

Health care financing in the Asia Pacific region

Dan Whitaker, Veronica Walford and Ben David

July 2013

The Asia Pacific region is in a period of transition as some economies grow, populations age, and health care needs change. Meanwhile substantial numbers of people live in poverty in middle-income countries.

This paper provides an overview of the challenges of financing health care in the region, where many countries are striving to achieve universal health coverage. It examines the contributions of the public and private sectors, and considers the future of external development aid. The paper concludes with reflections on the implications for development partners, discussing how policy issues can be tackled, how aid modalities should develop and where donor assistance should be focused to maximise impact.

The findings were presented at the 9th World Congress of the International Health Economics Association (iHEA), Sidney, 7-10 July 2013.



Summary

Socioeconomic, demographic and epidemiological change taking place in the Asia Pacific region is set to drive large-scale changes to most countries' health systems.

In many, especially larger countries, the fiscal space provided by growth is supported by a demographic 'window of opportunity' as the proportion of the population of working age increases, which should enable moves towards universal health coverage (UHC). However, achieving UHC is challenging because of high levels of informal employment and large numbers of people living in poverty, both of which limit the amount of funding which can be raised from the population. At the same time, the rise in non-communicable diseases (NCDs) and growing cost of health care mean that funding needs will rise substantially.

As health spending rises faster than GDP, reforming countries are using both tax-funding and social health insurance to extend both coverage and benefit packages, with the public share of spending on health increasing in most larger countries. The majority of health care in the region is still funded privately, mainly on an out-of-pocket basis. Social health insurance and other reforms have been shown to be effective in reducing the share of spending that is out-of pocket.

External development aid for health has grown substantially over the last decade but projections suggest that it is likely to plateau for the next two/three years. Large discrepancies between donor commitments and disbursements make it hard for countries (and other donors) to plan. There are also important inequalities between aid-receiving countries at similar levels of per capita income and overall disease burden. Further, the allocation of aid does not reflect the changing burden of disease, with large (and growing) allocations over the last decade to communicable diseases.

As their per capita incomes rise, more of the countries in the region will grow out of eligibility for funding from some key health donors (such as the Global Fund) whose programmes are not designed to target the poor within middle-income countries. Non-traditional donors are of growing importance, but there is limited information on the scale and use of their aid to health.

In this evolving situation, **what are the implications for donors?** Suggestions include:

- As countries become increasingly able to finance their own health services and systems, and especially where health aid is small, donors may want to increase their focus on **technical support** rather than financial aid. This would aim to help countries respond to the combination changes facing them, and develop sustainable health financing and provision with improving equity. Donors need to consider how to ensure the technical assistance (TA) they provide is relevant and applicable, as well as internal capacity to engage in health policy dialogue with partner countries. There may need to be exceptions to this TA focus, including in small island and fragile states, and where governments are unwilling or unable to address the needs of particular vulnerable groups.
- There is already significant experience within the region, as countries are at different stages in their economic and demographic transitions and their health reforms. Expanding support for regional **lesson learning** could be useful to ensure that this experience is shared.
- Donors and partners may want to reconsider their **aid allocation** and how far they are targeting poor countries versus poor people (most of whom are in middle income countries), and the allocation of aid between diseases and target groups. It will be particularly important to consider how to support the response to NCDs, while recognising the continuing burden of communicable disease and scope to improve maternal health.
- The changing set of donors in the region need to develop **effective partnerships and coordination mechanisms**. Some coordination and identification of comparative advantages can take place at regional level, while country-level partnerships, and in some cases province-level interaction will be critical to maximise impact.
- In the transition to lower aid dependency and changing donor roles it will be important to overhaul the form and content of aid provision, as well as to build in **flexibility**. Contingency planning for the region will be prudent, whether related to changes in the economy or epidemiology, or in anticipation of natural disasters.

1. Introduction

The Asia Pacific region is experiencing rapid economic, demographic and epidemiological change. This study considers these trends and the implications for health care financing and for the role of external donors in the region. It is intended to generate discussion among partners working in health in the region and may contribute to their future engagement in the sector. The study is based on a desk review of published data and evidence, supplemented by interviews with selected key informants.

The study covers thirty countries with per capita GDP below US\$8,000 within two WHO regions: South-East Asia (SEARO) and Western Pacific (WPRO).¹ Although the countries in Asia and the Pacific are extremely diverse, they can be broadly divided into four categories: middle income countries (MICs); low income countries (LICs); fragile states; and small island states (SIS).²

While we understand that countries may exhibit more than one of these characteristics (such as middle income and a fragile state, e.g. Papua New Guinea (PNG) and Timor Leste) this framework is useful in exploring key differences in the health sector between the countries of the region. Table 1 sets out the countries included by category. For reasons of space, one focus country has been selected from each category (in bold in Table 1) as having typical key indicators of the group. Table 2 gives basic data for the focus countries and the average for the categories that they represent.

Table 1 Countries included in this review, by category

MICs	LICs	Fragile States	Small Island States
China, Mongolia Philippines, Vietnam Bhutan, India Indonesia , Maldives Sri Lanka, Thailand	Cambodia , Laos Bangladesh, DPR Korea Myanmar, Nepal	Papua New Guinea Timor-Leste	Cook Islands, Fiji Kiribati, Marshall Islands Micronesia, Nauru Niue, Samoa Solomon Islands, Tonga Tuvalu, Vanuatu

Table 2 Basic relevant country data for focus countries and average for each category

	GDP/capita, \$ 2011	Health spend/capita, \$, 2011	Life expectancy, years	Population age structure % <15 /% > 60	Death rate/ 100,000, 2010
Indonesia (MIC)	3,495	95	70	27 / 8	654
MICs average	3,378	172	72	32 / 6	614
Cambodia (LIC)	897	51	63	32 / 6	607
LICs average	1,113	47	68	31 / 8	705
PNG (Fragile state)	1,845	79	64	39 / 5	949
Fragile states ³ average	1,371	63	64	43 / 5	743
Fiji (SIS)	4,397	168	70	29 / 8	749
SIS average	3,098	509	71	34 / 7	700
All countries in study	2,633	272	67	29 / 7	646

Note: category averages are equally weighted per country, not population-weighted.

¹ Three island states were excluded due to lack of data: American Samoa; Northern Mariana Islands; and Wallis and Futuna. Five more were excluded due to lack of sovereign status: French Polynesia; Guam; New Caledonia; Pitcairn Islands; and Tokelau.

² A more common developmental approach is to concentrate only on the poorest countries of a region. However, recent data confirms the extent to which the poor are not only in poor countries. Sumner (2012) estimates that 60% of the world's poor are in MICs, 18% in fragile states and only 7% in stable LICs (Sumner A., 2012. Where do the world's poor live? A new update. Institute of Development Studies Working Paper 393).

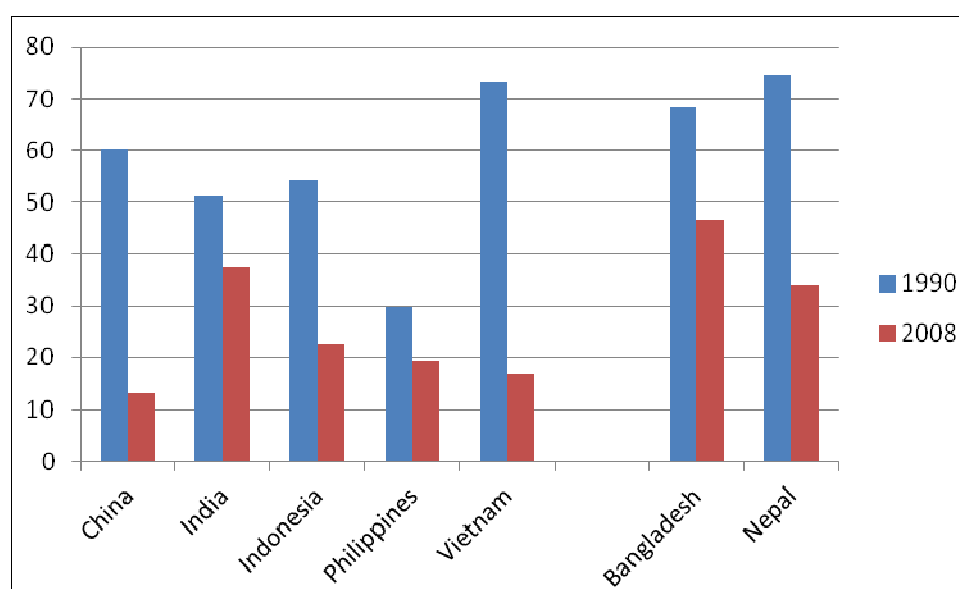
³ Note: many different definitions of 'fragile' exist. Sumner examined six leading lists, and found that the proportion of the poor in fragile states could vary between 6% and 40%, with his analysis concluding 38%, of which 18% were in LICs. Sumner (2012) cit., p9.

2. Trends in the region and implications for health financing

2.1 Socioeconomic context of the region

Overall, the Asia Pacific region has enjoyed substantial **economic growth** over recent decades. This is visible in both the MICs and most of the LICs, and is expected to continue in these countries, although the possibility of a regional economic downturn cannot be discounted. This has contributed to dramatic declines in the proportion of the population living in poverty (see Figure 1). In China alone, over 500 million people were lifted out of poverty between 1990 and 2008.⁴ But GDP per capita has stagnated for much of this period in several countries in the other two categories, for example, PNG, Fiji and the Solomon Islands.⁵

Figure 1 Poverty reduction: Share of population living on less than \$1.25/day (inflation-adjusted)



Source: based on data from Sumner (2012)

There are still significant numbers living in poverty in even the most successful Asia Pacific countries. For example in Indonesia, while average per capita GDP has grown rapidly to \$3,495 in 2011, there are still an estimated 124 million people living on less than \$2 a day. Marginalised populations, whose inequality may have a social or geographical aspect, are an important source of health need.

