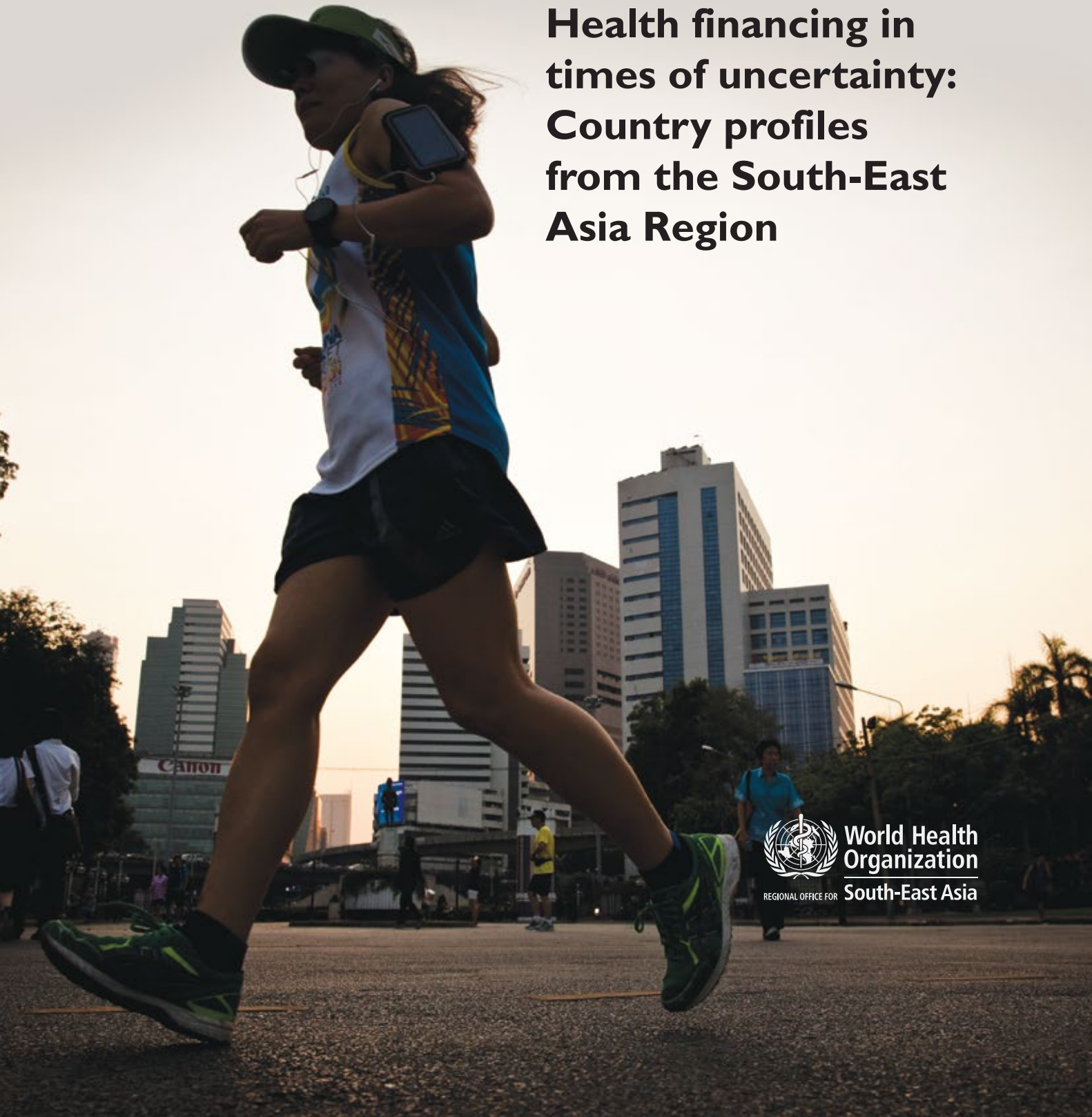
Crisis or opportunity?

Health financing in times of uncertainty: Country profiles from the South-East Asia Region



World Health Organization
REGIONAL OFFICE FOR South-East Asia

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Health financing in times of uncertainty: Country profiles from the SEA Region

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Contents

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Abbreviations

AB-PMJAY	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (of India)
ADB	Asian Development Bank
ANC	antenatal care
BDT	Bangladeshi Taka
BHTF	Bhutan Health Trust Fund
BHUs	basic health units
BPEHS	Basic Package of Essential Health Services
BPJS Kesehatan	Badan Penyelenggara Jaminan Sosial Kesehatan (Health Social Security Agency of Indonesia)
BPL	below poverty line
CGD	Comptroller General Department
CGHS	Central Government Health Scheme
CHE	current health expenditure
CHM	City Health Mission
COVAX	COVID-19 Vaccines Global Access Facility
COVID-19	SARS coronavirus disease 2019
CPEHS	Comprehensive Package of Essential Health Services
CPHC	comprehensive primary health care
CSMBS	Civil Servants Medical Benefit Scheme
D-GGHE	domestic general government health expenditure
DHM	District Health Mission
DHS	District Health Society
DJSN	Dewan Jaminan Sosial Nasional (of Indonesia)
DoHFW	State Department of Health and Family Welfare
DOTS	directly observed treatment, short-course
DRG	diagnostic-related groups
EPF	Employees Provident Fund
ESIS	Employee State Insurance Scheme
ESP	Essential Services Package
FHCP	free health care policy
GDP	gross domestic product
GGE	general government expenditure

GHED	Global Health Expenditure Database
GNHC	Gross National Happiness Commission
GoB	Government of Bangladesh
HCFS	Health Care Financing Strategy
HIB	Health Insurance Board
HIT	Health in Transition
HNGV	Guido Valadares National Referral Hospital (of Timor-Leste)
HTA	health technology assessment
HWC	health and wellness centres
ICMR	Indian Council of Medical Research
ICU	intensive care unit
IDR	Indonesian Rupiah
IGMH	Indira Gandhi Memorial Hospital (Male)
IMF	International Monetary Fund
INR	Indian Rupee
INS	national health institute
IPEHS	Intermediate Package of Essential Health Services
ISA	implementing support agency
JKN	Jaminan Kesehatan Nasional (of Indonesia)
LKR	Sri Lankan Rupee
LMICs	low- and middle-income countries
LSG	local self-government
MMK	Myanmar Kyat
MNCAH	maternal, newborn, child and adolescent health
MoF	Ministry of Finance
MoH	Ministry of Health
MoHFW	Ministry of Health and Family Welfare
MoHP	Ministry of Health and Population
MoHS	Ministry of Health and Sports
MoLESS	Ministry of Labour, Employment and Social Security
MoLGRDC	Ministry of Local Government, Rural Development and Cooperatives
MoLSS	Ministry of Labour, Immigration and Population
MoPF	Ministry of Planning and Finance
MoPH	Ministry of Public Health
MSG	Mission Steering Group

MVR	Maldivian Rufiyaa
NCD	noncommunicable diseases
NGOs	nongovernmental organizations
NHA	National Health Accounts
NHI	National Health Insurance
NHM	National Health Mission
NHSO	National Health Security Office
NPR	Nepalese Rupee
NSPA	National Social Protection Agency
Nu	Bhutanese Ngultrum
OECD	Organisation for Economic Co-operation and Development
OOPE	out-of-pocket expenditure
OOPS	out-of-pocket spending
PDHS	Provincial Department of Health Services
PF	Petroleum Fund
PFM	public finance management
PHC	primary health care
PHI	public health insurance schemes
PKH	Programme Keluarga Harapan (Hopeful Families Programme of Indonesia)
PM-JAY	Pradhan Mantri Jan Arogya Yojana (of India)
PNC	prenatal care
RDHS	Rural Department of Health Services
REDCap	Research Electronic Data Capture
RSBY	Rashtriya Swasthya Bima Yojana (of India)
RT-PCR	reverse-transcription-polymerase chain reaction
SAMES	Servico Autônomo de Medicamentos e Equipamentos de Saúde (medical stores of Timor-Leste)
SDG	(United Nations) Sustainable Development Goals
SEA	South-East Asia
SEARO	(WHO) Regional Office for South-East Asia
SHA	State Health Agency
SHI	social health insurance
SHM	State Health Mission
SHS	State Health Society

SISCa	Sistema Integrado de Saúde Comunitária (Integrated Community Health System of Timor-Leste)
SJGH	Sri Jayawardenapura General Hospital (Nugegoda)
SSB	Social Security Board
SSF	Social Security Fund
SSK	Shasthyo Surokhsha Karmasuchi (Social health insurance scheme of Bangladesh)
SSO	Social Security Office
SSS	social security scheme
STDs	sexually transmitted diseases
TABUCS	Transaction Accounting and Budget Control System
THB	Thai Bhat
UCEP	universal coverage for emergency patients
UCS	Universal Coverage Scheme
UHC	universal health coverage
UHC/CHC	urban health centres/community health centres
UHS	upazila health systems
UNICEF	United Nations Children's Fund
US$	United States dollar
VHI	voluntary health insurance
WDI	World Bank development indicators
WEO	World Economic Outlook

Foreword by the WHO Regional Director

Since 2014 the WHO South-East Asia Region has pursued universal health coverage (UHC) as a Flagship Priority. An estimated 65 million people in the Region are pushed into poverty as a result of out-of-pocket (OOP) expenditures, leading to foregone care and exacerbating inequalities. To ensure that all people can access quality health care without financial hardship, WHO continues to support countries in the Region to reduce catastrophic and OOP expenditures and improve health financing systems.

The Region has in recent years made considerable progress on this score, which this report documents and analyses in detail. Several countries have achieved substantial increases in the proportion of public expenditure allocated to health and have developed robust health financing strategies and basic benefits packages to expand access to primary care. Budget reforms and decentralization have helped countries make sustainable advances in the quality and reach of health services while decreasing dependence on external donors.

In the ongoing response and recovery from the COVID-19 pandemic, countries can leverage a range of innovative options to not only sustain, but also accelerate, their progress in strengthening health financing systems, especially with regard to resource mobilization, risk pooling and public financial management. As the following pages highlight, to drive rapid and lasting change, policy-makers and programme managers can increase public spending on health by prioritizing health in government budgets, enhance public spending to address the pandemic, and sustain and expand coverage with priority for the poor and vulnerable.

There is not a moment to lose. The COVID-19 pandemic has made clear the need for ongoing efforts to strengthen health financing systems as part of a wider quest to build health system resilience and achieve UHC, the target that underpins Sustainable Development Goal 3. Agility and innovation must continue to define the Region's onward mission, which I am certain this document will facilitate. Together, we must create a Region in which all people have access to quality health care, without financial hardship. The future is ours to make.

Dr Poonam Khetrapal Singh
Regional Director
WHO South-East Asia

Introduction

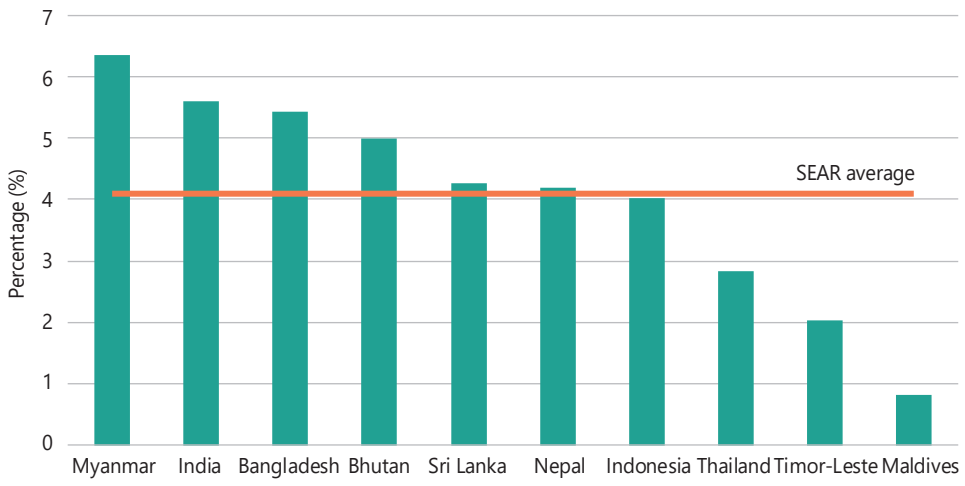
Population and the socioeconomic environment

The WHO South-East Asia (SEA) Region is home to over a quarter of the world's population, or more than 2 billion people.[1] It is a diverse region with some of the largest countries in the world such as India, Indonesia and Bangladesh, and also some of the smallest in terms of population such as Bhutan, Maldives and Timor-Leste.

Annual population growth has remained steady over the past 25 years, decreasing only slightly from 1.5% in 1996 to 1.2% in 2019, on average, in the Region. Despite continued growth, there have been marked changes to the demographic age structure in the Region, including a decrease in the dependency ratio (% of the working age population) and an increase in the proportion of population over the age of 65 – from 4.2% in 1996 to 6.9% in 2019. The effects of a decreasing working age and increased ageing population have implications on overall health spending, particularly in Nepal and Thailand, where adults over the age of 65 make up more than 10% of the total population.[2]

Prior to the COVID-19 pandemic, the WHO SEA Region was the fastest growing region in the world with an average GDP growth rate of 4.1% per capita annually during the period 2009–2019 (Fig. 1). Except for Maldives, all countries grew at a rate above 2% per year, with Myanmar being the fastest-growing country in the Region with a 6.4% growth rate.

Fig. 1. Average annual GDP per capita growth rate, 2009–2019



Source: World Development Indicators, December 2020, World Bank.

There are seven countries in the Region that fall in the lower-middle-income group (US$ 1026–US$3995). While Indonesia, Maldives and Thailand are now in the upper-middle-income group (US$ 3996–US$ 12375), there are no low-income countries in the Region, according to the most recent World Bank classifications. There is no GNI per capita data available to classify DPR Korea.

The size of an economy and the government's share of the economy also matters, as low government revenues constrain government spending, including for health. SEA Region countries vary widely in terms of government revenues (excluding grants). While some countries, such as Bhutan, India and Nepal, have seen variable but increasing revenues, other countries have faced declining revenues. Most countries in the Region have revenues around the average for low- and middle-income countries (16% of GDP), except Timor-Leste, which had government revenue amounting to 68.4% of GDP in 2018.

Tax revenues (a component of government revenue) as a percentage of GDP in SEA Region countries have been increasing slowly in recent years, from an average of 10.7% of GDP in 2009 to 13.3% in 2018; thus it came near the average of 13.8% for low- and middle-income countries in 2018.[2] Countries such as Nepal and Timor-Leste have had the highest shares of revenue, of above 15% of GDP, while Myanmar has the lowest in the Region at 5.4% in 2019.[2]

From 2018–2019, all countries in the Region ran public deficits, with most fiscal balances averaging below -5% of GDP. Sri Lanka and Timor-Leste had much greater deficits than the rest, with fiscal balances of -8.2% and -28.1%, respectively. Thailand is the only country in the Region that came close to a balanced budget, with a fiscal balance of -0.8% of GDP.

With regard to public debt, most countries in the Region had debt levels of around 30%–40% of GDP in 2019. However, like in many other growing regions in the world, the range of government debt in the South-East Asia Region too is wide, and spanned from as high as 104.4% of GDP in Bhutan in 2019 to 9.3% in Timor-Leste in 2018. In addition, India, Maldives and Sri Lanka have experienced higher levels of debt at above 70% of GDP.[2]

Between 2015 and 2019, the Region has had average employment to population ratios, with most countries having at least 50% or more of the population in the related age group employed. Many have experienced above average employment rates, such as Thailand (66.5%) and Indonesia (65.7%), while Nepal's labour market has struggled with employment, as demonstrated by its ratio of only 34.2%.[3] The majority of workers in the SEA Region are in the informal sector, making up an average of 78.6% of the total workforce in the Region between 2013 and 2019. In Bangladesh, the share of workers is as high as 94.7%, while Thailand has the lowest, with 64.4% of its workers in the informal sector.[4]

While the number of people living in extreme poverty (i.e. those living with less than US$ 1.90 per day) has decreased between 2009 and 2018, the improvement has not been fast enough. The Region still has one of the highest poverty rates in the world, particularly in India where more than one fifth of the population lives with less than US$ 1.90 per day, and more than 60% lives with less than US$ 3.20 per day.[2]

Social protection in many countries is still evolving. Social safety net programmes typically cover around 20% of the population in many countries, although it has a pro-poor distribution. In Myanmar, for instance, such programmes only covered 8.7% of the entire population and 10.2% of the poorest quintile. The coverage of social insurance programmes is even less in other countries, from below 1% in Bangladesh and Bhutan, to 17.7% in India.[5]

Health and the COVID-19 pandemic

The Region as a whole has witnessed vast gains in population health over the past decade. Life expectancy at birth on average has increased by almost three years, from 69.4 years in 2009 to 72.3 years in 2018, further converging towards the global mean for this indicator. For the same period, infant mortality rate has decreased by 29%–49% and in 2019 there were an average of 21 deaths per 1000 live births. The rates of decline for neonatal and under-5 mortalities were similar, and by 2019 there were an average of 14 and 25 deaths per 1000 live births, respectively. The improvement in maternal mortality ratio was more diverse across countries but typically slower than the above three indicators, with an average of 134 deaths per 100 000 live births in 2017.[2]

All countries in the Region showed an improvement in the overall essential health service coverage index;[a] with the regional average increasing from 49% in 2010 to 63% in 2020 (Fig. 2). The largest progress was made in Indonesia, where the service coverage index increased by 18 percentage points[6] (Fig. 2). However, progress was largely uneven: the biggest gains were made in providing infectious diseases-related services, such as tuberculosis treatment and HIV antiretroviral therapy, while improvements related to noncommunicable diseases have been less rapid.[6]

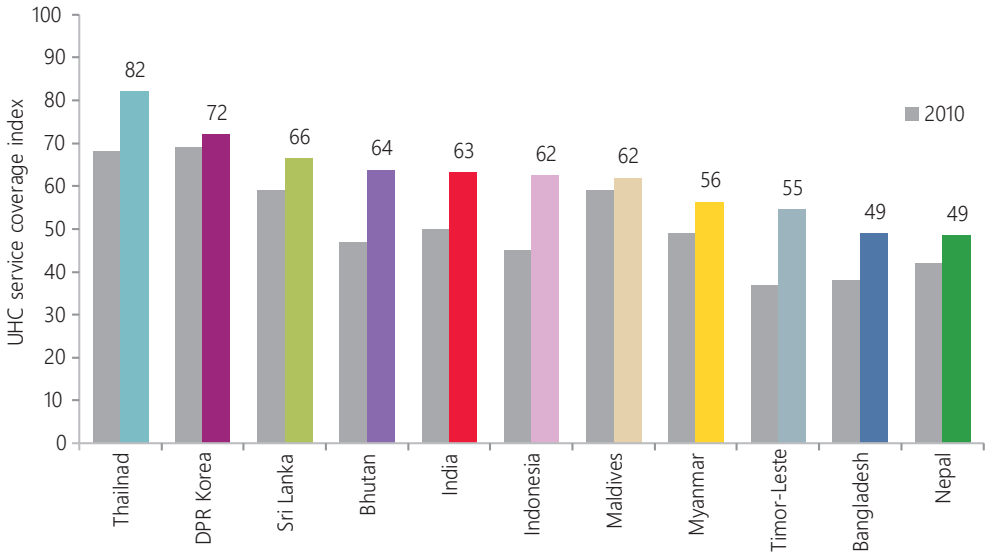
It is against this backdrop that the COVID-19 pandemic broke out in 2020. It has had a devastating impact on health, health services, the economy and livelihoods. Over 108 million cases and over 2.38 million deaths had been confirmed globally by mid-February 2021. The SEA Region has been affected severely as well. It has had around 12% of the global number of COVID-19 cases as of 14 February 2021.[7] With the emergence of new variants of SARS-CoV-2, there are concerns about a subsequent wave, which threatens the progress to contain the virus in the Region.

Since the beginning of the pandemic, India has had the highest number of cumulative cases in the Region, with more than 10.9 million cases since the start of the pandemic, till mid-February 2021. Despite relatively low absolute number of cases, Maldives has the

a This is one of the Sustainable Development Goal indicators, SDG3.8.1. It was designed to reflect the level of coverage, constructed as the geometric mean of several tracer indicators, each describing access to an essential health service, including reproductive, maternal, child and neonatal health, infectious diseases as well as noncommunicable diseases. It is the closest measure to provide a comparative and representative description of access to health services in a society. The current SDG 3.8.1 measurement includes tracer indicators that are not directly about health service access. Under noncommunicable diseases, for instance, the tracer indicators are a) prevalence of normal blood pressure level, b) prevalence of normal fasting blood sugar level and c) prevalence of tobacco non-use. They are proxy indicators, which should not be interpreted directly as percentage of population with access to essential health services. The composite measure can thus only 'indicate' the level of access.

highest number of cumulative cases per million population at 32 775 cases per million, as of 14 February 2021.[7]

Fig. 2. Changes in coverage of essential health services in Member States of the South-East Asia Region, 2010–2020



Sources: Health information platform for WHO South-East Asia Region. In: World Health Organization [online database] (http://hip.searo.who.int/dhis/dhis-web-commons/security/login.action, accessed 20 July 2020); Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) 2007–2019.

Besides its direct impact on health, COVID-19 has indirectly impacted health services due to lockdowns and other public health policies such as voluntary social distancing. In turn, these have led to decline in service utilization. According to the WHO Pulse survey conducted in 2020, all countries experienced health service disruptions to some extent. The services that were most frequently disrupted were routine immunization, noncommunicable disease diagnosis and treatment, family planning and contraception, treatment for mental health disorders, antenatal care and cancer diagnosis and treatment. On average, close to 60% of essential services were at least partially disrupted in the SEA Region.[8]

Lockdown policies and voluntary social distancing have also contributed to a reduction in economic activity and led to what the International Monetary Fund (IMF) has labelled as 'the Great Lockdown', which represents the worst economic downturn since the Great Depression of 1929. As a result, the global economy is expected to contract by -4.4% in 2020.[3] Extreme poverty (living on less than US$ 1.90 a day) is also predicted to rise for the first time in more than 20 years, reversing years of gains in poverty reduction.

It is estimated that COVID-19 will push an additional 48 to 59 million people in the SEA Region into extreme poverty in 2020. If the measure of US$ 3.20 per day is used,

which better reflects the reality of lower middle-income countries, an additional 110 to 134 million people could be pushed into poverty in the SEA Region.[9]

While the rapid approval and deployment of multiple vaccines in the latter part of 2020 and early 2021 signals towards the possibility of a turnaround and recovery, considerable uncertainty remains. So far, most countries have begun their vaccination campaigns for health workers and other priority groups. While securing vaccines has been challenging, the vaccines produced and approved in India have allowed other countries in the Region to secure some initial doses.[10] In addition, COVAX – the international partnership coordinating the manufacturing, financing and distribution of COVID-19 vaccines – has an interim distribution forecast as of 3 February 2021 to provide an estimated 134 157 300 doses of the vaccine to the Region by June 2021 (Table 1).[11]

Table 1. SEA Region COVAX interim distribution forecast

	Astra-Zeneca/ Oxford	Moderna Vaccine	Pfizer-BioNTech	Total
Bangladesh	12 792 000	0	0	12 792 000
Bhutan	108 000	0	5 850	113 850
DPRK	1 992 000	0	0	1 992 000
India	97 164 000	0	0	97 164 000
Indonesia	0	13 708 800	0	13 708 800
Maldives	108 000	0	5 850	113 850
Myanmar	4 224 000	0	0	4 224 000
Nepal	2 256 000	0	0	2 256 000
Sri Lanka	1 692 000	0	0	1 692 000
Thailand	0	0	0	0
Timor-Lese	100 800	0	0	100 800
Total	120 436 800	13 708 800	11 700	134 157 300

This report

With this backdrop, this report provides a comprehensive and up-to-date overview of health expenditures and health financing systems among SEA Region countries for the period 2008–2018; reviews the initial health financing policy responses adopted by countries in the immediate aftermath of the COVID-19 pandemic; and suggests priority actions to help countries navigate their way out of this crisis while maintaining their focus on universal health coverage.

To prepare this report, mainly publicly available data was used such as the WHO Global Health Expenditure Database (GHED), the World Bank Development Indicators (WDI) and the International Monetary Fund (IMF) World Economic Outlook (WEO). In addition, literature available in the public domain has been used, such as peer-reviewed journal articles, National Health Accounts (NHA) and Health in Transition (HIT) reports, among

others, including available government/academic reports. For Chapter 2, WHO country office focal points were also consulted on the information related to the immediate policy responses to the COVID-19 pandemic. Further details are provided in Annex I.

This report is structured as follows: The first chapter gives an overview of the macroeconomic and health spending trends in the South-East Asia Region prior to the COVID-19 pandemic, including comparisons within the Region and across other WHO regions, during the period of 2008–2018. Furthermore, it examines spending from all financial sources as well as spending on primary health care and according to disease groups for the countries where data are available.

The second chapter documents and analyses the initial health financing policy responses that countries in the Region have put in place to mitigate the immediate financial pressures faced by households since the onset of the COVID-19 pandemic. These responses are framed around measures to reduce financial barriers to seeking care, social protection (or social assistance programmes), resource generation and allocation, strategic purchasing, and public financial management, as well as benefit packages.

The third chapter contains two parts that compose the health financing profiles for the SEA Region countries. The first part is the narrative component containing an overview of each country's health financing system. The second part contains a dashboard with key health financing, macroeconomic and universal health coverage data for each country. Finally, the last chapter reflects upon the major changes in health financing trends, including the implications of the COVID-19 pandemic for the Region. It concludes with a proposed set of actionable policy options for the Region and countries to consider in order to enhance their health financing systems.

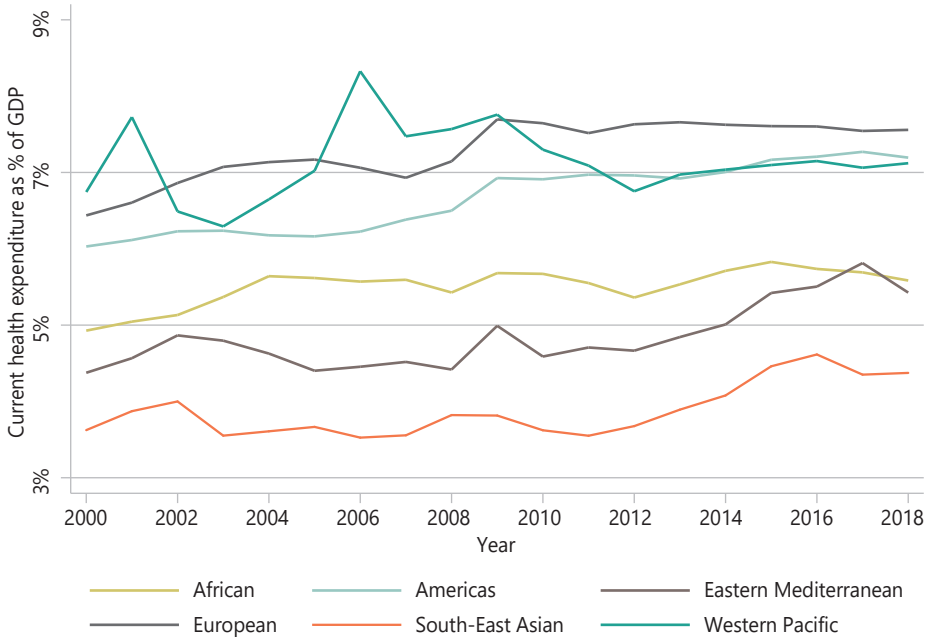
Overview of health spending in the South-East Asia Region

Key messages

- The SEA Region has the lowest level of health spending among all the WHO regions. On average, the Region spends less than 5% of GDP on health, and most countries in the SEA Region spent less on health than countries with similar income levels, globally.
- Per capita health expenditure growth rates were much lower than GDP per capita growth rates after the 2008 global financial crisis, contrasting with the experience prior to the crisis and diverging from trends in other WHO regions. As a result, by 2018, the SEA Region had the second lowest per capita health expenditures, on average, among all WHO regions.
- Domestic government spending on health continued to be low, comprising less than 50% of current health expenditure in most countries. There has been some improvement over the past decade in prioritizing the health sector in overall government spending, but in four countries, the health sector still accounted for less than 5% of overall government spending.
- The SEA Region thus remains the region with the highest share of out-of-pocket health spending, at 40% of current health expenditure in 2018. Countries in the Region have had divergent experiences. In some countries, the share of out-of-pocket expenditures has been not only very high but also without much decline over the past decade and it has even been increasing in some cases. By contrast, other countries have seen their OOPS at or below 20%.
- As most countries in the Region have reached lower middle-income status, there are signals of a health financing transition in the Region, as donor financing is declining as a proportion of current health expenditure in most countries. Social health insurance is a small source of health financing in most countries except for Indonesia, where social health insurance is growing in significance.
- Per capita spending on primary health care (PHC) in real terms (at 2018 constant prices) varied between US$ 32 and US$ 60 per capita in 2018, among countries with data. Country experiences varied significantly in terms of the scope and financing of PHC, with some relying primarily on public financing while others relying on out-of-pocket payments.
- Noncommunicable diseases comprised the largest share of overall health spending in three of four countries where data are available. NCD spending constitutes an average of 36% compared with 25% for infectious and parasitic diseases. Donor financing for NCDs is less than infectious diseases.

On average, the health sector is relatively small in relation to the overall size of the Region's economies. Current health spending as a percentage of GDP has remained the lowest among all WHO regions over the past two decades (Fig. 3), barely having increased to 4.5% of GDP, while all the other regions surpassed 5% by 2018.[b] There is a significant positive relationship between the size of the overall economy and the relative size of the health sector, and except for Nepal (5.8%) and Maldives (9.4%) in 2018, all the other countries have had an even smaller health sector compared with other countries at a similar income level (Fig. 4).

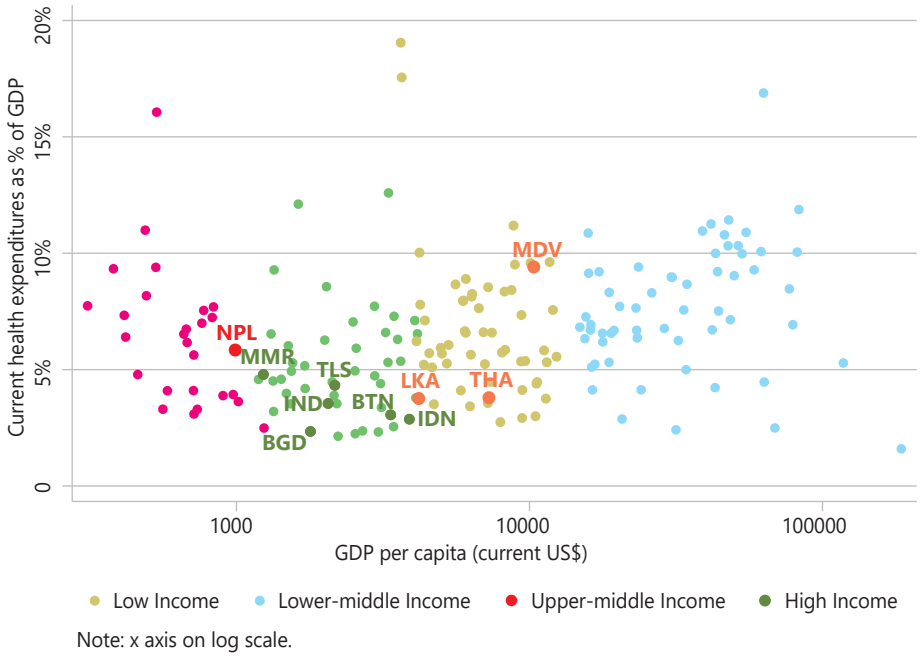
Fig. 3. Average current health expenditure as percentage of GDP by WHO regions, 2000–2018



Per capita spending in real terms in the Region increased by more than double over the past two decades, from US$ 94 in 2000 to US$ 195 in 2018 (at 2018 constant values). However, the rate of increase was uneven between the first and second half of the entire period. Prior to the 2008 global financial crisis, the average annual growth rate of real per capita health expenditures was 7.9%, much higher than the 5.4% per capita growth rate in GDP during the same period. However, after 2009, health expenditure growth slowed to an average of just 1.7%, lower than the GDP per capita growth rate of 2.4%.

b Unless otherwise specified, we used the unweighted average to represent regional average statistics. Health expenditure data used throughout this chapter came from WHO Global Health Expenditure Database, 2020. Others were based on World Development Indicators, World Bank, December 2020.

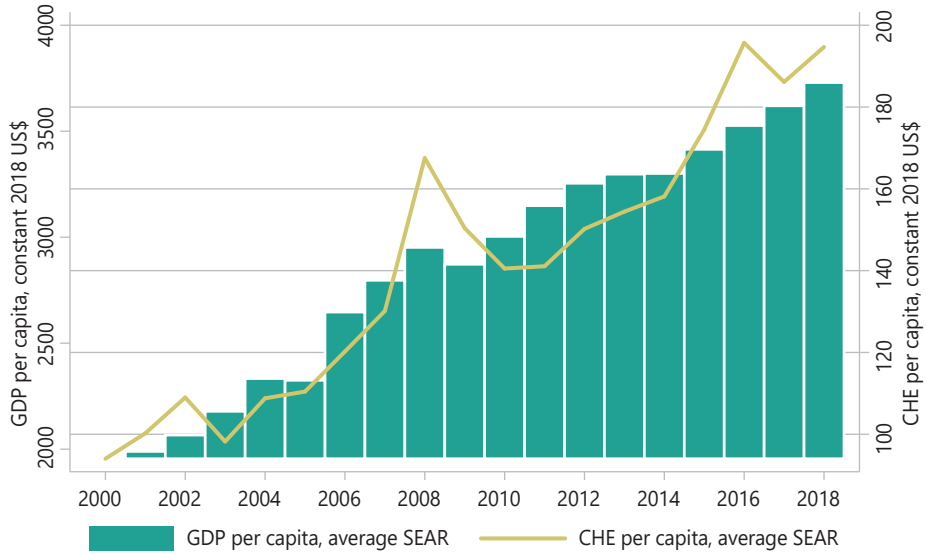
Fig. 4. Health spending share of GDP by national income level, 2018



Note: x axis on log scale.

This slower growth in per capita health expenditures in the post-financial crisis period is unique to the SEA Region as all other WHO regions continued to observe higher growth rates in health expenditures in the post-crisis period. As a result, by 2018, the SEA Region had the second lowest per capita health expenditures, on average, only slightly higher than the WHO African Region, and has no signs of convergence[12] (Fig. 5).

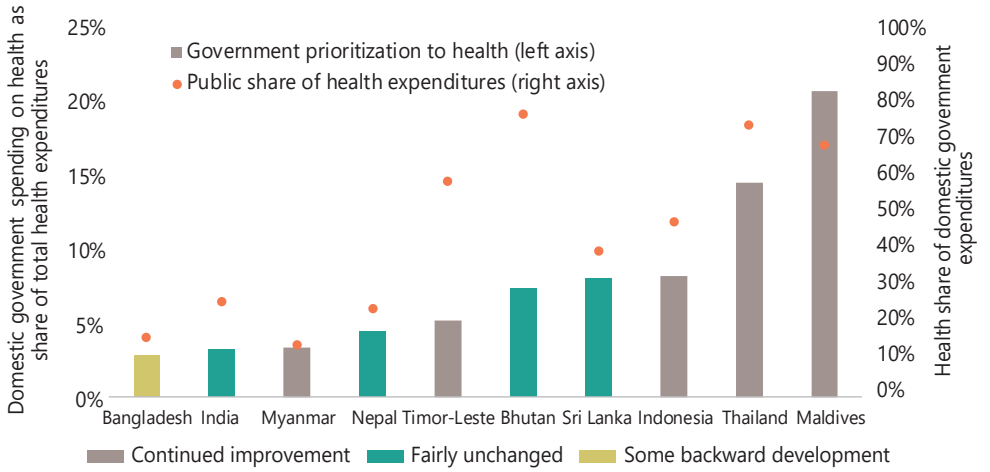
Fig. 5. Average per capita health spending compared with economic growth in the SEA Region, 2000–2018



In some countries, the lack of increase in health expenditures was linked to insufficient public investment on health over time. Domestic government spending on health constituted less than 50% of the current health spending in six out of 10 countries in 2018 (Fig. 6). In terms of priority to health in the entire government expenditures, the health sector received less than 10% in most countries, and less than 5% in four countries in the Region. Still, there has been some improvement over the past decade, at both ends of the distribution.

In Maldives, the government budget allocation to health started at close to 9% in 2000 – the highest in the region – and continued to climb to 16% in 2009 and again in 2018 to 21%. At the other end of the spectrum, Myanmar started with 1.4% of government budget allocation to health in 2000 and this has increased by almost 2 percentage points to 3.5% in 2018. In contrast, budget allocation for health was stagnant in India at around 3.3%, and in Bangladesh it decreased by more than 40% from 5.2% to 3.0% of total government expenditures during the same period.

Fig. 6. Domestic government spending on health among SEA Region Member States: its share in overall health spending and government health expenditures, 2018

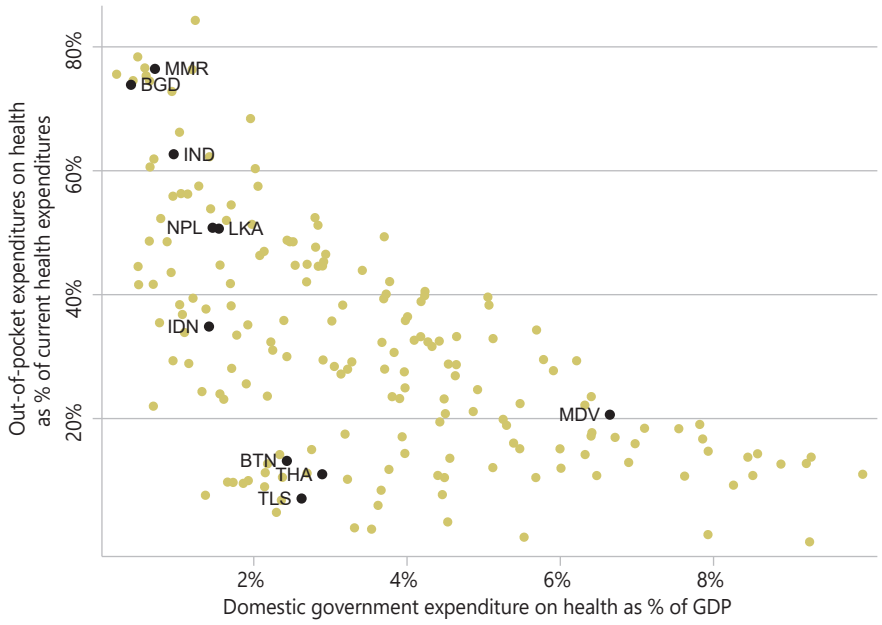


The colour coding of the columns represents a comparison of government prioritization to health, across three time points, 2000 (2003 for Timor-Leste as that is the first year with data reporting after the country became independent), 2009 and 2018:

Low public spending on health will either lead to a high share of out-of-pocket expenditures, as demonstrated in Fig. 7 below, and high rates of foregone care, or both. In most countries in the Region (six Member States), public spending on health accounts for less than 2% of GDP. Accordingly, the share of out-of-pocket expenditure is close to or higher than 40% of current health expenditure, indicating a high likelihood of financial hardship such as catastrophic incidence and impoverishment.[13] In line with Mcintyre et al. (2017), in order to progress towards UHC, governments should aim to spend at least 5% of GDP on the health sector,[14] a benchmark that only Maldives has achieved in this Region. On average, the SEA Region is ranked as the lowest among all WHO regions, in terms

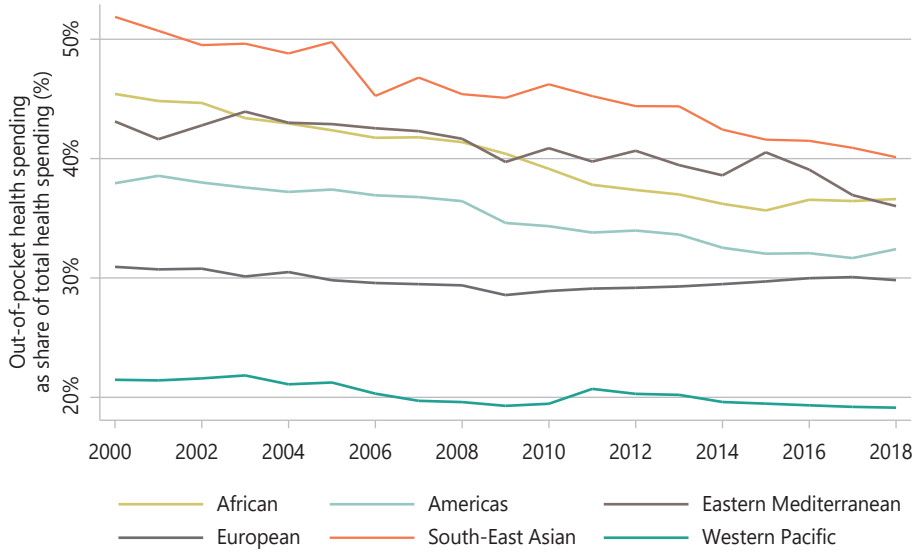
of government spending on health, at only 2.2% of GDP, which is far below the global average of 3.8%.

Fig. 7. Share of out-of-pocket spending against government spending on health, 2018



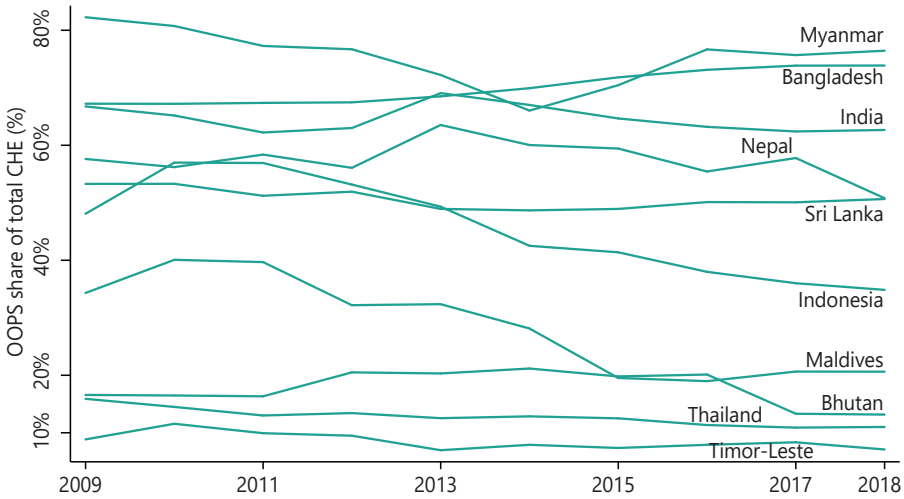
The out-of-pocket share of current health spending in the SEA Region remains the highest among all WHO regions, even though it has been continuously decreasing in recent decades (Fig. 8). By 2018, the health sector was financed with 40% of households' out-of-pocket spending at the point of care, on average. However, this is an improvement from more than 50% at the beginning of the millenium, and it is converging toward the global mean.

Fig. 8. Average share of out-of-pocket spending by WHO regions, 2000–2018



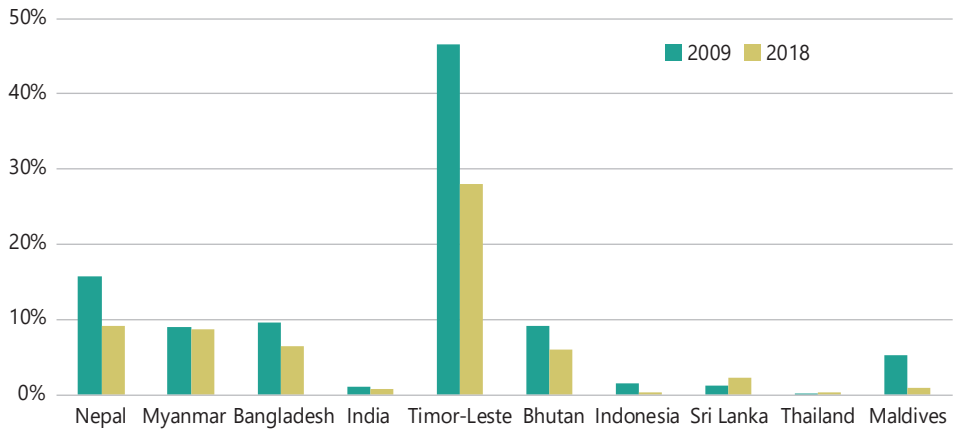
Countries have had diverse experiences across the Region, as some have a not only very high share of out-of-pocket expenditures but also have shown limited improvement in recent decades. In Bangladesh, this has even increased, while some other countries have seen the share of OOP expenditure decrease close to or below 20% (Fig. 9).

Fig. 9. Trends in out-of-pocket spending on health across SEA Region countries, 2009–2018



There are also signs of transition in the Region, with external health financing decreasing from 10% of current health spending in 2009, on average, to 6.3% in 2018. This transition has happened in the majority of the Region's countries, and most prominently in Nepal and Timor-Leste. However, in Timor-Leste external financing still plays a critical role, at almost 30% of current health spending. In Nepal and Myanmar, the role of donor financing remains important, with the share of external health spending near 10% of current health spending (Fig. 10).

Fig. 10. Share of external health spending across SEA Region countries, 2009 versus 2018

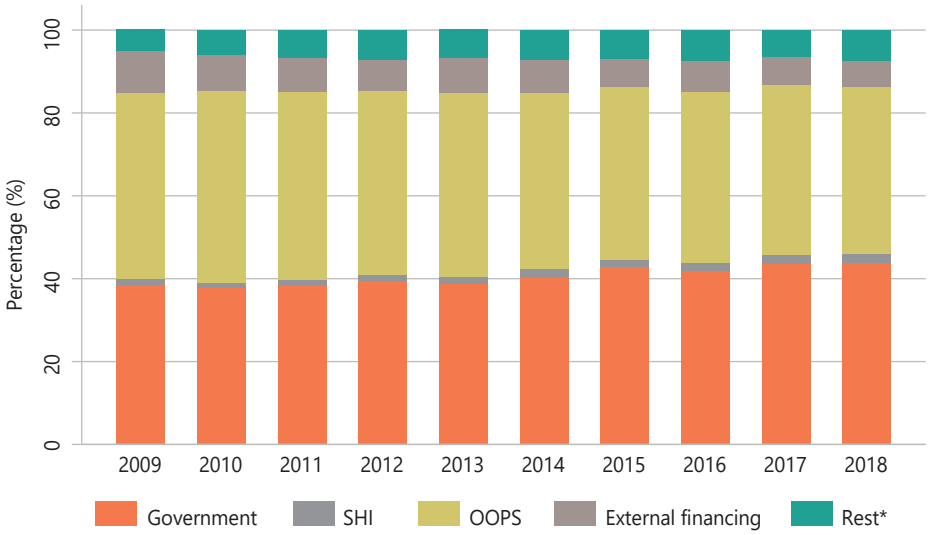


Note: countries are ordered ascendingly from left to right by their constant GDP per capita in 2018

Over the period of 2009–2018, the Region has seen a slightly reduced burden for health financing on households. OOPS comprised 45% of current health spending at the beginning of the decade, which was higher than domestic government spending at 38% of current health spending in 2009. This switched in 2018, when domestic government expenditures became the largest component of health financing at 44%, followed by OOPS at 40%. The external financing also decreased from nearly 10% in 2009 to 6% in 2018 (Fig. 11a).

Again, country experience varies, with domestic government financing comprising between 14% of current health expenditures in Myanmar and 80% in Bhutan. Health financing arrangements are also divergent, with social health insurance[c] playing some role in Indonesia (13%) and Thailand (6%), but almost neglible in other countries (Fig. 11b).

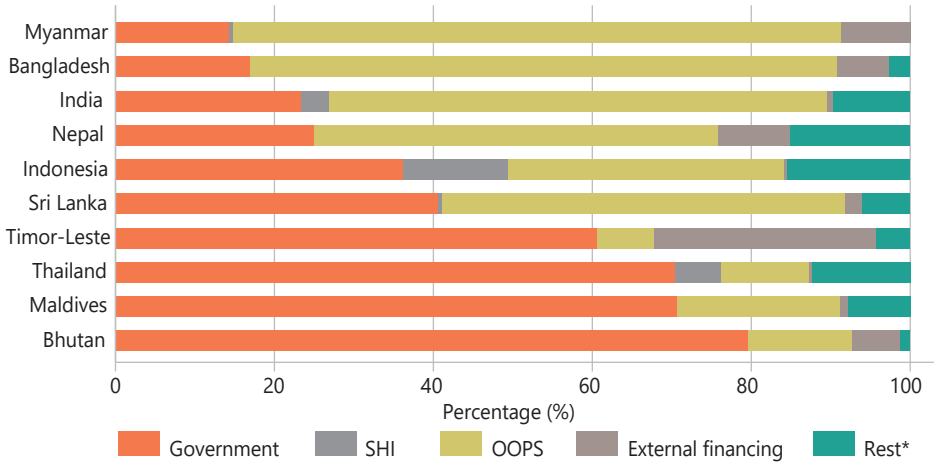
Fig. 11a. Sources of financing as a share of current health spending for the SEA Region on average, 2009–2018



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

c Based on the *Systems of Health Accounts, 2011*: "Social health insurance is a financing arrangement that ensures access to health care based on a payment of a non-risk-related contribution by or on behalf of the eligible person. The social health insurance (SHI) scheme is established by a specific public law, defining, among others, the eligibility, benefit package and rules for the contribution payment." It is distinguished from "government schemes" in two aspects: first, SHI is contribution-based, while government schemes are typically universally available for specific groups; second, the mode of participation is mandatory for SHI but automatic for government transfers.

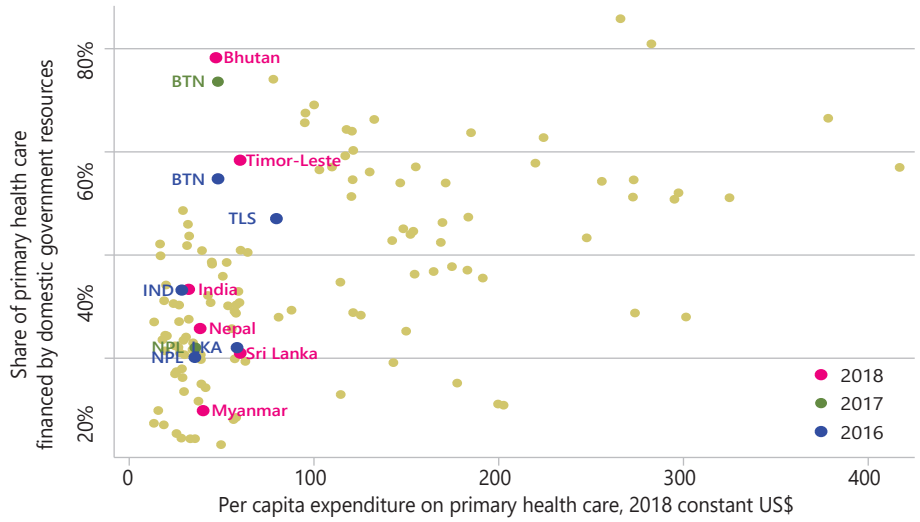
Fig. 11b. Sources of financing by country as a share of current health expentitures 2018



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

Primary health care is widely acknowledged as the most effective, efficient and equitable way to organize essential health services delivery and progress towards UHC,[15] and its importance is highlighted because of the demographic and epidemiological transitions that are taking place across the Region. WHO has developed a matrix based on National Health Accounts data and a framework to capture primary health care (PHC) spending in a consistent and comparable way.[16] Accordingly, in the SEA Region, per capita PHC spending in real terms (2018 constant price) among countries with data varied from US$ 32 in India to US$ 60 in Sri Lanka and Timor-Leste in 2018. There was no increases in PHC spending between 2016–2017 and 2018 (Fig. 12).

Fig. 12. Primary health care: real-term per capita spending (2018 constant prices) versus share from domestic government expenditures



Note: Four countries were excluded from the analysis, namely Barbados, Saint Kitts and Nevis, Seychelles and Trinidad and Tobago, for their PHC per capita constant went beyond US$450.

PHC financing varies across countries in the Region. While domestic government spending played a dominant role in Bhutan, and to a less extent in Timor-Leste, PHC was mainly financed by private spending (OOPS) in India, Nepal, Sri Lanka and Myanmar. There was a strong positive correlation between the share of PHC financed by domestic public sources and the level of PHC per capita spending, highlighting the importance of increasing government investment and spending in PHC. In Sri Lanka, Myanmar and Bhutan, PHC spending constituted less than half of the entire government spending on health.

Four countries in the SEA Region have collected data to track disease-specific health expenditures. Noncommunicable diseases comprise the biggest share of overall health spending in three countries, at an average of 36% of current health expenditure, or slightly higher than that of middle-income countries, globally.[12] This was followed by spending on infectious and parasitic diseases, at an average of 25% among the three countries. The exception is Myanmar, where the spending on these two disease categories is almost identical, at 23% and 24% respectively. Bhutan and Myanmar also spent a substantive amount on reproductive health services, comprising 20% and 15%, respectively. No country spent more than 10% on injuries or nutritional conditions (Fig. 13).

With regard to sources of financing, there is variation across countries: for infectious and parasitic diseases, the majority of spending came from domestic government spending in Bhutan, while private financing is dominant in Myanmar and Sri Lanka (Fig. 14a). In comparison, it is clear that external financing played a minor role in financing noncommunicable diseases in all SEA Region countries where data is available (Fig. 14b). Similar to infectious diseases, only Bhutan has seen a major financing component from domestic government spending, while in the other countries it is private spending, mainly households' out-of-pocket expenditures, that comprised the biggest share of financing for noncommunicable diseases.

Fig. 13. Health expenditures by diseases and health conditions, 2018

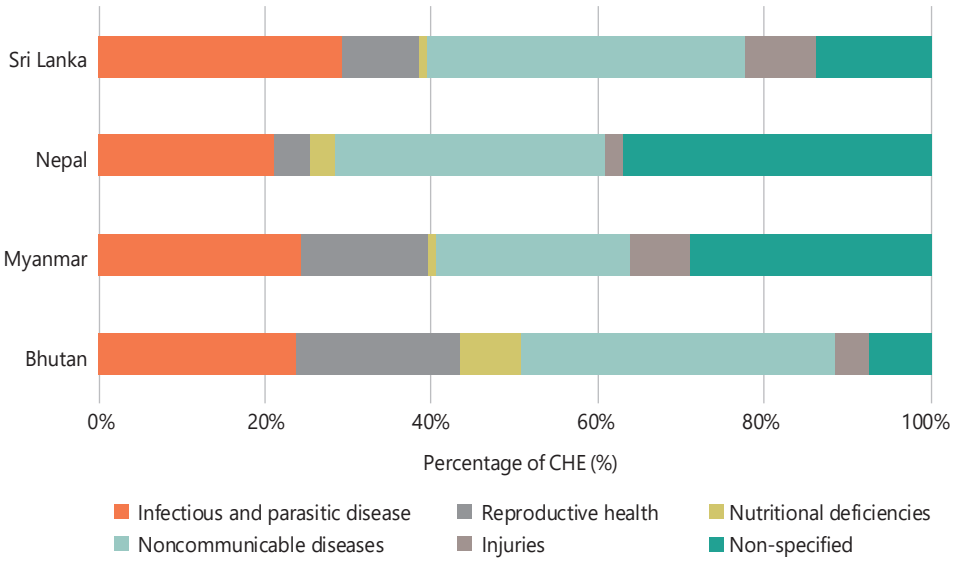


Fig. 14a. Sources of health spending on infectious and parasitic diseases

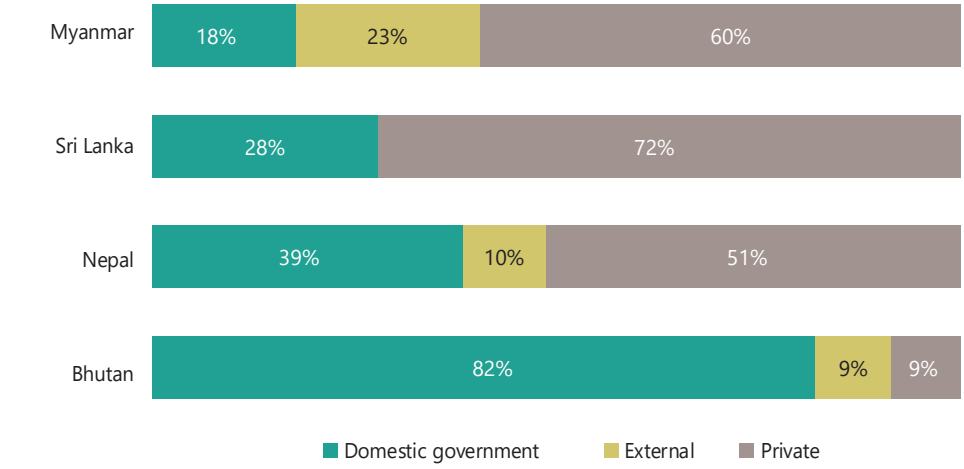
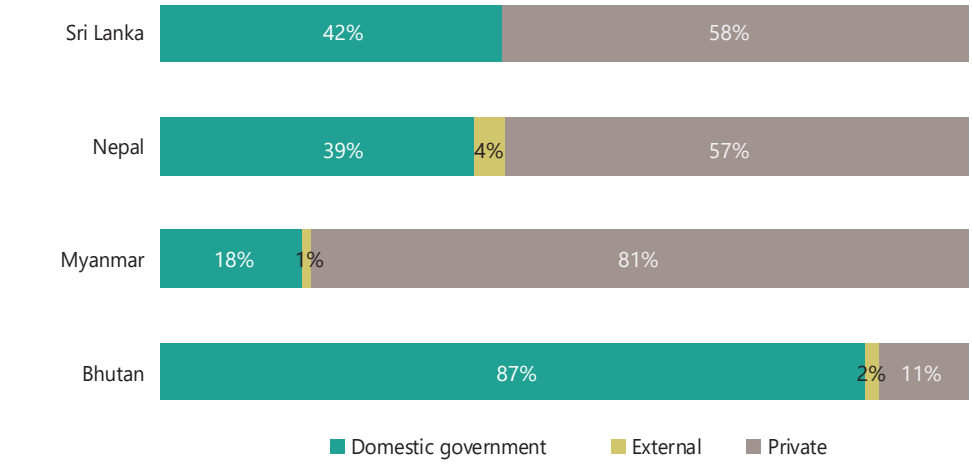


Fig. 14b. Sources of health spending on noncommunicable diseases



A review of health financing policy responses to COVID-19

Key messages

- In the first six months of the 2020 COVID-19 pandemic, SEA Region countries adopted a range of health financing policies to reduce financial barriers to care (testing and treatment), mitigate the immediate economic impacts of national lockdowns, and streamline public financial management systems to enable the rapid mobilization and disbursement of essential resources, including cash flows and protective equipment.
- Common approaches included extending free service coverage for COVID-19 testing in the public sector (albeit with varied eligibility criteria between countries), expanded engagement of the private sector in COVID-19 testing and treatment (either rapidly or subject to tight restrictions), the use of price ceilings to regulate the private sector, and the expansion or new implementation of social protection schemes (commonly cash transfer measures).
- The differences in the speed and magnitude in which these responses were implemented may reflect the stage of the outbreak in each country, the country's position in terms of progress towards UHC, and their relative budgetary and fiscal contexts.
- In some cases, the pandemic stimulated innovations that may support progress towards UHC, from the adoption of digital technologies to streamlined procurement systems, greater intersectoral collaboration, and the extension of free health-care services to marginalized populations.
- Funding commitments to health systems in the first six months of the pandemic may have been constrained by a lack of absorptive capacity. Further monitoring is needed to assess longer-term funding, the impact of health financing policy responses and whether they were implemented effectively.

Framework for evaluating COVID-19 policies

The outbreak of COVID-19 imposes unprecedented financing requirements on countries to implement rapidly effective prevention and control measures during a time when this

outbreak has also led to the deepest economic contraction since the Second World War. Consequently, fiscal space for health is under considerable pressure, both in terms of the volume of financial resources available and the capacity of public finance management (PFM) systems to efficiently deliver these resources where needed.

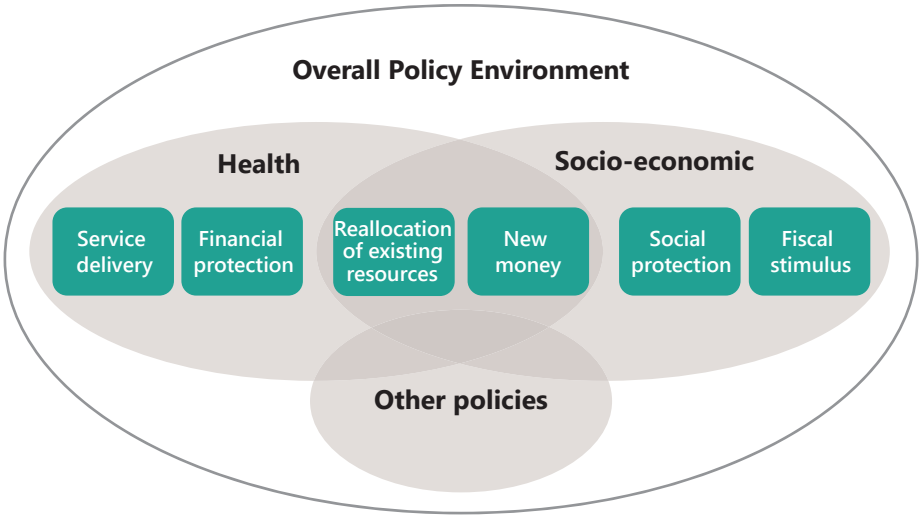
The pandemic has thus reinforced the critical importance of health systems that provide financial protection to all and have resilient PFM processes that can quickly expand sufficient, flexible and accountable fiscal space for health.

The diagram below sets out the framework for this review, situating the issues addressed within the broader context of an overall government response to COVID-19, which relate to the direct health response (service delivery and financial protection) and the broader socioeconomic response (social protection and fiscal stimulus), each of which was competing for resources within a defined fiscal space.

Within the context of the health response, these financing challenges was potentially be addressed with the injection of new money (existing government budget, increased domestic borrowing or donor assistance) or the reallocation of existing resources/budget (such as shifting spending across budget lines both within the health sector and from other sectors), each of which contributed to increased fiscal space for health.[17]

This review focuses on health financing responses, examining the initiatives of governments in the SEA Region in resource generation, financial protection, social protection and PFM. Although fiscal stimulus measures were a large part of the government response in many countries, analyses of these were outside the scope of this report given they were largely outside the remit of the health sector.

Government COVID-19 Response



This chapter provides a comprehensive overview of these dimensions of the immediate health financing policy arrangements made by SEA Region countries in response to the COVID-19 pandemic, in the initial six months of the outbreak from 1 March to 31 August 2020. The methods applied in this chapter are available in Annex I.

Policy responses to COVID-19 in the SEA Region

1. Policies to reduce financial barriers to seeking care

1.1 Cost-sharing policies for COVID-19 tests in the public sector

In response to the pandemic, all SEA Region countries rapidly expanded service coverage to provide free COVID-19 testing for suspect cases in the public sector and, in some cases, the private sector. However, eligibility varied by criteria such as exposure risk, age group, population group and, in some cases, membership of the respective national health insurance scheme.

Policies also considerably varied over time as countries responded to waves of the pandemic. Some countries (Indonesia, Nepal and Sri Lanka) allowed free testing only for close contacts, those who had visited high-risk areas, were symptomatic or met other criteria such as employment as a health worker or being over 60 years of age. In some cases (such as Indonesia, Sri Lanka, Thailand and Timor-Leste) foreigners and citizens were eligible for free testing, while in Nepal testing was limited to citizens only. Only four countries appeared to extend coverage to migrants from other countries (Indonesia, Maldives and Thailand) and domestic migrants (India).

Governments changed cost-sharing policies for COVID-19 tests over the course of the pandemic. Bangladesh was the only country in the Region that established a co-payment system for COVID-19 tests in the public sector. Though originally free, on 24 July 2020 the government announced that all COVID-19 tests at government facilities would incur a fee of BDT (Bangladeshi Taka) 200 (US$ 2.4) and those conducted at a patient's home would entail a fee of BDT 500 (US$ 5.9).[18] This was reportedly intended to avoid unnecessary tests and restore efficiency to the pandemic management. Notably, the change led to a reduction in the number of tests conducted per day from 18 426 (on 30 June 2020) to 10 759 (on 9 August 2020), equivalent to the second lowest ratio of number of tests to population size globally.[19] Subsequently, in August the government removed the co-payment for tests at public facilities and reduced the fee to US$ 1.2 for tests in private facilities.

Box 1. India's experience in establishing a cost-sharing policy for COVID-19 tests in the public sector

In India, against a backdrop of mounting cases and limited testing capacity, the Indian Council of Medical Research (ICMR) initially recommended a cap of INR 4500 (US$ 60) on co-payments for COVID-19 tests conducted in private facilities.[19] However, on 8 April the Supreme Court ordered all tests to be carried out free without clarifying if and how private laboratories would be reimbursed.[20]

Following a petition from the government to reconsider, on 13 April the Supreme Court ruled that the government will reimburse private facilities for testing beneficiaries of the country's flagship public health insurance scheme, AB-PMJAY (Ayushman Bharat Pradhan Mantri Jan Arogya Yojana).[21] The price cap of INR 4500 remained in place for all others, including the near-poor and middle class, until May 26, when ICMR removed the cap and advised all state governments to negotiate with private laboratories to set "mutually agreeable fees".[22] In the decentralized governance structure of India, health is under the responsibility of the state governments, hence the great pricing variations across states as shown in Table 2.

Table 2. Price ceiling on COVID-19 PCR tests in the private sector by state, India

State	Price ceiling on COVID-19 PCR tests*
Maharashtra	• INR 980 (US$ 13.10) in a private laboratory • INR 1400 (US$ 18.80) in COVID-19 care centre, hospital or dispensary • INR 1800 (US$ 24.10) for a swab collected at home
Karnataka	• INR 800 (US$ 10.70) for a swab collected in a government facility • INR 1200 (US$ 16.10) in private laboratory • INR 1600 (US$ 21.40) for a swab collected at home
Delhi	• INR 2400 (US$ 32.30)
Kerala	• INR 2100 (US$ 28.10)
Andhra Pradesh	• INR 2800 (US$ 37.50)
Telangana	• INR 2200 (US$ 29.50) for swabs collected at laboratories or hospitals • INR 2800 (US$ 37.50) for a swab collected at home
West Bengal	• INR 1500 (US$ 20.10)
Jharkhand	• INR 1050 (US$ 14.10)
Assam	• Free in all government facilities • INR 2200 (US$ 29.50) for an urgent result
Meghalaya	• Free testing ended 16 October • INR 3200 (US$ 42.90)
Gujarat	• INR 1500 (US$ 20.10) • INR 2000 (US$ 26.80) for a swab collected at home
Rajasthan	• INR 2200 (US$ 29.50) at private laboratories
Tamil Nadu	• INR 1500 (US$ 20.10) for beneficiaries of the Chief Minister's Comprehensive Health Insurance Scheme • INR 2000 (US$ 26.80) for non-beneficiaries

* As of 12 November 2020. Source: IndiaSpend: 'Exorbitant' COVID-19 treatment prices slashed as state governments step up.

1.2 Engagement of the private sector

The private sector was a major player in the national response to COVID-19 in several countries. Engagement appears to have occurred largely in three ways. In countries where the private sector accounted for a large proportion of health-care delivery, such as Indonesia, Thailand and in some states of India, it continued to act as a necessary service provider complementing the underfunded public system. In Thailand for instance, to address the increased demand at the peak of COVID-19 cases in April 2020, the Ministry of Public Health enforced the provision of health services by private hospitals for patients with COVID-19, with costs being covered by existing health insurance schemes for Thai citizens. Non-Thai patients were also fully covered by the Ministry, with additional budget earmarked by the government.[20]

Other countries with less prominent private sectors appeared hesitant to allow private facilities to provide COVID-19 related services but gradually relented in order to increase testing capacity and address the surge in health-care demand. This includes Bangladesh, Nepal and Sri Lanka, which initially restricted private facilities from providing COVID-19-related services at the beginning of the pandemic, and then selected a small number to provide services that was gradually expanded over time but subject to tight regulations.[21,22,23]

Regarding access to COVID-19 related health care in the private sector, nearly all SEA Region countries faced difficulties in ensuring fair access to affordable, quality COVID-19-related care. Several accounts documented arbitrary pricing of COVID-19 tests and treatment by private facilities in countries such as Bangladesh, India, Indonesia and Nepal.[24,25,26,27] In Indonesia for example, the price of a COVID-19 test in a private hospital reportedly was as high as IDR 1 million (US$ 68), effectively limiting access to the wealthy.[26]

In response, cost-sharing caps on the costs of COVID-19 tests in the private sector were commonly established across SEA Region countries as a control mechanism. Some were quicker to establish these measures (i.e. on 21 March in India) compared with others (6 July in Indonesia).

1.3 Cost-sharing policies regarding COVID-19 treatment

Limited information was available on COVID-19-related treatment costs. In Bangladesh, the government did not impose any price cap on COVID-19-related treatment in private hospitals, while in Nepal a price ceiling was established for designated private hospitals to reimburse costs for the treatment of COVID-19-positive inpatients according to their clinical status and resource requirements.

Table 3. COVID-19 testing policies in the public and private sector, eligibility and date of introduction, by country as of 31 August 2020

Country	Free testing		Eligibility criteria for free testing in public facilities	Eligibility criteria for free testing in private facilities	Price and cost-sharing ceiling on COVID-19 tests in private facilities	Date on which first price ceiling was established
	Public facilities (Y/N)	Private facilities (Y/N)				
Bangladesh	N	N	NA	NA	Co-payment of BDT 3500 (US$ 41.30)	28 June
Bhutan	Y	N	Symptomatic or contact with confirmed case	NA	NA†	NA
India	Y	Y	Symptomatic, contact with confirmed case or asymptomatic with travel history	Beneficiary of AB PMJAY	Varies by state	21 March
Indonesia	Y	N	Symptomatic and contact with confirmed case or visit to high-risk area	NA	IDR 150 000 (US$ 10.40) for rapid antigen tests‡	6 July
Maldives	Y	Y#	For locals and work permit holders who become symptomatic or had contact with confirmed case. For tourists and Maldivians and work permit holders who are travelling (local/ international) for personal reasons testing requires out-of-pocket costs	Y	MVR 675 (US$ 44) laboratory fee. MVR 1500+ (US$ 97) for travellers	June
Myanmar	Y	N	Citizenship, details of clinical or other risk eligibility not found	NA	NA†	NA
Nepal	Y	Y#	Citizenship and symptomatic and/or contact with confirmed case or visit to high-risk area, or asymptomatic and other risk (chronic disease or frontline health worker)	Y	NPR 4400 (US$ 37)	14 June
Sri Lanka	Y	N	Free for symptomatic citizens and contact with confirmed case or visit to high-risk area	NA	LKR 6000 (US$ 32.50) in private facilities,§ free in public sector	19 March 19 (private)
Thailand	Y	Y#	Free for citizens and foreigners at high risk or contact with high-risk people, or those who had returned from high-risk countries and symptomatic; all in line with Department of Disease Control protocol of testing eligibility	Same as private sector	Free of charge for patients. Public and private facilities receive same subsidies from the government	NA
Timor-Leste	Y	N	Free for all	NA	NA†	NA

*All data is up to 31 August 2020;† At this time no private facilities were providing COVID-19 related care;‡ Indonesia introduced a price cap of Rp 900 000 (US$ 60.60) for COVID-19 PCR tests on 5 October;§ Reports state that this rate varied from LKR 6500 to 8800 (US$ 35.80 to US$ 47.90) in different private hospitals;# In government approved or accredited facilities only.

In Nepal, for cases with mild symptoms, co-payments were capped at NPR 3500 (about US$ 29.50) per day, at NPR 7000 (US$ 59) for cases with moderate symptoms and NPR 15 000 (US$ 126.50) per day for patients requiring critical care services,[22] and treatment costs for COVID-19-positive patients were free for the public (no out-of-pocket payments). However, private facilities reportedly continued to charge the public much higher rates than the capped amount.[d]

1.4 Other financial protection policies

Other policy measures have also been employed by countries to extend financial protection for COVID-19 treatment. Indonesia, for instance, provided free medical treatment to all (including expatriates) regardless of their registration with the national health insurance scheme (BPJS Kesehatan), with the costs covered by general government revenues but channelled through the scheme.[28]

In Thailand, COVID-19 medical care was covered for those with existing health insurance, but classification of COVID-19 as an emergency condition under UCEP (Universal Coverage for Emergency Patients) meant that free emergency treatment was extended so that both nationals (such as non-registered nationals) and foreign residents without insurance coverage could access treatment at private and public hospitals.[28]

The costs of these services were reimbursed from the Ministry of Public Health contingency fund and no co-payments were required. Information was not yet available on the enforcement and impact of these extensions and while governments often reported that consultation occurred with private providers to establish price ceilings, details were limited.

