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## Commentary

# Asia-Pacific Countries Moving Toward Universal Health Coverage

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### CONTENTS

Motivation

Conceptual Framework

Status Quo and Lessons Learned

The Agenda Forward

References

### MOTIVATION

In 2015, world leaders adopted the 2030 Agenda for Sustainable Development, with 17 goals (including 169 targets) that are interconnected. These Sustainable Development Goals (SDGs) take a social determinants of health approach, explicitly recognizing the synergistic relationship between health and development. Under Goal 3 (promoting health and well-being), universal health coverage (UHC) is a specific target and serves as a unifying platform for the health sector.

UHC is consistent with past health goals, including the World Health Organization (WHO) Constitution, the 1978 Declaration of Alma-Ata that called for a “Health for All” agenda, and world health reports such as *Primary Health Care Now More Than Ever*<sup>1</sup> on the renewal of primary health care. In addition, the concept of UHC provides a more specific set of directions, compared to earlier statements, in pointing to needed actions on expanding population coverage, broadening access to quality services, and deepening financial protection.<sup>s2,3</sup>

As a shared commitment for countries, UHC is reflected in the aspirations of many national health policies and priorities on access, equity, quality, universality, accountability, efficiency, and participation. The 2016 WHO Western Pacific Regional Action Framework for UHC<sup>4</sup> builds on these stated policy goals from countries and notes that country-specific roadmaps are necessary. The challenge, however, is that creating a roadmap, as a series of sequential steps to achieving UHC, is not easy. Given the path dependency of health systems and the context specificity of health policy decisions, each country needs to decide on its own policy reforms to move toward UHC. A government, at any particular juncture, faces decisions that are informed by a combination of evidence, political economy, cultural norms, and institutional capabilities, so the evolution of health systems is inevitably through a series of iterative and context-specific choices. Indeed, the inherent heterogeneity of contexts among

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Western Pacific member states makes it important for each country to decide on its own path to move toward UHC.

### CONCEPTUAL FRAMEWORK

The SDG agenda demands that the health sector contribute to the production of equitable and sustainable health outcomes, in the overall aim of inclusive economics and societies. This necessarily calls for the health system to take an integrated, multistakeholder systems approach involving other parts of government and nonstate actors.<sup>5</sup> Figure 1 acknowledges that though health system strengthening forms a core part of what must be done by the health sector, the achievement of SDGs calls for the health sector to work with other sectors. How the health sector engages with other sectors becomes a question of governance for health.

We have organized this issue around the framework of the UHC Technical Advisory Group in the WHO Western Pacific Region,<sup>6</sup> which in turn follows the UHC 2030 consensus.<sup>7</sup> We focus on the three health system pillars of service delivery, financing, and governance (see Figure 2). This framework recognizes that the central interface for governments and communities with the health sector is the service delivery

system. The way in which finances flow through the system shapes the behavior of service providers and users. Therefore, to reach desired policy objectives, we require careful stewardship through governance mechanisms that allow for diverse voices, including different groups in the community, and selection of appropriate tools and actions.

Service delivery—through primary care, hospitals, and other settings, using Western and/or traditional medicines—requires the appropriate organization of a range of inputs, including workforce, infrastructure, products, and information systems. Regulatory standards for infrastructure, products, and workforce may assure basic safety and quality, but it is the financial flows through the health system and within organizations that often provide more immediate and stronger incentives that support or impede service delivery. Thus, understanding and managing financial arrangements and drivers are critical for supporting appropriate care and access.

Financing is an essential and critical tool available to government, but government stewardship, particularly in a system with private–public mix, requires other governance processes and tools. A governance framework stipulates the