Where economies have flourished, this has provided the **fiscal space** for the rollout of social health insurance (SHI) and moves towards universal health coverage (see section 3). However, the scope to introduce social security and tax-based reform is made more difficult by a large share of the population working in **informal employment**. A large proportion of these are non-poor. For example 64% of Indonesians are non-poor but work outside of the formal economy; as are 49% of Cambodians.⁶

Fragile and Small Island States that have not grown as rapidly, and where public expenditure has grown more slowly, continue to depend on aid to expand health care. Some Islands have experienced significant political instability, including Fiji, worsening their economic prospects.

⁴ Measured at \$1.25/day. Sumner, A (2012) cit.

⁵ UNDP Human Development Indicators GDP per capita (2005 PPP \$).

⁶ Lagomarsino, A et al. (2012) Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia. *Lancet* 380: 933–43.

2.2 Health challenges: demographic developments

A **demographic transition** is a key feature of the Asia Pacific region, happening faster than in any other world region. The numbers involved are significant, with the population having doubled since 1970 and now representing 45% of the world total.⁷ Yet during that period, the annual population growth rate has halved. Again there is regional divergence, with the fastest decline in South-East and East Asia and the least in South Asia and the Pacific Islands.

Meanwhile, mortality has declined throughout, with life expectancy generally now around fifteen years higher than in 1970,⁸ leading to rapid growth in the number of elderly. At the other end of the age spectrum, as countries urbanise and expand education, fewer babies are being born to each woman.⁹ This is forecast to lead to eventual population decline. The magnitude and timing of this decline however varies by country (see Table 3).

Table 3 Countries expecting a decline in total and young adult populations by 2030

Years	Expected start of fall in total population	Expected start of fall in age 15-34 population
2010-20	[only high income countries, e.g. Japan, South Korea]	Sri Lanka, Thailand, Mongolia, China, Myanmar, Vietnam, Bhutan
2020-30	China, Sri Lanka, Thailand, DPR Korea	Maldives, Samoa, Fiji, Indonesia

Source: analysis in Hugo (2008)

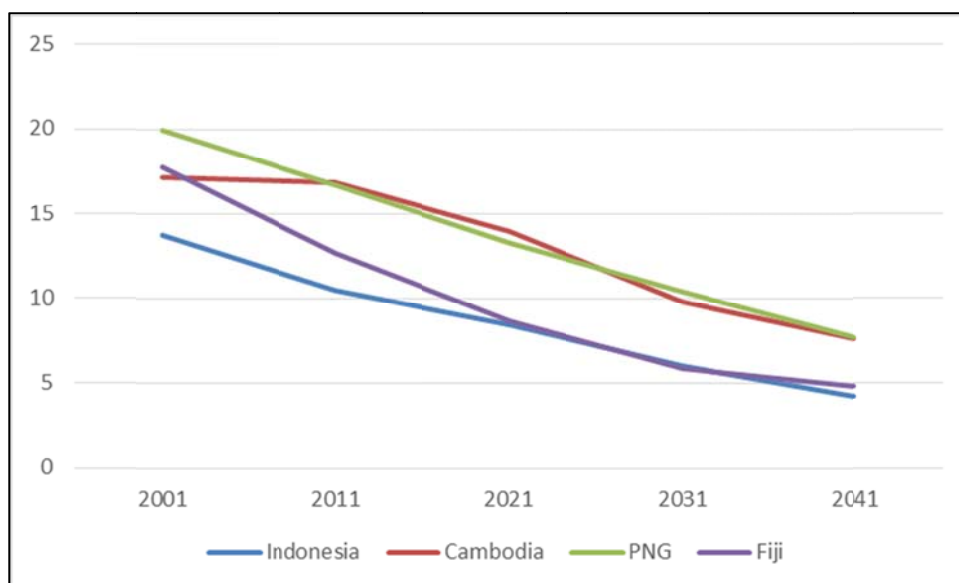
As a 'youth bulge' of the last high fertility generation passes up through the age pyramid, this demographic transition offers countries a **window of opportunity**, with a large working age population supporting a smaller dependent population of children and elderly people. Reform is relatively easy at this stage, as the workers' taxes or social security contributions can finance a major expansion of health care coverage. A few decades later, dependency rises, as a shrunken number of workers must support a growing elderly population. Expanding coverage of health care during this time is much more difficult and there may be challenges in maintaining extensive welfare systems without a sufficiently large population of working age. The speed of this 'grey tsunami' may outpace economic growth in some countries – i.e. they will become old before they become rich.

Figure 2 shows the forecast decrease in the working age population relative to the elderly for the four focus countries (Indonesia, Cambodia, PNG and Fiji). It shows that while in 2001 there were around 20 times as many workers as elderly, by 2041 there may be only between four and eight times as many. Indonesia, like most of the MICs, is taking advantage of its 'window' to roll out health coverage and financial protection to the bulk of its population, despite the challenge of high informal employment. Yet slowing population growth, now down to 1%, will make further improvement more difficult over the medium and long term, as fewer workers come on stream. Some MICs' fertility rates are falling faster than Indonesia (e.g. Thailand), others more slowly (e.g. Philippines). The figure shows that Indonesia is closely followed by Fiji in the decline of the ratio of working age citizens to the elderly. Among the Island States the picture varies, with Fiji and Samoa's working age populations expected to be in decline during 2020-30, while PNG, the Solomon Islands and Vanuatu are experiencing delayed transition. Cambodia, like all LICs in the region to various extents, lags demographically behind the MIC profile. Population growth here is closer to 2%, and is forecast still to be positive in 2020-30.

⁷ Hugo, G (2008). Emerging demographic trends in Asia and the Pacific: the implications for international migration. Transatlantic Council on Migration.

⁸ Ibid.

⁹ Especially fewer girls, as ultrasound scans allow parents to abort based on gender. China's population is expected to be 55% male by 2020.

Figure 2 Ratio of 15-64s to over 65s in focus countries¹⁰

Source: author's calculations using various sources.

In addition to changes in population growth and ageing, the Asia Pacific region is urbanising. Some 900 million more people will live in Asian cities by 2030 compared to 2010, while the rural population is expected to remain constant, so the proportion that is urban will rise to 55% by 2030, (up from less than 45% in 2010).¹¹ Urbanisation has been a key driver of economic growth, and has contributed to lifting millions out of poverty; however total numbers living in slums have increased. This affects the health risks people face, while also affecting their access to education and health services. Urbanisation and rising levels of education and income also serve to raise expectations, especially for specialised care and advanced medical technologies, for what often becomes a politically influential population segment: the urban middle class.

2.3 Burden of disease developments

The evolution of the burden of disease in the Asia Pacific region is much influenced by the socioeconomic and demographic changes described earlier. Health system investments and targeted programme achievements have contributed to reducing the incidence of some infectious diseases. But the overriding trend is an **epidemic rise in chronic non-communicable diseases (NCDs)** that is expected to intensify.

Demographic change acts as a driver for this in two ways. Lower fertility means that there are fewer communicable disease-susceptible infants and children. Higher life expectancy means that there are also more NCD-susceptible citizens. Higher incomes and a more urbanised, educated population further drive this trend as better living conditions reduce communicable disease spread, but behaviours and environments become more conducive to conditions such as heart disease and diabetes. Less exercise, worsening diet and growing obesity is complemented by greater access to tobacco and alcohol. Meanwhile rapid mechanisation and growth in motor transport also produces greater incidence of injuries.

The Millennium Development Goals (MDGs) have provided a welcome emphasis on improving maternal and child health. As shown in Table 4, the child mortality target is on track in East and South East Asia (UN-defined regions¹²). Only East Asia however is predicted to meet the target for reducing maternal deaths (the focus of MDG 5). In South-East Asia, including Indonesia, progress has been weaker. Maternal mortality rates are particularly poor in two LICs (Cambodia and Laos) and in the two

¹⁰ Note: this is not the same as a 'dependency ratio' as it excludes under-15s.

¹¹ Asian Development Bank (2008) Managing Asian cities.

¹² East Asia includes China, DP Korea and Mongolia, together with the developed economies Rep. Korea and Japan. South-East Asia includes Cambodia, Indonesia, Laos, Myanmar, Philippines, Thailand, Timor Leste and Vietnam, together with Brunei, Malaysia and Singapore.

fragile states (PNG and Timor Leste). The poor performance of Oceania (again, a UN-defined region, which includes PNG and Small Island States), which is not predicted to meet MDG 4 and 5 targets is also evident in other key systemic indicators, such as the proportion of children receiving measles vaccine which was 59% in 2010. This is well below the level in Sub-Saharan Africa (75%), as well as South East Asia (91%).

Table 4 Asia-Pacific (UN-designated) regions and MDGs 4 and 5

	Under-5 mortality/1,000 live births, 2010	Annual decline, 2000-2010	On track for 2015 MDG 4 target?	Maternal mortality rate/100,000 live births, 2010	On track for 2015 MDG 5 target?
S Asia	66	2.9%	No	220	No
Oceania	52	1.9%	No	200	No
SE Asia	32	4.1%	Yes	150	No
E Asia	18	5.9%	Yes	37	Yes

Source: UN MDG Report, 2012

Overall, communicable diseases are in retreat across the region. HIV incidence is relatively low, at 0.3% of 15-49 year olds in South and South East Asia and in Oceania in 2011; it is 0.1% in E Asia (compared to over 4.9% in Sub-Saharan Africa).¹³ TB deaths have fallen from 56 per 100,000 in Oceania (where rates are highest in the region) in 1990 to 33 per 100,000 in 2010. In East Asia where rates of TB are lowest, it fell from 20 per 100,000 in 1990 to just 4 per 100,000 in 2010. Malaria is also declining, although the emergence of drug resistance in the Mekong sub-region is of concern. The trend of falling rates of communicable disease however is not being experienced uniformly. HIV incidence for instance rose over 25% in Indonesia between 2001 and 2011, whereas it fell by more than 50% in PNG and Cambodia. There is also the possibility of the arrival of new infectious disease, such as SARS or other zoonoses (animal-borne diseases).

