent consultant, Heatherton, Australia

Abstract The Government of Cambodia is implementing ambitious reform initiatives to improve the country's social health protection system. In January 2018, it was announced that the Health Equity Fund (HEF), which is fully subsidized by a joint government-donor initiative for the reimbursement of user fees for the poor at public health facilities, is to be expanded to some segments of informal workers belonging to associations, as well as to commune and village chiefs. Since 2017, the National Social Security Fund (NSSF) has provided social health insurance for formal economy workers in enterprises with eight employees or more. In January 2018, it was expanded to civil servants and all employees regardless of the size of the enterprise. However, this article highlights that the new ambitious reforms are not accompanied by careful planning as regards funding, service delivery, human resources and institutional design. This article therefore aims to examine key policy issues and challenges for Cambodia's ambitious reform of its social health protection system in terms of resource generation, population coverage, strategic purchasing and governance.

Presentations:
More Money for Health

Jaeyong Bae

Head, Center for Health Care Research, Korea Institute for Health and Social Affairs

The 2nd ASEAN-ROK Health Webinar
on
Health Financing for
Universal Health Coverage

Securing Fundings for Health Care in Korea

2022.11.30

Jaeyong Bae, PhD
(Korea Institute for Health and Social Affairs)

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Agenda

- Overview of Health Care Coverage System in Korea
- Problems and Challenges
- Future Direction and Suggestion

Overview of Health Care Coverage System in Korea

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Social Security System in Korea

- Social Insurance
  - Benefits in Cash
    - National Pension, Unemployment Insurance
  - Benefits in Kind
    - National Health Insurance/Long-Term Care Insurance for the Elderly, Industrial Accident Compensation Insurance(in Kind & Cash)
- Public Aid
  - Basic Livelihood Security Program
    - Income assistance, housing assistance, educational assistance, childbirth assistance, funeral assistance, self-support assistance, Medical Aid
  - Basic Pension for the Elderly, Disability Pension
- Social Welfare Service

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National Health Insurance System

- Objectives
  - Resolve the medical expense problem → Protect public health and household budgets
  - Redistribute income and disperse risk → Strengthen social solidarity and promote social integration
- Function and Role
  - Social solidarity
  - Sharing health care expenses reasonably and providing insurance benefits equally.
  - Risk dispersion and income redistribution

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6 Functions of Health Insurance

- Financial protection to individuals with catastrophic health events
- Broad access for small usage fees (routine doctor visits, medical check-up)
- Negotiating health services with health care providers
- Enhancing and ensuring the quality of health care providers.
- Nudging individuals toward staying healthy
- Wealth transfer/redistribution

Source: Dey and Bach (2019 JAMA Health Forum)

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National Health Insurance System

- Features
  - Compulsory Insurance: Compulsory subscription by the law
  - Short-term insurance: Increase in annual financial balance and short-term payment
  - Contribution payment according to the level of household's income and property
  - Equal Insurance Benefits(The same benefits package offered regardless of contribution levels)
  - Compulsory collection of contribution
  - Freedom of choice of health providers
  - Healthcare services predominantly provided by the private sector

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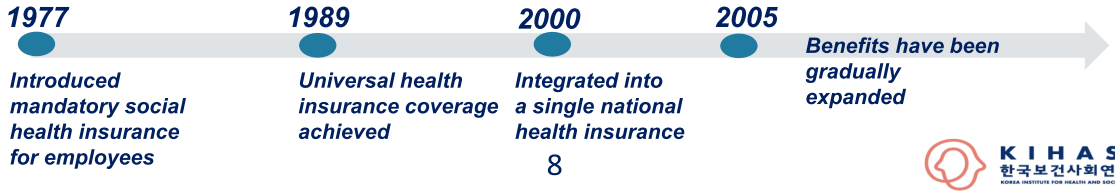
National Health Insurance (NHI) last 45 years

- In 1977, introduced mandatory social health insurance for employees in large corporations (500 or more employees)
- In 1989, universal health insurance coverage achieved
  - Regional health insurance for rural (self-employed) residents in 1988
  - Regional health insurance for urban (self-employed) residents in 1989
- In 2000, integrated into a single national health insurance
- Since 2005, benefits (covered services) have been gradually expanded
- In 2011, introduced a Long-term Care Insurance program



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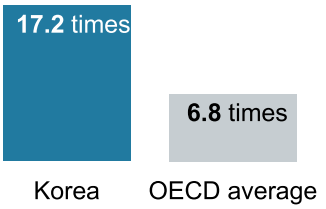
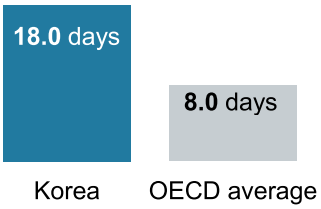
What We Have Achieved Last 45 years

- Access
  - Universal health insurance in 12 years (1977-1989)
  - Access to care both in ambulatory and hospital setting
    - Annual number of doctor consultations per person
      - 17.2 (OECD average: 6.8)
    - Average length of stay in hospital
      - 18.0 (OECD average: 8.0)

Annual number of doctor consultations per person (2019)



Average length of stay in hospital (2019)



Source: OECD Health Statistics

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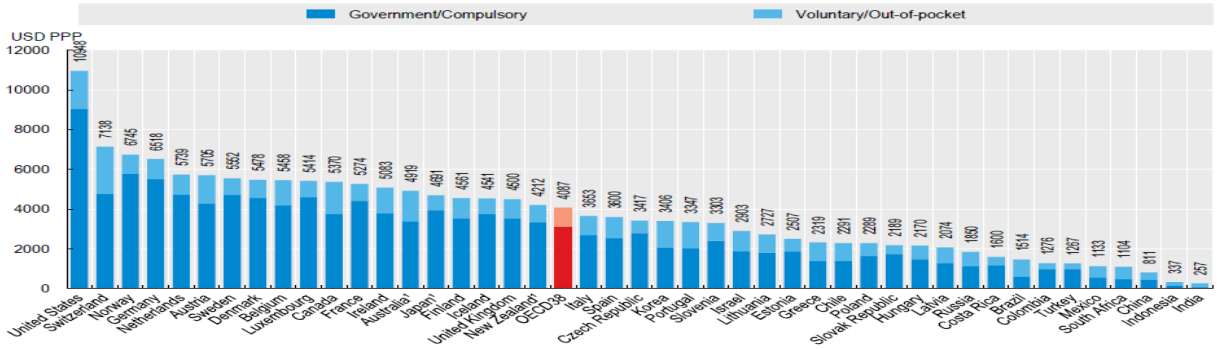
What We Have Achieved Last 45 years

- Health Care Cost (Expenditure)
  - Health expenditure as a share of GDP
    - 8.2% (OECD average: 8.8%)
  - Health expenditure per capita
    - $ 3,406 (OECD average: $4,087)

Health expenditure per capita in 2019



Source: OECD Health Statistics

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What We Have Achieved Last 45 years

- Quality of Care
  - Thirty-day mortality after admission to hospital for ischaemic stroke in 2019 (aged 45 years and over)
    - 3.5% (OECD average: 7.7%)
  - Thirty-day mortality after admission to hospital for AMI in 2019 (aged 45 years and over)
    - 11.0% (OECD average: 8.8%)
  - Cervical cancer five-year net survival (2010-2014)
    - 77.3% (OECD average: 65.5%)
- Health Outcomes
  - Life expectancy in 2019
    - 83.3 (OECD average: 81.0)
  - Mortality from preventable causes in 2019 [per 100,000 population]
    - 97 (OECD average: 126)
  - Mortality from treatable causes in 2019 [per 100,000 population]
    - 42 (OECD average: 73)

Source: OECD Health Statistics

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Problems and Challenges

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Increase in chronic diseases & Poor management of chronic diseases

- Diabetes hospital admission in 2019
  - 224 per 100,000 population (OECD average: 127)
- Asthma hospital admission in 2019
  - 65 per 100,000 population (OECD average: 37)

Source: OECD Health Statistics

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Non-reimbursable(Out-of-coverage) Services

- Due to
  - Focusing on expanding the coverage of the population
  - Low contribution rate of members (low premiums)
  - Low tax-based funds
- Demand side effects (patients)
  - Substantial burden on patients
    - High out-of-pocket expenses
      - 30% in 2019 (OECD average 20%)
    - High demand for supplementary private health insurance (PHI)
      - More than 80% of individuals purchase at least one PHI
- Supply side effects (doctors and hospitals)
  - Difficult to monitor/manage provider's behaviors
    - Providers have incentives to provide more non-covered services

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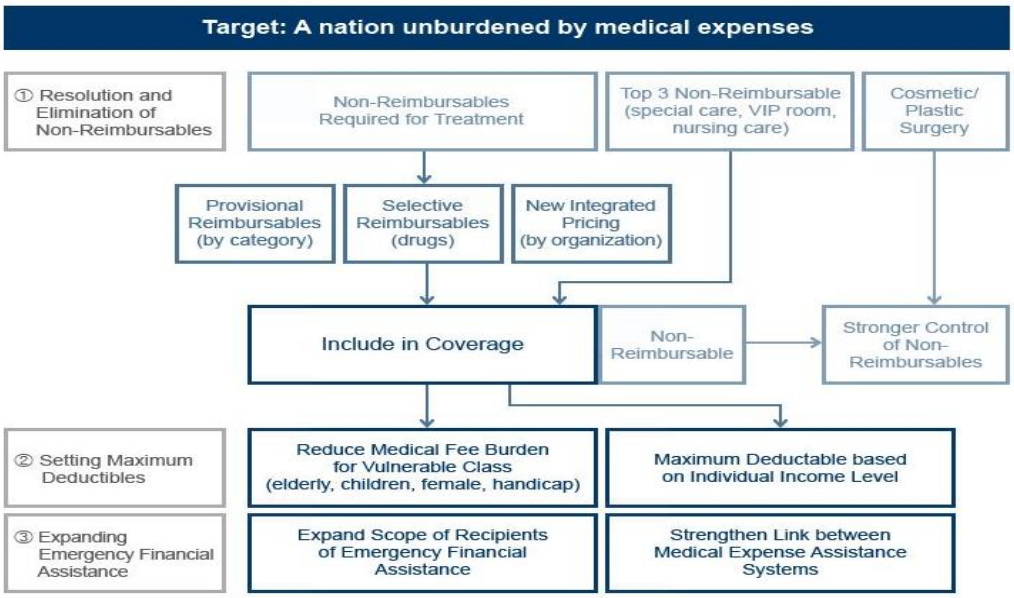
Moon's Health Care Reform



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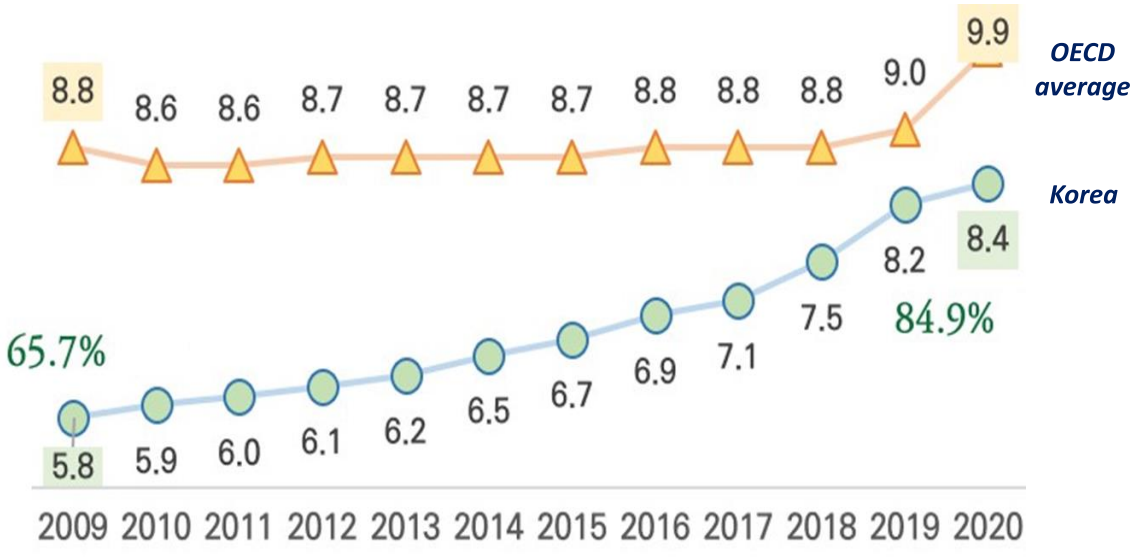
Trend in Health expenditure as a share of GDP



