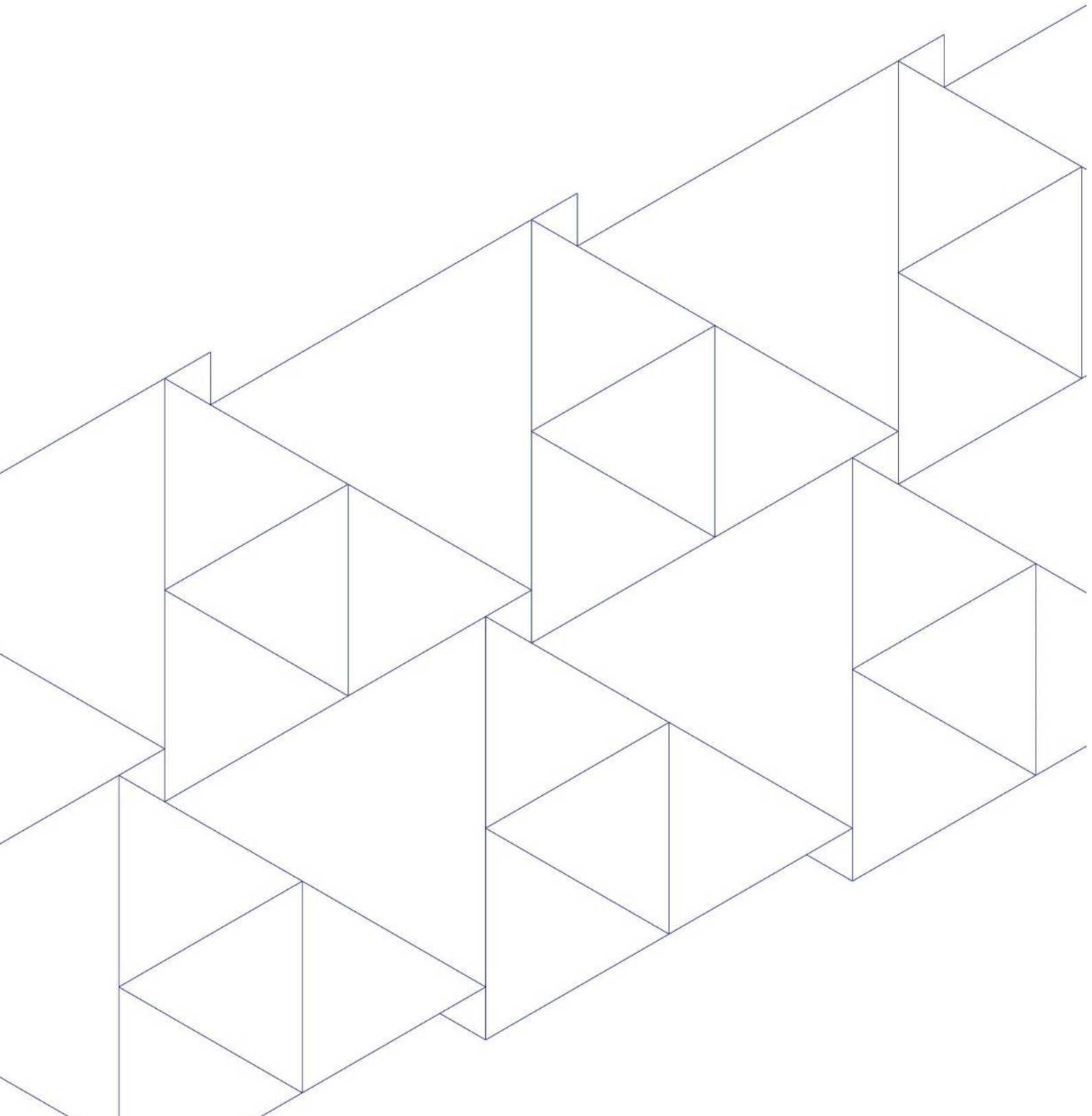
International Labour Organization

# Financing Social Health Protection in Asia and the Pacific



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This paper examines trends in SHP financing in the Asia and the Pacific region. It further explores the various pathways that have successfully ensured adequate resource mobilization, with a view to providing orientation to countries that will need to increase financing to achieve the goal of UHC (Universal Health Coverage). It is extracted from the report "Extending social health protection: Accelerating progress towards Universal Health Coverage in Asia and the Pacific", ILO, 2021.

## Key messages

- Under-funding and unpredictable funding remain major barriers to expanding coverageand enhancing adequacy. Enhanced public resources, in terms of quality and volume, are necessary to make solidarity in financing a reality, backed by comprehensive legal frameworks developed through social dialogue to ensure sustainable systems amidst changing political priorities.

- Social security contributions continue to constitute an important source of financing for SHP (Social health protection) in many countries, providing predictable and progressive earmarked sources of funds. However,social security contributions need to be complemented by other sources of revenues to ensuresolidarity with groups with limited contributory capacity, such as the poor.

- Securing a solid financing mix requires proactive efforts to ease the transition from the informal to formal economy. Formalization of the informal economy would increase thecollection of social security contributions, but also broaden the tax base. Indeed, while tax financing is identified as a means to raise revenues for SHP, the size of the informal economylargely influences the tax base for progressive taxation measures and constrains revenuecollection.

- Many governments have decided to use consumption taxes, including earmarked health taxeson consumer products that are harmful to health. Taxes on consumer goods are an important source of revenue and need to be considered within the overall fiscal framework of a countryto ensure progressive taxation and effective redistribution of resources.

- Reliance on out-of-pocket spending and private health insurance reduces social solidarity and maintains inequities in accessing health care and financing the system. Private health insurance plays a small role in health financing in the region and is mostly used to provide supplementary or complementary benefits for those who can afford it. It is, therefore, neitherseen nor appropriate as a tool to extend coverage.

- A number of countries in the region have transitioned out of external aid dependency forhealth financing in the last decades, as many saw their income levels rise and eligibility to external aid decrease. This transition entails some challenges, including pervasive gaps in accessibility of services for the specific health conditions that were previously vertically funded.

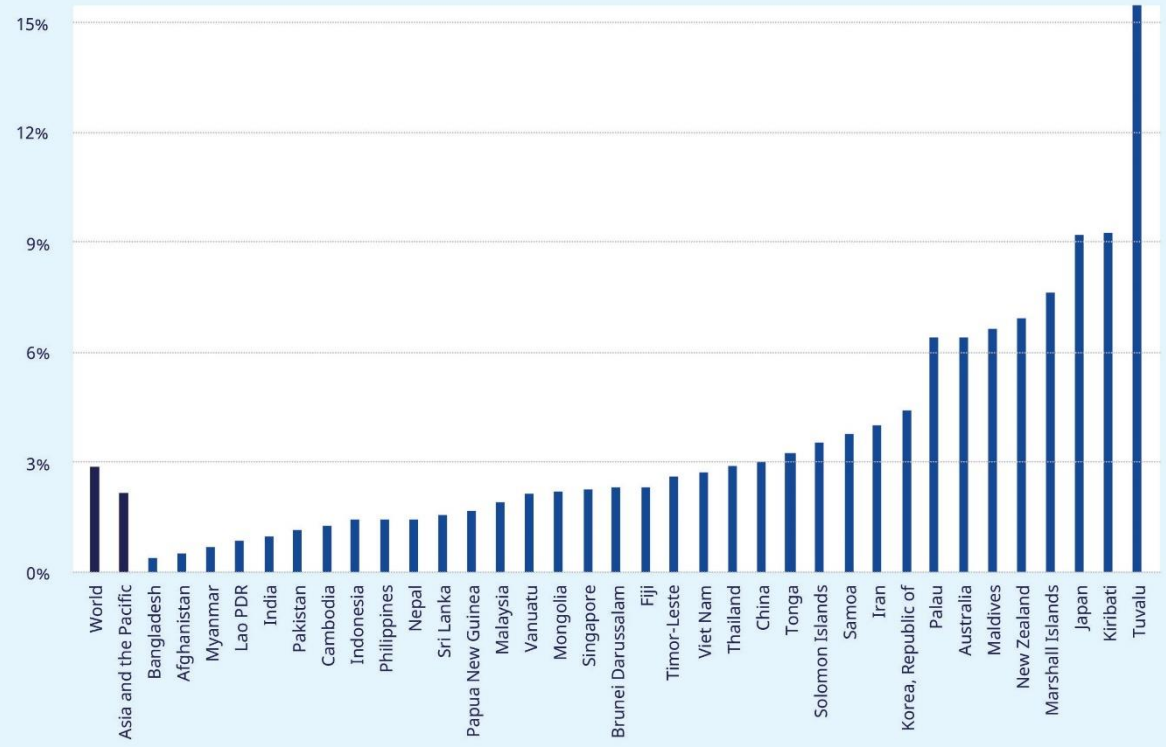
# 1. Increasing public resources: a necessity

## Essential role of public funding

### Trends in public expenditure

Government health expenditure as a share of GDP is an important indicator that reflects, to some extent[1], the prioritization of health in a country (Savedoff 2003) (see Figure 1). In the region, the governments of 20 countries spend less than 5 per cent of GDP on health, including six countries where this proportion is lower than 3 per cent. This suggests that the financing of health expenditure has, in most cases, largely shifted onto patients and their families and is therefore highly regressive (see Figure 3).