Rates of out-of-pocket spending for non-COVID services may have declined across the Region, and yet this likely reflected foregone care rather than improved financial protection. In India, for instance, the National Health Authority reported that by June 22, 10 weeks of lockdown had led to a 51% drop in the weekly claims of the AB-PMJAY scheme (compared with up to 12 weeks before the lockdown) and a reduction in institutional admissions for child delivery and oncology cases.[29] Several factors could explain this, including a national lockdown that contributed to reduced supply-side factors such as service availability, and demand-side factors such as patients delaying or foregoing treatment out of fear of infection, public transport shutdowns, or financial considerations related to seeking care.[8] Such foregone care most likely hit the poor much harder than other segments of society, exacerbating pre-existing inequities in coverage.

d Source: WHO Country Office survey.

2. Resource generation for the health sector

2.1 Mobilization of 'new money'

Ensuring health gets sufficient priority in budget discussions is critical, given the need to spend on the COVID-19 response while maintaining other essential health services. SEA Region countries have drawn on a wide range of funding sources – budgetary resources, private donations, and external sources – to maximize the revenues available for financing COVID-19 responses.

Table 4 shows the reported budget allocations for the COVID-19 response in each country. However, it should be emphasized that these were estimates based on initial government announcements, which rarely specify funding sources or whether donor funding was included. Because of the mixture of sources from which these data originate, or lack of completeness of records, the figures are not readily comparable across countries.

Table 4. Initial reported resource allocation to the health sector for the COVID-19 response by country, as of 31 August 2020

Country	Allocation to health sector	
	Local currency	US$
Bangladesh	BDT 100 billion[30]	US$ 1.2 billion
Bhutan	Nu 3.3 billion[31]	US$ ~45 million
India	INR 18 000 crore[32]	~US$ 2.5 billion
Indonesia	IDR 87.55 trillion[33]	US$ 6.1 billion
Maldives	MVR 1178.9 million[34]	US$ 77 million
Myanmar	NA	NA
Nepal	NPR 3 billion[e]	US$ 24.5 million
Sri Lanka	LKR 70 000 million[f]	US$ 373 million
Thailand	THB 6302 million	US$ 203.3 million
Timor-Leste	NA	US$ 63.5 million[35]

It is clear that in many countries, the fiscal response in the health sector to COVID-19 was a small proportion of the overall government support for the economy. According to IMF's fiscal response tracker, globally health spending increased by a relatively modest amount (0.2% of additional GDP in low-income countries, 0.3% additional GDP in emerging markets/middle-income countries).[31,36] Such apparently small increases in health spending have been compared unfavorably to increased spending on measures to shore up the economy such as firm bailouts.[36] In Indonesia, for example, of the IDR 695.2 trillion (US$ 49 billion) stimulus package, IDR 87.55 trillion (US$ 6.1 billion), or about 12%, was allocated to the health sector, compared with over IDR 200 trillion (US$ 14 billion) to strengthen

e Reported in the WHO PFM survey.

f Government of Sri Lanka, 2020 Budget speech.

social safety net programmes and IDR 124 trillion (US$ 8.8 billion) to provide incentives for micro, small and medium enterprises.[33]

A possible explanation for this apparent absence of priority on funding for health systems is inadequate absorptive capacity to translate large increases in expenditure into effective service delivery in a short space of time. In the aforementioned WHO PFM survey, around half of the 133 countries surveyed by May 2020 had not formulated spending plans in response to directives from relevant government executive branches. This bottleneck was attributed to confusion about health budgeting processes, lack of clear lines of responsibility and delays in approval processes.[37] Perhaps more instructive will be health sector spending trends over an extended period of the pandemic once governments are more confidently able to ensure that funding decisions align better with priorities on the ground.

Nonetheless, it is estimated that the average contraction in GDP in the SEA Region countries in 2020 was around 5%.[38] It has been argued that given the high levels of debt created by the overall fiscal response to the pandemic in these countries, there is a danger that in future, with a tighter budgetary environment, objectives such as UHC and the related Sustainable Development Goals will be neglected. In response, countries need to strengthen commitments to these goals; and one of the opportunities that COVID-19 presents is the chance to "reset" priorities in order to promote cost-effective, evidence-based investment targeting the poor and the vulnerable.[38,39]

2.2 Reallocation of existing resources

In their initial response, one way that countries were able to free up fiscal space was to prioritize overall public spending on the pandemic through a variety of financing sources such as emergency response funds, reserves and repurposing of non-urgent financing. In Thailand, the budget for the fiscal year 2020[g] for all government ministries was immediately revised, with the unspent budget – in particular, those earmarked for travel, meetings and other activities – recalled, pooled, reprioritized and reallocated, and priorities shifted to COVID-19-related activities.[20]

Similarly, in Myanmar up to 10% of the initial budget expenditure for the financial year 2019–2020 (excluding those implemented by foreign loans and grants) of each ministry was re-allocated to the COVID-19 response and unspent expenditures were returned to the General Reserve Fund. In total, reallocation within respective organizations accounted for 306 billion Myanmar Kyat while reallocation through the General Reserve Fund reached 2631 billion Kyat.[31]

Timor-Leste's response was largely "self-funded", drawing US$ 250 million from the country's sovereign wealth fund, the Timor-Leste Petroleum Fund, valued at US$ 18 billion.[40]

g October 2019–September 2020.

Four countries established extrabudgetary funds to support their broader response to the COVID-19 crisis. Both Bhutan and Nepal established off-budget funds for donations from public, private and external sources to support their national COVID-19 responses.[41] Sri Lanka's off-budget fund also accepted donations from all sources and by July 2020 had collected LKR 1.5 billion (US$ 8.1 million).[42] In the case of India's Prime Minister's Citizen Assistance and Relief in Emergency Situations Fund (PM-CARES Fund), there was a lack of clarity as to how off-budgetary allocations were converted into expenditures and at what level.[41, 43]

2.3 Development partner funding

Multilateral donors announced significant resources to support efforts to contain and mitigate COVID-19 in the SEA Region countries, as shown in Table 5. Unsurprisingly, LMICs in the Region appear to have received considerably more support compared with upper-middle income countries such as Maldives and Thailand. In Sri Lanka, for instance, due to limited capacity for domestic resource mobilization, the government took on a new US$ 500 million loan from the People's Republic of China to continue servicing past borrowings/debts and support response efforts.[44] However, very little information was available on how donor funding was used in country health responses, how quickly it was disbursed, whether it reached implementing organizations, and whether proposed activities were effectively implemented.[36]

Table 5. External financing from the World Bank, Asian Development Bank and IMF, by country, by 13 August 2020 (US$)

Country	World Bank COVID-19 emergency response projects (US$)	ADB COVID-19 Active Response and Expenditure Support Programme (US$)	IMF rapid credit facility (US$)	IMF rapid financing instrument (US$)
Bangladesh	100 million	500 million	244 million	488 million
Bhutan	5 million	20 million	–	–
India	1 billion	1.5 billion	–	–
Indonesia	250 million	1.5 billion	–	–
Maldives	31.2 million	52.3 million	28.9 million	–
Myanmar	50 million	250 million	86.1 million	172.3 million
Nepal	29 million	250 million	214 million	–
Sri Lanka	128 million	–	–	–
Thailand	–	1.5 billion	–	–
Timor-Leste	–	–	–	–

Sources: World Bank Group's Operational Response to COVID-19 (coronavirus) – Projects List (https://www.worldbank.org/en/about/what-we-do/brief/world-bank-group-operational-response-covid-19-coronavirus-projects-list); IMF COVID-19 Financial Assistance and Debt Service Relief (https://www.imf.org/en/Topics/imf-and-covid19/COVID-Lending-Tracker); ADB COVID-19 Active Response and Expenditure Support Programme (https://www.adb.org/what-we-do/covid19-coronavirus).

Although debt-financed stimulus has been essential, it raised concerns about government capacity to sustain future health and other social spending. Even before the crisis, several countries in the Region had debt service levels that far exceeded the share spent on health.[39] As shown in Table 6, in 2018 Maldives and Sri Lanka paid 27% and 37% of their government revenues on debt service, respectively.

With further borrowing due to the pandemic, debt was expected to surpass 60% of GDP in several countries – Sri Lanka's general government debt to GDP ratio was forecast to continuously increase up to 97.3% throughout 2020–2022.[45] These increasing levels of public debt would place countries under fiscal pressure in the short and medium term, and have the potential to create longer-term liabilities that could limit fiscal space to allocate additional resources to the health sector.[12]

Table 6. Domestic general government health expenditure and PPG debt service as a proportion of government revenue, by country, 2018, and projected 2021–2023 average

Country	Domestic general government health expenditure (GGHE) (% of revenue) 2018	PPG debt service (% of revenue) 2018	Projected PPG debt service (% of revenue) 2021
Bangladesh	4.12%	5.86%	9.23%
Bhutan	7.63%	10.59%	60.57%
India	4.72%	4.30%	4.03%
Indonesia	9.52%	11.20%	16.46%
Maldives	24.97%	27.43%	38.86%
Myanmar	4.03%	7.01%	7.99%
Nepal	5.79%	2.93%	4.01%
Sri Lanka	11.48%	37.32%	48.50%
Thailand	13.50%	1.48%	1.05%
Timor-Leste	4.51%	0.35%	1.69%

Sources: World Bank World Development Indicators, World Bank International Debt Statistics, IMF World Economic Outlook. Note: PPG debt is public and publicly guaranteed debt, which comprises long-term external obligations of public debtors.

2.4 Priority investments in the health sector to respond to the COVID-19 pandemic

Investments focused on scaling up testing and surveillance capacity, procuring COVID-19 medical supplies and protective equipment, recruiting and training additional health workers and laboratory technicians, and accelerating detection and curbing disease transmission.

In Thailand for instance, the Ministry of Public Health expanded the national laboratory network from 80 RT-PCR laboratories certified to conduct COVID-19 testing in April

to 190 laboratories by August.[20] Thai tertiary care hospitals also invested in major physical infrastructure modifications, notably airborne infection isolation rooms, which are modified negative pressure rooms. These investments were fully subsidized by an additional MoPH budget.

Similar expansions were found in India, where the country reportedly scaled up from one COVID-19 testing centre in January to 1511 centres (983 government and 528 private laboratories) by August; and Indonesia, where media reported testing capacity increased from 13 laboratories in mid-March to 163 laboratories running COVID-19 tests by 1 July.[46, 47]

In Bangladesh, the Ministry of Health and Family Welfare recruited 2000 doctors and 6000 nurses by June as part of "the biggest recruitment drive Bangladesh has ever seen".[48, 49] In Maldives, the ADB loaned US$ 20 million for strengthening critical care services, protection of frontline health workers, strengthening diagnostic capacity and enhancing disease surveillance capacity. Another US$ 600 000 was provided by the ADB by diverting loaned funds from a completed infrastructure project towards the provision of ICU equipment and devices for a regional hospital and related costs.

Box 2. Costing COVID-19 response plans in Myanmar and Nepal

The majority of countries developed pandemic response plans with indicators of budgetary needs. In Myanmar, for example, the Ministry of Health prepared a 5-year costed Myanmar Health Sector Contingency Plan on COVID-19, estimated at MMK 200.7 billion (US$ 156 million), relying on both domestic and donor funds.[50]

Nepal reportedly conducted a costing exercise modelled on the provision of COVID-19-related treatment in three scenarios (mild, moderate and severe case numbers). The costing included public health interventions, per unit costing for hospital-based treatment and care, quarantine arrangements, and laboratory test. Existing government financial and procurement data were used to calculate a per unit cost based on the existing financial, human resource, supplies, utilities, accommodation, transportation, information management, and waste management related data. Based on this, the total budget required to implement the COVID-19 response plan was estimated to be NPR 6.9 billion (US$58 million), with half of this amount due to public health and social measures (such as free health insurance for health workers), 43% incurred by hospital-based interventions, and 4% required for management oversight activities including monitoring, evaluation, research and information management.

3. Financing of COVID-19 services

3.1 Changes in strategic purchasing arrangements

Purchasing arrangements play a key role in facilitating and supporting the adjustments needed in the provision of health services due to the pandemic, for both COVID-19 and non-COVID-19 health services. Detailed country information on adjustments in purchasing arrangements as part of the COVID-19 response was scarce. All SEA Region countries had

some form of essential benefits package in place prior to COVID-19 with varying degrees of generosity. In some countries these were mostly provided in the public sector.

The majority of SEA Region countries expanded COVID-19 related health services in publicly funded benefits, namely COVID-19 testing, hospitalization and medication, and most, at least at the start of the pandemic, made them available free of charge in the public sector. For instance, in India, testing and inpatient care for COVID-19, i.e. hospitalization of severe cases, intensive care, and medication, were incorporated into the AB-PMJAY.

Similarly, in Indonesia the government covered the costs of all services associated with testing and treating COVID-19 patients who met the eligibility criteria, regardless of their insurance status. In Thailand, despite government announcements that hospital care would be covered for those without insurance, such as migrants, there was concern that some would not visit a hospital due to fear that they would not be accepted.[51] All countries introduced incentives ranging from allowances, life insurance, premium health insurance, and hotel stays during mandatory quarantine, to incentivize and support frontline health workers.

Limited information was found on how payment rates were calculated for COVID-19-related services, and the WHO report on strategic purchasing ('*Adjustments in health purchasing as part of the COVID-19 health response: results of a short survey and lessons for the future*') highlighted a strong need for more insights into actual details of modifications in payment methods and rates.[52] A key challenge in pricing strategy was balancing affordability with the need to incentivize private providers to extend access and availability of services. Furthermore, the method of paying for services and products needed to provide the incentives to achieve desired levels of service coverage and quality.[53]

In Indonesia, costs were calculated using the adjusted Indonesian case-based group rates considering comorbidities and complications as well as the use of ICU beds and ventilators.[h] Top-ups were allowed on a daily basis during hospitalization based on severity (ICU needs) and length of stay. In Nepal, providers were paid on a per diem basis (per patient, per day) for the management of COVID-19 patients, with the payment rate established through a costing exercise (mentioned in Section 3).

In Bangladesh, it was reported that from 10 May the Government would take on the operational costs of select private hospitals treating COVID-19 patients, including the salaries of health-care workers, half of whom had reportedly been unpaid since March 2020.[24] In Maldives, pathology services were outsourced to selected private hospital laboratories, who could charge MVR 675 (US$ 44) per test by invoicing a tertiary government hospital.[54]

New service delivery modes, such as teleconsultation, were also part of the benefit expansion in a couple of countries to reduce demand of in-person care seeking and mobility of non-critical patients. In Maldives, telehealth was used for patients with chronic

h Source: WHO Country Office survey.

diseases to provide continuity of care and allow access to specialized services, for example, cancer care.[55]

Similarly, in Thailand, the National Health Security Office approved expansion of the UHC benefit package to include new digital telehealth platforms such as tele-TB DOTS, dermatology services and diabetic retinopathy. Hospitals were encouraged to provide services to patients using telemedicine services.[56] In both Maldives and Thailand, an e-prescriptions scheme was introduced, which allowed patients to pick up prescriptions at local pharmacies or have them delivered by post or through village health volunteers (Thailand).[55,56]

Increasing the pool of service providers by issuing new or simplified contracts or accreditation mechanisms was another important purchasing instrument. Changes to accelerate and simplify contract or accreditation procedures were found in three countries. In India, the National Health Authority introduced several measures to empanel more private hospitals under the AB-PMJAY scheme. A new mechanism, called Hospital Empanelment Module Lite, was introduced to onboard private hospitals through a simple, user-friendly online system available on the scheme's website.[57] The National Health Authority also launched an express empanelment route which allowed hospitals that did not fully comply with normal eligibility criteria to get empaneled temporarily for three months.[i]

In Indonesia, MoH developed stringent guidelines to engage private providers, and these were subsequently implemented by the BPJS, which certifies private providers to deliver COVID-19 services through a modified online accreditation system.[j] In Thailand, the Ministry of Public Health approved temporary measures to shorten the process of registration and approval of private hospitals.[20] The registration fee was waived, but post-registration surveillance was strengthened to ensure quality.

In Bangladesh, during the initial stage of the pandemic the government relaxed procurement rules but without any formal orders or decrees. Subsequently, amidst complaints about fraudulent and corrupt practices, the government issued strict instructions that all government departments adhere to the public procurement rule, which includes special provisions for emergency procurements.[k]

i Source: WHO Country Office survey.

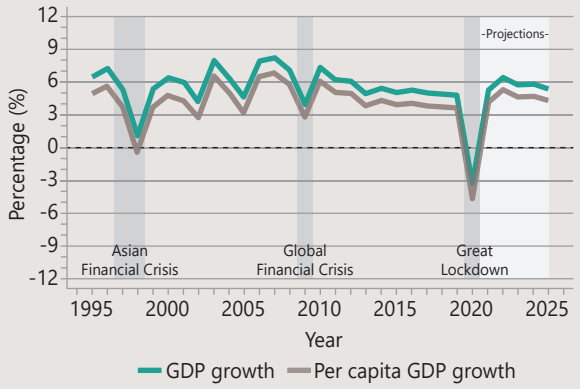
j Source: WHO Country Office survey.

k Source: WHO Country Office survey.

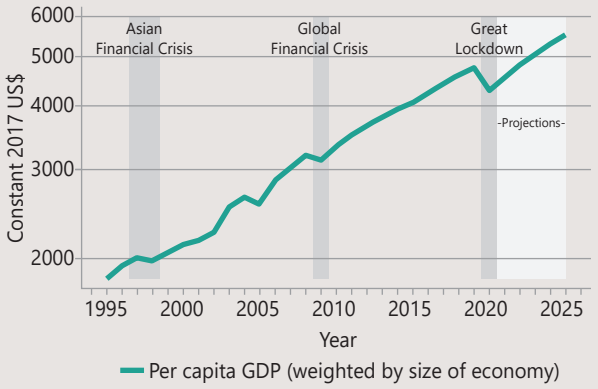
Box 3. Economic impact of COVID-19 and implications for health financing in the SEA Region[l]

The COVID-19 pandemic has caused the largest economic crisis since the Second World War, due to voluntary social distancing and lockdown policies resulting in declining demand and supply of goods and services. The projections suggested a global economic contraction of about -4.4% in 2020.[3] Similarly, the projections for the SEA Region indicated an average contraction of -4.2% across countries over the same period – the severest economic crisis the Region had experienced relative to previous crises and trends in growth rates from 2009 to 2019 (Fig. 15).

Fig. 15. The economic impact of COVID-19 in the South-East Asia Region



Source: IMF WEO



Source: WB/IMF staff estimates; Note: y-axis is log scale

Source: International Monetary Fund: World Economic Outlook, October 2020: A Long and Difficult Ascent. World Economic Outlook Reports. Washington, DC: IMF; 2020.

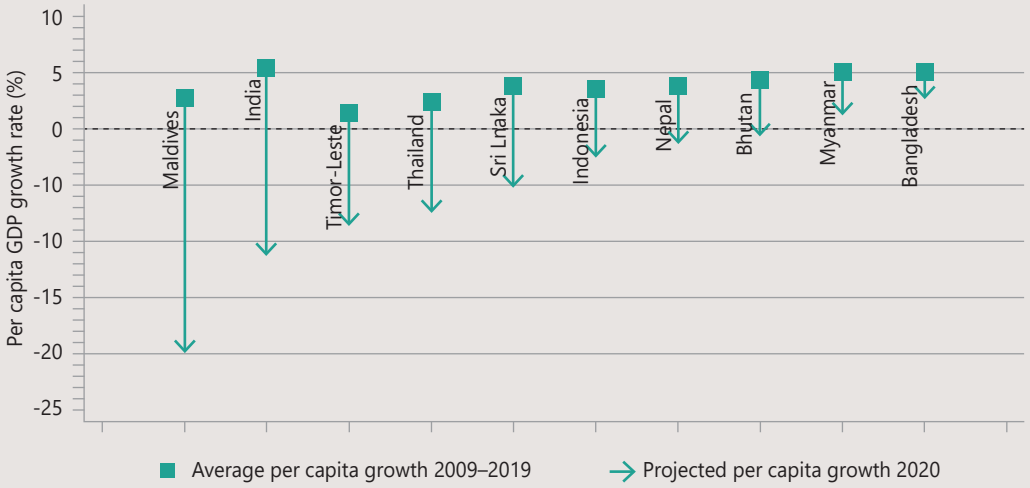
SEA Region countries have experienced different economic impacts due to the COVID-19 pandemic. This relates to factors that have constrained countries' abilities to tackle the economic impact of COVID-19, such as reduced trade, tourism, remittances as well as low tax revenues, high debt servicing and large deficits.[39] For instance, Maldives is among the worst-hit countries in the Region in this regard, as well as globally, with a projected decline of per capita GDP of 19.9%[m] in 2020, driven by substantial reduction in tourism revenues (Fig. 16).

India's economy was forecast to experience a contraction of -11.2%, a reduction from an average economic growth rate of 5.9% over 2009–2019. In contrast, Bangladesh and Myanmar were expected not to contract in 2020, yet they were likely to experience a substantial reduction in economic growth relative to past trends.

l This note is based on Tandon et al. (2021)[38] and Tandon et al. (2020)[39].

m Down from an average growth of 3.2% over 2009–2019.

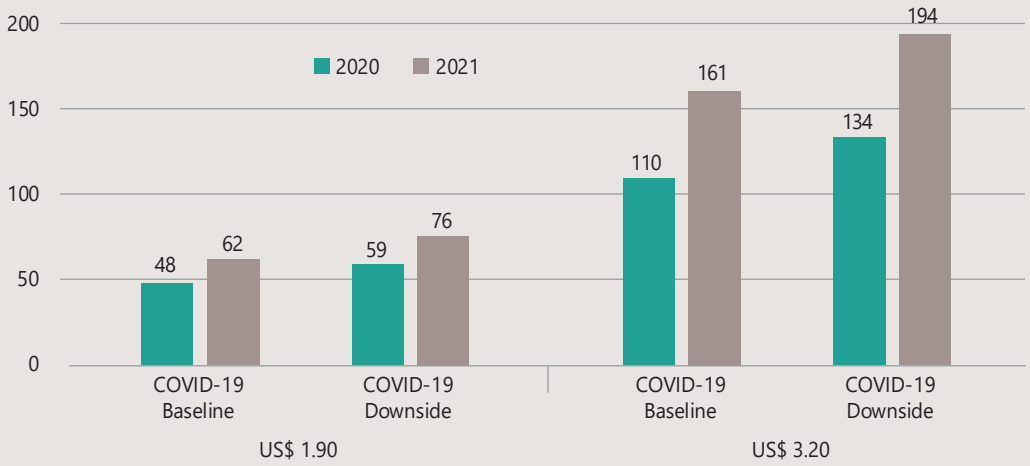
Fig. 16. The economic impact of COVID-19 across SEA Region countries; projected 2020 per capita GDP growth compared with average 2009–2019 growth



Source: International Monetary Fund: World Economic Outlook, October 2020: A long and difficult ascent. World Economic Outlook Reports. Washington, DC: IMF; 2020.

The reduction in economic activity was accompanied by an increase in unemployment and under-employment, a decline in remittances and a reversal in the trend of poverty reduction seen over the past several decades.[9,12] For instance, in Indonesia unemployment rates were expected to increase from 5.3% in 2019 to 8% in 2020 with women and workers in the informal sector worst affected.[9] Extreme poverty (less than US$ 1.90 a day) was projected to reach 48–59 million people in the SEA Region in 2020 and reach 62–76 million people in 2021 (Fig. 17).

Fig. 17. Number of additional poor in the SEA Region using US$ 1.9 a day poverty rate (left graph) and US$ 3.2 a day poverty rate (right graph) as a result of COVID-19



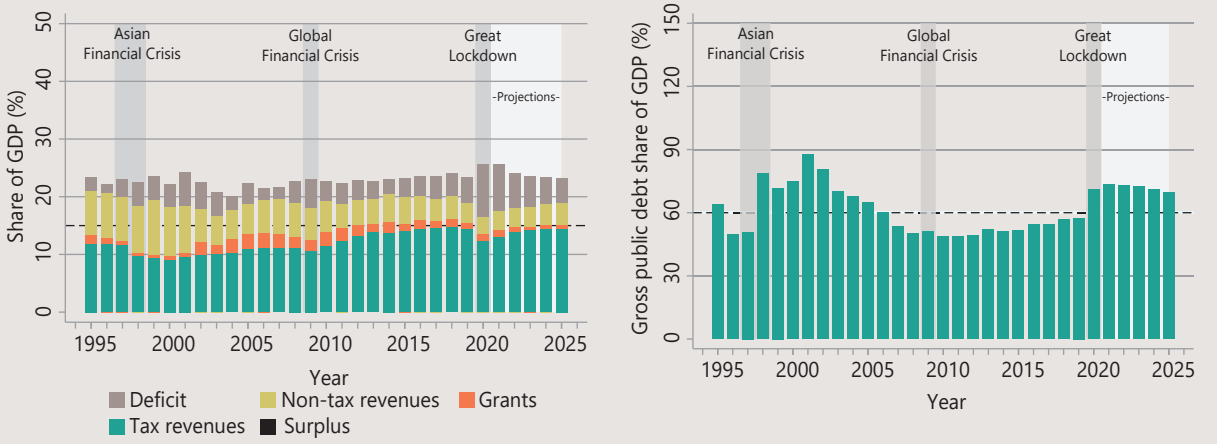
Source: Poverty forecasts. Washington (DC): World Bank; 2015 (https://www.worldbank.org/en/publication/global-monitoring-report/poverty-forecasts-2015, accessed 18 December 2020).

Using a measure of US$ 3.20 a day, which is more appropriate for SEA Region countries, which are mostly lower-middle income, 110–134 million people were predicted to fall into extreme poverty in 2020. Income inequality, which was already high among SEA Region countries prior to the onset of COVID-19, is likely to rise further if there are no strong and effective policy interventions in reaching the target groups.

The economic impact of COVID-19 has also resulted in declining public revenues, with the tax revenue as a share of GDP dropping by about 2% of GDP on average in the Region. However, to mitigate the immediate impact of the health and economic crises, governments have been implementing counter-cyclical policies,[n] largely to finance the emergency response, for expanding social assistance programmes and implementing economic stimulus packages. Hence, government expenditures as a share of GDP have increased (Fig. 18).

As a result, public debt levels were estimated to increase across countries in the Region and exceed 60% of GDP on average (Fig. 18). Countries like India, Maldives and Sri Lanka already experienced high levels of public debt prior to the start of the COVID-19 crisis and further borrowing is likely to lead to fiscal tightening in the medium and possibly the long term as well (depending on the country pre-crisis level of public debt) due to required debt servicing on account of high public debt levels.

Fig. 18. Government spending by source of financing and gross public debt as a share of GDP across SEA Region countries



Source: International Monetary Fund. World Economic Outlook, October 2020: A long and difficult ascent. World Economic Outlook Reports. Washington, DC: IMF; 2020.

Government spending on health can be categorized into two broad components: total government expenditures and the relative allocation to the health sector. Typically, the former drives the fiscal space for health, while the prioritization to the health sector played a secondary role.[17] From 2000 to 2018 the SEA Region countries experienced rapid economic growth (as part of a set of favorable macro-fiscal factors) which led to increased public spending for health.[58] However, in the light of the current economic crisis, government revenues have been sharply decreasing, meaning less fiscal space for the

n These are policies that increase government spending and reduce taxes during economic crises (recession).

total government budget and potentially less for public spending on health. If the health sector is not pro-actively prioritized, public spending on health could stagnate or even decline; reversing years of gains made towards UHC in the Region.

Due to declining household incomes, out-of-pocket spending could also decline. In other times, this would be a welcome message, especially in the SEA Region which has the highest share of out-of-pocket health spending globally.[o] However, it is likely that this decrease would disguise an increase in foregone care and a large proportion of unmet health-care needs, which would have had a negative impact on both population health and economic productivity. This in turn would have required an increase in public spending on health in order to offset the shortfall in out-of-pocket spending.

o As reported in Chapter 1.

3.2 Changes in public financial management systems

Several SEA Region countries amended the PFM systems to ensure that exceptional budget allocations were rapidly disbursed and could be used with more flexibility. Barroy et al. suggest that flexible but well-defined budgetary processes in countries have been critical in enabling efficient transfer of resources into programmes on the ground through measures such as fast-track spending authorizations, fiscal transfers to subnational levels, and advance payments to service providers.[37]

In India, the government relaxed internal budget transfer restrictions to ensure that states could reprogramme large amounts of funds, activated public procurement rules to secure essential medical supplies, authorized relevant ministries to allocate budget savings to COVID-19 related expenditure without prior approval and, if savings were unavailable, allowed ministries to charge emergency spending to a special budget line – 'Relief on Account of Natural Calamities' – up to a certain limit without prior approval.[59] Similarly, Maldives made use of fast-track emergency procurement processes, including direct contracting, shorter bidding time, and increased thresholds for quotations and national procurements.

However, some countries did not managed to use exceptional budget allocations for the COVID-19 response to their full potential, partly due to pre-existing PFM bottlenecks. In Indonesia for example, the Ministry of Health had spent just 1.54% of the 87.55 trillion rupiah (US$ 4.6 billion) budget by June 16.[60] Execution rates were not available for other countries, but more recent analyses suggested that actual country spending on the COVID-19 health response may vary significantly from the budgeted allocation.[12] These highlight the initial challenges of absorptive capacity highlighted in Section 3.

In some cases (such as Sri Lanka and Maldives), countries established new governance approaches and arrangements with special powers for accelerated decision-making and a coordinated and harmonized response to the crisis. In Maldives, a National Emergency Operational Committee was established, chaired by the Minister of Health, to coordinate

and implement the national emergency COVID-19 response, including overseeing the development of agreements between the government and private facilities, and price setting for pathology reimbursements.[55]

Laws were also been enacted to allow special powers for resource allocation decisions. For instance, the Indonesian government prepared a legal umbrella to deal with the emergency, namely Perpu Number 1 of 2020, which later became Law Number 2 of 2020 concerning "State Financial Policy and financial system stability for handling COVID-19".[61] This financial policy was considered to provide flexibility for the government to respond to extraordinary situations, and also provided a relaxation of the deficit, given the need for State spending to deal with the rise in COVID-19 cases at a time when state revenues declined.

The pandemic response also leveraged recent developments in information management systems in several countries. In Bhutan for instance, the country's electronic Public Expenditure Management System, launched in 2019, became the frontline tool that enabled rapid disbursement of cash grants from the Druk Gyalpo's Relief Kidu.[62] In Myanmar a customized COVID-19 resource mapping dashboard was developed that enabled tracking of funding received and allocation towards each of the pillars in the costed plan.[p] Countries have also modified existing health information systems to include new indicators to record COVID-19 testing, treatment and logistics.

In Nepal a standalone information management system was developed for COVID-19, which was managed under the existing management system but not integrated into it. Additionally, in Thailand, a new national integrated patient database was developed to support surveillance and billings, including information on laboratory results and reimbursement of laboratory and treatment fees.[63]

4. Social protection arrangements

Estimates by the World Bank suggested that the effects of COVID-19-induced national lockdowns and the global economic recession could raise the extreme poverty rate (US$ 1.90 a day) for the first time in several decades and push 48–59 million people in the SEA Region into extreme poverty in 2020.[38] In the absence of comprehensive social protection programmes, population health is likely to be hit hard. These circumstances may have grave implications for SEA Region countries with existing disparities in health-care access, high levels of out-of-pocket spending and limited financial protection (Box 1).

According to the World Bank, cash-based transfer measures have been the most common form of social assistance globally, followed by in-kind transfers, including distribution of food commodities, vouchers and school feeding programmes. Waiver or deferred payment of utility fees or financial obligations such as loan relief schemes, extended tax deadlines and reduced interest rates have also been common.[64] These trends have been reflected in the SEA Region, where countries typically implemented new emergency

p Source: WHO Country Office survey.

schemes or augmented existing social protection programmes by increasing payments, extending eligibility and suspending conditionalities.

Table 7 provides a snapshot of social protection measures taken by Member States of the SEA Region but is not intended to provide an exhaustive account of all programmes enacted or scaled up. The focus here is on those programmes targeting the most vulnerable groups where the impact was most likely to be reflected in health and health-care access.

Emergency cash transfer programmes were one of the most common strategies among SEA Region countries to rapidly disburse financial support to those who have lost employment and other vulnerable population groups. While some countries announced comprehensive packages, in others support was limited. Timor-Leste allocated the largest proportion of GDP (3.5%) towards a new unconditional cash transfer scheme. Using a universal approach, the government allocated cash transfers worth US$ 100 per month for two months to more than 214 000 households with a monthly income below US$ 500.[40] This scheme was relatively generous, representing 53% of the average monthly GDP per capita and estimated to cover 89% of the targeted population.[64]

Similarly, in Bhutan the Druk Gyalpo's Relief Kidu was established to provide immediate financial support ranging from Nu 7000–10 000 (US$ 99.40–142) for nine months for people who had been laid off, placed on reduced income or had their livelihood impacted by the pandemic.[65] These transfers were equivalent to 62% of the average monthly GDP per capita.[64] At the conclusion of Phase I (April–June 2020), a total amount of Nu 680 million (~US$ 9.2 million) had been disbursed to 25 126 beneficiaries.[65]

In other countries, cash transfer programmes were implemented for relatively shorter periods and offered smaller amounts. In Sri Lanka for instance, the Government quickly disbursed a payment of LKR 5000 (US$ 27) for two months to 66% of households across the country, yet the transfers covered 13% of the normal household monthly consumption requirements.[65] In Bangladesh, the payment of Tk 500 (US$ 5.92) per month to older people and widows only covered 2.4% of normal household monthly consumption requirements.[66]

The World Bank estimates that Indonesia's cash transfer programmes met 12% of the average monthly GDP per capita, even though they represented doubling of pre-COVID-19 levels.[64]

Extensive economic relief packages in Nepal and Maldives (NPR 60 billion or US$ 507 million, and MVR 2.5 billion or US$ 21 million respectively) included measures such as daily food provisions, utility subsidies, cash for work programmes and small farmer credit schemes, as opposed to a specific social assistance or protection scheme.[64]

A challenge with some emergency support measures was that they have built upon existing schemes with pre-existing inefficiencies in terms of eligibility and targeting. In some cases, these inefficiencies carried over into the new emergency measures.

For instance, a telephone survey conducted by UNICEF in May found that in Sri Lanka 31% of eligible households had not received support.[66] Similarly, in Bangladesh, distribution of the one-off payment of BDT 2500 (US$ 29.50) to 5 million vulnerable households was reportedly halted due to concerns regarding the list of beneficiaries.[67] Additionally, recent research found that the expansion of Indonesia's Hopeful Families Programme (PKH) faced challenges as shifting from in-person information sessions to online communication reportedly led to confusion among beneficiaries about the timing of payments, disbursement amount and procedures.[68]

Furthermore, the majority of middle-income families – the "missing middle" – were, by design, excluded from these social security programmes. Some countries devised specific programmes to target workers in informal employment to overcome this hurdle. In Indonesia, two new unconditional cash transfer programmes were introduced for, (i) residents outside the Greater Jakarta Region who have already registered with the social registry but were not recipients of PKH or the Food Assistance Programme; and (ii) who were negatively affected but had not registered in the social registry and were not recipients of PKH or the Food Assistance Programme.[64]

Thailand also introduced a scheme to provide Thai baht 5000 per month (US$165) for three months to informal workers and enrolled approximately 16 million workers (45% of the labour force) using an online registration form that was linked to other government databases to verify the information provided.[28] Food transfers/banks, vouchers and subsidies was also been a common feature of the COVID-19 response measures, particularly in countries where access to food was limited such as Bangladesh, India, Indonesia, Nepal and Timor-Leste.

Table 7. A snapshot of social protection measures introduced in response to COVID-19, as of 31 August 2020

Country	Name of scheme	Number of recipients	Increase in transfer per month per beneficiary (local currency and US$)	Transfer value (% of GDP per capita)	Duration of support	Packages as % of GDP
Bangladesh	Primary school stipends	14 million children	Tk 25–50 (US$ 0.29–0.58)	2.4%	12 months	0.16%
	Direct transfers to poor working households[+]	5 million households	Tk 2500 (US$ 29.60)	1.5%	One-time	
	Direct transfers to poor senior citizens, widows and women deserted by their husbands in 100 *upazilas* (administrative regions)	850 000 recipients	Tk 500 (US$ 5.92)	3.6%	12 months	
	Direct transfers to insolvent persons with disabilities in 100 *upazilas*	255 000 recipients	Tk 700 (US$ 8.29)	5.1%	12 months	

Country	Name of scheme	Number of recipients	Increase in transfer per month per beneficiary (local currency and US$)	Transfer value (% of GDP per capita)	Duration of support	Packages as % of GDP
Bhutan	Druk Gyalpo's Relief Kidu[†]	25 126 recipients	Nu 7000–10 000 (US$ 99.40–142.00) + Nu 800 (US$ 11.40) per child	36.1%–51.6% + 4.1% per child	9 months	Not available (NA)*
India	National Social Assistance Programme for the elderly, widows and disabled	35 million recipients	INR 1000 (US$ 14.60)	2.6%	One-time	0.15%
	Mahatma Gandhi National Rural Employment Guarantee Scheme	27.5 million workers	INR 202 (US$ 2.90)	NA	NA	
	Pradhan Mantri Kisan Samman Nidhi	87 million farmers	INR 2000 (US$ 26.50)	15.5%	3 months	
	PMJDY (Jan Dhan financial inclusion)	200 million women (aged 18–59)	INR 500 (US$ 6.50)	3.5%	3 months	
Indonesia	Programme Keluarga Harapan (PKH) (Hopeful Families Programme)	10 million households	IDR 39 375 (US$ 2.75) per month	2.2%	12 months	NA
	BLT (new unconditional cash transfer programme)[†]	9 million households (excluding PKH beneficiaries)	IDR 600 000 (US$ 36.80)	2.8%	9 months (April–Dec.)	
	BLT Dana Desa (second new unconditional cash transfer programme)[†]	11–12 million poor households (excluding PKH beneficiaries)	IDR 600 000 (US$ 36.80)	2.8%	6 months (Apr. – Sept.)	
Maldives	Economic relief package	10 538 recipients	Up to MVR 5000 (US$ 325)	NA	Ongoing support	0.0003%
Myanmar	Maternal and Child Cash Transfer Programme	241 425 households	MMK 30 000 (US$ 233)	NA	One-time	NA
	Social Pension Programme (over the age of 85)	200 301 recipients	MMK 30 000 (US$ 233)			
Nepal	NA	NA	NA	NA	NA	NA
Sri Lanka	Samurdhi, disability and chronic illness allowances	2 578 169 recipients	LKR 5000 (US$ 26.30)	1.3%	2 months	0.33%
	Senior citizens' allowances	559 059 recipients	LKR 3000 to LKR 5000 (US$ 15.80–26.30)	0.8%–1.3%		
	Farmers' and fishermen's pension schemes	165 275 recipients	LKR 5000 (US$ 26.30)	5.7%		
	Unemployed graduates	40 000 recipients	LKR 20 000 (US$ 105.30)	22.7%		

Country	Name of scheme	Number of recipients	Increase in transfer per month per beneficiary (local currency and US$)	Transfer value (% of GDP per capita)	Duration of support	Packages as % of GDP
	Self-employed workers	2 357 077 recipients	LKR 5000 (US$ 26.30)	1.3%		
	Pre-school teachers	39 784 recipients	LKR 5000 (US$ 26.30)	1.3%		
Thailand	Rao Mai Ting Gun ('We do not leave anyone behind') cash relief programme†	15 million recipients	THB 5000 (US$ 160)	23.3%	3 months	NA
	Farmers' cash relief programme	7.5 million recipients	THB 5000 (US$ 160)	23.3%		
	Welfare card holders cash relief programme	1.2 million recipients	THB 3000 (US$ 96)	NA		
	Vulnerable population cash relief programme	6.8 million recipients	THB 1000 (US$ 32)			
Timor-Leste	Cash transfer programme to households with a monthly income below US$ 500†	214 000 households	~US$ 100	NA	3 months	3.5%

* Not available (NA) indicates that this data could not be found; † Indicates a new scheme. Sources: (1) UNICEF. Addressing the economic impacts of the COVID-19 crisis in South Asia through universal lifecycle transfers, Working Paper. Special Series Paper 2: Responding to COVID Crisis in South Asia. Kathmandu: UNICEF; 2020; (2) Gentilini U, Almenfi M, Dale P, Palacios R et al., Social protection and jobs responses to COVID-19: A real-time review of country measures. "Living paper" version 13 (18 September 2020). World Bank; 2020; (3) Olivia S, Gibson, J. and Nasrudin, R. Indonesia in the time of COVID-19. Bulletin of Indonesian Economic Studies 2020, 56(2):143–174.

Reflections on policy interventions and implications for health financing

The COVID-19 pandemic placed unprecedented economic pressure on policy-makers to finance the emergency response and mitigate the immediate impact of health and economic crises. This review highlights the wide range of health financing policies and practices that SEA Region countries adopted in the first six months of the pandemic. Despite the wide variation in health systems, government institutions, levels of economic prosperity and cultural settings across countries in the Region, common policy themes emerged.

Nearly all SEA Region countries rapidly enacted policies to increase financial protection for households and enable access to immediate disease response measures. This included reducing financial barriers to seeking care (testing and treatment) for COVID-19-related services, implementing new cash transfer schemes or augmenting existing ones, and instituting PFM changes to streamline the procurement of essential resources and ensure cash flows swiftly to support emergency measures. Information on the equity impacts of these policies was limited.

The differences in the speed and magnitude in which these responses were implemented may reflect the stage of the outbreak in each country, the country's position in terms of progress towards UHC and their relative budgetary and fiscal contexts. For instance, countries with well-established purchasing functions and mechanisms (such as Thailand) were well positioned to promptly engage the private with oversight of price, quality and reporting of COVID-19-related treatment.

This avoided the challenges associated with the procurement of services from the private sector under duress, which may have occurred in other countries (i.e. Indonesia). Similarly, while some countries mobilized generous and long-lasting cash transfer schemes largely through domestic (i.e. Timor-Leste) or donor-financed (i.e. Bhutan) means, others in more precarious fiscal positions relied on debt financing (i.e. Sri Lanka) and comparatively limited social protection responses (i.e. Bangladesh).

However, the pandemic also created the political impetus to embolden countries to introduce meaningful financial protection measures and stimulated innovations that may support progress to UHC. Such innovations included: (i) accelerated deployment of telemedicine, (ii) increased public-private collaboration, (iii) streamlined procurement systems, (iv) increased investment to strengthen disease surveillance and diagnostic capacity of laboratories, and (v) extension of free health-care services to marginalized populations.

As countries recover from the pandemic they are encouraged to continue, consolidate and deepen these reforms, while recognizing the challenges to meeting their resource implications. Such achievements make it difficult to roll back these measures and thus may provide the political capital needed to ensure the longer-term prioritization of UHC.

The operationalization of the above-mentioned policies has required countries to mobilize significant resources to finance the COVID-19 response, re-emphasizing the importance of public spending on health and adequate fiscal space.

It appears that SEA Region countries have typically been mobilizing resources from multiple sources including reallocations within existing budget envelopes, additional aggregate spending and, for some countries, partner funding. Myanmar and Thailand, in particular, were examples of countries rapidly reprioritizing budgets towards the health sector. However, details on resource allocation, purchasing and changes to PFM systems were particularly scarce in the public domain.

On the face of it, the government funding response to COVID-19, as reflected in government budgetary allocations for health systems in the first months of the pandemic, was overshadowed by spending measures devoted to shoring up the economy. Such policies reflect to some extent a funding lag whereby many health systems had limited capacity to absorb large injections of money.

This reflected inadequate infrastructure, workforce and lack of institutions that could only be built with sustained investment. Longer-term monitoring is important to track spending and will enable a clearer assessment of the health systems financing response of each country, beyond what was immediately allocated to emergency spending.

It is worth emphasizing that the main limitation of this review is that it was conducted as a snapshot of health financing policy responses to the pandemic from March to August 2020, in the context of data incompleteness. Given the ongoing, rapid changes to the policy environments in each of these countries, it is likely that many of the policies highlighted above may have changed considerably. Additionally, the timing of the review (August 2020) meant that information on policy changes may not have yet been available in the public domain. As a result, it is beyond the scope of this review to assess the full impact of the health financing responses highlighted above and ascertain if they were implemented effectively. An important task going forward is to ensure that these financing responses are rigorously monitored and evaluated.

Health financing profiles

Bangladesh

Progress towards universal health coverage

Bangladesh is progressing to improve the availability of health services for the population. From 2010 to 2020, the UHC service coverage index increased from 38 to 49. On the other hand, the share of population affected by household catastrophic health expenditure increased sharply from 13.9% in 2009 to 24.7% in 2016. These increases were mirrored in 2016, as 7% of the population was pushed into poverty because of out-of-pocket health payments, up from 3.4% in 2009 (under the poverty line of US$ 1.90 per capita daily).[6]

Health system architecture and governance

The health system of Bangladesh is a pluralistic system with four key actors that define the structure and function of the system: government, private sector, nongovernmental organizations (NGOs) and donor agencies. The government's Constitutional obligation makes it responsible not only for policy and regulation, but also for provision of health services.[69] The government health services are managed by two different line ministries in Bangladesh.

The urban primary health care system is governed by the Ministry of Local Government, Rural Development and Cooperatives (MoLGRDC). The MoLGRDC, through city corporations and municipalities, coordinates the delivery of primary health care services in urban settings that is provided by nongovernmental organizations (NGOs). In rural settings, the Ministry of Health and Family Welfare (MoHFW) manages the *upazila* (sub-district administrative division) health systems (UHS), which consist of standardized referral hospitals and primary health care facilities such as community clinics.

In addition, the MoHFW is charged with providing secondary and tertiary care in both rural and urban settings. The growth of the private sector is significant in recent decades compared with the public sector. Bangladesh is known worldwide for having one of the most dynamic NGO sectors, providing mainly preventive and basic care.

Health planning and financing is centralized at the MoHFW and guided by five-year Health, Nutrition and Population Sector Programmes. The MoHFW oversees almost all government health resources; the local governments and other ministries such as MoLGRDC govern small shares. In addition, donors play an important role in financing and planning of health programmes.[70]

While a number of private insurance companies offer individual and group insurance to private persons and corporates, these health insurance initiatives cover a very small share of the total population of Bangladesh.

Raising revenue

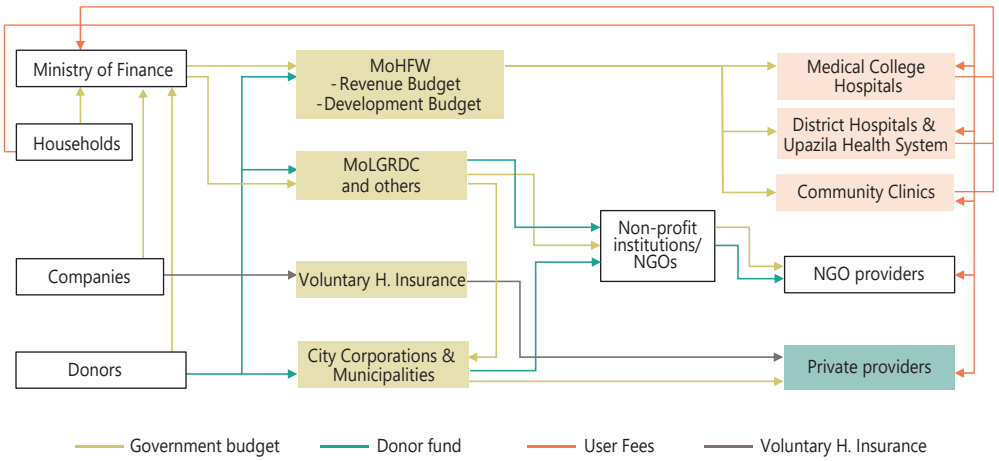
The share of current health expenditure (CHE) and domestic government expenditure on health (GGHE-D) in relation to the country's GDP remained at the same levels over the past decade. The CHE stood at 2.4% of GDP in 2009 and 2.3% in 2018, while GGHE-D has been approximately 0.4% of GDP over the same period. The three main sources of revenue for health are the government budget, household out-of-pocket payments and external donor funds. The government budget made up 17% of the CHE in 2018, down from 20.4% in 2009. Accordingly, government expenditure on health is 3% (2018) of general government expenditure (GGE), down from 4.1% in 2009.

Out-of-pocket expenditures or spending (OOPS) on health accounted for 73.9% of CHE in 2018, up from 67.2% in 2009. Voluntary health insurance and other private schemes made up 2.6% of the CHE in 2018. External donor sources to health have declined from 9.6% of CHE in 2009 to the 2018 levels of 6.5%. [70]

Pooling and flow of resources

Funds from MoF and donors are transferred to MoHFW and MoLGRDC. The MoHFW resources, mobilized from the government budget transfers and donor funds for the development budget, constitutes the only sizeable pool in Bangladesh's health sector.

Fig. 1. Simplified flow of funds in Bangladesh health sector



Source: Adapted from Ahmed SM, Alam BB, Anwar I, Begum T, Huque R, Khan JAM, et al. Bangladesh Health System Review. Vol.5 No.3. Manila: World Health Organization, Regional Office for the Western Pacific, 2015.

Benefits package

According to Article 15(a) of the Constitution, all citizens have the right to medical care. Primary, secondary and tertiary medical care is provided in government health facilities, largely free of charge for essential medicines, medical and surgical supplies and hospitals beds. In government hospitals, however, low user charges are applied for outpatient consultation, for inpatient shared rooms or individual rooms. Patients have to purchase items such as syringes, intravenous fluids, x-ray plates, etc.[70]

Since 1998, there has also been an explicit Essential Services Package (ESP) implemented, to ensure provision of selected primary health care services to the poor. The ESP was updated several times (most recently in 2016). The current ESP is comprehensive and structured in five categories: Maternal and child health, Family planning, Nutrition, Communicable and noncommunicable diseases, and condition management services.

In addition, three support services, laboratory, radiology and pharmacy, are also covered.[71] The different components of the ESP are implemented in government health facilities and through vertical programme delivery channels. A detailed costing showed[72] that the average cost per capita is between US$ 6–US$ 7 per annum. The poorest individuals are the ESP's priority.

Table 1. Essential Services Package

Level of care	Type of services
Primary health care	• NCD screening • Maternal care, including newborn sepsis, normal newborn, severe cases, basic emergency obstetric and neonatal care, pre-term newborn care • Child health, growth and immunization • Family planning (short acting) • Limited curative care • Social and behavioural change communication
Secondary and tertiary care	• Emergency care for severe cases • Maternal care, including antenatal and prenatal care, basic and comprehensive emergency obstetric and neonatal care, pre-term births, newborn sepsis, severe acute malnutrition • Child health, growth and immunization • Family planning (all methods) • NCD screening and management • Communicable diseases, including TB, malaria, HIV/AIDS, NTDs, etc. • Eye, ear, dental and skin care • Geriatric care • Social and behavioural change and communication

Purchasing arrangements

The MoHFW, the main purchaser in Bangladesh, pays for routine line-item expenses of government health facilities based on number of beds (medicines and operational costs) and staff (salaries).[73] The vertical programme managers at the central level transfer funds according to plans submitted by the facilities at the lower level.

City corporations and municipalities contract NGOs and/or private facilities for the delivery of urban primary health care services. NGOs are chosen through an open competitive bidding procedure for a certain period.[70] Implementing NGOs are expected to cover 20% of the costs by collecting some user fees. They are also expected to provide free services to at least 30% of the users who are classified as poor. Individual users who opt for private health care facilities pay fee-for-services, as set by each provider.

Public financial management

The government budget for health is composed of revenue and development budgets. The former is funded by the Government of Bangladesh (GoB) and the latter by both GoB and donor contributions. The planned MoHFW budget for the financial year 2019–2020 is made up of nearly equal contributions from revenue (52%) and development (48%) budgets. These two health budget components have been formulated separately and use different approaches.

Budgeting for salaries remain fixed, while medicine and diet budgets at different levels use some set norms. Budgets are disbursed quarterly. Over the financial years of 2012–2016, the execution of the revenue budget was between 93% and 97%, on average, driven largely by high execution rates of wages and salaries. On average, 77%–80% (2017–2019) of the development budget has been executed; nutrition (47%) and drug administration (48%) programmes had low execution, while information systems (206%) and procurement (106%) had the highest budget execution rates.[74]

Recent health financing reforms

The Health Care Financing Strategy (HCFS) 2012–2032 proposes the creation of a social health protection scheme, and aims at improving resource generation, equity and access, as well as enhancing efficiency in resource allocation and utilization.[75] The scheme aims at securing financial protection for all segments of the population, starting with the poorest and expanding to the formal sector. As part of the HCFS Action Plan, an insurance scheme targeting the poor, called Shasthyo Shurokhsha Karmasuchi (SSK), has been implemented in three *upazilas* of Tangail district since 2017. People from lower income groups are provided with cards that grant free access to services with an annual ceiling per household.[76]

Bangladesh

Macro picture

Indicator	Latest year	Value
Total population (thousands)[1]	2020	164 689
Employment to population ratio, 15+, total (%) (national estimate)[2]	2017	55.8
GDP per capita growth (annual %)[2]	2019	7.0
GDP per capita (current US$)[2]	2019	1 856
General government revenue (% of GDP)[3]	2019	9.8
Tax revenue (% of GDP)[2]	2016	8.8
General government total expenditure (% of GDP)[3]	2019	15.1
Fiscal balance (revenue–expenditure) (% of GDP)	2019	-5.4
General government gross debt (% of GDP)[3]	2019	35.8
Poverty headcount ratio at US$ 1.90 a day (2011 PPP) (% of population)[2]	2016	14.5
Poverty headcount ratio at national poverty lines (% of population)[2]	2016	24.3

[1] United Nations, Department of Economic and Social Affairs, Population Division (2019). *World Population Prospects 2019: Volume II: Demographic Profiles.*

[2] World Bank Group. World Development Indicators, 2020. Washington, D.C.: 15 Oct 2020. https://databank.worldbank.org/source/world-development-indicators.

[3] IMF. *World Economic Outlook: A Long and Difficult Ascent*. Washington, D.C.: October 2020. https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020.

Progress towards universal health coverage

Fig. 2. SDG 3.8.1 Service Coverage Index (0–100)

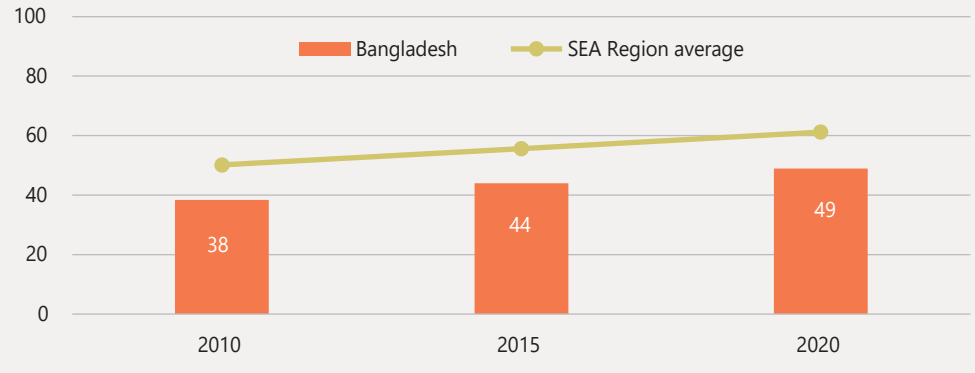
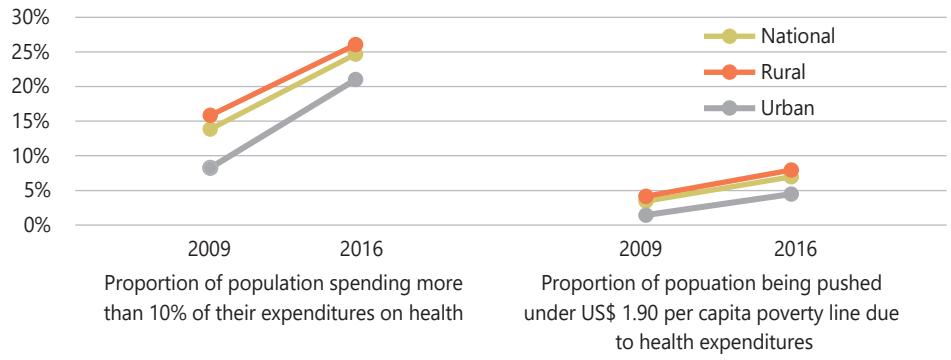


Fig. 3. SDG 3.8.2 Catastrophic and impoverishing incidence due to out-of-pocket expenditures on health



General health expenditure trends over the past decade

Fig. 4. Current health expenditures 2009–2018

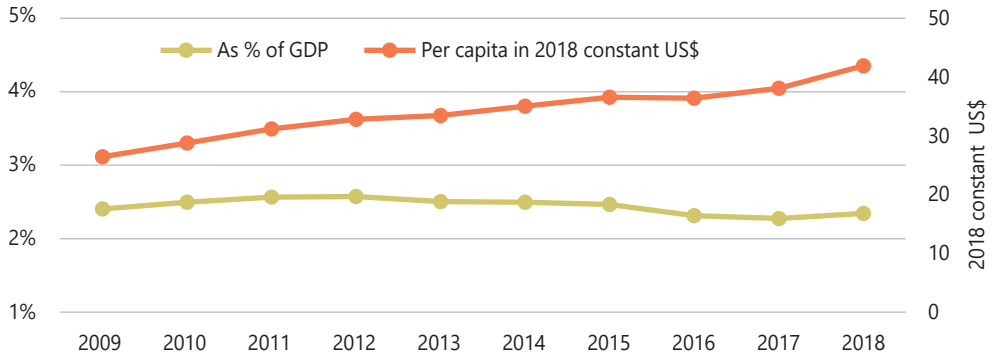


Fig. 5. Domestic government expenditures on health 2009–2018

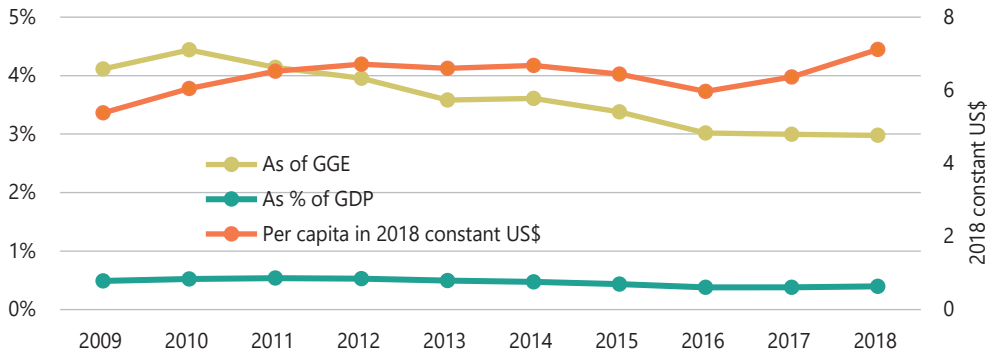
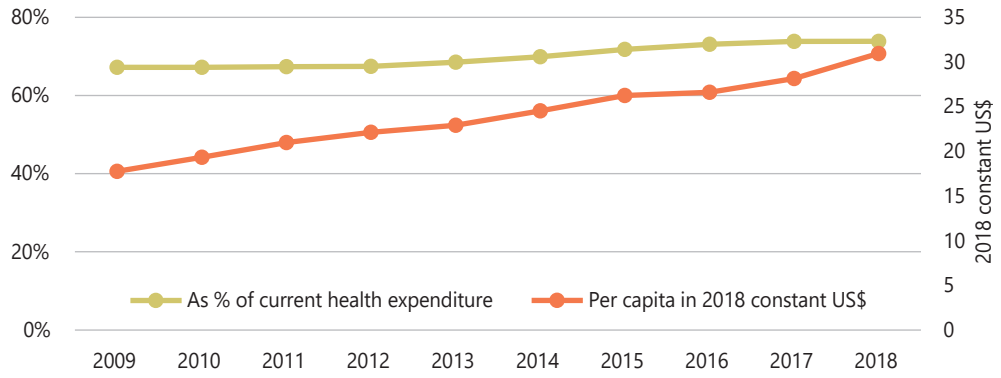


Fig. 6. Out-of-pocket spending on health (OOPS) 2009–2018

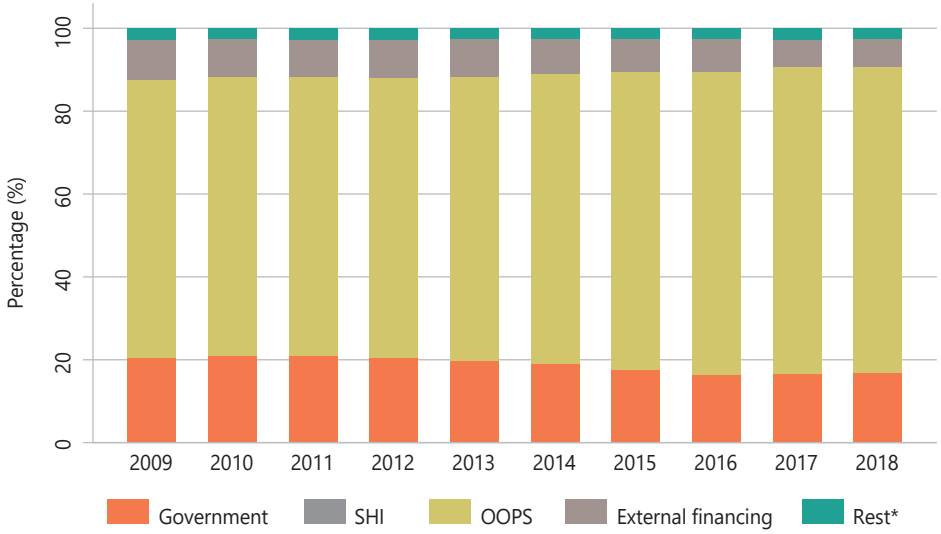


Primary health care expenditures

No data available

Composition of current health expenditures[a]

Fig. 7. Revenue sources of current health expenditures over the years



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

a "Ancillary services" and "medical goods" are independent consumptions that do not have a specific purpose (treatment, prevention, etc.) in themselves. Typical examples include laboratory services, imaging diagnosis, and patient transportation under "ancillary services" and pharmaceuticals (both prescribed and over-the-counter ones) as well as therapeutic goods (corrective glasses, hearing aids) under "medical goods". Consumption of such during a health-care contact are, therefore, lumped under other categories (i.e. curative care) and not separately reported.

Burden of disease and disease-specific government expenditures

Fig. 8. Burden of disease, 2019

Rank by disorder (2019)		DALYs (%)
1	Neonatal disorders	9.96
2	Stroke	8.11
3	Ischemic heart disease	7.13
4	Lower respiratory infections	3.97
5	Chronic obstructive pulmonary disease	3.36
6	Other musculoskeletal disorders	3.00
7	Depressive disorders	2.99
8	Diabetes mellitus	2.86
9	Diarrheal diseases	2.67
10	Low back pain	2.65
11	Congenital birth defects	2.42
12	Tuberculosis	2.32
13	Headache disorders	2.18
14	Road injuries	2.03
15	Cirrhosis and other chronic lever diseases	1.95
16	Dietary iron deficiency	1.69
17	Age-related and other hearing loss	1.63
18	Other malignant neoplasms	1.52
19	Gynecological diseases	1.50
20	Typhoid and paratyphoid	1.38
21	Blindness and vision loss	1.35
22	Anxiety disorders	1.13
23	Drowning	1.12
24	Chronic kidney disease	1.10
25	Maternal disorders	0.98

Infectious and parasitic diseases
Reproductive health
Injuries
Nutritional deficiencies
Noncommunicable diseases

Bhutan

Progress towards universal health coverage

Bhutan is making steady progress to achieve UHC. The UHC service coverage index grew from 47 in 2010 to 64 in 2020. Further, financial risk protection improved substantively where the proportion of population affected by catastrophic health expenditure declined from 4.01% in 2012 to 1.8% in 2017. In the same year, the percentage of people pushed into poverty because of out-of-pocket health payments was estimated at 0.01%, down from 0.04% in 2012 (under the daily US$ 1.90 per capita poverty line).[6]

Health system architecture and governance

Bhutan has a predominantly publicly financed and delivered health system. The service delivery is based on a three-tier structure, (i) basic health units (BHUs), sub-posts and satellite clinics at the primary level; (ii) district or general hospitals at the secondary level; and (iii) regional and national referral hospitals at the tertiary level. Private health businesses, as of now, are still limited to pharmacy outlets and selected diagnostic services. There are a few small and private voluntary health insurance (VHI) schemes in Bhutan.

Four institutions determine health financing policy in Bhutan. The Gross National Happiness Commission (GNHC) provides the national five-year plan, which guides the health sector in key result areas and plans. The Ministry of Finance manages the government Budget decisions to the health sector and institutions. The Ministry of Health (MoH) is a central player and defines the health financing policy directions, resource mobilization strategies, and provides oversight over several health facilities. It also provides technical guidance to district health offices.

It procures medicines, vaccines and supplies for the whole system, and provides support on public health, health information and others. The Bhutan Health Trust Fund (BHTF) is a semi-autonomous government body created in 1998 to ensure continued, sustainably financed, and timely supply of vaccines and essential medicines. The BHTF aims that these crucial components of primary health care services are regularly available.[77]

In 2008, administrative and financial powers and functions were shifted from central to local governments through a system of devolution. Still, the central MoH directly manages two regional referral hospitals, as well as three secondary-level facilities, while the District Health Authority manages the district hospitals and basic health units. District health offices are accountable to the district administration, and report to MoH on technical matters.

Raising revenue

Bhutan allocated 3.1% of GDP for health in 2018 – a moderate decline from 3.5% in 2009. Domestic government expenditure on health (GGHE-D) is 2.4% of GDP in 2018, with a slight decline from 2.6% in 2009. The GGHE-D is 7.6% of the general government expenditure (GGE) in 2018, and it has increased from 6.6% in 2009. The government budget revenue is the predominant source of financing for the health system in Bhutan, comprising about 80% of current health expenditure (CHE) in 2018.

The Bhutan Health Trust Fund mobilizes public revenues for health through contributions from potential donor countries, private and public organizations and financial institutions. It also receives donations from individuals, with matching contributions from the Royal Government, a 1% payroll contribution from formal sector workers, and other sources such as fundraising events.

Over the past decade, out-of-pocket expenditures on health have declined from 16.6% of CHE in 2009 to 13.2% of CHE in 2018. External donor financing remained below 10% of CHE (9.1% in 2009 and 6.1% in 2018). Voluntary health insurance (VHI) schemes account for 0.1% of CHE in 2018.[71]

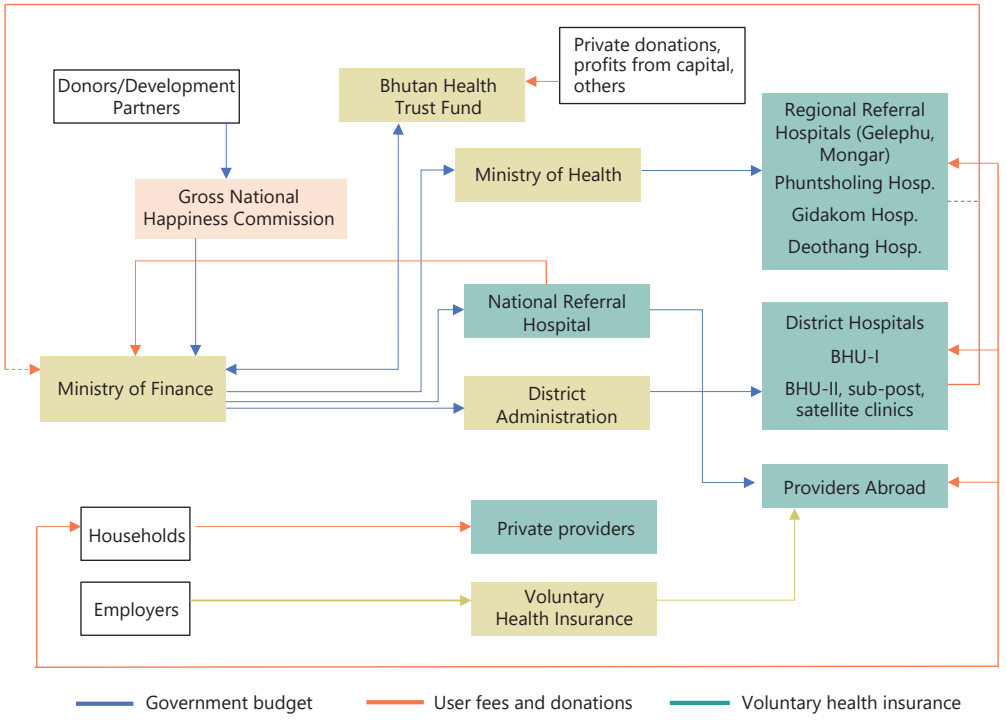
Pooling and flow of resources

The Ministry of Finance (MoF) of Bhutan is the main pooling institution for government health resources. It collects the general government Budget revenues and contributions from some donors. The MoF makes allocations to: i) local administrations; ii) the National Referral Hospital; and iii) MoH. The Bhutan Health Trust Fund is another pool of resources for health. According to the latest NHA 2017–2018, of the total public health sector budget, 78% was allocated to the central level (54% at MoH and 24% to the National Referral Hospital), and 22% was distributed to the district administrations.[78]

Benefits package

According to the 2008 Constitution of Bhutan, "the State shall provide free access to basic public health services in both modern and traditional medicine". Comprehensive services are provided to citizens through various levels of care, including treatment abroad if a particular service is not available in the country. There are some exceptions where user charges are applied, such as private rooms and after-hour consultations. VHI schemes largely cover medical care outside the country. Administratively, there is the Health Service Standards by the MoH, which is a list of services to be provided at each level of health care and used as general guidance.

Fig. 1. Simplified flow of health funds in Bhutan



Source: Adapted from Thinley S, Tshering P, Wangmo K, Wangmo K, Wangchuk N et al. (2017). The Kingdom of Bhutan Health System Review. World Health Organization. Regional Office for South-East Asia.

Purchasing arrangements

The MoF plays the role of purchaser for public sector providers (including the National Referral Hospital) and use line-item budgets. The payment covers personnel salaries, overheads, capital and recurrent expenditures to health facilities. The BHTF releases funds to MoH for procurement of vaccines, medicines and equipment.[78] The National Referral Hospital contracts overseas providers and pays according to itemized invoices. District and sub-district administrations directly pay salaries and operational costs of health facilities within the district network. Selected large hospitals charge patients for specific services, such as private rooms or after-hour consultations, on a fee-for-service basis.

Public financial management

The Budget process starts with the MoF preparing a multi-year rolling budget and forecast of central and local governments' expenditures, followed by the notification of annual ceilings for recurrent and capital expenditure. The MoH coordinates the bottom-up budgeting process within the sector. The MoH departments and divisions, as well as five regional and district hospitals, submit their budget proposals to MoF.

At the district level, health is one of the departments of the district administration, which coordinates the budgeting exercise. In general, public sector budgeting is reliant on a combination of past year expenditure and spending projections on new activities. Budget proposals for staff recruitment have to be based on the standard developed by the Civil Service Commission. The budget for medicines is governed by the "Annual Indent", whereby health facilities project their needs for the following year in terms of items and quantities based on past consumption and service output. Finally, the Budget proposals are negotiated with MoF, and compiled within the National Budget submission for Parliament's approval.

Budgets of all publicly funded institutions are disbursed electronically by the MoF based online-item invoices. The MoF also processes the execution of the share of donor funds channelled through the government financial system. Health facilities are supplied with medicines in kind, and do not administer an assigned budget.

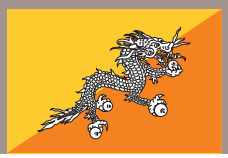
Overall government Budget execution was around 100% (104% in 2012–2013 and 98% in 2014–2015) between 2012 and 2015.[79] In the same period, execution of the MoH budget exceeded 100% every year (115% in 2012–2013). Although budgets are allocated to the local health system, most of the execution is done by the district administrator and reported within aggregated district budget execution data. Fee collections of large hospitals are deposited in MoF accounts and are not earmarked to the health sector.

Since 2014, the Prime Minister signs annual performance agreements with line ministries such as MoH as well as with local authorities to increase the transparency and accountability of public resources.

Recent health financing reforms

Since 2009, the main reform has been to decentralize the administrative and financial powers from the Central to local levels. District governments have become responsible for the use of the allocated resources, and to provide essential services, including health (from primary health care facilities to district hospitals). In addition, the National Referral Hospital has been granted the status of an autonomous budget unit; however, it is still subject to line-item budgeting and limited decision rights.