## SDGs, UHC and the health system

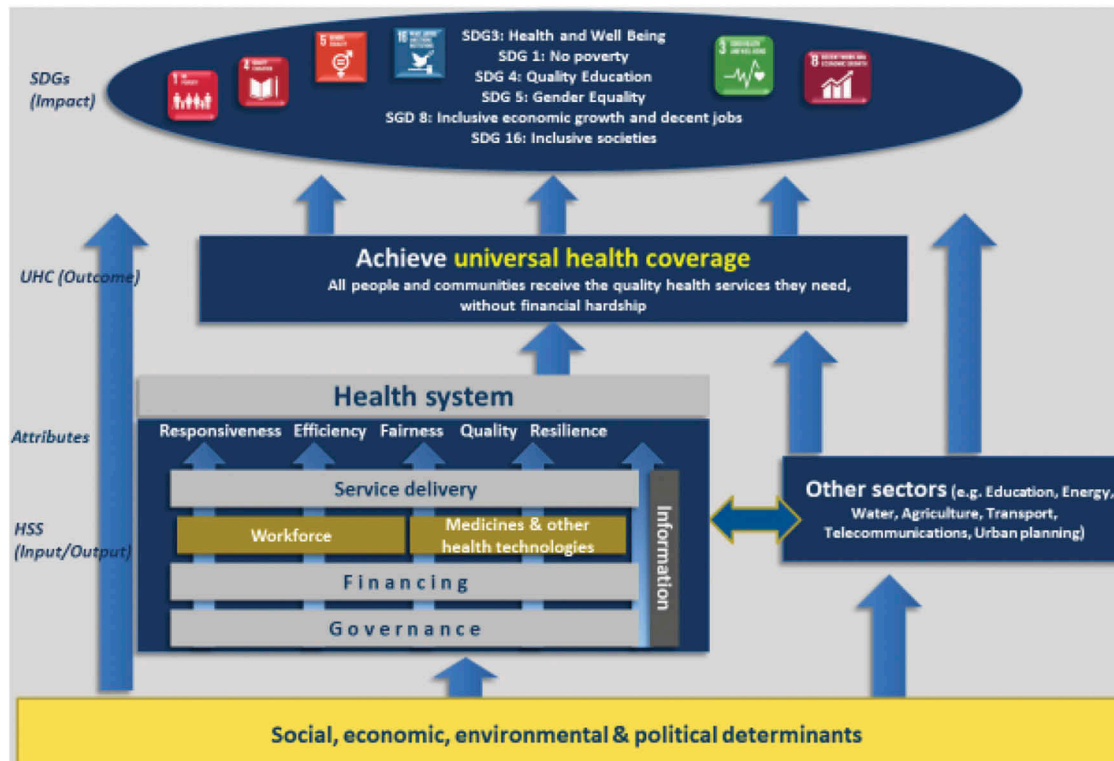
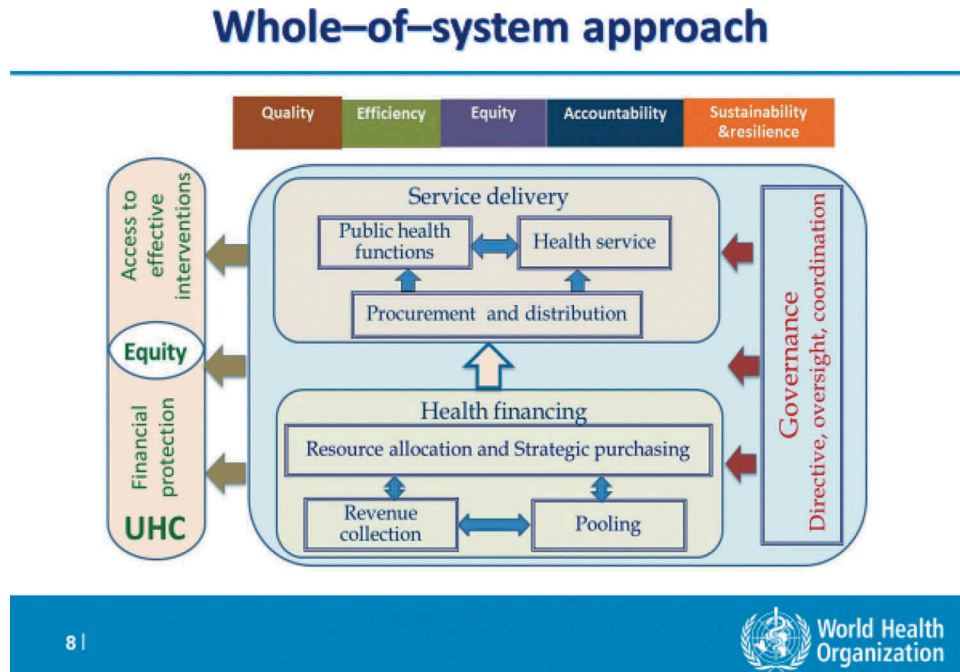


