Health Financing for UHC

ADB INSPIRE
7 July, 2025

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I. Context

GOAL: Minimize financial (and non-financial) barriers to access quality health care and maximize the role of public pre-paid financing such as tax and NHI (Social Health insurance or mandatory health insurance)

Evidence in LMICs: Huge OOP expenditure results in

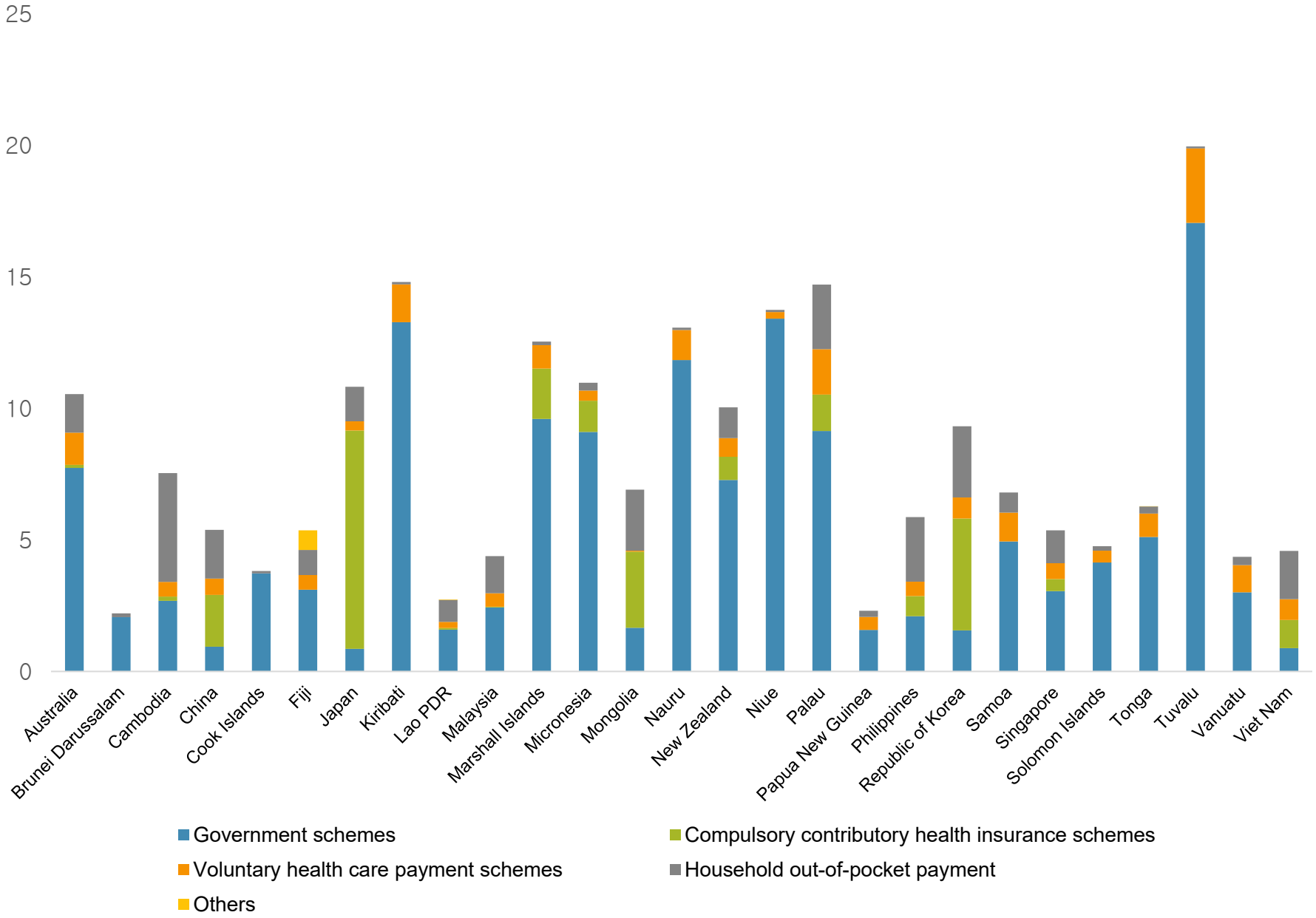
- Catastrophic payment for health care
- Impoverishment due to illness
- Unmet need for health care (Foregone care)

Why catastrophic pay or impoverishment happens?