Source: OECD Health Statistics

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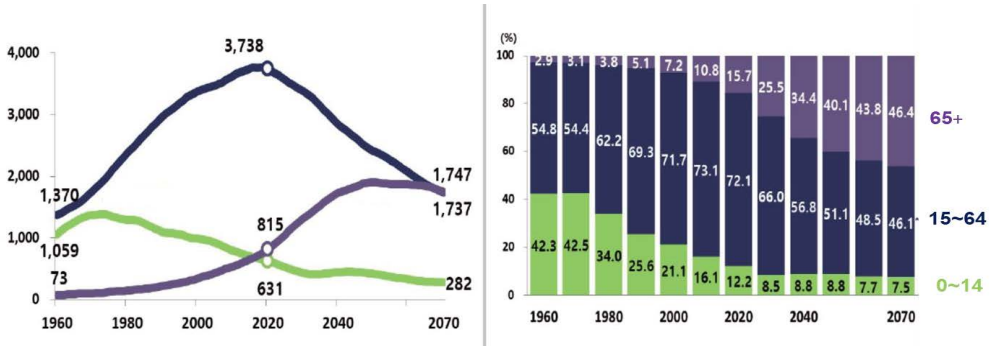
Population is Rapidly Aging in Korea

- % of aged 65 and above
  - 15.7% in 2020, 25.5% in 2030, 40.1% in 2050
- Dependency ratios
  - 38.7 in 2020, 51.4 in 2030, 95.8 in 2050



Source: Statistics Korea(2021)

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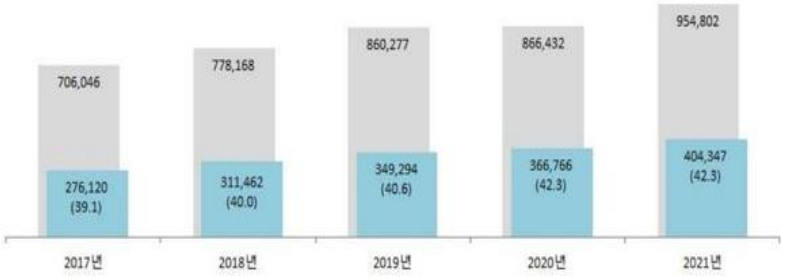
Health Expenditure for the Elderly

- Health Expenditure for the Elderly has been and is going to be increasing

(Unit: 100 million won, %)

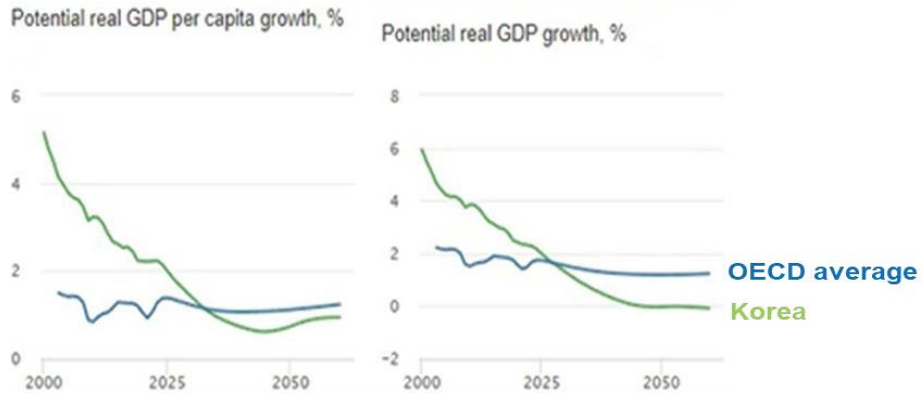


Source: NHIS (2022)

KIHASA 한국보건사회연구원

Declining Potential Growth

- Korea's potential economic growth rate has been and is going to be declining



Source: OECD (2021)

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Future Direction and Suggestion

KIHASA 한국보건사회연구원 KOREA INSTITUTE FOR HEALTH AND SOCIAL AFFAIRS

Threat to Sustainability of NHIS

Factors decreasing revenue	Factors increasing Expenditure
▪ Decrease in Working Population ▪ Low Economic Growth ▪ Low Employment Rate • Increase in self-employed/non standard employment	▪ Rapid Population Aging ▪ Increase in Chronic Disease ▪ Coverage Expansion ▪ Increase in Medical Fee(Price) ▪ Increase in Health Care Demand/Desire/Need ▪ New Technology

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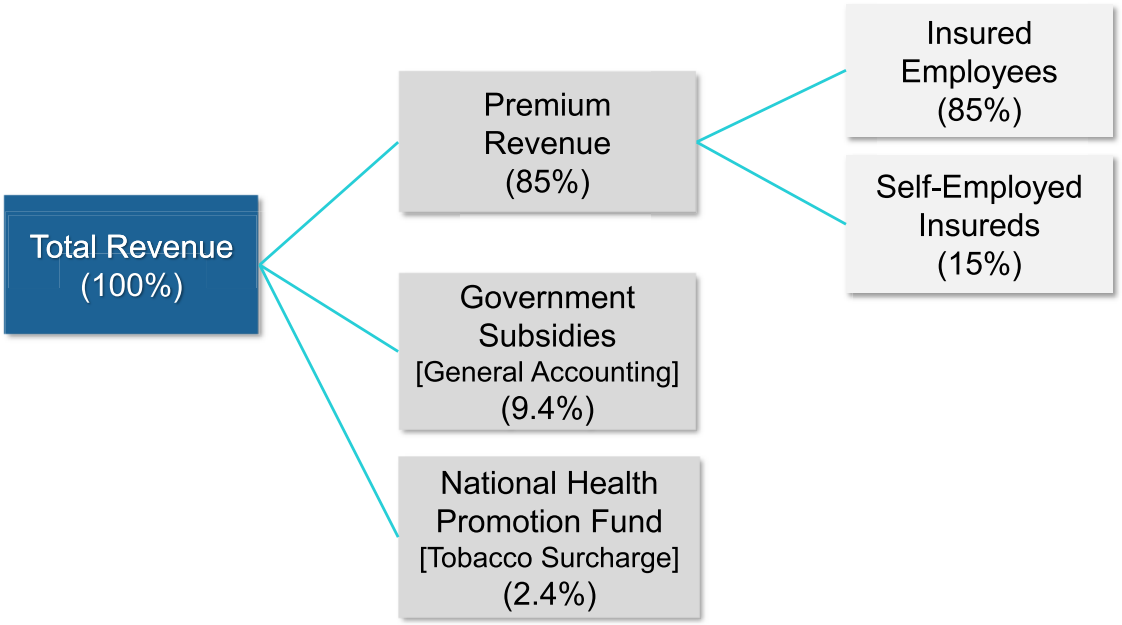
Source of NHIS Revenue



Source: 2021 National Health Insurance Statistical Yearbook

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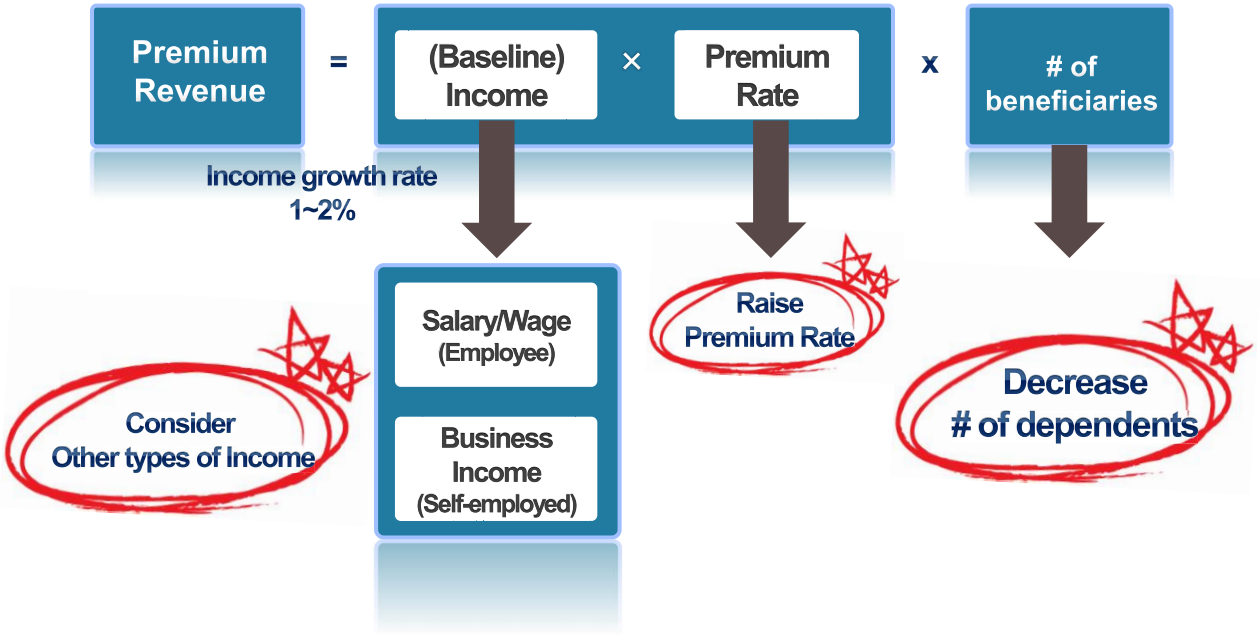
Securing Premium Revenue



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Securing Premium Revenue

- Raising Premium Rates
  - Premium Rates of SHI Countries
    - Germany(14.6% in 2017), France(13.0% in 2018), Japan(10.0% in 2016)
    - Korea (6.99% in 2022)
- Considering Other types of Income
  - Other income than salary for insured employees
  - Non-standard forms of employment
- Raising the bar to be qualified as dependents
- Addressing equity issues
  - Income-based premium setting

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Securing Government Subsidies

- Proportions of Government Subsidies for NHI
  - Germany(6.7% in 2017)
  - France(52.3% in 2018)
  - Japan(27.4% in 2016)
  - Korea (14.3% in 2021)

- Increasing tax-funded resources should be considered!

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Thank you!