**Figure 1. Domestic general government health expenditure, percentage of GDP, countriesand territories in Asia and the Pacific, 2018**




Note: No data available for the Cook Islands.

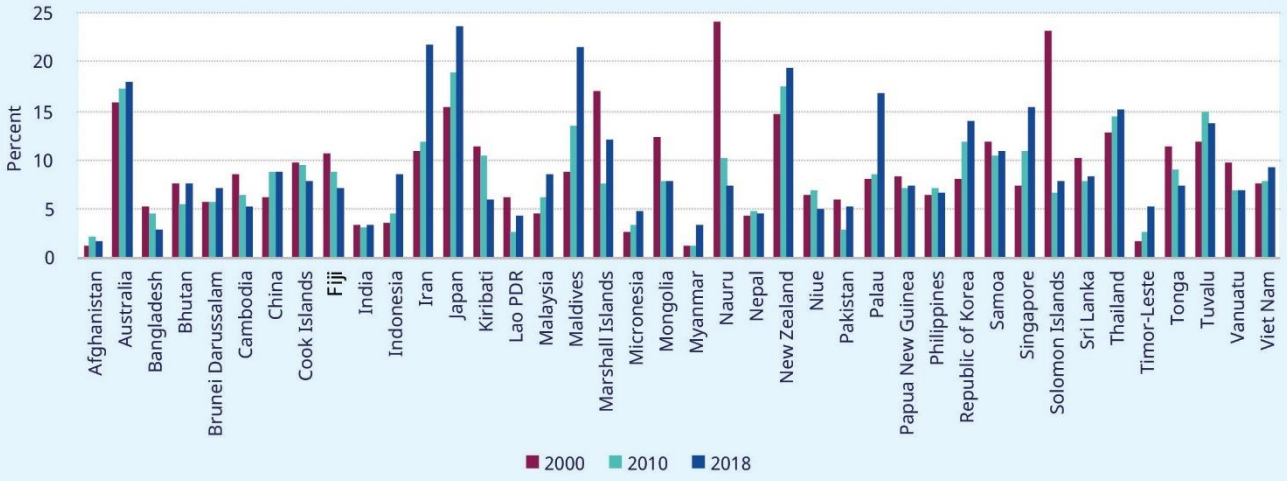
Source: Adapted from WHO Global Health Observatory.

[1] While the threshold of 5 per cent of GDP is often referred to as a reasonable amount for government to allocate to health spending, the appropriate level of spending depends on many factors, such as the epidemiological profile, the desired level of health status, the effectiveness of health inputs purchased at existing prices as well as the relative value and cost of other demands on social resources.

Changes that occurred leading to increased prioritization of health in general government expenditure in some countries are often multidimensional. Historical trajectories help to understand weaknesses in the current funding mechanisms that keep countries at low and stagnant levels of public spending.

Ensuring adequate public funding for SHP requires sustainability and predictability of funding sources. Figure 2 shows the countries that have seen the most severe declines in health's share of government expenditure including Bangladesh, Cambodia and Fiji with declines between 2000–2018. In Fiji, there was a decline in domestic government health spending compared to GDP, even though tax revenue mobilization has increased dramatically in recent years. Mongolia saw a decline in government health spending from 2000–2010 with no recovery back to previous levels. The country has faced substantial fluctuations in allocation of public resources for health. While PHC (Primary health care) initially was covered under NHI (National Health Insurance), in 2006the government committed to providing free PHC funded by the government budget. However, between2012–2017, the share of State funding allocated to PHC fell from nearly 25 per cent of government healthexpenditure in 2005 to under 16 per cent in 2016. These declines indicate a lack of sustainability of healthfinancing sources and explain why many line ministries in charge of SHP have requested earmarkedresources be included in the financing mix.

**Figure 2. Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE), countries and territories in Asia and the Pacific, 2000, 2010 and 2018**




Note: Values for Afghanistan and Timor-Leste were not available for 2000. Instead, data for 2002–2003, respectively, were used.
Source: Adapted from WHO Global Health Expenditure Database.

## Importance of public spending in national health expenditure

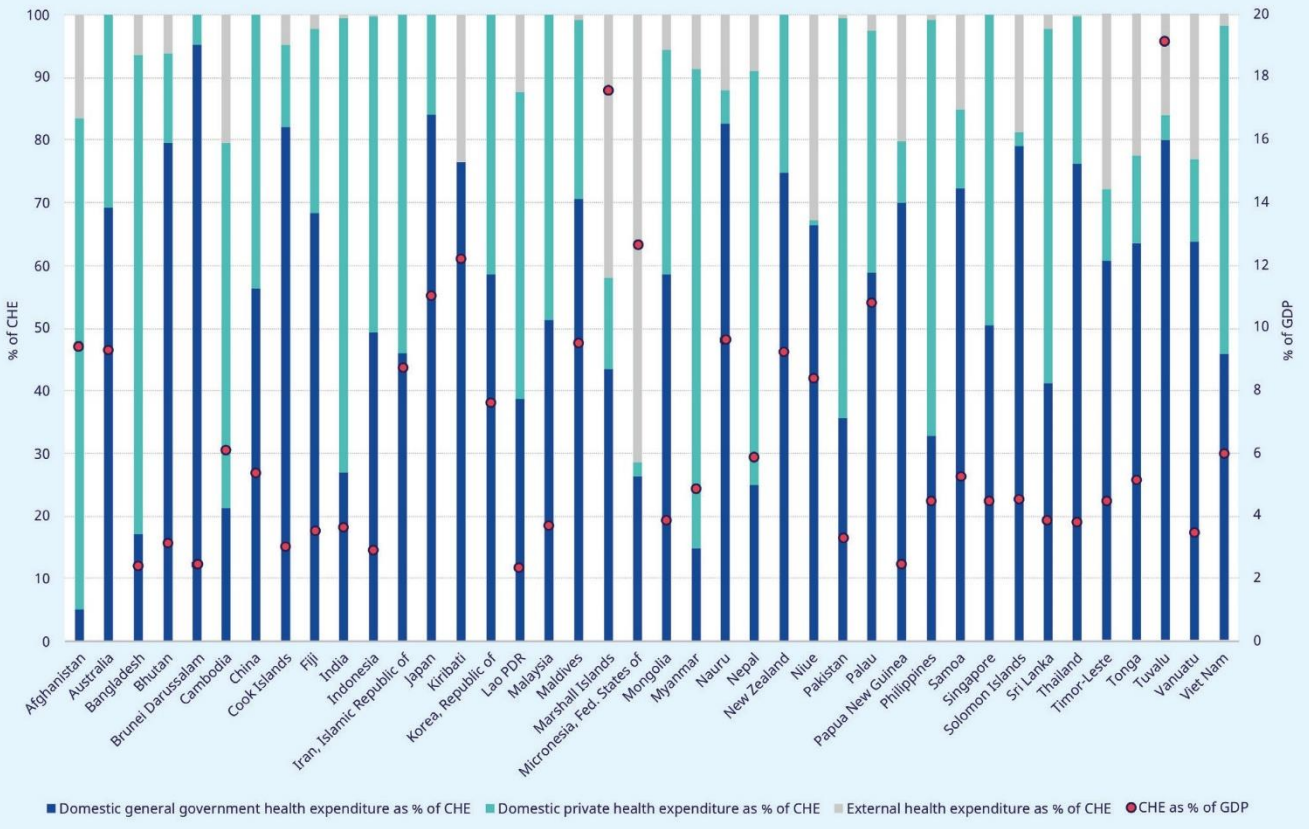
Public spending is considered the most appropriate source of funding in line with the principles of solidarity in financing and the overall and primary responsibility of the State embedded in ILO Convention No. 102, Recommendations No. 69 and 202. The relative share of public spending in national health expenditure is a reflection of the collective efforts towards expanding health coverage. The amount of resources allocated to health as a share of GDP also reveals the degree of priority a population is giving to the health sector (see Figure 3).