- Low population coverage of public financing
- Limited benefits/cost coverage of public financing
- Quality: low (perceived or real) quality of public providers

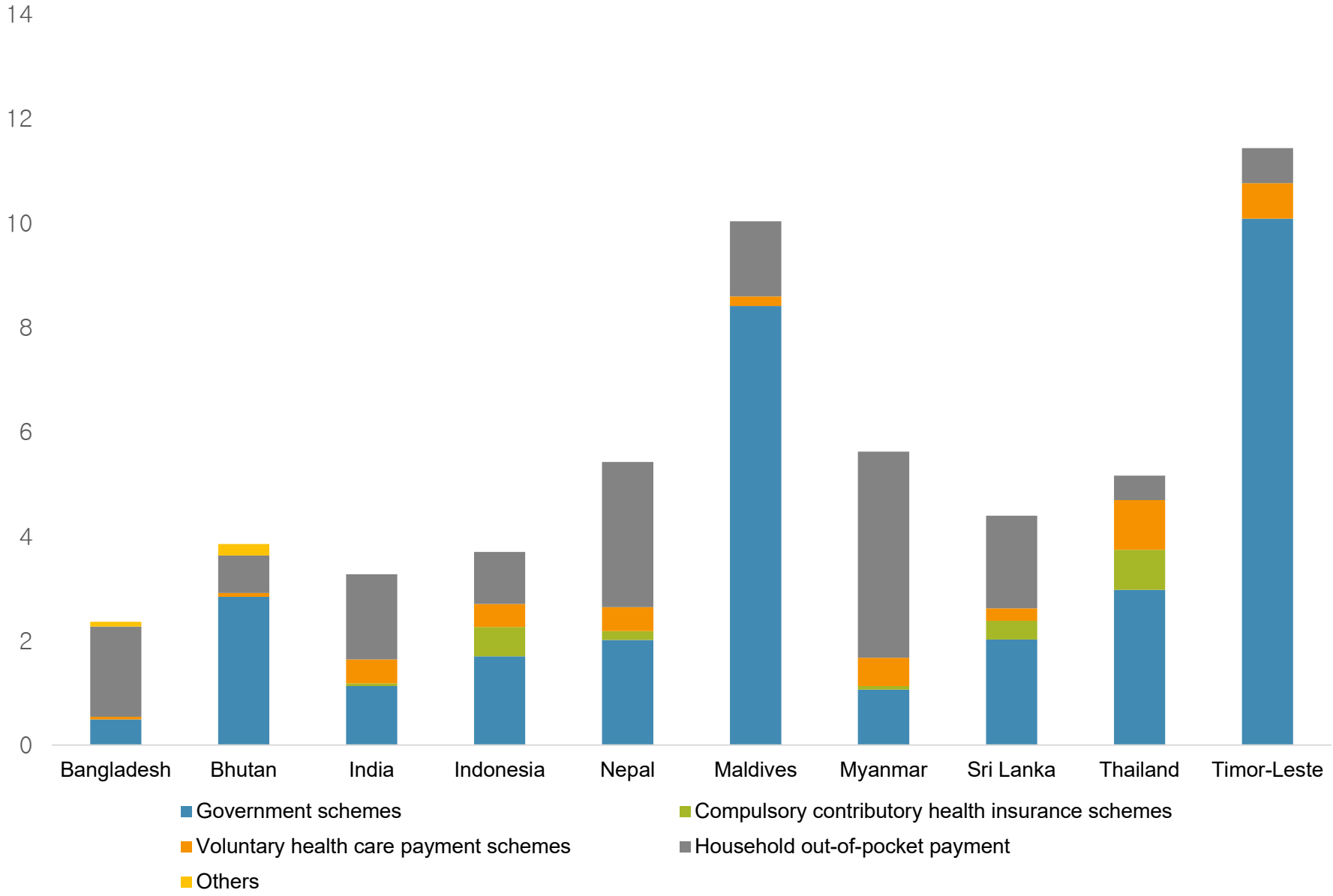
-> Use private providers, demand inducement