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Presentations:
More Money for Health

Somtanuek Chotchoungchatchai

Researcher, International Health Policy Programme, Thailand
(ASEAN Health Cluster 3 Country Coordinator for Thailand)

The 2nd ASEAN-ROK Health Webinar
on
Health Financing for
Universal Health Coverage

Health Financing towards UHC: More Money for Health

ASEAN Member States

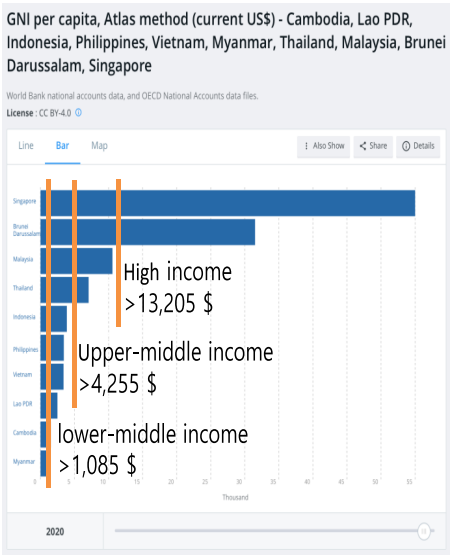
Dr. Somtanuek Chotchoungchatchai
International Health Policy Program (IHPP)
MOPH, Thailand

ASEAN Member States

High income
13,205 $ or more
- Singapore: 55,010
- Brunei Darussalam: 31,510

Upper-middle income
4,256 $ – 13,205 $
- Malaysia: 10,570
- Thailand: 7,070

Lower-middle income
1,086 $ – 4,255 $
- Indonesia: 3,870
- Philippines: 3,430
- Viet Nam: 3,390
- Lao PDR: 2,490
- Cambodia: 1,510
- Myanmar: 1,340



Gross national income (GNI) per capita (current US$) in 2020
https://data.worldbank.org/indicator/NY.GNP.PCAP.CD?locations=TH-BN-SG-MY-KH-LA-MM-ID-PH-VN

Country background 2021

	Brunei	Cambodia	Indonesia	Lao PDR	Malaysia	Myanmar	Philipines	Singapore	Thailand	Viet Nam
Population (million)	0.4	16.9	276.4	7.4	32.8	54.8	111.0	5.5	70.0	98.2
GDP per capita (current US$)	31,723	1,591	4,292	2,551	11,371	1,187	3,549	72,794	7,233	3,694
Tax (% GDP)	na	17.9 (2020)	8.3 (2020)	na	10.9 (2020)	6.4 (2019)	14.0 (2020)	12.9 (2020)	14.5 (2020)	na
CHE (% GDP)	2.16 (2019)	6.99 (2019)	2.90 (2019)	2.60 (2019)	3.83 (2019)	4.68 (2019)	4.08 (2019)	4.08 (2019)	3.79 (2019)	5.25 (2019)
CHE per capita (current US$)	671.56 (2019)	113.31 (2019)	120.12 (2019)	68.22 (2019)	436.61 (2019)	60.02 (2019)	142.08 (2019)	2632.71 (2019)	269.17 (2019)	180.72 (2019)
UHC index	77.0 (2019)	61.0 (2019)	59.0 (2019)	50.0 (2019)	76.0 (2019)	61.0 (2019)	55.0 (2019)	86.0 (2019)	83.0 (2019)	70.0 (2019)
Poverty headcount ratio at $2.15 a day (% of pop))	na	na	3.5 (2021)	7.1 (2018)	0.0 (2015)	2.0 (2017)	3.0 (2018)	na	0.0 (2020)	1.2 (2018)

https://data.worldbank.org/

Country background 2021 (cont.)

	Brunei	Cambodia	Indonesia	Lao PDR	Malaysia	Myanmar	Philipines	Singapore	Thailand	Viet Nam
General government health expenditure (% of CHE)	94.32 (2019)	24.31 (2019)	48.94 (2019)	36.93 (2019)	52.20 (2019)	15.76 (2019)	40.60 (2019)	50.20 (2019)	71.66 (2019)	43.80 (2019)
GGHE (% of GGE)	6.81 (2019)	7.01 (2019)	8.68 (2019)	4.71 (2019)	8.48 (2019)	3.64 (2019)	7.63 (2019)	14.54 (2019)	13.87 (2019)	10.07 (2019)
Private health expenditure (% of CHE)	5.68 (2019)	69.19 (2019)	50.51 (2019)	41.86 (2019)	47.80 (2019)	75.96 (2019)	58.99 (2019)	49.80 (2019)	28.23 (2019)	55.23 (2019)
External health expenditure (% of CHE)	0.0 (2019)	6.50 (2019)	0.56 (2019)	21.21 (2019)	0.0 (2019)	8.29 (2019)	0.41 (2019)	0.0 (2019)	0.11 (2019)	0.97 (2019)
Out-of-pocket expenditure (% of CHE)	5.68 (2019)	64.39 (2019)	34.76 (2019)	41.83 (2019)	34.57 (2019)	75.95 (2019)	48.56 (2019)	30.15 (2019)	8.67 (2019)	42.95 (2019)

https://data.worldbank.org/

Revenue raising & Pooling

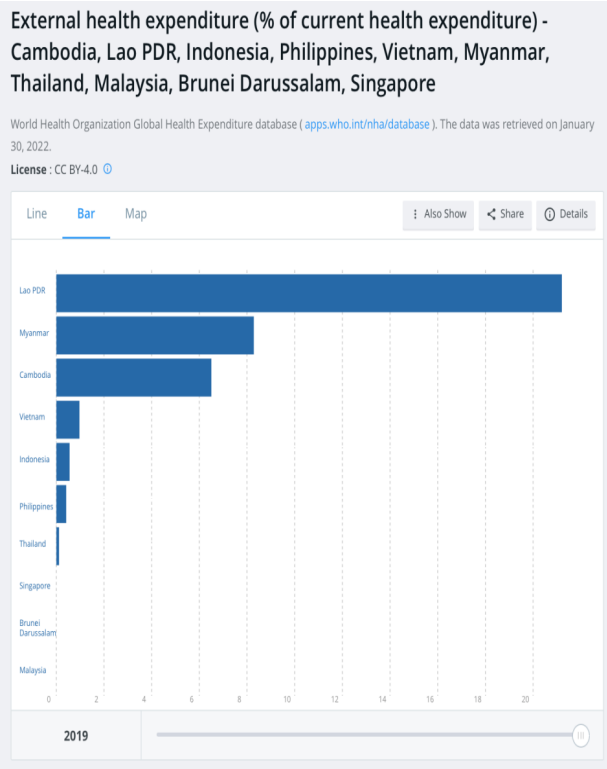
	Brunei	Cambodia	Indonesia	Lao PDR	Malaysia	Myanmar	Philipines	Singapore	Thailand	Viet Nam
Tax		✓	✓	✓	✓	✓	✓	✓	✓	✓
OOP		✓	✓	✓	✓	✓	✓	✓	✓	✓
External		✓		✓		✓				
Non-tax	✓									
Single pool	✓		✓		✓		✓			✓
Multiple pool		✓		✓		✓		✓	✓	
Schemes / details of revenue		- Social insurance - NGOs - Health equity funds		- Social insurance - NGOs - Health equity funds		-no formal arrangement -Social security system	PhilHealth	- Medisave - MediShield Life - Medifund	-CSMBS -Social health insulance -UCS	

Myint et al. 2019 PloS One 14 (6): e0217278

External revenue

Challenge

- Reliable funding
- Apporpriate identification of the eligible poor



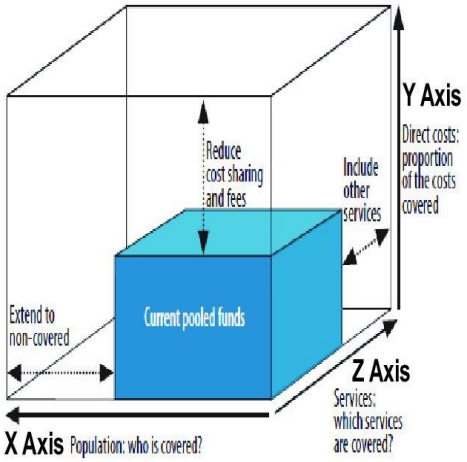
Tangcharoensathien et al. (2011). Lancet, DOI:10.1016/S0140- 6736(10)61890-9

Type of provider & Payment method

	Brunei	Cambodia	Indonesia	Lao PDR	Malaysia	Myanmar	Philipines	Singapore	Thailand	Viet Nam
Public	✓	✓		✓	✓	✓				✓
Public & Private			✓				✓	✓	✓	
Capitation		✓	✓	✓			✓		✓	✓
Fee-for-service					✓	✓	✓		✓	✓
DRGs			✓						✓	✓
Fee schedules			✓	✓						
Salary						✓				
Global Budget	✓				✓				✓	

Myint et al. 2019 PloS One 14 (6): e0217278

Steps towards Universal Health Coverage



- Reduce dependence on out-of-pocket payment
- Expanding coverage of good-quality servies
- Expanding population coverage

Tangcharoensathien et al. (2017) IJHPM, 6(2), 107–110

Population coverage & Benefit package

	Brunei	Cambodia	Indonesia	Lao PDR	Malaysia	Myanmar	Philipines	Singapore	Thailand	Viet Nam
Population coverage										
>90%	✓				✓			✓	✓	
50-90%			✓				✓			✓
<25%		✓		✓		✓				
Benefit package										
Essential health care				✓		✓	✓			
Essential + tertiary care	✓		✓		✓			✓	✓	✓
Not Defined		✓								

Myint et al. 2019 PloS One 14 (6): e0217278

UHC achievements (7 countries)

	Population coverage by financial protection schemes	Health service coverage by financial protection schemes	Financial protection for the total population (measured by out-of-pocket costs as % of THE, 2007)
Malaysia	100%	Primary care services focus on maternal and child health; curative services are free for all. Services are rationed by waiting time and number of family physicians in health centres; patients opt to pay for private services; survey reports 62% of ambulatory care was provided by private clinics.	40·7%
Thailand	98%	Comprehensive benefit package, free at point of service for all three public insurance schemes.	19·2%
Philippines	76%	Benefit package covers admission only except for the sponsored programme, which also covers outpatient services; high level of co-payment for all PhilHealth components: average reimbursement is 54% of the total medical bill, the balance being paid out-of-pocket.	54·7%
Indonesia	48%	Although the policy intention is to provide comprehensive services, the low per capita government subsidy for the poor of US$6 per year for a package of outpatient and inpatient services might result in inadequate service provision, high levels of self-payment, and low levels of financial protection.	30·1%
Vietnam	54·8%	Benefit package is comprehensive but has a substantial level of co-payment: 5–20% of medical bills.	54·8%
Laos	7·7%	In principle, there is a comprehensive coverage for social health insurance and government employee schemes, but low level of funding results in a small service package.	61·7%
Cambodia	24%	The poor covered by the health equity fund are entitled to a comprehensive package, including transport cost and food allowance, but the scope and quality of care provided at government health facilities are restricted.	60·1%

Information is from synthesis of the authors' research. THE=total health expenditure.

***Table 3*: Summary population, service coverage, and financial protection in seven countries in southeast Asia in 2009**

Tangcharoensathien et al. (2011). Lancet, DOI:10.1016/S0140- 6736(10)61890-9

Population coverage & Revenue

- Formal employment
  - tax
  - payroll
- Poor and vulnerable
  - general budget
  - health equity funds (better than a simple fee exemptions policy)
- Informal sectors and the rest of the population
  - contributory arrangements
  - tax

Tangcharoensathien et al. (2011). Lancet, DOI:10.1016/S0140- 6736(10)61890-9

Challenges in service coverage

- Expanding coverage of good-quality services
- Ensure adequate human resources
- Institutional capacity to generate evidences and inform policy

Tangcharoensathien et al. (2011). Lancet, DOI:10.1016/S0140- 6736(10)61890-9

Lesson learn: the first step

In initiated phase

- Primary healthcare services accessibility
  - Geographial access can be major problems
- Financial risk protection for the poor
  - Effective identification of the poor
  - User fee exemption
  - Adequate level of subsidy

Lesson learn: the second step

The formal sector is small

- Social health insurance can make important contribution to insurance coverage
- Tax funding might be preferable in the long run