Bhutan



Macro picture

Indicator	Latest year	Value
Total population (thousands)[1]	2020	772
Employment to population ratio, 15+, total (%) (national estimate)[2]	2015	61.6
GDP per capita growth (annual %)[2]	2018	1.8
GDP per capita (current US$)[2]	2018	3243
General government revenue (% of GDP)[3]	2019	23.8
Tax revenue (% of GDP)[2]	2018	16.0
General government total expenditure (% of GDP)[3]	2019	25.0
Fiscal balance (revenue–expenditure) (% of GDP)	2019	-1.1
General government gross debt (% of GDP)[3]	2019	104.4
Poverty headcount ratio at US$ 1.90 a day (2011 PPP) (% of population)[2]	2017	1.5
Poverty headcount ratio at national poverty lines (% of population)[2]	2017	8.2

[1] United nations, Department of Economic and Social Affairs, Population Division (2019). *World Population Prospects 2019: Volume II: Demographic Profiles.*

[2] World Bank Group. World Development Indicators, 2020. Washington, D.C.: 15 Oct 2020. https://databank.worldbank.org/source/world-development-indicators.

[3] IMF. *World Economic Outlook: A Long and Difficult Ascent*. Washington, D.C.: October 2020. https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020.

Progress towards universal health coverage

Fig. 2. SDG 3.8.1 Service Coverage Index (0–100)

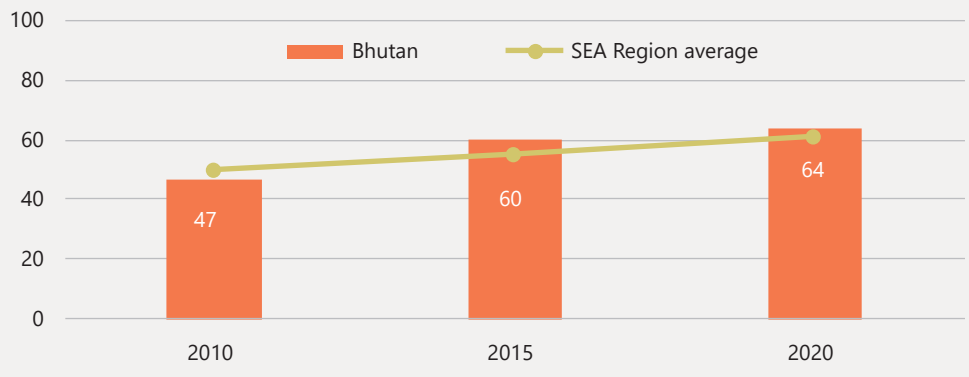
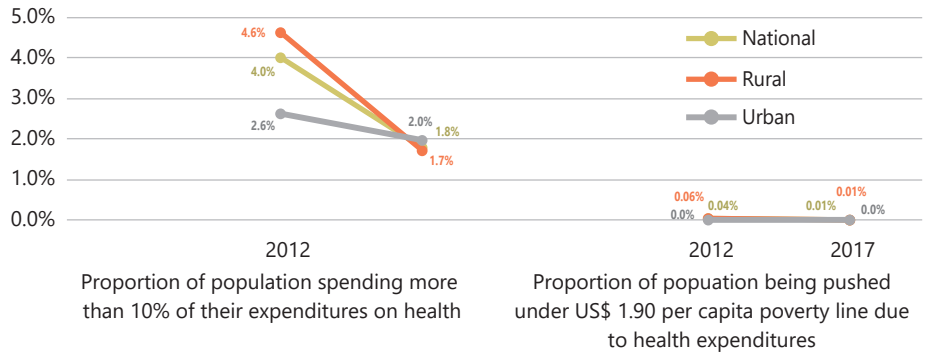


Fig. 3. SDG 3.8.2 Catastrophic and impoverishing incidence due to out-of-pocket expenditures on health



General health expenditure trends over the past decade

Fig. 4. Current health expenditures 2009–2018

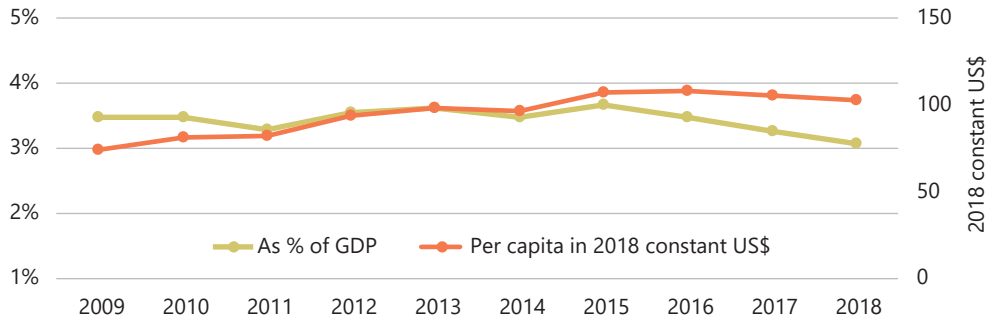


Fig. 5. Domestic government expenditures on health 2009–2018

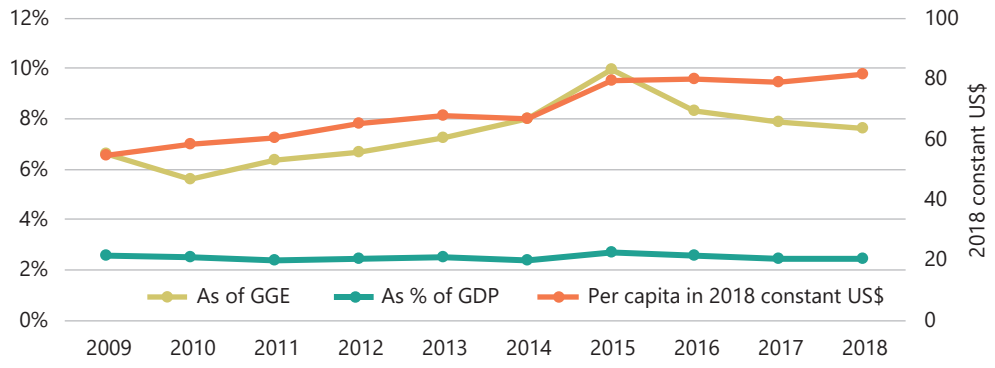
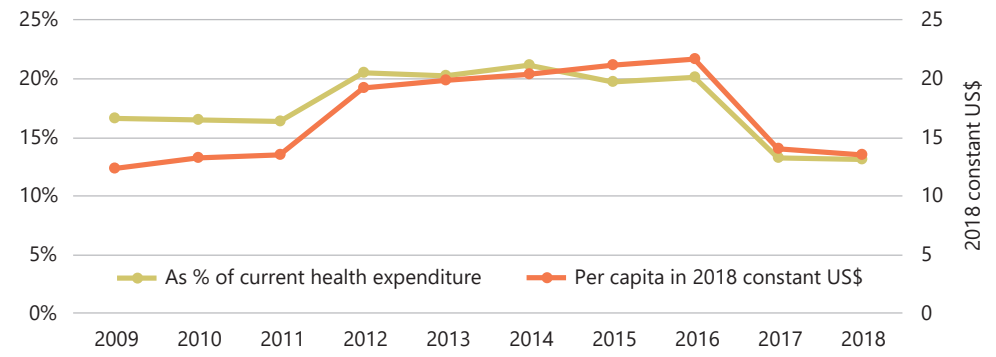
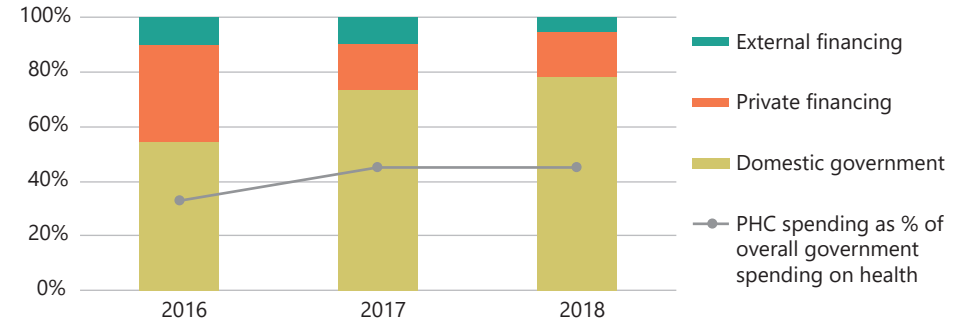


Fig. 6. Out-of-pocket spending on health (OOPS) 2009–2018



Primary health care expenditures[a]

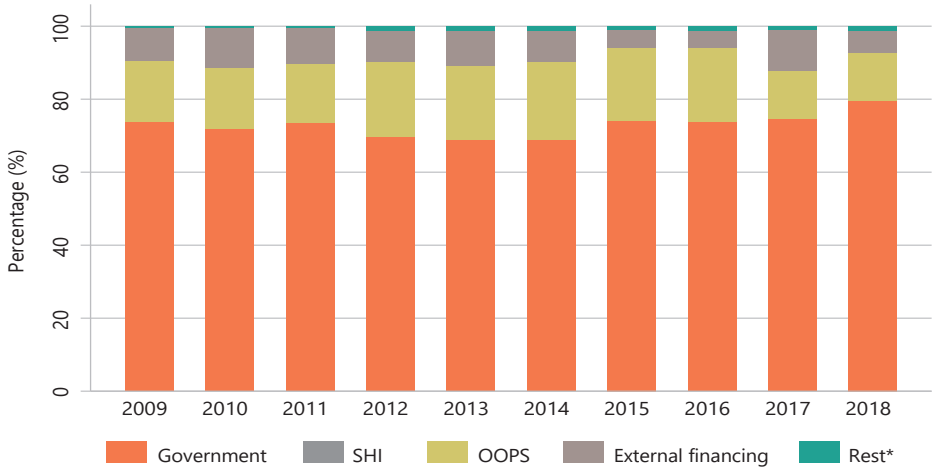
Fig. 7. Primary health care expenditures



a Primary health care measurement is entirely based on Health Care Functions classification. Details of the measurement can be found here: Global spending on health: a world in transition. Geneva: World Health Organization; 2019 (WHO/HIS/HGF/HFWorkingPaper/19.4).

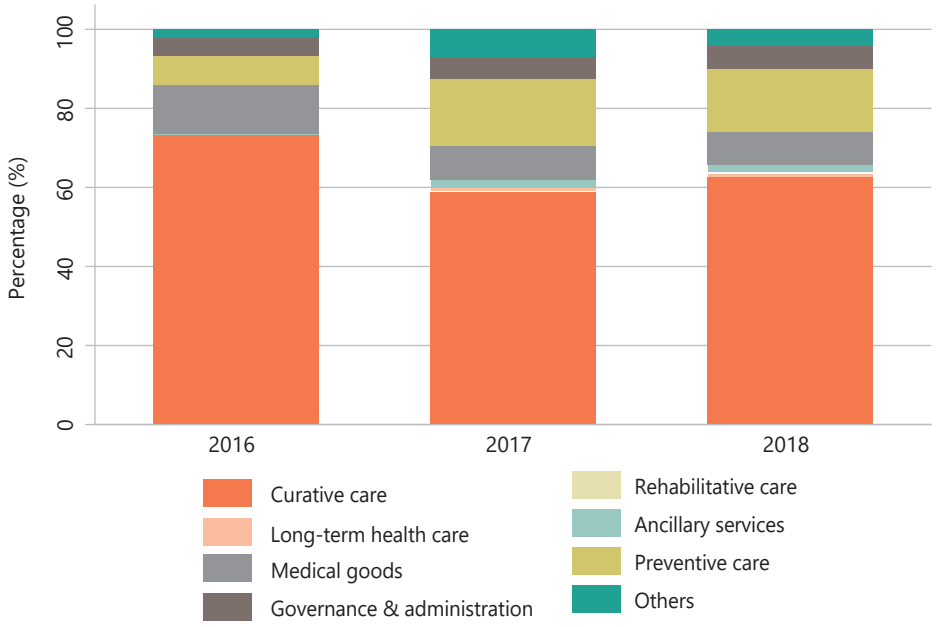
Composition of current health expenditures[b]

Fig. 8. Revenue sources of current health expenditures over the years



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

Fig. 9. Health expenditures by funtion



b "Ancillary services" and "medical goods" are independent consumptions that do not have a specific purpose (treatment, prevention, etc.) in themselves. Typical examples include laboratory services, imaging diagnosis, and patient transportation under "ancillary services", and pharmaceuticals (both prescribed and over-the-counter ones) as well as therapeutic goods (corrective glasses, hearing aids) under "medical goods". Consumption of such during a health-care contact are, therefore, lumped under other categories (i.e. curative care) and not separately reported.

Burden of disease and disease-specific government expenditures

In Bhutan, the biggest share of spenidng was on noncommunicable diseases (2018), and it was domestic government sources that finaced the majority of it.

Fig. 10a. Health spending by disease categories, and revenue sources for noncommunicable diseases, 2018

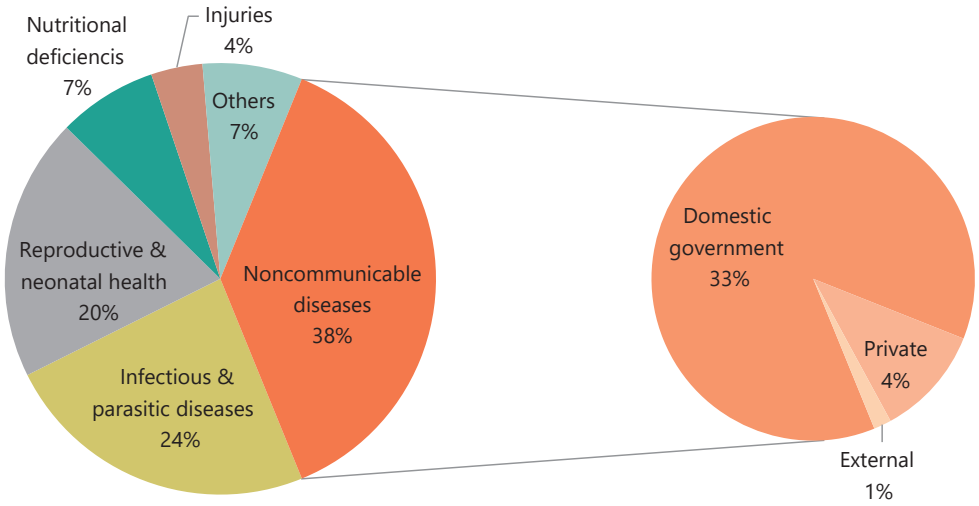


Fig. 10b. Burden of disease, 2019

Rank by disorder (2019)		DALYs (%)
1	Neonatal disorders	11.0
2	Ischemic heart disease	6.9
3	Chronic obstructive pulmonary disease	4.8
4	Stroke	3.5
5	Dietary iron deficiency	3.4
6	Lower respiratory infections	3.1
7	Diabetes mellitus	2.8
8	Cirrhosis and other chronic liver diseases	2.7
9	Road injuries	2.6
10	Low back pain	2.5
11	Depressive disorders	2.4
12	Diarrheal diseases	2.3
13	Other musculoskeletal disorders	2.3
14	Congenital birth defects	2.3
15	Chronic kidney disease	2.1
16	Headache disorders	2.1
17	Falls	1.8
18	Tuberculosis	1.7
19	Exposure to mechanical forces	1.6
20	Age-related and other hearing loss	1.5
21	Gynecological diseases	1.4
22	Anxiety disorders	1.1
23	Rheumatic heart disease	1.0
24	Typhoid and paratyphoid	1.0
25	Alcohol use disorders	1.0

Infectious and parasitic diseases
Reproductive health
Injuries
Nutritional deficiencies
Noncommunicable diseases

India

Progress towards universal health coverage

India's progress towards UHC has been improving steadily, with the UHC service coverage index increasing from 50 in 2010 to 63 in 2020. As for the financial risk protection, data from almost a decade ago show that the proportion of population facing catastrophic health expenditure increased from 13.3% in 2009 to 17.3% in 2011. In 2011, 4.2% of people were pushed into poverty because of out-of-pocket health expenditures, up from 3.6% in 2009 (under the daily US$ 1.90 per capita poverty line).

Health system architecture and governance

India is a decentralized country and the different layers of government – Union (Government of India), state, and local self-government (LSG) – provide health services in government-owned and government-run health facilities. Union and State governments also manage public health insurance schemes covering different population groups. The private sector is concentrated in urban settings and mainly provides hospital care. Two thirds of curative care is provided by private facilities.[80]

The Ministry of Health and Family Welfare has regulatory powers over the majority of health policy decisions, but is not directly involved in health-care delivery. At the state level, the Directorates of Health Services and the Departments of Health and Family Welfare are responsible for organizing and delivering health-care services to their populations.[81]

The Ministry of Health & Family Welfare (MoHFW) launched the National Health Mission (NHM) in 2005 to strengthen primary health care and implement national priorities and programmes (i.e. immunization, maternal care, communicable diseases control, etc.), by increasing funding to government facilities and public health interventions. In 2008, the Government launched the Rashtriya Swasthya Bima Yojana (RSBY), a non-contributory public insurance scheme to cover hospital care for people below the poverty line and vulnerable people. In 2018, the RSBY was further expanded into the Pradhan Mantri Jan Arogya Yojana (PM-JAY) to cover the bottom 40% of the poor and vulnerable population, though states can opt to provide greater coverage.

The policies and priorities are set by the Mission Steering Group (MSG) to the NHM.[82] The Union Minister of Health & Family Welfare chairs the MSG. At the state level, the Mission functions under the overall guidance of the State Health Mission (SHM) that is headed by the chief minister of the state. The State Health Society (SHS) carries out the functions under the Mission and is headed by the Chief Secretary. The District Health Mission (DHM)/City Health Mission (CHM) would be led by the head of the local self-government. Every district will have a District Health Society (DHS), which will be headed by the District Collector.

PM-JAY is managed by the National Health Authority, an autonomous body accountable to an 11-member board chaired by the Union Minister of Health & Family Welfare. At the state level, PM-JAY is managed by State Health Agencies (SHA) or an existing agency, trust, or any other society that can administer the programme. The SHA is responsible for implementation of PM-JAY in the state headed by a Chief Executive Officer. The SHA can hire an implementation support agency (ISA) such as an insurance company to perform the required tasks to operationalize the scheme.

In addition, the MoHFW manages the Central Government Health Scheme to provide social health protection for central government employees, dependents and pensioners. Another important public insurance scheme is the Employees' State Insurance Scheme, managed by the Employee's State Insurance Corporation, a statutory and autonomous body under the Ministry of Labour and Employment. This scheme covers public and private sector workers in companies with 10 or more employees. The Indian private voluntary health insurance market covers 1.7% of the population.[83]

Raising revenue

The shares of current health expenditure (CHE) and domestic government expenditure on health (GGHE-D) in the country's GDP have remained unchanged over the past decade. In 2018, the CHE was estimated at 3.5% of GDP and GGHE-D stood at 1% of GDP. GGHE-D represented about 3% of general government expenditure in 2009–2018. In 2018, 23.4% of CHE was financed by the government Budget, down from 24.7% in 2009.[71]

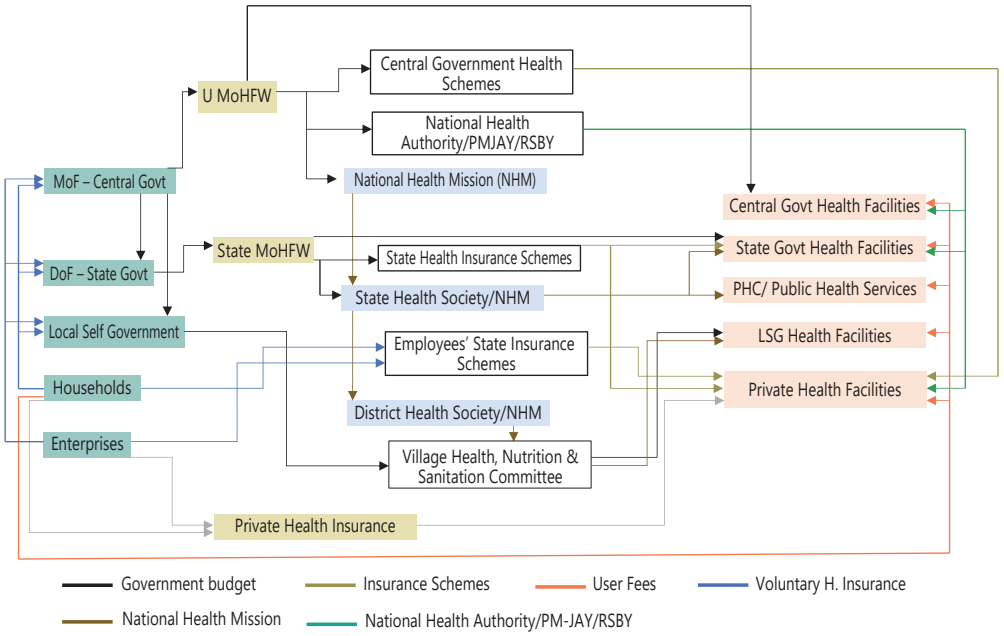
Both NHM and PMJAY are co-financed by Central (60% contribution) and state government (40% contribution) budgets, with few exceptions. Under the Central Government Health Scheme, beneficiaries are not subject to premium payments. For Employees' State Insurance schemes, both employees and employers share the premium contribution, with 0.75% and 3.25% of the wages respectively.[84]

Out-of-pocket expenditures is the largest source of health financing in India, comprising 62.7% of the CHE in 2018, down from 66.8% in 2009. Private voluntary health insurance and other private revenues from corporations and NGOs contributed 9.7% of CHE in 2018.[71]

Pooling and flow of resources

MoHFW is the main pooling institution in the health sector, complemented by the state health institutions. Sub-pools include PMJAY, NHM and other state insurance schemes at the state level (Fig. 1). Of the MoHFW's budget for the financial year 2020–2021, the NHM budget constitutes 51.4% and PM-JAY's is 9.8%.[85] The Central Government Health Scheme amounts to just above 2% of the MoHFW budget.

Fig. 1. Simplified flow of funds in India health sector



Source: Adapted from World Health Organization. Regional Office for South-East Asia. (2017). Health financing profile 2017: India. World Health Organization. Regional Office for South-East Asia. https://apps.who.int/iris/handle/10665/259642."

Benefits package

The services included in each package depend on the insurance scheme. Under the PM-JAY, secondary and tertiary care are covered but not outpatient care. The Central Government Health Scheme and Employees' State Insurance Corporation cover all types of care, including outpatient care and drugs. Under other publicly subsidized insurance coverage, all secondary, tertiary, pre-hospital and post-hospitalization treatment are covered.[82]

PM-JAY implements 867 packages split into 1573 procedures that include surgical procedures, medical and day care treatments, as well as costs of medicines and diagnostics within a ceiling of INR 500 000 (approximately US$ 6800) per enrolled family per year.[86]

With NHM, comprehensive primary health care (CPHC) includes a package of health services that cover both maternal and child health services, and communicable and noncommunicable diseases, including free essential drugs and diagnostic services (Table 1).[87]

Table 1. CPHC package of health services

1. Care in pregnancy and childbirth
2. Neonatal and infant health services
3. Childhood and adolescent health-care services
4. Family planning, contraceptive services, and other reproductive health-care services
5. Management of communicable diseases
6. General outpatient care for active simple illnesses and minor ailments
7. Screening, prevention, control, and management of noncommunicable diseases
8. Care for common ophthalmic and ENT problems
9. Basic oral health care
10. Elderly and palliative health-care services
11. Emergency medical services including burns and trauma
12. Screening of basic management of mental health ailments.

The package is being implemented by converting existing primary health care facilities into about 150 000 health and wellness centres (HWC) across India.

Health and wellness centres will deliver CPHC to address the primary health care needs of the entire population in close proximity to their communities. As on 31 March 2020, a total of 38 595 HWCs were functional.[88]

Purchasing arrangements

The MoHFW allocates funds directly to the centrally administered health facilities (hospitals) and health programmes under its aegis. The same approach is used by the State Department of Health and Family Welfare (DoHFW). Government health facilities, either Central, state/territory or LSG, are paid by line-item budgets set with an incremental approach. The SHMs and DHSs allocations to primary health care and LSG facilities are based on service targets, proposals in infrastructure, equipment, medicines and supplies, and operational and staff costs.

Health workers receive fixed salaries. Introduction of performance-related incentives for the HWC workers is underway.[89] Under PM-JAY, the SHAs purchase services from public and private hospitals that are empanelled based on general and specific criteria. NHA implements specified package rates to pay providers and states. State health insurance schemes can keep their own rates for all the packages. However, they are required to adhere to the mandatory 1391 procedures as specified on the PM-JAY list. Currently, most states follow NHA package rates. Hospitals submit claims and get reimbursed according to per diem payments for medical packages and case payments for surgical procedures. Private health-care providers charge fees for services to individual users according to their own itemized bills.

Public financial management

For NHM, budgeting is led by the state health societies, based on overall resource envelopes for the state and the planning guidelines by the Government of India. There is also a bottom-up annual planning and budgeting process, from LSGs to state-level agencies based on past year performance and budget execution. SHSs review the respective plans and budgets and consolidate for submission to the Central NHM.

In the health sector, transfers that were executed within the sector prior to 2014–2015 (i.e. NHM funds that were transferred to the state health societies), are now all disbursed through the State treasury.[89] Execution of MoHFW's regular Budget is usually above 90%.[90] State-level execution of the NHM budget is lower, at around 55% with large territorial variability observed in 2016–2017.[91] In order to ensure timely disbursement of funds, PM-JAY implemented changes to the public finance procedures on flow of funds. First, the Central and state governments/governments of Union Territories (UTs) open a separate designated escrow account for the scheme and then NHA and state/UT-level SHAs ensure that funds are disbursed on time to agencies lower in the order.[92] The NHA implements digital-based transaction processes to speed up the execution of the planned Budget. Accordingly, the claim should be settled no later than 15 days[93] after the hospital submits it.

Recent health financing reforms

The National Health Mission[a] created in 2005 aimed at increasing coverage of priority health programmes across the country. Following this, with the National Health Policy enacted in 2017, a new impetus for reform resulted in the establishment in 2018 of Ayushman Bharat – with the purpose of supporting the country to move towards universal health coverage. This is an umbrella flagship scheme that includes both a primary health care and a secondary and tertiary care[b] (hospital) component. The conversion of existing PHC facilities into health and wellness centres forms part of the former, while the latter entails the creation of PM-JAY. PM-JAY aims to cover 500 million people and is free for patients at the point of delivery. It includes public and private hospitals.[94]

a The Mission started as the National Rural Health Mission, then the National Urban Health Mission was created and finally the two were combined into the National Health Mission.

b Only inpatient care, no outpatient services.

India

Macro picture

Indicator	Latest year	Value
Total population (thousands)[1]	2020	1 380 004
Employment to population ratio, 15+, total (%) (national estimate)[2]	2018	45.4
GDP per capita growth (annual %)[2]	2019	4.0
GDP per capita (current US$)[2]	2019	2104
General government revenue (% of GDP)[3]	2019	19.3
Tax revenue (% of GDP)[2]	2018	12.0
General government total expenditure (% of GDP)[3]	2019	27.5
Fiscal balance (revenue–expenditure) (% of GDP)	2019	-8.2
General government gross debt (% of GDP)[3]	2019	72.3
Poverty headcount ratio at US$ 1.90 a day (2011 PPP) (% of population)[2]	2011	22.5
Poverty headcount ratio at national poverty lines (% of population)[2]	2011	21.9

[1] United nations, Department of Economic and Social Affairs, Population Division (2019). *World Population Prospects 2019: Volume II: Demographic Profiles.*

[2] World Bank Group. World Development Indicators, 2020. Washington, D.C.: 15 Oct 2020. https://databank.worldbank.org/source/world-development-indicators.

[3] IMF. *World Economic Outlook: A Long and Difficult Ascent*. Washington, D.C.: October 2020. https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020.

Progress towards universal health coverage

Fig. 2. SDG 3.8.1 Service Coverage Index (0–100)

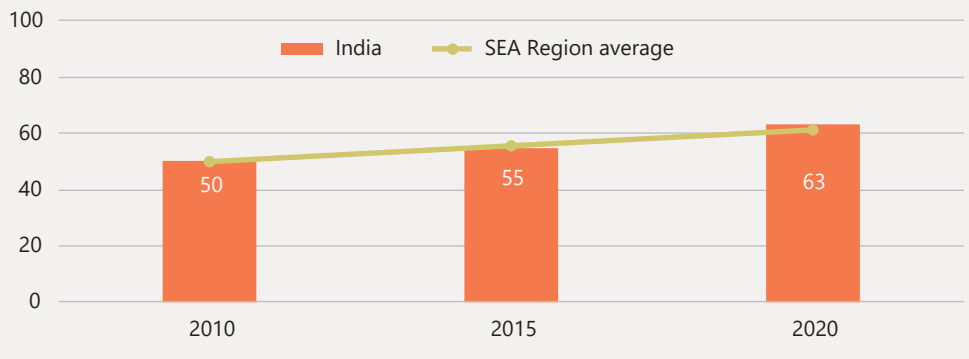
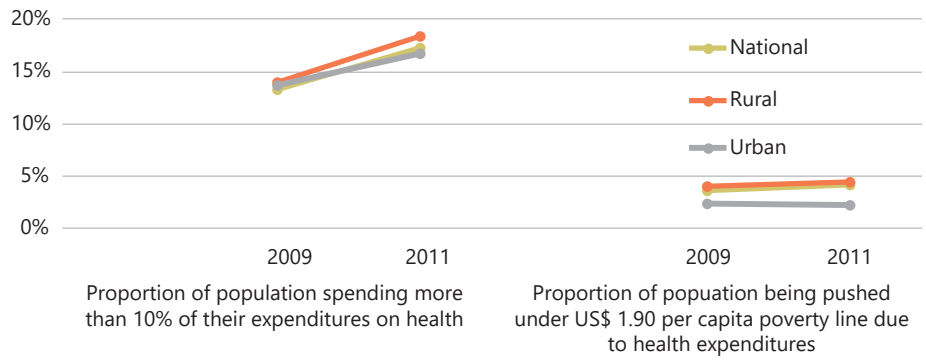


Fig. 3. SDG 3.8.2 Catastrophic and impoverishing incidence due to out-of-pocket expenditures on health



General health expenditure trends over the past decade

Fig. 4. Current health expenditures 2009–2018

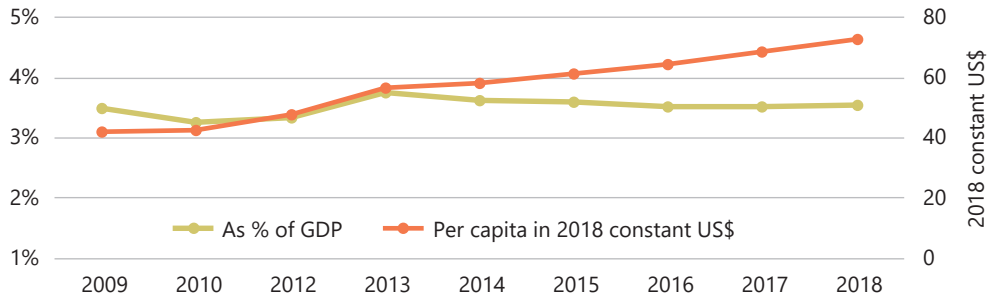


Fig. 5. Domestic government expenditures on health 2009–2018

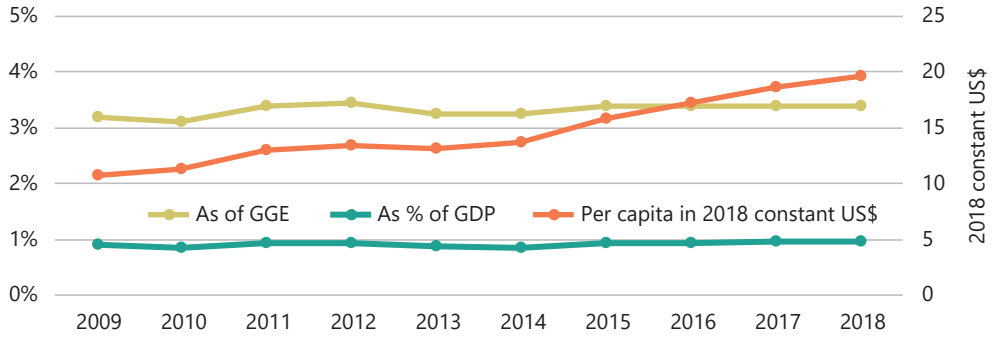
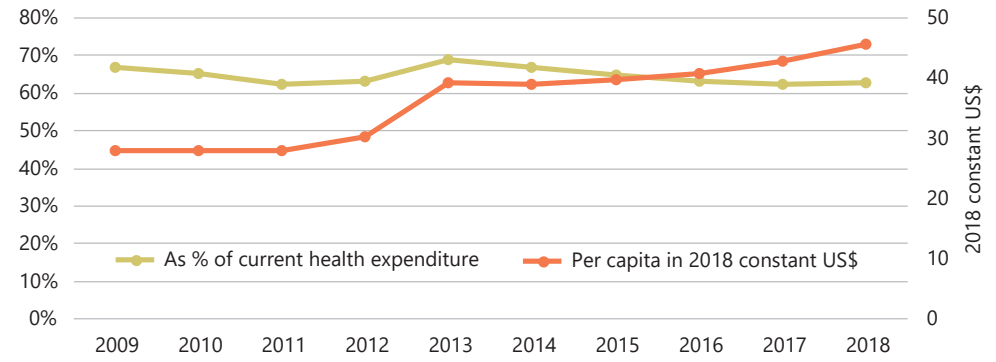
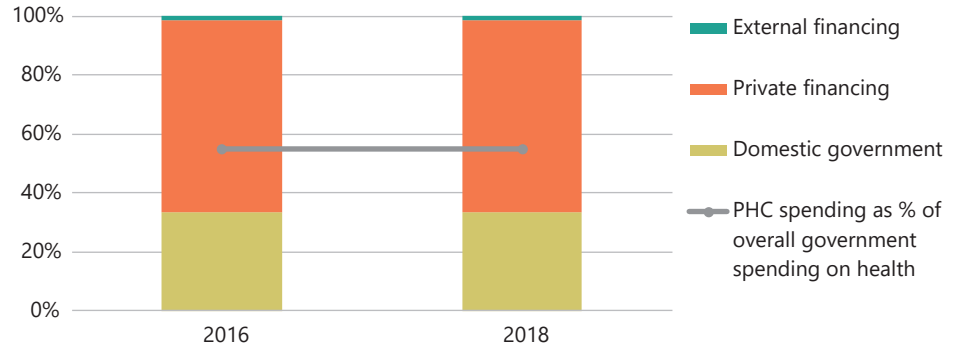


Fig. 6. Out-of-pocket spending on health (OOPS) 2009–2018



Primary health care expenditures[c]

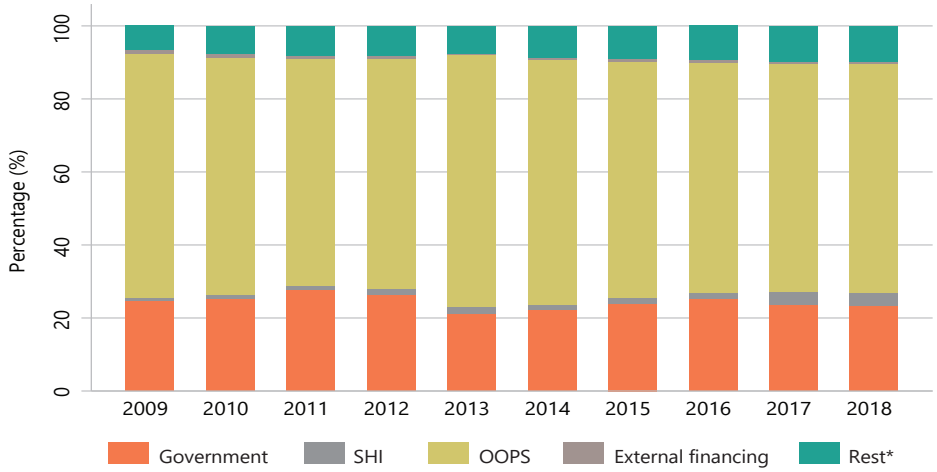
Fig. 7. Primary health care expenditures



c Primary health care measurement is entirely based on the health care functions classification. Details of the measurement can be found here: Global spending on health: a world in transition. Geneva: World Health Organization; 2019 (WHO/HIS/HGF/HFWorkingPaper/19.4).

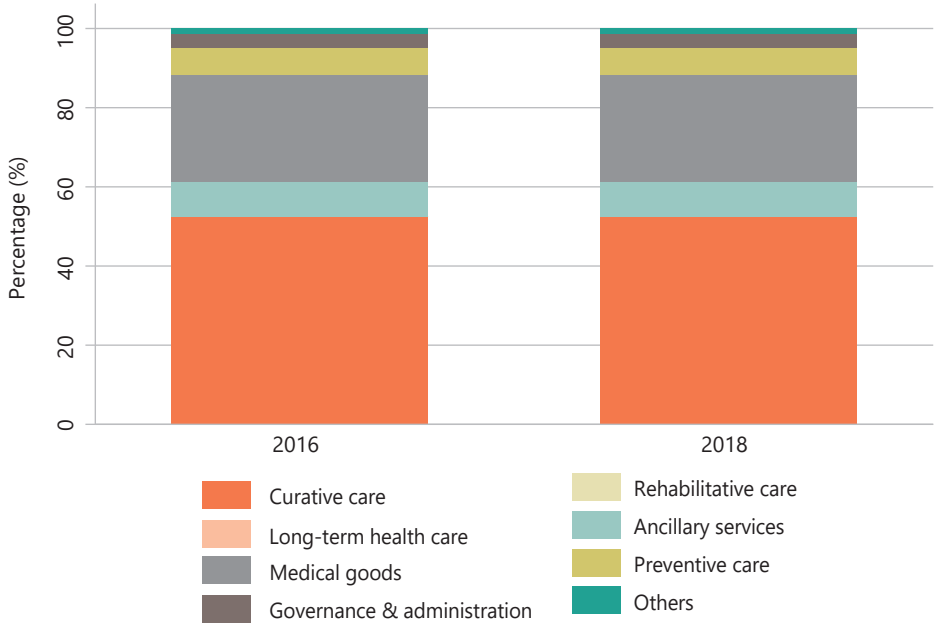
Composition of current health expenditures[d]

Fig. 8. Revenue sources of current health expenditures over the years



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

Fig. 9. Health expenditures by funtion



d "Ancillary services" and "medical goods" are independent consumptions that do not have a specific purpose (treatment, prevention, etc.) in themselves. Typical examples include laboratory services, imaging diagnosis, and patient transportation under "ancillary services", and pharmaceuticals (both prescribed and over-the-counter ones) as well as therapeutic goods (corrective glasses, hearing aids) under "medical goods". Consumption of such during a health-care contact are, therefore, lumped under other categories (i.e. curative care) and not separately reported.

Burden of diseases and disease-specific government expenditures

Fig. 10. Burden of diseases, 2019

Rank by disorder (2019)		DALYs (%)
1	Neonatal disorders	9.25
2	Ischemic heart disease	7.97
3	Chronic obstructive pulmonary disease	4.55
4	Diarrheal diseases	4.30
5	Lower respiratory infections	3.97
6	Stroke	3.71
7	Tuberculosis	3.35
8	Road injuries	3.33
9	Diabetes mellitus	2.73
10	Dietary iron deficiency	2.48
11	Self-harm	2.23
12	Other musculoskeletal disorders	2.12
13	Falls	2.09
14	Cirrhosis and other chronic liver diseases	2.06
15	Depressive disorders	1.80
16	Headache disorders	1.79
17	Congenital birth defects	1.61
18	Chronic kidney disease	1.61
19	Low back pain	1.60
20	Age-related and other hearing loss	1.46
21	Blindness and vision loss	1.27
22	Asthma	1.25
23	Gynecological diseases	1.18
24	Typhoid and paratyphoid	1.02
25	Rheumatic heart disease	0.98

Infectious and parasitic diseases
Reproductive health
Injuries
Nutritional deficiencies
Noncommunicable diseases

Indonesia

Progress towards universal health coverage

Indonesia is making steady progress towards universal health coverage. The UHC service coverage index increased from 45 in 2010 to 62 in 2020. Furthermore, the level of financial risk protection improved, as the share of population affected by household catastrophic health expenditure reduced from 3.9% in 2011 to 2.7% in 2018. In 2015, 0.8% of the population were pushed into poverty because of out-of-pocket health expenditures, a little less than 1.2% for the same in 2011 (under the daily US$ 3.20 per capita poverty line).[6]

Health system architecture and governance

Since the late 1960s, three public social protection schemes were created at the national level to cover civil servants and the military/police (*Askes*), the private sector (*Jamsostek*) and the poor (*Jamkesmas*). The *Jamkesmas* has been further replicated at the district level in more than 300 local schemes (*Jamkesda*). In 2014, the schemes merged into National Health Insurance Programme (*Jaminan Kesehatan Nasional or* JKN) (Table 1). Prior to the JKN merger, Askes covered 7% of the Indonesian population, *Jamsostek* covered 3%, and the central and local schemes for the poor covered 35% and 19% of the population, respectively. By the end of 2019, the JKN reached 222.1 million members (83% of the population), including 96 million poor people.[95]

Table 1. Government insurance schemes prior to JKN

Scheme	Coverage	Inception	Integration into JKN
Askes	Public sector (civil servants), military and police	1968	2014
TNI-Polri	Military and police	1968	2014
Jamsostek	Private formal sector	1992	2014
Jamkesmas	Poor	2005	2014
Jamkesda	Poor	2005	2019

The Social Health Insurance Agency for Health (BPJS-K) manages the JKN and is appointed by and accountable to H.E. the President of Indonesia. BPJS-K is a non-public entity supervised by Dewan Jaminan Sosial Nasional (DJSN), or the National Social Security

Board. DJSN members are a combination of government officials, community members, and representatives of employee associations and employer associations who are appointed by the President.[96]

Raising revenue

Current health expenditure (CHE) was estimated at just 2.9% of GDP in 2018, with little changes since 2009 (2.7% of GDP). While there was a slight increase in domestic government expenditure on health (GGHE-D) as share of GDP from 0.9% in 2009 to 1.4% in 2018; the increase was more substantial when analysing GGHE-D as a share of general government expenditure, which went up from 5.4% in 2009 to 8.5% in 2018.

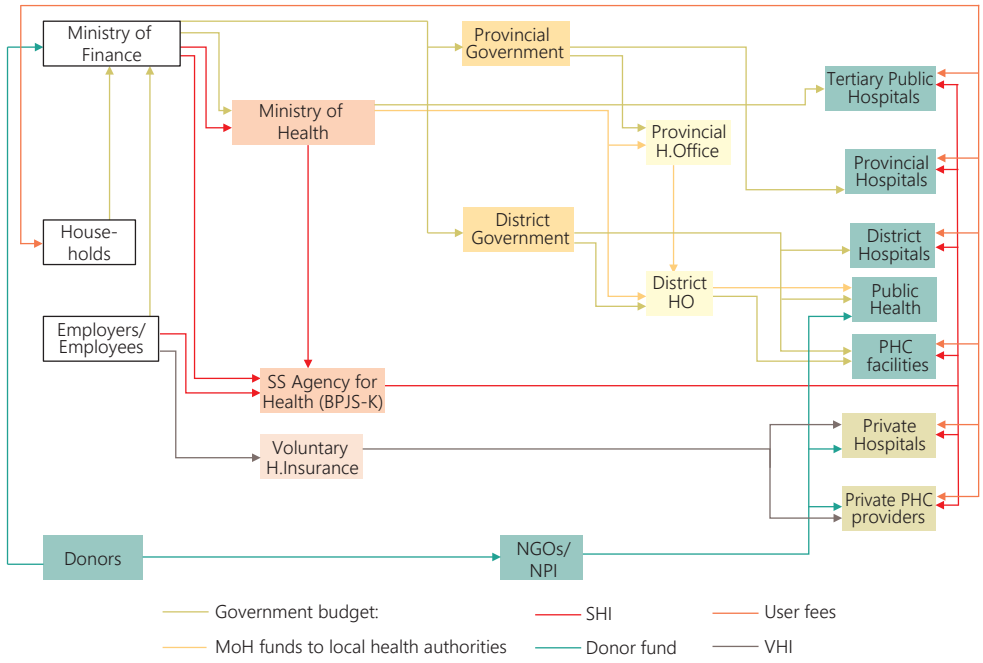
Almost half of the resources spent on health were raised publicly through the government Budget and compulsory social security schemes in 2018. The government Budget amounts to 36.1% and social health insurance contributes 13.2% to the CHE in 2018. More than one third (34.9%) of CHE is borne by out-of-pocket spending on health in 2018, down from 48.1% of CHE in 2009.[71]

JKN is funded through three different revenue streams. In the formal sector, the premium/contribution is levied as a percentage of employee salaries. In the public and private sectors, 4% is paid by the employer and 1% by the employee, as of 2019. The government Budget transfers cover membership of poor and near-poor through fixed monthly amounts per member (IDR 42 000 in 2019). Self-insured informal and non-salaried workers pay in fixed amounts (between IDR 25 000 and IDR 80 000 per person per month) based on the type of coverage for the three levels of the benefit package.[97]

Pooling and flow of resources

The two main pooling schemes are the government health budget and social health insurance. Since decentralization in 1999, the government health budget is divided into central (MoH and other ministries) and subnational/local components. BPJS-K is managed as a single trust fund (*Dana Amanat*), which is pooled from the contributions/premiums of a whole population, including government funds.[98]

Fig. 1. Simplified flow of funds in Indonesia health sector



Source: Adapted from Mahendradhata Y, Trisnantoro L, Listyadewi S, Soewondo P, Marthias T, Harimurti P, Prawira J, et al. The Republic of Indonesia Health System Review. Vol.7 No.1. New Delhi: World Health Organization, Regional Office for South-East Asia, 2017.

Benefits package

With the three government health insurance schemes merged, benefit packages were also unified, creating one comprehensive JKN benefit package.

Table 2. JKN Benefit package

Level of care	Types of services
Primary care	Primary care coverage includes: (i) promotive/preventive services; (ii) examination, treatment, and medical consultation; (iii) non-specialist medical treatment, both operative and nonoperative; (iv) medicine, medical consumables and materials; (v) blood transfusion in accordance with medical needs; (vi) laboratory diagnostic primary level; and (vii) primary hospitalization in accordance with medical indications.
Secondary and tertiary care	Secondary and tertiary care coverage includes: (i) examination, treatment and specialist consultation by a specialist and subspecialty; (ii) specialist medical treatment in accordance with the medical indications; (iii) drug services, medical consumables and materials; (iv) advanced diagnostic services in accordance with medical indications; (v) medical rehabilitation; (vi) blood services; (vii) forensic medical services; (viii) mortuary in health facilities; and (ix) non-intensive inpatient care; and (x) intensive care.

JKN offers a comprehensive benefits package based on medical indications, covering outpatient and inpatient care at the primary level up to the tertiary hospital level, excluding only a few types of services that are partially covered and fully uncovered based on the coverage type of the members.

Some medical assistive devices and equipment (such as eyeglasses, hearing aids and wheelchairs) are included in the benefits package, but with an upper limit determined by value or quantity. There is no upper ceiling applied under BPJS-K in relation to care provided in accordance with protocol guidelines. The policy forbids co-payments; however, additional payments may be required for non-medical benefits such as a higher class of hospital admission.[97] There is an explicit list of excluded services, namely, cosmetic surgery, orthodontia, infertility services and drug addiction-related conditions, among others.[98]

Purchasing arrangements

There are three purchasers in the Indonesian health system: BJPS-K, MoH and subnational local government authorities. The MoH provides funds for frontline services (*puskesmas,* or primary health centres), including public health activities, through a co-financing scheme with local governments. Provincial and district hospitals are funded directly by the respective local governments, while the District Health Office acts as a purchaser for primary health care facilities.

Public or government health facilities are paid by a mix of payment mechanisms. MoH and subnational local governments pay for salaries and operational costs through line-item budgets. These are complemented with BJPS-K payments that are used to cover salaries of non-civil servants, medicines and other expenses. Public primary health-care facilities are paid by capitation and hospitals according to the diagnostic-related groups (DRG). Privately paid out-of-pocket payments to government health facilities are usually charged for improved amenities.

More than 60% of hospitals empanelled with BJPS-K are private. BPJS contracts health facilities through a selection process. These providers are paid with the same mechanism as government facilities, but with higher payment rates to compensate for the government Budget allocated to public facilities.

Public financial management

Government planning and budgeting are managed by two institutions: the Ministry of Planning and Ministry of Finance. Allocation to health is determined by the Ministry of Planning in consultation with MoF and MoH. The MoH budgeting is structured in nine programmes, the largest of which is the JKN support (40% of the Budget, to be transferred to BJPS-K), followed by the Health Service Development programme (to support tertiary

hospitals and local health authorities), including human resources development, disease prevention, pharmaceuticals and research.[99]

The provincial and district health agencies prepare plans and budget proposals, which are largely based on the same factors as at central level (i.e. historical allocations, requests and proposals originating from the bottom-up planning process) and responses to identified local priorities, often determined by the political party in power.[97]

Donor funding, usually focused on mother-and-child care and control of selected communicable diseases, are disbursed to health facilities and providers through international (such as the Global Fund) and national nongovernmental bodies, and MoH. These funds are integrated into annual plans and budgets. Government Budget execution (including the health sector) in 2016 was 89.5%, with lower execution (75%) of the capital expenditure. The MoH budget execution was 83% in 2014, 110% in 2015 and 89% in 2016.[100]

Recent health financing reform

The main health financing reform initiated in Indonesia has been the merging of the existing government health insurance schemes into the JKN in 2014. This has been a substantive step in the country's collective efforts to move towards universal health coverage.

Indonesia

Macro picture

Indicator	Latest year	Value
Total population (thousands)[1]	2020	273 524
Employment to population ratio, 15+, total (%) (national estimate)[2]	2019	65.7
GDP per capita growth (annual %)[2]	2019	3.9
GDP per capita (current US$)[2]	2019	4 136
General government revenue (% of GDP)[3]	2019	14.2
Tax revenue (% of GDP)[2]	2018	10.2
General government total expenditure (% of GDP)[3]	2019	16.4
Fiscal balance (revenue–expenditure) (% of GDP)	2019	-2.2
General government gross debt (% of GDP)[3]	2019	30.5
Poverty headcount ratio at US$ 3.20 a day (2011 PPP) (% of population)[2]	2018	21.5
Poverty headcount ratio at national poverty lines (% of population)[2]	2018	9.8

[1] United nations, Department of Economic and Social Affairs, Population Division (2019). World Population Prospects 2019: Volume II: Demographic Profiles.

[2] World Bank Group. World Development Indicators, 2020. Washington, D.C.: 15 Oct 2020. https://databank.worldbank.org/source/world-development-indicators.

[3] IMF. World Economic Outlook: A Long and Difficult Ascent. Washington, D.C.: October 2020. https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020.

Progress towards universal health coverage

Fig. 2. SDG 3.8.1 Service Coverage Index (0–100)

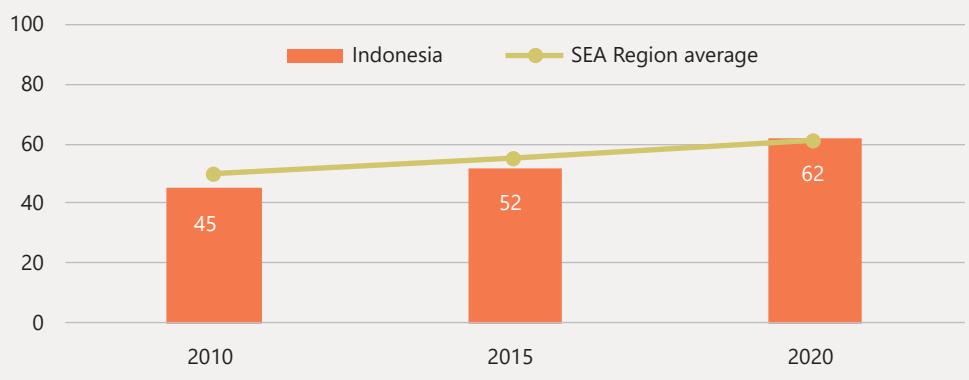
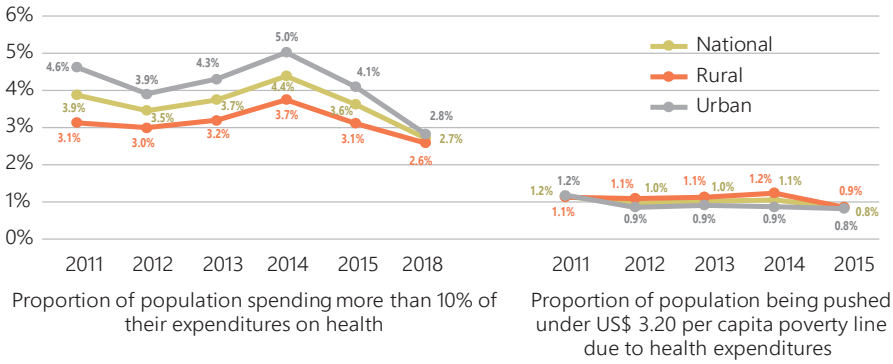


Fig. 3. SDG 3.8.2 Catastrophic and impoverishing incidence due to out-of-pocket expenditures on health



General health expenditure trends over the past decade, compared to regional and income group averages

Fig. 4. Current health expenditures 2009–2018

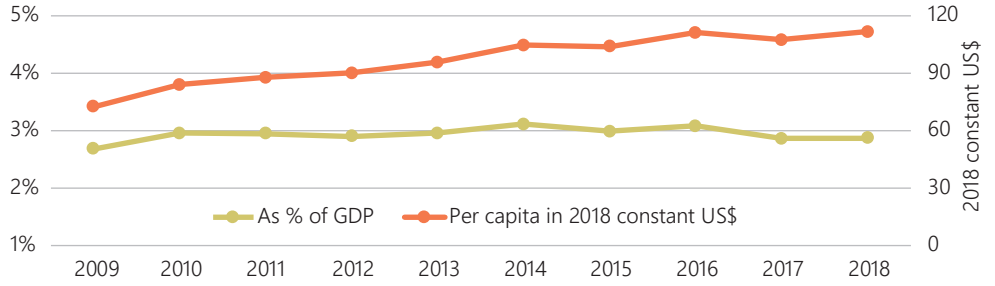


Fig. 5. Domestic government expenditures on health 2009–2018

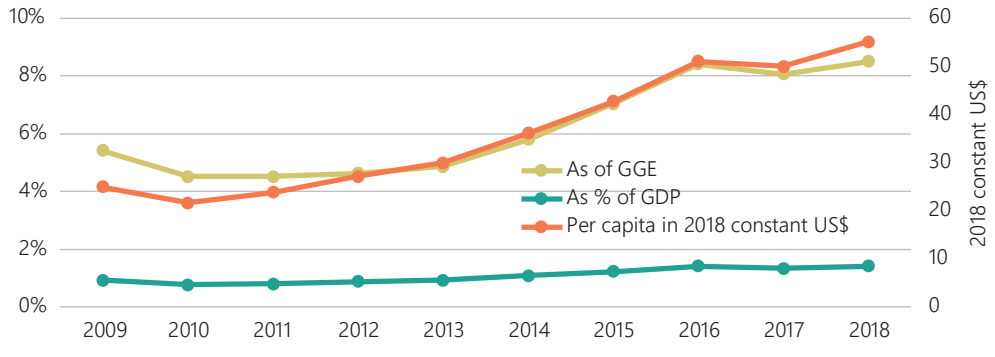
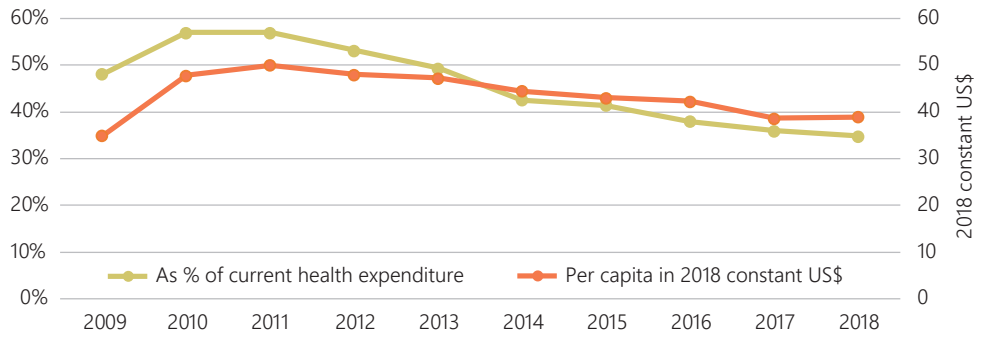


Fig. 6. Out-of-pocket spending on health (OOPS) 2009–2018

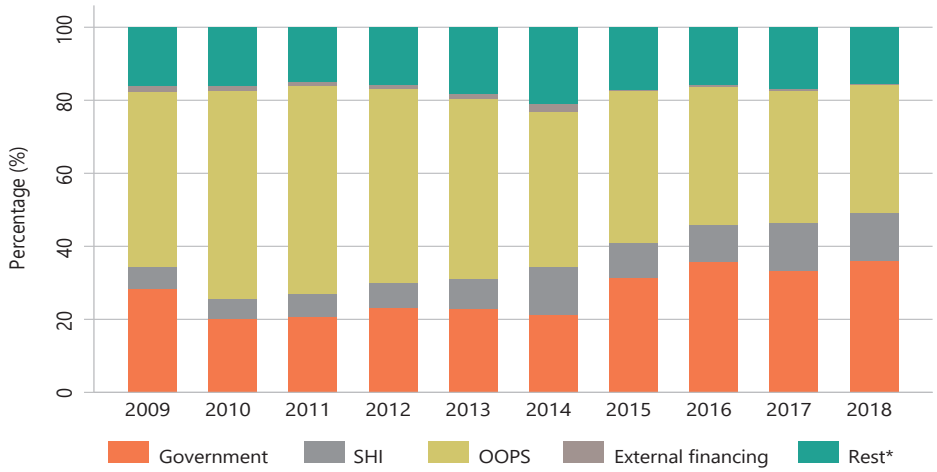


Primary health care expenditures

No data available

Composition of current health expenditures[a]

Fig. 7. Revenue sources of current health expenditures over the years



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

a "Ancillary services" and "medical goods" are independent consumptions that do not have a specific purpose (treatment, prevention, etc.) in themselves. Typical examples include laboratory services, imaging diagnosis, and patient transportation under "ancillary services", and pharmaceuticals (both prescribed and over-the-counter ones) as well as therapeutic goods (corrective glasses, hearing aids) under "medical goods". Consumption of such during a health care-contact are, therefore, lumped under other categories (i.e. curative care) and not separately reported.

Burden of disease and disease-specific government expenditures

Fig. 8. Burden of disease, 2019

Rank by disorder (2019)		DALYs (%)
1	Stroke	10.87
2	Ischemic heart disease	7.94
3	Neonatal disorders	5.06
4	Diabetes mellitus	4.98
5	Cirrhosis and other chronic liver diseases	3.50
6	Tuberculosis	3.44
7	Low back pain	3.14
8	Road injuries	2.91
9	Diarrheal diseases	2.78
10	Chronic obstructive pulmonary disease	2.57
11	Headache disorders	2.31
12	Chronic kidney disease	2.12
13	Lower respiratory infections	2.03
14	Congenital birth defects	1.94
15	Age-related and other hearing loss	1.70
16	Tracheal, bronchus, and lung cancer	1.65
17	Other musculoskeletal disorders	1.57
18	Hypertensive heart disease	1.50
19	Neck pain	1.50
20	Blindness and vision loss	1.45
21	Asthma	1.35
22	Breast cancer	1.27
23	Depressive disorders	1.23
24	Anxiety disorders	1.19
25	Falls	1.17

Infectious and parasitic diseases
Nutritional deficiencies
Reproductive health
Noncommunicable diseases
Injuries

Maldives

Progress towards universal health coverage

Maldives is making steady progress towards UHC. Its UHC service coverage index increased from 59 to 62 between 2010 and 2020. As for financial risk protection, the share of the population affected by household catastrophic health expenditure decreased from 19.9% in 2009 to 10.3% in 2016. In the same year, 0.1% of the population were pushed into poverty because of out-of-pocket health expenditures, down from 3.5% in 2009 (under the daily US$3.20 per capita poverty line).[6]

Health system architecture and governance

Health services in Maldives is currently delivered by a four-tier referral system, comprising island, atoll/regional and central level services. There are three tertiary hospitals in the country, two of which are privately owned, with Indira Gandhi Memorial Hospital (IGMH) in Malé being the only government tertiary care hospital.

There are six regional and 14 atoll hospitals in strategic locations across the country, which serve as the first referral. Each inhabited island also has a fully functional health centre.[101] The private sector has grown significantly in the past decade, with more than 50 clinics in addition to two tertiary hospitals. The voluntary sector is also present in the form of nongovernmental organizations (NGOs) working on specific health issues, mainly in urban areas.

The health financing architecture has undergone significant changes after the roll-out of social health insurance in 2012. The National Health Insurance (NHI) scheme (*Aasandha*) and the Ministry of Health (MoH) define and regulate health financing policies in Maldives. The non-contributory NHI scheme covers all Maldivian nationals. The MoH acts as policy-maker, provider and payer, overseeing about 60% of the health budget, including funds for government health facilities and centralized procurement of medicines and consumables.[102]

The National Social Protection Agency (NSPA), an autonomous government body, regulates the NHI scheme. It oversees the public Aasandha Insurance Company, which administers the scheme. Senior managers are appointed by the Office of the President, and the Agency is accountable to a Board (comprises MoF, MoH and NSPA as well as private sector representation).[103]

Currently, three voluntary private insurance companies provide health insurance schemes (Amana Thakaful, Allied Insurance Company and Solarelle Insurance Company) and also provide coverage to foreigners.

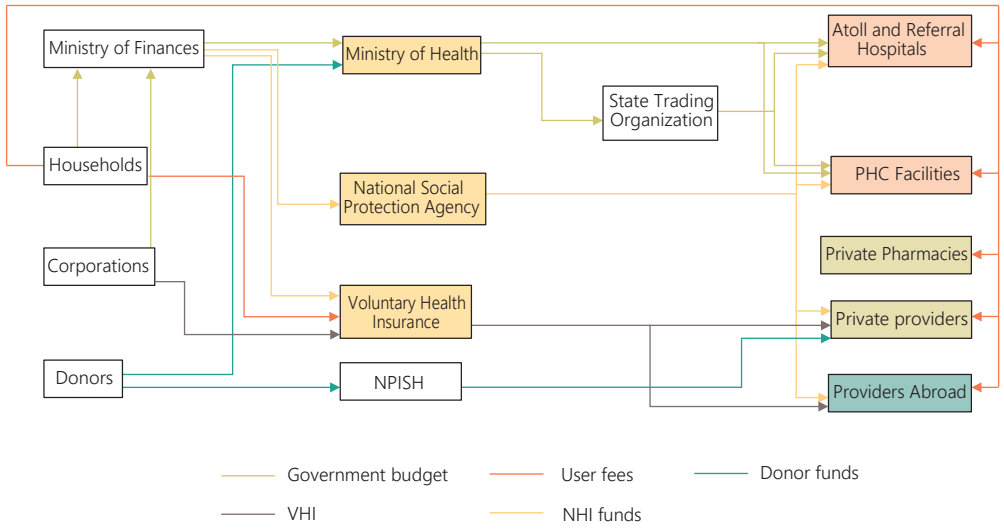
Raising revenue

Current health expenditure (CHE) was estimated at 9.4% of GDP in 2018 – a slight decline from 10.1% in 2009. Domestic general government health expenditure was 6.6% of GDP in 2018, up from 5.8% in 2009 with government contributions to the NHI scheme. Accordingly, the general government health expenditure increased from 15.8% of the general government expenditure in 2009 to 21.4% in 2018. The government Budget allocation constituted 70.7% of the CHE in 2018, up from 58% in 2009.[71] Tobacco taxation was increased to 25% *ad valorem* rate of the retail price from August 2020. Three percent of the proceeds will be allocated to a public health fund to conduct anti-tobacco public awareness campaigns under the Public Health Protection Act 2012/7.[104] External donor transfers have reduced over the years, from 5% in 2009 to 0.9% by 2018. Out-of-pocket expenditure on health as a percentage of CHE has seen a substantial reduction in the past decade – dropping from 34% in 2009 to 20.6% in 2018. Voluntary pre-payments through private health insurance schemes remains a small part of health financing, at 2.1% of CHE in 2018.[71]

Pooling and flow of resources

There are three main pools in use for public resources for health in Maldives. The Ministry of Finance transfers the government budget to the MoH and the NSPA. When official donors channel their funds through government, the MoH acts as an intermediary. Government, households and corporations channel certain funds through voluntary insurance payment mechanisms.[103]

Fig. 1. Simplified flow of funds in the Maldives health sector



Source: Adapted from Ministry of Health. Maldives National Health Accounts 2015–2017. Malé: Government of Maldives; 2019.

Benefits package

The NHI and the MoH provide a comprehensive package of health services. The MoH Budget covers all government health facilities in the country that provide services to the whole population. For any services not delivered at MoH facilities, the NHI provides coverage without a benefit ceiling. The benefits package is implicit and covers everything that is not included in a list of excluded services (Table 1). Some of the exclusions (i.e. disability care) are covered by a different social protection programme run by the NSPA. A substantial amount of health services used by Maldivians for care and treatment in health facilities overseas is also supported by the NHI.[103]

Table 1. Health services included and excluded from NHI

Broad categories of included services	Selected excluded services
• Both inpatient and outpatient treatments and medication • Diagnostic and surgical interventions • All transportation fees in emergencies • Annual medical check-up for those aged 18 or older • Treatment for terminally ill patients and those with special needs • Medical costs during pregnancy	• Private rooms • Services obtained from facilities not empanelled • Addiction-related services • Disability care (already covered by NSPA) • Cosmetic surgeries and treatments • Charges incurred without prescription • Infertility and abortion (unless explicitly allowed) • Massage and other physical therapies, weight reduction • Experimental or unproven treatments

User fees are also incurred at public and private facilities, including for services such as improved amenities. In Maldives, almost half of the out-of-pocket payments is spent on purchasing medicines from private pharmacy outlets. [103]

Purchasing arrangements

The MoH transfers, to government health facilities, pay for salaries and operational costs. The latter is mostly in kind (fuel, stationary, etc.), on a line-item basis, and using an incremental approach. In addition, the MoH allocates external donor funds for expenses linked to the implementation of specific global health initiatives (such as the Global Fund) and non-profit providers. The government-owned State Trading Organization organizes procurement and distribution of medicines and consumables for the public sector, with funds transferred from MoH.

The NSPA registers and contracts public and private facilities. Health care provided by public facilities is paid with a combination of MoH budgets and NSPA reimbursements (the latter spent on additional staff, medicines and other goods and services). Public providers do not submit actual claims to the NSPA.[103] On the other hand, private providers are reimbursed by NSPA against claims submitted by itemized bills. The NSPA prices are not fixed or negotiated and vary significantly across providers.[105]

Public financial management

The health masterplan outlines performance indicators for each outcome in the plan. This serves as the link between long-term planning and medium-term budgeting.[106] The Ministry of Finance issues the annual Budget Circular I, based on which MoH provides proposals for new policy initiatives. In Budget Circular II, proposals are submitted on Budget execution for the previous year and expenditure for the following.

All payments are disbursed centrally from the MoF Single Treasury Account through the "System Application Product" – a software that facilitates all stages of the financial management cycle starting with planning and setting the budget framework, through to reporting and review of the outcome of the budget (www.finance.gov.mv) – and in-year budget execution is available to the public. Official donors are expected to route their funds largely through the government system, while private donors are observed to disburse funds through own arrangements.

Recent health financing reform

The main health financing reform in Maldives led to the creation of the NHI Scheme in 2012 and its evolution into a non-contributory, tax-based insurance scheme covering all Maldivians. The Health Masterplan 2016–2025 envisions additional reforms. These include the allocation of adequate funds to public health and primary health care services, increase in technical efficiency of the funds allocated, alternative sources of funding for the NHI, and an audit of the health expenditure.[107]

Maldives

Macro picture

Indicator	Latest year	Value
Total population (thousands)[1]	2019	530 953
Employment to population ratio, 15+, total (%) (national estimate)[2]	2016	54.1
GDP per capita growth (annual %)[2]	2019	2.2
GDP per capita (current US$)[2]	2019	10 791
General government revenue (% of GDP)[3]	2019	27.2
Tax revenue (% of GDP)[2]	NA	NA
General government total expenditure (% of GDP)[3]	2019	33.6
Fiscal balance (revenue–expenditure) (% of GDP)	2019	-6.4
General government gross debt (% of GDP)[3]	2019	78.0
Poverty headcount ratio at US$ 3.20 a day (2011 PPP) (% of population)[2]	2016	0.2
Poverty headcount ratio at national poverty lines (% of population)[2]	2016	8.2

[1] United nations, Department of Economic and Social Affairs, Population Division (2019). World Population Prospects 2019: Volume II: Demographic Profiles.

[2] World Bank Group. World Development Indicators, 2020. Washington, D.C.: 15 Oct 2020. https://databank.worldbank.org/source/world-development-indicators.

[3] IMF. World Economic Outlook: A Long and Difficult Ascent. Washington, D.C.: October 2020. https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020.