The rise of NCDs is illustrated for the four focus countries in Table 5. It shows that communicable diseases and birth-related complications are declining in importance as causes of premature death over the last 20 years, while deaths from NCDs have increased.

This has led to a situation in which NCDs are already the leading cause of death in Indonesia (64% of deaths) and Fiji (77%), and indeed in all MICs and Island States for which there are data. In Cambodia (where NCD are estimated to cause 46% of deaths), PNG (44%) and other demographically lagging countries, deaths are more evenly balanced between communicable and NCD causes, but with a steady shift towards NCDs. The LICs in particular are currently confronting a double burden of increasing incidence of NCDs and stubborn resilience of some infectious diseases. Overall, the key epidemiological issue remains growing NCD incidence, and the increased prevalence of relevant risk factors.

¹³ UNAIDS, Report on the Global AIDS Epidemic 2012.

Table 5 Top five causes of death and trend in share of mortality in four focus countries, 2010 (measured in years of life lost – YLL)

Country	Cause of death		% of total YLL	% change in YLL 1990-2010
Indonesia	Stroke	NCD	11.8	76
	Tuberculosis	CMNN	10.6	-6
	Road injury	injuries	6.0	35
	Diarrheal diseases	CMNN	5.5	-42
	Ischaemic heart disease	NCD	5.2	86
Cambodia	Lower respiratory infection	CMNN	10.1	-61
	Ischaemic heart disease	NCD	7.4	80
	Stroke	NCD	6.3	63
	Preterm birth complications	CMNN	6.0	-32
	Congenital abnormalities	NCD	4.6	-41
PNG	Lower respiratory infection	CMNN	16.3	-21
	Diabetes	NCD	4.7	121
	Diarrheal diseases	CMNN	4.1	-38
	Tuberculosis	CMNN	3.3	11
	HIV/AIDS	CMNN	2.9	2,791
Fiji	Ischaemic heart disease	NCD	16.2	66
	Diabetes	NCD	11.0	265
	Stroke	NCD	5.8	-45
	Lower respiratory infection	CMNN	5.6	-28
	Preterm birth complications	CMNN	4.4	-18

Legend: YLL: years of life lost, takes into account age at death.

■ CMNN: communicable, maternal, neonatal and nutritional; ■ NCD: non-communicable diseases; ■ : injuries.

Source: Global Burden of Disease 2010, IHME 2013.

2.4 Implications for health systems

Health care systems in the region are currently configured to respond to communicable and acute conditions. Continuing socioeconomic, demographic and epidemiological changes are increasing and diversifying the demand for health care. Combined with changing expectations of increasingly affluent populations, and the changing medical technologies available, this will require a major overhaul of current systems.

The region's care systems are as diverse as its countries, and many have fragmented financing and service delivery systems. The public sector offers inadequate quality and quantity of services and in some instances has 'corporatised' some facilities, making them semi-independent. NGOs and an unregulated (but sometimes franchised and efficient) private sector play major roles in many countries. This fragmentation is not conducive to the more 'joined-up' approach that is needed to prevent and treat chronic conditions, common to NCDs. In addition, integrated information systems that sit across the different providers of health services will be needed if any new infectious diseases rapidly emerge.

Also, older populations will face longer periods of illness with higher costs of care. While data is lacking from the Asia Pacific, US evidence shows that patients aged 65-74 cost between three and four and a half times as much to treat per year than those aged 35-44.¹⁴ UK evidence indicates that those over 65 years cost the NHS annually almost twice the level of those younger than this age.¹⁵

¹⁴ Quoted in Gottret P and Schieber, G (2006). Health financing revisited: a practitioner's guide. World Bank.

¹⁵ "The ageing population" UK Parliament briefing, 2010. www.parliament.uk/business/publications/research/key-issues-for-the-new-parliament/value-for-money-in-public-services/the-ageing-population/

As a very approximate modelling exercise for the four focus countries, the following assumptions are made:

- Average per capita health care costs continue to increase from 2012 onwards at the same rate as they did during 2001-2011.
- Individuals over 65 years of age require 1.8 times the annual health care costs of those under that age throughout the period; (a conservative estimate based on the US and UK data above).
- Demographic change occurs in each country between 2011 and 2041 as forecast by the US Census.

This delivers the following forecasts of how much each country would need to spend annually (in 2011 \$s) on its over-65 population during selected years up until 2041 (Table 6):

Table 6 Forecasts of annual spending on citizens aged over 65 years

	% of population over 65 years		Health spend per capita over 65s		Estimated total health spending required for population over 65 years			
	2011 %	2041 %	2011 \$	2041 \$	2011 \$m	2021 \$m	2031 \$m	2041 \$m
Indonesia	6.3%	15.6%	163	13,837	2,460	15,600	101,935	642,067
Cambodia	3.8%	9.0%	89	719	48	144	476	1,358
PNG	3.6%	8.6%	138	2,124	34	122	455	1,718
Fiji	5.2%	13.8%	290	2,332	13	42	128	322

Source: Author's calculations; WHO NHA data; US Census. All sums are in constant \$(2011) and would require inflation adjustment to reach current \$ for the years in question.

These forecasts show **the very large increases** in funding that each focus country (and, by implication, all regional countries) will have to find **to deliver health services for the care of their older citizens**. While such modelling is necessarily speculative and approximate, it illustrates the scale of change in funding needs. For example, if recent growth rates in health spending continue, then medical costs for the elderly would rise from 11% to 27% of expected health expenditure in Indonesia. Note also, that demographic change is only one of the drivers of rising health expenditure, with increasing incomes and changing health technologies also exerting significant upward pressure.

3. Domestic financing of health care

3.1 Effect of structural changes

The socio-economic, demographic and epidemiological transformations presented in Section 2 all have implications for how domestic health care is paid for. Economic growth (provided a regional downturn is avoided) and 'demographic windows' offer the chance to expand public health funding further in many countries of the region, covering the bulk of the Asia Pacific population. But the transitory nature of the 'window' means that what appears currently sustainable may not remain so. Over the medium term, we can expect to see both SHI- and tax-funded pooling initiatives substituting out-of-pocket (OOP) finance in most countries, though not necessarily in fragile states or in all Pacific Island nations. Where these public policies omit targeted subsidies for the poor, falling national OOP rates may conceal a relatively worsening situation for poor and vulnerable groups.

3.2 Total health expenditure

Generally, per capita total **health spending**¹⁶ **rises with GDP** in the countries considered, usually growing at a faster rate than GDP.¹⁷ In all but two of the countries (Laos \$37 per capita and Myanmar \$23 per capita), spending is above the \$49-54 per capita amount estimated to be necessary to deliver the

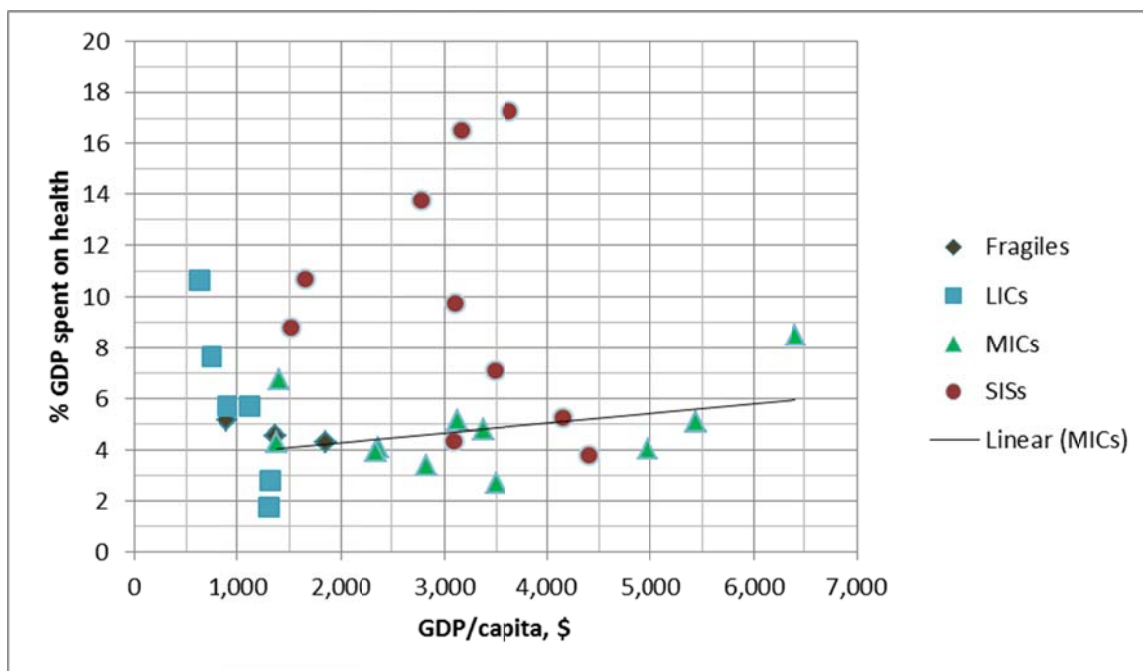
¹⁶ This includes external funding.

¹⁷ OECD (2012) Health at a Glance Asia/Pacific 2012. Although income elasticity is currently thought to be less than one; so advances in medical technology and other factors also play a role.