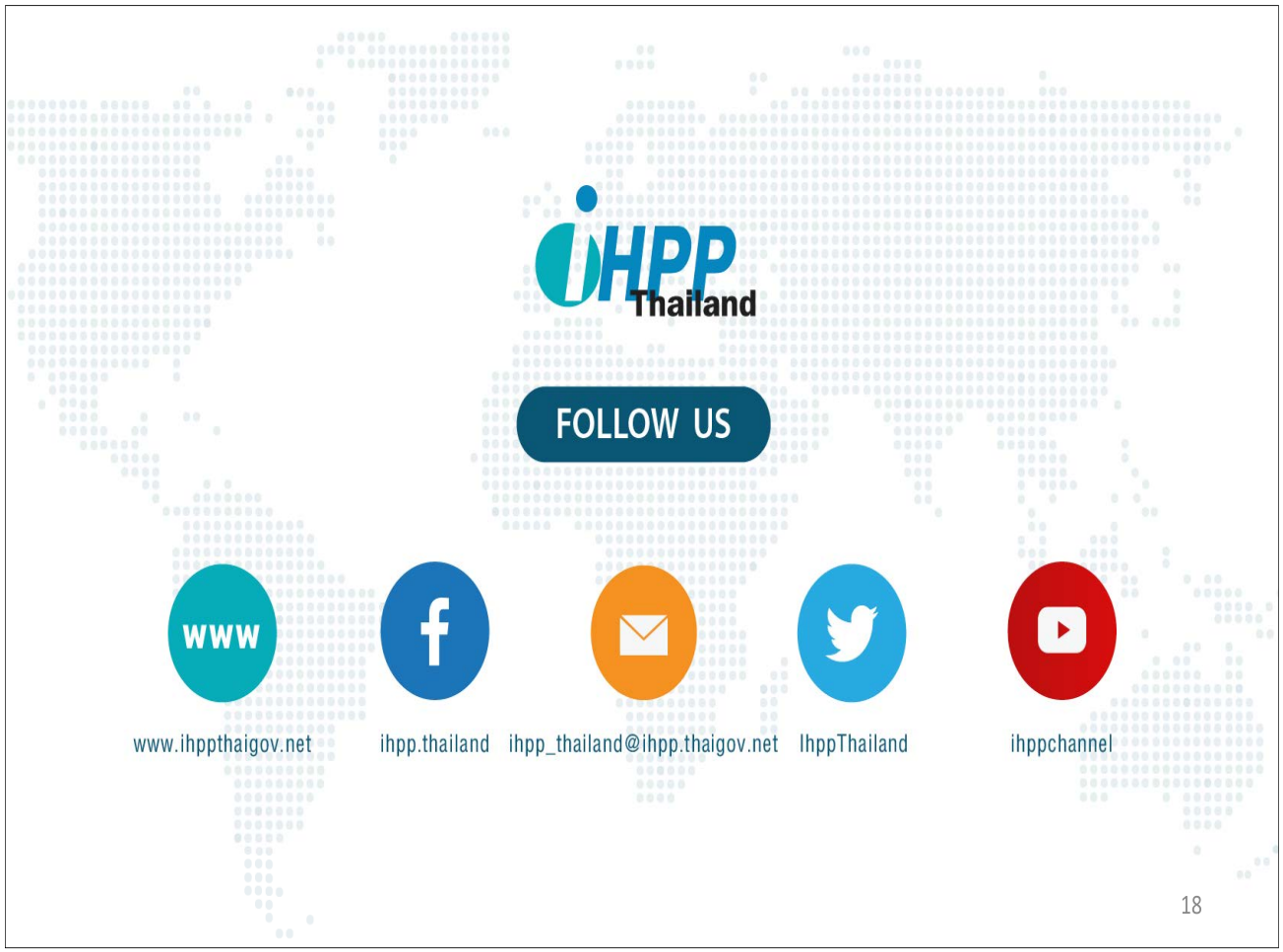
Lesson learn: the final step

The poor are adequatedly protected and fiscal capacity allows

- Partial subsidy for the informal sector could be an option
- Harmonising all prepayment or health insurance schemes

References

- Tangcharoensathien et al. (2011) Health-financing reforms in southeast Asia: challenges in achieving universal coverage. Lancet, DOI:10.1016/S0140- 6736(10)61890-9
- Tangcharoensathien et al. (2017) Policy Choices for Progressive Realization of Universal Health Coverage Comment on "Ethical Perspective: Five Unacceptable Trade-offs on the Path to Universal Health Coverage". IJHPM, 6(2), 107–110
- Myint C-Y, Pavlova M, Thein K-N-N, Groot W (2019) A systematic review of the health- financing mechanisms in the Association of Southeast Asian Nations countries and the People's Republic of China: Lessons for the move towards universal health coverage. PLoS ONE 14 (6): e0217278.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Presentations: More Health for Money

Wankyo Chung

Professor, School of Public Health, Seoul National University

The 2nd ASEAN-ROK Health Webinar
on
Health Financing for
Universal Health Coverage

More Health for Money

Wankyo Chung

Graduate School of Public Health
Seoul National University

November 2022

Outline

Medical Spending & Economic Value of Health

- Medical spending increased from 72 billion Won (2.6% of GDP) in 1970 to 78,263 billion Won (5.9% of GDP) in 2010 and 161,691 billion Won (8.4% of GDP)in 2020 (OECD Health Statistics 2022)
- Simultaneously, life expectancy increased from 62.3 years in 1970 to 80.2 years in 2010 and 83.5 years in 2020 (OECD Health Statistics 2022).
- to estimate the economic values of increased longevity from 1970 to 2010.
- to assess medical spending with economic values of the increased longevity

A framework by Murphy & Topel (2003, 2006)

Expected lifetime utility

$$V = \int_0^\infty e^{-\rho t} H(t) u(c(t), l(t)) S(t) dt \tag{1}$$

H(t): quality of life, S(t): survivor function from birth to age t, c(t): consumption, l(t): nonmarket time

Willingness to pay for increased discounted present value of lifetime utility due to increased health

$$\frac{dV}{\mu} = \frac{\int_0^\infty e^{-\rho t}[H(t)u(c(t), l(t))\Delta S(t) + u(c(t), l(t))S(t)\Delta H(t)]dt}{H(0)u_c(c(0), l(0))} \tag{2}$$

A framework by Murphy & Topel (2003, 2006)

$$\frac{dV}{\mu} = \int_0^\infty e^{-rt}\theta C_F(t)\Delta S(t) + \int_0^\infty e^{-rt}\theta C_F(t)S(t)\frac{\Delta H(t)}{H(t)}dt \tag{3}$$

where

$$C_F(t) = c(t) + w(t)l(t) \tag{4}$$

Willingness to pay as of age a

$$\frac{dV(a)}{\mu(a)} = \int_a^\infty e^{-r(t-a)}\theta C_F(t)\frac{S(t)}{S(a)}dt = \lambda W(a) \tag{5}$$

where W(a) is the value of a statistical life

Background Methodology Results Conclusion

A framework by Murphy & Topel (2003, 2006)

Willingness to pay as of age a for increased longevity from S_1 to S_2

$$V_R(t) = V_2 - V_1 = \int_a^\infty e^{-r(t-a)}[S_2(t) - S_1(t)]\theta C_F(t)dt \tag{6}$$

and aggregated value over the current and future population

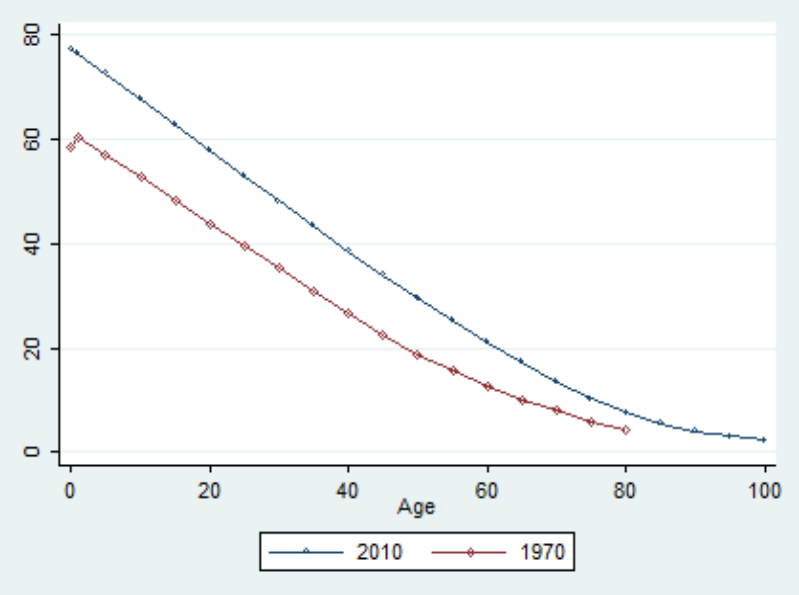
$$V_R(t) = \sum_{a=0}^{T} N(a,t)V_R(a,R) + N^*(t)V_R(0,R) \tag{7}$$

where $N(a,t)$ is the number of individuals of age a at date t, and N^* is the present value of the number of individuals that will be born in future years.

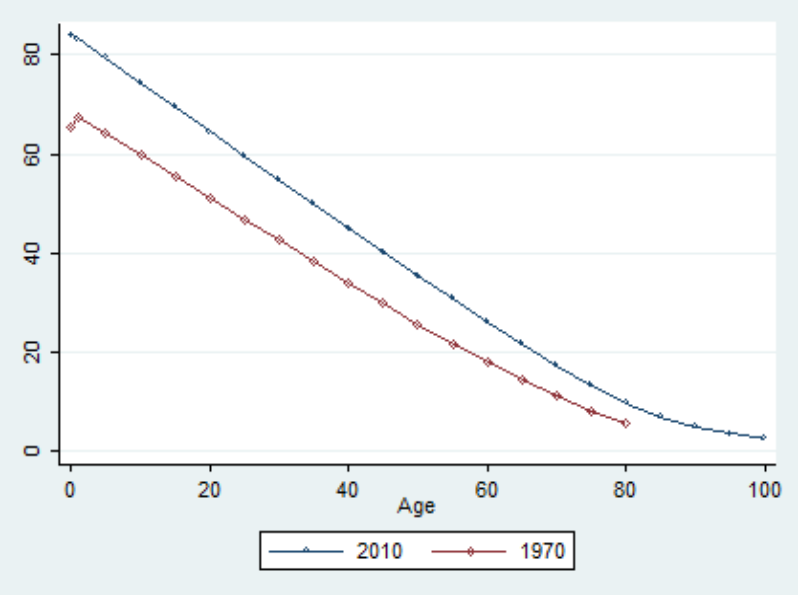
Implications

- Greater economic value as population grows,
- lifetime income grows,
- health level improves
- age distribution concentrates near but before the typical age of onset of the disease

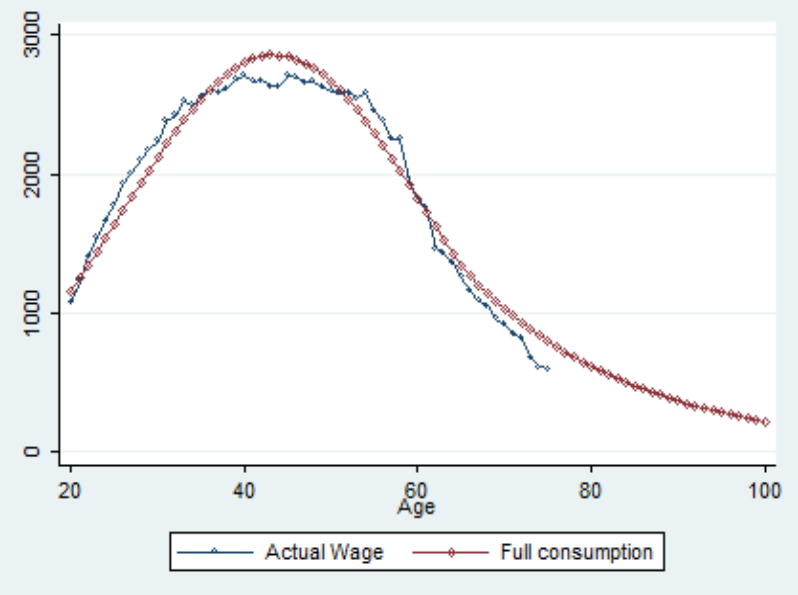
Male life expectancy by age, Korea, 1970-2010



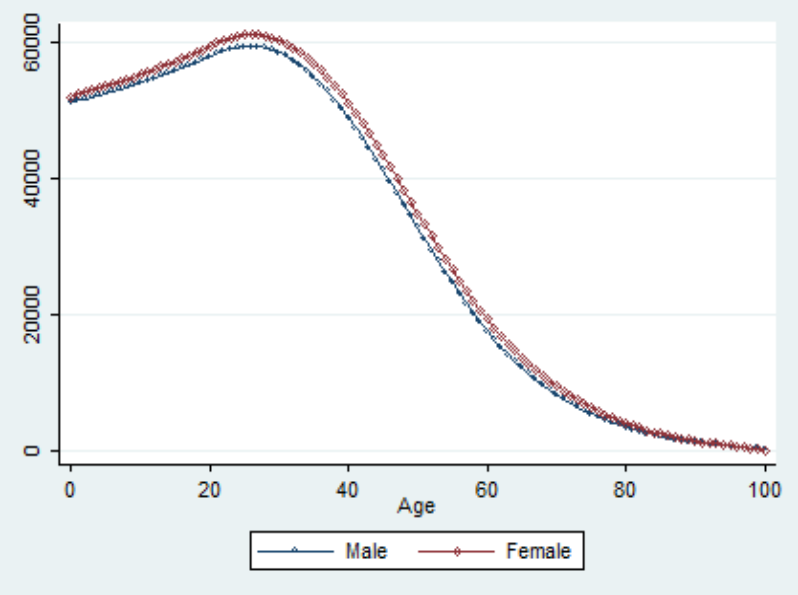
Female life expectancy by age, Korea, 1970-2010



