Importance of both Demand and Supply Side for UHC

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Soonman KWON, Ph.D.

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

GOAL of UHC:

Minimize financial (and non-financial) barriers to access <u>quality</u> health care and maximize the role of public pre-paid financing such as tax and NHI

Demand-side financing and **purchasing** can and should provide strong <u>incentives</u> for health care providers to improve performance and quality of health care (money follows the patient)

For effective incentives through purchasing, we need
- Governance PFM reform of public providers
- Selective contracting based on quality of care/performance

<u>Incentives</u> by demand-side financing are not enough
- Need government <u>investment</u> in infrastructure, workforce, and medicines, and <u>regulation</u> of (private) providers
- Implementation challenges in selective contracting
   e.g., rural areas, public providers
- Lessons from COVID-19 pandemic: role of public providers

What happens when Supply-side reforms do not work?

When people do not trust quality of care in HWC

- By-pass of HWC, resulting in excessive hospitalization
- Use private PHC providers, resulting in financial burden

When people do not trust quality of care in public hospitals/providers

- Use more and more private providers
- Potential demand inducement by private providers and increased financial burden on patients

Need to strengthen the capacity of public providers for healthy competition among public and private providers

What happens when Supply-side reforms do not work? (continued)

Challenges of <u>mandatory</u> contribution (insurance) in low- and middles-income countries (LMICs)

- Political difficulty in enforcement

- People do not want to pay premium if they are not satisfied with the quality of health care

- Very difficult to implement mandatory enrollment when quality of care is poor

Need pull-in strategy: making health insurance attractive, helping people more <u>willing</u> to pay premium, by ensuring high quality of care (supply-side readiness)

-> Virtuous circle vs. vicious circle