Progress towards universal health coverage

Fig. 2. SDG 3.8.1 Service Coverage Index (0–100)

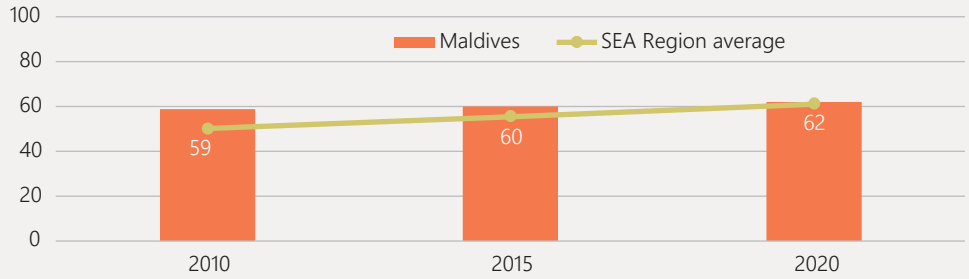
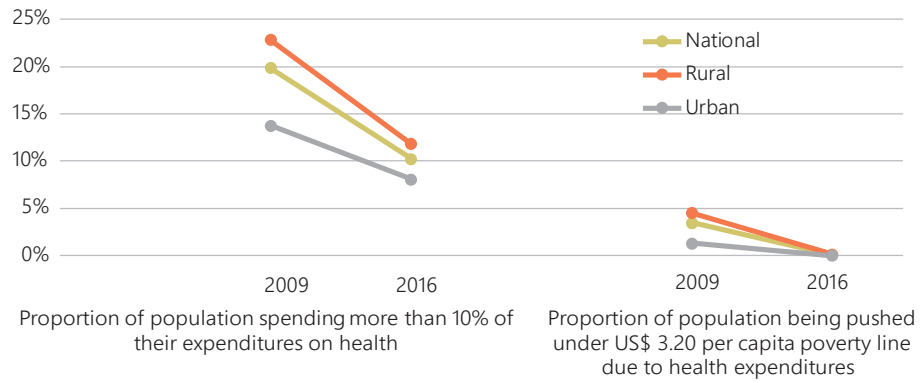


Fig. 3. SDG 3.8.2 Catastrophic and impoverishing incidence due to out-of-pocket expenditures on health



General health expenditure trends over the past decade

Fig. 4. Current health expenditures 2009–2018

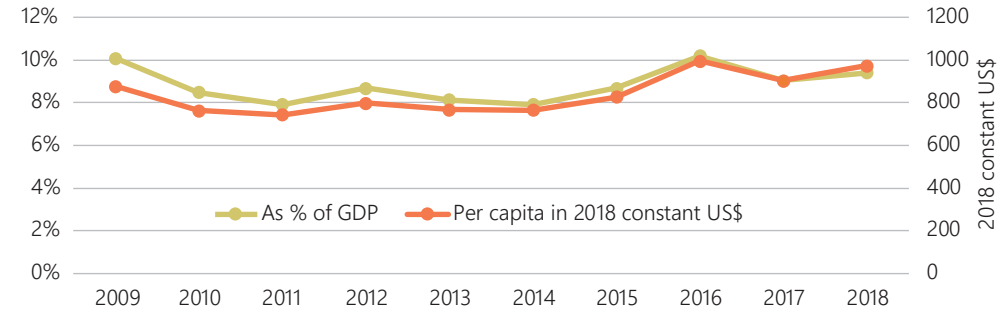


Fig. 5. Domestic government expenditures on health 2009–2018

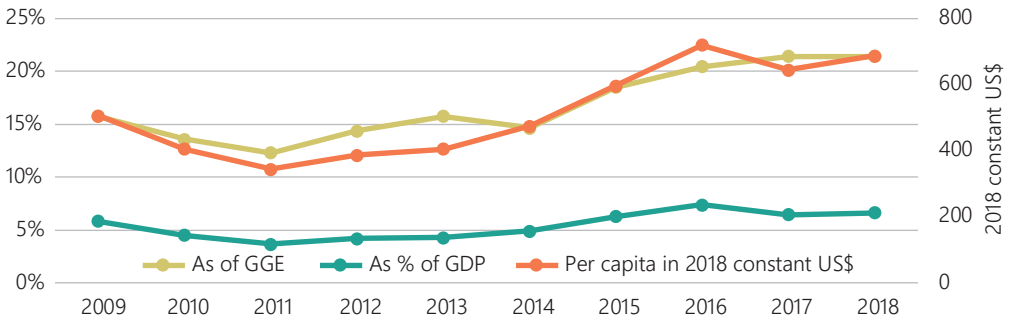
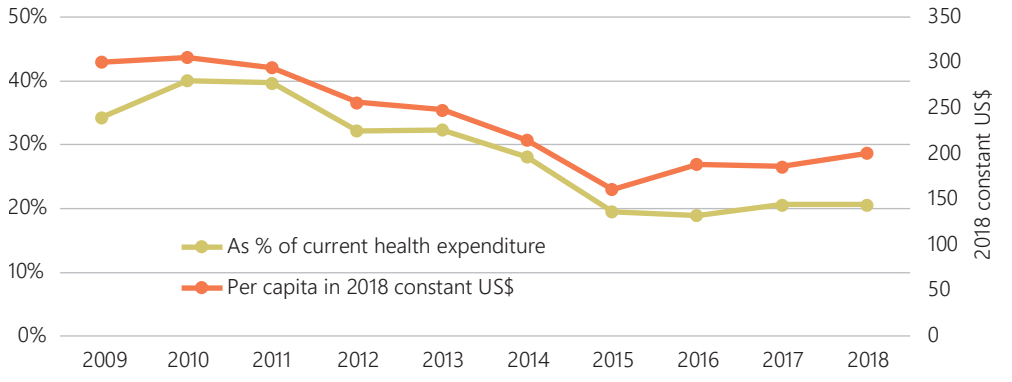


Fig. 6. Out-of-pocket spending on health (OOPS) 2009–2018

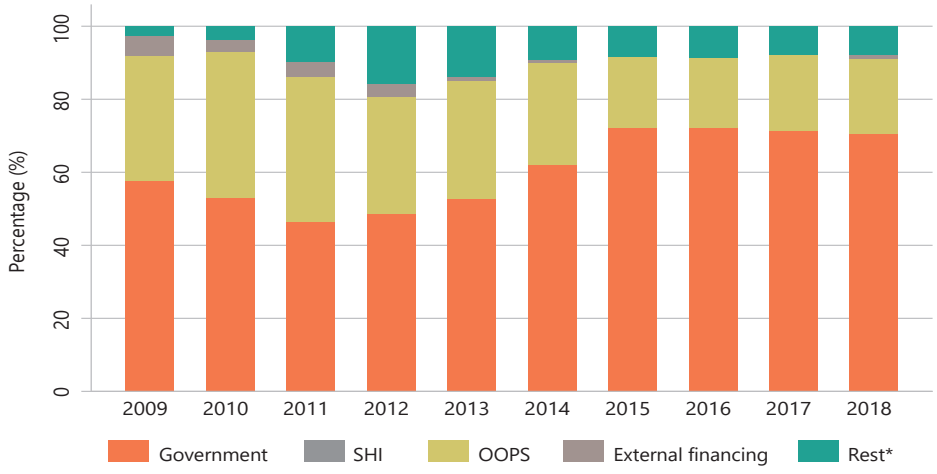


Primary health care expenditures

No data available

Composition of current health expenditures

Fig. 7. Revenue sources of current health expenditures over the years



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

Burden of disease and disease-specific government expenditures

Fig. 8. Burden of disease, 2019

Rank by disorder (2019)		DALYs (%)
1	Neonatal disorders	8.80
2	Ischemic heart disease	7.30
3	Stroke	4.36
4	Low back pain	4.22
5	Headache disorders	3.65
6	Congenital birth defects	3.34
7	Diabetes mellitus	2.98
8	Chronic kidney disease	2.97
9	Chronic obstructive pulmonary disease	2.87
10	Depressive disorders	2.63
11	Other musculoskeletal disorders	2.55
12	Age-related and other hearing loss	2.54
13	Neck pain	2.08
14	Anxiety disorders	1.96
15	Road injuries	1.66
16	Endocrine, metabolic, blood, and immune disorders	1.58
17	Falls	1.57
18	Schizophrenia	1.38
19	Gynecological diseases	1.33
20	Drowning	1.25
21	Cirrhosis and other chronic liver diseases	1.18
22	Dietary iron deficiency	1.16
23	Self-harm	1.13
24	Lower respiratory infections	1.09
25	Oral disorders	1.03

Infectious and parasitic diseases
Reproductive health
Injuries
Nutritional deficiencies
Noncommunicable diseases

Myanmar

Progress towards universal health coverage

Myanmar's progress towards UHC is marked by the increase in its UHC service coverage index from 49 in 2010 to 56 in 2020. As for the financial risk protection, data from 2015 shows that household catastrophic health expenditure impacted 14.4% of the population, while 0.6% were pushed into poverty (as per the poverty line of US$ 1.90 per capita daily).[6]

Health system architecture and governance

The Ministry of Health and Sports (MoHS) is the major governing agency as well as the provider of health care. It is responsible for planning, financing, administrating, regulating and providing health care. Health service provision is extended down to rural settings through a network of health-care facilities at different administrative levels.

Township health departments manage the township health system and are the backbone of primary health care, as they provide health services at the local level. At the regional administrative level, regional and state health departments provide supervisory and technical support, while managing the provision of tertiary care and referral services.[108] The MoHS centralizes the procurement and distribution of medicines and supplies. The commercial private sector mainly provides ambulatory care, though some private institutional care has emerged in larger cities in recent years.

The Social Security Scheme (SSS) is responsible for the health of insured workers in Myanmar. The scheme covers formal sector workers of companies with five or more employees, comprising less than 2% of the population. The SSS is managed by the Social Security Board (SSB) in the Ministry of Labour, Immigration, and Population (MoLSS). The SSB reports to the Social Security National Board, which is composed of MoLSS, MoHS, other government bodies, and representatives of employers and employees. The SSB has offices in townships and a presence in almost in all states and regions.

National and international nongovernmental bodies, largely funded by external donors, play a crucial role in the management and provision of health services. Donors also make significant funding contributions for the provision of essential medicines for communicable diseases, health systems development, and specific health programmes. UN agencies are key contributors as managers of funds from global health initiatives such as GAVI.

Raising revenue

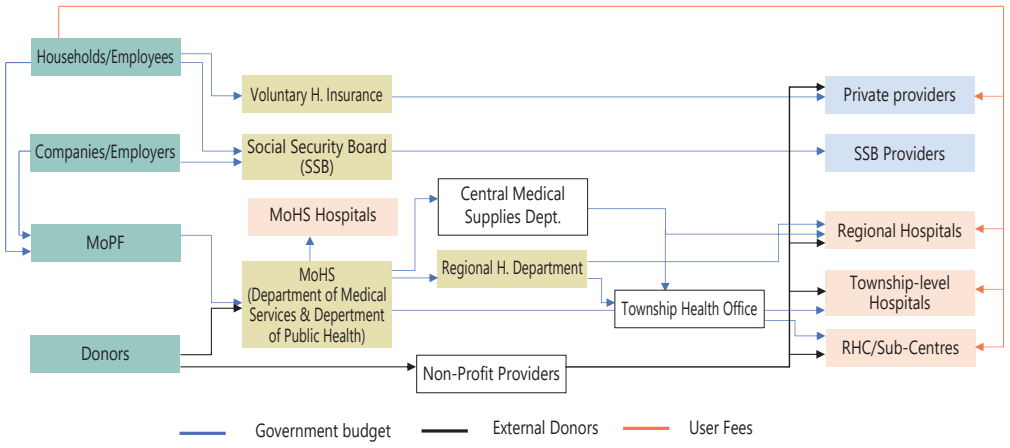
Current health expenditure was 4.8% of GDP in 2018, more than double the value of 2.1% in 2009. Domestic government expenditure on health (GGHE-D) also grew to 0.7% of GDP in 2018 from 0.2% in 2009. The share of general government expenditure devoted to health almost tripled from 1.4% in 2009 to 3.5% in 2018. Government budget allocation to health as a share of CHE increased from 8.5% in 2009 to 14.3% in 2018.

The Social Security Schemes represent 0.6% of the CHE, up from 0.2% (2.5% for all people aged 60 or older) of monthly payroll contribution by employees and employers. External donor financing as a revenue source for health was 9.1% in 2009 and 8.7% of CHE in 2018. Out-of-pocket spending on health constituted 76.4% of CHE in 2018, down from 82.3% in 2009.[71]

Pooling and flow of resources

The main pooling mechanism in the Myanmar health sector is the government health Budget allocated by the Ministry of Planning and Finance (MoPF), managed by the MoHS and its subordinate institutions. Due to the functional separation within the MoHS, activities carried out by individual departments are more vertical in nature and mirrored in separate funds at lower levels of public health system. The SSB manages the fund pool collected from contributions by members. The large majority of external funding is channeled through their own, mostly separate, systems.

Fig. 1. Simplified flow of funds in Myanmar health sector



Source: Adapted from World Health Organization. Regional Office for South-East Asia. (2017). Health financing profile 2017: Myanmar. World Health Organization. Regional Office for South-East Asia.

Benefits package

Networks of public hospitals and health centres provide curative services ranging from primary to tertiary health care. However, user charges at the point of service for goods and health services are applied in all public facilities. Users must purchase medicines and medical supplies from outside vendors if the health facility runs out of stocks of these.[109] The SSS covers medical treatment and delivery (outpatient, inpatient, medicine, laboratory and transportation in case of referral outside urban areas) for a maximum of 26 weeks. The benefits package is free in all SSB facilities except for retired workers who have a 50% co-payment clause. Newborns are also covered entirely for all services during their first year of life.

A new benefits package was designed in 2016 as part of the National Health Plan. The package of Essential Health Services (EPHS) aims to guarantee access for all in Myanmar without financial barriers. The EPHS will be implemented in three phases: Basic Package of Essential Health Services (BPEHS) by 2020, an Intermediate Package of Essential Health Services (IPEHS) by 2025, and Comprehensive Package of Essential Health Services (CPEHS) by 2030.[109]

Table 1. Services included in Myanmar's benefit packages

BPEHS	IPEHS (BPEHS + selected services)	CPEHS (IPEHS + selected services)
• Communicable diseases • RMNCAH • Noncommunicable diseases • Nutrition • Cross-cutting and other services such as emergency disaster management, occupational/ environmental health, eye care, ENT, oral health	• Increased screening and testing in RMNCAH • Malnutrition care • Comprehensive communicable disease prevention, treatment and social support • Enhanced screening, treatment, and pharma care for common NCDs • Assistive technologies for hearing and vision • Eye surgeries and other aids	• Supportive RMNCH care and peer outreach • Health promotion activities in malnutrition and NCDS • Enhanced imaging for cancers • Caregiver and psychosocial supports • Newborn hearing assessments • Common ENT surgeries • Radiology, ECG and echocardiograms

The EPHS package prioritized preventive and public health interventions as well as basic investigative and curative services in the areas of reproductive, maternal, neonatal, child and adolescent health, malnutrition, communicable diseases and NCDs, including injuries and mental health (Table 1).

Purchasing arrangements

In the Myanmar health system, both the MoHS and the SSB act as purchasers as well as providers of health services. In addition, there are NGO players involved in service purchasing. The public sector health providers are paid based on input-based, line-item budgets, and health professionals are salaried. Furthermore, patients pay user charges based on fee-for-services to both public and private providers.[110]

There are three worker's hospitals and 92 clinics under the SSB to provide free health care at the point of services to insured workers. The SSB provides a yearly allocation to these facilities and pays them on the basis of line-item budgets. Referrals to other public facilities entail payments based on rates fixed according to service.[111] The SSB monitors the providers on a monthly basis through a largely paper-based system.

Public financial management

The recurrent budgeting follows, by and large, a top-down process and is based on increments to historical spending levels. The MoHS allocates the government budget to regional and township-level health institutions and hospitals, according to the operational budget, based on the number of sanctioned hospital beds and bed utilization rates, while the budget for medicines is allocated on a per capita basis.

Public health programmes are funded based on existing staff and planned activities. Allocation of the capital budget is based on norms for population-to-facility ratios and plans for infrastructure works and procurement of equipment.[111] The budgets to health institutions and programmes are disbursed according to economic line-item expenses.

External donor resources remain mostly off-budget, disbursed through their own financial management systems to respective health institutions and nongovernmental bodies. The execution of the recurrent government health Budget has traditionally been above 90%, while spending on capital items was at 67% in 2017–2018.[112] The execution of the medical services budget reached 94% between 2015 and 2018, whereas the actual spending on public health programmes did not exceed 75% of approved budgets. Execution of the procurement of medicines and supplies budget approached 100%. Over the past years, the SSB is transitioning towards an autonomous financial management system.[113]

Recent reforms

Reforms included in the National Health Plan 2017–2021 aim at bringing the country closer to achieving UHC by 2030 through increased government health expenditure, better alignment and utilization of external funds, the implementation of the EPHS and of strategic purchasing for public and private providers.[114]

Myanmar

Macro picture

Indicator	Latest year	Value
Total population (thousands)[1]	2020	54 410
Employment to population ratio, 15+, total (%) (national estimate)[2]	2019	59.2
GDP per capita growth (annual %)[2]	2019	2.2
GDP per capita (current US$)[2]	2019	1 408
General government revenue (% of GDP)[3]	2019	16.4
Tax revenue (% of GDP)[2]	2019	5.4
General government total expenditure (% of GDP)[3]	2019	20.3
Fiscal balance (revenue–expenditure) (% of GDP)	2019	-3.9
General government gross debt (% of GDP)[3]	2019	38.8
Poverty headcount ratio at US$ 1.90 a day (2011 PPP) (% of population)[2]	2017	1.4
Poverty headcount ratio at national poverty lines (% of population)[2]	2017	24.8

[1] United nations, Department of Economic and Social Affairs, Population Division (2019). *World Population Prospects 2019: Volume II: Demographic Profiles.*

[2] World Bank Group. World Development Indicators, 2020. Washington, D.C.: 15 Oct 2020. https://databank.worldbank.org/source/world-development-indicators.

[3] IMF. *World Economic Outlook: A Long and Difficult Ascent*. Washington, D.C.: October 2020. https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020.

Progress towards universal health coverage

Fig. 2. SDG 3.8.1 Service Coverage Index (0–100)

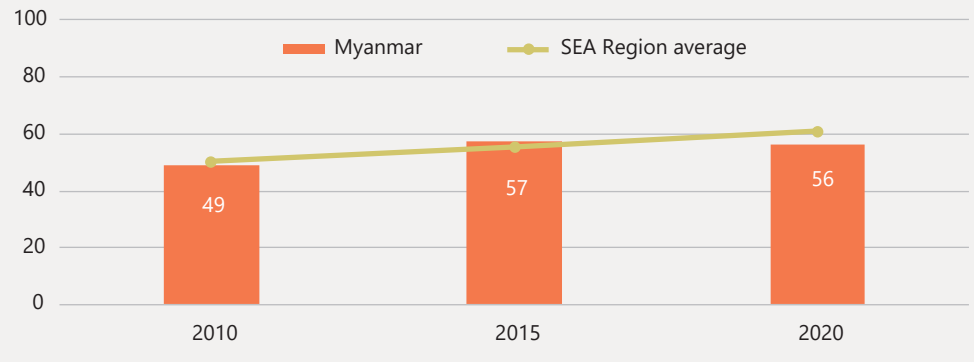
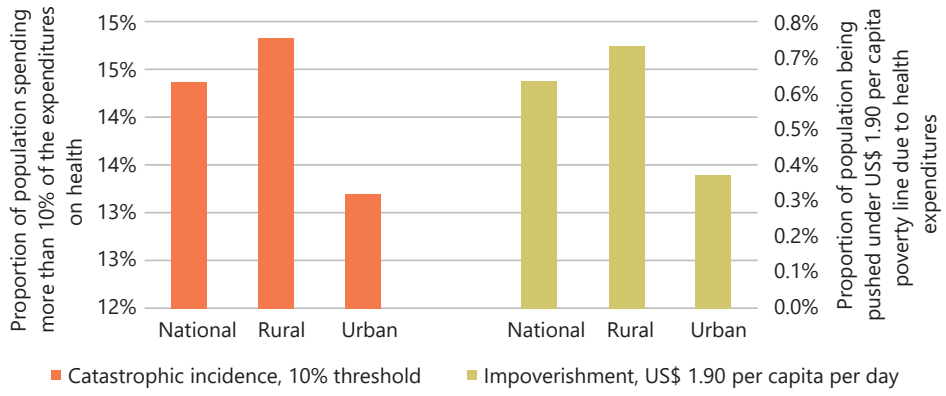


Fig. 3: SDG 3.8.2 Catastrophic and impoverishing incidence due to out-of-pocket expenditures on health



General health expenditure trends over the past decade

Fig. 4. Current health expenditures 2009–2018

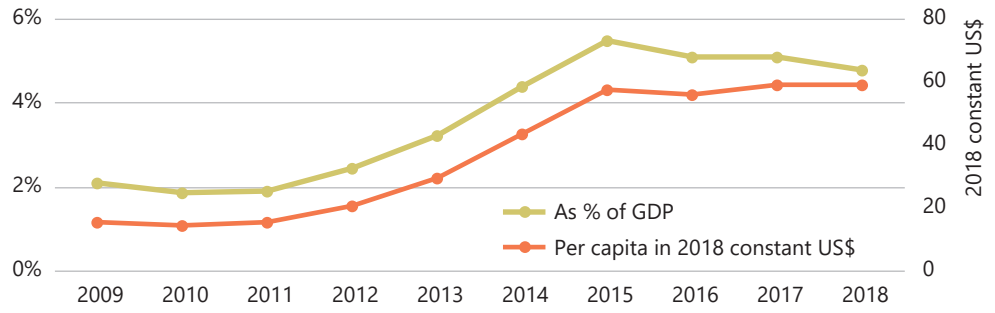


Fig. 5. Domestic government expenditures on health 2009–2018

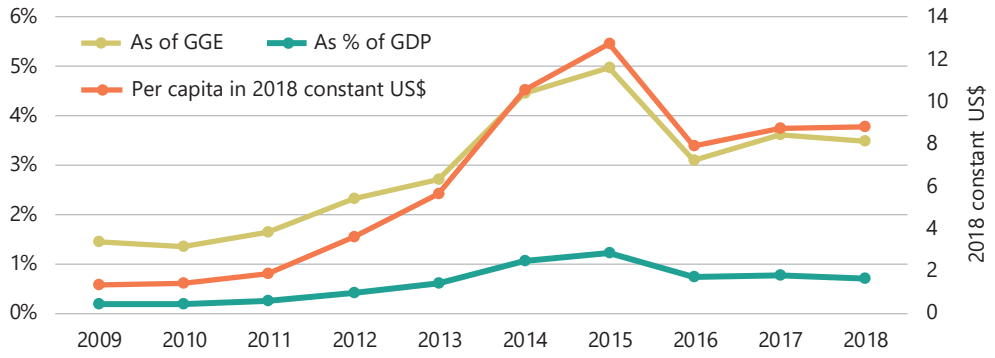
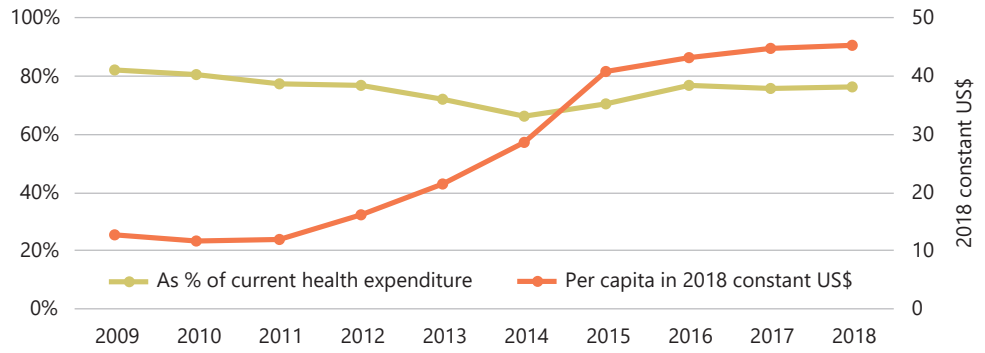
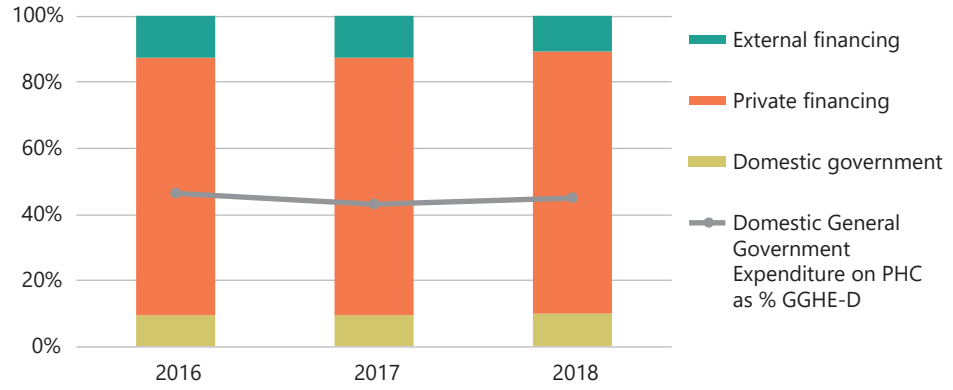


Fig. 6. Out-of-pocket spending on health (OOPS) 2009–2018



Primary health care expenditures[a]

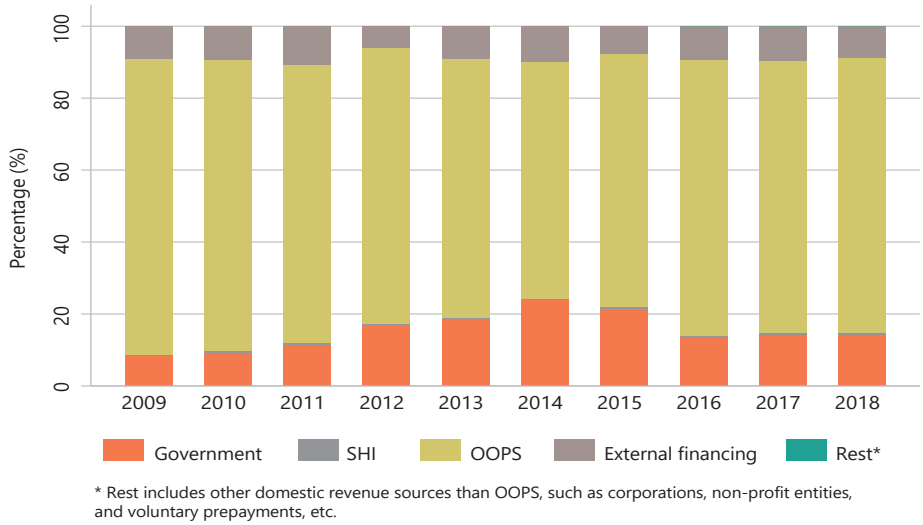
Fig. 7. Primary health care expenditures



a Primary health care measurement is entirely based on Health Care Functions classification. Details of the measurement can be found here: Global spending on health: a world in transition. Geneva: World Health Organization; 2019 (WHO/HIS/HGF/HFWorkingPaper/19.4).

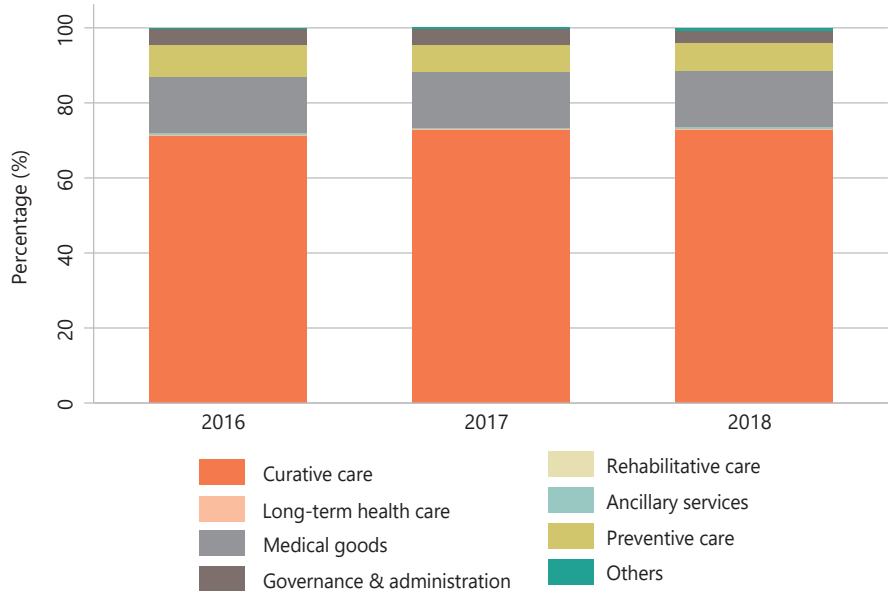
Composition of current health expenditures[b]

Fig. 8. Revenue sources of current health expenditures over the years



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

Fig. 9. Health expenditures by funtion



b "Ancillary services" and "medical goods" are independent consumptions that do not have a specific purpose (treatment, prevention, etc.) in themselves. Typical examples include laboratory services, imaging diagnosis, and patient transportation under "ancillary services", and pharmaceuticals (both prescribed and over-the-counter ones) as well as therapeutic goods (corrective glasses, hearing aids) under "medical goods". Consumption of such during a health-care contact are, therefore, lumped under other categories (i.e. curative care) and not separately reported.

Burden of diseases and disease-specific government expenditures

In Myanmar, spending on noncommunicable diseases (NCDs) and infectious & parasitic diseases were roughly the same (2018). For NCDs the dominant source of financing was from private financing.

Fig. 10a. Health spending by disease categories, and revenue sources for noncommunicable diseases, 2018

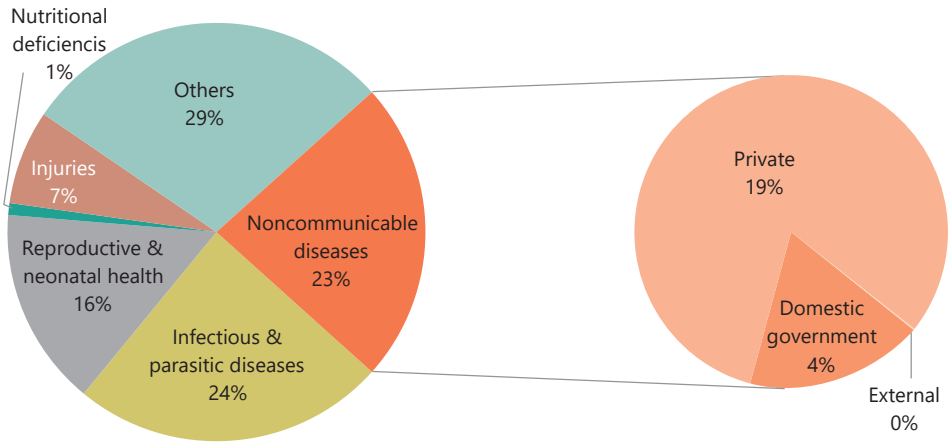


Fig. 10b. Burden of diseases, 2019

Rank by disorder (2019)		DALYs (%)
1	Stroke	10.06
2	Neonatal disorders	7.93
3	Lower respiratory infections	4.78
4	Ischemic heart disease	4.72
5	Diabetes mellitus	4.27
6	Cirrhosis and other chronic liver diseases	4.04
7	Chronic obstructive pulmonary disease	3.94
8	Congenital birth defects	3.46
9	Tuberculosis	2.67
10	Chronic kidney disease	2.25
11	Low back pain	2.20
12	Falls	1.88
13	Headache disorders	1.84
14	Road injuries	1.83
15	Diarrheal diseases	1.71
16	Asthma	1.62
17	Age-related and other hearing loss	1.53
18	Dietary iron deficiency	1.51
19	Tracheal bronchus, and lung cancer	1.40
20	HIV/AIDS	1.37
21	Other musculoskeletal disorders	1.16
22	Anxiety disorders	1.09
23	Neck pain	1.06
24	Hypertensive heart disease	1.04
25	Other unspecified infectious diseases	1.03

Infectious and parasitic diseases
Reproductive health
Injuries
Nutritional deficiencies
Noncommunicable diseases

Nepal

Progress towards universal health coverage

Nepal is making progress towards UHC. The UHC service coverage index increased from 42 in 2010 to 49 in 2020. Remarkably, the financial risk protection has substantively improved with the proportion of the population affected by household catastrophic health expenditure declining from 27.4% in 2010 to 10.7% in 2014. In 2014, 1.7% of the population were impoverished due to out-of-pocket health payments (under the per capita poverty line of US$ 1.90 daily).[6]

Health system architecture and governance

Nepal's public health system has moved from centralized to decentralized management when the government was structured into three levels in 2015. The Ministry of Health and Population (MoHP) governs national and specialized facilities (tertiary level), as well as ensures the supply of medicines and commodities. The provincial level oversees the general hospitals (secondary level) and coordinates and provides emergency health services that involve more than one municipality. Finally, the local level ensures that services follow the agreed standards and regulations. Local governments also fund, support, manage, and monitor primary health care institutions and community level providers – urban health centres (UHCs), primary health care centres (PHCCs), health posts (HPs) and community health units and clinics.

The health service delivery is done through a mix of providers, including public, private for-profit and nongovernmental organizations. Private providers, including NGOs and faith-based organizations, serve predominantly the urban population.

The main public financing scheme for health is the government budget. In the 2018–2019 financial year, 60% of the government health budget remained at the MoHP level, while 32% was allocated to the local level and less than 8% to the provincial level.[115]

The Social Health Insurance (SHI) scheme was introduced in 2016. After a phased implementation the coverage was estimated at 11% of the population by 2019.[116] The SHI scheme is implemented by the Health Insurance Board (HIB) – composed of MoHP and Ministry of Finance (MoF) – and its provincial and local coordination committees, which comprised representatives of the local government, health and education sectors, service providers and civil society.

In addition, there are two other public insurance schemes, the Employees Provident Fund (EPF) and Social Security Fund (SSF), that provide health insurance coverage. The latter operates under the Ministry of Labour, Employment and Social Security (MoLESS). EPF covers public sector employees while SSF is a contributory social security scheme for workers in the formal and non-formal sectors where health insurance is one of the components. Enrolment in private health insurance schemes is very low in Nepal.

Raising revenue

Nepal spent 5.8% of its GDP on health in 2018, which is an increase from 4.5% in 2009. Domestic government expenditure on health (GGHE-D) is 1.5% of GDP in 2018, up from 0.9% in 2009. The share of GGHE-D in general government expenditure remained at the same level – 4.7% in 2009 and 4.6% in 2018.

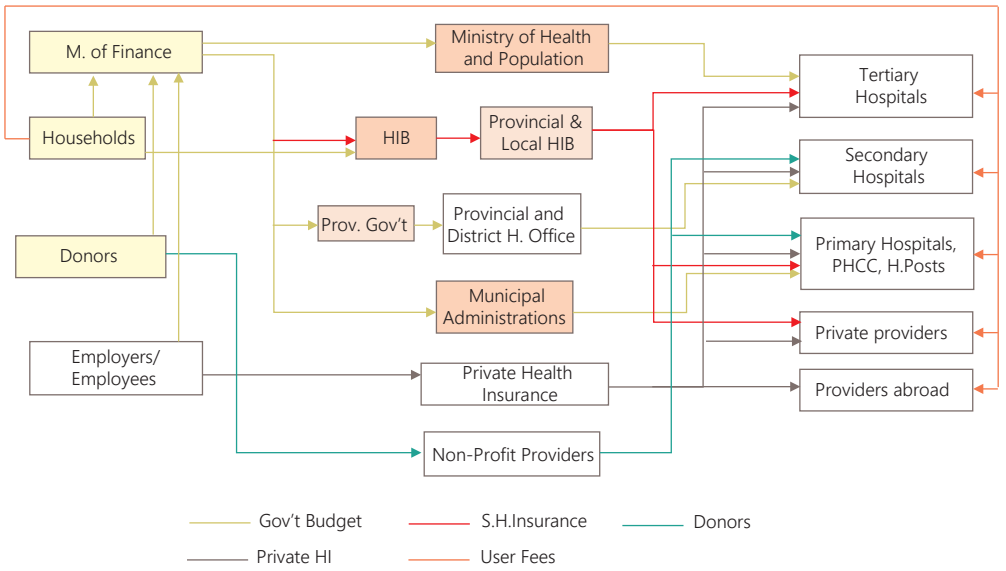
The government health budget makes up 25.1% of current health expenditure (CHE) in 2018, up from 20.4% in 2009. The SHI fund is raised from household contributions and government budgetary subsidies for the ultra-poor. A family of five members must pay Nepalese rupees (NPR) 3500 per year to cover all types of health service, with a maximum limit of NPR 100 000. If there are more than five members in the family, the payment is NPR 700 per person.

Out-of-pocket spending on health made up 50.8% of CHE in 2018, down from 57.6% in 2009. The non-profit institutions that provide direct financial assistance, such as goods or services to households (for free or at prices that are very low), are a significant contribution to the revenues for health in Nepal at about 14.7% of CHE. Voluntary health insurance schemes accounted for just 0.3% of CHE in 2018. External donor sources declined from 15.8% of CHE in 2009 to 9.1% in 2018.[71]

Pooling and flow of resources

There are several fund pools for Nepal's health sector. The government Budget transfers to health constitute the largest share and are pooled at the federal and provincial levels as well as at more than 750 municipalities. The donors' pool constitutes only a limited share of the health resources through the public system, and much remains off-budget to administer directly – for instance, at around 8.6% of CHE in 2015–2016.[117] For SHI, contributions are collected by the HIB and pooled at the Ministry of Finance.

Fig. 1. Simplified flow of funds in Nepal health sector



Benefits package

Over time, Nepal introduced several policies to increase coverage of benefits and reduce household out-of-pocket health expenditure. The Free Health Care Policy (FHCP), implemented in 2006, abolished user fees at the lowest level of care (health posts) and subsidized a limited number of drugs, among other actions.

The Aama (maternity incentive) Programme covers maternal care services, including antenatal consultations and caesarean sections performed at referral hospitals,[118] and offers cash transfers to cover user transportation costs.[119] Free and paid services coincide at first-level referral facilities, such as at the primary health care centre (i.e. antenatal consultations are free but doctor consultations are not). About 70 essential medicines are free when prescribed by the facilities above the level of health posts.

The Social Health Insurance Scheme is envisioned to provide coverage for services outside the BHSP and that otherwise would have been funded through OOP expenditure. SHI beneficiaries have to register with a public or private primary health-care provider who will act as gatekeeper for higher-level facilities or specialists. The Employees Provident Fund provides government and public sector workers retirement benefits, medical treatment reimbursement, and maternity and child benefits, among other social services.[120]

Table 1. Nepal Basic Health Services Package

A.	Immunization services
B.	Maternal, neonatal and child health services
	i) Management of neonatal and childhood illnesses
	ii) Nutrition services
	iii) Pregnancy, delivery and post-partum services
	iv) Services related to family planning, abortion, reproductive health morbidity, and female cancers
C.	Services for communicable diseases
D.	Services for noncommunicable diseases and differently abled people
E.	Services for mental diseases
F.	Geriatric health, adolescent health and men's health services
G.	Common emergency services
H.	Health promotion services
I.	Ayurveda and other traditional health services

In 2020, Nepal introduced a Basic Health Services Package, which emanates from Article 35 of the Nepalese Constitution that states that every citizen is entitled to receive services free at the point of delivery. The Nepal Benefit Package was designed to include the most essential services (Table 1)[121] to be provided free and made available to the whole population. A simplified costing exercise estimated the per capita costs (excluding capital costs) to be NPR 953 (less than US$ 9).[122]

Purchasing arrangements

The MoHP pays national and specialized hospitals by line-item budgets and procures medicines (i.e. TB, HIV) and medical supplies (i.e. vaccines, family planning commodities). Primary health care facilities are paid by the local governments through conditional grants, which receive more than 90% of their funding from the federal-level budget. The payment covers expenses on salaries, drugs as well as programme-related activities (i.e. training and supervision targeting specific activities). The HIB purchases services from private and public providers and pays according to each case or a fee for services according to agreed tariffs.

Performance-based approach has been used to pay for health services in Nepal. The Aama Programme transfers funds to health facilities according to set targets of maternal care and uses vouchers and cash transfers to incentivize service utilization. External partners pay for expenses of health programmes/projects directly, either through international/national NGOs or through MoHP based on targets and outputs.

Individual users can purchase the same services as with SHI (i.e. consultations with a doctor at the primary health care centre or hospital, investigations, hospital admissions and operations) in public health facilities according to listed prices (fee-for-services) set by the facility development committee.

Public financial management

The planning and budgeting process in Nepal continues, by and large, to be guided by the Central level. The Budget allocation to different localities is based on a needs-based resource allocation approach, using a formula that includes population, poverty, geographical area, relative cost of life, etc.[123] Annual budgets are generally prepared on an incremental basis according to the expenditures of the preceding fiscal year. In the health sector, the MoHP develops an annual budget, programme, and activity plan.

The conditional grants to local government institutions are then finalized by an agreement between the National Natural Resources and Fiscal Commission, National Planning Commission and the MoF, including discussions that involve the MoHP, state and local governments. Health sector authorities at local levels are expected to produce a budget proposal when additional funding is required from the municipal government resources.

Although the conditional grant is a unified transfer of funding from the Federal government to provincial or local governments, the amount is split and disbursed through several clusters, programmes, medicine purchases by types and programmes, and budget lines.[124] Individual municipalities execute the conditional grant according to the allocation. Budgets have been monitored through the recently updated online Transaction Accounting and Budget Control System (TABUCS), an application that provides detailed budget and expenditure information across the country.

Recent reforms

The principal recent reforms in Nepal with repercussions on health financing include the introduction of the Social Health Insurance Scheme (2016) and development of the Basic Health Services Package (2020). The SHI scheme is envisioned to provide coverage for services outside the BHSP that otherwise would have to be funded through OOP expenditure.

Nepal

Macro picture

Indicator	Latest year	Value
Total population (thousands)[1]	2020	29 137
Employment to population ratio, 15+, total (%) (national estimate)[2]	2017	34.2
GDP per capita growth (annual %)[2]	2019	5.0
GDP per capita (current US$)[2]	2019	1 071
General government revenue (% of GDP)[3]	2019	26.0
Tax revenue (% of GDP)[2]	2017	20.7
General government total expenditure (% of GDP)[3]	2019	30.6
Fiscal balance (revenue–expenditure) (% of GDP)	2019	-4.6
General government gross debt (% of GDP)[3]	2019	30.1
Poverty headcount ratio at US$ 1.90 a day (2011 PPP) (% of population)[2]	2010	15.0
Poverty headcount ratio at national poverty lines (% of population)[2]	2010	25.2

[1] United nations, Department of Economic and Social Affairs, Population Division (2019). World Population Prospects 2019: Volume II: Demographic Profiles.

[2] World Bank Group. World Development Indicators, 2020. Washington, D.C.: 15 Oct 2020. https://databank.worldbank.org/source/world-development-indicators.

[3] IMF. World Economic Outlook: A Long and Difficult Ascent. Washington, D.C.: October 2020. https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020.

Progress towards universal health coverage

Fig. 2. SDG 3.8.1 Service Coverage Index (0–100)

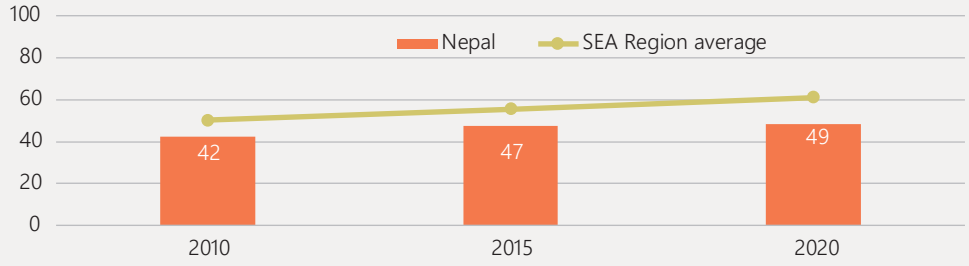
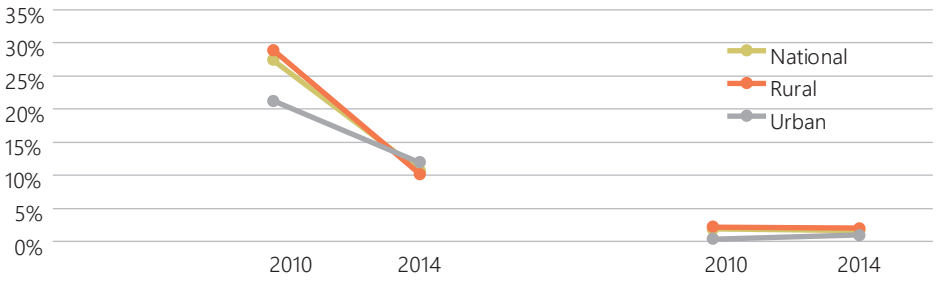


Fig. 3. SDG 3.8.2 Catastrophic and impoverishing incidence due to out-of-pocket expenditures on health



Proportion of population spending more than 10% of their expenditures on health

Proportion of population being pushed under US$ 1.90 per capita poverty line due to health expenditures

General health expenditure trends over the past decade

Fig. 4. Current health expenditures 2009–2018

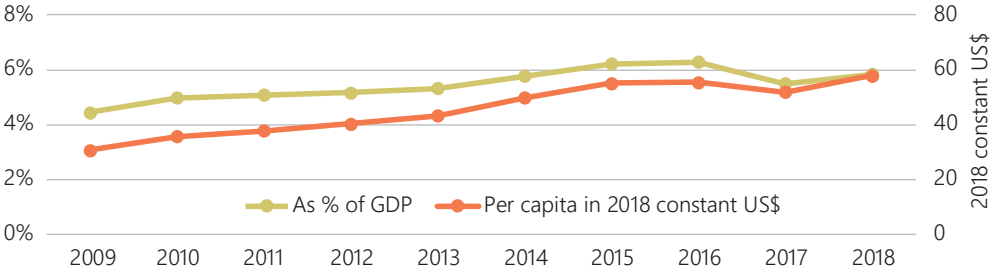


Fig. 5. Domestic government expenditures on health 2009–2018

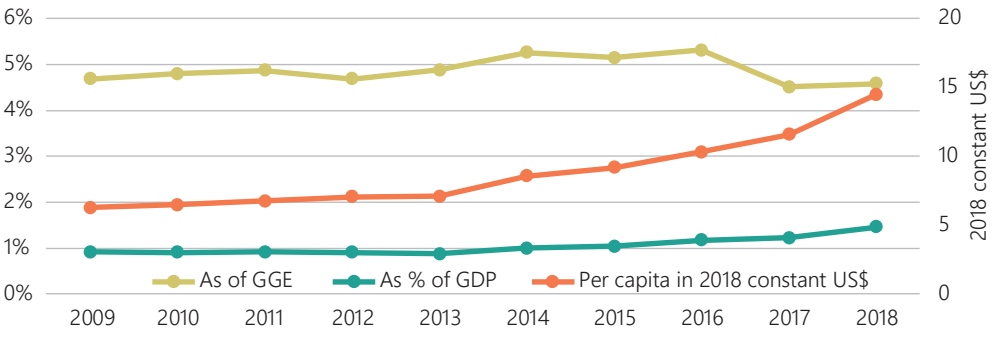
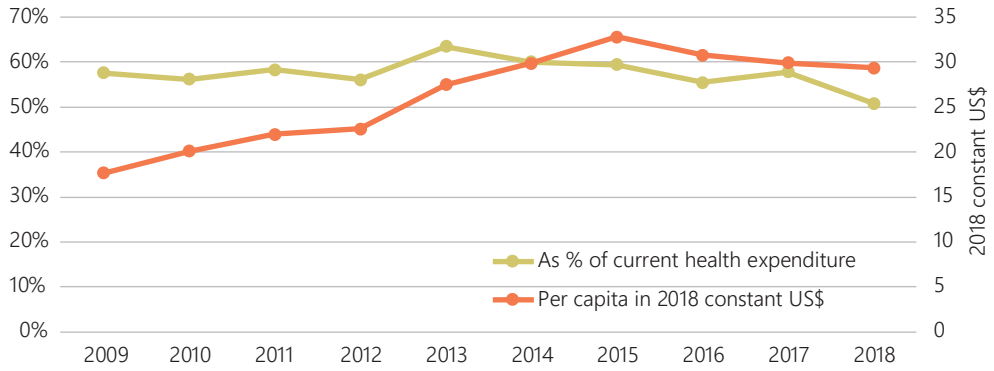
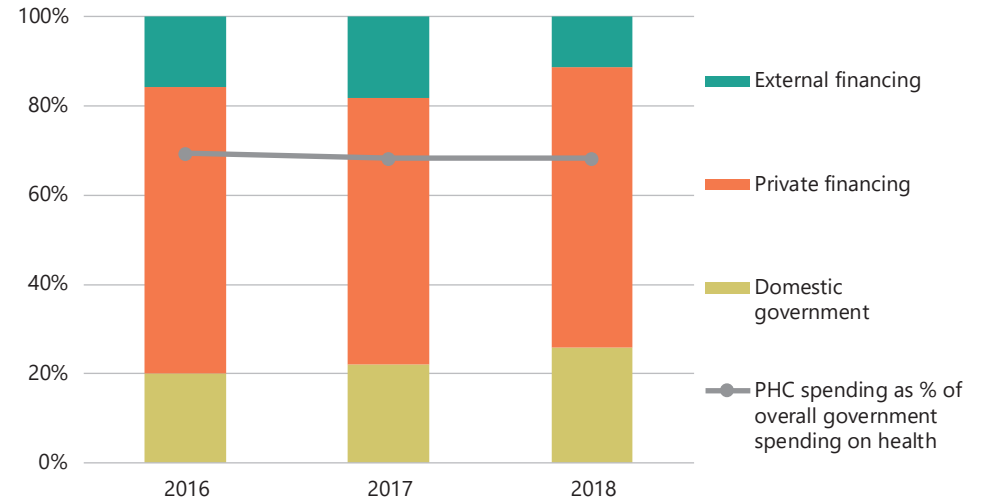


Fig. 6. Out-of-pocket spending on health (OOPS) 2009–2018



Primary health care expenditures[a]

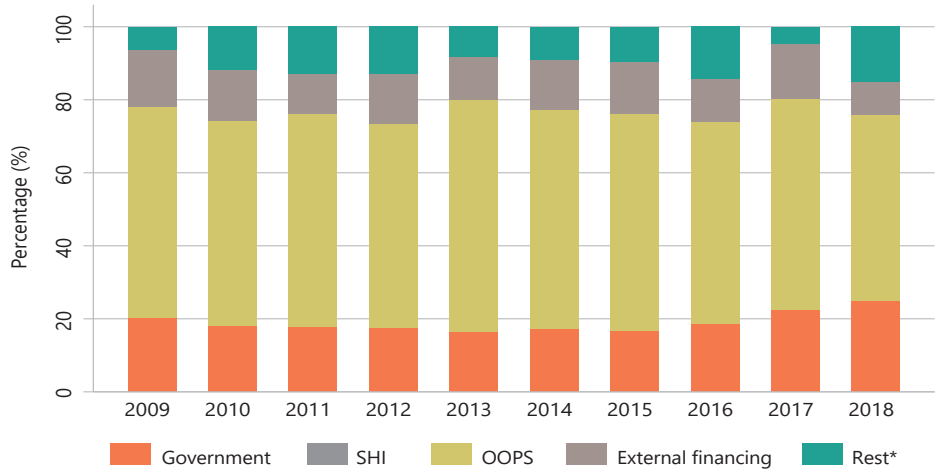
Fig. 7. Primary health care expenditures



a Primary health care measurement is entirely based on Health Care Functions classification. Details of the measurement can be found here: Global spending on health: a world in transition. Geneva: World Health Organization; 2019 (WHO/HIS/HGF/HFWorkingPaper/19.4).

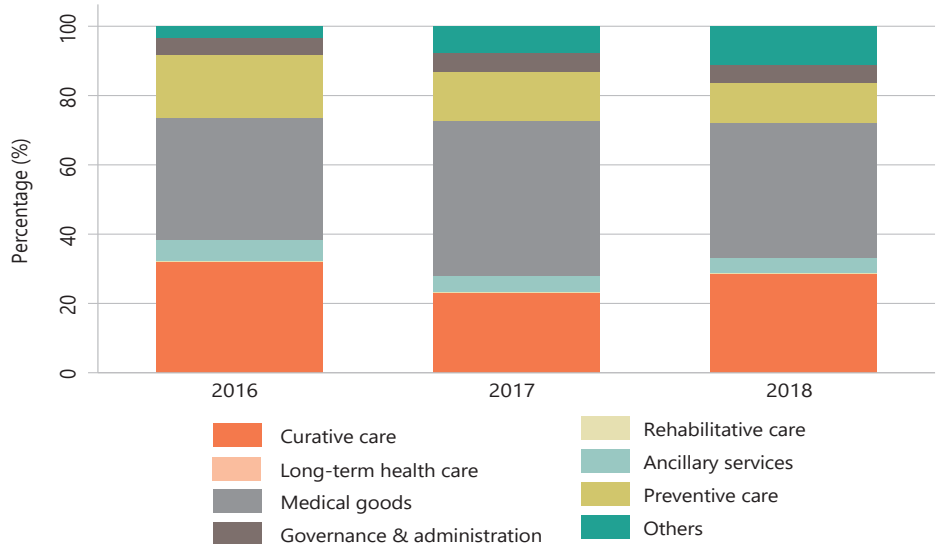
Composition of current health expenditures[b]

Fig. 8. Revenue sources of current health expenditures over the years



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

Fig. 9. Health expenditures by function



b "Ancillary services" and "medical goods" are independent consumptions that do not have a specific purpose (treatment, prevention, etc.) in themselves. Typical examples include laboratory services, imaging diagnosis, and patient transportation under "ancillary services", and pharmaceuticals (both prescribed and over-the-counter ones) as well as therapeutic goods (corrective glasses, hearing aids) under "medical goods". Consumption of such during a health-care contact are, therefore, lumped under other categories (i.e. curative care) and not separately reported.

Burden of disease and disease-specific government expenditures

In Nepal, the biggest share of spending was on noncommunicable diseases (2018), and it was mostly financed by private sources.

Fig. 10a. Health spending by disease categories, and revenue sources for noncommunicable diseases, 2018

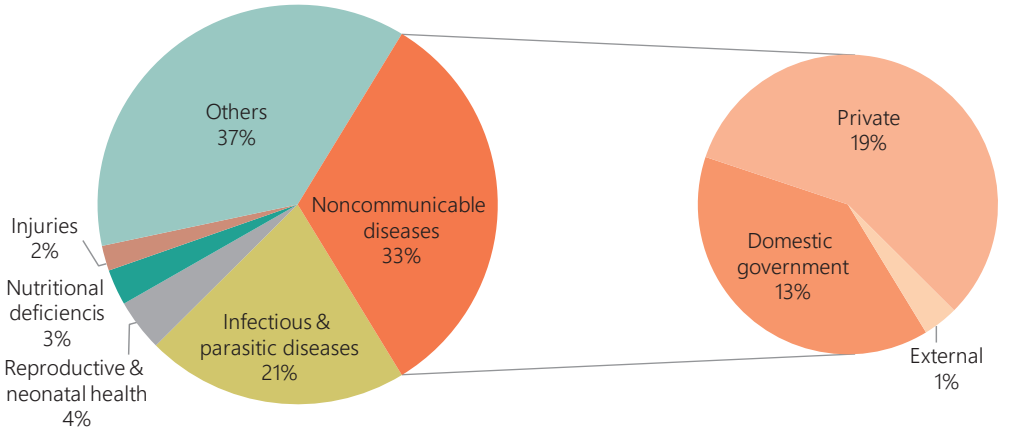


Fig. 10b. Burden of disease, 2019

Rank by disorder (2019)		DALYs (%)
1	Neonatal disorders	9.3
2	Chronic obstructive pulmonary disease	7.3
3	Ischemic heart disease	6.0
4	Lower respiratory infections	4.6
5	Stroke	3.7
6	Cirrhosis and other chronic liver diseases	2.7
7	Tuberculosis	2.7
8	Depressive disorders	2.6
9	Diarrheal diseases	2.5
10	Low back pain	2.5
11	Falls	2.2
12	Diabetes mellitus	2.0
13	Headache disorders	2.0
14	Other musculoskeletal disorders	2.0
15	Self-harm	1.9
16	Congenital birth defects	1.9
17	Road injuries	1.8
18	Dietary iron deficiency	1.8
19	Chronic kidney disease	1.8
20	Asthma	1.8
21	Other malignant neoplasms	1.4
22	Gynecological diseases	1.3
23	Age-related and other hearing loss	1.3
24	Blindness and vision loss	1.2
25	Maternal disorders	1.1

Infectious and parasitic diseases
Reproductive health
Injuries
Nutritional deficiencies
Noncommunicable diseases

Sri Lanka

Progress towards universal health coverage

Sri Lanka is making progress towards UHC. The UHC service coverage index increased from 59 in 2010 to 66 in 2020. As for financial risk protection, the percentage of the population that incurred household catastrophic health expenditure remained almost unchanged between 2012 and 2016 from 5.3% (2012) to 5.4% (2016). In the same year, 0.7% of the population was impoverished because of out-of-pocket health payments, a slight decline from the figure of 0.8% registered in 2012 (under the US$ 3.20 per capita daily poverty line).[6]

Health system architecture and governance

The country has a well-established public health system that provides 50% of all curative ambulatory care, 90% of inpatient care and almost 100% of preventive care. An expanding private sector is operating in selected urban settings through a mix of large hospital groups, small hospitals and private nursing homes, as well as full-time and part-time general practitioners.[125]

Accordingly, the government is the dominant service provider and financier for the health system in Sri Lanka. The Ministry of Finance (MoF) raises resources and makes the overall allocation to the health sector. The central Ministry of Health, Nutrition and Indigenous Medicine (MoH) directly finances and manages the teaching hospitals, specialized hospitals, provincial general and selected district general hospitals and vertical preventive/ disease control programmes. In addition, the State Pharmaceutical Corporation, a semi-autonomous body accountable to the MoH, ensures the supply of essential medicines throughout Sri Lanka.

With the devolution of administrative and financial powers in the early 1990s, a significant portion of health services have been carried out through the provincial council system of networks of health facilities (base hospitals, divisional hospitals, primary care units and medical officer of health units) and local governments (Municipal Councils and Pradeshiya Sabha health clinics). The Finance Commission oversees the provinces through its mandate under the Office of the President.[126]

Two main health insurance schemes exist In Sri Lanka: the social insurance scheme devoted to government employees which is called the "Agrahara fund", and voluntary contributory health insurance schemes operated by private companies.[127]

Raising revenue

Current health expenditure (CHE) was estimated at 3.8% of GDP in 2018, down from 4.2% in 2009. Domestic government expenditure on health (GGHE-D) as share of GDP also slowed down from 1.7% in 2009 to 1.5% in 2018. On the flip side, GGHE-D increased from 7.8% in 2009 to 8.3% of General Government Expenditure in 2018.

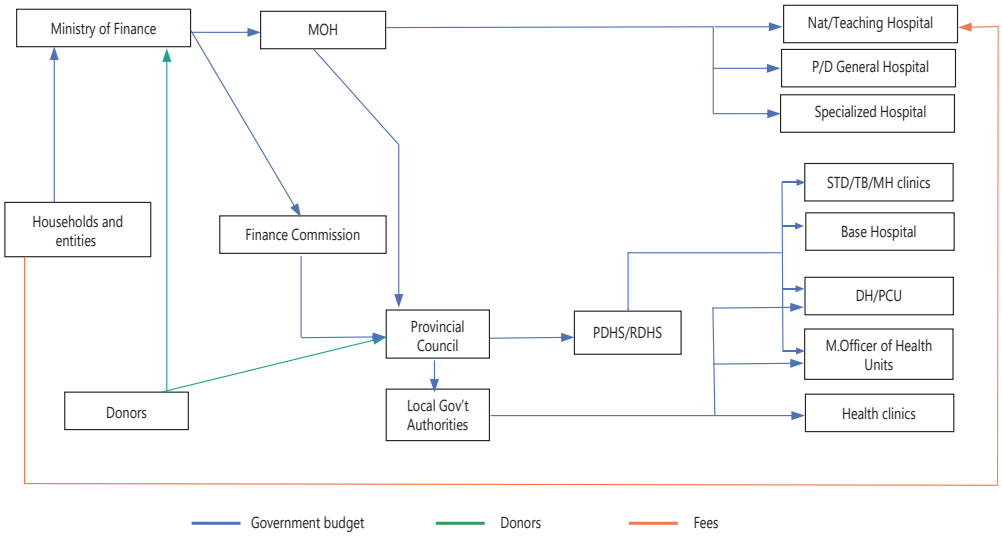
The government and individual households are the principal (over 90%) health financing revenue sources in Sri Lanka. Over the years, the proportion of government Budget and household out-of-pocket expenditure on health (OOPS) in relation to CHE has remained relatively stable, with the government health Budget increasing from 40.2% to 40.7% and OOPS declining from 53.3% to 50.7% from 2009–2018. Employers, private and social health insurance (Agrahara), NGOs and external donor revenues contributed relatively little to CHE. The relative importance of external funding stood at 2.3% of CHE in 2018. Voluntary pre-payments accounted for 2% of CHE while social insurance made up only 0.4% in 2018.[71]

Pooling and flow of resources

The general government Budget revenue is the main funding source for the public health system in Sri Lanka, both at the central and provincial/local levels. The government Budget for the central MoH is directly transferred from MoF, while funds for the provincial and local government institutions are usually channelled through the Finance Commission.

In addition, the central MoH directly channels a considerable amount of funds to provincial level health institutions. Provincial and Local Governments use self-generated funds for health services through the institutions under their administrative guidance.[127] In 2017, 29% of the total government health budget was managed at the provincial and local levels.[128] External donor resources are also transferred to the government Budget, and then distributed to the central and provincial levels (Fig.1).

Fig. 1. Simplified flow of funds in Sri Lanka public health system



Benefits package

In Sri Lanka, comprehensive promotive, preventive and curative services are available through the public health sector. Government services are universally accessible across the country and are free of charge at the point of service. Sri Jayawardenapura General Hospital (SJGH) is the only fee-levying state hospital and tertiary referral centre.

Sri Lanka has a tradition of designing and using specific and targeted packages of health services (i.e., for maternal care).[129] In 2018, an Essential Health Services Package (ESP) was designed,[130] integrating the existing packages into a comprehensive one for the population. The ESP contains a list of essential services provided in government facilities for all citizens (Table 1). A simplified costing exercise estimated that the per capita cost of implementing the ESP would almost double the amount of US$ 20 spent currently.[131]

Table 1. Essential Health Services Package (ESP)

- **Life Course Services:** Family planning; maternal and neonatal care; childcare; nutrition; school health; adolescent health; services for gender- based violence (SGBV); elderly care.
- **Communicable diseases:** TB; malaria; HIV/AIDS; STDs; dengue; leprosy; leptospirosis; and other communicable diseases.
- **Noncommunicable diseases:** Cardiovascular diseases; diabetes; chronic respiratory diseases; mental health; cancer.
- **Services and platforms:** Emergency care; outpatient care; inpatient care; surgery and trauma care; rehabilitation; palliative care; support services such as laboratory, radiology and other investigations, pharmacy/drug supply.

Purchasing arrangements

The Ministry of Health is the purchaser for national, provincial, district, teaching and specialized hospitals. The MoH also allocates funds for vertical programmes based on pre-set plans. The Medical Supplies Division of MoH performs centralized procurement of most medicines used in the public health system and distributes them to the District Medical Supply and to the hospitals. The provincial government distributes allocated funds to the regional health directorates and pays for services provided by the provincial and district network. Government health-care providers are paid through line-item budgets for their salaries, and operational costs and in-kind items such as medicines and supplies are also accorded for through this payment mechanism.

Public financial management

Since Independence, Sri Lanka has implemented the incremental, line-item approach in the government budgeting system, with limited involvement of local managers that has translated into a very stable system.[132] The central MoH Budget remains largely incremental, but there are three types of grants budgeted for provincial and local levels:

- A "block grant" for recurrent budgets, including salaries and operational funds (covering fuel, food, communications, etc.), excluding budgets for medicines;
- A "criteria-based grant" (CBG) for general capital outlays; and
- A "province-specific development grant" for specific development projects. This and CBG are based on a formula factoring indicators of population, income, poverty, health (low birth weight and neonatal mortality), education and infrastructure.[133]

Provincial and regional health managers rarely modify the allocated budgets. At government health institutions, staff wages and salaries, including allowances, are budgeted according to the appointed cadre. For medicines and supplies, health facilities produce an estimate in terms of items and quantities needed, but not the financial implications. Generally, regular Budget and block grant execution is close to 100%.[134]

Recent health financing reform

The adoption of the Essential Health Services Package in 2018 in Sri Lanka was one of the key steps towards broader reforms. This helped revise the curative primary health care system, making it better suited to address noncommunicable diseases, ageing and other challenges.[135] The proposed creation and operationalization of "shared care clusters" (local health systems following the district health system model) may impact the health financing system, as they have potential management responsibilities that impact the amount of government funding necessary and decentralized decision-making.

Sri Lanka

Macro picture

Indicator	Latest year	Value
Total population (thousands)[1]	2020	21 413
Employment to population ratio, 15+, total (%) (national estimate)[2]	2019	49.8
GDP per capita growth (annual %)[2]	2019	1.7
GDP per capita (current US$)[2]	2019	3 853
General government revenue (% of GDP)[3]	2019	12.7
Tax revenue (% of GDP)[2]	2018	11.9
General government total expenditure (% of GDP)[3]	2019	20.8
Fiscal balance (revenue–expenditure) (% of GDP)	2019	-8.2
General government gross debt (% of GDP)[3]	2019	86.8
Poverty headcount ratio at US$ 3.20 a day (2011 PPP) (% of population)[2]	2016	10.8
Poverty headcount ratio at national poverty lines (% of population)[2]	2016	4.1

[1] United nations, Department of Economic and Social Affairs, Population Division (2019). *World Population Prospects 2019: Volume II: Demographic Profiles.*

[2] World Bank Group. World Development Indicators, 2020. Washington, D.C.: 15 Oct 2020. https://databank.worldbank.org/source/world-development-indicators.

[3] IMF. *World Economic Outlook: A Long and Difficult Ascent*. Washington, D.C.: October 2020. https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020.

Progress towards universal health coverage

Fig. 2. SDG 3.8.1 Service Coverage Index (0–100)

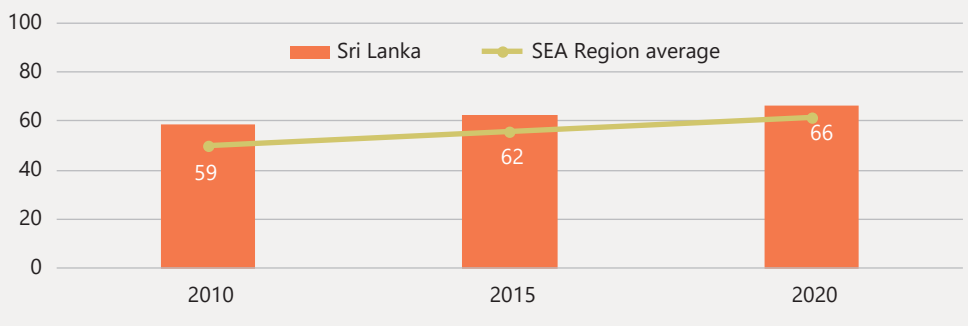
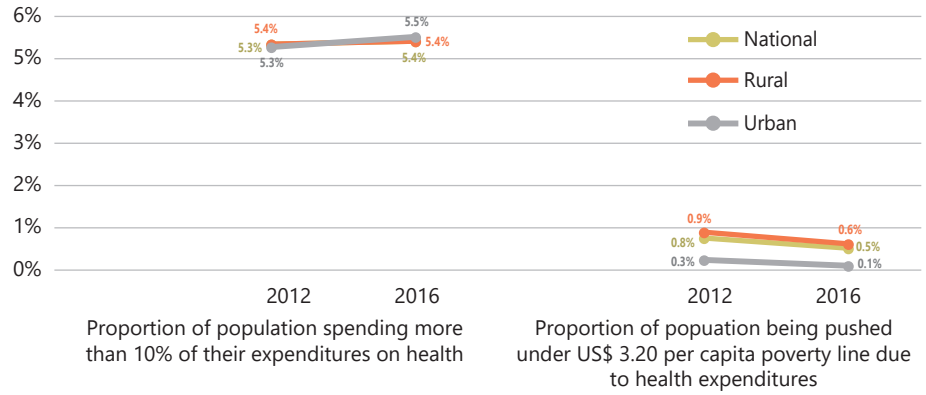


Fig. 3. SDG 3.8.2 Catastrophic and impoverishing incidence due to out-of-pocket expenditures on health



General health expenditure trends over the past decade

Fig. 4. Current health expenditures 2009–2018

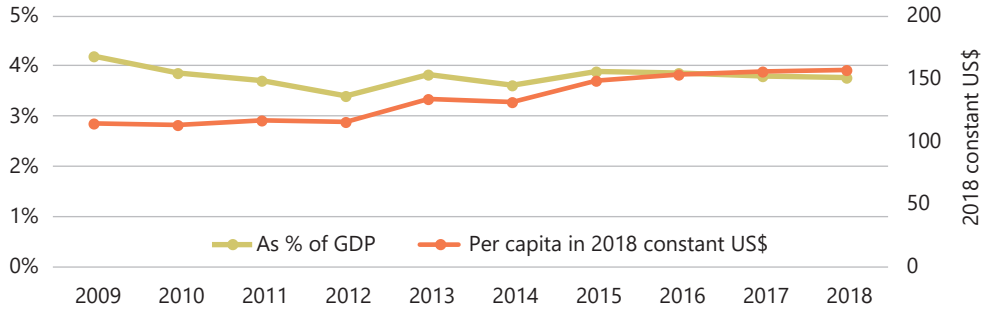


Fig. 5. Domestic government expenditures on health 2009–2018

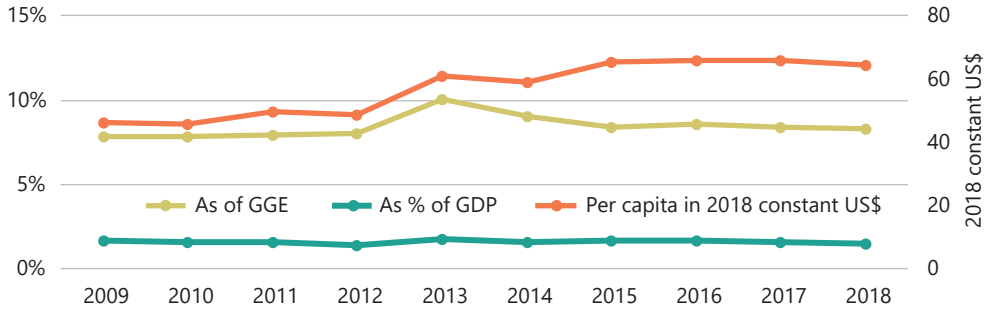
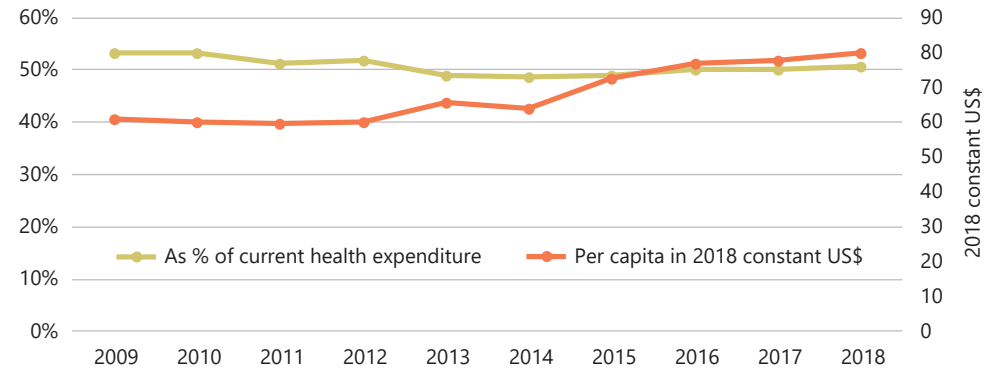
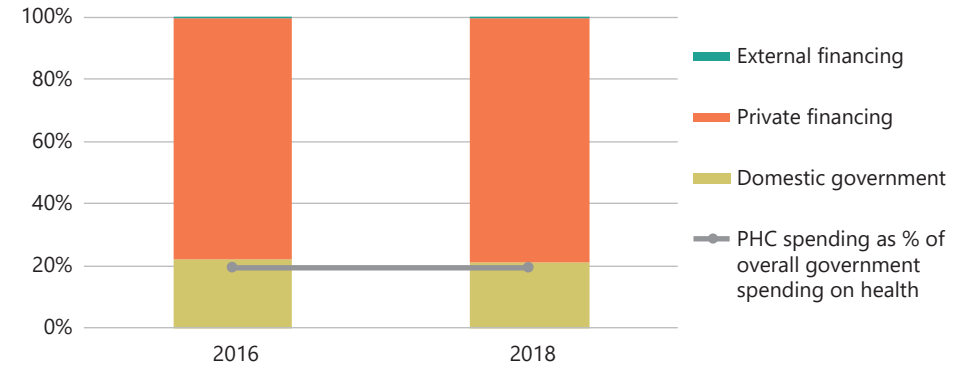


Fig. 6. Out-of-pocket spending on health (OOPS) 2009–2018



Primary health care expenditures[a]

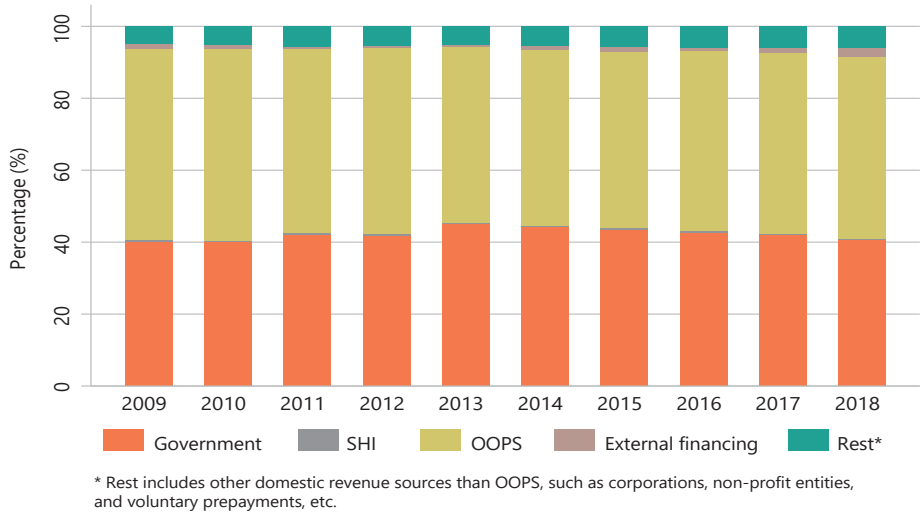
Fig. 7. Primary health care expenditures



a Primary health care measurement is entirely based on health care functions classification. Details of the measurement can be found here: Global spending on health: a world in transition. Geneva: World Health Organization; 2019 (WHO/HIS/HGF/HFWorkingPaper/19.4).

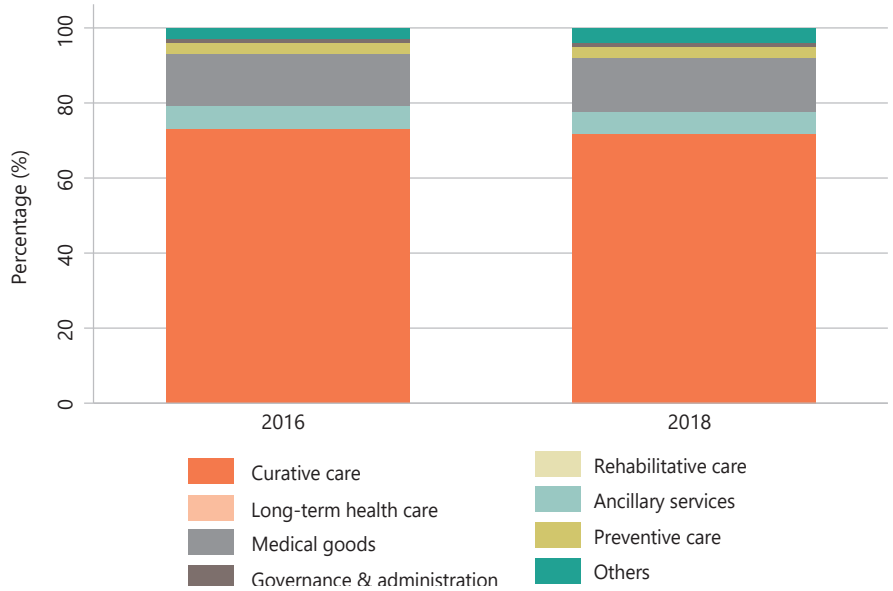
Composition of current health expenditures[b]

Fig. 8. Revenue sources of current health expenditures over the years



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

Fig. 9. Health expenditures by funtion



b "Ancillary services" and "medical goods" are independent consumptions that do not have a specific purpose (treatment, prevention, etc.) in themselves. Typical examples include laboratory services, imaging diagnosis, and patient transportation under "ancillary services", and pharmaceuticals (both prescribed and over-the-counter ones) as well as therapeutic goods (corrective glasses, hearing aids) under "medical goods". Consumption of such during a health-care contact are, therefore, lumped under other categories (i.e. curative care) and not separately reported.