Public spending accounts for more than half of current health expenditure in 25 out of 40 Asia and the Pacific countries with information available (Figure 3). Within South-East Asia, only five (Brunei Darussalam, Malaysia, Singapore, Thailand and Timor-Leste) of the 11 countries rely on public spending

for more than half of their current health expenditure. In South Asia, the only countries with the public share of current health expenditure exceeding 50 per cent are Bhutan and the Maldives.

Public resources raised domestically are often complemented by external resources in low-income countries. In this respect, ILO standards recognize the important role of international cooperation and solidarity in the establishment of SHP systems in countries that are particularly resource constrained. However, as countries reach middle-income status, external financing sources tend to decline – leaving domestic funding to ensure sustainability. In the region, an important share of health expenditure is generated from external sources in small Pacific Islands as well as countries affected by conflicts in the past decades, such as Cambodia and Timor-Leste. Two countries, the Federated States of Micronesia and the Marshall Islands, rely heavily on external assistance to achieve a high share of GDP spent on health.

**Figure 3. Composition of current health expenditure (CHE) and as a percentage of GDP, countries and territories in Asia and the Pacific, 2018**




Source: Adapted from WHO Global Health Expenditure database.

Private health expenditures include OOP expenditures by households as well as private health insurance contracted on a voluntary basis. If used as the main mechanism for financing health services, OOP expenditures can lead to substantial financial burdens on households and inequality in access. There is a large variation in the share of OOP health expenditures in current health expenditure (CHE) in the region, ranging from 0.1 per cent in Kiribati to 78.4 per cent in Afghanistan. Overall, for the 35 countries with available data for 2018, OOP expenditures accounted for less than 21 per cent of CHE in nearly half (17) of them, while for the remaining countries the rate exceeded 30 per cent. Some countries spend a high share of GDP on health through a heavy burden on private sources of health financing, including Afghanistan, Cambodia, Islamic Republic of Iran and Republic of Korea. Most countries were identified as not having taken a clear political commitment towards universal coverage with an over-reliance on private health expenditure. Private health insurance plays a small role, as explored in the following section.

## Limited role of private health insurance

Private health insurance contracted on a voluntary basis plays a small role in health expenditure in the region, whether of a commercial nature or not.

### Commercial insurance

There are several distinguishing features of private voluntary health insurance that inhibit its ability to contribute to equity or effective financial protection. The financial contributions are generally individually risk-rated premiums, meaning the amounts to be paid depend on people's health status and identified risks rather than their ability to pay. 'Cream skimming' [2] is common. Hence, older persons or people with pre-existing conditions are generally not eligible to purchase private insurance policies or must do so at a high cost. Premiums also tend to be high because private insurers are generally for-profit enterprises that have shareholders and their performance is measured by generated profits. To reduce risks of adverse selection, waiting periods are often applied before members can access services. As a result, private voluntary health insurance tends to be purchased mainly by the wealthiest and healthiest groups of the population. Private health insurance may also lead to higher costs of care when they adopt provider payment methods and levels less efficient than public mechanisms with broad risk pools.

Private voluntary health insurance (PVHI) is mostly used to provide supplementary or complementary benefits for those who can afford it. As such, it is not generally seen as a tool to extend primary coverage. Demand for and coverage of private health insurance is growing as people's incomes increase in step with a desire to access private services with more amenities that are not covered by SHP, such as shorter waiting times, choice of doctor or private rooms. Rising demand for PVHI can also sometimes be a signal of inadequacy in the benefit package offered by the SHP system, underlining the importance of periodic reviews and progressive expansion of the benefit packages as countries grow economically and technologically. For example, in the Republic of Korea a majority of Koreans (87 per cent) resort to private health insurancefor supplementary and complementary coverage from the NHI plan, driven by the high co-payments associated with the NHI. While inpatient care has co-payments of only 20 per cent, outpatient care co- payments vary between 30–60 per cent.

Although private insurance can fill these gaps, it is not a redistribution mechanism. Therefore, it does not foster solidarity and equity and can contribute to reinforcing inequities in access.

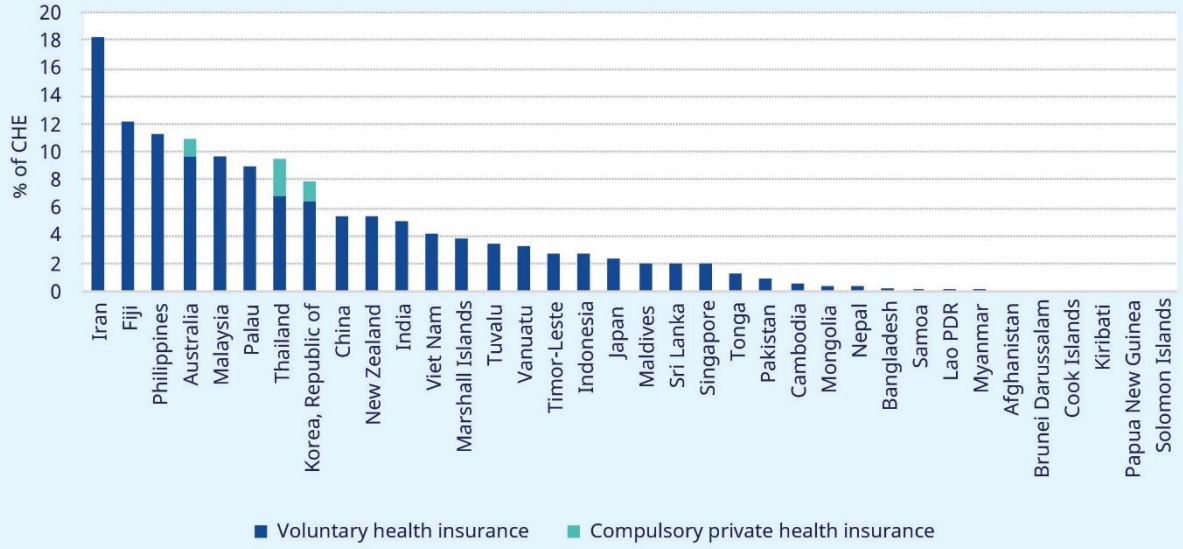
In this context, government oversight is necessary to guarantee consumer protection. Strong regulations are also needed to ensure that members are not allowed to opt out from the national system, which would be detrimental to public risk-pooling mechanisms.

Overall, private health insurance plays a small role in health financing in the region. Very few Asia and the Pacific countries have compulsory private health insurance requirements. These tend to mainly apply

[2] The practice of selecting customers based on their good health status or low health risk profiles to enhance the profitability of the insurance company.

to migrant workers, including in Malaysia and Singapore. Private health insurance accounts for less than 3 per cent of current health expenditure in Australia, Singapore and Thailand. Nine Asia and the Pacific countries indicate no PVHI contributions to current health expenditure, while 10 other countries indicated PVHI accounting for less than 2 per cent of current health expenditure (Pettigrew and Mathauer 2016). In only three countries (Fiji, Islamic Republic of Iran and the Philippines), PVHI accounted for more than 10 per cent of CHE (Figure 4).

**Figure 4. Voluntary health insurance as a share of current health expenditure, countries and territories in Asia and the Pacific, 2018 or latest year available**




Source: Adapted from WHO Global Health Expenditure Database.

## Community-based health insurance

Community-Based Health Insurance (CBHI) is usually characterized by voluntary affiliation, members' financial contributions with risk pooling defined, organized and managed at the community level or among a small group of individuals. It is usually not for profit. Some countries in the region have implemented various CBHI models, often publicly mandated and implemented or supported by NGOs.

In most cases, CBHI schemes were meant to fill a gap in national SHP systems and enabled unprotected individuals or households, mostly with limited income and dependent on informal employment, to access financial protection in case on illnesses or maternity. However, such schemes have not succeeded in expanding coverage in countries where not integrated in the SHP system and carried the risk themselves, mostly due to two inherent design flaws. Firstly, those schemes were voluntary in nature and exposed to the risk of adverse selection and to an immense awareness-raising task with little public support. Secondly, pooling risk at community level is inefficient as it does not allow a proper diversification of risks to be financially sustainable, and further presents limited redistributive potential and leads to fragmentation, which poses equity concerns. Impacts on financial protection have yet to be demonstrated, particularly in South Asia (Bhageerathy, Nair, and Bhaskaran 2017).