MDGs.¹⁸ A study of seven Pacific Island states, including Fiji and PNG¹⁹ showed that higher health spend was well correlated with lower infant and under-5 mortality and with lower crude death rates.

The four categories of our study show different relationships between GDP and the proportion of that GDP which is spent on health (Figure 3). Only the MICs show the relationship considered internationally typical, with the proportion of national income going to health increasing as the country becomes richer. The lack of this pattern within the other categories may be due to high levels of external funding. The unusually high shares of GDP going on health in some island states reflect in part what high cost environments these can be in which to operate.

Figure 3 Health care spending and GDP on per capita basis, Asia-Pacific study countries



Source: World Bank; WHO. Note: data includes external funding.

3.3 Public sector health care expenditure

There is currently significant reform activity within public sector health care finance across the region. Much of this is driven by a wide-ranging **goal to attain effective universal health coverage (UHC)**,²⁰ recently saluted by WHO’s Director-General as “the single most powerful concept that public health has to offer”.²¹ Predominant reliance on public financing is essential for UHC in the context of the countries in this study. It has also been shown that public spending on health is an important contributor to better average health outcomes (Bokhari, 2007) and also less unequally distributed ones (Gupta et al 2001).

But in many of the most populous countries in the region, the public health sector²² is expanding from a small base. This is in part because the public sector generally is limited in these countries. In the focus

¹⁸ Taskforce on Innovative International Financing for Health Systems (2009). Constraints to scaling up and costs. Working Group 1 Report. Though note that the WHO 2010-15 Asia-Pacific Health Financing Strategy (2009) calls for at least 4% of GDP to go towards health, which around a third of the regional countries fail to achieve.

¹⁹ Gani, A (2009) Health care financing and health outcomes in Pacific Island countries. Health Policy and Planning 24:72–81. Over 1990-2002, a 10% rise in public health spending meant a 7% decline in infant mortality. PNG’s 2007 Public Expenditure Review found that it was only spending 21% of what was needed for health.

²⁰ The WHO defines UHC as ‘to ensure that all people obtain the health services they need without suffering financial hardship when paying for them’ (www.who.int/universal_health_coverage/en/index.html).

²¹ Chan M. (2012) Best days for public health are ahead of us, says WHO Director-General. Address to WHA66.

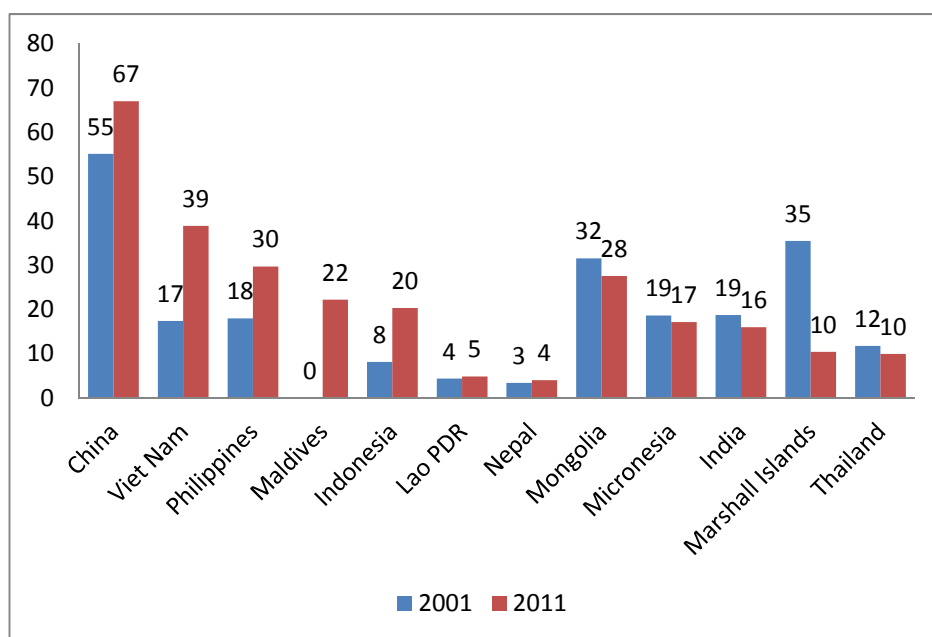
²² While this data offers insights on the development of the health sector financing in the Asia Pacific region, a note of caution is warranted. Many new organisational forms are evident, some of which are hard to classify, e.g. ‘corporatised’ profit-seeking public hospitals; extensive public use of user fees; growing medical tourism. There is

countries for instance, it varies between 17% and 36% of GDP (compared with many EU countries above 40%²³). The share of government expenditure devoted to health is more consistent across the region (8%-10%), apart from India, which allocates 4% of all government spending to health, and Samoa which allocates 20%.

Finances for public sector health spending can be raised either via **tax-funding** or through **SHI**, in which premiums are paid by/for members and the provision and purchase of care are separate. Experience in the Asia Pacific region suggests that **either can work as a basis for universal coverage**, though effective use **of targeted subsidies** for the poor and informal sector is vital (as shown in Indonesia, Cambodia and, especially, Thailand).

Most countries in the region rely mainly on tax-financing, but some (generally MICs) have a significant SHI element. The majority of the SHI schemes are expanding, though the SHI share of government health spending in the region remains smaller than the global MIC and high income country averages,²⁴ due to smaller formal sectors (comprising only 15% of the population in Indonesia for example) and slimmer benefit packages. The share from taxation and private funding are conversely relatively larger than international averages. Figure 4 shows the extent and trends in public funding that is channeled through SHI, with expansion especially in the MICs that currently have significant income to finance this (see section 2, above). A recent rapid rollout of SHI has taken place in India, where the national scheme RSBY reached 142 million below poverty line citizens between its 2008 launch and 2012.²⁵

Figure 4 Share of government health spending that is via social insurance, 2001 and 2011



Source: WHO NHA data. Note that SHI expenditure may be rising in absolute terms even as it declines as share of government spending, and that national classifications of funding may differ.

Public health care financing can best be analysed by looking at three elements: the risk pools involved; benefit packages offered; and the purchase of care. Decentralization is also relevant in the regional context (see Box 1).

often an attempt to retain public control, but use the best practice of private sector: such as performance-oriented organisations, incentives, exposure to market forces.

²³ OECD Revenue Statistics. <http://stats.oecd.org/Index.aspx?QueryId=21699>

²⁴ WHO Statistical Information System (WHOSIS).

²⁵ Lagomarsino (2012), cit.

Box 1 Key elements of health financing

Risk pools. SHI has proven able to boost utilization of services and financial protection in countries of the region,²⁶ but it will not necessarily contribute to UHC if it fragments the population into multiple pools, separating out, for example, the formally employed from other groups. Equitable access to care and financial protection (from potential catastrophic costs) requires pooling the whole population together so as to distribute resources, in some cases as an explicit subsidy, to those with greatest healthcare need.

Single SHI pools tend to be politically more sustainable in their funding as well as benefitting from economies of scale. Indonesia, Vietnam and the Philippines²⁷ are three major SHI systems which have moved to unified risk pooling, in place of fragmented coverage.

Most countries with a significant subsidy to cover the poorest are increasingly using tax for this (e.g. Indonesia, Philippines, India, Vietnam). The Philippines also tries to collect voluntary premiums from households though difficulties in collection limit revenue yield.

Benefit packages. Genuine **social health protection, however funded** requires a relatively comprehensive guaranteed health care package. Tax-funded benefit packages are usually not explicit about what is included, though resource constraints often mean that the services which are available are limited, or accessible only through user fees. SHI benefit packages in the region are in flux, but are generally becoming more comprehensive and unified. In Vietnam for instance there is a single national package; in the Philippines a comprehensive inpatient package for the poor is gradually being extended to primary care while Indonesia is in the process of merging several previously separate packages. This is appropriate given the rise of NCDs, which are often excluded from less comprehensive inpatient-only packages.

Purchasing. All SHI systems have separate purchasing organizations that buy care. Vietnam's SHI purchases services from public providers; India's RSBY scheme uses private insurers and mainly private hospitals for fully subsidized in-patient care to poor members; Indonesia and the Philippines do so from both public and private providers. This is 'demand side', in that it depends on the service being demanded or a member being enrolled with a facility; the extent of competition and choice varies, but this form of purchasing is on the increase. The payment format is gradually shifting from fee-for-service towards capitation (Thailand) and per-case payments (Vietnam), which both reduce fraud and contain cost, so purchasing effectiveness and sophistication is improving in the region. But quality assurance remains a challenge. At the same time, most SHI systems in the region also have separate supply-side tax allocations to public providers.

Decentralization. Another important issue in the public sector has been decentralization, which has weakened tax-funded health care in several countries (e.g. in PNG and the Philippines), with responsibilities becoming unclear and financing capacity being reduced. This can produce sub-national inequality, which countries are trying to address through reforms in resource allocation.

3.4 Private health spending

Private spending dominates the health sector in just ten of the thirty regional countries. But these ten include all of the LICs and larger MICs including India, Indonesia, Vietnam, and Philippines, but not China which has reduced private spending to just under half of total spending in recent years. So, **more Asian-Pacific health care is funded privately than publicly.**

The four categories of countries show very different public-private profiles of health spending over the last decade, with a slight shift away from the private sector in the LICs and MICs from a relatively high level. Conversely there has been a shift the other way in the other two categories, especially the fragile states, from low to somewhat higher levels of private health spending (see Table 7). Each of the four focus countries shows a private share of health spending that is close to the average for its category.

²⁶ Spaan E et al. (2012). The impact of health insurance in Africa and Asia: a systematic review. WHO Bulletin, 90:685–692.

²⁷ Covering 63%, 42% and 76% of their populations (Lagomarsino, 2012, cit.).