Health Exp (% GDP), WPRO countries, 2021



WHO. Global Health Expenditure Database. Accessed on 9 January 2024

Health Exp (% GDP), SEARO countries, 2021



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2. How to Raise Financial Resources?

Public source of financing for UHC:

Putting various sources of revenue in a big **pool** for effective **purchasing** of health care

- Contribution (from both employees and the self employed): Japan, Korea, Taiwan

- Add Earmarked consumption tax (Ghana), earmarked non-wage income tax (France, Korea)

- General revenue: UCS of Thailand, PM-JAY of India

Sehat Card of Pakistan, Health Equity Fund in Cambodia: Fully-subsidized scheme for the poor/vulnerable (demand-side financing/purchasing with tax funding)

3. How to Ensure more People have Access to Public Financing/Insurance?

Premium contribution of the informal sector is a big challenge in the NHI: Missing Middle

- Boundary between the informal sector and the poor is not clear in many LICs
- High cost of premium collection, adverse selection in voluntary enrollment
- Funds from the premium of the informal sector is usually small: many NHI systems charge lump-sum premium for the informal sector
- E.g., Indonesia, Ghana: bands for contributions, self declaration, effective?

-> Need government **SUBSIDY or budget financing** (financial commitment) for the informal sector

4. How to Pool Resources?

Single Pool

- **Efficiency**: Higher capacity for risk pooling, Lower administrative costs, Greater bargaining power of the purchaser relative to providers

- **Equity**: Larger scale cross-subsidy from the better-off to the poor, Same benefits coverage for all

e.g., Indonesia, Philippines, Korea

Context matters: Equity in service delivery and utilization? e.g., Vietnam, Indonesia

5. Purchasing: Benefits Package and Provider Payment

(Strategic) purchaser or insurance agency can strengthen service delivery and improve health system performance

- For effective purchasing, public providers should be given fiscal autonomy: Optimal degree of autonomy?

Who should be the purchaser?

- Separation of purchasing and provision
- Ideal model: Independent agency specializing in purchasing with close coordination with MoH
- Politics, Context?

1) Which Services to Offer?: Benefit Coverage

Purchase continuum of care

- Need good referrals, quality primary care

e.g., concerns in inpatient-based insurance in India, Pakistan

- Access to medicines, EML

Cannot cover every health care service

- Need **priority** setting, How?
- Benefits are still loosely defined, and the process to determine benefits package is not transparent in most LICs

Institutionalize a **formal transparent process** based on

- **Evidence**: economic evaluation, cost effectiveness
- Social **value judgement**: citizen participation, high-level committees, ethics and equity in decisions

2) Provider Payment System

How to motivate providers to provide health care in a cost-effective way?

How to pay

- Move away from fee-for-service toward bigger units of payment

e.g., capitation, case-based payment (e.g., DRG: Diagnosis-related Group)

e.g., P4P: vaccination, screening, NCD management

How much to pay

- Costing vs. Pricing: Costing as 'art' rather than 'science', Pricing based on cost and negotiation
- Differential or same payment to public and private providers?

6. Governance

How to ensure the **performance and accountability** of health financing (with clearly defined roles and responsibility)?

- Relation between government ministry and financing agency: optimum autonomy?

Conflicts and coordination among government ministries

- MoF, MoH, MoL, Social Security Agency (e.g., Vietnam)

Local/state governments: decentralization, coordination

- Equity, efficiency, technical/funding capacity, responsiveness to local needs

FUTURE: Population **Ageing**

- **UHCC (Universal Health and Care Coverage)**