Burden of diseases and disease-specific government expenditures

In Sri Lanka, the biggest share of spending was on noncommunicable diseases (2018), and it was mainly financed by private sources.

Fig. 10a. Health spending by disease categories, and revenue sources for noncommunicable diseases, 2018

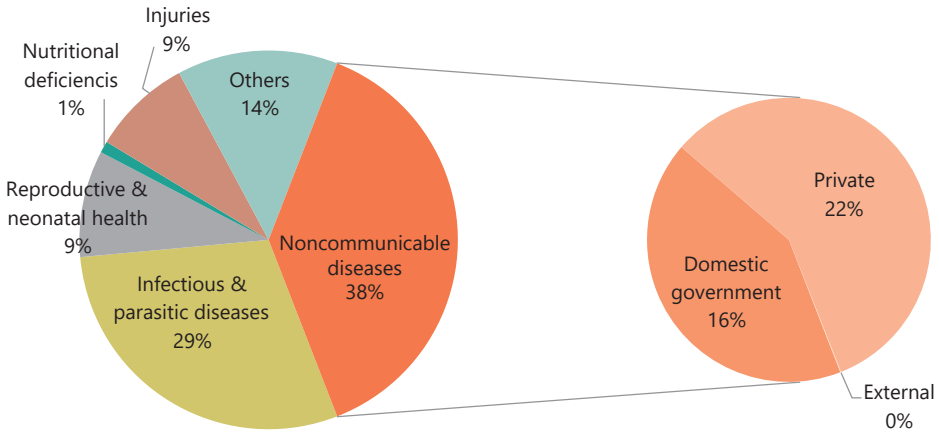


Fig. 10b. Burden of diseases, 2019

Rank by disorder (2019)		DALYs (%)
1	Diabetes mellitus	8.6
2	Ischemic heart disease	8.5
3	Stroke	5.5
4	Self-harm	3.5
5	Low back pain	3.4
6	Chronic kidney disease	2.9
7	Asthma	2.9
8	Road injuries	2.7
9	Neonatal disorders	2.6
10	Headache disorders	2.5
11	Chronic obstructive pulmonary disease	2.5
12	Age-related and other hearing loss	2.3
13	Cirrhosis and other chronic liver diseases	2.3
14	Lower respiratory infections	1.9
15	Falls	1.9
16	Depressive disorders	1.8
17	Other musculoskeletal disorders	1.8
18	Neck pain	1.7
19	Congenital birth defects	1.6
20	Anxiety disorders	1.6
21	Hypertensive heart disease	1.3
22	Blindness and vision loss	1.3
23	Alzheimer's disease and other dementias	1.2
24	Conflict and terrorism	1.1
25	Tracheal, bronchus, and lung cancer	1.1

Infectious and parasitic diseases
Reproductive health
Injuries
Nutritional deficiencies
Noncommunicable diseases

Thailand

Progress towards universal health coverage

Thailand's progress towards UHC has further accelerated in recent decades. Its UHC service coverage index increased from 68 in 2010 to 82 in 2020. As for financial risk protection, the share of the population affected by household catastrophic health expenditure increased from 1.5% in 2009 to 2.2% of population in 2017. In the same year, 0.01% were pushed into poverty because of out-of-pocket health expenditures, down from 0.06% in 2009 (under the US$ 3.20 per capita daily poverty line).[6]

Health system architecture and governance

In Thailand, three public health insurance schemes (PHI) coexist and cover the entire population, since 2002. They are: The Civil Servants Medical Benefit Scheme (CSMBS) covering civil servants and their relatives; the Social Health Insurance Scheme (SHI) covering private and formal sector employees of companies with more than 10 employees; and the Universal Coverage Scheme (UCS) covering the remaining population (i.e. poor and vulnerable, informal sector employees and those working in small companies). In addition, there are voluntary private health insurance schemes which cover about 2.2% of the population.[136]

The role of the Ministry of Public Health (MoPH) has changed significantly since the implementation of UHC in 2002. Now, it focuses on regulation, policy formulation and technical coordination, but it does not directly engage for instance in decisions on purchasing, or designing new benefit packages covered by the PHI.[137] Provincial health offices provide oversight and support for local health offices, health service delivery and has limited regulatory powers, while district health offices oversee, manage and deliver health services. In Thailand, public health facilities are the dominant care providers (75% of hospitals) and constitute networks – mostly following the district health system approach – under district and provincial health offices, alongside private providers that have contracts with the health insurance schemes.

Each of the PHI schemes is managed by semi-autonomous or autonomous agencies attached to different government ministries. The CSMBS is managed by the Department of the Comptroller-General (CGD), an agency of the Ministry of Finance (MoF). It is governed by an advisory board of 19 members that is chaired by the Permanent Secretary of the MoF. The SHI is managed by the Social Security Office (SSO), a department of the

Ministry of Labour. The SSO is accountable to a board composed of representatives of the government, employers and employees. The UCS is managed by the National Health Security Office (NHSO), an autonomous public agency.[138] The NHSO is accountable to a board that has broad participation, including from civil society organizations. Other autonomous health agencies include the Thailand Health Promotion Foundation (ThaiHealth), the Health Systems Research Initiative and the National Health Commission Office, which is in charge of developing health policy with broad participation from different elements of society.[139]

Raising revenue

Current health expenditure (CHE) as percentage of GDP was 3.8% in 2018, slightly up from 3.6% in 2009. Similarly, domestic government expenditure on health (GGHE-D) is 2.9% of GDP in 2018, up from 2.7% in 2009. By 2018, 15% of general government expenditure was allocated to the health sector, with a slight increase from 14.4% in 2009. The main sources of health sector revenue are the government Budget and compulsory pre-payment schemes. Domestic government expenditure on health as the percentage of CHE has increased from 67.7% in 2009 to 76.3% in 2018.[71]

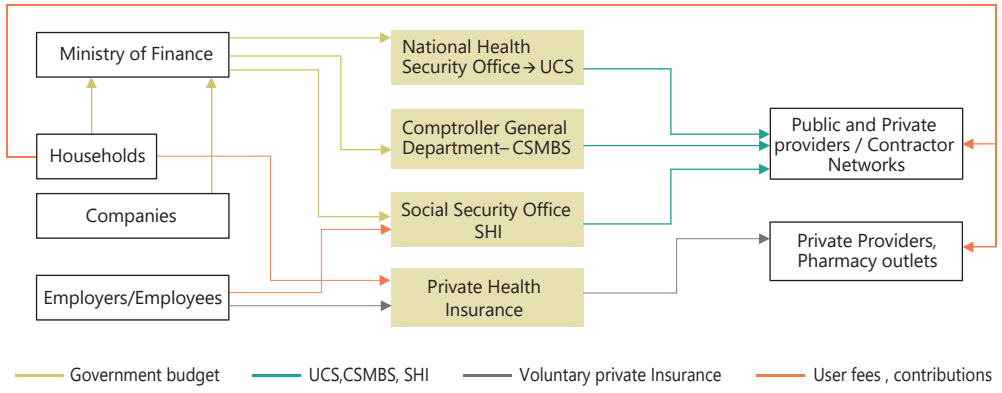
The government Budget is the revenue source for all three public health insurance schemes. CSMBS and UCS are fully funded by the government and there is no contribution from the beneficiaries. The SHI scheme is funded through tripartite and equally shared contributions: a 1.5% payroll tax contribution from the government, employers and employees in the private sector. A small proportion (less than 1%) of total health revenue is raised for ThaiHealth through a 2% surcharge levelled on excise taxes on alcohol and tobacco.

Voluntary private health insurance prepayments amounted to 6.8% of CHE in 2018. Out-of-pocket expenditure on health has fallen drastically since the achievement of UHC, and was 11% of CHE in 2018.[71]

Pooling and flow of resources

There are three separate funds for the health system in Thailand, which constitute around 80% of the total health budget. The MoF transfers budgets to CGD and NHSO, while three parties (MoF, employers and employees) deposit their contributions into the Social Security Office.

Fig. 1. Simplified fund flows in Thailand health system



Source: Adapted from World Health Organization. Regional Office for the Western Pacific. (2015) . The Kingdom of Thailand health system review. Manila: WHO Regional Office for the Western Pacific.

Benefits package

In Thailand, all three schemes provide comprehensive, and relatively similar, benefits to their target populations. All services, diseases and health conditions are covered by the health insurance schemes, with a few exceptions such as cosmetic surgeries, and services of unproven effectiveness such as stem-cell treatment.

Since 2010, the country is applying Health Technology Assessment (HTA) to decide whether to include high-cost services such as transplants and dialysis in the benefits package.[140] The HTA in Thailand allows for participation of different stakeholders, resulting in a more nuanced decision-making process for the adoption of new interventions and/or technologies.

Table 1. Benefits packages covered by public health insurance schemes in Thailand[140]

Benefits	UCS	SHI	CSMBS
Health services	Ambulatory and inpatient care, including emergency and accidents. Health promotion and prevention for beneficiaries of the three schemes	Ambulatory and inpatient care, including emergency and accidents. Health promotion and prevention under UCS	Ambulatory and inpatient care, including emergency and accidents. Health promotion and prevention under UCS
Medicines	Promote using drugs in the National Essential Drugs List	Promote using drugs in the National Essential Drugs List	Promote using ED but ways to approve non-essential drugs
Maternity	No limit	No limit and payment in cash (including ANC/PNC)	All related services included
Dialysis	Peritoneal dialysis and haemodialysis if have contraindication for PD	Both peritoneal & haemodialysis	Both peritoneal & haemodialysis
Organ transplantation	Kidney, liver, heart, bone marrow, cornea	Kidney, liver, heart, bone marrow, cornea	Includes all types of transplants
Dental care	Preventive and curative services	Reimbursements for user fees, but not exceeding a certain amount of money/ year	No limitation

With full premium, all private voluntary health insurance schemes offer similar benefits to the three public health insurance schemes, but with more choices to access private hospitals.[141]

Purchasing arrangements

Accordingly, there are three dominant purchasers of health services in Thailand: NHSO, SSO and CGD. They all exercise distinct purchasing mechanisms. The UCS uses a mix of capitation and case-based payments with a global budget payment mechanism. NHSO estimates age-adjusted capitation for outpatient services to a contractor, typically a district health-care provider network (including a district hospital and 10–12 subdistrict health centres serving a population of 50 000) based on the total number of members registered with the network. NHSO also sets a national global budget ceiling for admission

services. Based on the electronic record of every inpatient discharged from hospitals and the information on diagnostic-related groups (DRG), NHSO reimburses the total funds for admission services incurred by each hospital throughout the country on a monthly basis. A fee schedule is applied to certified providers, mostly those who provide high-cost services (such as bone marrow transplants). SSO allocates non-risk-adjusted capitation for outpatient and inpatient services to contracted hospitals based on the number of members registered with that contractor. Public and private hospitals are competing contractors for SHI members. In return, contractors must report the service output of both outpatients and inpatients (including DRG information) to the SSO on a monthly basis. There are also payments to providers based on a fee schedule, such as dialysis and other high-cost treatments, to mitigate the negative impact of capitation on under provision of services. CGD directly reimburses health-care providers for outpatient bills charged on fee-for-services on a monthly basis. Inpatient admission is paid by a conventional DRG, with the reimbursement rate varying by hospital. Individual hospitals receive different reimbursements based on the relative weight of DRG.[140]

Voluntary health insurance companies contract private providers on a fee-for-services basis. User fees are used to pay for medicines outside the essential drugs list covered by the PHI schemes, and for services and amenities not covered by the three schemes.

Public financial management

Since 2002, MoPH resource allocations to government health facilities and local health systems have been integrated into the UCS. With UCS, the annual Budget is estimated to be the total expenditure per UCS member for that Budget year, based on the previous year's utilization rate of outpatient and inpatient services as well as projections for that Budget year, cost for every outpatient and inpatient, plus other components such as prevention and health promotion services.

The UCS budget is a close-ended budget to keep overall expenditure under control. A similar process is followed with the SHI. On the other hand, the CSMBS budget planning approach is open-ended and based on historical trends and projections of total expenditure. CGD has overspent the approved budget for the last 20 years, but was cross-subsidized by the central emergency fund, subject to the approval of Parliament.[140]

Recent health financing reforms

Thailand continues to advance the main health financing reform of achieving universal health coverage (2002). This policy has been instrumental in supporting the country in containing health-care costs and improving strategic purchasing and accountability for public resources while at the same time ensuring wide coverage and in-depth financial protection. In 2010, Thailand adopted Health Technology Assessment as an explicit and evidence-based way of re-designing the health benefit packages.

Thailand

Macro picture

Indicator	Latest year	Value
Total population (thousands)[1]	2020	69 800
Employment to population ratio, 15+, total (%) (national estimate)[2]	2019	66.5
GDP per capita growth (annual %)[2]	2019	2.1
GDP per capita (current US$)[2]	2019	7808
General government revenue (% of GDP)[3]	2019	21.0
Tax revenue (% of GDP)[2]	2018	14.9
General government total expenditure (% of GDP)[3]	2019	21.8
Fiscal balance (revenue–expenditure) (% of GDP)	2019	-0.8
General government gross debt (% of GDP)[3]	2019	41.1
Poverty headcount ratio at US$ 3.20 a day (2011 PPP) (% of population)[2]	2018	0.5
Poverty headcount ratio at national poverty lines (% of population)[2]	2018	9.9

[1] United Nations, Department of Economic and Social Affairs, Population Division (2019). *World Population Prospects 2019: Volume II: Demographic Profiles.*

[2] World Bank Group. World Development Indicators, 2020. Washington, D.C.: 15 Oct 2020. https://databank.worldbank.org/source/world-development-indicators.

[3] IMF. *World Economic Outlook: A Long and Difficult Ascent*. Washington, D.C.: October 2020. https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020.

Progress towards universal health coverage

Fig. 2. SDG3.8.1 Service Coverage Index (0–100)

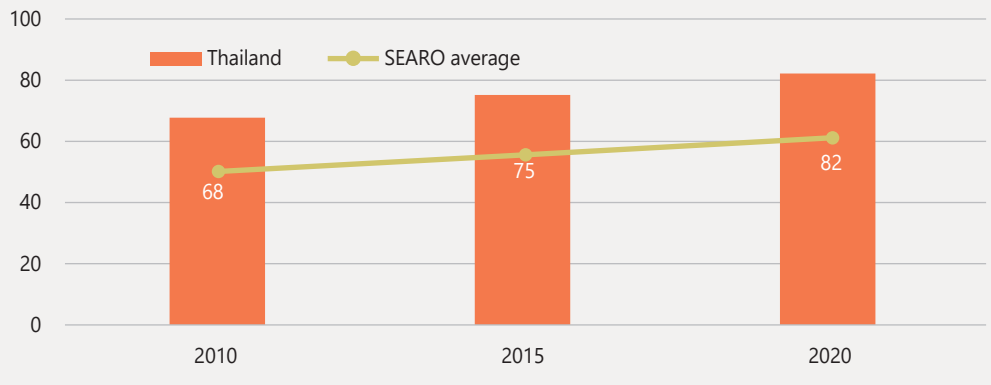
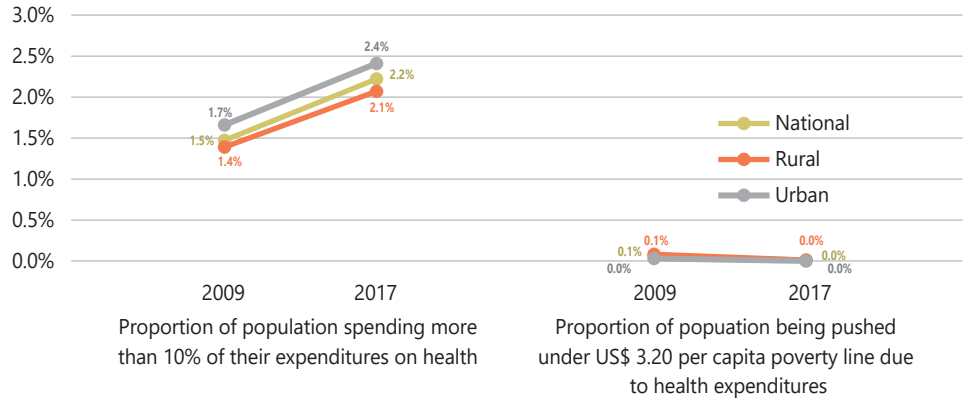


Fig. 3. SDG 3.8.2 Catastrophic and impoverishing incidence due to out-of-pocket expenditures on health



General health expenditure trends over the past decade

Fig. 4. Current health expenditures, 2009–2018

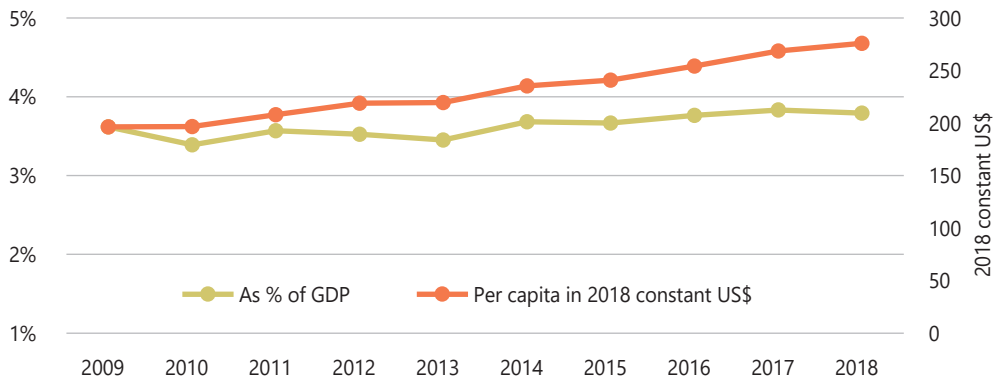


Fig. 5. Domestic government expenditures on health, 2009–2018

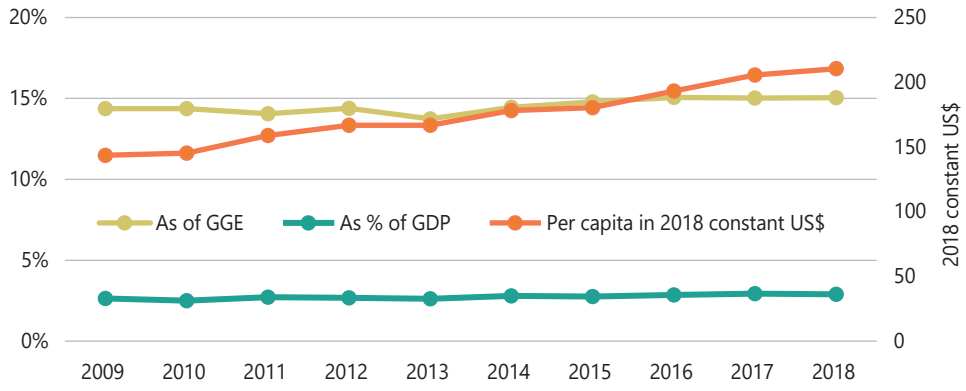
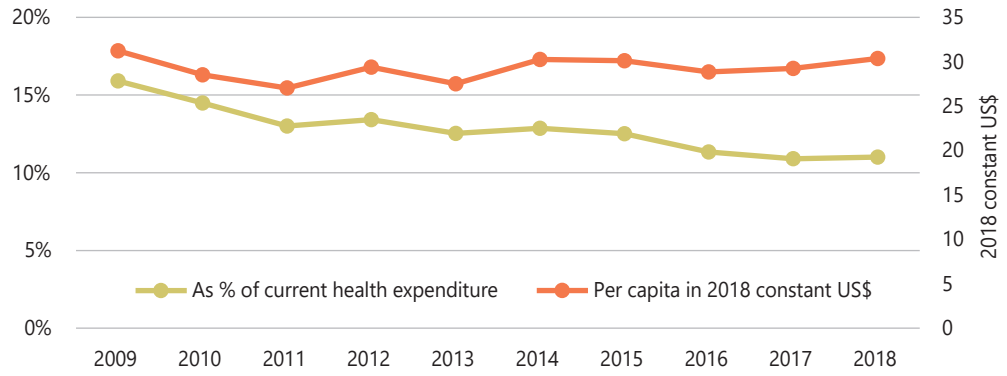


Fig. 6. Out-of-pocket spending on health (OOPS), 2009–2018

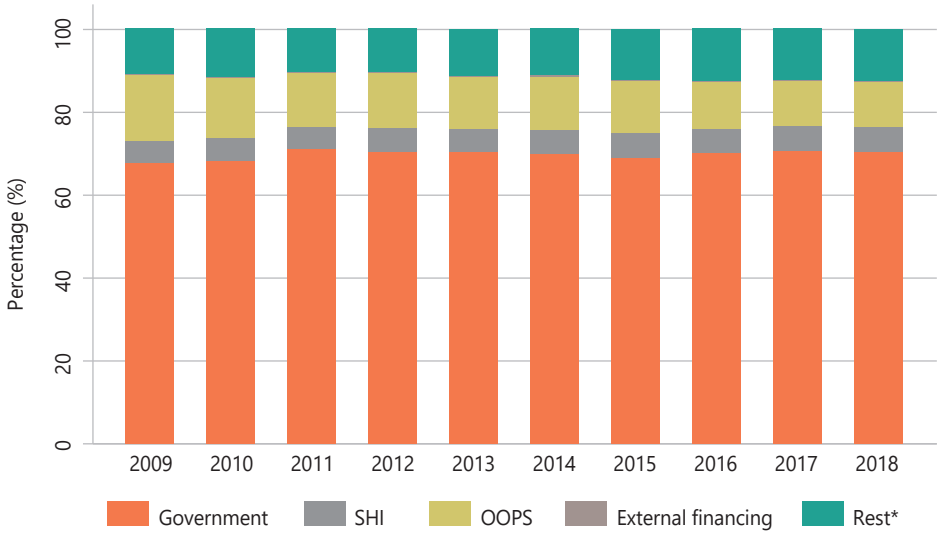


Primary health care expenditures

No data available.

Composition of current health expenditures

Fig. 7. Revenue source of current health expenditures over the years



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

Burden of disease and disease-specific government expenditures

Fig. 8. Burden of disease, 2019

Rank by disorder (2019)		DALYs (%)
1	Stroke	6.19
2	Road injuries	5.11
3	Ischemic heart disease	4.98
4	Diabetes mellitus	4.25
5	HIV/AIDS	3.88
6	Chronic kidney disease	3.50
7	Low back pain	3.50
8	Liver cancer	3.07
9	Cirrhosis and other chronic liver diseases	2.98
10	Lower respiratory infections	2.93
11	Other musculoskeletal disorders	2.88
12	Headache disorders	2.66
13	Tracheal bronchus and lung cancer	2.54
14	Chronic obstructive pulmonary disease	2.48
15	Age-related and other hearing loss	2.34
16	Depressice disorders	1.85
17	Neck pain	1.76
18	Alzheimer's disease and other dementias	1.61
19	Self-harm	1.59
20	Falls	1.53
21	Neonatal disorders	1.41
22	Blindness and vision loss	1.33
23	Anxiety disorders	1.25
24	Interpersonal violence	1.19
25	Colon and rectum cancer	1.18

Infectious and parasitic diseases
Nutritional deficiencies
Reproductive health
Noncommunicable diseases
Injuries

Timor-Leste

Progress towards universal health coverage

Timor-Leste is making steady progress towards UHC. The UHC service coverage index increased from 37 in 2010 to 55 in 2020. Recent data on financial risk protection shows that household catastrophic health expenditure impacts 2.9% of the population, while 0.62% were pushed into poverty due to out-of-pocket health payments in 2014 (under the US$3.20 per capita daily poverty line).[6]

Health system architecture and governance

Timor-Leste, by and large, has a publicly financed and delivered health system. The public health system is structured in four levels of care delivered via health posts and community health centres across all districts, five secondary referral hospitals and one national hospital, the Guido Valadares National Referral Hospital (HNGV) in Dili, the capital. The private sector is limited to a few private clinics (in urban areas) and pharmacies, but no hospitals.

With administrative and financial decentralization implemented since 2015, the municipal authorities and administrations are responsible for the management of the health services that were previously under the Ministry of Health. A partial financial decentralization is implemented with the municipal administrations, who may decide on some health resource allocations, while the bulk of the health budget remains under the responsibility of the Ministry of Health. However, a full devolution is implemented in the Autonomous Region of Oecusse-Ambeno where the local government exercises power over the health budget. In addition, four public institutions are involved in service delivery: the HNGV, Medical Stores (SAMES) and the National Health Institute (INS) and the National Laboratory. These organizations operate autonomously, with direct budget transfers from the Ministry of Finance (MoF).

Raising revenue

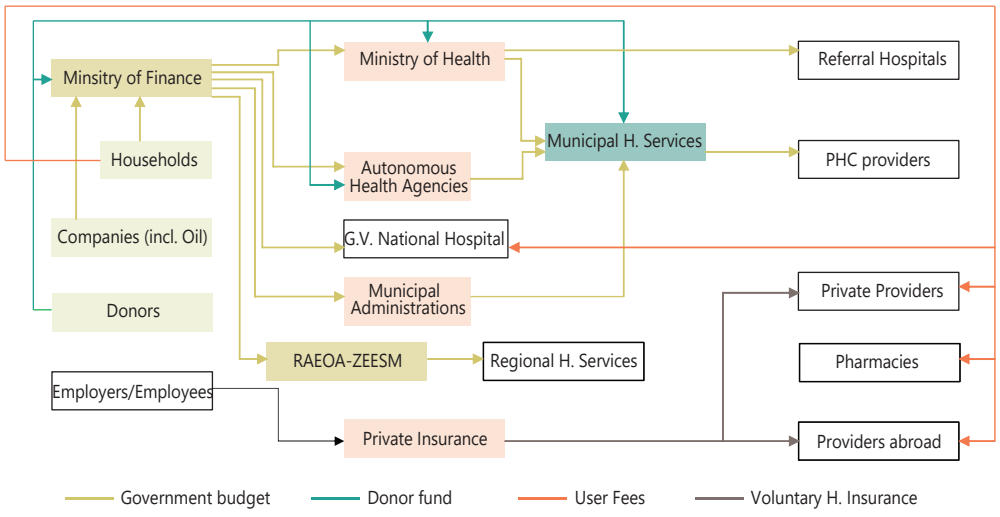
Current health expenditure (CHE) as percentage of GDP has increased as a result of oil-related revenues, from 1.7% in 2009 to 4.3% in 2018. The proportion of domestic government expenditures on health (GGHE-D) in relation to GDP grew sharply from 0.7% (2009) to 2.6% in 2018. The health sector is a priority for the government; hence GGHE-D

has doubled as a percentage of total government spending, from 2.7% in 2009 to 5.4% in 2018. As result, the government budget constitutes the largest source of health financing in Timor-Leste at 67.7% of CHE in 2018, up from 44.4% in 2009. External donors have provided substantial contributions to the health sector; however, this source of funding has drastically declined to 19.7% of CHE in 2018, from 46.7% in 2009. Out-of-pocket spending on health decreased from 8.8% of CHE in 2009 to 7.1% in 2018. Private revenues and voluntary health insurance contributed about 5% of CHE in 2018.[71]

Pooling and flow of resources

Public resources for the health sector are managed by several government institutions in part due to the decentralization reform in Timor-Leste. Until 2014, the vast majority of the government health budget was pooled at the MoH. By 2017, the MoH's pool was reduced to about 55% of the government health Budget. The rest remains with the MoF for allocation to municipal authorities, autonomous institutions and others (Fig. 1). Only a few donors channel their resources to the MoH fund.

Fig. 1. Simplified flow of funds in Timor-Leste health sector



Source: Adapted from World Health Organization. Regional Office for South-East Asia. Health financing profile 2017:Timor-Leste. World Health Organization. Regional Office for South-East Asia; 2017.

Benefits package

Services in government health facilities are free of charge at the point of delivery. In addition, the government has initiated community services through two main programmes: SISCa and *Saúde na Familia* (family health programme). Launched in 2015,

the *Saúde na Familia* is the government's flagship primary care programme which aims to provide service delivery close to households, including hard-to-reach families. SISCa (*Sistema Integrado de Saúde Comunitaria* or Integrated Community Health System) delivers most of the primary health care services offered at health facilities to communities without the confinements of physical structures. SISCa thereby extends the reach of basic PHC services to the community level promoting the involvement of beneficiaries in decisions about their health and health care. The range of health services provided at all five referral hospitals and the HNGV is limited, and patients are often referred for treatment abroad.[141] Private voluntary insurance schemes cover private provisions available in Timor-Leste and health care outside the country. User fees are charged at the national referral hospital (HNGV) for a few, specific and non-essential services.

In 2015, the MoH defined a Comprehensive Service Package for Primary Health Care,[142] which was revised in 2019, for an Essential Services Package.[143] The new package is more specific (i.e. it includes screening, diagnosis and management of selected noncommunicable diseases) and integrates all levels of the district health system. The cost of delivering the new package was estimated at US$ 57 per capita (against a per capita expenditure at the PHC level estimated at US$ 47).[144]

Table 1. Essential Services Package

Maternal care	Curative care
Postnatal care	Acute conditions
Child care	Noncommunicable diseases
Family planning	Diabetes
***Saúde na Familia* (home visits)**	Hypertension
	COPD/asthma
	Hospital admissions

Purchasing arrangements

The MoH acts as the main purchaser of services provided by the referral hospitals and municipal health services and monitors health service-related activities and outcomes across the sector. In general, line-item budgets for goods and services to health facilities and institutions are transferred either directly by MoF or through MoH. Health workers are salaried employees of MoH. Medicines procurement is centralized at SAMES, and is then distributed in kind to health facilities directly or through the municipal health services.

Health care abroad is contracted by the MoH to selected hospitals in Indonesia, Singapore and Malaysia on a fee-for-service arrangement.[142] People pay direct out-of-pocket payments mostly to purchase medicines from private pharmacy outlets.[145]

Public financial management

Budget formulation is done by different institutions, including MoF and the Prime Minister's Office, and MoH and Ministry of State Administration. The MoF and MoH budgeting process is largely a top-down one and based on past year line-item expenses. In 2017, the MoH introduced programme budgeting and is piloting an allocation formula to decide on budgets for goods and services for the programmes of the municipal health services.[142] The SAMES and MoH budget for medicine and supplies according to requisitions and past consumption patterns by government health facilities. A significant amount of donor funding remains off-budget.

The budgets are directly disbursed by the MoF to autonomous health institutions and municipalities. Non-spent or non-obligated (even if committed) funds revert to the MoF. User fee collections are deposited in the MoF account and integrated into the general government budget. Health budget execution has improved in recent years, from 63% in 2012 to 88% in 2019. The MoF publishes the government's Budget execution updates through its budget transparency portal that is accessible to the public. It is complemented by self-reported foreign assistance through the aid transparency portal.[146]

Recent health financing reforms

A five-year Health Financing Strategy (HFS) was launched in 2019[147] in the broader context of shrinking oil revenues in Timor-Leste. The strategy advocates for increased government health spending, streamlined pooling of health budgets, introduction of strategic purchasing and revision of the limited package of health services. To this end, pilots to introduce programme budgeting and resource allocation formulas, to revitalize the Family Health programme, and implement the Essential Services Package for primary care, are currently underway.

Timor-Leste

Macro picture

Indicator	Latest year	Value
Total population (thousands)[1]	2020	1318
Employment to population ratio, 15+, total (%) (national estimate)[2]	2016	63.9
GDP per capita growth (annual %)[2]	2019	1.4
GDP per capita (current US$)[2]	2019	1294
General government revenue (% of GDP)[3]	2018	58.2
Tax revenue (% of GDP)[2]	2018	25.0
General government total expenditure (% of GDP)[3]	2018	86.2
Fiscal balance (revenue–expenditure) (% of GDP)	2018	-28.1
General government gross debt (% of GDP)[3]	2018	9.3
Poverty headcount ratio at US$ 1.90 a day (2011 PPP) (% of population)[2]	2014	22.0
Poverty headcount ratio at national poverty lines (% of population)[2]	2014	41.8

[1] United Nations, Department of Economic and Social Affairs, Population Division (2019). *World Population Prospects 2019: Volume II: Demographic Profiles.*

[2] World Bank Group. World Development Indicators, 2020. Washington, D.C.: 15 Oct 2020. https://databank.worldbank.org/source/world-development-indicators.

[3] IMF. *World Economic Outlook: A Long and Difficult Ascent*. Washington, D.C.: October 2020. https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020.

Progress towards universal health coverage

Fig. 2. SDG 3.8.1 Service Coverage Index (0–100)

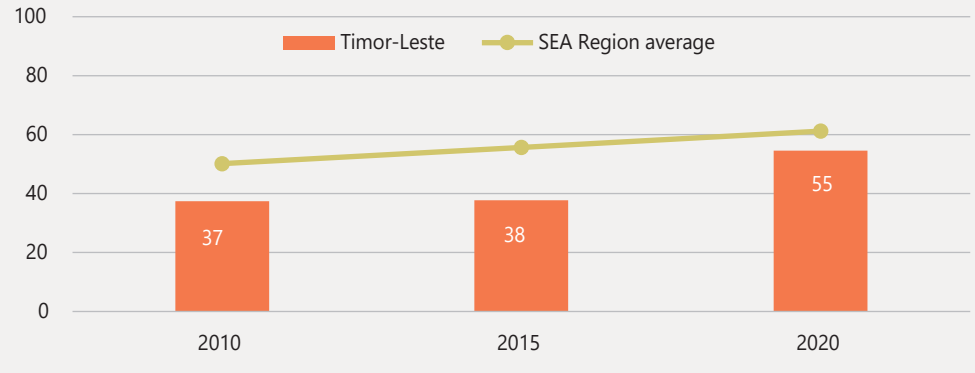
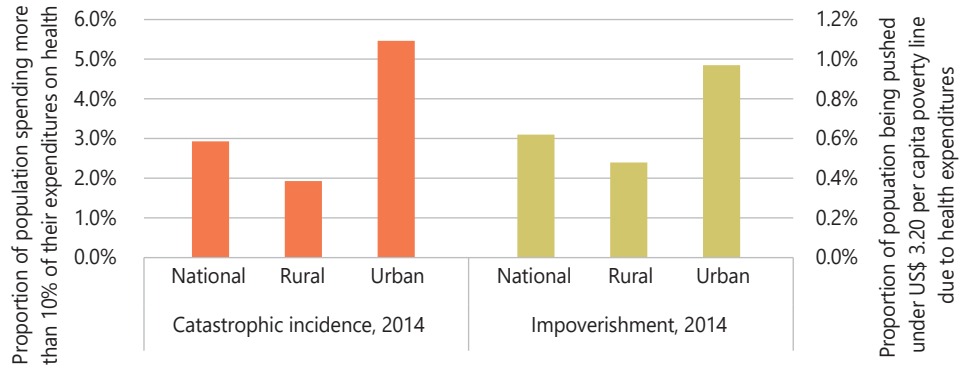


Fig. 3. SDG 3.8.2 Catastrophic and impoverishing incidence due to out-of-pocket expenditures on health



General health expenditure trends over the past decade

Fig. 4. Current health expenditures 2009–2018

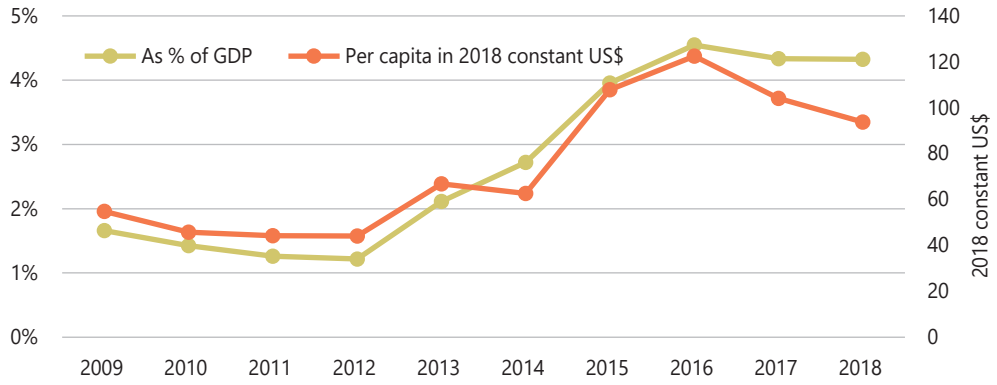


Fig. 5. Domestic government expenditures on health 2009–2018

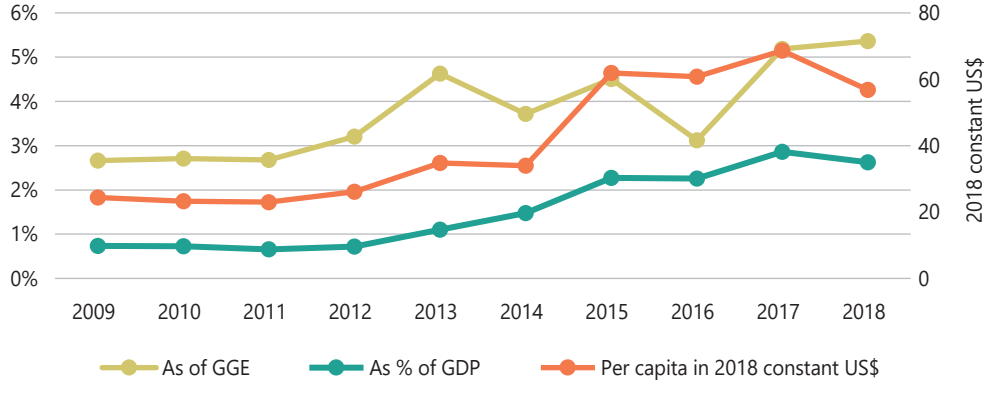
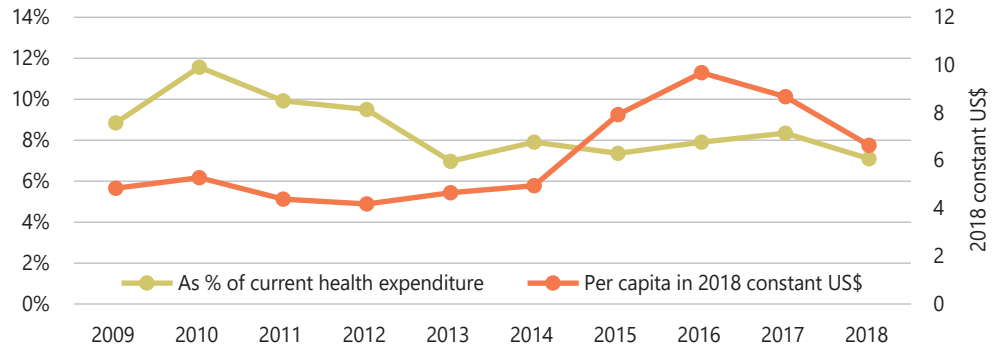
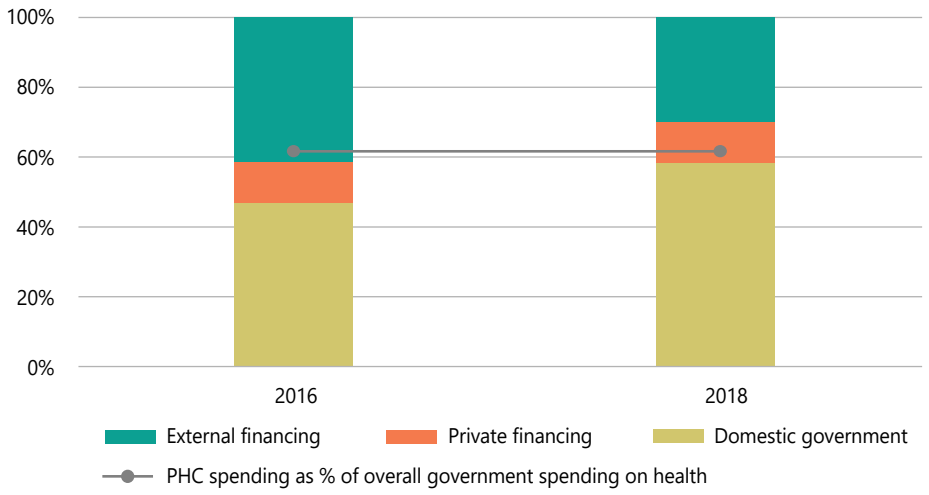


Fig. 6. Out-of-pocket spending on health (OOPS) 2009–2018



Primary health care expenditures[a]

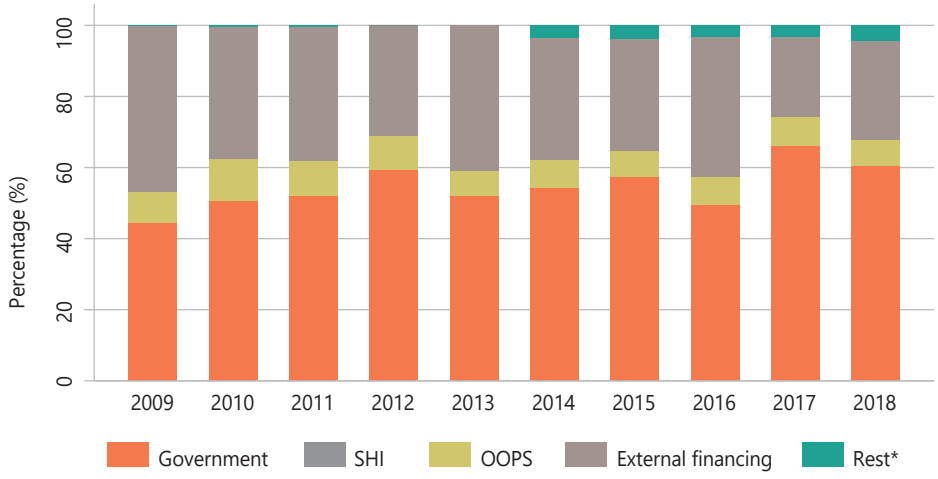
Fig. 7. Primary health care expenditures



a Primary health care measurement is entirely based on Health Care Functions classification. Details of the measurement can be found here: Global spending on health: a world in transition. Geneva: World Health Organization; 2019 (WHO/HIS/HGF/HFWorkingPaper/19.4).

Composition of current health expenditures[b]

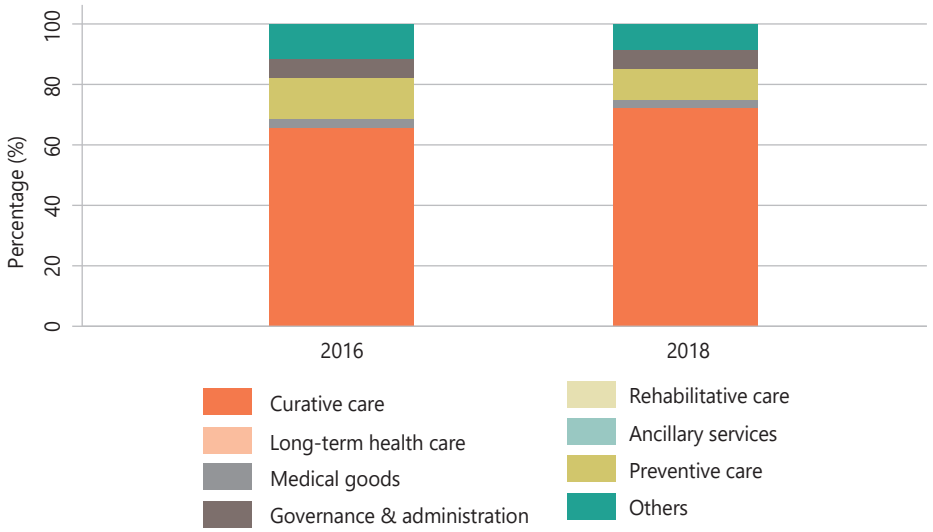
Fig. 8. Revenue sources of current health expenditures over the years



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

Burden of disease and disease-specific government expenditures

Fig. 9. Health expenditures by function



b "Ancillary services" and "medical goods" are independent consumptions that do not have a specific purpose (treatment, prevention, etc.) in themselves. Typical examples include laboratory services, imaging diagnosis, and patient transportation under "ancillary services", and pharmaceuticals (both prescribed and over-the-counter ones) as well as therapeutic goods (corrective glasses, hearing aids) under "medical goods". Consumption of such during a health-care contact are, therefore, lumped under other categories (i.e. curative care) and not separately reported.

Fig. 10. Burden of disease, 2019

Rank by disorder (2019)		DALYs (%)
1	Neonatal disorders	12.30
2	Stroke	7.02
3	Lower respiratory infections	6.97
4	Ischemic heart disease	5.57
5	Congenital birth defects	3.73
6	HIV/AIDS	3.34
7	Diarrheal diseases	3.04
8	Tuberculosis	2.69
9	Road injuries	2.41
10	Chronic obstructive pulmonary disease	2.26
11	Diabetes mellitus	2.10
12	Low back pain	2.09
13	Headache disorders	1.88
14	Chronic kidney disease	1.86
15	Cirrhosis and other chronic lever diseases	1.63
16	Asthma	1.40
17	Age-related and other hearing loss	1.38
18	Conflict and terrorism	1.38
19	Depressive disorders	1.21
20	Dietary iron deficiency	1.18
21	Anxiety disorders	1.10
22	Drowning	1.10
23	Whooping cough	1.08
24	Hypertensive heart disease	1.02
25	Blindness and vision loss	1.02

Infectious and parasitic diseases
Reproductive health
Injuries
Nutritional deficiencies
Noncommunicable diseases

Conclusions

During the unparalleled year 2020, countries have had to respond to the effects of the ensuing COVID-19 pandemic and the economic crisis – all while trying to maintain essential health services and continue progress towards UHC. There is still a high level of uncertainty as to what exactly will happen and what is the "new normal" in health financing, both in relation to the pandemic and to the economy. Currently, the prospects for recovery are still very mixed and will ultimately impact the trajectory of health financing in the Region in the coming years. Countries in the Region and elsewhere are dependent on the revival of economic activity (i.e. trade, tourism, investment) while balancing the massive challenge of ensuring sufficient supply and effective deployment of vaccines and the containment of COVID-19.

The COVID-19 pandemic could not have made the link between population health and economic growth clearer. The "new normal" will need to recognize the critical importance of health in contributing to economic growth. Sufficient and sustainable vaccine financing, and capacity to roll out a massive, targeted immunization effort,[148] can offer the opportunity for recovery of economic activities. In the pandemic context of negative economic growth, large proportion of debt servicing, and fiscal crunch, there is need for a comprehensive and systems-oriented financing approach that ensures countries can overcome this crisis and be prepared to withstand future ones.

This report analyses health spending trends across countries in the SEA Region over the period of 2009 to 2018 and provides brief health financing systems profiles of countries of the Region prior to the onset of COVID-19. In addition, this report reviews the immediate health financing policies that countries implemented in response to the early phase of the COVID-19 pandemic in 2020.

Until COVID-19 hit the world, WHO South-East Asia was the fastest growing Region in the world in economic terms. The average annual per capita GDP growth rate for the Region was 4.1% from 2009 to 2019 – with annual GDP growth rates in Bangladesh, India and Myanmar exceeding 5% per year. Population health improved substantially, with life expectancy at birth on average increasing from 69.4 years in 2009 to 72.3 years in 2018,[2] for example.

However, the Region still has one of the highest poverty rates in the world and the majority of its workers are in the informal sector (78.6% of the total workforce between 2013 and 2019).[4] Government revenues remain low, and some countries could be facing a looming debt crisis. Tax revenue as a share of GDP in the SEA Region was only 15% in 2018, on average, with most fiscal balances averaging below -5% of GDP over the period of 2018–2019. Public debt levels were around 30% to 40% of GDP on an average,

but some countries experienced debt levels above 70% of their GDP, such as India and Maldives.[2] Debt servicing represented about a third of all government spending in Sri Lanka in 2019.[3]

Health financing and the path to UHC

With regard to health expenditure, this report shows that prior to the COVID-19 crisis, lower-middle-income countries in the SEA Region were experiencing a transition. There has been a decline in reliance on donor financing and some improvement in prioritizing the health sector in overall government spending over the past decade.

At the same time, some trends have persisted despite the need for change. The health sector still received less than 5% of the entire government budget in four countries in the Region. When compared with other WHO regions, the SEA Region has the smallest health sector (as measured by current health spending as a percentage of GDP), and most countries spent less on health than countries with similar income levels in other WHO regions.

The growth rate of per capita health expenditures was much lower than that of GDP per capita after the 2008 financial crisis, contrasting with the experience prior to the crisis and diverging from other WHO regions. As a result, by 2018, the SEA Region had the second lowest per capita health expenditures, on average, among all WHO regions. In addition, domestic government spending on health continued to be low, comprising less than 50% of the entire health spending in most countries. As a result, the SEA Region remains the region with the highest share of out-of-pocket health spending – at 40% in 2018.

Like in other settings, health planning and financing in countries of the SEA Region is linked to overall government systems. A trend that is being observed in the Region is that it is becoming increasingly decentralized or deconcentrated, following broader public service reforms. While some countries such as India and Indonesia have a longer history of decentralization, others have only started in recent years with partial devolution, as in the case of Nepal and Timor-Leste. Nevertheless, the administrative devolution of functions and responsibilities was not always matched by extending financial means and enabling decision-making to health managers, as in the case of Nepal and Sri Lanka.

Resource pools for health in the Region tend to be fragmented across government institutions and schemes. In some cases, there is a plethora of parallel schemes, such as in India with PM-JAY, state-level schemes, NHM, ESIS and CGHS. In others, the number of schemes is more limited, such as in Thailand with UCS, CSMBS and SSS, though these still face inefficiencies and inconsistencies. Countries with more unified pools include Bhutan, Sri Lanka and Timor-Leste but, in many countries, donors pool only a limited share of their health resources through the public system.

Several countries in the Region still experience a more traditional public financial management system. In most countries, budgeting is incremental based on an input-

based, line-item approach. Thus, the link between health sector planning and budgeting is still weak. Although, low health budget execution rates have raised concerns in the SEA Region, several countries, such as Bhutan, Myanmar and Sri Lanka, have shown better execution rates in recent years. Still, many health budgets have been designed and implemented with limited managerial flexibility at the grassroots level. In contrast, several countries such as India, Nepal and Timor-Leste have initiated public financial management reforms.

Given the limited amount of public resources, most countries in the SEA Region have defined an explicit package of health services to ensure access to essential services: some are more comprehensive, while others are more basic. However, these packages have not always been clear with respect to financial implications and, for those where costing information is available, there seems to be a disconnect between the resource envelope available and budgetary allocations.

This results in unfunded mandates assigned to health-care providers as well as leads to disputes and mistrust among the population. For instance, in Bangladesh, the essential service package is estimated to cost between US$ 6 to US$ 7 per capita and was designed to be delivered at the district level and below. Yet, the total public spending on health per capita in Bangladesh corresponds to the same costed amount, i.e. US$ 7.

Health purchasing in most of the Member States of the SEA Region remains mainly passive. Resources tend to be allocated according to historical norms and patterns, while active monitoring and incentive systems towards providers tends to be limited or lacking. In contrast, both Thailand and Indonesia have introduced reforms over the past decade that led to the establishment of strong institutional arrangements to carry out strategic purchasing functions.

Among these are the set-up of provider payment mechanisms and tariffs that are results-oriented and linked to largescale demand-side health insurance schemes. Evidence on cost effectiveness, equitable access to new interventions and long-term budget impacts guided the benefits package in Thailand.[149] Other countries, such as India, have initiated reforms more recently with a view to establish rules and systems for managing and monitoring providers.

Recent reforms

Over the past decade, health financing strategies in the Region have been focused on policy directions in the medium to longer terms when common reforms included design of essential health benefit packages and the introduction of health insurance schemes. Further, health financing strategies have often been designed to generate additional resources for health; pilot resource allocation formulas; and introduce elements of strategic purchasing.

However, in some instances, implementation has been hampered by the lack of a necessary legal framework and limited fiscal space for health, such as in Bangladesh. Health insurance schemes introduced in India, Indonesia, Maldives and Nepal between 2012 and 2018 have been largely driven by the impetus to achieve UHC. Indonesia was able to expand coverage by rapidly reaching 83% of the country's population by 2019. Now, it faces financial viability challenges due to substantial deficits, linked to low levels of premium contributions and insufficient government subsidies.

Benefits packages introduced over the past decade in several countries have not been consistently accompanied by reforms to facilitate their effective implementation. A few lessons can be drawn from the evolution of the benefits package in Thailand over the last 20 years.[141] Addressing weak supply-side readiness; improving the scope for reallocation of existing resources; enhancing managerial capacity and accountability,[150] besides ensuring adequate levels of financing to match the costs of delivering the package, and integrating the flow of funds towards the package, should have also been addressed in the reforms.

It appears that some of the reforms introduced in the Region in the past decade have not always been cognizant of the broader context within the health sector or been integrative of other parts of the public system. For instance, there have been reforms that introduced health insurance schemes to cover only hospital care, which challenge the crucial integration with the PHC system that is a prerequisite to supporting the continuum of care.

Furthermore, the sustainability of these schemes has also not always been central to budgetary negotiations between the ministries of health and finance and their priorities. Experience suggests that the feasibility of implementing such reforms need to go beyond technical solutions to explore the political economy levers that play a role in their success.[151] As demonstrated by Thailand, political economy and power played a significant role in shaping the UCS reform.[152]

Responding to the COVID-19 pandemic

It is against this backdrop that countries in the Region were hit by the COVID-19 pandemic in 2020. The pandemic imposed unprecedented resource and multisectoral policy challenges on all countries, requiring them to implement rapid and effective prevention and control measures. However, the immediate health financing policy measures put in place – i.e. in the first six months of the outbreak – revealed that the pandemic created political impetus for countries to introduce meaningful financial protection measures to improve access to essential health services.

Nearly all Member States of the SEA Region rapidly enacted policies to reduce financial barriers to seeking care (testing and treatment) for COVID-19-related services, implemented new cash transfer schemes or augmented existing ones, and instituted

PFM changes to streamline the procurement of essential resources and ensure cash flows swiftly to support emergency measures.

The majority of SEA Region countries ensured and expanded COVID-19-related health services in publicly funded benefit packages, namely COVID-19 testing, hospitalization and medication. Most countries, at least at the start of the pandemic, made them available free of charge in the public sector. Contracting arrangements were simplified in several countries such as in India in order to empanel or accredit hospital facilities, often on a temporary basis, with the strengthening of post-registration surveillance to ensure quality, in some instances.

The operationalization of these policies has required countries to mobilize significant resources to finance the COVID-19 response, re-emphasizing the importance of public spending on health and adequate fiscal space. As experience has shown, progress towards the Sustainable Development Goals, relies on public spending on social sectors, including health.[153,154,155,156,157,158] While data are scarce, it appears that SEA Region countries typically mobilized resources from multiple sources including by reallocations within the existing budget envelope and additional aggregate spending. Also, for some countries, partner funding has been a significant component of the overall response.

The government funding response to COVID-19 as reflected in government budgetary allocations for health systems in the first months of the pandemic was overshadowed by spending measures devoted to shoring up the economy. The magnitude of needs in each sector is different, and these allocations are complementary. Investing in health means investing in the economy, as the COVID-19 crisis made ever clearer. However, the limited allocation to the health sector in some settings could be linked to the lack of absorptive capacity to translate large increases in expenditure into effective service delivery in a short space of time. This has been a chronic problem faced by health systems in low- and middle-income countries, which have used this in the past to justify the use of parallel vertical programmes.[159] Another possible explanation is that additional resources for health were allocated later and were outside the timeframe during which data was gathered for this review. Careful monitoring will be required to track such spending over the duration of the pandemic and beyond to allow for policies to secure investments in health security and health systems strengthening.[12]

Several SEA Region Member States made changes to PFM systems to ensure that exceptional budget allocations were rapidly disbursed and could be used with more flexibility while at the same time safeguarding accountability and transparency. Advance payment, electronic payment systems to accelerate funding disbursements, reducing virement restrictions to rapidly reallocate domestic budget, and relaxing approval processes for appropriations were common examples of these changes. However, some countries have not managed to use exceptional budget allocations for the COVID-19 responses to their full potential, partly due to pre-existing public financial management bottlenecks and lack of broad implementation capacity.

Most countries in the SEA Region provided some form of social welfare assistance for some targeted groups of the population that were affected by the COVID-19 'stay home policy'. This mostly took the form of unconditional cash transfers; however, these tended to be small, of limited duration and, occasionally, built upon existing programmes that often had inefficient eligibility and targeting. Yet, such support was and remains critical as income inequality, disparities in health-care access, and out-of-pocket spending have been historically very high among several SEA Region countries.

The situation is likely to worsen, as poverty is projected to rise due to the reduction in economic activity imposed by the COVID-19 pandemic, for the first time in several decades. Between 48 to 59 million people are estimated to have been pushed into extreme poverty (less than US$ 1.90 a day) in 2020 in the SEA Region.[9] The differences in the speed and magnitude of implementation of health financing policy responses likely reflects the stage of the outbreak in each country, the country's position in terms of progress towards UHC and their relative budgetary and fiscal contexts.

For instance, countries with well-established purchasing functions were able to engage the private sector rapidly with oversight of price, quality and reporting of COVID-19-related treatment (such as Thailand). But limited regulatory frameworks, in several countries, meant COVID-19 tests and treatment was common, and price ceilings were needed as a control mechanism. These experiences reiterate the importance of preparing a coordinated and integrated approach with the private sector to ensure that the activities of the public and private health sector actors are well aligned for future preparedness strategies.

The pandemic also stimulated innovations and refocused priorities that may support progress towards UHC, such as the adoption and enhanced use of digital technologies, streamlined procurement systems, greater intersectoral collaboration, and importantly, the extension of free health-care services to marginalized populations.

As countries recover from the pandemic they are encouraged to continue, consolidate and deepen these reforms, while recognizing the challenge to meeting their resource implications. Such achievements make it difficult to roll back these measures and thus may provide the political capital needed to ensure the longer-term prioritization of UHC.

Recommendations

Countries will need to continue responding to the crisis, while maintaining essential health services, and undertaking herculean efforts to deploy the COVID-19 vaccine equitably to a large share of their population and rapidly. This is one of the largest public health efforts in recent history, both globally as well as regionally. This is also a unique opportunity when resources can be channelled to the health sector with a view of strengthening and not undermining health systems; while reducing fragmentation and inefficiencies.

By aligning these efforts along the common goal of strengthening existing health systems, countries will be better equipped to achieve both their short-term goals and also their long-term goal of progressing on the road to UHC. While improving the efficiency and equity of public spending on health will be more important than ever, increasing or at least sustaining public spending on health will determine the ability of countries to protect the gains made thus far on population health while continuing to advance the 2030 SDGs agenda.

To this end, it is recommended that Member States of the SEA Region achieve the following.

Increase public spending on health

Through a coordinated process of spending decisions across sectors and levels of government, ministries of health will need to strengthen their collaboration with ministries of finance and other authorities to explore options for increasing domestic public spending on health. In order to increase the overall amount of public resources that can, in turn, contribute to the reduction in out-of-pocket spending by households, countries in the Region can and should improve their national tax revenue collection system, while also reducing levies and taxes on medical goods and services. Another option is for countries to remove or reduce tax exemptions for voluntary private health insurance.

In addition, countries should consider the adoption or ramping up of "pro-health taxes", such as those that apply to goods and services with harmful health effects as with tobacco, alcohol, sugar-sweetened beverages and carbon emissions. Pro-health taxes can augment government revenues. Introducing pro-health taxes is less likely to face political opposition during a fiscal contraction except for pressure from the industry concerned – which will require the introduction of measures to manage such pressure. Furthermore, an increase in taxes and prices of products harmful for health offer health benefits from reduced consumption, resulting in a win-win situation for the ministries of finance and health in their collaboration to improve health outcomes.

Another source of revenue that can be further explored is additional external financing, including debt relief, cancellation and negotiation for debt servicing terms. In this context, countries may consider, where applicable, the swap of existing debts for investments in the health sector.

In 2020, Sri Lanka completed the arrangements for a debt swap by the German government which allowed debt payments to be converted into investment in health through the Global Fund for TB, HIV and Malaria. Such a "debt2health" financing scheme could increase budgetary space for health while also easing the financial sustainability of countries.

Prioritize health in government budgets

Not only does the size of the government Budget need to increase, but also the share that is allocated to the heath sector. Thus, prioritization of health will need to take place through a pro-active approach where the health share in the government Budget increases substantively in most countries.[160] This should also include donor funding in the countries where this is applicable.

Without this shift towards a larger share of public financing for health, it is expected that public financing will stagnate or even decline across SEA Region countries. This could risk reversing years of progress made towards universal health coverage in several countries. Political leadership is essential to increase fiscal space; especially during the challenging recession caused by the COVID-19 pandemic.

Governments also need to take this crisis as an opportunity to see health as an investment, not a cost, and to recognize the intrinsic inter-connection between health and economic growth. These linkages are long established and have been well documented by the Commission on Macroeconomics and Health, which analysed the impact of health on development and examined how health-related investments could promote economic growth. By investing in health, millions of lives could be saved, life expectancy extended and productivity and economic well-being among the poor spurred.

Diseases represent an impediment to economic growth; and without specific investment to enable the delivery of health interventions, ill health cannot be tackled. To this end, there is need to scale up health sector investments and to overcome non-financial constraints that have hindered the capacity of countries to deliver effective health services.[161] As the COVID-19 pandemic has shown, the resources necessary for such a scale-up exist: i.e. human, scientific and financial. But health needs to be prioritized for these resources to contribute to better health outcomes and economic development.

In the short to medium terms, as governments prepare their 2021–2022 budgets and have ongoing negotiations with their ministries of finance, the health sector needs to make a very strong, well-informed and clear case for continued investment to increase allocations during these budgeting processes.

Prioritize public spending to effectively address the pandemic

Countries need to prioritize public spending for pandemic response.[161] This includes sustaining the COVID-19 response; introducing and rolling out COVID-19 vaccines; maintaining surveillance of emerging SARS-CoV-2 variants that have higher infectivity and mortality;[162] and investing in common goods for health. In the short run, countries will need to continue prioritizing public resources to be able to finance the supplies, testing, contact tracing and surveillance to control the pandemic, as well as the health system capacity for treating those who require hospitalization, including intensive care.

In addition, with COVID-19 vaccines beginning to be approved for emergency use in different settings, countries will also need to prioritize funding for the deployment of the vaccine among key population groups, though the full costs of deployment and the budgetary implications are just starting to emerge.

It will be critical that countries invest in a vaccine deployment strategy that is horizontal as opposed to vertical in nature, and does not weaken health systems by adding fragmentation and creating inefficiencies. Instead, countries should invest in a roll-out that takes a comprehensive and systems-oriented financing approach, ensuring additionality and not displacement of funds. Countries can use this opportunity to build stronger and more resilient health systems.

As a "step zero" for universal health coverage, countries will need to prioritize investments in common goods for health.[12] Common goods for health are core public health functions that include: policy coordination, laws and regulations, information (including surveillance), taxes and subsidies, and public health programmes.[163] In ordinary times, every dollar invested in health yields an average return of two to four dollars, which can be up to 20 times higher in low- and middle-income countries.[155] By investing in common goods for health that return can be multiplied further. Public health officers and trained field epidemiologists form the corpus of surveillance and response. Despite their vital role, a vast majority of countries do not achieve the target of one trained epidemiologist per 200 000 population[164] as is mandated by WHO.[165]

Use resources more strategically and efficiently

Governments will need to use resources more strategically and efficiently. In their budget submissions, ministries of health will need to be very realistic and cognizant of the current overall fiscal tightening. They should demonstrate opportunities for efficiency gains by improving purchasing arrangements and PFM systems, and apply these during the crisis as well as sustain these in the future.

Countries should improve their strategic focus and efficiency by consolidating financing, maximizing the use of resources, and closely monitoring and reducing wasteful spending (for instance, by removing subsidies that are pro-rich and not supportive of a green economy such as subsidies on fossil fuels). They should capitalize on telemedicine and digital solutions, where appropriate. They should also promote essential generic medicines and move from poor- to high-quality health care so that wastage related to overuse of unnecessary care or ineffective approaches, medical errors, unsafe care, poorly coordinated care, misuse (i.e. inappropriate hospital admissions and bypassing), and abuse are curtailed.[166]

Governments will need to improve budgeting and planning, ensure effective budget execution, and monitor its effective use. In some settings, the budgeting process could be improved with explicit allocation formulas and the synchronization of planning and budgeting cycles to facilitate, for example, the integration of external funds.

Critically, funds need to flow rapidly and be used flexibly to enable a further timely response at all levels of the system (i.e. at Central as well as at subnational levels) alongside effective accountability mechanisms. This must continue where it is already happening, and also be implemented in areas where it is not yet optimal.

Sustain and expand coverage with priority for the poor and vulnerable

Governments need to close the gaps in coverage and apply targeting measures to ensure that the poor, who are far more dependent on public financing sources, are better protected than the relatively well-off.[167,168,169] This should be linked to UHC reforms that extend entitlements and deepen financial protection for all vulnerable populations.

Governments should continue to make COVID-19-related services universally accessible so that the poor do not have to face financial barriers to access needed services.[161] Recently designed essential service packages should receive priority funding allocations and necessary reforms for their effective implementation should be carried out in order to expand access to such services to this priority population group and beyond, as much as possible. Until all those in need are covered, other individuals remain at risk.

As discussed earlier in this report, between 110–135 million more people are estimated to be pushed into extreme poverty in 2020 and 2021 in the SEA Region as a result of the COVID-19 pandemic.[9] This, in a region that already has one of the highest poverty rates in the world, means that without pro-active measures, the health of the poor and vulnerable is likely to suffer as extreme poverty will force people to forego necessary health care and contribute to a rise in inequalities. The 1997 financial crisis in Asia served as a trigger for health reforms, with the expansion of coverage, especially for the poor, until universal coverage was achieved[170] in Indonesia and Thailand.

Thus, this crisis offers a unique opportunity, which should and cannot be missed, for implementing these pressing reforms. Ultimately, these necessary reforms will bring long lasting improvements to both the health and financial protection of the population living in the WHO SEA Region.

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Annex: Methods

Chapter 1 used publicly available data from the WHO Global Health Expenditure Database (GHED), the World Bank Development Indicators (WDI), national health accounts (NHAs), and the International Monetary Fund (IMF) World Economic Outlook (WEO) to gather key health financing indicators. In addition, some relevant WHO reports and peer-reviewed journal articles were used. All of these sources were identified through Internet searches or shared by country offices of WHO in the Region.

Chapter 2 collected information on the first six months of the COVID-19 (i.e. from March 1 to August 31 2020. Information on five key domains was prioritized: financial protection measures against COVID-19 testing and treatment; resource generation and allocation; strategic purchasing and/or PFM measures; adjustments of benefits packages; and broader social protection programmes. The following sources and methods were used:

1. Review of strategic purchasing and PFM surveys conducted by WHO HQ

Two separate WHO surveys informed this review. The WHO online survey of strategic purchasing collected information on purchasing arrangements, payment methods, governance arrangements and benefit packages during COVID-19, including any adjustments or modifications for existing practice. Fifty six individuals completed the survey, the majority of whom were from national government institutions, including ministries of health, health insurance agencies and other government offices. The second largest group of responses was staff of the WHO regional or country offices.

The WHO PFM web survey gathered information from regional, country and expert counterparts across 130 countries, including 10 SEA Region countries, between 5 April 2020 and 5 May 2020. The survey was developed around five key PFM questions: 1) spending measures by the executive; 2) enactment of spending plans; 3) formulation and structure of spending plans; 4) spending modalities; 5) reporting mechanisms.

2. Search and review of publicly available information.

Information relevant to individual countries in the SEA Region was collected through a detailed desk review of journal publications including recent peer-reviewed articles, opinion editorials, directives and reports from WHO and other international organizations

(i.e. IMF, World Bank, OECD), and media articles. Key national planning documents were reviewed, including situation reports from the Emergency Operations Centre, presidential statements and addresses by Ministry of Health officials, national plans for COVID-19, and related health planning documents.

3. Key informants/stakeholder survey

An online survey was electronically distributed to the focal points in the WHO country offices of the 11 Member States of the SEA Region and contacts in ministries of health.[a] The survey was conducted using REDCap (Research Electronic Data Capture), a secure web-based application that allows researchers to quickly design project-specific data capture tools for research studies. The questions covered the five key domains mentioned above. Responses were analysed for each domain and countries with more than one respondent were considered together.

Responses were received from 10 WHO country offices. Limited information was obtained in both searches for and survey responses from the Democratic People's Republic of Korea. Additional responses to the survey were received from one representative in the Ministry of Health in Myanmar and one representative from the Indonesian national health insurance agency (BPJS Kesehatan).

Chapter 3 used a variety of relevant sources to provide context on health financing governance, structure and history. Internet sources were the most commonly used, and sources were identified by Internet searches using "country name" and keywords (i.e. health financing, sin taxes, resource mobilization, etc.). The websites of the ministries of health of Member States and other related institutions (i.e. social health insurance corporations, ministries of finance, etc.) were consulted to obtain the latest editions of the national health accounts, budget documents, and other key policy documents.

The websites of several international organizations – the World Bank, International Monetary Fund, World Health Organization, etc. – also provided general information on the context and the health system's characteristics, while the WHO Global Health Expenditure Database was also used to gather key health financing figures.

Publicly available literature on health financing was also used, including sources from peer-reviewed journal articles, Health in Transition (HIT) reports, and other available government/academic reports. Finally, WHO country offices were consulted for various documents and sources, including papers on public finance management, whose procedures are often recorded in grey literature available only on requests made to the relevant administrative body.

a Contacts of The George Institute for Global Health and those working in ministries of health in countries were invited to complete the survey.

This report, developed during the COVID-19 outbreak in 2020, provides a comprehensive, updated overview of health expenditure and health financing systems in Member States of the WHO SEA Region during the period 2008–2018. It also reviews the health financing policy responses adopted by countries in the immediate aftermath of the outbreak, and suggests priority actions to help them navigate out of this crisis while maintaining their focus on universal health coverage.

Government officials and development partners will be able to use the information and analysis presented in this report in their planning, decision-making, as well as monitoring and evaluation processes. Others, such as researchers and those in the nongovernmental sector, can use this report to enrich their analyses and bolster their advocacy efforts. This report helps establish a benchmark on how SEA Region countries were placed before the onset of the COVID-19 crisis and their initial responses into the pandemic. Future analyses will help assess how countries may have used the opportunities created by the pandemic to reform health financing in the Region.

World Health Organization
REGIONAL OFFICE FOR South-East Asia

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Bangladesh

Progress towards universal health coverage

Bangladesh is progressing to improve the availability of health services for the population. From 2010 to 2020, the UHC service coverage index increased from 38 to 49. On the other hand, the share of population affected by household catastrophic health expenditure increased sharply from 13.9% in 2009 to 24.7% in 2016. These increases were mirrored in 2016, as 7% of the population was pushed into poverty because of out-of-pocket health payments, up from 3.4% in 2009 (under the poverty line of US$ 1.90 per capita daily).[6]

Health system architecture and governance

The health system of Bangladesh is a pluralistic system with four key actors that define the structure and function of the system: government, private sector, nongovernmental organizations (NGOs) and donor agencies. The government's Constitutional obligation makes it responsible not only for policy and regulation, but also for provision of health services.[69] The government health services are managed by two different line ministries in Bangladesh.

The urban primary health care system is governed by the Ministry of Local Government, Rural Development and Cooperatives (MoLGRDC). The MoLGRDC, through city corporations and municipalities, coordinates the delivery of primary health care services in urban settings that is provided by nongovernmental organizations (NGOs). In rural settings, the Ministry of Health and Family Welfare (MoHFW) manages the *upazila* (sub-district administrative division) health systems (UHS), which consist of standardized referral hospitals and primary health care facilities such as community clinics.

In addition, the MoHFW is charged with providing secondary and tertiary care in both rural and urban settings. The growth of the private sector is significant in recent decades compared with the public sector. Bangladesh is known worldwide for having one of the most dynamic NGO sectors, providing mainly preventive and basic care.

Health planning and financing is centralized at the MoHFW and guided by five-year Health, Nutrition and Population Sector Programmes. The MoHFW oversees almost all government health resources; the local governments and other ministries such as MoLGRDC govern small shares. In addition, donors play an important role in financing and planning of health programmes.[70]

While a number of private insurance companies offer individual and group insurance to private persons and corporates, these health insurance initiatives cover a very small share of the total population of Bangladesh.