While this holds true, some countries have made good use of CBHI as action-oriented research and piloting and transformed their CBHI or absorbed it into national SHP systems. For instance, in Lao PDR, the MOH (Ministry of Health)-run CBHI has been reformed and absorbed by the MOH's National Health Insurance scheme. Cambodia's experience in running CBHI in selected provinces for many years helped

gather knowledge and develop management tools which were then transferred to the government, and particularly supported the National Social Security Fund to extend coverage to garment factory workers.

In this respect, CBHI schemes helped strengthen local governance and fostered a culture of SHP, building strong foundations for developing national health protection systems. Bridging CBHI schemes and the respective national system is essential to move towards a universal SHP system, anchored in laws, and based on broad risk pooling (Carrin 2003).

Despite a trend towards increasing public spending, private expenditure on health – including OOP (Out-of-pocket) expenditures from households still represents an important share of health expenditure. This suggests that gaps in SHP need to be addressed urgently with the mobilization of additional resources.

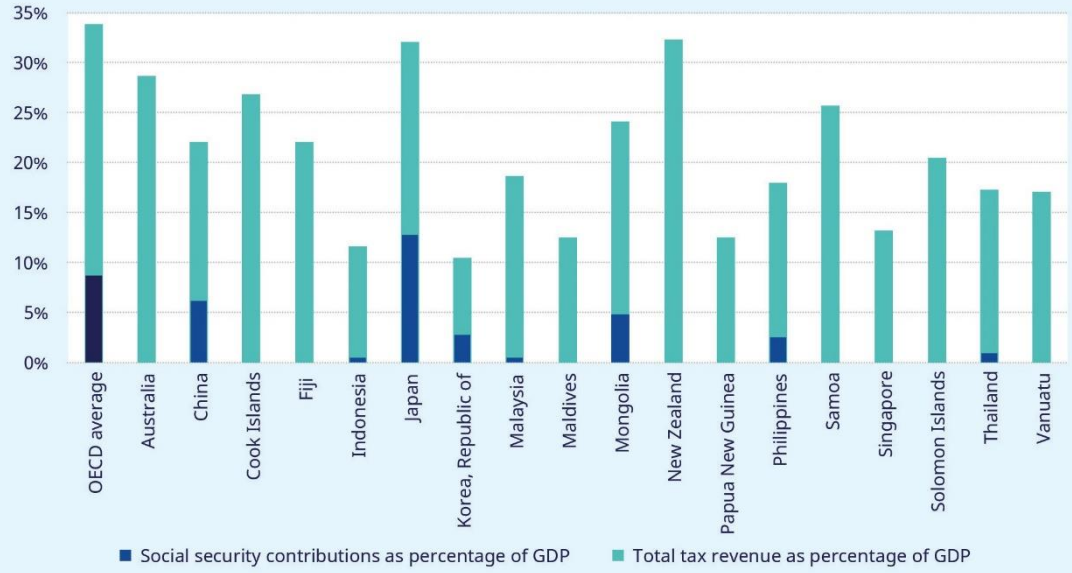
# 2. Strategies for resource mobilization

Arguments that SHP is unaffordable are becoming less and less compelling in low- and middle-income countries. In fact, countries cannot afford not to have SHP, and must invest in robust and shock responsive social protection systems to accompany an equitable economic recovery path from COVID-19. As incomes rise, resources are available and politics, laws and institutions need to adapt to ensure these resources are allocated to meet national commitments to provide adequate SHP coverage, particularly by increasing the fiscal space. Indeed, the fiscal space is defined as "the resources available as a result of the active exploration and utilization of all possible revenue sources by a government" (Ortiz, Cummins, and Karunaneth 2015). There are many ways to create fiscal space for SHP, and a mix of financing options are usually explored. Strategies devised by institutions in charge of SHP can focus on raising earmarked resources via the expansion of social insurance coverage and contributory revenues or the establishment of health taxes. They can also focus on increasing non-earmarked tax revenues and advocate for priorization of health as well as other ways of mobilizing more resources, including improving efficiency, eliminating illicit financial flows and increasing aid and transfers. The next sections will explore how countries have made use of these opportunities to increase the amount of public resources available for SHP.

## Political will drives fiscal space mobilization

As discussed in the previous section, domestic revenues provide the most sustainable source of funding for SHP. In most countries, including in the Asia and the Pacific region, taxes and social security contributions are the main sources of public finance, particularly as foreign aid is declining. On average, the tax-to-GDP ratio – which calculation include social contributions –increased from around 15 per cent during 1990–2009 to around 22 per cent during 2010–2014. Despite much progress, low- and middle-income countries in Asia and the Pacific collect lower proportions of their GDPs from public revenues than OECD countries.

**Figure 5. Social security contributions and tax revenue as a share of GDP, countries and territories in Asia and the Pacific with available data, 2019**




Note: Only countries with data available are shown. Values for 2019 were unavailable for Australia, Japan and the OECD average. Instead, values for 2018 were used.

Source: Author calculations based on OECD (2021).

With strong political will, raising public revenues is not out of reach. Appropriate fiscal reforms are necessary not only to increase the ratio, but also to reduce income inequalities by improving progressivity (see Box 1). This requires decreasing reliance on indirect taxes, which are most often regressive in nature and to enforce direct taxation. Several middle-income countries have successfully mobilized public resources to extend SHP coverage to their populations in a sustainable fashion embedded in law. In 2014, Indonesia's national social health insurance scheme JKN (Jaminan Kesehatan Nasional) consolidated all previously fragmented SHI schemes and assistance programmes at national and provincial levels after citizens brought legal action to hold the government accountable to implement the 2004 Law on the National Social Security System. Viet Nam also consolidated fragmented schemes and made commitments to governmentsubsidies for the contributions of vulnerable groups in the Health Insurance Law as a way to increase public financing of health services.

**Box 1. Political will drives fiscal space mobilization**

Thailand relies heavily on government budget to fund the Civil Servant Medical Benefit Scheme and the UCS (Universal Coverage Scheme) for a large part of the population. Thailand was able to ensure government annualallocations for the UCS through passage of the National Health Security Act (2002), which achieved efficiency gains by consolidating funding from existing schemes (Medical Welfare Scheme and Voluntary Health Card Scheme) into the UCS and applying provider payments and other measures that ensured efficiency in health service delivery.

In March 2009, the Central Committee of the Communist Party of China and the State Council issued a guiding policy document, Deepening the Health System Reform, aiming to achieve UHC by 2020. This event launched comprehensive health system reforms to extend social health insurance coverage and promote universal access to health services. To facilitate these reforms, government expenditure on health tripled between 2009–2017 and the SHP landscape in China has witnessed significant improvements through enhanced subsidies for vulnerable groups and the consolidation of schemes for rural and urban residents.

In Japan, the Ministry of Finance has played a major role in securing funding for Japan's SHP, with involvement from the early stage of the Ministry in the insurance system design process in the 1920s to ensure SHP's financial sustainability. The ministry contributed to further shape reform and to introduce policies that led to UHC, particularly by assuring availability and sustainability of the financial resources necessary to keep the promises of providing health benefits. A key aspect was the determinant role of the Ministry of Finance to set a global budget for public health insurance, and later to earmark consumption tax revenue to social security expenses, including health, to secure the sustainability of its social security system (Aso 2017).

Among the options available, earmarked revenues play an important role in financing SHP. The arguments for and against earmarking are numerous. Earmarking policies may vary according to the country contexts, political priorities and budget processes to ensure positive results. Fiscal and public financial management impacts of earmarked revenues for SHP must be carefully analysed. However, earmarking enables MOHs and social security institutions to benefit from stable revenues. It protects institutions from the risk of insufficient allocation in case policy and budget process are not well aligned or competing political interests are at play, and participate to increased accountability. Earmarking revenues in the form of social security contributions and health taxes contributes to these objectives. At the same time, a financing mix remains necessary to ensure SHP systems have sufficiently diversified revenues to guarantee their sustainability and equity.

## Raising earmarked revenues from social security contributions

Social security contributions are explicitly earmarked to cover health spending and alleviate the burden of health care costs for households by redistributing and pooling. Social security contributions to SHP schemes are earmarked nominal financial contributions made to a dedicated fund or institution which enjoys autonomy for the administration of those funds under participatory governance. Social security contributions may be collected from workers, employers and government and are calculated in such a way that each individual pays according to their capacity to contribute, while entitlements to benefits are equal for all covered in line with the principle of solidarity in financing. They are redistributive in nature in that they allow transfers from employers to workers, and from the health to the sick or unable to work, and across generations. Social security contributions, as per guidance provided by ILO standards, should be set in a way that ensures equity and solidarity, and therefore be progressive.