Table 7 Private share of health spending

	2001	2011	Change in % pts
Average MIC	50%	47%	-3%
Average LIC	74%	70%	-4%
Average Fragile State	22%	36%	+14%
Average SIS	13%	14%	+1%

Source: WHO NHA data. In accordance with NHA convention, external funding is included in both public and private finance. Note that averages are across countries, not population-weighted.

A key question is how much of this private care is financed collectively through (privately-funded) insurance and how much through OOP payments. The former is more efficient²⁸ and equitable,²⁹ though less so than publicly pooled funding. But **OOP dominates private health spending in the region**, except in the fragile states.³⁰ In our focus countries: 75% of private health spending is OOP in Indonesia; 64% in Cambodia; 66% in Fiji; but only 28% in PNG. OOP's share of private health spending is falling in more countries of the region than rising, but it rose in at least seven countries during 2001-2011, so there is no clear trend. However, throughout the region **reducing the overall share of OOP in health funding is a policy priority**. Because of its negative impact on equity and efficiency, WHO recommends OOP no higher than 20% of total health spend.³¹ In the LICs included in this study however, it is at an average of 57% and among MICs is on average 39%.³² OOP remains high due to limited enrolment in insurance, narrow benefit packages of the insurance schemes that are available,³³ official and unofficial charges by public providers (copayments),³⁴ limited access to subsidised public services, and indirect costs, such as transport.

Where governments have the fiscal capacity to expand SHI as a source of funds, OOP tends to retreat (Table 8), although the opposite movement in the Philippines points to the impact of high copayments and a slim benefit package within SHI. Tax (and donor) funded expansion of coverage can also reduce OOP, as in Cambodia, where Health Equity Funds have removed two thirds of the poor population from the need to pay copayments.³⁵ This helped reduce OOPs from 62% of health spending in 2001 to 40% in 2011.

Table 8 The effect of major health reforms on OOP

Country (scheme)	% population enrolled*	Scope of benefits	OOP as % of THE, 2011	Change in OOP since reform (date)
Indonesia (SHI: BPJS)	63%	Comprehensive	38%	-2% (2004)
Philippines (SHI: PhilHealth)	76%	In-patient, with out-patient for poor	54%	+4% (1995)
Vietnam (SHI: VSS)	42%	Comprehensive	58%	-6% (2002)
India (SHI: RSBY)	8%	In patient, pilot out-patient	61%	-2% (2008)
Thailand (SHI/tax: UC)	95%	Comprehensive	14%	-19% (2001)
Cambodia (tax/donor: HEFs)	17%	In patient, pilot out-patient	40%	-22% (2000)

Source: own calculations using NHA and Lagomarsino (2012) for enrollment and benefit data.

*2012 or most recent data.

²⁸ A 1% rise in share of health spend going to OOP associated with 2.2% rise in catastrophic health spend.

Tangcharoensathien V et al. (2011). Health-financing reforms in Southeast Asia: challenges in achieving universal coverage. *The Lancet* 377, 863-873.

²⁹ Kutzin J (2008) Health financing policy: a guide for decision-makers. WHO.

³⁰ Note that external private funds may be a major factor here.

³¹ WHO, World Health Report 2010. Health systems financing: the path to universal coverage. Note that the 2010-15 Asia-Pacific Health Financing Strategy suggests 30-40% as a limit, possibly in reaction to the low public share of health spending in the region.

³² Own calculations from country NHAs.

³³ While over 92% of China's population is covered by one of three social health insurance programs, the schemes pay for only about half of inpatient costs, with patients paying the rest. Winnie Chi-Man Yip et al. (2012) Early appraisal of China's huge and complex health reforms, *Lancet* 379, 833-842.

³⁴ Vietnam and the Philippines retain copayments; Indonesia, India and Thailand have officially abolished them.

³⁵ Tangcharoensathien et al. (2011), cit.

It is worth noting that some recorded private spending may in fact be external finance, and this can have a major effect on health outcomes. For example, remittances from New Zealand pay for much of the Cook Islands primary health care (PHC) (Gani). This may be part of the explanation of why only 4% of under-5 deaths there are from non-neonatal causes, compared with 93% in Nauru, where PHC is poor and there is a lack of remittance funding.

The following table sums up the main health care financing trends in the focus countries between 2001 and 2011. It shows significant expansion of per capita THE and government health spending in Indonesia, for example, where both have more than doubled, compared to PNG where they are virtually unchanged (last two rows). There would appear to be a close correlation between these trends and the macroeconomic growth discussed in Section 2. Faster growing economies are delivering more rapid growth in health spending and of the public sector share of health spending.

Table 9 Health care financing trends, 2001-2011 in focus countries

	Indonesia	Cambodia	Fiji	PNG
Total health expenditure / GDP	+	Static	+	-
Public sector share / Total health expenditure	+	+	-	-
Health share in all government spending	+	static	static	-
SHI share in government health spending	+	n/a	n/a	n/a
OOP share of private health spending	static	-	static	static
Change in per capita total health spend (ppp basis)	+ (2.1x)	+ (1.7x)	+ (1.7x)	(1.1x)
Change in per capita government health spend	+ (2.3x)	+ (2.7x)	+ (1.5x)	(1.0x)

Source: NHAs. Note: + = increase; - = decrease; static = relatively unchanged

Is spending efficient?

The countries of the Asia Pacific region do not simply face a question of raising sufficient funds for health; it is also critical that resources are used efficiently. Attention needs to be paid to 'allocative efficiency'. In many countries, for instance, health systems currently offer greater benefits to men than to women relative to health needs. Income-based, geographical, ethnic, generational and health status inequalities may also exist, especially given the continuing large role of OOP. Risk pooling is a key mechanism to ensure that resources reach those most in need. Adequate subsidies and financial protection are necessary to bring in the poor. 'Technical' efficiency involves a focus on reducing the input costs required to deliver the outputs of a quality health system. This includes bearing down on administrative costs (which can sometimes be high with SHI schemes). It also means development of efficient provider payment mechanisms, that encourage sufficient care (often lacking in tax-funded systems) but discourage unnecessary care ('supplier/provider induced demand' is common in SHI systems). Such mechanisms would represent a move away from the 'fee for service' approach still common in much of the region.³⁶

A key area for efficiency and quality is the rational use of medical technologies, including prescribing practices. Pharmaceuticals spending in the Asia Pacific is a greater (and faster increasing) share of health spend on average than is the case in OECD countries, at 30% (the average of 19 regional countries) compared to 16% in 2009,³⁷ sometimes due to the incentives contained in physician dispensing. In PNG the share was 51%. Expanding the use of generic rather than branded medicines, suppressing fakes and combating drug resistance due to over-prescribing are all desirable policies, alongside payment mechanisms that discourage over-prescription.

It is also likely that primary health care is inefficiently under-resourced. The Gani (2009) study of Pacific Island states found PHC funding to be especially effective, including having an impact on increased immunization and maternal education. Additional regional priorities are hospital reform, to increase the efficiency and quality of hospital care, and governance. Low spending on salaries (which comprise just 15% of total health spending in Cambodia for example) also create inefficiencies, such as absenteeism, low productivity and a search by staff for additional funding sources.

³⁶ Many positive examples exist, such as Thailand's capitation system or Bangladesh's vouchers for skilled birth attendants. The Filipino SHI system suffers much reduced efficiency due to use of 'fee for service'.

³⁷ OECD Health Data 2012.

Finally, NCDs increase the need for integration between primary and secondary care, yet may be omitted from some SHI benefit packages, which means the diseases are addressed in less efficient ways. NCDs are likely to be more financially debilitating and have more effect on health outcomes than acute in-patient conditions.³⁸ As NCDs and elderly populations increase, the health system must find a cost-effective balance between institutional and home-based care.³⁹

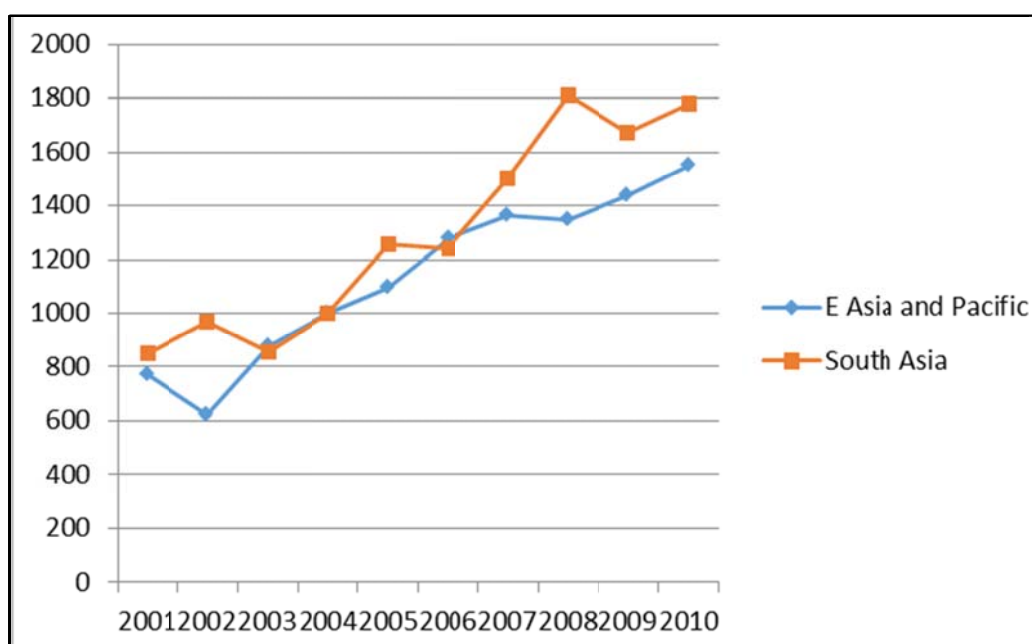
4. Donor financing trends in the Asia Pacific region

4.1 Where is external aid going?

Total aid flows

The decade to 2010 was one in which external development aid for health (DAH) in both the East Asia Pacific and South Asia regions expanded significantly from around \$800m to over \$1.5bn per year for each sub-region. This doubling in aid flows was remarkable, although slower than the growth in global aid to health, with the share of DAH used in East Asia and Pacific falling from over 9% to below 6%.⁴⁰ South Asia's share remained broadly constant (a slight decline from 6.7% to 6.3%). These figures are taken from a survey of disbursements of aid for health that covers a wide range of funding agencies.⁴¹

Figure 5 Trends in DAH, Asia-Pacific countries, 2001-2010, US\$



Source: IHME, Financing Global Health 2012. Note that both regions include a small number of countries not covered by this study.