FIGURE 1. SDGs, UHC and the Health System



**FIGURE 2.** Whole of System Approach for UHC

processes and systems of authority and control. Legislation may specify the roles and functions of institutions and the relationship between the state and service providers, ensure the protection of rights, and mandate accountability arrangements. Other nonlegislative policy instruments may provide authorization for methods of resource allocation and establish mechanisms for input by nonstate actors, particularly allowing for input from civil society. Good governance is ultimately concerned with setting the rules of accountability in order to produce good and fair outcomes.

At different points in time, governments may focus more strongly on a single policy action area. However, to move a system forward requires bringing these policy action areas together, creating synergy between them, and thus charting paths forward for progress on UHC. This special issue is organized around overview articles on the ways in which countries in the Western Pacific Region have developed and evolved arrangements for service delivery, financing, and governance (including community engagement). Country case studies provide illustrative lessons about policy reforms in moving toward UHC, beyond the theme-based overview papers. Though the three policy areas are considered separately, effective policy implementation of any one area necessarily has to take into account other areas, including how broad policies are driven to the front line of service delivery. The issue concludes with consideration of implementation challenges.

### STATUS QUO AND LESSONS LEARNED

Across the Western Pacific Region, health service delivery systems can be characterized as pluralist. There is much heterogeneity in public versus private financing and provision of care, as well as varying degrees of integration of traditional medicines. Such variations are illustrative of the path dependency of health systems and point to the multiple paths that exist in moving toward UHC. Nonetheless, certain common patterns do appear. For example, hospitals dominate and primary health care tends to be underdeveloped. Service providers often work in silos, and access is typically not assured by government policy or financing mechanisms. This special issue seeks to identify some of those common patterns in the Western Pacific region.

In the first article of this issue, Bloom highlights the different development and institutional contexts between selected regions and countries in the Asia-Pacific and discusses various ways in which particular health systems have managed change in order to respond to increased demand for hospital services related to noncommunicable diseases, adapted primary health care (PHC), and built workforce capacity to respond to the needs of an aging population. This article also explores the potential contribution of digital technologies in helping individuals manage chronic health conditions and concludes with an outline of steps that governments can take in adapting their health system to changing needs of an aging society.

In the next article, Park and Canaway discuss the role that traditional and complementary medicine can play in UHC, especially the potential of engaging with local communities in low resourced settings about their use of traditional Chinese medicine (TCM), in order to address ongoing and emerging public health challenges. In addition, more broadly, they discuss the various ways in which TCM is used and managed in the region. They highlight how government policy to integrate TCM into key infrastructure components of national health systems can contribute to advancement of quality, efficiency, equity, accountability, sustainability, and resilience—attributes recognized as essential for UHC.

Service delivery systems need to become more agile and responsive to the demographic and epidemiological transitions, the pace of which have quickened in the region. Change is difficult and systems vary in change readiness, but there have been a few attempts at more integrated service delivery. In their article on the development of service models in Singapore, Tan and Earn describe the integration of public and private hospitals and primary care clinics. This integration enables the provision of services for acute conditions and also facilitates referral between PHC and hospitals. This model of care also enables the provision of multidisciplinary, one-stop family-centered services, including team-based care for maternal and child health care, as well as acute and chronic disease management, to cater for the health needs of an aging population. China, Japan, and the Republic of Korea have well-established integration of TCM within national health systems, which includes regulation of TCM products, practices, and practitioners and education systems for practitioners.

Because health systems have evolved in their particular historical, political, economic, and cultural contexts, service delivery arrangements will necessarily evolve within and adapt to changing contexts. This means that governments need to focus on shaping institutional arrangements that can best adapt to and address the challenges of noncommunicable diseases and aging.