Historically, models of financing to guarantee access to health care without hardship were commonly referred to as the Bismarck and the Beveridge models, in reference to the national models of financing chosen by Germany and the United Kingdom. Distinct features that usually distinguished these two models were essentially the source of funding and the way services were procured either through direct provision or contracting providers. In the Bismarck model, employers, workers and the government made mandatory contributions to a social health insurance scheme under participatory governance, which funded access to public and private health care providers for the covered population (workers, pensioners and their families). In the Beveridge model, access to free or largely subsidized health services was guaranteed for the whole population within a network of providers directly financed and managed by the MOH. This distinction does not fit the reality of financing and institutional arrangements adopted in most countries, including in the Asia and the Pacific region. Further, the distinctions that some may have made between those two models has been a poor predictor of outcomes in terms of effective and adequate SHP.

National efforts to extend coverage have led a majority of countries resorting to a financing mix combining revenues from social security contributions and taxes (general and earmarked). For instance, in China, Indonesia, Japan, Mongolia, the Philippines, Republic of Korea, Thailand and Viet Nam all have systems financed with a diversity of funding sources. Similarly, the distinction between the Bismarck and Beveridge models does not hold when it comes to institutional arrangements, as many countries with models based only on tax-financed free public provision have started purchasing from private facilities (Brunei Darussalam and Malaysia) and conversely some countries' SHI remains largely limited to their own facilities (ESIC (Employees' State Insurance Corporation) in India and SSB (Social Security Board) in Myanmar).

In practice, the combination of social security and tax revenues in the financing mix can take several forms, for example:

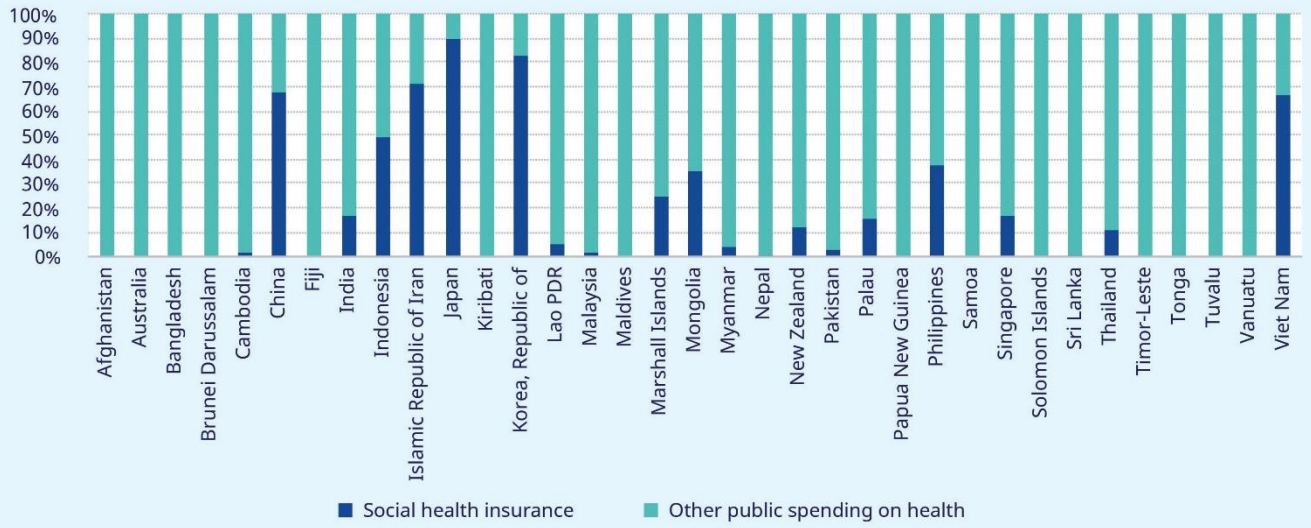
- Tax revenues are used to provide either population-based interventions or the entire primary level of care, while social security contributions are used to finance higher levels of care. In Viet Nam, disease prevention services and health promotion are financed by taxes to mostly public preventive service providers. In Mongolia, taxes fund public and private providers for PHC services. Singapore provides partial tax-financed supply-side subsidies for health services in public hospitals with the amounts depending on means testing of users.
- Tax revenues and social security contributions are used to cover different cost items. For example, many countries use social security contributions to pay for service utilization, while using taxes to provide supply-side subsidies to cover certain cost items, such as human resources or capital costs. For example, Mongolia and the Philippines provide line-item budgets to cover certain costs at public hospitals. In Thailand, the State budget subsidizes payrolls in public hospitals. In Viet Nam, capital costs of public hospitals are often subsidized by the State budget.
- Tax revenues are used to subsidize the social security contributions of specific categories of the population. In Viet Nam, partial subsidies are provided to war veterans and full subsidies are provided to children under-six, among others.
- A contributory system is in place with some level of co-payment, while tax revenues are used to cover co-payments for the poorest and most vulnerable or specific groups, for example China's Catastrophic Medical Insurance (TBCMI) and MFA (Medical Financial Assistance for the Poor).

As a predictable source of revenue, social security contributions play an important role in financing SHP. Similarly, they contribute to the financial sustainability of SHP systems in many countries, as illustrated in Figure 5. In practice, in the Asia and the Pacific region, social security contributions are diverse:

- Countries with small proportions of informal employment – such as Japan, Republic of Korea and Singapore – all have strong contributory schemes that rely on compulsory contributions from workers and employers. Despite having larger shares of informal employment, some middle-income countries, such as China and Viet Nam, strongly rely on social contributions. In Viet Nam, social security contributions represented 47.9 per cent of total revenues of the national health insurance scheme in 2020, which were generated by employers and workers in formal employment representing only 20.2 per cent of the total population protected.

- In some countries, the government fully covers the cost of social security contributions with tax revenues for specific categories of population that cannot contribute (for instance, in Indonesia, Japan, the Philippines and Viet Nam) and/or for whom the contribution collection cost-to-revenue ratio is deemed too low to be worth it (for instance, Thailand).
- In some countries, governments put in place either a unique or a schedule of fixed contribution amounts destined to the self-employed, for which the government itself covers the equivalent of the employer's share of the contribution from tax revenues. Experiences where the government does not match this individual contribution have proven relatively unsuccessful to expand, as it can be unaffordable for the self-employed as they must pay both worker and employer contribution amounts. Fixed amount contributions are sometimes the only practical option, but they are also less progressive which reduces their redistributory effect.

**Figure 6. Social health insurance as a share of public spending on health, countries and territories in Asia and the Pacific with available data, 2018**




Note: No data available for the Cook Islands. Public spending on health constitutes of government financing arrangements and social health insurance.
Source: Adapted from WHO Global Health Expenditure Database.

In many countries, social health insurance schemes collect mandatory contributions from workers and employers automatically from the payroll. While this is extremely convenient for the managing authority, the efficiency of contribution collections is often limited to the formal economy, which complies with tax regulations and is a more costly exercise when it comes to expanding coverage to smaller business units. Similarly, while this financing stream secures a significant volume of revenues relatively easily, it is also vulnerable to fluctuations in the job market and contractions in employment.

Ways to overcome these challenges associated with extension of coverage exist and include a vast spectrum of actions. Social security contributions are linked to legal entitlements and one main strategy for extension includes expansion of legal coverage, by identifying gaps and undertaking necessary legal reforms. A government must then ensure its effective implementation to ensure coverage becomes effective. Simplification of administrative procedures, improving compliance through a mix of enrolment and contributions controls and labour and social security inspections are essential. All these strategies must go hand-in-hand with efforts to transition from the informal to formal economy.

Sustainability and adequate levels of financing for equitable SHP calls for a diversity of financing sources, with recourse to a financing mix allying taxes and social security contributions, but also exploring new sources of revenues and ways to generate efficiency gains for decreasing reliance on external funding and out-of-pocket expenditures.