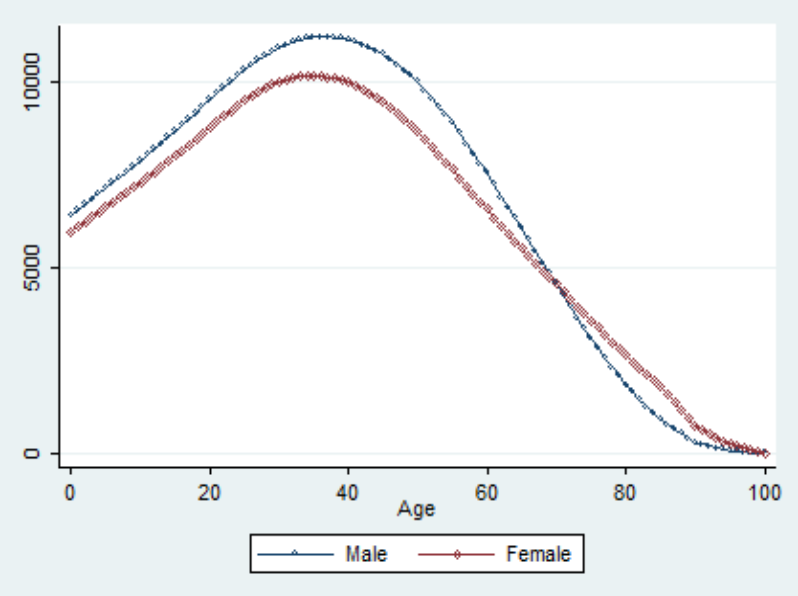
Full consumption by age, Korea, (2010, 10,000 Won)



Value of life by age, Korea, (2010, 10,000 Won)



Economic gain from increased longevity by age, Korea, (2010, 10,000 Won)



Aggregate economic gains from increased longevity, Korea, (2010, trillion won, Chung(2014))

	1970-2010	
Males	2,509	
Females	2,236	
Total	4,744	119 per year (vs. nominal GDP 1,173 in 2010)

Conclusion

- Economic value of increased longevity from 1970 to 2010 was 4,744 trillion Won (in 2010) and 119 trillion Won per year.
- Potential gain from further decline in mortality is immense, expecially with growing old population, more lifetime income, and better health status.
- Greater need for more cost-effective health interventions especially under the Korean National Health Insurance, which may increase the incentive toward cost-increasing technology development and adoption.

References

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- Murphy K. M. and R. H. Topel, "The Value of Health and Longevity," Journal of Political Economy, Vol. 114, 2006.

Presentations:
More Health for Money

Ackhmad Afflazir

Project Management Officer, Health Policy Agency, Ministry of Health,
Republic of Indonesia

The 2nd ASEAN-ROK Health Webinar
on
Health Financing for
Universal Health Coverage

The 2nd ASEAN-ROK Health Webinar on "Health Financing for Universal Health Coverage: More Money for Health, More Health for Money"

More Health for Money

Centre for Health Financing and Decentralization Policy
Health Policy Agency, Ministry of Health R.I.

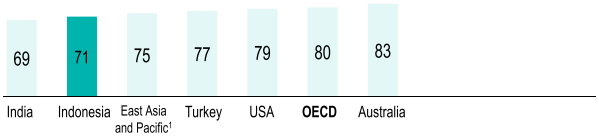
November, 30th 2022

TOPICS

- **Current situation**
- Challenges
- Strategies health financing
  - Health Financing Transformation
  - Public Financial Management (PFM)
  - National Health Insurance
  - Public Health Strengthening
- Way forward

We have persistent health challenges

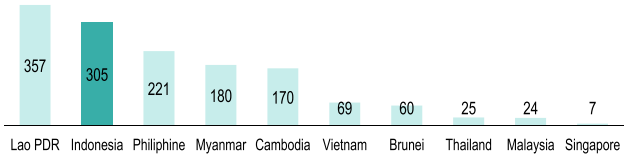
Life expectancy at birth (2018), year



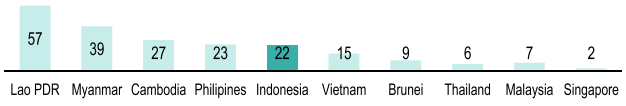
1. Including China, Malaysia, Myanmar, Philippines, Thailand, Vietnam, Papua new Guinea, East Timor, Pacific islands

Source: World Bank, WHO Global Health Observatory

Maternal mortality[2] (2015), per 100,000 live-births

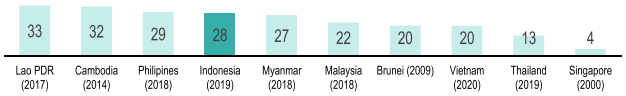


Infant mortality rate (2015)[2], per 1,000 live-births



2. ASEAN Statistical Report on Millennium Development Goals 2017 Jakarta, ASEAN Secretariat, August 2017

Stunting prevalence[3], %



3. ASEAN Food and Nutrition Report 2021

In addition,

2nd Highest **Tuberculosis** burden in the world

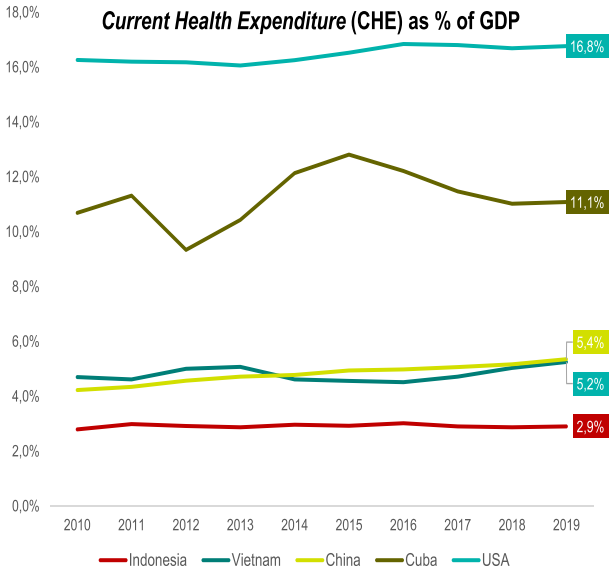
73% of deaths are **contributed by NCDs**, higher than SEA average of 60%

39% of population **aged 15+ years are smoking** – highest prevalence of smoking amongst ASEAN

KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

Health expenditure in Indonesia is still low, despite an increase in the proportion of health expenditure to Central & Local Government Budget

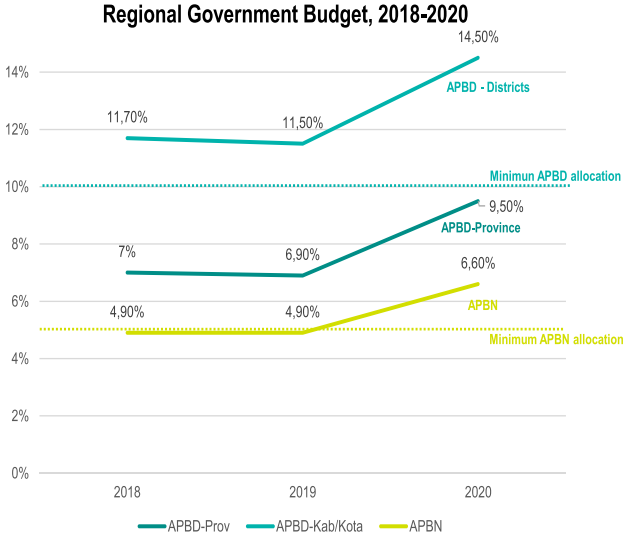
***Current Health Expenditure* (CHE) as % of GDP**



Source: WHO, 2021

Total Health Expenditure as % of GDP in Indonesia is the lowest among ASEAN countries.

Proportion of Health Expenditure to the Central and Regional Government Budget, 2018-2020



Source: MOF, 2022

The proportions of health expenditure (including salary) to the Central (APBN) and Districts (APBD) Government Budget have already met the minimum of 5% and 10% respectively.

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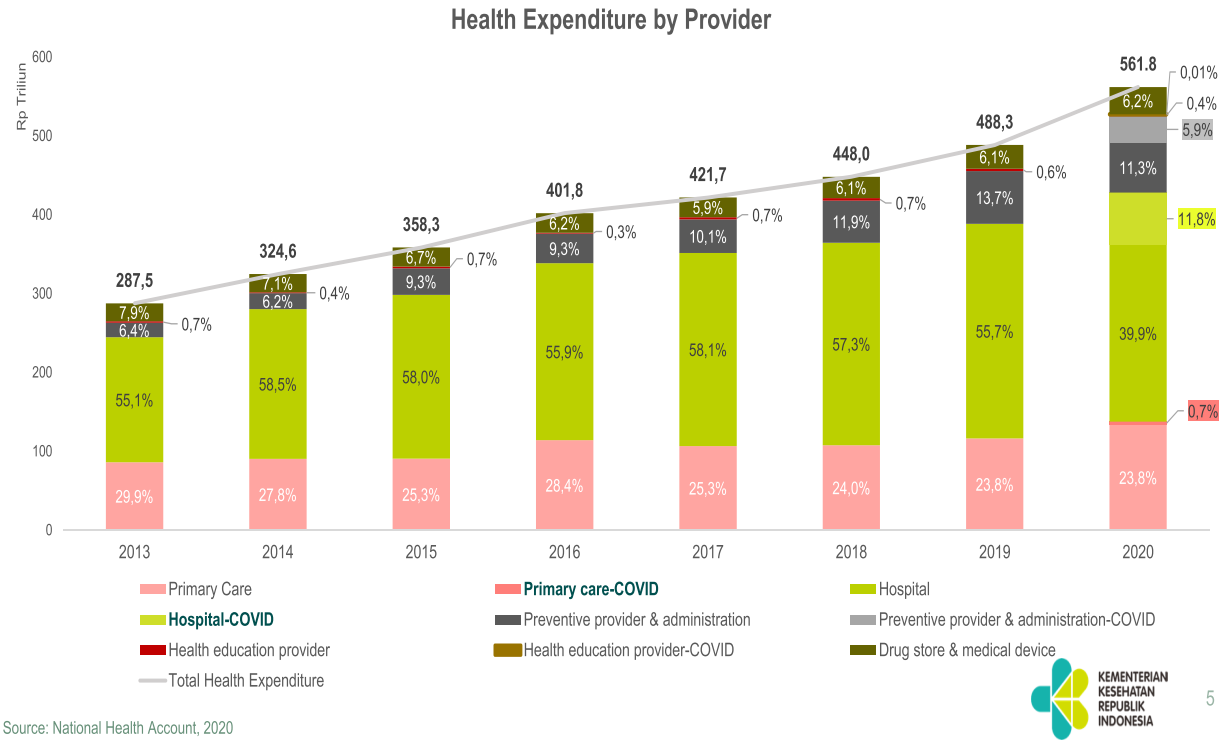
More than 50% of health expenditure is spent in Hospital.

Hospitals are essential component of health system, while also being the most costly. In Indonesia, they accounted for more than 50% of total health expenditure.