Raising revenue

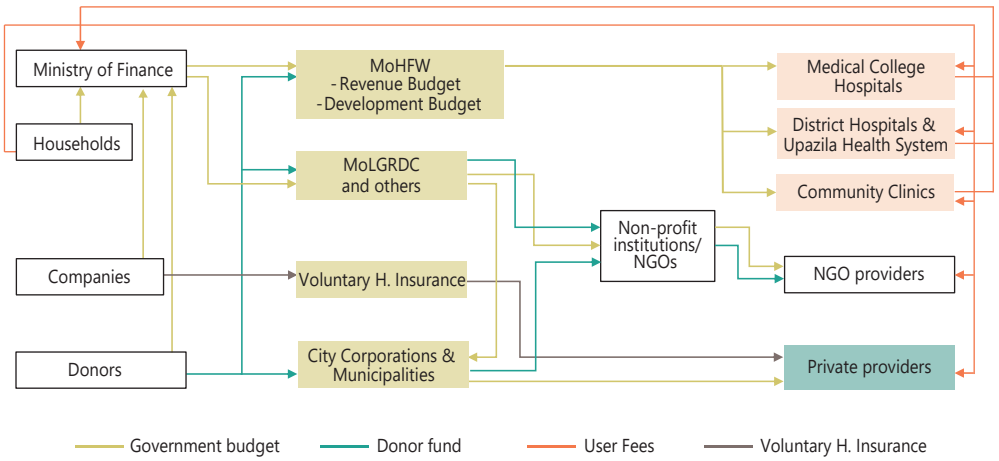
The share of current health expenditure (CHE) and domestic government expenditure on health (GGHE-D) in relation to the country's GDP remained at the same levels over the past decade. The CHE stood at 2.4% of GDP in 2009 and 2.3% in 2018, while GGHE-D has been approximately 0.4% of GDP over the same period. The three main sources of revenue for health are the government budget, household out-of-pocket payments and external donor funds. The government budget made up 17% of the CHE in 2018, down from 20.4% in 2009. Accordingly, government expenditure on health is 3% (2018) of general government expenditure (GGE), down from 4.1% in 2009.

Out-of-pocket expenditures or spending (OOPS) on health accounted for 73.9% of CHE in 2018, up from 67.2% in 2009. Voluntary health insurance and other private schemes made up 2.6% of the CHE in 2018. External donor sources to health have declined from 9.6% of CHE in 2009 to the 2018 levels of 6.5%. [70]

Pooling and flow of resources

Funds from MoF and donors are transferred to MoHFW and MoLGRDC. The MoHFW resources, mobilized from the government budget transfers and donor funds for the development budget, constitutes the only sizeable pool in Bangladesh's health sector.

Fig. 1. Simplified flow of funds in Bangladesh health sector



Source: Adapted from Ahmed SM, Alam BB, Anwar I, Begum T, Huque R, Khan JAM, et al. Bangladesh Health System Review. Vol.5 No.3. Manila: World Health Organization, Regional Office for the Western Pacific, 2015.

Benefits package

According to Article 15(a) of the Constitution, all citizens have the right to medical care. Primary, secondary and tertiary medical care is provided in government health facilities, largely free of charge for essential medicines, medical and surgical supplies and hospitals beds. In government hospitals, however, low user charges are applied for outpatient consultation, for inpatient shared rooms or individual rooms. Patients have to purchase items such as syringes, intravenous fluids, x-ray plates, etc.[70]

Since 1998, there has also been an explicit Essential Services Package (ESP) implemented, to ensure provision of selected primary health care services to the poor. The ESP was updated several times (most recently in 2016). The current ESP is comprehensive and structured in five categories: Maternal and child health, Family planning, Nutrition, Communicable and noncommunicable diseases, and condition management services.

In addition, three support services, laboratory, radiology and pharmacy, are also covered.[71] The different components of the ESP are implemented in government health facilities and through vertical programme delivery channels. A detailed costing showed[72] that the average cost per capita is between US$ 6–US$ 7 per annum. The poorest individuals are the ESP's priority.

Table 1. Essential Services Package

Level of care	Type of services
Primary health care	• NCD screening • Maternal care, including newborn sepsis, normal newborn, severe cases, basic emergency obstetric and neonatal care, pre-term newborn care • Child health, growth and immunization • Family planning (short acting) • Limited curative care • Social and behavioural change communication
Secondary and tertiary care	• Emergency care for severe cases • Maternal care, including antenatal and prenatal care, basic and comprehensive emergency obstetric and neonatal care, pre-term births, newborn sepsis, severe acute malnutrition • Child health, growth and immunization • Family planning (all methods) • NCD screening and management • Communicable diseases, including TB, malaria, HIV/AIDS, NTDs, etc. • Eye, ear, dental and skin care • Geriatric care • Social and behavioural change and communication

Purchasing arrangements

The MoHFW, the main purchaser in Bangladesh, pays for routine line-item expenses of government health facilities based on number of beds (medicines and operational costs) and staff (salaries).[73] The vertical programme managers at the central level transfer funds according to plans submitted by the facilities at the lower level.

City corporations and municipalities contract NGOs and/or private facilities for the delivery of urban primary health care services. NGOs are chosen through an open competitive bidding procedure for a certain period.[70] Implementing NGOs are expected to cover 20% of the costs by collecting some user fees. They are also expected to provide free services to at least 30% of the users who are classified as poor. Individual users who opt for private health care facilities pay fee-for-services, as set by each provider.

Public financial management

The government budget for health is composed of revenue and development budgets. The former is funded by the Government of Bangladesh (GoB) and the latter by both GoB and donor contributions. The planned MoHFW budget for the financial year 2019–2020 is made up of nearly equal contributions from revenue (52%) and development (48%) budgets. These two health budget components have been formulated separately and use different approaches.

Budgeting for salaries remain fixed, while medicine and diet budgets at different levels use some set norms. Budgets are disbursed quarterly. Over the financial years of 2012–2016, the execution of the revenue budget was between 93% and 97%, on average, driven largely by high execution rates of wages and salaries. On average, 77%–80% (2017–2019) of the development budget has been executed; nutrition (47%) and drug administration (48%) programmes had low execution, while information systems (206%) and procurement (106%) had the highest budget execution rates.[74]

Recent health financing reforms

The Health Care Financing Strategy (HCFS) 2012–2032 proposes the creation of a social health protection scheme, and aims at improving resource generation, equity and access, as well as enhancing efficiency in resource allocation and utilization.[75] The scheme aims at securing financial protection for all segments of the population, starting with the poorest and expanding to the formal sector. As part of the HCFS Action Plan, an insurance scheme targeting the poor, called Shasthyo Shurokhsha Karmasuchi (SSK), has been implemented in three *upazilas* of Tangail district since 2017. People from lower income groups are provided with cards that grant free access to services with an annual ceiling per household.[76]

Bangladesh

Macro picture

Indicator	Latest year	Value
Total population (thousands)[1]	2020	164 689
Employment to population ratio, 15+, total (%) (national estimate)[2]	2017	55.8
GDP per capita growth (annual %)[2]	2019	7.0
GDP per capita (current US$)[2]	2019	1 856
General government revenue (% of GDP)[3]	2019	9.8
Tax revenue (% of GDP)[2]	2016	8.8
General government total expenditure (% of GDP)[3]	2019	15.1
Fiscal balance (revenue–expenditure) (% of GDP)	2019	-5.4
General government gross debt (% of GDP)[3]	2019	35.8
Poverty headcount ratio at US$ 1.90 a day (2011 PPP) (% of population)[2]	2016	14.5
Poverty headcount ratio at national poverty lines (% of population)[2]	2016	24.3

[1] United Nations, Department of Economic and Social Affairs, Population Division (2019). *World Population Prospects 2019: Volume II: Demographic Profiles.*

[2] World Bank Group. World Development Indicators, 2020. Washington, D.C.: 15 Oct 2020. https://databank.worldbank.org/source/world-development-indicators.

[3] IMF. *World Economic Outlook: A Long and Difficult Ascent*. Washington, D.C.: October 2020. https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020.

Progress towards universal health coverage

Fig. 2. SDG 3.8.1 Service Coverage Index (0–100)

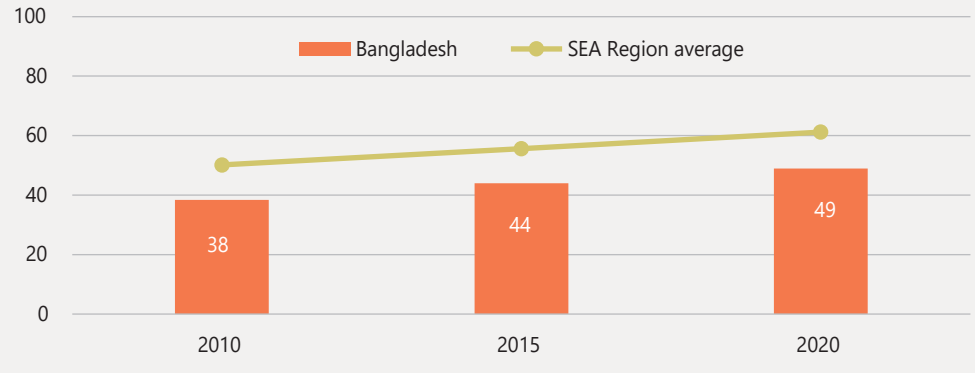
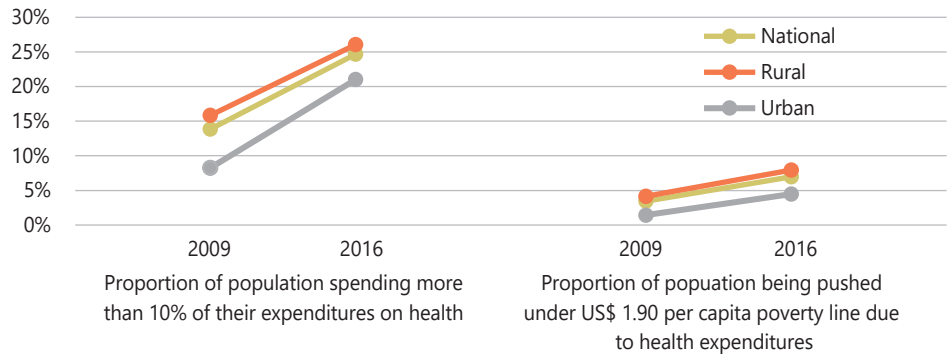


Fig. 3. SDG 3.8.2 Catastrophic and impoverishing incidence due to out-of-pocket expenditures on health



General health expenditure trends over the past decade

Fig. 4. Current health expenditures 2009–2018

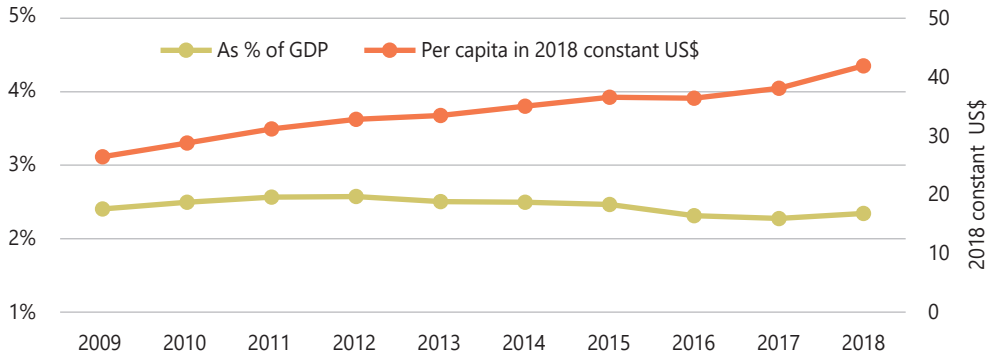


Fig. 5. Domestic government expenditures on health 2009–2018

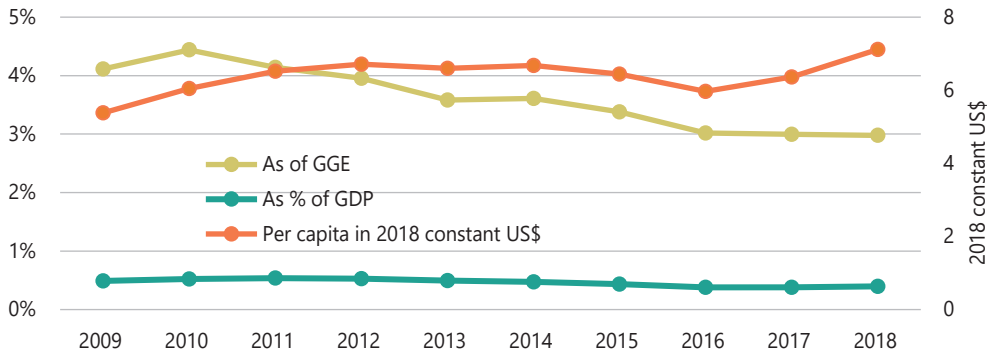
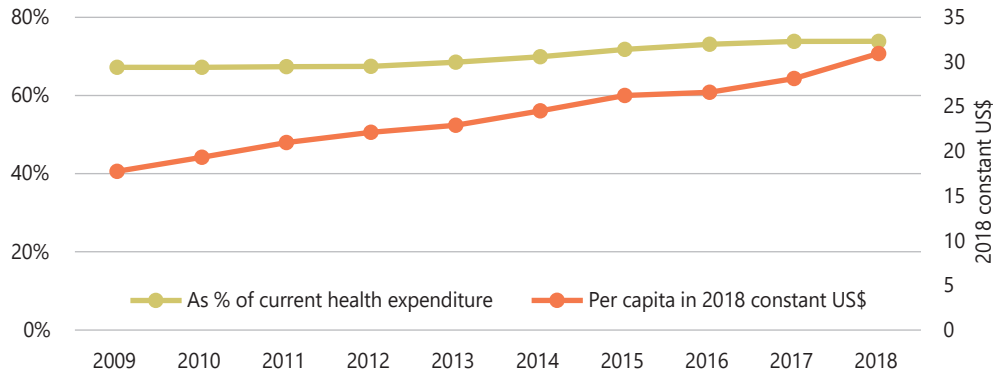


Fig. 6. Out-of-pocket spending on health (OOPS) 2009–2018

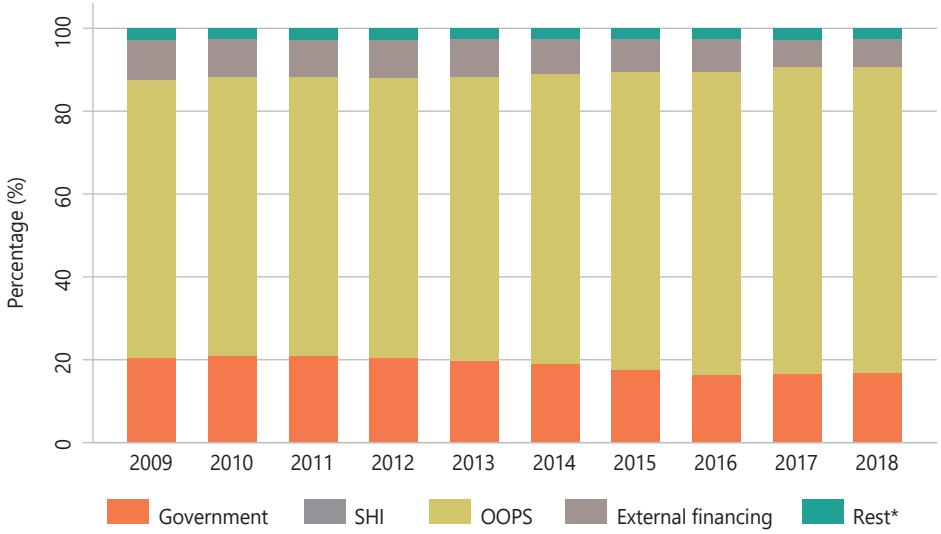


Primary health care expenditures

No data available

Composition of current health expenditures[a]

Fig. 7. Revenue sources of current health expenditures over the years



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

a "Ancillary services" and "medical goods" are independent consumptions that do not have a specific purpose (treatment, prevention, etc.) in themselves. Typical examples include laboratory services, imaging diagnosis, and patient transportation under "ancillary services" and pharmaceuticals (both prescribed and over-the-counter ones) as well as therapeutic goods (corrective glasses, hearing aids) under "medical goods". Consumption of such during a health-care contact are, therefore, lumped under other categories (i.e. curative care) and not separately reported.

Burden of disease and disease-specific government expenditures

Fig. 8. Burden of disease, 2019

Rank by disorder (2019)		DALYs (%)
1	Neonatal disorders	9.96
2	Stroke	8.11
3	Ischemic heart disease	7.13
4	Lower respiratory infections	3.97
5	Chronic obstructive pulmonary disease	3.36
6	Other musculoskeletal disorders	3.00
7	Depressive disorders	2.99
8	Diabetes mellitus	2.86
9	Diarrheal diseases	2.67
10	Low back pain	2.65
11	Congenital birth defects	2.42
12	Tuberculosis	2.32
13	Headache disorders	2.18
14	Road injuries	2.03
15	Cirrhosis and other chronic lever diseases	1.95
16	Dietary iron deficiency	1.69
17	Age-related and other hearing loss	1.63
18	Other malignant neoplasms	1.52
19	Gynecological diseases	1.50
20	Typhoid and paratyphoid	1.38
21	Blindness and vision loss	1.35
22	Anxiety disorders	1.13
23	Drowning	1.12
24	Chronic kidney disease	1.10
25	Maternal disorders	0.98

Infectious and parasitic diseases
Reproductive health
Injuries
Nutritional deficiencies
Noncommunicable diseases

Bhutan

Progress towards universal health coverage

Bhutan is making steady progress to achieve UHC. The UHC service coverage index grew from 47 in 2010 to 64 in 2020. Further, financial risk protection improved substantively where the proportion of population affected by catastrophic health expenditure declined from 4.01% in 2012 to 1.8% in 2017. In the same year, the percentage of people pushed into poverty because of out-of-pocket health payments was estimated at 0.01%, down from 0.04% in 2012 (under the daily US$ 1.90 per capita poverty line).[6]

Health system architecture and governance

Bhutan has a predominantly publicly financed and delivered health system. The service delivery is based on a three-tier structure, (i) basic health units (BHUs), sub-posts and satellite clinics at the primary level; (ii) district or general hospitals at the secondary level; and (iii) regional and national referral hospitals at the tertiary level. Private health businesses, as of now, are still limited to pharmacy outlets and selected diagnostic services. There are a few small and private voluntary health insurance (VHI) schemes in Bhutan.

Four institutions determine health financing policy in Bhutan. The Gross National Happiness Commission (GNHC) provides the national five-year plan, which guides the health sector in key result areas and plans. The Ministry of Finance manages the government Budget decisions to the health sector and institutions. The Ministry of Health (MoH) is a central player and defines the health financing policy directions, resource mobilization strategies, and provides oversight over several health facilities. It also provides technical guidance to district health offices.

It procures medicines, vaccines and supplies for the whole system, and provides support on public health, health information and others. The Bhutan Health Trust Fund (BHTF) is a semi-autonomous government body created in 1998 to ensure continued, sustainably financed, and timely supply of vaccines and essential medicines. The BHTF aims that these crucial components of primary health care services are regularly available.[77]

In 2008, administrative and financial powers and functions were shifted from central to local governments through a system of devolution. Still, the central MoH directly manages two regional referral hospitals, as well as three secondary-level facilities, while the District Health Authority manages the district hospitals and basic health units. District health offices are accountable to the district administration, and report to MoH on technical matters.

Raising revenue

Bhutan allocated 3.1% of GDP for health in 2018 – a moderate decline from 3.5% in 2009. Domestic government expenditure on health (GGHE-D) is 2.4% of GDP in 2018, with a slight decline from 2.6% in 2009. The GGHE-D is 7.6% of the general government expenditure (GGE) in 2018, and it has increased from 6.6% in 2009. The government budget revenue is the predominant source of financing for the health system in Bhutan, comprising about 80% of current health expenditure (CHE) in 2018.

The Bhutan Health Trust Fund mobilizes public revenues for health through contributions from potential donor countries, private and public organizations and financial institutions. It also receives donations from individuals, with matching contributions from the Royal Government, a 1% payroll contribution from formal sector workers, and other sources such as fundraising events.

Over the past decade, out-of-pocket expenditures on health have declined from 16.6% of CHE in 2009 to 13.2% of CHE in 2018. External donor financing remained below 10% of CHE (9.1% in 2009 and 6.1% in 2018). Voluntary health insurance (VHI) schemes account for 0.1% of CHE in 2018.[71]

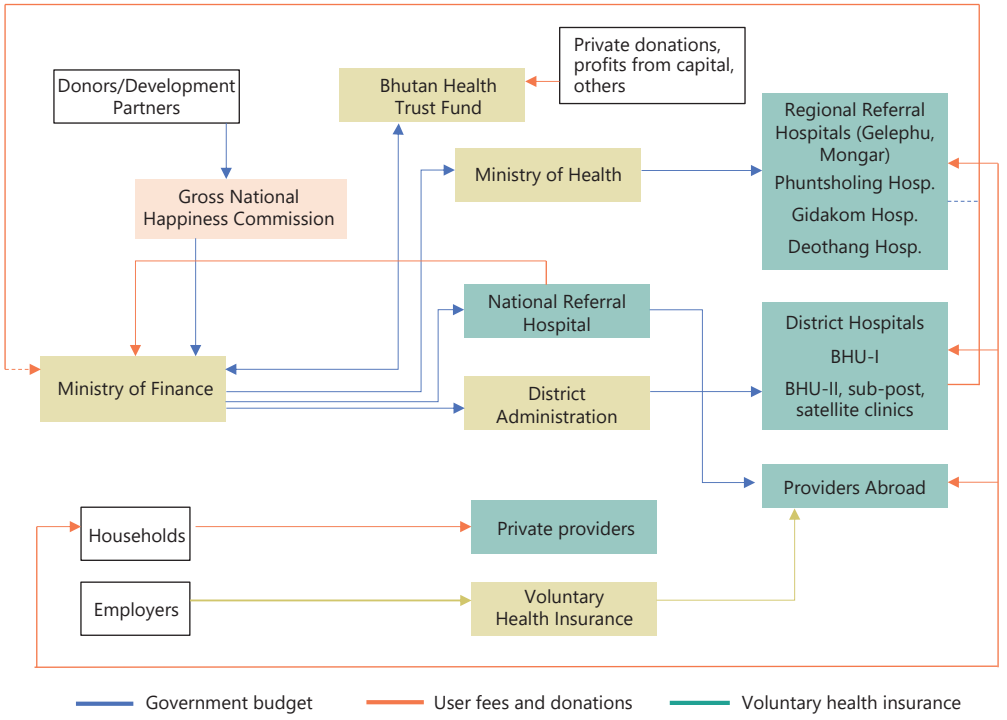
Pooling and flow of resources

The Ministry of Finance (MoF) of Bhutan is the main pooling institution for government health resources. It collects the general government Budget revenues and contributions from some donors. The MoF makes allocations to: i) local administrations; ii) the National Referral Hospital; and iii) MoH. The Bhutan Health Trust Fund is another pool of resources for health. According to the latest NHA 2017–2018, of the total public health sector budget, 78% was allocated to the central level (54% at MoH and 24% to the National Referral Hospital), and 22% was distributed to the district administrations.[78]

Benefits package

According to the 2008 Constitution of Bhutan, "the State shall provide free access to basic public health services in both modern and traditional medicine". Comprehensive services are provided to citizens through various levels of care, including treatment abroad if a particular service is not available in the country. There are some exceptions where user charges are applied, such as private rooms and after-hour consultations. VHI schemes largely cover medical care outside the country. Administratively, there is the Health Service Standards by the MoH, which is a list of services to be provided at each level of health care and used as general guidance.

Fig. 1. Simplified flow of health funds in Bhutan



Source: Adapted from Thinley S, Tshering P, Wangmo K, Wangmo K, Wangchuk N et al. (2017). The Kingdom of Bhutan Health System Review. World Health Organization. Regional Office for South-East Asia.

Purchasing arrangements

The MoF plays the role of purchaser for public sector providers (including the National Referral Hospital) and use line-item budgets. The payment covers personnel salaries, overheads, capital and recurrent expenditures to health facilities. The BHTF releases funds to MoH for procurement of vaccines, medicines and equipment.[78] The National Referral Hospital contracts overseas providers and pays according to itemized invoices. District and sub-district administrations directly pay salaries and operational costs of health facilities within the district network. Selected large hospitals charge patients for specific services, such as private rooms or after-hour consultations, on a fee-for-service basis.

Public financial management

The Budget process starts with the MoF preparing a multi-year rolling budget and forecast of central and local governments' expenditures, followed by the notification of annual ceilings for recurrent and capital expenditure. The MoH coordinates the bottom-up budgeting process within the sector. The MoH departments and divisions, as well as five regional and district hospitals, submit their budget proposals to MoF.

At the district level, health is one of the departments of the district administration, which coordinates the budgeting exercise. In general, public sector budgeting is reliant on a combination of past year expenditure and spending projections on new activities. Budget proposals for staff recruitment have to be based on the standard developed by the Civil Service Commission. The budget for medicines is governed by the "Annual Indent", whereby health facilities project their needs for the following year in terms of items and quantities based on past consumption and service output. Finally, the Budget proposals are negotiated with MoF, and compiled within the National Budget submission for Parliament's approval.

Budgets of all publicly funded institutions are disbursed electronically by the MoF based online-item invoices. The MoF also processes the execution of the share of donor funds channelled through the government financial system. Health facilities are supplied with medicines in kind, and do not administer an assigned budget.

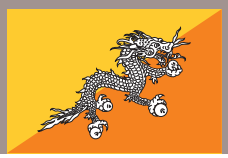
Overall government Budget execution was around 100% (104% in 2012–2013 and 98% in 2014–2015) between 2012 and 2015.[79] In the same period, execution of the MoH budget exceeded 100% every year (115% in 2012–2013). Although budgets are allocated to the local health system, most of the execution is done by the district administrator and reported within aggregated district budget execution data. Fee collections of large hospitals are deposited in MoF accounts and are not earmarked to the health sector.

Since 2014, the Prime Minister signs annual performance agreements with line ministries such as MoH as well as with local authorities to increase the transparency and accountability of public resources.

Recent health financing reforms

Since 2009, the main reform has been to decentralize the administrative and financial powers from the Central to local levels. District governments have become responsible for the use of the allocated resources, and to provide essential services, including health (from primary health care facilities to district hospitals). In addition, the National Referral Hospital has been granted the status of an autonomous budget unit; however, it is still subject to line-item budgeting and limited decision rights.

Bhutan



Macro picture

Indicator	Latest year	Value
Total population (thousands)[1]	2020	772
Employment to population ratio, 15+, total (%) (national estimate)[2]	2015	61.6
GDP per capita growth (annual %)[2]	2018	1.8
GDP per capita (current US$)[2]	2018	3243
General government revenue (% of GDP)[3]	2019	23.8
Tax revenue (% of GDP)[2]	2018	16.0
General government total expenditure (% of GDP)[3]	2019	25.0
Fiscal balance (revenue–expenditure) (% of GDP)	2019	-1.1
General government gross debt (% of GDP)[3]	2019	104.4
Poverty headcount ratio at US$ 1.90 a day (2011 PPP) (% of population)[2]	2017	1.5
Poverty headcount ratio at national poverty lines (% of population)[2]	2017	8.2

[1] United nations, Department of Economic and Social Affairs, Population Division (2019). *World Population Prospects 2019: Volume II: Demographic Profiles.*

[2] World Bank Group. World Development Indicators, 2020. Washington, D.C.: 15 Oct 2020. https://databank.worldbank.org/source/world-development-indicators.

[3] IMF. *World Economic Outlook: A Long and Difficult Ascent*. Washington, D.C.: October 2020. https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020.

Progress towards universal health coverage

Fig. 2. SDG 3.8.1 Service Coverage Index (0–100)

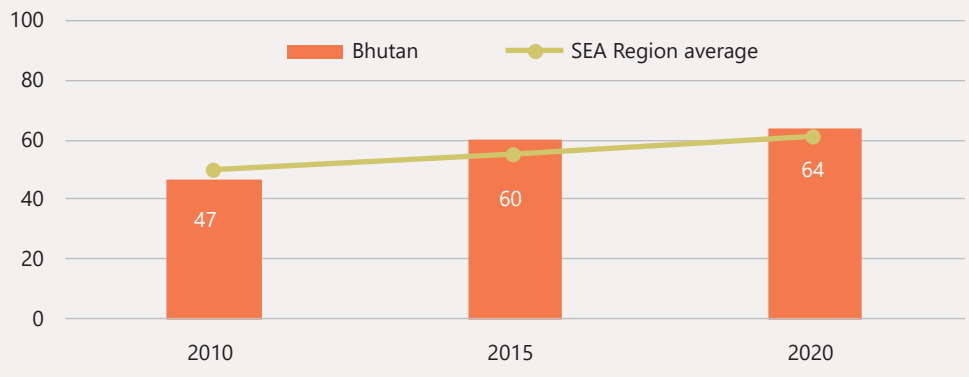
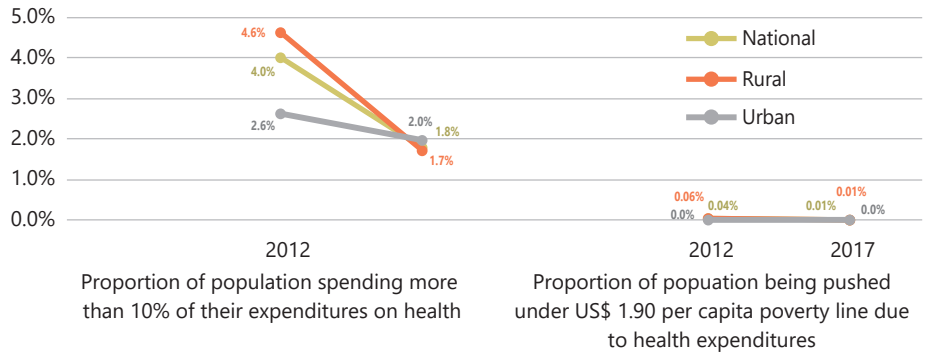


Fig. 3. SDG 3.8.2 Catastrophic and impoverishing incidence due to out-of-pocket expenditures on health



General health expenditure trends over the past decade

Fig. 4. Current health expenditures 2009–2018

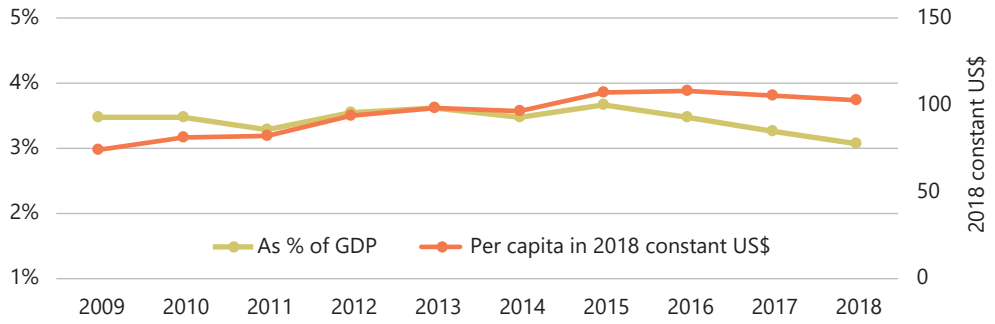


Fig. 5. Domestic government expenditures on health 2009–2018

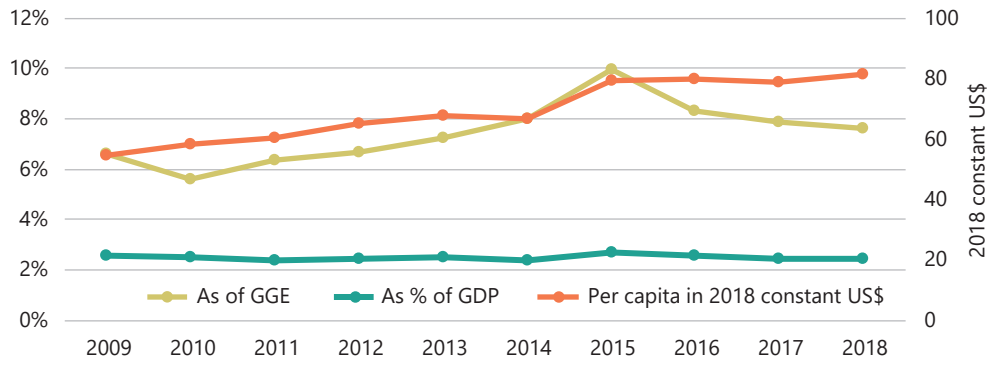
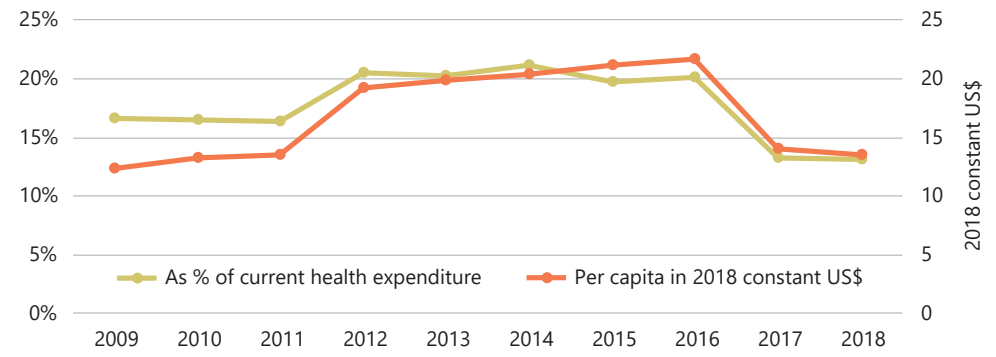
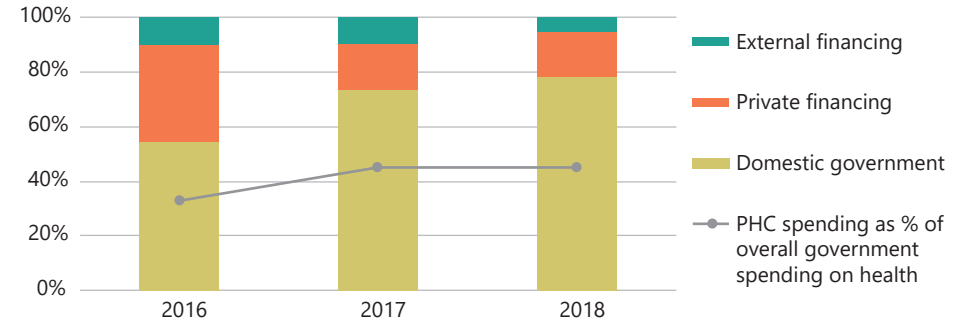


Fig. 6. Out-of-pocket spending on health (OOPS) 2009–2018



Primary health care expenditures[a]

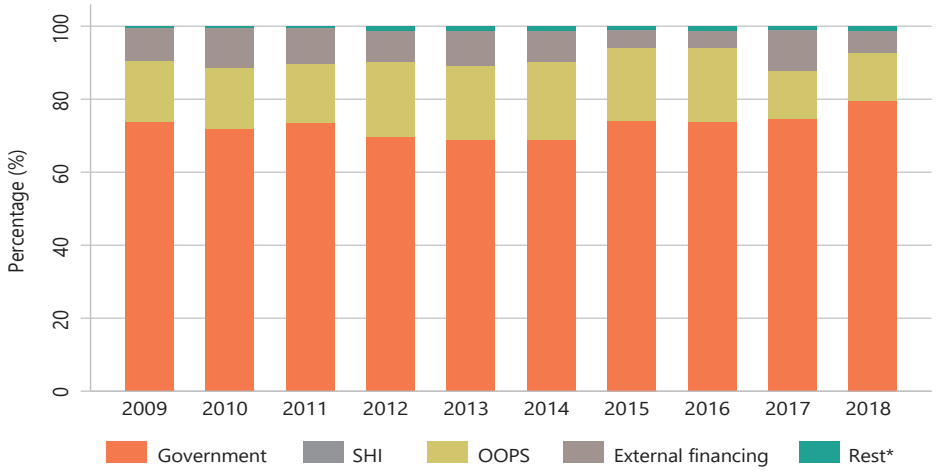
Fig. 7. Primary health care expenditures



a Primary health care measurement is entirely based on Health Care Functions classification. Details of the measurement can be found here: Global spending on health: a world in transition. Geneva: World Health Organization; 2019 (WHO/HIS/HGF/HFWorkingPaper/19.4).

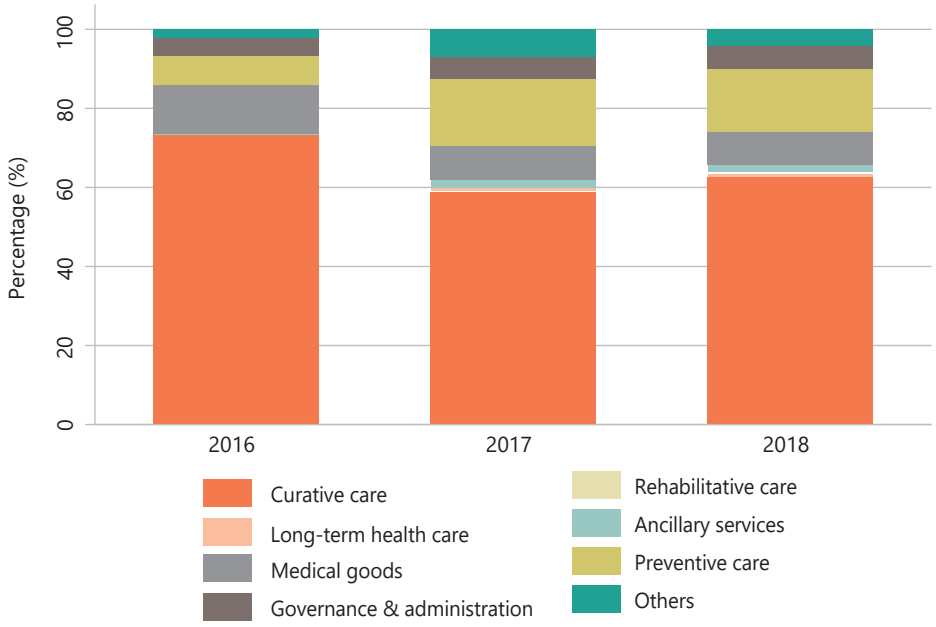
Composition of current health expenditures[b]

Fig. 8. Revenue sources of current health expenditures over the years



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

Fig. 9. Health expenditures by funtion



b "Ancillary services" and "medical goods" are independent consumptions that do not have a specific purpose (treatment, prevention, etc.) in themselves. Typical examples include laboratory services, imaging diagnosis, and patient transportation under "ancillary services", and pharmaceuticals (both prescribed and over-the-counter ones) as well as therapeutic goods (corrective glasses, hearing aids) under "medical goods". Consumption of such during a health-care contact are, therefore, lumped under other categories (i.e. curative care) and not separately reported.

Burden of disease and disease-specific government expenditures

In Bhutan, the biggest share of spenidng was on noncommunicable diseases (2018), and it was domestic government sources that finaced the majority of it.

Fig. 10a. Health spending by disease categories, and revenue sources for noncommunicable diseases, 2018

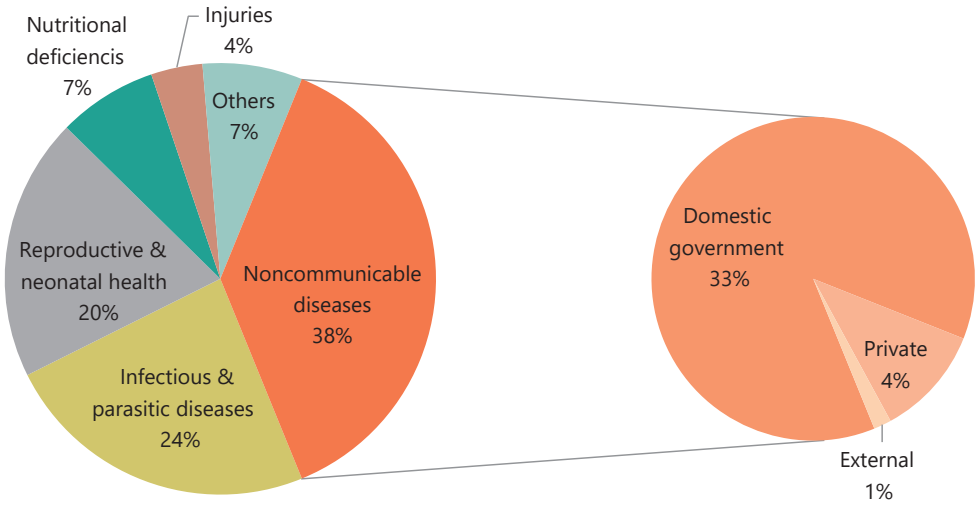


Fig. 10b. Burden of disease, 2019

Rank by disorder (2019)		DALYs (%)
1	Neonatal disorders	11.0
2	Ischemic heart disease	6.9
3	Chronic obstructive pulmonary disease	4.8
4	Stroke	3.5
5	Dietary iron deficiency	3.4
6	Lower respiratory infections	3.1
7	Diabetes mellitus	2.8
8	Cirrhosis and other chronic liver diseases	2.7
9	Road injuries	2.6
10	Low back pain	2.5
11	Depressive disorders	2.4
12	Diarrheal diseases	2.3
13	Other musculoskeletal disorders	2.3
14	Congenital birth defects	2.3
15	Chronic kidney disease	2.1
16	Headache disorders	2.1
17	Falls	1.8
18	Tuberculosis	1.7
19	Exposure to mechanical forces	1.6
20	Age-related and other hearing loss	1.5
21	Gynecological diseases	1.4
22	Anxiety disorders	1.1
23	Rheumatic heart disease	1.0
24	Typhoid and paratyphoid	1.0
25	Alcohol use disorders	1.0

Infectious and parasitic diseases
Reproductive health
Injuries
Nutritional deficiencies
Noncommunicable diseases

India

Progress towards universal health coverage

India's progress towards UHC has been improving steadily, with the UHC service coverage index increasing from 50 in 2010 to 63 in 2020. As for the financial risk protection, data from almost a decade ago show that the proportion of population facing catastrophic health expenditure increased from 13.3% in 2009 to 17.3% in 2011. In 2011, 4.2% of people were pushed into poverty because of out-of-pocket health expenditures, up from 3.6% in 2009 (under the daily US$ 1.90 per capita poverty line).

Health system architecture and governance

India is a decentralized country and the different layers of government – Union (Government of India), state, and local self-government (LSG) – provide health services in government-owned and government-run health facilities. Union and State governments also manage public health insurance schemes covering different population groups. The private sector is concentrated in urban settings and mainly provides hospital care. Two thirds of curative care is provided by private facilities.[80]

The Ministry of Health and Family Welfare has regulatory powers over the majority of health policy decisions, but is not directly involved in health-care delivery. At the state level, the Directorates of Health Services and the Departments of Health and Family Welfare are responsible for organizing and delivering health-care services to their populations.[81]

The Ministry of Health & Family Welfare (MoHFW) launched the National Health Mission (NHM) in 2005 to strengthen primary health care and implement national priorities and programmes (i.e. immunization, maternal care, communicable diseases control, etc.), by increasing funding to government facilities and public health interventions. In 2008, the Government launched the Rashtriya Swasthya Bima Yojana (RSBY), a non-contributory public insurance scheme to cover hospital care for people below the poverty line and vulnerable people. In 2018, the RSBY was further expanded into the Pradhan Mantri Jan Arogya Yojana (PM-JAY) to cover the bottom 40% of the poor and vulnerable population, though states can opt to provide greater coverage.

The policies and priorities are set by the Mission Steering Group (MSG) to the NHM.[82] The Union Minister of Health & Family Welfare chairs the MSG. At the state level, the Mission functions under the overall guidance of the State Health Mission (SHM) that is headed by the chief minister of the state. The State Health Society (SHS) carries out the functions under the Mission and is headed by the Chief Secretary. The District Health Mission (DHM)/City Health Mission (CHM) would be led by the head of the local self-government. Every district will have a District Health Society (DHS), which will be headed by the District Collector.

PM-JAY is managed by the National Health Authority, an autonomous body accountable to an 11-member board chaired by the Union Minister of Health & Family Welfare. At the state level, PM-JAY is managed by State Health Agencies (SHA) or an existing agency, trust, or any other society that can administer the programme. The SHA is responsible for implementation of PM-JAY in the state headed by a Chief Executive Officer. The SHA can hire an implementation support agency (ISA) such as an insurance company to perform the required tasks to operationalize the scheme.

In addition, the MoHFW manages the Central Government Health Scheme to provide social health protection for central government employees, dependents and pensioners. Another important public insurance scheme is the Employees' State Insurance Scheme, managed by the Employee's State Insurance Corporation, a statutory and autonomous body under the Ministry of Labour and Employment. This scheme covers public and private sector workers in companies with 10 or more employees. The Indian private voluntary health insurance market covers 1.7% of the population.[83]

Raising revenue

The shares of current health expenditure (CHE) and domestic government expenditure on health (GGHE-D) in the country's GDP have remained unchanged over the past decade. In 2018, the CHE was estimated at 3.5% of GDP and GGHE-D stood at 1% of GDP. GGHE-D represented about 3% of general government expenditure in 2009–2018. In 2018, 23.4% of CHE was financed by the government Budget, down from 24.7% in 2009.[71]

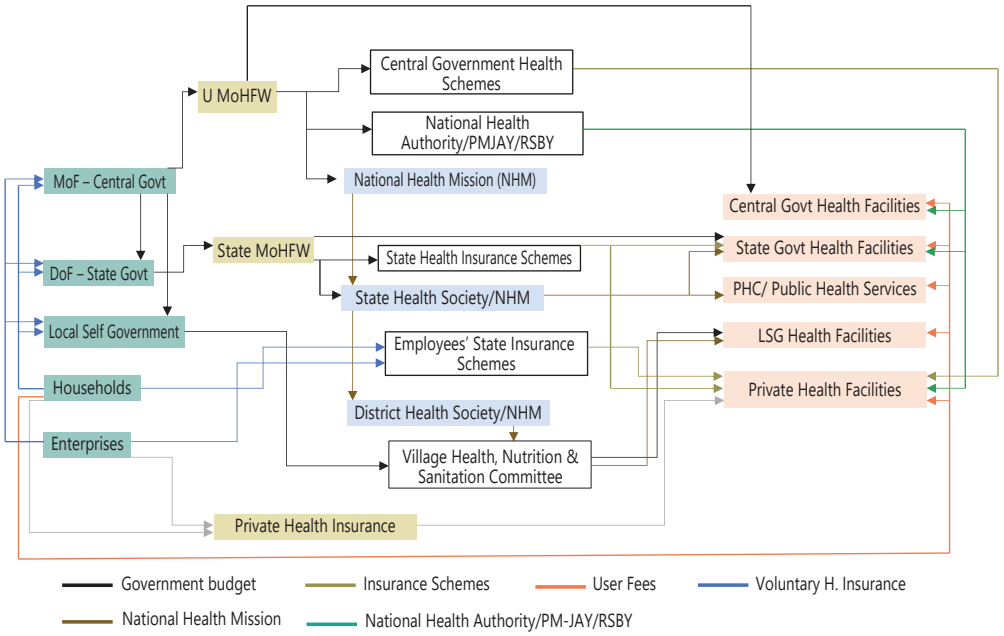
Both NHM and PMJAY are co-financed by Central (60% contribution) and state government (40% contribution) budgets, with few exceptions. Under the Central Government Health Scheme, beneficiaries are not subject to premium payments. For Employees' State Insurance schemes, both employees and employers share the premium contribution, with 0.75% and 3.25% of the wages respectively.[84]

Out-of-pocket expenditures is the largest source of health financing in India, comprising 62.7% of the CHE in 2018, down from 66.8% in 2009. Private voluntary health insurance and other private revenues from corporations and NGOs contributed 9.7% of CHE in 2018.[71]

Pooling and flow of resources

MoHFW is the main pooling institution in the health sector, complemented by the state health institutions. Sub-pools include PMJAY, NHM and other state insurance schemes at the state level (Fig. 1). Of the MoHFW's budget for the financial year 2020–2021, the NHM budget constitutes 51.4% and PM-JAY's is 9.8%.[85] The Central Government Health Scheme amounts to just above 2% of the MoHFW budget.

Fig. 1. Simplified flow of funds in India health sector



Source: Adapted from World Health Organization. Regional Office for South-East Asia. (2017). Health financing profile 2017: India. World Health Organization. Regional Office for South-East Asia. https://apps.who.int/iris/handle/10665/259642."

Benefits package

The services included in each package depend on the insurance scheme. Under the PM-JAY, secondary and tertiary care are covered but not outpatient care. The Central Government Health Scheme and Employees' State Insurance Corporation cover all types of care, including outpatient care and drugs. Under other publicly subsidized insurance coverage, all secondary, tertiary, pre-hospital and post-hospitalization treatment are covered.[82]

PM-JAY implements 867 packages split into 1573 procedures that include surgical procedures, medical and day care treatments, as well as costs of medicines and diagnostics within a ceiling of INR 500 000 (approximately US$ 6800) per enrolled family per year.[86]

With NHM, comprehensive primary health care (CPHC) includes a package of health services that cover both maternal and child health services, and communicable and noncommunicable diseases, including free essential drugs and diagnostic services (Table 1).[87]

Table 1. CPHC package of health services

1. Care in pregnancy and childbirth
2. Neonatal and infant health services
3. Childhood and adolescent health-care services
4. Family planning, contraceptive services, and other reproductive health-care services
5. Management of communicable diseases
6. General outpatient care for active simple illnesses and minor ailments
7. Screening, prevention, control, and management of noncommunicable diseases
8. Care for common ophthalmic and ENT problems
9. Basic oral health care
10. Elderly and palliative health-care services
11. Emergency medical services including burns and trauma
12. Screening of basic management of mental health ailments.

The package is being implemented by converting existing primary health care facilities into about 150 000 health and wellness centres (HWC) across India.

Health and wellness centres will deliver CPHC to address the primary health care needs of the entire population in close proximity to their communities. As on 31 March 2020, a total of 38 595 HWCs were functional.[88]

Purchasing arrangements

The MoHFW allocates funds directly to the centrally administered health facilities (hospitals) and health programmes under its aegis. The same approach is used by the State Department of Health and Family Welfare (DoHFW). Government health facilities, either Central, state/territory or LSG, are paid by line-item budgets set with an incremental approach. The SHMs and DHSs allocations to primary health care and LSG facilities are based on service targets, proposals in infrastructure, equipment, medicines and supplies, and operational and staff costs.

Health workers receive fixed salaries. Introduction of performance-related incentives for the HWC workers is underway.[89] Under PM-JAY, the SHAs purchase services from public and private hospitals that are empanelled based on general and specific criteria. NHA implements specified package rates to pay providers and states. State health insurance schemes can keep their own rates for all the packages. However, they are required to adhere to the mandatory 1391 procedures as specified on the PM-JAY list. Currently, most states follow NHA package rates. Hospitals submit claims and get reimbursed according to per diem payments for medical packages and case payments for surgical procedures. Private health-care providers charge fees for services to individual users according to their own itemized bills.

Public financial management

For NHM, budgeting is led by the state health societies, based on overall resource envelopes for the state and the planning guidelines by the Government of India. There is also a bottom-up annual planning and budgeting process, from LSGs to state-level agencies based on past year performance and budget execution. SHSs review the respective plans and budgets and consolidate for submission to the Central NHM.

In the health sector, transfers that were executed within the sector prior to 2014–2015 (i.e. NHM funds that were transferred to the state health societies), are now all disbursed through the State treasury.[89] Execution of MoHFW's regular Budget is usually above 90%.[90] State-level execution of the NHM budget is lower, at around 55% with large territorial variability observed in 2016–2017.[91] In order to ensure timely disbursement of funds, PM-JAY implemented changes to the public finance procedures on flow of funds. First, the Central and state governments/governments of Union Territories (UTs) open a separate designated escrow account for the scheme and then NHA and state/UT-level SHAs ensure that funds are disbursed on time to agencies lower in the order.[92] The NHA implements digital-based transaction processes to speed up the execution of the planned Budget. Accordingly, the claim should be settled no later than 15 days[93] after the hospital submits it.

Recent health financing reforms

The National Health Mission[a] created in 2005 aimed at increasing coverage of priority health programmes across the country. Following this, with the National Health Policy enacted in 2017, a new impetus for reform resulted in the establishment in 2018 of Ayushman Bharat – with the purpose of supporting the country to move towards universal health coverage. This is an umbrella flagship scheme that includes both a primary health care and a secondary and tertiary care[b] (hospital) component. The conversion of existing PHC facilities into health and wellness centres forms part of the former, while the latter entails the creation of PM-JAY. PM-JAY aims to cover 500 million people and is free for patients at the point of delivery. It includes public and private hospitals.[94]

a The Mission started as the National Rural Health Mission, then the National Urban Health Mission was created and finally the two were combined into the National Health Mission.

b Only inpatient care, no outpatient services.

India

Macro picture

Indicator	Latest year	Value
Total population (thousands)[1]	2020	1 380 004
Employment to population ratio, 15+, total (%) (national estimate)[2]	2018	45.4
GDP per capita growth (annual %)[2]	2019	4.0
GDP per capita (current US$)[2]	2019	2104
General government revenue (% of GDP)[3]	2019	19.3
Tax revenue (% of GDP)[2]	2018	12.0
General government total expenditure (% of GDP)[3]	2019	27.5
Fiscal balance (revenue–expenditure) (% of GDP)	2019	-8.2
General government gross debt (% of GDP)[3]	2019	72.3
Poverty headcount ratio at US$ 1.90 a day (2011 PPP) (% of population)[2]	2011	22.5
Poverty headcount ratio at national poverty lines (% of population)[2]	2011	21.9

[1] United nations, Department of Economic and Social Affairs, Population Division (2019). *World Population Prospects 2019: Volume II: Demographic Profiles.*

[2] World Bank Group. World Development Indicators, 2020. Washington, D.C.: 15 Oct 2020. https://databank.worldbank.org/source/world-development-indicators.

[3] IMF. *World Economic Outlook: A Long and Difficult Ascent*. Washington, D.C.: October 2020. https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020.

Progress towards universal health coverage

Fig. 2. SDG 3.8.1 Service Coverage Index (0–100)

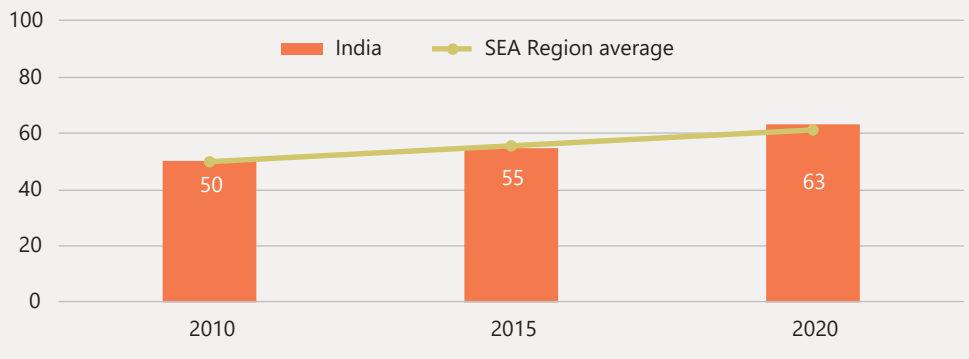
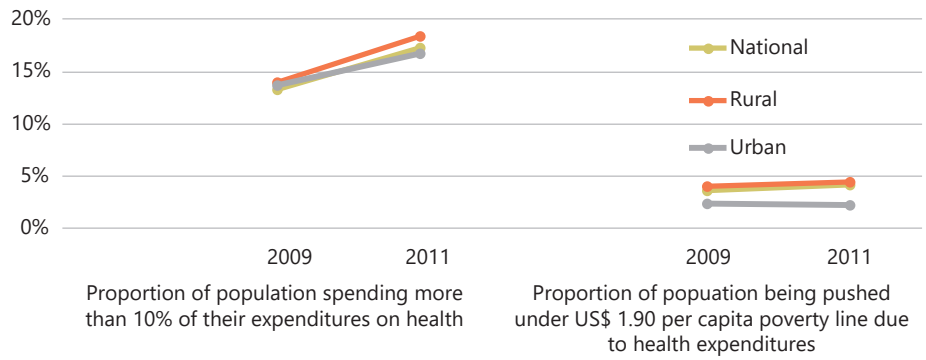


Fig. 3. SDG 3.8.2 Catastrophic and impoverishing incidence due to out-of-pocket expenditures on health



General health expenditure trends over the past decade

Fig. 4. Current health expenditures 2009–2018

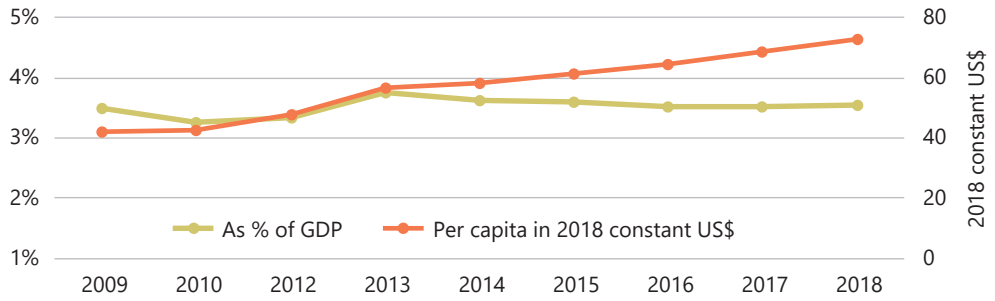


Fig. 5. Domestic government expenditures on health 2009–2018

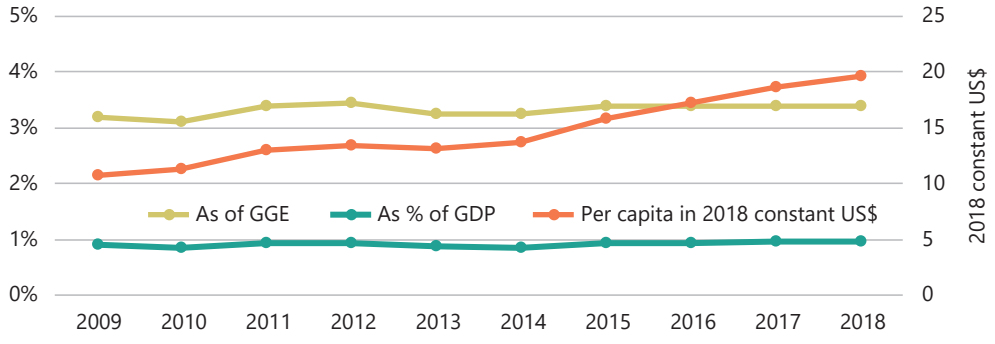
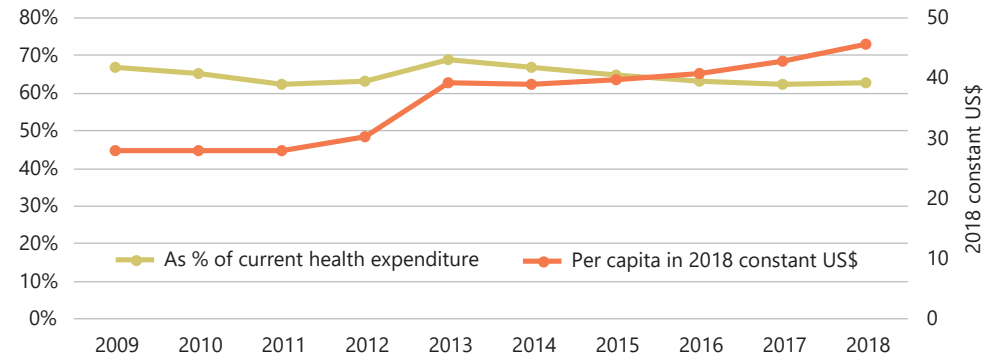
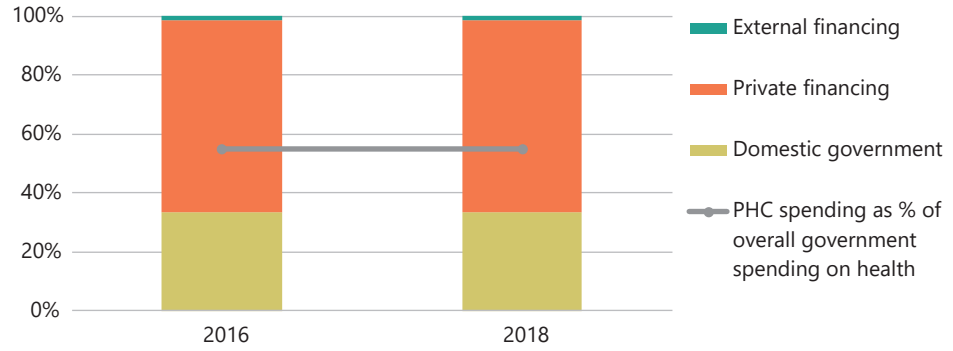


Fig. 6. Out-of-pocket spending on health (OOPS) 2009–2018



Primary health care expenditures[c]

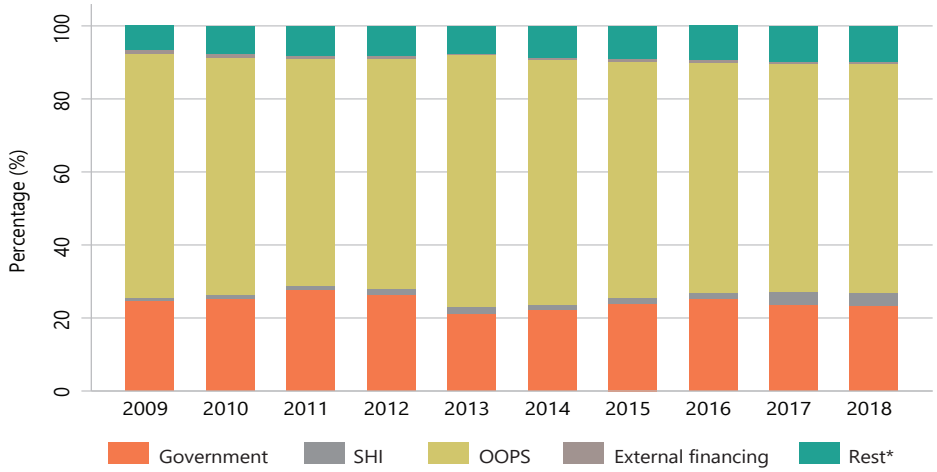
Fig. 7. Primary health care expenditures



c Primary health care measurement is entirely based on the health care functions classification. Details of the measurement can be found here: Global spending on health: a world in transition. Geneva: World Health Organization; 2019 (WHO/HIS/HGF/HFWorkingPaper/19.4).

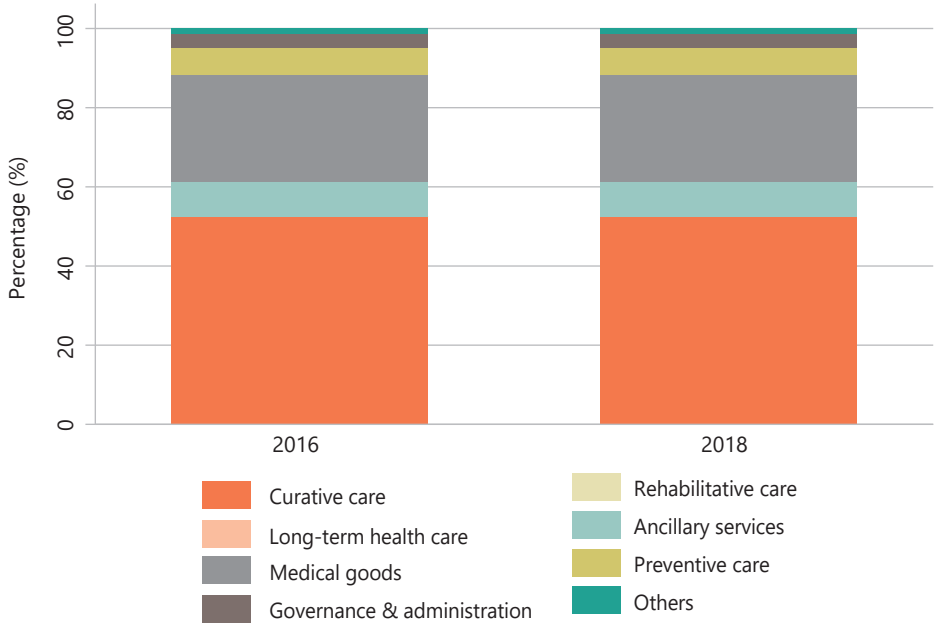
Composition of current health expenditures[d]

Fig. 8. Revenue sources of current health expenditures over the years



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

Fig. 9. Health expenditures by funtion



d "Ancillary services" and "medical goods" are independent consumptions that do not have a specific purpose (treatment, prevention, etc.) in themselves. Typical examples include laboratory services, imaging diagnosis, and patient transportation under "ancillary services", and pharmaceuticals (both prescribed and over-the-counter ones) as well as therapeutic goods (corrective glasses, hearing aids) under "medical goods". Consumption of such during a health-care contact are, therefore, lumped under other categories (i.e. curative care) and not separately reported.

Burden of diseases and disease-specific government expenditures

Fig. 10. Burden of diseases, 2019

Rank by disorder (2019)		DALYs (%)
1	Neonatal disorders	9.25
2	Ischemic heart disease	7.97
3	Chronic obstructive pulmonary disease	4.55
4	Diarrheal diseases	4.30
5	Lower respiratory infections	3.97
6	Stroke	3.71
7	Tuberculosis	3.35
8	Road injuries	3.33
9	Diabetes mellitus	2.73
10	Dietary iron deficiency	2.48
11	Self-harm	2.23
12	Other musculoskeletal disorders	2.12
13	Falls	2.09
14	Cirrhosis and other chronic liver diseases	2.06
15	Depressive disorders	1.80
16	Headache disorders	1.79
17	Congenital birth defects	1.61
18	Chronic kidney disease	1.61
19	Low back pain	1.60
20	Age-related and other hearing loss	1.46
21	Blindness and vision loss	1.27
22	Asthma	1.25
23	Gynecological diseases	1.18
24	Typhoid and paratyphoid	1.02
25	Rheumatic heart disease	0.98

Infectious and parasitic diseases
Reproductive health
Injuries
Nutritional deficiencies
Noncommunicable diseases

Indonesia

Progress towards universal health coverage

Indonesia is making steady progress towards universal health coverage. The UHC service coverage index increased from 45 in 2010 to 62 in 2020. Furthermore, the level of financial risk protection improved, as the share of population affected by household catastrophic health expenditure reduced from 3.9% in 2011 to 2.7% in 2018. In 2015, 0.8% of the population were pushed into poverty because of out-of-pocket health expenditures, a little less than 1.2% for the same in 2011 (under the daily US$ 3.20 per capita poverty line).[6]

Health system architecture and governance

Since the late 1960s, three public social protection schemes were created at the national level to cover civil servants and the military/police (*Askes*), the private sector (*Jamsostek*) and the poor (*Jamkesmas*). The *Jamkesmas* has been further replicated at the district level in more than 300 local schemes (*Jamkesda*). In 2014, the schemes merged into National Health Insurance Programme (*Jaminan Kesehatan Nasional or* JKN) (Table 1). Prior to the JKN merger, Askes covered 7% of the Indonesian population, *Jamsostek* covered 3%, and the central and local schemes for the poor covered 35% and 19% of the population, respectively. By the end of 2019, the JKN reached 222.1 million members (83% of the population), including 96 million poor people.[95]

Table 1. Government insurance schemes prior to JKN

Scheme	Coverage	Inception	Integration into JKN
Askes	Public sector (civil servants), military and police	1968	2014
TNI-Polri	Military and police	1968	2014
Jamsostek	Private formal sector	1992	2014
Jamkesmas	Poor	2005	2014
Jamkesda	Poor	2005	2019

The Social Health Insurance Agency for Health (BPJS-K) manages the JKN and is appointed by and accountable to H.E. the President of Indonesia. BPJS-K is a non-public entity supervised by Dewan Jaminan Sosial Nasional (DJSN), or the National Social Security

Board. DJSN members are a combination of government officials, community members, and representatives of employee associations and employer associations who are appointed by the President.[96]

Raising revenue

Current health expenditure (CHE) was estimated at just 2.9% of GDP in 2018, with little changes since 2009 (2.7% of GDP). While there was a slight increase in domestic government expenditure on health (GGHE-D) as share of GDP from 0.9% in 2009 to 1.4% in 2018; the increase was more substantial when analysing GGHE-D as a share of general government expenditure, which went up from 5.4% in 2009 to 8.5% in 2018.

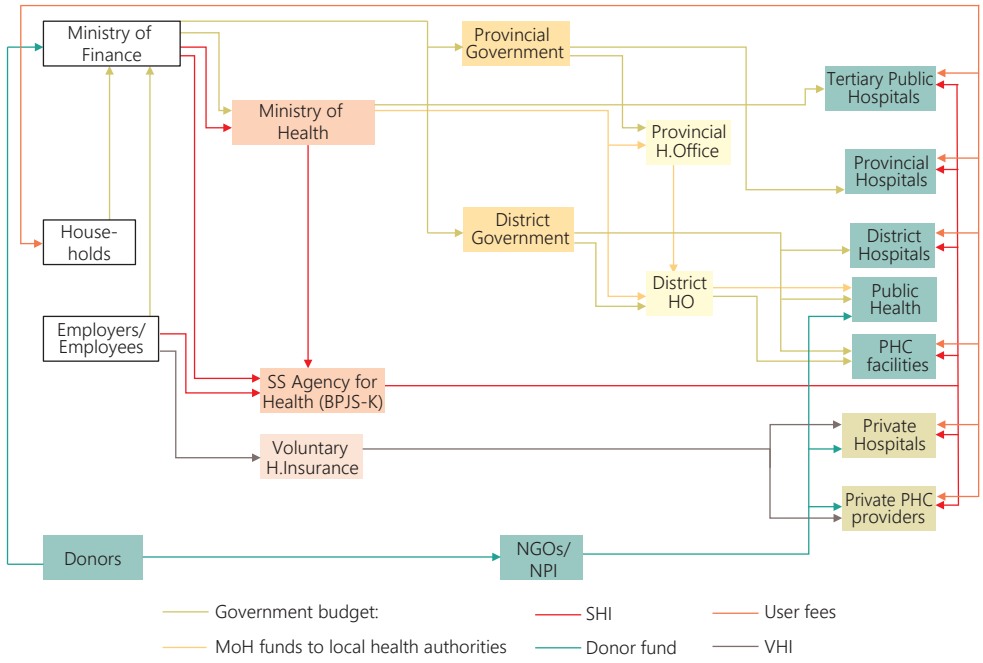
Almost half of the resources spent on health were raised publicly through the government Budget and compulsory social security schemes in 2018. The government Budget amounts to 36.1% and social health insurance contributes 13.2% to the CHE in 2018. More than one third (34.9%) of CHE is borne by out-of-pocket spending on health in 2018, down from 48.1% of CHE in 2009.[71]

JKN is funded through three different revenue streams. In the formal sector, the premium/contribution is levied as a percentage of employee salaries. In the public and private sectors, 4% is paid by the employer and 1% by the employee, as of 2019. The government Budget transfers cover membership of poor and near-poor through fixed monthly amounts per member (IDR 42 000 in 2019). Self-insured informal and non-salaried workers pay in fixed amounts (between IDR 25 000 and IDR 80 000 per person per month) based on the type of coverage for the three levels of the benefit package.[97]

Pooling and flow of resources

The two main pooling schemes are the government health budget and social health insurance. Since decentralization in 1999, the government health budget is divided into central (MoH and other ministries) and subnational/local components. BPJS-K is managed as a single trust fund (*Dana Amanat*), which is pooled from the contributions/premiums of a whole population, including government funds.[98]

Fig. 1. Simplified flow of funds in Indonesia health sector



Source: Adapted from Mahendradhata Y, Trisnantoro L, Listyadewi S, Soewondo P, Marthias T, Harimurti P, Prawira J, et al. The Republic of Indonesia Health System Review. Vol.7 No.1. New Delhi: World Health Organization, Regional Office for South-East Asia, 2017.

Benefits package

With the three government health insurance schemes merged, benefit packages were also unified, creating one comprehensive JKN benefit package.

Table 2. JKN Benefit package

Level of care	Types of services
Primary care	Primary care coverage includes: (i) promotive/preventive services; (ii) examination, treatment, and medical consultation; (iii) non-specialist medical treatment, both operative and nonoperative; (iv) medicine, medical consumables and materials; (v) blood transfusion in accordance with medical needs; (vi) laboratory diagnostic primary level; and (vii) primary hospitalization in accordance with medical indications.
Secondary and tertiary care	Secondary and tertiary care coverage includes: (i) examination, treatment and specialist consultation by a specialist and subspecialty; (ii) specialist medical treatment in accordance with the medical indications; (iii) drug services, medical consumables and materials; (iv) advanced diagnostic services in accordance with medical indications; (v) medical rehabilitation; (vi) blood services; (vii) forensic medical services; (viii) mortuary in health facilities; and (ix) non-intensive inpatient care; and (x) intensive care.