## Raising earmarked revenues from health taxes

Financing for extension of SHP is being achieved through a diversity of financing sources in the region, including newer funding sources within the financing mix. Several countries have resorted to earmarking certain consumption taxes for health care, with substantial attention paid to what is known in the region as "sin taxes". Those taxes are a type of excise tax that targets goods and services that are harmful to health, specifically alcohol, tobacco, sugar (or sweetened beverages) and gambling. These taxes are often applied not only to generate revenues, but also to discourage harmful consumption. For example, the Philippines has mobilized a substantial amount of additional government health funding to further extend SHP coverage in all three dimensions through public health taxes consisting of excise taxes imposed on the consumption of tobacco and alcohol, aiming to reduce consumption, raise additional revenue and improve population health. This started with the 2012 Sin Tax Law, which assigned 85 per cent of sin tax revenues to the health sector. Funding was increased further with the 2019 Tobacco Tax Law and allocated to the goal of UHC through the 2019 UHC Law. This approach was also successfully applied in the Republic of Korea to extend NHI coverage for workers not otherwise covered, through contribution subsidies funded by tobacco taxes.

Countries vary in the way they allocate revenue raised from tobacco and other health taxes. Most allocate a set percentage of the tax to health, such as Mongolia (2 per cent), Republic of Korea (54 per cent) and the Philippines (85 per cent in 2012). Thailand and Viet Nam charge a surcharge on top of the excise tax value, which is earmarked in Thailand to fund the Thai Health Promotion Foundation and in Viet Nam for tobacco control activities (Law on Tobacco Control).

Health taxes hold potential for generating a diversified source of revenue for health and SHP in particular. It remains a financing source that holds untapped potential in the region since excise taxes on tobacco in many countries in the Asia and the Pacific region remain below the level of 75 per cent recommended by the WHO Framework Convention on Tobacco Control (WHO 2015a). However, it is important to consider them within the overall taxation system to ensure fiscal justice and financial sustainability:

- First, health taxes are an interesting tool in their double function. They generate revenues, but first and foremost have a public health purpose related to behaviour change. This means that when the expected behaviour change will occur, the revenues from those taxes will decrease over time, unless tax rates increase. For example, after the 'sin taxes' on tobacco were introduced in the Philippines in 2012, smoking rates reduced by 25 per cent. As consumption dropped, so did tax revenues and subsequently the tax rate was raised again and overall revenues continued to increase (Mendoza 2020). For this reason, they are best used as part of a broader financing mix.

- Second, health taxes need to be designed carefully to secure their alignment with the principles of solidarity in financing and equity. Indeed, since tobacco, alcohol and poor quality foods are often consumed by low- and middle-income households and represent a larger share of their consumption basket than for high-income earners, heavily taxing such products can be viewed as regressive. It is crucial to ensure that the scope and level of those taxes does not place an inequitable burden on lower-income households or reinforce tax systems already based almost exclusively on consumption taxes targeted at households, which tend to be regressive.

Other countries have put in place earmarked resources through dedicated funding streams or shares of specific tax revenues. In Malaysia, the MySalam scheme – which provides sickness cash benefits in case of hospitalization or critical illness for the population in the lowest income quintile, is supported by a trust fund donated as seed money from a private holding company. Fiji has also used a trust fund created based on revenues from a levy, which is utilized to incentivize general practitioners in underserved communities.

## Efficiency gains

### Strategies towards efficiency

When public funds for SHP are limited and coverage is incomplete, another essential strategy is to increase efficiency to get greater value for money. Evidence suggests that a significant share of health spending could be spent more efficiently. In OECD countries, up to one-fifth of health spending could be better used (OECD 2017). This commonly materializes in practices such as unnecessary admissions or C-Sections, treatment of simple diseases at tertiary hospitals when they could be addressed at primary level or unnecessary drug prescriptions. Therefore, there is potential for greater access to effective services within the existing envelope allocated to SHP.

More strategic purchasing, including shifting from line-item budgets or fee-for-service towards prospective payment mechanisms, and efficient procurement of pharmaceuticals also bear potential to generate greater value for money. Thailand's success in extending coverage to the entire population with its UCS was feasible because measures were in place to ensure that the funds would be used effectively. This included DRG (Diagnosis-related group) and capitation payments as well as health technology assessmentand price negotiation measures. Such efforts kept prices down and avoided introducing excessively expensive technologies into the service package. This further benefited the contributory scheme under SSO (Social Security office), which adopted similar practices.

Reducing fragmentation and duplication of SHP schemes and aligning coverage parameters can also help to achieve greater efficiency. The modernization of administration through business process streamlining also contributes to lower administrative costs. Sri Lanka's public delivery system is highly cost efficient in global comparison. This has been achieved through an organizational and management structure that has: i) used managerial methods to drive and incentivize cost efficiency, ii) kept government health workers' salaries relatively low, with doctors' wages kept below market rates by allowing them rights to private practice, iii) used global tender and centralized procurement of drugs to maintain very low unit costs for supplies and iv) used global budgets at national and facility levels to restrain cost growth. The managerial approach depends on intensive and constant supervision and accountability of managers at all levels, considerable peer learning, professionalization of medical management, and extensive de facto managerial autonomy granted to institutional managers, which belies a de jure lack of facility autonomy (Dalpatadu et al. 2016).

Efficiency gains are all the more needed that over time health spending continues to increase (Cichon et al. 1999). Globally, increased demand for care is led by multiple factors. These include the constant development over the past decades of medical knowledge and health technologies. To ensure only effective interventions are included in SHP benefit packages, it is important that countries develop and use health care technology assessments. Other factors drive health spending. Notably, demographic trends – starting with population growth and ageing, play a role. Similarly, the changing burden of diseases related to demography, economics and changing life-styles is a key factor. The latter is increasingly associated with high-fat and sugar diets resulting in obesity and increases in non-communicable chronic diseases, such as cardiovascular disease, some cancers and respiratory illnesses.

### The economic case for health promotion and disease prevention

Health promotion empowers people to improve and increase control over their health, through population-based activities that usually focus on addressing behavioural risk factors, such as diet and physical inactivity, mental health, injury prevention and sexual health. Disease prevention helps detect or prevent serious diseases and medical problems, hence lessen chances they appear or become serious. It includes population-based and individual-based interventions such as immunization programmes, nutritional and food supplementation, evidence-based screening programmes for early detection of disease. Collectively, health promotion and disease prevention aim to protect, promote and maintain health and well-being and to reduce the risk of diseases, disabilities and death. They contribute to address social determinants and health inequity.

Not only do these interventions contribute to the achievement of the right to health and have a strong legitimacy from a human perspective, there is also an economic case for action. Keeping people healthy and minimizing the burden of diseases helps to keep the cost of care low, but also lower overall economic costs resulting from a lack of intervention. For instance, WHO-UNDP research shows that one million people die of tobacco-related diseases in China every year and that smoking-related diseases are on-track to kill another 200 million lives in China in this century, and will result in decreased economic productivity and will push tens of millions of people into poverty (WHO 2017).

Multiple strong evidence of the cost-effectiveness of prevention exist for tobacco and alcohol control, quality of people's diets, promotion of physical activities, particularly when targeting the adult population and individuals at higher risk, prevention of traffic accidents or tackling environmental chemical hazards. A combination of interventions is likely to generate additional health benefits, while still remaining cost-effective (WHO 2015b).

A combination of measures involving fiscal policies, regulation and improved access to information on health are needed and should be part of a broader strategy to create fiscal space.

## External financing

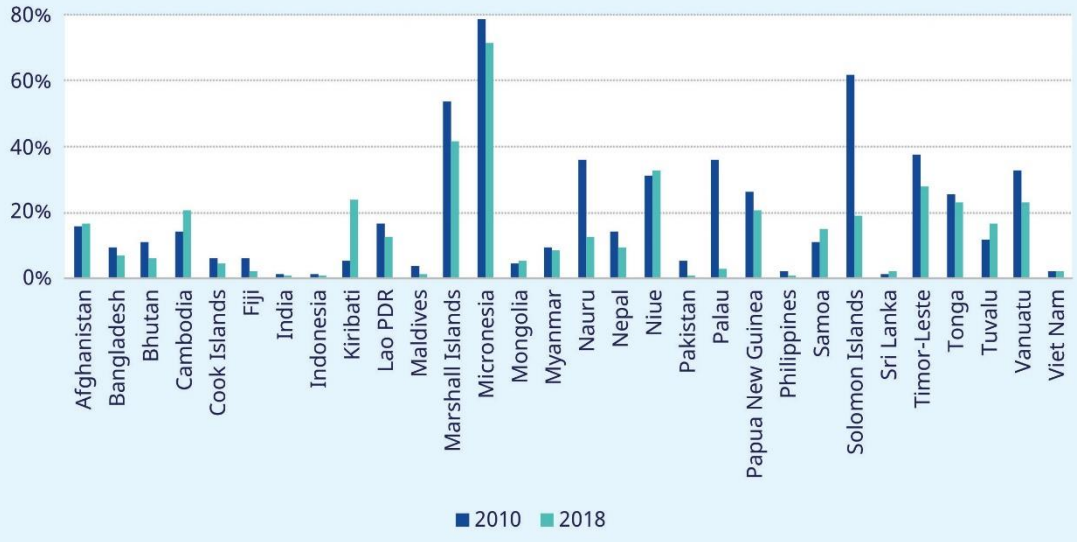
External funding has played an important role in financing population-based health programmes, such as vertical disease control programmes and immunizations over the past decades, especially in