Source: National Health Account, 2020

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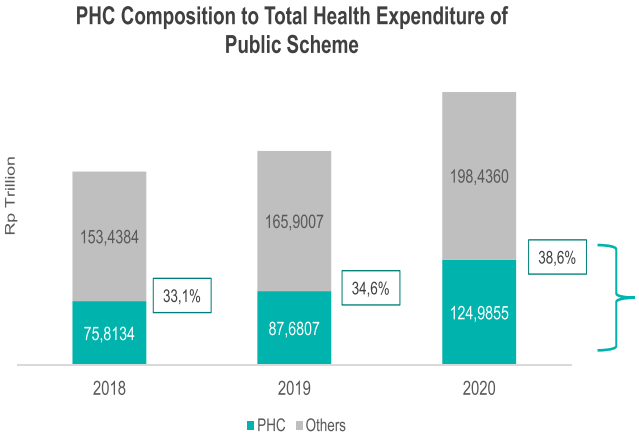
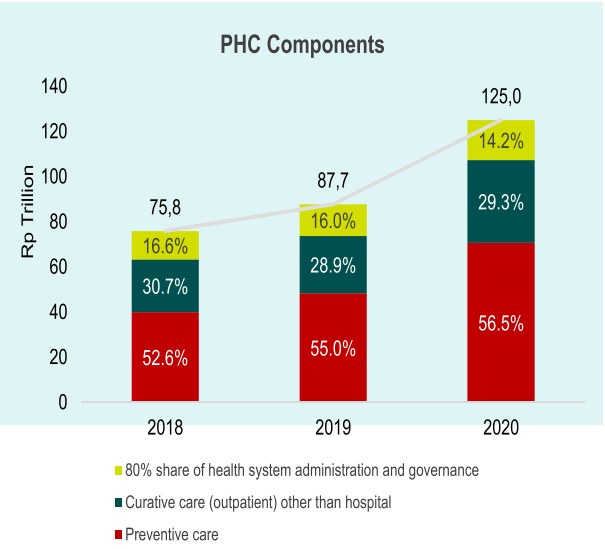
More than 30% of public health expenditure was spent on *Primary Health Care*

In 2020, the share of public scheme expenditure on Primary Health Care (PHC) amounted to **US$ 8,4 billion/ IDR125 trillion (38,6%) with a per capita expenditure of US$ 30,78/IDR461,088.**



Notes:

- Others included all expenditures on public scheme for inpatient, outpatient in hospital and 20% of administrative & capital expenditures.
- PHC expenditure estimation does not include outpatient in hospital with the assumption that hospital are categorized as part of referral services.

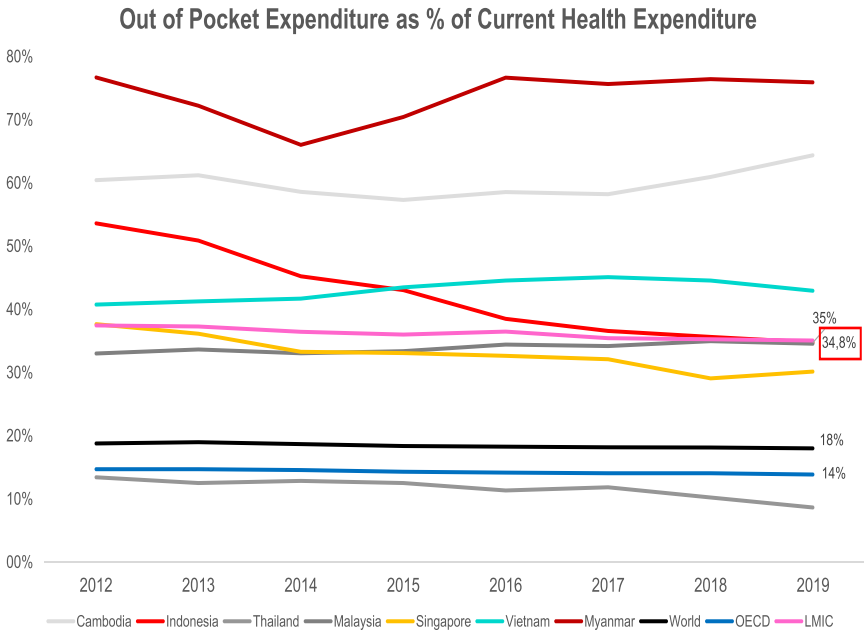


The largest component for **PHC** during 2018-2020 was for **preventive care** (IDR70.6 trillion/56.5%), followed by **curative care** (outpatient) other than hospital (IDR36.6 trillion/29.3%).

6

As a share of current health expenditure (CHE), OOP tends to decrease over years in Indonesia and reached 34,8% in 2019

This number is slightly lower than that in LMICs, but almost double the world's number.



Source: WHO, 2022

- OOP as % of CHE decreased significantly (-11.1%) in 2014.
- This high OOP may caused by access to health services while households were not protected against high payment of medical costs.
- In 2014, Indonesia implemented National Health Insurance (refer to as JKN) that covers comprehensive benefit package for its members.

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National Health Insurance/JKN

JKN Overview : Benefit, Scheme, Members & Provider

Indonesia implements social health insurance to provide access to health services for citizens without financial barrier ; Since 2014

Membership

Contributory : Non Poor Population, Including Formal & Informal Workers
Non Contributory : Poor & Near Poor Population (PBI), Premium paid by Government/ Local Goverment

Benefit

Medical Services : Based on Basic Medical Needs including drug, medical treatment, diagnostic examination, etc., both in Primary and Specialistic Health Service
Non Medical Services : Based on Premium Paid (Inpatient Accomodation)

Funding Scheme

Premium paid by members, employer or Government pooled and managed by BPJS Kesehatan as non-profit Body

Health Service Provider

BPJS Kesehatan cooperates with government or private primary and referral health facilities to ensure JKN members can easily access health service

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TOPICS

- Current situation
- Challenges
- Strategies health financing
  - Health Financing Transformation
  - Public Financial Management (PFM)
  - National Health Insurance
  - Public Health Strengthening
- Way forward

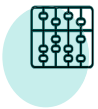
Identified Challenges to Implement Health Financing Transformation

Insufficiency and unsustainability

- Health expenditure as of GDP is lower than other ASEAN countries.
- Imbalance JKN revenue and spending.

Not allocated equitably

- Poor and near poor receive less health benefit (access to health services) compared to the rich.
- Maldistribution of health facilities.



Ineffective and inefficient health financing

- Discrepancy between financing and health indicator targets.
- Many districts spend their resources inefficiently to achieve health output.

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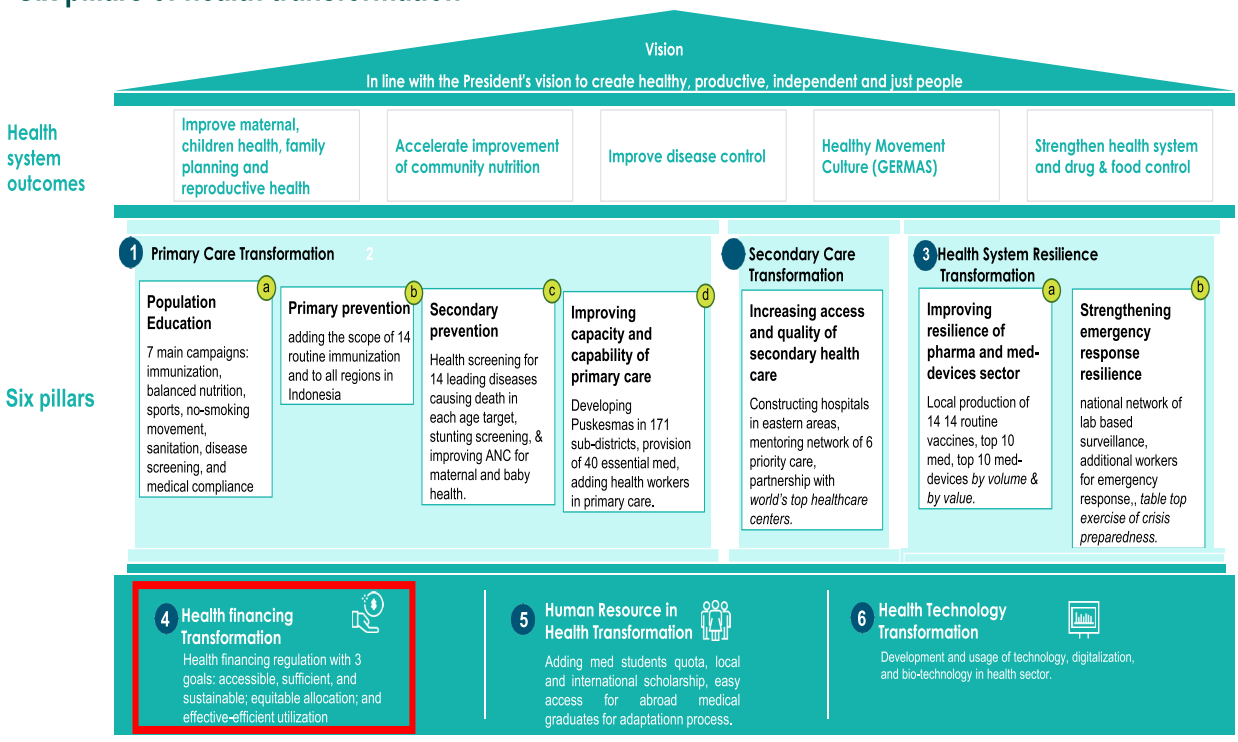
TOPICS

- Current situation
- Challenges
- **Strategies health financing**
  - **Health Financing Transformation**
  - **Public Financial Management (PFM)**
  - **National Health Insurance**
  - **Public Health Strengthening**
- Way forward

MoH is committed to implement Health System Transformation

Six pillars of health transformation



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#Public Financial Management

PFM to support the implementation of health financing reform toward UHC

To synchronize financing between Central and Local Government with transparent, effective and efficient way

Re-designing General Allocation Funds (DAU)

National Level → **Subnational Level**

Block Grant

Allocated for **routine activities**, such as drugs, salary and consumable goods

Specific Grant

Allocated for **basic health needs** that must be fulfilled by Local Government, such as SPM (Minimum Health Services Standard)

Set up indicators -- SPM

Indicators should be measurable, middle-term, and available.
Ex: immunization; ANC

Set up activities – refer to indicators

Implementation

Evaluation

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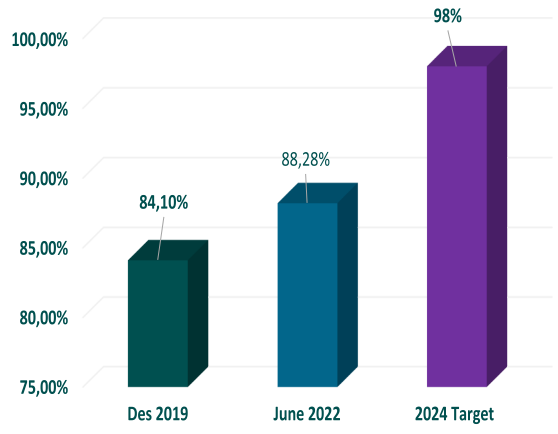
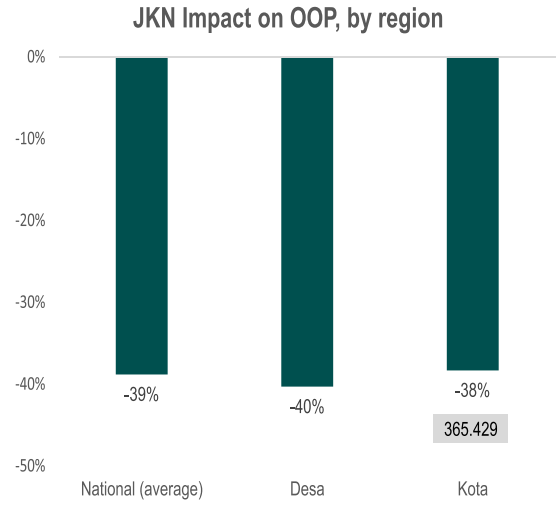
#National Health Insurance

Indonesia National Health Insurance (JKN) to protect people from financial barrier and to ensure access to health services



Sumber: BPJS Kesehatan, 2022



Source: Thinkwell, 2021

- By June 2022, the JKN coverage was at 88.28% of population. It's only 10% more to achieve the 2024 target.
- JKN households have lower OOP by 39% than uninsured households (Thinkwell, 2021)

JKN households have lower Out of Pocket (OOP) by 39% than uninsured households.