JKN offers a comprehensive benefits package based on medical indications, covering outpatient and inpatient care at the primary level up to the tertiary hospital level, excluding only a few types of services that are partially covered and fully uncovered based on the coverage type of the members.

Some medical assistive devices and equipment (such as eyeglasses, hearing aids and wheelchairs) are included in the benefits package, but with an upper limit determined by value or quantity. There is no upper ceiling applied under BPJS-K in relation to care provided in accordance with protocol guidelines. The policy forbids co-payments; however, additional payments may be required for non-medical benefits such as a higher class of hospital admission.[97] There is an explicit list of excluded services, namely, cosmetic surgery, orthodontia, infertility services and drug addiction-related conditions, among others.[98]

Purchasing arrangements

There are three purchasers in the Indonesian health system: BJPS-K, MoH and subnational local government authorities. The MoH provides funds for frontline services (*puskesmas,* or primary health centres), including public health activities, through a co-financing scheme with local governments. Provincial and district hospitals are funded directly by the respective local governments, while the District Health Office acts as a purchaser for primary health care facilities.

Public or government health facilities are paid by a mix of payment mechanisms. MoH and subnational local governments pay for salaries and operational costs through line-item budgets. These are complemented with BJPS-K payments that are used to cover salaries of non-civil servants, medicines and other expenses. Public primary health-care facilities are paid by capitation and hospitals according to the diagnostic-related groups (DRG). Privately paid out-of-pocket payments to government health facilities are usually charged for improved amenities.

More than 60% of hospitals empanelled with BJPS-K are private. BPJS contracts health facilities through a selection process. These providers are paid with the same mechanism as government facilities, but with higher payment rates to compensate for the government Budget allocated to public facilities.

Public financial management

Government planning and budgeting are managed by two institutions: the Ministry of Planning and Ministry of Finance. Allocation to health is determined by the Ministry of Planning in consultation with MoF and MoH. The MoH budgeting is structured in nine programmes, the largest of which is the JKN support (40% of the Budget, to be transferred to BJPS-K), followed by the Health Service Development programme (to support tertiary

hospitals and local health authorities), including human resources development, disease prevention, pharmaceuticals and research.[99]

The provincial and district health agencies prepare plans and budget proposals, which are largely based on the same factors as at central level (i.e. historical allocations, requests and proposals originating from the bottom-up planning process) and responses to identified local priorities, often determined by the political party in power.[97]

Donor funding, usually focused on mother-and-child care and control of selected communicable diseases, are disbursed to health facilities and providers through international (such as the Global Fund) and national nongovernmental bodies, and MoH. These funds are integrated into annual plans and budgets. Government Budget execution (including the health sector) in 2016 was 89.5%, with lower execution (75%) of the capital expenditure. The MoH budget execution was 83% in 2014, 110% in 2015 and 89% in 2016.[100]

Recent health financing reform

The main health financing reform initiated in Indonesia has been the merging of the existing government health insurance schemes into the JKN in 2014. This has been a substantive step in the country's collective efforts to move towards universal health coverage.

Indonesia

Macro picture

Indicator	Latest year	Value
Total population (thousands)[1]	2020	273 524
Employment to population ratio, 15+, total (%) (national estimate)[2]	2019	65.7
GDP per capita growth (annual %)[2]	2019	3.9
GDP per capita (current US$)[2]	2019	4 136
General government revenue (% of GDP)[3]	2019	14.2
Tax revenue (% of GDP)[2]	2018	10.2
General government total expenditure (% of GDP)[3]	2019	16.4
Fiscal balance (revenue–expenditure) (% of GDP)	2019	-2.2
General government gross debt (% of GDP)[3]	2019	30.5
Poverty headcount ratio at US$ 3.20 a day (2011 PPP) (% of population)[2]	2018	21.5
Poverty headcount ratio at national poverty lines (% of population)[2]	2018	9.8

[1] United nations, Department of Economic and Social Affairs, Population Division (2019). World Population Prospects 2019: Volume II: Demographic Profiles.

[2] World Bank Group. World Development Indicators, 2020. Washington, D.C.: 15 Oct 2020. https://databank.worldbank.org/source/world-development-indicators.

[3] IMF. World Economic Outlook: A Long and Difficult Ascent. Washington, D.C.: October 2020. https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020.

Progress towards universal health coverage

Fig. 2. SDG 3.8.1 Service Coverage Index (0–100)

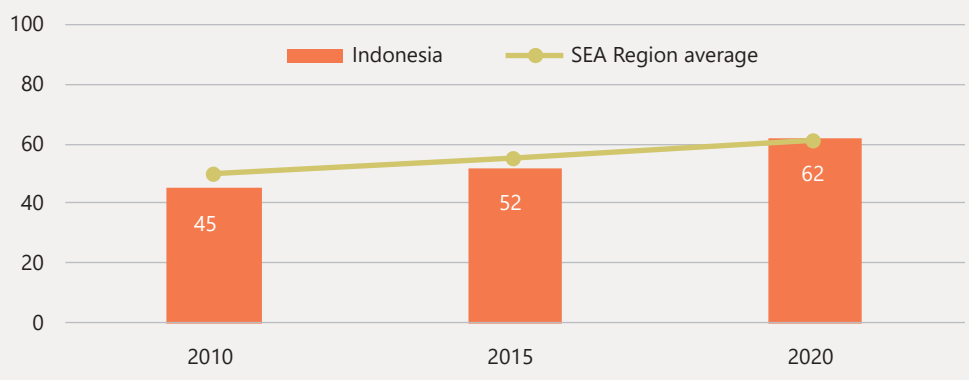
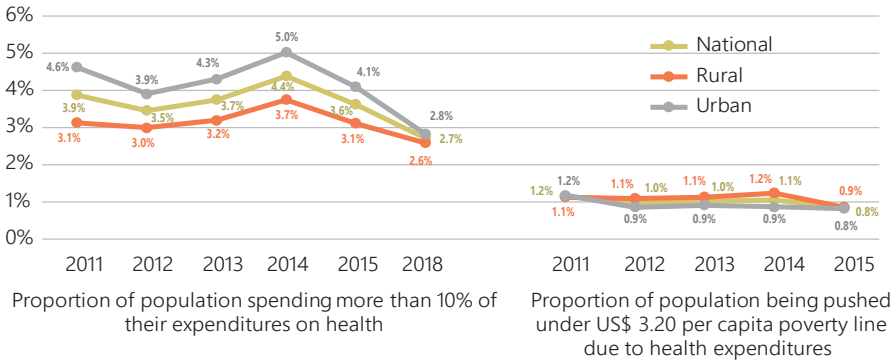


Fig. 3. SDG 3.8.2 Catastrophic and impoverishing incidence due to out-of-pocket expenditures on health



General health expenditure trends over the past decade, compared to regional and income group averages

Fig. 4. Current health expenditures 2009–2018

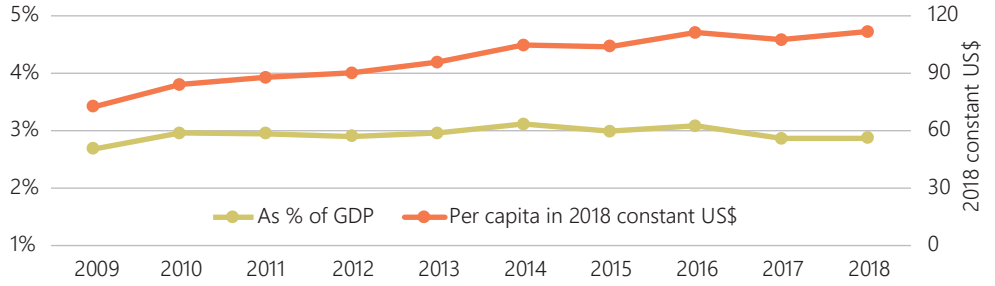


Fig. 5. Domestic government expenditures on health 2009–2018

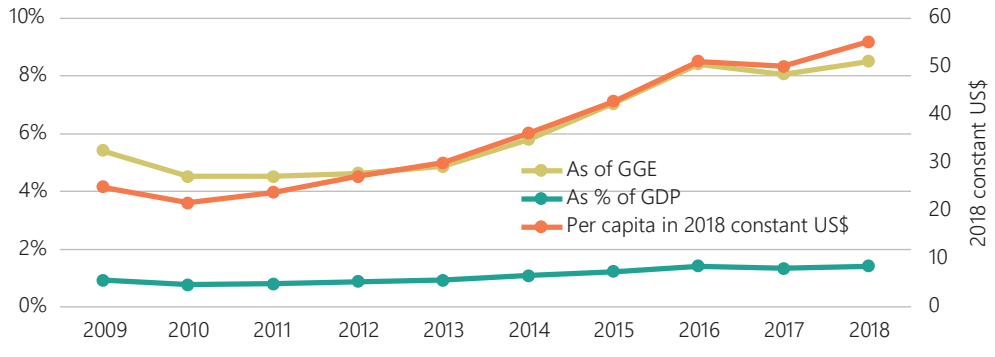
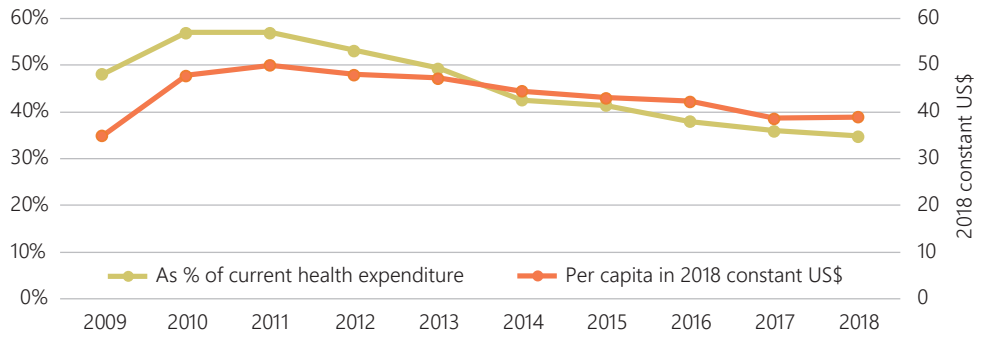


Fig. 6. Out-of-pocket spending on health (OOPS) 2009–2018

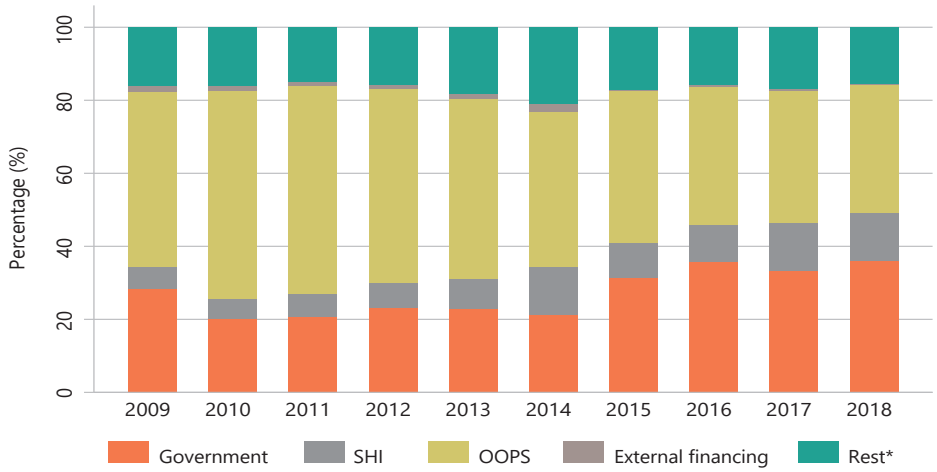


Primary health care expenditures

No data available

Composition of current health expenditures[a]

Fig. 7. Revenue sources of current health expenditures over the years



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

a "Ancillary services" and "medical goods" are independent consumptions that do not have a specific purpose (treatment, prevention, etc.) in themselves. Typical examples include laboratory services, imaging diagnosis, and patient transportation under "ancillary services", and pharmaceuticals (both prescribed and over-the-counter ones) as well as therapeutic goods (corrective glasses, hearing aids) under "medical goods". Consumption of such during a health care-contact are, therefore, lumped under other categories (i.e. curative care) and not separately reported.

Burden of disease and disease-specific government expenditures

Fig. 8. Burden of disease, 2019

Rank by disorder (2019)		DALYs (%)
1	Stroke	10.87
2	Ischemic heart disease	7.94
3	Neonatal disorders	5.06
4	Diabetes mellitus	4.98
5	Cirrhosis and other chronic liver diseases	3.50
6	Tuberculosis	3.44
7	Low back pain	3.14
8	Road injuries	2.91
9	Diarrheal diseases	2.78
10	Chronic obstructive pulmonary disease	2.57
11	Headache disorders	2.31
12	Chronic kidney disease	2.12
13	Lower respiratory infections	2.03
14	Congenital birth defects	1.94
15	Age-related and other hearing loss	1.70
16	Tracheal, bronchus, and lung cancer	1.65
17	Other musculoskeletal disorders	1.57
18	Hypertensive heart disease	1.50
19	Neck pain	1.50
20	Blindness and vision loss	1.45
21	Asthma	1.35
22	Breast cancer	1.27
23	Depressive disorders	1.23
24	Anxiety disorders	1.19
25	Falls	1.17

Infectious and parasitic diseases
Nutritional deficiencies
Reproductive health
Noncommunicable diseases
Injuries

Maldives

Progress towards universal health coverage

Maldives is making steady progress towards UHC. Its UHC service coverage index increased from 59 to 62 between 2010 and 2020. As for financial risk protection, the share of the population affected by household catastrophic health expenditure decreased from 19.9% in 2009 to 10.3% in 2016. In the same year, 0.1% of the population were pushed into poverty because of out-of-pocket health expenditures, down from 3.5% in 2009 (under the daily US$3.20 per capita poverty line).[6]

Health system architecture and governance

Health services in Maldives is currently delivered by a four-tier referral system, comprising island, atoll/regional and central level services. There are three tertiary hospitals in the country, two of which are privately owned, with Indira Gandhi Memorial Hospital (IGMH) in Malé being the only government tertiary care hospital.

There are six regional and 14 atoll hospitals in strategic locations across the country, which serve as the first referral. Each inhabited island also has a fully functional health centre.[101] The private sector has grown significantly in the past decade, with more than 50 clinics in addition to two tertiary hospitals. The voluntary sector is also present in the form of nongovernmental organizations (NGOs) working on specific health issues, mainly in urban areas.

The health financing architecture has undergone significant changes after the roll-out of social health insurance in 2012. The National Health Insurance (NHI) scheme (*Aasandha*) and the Ministry of Health (MoH) define and regulate health financing policies in Maldives. The non-contributory NHI scheme covers all Maldivian nationals. The MoH acts as policy-maker, provider and payer, overseeing about 60% of the health budget, including funds for government health facilities and centralized procurement of medicines and consumables.[102]

The National Social Protection Agency (NSPA), an autonomous government body, regulates the NHI scheme. It oversees the public Aasandha Insurance Company, which administers the scheme. Senior managers are appointed by the Office of the President, and the Agency is accountable to a Board (comprises MoF, MoH and NSPA as well as private sector representation).[103]

Currently, three voluntary private insurance companies provide health insurance schemes (Amana Thakaful, Allied Insurance Company and Solarelle Insurance Company) and also provide coverage to foreigners.

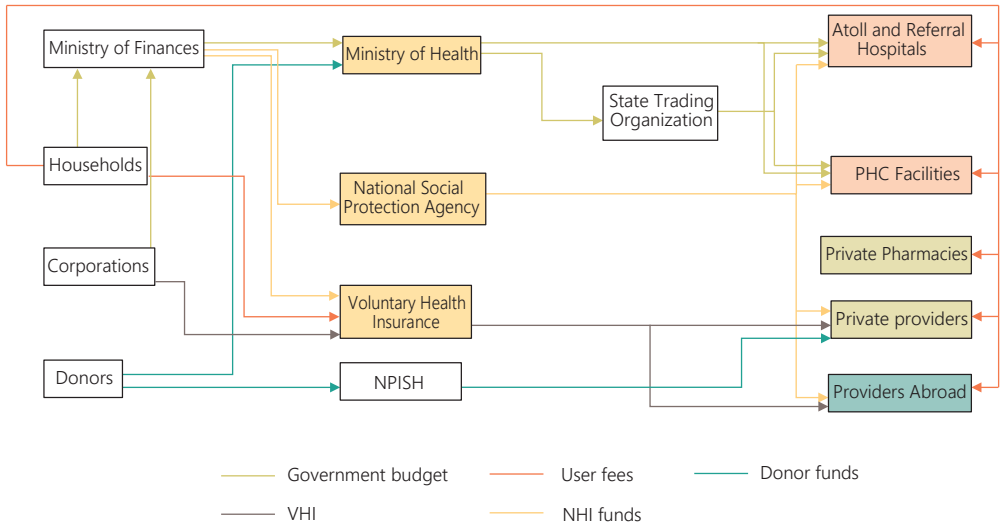
Raising revenue

Current health expenditure (CHE) was estimated at 9.4% of GDP in 2018 – a slight decline from 10.1% in 2009. Domestic general government health expenditure was 6.6% of GDP in 2018, up from 5.8% in 2009 with government contributions to the NHI scheme. Accordingly, the general government health expenditure increased from 15.8% of the general government expenditure in 2009 to 21.4% in 2018. The government Budget allocation constituted 70.7% of the CHE in 2018, up from 58% in 2009.[71] Tobacco taxation was increased to 25% *ad valorem* rate of the retail price from August 2020. Three percent of the proceeds will be allocated to a public health fund to conduct anti-tobacco public awareness campaigns under the Public Health Protection Act 2012/7.[104] External donor transfers have reduced over the years, from 5% in 2009 to 0.9% by 2018. Out-of-pocket expenditure on health as a percentage of CHE has seen a substantial reduction in the past decade – dropping from 34% in 2009 to 20.6% in 2018. Voluntary pre-payments through private health insurance schemes remains a small part of health financing, at 2.1% of CHE in 2018.[71]

Pooling and flow of resources

There are three main pools in use for public resources for health in Maldives. The Ministry of Finance transfers the government budget to the MoH and the NSPA. When official donors channel their funds through government, the MoH acts as an intermediary. Government, households and corporations channel certain funds through voluntary insurance payment mechanisms.[103]

Fig. 1. Simplified flow of funds in the Maldives health sector



Source: Adapted from Ministry of Health. Maldives National Health Accounts 2015–2017. Malé: Government of Maldives; 2019.

Benefits package

The NHI and the MoH provide a comprehensive package of health services. The MoH Budget covers all government health facilities in the country that provide services to the whole population. For any services not delivered at MoH facilities, the NHI provides coverage without a benefit ceiling. The benefits package is implicit and covers everything that is not included in a list of excluded services (Table 1). Some of the exclusions (i.e. disability care) are covered by a different social protection programme run by the NSPA. A substantial amount of health services used by Maldivians for care and treatment in health facilities overseas is also supported by the NHI.[103]

Table 1. Health services included and excluded from NHI

Broad categories of included services	Selected excluded services
• Both inpatient and outpatient treatments and medication • Diagnostic and surgical interventions • All transportation fees in emergencies • Annual medical check-up for those aged 18 or older • Treatment for terminally ill patients and those with special needs • Medical costs during pregnancy	• Private rooms • Services obtained from facilities not empanelled • Addiction-related services • Disability care (already covered by NSPA) • Cosmetic surgeries and treatments • Charges incurred without prescription • Infertility and abortion (unless explicitly allowed) • Massage and other physical therapies, weight reduction • Experimental or unproven treatments

User fees are also incurred at public and private facilities, including for services such as improved amenities. In Maldives, almost half of the out-of-pocket payments is spent on purchasing medicines from private pharmacy outlets. [103]

Purchasing arrangements

The MoH transfers, to government health facilities, pay for salaries and operational costs. The latter is mostly in kind (fuel, stationary, etc.), on a line-item basis, and using an incremental approach. In addition, the MoH allocates external donor funds for expenses linked to the implementation of specific global health initiatives (such as the Global Fund) and non-profit providers. The government-owned State Trading Organization organizes procurement and distribution of medicines and consumables for the public sector, with funds transferred from MoH.

The NSPA registers and contracts public and private facilities. Health care provided by public facilities is paid with a combination of MoH budgets and NSPA reimbursements (the latter spent on additional staff, medicines and other goods and services). Public providers do not submit actual claims to the NSPA.[103] On the other hand, private providers are reimbursed by NSPA against claims submitted by itemized bills. The NSPA prices are not fixed or negotiated and vary significantly across providers.[105]

Public financial management

The health masterplan outlines performance indicators for each outcome in the plan. This serves as the link between long-term planning and medium-term budgeting.[106] The Ministry of Finance issues the annual Budget Circular I, based on which MoH provides proposals for new policy initiatives. In Budget Circular II, proposals are submitted on Budget execution for the previous year and expenditure for the following.

All payments are disbursed centrally from the MoF Single Treasury Account through the "System Application Product" – a software that facilitates all stages of the financial management cycle starting with planning and setting the budget framework, through to reporting and review of the outcome of the budget (www.finance.gov.mv) – and in-year budget execution is available to the public. Official donors are expected to route their funds largely through the government system, while private donors are observed to disburse funds through own arrangements.

Recent health financing reform

The main health financing reform in Maldives led to the creation of the NHI Scheme in 2012 and its evolution into a non-contributory, tax-based insurance scheme covering all Maldivians. The Health Masterplan 2016–2025 envisions additional reforms. These include the allocation of adequate funds to public health and primary health care services, increase in technical efficiency of the funds allocated, alternative sources of funding for the NHI, and an audit of the health expenditure.[107]

Maldives

Macro picture

Indicator	Latest year	Value
Total population (thousands)[1]	2019	530 953
Employment to population ratio, 15+, total (%) (national estimate)[2]	2016	54.1
GDP per capita growth (annual %)[2]	2019	2.2
GDP per capita (current US$)[2]	2019	10 791
General government revenue (% of GDP)[3]	2019	27.2
Tax revenue (% of GDP)[2]	NA	NA
General government total expenditure (% of GDP)[3]	2019	33.6
Fiscal balance (revenue–expenditure) (% of GDP)	2019	-6.4
General government gross debt (% of GDP)[3]	2019	78.0
Poverty headcount ratio at US$ 3.20 a day (2011 PPP) (% of population)[2]	2016	0.2
Poverty headcount ratio at national poverty lines (% of population)[2]	2016	8.2

[1] United nations, Department of Economic and Social Affairs, Population Division (2019). World Population Prospects 2019: Volume II: Demographic Profiles.

[2] World Bank Group. World Development Indicators, 2020. Washington, D.C.: 15 Oct 2020. https://databank.worldbank.org/source/world-development-indicators.

[3] IMF. World Economic Outlook: A Long and Difficult Ascent. Washington, D.C.: October 2020. https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020.

Progress towards universal health coverage

Fig. 2. SDG 3.8.1 Service Coverage Index (0–100)

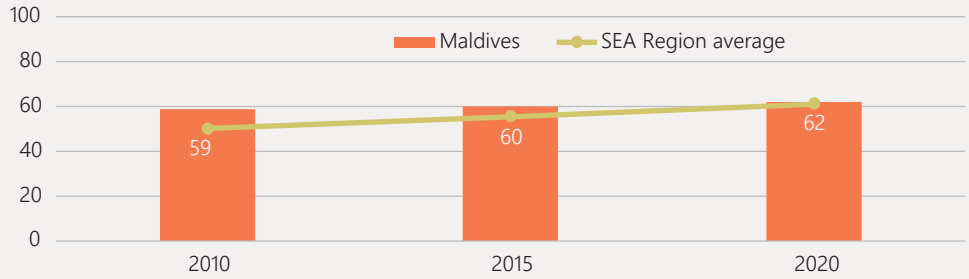
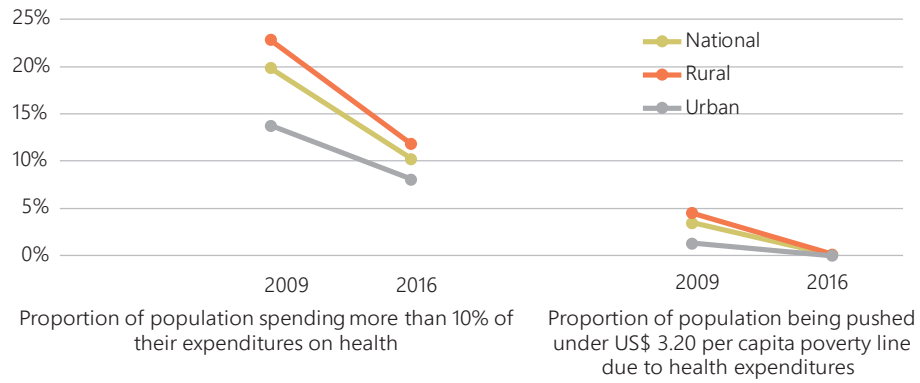


Fig. 3. SDG 3.8.2 Catastrophic and impoverishing incidence due to out-of-pocket expenditures on health



General health expenditure trends over the past decade

Fig. 4. Current health expenditures 2009–2018

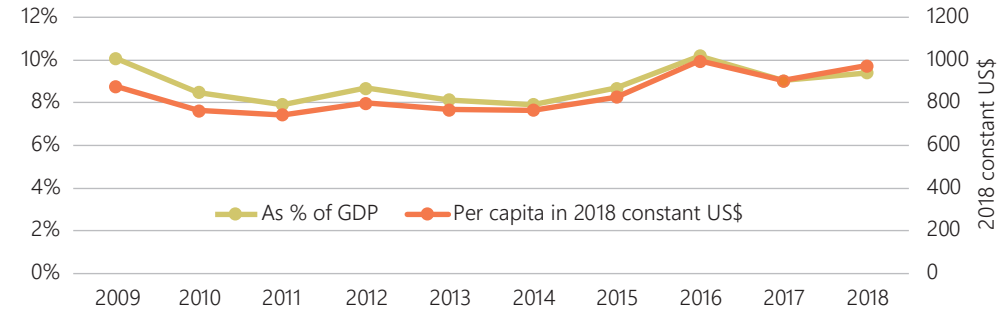


Fig. 5. Domestic government expenditures on health 2009–2018

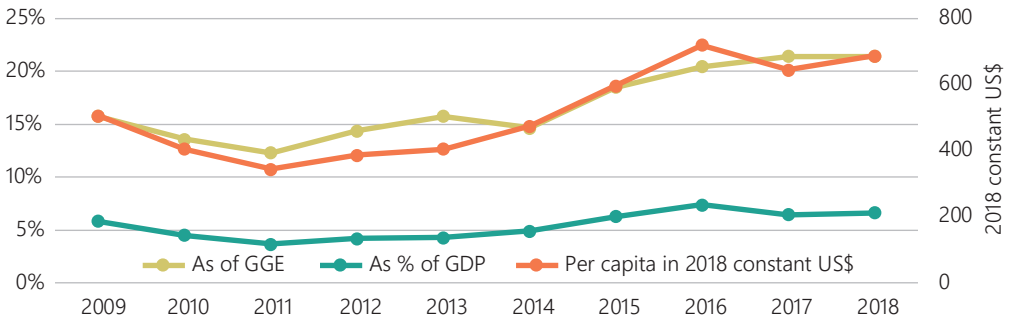
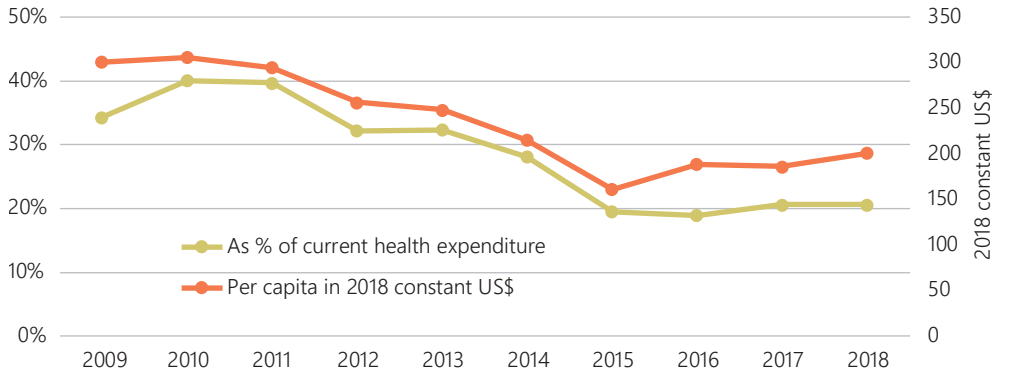


Fig. 6. Out-of-pocket spending on health (OOPS) 2009–2018

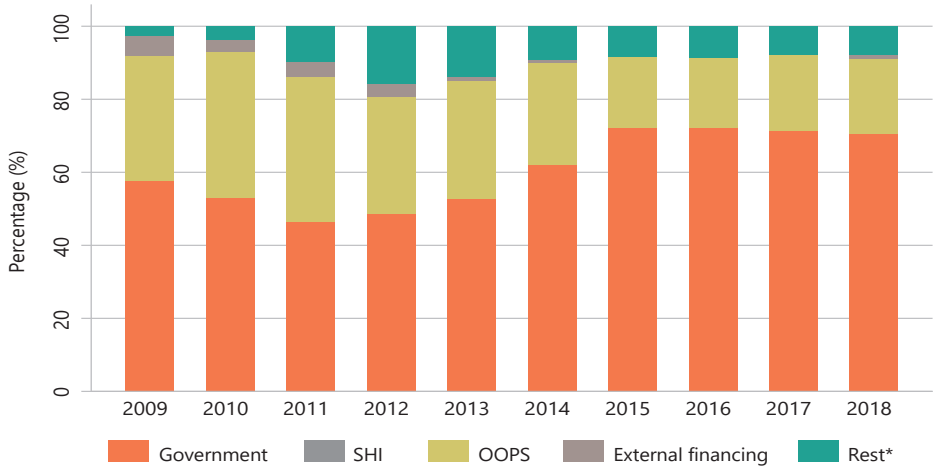


Primary health care expenditures

No data available

Composition of current health expenditures

Fig. 7. Revenue sources of current health expenditures over the years



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

Burden of disease and disease-specific government expenditures

Fig. 8. Burden of disease, 2019

Rank by disorder (2019)		DALYs (%)
1	Neonatal disorders	8.80
2	Ischemic heart disease	7.30
3	Stroke	4.36
4	Low back pain	4.22
5	Headache disorders	3.65
6	Congenital birth defects	3.34
7	Diabetes mellitus	2.98
8	Chronic kidney disease	2.97
9	Chronic obstructive pulmonary disease	2.87
10	Depressive disorders	2.63
11	Other musculoskeletal disorders	2.55
12	Age-related and other hearing loss	2.54
13	Neck pain	2.08
14	Anxiety disorders	1.96
15	Road injuries	1.66
16	Endocrine, metabolic, blood, and immune disorders	1.58
17	Falls	1.57
18	Schizophrenia	1.38
19	Gynecological diseases	1.33
20	Drowning	1.25
21	Cirrhosis and other chronic liver diseases	1.18
22	Dietary iron deficiency	1.16
23	Self-harm	1.13
24	Lower respiratory infections	1.09
25	Oral disorders	1.03

Infectious and parasitic diseases
Reproductive health
Injuries
Nutritional deficiencies
Noncommunicable diseases

Myanmar

Progress towards universal health coverage

Myanmar's progress towards UHC is marked by the increase in its UHC service coverage index from 49 in 2010 to 56 in 2020. As for the financial risk protection, data from 2015 shows that household catastrophic health expenditure impacted 14.4% of the population, while 0.6% were pushed into poverty (as per the poverty line of US$ 1.90 per capita daily).[6]

Health system architecture and governance

The Ministry of Health and Sports (MoHS) is the major governing agency as well as the provider of health care. It is responsible for planning, financing, administrating, regulating and providing health care. Health service provision is extended down to rural settings through a network of health-care facilities at different administrative levels.

Township health departments manage the township health system and are the backbone of primary health care, as they provide health services at the local level. At the regional administrative level, regional and state health departments provide supervisory and technical support, while managing the provision of tertiary care and referral services.[108] The MoHS centralizes the procurement and distribution of medicines and supplies. The commercial private sector mainly provides ambulatory care, though some private institutional care has emerged in larger cities in recent years.

The Social Security Scheme (SSS) is responsible for the health of insured workers in Myanmar. The scheme covers formal sector workers of companies with five or more employees, comprising less than 2% of the population. The SSS is managed by the Social Security Board (SSB) in the Ministry of Labour, Immigration, and Population (MoLSS). The SSB reports to the Social Security National Board, which is composed of MoLSS, MoHS, other government bodies, and representatives of employers and employees. The SSB has offices in townships and a presence in almost in all states and regions.

National and international nongovernmental bodies, largely funded by external donors, play a crucial role in the management and provision of health services. Donors also make significant funding contributions for the provision of essential medicines for communicable diseases, health systems development, and specific health programmes. UN agencies are key contributors as managers of funds from global health initiatives such as GAVI.

Raising revenue

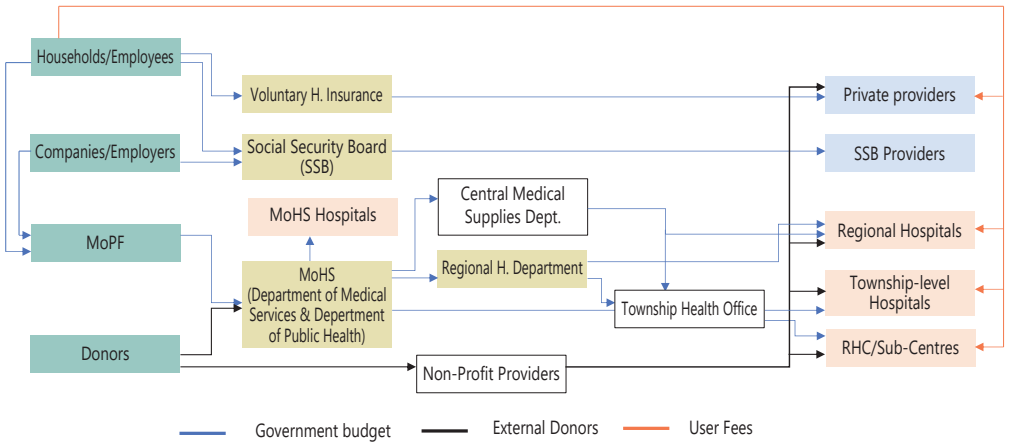
Current health expenditure was 4.8% of GDP in 2018, more than double the value of 2.1% in 2009. Domestic government expenditure on health (GGHE-D) also grew to 0.7% of GDP in 2018 from 0.2% in 2009. The share of general government expenditure devoted to health almost tripled from 1.4% in 2009 to 3.5% in 2018. Government budget allocation to health as a share of CHE increased from 8.5% in 2009 to 14.3% in 2018.

The Social Security Schemes represent 0.6% of the CHE, up from 0.2% (2.5% for all people aged 60 or older) of monthly payroll contribution by employees and employers. External donor financing as a revenue source for health was 9.1% in 2009 and 8.7% of CHE in 2018. Out-of-pocket spending on health constituted 76.4% of CHE in 2018, down from 82.3% in 2009.[71]

Pooling and flow of resources

The main pooling mechanism in the Myanmar health sector is the government health Budget allocated by the Ministry of Planning and Finance (MoPF), managed by the MoHS and its subordinate institutions. Due to the functional separation within the MoHS, activities carried out by individual departments are more vertical in nature and mirrored in separate funds at lower levels of public health system. The SSB manages the fund pool collected from contributions by members. The large majority of external funding is channeled through their own, mostly separate, systems.

Fig. 1. Simplified flow of funds in Myanmar health sector



Source: Adapted from World Health Organization. Regional Office for South-East Asia. (2017). Health financing profile 2017: Myanmar. World Health Organization. Regional Office for South-East Asia.

Benefits package

Networks of public hospitals and health centres provide curative services ranging from primary to tertiary health care. However, user charges at the point of service for goods and health services are applied in all public facilities. Users must purchase medicines and medical supplies from outside vendors if the health facility runs out of stocks of these.[109] The SSS covers medical treatment and delivery (outpatient, inpatient, medicine, laboratory and transportation in case of referral outside urban areas) for a maximum of 26 weeks. The benefits package is free in all SSB facilities except for retired workers who have a 50% co-payment clause. Newborns are also covered entirely for all services during their first year of life.

A new benefits package was designed in 2016 as part of the National Health Plan. The package of Essential Health Services (EPHS) aims to guarantee access for all in Myanmar without financial barriers. The EPHS will be implemented in three phases: Basic Package of Essential Health Services (BPEHS) by 2020, an Intermediate Package of Essential Health Services (IPEHS) by 2025, and Comprehensive Package of Essential Health Services (CPEHS) by 2030.[109]

Table 1. Services included in Myanmar's benefit packages

BPEHS	IPEHS (BPEHS + selected services)	CPEHS (IPEHS + selected services)
• Communicable diseases • RMNCAH • Noncommunicable diseases • Nutrition • Cross-cutting and other services such as emergency disaster management, occupational/ environmental health, eye care, ENT, oral health	• Increased screening and testing in RMNCAH • Malnutrition care • Comprehensive communicable disease prevention, treatment and social support • Enhanced screening, treatment, and pharma care for common NCDs • Assistive technologies for hearing and vision • Eye surgeries and other aids	• Supportive RMNCH care and peer outreach • Health promotion activities in malnutrition and NCDS • Enhanced imaging for cancers • Caregiver and psychosocial supports • Newborn hearing assessments • Common ENT surgeries • Radiology, ECG and echocardiograms

The EPHS package prioritized preventive and public health interventions as well as basic investigative and curative services in the areas of reproductive, maternal, neonatal, child and adolescent health, malnutrition, communicable diseases and NCDs, including injuries and mental health (Table 1).

Purchasing arrangements

In the Myanmar health system, both the MoHS and the SSB act as purchasers as well as providers of health services. In addition, there are NGO players involved in service purchasing. The public sector health providers are paid based on input-based, line-item budgets, and health professionals are salaried. Furthermore, patients pay user charges based on fee-for-services to both public and private providers.[110]

There are three worker's hospitals and 92 clinics under the SSB to provide free health care at the point of services to insured workers. The SSB provides a yearly allocation to these facilities and pays them on the basis of line-item budgets. Referrals to other public facilities entail payments based on rates fixed according to service.[111] The SSB monitors the providers on a monthly basis through a largely paper-based system.

Public financial management

The recurrent budgeting follows, by and large, a top-down process and is based on increments to historical spending levels. The MoHS allocates the government budget to regional and township-level health institutions and hospitals, according to the operational budget, based on the number of sanctioned hospital beds and bed utilization rates, while the budget for medicines is allocated on a per capita basis.

Public health programmes are funded based on existing staff and planned activities. Allocation of the capital budget is based on norms for population-to-facility ratios and plans for infrastructure works and procurement of equipment.[111] The budgets to health institutions and programmes are disbursed according to economic line-item expenses.

External donor resources remain mostly off-budget, disbursed through their own financial management systems to respective health institutions and nongovernmental bodies. The execution of the recurrent government health Budget has traditionally been above 90%, while spending on capital items was at 67% in 2017–2018.[112] The execution of the medical services budget reached 94% between 2015 and 2018, whereas the actual spending on public health programmes did not exceed 75% of approved budgets. Execution of the procurement of medicines and supplies budget approached 100%. Over the past years, the SSB is transitioning towards an autonomous financial management system.[113]

Recent reforms

Reforms included in the National Health Plan 2017–2021 aim at bringing the country closer to achieving UHC by 2030 through increased government health expenditure, better alignment and utilization of external funds, the implementation of the EPHS and of strategic purchasing for public and private providers.[114]

Myanmar

Macro picture

Indicator	Latest year	Value
Total population (thousands)[1]	2020	54 410
Employment to population ratio, 15+, total (%) (national estimate)[2]	2019	59.2
GDP per capita growth (annual %)[2]	2019	2.2
GDP per capita (current US$)[2]	2019	1 408
General government revenue (% of GDP)[3]	2019	16.4
Tax revenue (% of GDP)[2]	2019	5.4
General government total expenditure (% of GDP)[3]	2019	20.3
Fiscal balance (revenue–expenditure) (% of GDP)	2019	-3.9
General government gross debt (% of GDP)[3]	2019	38.8
Poverty headcount ratio at US$ 1.90 a day (2011 PPP) (% of population)[2]	2017	1.4
Poverty headcount ratio at national poverty lines (% of population)[2]	2017	24.8

[1] United nations, Department of Economic and Social Affairs, Population Division (2019). *World Population Prospects 2019: Volume II: Demographic Profiles.*

[2] World Bank Group. World Development Indicators, 2020. Washington, D.C.: 15 Oct 2020. https://databank.worldbank.org/source/world-development-indicators.

[3] IMF. *World Economic Outlook: A Long and Difficult Ascent*. Washington, D.C.: October 2020. https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020.

Progress towards universal health coverage

Fig. 2. SDG 3.8.1 Service Coverage Index (0–100)

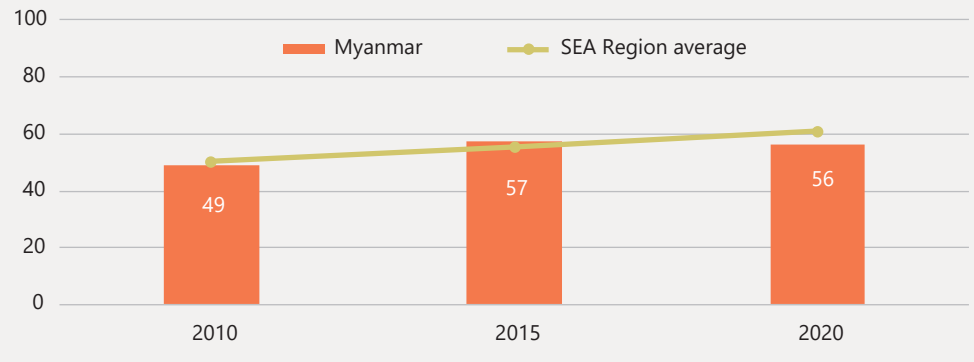
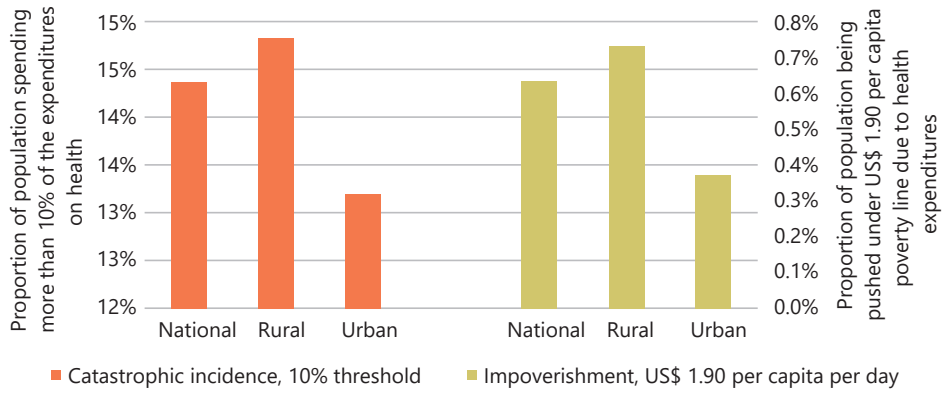


Fig. 3: SDG 3.8.2 Catastrophic and impoverishing incidence due to out-of-pocket expenditures on health



General health expenditure trends over the past decade

Fig. 4. Current health expenditures 2009–2018

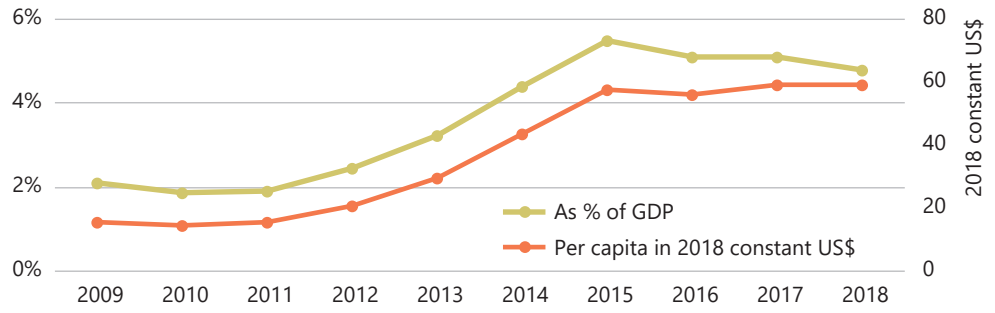


Fig. 5. Domestic government expenditures on health 2009–2018

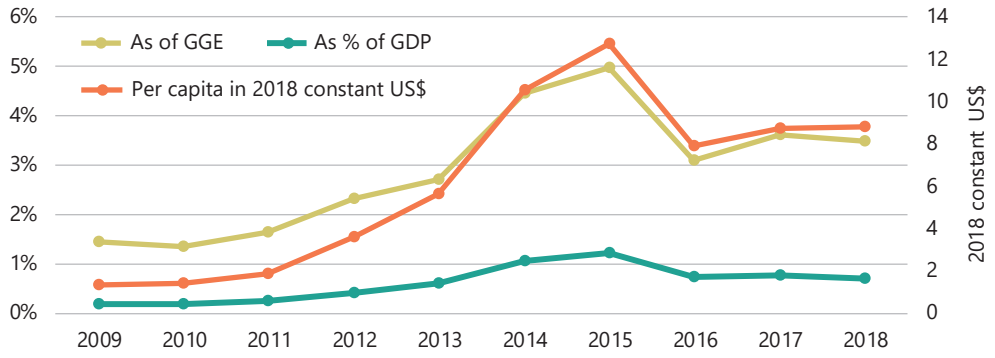
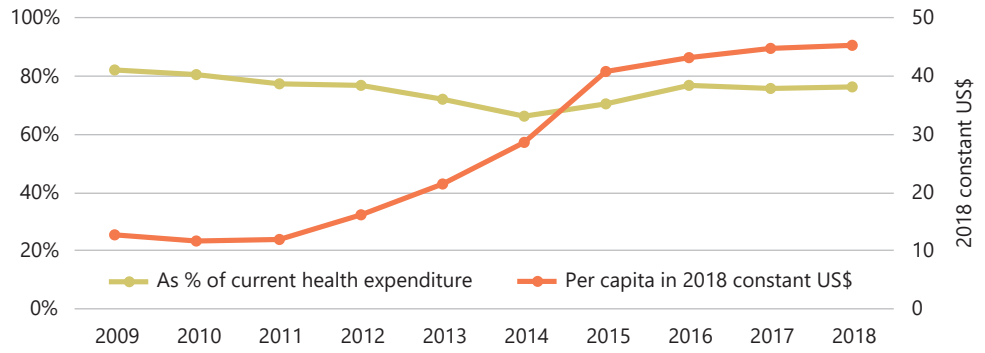
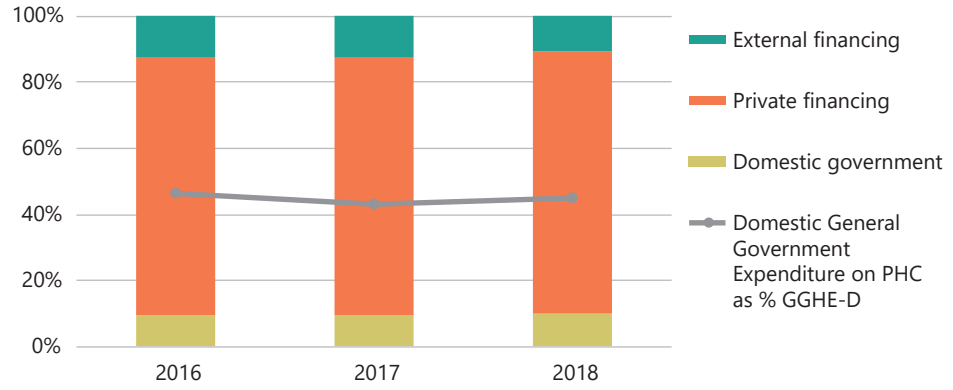


Fig. 6. Out-of-pocket spending on health (OOPS) 2009–2018



Primary health care expenditures[a]

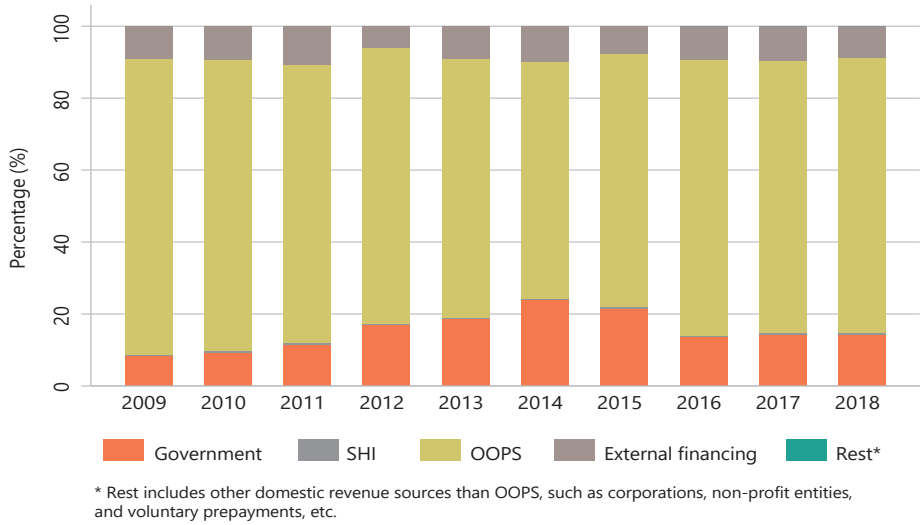
Fig. 7. Primary health care expenditures



a Primary health care measurement is entirely based on Health Care Functions classification. Details of the measurement can be found here: Global spending on health: a world in transition. Geneva: World Health Organization; 2019 (WHO/HIS/HGF/HFWorkingPaper/19.4).

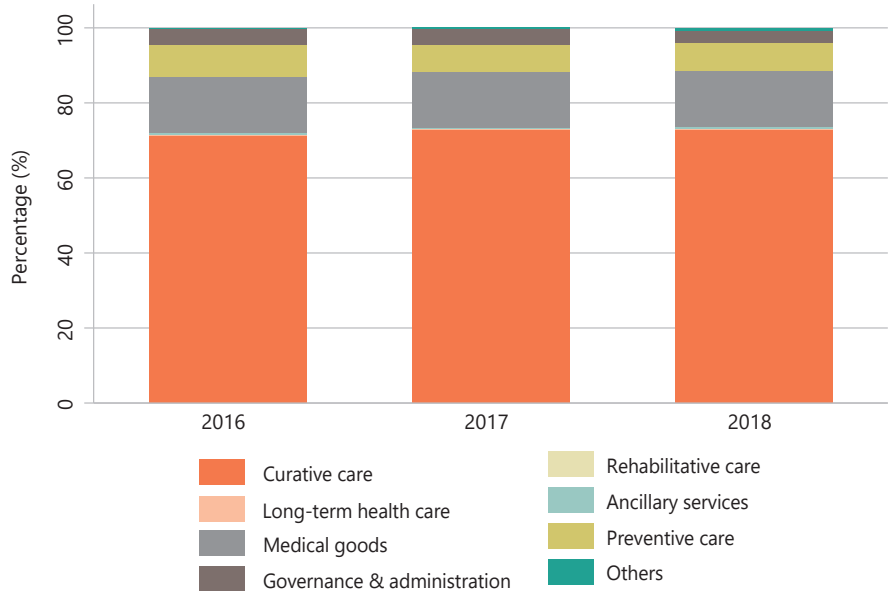
Composition of current health expenditures[b]

Fig. 8. Revenue sources of current health expenditures over the years



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

Fig. 9. Health expenditures by funtion



b "Ancillary services" and "medical goods" are independent consumptions that do not have a specific purpose (treatment, prevention, etc.) in themselves. Typical examples include laboratory services, imaging diagnosis, and patient transportation under "ancillary services", and pharmaceuticals (both prescribed and over-the-counter ones) as well as therapeutic goods (corrective glasses, hearing aids) under "medical goods". Consumption of such during a health-care contact are, therefore, lumped under other categories (i.e. curative care) and not separately reported.

Burden of diseases and disease-specific government expenditures

In Myanmar, spending on noncommunicable diseases (NCDs) and infectious & parasitic diseases were roughly the same (2018). For NCDs the dominant source of financing was from private financing.

Fig. 10a. Health spending by disease categories, and revenue sources for noncommunicable diseases, 2018

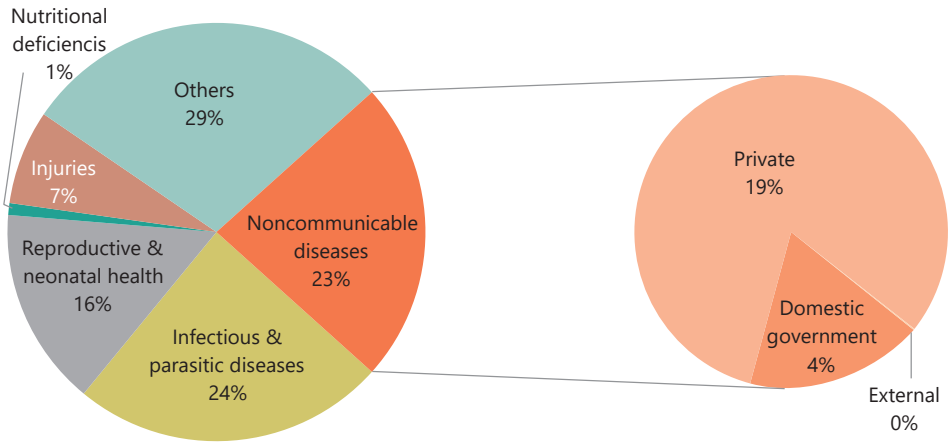


Fig. 10b. Burden of diseases, 2019

Rank by disorder (2019)		DALYs (%)
1	Stroke	10.06
2	Neonatal disorders	7.93
3	Lower respiratory infections	4.78
4	Ischemic heart disease	4.72
5	Diabetes mellitus	4.27
6	Cirrhosis and other chronic liver diseases	4.04
7	Chronic obstructive pulmonary disease	3.94
8	Congenital birth defects	3.46
9	Tuberculosis	2.67
10	Chronic kidney disease	2.25
11	Low back pain	2.20
12	Falls	1.88
13	Headache disorders	1.84
14	Road injuries	1.83
15	Diarrheal diseases	1.71
16	Asthma	1.62
17	Age-related and other hearing loss	1.53
18	Dietary iron deficiency	1.51
19	Tracheal bronchus, and lung cancer	1.40
20	HIV/AIDS	1.37
21	Other musculoskeletal disorders	1.16
22	Anxiety disorders	1.09
23	Neck pain	1.06
24	Hypertensive heart disease	1.04
25	Other unspecified infectious diseases	1.03

Infectious and parasitic diseases
Reproductive health
Injuries
Nutritional deficiencies
Noncommunicable diseases

Nepal

Progress towards universal health coverage

Nepal is making progress towards UHC. The UHC service coverage index increased from 42 in 2010 to 49 in 2020. Remarkably, the financial risk protection has substantively improved with the proportion of the population affected by household catastrophic health expenditure declining from 27.4% in 2010 to 10.7% in 2014. In 2014, 1.7% of the population were impoverished due to out-of-pocket health payments (under the per capita poverty line of US$ 1.90 daily).[6]

Health system architecture and governance

Nepal's public health system has moved from centralized to decentralized management when the government was structured into three levels in 2015. The Ministry of Health and Population (MoHP) governs national and specialized facilities (tertiary level), as well as ensures the supply of medicines and commodities. The provincial level oversees the general hospitals (secondary level) and coordinates and provides emergency health services that involve more than one municipality. Finally, the local level ensures that services follow the agreed standards and regulations. Local governments also fund, support, manage, and monitor primary health care institutions and community level providers – urban health centres (UHCs), primary health care centres (PHCCs), health posts (HPs) and community health units and clinics.

The health service delivery is done through a mix of providers, including public, private for-profit and nongovernmental organizations. Private providers, including NGOs and faith-based organizations, serve predominantly the urban population.

The main public financing scheme for health is the government budget. In the 2018–2019 financial year, 60% of the government health budget remained at the MoHP level, while 32% was allocated to the local level and less than 8% to the provincial level.[115]

The Social Health Insurance (SHI) scheme was introduced in 2016. After a phased implementation the coverage was estimated at 11% of the population by 2019.[116] The SHI scheme is implemented by the Health Insurance Board (HIB) – composed of MoHP and Ministry of Finance (MoF) – and its provincial and local coordination committees, which comprised representatives of the local government, health and education sectors, service providers and civil society.

In addition, there are two other public insurance schemes, the Employees Provident Fund (EPF) and Social Security Fund (SSF), that provide health insurance coverage. The latter operates under the Ministry of Labour, Employment and Social Security (MoLESS). EPF covers public sector employees while SSF is a contributory social security scheme for workers in the formal and non-formal sectors where health insurance is one of the components. Enrolment in private health insurance schemes is very low in Nepal.

Raising revenue

Nepal spent 5.8% of its GDP on health in 2018, which is an increase from 4.5% in 2009. Domestic government expenditure on health (GGHE-D) is 1.5% of GDP in 2018, up from 0.9% in 2009. The share of GGHE-D in general government expenditure remained at the same level – 4.7% in 2009 and 4.6% in 2018.

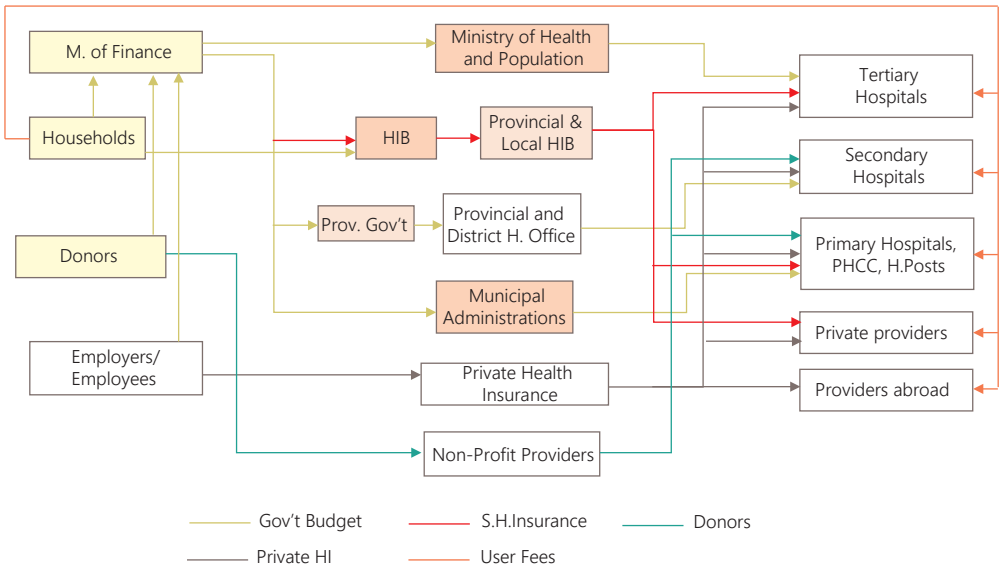
The government health budget makes up 25.1% of current health expenditure (CHE) in 2018, up from 20.4% in 2009. The SHI fund is raised from household contributions and government budgetary subsidies for the ultra-poor. A family of five members must pay Nepalese rupees (NPR) 3500 per year to cover all types of health service, with a maximum limit of NPR 100 000. If there are more than five members in the family, the payment is NPR 700 per person.

Out-of-pocket spending on health made up 50.8% of CHE in 2018, down from 57.6% in 2009. The non-profit institutions that provide direct financial assistance, such as goods or services to households (for free or at prices that are very low), are a significant contribution to the revenues for health in Nepal at about 14.7% of CHE. Voluntary health insurance schemes accounted for just 0.3% of CHE in 2018. External donor sources declined from 15.8% of CHE in 2009 to 9.1% in 2018.[71]

Pooling and flow of resources

There are several fund pools for Nepal's health sector. The government Budget transfers to health constitute the largest share and are pooled at the federal and provincial levels as well as at more than 750 municipalities. The donors' pool constitutes only a limited share of the health resources through the public system, and much remains off-budget to administer directly – for instance, at around 8.6% of CHE in 2015–2016.[117] For SHI, contributions are collected by the HIB and pooled at the Ministry of Finance.

Fig. 1. Simplified flow of funds in Nepal health sector



Benefits package

Over time, Nepal introduced several policies to increase coverage of benefits and reduce household out-of-pocket health expenditure. The Free Health Care Policy (FHCP), implemented in 2006, abolished user fees at the lowest level of care (health posts) and subsidized a limited number of drugs, among other actions.

The Aama (maternity incentive) Programme covers maternal care services, including antenatal consultations and caesarean sections performed at referral hospitals,[118] and offers cash transfers to cover user transportation costs.[119] Free and paid services coincide at first-level referral facilities, such as at the primary health care centre (i.e. antenatal consultations are free but doctor consultations are not). About 70 essential medicines are free when prescribed by the facilities above the level of health posts.

The Social Health Insurance Scheme is envisioned to provide coverage for services outside the BHSP and that otherwise would have been funded through OOP expenditure. SHI beneficiaries have to register with a public or private primary health-care provider who will act as gatekeeper for higher-level facilities or specialists. The Employees Provident Fund provides government and public sector workers retirement benefits, medical treatment reimbursement, and maternity and child benefits, among other social services.[120]

Table 1. Nepal Basic Health Services Package

A.	Immunization services
B.	Maternal, neonatal and child health services
	i) Management of neonatal and childhood illnesses
	ii) Nutrition services
	iii) Pregnancy, delivery and post-partum services
	iv) Services related to family planning, abortion, reproductive health morbidity, and female cancers
C.	Services for communicable diseases
D.	Services for noncommunicable diseases and differently abled people
E.	Services for mental diseases
F.	Geriatric health, adolescent health and men's health services
G.	Common emergency services
H.	Health promotion services
I.	Ayurveda and other traditional health services

In 2020, Nepal introduced a Basic Health Services Package, which emanates from Article 35 of the Nepalese Constitution that states that every citizen is entitled to receive services free at the point of delivery. The Nepal Benefit Package was designed to include the most essential services (Table 1)[121] to be provided free and made available to the whole population. A simplified costing exercise estimated the per capita costs (excluding capital costs) to be NPR 953 (less than US$ 9).[122]

Purchasing arrangements

The MoHP pays national and specialized hospitals by line-item budgets and procures medicines (i.e. TB, HIV) and medical supplies (i.e. vaccines, family planning commodities). Primary health care facilities are paid by the local governments through conditional grants, which receive more than 90% of their funding from the federal-level budget. The payment covers expenses on salaries, drugs as well as programme-related activities (i.e. training and supervision targeting specific activities). The HIB purchases services from private and public providers and pays according to each case or a fee for services according to agreed tariffs.

Performance-based approach has been used to pay for health services in Nepal. The Aama Programme transfers funds to health facilities according to set targets of maternal care and uses vouchers and cash transfers to incentivize service utilization. External partners pay for expenses of health programmes/projects directly, either through international/national NGOs or through MoHP based on targets and outputs.

Individual users can purchase the same services as with SHI (i.e. consultations with a doctor at the primary health care centre or hospital, investigations, hospital admissions and operations) in public health facilities according to listed prices (fee-for-services) set by the facility development committee.

Public financial management

The planning and budgeting process in Nepal continues, by and large, to be guided by the Central level. The Budget allocation to different localities is based on a needs-based resource allocation approach, using a formula that includes population, poverty, geographical area, relative cost of life, etc.[123] Annual budgets are generally prepared on an incremental basis according to the expenditures of the preceding fiscal year. In the health sector, the MoHP develops an annual budget, programme, and activity plan.

The conditional grants to local government institutions are then finalized by an agreement between the National Natural Resources and Fiscal Commission, National Planning Commission and the MoF, including discussions that involve the MoHP, state and local governments. Health sector authorities at local levels are expected to produce a budget proposal when additional funding is required from the municipal government resources.

Although the conditional grant is a unified transfer of funding from the Federal government to provincial or local governments, the amount is split and disbursed through several clusters, programmes, medicine purchases by types and programmes, and budget lines.[124] Individual municipalities execute the conditional grant according to the allocation. Budgets have been monitored through the recently updated online Transaction Accounting and Budget Control System (TABUCS), an application that provides detailed budget and expenditure information across the country.

Recent reforms

The principal recent reforms in Nepal with repercussions on health financing include the introduction of the Social Health Insurance Scheme (2016) and development of the Basic Health Services Package (2020). The SHI scheme is envisioned to provide coverage for services outside the BHSP that otherwise would have to be funded through OOP expenditure.

Nepal

Macro picture

Indicator	Latest year	Value
Total population (thousands)[1]	2020	29 137
Employment to population ratio, 15+, total (%) (national estimate)[2]	2017	34.2
GDP per capita growth (annual %)[2]	2019	5.0
GDP per capita (current US$)[2]	2019	1 071
General government revenue (% of GDP)[3]	2019	26.0
Tax revenue (% of GDP)[2]	2017	20.7
General government total expenditure (% of GDP)[3]	2019	30.6
Fiscal balance (revenue–expenditure) (% of GDP)	2019	-4.6
General government gross debt (% of GDP)[3]	2019	30.1
Poverty headcount ratio at US$ 1.90 a day (2011 PPP) (% of population)[2]	2010	15.0
Poverty headcount ratio at national poverty lines (% of population)[2]	2010	25.2

[1] United nations, Department of Economic and Social Affairs, Population Division (2019). World Population Prospects 2019: Volume II: Demographic Profiles.

[2] World Bank Group. World Development Indicators, 2020. Washington, D.C.: 15 Oct 2020. https://databank.worldbank.org/source/world-development-indicators.

[3] IMF. World Economic Outlook: A Long and Difficult Ascent. Washington, D.C.: October 2020. https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020.

Progress towards universal health coverage

Fig. 2. SDG 3.8.1 Service Coverage Index (0–100)

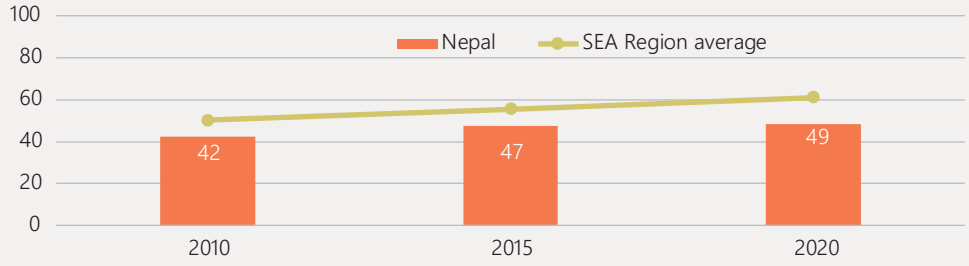
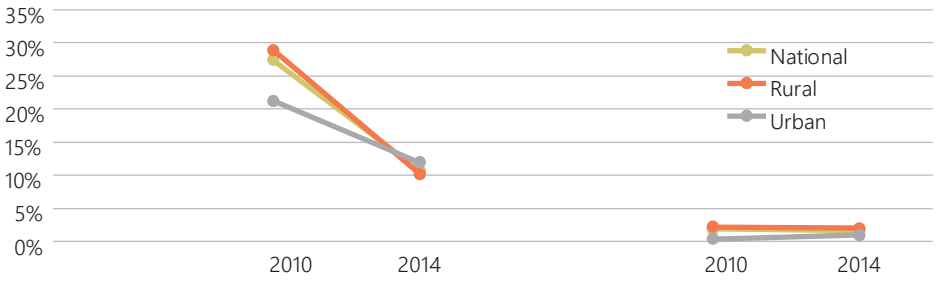


Fig. 3. SDG 3.8.2 Catastrophic and impoverishing incidence due to out-of-pocket expenditures on health



Proportion of population spending more than 10% of their expenditures on health

Proportion of population being pushed under US$ 1.90 per capita poverty line due to health expenditures

General health expenditure trends over the past decade

Fig. 4. Current health expenditures 2009–2018

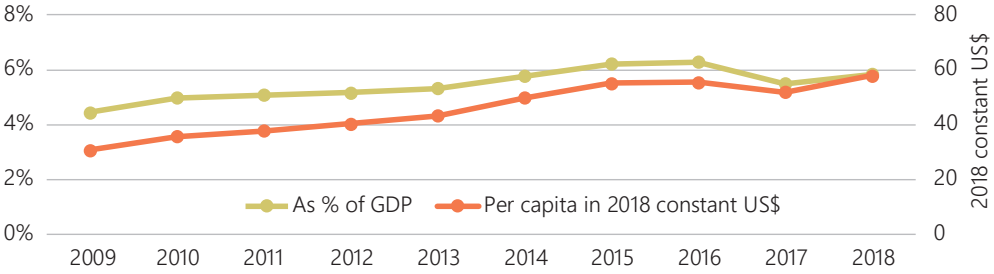


Fig. 5. Domestic government expenditures on health 2009–2018

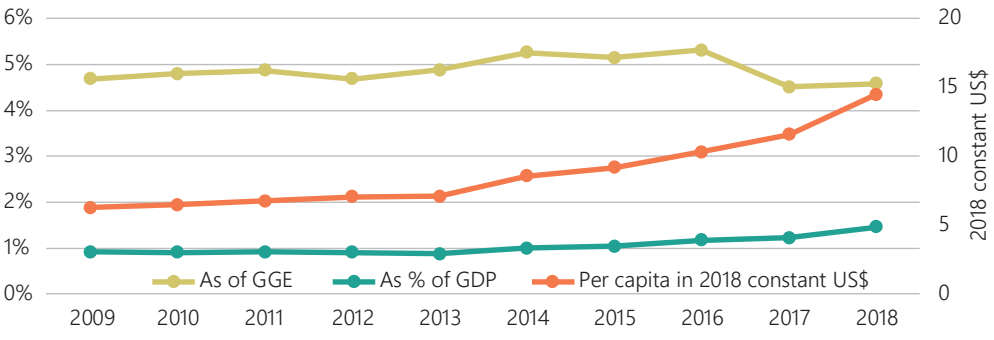
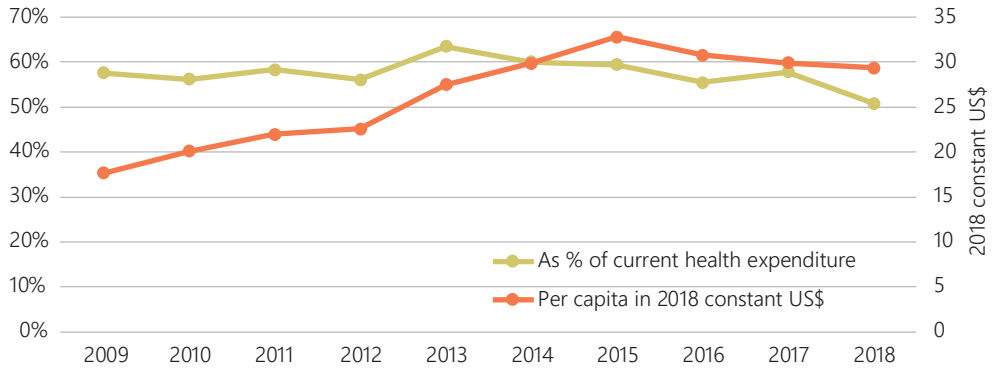
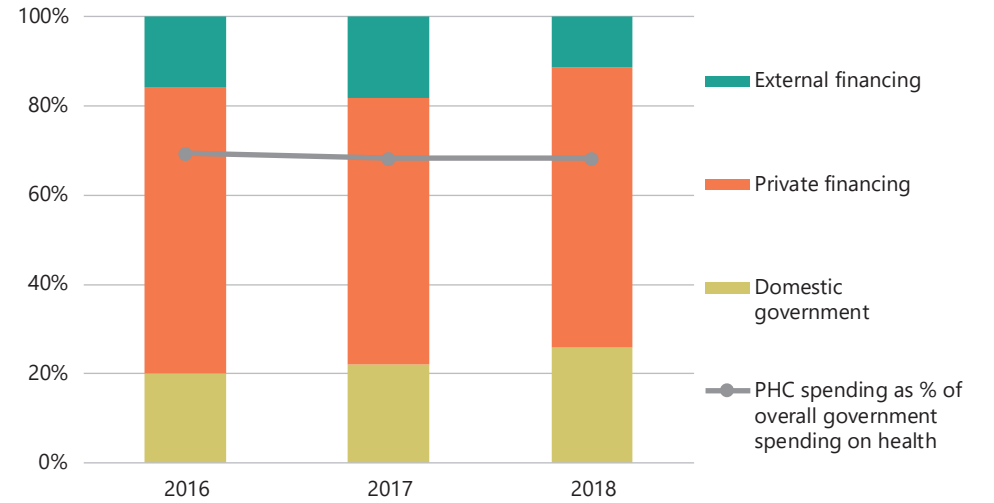


Fig. 6. Out-of-pocket spending on health (OOPS) 2009–2018



Primary health care expenditures[a]

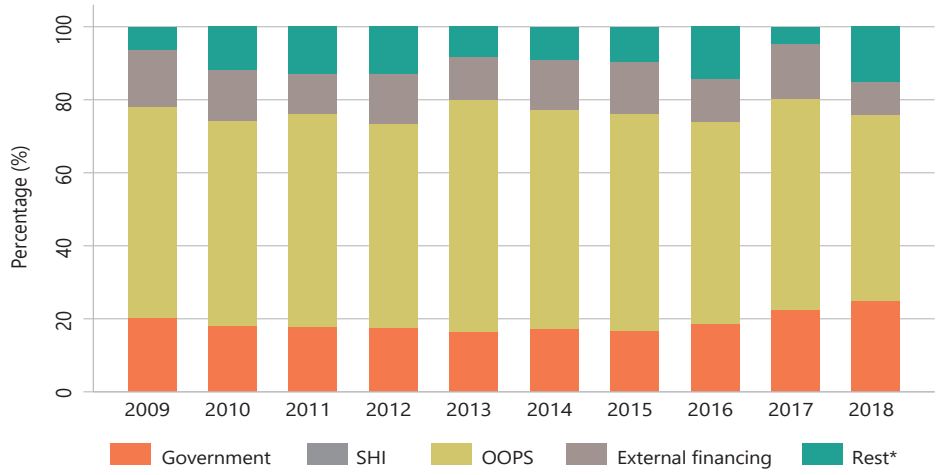
Fig. 7. Primary health care expenditures



a Primary health care measurement is entirely based on Health Care Functions classification. Details of the measurement can be found here: Global spending on health: a world in transition. Geneva: World Health Organization; 2019 (WHO/HIS/HGF/HFWorkingPaper/19.4).