Aid flows to health globally seem robust at their current level in the short term⁴², based on the data collected by OECD Development Assistance Committee (DAC) on planned DAH to the end of 2015 which shows constant global health funding, with small rises in bilateral funds balancing small declines in multilateral spending. This is despite the pressure on donor budgets from austerity measures and disappointing economic growth. Asia's share may continue to decline but this may be offset by rising support from non-DAC donors in the region (e.g. India and China). The volume of regional funding after 2015 is hard to predict but seems more likely to stabilise or decline than continue the 2000s trend of rapid growth. This is in response to pressure to reduce support to those Asian economies expanding much faster than donor countries, and policies to focus aid resources on low income countries.

³⁸ Kumar et al. (2011) Financing health care for all: challenges and opportunities. *Lancet* 377: 668–79.

³⁹ Langenbrunner J and A Somanathan (2011) Financing health care in East Asia and the Pacific: best practices and remaining challenges. The World Bank.

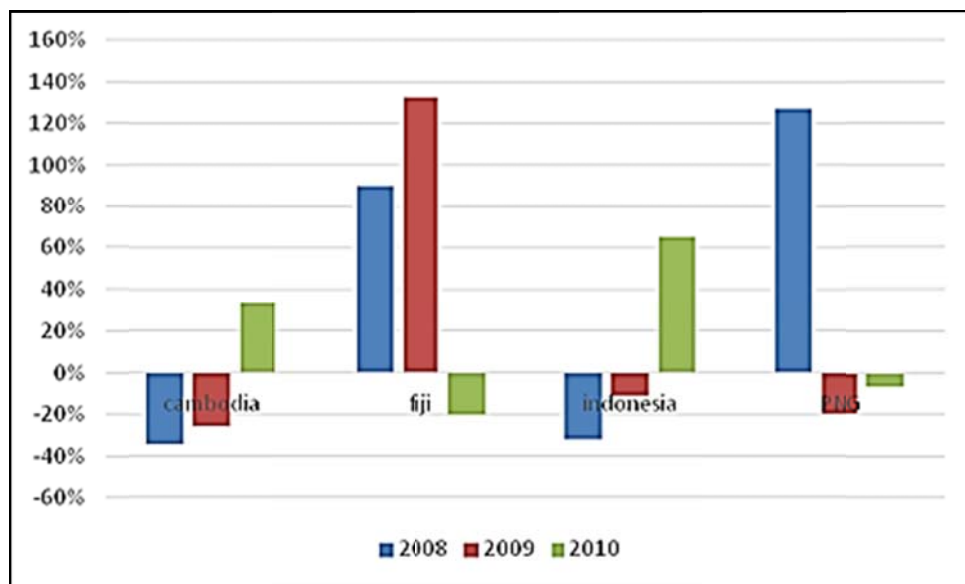
⁴⁰ IHME (2013) The Global Burden of Disease: generating evidence, guiding policy.

⁴¹ IHME (2012) Financing global health 2012: The end of the golden age? (Data includes funding from foundations.)

⁴² OECD (2013) Outlook on Aid: Survey on Donors' Forward Spending Plans 2012-15.

There continue to be important discrepancies between aid commitments and disbursements, which present problems for countries as they attempt to plan health sector activity. Figure 6 illustrates the problem for the four focus countries between 2008 and 2010. As can be seen, disbursement can easily be a third less or more than twice the size of the funds committed. This is a longstanding international problem.⁴³

Figure 6 Difference between DAH funds committed and disbursed, Focus countries, 2008-10



Source: WHO (2012) From Whom to Whom: Official Development Assistance for Health 2000-2010.

Recipient countries

Table 10 shows how DAH has increased to some countries (e.g. Cambodia) far more than to others (e.g. Fiji) over the decade to 2010 (WHO data not yet available beyond 2010). Per capita DAH varies across the region even more than is indicated by our Focus countries. It may be understandable that Cambodia receives 15 times the per capita DAH that Indonesia receives, given Indonesia’s greater internal per capita resources. But Cambodia also received more than seven times as much DAH on a per capita basis as Bangladesh, a fellow LIC with similar resources, in 2010. Highest of all in the region was the Solomon Islands at \$39.86 per capita in 2010, almost four times the level of Fiji.

The significant inequality in regional flows of DAH between countries is likely to be due to a range of factors such as domestic/international policy priorities and historical/colonial relationships. It also reflects the costs of providing services which are typically high in small island states, especially compared to costs in the large south Asian countries. However, it is clear that disease burden and national income levels are not as influential as might be expected.

Table 10 Development aid for health (DAH), focus countries

	DAH, 2000 (\$m)	DAH, 2010 (\$m)	% change	Per capita 2010 DAH (\$)	Largest donor
Cambodia	27	199	+637%	14.05	GF 30%
Fiji	8	9	+13%	10.82	Aus 56%
Indonesia	112	224	+100%	0.93	GF 39%
PNG	44	84	+91%	12.22	Aus 55%

Source: WHO (2012).

⁴³ Dodd, R and Lane, C (2010) Improving the long-term sustainability of health aid: are Global Health Partnerships leading the way. *Health Policy and Planning*, 25 (5): 363-371.

Aid dependency in the Asia Pacific region generally varies by category. External funding plays only a tiny part in the financing of health care in the MICs (average of 3% in 2011, according to National Health Accounts; 1% in Indonesia). In LICs it is 14% on average (24% in Cambodia). In fragile states the average is 29% (24% in PNG) whereas in the small island states it is at 26% (although only 9% in Fiji). These rates are significantly lower than several countries in Sub-Saharan Africa (e.g. Mozambique 70% in 2011).

4.2 Who are the main donors to the region?

The largest donors for health in the region are the multilaterals and the US, with Australia playing a critical role for the fragile and island states. The Global Fund to Fight AIDS, TB and Malaria (The Global Fund) is the largest donor to nine of the fifteen LICs and MICs in the region for which there was data for 2010, followed by the World Bank (in three of the remainder) and the US and UK (one each). Among the focus countries, the US still plays an important role in Cambodia, with UK aid declining; meanwhile Australian aid is increasing, making it an increasingly prominent bilateral partner. Australia is also the dominant bilateral donor in Fiji and PNG, as well as sharing an important role in Indonesia (though aid dependency there is very much lower). Note that the other bilateral donors are also the main funders of the global health partnerships, development banks and other multilateral agencies.

The following table shows the six largest aid recipients in the region by commitment (rather than disbursement), from OECD donors (2011 OECD data, which is only available for a limited range of countries). It shows diverse patterns of support, reflecting in part different eligibility policies of different agencies. Indonesia, Fiji and other higher income MICs have already reached income levels that mean they cannot access International Development Association (IDA) funds through the World Bank or GAVI funds, for example. This is also likely to affect India and Vietnam in the near future and eventually others in the region as they grow. The Global Fund is moving towards allocations based on income and disease burden, which is likely to result in a reallocation of funding within the region to the advantage of LICs.

Table 11 2011 data, health commitments to main regional recipient countries, \$m

	Bangladesh	India	Vietnam	Indonesia	Cambodia	China
IDA	554	152	35	0	0	0
GF	8	166	68	83	60	5
US	46	102	69	54	36	13
Germany	9	2	2	1	1	68
Japan	5	4	7	6	5	9
Australia	25	5	17	39	23	12
Canada	65	2	0	0	2	0
GAVI	32	14	18	0	7	0
UNFPA	6	14	4	5	4	2
S. Korea	1	0	25	0	5	0
Other DPs	93	78	58	7	22	52
Total by country	843	539	304	196	166	161

Source: OECD (2013) Asia: development aid at a glance 2013.

Non-traditional bilateral donors are of growing importance globally⁴⁴ and of particular importance in the Asia Pacific region, since it is within the sphere of influence of India, South Korea and, especially, China (see Box 2). Korea is, since 2010, a member of the OECD DAC, while the other two are not and so are under less obligation to report aid.

⁴⁴ While measurement is approximate, their total development assistance was estimated at \$10bn in 2009, more than double its level in 2005. Smith, K (2011) Non-DAC donors and humanitarian aid: shifting structures, changing trends.

Box 2 Key characteristics of DAH from Korea, India and China**Korea**

OECD data shows DAH to Asia and Oceania from Korea increasing from \$89m in 2007 to \$105m in 2011. Continued economic growth should allow for meeting a stated intention of more than doubling the proportion of GDP going to aid from 0.12% in 2011 to 0.25% by 2015. Vietnam, Mongolia and Indonesia account for around 20% of funding.