Financial resources across the region generally come from national budgets or social insurance, with varying degrees of out-of-pocket (OOP) expenses. Donor dependency has been decreasing in Asia, due in part to rapid economic development. Graduation from global health initiatives (such as Gavi, the Vaccine Alliance and the Global Fund for AIDS, Tuberculosis and Malaria) will pose challenges for more integrated financing as well as service delivery. Some countries have explored earmarking of tobacco and other taxes to both expand the revenue pool for health as well as influence behavior. Additional financing is particularly needed where there is high OOP payment, but the issue of more efficient

resource allocation, from both technical and allocative efficiency viewpoints, remains a challenge for all countries. The article in this issue by Chu and colleagues examines health financing in moving toward UHC, with a focus on resource mobilization, risk pooling, resource allocation and strategic purchasing, improved governance of health financing service delivery, and budget reforms. With catastrophic health expenditure higher in this region, countries are introducing prepaid financing mechanisms with government subsidies to reduce OOP expenditure. Various health financing reforms in some countries have led to improved population coverage in shorter time frames.

More than a few countries in the region have progressed beyond resource mobilization and risk pooling to recognizing that provider payment incentives are key to how service delivery agents behave. A shift away from fee-for-service is occurring in order to control increasing health expenditure and improve cost-efficiency of care to better meet population health needs.

More broadly, health financing schemes are beginning to move beyond the goals of equitable population coverage to shaping the behavior of public and private providers through strategic purchasing. However, using financial levers for reorienting primary health care as the foundation of the health system remains an immediate agenda that requires attention. The article by Chu and others describes how in China, Mongolia, and Viet Nam public-private partnerships are being strengthened to channel funds for PHC in both urban and rural areas. In Mongolia, health insurance funds are by law specifically allocated to four main areas of primary care (rehabilitation, home-based care, day care, and diagnostics), but ongoing challenges include how to define and pay for care within this framework and how to fund efficient and effective interventions. Other ongoing challenges in prioritizing funds for PHC include how to define specific services covered and how to implement such services across public and private providers.

Though most countries have routinized national planning processes and many have monitoring mechanisms to close the loop, a remaining common challenge concerns how the authorities conceptualize the broader public administration framework, such as decentralization. The article by Yeoh and colleagues on governance considers the role of decentralization of the public sector in enabling government to implement policies and steer the health system toward prioritizing UHC. However, decentralization has tended to favor urban populations. In Viet Nam, decentralization coupled with lack of alignment with UHC reforms constrained progress around reducing OOP and expansion of coverage. In China, high responsibility placed on subnational governments to generate

funds and provide services and poor accountability between the two levels of government has produced inequity and constrained enforcement of compliance with reforms. The article shows how pursuing UHC reforms has demanded greater attention to regulation, accountability, and oversight arrangements. It is equally important to take into fuller account the nature and power of service providers and the ability of governments to ensure accountability throughout the health system, deploying policy tools such as the purchaser-provider split.

A key test of the stewardship role is the ability to balance provider interests through a level playing field while ensuring access to services. The more decentralized a country and the more involved nonstate providers are, the greater attention needed toward rule setting or simply getting a disorganized system more organized. The article by Cowley and Chu compares private hospital expansion in transitional economies in the region. The authors conclude that for private hospitals in these countries to fully contribute toward UHC, government policy must incentivize and regulate the sector so that private hospitals can grow in size to make regulatory compliance affordable and also expand into rural areas. At the same time, enforcement is essential and controls are also needed to contain OOP and prevent overservicing.

Significant efforts are also required to build links and establish networks between hospitals and primary care providers and the social sector, as highlighted by Lee and Tan in their analysis of the integration of hospital services with public and private primary care clinics in Singapore. Integrated service networks will also need to pay particular attention to the needs of vulnerable and disadvantaged populations.

The nature and extent of community voices in the health system reflects culture and history in context. Countries across the region have different political traditions, ranging from authoritarian regimes to unstable democracies, from centralized states to highly devolved systems of public administration. Community engagement is not uniformly mature or accepted across all countries in the region, as discussed by Allotey and colleagues in this issue, so health policy making may or may not reflect diverse community voices. Their article reflects on case studies of engagement of communities with health systems to improve or inform the system, such as in relation to policy or service design or implementation. The focus is on programs that aim to give voice to marginalized or vulnerable groups. Engagement was found to occur at various levels. The inclusive social and economic systems in the SDG era are likely to challenge countries to create space for a stronger citizen voice, even if expressed through “netizens.” If UHC is about transforming

health systems to become more people focused (on patients, families, and communities), then community engagement will need to become a core part of a governance pathway to achieve UHC.