low-income countries. In particular, it has played a crucial role in containing infectious diseases through timely delivery of much needed prevention, detection and treatment free of charge to the patient. Vertical funding mechanisms also allowed, via pooled mechanisms for purchasing at global level, a lower cost of expensive drugs and devices for low- and middle-income countries, therefore improving health spending efficiency. However, such funding is reliant on changing international priorities. Therefore, is not considered a sustainable form of financing, but rather an opportunity to support countries temporarily as they progressively mobilize the necessary resources to finance such programmes with their own resources. A number of countries have transitioned out of external aid dependency in the last decades and their experiences may provide helpful lessons for other countries.

Challenges in the transition process include pervasive gaps in accessibility of services for specific diseases that were previously vertically funded, and risk of leaving large groups of vulnerable individuals previously dependent on external funding uncovered. The transition may be particularly challenging for key populations living with HIV/AIDs, who often experience multi-dimensional deprivations and even criminalization, and for whom highly specialized and sensitized vertical programmes have managed to ensure outreach and effectiveness. Integration of these groups into mainstream SHP may require active efforts of inclusiveness and outreach from government-led institutions and will most likely involve partnering with community-based organizations closest to them (ILO, forthcoming).

External funding as a share of CHE has been declining in most countries in the Asia and the Pacific region (Figure 7). Nevertheless, it still contributes a high share of CHE in most middle-income Pacific Island countries, and remains above 10 per cent of CHE in Afghanistan, Cambodia, Lao PDR and Timor-Leste. The latter two are heavily dependent on external assistance for vertical disease programmes. Several countries in the region have been able to transition away from donor dependence for vertical disease control programmes by incorporating such diseases (HIV, TB) into the SHP package (Indonesia, the Philippines, Thailand and Viet Nam). In Lao PDR, careful planning and gradual integration of these programmes into the overall SHP architecture will allow it to adjust to the donor transition, using savings from eliminating parallel administrative structures to boost the resources available for service delivery.

**Figure 7. Trends in external health expenditure as percentage of CHE, countriesand territories in Asia and the Pacific for which data is available, 2010 and 2018**




Source: Adapted from WHO Global Health Expenditure Database.

In Timor-Leste, the transition will be more challenging due to the limited domestic revenue raising with large amounts of resources to cover the gaps when donors withdraw.

In Cambodia, external assistance is integrated with government funds and used to purchase health services for poor and vulnerable groups through a unique Health Equity and Quality Improvement Programme (H-EQIP) (see Box 2). Bangladesh has been using a "Sector Wide Approach" (SWAp) to reduce its dependence on external assistance through a pooled funding mechanism from multiple international donors, with contributions made directly into a government account at the central bank and subsequently distributed by the government to implementing agencies through regular budgetary channels. The funding mechanism has been noted to reduce duplication and bring greater control over funds to the government.

**Box 2. Cambodia's pooling of external assistance and government counterpartfunds (H-EQIP)**

The Health Equity and Quality Improvement Programme (H-EQIP) is a five-year (May 2016–June 2021) US$180.2 million pooled funding arrangement between selected development partners and the Cambodian Government (US$94.2 million counterpart funding) (World Bank 2018). The programme aims to improve access to quality health services for targeted population groups through use of a nationwide performance-based financing programme to enhance quality. It also seeks to improve financial protection against (further) impoverishment due to out-of-pocket health expenditure by financially and technically supporting the Health Equity Fund and associated structures. They were established to provide free access to health care for the poorest, reimbursing public health providers the user fees for eligible poor people.

Social health protection programmes can count on some earmarked resources from domestic and, sometimes, external sources in most countries in the region. Countries can also make efforts to improve the efficiency of their spending. Still, a balanced financing mix will require some revenues to be allocated from the general government budget and therefore will require looking at increasing fiscal space more broadly.

## Raising unearmarked revenues through tax base expansion and securing the prioritization of health

### Widening the tax base through formalization

Many low- and middle-income countries in the Asia and the Pacific region have high rates of informal employment, reaching more than 80 per cent in countries like Bangladesh, Cambodia, India, Indonesia, Lao PDR, Nepal and Pakistan. In such countries, mobilizing funding through social security contributions can be challenging. At the same time, raising funds through taxation is also difficult, as the size of the informal economy largely influences the tax base for progressive taxation measures on individual and corporate income. Hence, the same countries that have high rates ofinformal employment also tend have limited ability to mobilize public resources through taxation.

Supporting the formalization of the economy is a necessity to ensure decent work for all and equity, but also a prerequisite to broaden taxes on profits and income (see Box 3). ILO recommendation 204 on the Transition from the Informal to the Formal Economy outlines strategies and policies countries can develop to support this path. Formalization of the economy is a long-term process requiring a complex mix of well-coordinated interventions. Assessment and diagnostics of factors, characteristic causes and circumstances of informality form the basis of developing and implementing a legislative and regulatory

framework to address informality, based of tripartite consultations. This must be accompanied by the formulation and implementation of national employment policies promoting decent, productive jobs. A combination of preventive measures and incentives for compliance, law enforcement and effective sanctions, to address tax evasion and avoidance of social security contributions, labour laws and regulations is necessary to facilitate the effective and timely transition from the informal to the formal economy. Such administrative measures are explored in Chapter 3 of "Extending social health protection: Accelerating progress towards Universal Health Coverage in Asia and the Pacific".

**Box 3. Importance of collective financing and plurality of financing sources to guarantee SHP for all, in the context of the Future of Work**

In recent years, the world of work has undergone dramatic changes due to technological advances, urbanization, migration and climate change, which have been accelerated by the COVID-19 pandemic. Although technological advances and new opportunities for environmentally-friendly industries are creating new jobs, many of those who lose employment lack the necessary skills to get new jobs in these growing industries. Many of these new job opportunities consist of forms of self-employment lacking access to social protection. These trends impede the formalization of employment to ensure decent work conditions, which include social protection, not only in lower-income economies with a large informal economy, but also in high-income economies where the gig/platform economy is growing. Large populations of young people in some countries and aging populations in others create tensions in labour markets and social protection systems. Recognizing these challenges and unfinished development agendas, international actors/entities have begun imagining a new and improved future for the world of work that not only responds to the inevitable changes in the labour market, but also strives to improve the quality of working lives, leaving no one behind.

The future of work agenda includes increasing investment in people's capabilities, with USP, from birth to old age being one of its key components. The ILO Centenary Declaration for the Future of Work adopted in 2019 declared that Member States must direct efforts to develop and enhance social protection systems, which are adequate, sustainable and adapted to the developments in the world of work, protecting workers and taking into account the need to create sustainable enterprises (ILO 2019). The large size and even growth of the informal economy, including digital platform work, leaves large shares of the population with inadequate coverage to protect themselves from life contingencies. In this context, ILO promotes mechanisms reliant on collective solidarity-based financing and a plurality of financing sources to secure their sustainability.

## Introducing other taxes

The introduction of taxes on sectors not previously taxed can provide additional revenues to finance SHP, or social investments as a whole.

More countries are considering introducing financial sector tax schemes, including financial transaction taxes, defined as "a small tax levied on various types of financial instruments such as shares, bonds, foreign currency transactions, derivatives (futures, forwards, swaps and options), and bank debits and credits, and other types of banking services" (Ortiz, Cummins, and Karunaneth 2015). Countries in Asia and the Pacificare no exception, with examples including the Securities Transaction Tax in India and Republic of Korea, stamp duty in China, Malaysia, Singapore and Thailand and a transfer tax in the Philippines (Dowd 2020). The potential for raising resources from the financial sector remains largely untapped in the majority of countries in the Asia and the Pacific region.