India

Indian ODA has grown strongly from \$443m in 2004 to \$730m in 2010.⁴⁵ The amount for health was estimated at \$100m between 2009 and 2011, through bilateral channels to 20 countries in South and South East Asia and Africa.⁴⁶ Nepal and Bhutan are historically the largest recipients of Indian ODA. As well as infrastructure, India provides significant aid in the form of training, information technology and medical supplies.⁴⁷ The country also remained the largest recipient of DAH between 2008 and 2010.⁴⁸

China

Chinese development assistance in total was estimated at \$3.9bn in 2010 (health assistance data not available) channelled mainly bilaterally with limited support to multilaterals (WHO, UNICEF and GFs). Much Chinese assistance is loans for infrastructure construction in return for resources.⁴⁹ The publication of a Chinese government White Paper on ODA in 2011 is an important step forward in the aid transparency agenda and for the management of China's aid. The majority of Chinese health aid is in the form of infrastructure investment, including building hospitals and supplying them with equipment and drugs. Additional contributions have been to regional public health preparedness; disease surveillance particularly around influenza and emerging infectious diseases; medical teams; malaria support; family planning; research and development.

In some recipient countries, at times, non-traditional donors may be more important than traditional donors. For instance in 2007, it was estimated that almost 70% of external humanitarian aid to Bangladesh was from non-DAC sources.⁵⁰ Private sector philanthropy and remittances are also an important and often overlooked form of development assistance. Looking at external flows overall (rather than just for health) in 2010, OECD donor countries provided an estimated \$128bn, compared to \$190bn in remittances and \$56bn in private philanthropy.⁵¹ The Bill and Melinda Gates Foundation has provided substantial DAH, particularly to India.

4.3 How are donor funds for health used?**Allocation of health aid**

A dominant trend in allocation has been the continued focus of external funding on communicable diseases, including in support of MDG 6 (on HIV, malaria and other diseases). Figure 7 shows how the share of DAH provided to MDG 6 has risen over time in the focus countries, although three of the four show declines in 2010 compared to the previous year. For example, in large part due to the resources channelled through the Global Fund, the communicable diseases covered by MDG 6 accounted for 47% of all aid disbursements in 2010 in Cambodia, compared to 38% in 2000, and the majority was spent on HIV/AIDS.

⁴⁵ <http://www.oecd.org/dac/stats/statisticsonresourceflowstodevelopingcountries.htm>

⁴⁶ Global Health Strategies Initiative (2012). Shifting paradigm: how BRICS are reshaping global development.

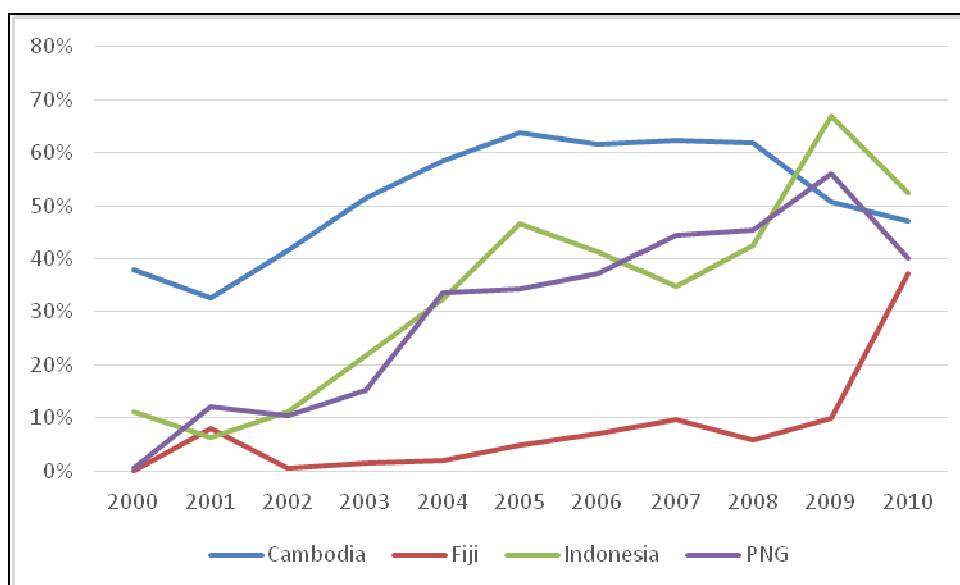
⁴⁷ However Indian ODA is difficult to analyse, as neither the Indian Ministry of External Affairs nor the Ministry of Finance publishes records of flows or their use. Agrawal (2007) Emerging donors in international development assistance: the India case.

⁴⁸ IHME (2012).

⁴⁹ Smith (2011) cit.

⁵⁰ Smith (2011) cit.

⁵¹ Hudson Institute (2012). The Index of Global Philanthropy and Remittances.

Figure 7 Share of total DAH allocated to meet MDG-6, Focus countries, 2000-10

Source: WHO (2012)

Conversely, there has been limited external funding available for family planning and reproductive health and non-communicable diseases. Table 12 shows the breakdown of ODA disbursements in the focus countries in 2010. Health policy, administration and management accounted for 60% and 49% of DAH in the Solomon Islands and Fiji respectively. But the small share of ODA for 'Policy, administrative, management' in all but small island states may also be considered inadequate, given the substantial needs in this area discussed in Section 3.

Table 12 Allocations of ODA by purpose, by country category, 2010 disbursements

	Health policy, administrative, management	HIV, TB, malaria (MDG 6)	Other health purposes	Reproductive health, family planning
Fragile states	23%	21%	41%	14%
LICs	13%	41%	33%	12%
MICs	21%	48%	22%	9%
Island states	54%	33%	13%	0%
Asia Pacific region	22%	41%	27%	10%

Source: WHO (2012)

Comparing this to the epidemiological transition discussed earlier in Section 2, demonstrates a lack of fit with the region's burden of disease. In Indonesia in 2010 for example 52% of DAH was related directly to MDG 6, but two years earlier less than 28% of their cause of death was infectious diseases, and this on a declining trend. Similarly, external funding for HIV in the Pacific has been increasing for the last decade with large amounts provided by Australia (through for example the Pacific Regional HIV Programme and HIV programmes in PNG and Indonesia) and the Global Fund.⁵² However the health burden due to HIV is far lower than the growing NCD disease burden, yet the NCD response has received much less earmarked funding from donor partners. This is consistent with the global pattern of very low allocation of DAH for NCDs: of global DAH disbursed in 2010, only \$185m, less than 1%, was targeted for NCDs.⁵³ Earmarked support for NCDs is emerging in the region, including AusAID's regional NCD program in the Pacific; in addition, some of the funding for health policy and systems can be allocated to strengthen policy and services for NCDs.

⁵² Negin J and H Robinson (2010). Funding for HIV and non-communicable diseases: implications for priority setting in the Pacific region. Nossal Institute for Global Health. The study also notes US allocations for US-affiliated territories/countries (excluded from this paper).

⁵³ IHME (2012) Financing Global Health, cit.

Aid modalities

Sector-wide Approaches (SWAp) for health have been applied in several countries in Asia Pacific, notably Nepal, Bangladesh, Cambodia and Solomon Islands. Common funds also exist in PNG, Timor-Leste and Myanmar. Issues include whether countries' public financial management systems are strong enough to enable support to be channelled where it is intended, and how to strengthen these systems; the continuing preferences of some significant donors to use individual channels of funding to be able to identify use of their funds and national visibility; and the extent to which SWAps genuinely function as intended. Informants for this paper indicated that SWAps have contributed to getting donors round the table to discuss health sector strategies, but have had less traction in terms of using pooled funds.

In other countries and in parallel with sector support, donors support a range of aid modalities including projects with government, support to NGOs and technical assistance. As economies grow and the significance of aid funding declines, this raises questions around the strategy for its use. Should aid be more focused on technical support for example, for policy development or should aid continue to fund service delivery targeted to under-served groups? Some donors are already increasing the focus of their support – for example, Global Fund policy requires Upper MICs to target any new funds towards most at risk populations and high impact interventions, while Lower MICs are expected to target at least half their support in this way.

Strategic engagement of partners

The changing range and priorities of development partners operating in the region is changing the nature of donor relationships including the ways in which aid is or will be delivered (the implications of this for existing donors are discussed in Section 5). For example, China has started to develop relationships with other agencies. A number of countries have undertaken joint assessment of aid projects with Chinese counterparts; China signed a trilateral cooperation project with New Zealand in the Cook Islands in 2012; and most recently, China and Australia developed a Memorandum of Understanding which paves the way for delivering aid together in the region and enables joint cooperation on regional health issues including malaria and HIV/AIDS.

These agreements mark a departure from the traditional 'donor-recipient' relationship. Although financial aid will still be required in some countries, delivering technical assistance based on regional knowledge, and experience from other fast growing MICs, is likely to play an increasingly prominent role in the way partners engage in the region.

5. Conclusions: what does this mean for partners and donors?

In a large, diverse region, there are a range of both domestic and external financing issues which must be addressed. Key issues for donors and other development partners include the following:

5.1 Tackling policy issues

As countries become increasingly able to finance their own health services and systems, the role of donors will need to adapt. In the larger low and middle income countries where DAH is small compared to health spending, donors may want to consider focusing more on technical support than financial aid. Some donors and agencies are already moving their support in this direction.

It is likely that technical advice will need to focus on the complex policy challenges that MIC and LIC governments face as they move from the delivery of basic services to building a strong functioning health system with a sustainable health financing and coverage model. The speed of epidemiological, demographic and socioeconomic change in these countries; the novelty (in the national context) of many of the health sector reforms being attempted; the attendant complexities in such reforms; and policy-making/managerial capacity limits all underline the need for technical capacity and assistance.

If universal health coverage and building resilient health systems are to be at the centre of donor agencies', strategies this will mean those agencies having the appropriate technical capacity and access to the right technical expertise to support countries. It will also involve a move away from a focus on specific diseases and towards building health systems able to adapt to changing disease burdens and meeting the needs particularly of marginalised populations.