Even if formalized processes for representation and participation in policy making are fairly new in many countries in the Western Pacific, some countries have traditional systems and expectations for community involvement. It is therefore possible to build on traditional means and cultural norms, such as in Samoa with women’s community groups, and, in doing so, build on community practices as well as partner with others with community resources. The article by Bagirov, Ah-Ching, and Bollars describes the importance of the role of traditional women’s groups in the management and prevention of communicable diseases and, in the present day, the potential for further collaboration in addressing noncommunicable diseases.

At the end of the day, governments may act on changing service delivery models, revising financing arrangements, and adopting new legislation and monitoring mechanisms. However, it is bringing these components together, based on community expectations and institutional capabilities, that will bring about service and financing models that are fit for purpose and responsive to local needs. Bringing together policy actions to improve the delivery of integrated primary health care (with appropriate service models), increasing the share of resources for primary health care, and improving the management of human and financial resources in combination are more likely to achieve better quality and access to health care than any measure alone. In the final article in this issue, Gilbert and colleagues describe these three key challenges to implementation and how they are being addressed through country-specific reforms across the region.

## THE AGENDA FORWARD

There is now both high-level political commitment and a groundswell of community expectation across the world about moving to achieve UHC in all countries. The 2018 World Health Day was centered on the UHC theme, and the celebration of the 40th anniversary of the Declaration of Alma-Ata in the same year is a reaffirmation of primary health care as the foundation for UHC. WHO and the World Bank signed a Memorandum of Understanding for collaboration on supporting countries to achieve UHC. Major donors, such as Japan and the European Union, made major commitments to support UHC work in countries. In 2019, the United Nations General Assembly will be giving consideration to UHC, as will the G20 Summit. This international momentum places pressure on governments to

accelerate progress toward UHC, especially in countries of rapid and significant economic growth, such as in East and Southeast Asia.

These expectations highlight the importance of systematic assessment of national policy experiences and expansion of the evidence base, in order to support action on UHC, particularly in recognition of the diverse historical, political, social, and economic contexts across different countries.

In the Western Pacific Region, health systems and policy research remain underdeveloped, in part because of the disconnect between research institutions and policy makers and the dominance of biomedical research in health research institutions. In the rush for health system improvement, policy change is often initiated without systematic pilot testing or a rigorous framework for monitoring and evaluation. Research and evaluation are challenged by not only limited data availability but also the research skills needed to understand policy impacts, political economy, as well as history, institutions, and culture.

To fill these gaps, and to strengthen the robustness of the evidence base for UHC, researchers, funders, and governments should give more consideration to (1) improving the interaction between researchers and policy makers; (2) shifting the nature of research, specifically the place of action research; and (3) diversifying methodological approaches for health systems and policy research, ranging from rigorous evaluation to realist paradigms. The divide and the distance between the world of researchers and that of policy makers is reinforced by policies that reward basic over applied research and by reductionist and mechanistic paradigms that fail to capture the complexity and messiness of policy making. Dialogue is needed among relevant parties to alter the funding of research, the training of researchers, and the translation of knowledge into policy.

There are efforts to support research across countries, although language barriers and system differences can make collaboration challenging. Nonetheless, more comparative analysis can be helpful, provided that the comparison (1) is logically sound; for example, examines specific changes across similar systems; (2) goes beyond description and is informed by theory; and (3) leads to explanations that include exploration of the underlying drivers, imperatives, and dynamics of change. As countries are now moving quickly on reforming health systems to move toward UHC, the need to understand effective policies that promote UHC is becoming urgent. Development partners, from multilaterals to

philanthropic organizations, can all play a role to encourage and support comparative studies.

There are substantial gaps in the regional evidence base on how contextual factors influence policy design and implementation and on how actors and their networks shape the adoption and implementation of health system reforms. This requires bringing diverse disciplines together, as well as bringing researchers closer to policy making, as we have sought to do in this special issue. It is important to reflect on, share, and learn the conditions under which policy interventions can be effective. Strengthening the links between policy and research will enhance accountability, to ensure that technical design is appropriate to context and that policy making is informed by appropriate evidence.

## DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

No potential conflict of interest was reported by the authors.

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