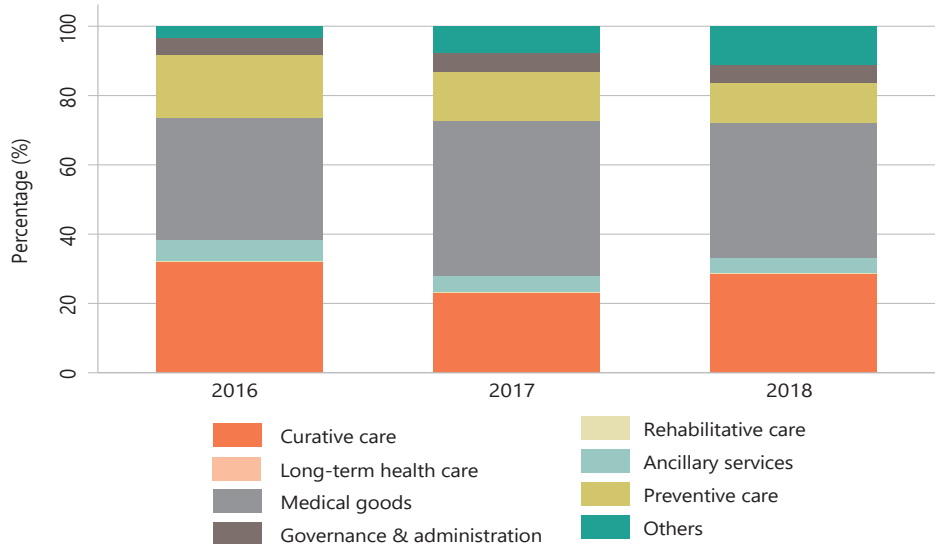
Composition of current health expenditures[b]

Fig. 8. Revenue sources of current health expenditures over the years



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

Fig. 9. Health expenditures by function



b "Ancillary services" and "medical goods" are independent consumptions that do not have a specific purpose (treatment, prevention, etc.) in themselves. Typical examples include laboratory services, imaging diagnosis, and patient transportation under "ancillary services", and pharmaceuticals (both prescribed and over-the-counter ones) as well as therapeutic goods (corrective glasses, hearing aids) under "medical goods". Consumption of such during a health-care contact are, therefore, lumped under other categories (i.e. curative care) and not separately reported.

Burden of disease and disease-specific government expenditures

In Nepal, the biggest share of spending was on noncommunicable diseases (2018), and it was mostly financed by private sources.

Fig. 10a. Health spending by disease categories, and revenue sources for noncommunicable diseases, 2018

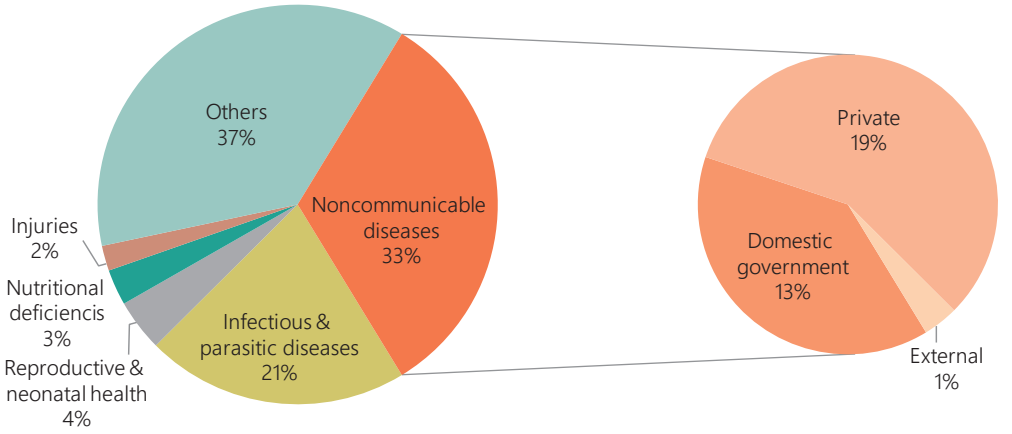


Fig. 10b. Burden of disease, 2019

Rank by disorder (2019)		DALYs (%)
1	Neonatal disorders	9.3
2	Chronic obstructive pulmonary disease	7.3
3	Ischemic heart disease	6.0
4	Lower respiratory infections	4.6
5	Stroke	3.7
6	Cirrhosis and other chronic liver diseases	2.7
7	Tuberculosis	2.7
8	Depressive disorders	2.6
9	Diarrheal diseases	2.5
10	Low back pain	2.5
11	Falls	2.2
12	Diabetes mellitus	2.0
13	Headache disorders	2.0
14	Other musculoskeletal disorders	2.0
15	Self-harm	1.9
16	Congenital birth defects	1.9
17	Road injuries	1.8
18	Dietary iron deficiency	1.8
19	Chronic kidney disease	1.8
20	Asthma	1.8
21	Other malignant neoplasms	1.4
22	Gynecological diseases	1.3
23	Age-related and other hearing loss	1.3
24	Blindness and vision loss	1.2
25	Maternal disorders	1.1

Infectious and parasitic diseases
Reproductive health
Injuries
Nutritional deficiencies
Noncommunicable diseases

Sri Lanka

Progress towards universal health coverage

Sri Lanka is making progress towards UHC. The UHC service coverage index increased from 59 in 2010 to 66 in 2020. As for financial risk protection, the percentage of the population that incurred household catastrophic health expenditure remained almost unchanged between 2012 and 2016 from 5.3% (2012) to 5.4% (2016). In the same year, 0.7% of the population was impoverished because of out-of-pocket health payments, a slight decline from the figure of 0.8% registered in 2012 (under the US$ 3.20 per capita daily poverty line).[6]

Health system architecture and governance

The country has a well-established public health system that provides 50% of all curative ambulatory care, 90% of inpatient care and almost 100% of preventive care. An expanding private sector is operating in selected urban settings through a mix of large hospital groups, small hospitals and private nursing homes, as well as full-time and part-time general practitioners.[125]

Accordingly, the government is the dominant service provider and financier for the health system in Sri Lanka. The Ministry of Finance (MoF) raises resources and makes the overall allocation to the health sector. The central Ministry of Health, Nutrition and Indigenous Medicine (MoH) directly finances and manages the teaching hospitals, specialized hospitals, provincial general and selected district general hospitals and vertical preventive/ disease control programmes. In addition, the State Pharmaceutical Corporation, a semi-autonomous body accountable to the MoH, ensures the supply of essential medicines throughout Sri Lanka.

With the devolution of administrative and financial powers in the early 1990s, a significant portion of health services have been carried out through the provincial council system of networks of health facilities (base hospitals, divisional hospitals, primary care units and medical officer of health units) and local governments (Municipal Councils and Pradeshiya Sabha health clinics). The Finance Commission oversees the provinces through its mandate under the Office of the President.[126]

Two main health insurance schemes exist In Sri Lanka: the social insurance scheme devoted to government employees which is called the "Agrahara fund", and voluntary contributory health insurance schemes operated by private companies.[127]

Raising revenue

Current health expenditure (CHE) was estimated at 3.8% of GDP in 2018, down from 4.2% in 2009. Domestic government expenditure on health (GGHE-D) as share of GDP also slowed down from 1.7% in 2009 to 1.5% in 2018. On the flip side, GGHE-D increased from 7.8% in 2009 to 8.3% of General Government Expenditure in 2018.

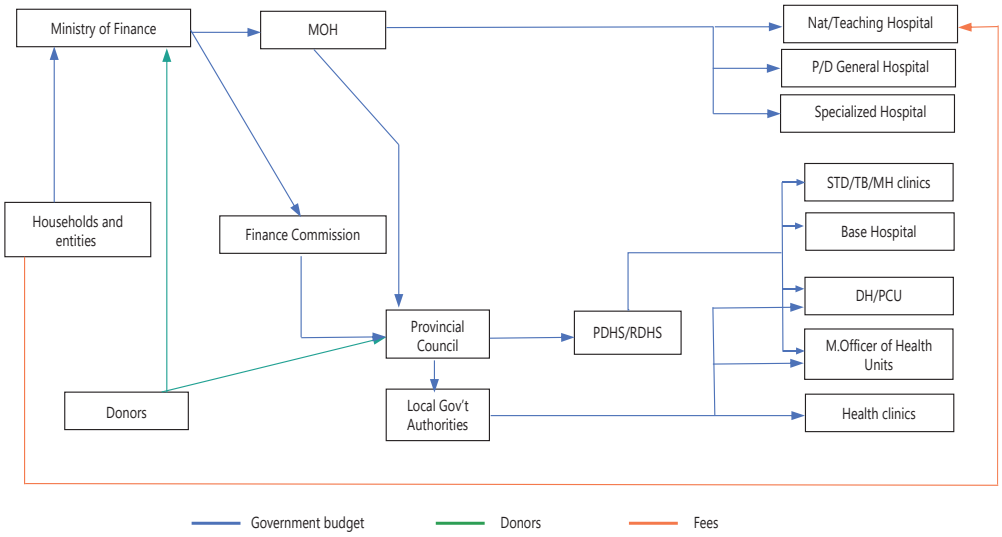
The government and individual households are the principal (over 90%) health financing revenue sources in Sri Lanka. Over the years, the proportion of government Budget and household out-of-pocket expenditure on health (OOPS) in relation to CHE has remained relatively stable, with the government health Budget increasing from 40.2% to 40.7% and OOPS declining from 53.3% to 50.7% from 2009–2018. Employers, private and social health insurance (Agrahara), NGOs and external donor revenues contributed relatively little to CHE. The relative importance of external funding stood at 2.3% of CHE in 2018. Voluntary pre-payments accounted for 2% of CHE while social insurance made up only 0.4% in 2018.[71]

Pooling and flow of resources

The general government Budget revenue is the main funding source for the public health system in Sri Lanka, both at the central and provincial/local levels. The government Budget for the central MoH is directly transferred from MoF, while funds for the provincial and local government institutions are usually channelled through the Finance Commission.

In addition, the central MoH directly channels a considerable amount of funds to provincial level health institutions. Provincial and Local Governments use self-generated funds for health services through the institutions under their administrative guidance.[127] In 2017, 29% of the total government health budget was managed at the provincial and local levels.[128] External donor resources are also transferred to the government Budget, and then distributed to the central and provincial levels (Fig.1).

Fig. 1. Simplified flow of funds in Sri Lanka public health system



Benefits package

In Sri Lanka, comprehensive promotive, preventive and curative services are available through the public health sector. Government services are universally accessible across the country and are free of charge at the point of service. Sri Jayawardenapura General Hospital (SJGH) is the only fee-levying state hospital and tertiary referral centre.

Sri Lanka has a tradition of designing and using specific and targeted packages of health services (i.e., for maternal care).[129] In 2018, an Essential Health Services Package (ESP) was designed,[130] integrating the existing packages into a comprehensive one for the population. The ESP contains a list of essential services provided in government facilities for all citizens (Table 1). A simplified costing exercise estimated that the per capita cost of implementing the ESP would almost double the amount of US$ 20 spent currently.[131]

Table 1. Essential Health Services Package (ESP)

- **Life Course Services:** Family planning; maternal and neonatal care; childcare; nutrition; school health; adolescent health; services for gender- based violence (SGBV); elderly care.
- **Communicable diseases:** TB; malaria; HIV/AIDS; STDs; dengue; leprosy; leptospirosis; and other communicable diseases.
- **Noncommunicable diseases:** Cardiovascular diseases; diabetes; chronic respiratory diseases; mental health; cancer.
- **Services and platforms:** Emergency care; outpatient care; inpatient care; surgery and trauma care; rehabilitation; palliative care; support services such as laboratory, radiology and other investigations, pharmacy/drug supply.

Purchasing arrangements

The Ministry of Health is the purchaser for national, provincial, district, teaching and specialized hospitals. The MoH also allocates funds for vertical programmes based on pre-set plans. The Medical Supplies Division of MoH performs centralized procurement of most medicines used in the public health system and distributes them to the District Medical Supply and to the hospitals. The provincial government distributes allocated funds to the regional health directorates and pays for services provided by the provincial and district network. Government health-care providers are paid through line-item budgets for their salaries, and operational costs and in-kind items such as medicines and supplies are also accorded for through this payment mechanism.

Public financial management

Since Independence, Sri Lanka has implemented the incremental, line-item approach in the government budgeting system, with limited involvement of local managers that has translated into a very stable system.[132] The central MoH Budget remains largely incremental, but there are three types of grants budgeted for provincial and local levels:

- A "block grant" for recurrent budgets, including salaries and operational funds (covering fuel, food, communications, etc.), excluding budgets for medicines;
- A "criteria-based grant" (CBG) for general capital outlays; and
- A "province-specific development grant" for specific development projects. This and CBG are based on a formula factoring indicators of population, income, poverty, health (low birth weight and neonatal mortality), education and infrastructure.[133]

Provincial and regional health managers rarely modify the allocated budgets. At government health institutions, staff wages and salaries, including allowances, are budgeted according to the appointed cadre. For medicines and supplies, health facilities produce an estimate in terms of items and quantities needed, but not the financial implications. Generally, regular Budget and block grant execution is close to 100%.[134]

Recent health financing reform

The adoption of the Essential Health Services Package in 2018 in Sri Lanka was one of the key steps towards broader reforms. This helped revise the curative primary health care system, making it better suited to address noncommunicable diseases, ageing and other challenges.[135] The proposed creation and operationalization of "shared care clusters" (local health systems following the district health system model) may impact the health financing system, as they have potential management responsibilities that impact the amount of government funding necessary and decentralized decision-making.

Sri Lanka

Macro picture

Indicator	Latest year	Value
Total population (thousands)[1]	2020	21 413
Employment to population ratio, 15+, total (%) (national estimate)[2]	2019	49.8
GDP per capita growth (annual %)[2]	2019	1.7
GDP per capita (current US$)[2]	2019	3 853
General government revenue (% of GDP)[3]	2019	12.7
Tax revenue (% of GDP)[2]	2018	11.9
General government total expenditure (% of GDP)[3]	2019	20.8
Fiscal balance (revenue–expenditure) (% of GDP)	2019	-8.2
General government gross debt (% of GDP)[3]	2019	86.8
Poverty headcount ratio at US$ 3.20 a day (2011 PPP) (% of population)[2]	2016	10.8
Poverty headcount ratio at national poverty lines (% of population)[2]	2016	4.1

[1] United nations, Department of Economic and Social Affairs, Population Division (2019). *World Population Prospects 2019: Volume II: Demographic Profiles.*

[2] World Bank Group. World Development Indicators, 2020. Washington, D.C.: 15 Oct 2020. https://databank.worldbank.org/source/world-development-indicators.

[3] IMF. *World Economic Outlook: A Long and Difficult Ascent*. Washington, D.C.: October 2020. https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020.

Progress towards universal health coverage

Fig. 2. SDG 3.8.1 Service Coverage Index (0–100)

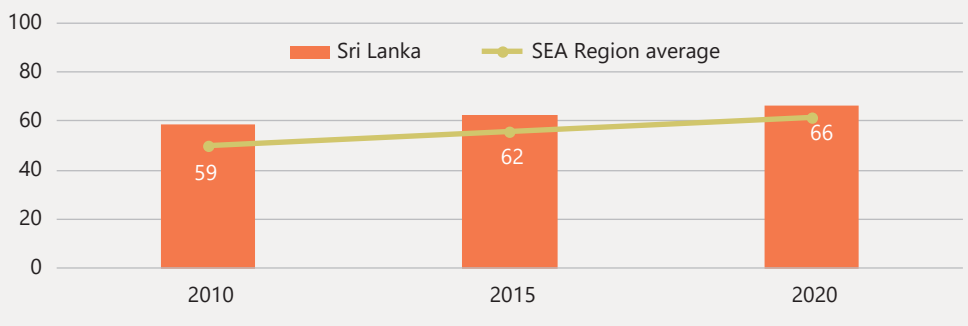
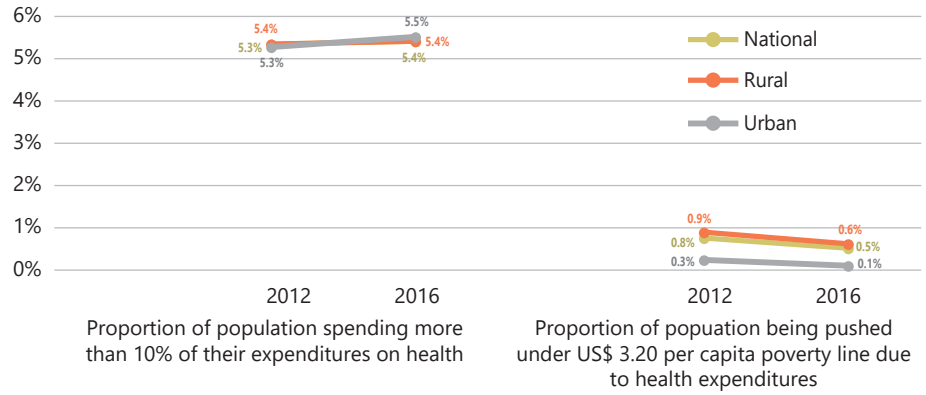


Fig. 3. SDG 3.8.2 Catastrophic and impoverishing incidence due to out-of-pocket expenditures on health



General health expenditure trends over the past decade

Fig. 4. Current health expenditures 2009–2018

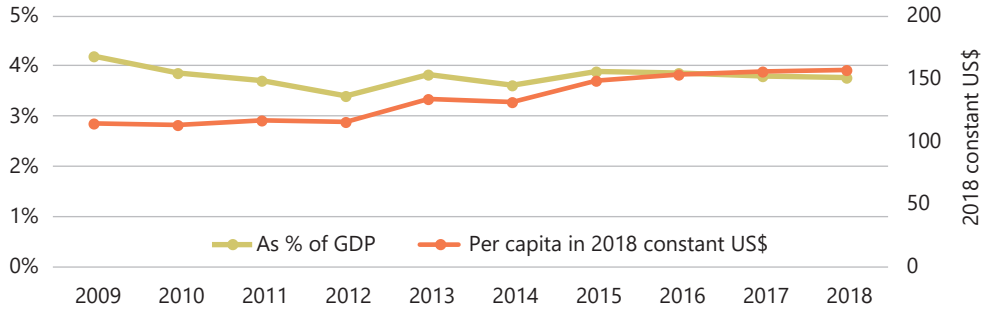


Fig. 5. Domestic government expenditures on health 2009–2018

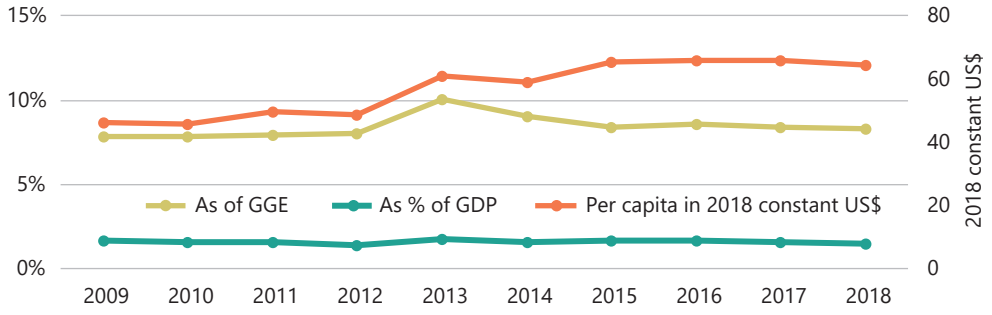
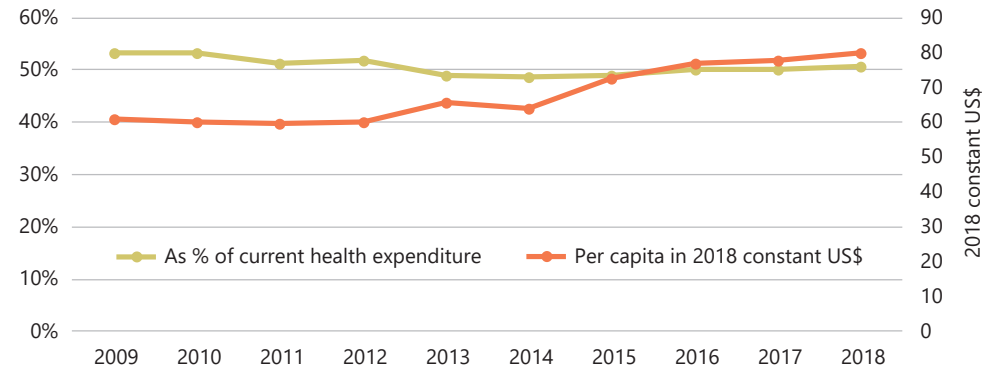
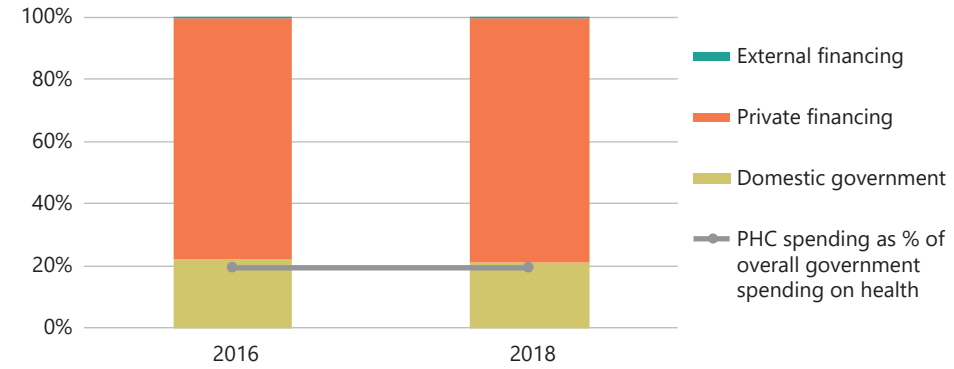


Fig. 6. Out-of-pocket spending on health (OOPS) 2009–2018



Primary health care expenditures[a]

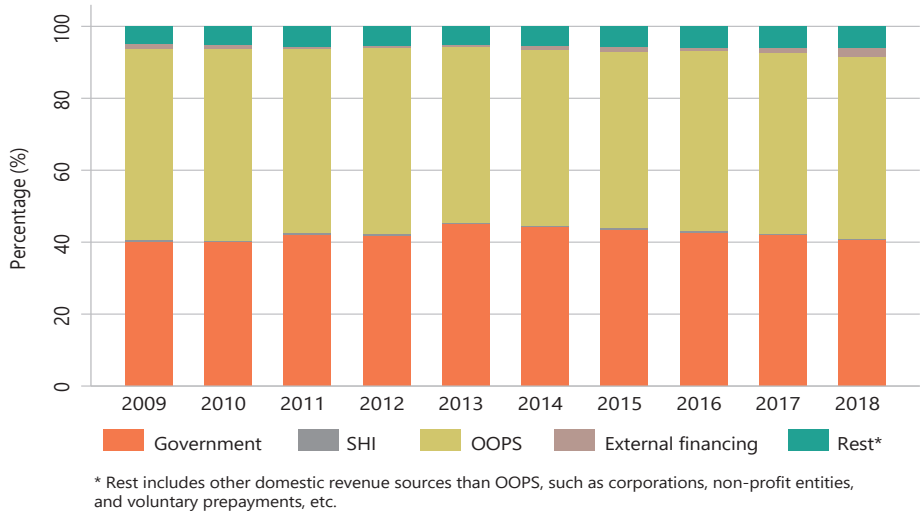
Fig. 7. Primary health care expenditures



a Primary health care measurement is entirely based on health care functions classification. Details of the measurement can be found here: Global spending on health: a world in transition. Geneva: World Health Organization; 2019 (WHO/HIS/HGF/HFWorkingPaper/19.4).

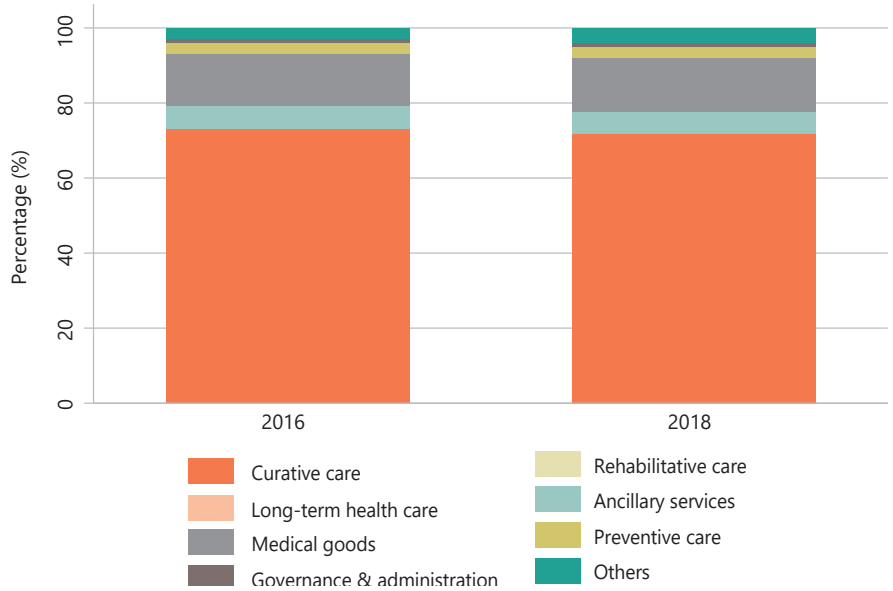
Composition of current health expenditures[b]

Fig. 8. Revenue sources of current health expenditures over the years



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

Fig. 9. Health expenditures by funtion



b "Ancillary services" and "medical goods" are independent consumptions that do not have a specific purpose (treatment, prevention, etc.) in themselves. Typical examples include laboratory services, imaging diagnosis, and patient transportation under "ancillary services", and pharmaceuticals (both prescribed and over-the-counter ones) as well as therapeutic goods (corrective glasses, hearing aids) under "medical goods". Consumption of such during a health-care contact are, therefore, lumped under other categories (i.e. curative care) and not separately reported.

Burden of diseases and disease-specific government expenditures

In Sri Lanka, the biggest share of spending was on noncommunicable diseases (2018), and it was mainly financed by private sources.

Fig. 10a. Health spending by disease categories, and revenue sources for noncommunicable diseases, 2018

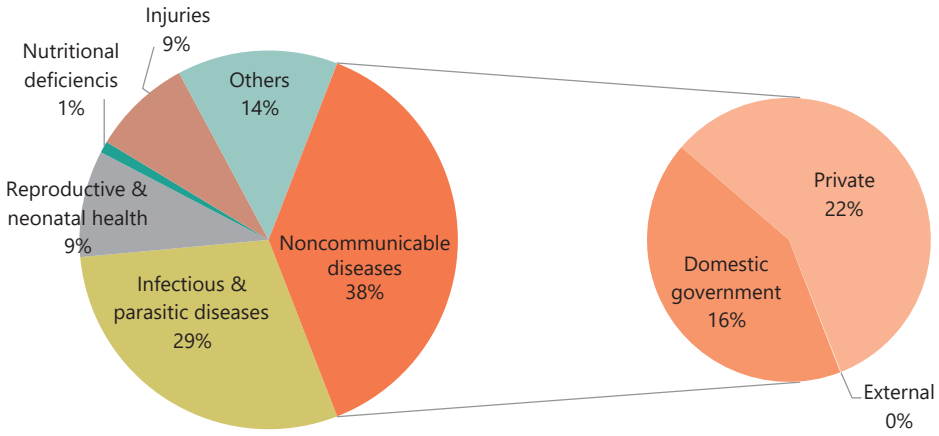


Fig. 10b. Burden of diseases, 2019

Rank by disorder (2019)		DALYs (%)
1	Diabetes mellitus	8.6
2	Ischemic heart disease	8.5
3	Stroke	5.5
4	Self-harm	3.5
5	Low back pain	3.4
6	Chronic kidney disease	2.9
7	Asthma	2.9
8	Road injuries	2.7
9	Neonatal disorders	2.6
10	Headache disorders	2.5
11	Chronic obstructive pulmonary disease	2.5
12	Age-related and other hearing loss	2.3
13	Cirrhosis and other chronic liver diseases	2.3
14	Lower respiratory infections	1.9
15	Falls	1.9
16	Depressive disorders	1.8
17	Other musculoskeletal disorders	1.8
18	Neck pain	1.7
19	Congenital birth defects	1.6
20	Anxiety disorders	1.6
21	Hypertensive heart disease	1.3
22	Blindness and vision loss	1.3
23	Alzheimer's disease and other dementias	1.2
24	Conflict and terrorism	1.1
25	Tracheal, bronchus, and lung cancer	1.1

Infectious and parasitic diseases
Reproductive health
Injuries
Nutritional deficiencies
Noncommunicable diseases

Thailand

Progress towards universal health coverage

Thailand's progress towards UHC has further accelerated in recent decades. Its UHC service coverage index increased from 68 in 2010 to 82 in 2020. As for financial risk protection, the share of the population affected by household catastrophic health expenditure increased from 1.5% in 2009 to 2.2% of population in 2017. In the same year, 0.01% were pushed into poverty because of out-of-pocket health expenditures, down from 0.06% in 2009 (under the US$ 3.20 per capita daily poverty line).[6]

Health system architecture and governance

In Thailand, three public health insurance schemes (PHI) coexist and cover the entire population, since 2002. They are: The Civil Servants Medical Benefit Scheme (CSMBS) covering civil servants and their relatives; the Social Health Insurance Scheme (SHI) covering private and formal sector employees of companies with more than 10 employees; and the Universal Coverage Scheme (UCS) covering the remaining population (i.e. poor and vulnerable, informal sector employees and those working in small companies). In addition, there are voluntary private health insurance schemes which cover about 2.2% of the population.[136]

The role of the Ministry of Public Health (MoPH) has changed significantly since the implementation of UHC in 2002. Now, it focuses on regulation, policy formulation and technical coordination, but it does not directly engage for instance in decisions on purchasing, or designing new benefit packages covered by the PHI.[137] Provincial health offices provide oversight and support for local health offices, health service delivery and has limited regulatory powers, while district health offices oversee, manage and deliver health services. In Thailand, public health facilities are the dominant care providers (75% of hospitals) and constitute networks – mostly following the district health system approach – under district and provincial health offices, alongside private providers that have contracts with the health insurance schemes.

Each of the PHI schemes is managed by semi-autonomous or autonomous agencies attached to different government ministries. The CSMBS is managed by the Department of the Comptroller-General (CGD), an agency of the Ministry of Finance (MoF). It is governed by an advisory board of 19 members that is chaired by the Permanent Secretary of the MoF. The SHI is managed by the Social Security Office (SSO), a department of the

Ministry of Labour. The SSO is accountable to a board composed of representatives of the government, employers and employees. The UCS is managed by the National Health Security Office (NHSO), an autonomous public agency.[138] The NHSO is accountable to a board that has broad participation, including from civil society organizations. Other autonomous health agencies include the Thailand Health Promotion Foundation (ThaiHealth), the Health Systems Research Initiative and the National Health Commission Office, which is in charge of developing health policy with broad participation from different elements of society.[139]

Raising revenue

Current health expenditure (CHE) as percentage of GDP was 3.8% in 2018, slightly up from 3.6% in 2009. Similarly, domestic government expenditure on health (GGHE-D) is 2.9% of GDP in 2018, up from 2.7% in 2009. By 2018, 15% of general government expenditure was allocated to the health sector, with a slight increase from 14.4% in 2009. The main sources of health sector revenue are the government Budget and compulsory pre-payment schemes. Domestic government expenditure on health as the percentage of CHE has increased from 67.7% in 2009 to 76.3% in 2018.[71]

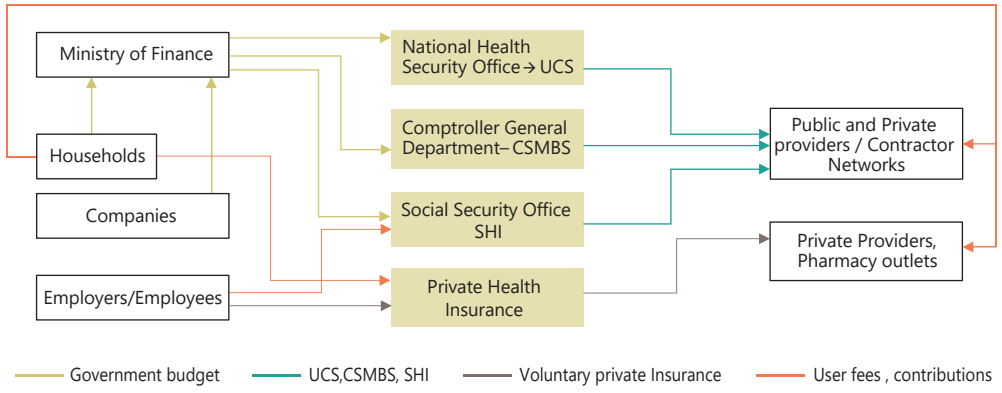
The government Budget is the revenue source for all three public health insurance schemes. CSMBS and UCS are fully funded by the government and there is no contribution from the beneficiaries. The SHI scheme is funded through tripartite and equally shared contributions: a 1.5% payroll tax contribution from the government, employers and employees in the private sector. A small proportion (less than 1%) of total health revenue is raised for ThaiHealth through a 2% surcharge levelled on excise taxes on alcohol and tobacco.

Voluntary private health insurance prepayments amounted to 6.8% of CHE in 2018. Out-of-pocket expenditure on health has fallen drastically since the achievement of UHC, and was 11% of CHE in 2018.[71]

Pooling and flow of resources

There are three separate funds for the health system in Thailand, which constitute around 80% of the total health budget. The MoF transfers budgets to CGD and NHSO, while three parties (MoF, employers and employees) deposit their contributions into the Social Security Office.

Fig. 1. Simplified fund flows in Thailand health system



Source: Adapted from World Health Organization. Regional Office for the Western Pacific. (2015) . The Kingdom of Thailand health system review. Manila: WHO Regional Office for the Western Pacific.

Benefits package

In Thailand, all three schemes provide comprehensive, and relatively similar, benefits to their target populations. All services, diseases and health conditions are covered by the health insurance schemes, with a few exceptions such as cosmetic surgeries, and services of unproven effectiveness such as stem-cell treatment.

Since 2010, the country is applying Health Technology Assessment (HTA) to decide whether to include high-cost services such as transplants and dialysis in the benefits package.[140] The HTA in Thailand allows for participation of different stakeholders, resulting in a more nuanced decision-making process for the adoption of new interventions and/or technologies.

Table 1. Benefits packages covered by public health insurance schemes in Thailand[140]

Benefits	UCS	SHI	CSMBS
Health services	Ambulatory and inpatient care, including emergency and accidents. Health promotion and prevention for beneficiaries of the three schemes	Ambulatory and inpatient care, including emergency and accidents. Health promotion and prevention under UCS	Ambulatory and inpatient care, including emergency and accidents. Health promotion and prevention under UCS
Medicines	Promote using drugs in the National Essential Drugs List	Promote using drugs in the National Essential Drugs List	Promote using ED but ways to approve non-essential drugs
Maternity	No limit	No limit and payment in cash (including ANC/PNC)	All related services included
Dialysis	Peritoneal dialysis and haemodialysis if have contraindication for PD	Both peritoneal & haemodialysis	Both peritoneal & haemodialysis
Organ transplantation	Kidney, liver, heart, bone marrow, cornea	Kidney, liver, heart, bone marrow, cornea	Includes all types of transplants
Dental care	Preventive and curative services	Reimbursements for user fees, but not exceeding a certain amount of money/ year	No limitation

With full premium, all private voluntary health insurance schemes offer similar benefits to the three public health insurance schemes, but with more choices to access private hospitals.[141]

Purchasing arrangements

Accordingly, there are three dominant purchasers of health services in Thailand: NHSO, SSO and CGD. They all exercise distinct purchasing mechanisms. The UCS uses a mix of capitation and case-based payments with a global budget payment mechanism. NHSO estimates age-adjusted capitation for outpatient services to a contractor, typically a district health-care provider network (including a district hospital and 10–12 subdistrict health centres serving a population of 50 000) based on the total number of members registered with the network. NHSO also sets a national global budget ceiling for admission

services. Based on the electronic record of every inpatient discharged from hospitals and the information on diagnostic-related groups (DRG), NHSO reimburses the total funds for admission services incurred by each hospital throughout the country on a monthly basis. A fee schedule is applied to certified providers, mostly those who provide high-cost services (such as bone marrow transplants). SSO allocates non-risk-adjusted capitation for outpatient and inpatient services to contracted hospitals based on the number of members registered with that contractor. Public and private hospitals are competing contractors for SHI members. In return, contractors must report the service output of both outpatients and inpatients (including DRG information) to the SSO on a monthly basis. There are also payments to providers based on a fee schedule, such as dialysis and other high-cost treatments, to mitigate the negative impact of capitation on under provision of services. CGD directly reimburses health-care providers for outpatient bills charged on fee-for-services on a monthly basis. Inpatient admission is paid by a conventional DRG, with the reimbursement rate varying by hospital. Individual hospitals receive different reimbursements based on the relative weight of DRG.[140]

Voluntary health insurance companies contract private providers on a fee-for-services basis. User fees are used to pay for medicines outside the essential drugs list covered by the PHI schemes, and for services and amenities not covered by the three schemes.

Public financial management

Since 2002, MoPH resource allocations to government health facilities and local health systems have been integrated into the UCS. With UCS, the annual Budget is estimated to be the total expenditure per UCS member for that Budget year, based on the previous year's utilization rate of outpatient and inpatient services as well as projections for that Budget year, cost for every outpatient and inpatient, plus other components such as prevention and health promotion services.

The UCS budget is a close-ended budget to keep overall expenditure under control. A similar process is followed with the SHI. On the other hand, the CSMBS budget planning approach is open-ended and based on historical trends and projections of total expenditure. CGD has overspent the approved budget for the last 20 years, but was cross-subsidized by the central emergency fund, subject to the approval of Parliament.[140]

Recent health financing reforms

Thailand continues to advance the main health financing reform of achieving universal health coverage (2002). This policy has been instrumental in supporting the country in containing health-care costs and improving strategic purchasing and accountability for public resources while at the same time ensuring wide coverage and in-depth financial protection. In 2010, Thailand adopted Health Technology Assessment as an explicit and evidence-based way of re-designing the health benefit packages.

Thailand

Macro picture

Indicator	Latest year	Value
Total population (thousands)[1]	2020	69 800
Employment to population ratio, 15+, total (%) (national estimate)[2]	2019	66.5
GDP per capita growth (annual %)[2]	2019	2.1
GDP per capita (current US$)[2]	2019	7808
General government revenue (% of GDP)[3]	2019	21.0
Tax revenue (% of GDP)[2]	2018	14.9
General government total expenditure (% of GDP)[3]	2019	21.8
Fiscal balance (revenue–expenditure) (% of GDP)	2019	-0.8
General government gross debt (% of GDP)[3]	2019	41.1
Poverty headcount ratio at US$ 3.20 a day (2011 PPP) (% of population)[2]	2018	0.5
Poverty headcount ratio at national poverty lines (% of population)[2]	2018	9.9

[1] United Nations, Department of Economic and Social Affairs, Population Division (2019). *World Population Prospects 2019: Volume II: Demographic Profiles.*

[2] World Bank Group. World Development Indicators, 2020. Washington, D.C.: 15 Oct 2020. https://databank.worldbank.org/source/world-development-indicators.

[3] IMF. *World Economic Outlook: A Long and Difficult Ascent*. Washington, D.C.: October 2020. https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020.

Progress towards universal health coverage

Fig. 2. SDG3.8.1 Service Coverage Index (0–100)

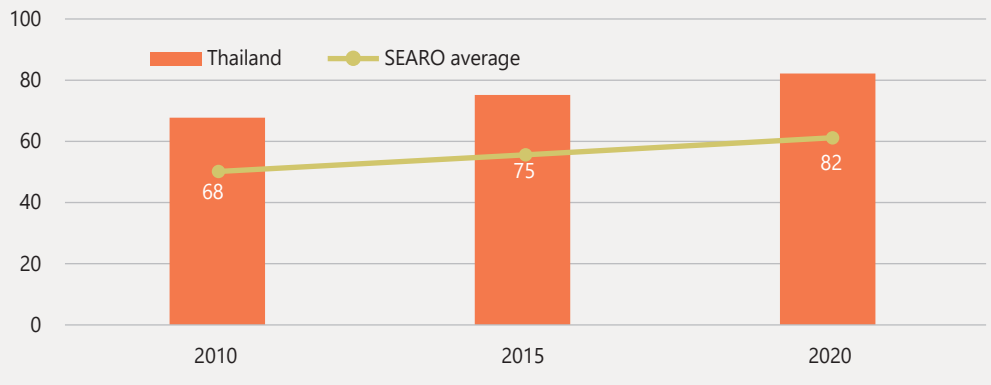
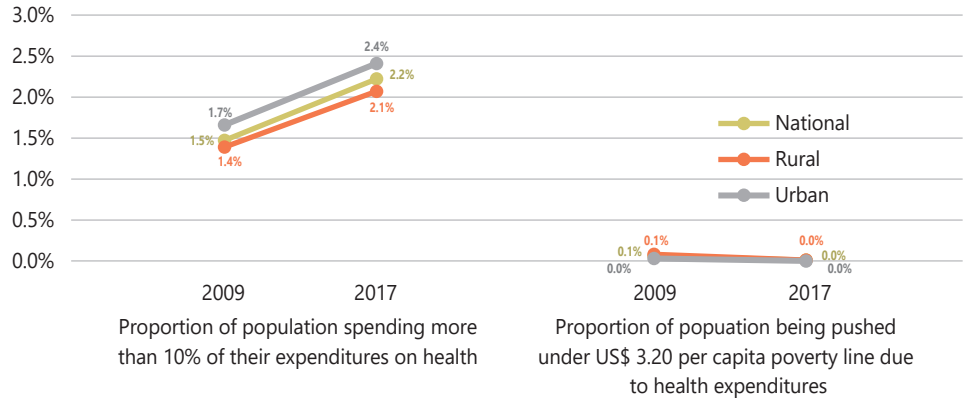


Fig. 3. SDG 3.8.2 Catastrophic and impoverishing incidence due to out-of-pocket expenditures on health



General health expenditure trends over the past decade

Fig. 4. Current health expenditures, 2009–2018

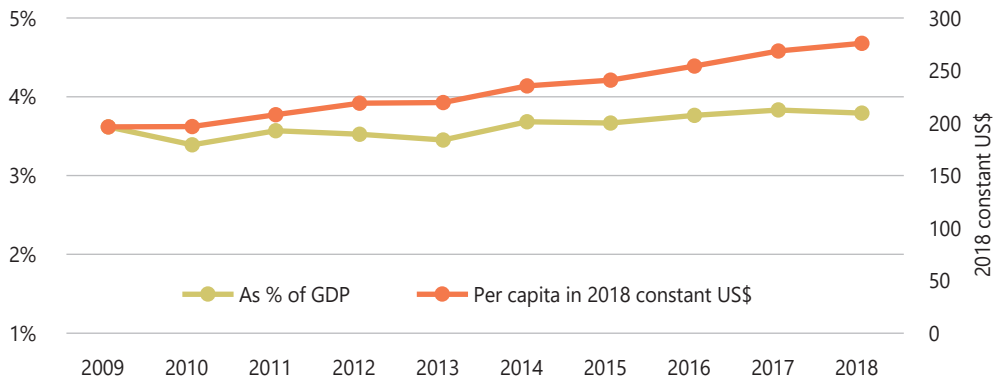


Fig. 5. Domestic government expenditures on health, 2009–2018

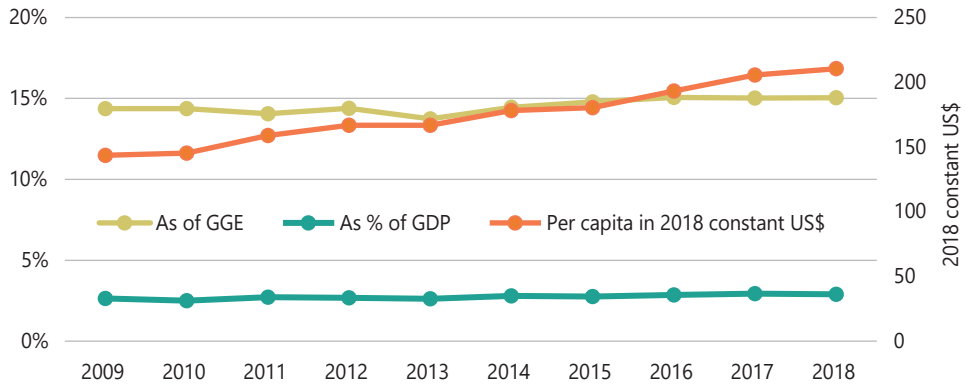
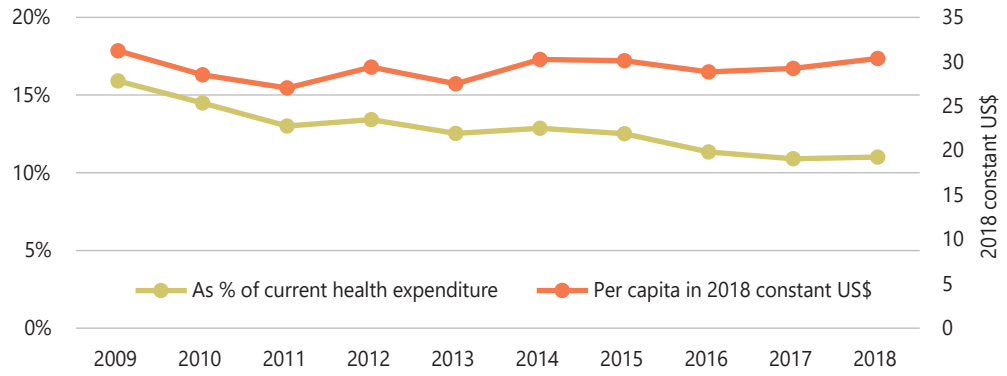


Fig. 6. Out-of-pocket spending on health (OOPS), 2009–2018

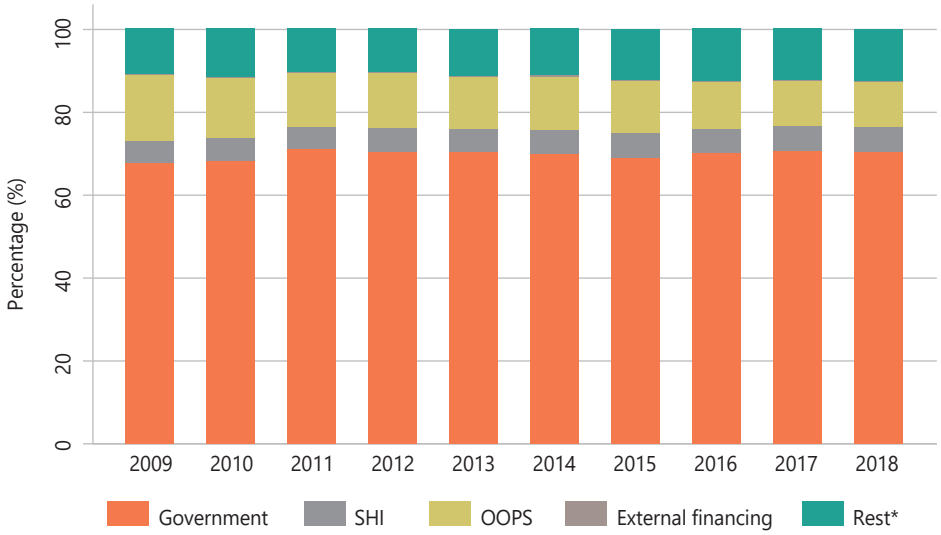


Primary health care expenditures

No data available.

Composition of current health expenditures

Fig. 7. Revenue source of current health expenditures over the years



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

Burden of disease and disease-specific government expenditures

Fig. 8. Burden of disease, 2019

Rank by disorder (2019)		DALYs (%)
1	Stroke	6.19
2	Road injuries	5.11
3	Ischemic heart disease	4.98
4	Diabetes mellitus	4.25
5	HIV/AIDS	3.88
6	Chronic kidney disease	3.50
7	Low back pain	3.50
8	Liver cancer	3.07
9	Cirrhosis and other chronic liver diseases	2.98
10	Lower respiratory infections	2.93
11	Other musculoskeletal disorders	2.88
12	Headache disorders	2.66
13	Tracheal bronchus and lung cancer	2.54
14	Chronic obstructive pulmonary disease	2.48
15	Age-related and other hearing loss	2.34
16	Depressice disorders	1.85
17	Neck pain	1.76
18	Alzheimer's disease and other dementias	1.61
19	Self-harm	1.59
20	Falls	1.53
21	Neonatal disorders	1.41
22	Blindness and vision loss	1.33
23	Anxiety disorders	1.25
24	Interpersonal violence	1.19
25	Colon and rectum cancer	1.18

Infectious and parasitic diseases
Nutritional deficiencies
Reproductive health
Noncommunicable diseases
Injuries

Timor-Leste

Progress towards universal health coverage

Timor-Leste is making steady progress towards UHC. The UHC service coverage index increased from 37 in 2010 to 55 in 2020. Recent data on financial risk protection shows that household catastrophic health expenditure impacts 2.9% of the population, while 0.62% were pushed into poverty due to out-of-pocket health payments in 2014 (under the US$3.20 per capita daily poverty line).[6]

Health system architecture and governance

Timor-Leste, by and large, has a publicly financed and delivered health system. The public health system is structured in four levels of care delivered via health posts and community health centres across all districts, five secondary referral hospitals and one national hospital, the Guido Valadares National Referral Hospital (HNGV) in Dili, the capital. The private sector is limited to a few private clinics (in urban areas) and pharmacies, but no hospitals.

With administrative and financial decentralization implemented since 2015, the municipal authorities and administrations are responsible for the management of the health services that were previously under the Ministry of Health. A partial financial decentralization is implemented with the municipal administrations, who may decide on some health resource allocations, while the bulk of the health budget remains under the responsibility of the Ministry of Health. However, a full devolution is implemented in the Autonomous Region of Oecusse-Ambeno where the local government exercises power over the health budget. In addition, four public institutions are involved in service delivery: the HNGV, Medical Stores (SAMES) and the National Health Institute (INS) and the National Laboratory. These organizations operate autonomously, with direct budget transfers from the Ministry of Finance (MoF).

Raising revenue

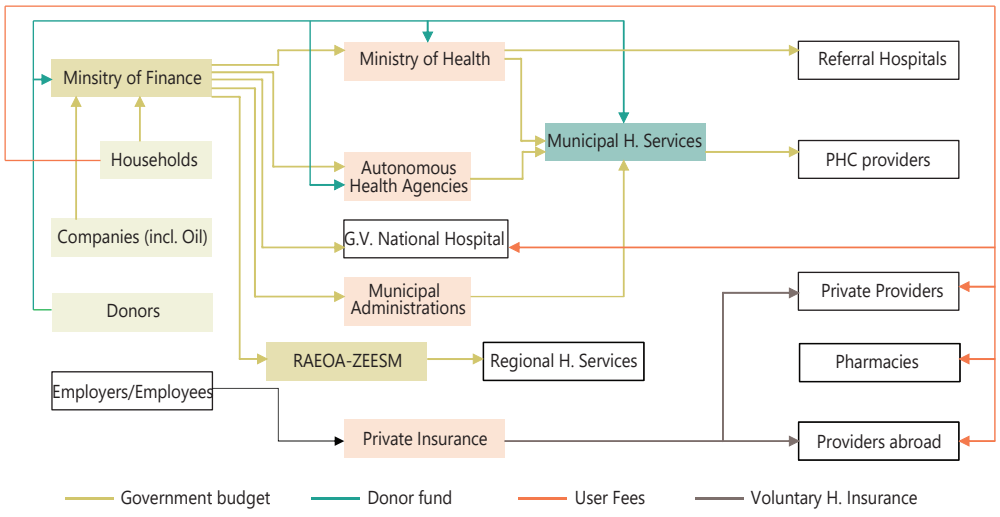
Current health expenditure (CHE) as percentage of GDP has increased as a result of oil-related revenues, from 1.7% in 2009 to 4.3% in 2018. The proportion of domestic government expenditures on health (GGHE-D) in relation to GDP grew sharply from 0.7% (2009) to 2.6% in 2018. The health sector is a priority for the government; hence GGHE-D

has doubled as a percentage of total government spending, from 2.7% in 2009 to 5.4% in 2018. As result, the government budget constitutes the largest source of health financing in Timor-Leste at 67.7% of CHE in 2018, up from 44.4% in 2009. External donors have provided substantial contributions to the health sector; however, this source of funding has drastically declined to 19.7% of CHE in 2018, from 46.7% in 2009. Out-of-pocket spending on health decreased from 8.8% of CHE in 2009 to 7.1% in 2018. Private revenues and voluntary health insurance contributed about 5% of CHE in 2018.[71]

Pooling and flow of resources

Public resources for the health sector are managed by several government institutions in part due to the decentralization reform in Timor-Leste. Until 2014, the vast majority of the government health budget was pooled at the MoH. By 2017, the MoH's pool was reduced to about 55% of the government health Budget. The rest remains with the MoF for allocation to municipal authorities, autonomous institutions and others (Fig. 1). Only a few donors channel their resources to the MoH fund.

Fig. 1. Simplified flow of funds in Timor-Leste health sector



Source: Adapted from World Health Organization. Regional Office for South-East Asia. Health financing profile 2017:Timor-Leste. World Health Organization. Regional Office for South-East Asia; 2017.

Benefits package

Services in government health facilities are free of charge at the point of delivery. In addition, the government has initiated community services through two main programmes: SISCa and *Saúde na Familia* (family health programme). Launched in 2015,

the *Saúde na Familia* is the government's flagship primary care programme which aims to provide service delivery close to households, including hard-to-reach families. SISCa (*Sistema Integrado de Saúde Comunitaria* or Integrated Community Health System) delivers most of the primary health care services offered at health facilities to communities without the confinements of physical structures. SISCa thereby extends the reach of basic PHC services to the community level promoting the involvement of beneficiaries in decisions about their health and health care. The range of health services provided at all five referral hospitals and the HNGV is limited, and patients are often referred for treatment abroad.[141] Private voluntary insurance schemes cover private provisions available in Timor-Leste and health care outside the country. User fees are charged at the national referral hospital (HNGV) for a few, specific and non-essential services.

In 2015, the MoH defined a Comprehensive Service Package for Primary Health Care,[142] which was revised in 2019, for an Essential Services Package.[143] The new package is more specific (i.e. it includes screening, diagnosis and management of selected noncommunicable diseases) and integrates all levels of the district health system. The cost of delivering the new package was estimated at US$ 57 per capita (against a per capita expenditure at the PHC level estimated at US$ 47).[144]

Table 1. Essential Services Package

Maternal care	Curative care
Postnatal care	Acute conditions
Child care	Noncommunicable diseases
Family planning	Diabetes
***Saúde na Familia* (home visits)**	Hypertension
	COPD/asthma
	Hospital admissions

Purchasing arrangements

The MoH acts as the main purchaser of services provided by the referral hospitals and municipal health services and monitors health service-related activities and outcomes across the sector. In general, line-item budgets for goods and services to health facilities and institutions are transferred either directly by MoF or through MoH. Health workers are salaried employees of MoH. Medicines procurement is centralized at SAMES, and is then distributed in kind to health facilities directly or through the municipal health services.

Health care abroad is contracted by the MoH to selected hospitals in Indonesia, Singapore and Malaysia on a fee-for-service arrangement.[142] People pay direct out-of-pocket payments mostly to purchase medicines from private pharmacy outlets.[145]

Public financial management

Budget formulation is done by different institutions, including MoF and the Prime Minister's Office, and MoH and Ministry of State Administration. The MoF and MoH budgeting process is largely a top-down one and based on past year line-item expenses. In 2017, the MoH introduced programme budgeting and is piloting an allocation formula to decide on budgets for goods and services for the programmes of the municipal health services.[142] The SAMES and MoH budget for medicine and supplies according to requisitions and past consumption patterns by government health facilities. A significant amount of donor funding remains off-budget.

The budgets are directly disbursed by the MoF to autonomous health institutions and municipalities. Non-spent or non-obligated (even if committed) funds revert to the MoF. User fee collections are deposited in the MoF account and integrated into the general government budget. Health budget execution has improved in recent years, from 63% in 2012 to 88% in 2019. The MoF publishes the government's Budget execution updates through its budget transparency portal that is accessible to the public. It is complemented by self-reported foreign assistance through the aid transparency portal.[146]

Recent health financing reforms

A five-year Health Financing Strategy (HFS) was launched in 2019[147] in the broader context of shrinking oil revenues in Timor-Leste. The strategy advocates for increased government health spending, streamlined pooling of health budgets, introduction of strategic purchasing and revision of the limited package of health services. To this end, pilots to introduce programme budgeting and resource allocation formulas, to revitalize the Family Health programme, and implement the Essential Services Package for primary care, are currently underway.

Timor-Leste

Macro picture

Indicator	Latest year	Value
Total population (thousands)[1]	2020	1318
Employment to population ratio, 15+, total (%) (national estimate)[2]	2016	63.9
GDP per capita growth (annual %)[2]	2019	1.4
GDP per capita (current US$)[2]	2019	1294
General government revenue (% of GDP)[3]	2018	58.2
Tax revenue (% of GDP)[2]	2018	25.0
General government total expenditure (% of GDP)[3]	2018	86.2
Fiscal balance (revenue–expenditure) (% of GDP)	2018	-28.1
General government gross debt (% of GDP)[3]	2018	9.3
Poverty headcount ratio at US$ 1.90 a day (2011 PPP) (% of population)[2]	2014	22.0
Poverty headcount ratio at national poverty lines (% of population)[2]	2014	41.8

[1] United Nations, Department of Economic and Social Affairs, Population Division (2019). *World Population Prospects 2019: Volume II: Demographic Profiles.*

[2] World Bank Group. World Development Indicators, 2020. Washington, D.C.: 15 Oct 2020. https://databank.worldbank.org/source/world-development-indicators.

[3] IMF. *World Economic Outlook: A Long and Difficult Ascent*. Washington, D.C.: October 2020. https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020.

Progress towards universal health coverage

Fig. 2. SDG 3.8.1 Service Coverage Index (0–100)

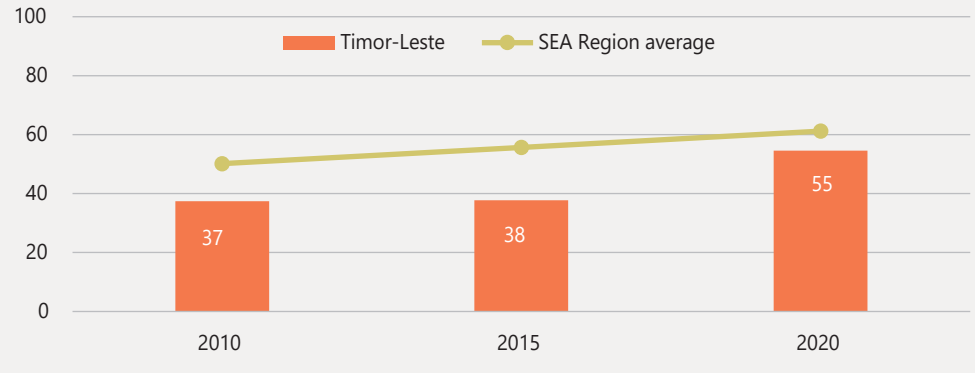
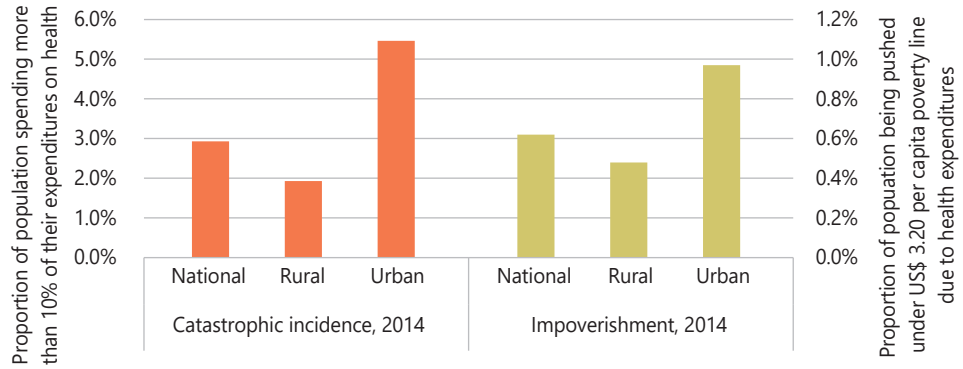


Fig. 3. SDG 3.8.2 Catastrophic and impoverishing incidence due to out-of-pocket expenditures on health



General health expenditure trends over the past decade

Fig. 4. Current health expenditures 2009–2018

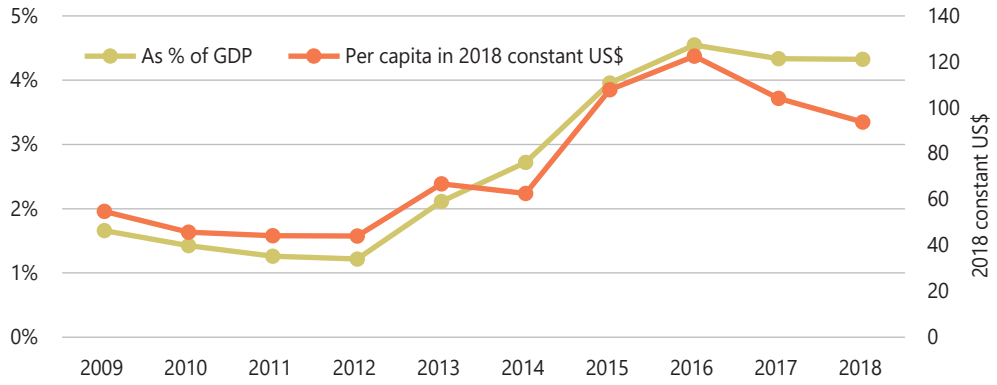


Fig. 5. Domestic government expenditures on health 2009–2018

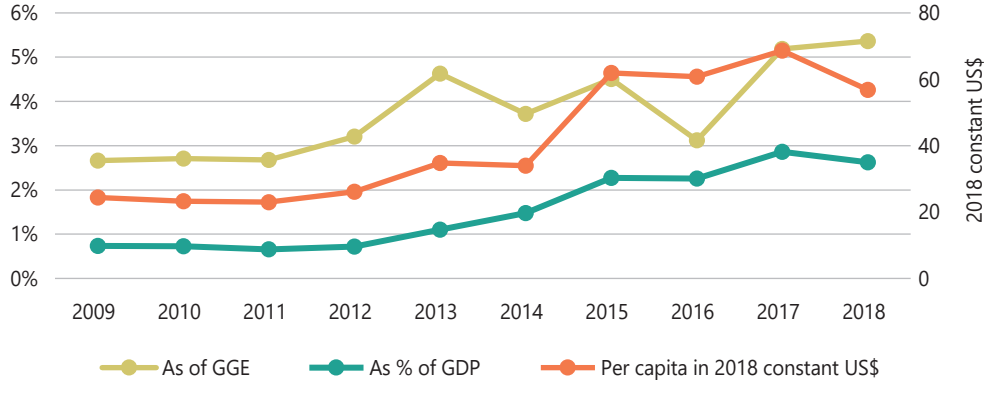
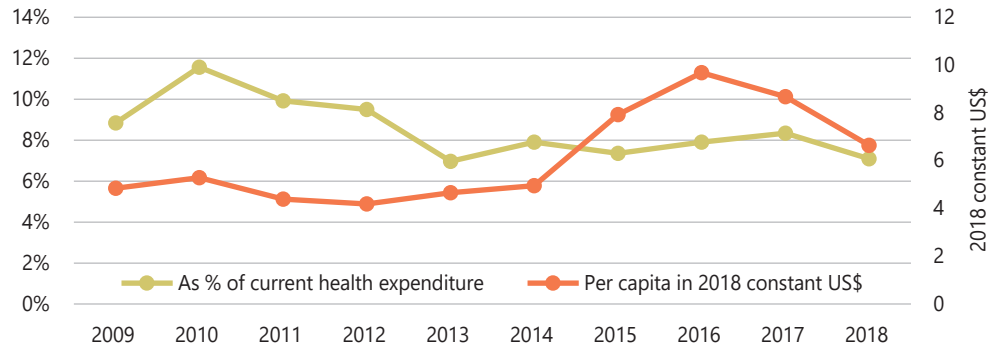
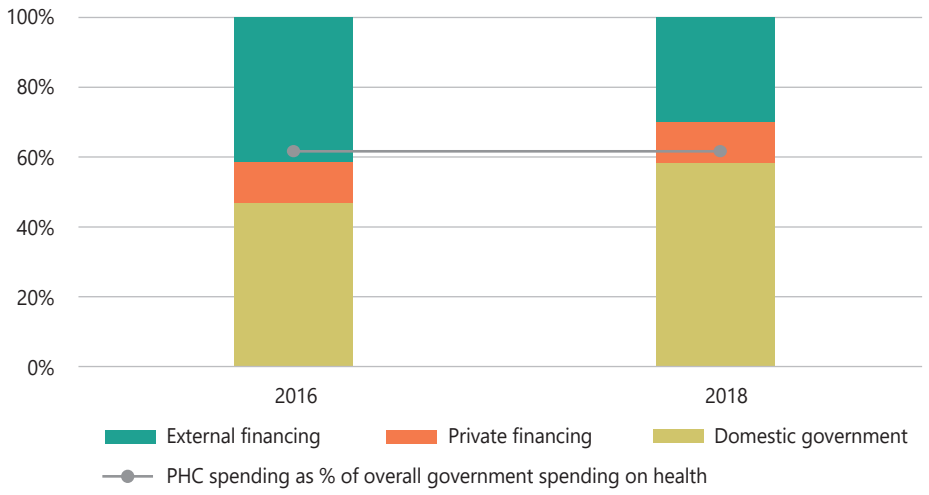


Fig. 6. Out-of-pocket spending on health (OOPS) 2009–2018



Primary health care expenditures[a]

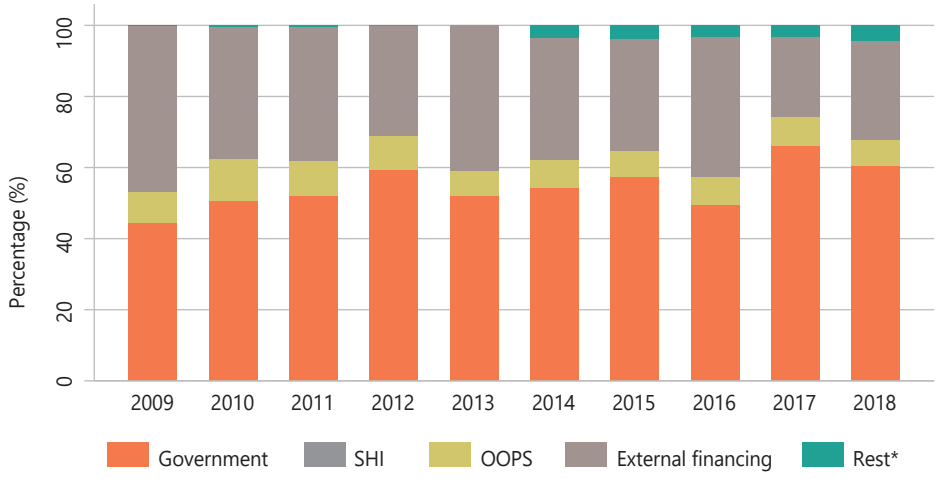
Fig. 7. Primary health care expenditures



a Primary health care measurement is entirely based on Health Care Functions classification. Details of the measurement can be found here: Global spending on health: a world in transition. Geneva: World Health Organization; 2019 (WHO/HIS/HGF/HFWorkingPaper/19.4).

Composition of current health expenditures[b]

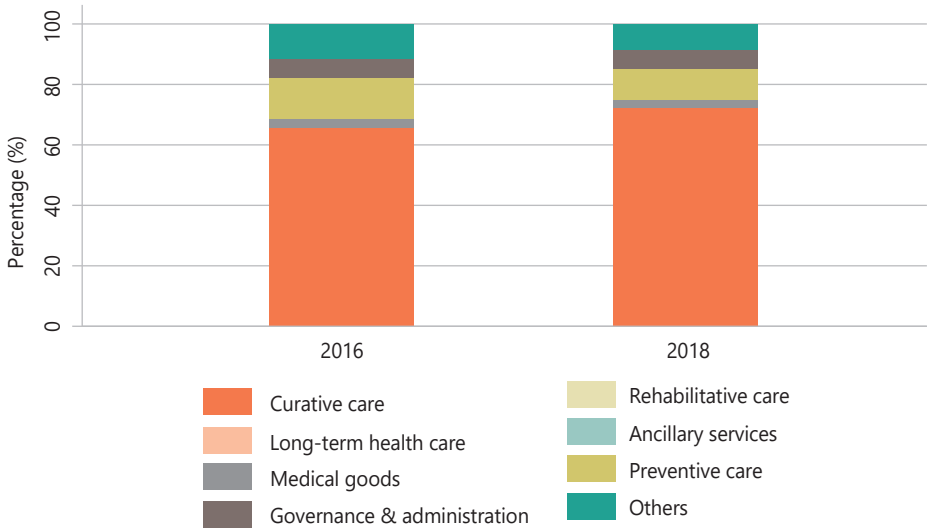
Fig. 8. Revenue sources of current health expenditures over the years



* Rest includes other domestic revenue sources than OOPS, such as corporations, non-profit entities, and voluntary prepayments, etc.

Burden of disease and disease-specific government expenditures

Fig. 9. Health expenditures by function



b "Ancillary services" and "medical goods" are independent consumptions that do not have a specific purpose (treatment, prevention, etc.) in themselves. Typical examples include laboratory services, imaging diagnosis, and patient transportation under "ancillary services", and pharmaceuticals (both prescribed and over-the-counter ones) as well as therapeutic goods (corrective glasses, hearing aids) under "medical goods". Consumption of such during a health-care contact are, therefore, lumped under other categories (i.e. curative care) and not separately reported.

Fig. 10. Burden of disease, 2019

Rank by disorder (2019)		DALYs (%)
1	Neonatal disorders	12.30
2	Stroke	7.02
3	Lower respiratory infections	6.97
4	Ischemic heart disease	5.57
5	Congenital birth defects	3.73
6	HIV/AIDS	3.34
7	Diarrheal diseases	3.04
8	Tuberculosis	2.69
9	Road injuries	2.41
10	Chronic obstructive pulmonary disease	2.26
11	Diabetes mellitus	2.10
12	Low back pain	2.09
13	Headache disorders	1.88
14	Chronic kidney disease	1.86
15	Cirrhosis and other chronic lever diseases	1.63
16	Asthma	1.40
17	Age-related and other hearing loss	1.38
18	Conflict and terrorism	1.38
19	Depressive disorders	1.21
20	Dietary iron deficiency	1.18
21	Anxiety disorders	1.10
22	Drowning	1.10
23	Whooping cough	1.08
24	Hypertensive heart disease	1.02
25	Blindness and vision loss	1.02

Infectious and parasitic diseases
Reproductive health
Injuries
Nutritional deficiencies
Noncommunicable diseases