The countries need to design, pilot and roll-out new policies adapted to country contexts. Note that 'tax-funded' and 'SHI' are labels that may obscure more than they illuminate. What matters is to look at the funding sources, pooling arrangements, purchasing methods, policies on benefits and cost-sharing. Any approach must address these functions and policy choices. This could include developing a coordinated mix of the various mechanisms, such as SHI combined with significant tax-funding; social care integration; home care; cash transfers; and health equity funds. For instance, SHI may significantly boost utilisation of care, reduce OOP, and improve health status; but studies including in China and Vietnam show this will not occur automatically,⁵⁴ so it needs to be designed with care.

For SHI, particular expertise is needed to assist with the enrolment of, and safety nets for the poor, the vulnerable, and informal sector workers. Provider reimbursement and quality assurance are also key challenges in SHI design. Technical assistance could contribute to facilitate rational use of medicines, and the integration of PHC with other care levels. In some countries, capacity remains the most serious bottleneck. This has implications for the design of reforms as well as methods of providing technical assistance. The private sector both finances most health care in the region and accounts for much of provision, yet government regulation is weak. The role of private providers needs to be addressed within the design of expanding SHI/social protection systems.

Sustainability is also an important question, whether due to reliance on external funds, poor incentive structures or impending demographic change. Increasing spending cannot be an unquestioned objective. Even strong policy examples such as that of Thailand are liable to concern on sustainability (due to its large benefit package).

The risks in respect of technical assistance to policy include: a) that donors may shrink from offering policy-related advice; b) that they do so in an unconsidered and uncoordinated manner, and with inadequate understanding of the country context and the political processes inherent in policy reforms; c) countries may not want policy advice from sources that are seen as having a particular agenda or system to promote; or d) that countries do not have the capacity to absorb the TA provided (this can be a particular challenge in the Pacific). Key questions for DAC donors are how relevant is their technical support and experience to address the challenges facing in the region, and how can they convince countries that their lessons learned (e.g. from developing their own health system) are useful and applicable.

5.2 Making use of evidence within the region

The region is a great laboratory for bold reform policies (more so than the donor countries) and much can be learnt from what other countries have done. There is a great risk that nationally-focused aid will miss useful evidence and lead to attempts to 'reinvent many wheels'.

Thailand, for example, is in many ways a beacon for how publicly-funded care can work: a rapidly rolled out universal system, no copayments, a purchaser-provider split, capitation payment, all showing that tax-finance can work with SHI to deliver more equity in access. As in Indonesia and the Philippines, success has involved broadening risk pools; using tax funds to subsidise target populations; and purchasing services with demand-side financing mechanisms (e.g. capitation) that allow recipients to overcome financial barriers and exert purchasing power.

There is also growing evidence on technological innovations, such as use of smartcards for over 140 million Indian members of the RSBY for patient verification and provider reimbursement and Phil Health's use of payment by mobile phone. But technological challenges remain with identification of the poor, provider reimbursement and quality assurance needs, all of which require continuous use of data generated by the health system.

Improved evidence and information is needed for policy-making, as well as for financiers and providers of care. Monitoring and evaluation of policy changes is also often lacking. As part of this, governments could use common, comparable standards for measuring key outputs and outcomes of UHC reforms – to guide midcourse policy corrections, and improve implementation, e.g. in relation to fairness of resource distribution, delivery of services, change to impoverishment due to health costs.

⁵⁴ Archaya, et al (2013). The impact of health insurance schemes for the informal sector in low- and middle-income countries. World Bank Policy Research Paper 6324.

Donors, especially those from the region, should have greater focus on strengthening regionally owned technical and institutional networks to provide knowledge generation and cooperation, and to be able to respond to the rapidly changing regional context. Some donors and agencies are already providing funding for regional institutions. Continuing and scaling up support for regional lesson learning and cross-country exchange of experience could facilitate national efforts to address the policy challenges. A positive example is the Asia Pacific Health Systems Observatory.

5.3 Disease focus

Where DAH is related to specific diseases, it still has some way to go to become well aligned with the evolving burden of disease. Maternal, neonatal and primary health more generally all tend to be under-funded relative to their importance in potential health benefits. The allocation for NCDs is extremely low relative to their growing importance as a source of ill health and may be an area where donors will want to place more emphasis in the future. Governance too is still often neglected, though some donors including AusAID and DFID are addressing this.

5.4 Regional, national or sub-national level?

In many instances assistance to national-level is appropriate, in which case donor coordination will be an important issue with each donor offering TA in accordance with their comparative advantage. Indeed, the appropriateness of the TA offered may determine how much influence over policy donors can exert. For some TA, however, regional exchange will be a more efficient way of addressing common policy issues, suggesting that donor support to the respective WHO region may be a better approach. This includes common disease threats, as well as opportunities to share evidence of successful policy innovation (see above).

Decentralisation is also an important policy trend in many countries in the region, including Indonesia, PNG and the Philippines. Where this is the case, this demands more constructive donor engagement with regional and local government, where it has responsibility for health policy or health service delivery. In many instances it will be more efficient for donors to help various sub-national entities when those entities can organise together for the purposes of DAH and sharing experiences and knowledge.

5.5 Poor countries or poor people?

The vast bulk of the region's population (almost 92%) live in the MICs, but this is not just a middle-income population; it is also where the bulk of the region's poor people reside. Within the MICs, aid now accounts for only a tiny fraction of health expenditure (3%, and falling), so DAH funding is of limited relevance. Such funds could be earmarked for the poor and under-served populations of the MICs, but it is increasingly challenging politically in a number of donor countries to continue to aid ever-wealthier MICs. Aid targeted to service delivery to these groups would offer minimal leverage over national policy and MICs should increasingly have the funds to address the health needs of their poor and under-served populations themselves should they choose to do so. Where governments continue to neglect the needs of marginalised groups, donors may still decide to step in to aid them, when attempts at policy influence have been unsuccessful.

Given the rapid growth evident in the LICs, and the exemplary influence of the nearby MICs over such countries, donors could increasingly find a similar situation occurs in these countries too. The difference is likely to be one of degree of donor influence over the policy agenda, given the several orders of magnitude greater aid dependency in such countries.

Within donor countries themselves, a debate may be warranted on how far the focus of aid should be low income countries or poor and under-served populations within countries, though the countries will themselves have a role in the debate. This issue in turn links to the possibility to influence a consensus on how to distribute resources across poor/non-poor/elite groups. Health care financing reform, especially SHI with its focus on inter-group transfers and subsidies, offers an excellent opportunity to do just this. Within donor agencies, these evolving country needs may require changes to staff and contractors' skill sets, strengthening mentoring, capacity building and partnership skills in addition to improving existing technical knowledge.⁵⁵

⁵⁵ Negin, J (2013) The future of aid: not all about the money? <http://devpolicy.org/>

In the case of the fragile states, forecast economic growth (e.g. in PNG) may soon transfer these countries into similar situations. DAH may need to remain closely tied to other assistance in order to address fragility and governance issues. For the Island States, the situation is likely to be quite different, with limited economic growth implying that donors will have to continue an operational financing involvement in addition to TA on policy issues. In short, donors may need to continue to underwrite many Pacific Island health sectors for the long term, with little prospect of transition to a self-financed health system.

5.6 Funding levels and modalities

As the analysis in Section 2 shows, the region's demographic and epidemiological transitions over the longer term will mean that health sector funding needs to grow significantly. These are likely to be met given continued economic growth, but the challenge will be to ensure the growth in health funding is used efficiently and with improving equity. This may coincide with an effect of graduation to MIC/UMIC status, when IDA grants are no longer available, other funding agencies may reduce or end their support and countries may decide not to allocate development bank loans to the health sector. This may slow down the medium term situation of increasing coverage of financing mechanisms (with an expanding public sector share of health care funding) in the region's MICs and LICs.

In the meantime, an evolving cast of donors must find as complementary a way of working together as is feasible. This is likely to mean multiple modalities between donors, ideally driven by comparative advantage, and also different situations in different categories of country. In many Island States (possibly also the current fragile ones), Australia is likely to continue as dominant donor, to an extent influenced by as yet unknown decisions on funding allocation at the Global Fund. Steady pressure and diplomacy will be needed to improve the current level of donor coordination and evaluation of aid and its effectiveness.

5.7 Preparing for change

The transition to an era of lower dependence on donors and development bank funding for health will need to be carefully planned to avoid disruption to service delivery or neglect of some of the underserved groups currently benefitting from external support. The requirement for counterpart funding (including recently by the Global Fund) is one approach that can help to ensure budget lines are in place, although experience suggests it will not necessarily lead to sustained funding once support ends. Joint planning and strong partnerships at country level to coordinate changes in support and allow particular partners to phase in or out could minimise disruption to programmes. It may also be necessary to plan for reductions in some programmes that cannot be continued when external support ends, if they are not prioritised by other partners or national funding agencies.

Donors could consider contingency planning, for example making allowance for four main scenarios:

1. A continuation of the current situation of generally improving coverage, but with several inefficiencies and looming challenges;
2. A marked reduction in funding from some existing donors leading to short term gaps in key programmes;
3. The possibility of a regional economic downturn, something predicted in 2008 but as yet averted; and
4. A major new epidemiological development, such as an emerging infectious disease, on top of the current NCD epidemic.

Ultimately donors will need to adapt to maximise the impact of DAH in this rapidly changing and diverse sub-region. For regional donors, a conceptual shift is required which takes them beyond traditional forms of aid financing to more innovative approaches, such as development cooperation based on areas of mutual self-interest between a range of countries, mutual lesson learning and knowledge brokering.

About the authors

Dan Whitaker is an independent consultant on health financing. **Veronica Walford** is an independent consultant working on health systems and financing. Both Dan and Veronica have a long standing relationship with HLSP. **Ben David** is Principal Sector Specialist, Health, at AusAID. He contributed to this paper in a personal capacity.