Property taxes are common place in OECD countries, but represent a small share of GDP in most developing countries. They offer a stable source of income, are difficult to evade and do not penalize the poorest, as the property tax burden usually falls on middle- or high-income households. In Asia, property taxations have been introduced in countries such as Cambodia, China, Singapore and Viet Nam (Ortiz et al. 2019).

Taxation on natural resources and extractive industries channelled to social spending offers additional revenue streams. Brunei Darussalam and Timor-Leste currently rely mainly on oil and gas revenues to fully subsidize their health services. Such revenues may be volatile (reliant on global market price fluctuations) or erode over time (based on non-renewable natural resources) and need to be complemented by more stable sources.

Other innovative taxes on sectors not previously taxed include environment protection taxes and lottery taxes. Viet Nam introduced the first in 2011 and the second in 2017, the year following the removal of the Business Licence Tax. Based on calculations from the State budget in 2019, both respectively represented 6 and 3 per cent of total direct and indirect taxes (Viet Nam Ministry of Finance 2019).

### Tackling corruption, tax evasion and illicit financial flows through international and regional collaboration

Reducing tax evasion and combatting illicit transactions are among strategies that have recently gained renewed attention, given the importance and tremendous potential to expand the tax base if addressed. In addition to mechanisms countries can put in place to facilitate compliance with tax payment at national level, international and regional collaboration is needed. Through the 2015 Addis AbabaAction Agenda, countries committed to implement measures to combat corruption, tax evasion and illicit financial flows, including money laundering through strengthened national regulations and increasedinternational cooperation (UN 2015). It emphasizes the importance of inclusive cooperation and dialogue among national tax authorities.

In Asia, the Study Group on Asian Tax Administration and Research (SGATAR) aims to provide "a platform to enhance the performance of tax administrations in the Asia-Pacific region by promoting collaboration and communication among member tax administrations" (SGATAR 2021). Other regional cooperation frameworks on taxation in Asia and the Pacific include the ASEAN Forum on Taxation, the Pacific Islands Tax Administrators' Association (PITAA), and the South Asian Association for Regional Cooperation (SAARC).

### A more accommodating macroeconomic framework

Governments can use both fiscal and monetary policies to create and maintain social protection and health sector investments. Fiscal policy comprises government revenues and expenditure as discussed earlier in this section, and monetary policy deals with money supply and interest rates. As noted by Ortiz et al, "with macro-prudential regulations on capital flows and the supporting role of public provision of social goods (health care, education), countries can accommodate moderate inflation and budget deficits. Ultimately, this means that inflation and deficit thresholds are policy choices. Thus, governments have some room for manoeuvre to design monetary and fiscal policies to generate employment and social protection" (Ortiz et al. 2019). In this respect, it is important to note that, several countries in the region had inflation rates below 1 per cent (Samoa, Thailand, Tonga) or negative (Brunei Darussalam, Lao PDR, Timor-Leste) in 2016 (IMF 2017).

In addition to earmarked revenues, the availability of greater resources in general government revenues would make expanding SHP feasible, but still requires prioritization of spending on health.

### Prioritization of the health sector

Increased public resources may not benefit the health sector unless policies give high priority to health and laws are in place. Ensuring that policy-makers prioritize health in public resource allocations is facilitated when legislation stipulates explicit entitlements related to SHP. Indonesia, Lao PDR, the

Philippines, Thailand and Viet Nam have all set concrete UHC goals in laws and regulations, which are then used to justify State budget funding requests (see Box 4). This includes the UHC Law in the Philippines setting concrete goals to expand population and service coverage and increase financial protection. The Health Insurance Law in Viet Nam stipulates that population groups receive government subsidies for their contribution amounts. The Thai Health Security Law since 2003 and the Indonesian Law on the National Social Security System and Law No. 24 on the Social Security Administrative Body, also evidence these governments' commitment to achieve UHC.

### Box 4. Thailand: Reallocating military expenditures for the Universal Coverage Scheme

The 1997–1998 Asian Financial Crisis severely hit the Thai economy and its society. With the backing of the 1997 Constitution, civil society calls to address neglected social policies led the government to adopt the Universal Coverage Scheme in 2001. Given that approximately a third of the population was excluded from health coverage at that time, most of whom belonged to the informal agricultural sector without regular income, achieving universal coverage through contributory schemes alone was not possible, as it needed budget support. Most of the funding for the UCS was financed through reduced spending on defense (from 25 per cent of total expenditures in the 1970s to 15 per cent during the 2000s and to 7.62 per cent in 2015) and lower debt service payments. The government included the UCS as part of a more general fiscal stimulus plan. Other measures increased the amount of money in the hands of people with a high propensity to spend, including the creation of a People's Bank, a debt moratorium for farmers and a village fund.

Source: Adapted from Ortiz, Cummins, and Karunaneth (2015)

# References


Aso, Taro. 2017. "Crucial Role of Finance Ministry in Achieving Universal Health Coverage." *The Lancet* 390 (10111): 2415–17.

Bhageerathy, Reshmi, Sreekumaran Nair, and Unnikrishnan Bhaskaran. 2017. "A Systematic Review of Community-Based Health Insurance Programs in South Asia." *The International Journal of Health Planning and Management* 32 (2): e218–31.

Carrin, Guy. 2003. *Community Based Health Insurance Schemes in Developing Countries: Facts, Problems and Perspectives*. WHO.

Cichon, Michael, William Newbrander, Hiroshi Yamabana, Charles Normand, Axel Weber, David Dror, and Alexander Preker. 1999. *Modelling in Health Care Finance: A Compendium of Quantitative Techniques for Health Care Financing*. ILO.

Dalpatadu. S., P. Perera, R. Wickramasinghe, and R.P. Ranan-Eliya. 2016. *The Sri Lankan Model of Public Hospital Governance: A Case Study*. Asia Pacific Network in Health Systems Strengthening, and Institute for Health Policy.

Dowd, Christopher. 2020. "Financial Transactions Taxes Around the World". *Center for Economic and Policy Research Blog*. Available at: https://cepr.net/report/financial-transactions-taxes-around-the-world/.

ILO (International Labour Organization). 2019. *Work for a Brighter Future*. Global Commission on the Future of Work.

——. Forthcoming. *Making Universal Social Protection a Reality for People Living with, at the Risk of and Affected by HIV or Tuberculosis*.

IMF (International Monetary Fund). 2017. *World Economic Outlook, October 2017: Seeking Sustainable Growth– Short-Term Recovery, Long-Term Challenges*.

Mendoza, Jestine. 2020. "For Universal Healthcare, the Philippines Tries 'Sin Taxes'". *The Asia Foundation Blog*. Available at: https://asiafoundation.org/2020/03/04/for-universal-healthcare-the-philippines-tries-sin-taxes/.

OECD (Organisation for Economic Co-operation and Development). 2017. *Tackling Wasteful Spending on Health: Highlights*.

Ortiz, Isabel, Anis Chowdhury, Fabio Durán Valverde, Taneem Muzaffar, and Stefan Urban. 2019. *Fiscal Space for Social Protection: A Handbook for Assessing Financing Options*. ILO.

Ortiz, Isabel, Matthew Cummins, and K. Karunaneth. 2015. "Fiscal Space for Social Protection and the SDGs: Options to Expand Social Investments in 187 countries", Extension of Social Security Working Paper No. 48. ILO.

Pettigrew, Luisa M., and Inke Mathauer. 2016. "Voluntary Health Insurance Expenditure in Low-and Middle-Income Countries: Exploring Trends during 1995–2012 and Policy Implications for Progress towards Universal Health Coverage." *International Journal for Equity in Health* 15 (1): 1–19.

Savedoff, William. 2003. *How Much Should Countries Spend on Health?* Discussion Paper No. 2. WHO.

SGATAR. (Study Group on Asian Tax Administration and Research). 2021. "Mission and objectives", available at: https://sgatar.org/public/about/mission-objectives/.

Viet Nam Ministry of Finance. 2019. "NGÂN SÁCH NHÀ NƯỚC: Quyết Toán Ngân Sách Nhà Nước Năm 2019", available at: https://ckns.mof.gov.vn/SitePages/home.aspx.

WHO (World Health Organization). 2015a. *Promoting Health, Preventing Disease: The Economic Case*. The European Observatory on Health Systems and Policies Series.

——. 2015b. *WHO Report on the Global Tobacco Epidemic*, 2015: Raising Taxes on Tobacco.

——. 2017. *The Bill China Cannot Afford: Health, Economic and Social Costs of China's Tobacco Epidemic*. WHO Regional Office for the Western Pacific.

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