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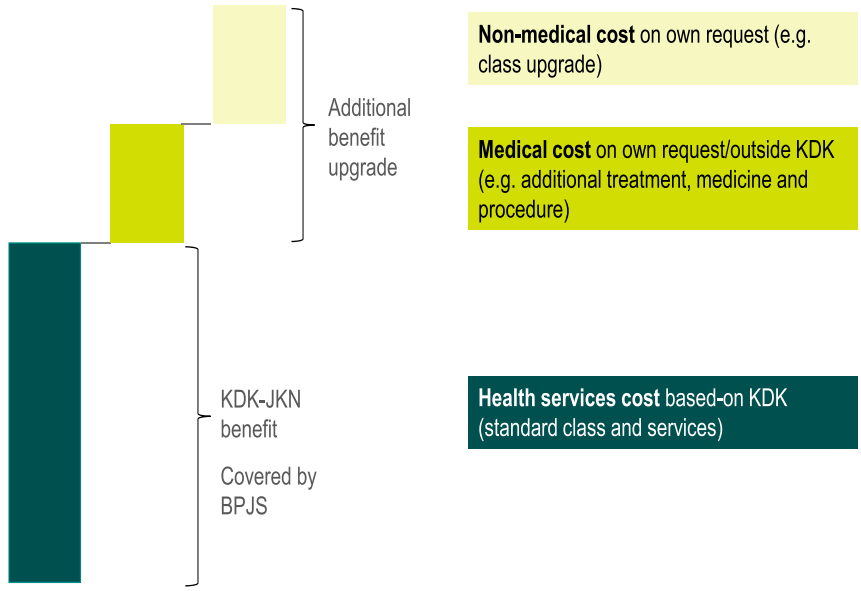
#National Health Insurance

It's expected to control OOP through Supplementary Health Insurance



Positive impact of this concept is:

- **To give Supplementary Health Insurance opportunity** to design health insurance products as a complement to JKN benefit.
- **To increase member coverage,** especially in the middle to upper segment.
- **Health financing efficiency** by mobilizing health financing through **Supplementary Health Insurance** to control OOP.

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#National Health Insurance

Capitation as payment mechanism in primary care

The reform of capitation to improve fairness, quality and efficiency is needed by implementing **performance-based-payment.**

Performance-based-Payment development in primary care

- To develop risk-adjusted capitation – age and sex – for curative care payment.
- To combine capitation with pay-for-performance (P4P) to improve the quality of healthcare (incentive mechanism).
- To develop a non-capitation payment mechanism for preventive care, such as screening, ANC, etc.

Utilization Review (UR) implementation and utilization

- To conduct health services data review and analysis periodically.
- To formulate policy on JKN health services improvement based on UR.

JKN members redistribution

- JKN members redistribution to improve the quality of healthcare and Puskesmas involvement in public health care services implementation.
- Determination of members ratio in primary care by considering the capacity factor and operational burden of primary care.

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#Public Health Strengthening

Primary Health Care Investment

Everyone has access to primary care such as immunization, general practitioner consultation, medical check up and health education.

Priority programs to strengthen preventive care in primary care

Routine immunization:
From 11 to 14 types of vaccines

BCG, DPT-Hib, Hep B, MMR/MR, Polio (OPV-IPV), TT/DT/td, JE, **HPV, PCV, Rotavirus**

HPV to prevent **Cervical Cancer.**

PCV and Rotavirus vaccine are for **pneumonia and diarrhea** which are 2 of the 5 highest causes of under-five mortality.

Early detection expansion

***Screening* for the highest causes of death in each age target:**

- Congenital hypothyroid
- Thalassemia
- Anemia
- Stroke
- Heart attack
- Hypertension
- COPD
- Tuberculosis
- Lung cancer
- Hepatitis
- Diabetes
- Breast cancer
- Cervical cancer
- Colon cancer

Mother & child health improvement

Child growth & development monitoring at Posyandu with standardized anthropometric tools

Antenatal care from 4 times to 6 times, including **2 times USG** with doctor in the 1st and 3rd trimesters

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#Public Health Strengthening

Strategic Purchasing (SP) to encourage health services efficiency and effectiveness and to accelerate progress towards UHC

Indonesia is trying to introduce SP to 2 priority programs, which are Tuberculosis and MNCH

#MNCH

What to buy

- **Antenatal care (ANC)**: 6x; with USG and doctor at ANC 1 & 5
- **Delivery at health facility** by doctor-midwife-nurse or doctor-midwife-midwife in combination.
- **Post-natal care (PNC)**: 4x

From whom to buy

- **Puskesmas** provide supervision to health facilities in its area.
- **Contract and payment mechanism** are in accordance with health services standard/quality indicators that have been set.
- **Quality assurance**: coordinator to assure quality, to minimize loss to follow up and to assess referral cases; and indicators integrating to BPJS information system.

How to buy

- **Semi bundle payment** at 4 stages (3x ANC and 1x PNC).
- **Providing incentive** when service standards are met and carried out comprehensively from pregnancy to postpartum.

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#Public Health Strengthening

Public Health Incentive

This incentive is directed to support Health System Transformation by providing incentive for Health and Non-health Workers at Puskesmas.

Background:

1. Promotive and preventive programs prioritization.
2. Lack of performance of public health programs.
3. Increase in BOK (transfer funds) allocation.

Public Health Incentive (7.5% of BOK Puskesmas)

Performance:

- Priority programs (MNCH, nutrition, environmental health, disease prevention & control, SPM)
- BOK realization/spending

Fairness:

- Puskesmas location & workload
- Puskesmas workers (management & outreach)

Performance improvement in promotive and preventive program implementation

Health Ministerial Regulation No 19/2022 (DAK Nonfisik/BOK Puskesmas)

*BOK: Health Operational Fund

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#Public Health Strengthening

Health Financing Innovation through Public Private Partnership (PPP) to support health program

	KPBU (Government-private sector partnership)	KSO (operational partnership)	KTJS/CSR (Corporate social responsibility)	*Philanthropy*
Area	Building, medical devices, and related services	Medical devices and related services	Grants for health infrastructure and medical devices, promotive-preventive activities, and capacity building	Grants for health infrastructure and medical devices, promotive-preventive activities, capacity building, and research
Timeline	Long-term (10-20 years) based on contract	Short-term (3-5 years) based on contract	Occasional/one time off	Occasional/one time off
	Existing			

KPS Government-private sector partnership

Non-Infrastructure, for the implementation of health programs and services

New regulation

Blended Finance

The use of public funding sources to mobilize additional funding from the private sector using innovative ways to generate project structures that have optimal risk returns to achieve sustainable development in developing countries

Future Plan

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TOPICS

- Current situation
- Challenges
- Strategies health financing
  - Health Financing Transformation
  - Public Financial Management (PFM)
  - National Health Insurance
  - Public Health Strengthening
- **Way forward**

Way forward

- National Health Insurance (JKN) for financial protection and primary health care makes keep people healthy. With a healthy body people are able to work and be more productive.

- National Health Insurance (JKN) can prevent people from paying services fees out of their own pocket
- Primary health care is better for people, and it saves money. with an emphasis on promoting health, preventing disease and keeping people out of high-priced hospital stays.
- PFM to support the implementation of health financing transformation toward UHC by formulating, executing, and evaluating health budget according to health indicators.

- Support health investment apart from financing from the government, can be pursued through innovative financing such as PPP
- Strategic Purchasing (SP) to encourage health services efficiency and effectiveness and to accelerate progress towards UHC.

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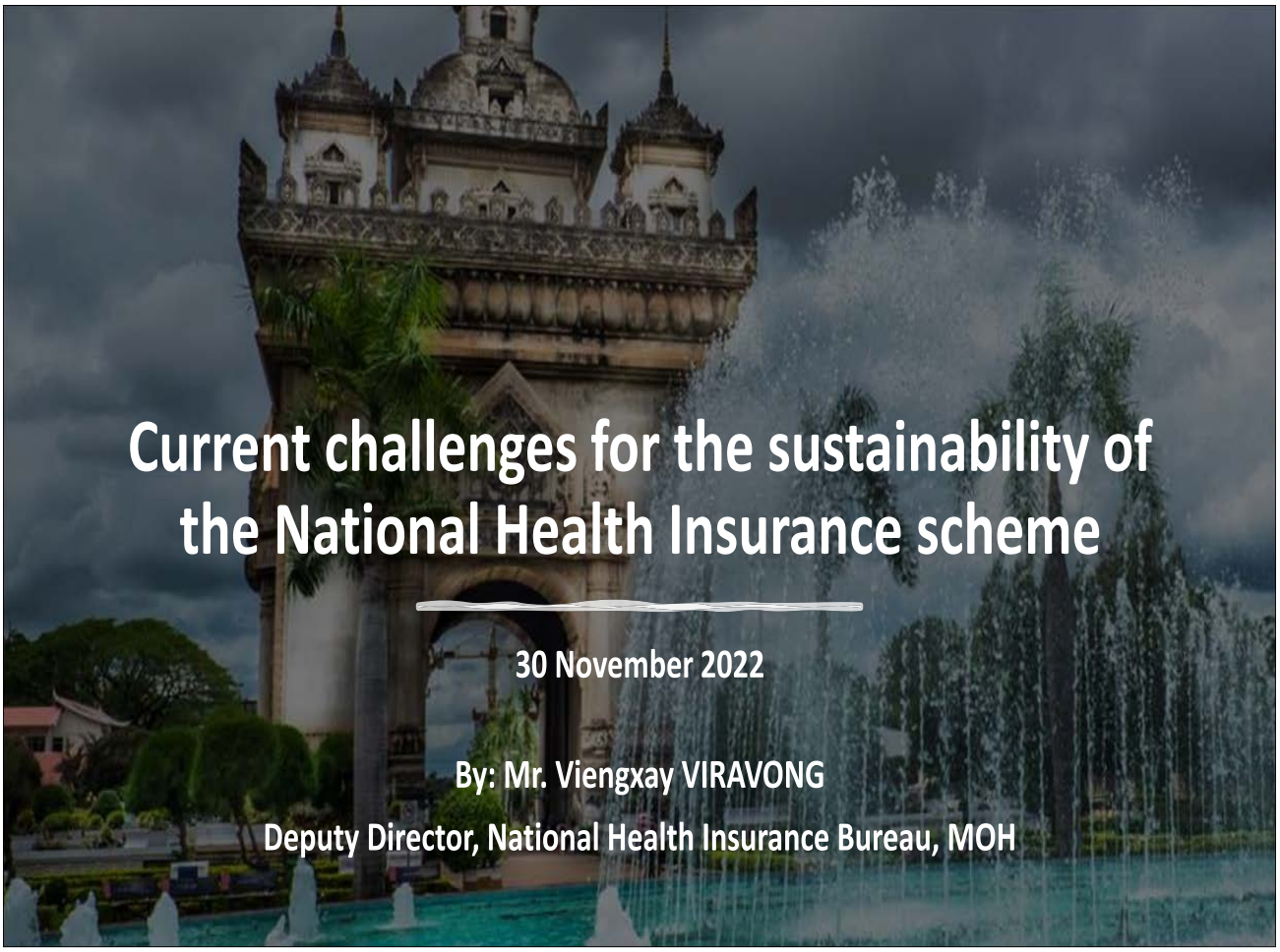
Round Table: Designated Discussion

Mr. Viengxay VIRAVONG

Deputy Director, National Health Insurance Bureau, MOH

The 2nd ASEAN-ROK Health Webinar
on
Health Financing for
Universal Health Coverage



Current challenges for the sustainability of the National Health Insurance scheme

30 November 2022

By: Mr. Viengxay VIRAVONG

Deputy Director, National Health Insurance Bureau, MOH

Outline

- Background
- Challenges for the sustainability of the NHI scheme

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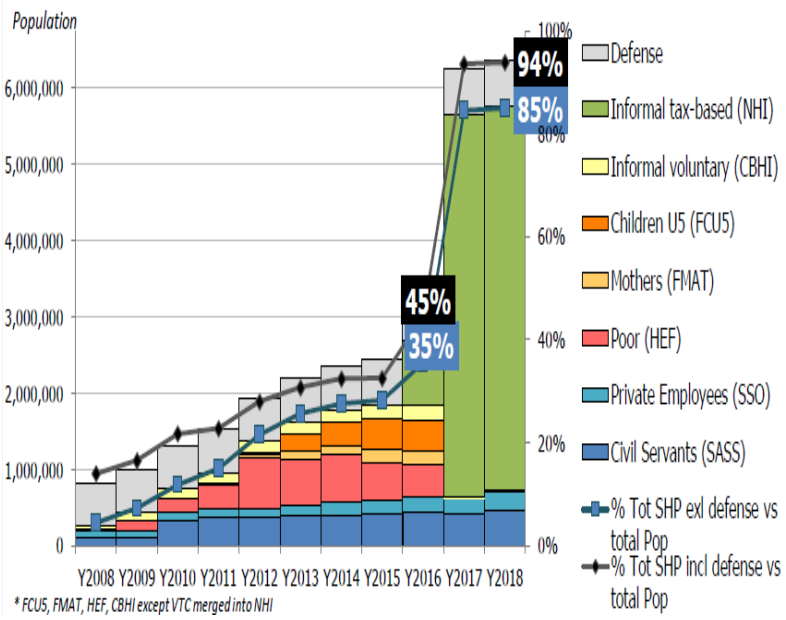
Background | Social health protection in Lao PDR

- The Government of Lao PDR (GoL) is **committed to achieve universal health coverage (UHC) in 2025** by expanding population and service coverage, and achieving financial protection for all
- The **Health Sector Reform (HSR) Strategy and Framework till 2025** outlines the strategy towards UHC
  - The **Phase Three (2021-2025)** is expected to complete the health sector reform and **reach UHC with an adequate benefit package and appropriate financial protection for a vast majority of the population**
  - It is expected that **over 95% of the population will be covered by 2025** and that **OOP payments** will be reduced from more than 40% of THE **to less than 30%**
- To achieve these objectives, GoL has strengthened efforts in recent years to enhance financial protection through the **extension of social health protection mechanisms**
  - **The roll out of the National Health Insurance (NHI) scheme** targeting previously uninsured population groups and managed by the National Health Insurance Bureau (NHIB) under the Ministry of Health (MoH) has resulted in a rapid increase in coverage **since 2016**
  - Following the new policy orientation, **the total population coverage of all schemes** (including the public sector, the military and the police) reached 60% in 2016 and **about 94% in 2020**
- The rapid increase in the population coverage and the harmonization of the schemes aimed to **enhance access to health services and financial protection** from catastrophic health expenditure for all Lao people, thus contributing to the government's policy directions towards achieving universal health coverage by 2025

Background | Before the introduction of NHI

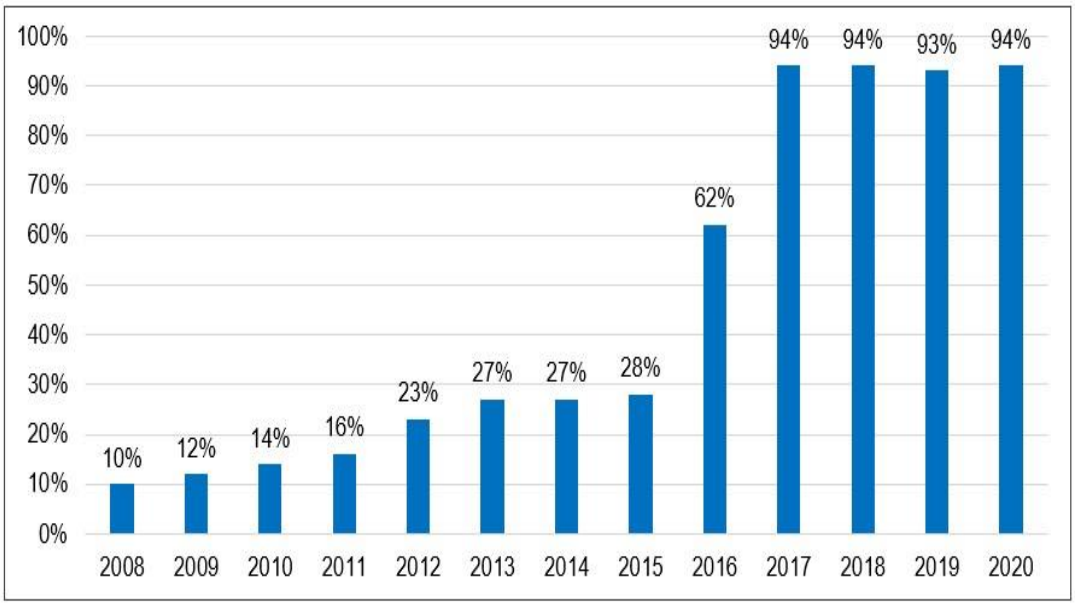
- Before the introduction of NHI scheme in 2016, there were **five social protection schemes** for different population groups across the country:
  - **State Authority for Social Security (SASS)** for civil servants
  - **Social Security Organization (SSO)** for the private formal sector employees
  - **Health Equity Funds** for the poor
  - **Community-Based Health Insurance (CBHI)**
  - **Free maternal and child health services (Free MNCH)**

Coverage of social health protection schemes in Lao PDR (%), 2008-2018



Source: Adapted from the National Health Insurance Bureau of Lao PDR, 2020

National Health Insurance coverage including all social protection schemes, 2020



Source: NHIB annual report, 2020.

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Challenges for the sustainability of the NHI scheme

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Challenges

Institutional status

- NHIB: Currently operating as a department of MOH, reporting to the Minister of Health
- Not clear institutional separation of provider and purchaser

Financial autonomy

- Financed mainly from the government budget; all financial transactions are currently channeled through the national treasury system, both at the central and sub-national levels
- Prone to delays of payments and administrative encumbrances
- Currently no NHI reserve fund; the budget amount that can be committed in each period is limited by the quarterly budget allocation

Financial sustainability

- Currently insufficient budget allocated to NHI by MOF to cover the benefit expenditure of NHI scheme for the informal sector. In 2020, total claims for NHI target population amounted to LAK 265.4 billion; the budget allocated was LAK 180 billion only
- The scheme currently relies heavily on cross-subsidies from the formal sector scheme, but it is unlikely the cross-subsidies can be sustained in the future at the same level of magnitude
- A pressing political and financial imperative to collect more contributions from those segments of the population that can afford to contribute more

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Challenges (cont'd)

Operational issues

- No membership cards have been issued and distributed so far
- Need to improve access to care for the poor; identification of the poor; needs to improve awareness of entitlements and obligations by issuing NHI membership cards starting with the poor
- Copayment exemption for the poor and vulnerable; options for covering the poor and vulnerable in Vientiane Capital in the near future should be examined
- Needs to adopt a long-term strategy on NHI management information systems

Role of NHI in the context of donor transition

- Health insurance may be one of the potential mechanisms to cover the cost of selected services and functions that were previously funded vertically.
- Individual-based clinical services can be covered easily by NHI, while population-based services and functions should be covered through general budget allocation.
- Currently, maternal and child health services are covered by NHI with copayment exemption.
- The role of NHI in covering HIV, TB, Malaria, and immunization should be further discussed and defined in the Lao context.

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Challenges for sustaining essential health services

System level

- **Limited fiscal space for health**
  - **GDP growth** is projected to be lower than that of pre-COVID-19 era
  - **High government debt burden**
  - **Government budget cuts** by 30% at the central level and 10% at the provincial levels
  - **Government budgets in deficit** for many years
- **High reliance on external funding but reduced external funding in the future**
  - **External funding as a share of total health expenditure is more than 22% in 2019**
  - Lao PDR is preparing to **graduate from LDC status by 2026 and donor transition (Gavi, Global Fund)**
- **Weak PFM and NHI systems**
  - **Misalignment of human and physical resource** planning and management
  - **Delays in financing** and low budget execution
  - **Delayed payment** on NHI reimbursement/claims that may affect the quality of care and service provisions; **sustainability issues** in the tax-based newly introduced **NHI system**

Program level

- **Fragmented management and financing in vertical health programs**
  - Lack of governance resulting in **weak and uncoordinated planning and budgeting** processes
  - **Uncoordinated service delivery** and management

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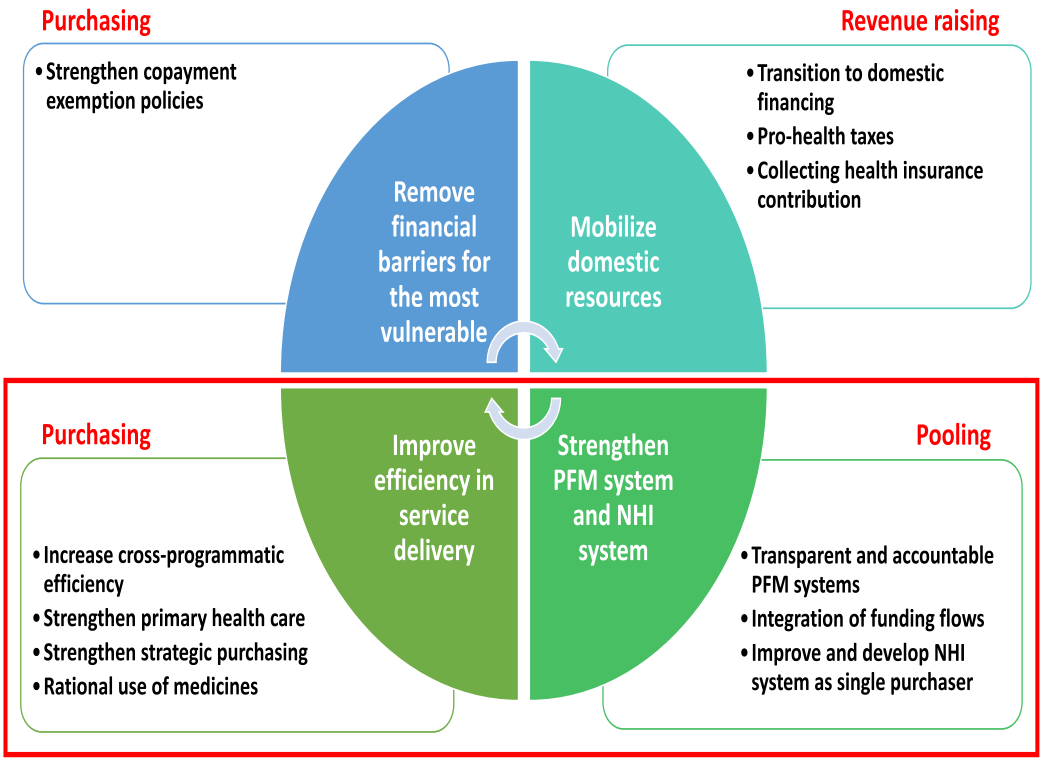
Overview of health financing strategies

[Overall goal] Achieve UHC by strengthening primary health care by 2025



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Strategic objectives of NHI Strategy 2021-2025

- Strengthen the legal framework of NHI and NHIB governance mechanisms towards a semi-autonomous agency
- Strengthen financial independence, accountability, and sustainability of NHI fund, including financial management and donor transition strategy
- Strengthen NHIB's institutional capacity and operational effectiveness and efficiency at all levels (NHIB, PHIB, and DHIB), including NHIB management information system
- Ensure responsiveness of health facilities and improve quality of health care services, including pro-poor policies and strategic purchasing
- Raise awareness among the general population about NHI benefit entitlements

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Approaches to improve sustainability of the NHI scheme

- There are various approaches to improve the financial sustainability of the NHI system, such as increasing government budget, reviewing benefit package, increasing copayments, and collecting contribution from all citizens. The coverage of the contributory social security schemes also needs to be increased.

Increase government budget	• Introduction of pro-health taxes could be an option for increasing domestic government budget for health. • The usage of tobacco tax revenues for NHI should be implemented as stated in the decree on tobacco taxes in close collaboration with MOF.
Reviewing benefit package and increasing copayments	• NHIB could also consider the review of benefit packages and limit less cost-effective services using health technology assessment and other budget impact assessment. • Along with increasing copayment rates, strengthening copayment exemption mechanisms for the poor and vulnerable population should be highlighted at the same time.
Collect contributions from all citizens	• There should be a consensus on this policy direction first among key stakeholders including the Ministry of Labour and Social Welfare (MOLSW) and the public.
Increase the coverage of the contributory schemes	• MOH should cooperate with MOSLW to increase the coverage of the contributory schemes, in particular the scheme for the private sector. • The contributory social security schemes for the formal sector cover about 11.2% of the population, including the private sector schemes (former SSO, 3.4%).

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Current challenges

- With high inflation rates,
  - The de facto budget of the NHIB almost halved
  - Decreased value of the costing exercise results, not reflecting the current economic situation
  - How to manage high prices of medicines under the capitation and case-based payment provider methods?

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Thank you!

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Republic of Korea
to ASEAN


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